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

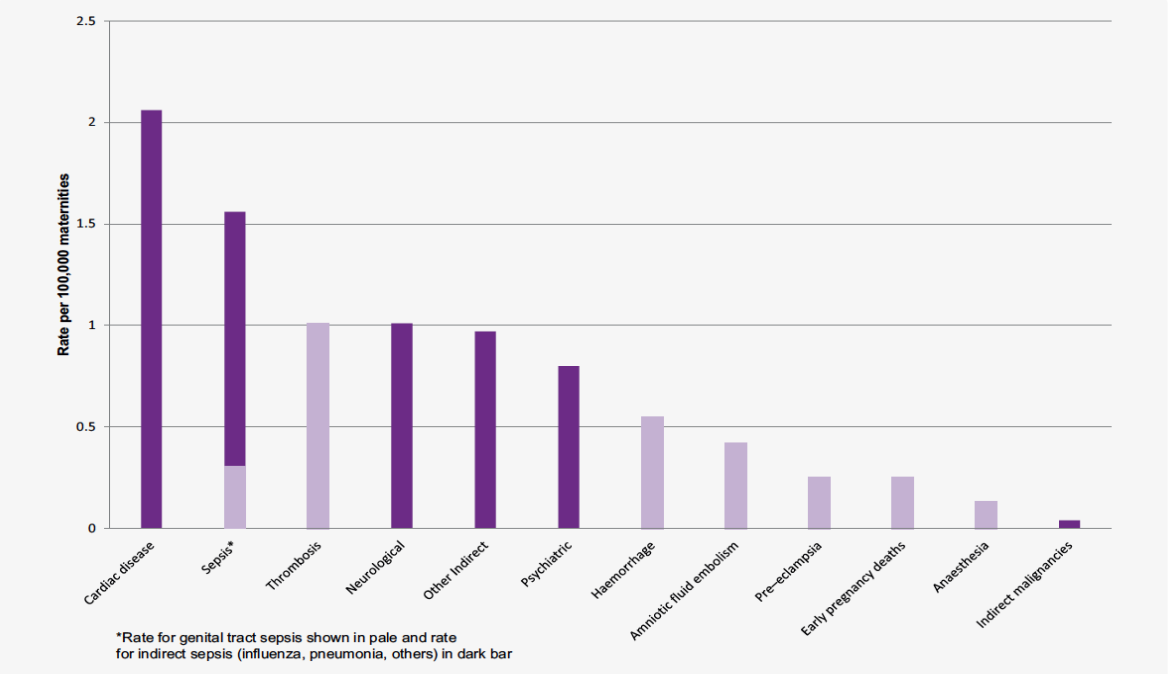
12.1. For the vast majority of mothers and babies in high-income countries, pregnancy outcomes are good, which means that major complications such as the death of the mother and/or baby are rare.

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)
Fax Line: (01296) 316144

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		Risk Rating Post Controls	
			L	C	L	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 12	1	4 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 12	1	4 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 9	1	3 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 15	3	3 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 20	3	2 6

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
	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 16	2	2 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 9	1	2 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