Notice of Meeting Public Document Pack

Oxfordshire Joint Health Overview & Scrutiny Committee

Friday, 30 September 2016 at 10.00 am

Rooms 1&2 - County Hall, New Road, Oxford OX1 1ND

Membership

Chairman - Councillor Yvonne Constance OBE
Deputy Chairman - District Councillor Nigel Champken-Woods

Councillors:	Kevin Bulmer	Tim Hallchurch MBE	Alison Rooke
	Surinder Dhesi	Laura Price	Les Sibley
District Councillors:	Jane Doughty	Susanna Pressel	
	Monica Lovatt	Vacancy	
Co-optees:	Moira Logie	Dr Keith Ruddle	Mrs A. Wilkinson

Notes: ***Date of next meeting:*** *17 November 2016*

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Yvonne Constance OBE Email: *yvonne.constance@oxfordshire.gov.uk*
Policy & Performance Officer	-	*Katie Read Tel: 07584 909530* *Email: Katie.read@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: 07393 001089* *Email: julie.dean@oxfordshire.gov.uk*

Peter G. Clark
County Director

September 2016

About the Oxfordshire Joint Health Overview & Scrutiny Committee

The Joint Committee is made up of 15 members. Twelve of them are Councillors, seven from Oxfordshire County Council, and one from each of the District Councils – Cherwell, West Oxfordshire, Oxford City, Vale of White Horse, and South Oxfordshire. Three people can be co-opted to the Joint Committee to bring a community perspective. It is administered by the County Council. Unlike other local authority Scrutiny Committees, the work of the Health Scrutiny Committee involves looking 'outwards' and across agencies. Its focus is on health, and while its main interest is likely to be the NHS, it may also look at services provided by local councils which have an impact on health.

About Health Scrutiny

Health Scrutiny is about:

- Providing a challenge to the NHS and other organisations that provide health care
- Examining how well the NHS and other relevant organisations are performing
- Influencing the Cabinet on decisions that affect local people
- Representing the community in NHS decision making, including responding to formal consultations on NHS service changes
- Helping the NHS to develop arrangements for providing health care in Oxfordshire
- Promoting joined up working across organisations
- Looking at the bigger picture of health care, including the promotion of good health
- Ensuring that health care is provided to those who need it the most

Health Scrutiny is NOT about:

- Making day to day service decisions
- Investigating individual complaints.

What does this Committee do?

The Committee meets up to 5 times a year or more. It develops a work programme, which lists the issues it plans to investigate. These investigations can include whole committee investigations undertaken during the meeting, or reviews by a panel of members doing research and talking to lots of people outside of the meeting. Once an investigation is completed the Committee provides its advice to the relevant part of the Oxfordshire (or wider) NHS system and/or to the Cabinet, the full Councils or scrutiny committees of the relevant local authorities. Meetings are open to the public and all reports are available to the public unless exempt or confidential, when the items would be considered in closed session.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - see guidance note on the back page

3. Speaking to or Petitioning the Committee

4. Emergency Closure of Consultant-led Maternity Services at Horton General Hospital (Pages 1 - 44)

10:05

At the request of the Committee, Paul Brennan, Director of Clinical Services, Oxford University Hospitals Foundation Trust (OUH) and Andrew Stevens, Director of Planning and Information, OUH, will attend to answer further questions on the contingency Plan for Maternity and Neonatal services at the Horton Hospital. The purpose of this is so that the Committee can be assured that there are satisfactory reasons for invoking emergency measures to temporarily close the Obstetrics Unit at the Horton General Hospital.

This will include evidence of efforts made by the Trust to maintain a consultant-led maternity service at the Horton and discussion about the risks and impacts of closing the Obstetrics Unit.

The OUH report on its contingency plans which was first published for the Committee's 15 September 2016 meeting is attached for reference, together with various background information **(JHO4).**

5. Acute Bed and Service Reconfiguration (Pages 45 - 72)

11:30

At the request of the Committee at its last meeting, Paul Brennan, Director of Clinical Services, Oxford University Hospitals Foundation Trust (OUH) will attend to answer more detailed questions on proposals to further develop an outpatient (ambulatory) model of care across the Trust.

The Committee will determine whether it considers the proposal to be a substantial service variation requiring consultation.

The impact of the proposal on patients, staff and partners will be explored in greater detail, including the impact of reducing the number of beds across several of the Trust's hospitals.

The OUH reports on the proposal, which were first published for the Committee's 15 September 2016 meeting, are attached again for reference **(JHO5).**

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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Oxford University Hospitals NHS
NHS Foundation Trust

Health Overview and Scrutiny Committee Meeting

Thursday 15th September 2016

Title	**Report on the Contingency Plan for Maternity and Neonatal Services**

Mr Paul Brennan
Director of Clinical Services
Oxford University Hospitals NHS Foundation Trust

31 August 2016

Executive Summary

1. This report outlines the events since September 2012 which have led to the current acute issues in recruitment of middle grade doctors to the Obstetric Unit at the Horton General Hospital which make continuation of this service unsafe beyond 3rd October 2016.

2. The detailed Contingency Plan is attached at Annex 1 and is summarised in the report.

3. **Recommendation**

OUH's lead commissioner (Oxfordshire CCG), the CQC and NHS Improvement have been advised of the risks posed by impending shortages of medical staff to the safety of Maternity Services at the Horton General Hospital. In light of the inability to adequately staff the Maternity Unit at the Horton General Hospital in a safe and sustainable manner it is not possible to maintain the current service provision. The risks of continuing to retain a Maternity Service without resident experienced and skilled medical staff is substantially higher, and without precedence in the UK, than operating as a MLU in line with the attached Contingency Plan and therefore the Board is recommended to **agree** that:

- The contingency plan for maternity services at the Horton General Hospital be implemented in full, including:
    - The temporary establishment of a midwife-led birth unit at the Horton General Hospital
    - The temporary cessation of obstetric care at the Horton General and its transfer to the John Radcliffe Hospital
    - The temporary cessation of the Special Care Baby Unit at the Horton General and its transfer to the John Radcliffe Hospital
    - The temporary cessation of the inpatient emergency gynaecology service and the establishment of a seven day ambulatory emergency gynaecology unit at the Horton General Hospital
    - The temporary withdrawal of the dedicated obstetric anaesthetic rota from the Horton General Hospital
- Efforts to recruit to the middle-grade obstetrician posts necessary to provide a consultant-led service in Banbury will continue. The outcome of future recruitment initiatives will be reviewed at the end of October 2016 to determine whether it is feasible to reverse the temporary service changes by 9th January 2017.
- In the event that the required numbers of suitably qualified doctors have not been appointed by the end of October 2016 a further round of recruitment initiatives will be implemented and the position reviewed at the end of December 2016. If this produces a positive outcome the aim will be to reverse the temporary service changes by 1st March 2017.
- The Board will be advised of progress in recruitment at its future meetings.
- The Board will keep under review the consistency of its maternity service delivery with the NHS' Core Principles as the contingency plan is implemented.

- The Board will keep all risks under regular review and ensure regular monitoring of the implementation plan.

The recommendation may be amended subject to the extent to which appropriately skilled and qualified doctors apply for the Trust Grade posts currently advertised in the British Medical Journal.

Report on the Contingency Plan for Maternity and Neonatal Services

1. Introduction

1.1. The Horton General Hospital (HGH) is rightly cherished by the people of Banbury, and the surrounding localities, as the hospital that has delivered acute hospital care to them since 1872. During the last century as it grew and adapted to changing health economic circumstances and the needs of its population, it first became a National Health Service (NHS) Trust in 1993 and then, part of the Oxford Radcliffe Hospitals NHS Trust in 1998. At its heart, throughout this period, the model of healthcare delivery at the HGH has remained largely unchanged; providing secondary care, including hospital bed-based care, for the acutely ill on its site in Banbury.

1.2. However, Maternity Services at the HGH have been challenged over the recent past and different and innovative workforce models (resident Consultant Paediatricians, resident Consultant Anaesthetists and Obstetric Clinical Research Fellows) have been deployed to maintain the service in comparison to other smaller units across the country, which have been re-designated as Midwifery Led Units (MLU). The HGH is now the fifth smallest unit in England with 1,466 births and the Royal College of Obstetricians and Gynaecologists only produce guidelines for Obstetrician presence on the Labour Wards for units with a minimum of 2,500 births.

2. Background

2.1. The Trust were informed by the Head of School for Obstetrics and Gynaecology in September 2012 that training recognition for Junior Doctors working in Obstetrics at the Horton General Hospital was to be withdrawn in 2013 predominantly due to the low number of deliveries (1,723 in 2012/13) as this minimised the obstetric training experience. In order to support the continued provision of Obstetric Services at the Horton General Hospital an innovative Clinical Research Fellow programme was developed by the University Department of Obstetrics and Gynaecology which demonstrates the Trust had and continues to have strong support for a consultant led Unit at the HGH. This programme was implemented, based on eight Clinical Research Fellow posts and attracted a high calibre of doctors.

2.2. However, whilst the programme was initially successful, recruitment to the posts became more challenging during 2015 due to national recruitment shortages in Obstetric posts in general leading to a reduction in the number of doctors able to participate in the Out of Programme initiative and a reduction in applications from EU and overseas doctors. During 2015 the University advertised nationally and internationally on four occasions and despite shortlisting a total of 17 doctors only six had the necessary experience to be offered the roles. Only two of the six doctors offered positions by the University decided to accept the posts. In December 2015, the University concluded that the Clinical Research Fellow programme was no longer viable, due to the recruitment challenges, and decided to close the programme and it was agreed the Trust would create a new 1:9 rotational Trust middle grade rota.

2.3. At this point in time seven of the eight posts were filled and an offer had been made and accepted to fill the eighth post. Unfortunately the doctor then withdrew their acceptance in February 2016 and one of the seven in post doctors also resigned. From April 2016 onwards there were six Clinical Fellows in post and it was expected

that these doctors would remain in post until at least October 2016 while the Trust recruited to the new 1:9 Trust Grade roles.

2.4. Adverts for the Trust Grade posts were placed in April, May, July and August 2016 leading to 16 applications of which 10 were considered to have sufficient experience to be shortlisted. Unfortunately only six of the ten doctors attended the interview and five of the six doctors were offered posts, however only one has accepted and this candidate is not yet registered with the GMC. During this period four of the remaining six Clinical Research Fellows resigned leaving only two doctors in post from October 2016 out of nine required for the new Trust Grade rota.

2.5. There remains a live advert in the BMJ with a closing date of 26th August 2016. However, there is no prospect of recruiting to all the vacant posts by the end of September 2016. The number of applications submitted by midnight 25th August 2016 is seven.

3. General Context for Obstetric Recruitment

3.1. The Royal College of Obstetrics and Gynaecology does not currently hold national information on the number of non-training middle grade posts and vacancy levels. However, the Head of School for Health Education Thames Valley (HETV) has confirmed that there are vacancies across all middle grade training rotas in the Thames Valley. All HETV Trusts have an eight to ten doctor middle grade training rota (ST3 to ST7) and of the 40 posts across the five Trusts the overall fill rate is 76.25% meaning 9.5 are vacant. This position is reflected nationally meaning doctors wanting to take on these roles have plenty of choice and will focus on posts which provide the optimum training opportunity.

4. OUHFT Position

4.1. The Trust has 13 ST3 to ST7 accredited posts and these posts are all at the John Radcliffe Obstetric Unit. As the posts at the Horton General Hospital are not accredited for training due to the low number of births (1,466 in 2015/16) these doctors cannot be redeployed to the Horton General Hospital. Notwithstanding the training accreditation issue, they are required to maintain the resident rota at the John Radcliffe Hospital so cannot be utilised to support the resident Trust Grade rota at the Horton General Hospital.

5. Options Considered

5.1. The inability to provide a resident middle grade obstetric rota means the continued provision of the current Maternity services at the HGH is not a viable option. Two options were considered; namely the complete closure of Maternity Services at the HGH or the switch from a consultant led unit to a midwifery- led unit.

5.2. The contingency plan is based on the provision of a midwifery- led unit at the HGH taking account of best practice, the recommendations of the Birth Place Study and NICE Guidance CG190 –Choosing planned place of birth which advises that low risk multiparous and nulliparous women that plan to give birth in a midwifery-led unit (freestanding or alongside) is suitable for them because the rate of intervention is lower and the outcome for the baby is no different compared with an obstetric unit.

5.3. The option of complete closure was not supported as, unlike the middle grade doctor rota, it is possible to sustainably staff a midwifery-led unit and therefore there is no justification for a complete withdrawal of the service.

5.4. However it should be recognised the success of the proposed midwifery-led unit will be dependent on the support of the local community, GP's and our staff; together with the appropriate enactment of all protocols and escalation procedures by staff.

5.5. The Executive does not underestimate leadership and engagement challenge of making a success of the temporary move to a midwifery-led unit.

6. Contingency Plan

6.1. The Trust has developed a Contingency Plan to accommodate an additional 1,000 births at the John Radcliffe Hospital in the event that it is necessary to redesignate the Horton General Hospital Obstetric Service as a Midwifery Led Unit. The Contingency Plan is attached as Annex 1 to this report and sets out the implications of the Horton General Hospital being designated as a Midwifery Led Unit. The Contingency Plan contains:

- The current service provision (section 2)
- An overview of the actions taken to maintain Obstetric Services at the Horton General Hospital since the withdrawal of training recognition and subsequent recruitment initiatives (section 3)
- Proposed service reconfiguration in the event of implementing the Contingency Plan and subsequent service provision at the Horton General Hospital (sections 4 and 5)
- The proposals to increase capacity at the John Radcliffe Hospital to manage up to an additional 1,000 births (section 6)
- Workforce implications (section 8)
- Training implications (section 9)
- Impact on existing protocols and risk assessments (section 10 and 11)
- Maternal Mortality and Stillbirths rates (section 12)
- Communications (section 13)
- The risk register and supporting documentation is contained in the Appendices.

7. Recommendation

7.1. OUH's lead commissioner (Oxfordshire CCG), the CQC and NHS Improvement have been advised of the risks posed by impending shortages of medical staff to the safety of Maternity Services at the Horton General Hospital. In light of the inability to adequately staff the Maternity Unit at the Horton General Hospital in a safe and sustainable manner it is not possible to maintain the current service provision. The risks of continuing to retain a Maternity Service without resident experienced and skilled medical staff is substantially higher, and without precedence in the UK, than operating as a MLU in line with the attached Contingency Plan and therefore the Board is recommended to **agree** that:

- The contingency plan for maternity services at the Horton General Hospital be implemented in full, including:
    - The temporary establishment of a midwife-led birth unit at the Horton General Hospital
    - The temporary cessation of obstetric care at the Horton General and its transfer to the John Radcliffe Hospital
    - The temporary cessation of the Special Care Baby Unit at the Horton General and its transfer to the John Radcliffe Hospital

  - The temporary cessation of the inpatient emergency gynaecology service and the establishment of a seven day ambulatory emergency gynaecology unit at the Horton General Hospital
  - The temporary withdrawal of the dedicated obstetric anaesthetic rota from the Horton General and its transfer to the John Radcliffe Hospital
- Efforts to recruit to the middle-grade obstetrician posts necessary to provide a consultant-led service in Banbury will continue. The outcome of future recruitment initiatives will be reviewed at the end of October 2016 to determine whether it is feasible to reverse the temporary service changes by 9th January 2017.
- In the event that the required numbers of suitably qualified doctors have not been appointed by the end of October 2016 a further round of recruitment initiatives will be implemented and the position reviewed at the end of December 2016. If this produces a positive outcome the aim will be to reverse the temporary service changes by 1st March 2017.
- The Board will be advised of progress in recruitment at its future meetings.
- The Board will keep under review the consistency of its maternity service delivery with the NHS' Core Principles as the contingency plan is implemented.
- The Board will keep all risks under regular review and ensure regular monitoring of the implementation plan.

7.2. The recommendation may be amended subject to the extent to which appropriately skilled and qualified doctors apply for the Trust Grade posts currently advertised in the British Medical Journal.

Paul Brennan, Director of Clinical Services

26 August 2016

Contingency Plan for Maternity and Neonatal Services

1. Introduction

1.1. This paper has been written to address an acute recruitment problem with middle-grade obstetric medical staff at the Horton General Hospital (HGH), which, if unresolved, will make the continuation of the inpatient Maternity Services on this site unsustainable and unsafe beyond 3rd October 2016.

1.2. A multidisciplinary approach has been adopted to address contingency planning as any changes to Maternity Services at the HGH will also affect the Special Care Baby Unit (SC), the second anaesthetic rota established specifically to provide Obstetric cover and out- of- hours emergency Gynaecology.

1.3. This paper will detail current service provision on all OUHFT sites, and provide information relating to medical staffing, service requirements, and the actions required to implement the proposed contingency plan.

1.4. It is important to stress that the acute problem relating to medical staffing at the HGH, which has led to this contingency plan, is a separate issue from the ongoing System Transformation Plan (STP) work. The review of the HGH, as part of the STP, currently being led by Oxfordshire Clinical Commissioning Group, could impact on how Maternity Services are provided across the county in the future.

2. Current service provision

2.1. Maternity Services

2.1.1. Maternity and Midwifery Services (Women's Directorate) are provided on five sites. At the John Radcliffe Hospital (JRH) and the HGH there are Delivery Suites, Obstetric Ultrasound Departments, Antenatal out-patient clinics, a Prenatal Diagnosis Unit and Day Assessment Units. At the JRH there is a Maternity Assessment Unit (MAU), a High Risk Pregnancy Service (Maternal Medicine [Silver Star] Unit and the Fetal Medicine Unit), an observation area and an integrated Midwifery Led Unit (MLU) (Spires). In addition, the Trust provides stand-alone MLUs and community midwifery services.

2.1.2. The Maternity obstetric services are provided on two sites: the JRH and HGH. There are three stand-alone midwifery units at Wallingford, Wantage and Chipping Norton. The JRH has an alongside MLU, located on Level 7 of the Women's Centre, which is separate from the Delivery Suite on Level 2. The JRH alongside MLU is staffed by two midwives on each shift and provides intrapartum and postnatal care for women who are at low risk of complications. No obstetric medical staff provide intrapartum care in the MLU.

2.1.3. Women in a MLU who require a review by a doctor or an intervention have to be transferred to one of the obstetric units. In addition, a homebirth service is offered to women across the county and approximately 100 women per year have a planned home birth. In total there were approximately 8,500 births in 2015/16.

Year	Births JRH	Births Spires	Births South MLU's Wallingford/Wantage	Births HGH	Births North MLU's	Total
2015/16	5,729	844	216/93 = 309	1,466	142	8490
Year to date	1,774	262	73/23= 96	444	51	2627

2.1.4. Some women from Warwickshire and Northamptonshire currently choose to have their baby at the OUHFT; the table below details the number of women that gave birth at the HGH during 2015/16 based on postal area.

Warwickshire	Northamptonshire
63	212

2.2. Neonatal and Special Care Services

2.2.1. Neonatal Services (Children's Directorate) are provided on two sites – a Neonatal Intensive Care Unit (NICU) at the JRH and a SCBU at the HGH. The NICU provides Intensive Care (IC), the highest level of care, for all babies in Thames Valley, High Dependency (HD) Care for Oxfordshire, and Special Care (SC), the least complex level of care for babies in Oxfordshire. The SCBU at the HGH provides SC for babies in North Oxfordshire. The postnatal wards at both hospitals provide SC for babies who are well enough to stay with their mothers, some of whom may be classified as receiving transitional care (TC). Last year 1,125 babies were admitted to the neonatal and SC units across both sites and in addition 960 babies received TC care with their mothers on the postnatal wards.

2.2.2. The following table represents the number of neonatal, SC and postnatal ward TC cots used (80% occupancy) at both sites in the last year.

	IC cots	HD cots	SC cots	TC cots
JRH	15	10	21	12
HGH	0	0	6	2

2.2.3. In addition to inpatient services, outpatient clinics are provided on both sites and a community neonatal outreach service for the whole of Oxfordshire operates from the JRH site.

2.3. Theatre Capacity

2.3.1. A major challenge facing the OUHFT if this contingency plan has to be implemented is the availability at the JRH of emergency theatre time, post-operative recovery beds, anaesthetists and theatre staff.

2.3.2. Currently 1 in 10 women have an elective Caesarean section in the Delivery Suite theatres at the JRH and 1 in 3 women have a surgical intervention in the same theatres; for example, an emergency Caesarean section or forceps delivery, many of which are time critical procedures. If an extra 1000 women delivered at the JRH there would be approximately 100 extra elective Caesarean sections and 330 other theatre cases. Very few additional high-risk women would contribute to these numbers as most already give birth at the JRH.

2.3.3. There would also be a small number of women who would need to be transferred to the JRH from a HGH MLU for a procedure in theatres.

2.3.4. Emergency theatre space and recovery beds are already fully utilised so it would be necessary to have a third theatre on the JRH Delivery Suite or move elective work entirely off the Delivery Suite; for example, in the Gynaecology Theatres with a dedicated recovery area. The only other alternative would be a mobile unit if it could be linked to the Delivery Suite. There are currently 17 elective Caesarean section booked slots per week on

the Delivery Suite at the JRH. To accommodate the extra births the number would need to be increased to 19 slots.

2.3.5. At this stage it is proposed to run two all day sessions (Tuesday and Friday) and three morning sessions (Monday, Wednesday and Thursday) for elective Caesarean sections in one of the two Gynaecology Theatres to create the 19 slots (three per morning and two per afternoon session) and relocate the Gynaecology work to an alternative location or move to three theatre shifts per day in the second Gynaecology Theatre.

3. Potential Impact on Current Service Configuration

3.1. Background

3.1.1. The Maternity Service based at the HGH lost recognition as a Royal College of Obstetrics and Gynaecology training centre in 2013, predominantly due to the low number of deliveries, which currently average four per day, as this minimised the obstetric training experience. This decision was communicated by the Deanery to the OUHFT in September 2012. See Appendix 1.

3.1.2. The service at the HGH is provided at night by a single resident middle-grade obstetrician. The doctors who provide the resident cover require a high degree of operative skill and clinical knowledge. Such clinicians are in short supply throughout the NHS largely because there is a national shortfall in recruitment and retention of obstetric trainees in the UK.

3.1.3. The middle grade obstetric cover has been provided by Oxford University Clinical Research Fellows (CRFs); however, this academic programme has now ended.

3.2. Oxford University Clinical Research Fellows

3.2.1. The academic programme was an initial success, which has enabled the HGH Obstetric Service to be safely delivered until now. However, it has become increasingly difficult to recruit and retain sufficient numbers of adequately qualified and trained CRFs for the following reasons:

- Very few UK graduates are now being allowed to use the CRF post for 'Out-of-Programme Experience' (OOPE). OOPE offers Senior Obstetric Trainees the opportunity to take a year out to gain specialist clinical experience to benefit the NHS and the trainee, or to enable the trainee to undertake a period of research preferably leading to a higher degree.
- Non-EU graduates are discouraged by the process from applying because obtaining a visa, work-permit, language qualifications and GMC registration is too laborious and time-consuming.
- Most EU graduates are not experienced enough to function as CRFs.

3.2.2. At the end of 2015, despite regular recruitment drives in the UK and internationally, it became clear that the University of Oxford could no longer sustain the programme. Therefore, on 22nd December 2015, Professor Stephen Kennedy (Head of the University Department of Obstetrics & Gynaecology) informed the OUHFT Chief Executive and Director of Clinical Services that the programme was no longer viable and would have to close at the start of the following academic year (October 2016) although the plan was to continue the employment of the six doctors who had contracts beyond that date.

3.2.3. Appendix 2 summarises the recruitment cycles in 2014/15 and the table below provides information on the current situation.

CRF	Date CRF contract ends	In post/Left OUHFT	Applied for OUHFT post	Comments
1	30/09/16	In post leaving September 2016	no	New post in London
2	5/10/16	Resigned in February 2016 and left in April 2016	no	Handed in notice to take up substantive consultant post in London.
3	9/10/16	In post and leaving 9th October 2016	no	In April 2016 this doctor applied for a Trust grade post at the JRH to start after the end of their CRF contract at the HGH. The doctor is looking for a post that will count towards accreditation as a specialist in O&G through the CESR programme and therefore the HGH post is not suitable. The doctor has been offered a post at the JRH which has been accepted.
4	1/2/17	In post but resigned in August 2016, leaving date tbc	yes	Offered position but handed in resignation to take post in Portsmouth
5	31/7/17	In post	no	
6	30/9/17	In post, resigned in July and leaving 1st October 2016	yes	Offered position but handed in resignation to take post in Derby
7	18/11/17	In post	no	
8	01/2/18	Appointed and due to start in February 2016 but withdrew in February 2016 before starting	no	

3.3. **Trust-grade doctors**

3.3.1. Following the University's conclusion that the CRF programme was no longer viable, the OUHFT decided to recruit Trust-grade doctors to the posts that were becoming vacant. To make the posts as attractive as possible:

- A 9-cell, rather than an 8 cell rota, was developed to make the posts more attractive and compliant with the European Working Times Directive.
- The doctors will have opportunities for continued professional development as the rota involves clinical sessions at the JRH, with exposure to many specialist services.
- The posts have an enhanced pay level above the national recommendations.
- Financial assistance for visa applications is being offered.

3.3.2. In January 2016, it was expected that seven of the eight middle-grade posts would remain filled until September 2016 (see above table) and that agency doctors would provide cover for the remaining post whilst the OUHFT attempted to recruit to the new middle grade rota. However, of the eight positions one doctor declined to take up post in February and five doctors have resigned leaving only two doctors in-post from October 2016, numbered 5 and 7 in the above table. The resignations occurred in February, April, July and August 2016.

3.3.3. Recruitment commenced in April 2016 and advertisements were run nationally in April, May, July and August 2016 the detailed outcomes are set out in the table below.

Date of Advert	Applications	Shortlisted	Attended for Interview	Offered Position	Accepted Offer
20/04/16	5	4	1	Nil	N/A
20/05/16	7	3	3	3	Nil
13/07/16	4	3	2	2	1
12/08/16					

Note the advert placed in the BMJ on the 12th August is open until 26th August 2016.

3.3.4. Interviews were held in June (twice) and August 2016. Unfortunately, the OUFHT was not successful in attracting sufficient candidates with the necessary experience to deliver a safe obstetric service at the HGH. As a result, as of 24th August 2016, only two out of the eight middle-grade doctors will be in post from October 2016. More attempts are being made to recruit long-term Trust-grade locums from national agencies. In addition the advert placed in July 2016 resulted in three candidates being shortlisted but only two attended the interviews in August 2016. Both candidates were offered roles; however, one subsequently declined and although the second doctor has accepted the post he will not be in post for some time as he is not registered with the General Medical Council. A further advert has been placed in the BMJ with a closing date of 26th August 2016. However, if the OUHFT is unable to recruit to the vacant posts by late August 2016, the Obstetric Service at the HGH will have to cease on Monday 3rd October 2016 as there will be insufficient middle-grade doctors to provide the required resident presence which is now based on a Trust Grade 9 cell rota.

4. Proposed Service Configuration Associated with the Contingency Plan

4.1. Move HGH inpatient Maternity service and SC to the JRH.

4.2. Provide a MLU at the HGH.

4.3. **Modelling Assumption Associated with the Contingency Plan**

4.3.1. Women with low risk pregnancies will be able to give birth at the HGH.

4.3.2. Some women will choose to give birth in neighbouring maternity units in Northampton and South Warwickshire.

4.3.3. Women from the Brackley area will be supported if they wish to book for care at the OUHFT as the OUHFT provides the community midwifery service to Brackley. However, all women from South Warwickshire and Northamptonshire will be asked to book for care in their local Trust.

4.3.4. The Cotswold MLU at Chipping Norton will remain open.

4.3.5. It is anticipated that an additional 700-1000 women will give birth at the JRH either in the Obstetric Unit or Spires MLU. The range is wide because women may choose the HGH as a MLU (up to 500 of the 1,466 births in 2015/16) instead of the JRH, and the 275 women from Warwickshire and Northamptonshire who currently deliver at the HGH may choose their local hospital rather than the JRH. However, the contingency plan is based on 1,000 extra births at the JRH.

4.3.6. Implement an ambulatory model of care for emergency Gynaecology services at the HGH.

4.3.7. A MLU does not require a SC facility and the ongoing presence of an adjacent SC facility is not a recognised model of care because it could lead to confusion and delays in maternal and neonatal transfer practices that form part of standard MLU care. Hence, if Maternity services were to close temporarily at the HGH, the SC would also be temporarily closed until such time as adequate numbers of appropriately trained middle-grade obstetric staff could be recruited to staff the rota safely again. This view is supported by Specialist Commissioners and the Thames Valley and Wessex Neonatal Operational Delivery Network as the Network has confirmed that retaining a SC alongside a MLU at the HGH presents governance issues, has no precedent in the UK as a safe model of care and is not compliant with the National Guidelines and Standards. See Appendix 4.

4.3.8. Currently a number of babies are transferred from the JRH to the HGH for ongoing care (52 in the last year); these will have to remain at the JRH. The average length of stay for babies in the HGH SC from April 2015 to March 2016 was 5.6 days.

5. Service Provision at the HGH in the event of implementing the Contingency Plan

5.1. Maternity

5.1.1. The service will consist of a MLU with five labour, delivery, recovery and postnatal rooms (LDRP) and women will be discharged home with their baby from this facility. Outpatient services will be provided and will include ultrasound, antenatal clinics and the Day Assessment Unit. The Day Assessment Unit will be available five days per week.

5.2. Gynaecology Services

5.2.1. It would not be possible to maintain a full emergency Gynaecology service without 24/7 consultant cover and the service would therefore have to move to an ambulatory model. A plan is being developed to ensure the following issues are addressed:

- Appropriately staffed Early Pregnancy Assessment Unit and Emergency Gynaecology Clinic at the HGH during day-time hours over seven days, both fully integrated with Ultrasound Services.
- Provision of emergency operating lists at the HGH.
- Out of hours Emergency Department support for gynaecological emergencies underpinned by protocols and guidelines with consultant support from the JRH.

5.2.2. Women with an acute gynaecology problem requiring out of hours surgery will be transferred to the JRH.

5.3. Neonates

5.3.1. Neonates in North Oxfordshire requiring review from the community would be seen in either the Children's outpatients at the HGH or at the JRH NICU depending on the type of problem (referral pathways are being revised to provide clear guidance to midwives, GP's, South Central Ambulance Service and paediatric staff).

5.3.2. Neonates requiring readmission will be admitted to either a cubicle on HGH Children's ward, the JRH postnatal ward or the JRH NICU (referral pathways are being revised).

5.3.3. Outpatient follow up for patients living in North Oxfordshire will be arranged at the HGH.

5.4. Access

5.4.1. In order to minimise transfer times to the JRH Maternity Unit in the event the HGH is designated as a MLU the Trust has discussed with South Central Ambulance Service (SCAS) the potential to station a 24/7 ambulance at the HGH solely for transferring women. Further discussions are being held within the Contingency Planning Team, as there are risks associated with this option, however initial views are to proceed for a three month period and then review the impact of deploying a 24/7 ambulance at HGH.

6. Actions Required to Implement the Contingency Plan

6.1. Estates

6.1.1. A senior team from the Division has reviewed the physical space required resulting in a number of recommendations and options which are being considered including:

6.1.2. **Maternity Services at the JRH**

Clinical area	What	How	Effect
MAU	Increase x 2 clinical rooms	Convert 2 offices to clinical rooms.	Relocate office space to the corridor leading to MAU.
Delivery Suite	Increase the number of delivery rooms x 2/3	Use the existing rooms adjacent to the Delivery Suite. The procedure room could be converted to a multi-purpose room for women in labour.	Relocate the waiting area.
Theatres	Increase the elective Caesarean section lists in a manner that reduces elective workload in the Delivery Suite and Observation Area to increase capacity for	Move all elective Caesarean sections off the Delivery Suite to provide adequate access to emergency theatres by running two full day and three half day sessions in the Gynaecology Theatre Suite.	Review and increase staffing for theatres and recovery. Gynaecology: consider 3 session operating lists thus increasing capacity

Clinical area	What	How	Effect
	emergency cases.		or relocate to an alternative theatre.
Spires	Increase the number of birthing rooms x 2.	Convert 2 existing single rooms into birthing rooms.	Review the space on Level 7 to accommodate postnatal women. Relocate community midwives office and the research office.
Level 5	Open all available clinical areas to beds.	Relocate Baby Café to waiting room. Consider relocating the training room to the Café area on Level 4. Convert one end of Level 5 to an elective area by increasing the Induction bay to 8 beds and caring for the women having elective Caesarean sections. Review office accommodation and relocate. Relocate the Registrar of Births office to Level 1.	Disruption for staff. Estates involvement.
Level 4	Office space	Convert one large facility	Relocate displaced staff.

6.1.3. Maternity Services at the HGH

- The existing Delivery Suite at the HGH will be used as a MLU and the rooms converted into Labour, Delivery, Recovery and Postpartum (LDRP) rooms, which will be set up so women can labour, give birth and stay after the birth until they are discharged home. The postnatal ward will close temporarily. The antenatal clinics will continue on Wednesday and Friday and the Day Assessment Unit will be operational throughout the week. Pregnant women will continue to have antenatal ultrasound scans at HGH.

6.1.4. Neonates at the JRH

- Refurbishment of the currently unused intensive care nurseries to provide up to 6 additional SC cots.
- Additional parent and baby room adjacent to the NICU for parents to room in prior to discharge.
- Additional parent facilities - kitchen/ dining/sitting room/ counselling room.
- Additional 2 postnatal beds for TC.

Clinical area	What	How	Effect
Unused ITU Nurseries	Provide emergency overflow space for SC	Refurbishment to allow space to be used for 6 SC patients. Relocate the equipment currently	Provides emergency overflow space for SC during peak activity (subject to approval from estates).

Clinical area	What	How	Effect
		stored in this area to the adjacent resuscitation room. Relocate the neonatal resuscitation training room and equipment to Kadoorie Centre.	
Homeward Bound Parents Rooms	Provide additional accommodation for parents to room in with their baby	Create additional parent en-suite bedroom adjacent to SC area of NICU. Relocate the current users of this area (neonatal outreach service/ ANNPs) to neonatal administration area (requires a knock-on move for national cytogenetics lab).	Increases Homeward bound parent rooms from 3 to 4. Use of these rooms prior to discharge improves parent skills and confidence with their babies and reduces length of stay for patients in the NICU.
Parent facilities in NICU	Provide additional kitchen/dining/ sitting/counselling room	Relocation of staff sitting room to neonatal administration corridor, refurbishment of current staff area for parent sitting/dining area. Reconfiguration of administration area adjacent to nurseries to provide additional counselling room.	Significant improvement in current parent facilities which are insufficient for any growth in activity.

- Completion of the homeward bound room is the main priority before 30th September. However, contingency plans are in place in case the work has not been completed by this stage: 3-4 bedded areas at the top of the HDU will be put into permanent use for SC/HDU (currently used for patient reviews and IV antibiotic administration for patients from post-natal ward/ community) Occupancy of these beds may exceed the 80% standard whilst estates work is completed.
- Patient reviews/administration of IV antibiotics will move (either to the University clinical research room, the radiology reporting room in the NICU or the parent waiting area in the HDU, depending on other estates work in process).
- Use of further 2 TC beds where possible.

6.1.5. Completion of remaining works to improve parental facilities will take place following the HGH move if these are not possible in the short-time available before changes in the service model are implemented.

7. Medical Equipment

7.1. Maternity

7.1.1. All equipment at the HGH will remain as it will be required by the services remaining on site with the exception of redeploying equipment from the Obstetric Theatre and Maternity Ward. An inventory will be produced to

ensure any equipment transferred to the JRH is returned when the unit reopens.

7.2. **Neonates**

7.2.1. All equipment currently in use in the HGH SC will need to be redeployed at the JRH. An inventory will be produced, which will be discussed with the general HGH Children's Service to check whether certain pieces of equipment are shared with any other service. Any deficit will be managed in the first instance using the equipment library with a view to purchasing any additional requirements in due course.

8. Staffing

8.1. **Midwifery and Maternity Support Worker Staffing**

8.1.1. It is proposed to increase the numbers of maternity support workers (MSW) on the postnatal wards at the JRH and in the community. The MSW's will work closely with, and under the direction of, midwives caring for women and their babies. It is important to emphasise that MSW's will not be able to care for women in labour or provide antenatal care.

8.1.2. Recruitment of midwives will continue as planned. A recent highly successful campaign has led to the recruitment of 24 midwives who will take up post in September/October 2016. All these are rotational posts meaning the midwives can work in any area.

8.1.3. A HGH MLU would require a minimum of 6.6 WTE midwives and 5.6 WTE MSW's to provide 24/7 staffing of the unit. This would ensure the unit is staffed by one midwife and an MSW over every 24 hour period. In addition, the unit would be supported by 24/7 midwifery on-call cover provided by the Banbury community team. At the MLU the Banbury team would continue to provide drop-in clinics for antenatal care and intrapartum care in support of the MLU and home births. Additional on-call support would be available from the existing Trust Community Midwifery groups at Bicester, Witney and Cotswold. The activity will be monitored closely to evaluate the appropriate safe staffing levels. The Witney, Cotswold and Bicester staff will continue to provide on-call support for labouring women at the Cotswold MLU. Staffing at the existing MLU in Chipping Norton would remain as at present.

8.2. **Medical staff**

8.2.1. **Obstetrics**

- The consultant medical staff currently working at the HGH would not be required for some clinical sessions at the HGH and would therefore need to be redeployed to some clinical duties at the JRH. However they would continue to support the ambulatory emergency services in gynaecology and the ante natal clinics at the HGH. At present the 5 WTE consultants have combined Obstetrics and Gynaecology service commitments. They would be required instead to provide Consultant presence on the in-patient wards and other clinical duties i.e. elective work as well as covering antenatal clinics at the HGH. The two middle-grade doctors still in post would also be redeployed to the JRH.
- To ensure that the service is as efficient as possible an increased Consultant Obstetric presence would be required to cover all elective lists

prospectively (including week end lists) at the JRH, as well as restructuring of inpatient ward rounds and senior cover for the Maternity Assessment Unit.

- Three WTE Obstetric Consultants would be required at the JRH and the HGH to provide the required antenatal clinics.

8.2.2. **Vocational Training Scheme**

- There are currently two General Practitioner trainees in Obstetrics and Gynaecology at the HGH, whose training in ambulatory care would continue. The loss of Delivery Suite experience is not a major issue as the individuals could be allocated one day a week/fortnight at the JRH.

8.2.3. **Anaesthetic**

- A resident consultant rota was established at the HGH specifically to cover Obstetric services, in addition to maintaining an on-call consultant at home rota for other problems.
- This rota was established through the willingness of a number of dedicated existing HGH consultant anaesthetists to accept the personal inconvenience of resident status, for which they are recompensed through their job plans. The total out-of-hours consultant time required for the resident rota is 108 hours per week (12 hours per day Monday to Friday, and 24 hours per day for Saturday and Sunday). This equates to 36 direct clinical care sessions of consultant time or 4 WTE consultants.
- If the HGH is temporarily designated as a MLU, the resident consultant rota for Obstetric cover will not be required during this period. In line with the provisions of the consultant contract, Trust management will discuss with the ten consultant anaesthetists affected whether they wish to maintain their extra payments by providing alternative activity in Oxford (including supporting the care of women delivering in Oxford as part of the contingency plan), or would prefer to reduce the additional payments to match the new workload at the HGH site during the period the contingency plan is active.
- Resident anaesthetic presence at the HGH will be provided by the existing Core Trainees 1(CT1) and 2 (CT2) and Trust Grade Doctors. This is in line with the Royal College of Anaesthetic Guidelines which states that once a CT1 trainee has successfully completed their 'Initial Assessment Competence' they are deemed competent to be resident on call with consultant on-call at home back up.
- Therefore providing CT1s have achieved their competencies after three months, the resident consultant rota will not be required if the Maternity Services are temporarily suspended from the 3rd October 2016. This position will need to be reviewed for the next rotation in February 2017 as cover maybe required during the initial period of training for the CT1 doctors on the rota.

8.3. **Neonates**

8.3.1. **Nursing**

- It is proposed that all nursing staff currently working in the HGH SCBU would be offered posts at the JRH Unit in the first instance. No additional staff would be required at the JRH if the existing staff agree to relocate.

8.3.2. **Medical**

- No additional consultant or middle-grade doctor time is required at the JRH. More junior doctors/ANNPs are required to support additional delivery attendance, and TC and SC inpatient services.
- There are eight trainees (three Foundation Year (FY2) and five Specialty (ST1-3) GP trainees) based at the HGH. Currently two of these doctors work in the HGH SC Monday to Friday 9-5pm and one junior doctor covers all areas of the children's service out-of-hours.
- Two ST1-3 junior doctors are required to support the additional workload at the JRH. This could either be provided by redeployment of trainees currently working in the HGH SC or through additional recruitment to the successful MTI overseas training programme or recruitment of further Advanced Neonatal Nurse Practitioners. Advice has been sought from the Director for Medical Education regarding the suitability and feasibility of any changes to the training programs. He is in discussion with the appropriate Deanery Training Programme Directors (currently there are no FY or GP trainees working in the JRH NICU).

9. Training

9.1. **Maternity**

9.1.1 All staff working in the Maternity Services attend annual updates on the management of emergency situations such as neonatal resuscitation. A training needs analysis will be completed to ensure all staff who might be working in the MLU are up to date and if necessary specific training sessions will be arranged for individual members of staff.

9.2. **Neonates**

9.2.1 The education of Neonatal Nurses is the same across both sites and nurses already rotate between the two sites. Any identified gaps in knowledge or skills will be addressed on an individual basis.

9.2.2 FY and GP trainees would be offered training similar to that offered at the HGH providing a general training for common neonatal conditions. They would not be expected to take on responsibilities in areas of the NICU where tertiary neonatal care is undertaken. MTI trainees and ANNP's would follow the same training as existing trainees.

10. Protocols

10.1. The existing policies and guidelines in both Maternity and Neonatal Services are relevant to all services across the OUHFT and are up to date. These will not require any revision aside from some modifications to the neonatal admission and referral pathways.

11. Risks

11.1. The risks associated with the implementation of the Contingency Plan have been identified and the risk register is set out in Appendix 3.

11.2. The risks will be reviewed weekly to ensure they remain valid, are in control and to identify if any additional risks have emerged during the implementation period.

12. Maternal Mortality and Stillbirth rates for England and Oxfordshire

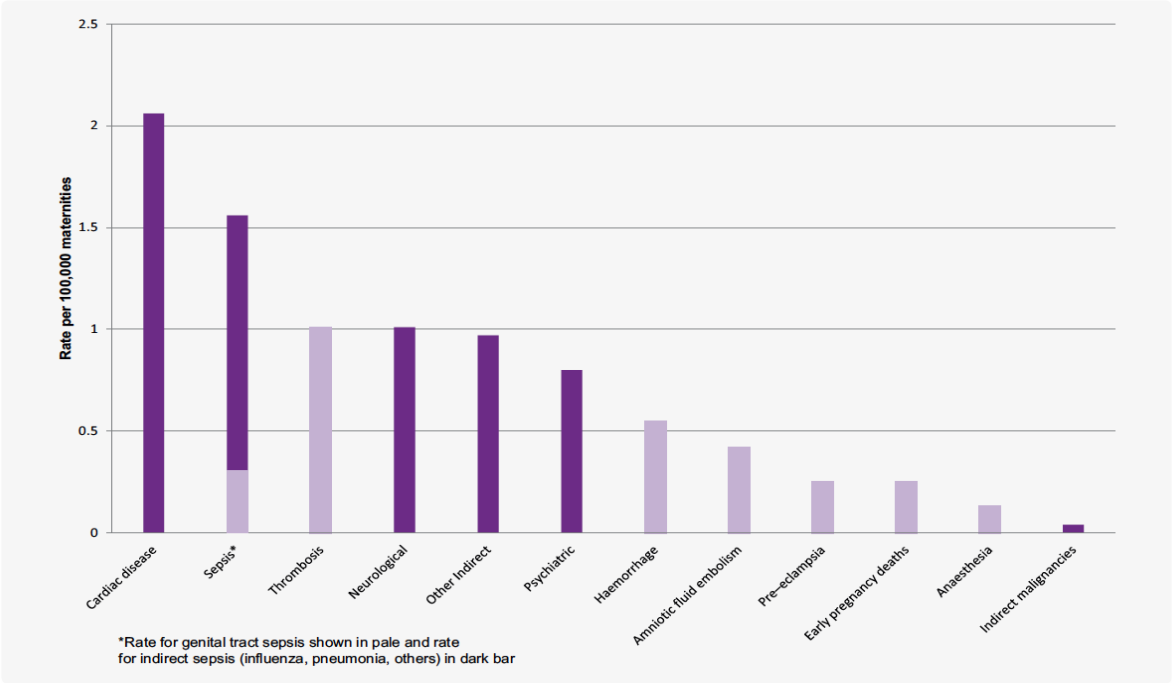
12.1. For the vast majority of mothers and babies in high-income countries, pregnancy outcomes are good, which means that major complications such as the death of the mother and/or baby are rare.

12.2. However, despite major improvements in health care and the health of pregnant women over the last century, some mothers and babies unfortunately still die during pregnancy, childbirth and the postnatal period.

12.3. Maternal deaths are classified internationally as direct or indirect. Direct deaths are those that result from obstetric complications, i.e. interventions, omissions, incorrect treatment or a chain of events resulting from any of these factors. Indirect deaths result from existing disease, or disease that developed during pregnancy that was not the result of direct obstetric causes.

12.4. In the UK, between 2011-13, there were 214 deaths due to direct and indirect causes among 2,373,213 pregnancies, a maternal death rate of 9.02 per 100,000 pregnancies.[1] The most common causes of direct death were sepsis and thrombosis; the most common causes of indirect deaths were cardiac disease and sepsis (see Fig 1). In the same time period, in the Oxford University Hospitals NHS Foundation Trust, there were 2 direct and 3 indirect deaths.

Fig 1: Maternal mortality by cause (UK, 2011-13)



Dark bars indicate indirect causes of death, pale bars show direct causes of death; Source: MBRRACE-UK

[1] MBRRACE-UK report, December 2015

12.5. In 2015, there were 2,952 (0.44%) stillbirths amongst 664,399 births in England. The data for Oxfordshire residents for the same time period are shown in Table 1 below. The most common cause is intrauterine growth restriction.

Table 1: Stillbirths in Oxfordshire and England, 2015

Location	Births	Stillbirths	%
Oxfordshire	**7,893**	**35**	0.44
Cherwell	1,848	9	0.49
Oxford	1,899	8	0.42
South Oxfordshire	1,544	13	0.84
Vale of White Horse	1,413	3	0.21
West Oxfordshire	1,189	2	0.17
England	**664,399**	**2,952**	**0.44**

13. Communication

13.1. The OUHFT Communications team are working with the service to communicate plans as they develop with staff, patients and key stakeholders. The service are ensuring that Commissioners and neighbouring Trusts are aware of the situation.

13.2. Meetings have been held with the maternity and neonatal staff at the HGH informing them of the current situation.

13.3. Letters and emails have been sent to maternity and neonatal staff on all sites regarding the current situation with recruitment and informing them of the contingency plan being developed.

13.4. Letters explaining the current challenges will be sent to pregnant women planning to give birth at the HGH maternity unit, in the week beginning 21st August 2016. Pending the decision of the Trust Board women who live out of the catchment area of Oxfordshire will be unable to request to have their care at the OUHFT after 20 weeks gestation and will have to book with their local provider. The only exception will be those women requiring tertiary level care.

13.5. It is predicted that on 2nd October 2016 there will be mothers and babies on the HGH SC and they will need to be transferred to the NICU at the JRH. In order to keep these to a minimum, from 15th September 2016 there will be a screening process to ensure transfers and admissions are appropriate.

13.6. Letters will be sent to the parents who may need to be transferred to the NICU at the JRH on 2nd October 2016 if the SC has to close informing them of the changes and transfer arrangements.

13.7. The SCAS has been informed about the need for contingency planning and the OUHFT will be working closely will them once plans have been agreed.

14. Gantt chart

14.1. Weekly Project Team meetings have been in place since early July 2016 to develop the Contingency Plan and these will continue to oversee, subject to the Trust Board decision on 31st August 2016, the implementation of the Contingency Plan.

Paul Brennan, Director of Clinical Services

26 August 2016

Letter re withdrawal of training

DEPARTMENT OF OBSTETRICS &GYNAECOLOGY
CLAYDON WING
Direct Line: (01296) 316554 (Secretary)
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26th September 2012
FA/DEB

PRIVATE AND CONFIDENTIAL

Dr M Bannon
Postgraduate Dean
Oxford PGMDE
The Triangle
Roosevelt Drive
Headington
Oxford
OX3 7XP

Dear Dr Bannon

Re: ST3-5 Trainees in O&G at the Horton Hospital, Banbury

I met with Stephen Kennedy, Clinical Director O&G at OUH, yesterday to discuss plans to replace ST3-5 trainees whilst maintaining a clinical service at the hospital.

We have already discussed the reasons why trainees should not work at the Horton Hospital, predominantly due to the low number of deliveries and hence reduced obstetric experience. There is increasing anxiety from the ST3 trainees that they are working alone at night and many of the trainees have complained about the lack of obstetric experience. The Unit has not responded to the Deanery request to introduce ultrasound training or other additional training opportunities and I anticipate an outcome C2 or D at the DQMC in October 2012. A further reason to remove the trainees is a necessity to reduce the number of ST3-5 trainees in our scheme due to the reduced appointments of ST1 (national move to reduce number of O&G specialists).

The plan is that:-

1. The OHU will appoint 8 clinical research fellows from the 07.08.13 (2 already recruited) who will provide the on call cover for the Horton Hospital. They will work 50% clinically and 50% research.
2. The research will be based at the JRH, supervised by 2 new academic clinicians in the field of fetomaternal medicine/ultrasound.
3. The daytime clinical work will be supported by the existing Consultants and Speciality Doctor at the Horton Hospital alongside speciality nurse practitioners and GP assistants.
4. The 6 O&G training posts will be removed and one additional ST3-5 post allocated to JRH (the 6th post will be removed from Bucks) from 07.08.13.
5. The O&G trainees, based at JRH, should be rotated to the Horton Hospital for daytime training in gynaecological operating and access to O&G clinics. They will not provide on call work (obs nor gynae) neither in daytime nor at night at the Horton Hospital. How this daytime allocation is

organised will be for the College tutor at JRH to decide but it will allow greater access to surgical training.

6. Stephen has given me reassurances that there is sufficient training capacity at JRH. The clinical research fellows will not reduce access to training (particularly maternal medicine and ultrasound) for the ST's. This is particularly important for senior ATSM training and ultrasound requirements for all the trainees.

My opinion is that Stephen's proposed scheme is a good solution to the problem of insufficient training opportunities at the Horton Hospital for our speciality trainees whilst maintaining a clinical service at the hospital. He will be writing a business case for the above appointments, which are envisaged to commence 07.08.13, and will be presenting it to his Trust managers. At least 3 of the 6 posts at the Horton Hospital are Trust funded – details will need to be confirmed with HR and the Deanery business manager.

There is some urgency in the decision making as the appointment process will need to commence at the end of 2012 and I will need to reorganise the training rotations.

I am grateful to you for giving this proposal your consideration.

Yours sincerely

Felicity Ashworth

HOS O&G

Cc: Stephen Kennedy, Head of Department, Obstetrics & Gynaecology, John Radcliffe Hospital

University Post in Obstetrics & Gynaecology

The table below shows the recruitment profile for the Clinical Research Fellows undertaken in 2015.

Date of Advert	Applicants	Shortlisted	Attended for Interviewed	Offered Position	Accepted Offer
16/09/15	6	2	2	1	0
30/06/15	5	4	4	2	1
10/04/16	4	4	4	2	0
05/12/14	20	7	6	1	1

Risk Register

Risk ID	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Initial Risk Rating : Before Controls L	Initial Risk Rating : Before Controls C	Risk Rating Post Controls L	Risk Rating Post Controls C
1.1	**Risk: Competency of staff** Potential gap in some competency/skill sets for midwives working in the Horton General Hospital to support the effective delivery of a new Midwifery Led Unit	**Controls:** • Maternity service management to define required competency/skill set for a new MLU at HGH. **(*Action to be completed by HoM by 01.09.2016)*** • Practice Development Team will complete a training needs analysis for staff who will work at the midwifery led unit **(*Action to be completed by PDT by 01.09.2016)*** • Competency assessments and skill set assessments of staff will be completed. **(*Action to be completed by 12.09.2016)*** • Ongoing clinical supervision, mentorship and practice development programme for new MLU staff, including opportunities for sharing practice with other MLU midwives. **(*Action to be completed by PDT/MW by 9.09.2016)*** • Based on the assignments of staff, complete individual plans for training needs/support. **(*Action to be completed by 12.09.2016)***	2	4	1	4
			8		4	
1.2	**Risk: Inappropriate booking/attendance at HGH MLU** Failure to correctly assess the level of care required for a pregnant woman when they present at booking **and/or:** Pregnant women in labour may still self-present to MLU even if they do not fit the admission criteria **And/or:** SCAS inappropriately transport a high risk woman in labour to MLU or ED	**Controls:** • Develop, implement and widely publicise the admission criteria and standard operating procedure to all staff. **(*Action to be completed by SMM by 01.09.2016)*** • Letter sent to all pregnant women planning to birth at the Horton Maternity Unit, explaining the potential changes if approved by the Trust Board. **(*Action to be completed by HoM / CD by 22.08.2016)*** • A second letter will be sent to women following any decision advising them to discuss place of birth with their midwife including admission criteria and booking process. **(*Action to be completed by 01.09.2016)*** • Arrange new bookings for women not suitable for, or wishing to have, MLU care. **(*Action to be completed by HoM by 12.09.2016)*** • Devise and implement clear protocol for booking out of area patients, and communicate this to HGH staff. **(*Action to be completed by HoM by 20.09.2016)*** • Implement robust communication with SCAS regarding admissions protocols, ensuring clear understanding that obstetric emergencies are never transported to HGH MLU. **(*Action to be completed by HoM by 05.09.2016)***	4	3	2	2
			12		4	

Risk ID	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Initial Risk Rating : Before Controls L	C	Risk Rating Post Controls L	C
1.3	**Risk: Escalation processes (Maternal):** Potential failure to appropriately escalate cases where the condition of a woman in labour deteriorates or her level of risk changes either in HGH or Chipping Norton (which has previously escalated some cases to HGH obstetric unit), resulting in a poor maternal outcome	**Controls:** • Reinforce and widely publicise the escalation protocol to all staff (***Action to be completed by CD/HoM by12.09.2016)*** • Linked to the training needs analysis for staff, support will be provided to ensure each staff member is competent to accurately and promptly assess if a woman requires obstetric led care and requires transfer to JR (***Action to be completed by 12.9.2016)*** • Implement a forum in line with other MLU's for the discussion of all cases of escalation and transfer, involving midwives from HGH MLU (***Action to be completed by CD/HoM from date of transfer)***	3	4	1	4
			12		4	
1.4	**Risk: Escalation processes (Neonate):** Potential failure to appropriately escalate cases where a neonate's condition deteriorates in HGH MLU, and/or requires a transfer to JR, resulting in a poor neonatal outcome	**Controls:** • In line with all existing MLUs, implement a standard operating procedure to ensure midwives, paediatricians and emergency ambulance staff are clear on when to call, who to call, and prioritisation in order to ensure no avoidable delays in transfer. (***Action to be completed by HoM/CPaed by 12.09.2016)*** • Temporarily close HGH Special Care Baby Unit, based on advice from the Thames Valley and Wessex Neonate Operational Delivery Network that maintenance of SCBU in the current HGH location or as part of the HGH children's ward would be incompatible with national guidelines and standards. The closure will protect patients and staff from confusion relating to escalation and transfer protocols. (***Action to be completed by CLN by 03.10.2016)***.	4	4	1	4
			12		4	
1.5	**Risk: Transfer Procedures** Potential failure to appropriately transfer a patient (woman and/or neonate) in an emergency from HGH MLU to JR in a timely or safe manner, resulting in a poor maternal, fetal and/or neonatal outcome.	**Controls** • Implement a detailed transfer protocol, ensuring formal arrangements are in place with South Central Ambulance Service for emergency and elective patient transfer ***(Action completed by SMM by 29.08.2016)*** • Ensure all staff are clear about when transfer to the obstetric led unit is required, highlighting the importance of this being within a certain timeframe (Pending decision). (***Action to be completed by SMM by 12.9.2016)***	3	3	1	3
			9		3	

Risk ID	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Initial Risk Rating : Before Controls L	C	Risk Rating Post Controls L	C
1.6	**Risk: Timeliness of transfer** Delayed availability of an ambulance and/or road traffic delays adversely affects transfer time, resulting in a poor maternal, fetal and/or neonatal outcome.	**Controls** • Confirm formal arrangements with SCAS for priority transfers (category 1 patients) from HGH MLU. **(*Action to be completed by SMM by 29.08.2016)*** • Confirmation of response times from SCAS for category 1 patients (Blue light requests). **(*Action completed)*** • Review of existing data relating to blue light transfer times and ongoing monitoring post implementation of any changes. **(*Action completed)***	**3**	**5**	2	5
			15		10	
1.7	**Risk: Staffing Levels** Failure to implement appropriate staffing establishment (agreed levels of staffing) for the Midwifery Led Unit at HGH	**Controls** • Establish accurate forecasts of estimated attendances in the next 3 months, establishment required to meet this need and review on a regular basis post transfer **(*Action to be completed by HoM by 31.09.2016)*** • Maintain enhanced staffing levels for the period of temporary transfer. **(*Action to be completed by 30.9.2016)*** • Enhanced orientation and skills acquisition during this period to be supported. **(*Action to be completed by 30.9.2016)*** • Work with existing staff to assign individuals to potentially work at the Horton MLU and Banbury Community Teams ***(Action completed by HoM/SMM on 22/08/2016)*** • Ensure there is management and close monitoring of safe staffing levels and other workforce metrics, at both the Horton and the community teams, including at board level (Pending Trust Board decision). **(*Action to be completed by HoM/SMM from date of transfer)***	2	3	1	3
			6		3	
1.8	**Risk: Use of Equipment** Lack of staff familiarity and competence with neonatal equipment moved to JR site to accommodate increased activity due to transfer of HGH mothers	**Controls** • Training will be provided for any equipment where JR staff are unfamiliar or lack competence in its use. **(*Action to be completed by SMM by 30.9.2016)*** • Standardised inventory of equipment for use in JR obstetric unit. **(*Action to be completed by SMM by 30.9.2016)***	2	2	1	2
			4		2	

Risk ID	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Initial Risk Rating : Before Controls L	Initial Risk Rating : Before Controls C	Risk Rating Post Controls L	Risk Rating Post Controls C
1.9	**Risk: Impact on wider HGH services** Transfer of obstetric services from HGH may negatively impact on other services at HGH site e.g. accessibility to consultant anaesthetic advice and support for other services out of hours	**Controls:** • CT1/CT2 grade Doctors (with a completed Initial Assessment of Competence) will be on site out of hours, supported by an on-call from home consultant anaesthetist for HGH **(*Action to be completed by CD by 30.09.2016)*** • Review of consultant job plans to manage changes of activity in relevant specialties. **(*Action to be completed by CD by 30.09.2016)***	2	2	1	2
			4		2	
1.10	**Risk: Impact on JR maternity service (Obstetrics)** Transfer of the Obstetric services to the JR may negatively impact on the capacity and quality of experience of the JR service	**Controls:** • Essential preparatory estates work to be undertaken at JR maternity unit, in advance of any Trust Board decision, to enable readiness in the event of a positive decision to transfer services temporarily. **(*Action to be completed by 3.10.2016)*** • Inform women, neighbouring trusts and relevant primary care providers that women who live out of the catchment area of Oxfordshire will be unable to request to have their care at the OUHFT after 20 weeks gestation and that they will be required to book this with their local provider. The only exception to this will be those women requiring tertiary level care.***(Action to be completed by DCS/CD/HoM by 01/09/2016)*** • Establish additional capacity for Theatre and recovery work, including utilisation of Level 1 Theatres for elective caesarean section activity. **(*Action to be completed by CD by 15.08.2016)*** • Review, assess and implement increased capacity of induction labour suite to address the increased numbers of additional inductions of labour ***(Action to be completed by CD by 12.09.2016)*** • Review staffing establishments for all JR maternity services impacted by the move from HGH ***(Action to be completed by HoM by 15.08.2016)*** • Ward managers will monitor capacity issues and escalate as necessary to clinical midwifery managers (Pending decision). **(*Action to be completed by SMM from date of transfer)*** • The maternity governance team will monitor any incidents related to capacity issues and to escalate the senior team (Pending decision). **(*Action to be completed by HoM from date of transfer)*** • Review of consultant job plans to manage changes of activity in relevant specialties. **(*Action to be completed by DD by 31.08.2016)***	4	4	2	3
			16		6	

Risk ID	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Initial Risk Rating : Before Controls L	C	Risk Rating Post Controls L	C
1.11	**Risk: Impact on JR maternity service (MLU Spires)** Transfer of the Obstetric services to the JR may negatively impact on the capacity and quality of experience of the Spires MLU :	**Controls** • Creation of two additional birthing rooms in the Spires MLU to support increase capacity. **(*Action to be completed by DGM by 09.09.2016)*** • Review staffing establishments for Spires MLU in case impacted by the move from HGH ***(Action to be completed by HoM by 15.08.2016)*** • Ward managers will be required to monitor capacity issues and to escalate as necessary to clinical midwifery managers. **(*Action to be completed by SMM from date of transfer)*** • The maternity governance team will monitor any incidents related to capacity issues and escalate the senior team. **(*Action to be completed by HoM from date of transfer)*** • Continue recruitment programme for all staff groups. **(*Action to be completed by DGM - ongoing)***	3	2	1	2
			6		2	
1.12	**Risk: Impact on JR maternity service (Neonates)** Transfer of the Obstetric services to the JR may negatively impact on the capacity and quality of experience of the JR service for neonates	**Controls:** • Review staffing establishments for Neonate Services in case impacted by the move from HGH ***(Action to be completed by CLN/CM/SM-NC by 15.08.2016)*** • Ward managers will monitor capacity issues and escalate as necessary to Divisional Nurse. **(*Action to be completed by DN from date of transfer Capacity constraints affecting regional service for intensive care will be monitored by the Thames Valley neonatal network (Action by CLN: continuous and ongoing)*** • The Women's and Children's Directorate Governance teams will monitor any incidents related to capacity issues and escalate to the Divisional Senior management team. **(*Action to be completed by DN/HoM from date of transfer)*** • Interim transfer of equipment from HGH to create increased capacity **(*Action to be completed by DGM by 01.10.2016)*** • Establish facilities that enhance existing facilities for parents. **(*Action to be completed by DGM/SUM-NC by 01.10.2016)*** • Reinforce current allocation system for parental accommodation which considers severity and travel time **(*Action to be completed by DN/DGM by 01.10.2016)*** • Increase the special care cots capacity by 6-9 9 **(*Action to be completed by***	2	4	1	3
			8		3	

Risk ID	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Initial Risk Rating : Before Controls L	C	Risk Rating Post Controls L	C
		/DGM/SUM-NC by 01.10.2016) • Clear communication plan agreed as to where to send neonatal referrals once patient has been discharged. **(*Action to be completed by /CLN/CLHGHP by 15-09-2016)*** • ***Set up referral pathways for location dependent outpatient follow up (Action to be completed by CLN/CLHGHP BY 15-09-2016)*** • Continue recruitment programme for all staff groups. **(*Action to be completed by CLN/CM/SM-NC by date)*** • Review of consultant job plans to manage changes of activity in relevant specialties. **(*Action to be completed by DD/CDP by 31.08.2016)***				
1.13	**Risk: Impact on JR maternity service (Gynaecology)** Transfer of the Obstetric services to the JR may negatively impact on the capacity and quality of experience of the JR service	**Controls:** • Review and assess the additional elective caesarean sections and identify any implications for Gynaecology ***(Action to be completed by DGM/DN by 12.09.2016)*** • Identify ways of creating additional capacity by maximising efficiency in all theatre facilities, including the utilisation of level 1 theatres, **(*Action to be completed by DGM by 15.08.2016)*** • Review the capacity for the elective day case gynaecology procedures at HGH releasing capacity at the JR site. **(*Action to be completed by CD by 30.9.2016)*** • Review nursing and medical staffing establishments for Gynaecology impacted by the move from HGH ***(Action to be completed by CD by 30.09.2016)*** • Ward managers will monitor capacity issues and escalate as necessary to the Divisional Nurse and OSM **(*Action to be completed by OSM/DN from date of transfer)*** • The Women's Governance Team will be required to monitor any incidents related to capacity issues and escalate to the Divisional Senior Team. **(*Action to be completed by DN by date of transfer)***	3	3 9	2	2 4
1.14	**Risk: Impact on training programme** Transfer of temporary obstetric services to JR has an adverse impact of training programme recognition for medical staff, midwives and nursing education	**Controls:** • Deanery has confirmed that recognition of training for paediatricians will not be impacted by the temporary suspension. **(*Action completed by PB August 2016)*** • Agreement received that the existing GP trainees (x2) training in ambulatory care will continue. Obstetric experience will be covered by the GP trainees undertaking training at JR one day a week/fortnight. **(*Action to be completed by PB august 2016)***	2	3 6	1	3 3

Risk ID	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Initial Risk Rating : Before Controls L	C	Risk Rating Post Controls L	C
		• Student midwifery training placements will be re-organised and increased at the JR site. **(*Action to be completed by HoM by 12.09.2016)***				
1.15	**Risk: Decrease in quality of patient experience** Changes have an adverse impact on the quality of the patient experience	**Controls:** • Ensure the Implementation of communication plan with patients and public. **(*Cross reference with risk 1.18)***. • Monitor patient feedback including Friends and Family test (FFT), complaints and patient survey **(*Action to be completed by HoM from date of transfer)***. • As part of staff training packages, the importance of maintaining patient experience will be emphasised **(*Action to be completed by HoM by 12.09.2016)***. • Implement the neonatal estates plan, including improvements to parental rooming –in-rooms, counselling rooms and additional parent sitting /kitchen/dining facilities. **(*Action to be completed by DGM/SUM-NC by 12.09.2016)***.				
1.16	**Risk: Retention of staff** The temporary transfer of the obstetric service from HGH to JR and closure of SCBU may negatively impact on retention of staff affected by the changes.	**Control:** • Clear, timely and effective continuous communication with staff affected and wider staffing groups at both HGH and JR units. **(*Action to be completed by CD/HoM/CLN/CM by 01. 10.2016)*** • Ensure individual and departmental leadership, support and mentorship is provided to staff during this change process. **(*Action to be completed by CD/HoM/CLN/CM by 01.10.2016)*** • Ensure support for managers and leaders who are required to implement changes and support staff. **(*Action to be completed CD/ CDP/DGM/HoM/DN by 01.09.2016)*** • Offer interim support for staff affected by changes on an individual basis such as temporary flexible working arrangements etc., in consultation with line managers. **(*Action to be completed by CD/CDP/DGM/HoM/DN by 01.09.2016)***	5	3	3	3
			15		9	
1.17	**Risk: Loss of patient, public and staff confidence in the service and the Trust** Despite the immediate case of need to transfer services temporarily based on safety concerns, the decision and subsequent changes impacts negatively on patient, public and staff perception of the	**Controls:** • Communication of rationale for action and implementation of the contingency plan to all stakeholders and wider public. ***(Action to be completed by DCS by 31.09.2016)*** • Demonstration of transparency of decision making by the Trust Board including	5	4	3	2
			20		6	

Risk ID	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Initial Risk Rating : Before Controls L	C	Risk Rating Post Controls L	C
	Trust.	Trust Board meeting in public. **(*Action to be completed by CEO by date)*** • Continue to monitor the impact of change through Trust Board Meetings in public and the Trust Quality Committee ***Action to be completed by DCS from date of transfer)***				
1.18	**Risk: Inadequate Communication** Inadequate communication adversely impacts on quality of care, public and staff confidence in the service and the trust	**Controls:** • Implement a comprehensive communications plan to include women and the general public, staff, CPN, GPs, SCAS, external stakeholder organisations, Members of Parliament and media. **(*Action to be completed by DCS by 12.09.2016)*** • Communication Plan to include formal and informal routes of communication such public meeting, meetings with MPs, meetings with HOSC, Meetings with CPN. **(*Action to be completed by DCS by 12.09.2016)*** • Letters to women booked to deliver at the HGH prior to decision to transfer and after any decision is made to inform them of the outcome and to offer options for care. **(*Action to be completed by CD/HoM by 12.09.2016)*** • ***Letters to parents of patients in HGH SCBU and Banbury catchment inpatients at the JR NICU to inform them about the change in service (Action to be completed by SM-NC/CLN by 12-09-2016*** • Meetings for women affected by any potential changes to be held at the HGH (Q&A format). **(*Action to be completed by CD/HoM by 19.09.2016)*** • Implement specific communication actions for GPs, including meetings s with GPs co-ordinated by CCG Locality Lead and letters to be sent to all GPs, LMC, and GP Federations to communicate the outcome of the Board decision and any resultant changes. **(*Action to be completed by DCS by 12.09.2016)***	4	4	2	2
			16		4	
1.19	**Risk: Complexity of the contingency plan** Failure to identify all risks given the timescales imposed by the emergence of the safety issues at HGH maternity unit	**Controls:** • Contingency plan is clinically led and developed by clinicians from HGH and JR. **(*Action to be completed by DCS by 25.08.2016)*** • Contingency plans have been risk-assessed independently of the service leads by the Medical Director, Chief Nurse and Director of Assurance. **(*Action to be completed by EDs by 24.08.2016)*** • Scrutiny and challenge by the Trust Board in public. **(*Action to be completed by CEO by 31.08.2016)*** • Discussions of outline of the contingency plan prior to Trust Board decision to provide opportunities to raise potential risks via discussions with HGH	3	3	1	2
			9		2	

Risk ID	RISK DESCRIPTION	KEY CONTROLS & CONTINGENCY PLANS	Initial Risk Rating : Before Controls L	C	Risk Rating Post Controls L	C
		clinicians, JR clinicians, Trust Management Executive, CPN, GPs , MPs, HOSC, CQC, NHSI, NHS England. **(*Action to be completed by DCS by 26.08.2016)*** • Publication of the contingency plan and risk register on the trust website following board decision. **(*Action to be completed by CEO by 01.09.2016)*** • Continuous monitoring of maternity indicators across all maternity services to identify any additional emerging risks. **(*Action to be completed by CD/HoM from date of transfer)*** • Monitoring of patient complaints and feedback to identify any emerging risks as part of linked communications plan **(*Action to be completed by CD/HoM from date of transfer)***				

Thames Valley & Wessex Neonatal Operational Delivery Network
(Hosted by University Hospital Southampton NHS Foundation Trust)

Unit 3, Tidbury Farm
Bullington Cross, Winchester
Hampshire, SO21 3QQ
Telephone: 01962 763956
Email Address: teresagriffin@nhs.net

12 August 2016

Letter via email to:
Dr Eleri Adams, Consultant Neonatologist (OUH) / TV Neonatal Clinical Lead

Dear Eleri

This letter is in response to your email dated 28th July 2016 requesting the Network and Commissioner's views on two potential models around accommodating the additional SCU activity from the Horton whilst ensuring that the regional ICU service is not affected.

These being:

- *HGH SCU to remain in its existing location (this will be adjacent to the MLU).*
- *HGH paediatric ward – segregate a 4-bedded area for use for neonates to act as a step-down special care unit for babies from the JR for parents living in the north of the county (subject to evaluation and signoff by infection control).*

The Network has consulted with Dr Victoria Puddy, Consultant Neonatologist & Wessex Neonatal Clinical Lead and NHS England (Wessex) Specialist Commissioning about these proposed models of care and concludes that we are unable to support either model as both present governance issues, have no precedence within the UK as a safe model of care and are not compliant with National Guidelines & Standards.

Several National documents including The NHS England Service Specification for Neonatal Critical Care and The DH Toolkit for High-Quality Neonatal Services (2009) clearly state the criteria required for Special Care Units and neither of the proposed models would comply with these.

Please do not hesitate to contact if you would like further discussion or clarification.

Yours sincerely

TERESA GRIFFIN
Network Manager

cc Paul Brennan, Director of Clinical Services, OUH
Dr Karen Steinhardt, Clinical Director of **Children's Services** - CHN (OUH)
Paul Byrne, Divisional General Manager Children's & Women's - CHN (OUH)
Una Vujakovic, ODN Director, Thames Valley & Wessex Operational Delivery Networks
Dr Victoria Puddy, Consultant Neonatologist & Wessex Neonatal ODN Clinical Lead
Jo Snape, Head of Supplier Management, NHS England (Wessex) Specialist Commissioning
Sian Summers, Service Specialist, NHS England (Wessex) Specialist Commissioning

Neonatal Generic email: england.tv-w-neonatalnetwork@nhs.net
Neonatal Website: http://www.networks.nhs.uk/nhs-networks/thames-valley-wessex-neonatal-network

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VICTORIA PRENTIS MP

Dr Bruno Holthof
Chief Executive
Oxford University Hospitals NHS Foundation Trust
John Radcliffe Hospital
Headley Way
Oxford OX3 9DU

4 August 2016

Dear Bruno

I write to you with considerable concern as to the immediate future of the Horton General Hospital, and request that you take urgent action to ensure that the provision of acute services for the patients of North Oxfordshire continues at the Horton site. There is an immediate risk that maternity services could be withdrawn in September, and considerable concern as to the future stability of the trauma unit.

As you know, we were engaged in a consultation process in which the future of the provision of Accident and Emergency, trauma, maternity and paediatric services at the Horton General Hospital, was being considered. This consultation process has not formally started, and we had been told it would come to an end in spring 2017. There is concern that staff who are supportive of services in Banbury are specifically being excluded from these discussions.

In addition, there is also real concern that services will be removed, or disintegrated or fatally destabilised, before the consultation process has started, let alone before it is finished. To an outside observer, it would seem that the Horton is being set up to fail and that the downgrading of the maternity unit will act as a catalyst and excuse to remove the remaining acute services.

On 20th July the OUHFT announced that staffing numbers could fall below a safe level in September. We are now in limbo, with the situation far from clear. What is apparent is that we are not being consulted on the changes which are taking place on the ground. I would ask you to clarify what steps have been taken to ensure that there is adequate medical staff for the maternity unit at the Horton Hospital.

In recent days I have had several conversations with senior consultants at the Horton General, who have said that recruitment is not just a problem for maternity, but that all acute services are now at risk. It becomes increasingly difficult to recruit junior staff when the immediate future of any service is difficult to predict.

The domino effect is particularly strong in a small hospital; for example, if anaesthetic cover is no longer needed in maternity then anaesthetists – who also cover accident and emergency and trauma services – may be moved to work at another site. They feel, bluntly, that posts are being made deliberately unattractive because of the desire of the OUHFT to reduce acute services at the Horton site, and that generally services are being run down and posts not filled. There are concerns that problems with recruitment are being used as an excuse to consider a service to be unsafe and therefore reduce or close the service.

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The Trust has a duty to provide safe services across all of its sites. There is no clear reason why medical staff could not be asked to work in Banbury while the future of any vulnerable services is discussed without the pressure of imminent closure. If the OUHFT were genuinely committed to keeping acute services at the hospital, I would have expected some creative thinking. Could not a way be found to encourage staff to work in Banbury? Can they not be asked to do so in their contractual terms? Of course an on call of one in four, with minimal junior assistance, is less attractive to a surgeon than an on call 1/14 with considerable junior back up.

I understand that in trauma, a consultant has proposed a solution which would involve the building up of services at the Horton General, and which would potentially save the Trust some £750,000 per annum. Apparently this has not been given serious consideration, though the trauma unit at the Horton General achieves excellent results. This expansion would be impossible if the trauma ward is moved into the medical unit with a reduced number of beds. I would be interested to know your reaction to this suggestion.

It seems to me that the model that is working well with the trauma service should be looked at more closely. In Banbury there are only five consultants but the middle grade juniors are experienced; this means that although on-call is frequent the volume of activity is acceptable. There are close working relationships with the trauma service in Oxford which allows patients to be transferred between both sites. Complex cases are dealt with in Oxford, and the more routine patients are transferred for management in Banbury when there is limited capacity in Oxford. This two-way transfer of trauma patients could be expanded with considerable cost savings for the Trust and a better service for patients. There is no obvious reason why this model should not be adapted to use in all the acute services at the Horton Hospital. It requires consultant staff who work (almost) exclusively at the Horton, and is likely to be substantially cheaper for the Trust. It also has the benefit of being preferred by patients.

If the problems are related to national shortages of medical staff, then I am happy to assist in any way I can with discussions with the Department of Health. Meanwhile, if there are specific immigration issues – I am aware that some Ugandan doctors have been found who would like to come to work in maternity – then please do let me know if I can help. If the goal is to keep acute services functioning then we will pull together as a town with the Trust to help achieve this.

If we do not keep consultant-led accident and emergency, trauma, maternity and paediatrics at the Horton General I am deeply concerned that lives will be lost in transit. The transfer to the John Radcliffe site is particularly difficult in times of heavy traffic. Real worries have been voiced, not least from consultants working at the John Radcliffe, that there is insufficient capacity to receive the extra numbers of patients from the north; some 1,200 extra births per annum for example. Patient safety must be paramount, and we need real evidence that the health of my constituents will not be put at risk by changes to services. I would be grateful if you would share with me any risk assessments which have been prepared as part of the contingency planning. It is not appropriate to make major changes of policy without a full evaluation, and on the basis of staffing issues alone.

Of course safety issues are the greatest concern, but it is fair to say that the removal of acute services from the Horton General site would cause considerable inconvenience and distress to those living in the north of the county, including the second greatest area of deprivation after Blackbird Leys. A model of service provision which suits urban areas, is not appropriate for rural north Oxfordshire, where there is little or no public transport, and parking at the John Radcliffe site is extremely difficult, and journeys often take more than an hour at peak times. I am worried that the fathers of babies transferred during birth will not be allowed to travel in the ambulance with the labouring mother. It is well known that contact with family is significant in patient recovery, and this will be much more difficult, especially for the elderly who make up such a significant part of the patient group.

I have for many years been a vociferous supporter of the OUHFT, and have, together with other volunteers, raised many hundreds of thousands of pounds for Children's services. The Horton General can benefit enormously from being part of such a Trust, but only if it is treated as a serious part of the solution to meeting patient needs. We must not forget that the Horton General Hospital was given to the people of Banbury by Mary Ann Horton and her family almost 150 years ago. I believe we should bear the spirit of that gift in mind when making plans for the hospital's future.

I ask that you now take action to ensure that sufficient staff are provided while we engage in a proper consultation process about the future of maternity. This consultation cannot take place under the threat of closure. I would also ask that the reduction in the trauma service in Banbury should be suspended whilst the potential to move patients from Oxford is properly explored.

Without this, the consultation process is meaningless. I look forward to receiving your reply or meeting with you shortly.

Yours,

Victoria

Victoria Prentis MP

Cc:
David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group
Councillor Yvonne Constance OBE, Chairman, Oxfordshire Joint Health Overview & Scrutiny Committee
Councillor Barry Wood, Leader, Cherwell District Council
All Oxfordshire MPs
Rt Hon Andrea Leadsom MP
Nadhim Zahawi MP

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Oxford University Hospitals NHS
NHS Foundation Trust

The John Radcliffe
Headley Way
Headington
Oxford
OX3 9DU
Tel: 01865 743217

Your ref: DC/rr/H

18 August 2016

Mrs Victoria Prentis MP
House of Commons
London
SW1A 0AA

Dear Victoria

Thank you for your letter of 4 August to Bruno concerning the maintenance and development of acute services at the Horton General Hospital and, in particular, the immediate challenge of retaining an Obstetric service at the hospital.

I can assure you that there is no risk to maintaining acute services at the Horton as the Trust is well able to support the Emergency Department, Acute Medical Services and the Trauma Unit. In terms of the long term strategy for the future role of the Horton, the Trust has developed a number of emerging options and acted in an open and transparent way with all stakeholders in sharing all details of the emerging options and the clinical and activity analysis. The Trust has also highlighted the financial and workforce challenges we face and how these impact on the appraisal of the emerging options. Staff working in all the Trust's hospitals have been involved in this programme and we have regularly presented 'live' updates to the Community Partnership Network, Cherwell District Council, North Oxfordshire Locality GP Forum, you and our staff. The Trust has also participated in the Clinical Commission Group-led engagement programme with the Oxfordshire Joint Health Overview and Scrutiny Committee and the locality engagement events, including the event held in Banbury which was very well attended.

In addition, we are meeting with you and local MP colleagues on Monday and have a further event specifically focused on Maternity on Wednesday. As requested, we are also participating in the event you have arranged next Thursday evening at St Mary's Church, Banbury. As a Trust we are committed to developing services at the Horton General Hospital, investing substantial capital in creating new facilities and seeking to provide new services at the Horton General Hospital resulting in potentially up to an additional 100,000 episodes of care for Banbury residents being delivered from the hospital and thereby negating the need to travel to Oxford. This reflects the ambition of the Trust to secure the role of the Horton General Hospital as being the hospital of choice for local people. We believe the Trust is an integral and leading partner in the Save the Horton Campaign.

In the short term, the Trust is investing in services to support the Horton General Hospital in providing care to patients close to home with developments in our Supported Hospital Discharge Service, Acute Hospital at Home and Early Supported Discharge for Stroke patients. The Trust is also working with colleagues across the health and social care system, as part of the Transformation

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Oxford University Hospitals

Programme, to develop community and primary healthcare services in Banbury although I acknowledge that elements of the programme may be subject to a broader formal public consultation.

In relation to Obstetric services we do face an immediate challenge of maintaining this service beyond 30 September 2016 due to severe recruitment issues with the resident middle grade doctor rota. As I have previously explained, the current position relates to a number of resignations of doctors who have moved to other Trusts to gain increased exposure to Obstetric management as we have to face the fact that the number of births at the Horton General Hospital average four per day and this does not provide sufficient exposure for doctors who wish to obtain entry on to the Specialist Register as Obstetric consultants. Whilst we are continuing our recruitment campaign we have to recognise that only two of the eight middle grade Obstetric posts may be filled by early October and unless we can recruit additional doctors within the next week the Trust Board will need to determine whether it is possible to main a safe Obstetric service at the Horton General Hospital. The most recent advertisement resulted in three applications all of whom were shortlisted. Unfortunately, one doctor did not attend the interview and whilst two doctors were offered the posts, one has subsequently declined and the second, despite accepting the post, has not responded to our offer to support the individual to obtain GMC registration.

Bruno and I will update you on the status of recruitment to these essential posts at our meeting on Monday and he wishes me to assure you that we are exploring every opportunity to recruit to these posts.

With best wishes,

Yours sincerely

Paul Brennan
Director of Clinical Services

Copies:

David Smith, Chief Executive, Oxfordshire Clinical Commissioning Group
Councillor Yvonne Constance, Chairman, Oxfordshire Joint Health Overview and Scrutiny Committee
Councillor Barry Wood, Leader, Cherwell District Council
All Oxfordshire MPs
Rt Hon Andrea Leadsom MP
Nadhim Zahawi MP
Dr Bruno Holthof, Chief Executive, Oxford University Hospitals NHS Foundation Trust

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Trust Doctor in Obstetrics and Gynaecology

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Job Description

Report

The Oxford University Hospitals NHS Foundation Trust is one of the largest NHS teaching trusts in the country. It provides a wide range of general and specialist clinical services and is a base for medical education, training and research.

The Trust comprises of four hospitals - the John Radcliffe Hospital, Churchill Hospital and Nuffield Orthopaedic Centre in Headington and the Horton Hospital in Banbury.

Applications are invited for the above post at the Horton General Hospital, Banbury, and John Radcliffe Hospital, Oxford. The appointment, which commences on August 2016, is for 12 months.

The post offers an opportunity for senior middle grade doctors, who have achieved competencies to at least ST5 level, to consolidate their clinical skills by working in a small friendly unit whilst gaining additional experience in a tertiary level department. There may be also be an opportunity to participate in some ATSM skills modules and become involved in clinical research.

The enhanced pay premia of 5K reflects the seniority of medical staff expected to fill the post. The regular sessions at the John Radcliffe Hospital will ensure that clinical skills are enhanced for the purposes of career progression.

For further details / informal visits contact:
For further information regarding this post, please contact Miss Veronica Miller, Clinical Director
email: (Email address removed)

No unsolicited recruitment agency telephone calls or emails.

Please note that this post is subject to a 6 month probationary period. If you currently hold a contract of employment with the Oxford University Hospitals, this will not apply. This statement does not apply to Medical staff or Executive Appointments.

When providing employment reference details please provide correct work related email addresses so references can be sought promptly when we are looking to progress your application. Your first referee will need to be your line manager, supervisor or clinical lead from your current or most recent post or place of study. This information is essential if your offer of employment is to be confirmed.

Candidates selected for interview will be contacted after the short listing process, usually within 2 weeks. (Please note that shortlisting times vary when applying for a Medical position within the Trust) The majority of correspondence will be via the e-recruitment system, therefore you should check your emails regularly including junk mail folders in web-based email products.

Disclosure and Barring Service Check

This post is subject to the Rehabilitation of Offenders Act (Exceptions Order) 1975 and as such it will be

Job Overview

Company: NHS

Salary: £38,200.00 to £47,676.00

Employee Type: Full Time

Industry: Other Great Industries

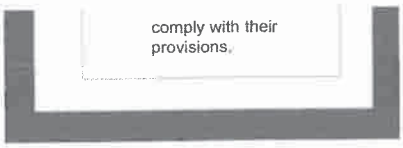
Job Type: Health Care

Required Experience: Not Specified

Required Travel: Not Specified

Location: Medical & Sec. Staff- HH A79160, Banbury

Email: Not Available



necessary for a submission for Disclosure to be made to the Disclosure and Barring Service (formerly known as CRB) to check for any previous criminal convictions.

Tier 2 Certificate of Sponsorship (formerly a Work Permit)

Applications from job seekers who require Tier 2 sponsorship to work in the UK are welcome and will be considered alongside all other applications. However, non-EEA candidates may not be *appointed* to a post if a suitably qualified, experienced and skilled EU/EEA candidate is available to take up the post as the employing body is unlikely, in these circumstances, to satisfy the Resident Labour Market Test. The UK Visas and Immigration department requires employers to complete this test to show that no suitably qualified EEA or EU worker can fill the post. For further information please visit the UK Visas and Immigration website.

UK Registration

Applicants must have current UK professional registration. For further information please see applying from overseas.

Job Requirements

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Report

Oxford University Hospitals NHS
NHS Foundation Trust

Health Overview and Scrutiny Committee Meeting

Thursday 15th September 2016

Title	**Rebalancing the System – Update and review of an Oxfordshire-wide initiative to address patients delays in hospitals beds**

Mr Paul Brennan
Director of Clinical Services
Oxford University Hospitals NHS Foundation Trust

31 August 2016

On behalf of the System-Wide Chief Operating Officers

Rebalancing the System – Update and review of an Oxfordshire-wide initiative to address patients delays in hospitals beds

Summary

1.	Delays in transferring patients out of hospital have been a well-recognised and long standing issue within Oxfordshire. In autumn 2015, strategic work across the health and social care system (including the two Oxfordshire NHS Trusts, Oxfordshire Clinical Commissioning Group and Oxfordshire County Council) led to the implementation of an innovative approach to address delays and improve patient flow and experience. The aim of the initiative was to create a sustainable approach that would 'rebalance the system'.
2.	The impact of this project on the number of patients delayed in OUH and OHFT beds and more widely across Oxfordshire has been significant. Since the end of March 2016, the number of patients delayed in beds across Oxfordshire has been on a downward trajectory with the lowest level of DTOC in OUHFT beds in the previous five years recorded in June 2016.
3.	Given the different approach to care of patients, insight into the impact on quality and patient experience was vital. The Liaison Hub has clearly played a crucial role in ensuring effective communication and coordination of patient care and discharge processes and in particular, effectively managing complex discharges. Cross system working was highly valued by all staff involved particularly by those who had been involved in previous attempts to work in an integrated way and who commented that this time 'we have got it right'.
4.	Discussions with nursing homes and staff across the health and social care sector found that the experience of working with nursing homes has been mutually rewarding and positive. Nursing homes, without exception praised the Liaison Hub as being responsive, experienced and knowledgeable. A number of areas were identified that can inform the future and expanded role of the Liaison Hub, including continuing the strengthen governance processes. The paper outlines the plans in place to address these.
5.	A patient survey sent to the first 150 patients who had received care in nursing homes found that most were very positive about their experience, with the majority agreeing that a nursing home bed was a better environment for them while they waited for ongoing care. There were a small number of patients who raised some issues and concerns which mainly related to being unhappy with the decision to be moved and concerns about care within the nursing homes. Review of these concerns has shown that, the hub were aware of these and that changes had been made (where possible) to processes to address these.

Rebalancing the System – An Oxfordshire-wide Initiative to Address the Issue of Patients Delayed in Hospitals Beds

1. Purpose

1.1. Delays in transferring patients out of hospital have been a well-recognised and long standing issue within Oxfordshire. In autumn 2015, strategic work across the health and social care system (including the two Oxfordshire NHS Trusts, Oxfordshire Clinical Commissioning Group and Oxfordshire County Council) led to the implementation of an innovative approach to address delays and improve patient flow and experience. The aim of the initiative was to create a sustainable approach that would 'rebalance the system'.

1.2. The approach focused on transferring patients who were delayed into beds in nursing homes across Oxfordshire for a short period of time, while they awaited the next stage of their care (mainly home care packages or the organisation of a long term care home). This approach had been tried the previous winter on a much smaller scale.

2. Background

2.1. The central aims of the 'Rebalancing the System' initiative were to:

- Ensure that patients who were medically fit to be discharged from hospital, but awaiting non-acute health and social care support, were cared for in the right environment
- Linked to this, reduce avoidable patient deterioration caused by delays in bed-based care
- Reduce the number of patients delayed
- Enable the shift to ambulatory (as opposed to bed-based care) thereby supporting the management of the expected increase in hospital admissions due to winter illness affecting the elderly and those with chronic conditions.

2.2. 'Intermediate care beds' (now called transitional beds) were commissioned and managed by Oxford University Hospitals NHS Foundation Trust (OUHFT). Initially, this included 130 beds to the end of March 2016, reducing to 75 in April 2016 and then to 55 in August 2016 and onwards. Medical cover for the patients in the interim nursing home beds was provided by specifically commissioned primary care or by the OUHFT directly. Additional nursing, therapy, social work and domiciliary care support was provided by OUHFT, OHFT and OCC. These beds and the supporting social work and therapy staff were funded via a £2m allocation from OCCG.

2.3. Critically, in order to coordinate and manage the needs of the patients being transferred to the care homes, a multi-agency Liaison Hub, located in OUHFT, was established in December 2015. This included involvement of the three provider organisations. The hub (which is still in place) acted as a key liaison point supporting patients during this transitionary period. In particular it:

- Ensures proactive discharge planning for patients who are transferred
- Administers arrangements and agreements with nursing homes, social workers, therapists, GPs and hospital clinicians.
- Manages the logistics of communication with patients and families and escalates any concerns and issues.
- Maintains a tracking system via a virtual ward on all patients who have moved and their onward destination.

- Provide day to day support to nursing homes to proactively support patient management.

3. Programme Implementation

3.1. Governance and Management

3.1.1. Rapid implementation of this programme was undertaken with senior management oversight of six work streams and representation from each of the four organisations in each of these work streams. These were:

- Communication and patient information
- Procurement of Nursing Home Beds, Transport, Logistics and nursing Home Exit Strategy
- Risk Assessment, Mitigation and Patient Safety
- Workforce
- Performance Management, Escalation and Finance
- Pathways (models of care linked to stabilisation and patient acuity).

3.1.2. A daily command and control structure (the DTOC Control Group) was put in place with the Chief Operating Officers from each of the four organisations meeting daily with senior clinical and operational managers. This daily contact enabled close monitoring of developments, but also resolution of factors across the system that were contributing to patient delays.

3.1.3. A project manager was appointed to support and oversee the programme of work. In order to manage the work programme and associated risks, a detailed workplan and risk register was developed and regularly reviewed by the DTOC control group.

3.1.4. In early December 2015, a workshop was held to bring managers and clinicians together from across the health and social care system to further develop implementation plans for each of the work streams.

3.1.5. Weekly updates on progress were provided to the four Chief Executives of Oxfordshire Clinical Commissioning Group (OCCG), OUHFT, Oxford Health Foundation NHS Trust (OHFT) and Oxfordshire County Council (OCC).

3.1.6. Comprehensive modelling of the expected pathway of the initial 150 patients was undertaken. This was based on 200 patients tracked over the same period in the previous year to provide an indication of the number of patients that would move to a nursing home permanently, how many would go home (with and without support), how many might be expected to be readmitted and what the expected mortality rate would be. The outcome data for the initial 150 patients transferred is shown below:

Table 1:Patient transfers at 12th March 20165 at point 150 Patient Discharges Attained

	Actual	**Projected Profile based on 150 Discharges**
Transferred to Nursing Home Beds	250 (222 OUH/38 OH)	-
Number Discharged Home	72	65-89
Number Permanent Placements	56 927)	48-55
RIP in Nursing Home Beds	22	20-30

	Actual	Projected Profile based on 150 Discharges
Total Number Discharged	150	-
Number of Patients Currently in Nursing Home Beds	80	-
Number Readmitted	30	10
Number Readmitted and Returned	19	-

3.1.7. The following metrics were developed and monitored weekly by the DTOC Control group.

Table 2: Key performance Indicators

Quality Measure	Metric	Data Source	Target/ benchmark
Access in	Total new admissions to Intermediate care beds	virtual ward report	35-40 week
Access out	Total Discharges from Intermediate care beds	virtual ward report	35-40 week
Access	% of patients discharged to long term care home	Hub patient tracker	32-37%
Access	% of patients discharged home with long term care	Hub patient tracker	27-33%
Access	% of patients discharged home with no support	Hub patient tracker	
Access	% of patients transferred home from ICB with reablement support	SHD/ORS report	
LOS	Average length of stay (LOS) in hospital from admission to discharge from ICBs	virtual ward report	
Access	Total readmissions to hospital (add narrative for performance report)	virtual ward report	
Mortality	Total deaths as a % of all admissions to ICBs	virtual ward report	13-20%
LOS	Av LOS from admission to discharge from ICBs	virtual ward report	< 28 days
LOS	% of patients with LOS greater than ICB greater than 8 weeks	virtual ward report	
LOS	Number of weekly DTOC at Snapshot - sitrep (commencing 17/12/15)	Sitrep Dtoc report	
Flow	Number of Bed days delayed (Jan - March 16) compared to Jan - March 15	Sitrep Dtoc report	
Flow	Total homes contracted by OUHFT	virtual ward report	
Flow	Total beds utilised	virtual ward report	
Workforce	Additional staff recruited/ redeployed to support initiative	HR report	

3.1.8. Daily updates were also presented on the development of the Liaison Hub, procurement of nursing home beds, flow of patients through the beds, and progress on the recruitment of the additional workforce required. However it is acknowledged by all partners that the reporting information and performance indicators need to be strengthened prior to the coming winter.

3.1.9. Communication to patients directly and to the wider media was managed by the three communication teams (OUHFT, OHFT and OCCG). The relevant

Boards and the Health and Overview Scrutiny Committee were regularly updated on progress.

3.2. **Development and work of the Liaison Hub**

3.2.1. In December 2015, in order to make staff available to lead on the hub development and enable patient moves, 76 acute beds were released in the OUHFT. The Liaison Hub was established and rapidly began to develop processes to support patient moves to the nursing homes. The hub's multi-disciplinary team (MDT) consists of qualified nurses with acute medical experience and expertise in discharge planning with discharge planners working alongside them, the OUH lead for discharge planning and an administrator. The hub worked closely with staff from adult social care, therapy staff, consultant Geriatricians and senior interface Physicians.

3.2.2. Careful and detailed planning was undertaken to ensure that the move for patients, many of whom were frail with complex needs, was well managed. This included the following processes:

- Each patient had a long term discharge and therapy plan where necessary targeted at maintenance or rehabilitation.
- Adult Social Care actively involved in discussing and agreeing patient moves.
- Once determined as medically fit for discharge, patients and their families were informed of the move and had an opportunity to discuss this with staff.
- Each patient and their family/carer was provided with a personalised letter explaining the reason for the move and a contact number for the Liaison Hub.
- The patient's GP was also informed by letter that the patient had been transferred to an intermediate care bed whilst discharge planning continued.
- Each patient was transferred with a pack which contains the following:
  - Nursing Summary
  - Medical summary (EiDD) with list of take home medication
  - If relevant a completed Do Not Attempt Resuscitation (DNAR) form.

3.2.3. Importantly, arrangements were made for each nursing home to have an assigned MDT. This includes a named nurse from the Liaison Hub, social worker, therapist where required and medical staff member. The contact details for each one was made available to the Care Home Support Service, Adult Social Care and the Liaison Hub team.

3.2.4. A weekly MDT review of all patients was put in place to review their progress and ensure their onward transfer was expedited.

3.2.5. Patient moves began in early December 2015 and while the initial plan was to move patients quickly in cohorts, it was apparent that more time was needed to put logistical arrangements in place. Nursing homes also needed a managed approach, so new patients could be adequately supported and settled into the home. Rapid progress however was made with careful management. By 10 December 2015, 126 nursing home beds had been procured and by 31 December, 115 patients had been moved into the beds procured in 15 nursing homes across Oxfordshire.

3.3. Impact of the programme on DTOC

3.3.1. The impact of this project on the number of patients delayed in OUH and OHFT beds and more widely across Oxfordshire has been closely monitored. After a promising start in December 2015 (when the number of patients delayed in OUHFT and OHFT beds fell from 159 to 83), the figures for late January showed an increase to 168 patients delayed within OUHFT and OHFT beds.

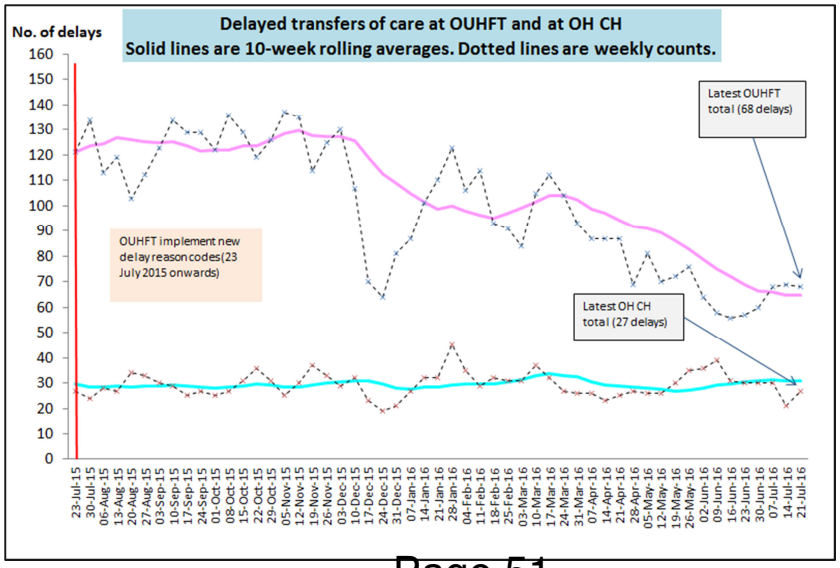
3.3.2. At this time, system leaders agreed a new single cross-system approach was required to more effectively manage patients who required support to leave the nursing home. A central 'Gold Command' structure was introduced at the end of February, based at the OUHFT to prioritise patients with complex discharge needs to identify available resources more quickly and unblock any barriers or delays.

3.3.3. On a daily basis, a nominated 'Gold Command' representative was to lead on behalf of all three organisations involved in the DTOC project and make the necessary decisions on behalf of one or more of the organisations. This includes allocation of available resources and directing senior staff to address any issues.

3.3.4. In addition, in order to improve the discharge of patients waiting for reablement or domiciliary care in their own homes, it was also identified that the system needed to provide an additional 1,600 hours of home care each week. The decision was taken in March 2016 for the OUH (as a registered social care provider) to directly recruit and train 50 new home carers to increase the overall availability of home care in Oxfordshire. This has not been without its challenges, due to the well-known recruitment and retention issues in Oxfordshire. However, by July 2016 the OUHFT had recruited an additional 47 WTE care workers.

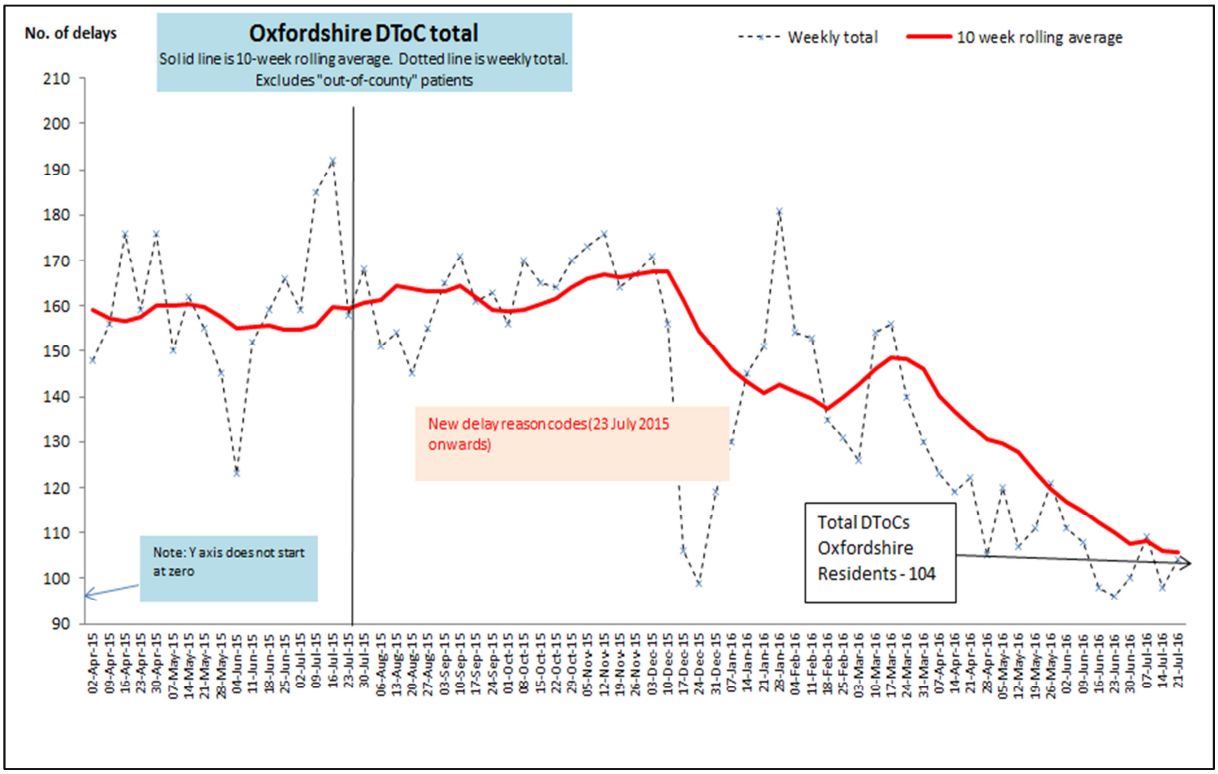
3.3.5. These additional actions alongside the multi-agency working has had a significant impact on the number of patients now delayed in an inpatient bed. Since the end of March 2016, the number of patients delayed in beds across Oxfordshire has been on a downward trajectory, as shown in Chart 1 below. In June 2016, the lowest level of patients delayed in OUHFT beds in the previous five years was recorded.

Chart 1: Delayed transfers of care at OUHFT and OH CH



3.3.6. Since the beginning of the 'Rebalancing the system' initiative, across the whole of the Oxfordshire system, the numbers of patients delayed has significantly fallen as shown in Chart 2 below:

Chart 2: Oxfordshire Delayed Transfers of Care Total



3.4. Current flow of patients through Liaison Hub beds

3.4.1. In summary, as of the 24 August 2016, 476 patients have been transferred to nursing home beds. The outcome for the 426 patients that have been discharged/left the nursing home beds is set out in Table 3:

Table 3: Flow of patients through the hub beds

Placement	Numbers
Permanent nursing home placement	145 (68 private funders, 70 social funding and 7 continuing health care funding)
Supported Hospital Discharge Service or Oxfordshire Reablement Service	83 (70 SHDS and 13 ORS)
Home with domiciliary care	70 (11 of these private funders)
Home with no care	18
Readmitted	62
Died (in hospital or nursing home)	48
Total	**426**

3.4.2. There are currently 50 patients in the 'hub' beds awaiting various discharge care packages. Some require further assessment and rehabilitation.

4. Patient experience and feedback

4.1. Survey Methodology

4.1.1. Given that this initiative was unprecedented in its scale, it was important alongside the MDT feedback, to gain direct feedback from patients and their carers about their experience of being transferred, cared for in nursing homes and discharged to their onward destination.

4.1.2. In April 2016, patient surveys were sent out to the first 150 patients who had been transferred to hub beds from either the OUHFT or from an OHFT Community Hospital bed. A total of 40 questionnaires were returned, 23 from those who had returned home and 17 from patients and their relatives/carers who had moved to a care home permanently. Of those returned, 11 were filled out by patients, 14 by patients with support and 13 were completed on behalf of the patient by a relative or carer (one did not state who had completed the form).

4.1.3. Patients and their families/carers were asked to rate a series of statements (with 5 options from strongly agree to strongly disagree), with the opportunity to comment on each statement.

4.2. Survey findings

4.2.1. Feedback from patients and their families was largely positive, with the majority of respondents strongly agreeing or agreeing with all statements (see Appendix 1 for the full responses to each of the statements). However, there were a small number of patients who raised some issues and concerns. These mainly related to being unhappy with the decision to be moved and concerns about care within the nursing homes.

4.2.2. **Involvement in the decision to move**

- Of those who responded, 77.5% strongly agreed or agreed that they were involved in the decision to be moved to a care home, with 12.5% (5) saying that neither agreed nor disagreed. Two patients commented that they didn't feel they had a choice whether they moved or stayed.

4.2.3. **Information about the move**

- 77.5% of respondents strongly agreed or agreed they had sufficient information about their transfer and the support they would receive once in the care home. 7.5% (3) said they neither agreed or disagreed. Comments highlighted that a few patients and their families felt they could have had more information about the home (prior to their transfer) and more information once they reached the care home about what to expect.

4.2.4. **Family/carer involvement**

- 85% of respondents strongly agreed or agreed that their family/carer was involved as much as they wanted them to be in decisions relating to their care. Two disagreed. One patient stated that the care home had not managed their care well and another commented that they wanted to be at home.

4.2.5. **Transfer process**

- 92.5% of respondent agreed they had been treated with dignity and respect in the move to the care home. One patient was unhappy about the welcome they received when they arrived. They stated that they were '*just put in the room, no menu's given'.*

4.2.6. **Health and social care needs being met, while in the care home**

- Patients (and their families) were asked whether their health and social care needs had been met while in the care home and the majority (82.5%) strongly agreed or agreed. Patients commented positively '*Staff looked after me very well. Physio was excellent and there were social activities every afternoon, if you wanted to join in'.* Four respondents disagreed that their needs had been fully met, commenting that they were not happy with the standard of care within the nursing home. One family member stated that they had not received enough therapy support.

4.2.7. **Medication review**

- 80% of respondents stated that they had their medication was reviewed and they were informed about the changes. 12.5% remained neutral with some stating they didn't require a review. Three respondents disagreed. One stated '*I had to follow up to ensure my mothers' medications were correct'*. Another commented that '*Anxiety tablet given although I felt this was not needed. Made him very drowsy and more confused. He is not taking it anymore and is now more aware of his surroundings'.*

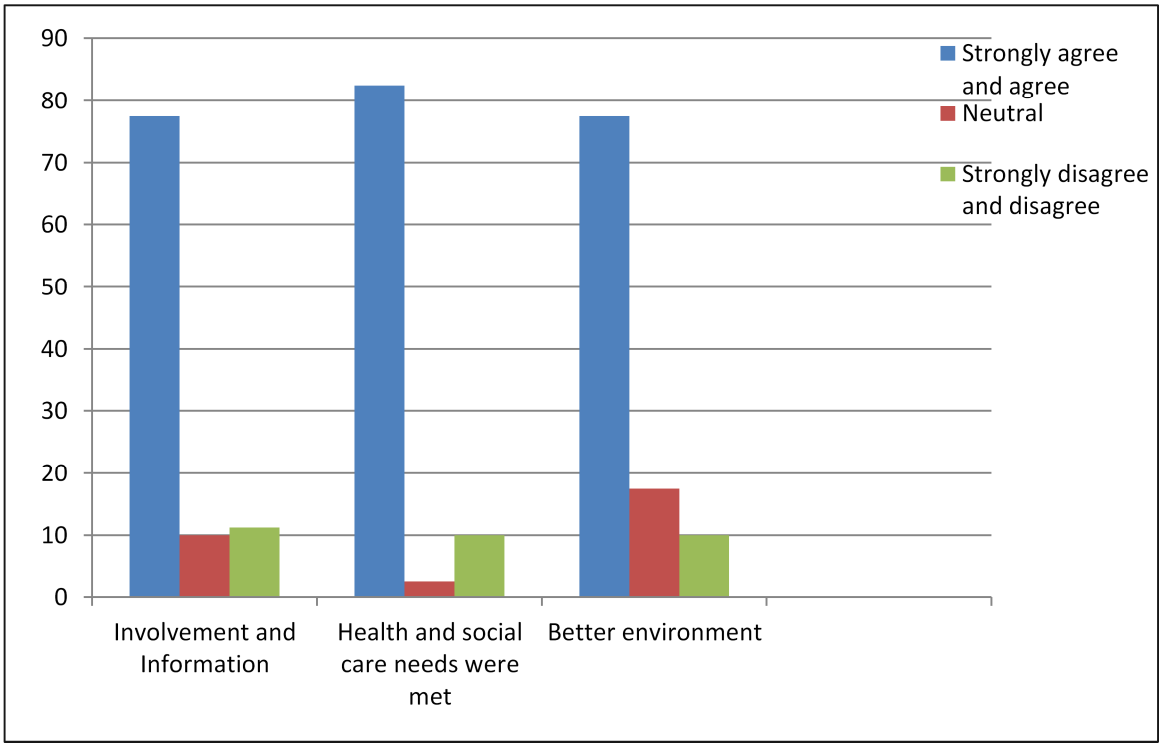
4.2.8. **Feeling safe while in the care home**

- 87.5% of respondents strongly agreed or agreed that they had felt safe while in the home. Three respondents, however, disagreed. One stated '*I was troubled by another resident of the care home for 2/3 nights who insisted on coming into my room'*. Another commented: '*My Dad felt reasonable safe, but not as safe as when he was in hospital and we felt as though if he had a fall, staff would not have reacted quickly enough as he was not checked upon regularly while he was in his room'*.

4.2.9. **Was the care home a better environment?**

- The majority (77.5%) of respondents either strongly agreed or agreed that the nursing home was a better environment for them while they awaited further care, with 17.5% (7) respondents neither agreeing nor disagreeing. One patient commented: '*It was lovely, I had my own private room and en-suite. Very peaceful. Food Good. Would go to [this care home] again, if the occasion arose'.* Four respondents disagreed, with three making the following comments:
  - *'My Dad feels he would rather have come straight home as he is better cared for than he was in the care home. Dad received no rehabilitation from the care home or any physiotherapy'.*
  - *'The care home was not for me. I was treated like one of them, though I was perfectly normal'.*
  - *As there wasn't a choice of care home at this stage, it felt mum was very isolated there and not very happy.*

Chart 3: Analysis of feedback of 3 key questions



4.2.10. **Managing the move to home or permanent care home**

- Of those who returned home, 91.2% agreed that they were well supported and informed about the move. Respondents commented positively on the support in place: '*OT was wonderful – had everything in place for when I returned home'*. Another stated: '*Dad has been very well supported by Occupational therapists and social services. They have made sure everything is in place to care for Dad's needs at home and the NHS nurses have been wonderful – for this, we are grateful'*.
- One respondent who had not wanted to move to a care home stated that: *'I was only happy to get out. I missed X-mas with my family and hopefully I will never have to go in one of those places. I had a lot of support once I was home'.*
- Of those who moved permanently to a care home, 70.6% strongly agreed or agreed that the move was well managed. 17.6% did not respond. One respondent commented: '*I love it in my permanent care home. I'm very happy here*'. One disagreed stating '*It was very rushed and when transport was arranged, it was very late in the evening. When mum arrived, the staff were not aware of her background'.*

4.3. **General feedback**

4.3.1. A few patients and their families raised some issues in their responses:

'Had concerns about transport home – should have been 4p.m. and arrived at 6.45 and he was quite grumpy'.

'They should put the right people in the right places. I had my hips done – that's the reason. But I should never have been put in there. The food was cold, bland, no choice'.

4.3.2. However, most comments highlighted that moving to the care home was a positive experience where they felt their needs were met. Comments included:

'I was very well looked after, both in the hospital and in the care home. I am very appreciative of everything that was done for me'

'On the basis that I was deemed unsuitable for a hospital bed, I was very grateful that a nursing home was an option whilst I got a feel a bit better'.

'We would like to state that we have been delighted with Dad's care under the NHS at the Horton Hospital and Wallingford Community Hospital'.

'Very impressed that effort was made by all concerned to get home into this care home as he had a long standing female friend already resident'.

'The process was well managed throughout which was helpful to a person who was new to this environment (regarding a person with dementia)'.

4.4. Summary

4.4.1. The feedback from patients showed that on the whole, patients and their families and carers felt the care was good and their experience of care within nursing homes had been positive. However, it is clear that for a few patients, there was scope to improve the management of their care within the nursing homes and ensuring their needs were well matched to the nursing home placement.

4.4.2. Some of the problems identified have been addressed by the Liaison Hub as it has become more established and more familiar with the individual nursing homes. This familiarity has enabled more effective communication and placement of patients. Where there have been persistent issues identified during OCC assurance visits and by the hub staff within any of the nursing homes, the procurement of beds has been discontinued.

4.4.3. Patient surveys will continue to be undertaken at regular intervals to inform future developments and any further changes that may be required.

5. Reviewing the Liaison Hub systems and processes

5.1. Review methodology and approach

5.1.1. Given the initiative's success in relation to effective and sustained cross system working, patients being cared for in a better environment and more effective discharge processes, agreement was reached with commissioners to extend and expand the role of the hub for a further year. As part of this agreement OCCG have provided a significant level of the resource required to develop the hub.

5.1.2. It was agreed that a review of the hub, and feedback from nursing homes in particular, would be valuable to inform the future development and the expanded role of the Liaison Hub.

5.1.3. The aim of the review was to gain more formal and comprehensive feedback from nursing homes and from staff involved about the process of transferring, caring for and moving patients to their final destination, thereby enabling any required improvements to be made.

5.1.4. This section outlines the findings from the review that included speaking to nursing home managers, Liaison Hub staff (cross system), OUH medical staff

providing care to the hub patients, and ward sisters and discharge planners at the OUH.

5.1.5. The review used semi-structured (informal) interviews to gain feedback. Of the 15 care homes, eight interviews were conducted face-to-face and a further seven were telephone interviews.

5.2. Findings

5.2.1. The findings have been into broad key themes and have been fed back to those leading and working in the Liaison Hub to inform developments and improvements to ways of working.

5.2.2. A positive initiative

- All hub staff highlighted that the development of the Liaison Hub and the initiative to transfer and improve discharge processes had been a positive and exciting programme of work to be involved in. The Liaison Hub was valued as being well placed to 'respond to issues as they arise'. Some staff stated that they felt proud to represent their organisation in such an initiative.
- The overwhelming feedback from nursing home managers was that the provision of transitional beds and support from the Liaison Hub throughout this process had been very positive. They commented that their staff enjoyed working with a range of patients, enabling some of them to go home.
- Those involved in previous arrangements to have interim beds (in 2014/15) felt that the hub had enabled better communication and smoother processes for staff and patients.
- Nursing home managers, without exception, commented that they had a good relationship with the Liaison Hub. They commented that staff were responsive and that communication and the coordination function was excellent. The nursing homes in the North of the County, which were supported by the discharge planning team within the Horton General Hospital also commented that support and communication was very good.

5.2.3. Factors that have supported developments

- Liaison Hub staff highlighted that the initial stages of establishing and implementing the programme was intensive. There were high expectations and the initial set up was rapid and focused, where they were on a 'steep learning curve'. Staff identified a range of factors that supported them including:
  - detailed planning and regular meetings to sort out logistical arrangements which were very inclusive
  - being able to use a trial and error approach, which meant that could make swift immediate changes as work progressed
  - effective and proactive communication with those wh o manage MDT members including social workers and the therapists
  - within the OUH, having direct access for patient referral and assessment to the (relatively) newly formed Adams Ambulatory Unit was seen to be invaluable
  - having dedicated transport was highlighted as essential for ease of transfer and positive patient experience.

5.2.4. **Importance of effective MDTs**

- Staff commented that the hub demonstrated excellent multi-agency working which enabled an appreciation of each organisation's pressures and ways of working.
- This was reiterated by nursing home managers who saw the MDT meetings as essential and helpful, with good attendance from all relevant disciplines. They commented that health and social care staff were experienced and knowledgeable. There was one exception to this, with one home commenting that agency staff were assigned late and that assessments took far too long. This was verified by the doctor providing cover to this home and has been fed back to the relevant team.
- The MDTs were seen as an effective approach as they brought varied expertise and experience into one domain and enabled access to all relevant agencies required to resolve complex discharge delays including the Fire service, Environmental health, Housing via District Council and the Voluntary sector.
- Many hub staff commented that the process had helped the different organisations to be more open and transparent, where issues could be dealt with on the ground by front line staff rather than 'escalating them upwards'. However, when necessary, the Gold Command approach was seen to be helpful in resolving difficult problems. The hub was also seen as useful in exposing where system-wide improvements were required.
- Liaison Hub staff stated that, they had developed a greater understanding and insight into how nursing homes operated. In working closely with the homes, they had become familiar with how they worked, could identify their strengths and were therefore able to place patients more easily.

5.2.5. **Clinical governance systems and processes**

- It was decided at the outset of the initiative that the governance systems for each organisation would remain in place. Each staff member would follow their own policies and procedures, including incident reporting and safeguarding.
- There were, however, inherent challenges in ensuring that there was a joined up incident reporting system, due to the multiple systems being used. Due to regular and effective communication, hub staff felt that they were aware of most incidents, but acknowledged that they sometimes found out about incidents at a later date or inadvertently. Hub staff stated that any safeguarding concerns were reported directly to the OCC team.
- Nursing homes managers were clear on processes for reporting safeguarding concerns and stated they used their own systems to report any incidents that occurred while a patient was in their care. Similarly, staff from OHFT and OCC reported incidents as they occurred.
- Staff felt that in order to gain oversight of all incidents and safeguarding alerts, that they needed to implement a process that would enable these to be logged and regularly reviewed by the MDT. This would ensure they received feedback on the outcomes of investigation into incidents and enable shared learning with colleagues.
- Since December 2016, there have been two formal complaints relating to patients who have been transferred to a nursing home bed. A review of PALS contacts relating to discharge in the OUHFT (across all areas) has

shown a gradual decline in the number of concerns raised, with 16 contacts in January 2016, eight in May and four in June.

- Hub staff developed a tracking system of all patients, their status and review dates and any issues that needed to be resolved with their discharge.
- A more detailed communication log was not maintained, simply due to time constraints and in hindsight, staff commented that this would have been helpful to track any issues within nursing homes more systematically. Some felt that more formal links to the OCC team who conduct assurance visits within nursing homes would be valuable.
- Overall, hub staff fed back that, given the greater permanency of the hub that they recognised the need to develop more formal and robust governance processes and that they were in the process of implementing the following:
    - a single approach to incident reporting using the OUH Datix system to enable feedback and learning
    - monthly governance meetings
    - ongoing mortality reviews
    - clinical supervision processes to raise concerns and provide support to resolve any ongoing issues
    - a review of communication with wards and patients including transfer documentation.

5.2.6. **Medicines management**

- Liaison Hub staff fed back that medicines management processes could be 'tightened up', and acknowledged that this wasn't unique just to 'hub' patients. Some staff felt that because it was sometimes difficult to coordinate the timing of patient transport with medicines being ready 'to take home' (TTO) that they would often use couriers to send TTOs once patients had been transferred. Ward staff commented that while not ideal, it enabled the patient to be transferred when transport was ready and to make beds available for other patients.
- Some processes had the potential to lead to errors if careful medicines reconciliation was not maintained. For example, when nursing home managers assessed patients while they were still in hospital, they were provided with a copy of the drugs chart. Patients are then discharged with a letter and a list of their TTOs. This list and the drugs chart have the potential to be different. This has now been addressed with one chart only being provided on discharge.
- Nursing home managers reiterated some concerns about the management of medicines. There was confusion about the amount of supply of medication (whether 14 or 28 days). This was, in part, due to the fact that the OUH processes changed at this time. Some managers commented that medication had sometimes been missing or required clarification and they would phone the Liaison Hub who 'always sorted it out'. They acknowledged that this issue had improved over time.
- Some homes felt that more information on review dates for medications would be helpful. One nursing home commented that sometimes patients came with the drugs they had at home (before they came to hospital) and that it would be helpful to relabel them as they are out of the boxes.

- OUH medics covering the homes stated that they had tightened up on prescribing considerably as there had been issues such as requests for repeat medications from nursing homes when a prescription had been recent been made.
- There is clearly scope to review and improve on processes for supply and management of medicines. The pharmacy team within the OUHFT have been involved in reviewing processes as the Liaison Hub has developed. An audit is underway to review the extent to which medicines are missing or incorrect for patients and this will include process mapping to determine where improvements can be made.

5.2.7. **Ward liaison and discharge processes**

- Most nursing home managers visited patients while they were in hospital to assess their suitability for the nursing home. However, many fed back that the single page handover document that was sent about patients (before the visit) lacked enough information to know whether patients would be suitable for placement. One commented 'things get missed off such as whether patient wanders. If we only have an upstairs room, then they would not be suitable'. Most acknowledged that this had improved over time, but that they would still appreciate more information on the form. Liaison Hub staff are in the process of reviewing the transfer document and its content to ensure all relevant information is relayed.
- A few managers commented that they had difficulties on the ward finding someone to help provide them with the necessary patient information. Some were more proactive than others and would visit the hub if they couldn't find what they needed.
- Ward sisters and discharge planners fed back that having a leaflet for patients and families (in addition to the letter they receive) would help in managing their expectations.
- Ward staff also stated that they had initially been briefed on the role of the hub but felt, with its expanded role, that they would welcome an update for staff. One staff member commented that an Standard Operating Procedure clarifying roles and responsibilities and selection criteria for patients being transferred would be a useful document to share with ward staff.

5.2.8. **Medical provision and support**

- The nursing homes without exception felt that the medical cover provided to patients was responsive, whether OUH staff or GPs. They said that GPs were complimentary about the role of the hub in coordinating responses and enabling patients to be readily brought into the Adams Ambulatory Unit when required.
- Given the greater permanency of the hub, medical staff also commented that while informal guidance and support had been provided to the SHO working within the nursing homes, this should be formalised.

5.2.9. **Improving information systems going forward**

- While effective workarounds have been established to enable oversight of patient information, the use of multiple systems across health and social care is not ideal. Some staff fed back that updating multiple spreadsheets duplicated information and was time consuming. Work is underway to

investigate the use of the OCC system, Liquid Logic, as the best joint system to use for patients under the care of the Liaison Hub.

6. Summary

6.1. The Liaison Hub has clearly played a crucial role in ensuring effective communication and coordination of patient care and discharge processes and in particular, effectively managing complex discharges. Cross system working was highly valued by all staff.

6.2. A patient survey sent to the first 150 patients who had received care in nursing homes found that most were very positive about their experience, with the majority agreeing that a nursing home bed was a better environment for them while they waited for ongoing care. There were a small number of patients who raised some issues and concerns which mainly related to being unhappy with the decision to be moved and concerns about care within the nursing homes. Review of these concerns has shown that, the hub were aware of these and that changes had been made (where possible) to processes to address these.

6.3. Discussions with nursing homes and staff across the health and social care sector found that the experience of working with nursing homes has been mutually rewarding and positive. Nursing homes, without exception praised the Liaison Hub as being responsive, experienced and knowledgeable. A number of areas were identified that can inform the future and expanded role of the Liaison Hub.

6.4. There was recognition of the need to create more formalised and robust governance systems and to ensure that learning from incidents was shared with all relevant staff.

6.5. The issues identified in this review relating to governance, provision of patient information, medicines management and communication between the hub and wards are in the process of being reviewed and addressed.

Paul Brennan,
Director of Clinical Services

Appendix 1: Patient and carers survey: detailed findings

Statements	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	No response
1. I was involved in the decision to be moved to a care home	11 (27.5%)	20 (50%)	5 (12.5%)	1 (2.5%)	3 (7.5%)	
2. I had sufficient information that I needed about my transfer and the support I would receive once in the care home	8 (20.0%)	23 (57.5%)	3 (7.5%)	4 (10%)	1 (2.5%)	1 (2.5%)
3. My family (or carer) was involved as much as I wanted them to be in decisions about my care and support	12 (30.0%)	22 (55.0%)	3 (7.5%)	1 2.5%	1 2.5%	1 2.5%
4. I was treated with dignity and respect at all times when being transferred from hospital to the care home.	17 (42.5%)	20 (50%)	1 (2.5%)	1 (2.5%)	1 (2.5%)	
5. My health and social care needs were met during my stay at the care home.	17 (42.5%)	16 (40%)	1 (2.5%)	2 (5%)	2 (5%)	2 (5%)
6. Any medication I was on was reviewed and I was informed about any changes	10 (25%)	22 (55.0%)	5 (12.5%)	3 (7.5%)		
7. I felt safe while I was in the care home	21 (52.5%)	14 (35%)	1 (2.5%)	1 (2.5%)	2 (5%)	1 (2.5%)
8. The care home was a better environment for me while I was waiting for be transferred back home	19 (52.5%)	10 (25%)	7 (17.5%)	1 (2.5%)	3 (7.5%)	
9. I was well supported and informed about the move back home (23 returned)	13 (56.5%)	8 (34.7%)	1 (4.4%)			1 (4.4%)
10. The move to my permanent care home was well managed (17 returned)	2 (11.8%)	10 (58.8%)	1 (5.9%)	1 (5.9%)		3 (17.6%)

Oxford University Hospitals NHS
NHS Foundation Trust

Health Overview and Scrutiny Committee Meeting

Thursday 15th September 2016

Title	**Plans for acute bed and service reconfiguration at the Oxford University Hospitals NHS Foundation Trust**

Mr Paul Brennan
Director of Clinical Services
Oxford University Hospitals NHS Foundation Trust

31 August 2016

Plans for acute bed and service reconfiguration at the Oxford University Hospitals NHS Foundation Trust

1. Introduction

1.1. This paper sets out how the Oxford University Hospitals NHS Foundation Trust (OUHFT) plans to further develop an ambulatory model of care to improve patient experience and outcomes. The aim of this programme of work is to deliver care to patients in the most appropriate environment for them. It also provides the opportunity to optimise the use of beds across the organisation and improve aspects of the estate which will enhance the quality of the environment for patients and staff.

1.2. This paper details the current work programme undertaken to move patients to more appropriate care settings while they await further care and which enabled the release of beds within the Trust.

1.3. Plans for further acute bed and service reconfigurations are also outlined. These will utilise and expand the already established Liaison Hub and further develop ambulatory approaches, thereby enabling the release of a further 118 beds across the Trust.

2. Background: Implementing an ambulatory model of care

2.1. Evidence has shown that many patients, in particular frail older people, have better outcomes and experience when an in-patient stay is avoided and when they instead are treated with appropriate, integrated support as an outpatient, as a day case patient, or through outreaching directly into the patients' own homes[1].

2.2. There are times when patients who are frail, develop acute illness or have long term conditions which requires care within a hospital setting. However, there are risks with an in-patient admission, particularly for this cohort of patients. There is evidence to support a responsive and rapid assessment of frail patients followed by treatment, supportive care and rehabilitation closer to or in patients' homes. This is associated with lower mortality, greater independence and a reduced need for long term care. This growing confidence to safely assess and manage 'frailty' patients in their own environment requires effective co-ordination between secondary and primary care.

2.3. Patients have also expressed a clear preference to be treated in the community, whenever possible[2,3,4]. There is real mutual benefit to be gained, therefore, by providing care closer to home. The need for inpatient beds can be reduced by introducing innovative approaches to care, as outlined below supported by:

- the deployment of rapid diagnostic tests (eg. point-of-care blood analysis),
- improved imaging facilities (CT, MRI),
- an advanced ambulatory emergency care capability,
- improved clinical coordination of health and social care services, and
- improved network support for specialist conditions.

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[1] Future Hospitals Commission (2013) Future Hospital: Caring for Medical Patients A report from the Future Hospital Commission to the Royal College of Physicians

[2] ibid (pages 49-62)

[3] Shepperd S, Doll H, Broad J, Gladman J, Iliffe S, Langhorne P, Richards S, Martin F, Harris R (2009) Hospital at home early discharge. Cochrane Database of Systematic Reviews

[4] Fearon P, Langhorne P, (2012) Early Supported Discharge Services for reducing duration of hospital care for acute stroke patients. Cochrane Database of Systematic Reviews

2.4. Reflecting contemporary evidence, the set of pervasive, patient-centred care principles which underpins this care model include:

- Embedding pragmatic, evidence-based preventative interventions as 'business as usual' during all planned and unplanned patient encounters
- 'Ambulatory by default' (a set of patient-care principles, the most prominent of which is minimisation of overnight hospital admission)
- 'Assess to admit' (capable clinical assessment, often multidisciplinary, before a decision to admit to hospital is made)
- 'Enhanced recovery' (a set of enabling care principles that de-escalates care rapidly as the patient improves, minimising iatrogenic or hospital-induced illness and the 'post-hospital syndrome' of physical and mental debility)
- 'Discharge to assess' (an early move from hospital closer to home to deliver enabling care and determine ongoing care needs).

3. Initial stage of development November 2015 – March 2016

3.1. 'Rebalancing the System' initiative

3.1.1. In November 2015, Oxfordshire health and social care providers agreed to work together to develop a joint plan to enable patients who no longer needed acute medical care to move from the hospital setting into a nursing home. This enabled their needs to be met more appropriately while they waited either to be transferred home with community-based support or to a permanent care home placement.

3.1.2. The central aims of this initiative (entitled 'Rebalancing the System') were to:

- Ensure that patients who were medically fit to be discharged from hospital, but awaiting non-acute health and social care support, were cared for in the right environment.
- Linked to this, reduce avoidable patient deterioration caused by delays in bed-based care.
- Reduce the number of patients delayed.
- Enable the shift to ambulatory (as opposed to bed-based care) thereby supporting the management of the expected increase in hospital admissions due to winter illness affecting the elderly and those with chronic conditions.

3.2. The development of a Liaison Hub

3.2.1. In order to coordinate and manage the needs of the patients being transferred to nursing homes, a multi-agency Liaison Hub, located in OUHFT, was established in December 2015. This included involvement of the three provider organisations (OUHFT, Oxford Health NHS Foundation Trust and Oxfordshire County Council).

3.2.2. At this time, 76 acute beds were released which included 23 beds in the Post-Acute Unit (PAU). A number of staff from PAU, capable and experienced in complex discharge planning moved to the Liaison Hub in order to focus on this activity.

3.2.3. The hub acts as a key liaison point supporting patients during this transitionary period. In particular it:

- Ensures safe and proactive discharge planning for patients who are transferred
- Administers arrangements with nursing homes, social workers, therapists, GPs and hospital clinicians.
- Manages the logistics of communication with patients and families and escalates any concerns and issues.
- Maintains a tracking system via a virtual ward of all patients who have moved and their onward destination.
- Actively liaises with Community Hospitals to ensure good patient flow from OUHFT to CH beds
- Provides day to day support to nursing homes to proactively support patient management.

3.2.4. The Liaison Hub's multi-disciplinary team (MDT) consists of qualified nurses with acute medical experience and expertise in complex discharge planning with discharge planners working alongside them, the OUH lead for discharge planning and an administrator. The hub works closely with staff from adult social care, therapy staff, consultant Geriatricians and senior interface Physicians.

3.2.5. Careful and detailed planning is undertaken to ensure that the move for patients, many of whom are frail with complex needs, is well managed. This includes the following processes:

- Each patient has a long term discharge destination and a therapy plan (where necessary) targeted at maintenance or rehabilitation.
- Once determined as medically fit for discharge, patients and their families are informed of the move and have an opportunity to discuss this with staff.
- Each patient and their family/carer is provided with a personalised letter explaining the reason for the move and a contact number for the Liaison Hub.
- The patient's GP is also informed by letter that the patient has been transferred to an intermediate care bed whilst discharge planning continues.
- Each patient is transferred with an information pack which contains the following:
  - Nursing Summary
  - Medical summary (EiDD) with list of take home medication
  - If relevant a completed Do Not Attempt Resuscitation (DNAR) form.

3.2.6. Importantly, arrangements are made for each nursing home to have an assigned Multi-disciplinary Team (MDT). This includes a named nurse from the Liaison Hub, social worker, therapist where required and medical staff member. The contact details for each one are made available to the Care Home Support Service, Adult Social Care and the Liaison Hub team.

3.2.7. A weekly MDT review of all patients is put in place to review the progress of those transferred and ensure that onward transfer is expedited.

3.2.8. As of the 30 August, 483 patients have been transferred from an OUHFT bed or an OHFT community hospital bed to a nursing home.

3.3. **The Acute Ambulatory Unit**

3.3.1. The Adams Ambulatory Unit, situated on Level 5 at the JR Hospital plays a crucial role in providing a responsive, multi-functional hub, delivering three main pathways of care, seven days/week.

- **Next day assessment:** this builds on the existing day hospital function, delivering next day MDT assessment, diagnosis and treatment on an ambulatory basis following initial assessment and referral from primary/community care, OP attendance and EAU/ED attendance.
- **First Assessment:** primarily focused on Geratology Rapid Access for patients deemed as requiring urgent assessment on the same day, but not deemed as requiring emergency/blue light review. This service will concentrate not uncommonly on patients with complex needs.
- **Immediate streaming of patients from Level 1:** largely older, frail patients where assessment can be done on an ambulatory basis. The very early filtering from Level 1 of this cohort of patients helps to de-congest Level 1 and prevents overcrowding of the Emergency Department.

4. Next steps in releasing beds and increasing ambulatory provision

4.1. In order to move from a dependency on bed based care to bed and non-bed based care, the Trust needs to continue to develop an ambulatory model of care which provides continuing care/treatment for patients, in their own home. This release of inpatient beds only becomes viable with the continued implementation of the following developments, which release staff to deliver patient care in an increased ambulatory way. This includes the following:

- Acute Hospital at Home (AHAH): providing ambulatory care in-reaching into patients' homes delivering acute care for a defined time period
- Continuation and expansion of the role of the Liaison Hub
- Implementation of a Trust wide Discharge Liaison Team
- Expansion of the Supported Hospital Discharge Service (SHDS)
- Refurbishment of Level 7, John Radcliffe Hospital
- Increasing capacity in Ambulatory Care, Level 5.

4.2. **Acute Hospital at Home**

4.2.1. This is a service that provides acute care into patients' homes for a defined time period. This can be achieved either by assessing the patient in their home using point of care testing or transferring them to the hospital for assessment only but continuing to provide care /treatment in the patient's home, where feasible.

4.2.2. The service aims to achieve two goals: to avoid hospital admission and to support the safe transfer of patients from secondary care to the patient's own home where care can be safely continued. This will include patients who require ongoing treatment, monitoring, nursing care, therapy support, and who would otherwise remain in hospital without this intervention.

4.2.3. The Acute Hospital at Home service will accept referrals from General Practitioners (GP's) and other health care professionals within the community setting e.g. District Nurses, heart failure and respiratory specialist nurses, Palliative care teams, South Central Ambulance service and carers. To enable early and safe transfer of continuing care from hospital to home, it will

also accept referrals from acute medical physicians, ward sisters, specialist nurses and other specialist services.

4.2.4. Patients with the following conditions will be those most able to benefit from this service in the first instance:

- Community acquired pneumonia
- Cellulitis
- Volume depletions/dehydration
- Urinary tract infection/urosepsis
- Deep vein thrombosis and pulmonary embolism
- Acute decompensating heart failure

4.2.5. Patients not included are listed below:

- Patients under the age of 16yrs
- Patients with resolving alcohol or substance misuse issues which would prevent them from engaging with Multidisciplinary case management
- Patients with acute/severe mental health problems
- Patients who decline this service

4.2.6. The types of treatments delivered by AHAH will include:

- Administration of parenteral therapy:
  - IV Antibiotics (to include 2nd dose) IV or S/C Diuretics
  - IV or SC Fluid (S/C to include full range of approved s/c crystalloid preparations).
- Supplemental oxygen via O2 concentrators – monitoring and further titration if required of O2 via appropriate delivery device.
- Palliative medication to be administered where appropriate via s/c syringe driver or prn injection.

4.2.7. Patients will be discharged back to the care of their GP within 5-7 days after transfer home and patients ongoing medication will be prescribe for up to 14 days following discharge to the care of the patients GP.

4.2.8. The team delivering the service will consist of senior registered nurses, supported by clinical support workers, therapists, pharmacists and Geratologists.

4.3. **Continuation and expansion of the role of the Liaison Hub**

4.3.1. As described in Section 3.2 above, the Liaison Hub provides a valuable and crucial role in coordinating the transfer of patients with complex discharge needs.

4.3.2. This allows time to complete the discharge planning thereby releasing an acute bed. The cost of the ongoing running of the hub is part funded by the Clinical Commissioning Group (CCG). Its role has expanded to include support and management of the following (a total of 134 beds):

- 55 transitional beds in Care Homes
- 18 Interim beds
- 49 intermediate are beds
- 12 CHC beds.

4.4. **Implementation of a Trust wide Discharge Liaison team**

4.4.1. The Medicine, Rehabilitation and Cardiac Division (MRC) are in the process of developing the existing Discharge Liaison (DL) team to enable them to support all sites within the OUH Foundation Trust. The existing team is being expanded to focus on a further reduction of avoidable delays.

4.4.2. There are some 350 beds at the JR, 220 beds at the Churchill and 130 beds at the Nuffield Orthopaedic Centre (NOC) that have very limited input from the DL team. The team will be expanded to improve focus and input and will be managed by MRC to ensure consistency in practice and robust cross cover for leave and sickness.

4.5. **Expansion of the Supported Hospital Discharge Service (SHDS)**

4.5.1. In order to improve the discharge of patients waiting for reablement or domiciliary care in their own homes, an analysis of this provision (conducted in February 2016) identified that the system needed to provide an additional 1,600 hours of home care each week.

4.5.2. The decision was taken in March 2016 for the OUHFT (as a registered social care provider) to directly recruit and train up to an additional 50 reablement staff to increase the overall availability of reablement and home care delivery in Oxfordshire. This development will support discharging patients directly from the Emergency Departments, Emergency Assessment Units and Ambulatory Care in addition to supporting inpatient clinical areas across the Trust. This has not been without its challenges due to the well-known recruitment and retention issues associated with this staff group in Oxfordshire however an additional 42 staff have been recruited.

4.6. **Refurbishment of Level 7, John Radcliffe Hospital**

4.6.1. It is recognised that Level 7 in the main John Radcliffe hospital requires significant refurbishment to continue to deliver care in a suitable environment for older patients who require admission to hospital. Patients are increasingly presenting with cognitive behavioural challenges and high care needs (acutely unwell and require continuous monitoring) and ward environments need to reflect the demands placed upon them. Likewise for patients who choose to die in hospital, an improved environment conducive to good end of life care needs to be provided for them and their families.

4.6.2. The four wards on level 7 will be refurbished and integrated into two 30 bed wards releasing 26 beds.

4.7. **Repatriation Policy**

4.7.1. In order to help underpin the developments described earlier the Trust has also reviewed its mechanisms for the timely transfer of patients back to their referring hospital and to this end a revised Repatriation Policy for the Thames Valley is being trialled.

4.8. **Summary**

4.8.1. In summary, this programme of change supports the following:

- Single point of access to medical review, specialist opinion and diagnostics.
- Reducing long waits for medical and ‘frailty’ patients in the Emergency Departments.

- Improved access to senior, expert decision makers seven days a week between 08:00 and 20:00hrs, in late 2016 this will be extended to 08:00 - 22:00.
- Ambulatory care pathway managed by a single MDT and supported by psychological medicine.
- Patient and carer involvment in decision making.
- Prompt discharge planning within 24hrs unless hospital treatment is necessary.
- Post discharge support.
- Effective and appropriate rehabilitation and reablement after acute illness.

5. Details of Ward Relocations

5.1. In total, supported by these ongoing developments, the MRC and NOTSS Divisions are aiming to release 118 beds in General Medicine, Orthopaedics, Trauma and the West Wing. The key changes are:

- The current Acute Ambulatory unit has relocated to a larger facility on Ward 5B.
- Ward 5B (stroke) has relocated to ward 6B.
- Infectious diseases inpatients will relocate from John Warin ward on the Churchill site to the Bedford end of Adams and Bedford ward on level 4 in the John Radcliffe Hospital. John Warin ward will decrease from a 20 bedded ward on the Churchill site to occupy 11 of the existing beds on Bedford ward, four of which will be negative pressure rooms with access to the garden.
- Vascular inpatients, which are expanding linked to the transfer of emergency and elective inpatients from Buckinghamshire, will transfer from Ward 6A to released inpatient capacity in the West Wing.
- The option then exists to transfer Renal inpatients from the Churchill to either Ward 6A or Ward 7F at the John Radcliffe.

5.2. **Surgery and Oncology and Children's and Women's Divisions**

5.2.1. In addition to the above, it is essential the Trust achieves the integration of elective and urgent/emergency Urological Services on the Churchill site. The Surgery and Oncology Division has identified the ability to release 8 beds in the Cancer Centre which can then be reallocated to create inpatient capacity and a triage facility to support the transfer from the JR to the Churchill. This means the change can be achieved on a cost neutral basis.

5.3. An overview of bed realignment proposals are set out in Table 1.

Table 1 Bed re-configuration programme MRC and NOTSS

Ward	Present bed numbers	Beds Realigned	Beds left
Oak (ground floor)	36	0	**36** based on 18 designed for Trauma and emergency Gynaecology and 18 acute medical short stay aligned with medical assessment.
Laburnum (1st floor)	28	0	**28** Female patients
Juniper (1st floor)	30	0	**30** Male patients, bay in between can flex between either gender
JWW	20	20	**0** ID will occupy 11 of the existing beds on Bedford ward
5B converting to ambulatory Stroke 5B will	18 for ambulatory day time	10	**8** inpatient for those who need to stay overnight

Ward	Present bed numbers	Beds Realigned	Beds left
relocate to ward 6B			
Level 7A, B, C, and D if refurbished will have a reduced bed stock to meet present day requirements: dependant on capital program or charitable funds for older people, whilst works are completed move into 6A or 7F realigning 20 beds throughout the refurbishment which will take a year to complete.			
Combine 7C and 7D	42	12	**30**
Combine 7A and 7B	44	14	**30**
Total MRC	**218**	**56**	**162**
F ward HGH	28	28	**0** See above linked to Oak Ward
Orthopaedic (NOC)	102	12	**90** Close 12 beds on C Ward but keeping 12 day beds on A Ward open 24/7 that currently close at 6pm
Neuroscience	75	0	**75**
Vascular Wards 6A and 5C	22	22(26)	**0** Relocate to the West Wing
Total NOTSS	**227**	**62**	**165**
Total Trust		**118**	

6. Financial consequences and investments

6.1. The estimated savings associated with these changes are provided in Table 2 below.

Table 2 Estimated Savings

Ward	Full Year Savings
F ward HGH	**1288**
JWW	**663**
5B converting to ambulatory	**336**
Combine 7C and 7D into one ward	**1231**
Combine 7A and 7B	**0**
C Ward	**195**
6A/5C to WW	**1197**
Total	**4910**

6.2. The investments associated with the service developments articulated in section 4 of this paper are set out in Table 3.

Table 3 –Service Development Investments

Service	Pay	Non Pay	Total cost
Liaison Hub	1,103,000	24,900	1,127,900
Acute Ambulatory Unit	1,650,000		1,650,000
Supported Hospital Discharge	1,250,000		1,250,000
Trust Discharge Team Expansion	100,000		100,000
Totals	**4,103,000**	**24,900**	**4,127,900**

7. Additional benefits to the re-configuration and release of beds

7.1. In addition to the improvements in patient outcomes and experience of being cared for closer to home, further benefits to be realised from releasing beds includes:

- A reduction in agency spend for all staff groups.
- A reduction in staff from clinical and non-clinical support services.

- That medical cover is easier to deliver where beds are co-located within a defined area.
- The development of ambulatory care that continues after the patient is transferred home will benefit all clinical areas within the Trust.

8. Conclusion

8.1. This paper has outlined the ongoing and proposed service developments that are supporting the development of ambulatory pathways for patients and the subsequent realignment and release of inpatient beds.

8.2. Patients who are complex delayed discharges are better cared for in Nursing homes with the support from the Liaison Hub, which incorporates social care and therapy provision.

8.3. A release of 118 beds within MRC and NOTSS can be achieved by releasing staff to care for patients in non-bed based care (ambulatory care) across Oxfordshire. The expansion of staff within SHDS will support the ambulatory care pathway by providing the domiciliary care required to enable the patient to remain at home. A Trust wide Discharge Liaison team will support all clinical areas within the trust to prevent avoidable delays when discharging patients.

8.4. A Project Risk Register has been developed which identifies potential risks and mitigations for the programme. A risk assessment will be undertaken for each individual service change and a Quality Impact Assessment will be completed for the programme.

8.5. Delivery of this programme will improve the quality of the environment for both patients and staff through bed optimisation; ensuring patients are seen and treated in the most appropriate setting for them, thereby improving their experience of care.