Appendix 2 Response from OUH

Oxford University Hospitals
NHS Foundation Trust

Obstetrics services in Oxfordshire: Oxford University Hospitals overview of what it would take to deliver the two highest scoring models from the options appraisal.

Introduction and Executive Summary

1. Over the last year, Oxford University Hospitals (OUH) has worked closely to support the Oxfordshire Clinical Commissioning Group (OCCG)'s process to look again at options for obstetrics in Oxfordshire, following the recommendations of the Independent Reconfiguration Panel. In the options appraisal undertaken as part of this process, two models were scored most highly by the stakeholder panel:
   - Option Ob9: Two Obstetric Units both with alongside Midwife-Led Unit (MLU)
   - Option Ob6: Single Obstetric Unit at the John Radcliffe Hospital

2. Both these models have different strengths and weaknesses. OCCG has asked OUH to set out its views on what it would take to deliver each of the two models, including addressing the issues identified during the options appraisal. This paper sets out those views.

3. Two Obstetric Units, both with alongside MLUs, should provide greater patient choice and improve patient experience of maternity services for women in the Horton catchment area. In an ideal world, without workforce or financial constraints, this model would be very attractive. However, in reality, it is very difficult to implement. To deliver it safely and sustainably would require a new approach to workforce, untested in the medium to long-term; additional revenue and capital funding; and substantial support from other organisations. The Trust does not have sufficient evidence to be sure if the new approach to workforce would overcome ongoing and severe recruitment and retention challenges, particularly in relation to obstetric doctors, nor if the necessary external support would be forthcoming. For this reason, OUH cannot fully mitigate risks to rota sustainability – and our Board, clinicians and managers remain highly concerned about the risks to patient safety as a result of rota gaps; and the Trust's ability to ensure a safe, quality service in the short, medium and long-term under this model.

4. The model of a Single Obstetric Unit at the John Radcliffe has been temporarily in place since 2016 and has been proven to provide a safe, quality service, with improving outcomes and positive overall feedback from patients (including in North Oxfordshire, South Northamptonshire and South Warwickshire). But there has been a detrimental impact on patient choice and experience for some women in the Horton catchment area in using maternity services, particularly vulnerable women, due to the increased distance to travel to access obstetric services at the John Radcliffe. Delivering this model, whilst addressing the issues identified, would require: more joined-up, tailored information on choice for women in the Horton catchment area; improved patient and visitor access to the John Radcliffe site; expansion of the MLU into a 'maternity hub' providing a wider range of ante-natal and post-natal care (including for vulnerable women); and building in flexibility

to respond to long-term population changes. However, the suggested actions can never fully mitigate the need for women living in North Oxfordshire, South Warwickshire and South Northamptonshire who want an obstetric-led birth to travel further and longer to do so, nor the risk this may negatively impact on some of their experiences of maternity care.

5. Once the OCCG Board has made its decision, the Trust stands ready to work together on implementation – including the production of any relevant business cases and quality impact assessments required under the selected model. When there is greater certainty over the future model for obstetrics, whichever model is selected, OUH is keen to press ahead with developing its wider vision for the Horton as a thriving 21st century district general hospital for North Oxfordshire and beyond, including submitting a business case for significant investment to develop the site.

6. This paper will now examine what it would take to deliver each of the options in turn.

Option Ob9: Two Obstetric Units both with alongside MLU

7. Compared to a single obstetric unit at the John Radcliffe, the stakeholder panel scored this option:
   - more highly than the single obstetric unit on 'patient and carer experience'; 'distance and time to access service'; 'patient choice'; 'consultant hours on the labour ward';
   - the same on 'clinical outcomes' and 'clinical effectiveness and safety' (assuming workforce challenges are overcome); 'recruitment and retention'; and 'supporting early risk assessment';
   - less well on 'service operating hours'; 'delivery within the current financial envelope'; and 'ease of delivery'; and
   - significantly less well on 'rota sustainability' and 'alignment with other strategies'.

Areas of strength

8. Oxford University Hospitals view is that 2 obstetric units with alongside MLUs would be an ideal option for people living in the Horton catchment area, in a system with unlimited resources and no workforce shortages. Whilst the choice of an Obstetric Unit with alongside Midwife-Led Unit is available at both the John Radcliffe (23 miles from the Horton General) and Warwick Hospital (22 miles from the Horton General Hospital), this model would widen the number of places where this choice is available and reduce the distance and travel time to access obstetric services for women in North Oxfordshire, South Northamptonshire and South Warwickshire.

9. The patient survey conducted by OCCG suggests that this option would reduce the increased anxiety around the choice of birth location currently experienced by women in North Oxfordshire and South Northamptonshire. It should also mitigate some of the difficult experiences reported by women and their families when accessing obstetric

services at the John Radcliffe – whilst these are a small proportion of overall births at OUH and we cannot comment on the individual cases, it still very important to the Trust to address the issues these experiences raise. The Trust is grateful to the women and their families who shared their stories.

10. This model would be likely to improve patient experience and choice for some women in the Horton catchment area. According to the patient survey, 24% of women surveyed would choose Banbury as their ideal location to give birth (74% of Cherwell respondents and 97% of South Northamptonshire respondents). When reflecting on their experience, 75% of women surveyed who live 'far' from an obstetric unit would have chosen the same place to give birth, versus 84% of those who live 'near' to an obstetric unit. (Although, it should be noted that, even if there was an obstetric unit with alongside MLU at the Horton General Hospital, some of these women may still choose to give birth elsewhere and some would still need to give birth at a specialist centre.) Local councillors, community groups and campaign organisations in North Oxfordshire, South Warwickshire and South Northamptonshire feel very strongly that obstetrics services should be available at the Horton.

Overcoming challenges and mitigating risks

11. This section sets out what it would take for Oxford University Hospitals to overcome the risks and challenges identified by the scoring panel on sustainability, affordability and alignment with other strategies.

A. <u>Rota sustainability</u>

Workforce challenges across the NHS and at OUH

12. Across the NHS, there are severe workforce shortages. In 2018, the Kings Fund, Nuffield Trust and Health Foundation published a joint briefing that highlighted:
    - There are over 100,000 vacancies across NHS Trusts (1 in 11 posts). The greatest challenge is in nursing and midwifery with 36,000 vacancies (1 in 8 posts).
    - Based on current trends, they project that the gap between staff needed and the number available could reach 250,000 by 2030. If the emerging trends of staff leaving the workforce early continues and the pipeline of newly trained staff and international recruits does not rise sufficiently, the worst case scenario is a gap of more than 350,000 by 2030.
    - International recruitment can be a useful short-term initiative but is not a long-term solution and global competition for trained healthcare staff is high. The World Health Organisation looked at demand across 31 of its member countries and projected that by 2030, all countries could experience shortfalls of 50,000 midwives, 1.1m nurses and 750,000 doctors.

According to the Royal College of Midwives, as of summer 2019, the NHS in England is short of the equivalent of 2,500 full time midwives.

13. Oxford University Hospitals suffers from these workforce challenges alongside the rest of the NHS. These difficulties are exacerbated by the high cost of living compared to other areas of the country, coupled with a national pay scale. OUH also operates in a highly competitive job market: unemployment in Oxfordshire (including in Banbury) is low and there are relatively good transport links (to London, Birmingham and elsewhere) from both the North and the South of the County which opens up a wider jobs market. London Trusts are able to offer London weighting which is not available for staff in Oxfordshire. Some Trusts within commuting distance of Oxford and Banbury are able to offer outer–London weighting which OUH is not funded to do. OUH is very reliant on international staff – around 1 in 8 of our workforce are EU citizens, rising to 1 in 5 nurses – and is therefore vulnerable to uncertainties created by Brexit.

14. In summer 2019, the OUH vacancy rate is 1,250 – around 10 percent of staff, including 600 nursing posts. The Trust has ambitious targets to grow substantive staffing by nearly 4 per cent in 2019-20 by reducing turnover, further international recruitment and doubling apprenticeships. OUH will be looking at: expanding international recruitment, where we can leverage the Oxford brand (although the Trust faces fierce national and global competition); developing better career pathways for OUH staff to improve retention; and improving the Oxfordshire 'offer' on housing and transport. OUH continues to lobby nationally for additional funding to pay our staff 'Oxford weighting' but have not yet been successful.

15. Within the Trust, the Horton General Hospital also suffers from the same workforce shortages as the rest of the NHS. The Horton has some advantages such as:
    - Lower housing costs
    - Easier travel to work with fewer traffic difficulties than in Oxford; and
    - Higher levels of staff engagement, according to analysis of staff survey results.

16. However, there are other challenges that make the Horton equally difficult to recruit to. For example:
    - Whilst the cost of housing is lower in Banbury than in Oxford, it is still considerably higher than the UK average.
    - Employment levels in North Oxfordshire are high; and travel links to London and Birmingham (and to other NHS Trusts e.g. in Warwickshire, Buckinghamshire and Berkshire) are as good, if not better than the rest of the county so there is a very competitive job market.
    - Clinical teams at the Horton are often required to operate fairly independently and required to take serious decisions on the level of risk for their patients, which can make the experience more stressful. This also means that OUH often needs more senior doctors, nurses, midwives and managers to work at the Horton who have a

broad range of skills and are comfortable working independently and experienced in making judgements on risk levels. These posts are in high demand nationally and are particularly difficult to recruit to.

- Some candidates are interested in the more specialist clinical and research opportunities that are not always available at the Horton. In order to address this issue, the Trust is looking to expand the amount of research conducted at the Horton and try to build time at specialist sites - within OUH or elsewhere - to job plan but that time away has to be covered and, therefore, the more time away is built in, the more additional staff need to be recruited. It also means additional travel for staff, which negates one of the positive aspects of working at the Horton.
- The lack of training posts restricts the supervisory elements of some jobs at the Horton, which make also them less attractive from a career development perspective.

Obstetric workforce challenges to date

17. Nationally, there has been a shortage of obstetricians over the past few years. According to the Royal College of Obstetrics & Gynaecology Update on Workforce Recommendations (2018):
    a. 9 out of 10 obstetric units report a gap in their middle-grade rota, which can affect job satisfaction, postgraduate training, quality of care and staff wellbeing.
    b. A 30% attrition rate from the Obstetrics & Gynaecology training programme is typical, further compounded by a loss at transition from training to consultant grade posts.
    c. 54% of those on the Obstetrics & Gynaecology Specialist Register are international medical graduates with 14% from the EEA.

18. OUH had to temporarily close the Horton obstetrics unit in 2016 because the Trust could not secure the workforce required to operate a safe and sustainable service. The service had experimented with a model of 8 clinical fellows but this was not sustainable as they could not devote enough time to both running a safe service at the Horton and meeting their contractual commitments on clinical research. When it closed, the service was dependent on locum doctors and, despite very intensive efforts, the Trust was not able to recruit enough middle grade obstetric doctors to sustain a safe service. In addition to the general challenges in obstetric staffing, these posts are particularly hard to recruit to – because the obstetric doctors need to be able to operate independently, these are senior roles and people qualified to do it are in high demand and can take their pick of roles. In the OUH experience, these people choose units with the highest benefit to their careers and the chance to develop the broadest range of skills. The Horton Unit cannot provide all those competitive advantages.

19. Since 2016, OUH has made continuous, intensive efforts to recruit 9 middle grade obstetric doctors for the Horton, including:
    - Offering a very competitive package, including £5000 per annum additional salary; paying for visas for the applicant and family, including the health surcharge (also

worth £5000); and, on the suggestion of HOSC, offering a relocation package of up to £8000.

- Making the jobs as attractive as possible, including (on the advice of the Royal College) offering time in the job plans at the John Radcliffe to develop specialist skills and the opportunity to participate in RCOG ATSM skills modules on Advanced Labour Ward Practice, Advanced Antenatal Practice and Early Pregnancy. OUH has tested this package with other Trusts and are reassured that it is very competitive. The only additional suggestion made was introducing CESR (see below).
- Running around 20 recruitment processes (with 2 more live at the moment, at various stages), sifting over 300 applications; conducting over 30 interviews and offering positions to 20 people. Since 2016, OUH estimates that the Horton Medical Recruitment campaigns have nominally cost the Trust approximately £33,000 and taken around 200 hours of Consultant time; and 285 hours of HR specialists' time.
- Being open to suggestions from Cherwell District Council and other local representatives to additional offers to attract staff – if they comply with national frameworks and legal duties.
- On the suggestion of HOSC, engaging an international recruitment agency. In January 2019, OUH commenced working with a specialist medical staff agency who submitted just two overseas CV's but both doctors were not appointable against the job description, person specification and required competencies. This Agency subsequently informed the Trust they were unable to find candidates who satisfied the competencies. OUH is building up expertise in international recruitment and an aggressive effort in this area would be required for this option to be successful (see below).

20. Despite these efforts, OUH has been unable to attract close to the 9 substantive doctors needed to re-open the Unit under the 2016 workforce model. The highest number in post at any one time has been 5 people – however, once at that number, almost immediately one of the people in post decided to move on. The Trust experiences high levels of turnover in obstetrics - over the last 5 years, 29 doctors have voluntarily moved on from OUH: 7 consultants, 4 specialty doctors and 18 registrars. People leave for a variety of reasons but mainly for career development or for personal/family reasons. Due to national shortages, the obstetric profession is very competitive and experienced doctors are very much in demand. OUH has multiple examples of our experienced doctors being recruited elsewhere.

21. Similarly, when an obstetrician is made an offer to work at OUH, often their home Trust (or another Trust to which they have also applied) will match or better the OUH offer and they decide to stay put or go elsewhere, often to places with a lower cost of living. Some also change their mind for family or personal reasons. Of the 20 doctors offered positions since 2016: 9 both accepted an offer and attended the induction programme, 8 of which would have been experienced enough to start work at the Horton General immediately.

However, only 4 of these 8 have been retained (2 of whom have just started). The other 4 accepted alternative career opportunities over time.

22. HOSC have previously questioned the drop off ratio between the number of applications received (300) and shortlisted candidates (30), leading to 20 offers. This is not unusual. As a comparison, in the 6 months between 1 February 2019 and 31 July 2019, 8 Emergency Medicine Fellows were shortlisted from 52 applications and 15 Anaesthetic Specialty Doctors and Fellows shortlisted from 121 applications.

23. When OUH has strengthened the package available – for example, by paying for visas or offering a relocation package, we do see an increase in the number of applications. Sadly, we do not usually see an increase in the quality of applicants. As these clinicians will be working without supervision, they have to have considerable experience to be able to safely practice at the Horton. The Trust is confident in the fairness and scrupulousness of our processes. OUH shortlist only on the basis of candidates being able to demonstrate they have the key experience and skills in the job description - and we have not changed our approach during this time period. The Trust is happy to be flexible in our approach where possible but, of course, we will not compromise the standards required to provide a safe and quality service for patients.

24. The recruitment and retention experience above has been confirmed by the results of the options appraisal and the views of the stakeholder panel, which scored the 2016 model the lowest of all options. This process has enabled the Trust to explore different possible workforce models to make an obstetric unit with alongside MLU at the Horton deliverable in a safe and sustained way.

Preferred workforce model - obstetricians

25. OUH clinicians and HR experts tested the theoretical possibility of constructing a rota for all the workforce options in the long list agreed with HOSC. For all except one option, we were able to theoretically construct a rota that complies with national rules. The table in Annex 1 sets out the additional obstetric doctors that would be required for each of the different workforce models. However, actually being able to fill such rotas sustainably is much more challenging.

26. Working with OCCG, and taking into account findings from the report compiled by 'Keep the Horton General' campaign group, the Trust has sought to learn from other smaller units. There are c13-14 units in England, which are rated good or outstanding by the CQC and have under 2200 births per year. OCCG's research suggests that not all of these Units are in a similar position to the Horton (often much more rural, with further travel distances to the next nearest Unit and not part of such large or specialist Trusts). OUH's discussions with these Units – through visits, calls and workshops - indicate that, whilst they are proud of the services they provide to patients, workforce is a continuous

challenge. These units are managing, in the majority of cases, to maintain their rotas but the ongoing difficulties in recruitment and retention (particularly of obstetricians and sometimes also of paediatricians) and the subsequent risks to patient safety is a constant concern. The Trust has drawn on learning from these Units in developing possible workforce models and potential new approaches.

27. Learning from other smaller units, the model which seems to work best is a 'hybrid rota'. This involves recruiting a higher number of consultants who also participate in the middle grade rota. As there are fewer shortages at consultant level, this helps mitigate recruitment challenges and increases sustainability. This model was the highest scored by the stakeholder panel. The balance between consultants and middle grade doctors can change as set out below, but the most common ratio in other smaller units seems to be c8 consultants and c7 middle grade doctors. There is also a question of whether the hybrid rota should be just for the Horton General or pooled across the John Radcliffe and the Horton. The hybrid rota just for the Horton General scored more highly in the options appraisal and is more in line with other smaller units. The table below sets out the relationship between number of middle grade doctors and number of consultants under the hybrid model to meet rota requirements.

No. Middle trust grades	**No. consultants**
9	5
8	6.6
7	**8.2**
6	9.8
5	11.4
4	13
3	14.6
2	16.2
1	17.8
0	20

28. The current recruitment gaps are set out in annex 2, based on the preferred hybrid rota model at 8.2 consultants and 7 middle grade doctors, for the Horton General only. This assumes no further attrition from current rates. These are:
    - Consultants: add 3.2 to funded establishment then need to recruit 6.2 additional to fill gaps.
    - Middle grade Trust doctors: reduce funded establishment by 2 then need to recruit 3 additional to fill gaps.
    - Junior doctors: based on BMA guidance, add 8 junior doctors to the rota. We currently have 3 junior doctors available for the Horton Unit via the GP Vocational Training Scheme. OUH would reapply through the Deanery for accreditation for training junior doctors via the General Medical Council and Health Education England (HEE) Thames Valley. Depending on how many trainees the Trust was allocated, gaps would need to

be filled through direct recruitment of junior grade Trust doctors. This is a more expensive option than training doctors –but is a much easier role to recruit than middle grades.

29. As under the 2016 model, the majority of consultants would be obstetricians and gynaecologists who could also support elective gynaecology lists and outpatient clinics at the Horton. Employing joint obstetric and gynaecological consultants will also mean they would be trained to undertake the obstetric emergency surgery that requires gynaecological expertise, 24/7 if needed. The Trust would need to more fully explore what additional support might be needed to ensure this can be done safely in the Horton unit. These consultants would need to be passionate about and dedicated to prioritising the development of a really quality, safe and sustainable Obstetric Unit and alongside MLU at the Horton, alongside their gynaecology work.

30. As part of this model, OUH could consult with the Deanery on the option for trainees to spend up to 8 hours at the Horton. OUH would never be comfortable that reopening a Unit that relied on using trainees in this way to stay open would be a sustainable future option. But redeploying trainees at the Horton would be likely to increase the attractiveness of the middle grade posts to applicants. The Trust would be concerned that we would need to backfill the trainees' time at the John Radcliffe, so we would need to ensure this would not jeopardise the overall obstetric service for Oxfordshire. As above, the Trust would rather pursue reaccreditation and the allocation of training grade doctors from the Deanery. Not securing the full 8WTE training doctors/junior Trust grade doctors under the hybrid model would mean having to recruit more middle grade doctors to cover the role, which is extremely difficult or more consultants which is very expensive.

Sustainability of workforce model

31. One of the key challenges with this model is not just the initial recruitment, but the ongoing sustainability of the workforce. If the Trust cannot be confident that we can sustainably staff the rotas, then OUH clinicians and managers cannot be confident in providing a safe service to patients and we cannot maintain an Obstetric Unit. It would be completely wrong to re-open an obstetric unit at the Horton, only to have to close it again because it is not possible to fill the rotas sustainably and patient safety risks are too high.

32. One piece of learning from previous experience in obstetrics; some other Horton services; and other smaller units - is the importance of dedicated, local clinical leadership in rebuilding a service that is sustainable for the future. For this option to work, OUH will need to recruit a dedicated clinical lead for the new Unit, based at the Horton and, possibly also a dedicated Head of Horton Midwifery.

33. Given the overall shortages in obstetrics middle grade doctors in particular, and learning from other small units, it is highly unlikely rota sustainability can be achieved with a

standard approach to recruitment and retention. OUH and OCCG have discussed with the Royal College and consulted with other Trusts and to pursue this model would involve looking at some or all of the following innovative options for the new Unit. All of these options take 1-2 years to set up; incur additional costs for which the Trust would need funding support above the £4.6m already described in the finance section; and will require considerable clinical and administrative support and focus to set up. The costs and resource are summarised below and set out in detail in Annex 3. Some of these initiatives are untested in the medium to long-term - and OUH cannot know if they would be individually or collectively successful in securing the required workforce levels, given the difficulties in recruiting and level of turnover we experience in obstetrics.

34. The options to consider are set out below with the length of time to set up and the costs attached. Most options will take 1-2 years to put into place and, if we recruited one doctor through each scheme, we estimate it would cost between £200,000 and £250,000 and would require support from a small, dedicated recruitment team. More detail on each of these is set out in Annex 3.
    - CESR Fellowship Rotation posts: 1 year and c£20,000
    - Research Fellow posts: 1 year and c£105,000 (tried before and did not work as roles did not allow enough time for research and practice)
    - Medical Training Initiative placements: 1.5yrs and c£10,000 per doctor
    - Associate Specialist Grade: 1.5yrs, c£11,500 plus c£17,000 per doctor
    - Multiple international recruitment agencies: 1.5 years, c£9500 plus c£34,500 per doctor
    - Ongoing partnership with international health organisation: 1.5yrs , £20,000 plus £3200 per doctor
    - Step In, Step Out – potential RCOG pilot, more information needed.

35. To implement the above proposed options, the Trust would initially need to have a dedicated Medical Staffing Talent Specialist (approx. Band 6) working on this project to set up the service and then would need continued additional resource (probably reducing to 0.5 of a Band 6) to ensure there was regular recruitment initiatives, drives and flow of doctors to sustain the service. From the estimated time above, the Medical Staffing team would also initially need one dedicated Medical Staffing Recruitment Assistant (Band 4) releasing the advertisements, assisting the shortlisting, setting up interviews, co-ordinating with other partnership Trust's, agencies and overseas units (probably dropping to 0.5 in the longer term). This excludes any additional resources needed for other new clinical and non-clinical staff to support the service. The level of HR effort and cost required to staff this unit would be significant vs other specialties.

Midwifery recruitment

36. The below table shows the additional staffing required to run an obstetric unit at the Horton hospital. It shows the midwifery staffing levels required for 1000-1500 births and

1500-2000 births. These staff would be required to provide antenatal, intrapartum and postnatal inpatient care. The current staff required to cover outpatient and community services are not included in the below. The service is currently funded to recruit the number of additional midwifery staff for 1000-1500 births and so could begin this immediately.

Midwifery Staff	**Birth numbers**	
	1000-1500	**1500-2000**
Band 8 Matron	1	1
Band 7 Manager	1	1
Band 7 Coordinators	5.15	5.15
Band 6 Midwives	18.61	21.18
Band 5 Preceptee Midwives	4.58	4.58
Band 4 Maternity Assistant Practitioner *	5.15	5.15
Band 3 Maternity Support Workers	7.5	10.5
Band 2 Maternity Support Workers	3	3

**Dependent on the staffing model, the Band 4 Maternity Assistant Practitioner is second assistant in theatre and required during caesarean sections.*

37. Overall at OUH, we continue to face pressures on midwifery recruitment and retention. Historically, midwife recruitment and retention of staff has been successful in the north of the county due to lower costs of living than in Oxford city and surrounding areas. OUH is broadly confident we could recruit sufficient midwives to staff the Horton service – although this may put more pressure on recruitment for the rest of the maternity services across Oxfordshire.

Neo-natal nursing recruitment

38. OUH would need 12 neo-natal nurses to open up the Level 1 SCBU with 8 cots at the Horton required to reopen an obstetric unit. Nursery nurse support would also be required. Administrative and clerical staff would be shared with paediatrics services.

39. Overall, there is a national shortage of neo-natal nurses. At present, there is a high level of vacancies at the John Radcliffe, despite intensive recruitment and retention efforts. Any of the current neo-natal nurses moving to the Horton would also need to be backfilled at the John Radcliffe. We could look at dedicated international recruitment of neo-natal nurses at an approximate cost of £10,000 per post but this is a competitive area. It would be extremely challenging to sustainably staff the SCBU sustainably, given the pressure on

neo-natal nurse recruitment. Nursery nurses are relatively easy to recruit, although turnover is high.

Anaesthetic recruitment and other theatre staff

40. There is a current national shortage of Anaesthetists. OUH also experiences these workforce challenges, with gaps in our rota which we find it difficult to fill and on current projections it will take us more than 3 years to sustainably fill our existing workforce gaps. In addition, almost 20% of our anaesthetists are over the age of 55 therefore this represents another challenging ask for us to replace this proportion of our workforce over the next 5 years. Across the Trust we are examining additional international recruitment options and other incentives in order to speed up this process – particularly with the general national shortage in this field. When an obstetric unit previously operated at the Horton General Hospital, to meet required standards the Trust needed to operate a full on-call rota. If organised on the same basis as previously, that would require us to recruit 2-3 WTE additional consultants at the Horton. The Trust would want to examine if there are any ways to deploy innovative workforce models to safely achieve the standards with a different staff mix, given the overall shortages of Anaesthetists, locally and nationally.

41. OUH will also need to recruit additional theatre staff to support an obstetric theatre at the Horton: this is another area where we face shortages across the Trust as a whole and have found it difficult to recruit.

B. <u>Affordability</u>

42. Our financial analysis indicates that to re-open an obstetric unit with an alongside MLU, operating the preferred workforce model described above will cost £4.6m more per year to the local health system, compared to the current, temporary model. This money will need to be found from within the existing funding envelope for Oxfordshire health and care.

43. Our previous condition assessment report for the Horton maternity block indicates it needs significant investment. Whatever decision the CCG makes on the future of obstetrics, we will need capital investment in the maternity unit. For this option, the investment will be more immediate and significant. Current safety standards mean we would not be able to simply re-open the existing obstetric theatre facility but would need to update it. We will also need to create the space for both an obstetric unit and an alongside MLU, whereas we have only previously operated one or the other. Based on the potential future birth projections for the obstetrics unit, we would also need to build in capacity for the unit to grow in the future. We will also need to make sure there is enough space for current and future maternity outpatient clinics we currently run. This means we require a new build unit. We would expect such a unit would be attractive to

women and increase the numbers choosing to give birth at the Horton and be an attractive environment for staff to come and work in.

44. OUH commissioned an estimate from external consultants (based on accepted methodology and benchmarks) on the capital investment required for a new build obstetrics unit alongside a midwife-led unit at the Horton. The estimate for a stand-alone, new build unit is between c£40-45m. OUH would need to submit a business case to the Department of Health & Social Care for this capital investment, either just for obstetrics or as part of a wider business case for capital to redevelop the Horton site. There is currently no open process for capital investment bids and we do not know the timeline for the next round. We would also need to consider if there are other ways of raising some of the capital needed for investment – for example, philanthropic donations.

C. Support from partners and national organisations.

45. In order to open an obstetric unit with an alongside midwifery led Unit, we will need support from a number of our system partners and national organisations. This includes:
    - Our Local Maternity System (LMS) in Buckinghamshire, Oxfordshire and Berkshire West – and also the Local Maternity Systems for Northamptonshire and Coventry & Warwickshire: our LMS will need to be supportive of the potential to extend the catchment area of the Horton and be comfortable about the impact on other services in the area of more women from wider geographies choosing to give birth at the Horton. We will also need their support to implement the learning from other smaller units to develop the Horton as a beacon of good practice in certain areas. This could build on existing strengths or current plans: such as early risk assessment; supporting women who would like low intervention births; or working with vulnerable women to support them before and after labour.
    - The Deanery, HEE and the GMC – to support the reaccreditation of the Horton for trainees and help fund and support some of the innovative new workforce models.
    - The Royal College of Obstetrics & Gynaecology – to prioritise the Horton for the piloting of new and innovative schemes to address workforce challenges; and to develop the Horton as a beacon of good practice. We may also need support from other Royal Colleges on workforce shortage areas.
    - The Department of Health & Social Care, HM Treasury, NHS England/Improvement and the BOB Integrated Care System to approve the business case for capital investment required for the Horton Unit and make it a priority against other requests for capital.
    - The Oxfordshire Clinical Commissioning Group and the wider Oxfordshire system to make the additional funding available.

46. Given the trade-offs required for some of these external organisations to provide the support above; the need to consider the impact on other providers and services; and the formal processes which need to be conducted to make some of these decisions, OUH is not

currently in position to know whether the necessary support from all these organisations would be forthcoming.

Summary on option 9b) 2 joint obstetric units with alongside MLUs:

47. To implement this model would require OUH to adopt a new hybrid rota and put in place a package of innovative new approaches to recruitment and retention. These approaches would take 1-2 years to put into place and require considerable resource from clinicians and HR specialists. Even then, we cannot be certain they would be successful in enabling us to successfully fill our rotas. 2 joint obstetric units with alongside MLUs would cost an addition £4.6 million per year in additional funding, plus £40-45m capital investment for a new build. OUH will also need support from a range of local and national partners, which we do not know will be forthcoming.

48. The OUH view is that this model would be likely to improve the patient choice and experience of maternity services for women in the Horton catchment area and it is strongly supported by local councillors, community groups and campaign organisations. However - because of the uncertainty over whether the approaches suggested would be successful in overcoming recruitment and retention challenges - the OUH Board, clinical leads and managers continue to be highly concerned about the risks to patient safety of unfilled rotas and therefore the sustainability of service provision under this model in the short, medium and longer term.

<u>Option Ob6: Single Obstetric Unit at the John Radcliffe Hospital</u>

49. Compared to reopening an obstetric unit with an alongside midwifery-led unit at the Horton General Hospital, the stakeholder panel scored this option:
    - More highly on alignment with other strategies, ease of delivery, rota sustainability, delivery within the financial envelope and service operating hours;
    - The same on clinical outcomes and clinical effectiveness and safety; and on recruitment and retention.
    - Less well on consultant hours on the labour ward and patient choice
    - Significantly less well on distance and time to access service and patient and carer experience.

Areas of strength

50. This model has been in operation since 2016, in response to the need to temporarily close obstetric services at the Horton, and is proven to provide safe, quality services overall for the population of Oxfordshire and surrounding areas within the current financial envelope. It fits with the Local Maternity System strategy. The description of the services we offer, previously outlined in papers to HOSC, is attached at Annex 4. Women are able to choose an obstetric-led birth at the John Radcliffe (or Warwick Hospital); an alongside

midwifery-led unit at the John Radcliffe (or Warwick Hospital); a freestanding midwifery-led unit (at the Horton General, Chipping Norton, Wantage and Wallingford); or a Home Birth. Ante-natal and Post-natal care is also offered at the Horton General, including scans, blood test and support clinics.

51. The Maternity services provided by OUH are recognised nationally as delivering safe care with good outcomes for mothers and their babies. In 2019, CQC rated OUH maternity services as 'Good' both overall as a Trust and at the John Radcliffe. (The Horton General was also rated 'Good' for maternity but this inspection dates back to 2014.) The annual CQC maternity survey of patients for 2018 rates OUH services as above average for labour and birth and in line with average for other areas.

52. In the patient survey carried out in response to the IRP recommendations, feedback on the maternity care provided by the Trust is positive overall with common words to describe our services including 'professional', 'excellent', 'good', 'helpful', 'friendly', 'reassuring' and 'positive'. OUH maternity services had a net satisfaction score for all elements, with the exception of parking cost, with particularly positive ratings for the quality of ante-natal care; cleanliness and hygiene during labour and post-natal care; and the competence of healthcare staff. The majority of respondents from Cherwell and South Northamptonshire agreed or strongly agreed with almost all the positive statements about OUH maternity services – with the exception of three elements of post-natal care: ease of people travelling to visit; ability of children to come and visit; and ease of parking for visitors.

53. The Trust reports marked improvement in rates in the serious outcome measures for maternity (still birth and perinatal death at term; significant brain damage to term babies; unexpected admissions of term babies to special care units) including from 2014-2018. OUHFT was one of the few trusts in the UK to be declared 100% compliant in all 10 safety action plans of the NHSLA National Maternity Incentive Scheme introduced at the beginning of 2018. This information is all included in the service description in Annex 4, previously provided to the HOSC.

54. Whilst midwifery recruitment and retention are still an ongoing challenge, many of the most severe workforce difficulties outlined in the first section are not applicable to this model – the Trust would not require additional obstetricians, neo-natal nurses and anaesthetic staff (the harder to recruit professions) under this model. Extensive engagement with staff has led to improving retention and reducing turnover in midwifery and the Trust has appointed of a new, permanent Director of Midwifery from September. Through these efforts, we have increased our shift cover and fill rates, enabling us to maintain all areas of service provision throughout this year. These improvements give OUH clinicians and managers confidence that this model can be sustainably provide a safe, quality service; and overall good experience for patients.

Overcoming challenges and mitigating risks

Appendix 2 Response from OUH

55. This section sets out what it would take for Oxford University Hospitals to overcome the challenges identified by the scoring panel on patient choice; distance and time to access service; and patient/carer experience.

A. <u>Better, tailored information for women in the Horton catchment area on the choice of options available, across both Oxfordshire and surrounding counties</u>

56. The patient survey shows that, whilst there is a net positive satisfaction score of 41% in the choice of where to give birth, there is only a net positive of 12% for Cherwell residents responding and net negative satisfaction score of -2% for South Northamptonshire residents. 68% of Cherwell service users (82% in S. Northamptonshire) feel that the temporary closure of the obstetric unit at the Horton impacted their decision of where to deliver and 59% in Cherwell and S. Northamptonshire feel it impacted their overall experience. Another obstetric unit with an alongside MLU in Oxfordshire does not increase the range of choices open to women – both of these exist at the John Radcliffe and Warwick Hospital. It does, however, offer an additional choice of locations at which these services are available in our local area and reduces time and distance to travel. 75% of service users in Cherwell and 93% in S. Northamptonshire said they would have preferred to give birth at the Horton if obstetric services had been available. However, there is also a net positive satisfaction score of 48% and 64% for Cherwell and South Northamptonshire for, on reflection, the choice made on where to give birth. 79% overall, 66% of Cherwell residents and 68% of South Northamptonshire residents would have chosen the same place to give birth.

57. The patient survey gives a net satisfaction rating of 48% across Oxfordshire for the support received in choosing where to give birth – 30% net satisfaction for Cherwell residents and 36% net satisfaction for South Northamptonshire. Feedback from the survey/focus groups and from the stories we heard from women and their families throughout this process indicates that many women in Oxfordshire and South Northamptonshire do not necessarily view the Warwick Hospital as a good choice for them, despite the fact that it offers an obstetric unit with alongside MLU, within a shorter travel time than Oxford for many in the Horton catchment area.

58. To make this model work, OUH would need to do more with our colleagues at South Warwickshire Foundation Trust and other hospitals in the surrounding area to improve information for women about this option. The two Trusts would need to build on work already done with women on communications, to jointly refresh our patient information to provide specifically tailored information on choice for women in the Horton catchment area that covers options in both Oxfordshire and Warwickshire together. OUH would work with patients, including organisations such as Maternity Voices to examine the best ways to provide helpful information – for example, the Trust website is already being updated OUH could include videos and information about Oxfordshire and South

Warwickshire care options. A new mobile phone app is also in development to help women with maternity journey.

B. Improving patient and visitor access to the John Radcliffe site.

59. In the patient survey, residents of all council areas disagreed that it was easy for visitors to park and for other children to visit. Cherwell and S. Northamptonshire residents reported significantly less satisfaction with ease of visitor travel. The CCG analysis shows that whilst travel times to the John Radcliffe are around the same from the Horton catchment area as the rest of the county, the distance and time to services has increased for residents of that area, compared to when the Horton obstetric unit was open, as more of them have to travel to the John Radcliffe for some of their care.

60. Traffic congestion coming into Oxford and particularly around the Headington area is a well-known issue with consequent effect on travel to the Oxford hospital sites. This affects all services, not just maternity. OUH is working to improve overall access to the John Radcliffe, whilst also mindful of our environmental responsibilities to promote sustainable travel and help improve air quality. Actions to date include relocating the majority of our administrative staff to a new site at Cowley to reduce the need for staff travel onto the John Radcliffe site; encourage staff and patients to use public transport where possible; and moving some services into the community and up to the Horton General.

61. OUH are keen to move much more activity closer to home where possible, particularly if we are successful in securing capital to develop the Horton site. The Trust will begin to install Automatic Number Plate Recognition at the John Radcliffe this winter, which should lead to improved flow of traffic around our sites, quicker access and exit from our car parks, and more convenient payment methods. OUH is also looking to apply for permission to consolidate our ground level car parks into a multi-story car park. The Trust will continue to investigate various internal and external measures to ease the pressure on parking at the John Radcliffe and is committed to working with local partners involved to improve the patient access experience. However, these issues continue to be very difficult to resolve and access and parking difficulties are likely to persist for some time, despite the Trust's best efforts.

62. There is a particular issue if women in labour have difficulties accessing the site in private transport at peak times. OUH indicatively estimates that this could apply to up to 5 of total John Radcliffe births a day (although this number is not reflected in our feedback and complaints). To mitigate the risk for these women, OUH would need to look at setting up a dedicated hotline for women and their families who are trying to access the site through private transport in an emergency. The hotline would advise women in an emergency situation on how to navigate the site, including deploying security teams if necessary; and direct them to available priority parking places.

63. The transfer times are comparable to the other MLUs across Oxfordshire due to the presence of the dedicated ambulance (and in line with median travel times in the findings of the national Birth place cohort study). OUH would need OCCG to continue to pay for this dedicated ambulance in order to maintain transfer times under this service model.

64. The patient survey provided clear feedback that the ability of partners to stay overnight at the John Radcliffe would improve the experience for mothers, particularly first time mothers. This was the number 1 improvement priority identified. OUH has already taken recent action to expand these options – we have increased the number of family rooms and our new single rooms have drop down beds for partners to stay. For women in four-bedded single sex bays, OUH could look at creating a partners rest room with convertible chairs that would allow partners to stay overnight at the end of the ward. For families with babies in the Neonatal Intensive Care, the Ronald McDonald facilities at the John Radcliffe site are increasing from the 17 current bedrooms to a new Ronald MacDonald House on-site with 62 bedrooms. This will be opening in the Summer 2020.

65. OUH is also responding to feedback that most women wish to have their postnatal care as soon as possible after birth. The OUH service has developed enhanced recovery pathways to allow women a safe and quicker discharge home after all births, including women who have had caesarean sections. Feedback from user representative groups has been positive. The Trust will continue to focus on this area and would look to expand post-natal care available at the Horton General (see below). This should mean that more women stay less time at the John Radcliffe which would help address some of the impact of concerns on visitor access.

C. <u>An expansion of services available at the Horton MLU or virtually to enable women to receive the majority of their maternity care closer to home.</u>

66. The main action required under this option is to increase the antenatal and postnatal services available at the Horton, or virtually, enabling women in North Oxfordshire, South Warwickshire and South Northamptonshire to receive the majority of their maternity care closer to home.

67. The Trust already offers antenatal and postnatal care at the Horton, including: blood tests, scans, a perinatal mental health clinic and an enhanced breast feeding service (including an overnight stay with midwife support if required). The patient survey showed that Cherwell residents rate their ante-natal care particularly highly. 64% of Cherwell residents had their scans at the Horton; and 55% had blood tests. 42% were able to have an appointment with an obstetrician/gynaecologist at the Horton. OUH would look to increase these percentages.

68. To make this model work better for the residents of the Horton catchment area, OUH would need to build on the current MLU and outpatient clinics to create a maternity hub which would include:
    - An expanded maternity assessment unit (MAU) to include reduced fetal movement assessments and early labour assessments, allowing between 5-10 women per day to be reviewed closer to home. The dedicated ambulance could also cover transfers from the MAU, if required.
    - Refurbishing the second floor of the current unit to open more specialist ante-natal and post-natal outpatient clinics, including an expansion of the mental health clinics; the new diabetes clinic; and, possibly (subject to clinical appropriateness) a pre-term labour clinic.
    - Expanding telemedicine between the Horton and the John Radcliffe, with new equipment to allow consultants to remotely review monitoring of fetal wellbeing. The Trust would also like to look at expanding telemedicine further to women in their own homes to allow remote monitoring – for example on blood sugar levels for those with gestational diabetes.

69. Throughout this process, there have been particular concerns raised around vulnerable women. OUH has secured funding to set up a case loading team for vulnerable women, which will provide them with a named midwife providing 1-2-1 continuity of care throughout their pregnancy, including in labour. This will also allow the Trust to respond to some of the concerns in the patient survey around continuity of care. OUH is currently recruiting to this team and once in place, they will be able to work with vulnerable women across the county, including in the Horton catchment area to help ensure their needs are addressed. OUH would need to also look at developing outreach clinics to local communities, working with Primary Care Networks, to particularly target areas in the Horton catchment area where women may be high-risk, working with community groups.

70. The Trust has met with representatives from South Warwickshire Foundation Trust and agreed to explore ways to allow women who require obstetric led care to access more of their antenatal care at a local level. This will focus on the Ultrasound Scan provision, the possibility of consultant antenatal clinics at the Horton and providing local maternity assessment including some pathways e.g. screening for gestational diabetes and decreased foetal movements. This ambition would not be easy to realise and would require detailed work between the two Trusts across two different Local Maternity Systems.

71. During this process, concerns have also been raised about the effects of increased anxiety in pregnancy on mothers and babies. There is evidence that women with a diagnosed General Anxiety Disorder can suffer from poorer outcomes if they do not receive support. As part of the booking process and throughout pregnancy, OUH screens for a variety of mental health issues, including General Anxiety Disorder and depression. Our clinicians and managers make sure women who are diagnosed with mental health issues get the

help they need – for example, from community mental health services, Oxford Parent Infant Project, Infant Parent Psychology Support, Talking Spaces or our internal OUH services if appropriate. These services are largely provided locally in the community. There is a general increase in the proportion of women presenting with mental health issues but OUH screening is not identifying more women with previously undiagnosed mental health issues and there no greater rise in the North Oxfordshire population than elsewhere. OUH continues to monitor these issues closely.

72. The Trust would need to make some short-term capital investment at the Horton MLU to create the expanded maternity hub. We would expect that to be deliverable within usual capital planning. In the longer-term, under this model, the Trust would need more significant investment to refurbish/build a new freestanding midwifery-led unit. External consultants estimate that a full refurbishment on the existing footprint would be c£17-18m. OUH would incorporate this into the business case we intend to submit for the redevelopment of the Horton site. As set out above, there is currently no open process for capital investment bids and we do not know the timeline for the next round. And, as above, the Trust would also need to consider if there are other ways of raising some of the capital needed for investment – for example, philanthropic donations.

D. <u>Long-term flexibility to respond to changing population and demographics</u>

73. The CCG's population growth estimates demonstrate considerable variation in projections of the future birth rate, depending on the rate of housebuilding and its impact on demographics. That analysis does not yet include an estimate of the impact on population growth from the Oxford-Cambridge ARC which is not yet in local plans. Growth in population over the last few years has not translated into increased birth rates - since 2010, Oxfordshire has seen an 18% decrease in births.

74. However, if the upper estimates of the population growth and birth rate projections do materialise over the next 5-10 years, additional obstetric capacity would be required in Oxfordshire. In that case, under the population health planning framework agreed by the Health & Wellbeing Board, the CCG would need to review the model for obstetrics. If the single obstetric unit model is selected in this current process - and if OUH can secure capital to redevelop the overall Horton hospital site – it would be sensible to build flexibility into the design of the site, so it is possible to re-open an obstetric unit in the future.

Summary on Option 6) single obstetric unit at the John Radcliffe Hospital

75. To address the issues identified with this model, OUH would need to: work with South Warwickshire Foundation Trust and other local providers to provide joint, comprehensive and tailored information on choices for women in the Horton catchment area; improve patient and visitor access to the John Radcliffe site; expand the range of

antenatal and postnatal care that can be accessed at the Horton MLU, so women can receive the majority of their maternity care close to home; and build in flexibility to respond to long-term population growth, if possible.

76. The OUH Board, clinicians and managers are confident in the safety and quality of the service provided through this model over the past 3 years, which has positive feedback from patients, including those within the Horton catchment area, and the independent inspectorate. However, the suggested actions can never fully mitigate the need for women living in North Oxfordshire, South Warwickshire and South Northamptonshire who want an obstetric-led birth to travel further and longer to do so – and we recognise this may have a negative impact on some of their experiences of maternity care.

Overall conclusion

77. At request of OCCG, OUH has set out what it would take to deliver each of the highest scoring options for obstetrics in Oxfordshire. Once the OCCG Board has made its decision, the Trust stands ready to work together with commissioners, other stakeholders and our patients on implementation – including the production of any relevant business cases and quality impact assessments required under the selected model.

78. This has been a valuable process, including the opportunity to engage with a range of stakeholders and gain feedback on OUH maternity services, including ideas for improvement. The Trust is keen for the local Maternity Voices Partnerships to review the full patient survey and identify whether there are other actions we should consider to improve patient experience.

79. More broadly, the Trust has an exciting vision for the future of the Horton as a thriving, 21st century district general hospital for the population of North Oxfordshire and beyond. In order to make this vision a reality, whichever, model of obstetrics is selected, we need to develop a strong business case to the Secretary of State for Health & Social Care and HM Treasury for the significant investment required. Throughout this process, there have been real positives from engaging closely with local stakeholders to shape thinking – OUH is keen to continue building relationships and working together to take this vision forward. We hope we will benefit from the strong support of Health and Wellbeing Board partners and also our local MPs, councillors and community in making our compelling case for investment in the future of the Horton.

Appendix 2 Response from OUH

Annex 1: Number of obstetric doctors required for each of the workforce options considered by the stakeholder panel

Option number	Consultant obstetricians	Middle grade doctors	Tier 1 doctors	Associate specialists MSW	Total additional staff required
Ob1 – 2 obstetric units, 2016 model	20 (15 JR 5 HGH)	29 (9 HGH 20 JR)	15 (JR) 3 (HGH)	4 (HGH)	0
Ob2a – 2 obstetric units, fixed consultant	38 (total) 15 (JR) 23 (HGH)	20 (JR)	15 (JR)		18 consultants
Ob2a (as above, with Tier 1 support)	35 (total) 15 (JR) 20 (HGH)	20 (JR)	15 (JR) 9 (HGH)	Or 6 (HGH)	15 consultants 9 tier 1 doctors or 6 Ass MSW
Ob2b – 2 obstetric units, rotating consultants	30 (total) 32.4 (total) if no tier 1 support	20 (JR)	15 (JR) 9 (HGH)	Or 6 (HGH)0	10-12.5 consultants but would need to have further specialist training
Ob2c – fixed, combined consultant and middle grade	**20-40 (total) 15 (JR) 5-20 (HGH) 5-23 if no tier 1 support)**	**20 (JR) 0-9 (HGH)**	**15 (JR) +/- 9 (HGH)**	**+/- 6 (HGH)**	**Up to 23 new consultants. Depending on ratio would have to consider some requiring further specialist training**
Ob2d – rotating combined consultant and middle grade	21-33	20-28	15 (JR) 9-1	3-6	Up to 13 new consultants but actually would be difficult to cover all the specialties and provide structured training for ST6/7 e.g. SST the SST
Ob6 – single obstetric unit	16	20	15	0	0 current temporary reconfiguration

Appendix 2 Response from OUH

Annex 2: Summary of recruitment at the Horton General required to achieve both highest scoring options.

Doctors currently in post[1]				Required						Gap (need to recruit at HGH)		
Consultants	Middle grade	Junior doctors		Consultants		Middle grade		Junior doctors		Consultants	Middle grade	Junior doctors
				JR	HG	JR	HG	JR	HG			
Currently 17 are in post[2] This includes 2 recruited to work at HGH	Currently 22 are in post This includes 4 recruited to work at HGH.	Currently 12 are in post This includes 0 recruited to work at HGH	**Two obstetric units[3]**	15[4]	8	20[4]	7	15[4]	8	6	3	8
			Single obstetric unit	16	0	20	0	15	0	N/A	N/A	N/A

Current in post[1]					Required				Gap to recruit at HGH	
Midwives		Neo-natal nurses			Midwives		Neo-natal nurses		Midwives	Neo-natal nurses
JR	HGH	JR	HGH		JR	HGH	JR	HGH		
270.6	9.04	Currently 109.6 are in post. This includes 5 who were originally part of the HGH establishment		**Two obstetric units**	269[5]	38[6]	121	12	16.5	7-12[7]
				Single obstetric unit	285.5[5]	11	121	0	0[8]	0

1- As at September 2019.
2 - Consultants at the JR include 9 specialist obstetricians who must stay at JR to manage complex cases.
3 – With alongside MLUs, operating a hybrid rota. This means a mix of consultants and middle grade doctors with more consultants covering some duties usually covered by middle grade doctors. This is beneficial if middle grade doctors are in short supply. The calculation in the table above is considered to be the most feasible mix of consultants (8.2) and middle grade doctors (7) but this could be flexed depending on success in recruiting.
4 - The number of consultants required at the JR will not change significantly with an obstetric unit being open at the HGH. The minimum number of consultants required on a ward is related to the number of births that take place and because the JR has a large number of births and offers care for women with complex needs they must have more consultants available.
5 - Based on Birthrate recommendations
6 – Depending on whether catering for 1000-1500 births or 1500–2000 births
7 – Nurses who were formerly part of the Horton establishment would need to be consulted on whether they want to move back up to the Horton unit. Any nurses who did choose to move back up would need to be backfilled at the John Radcliffe.
8 – We may need to recruit additional midwives for the Horton to provide the expanded services described in our mitigations above, which we need to work through in more detail, depending on the design and roll-out of services. As described, in the main paper, the Trust has found it easier to recruit midwives for the Horton compared to other staff groups.

Appendix 2 Response from OUH

Annex 3 – Detailed options for new recruitment and retention initiatives

Obstetrics and Gynaecology CESR Fellowship Rotation Posts
Similar to the Orthopaedic CESR rotation posts, the Trust would partner with other Obs & Gynae departments in the UK and form rotational posts that attract candidates who want to complete a fellowship prior to being appointed as a Consultant. Due to the shortage of Obstetrics and Gynaecology doctors, there are no guarantees that we would find other Trust's interested in forming a partnership and there is no knowledge of whether this would be attractive enough to senior trainees. The rotations would need to be fixed to meet the immigration requirements should candidates require a visa and each Trust is required to pay for a new visa as the doctor rotates around the different Trusts which adds a cost pressure to the partnering Trusts and the doctor. However, this initiative was most strongly recommended to OUH by other smaller units and would be the most likely initiative to try first. Approx timescales: 6 months to formalise a relationship, documentation, create rotations and advertise. Interview and notice period would take approx. 5 months. Total – 11-12 moths <u>Costs of implementation</u> Regular meetings with the partner organisation to set-up the rotation - £1,797.00 (1 week Consultant time) Advertisement costs – BMJ - £700.00 Joint shortlisting and interviewing - £8,986.00 Recruitment and administration of the rotations - £500.00 Total Set-Up Fees: £11,283.00 Visa if rotating for 1 years - £1,199.00 per trainee, per hospital Total for 6 candidates - £7,194.00 Overall total approx: £19,177.00
Obstetrics and Gynaecology Research Fellow Posts
Similar to Gastroenterology, the Trust would advertise a year in advance for Obs and Gynae Research Fellow posts. The post would have a 'job plan' that outlines particular time for research activities. This does impact on service delivery and would require a greater number of 'other' roles or doctors to cover the duties. Start dates would be in 12 months' time therefore this option does not provide an immediate solution to vacancies. But once recruited, they should be ready to work at the Horton straight away. The Trust tried operating a clinical fellow model before at the

Horton and it was not sustainable so the Trust will need to work with the University and the potential candidates to overcome the issues experienced previously.

Costs of Implementation

Advertisement costs BMJ - £700.00
Shortlisting and interviewing - £8,986.00
Recruitment - £400.00
Increased number of doctors to sustain the rota - £94,264.00 (2 additional doctors required)
Total cost: £104,350.00

Obstetrics and Gynaecology Medical Training Initiative (MTI) placements

The MTI scheme allows International Medical Graduates (IMGs) to come to the UK for a maximum of two years to train within the National Health Service (NHS). The expectations of IMGs in terms of their performance and targets should be based on the same standards as UK trainees at ST2 level initially, until, with support from the hospital, they move to ST3–4 level for the majority of their placement. During the placement, IMGs follow a similar assessment process to UK trainees.

This type of placement would require robust training and the candidates would not be at the level to work autonomously therefore this would require a greater Consultant/registrar presence and clear training plans which as cost and recruitment implications. If the level of complexity is not available, the Trust could risk not giving the adequate training/education that is required for these posts.

We have heard mixed reports from Trusts that have used this model and we know that the Royal College are working on refreshing the scheme to tackle some of the issues raised – but it is not certain that the quality of candidates required for the Horton would be secured through this route. We can mitigate this through placing candidates in the John Radcliffe for their first year and, if they reach the required level of competency, they would move to the Horton for their second year.

Each placement costs £2,500.00, the cost of supporting these roles would need to be factored into this option.

Timescales: 3 months for appointment into the role. And then up to 12 months at the John Radcliffe developing the required competencies and experience required to fill a Horton post.

Costs of Implementation

Cost of the placement - £2,500.00

Appendix 2 Response from OUH

Senior support, supervision and training opportunities - £6,740.00 Recruitment – £400.00 Total cost: £9,640.00 per doctor
Associate Specialist Grade
The Associate Specialist grade closed in 2008 but as a Foundation Trust there is the option to re-create this type of role which may increase the volume of applicants. An Associate Specialist is normally a permanent appointment and attracts a salary of £54,764.00 to £90,147.00. An associate specialist is required to have: a. full registration with the General Medical Council; b. served for a minimum of four years in the registrar or staff grade and/or specialty doctor grade and/or in the clinical and/or senior clinical medical officer grades, at least two of which have been in the appropriate specialty. Equivalent service is also acceptable, with the agreement of the relevant College or Faculty Regional Adviser and the Regional Postgraduate Dean; c. have completed 10 years medical work (either a continuous period or in aggregate) since obtaining a primary medical qualification which is (or would at the time have been) acceptable by the GMC for full, limited or temporary (but not provisional) registration. Placement on the overseas list will not by itself count towards the qualifying period. A robust business case would need to be written which outlines the difference between appointing an Associate Specialist or appointing a Consultant as the level of experience and the expectations for this role is that the individual works autonomously. Nationally, the BMA and NHS Employers are re-looking at the Associate Specialist contract but no timescales are known to date. There are wider Trust/system implications as if the Trust commences an Associate Specialist contract in Obs and Gynae at the Horton, this will give wider requests for the same to be adopted. To move this forward the Trust would need to create its own Associate Specialist Terms and Conditions of Service, obtain legal advice, Trust Management Executive and Board approval before discussing with system partners to ensure we do not destabilise their Obs and Gynae services then commence negotiations with the British Medical Association. This could take approx. 8 months. The difference between the two salary scales are: Specialty Doctor - £39,060.00 to £72,840.00 Associate Specialist - £54,764.00 to £90,147.00

Appendix 2 Response from OUH

The Trust would then commence advertising, shortlisting and appointing candidates who come forward. Candidates would then serve 3 months' notice.

Approx total: 1.5 years.

Costs of Implementation

Creation of Trust Associate Specialist Terms and Conditions - £475.00
Lawyers review the Trust Associate Specialist Terms and Conditions - £600.00
LNC and BMA agreement - £1000.00
Advertisement – BMJ - £700.00
Shortlisting and interviewing - £8,986.00
Increased salary payments – approx £17,000.00 per annum per doctor

Total cost of implementation: £11,761.00
Total additional cost of 6 doctors as Associate Specialists and implementation: £113,761.00

Engage multiple overseas recruitment agencies to recruit on our behalf

This approach to recruitment could give a wider and more diverse pool of applicants. From the experience of recruiting a small number of doctors from overseas into the Emergency Department and from overseas nurse recruitment, it is better for overseas recruits to start as a cohort onto a bespoke induction with induction lasting approx. 2/3 weeks. The Trust would need to assign each overseas recruit with a clinical and educational supervisor and for this to remain in place for 12/18 months dependent on experience.

The cost of a visa is £1,199.00 per annum and the Trust can sponsor for a maximum period of 3 years initially as a total cost of £3,199.00 per person.

The Trust's attempts to date to recruit middle grade obstetricians through international recruitment have not been successful. In Emergency Medicine (another shortage occupation where suitable candidates are limited) overseas recruitment did not provide the volume of recruitment required for the number of vacancies and this is not a reliable method for staffing a whole unit on a regular basis.

There are increased costs associated with overseas recruitment of 40% of the candidates' basic salary (approx. £16,000.00) as a one-off agency cost and a consideration for time spent shortlisting, inducting, supervising etc would need to factored in. The doctor would not be able to work independently until ready and from the experiences in the Emergency Department this has taken approx. 8 months.

Appendix 2 Response from OUH

Potential timescales: Advertising, obtaining interested candidates, shortlisting and interviewing – 5 months
Arranging the visa – 3 months
Notice, travel, accommodation and induction – 1/2 months
Training/supervision – 8 months

Total: 1.5 years

Costs of Implementation

Agency costs plus £3,199.00 per person
Shortlisting and Interviewing - £8,986.00
Recruitment - £400.00
Backfill whilst undergoing training - £24,794.00 per overseas doctor
Training/supervision - £6,740.00

Total cost per doctor - £34,733.00 (Excluding their salary)
If 6 doctors and implementation - £217,784.00

Obstetrics and Gynaecology Step in, Step Out Training Opportunities

The NHS Long Term Plan provides a step change in health and provides a focus on changing models of working. The plan includes a section about the health, wellbeing and morale of doctors and proposes changes to training programmes.

Royal Colleges are looking to pilot programmes called 'Step In, Step Out' which enables trainees to take a 12 month break from their training to help reduce burnout. To increase applicants the Trust could offer 'step out' placements at the Horton which may be an attractive place to work during a step out phase. However, as the positions at the Horton require our middle grade doctors to operate more independently and take judgements on the level of risk involved with patients, these roles could also be perceived as challenging – it will depend on the views of the individuals involved.

As this scheme is in its infancy, this will not generate large volume regular candidate applications but it could be implemented in addition to other schemes.

Link with an International Obstetric Unit

If the Trust could link with an international unit in places such as Australia, Malta or India, placements could be offered for doctors to rotate between two/three countries and experience Obstetrics and Gynaecology in more diverse settings.

This would require some exploration, relationship building, creation of the rotations, learning opportunities and induction prior to advertising these roles but would provide

a regular rotation of talent to the Horton.

The Trust would need to ensure the rotating doctors have regular supervision and support through-out their time at the Trust which will require additional senior resource to support this initiative.

This initiative is dependent on finding an International unit that wants to pair with the Trust and candidates who are interested in rotating to the countries we pair with. The long-term sustainability of this option is unsure as it often depends on individual clinical leads establishing strong relationships which can then suffer if people move on.

It would be likely to take 1.5-2 years to establish a relationship and to see doctors start to arrive at OUH via this route.

Costs of implementation

Regular meetings with the overseas partners to set-up the rotations - £7,188.00
Advertisement costs – BMJ and overseas journals - £3500.00 (cost could be shared with other parties)
Joint shortlisting and interviewing - £8,986.00
Recruitment and administration of the rotations - £1,000.00
Total Set-Up Fees: £20,674.00

Visa if rotating for 1 years - £1,199.00 per trainee, per hospital
Travel costs - £2,000.00 per trainee
Total for 6 candidates - £19,194.00

Overall total approx: £39,868.00

Appendix 2 Response from OUH

Annex 4: Description of the Maternity Services (previously provided to HOSC)

Background

The Maternity services in Oxfordshire are provided by Oxford University Hospitals NHS Foundation Trust (OUHFT). As well as providing community midwifery and intrapartum care to Oxfordshire women, OUHFT provides tertiary care for women and babies across the Thames Valley region. The service delivers between 7500-8000 babies per year. Around 12% of these births are referred from outside Oxfordshire into the regional centre.

The Maternity services are recognised nationally as delivering safe care with good outcomes for mothers and their babies. These outcomes have continued to improve over the last 3 years.

The Maternity services are rated "Good" by the CQC. (2017)

The recent CQC maternity survey (2018) reported "Labour and delivery care" as "Better than most trusts"

The trust reports marked improvement in rates in the serious outcome measures for maternity including from 2014-2018.

- Still birth and perinatal death at term **(Figure 1)**
- Significant brain damage to term babies. **(Figure 2)**
- Unexpected admissions of term babies to special care units. **(Figure 3)**

OUHFT was one of the few trusts in the UK to be declared 100% compliant in all 10 safety action plans of the NHSLA National Maternity Incentive Scheme introduced at the beginning of 2018.

To enable women to make appropriate choices and provide effective personalised care there must be consistent quality of service and assessment of individual risk. There are robust, evidence- based, national standards of care for women with more complex pregnancies so that safer care is delivered by specialised or dedicated services e.g. twin clinic or and Diabetic clinics (see list of NICE guidance in appendix).

The improvement in outcomes has been achieved by ensuring as many women as possible are seen early in their pregnancy. Women have an extensive clinical risk assessment away from the hospital by the community midwives and the GPs. The community midwife then coordinates the appropriate care and ensures low risk women have access to quality antenatal care. This includes new screening programmes and a choice to deliver in midwife-led settings. Those women who are identified as having increased risks or complex pregnancies are seen in the appropriate obstetric or specialist clinics. This is in line with the Better Births Agenda and with the relevant NICE guidelines.

Appendix 2 Response from OUH

Figure 1

	No. pregnancies with EDD Oct 14-Oct 16	No. pregnancies with EDD Oct 16-Oct 17	Percentage change
No. pregnancies	14328	6522	
No. PNM	47 (0.32%)	17 (0.26%)	-19%
PNM>/= 36 weeks	31 (0.22%)	6 (0.09%)	-59% (p=0.04)
SGA detection	35%	62%	

PNM adjusted Perinatal Mortality is the number of deaths in babies who are born over 24 weeks with no congenital abnormalities. This includes still births and early neonatal deaths (7 days of life).

Figure 2

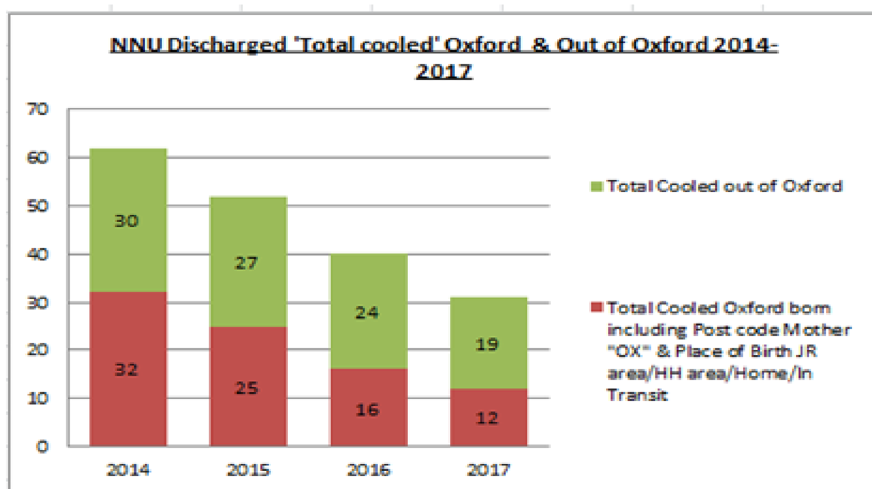
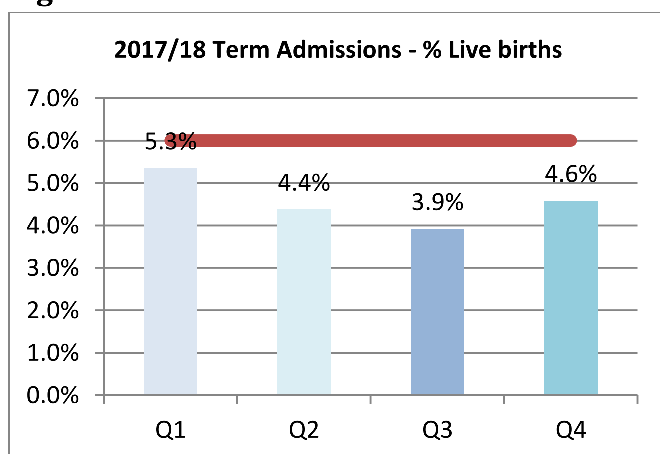


Figure 3



The national target is to be below 5.3%.

<u>Community Midwifery Teams</u>

Appendix 2 Response from OUH

Women receive care from one of eight Community Midwifery Teams across Oxfordshire in conjunction with their GP plus Obstetrician or Specialist if required. This way the women receive personalised care which is coordinated by a small team of midwives.

All antenatal care for low risk women is provided by a team of midwives who are supported by Maternity Support Workers (MSWS). The community midwives run the home birth service, support the free standing midwifery units (FMLU) and the alongside midwife led unit (AMLU) these services are described further under intrapartum care section.

Community midwives from OUHFT also provide care for women in Brackley, Northamptonshire.

The community midwives provide a comprehensive range of additional services:

- Antenatal Education classes
- Teenage support groups
- Saplings group for vulnerable women.
- Mindfulness sessions
- Infant feeding workshops
- 24 hour on-call triage service

The community midwives also co-ordinate the woman's postnatal care plan. In the first postnatal week women are reviewed at home or in nearby clinic settings and are able to access a wide range of other clinics in local settings including breastfeeding support, neonatal examination and neonatal hearing screening.

This service design supports the "hub and spoke" model to provide care closer to the family.

Antenatal Ultrasound Service

All pregnant women in Oxfordshire are offered a routine dating scan at around 12 weeks and a further anomaly screening scan at 20 weeks. OUHFT is the only trust in the country to offer a new screening programme to detect babies whose growth is poor later in pregnancy. This includes a 36 week growth scan for all women and additional growth scans for women whose pregnancies are higher risk.

The Ultrasound scans for this service are based at both the HGH and the JR.

Obstetric Care

Women who have been identified as requiring support from an Obstetrician are referred to Consultant led Antenatal clinics. These are situated both at the HGH and the JR. This includes clinics for women who fall into these categories:

- Already have a medical condition for example Asthma

- Have had a problem in a previous pregnancy
- Develop problems during their pregnancy
- Have risk factors that may lead to an increase in complications during labour
- Have complex social issues that require multiagency support
- Require perinatal mental health support.

Specialist Antenatal Services (Fetal Medicine and Maternal Medicine)

Fetal medicine

These services are provided by a team of accredited sub-specialist Fetal and Maternal Medicine doctors and specialist midwives. The unit is based at the John Radcliffe Hospital and offers diagnosis and treatment of complications which may arise in unborn babies, including:

- Detailed ultrasound scanning (in the first, second and third trimesters) including fetal heart scans
- Provision of rapid fetal karyotyping by amniocentesis, Chorionic Villus Sampling (CVS) service and amniocentesis.
- The treatment of pregnancies with rhesus disease and other causes of severe fetal anaemia requiring in-utero transfusion of the baby
- Diagnosis and management of feto-fetal transfusion (twin-twin transfusion syndrome) syndrome
- Diagnosis and management of abnormal invasive placentae

Maternal Medicine

There are also specialist ante natal clinics for pregnant women with any pre-existing medical disorder in addition to severe pregnancy-specific medical disorders. These are provided by a multidisciplinary teams consisting of accredited sub-specialist Fetal and Maternal Medicine doctors, Obstetric Physicians, Specialist midwives, Anesthetists, Cardiologists, Endocrinologists and other specialists. The specialist clinics include

- Multi-disciplinary cardiac clinic
- Specialist Diabetic clinics
- High risk maternal medicine clinics for women with serious preexisting medical conditions and high blood pressure/severe preeclampsia/HELLP syndrome

Intrapartum care

Midwife led care

The maternity service offers all four choices for place of birth; home, freestanding MLU, alongside MLU or obstetric unit. The options are discussed with the woman and an explanation given about what services are available in each maternity setting. It is important

that the woman is aware that she can change her mind about where she wishes to give birth at any time in her pregnancy.

Oxfordshire has three permanent Freestanding Midwife Led Units (FMLUs) in Wallingford, Wantage and Chipping Norton. Community midwives are based in the FMLUs and provide antenatal and postnatal care in the FMLU, at the GP surgery or in the woman's home. Intrapartum care is provided either in the FMLU or in a woman's home. Two of the FMLU's are closed overnight and the workload for the evening and night is coordinated by a Maternity Support Worker based in one of the FMLU's. The MSW contacts the on call midwives to care for a woman in labour. If the woman is planning to birth in one of the FMLU's the midwife will meet the woman at the unit. This service is provided in line with the 'hub and spoke' model being developed in other services; it is based in the community and provides a range of services for women and their families. The planned home birth rate is 2 - 3%.

A decision was taken by Oxfordshire CCG in August 2017 to permanently close the Consultant Led Unit at the Horton General Hospital in Banbury. This decision was part of a wider consultation that was then subject to a Judicial Review, which found in favour of OCCG. The obstetrics decision specifically was referred to the Independent Reconfiguration Panel which recommended that OCCG undertaken further work locally before making their decision. The Horton Obstetric Unit currently remains shut on a temporary emergency closure, due to safety concerns arising from a lack of obstetric staff to fill the required rota, and is operating as a fourth Freestanding Midwife Led Unit.

Alongside Midwifery Led Unit (Spires)

The alongside midwifery unit is on level 7 at the John Radcliffe Hospital. Low risk women can deliver here from all over Oxfordshire.

Obstetric led delivery unit

This is based at the John Radcliffe Hospital. There are a full range of services including the anaesthetic and neonatal support required to run a tertiary level department caring for very high risk and complex maternity cases.
Women from Oxfordshire who require general obstetric care and low risk women who choose to deliver in an obstetric led unit may also deliver in one of the following neighbouring units

- Warwick Hospital, Warwickshire
- Stoke Mandeville Hospital, Buckinghamshire
- Northampton General Hospital, Northampton
- Royal Berkshire Hospital, Reading
- Great Western Hospital, Swindon

Further information about this service and the neighbouring units can be found here
www.cqc.uk/publications/surveys/maternity-services-survey-2018

Appendix 2 Response from OUH

www.ouh.nhs.uk/women/maternity/default.aspx
www.swft.nhs.uk/our-services/adult-hospital-services/ma
www.buckshealthcare.nhs.uk/birthchoices/contact-us.htm
www.northamptongeneral.nhs.uk/Services/Our-Clinical-Services-and-Departments/Obstetrics-and-Gynaecology/Maternity/Maternity.aspx
http://www.royalberkshire.nhs.uk/wards-and-services/maternity.htm
https://www.gwh.nhs.uk/wards-and-services/a-to-z/maternity-services/where-should-i-have-my-baby/delivery-suite-at-the-great-western-hospital/

Neonatal services

Neonatal care forms a key part of the NHS maternity service. It is part of the routine service for all women and their newborn babies. Neonatal Critical care provides an emergency service and ongoing support for babies and their families when a baby is born very prematurely, becomes sick or develops a medical problem.

Since 2011 the Neonatal services in the UK are designated by NHS England. They consist of 3 levels of care.

The Oxford Newborn Care Unit is a Neonatal Intensive Care Unit (NICU Level 3). It is the only designated NICU (Level 3) in Thames Valley and therefore provides intensive care for all babies born in Thames Valley region.

The Oxford NICU also provides high dependency care (HDU, medium level of care, level 2) e.g. non-invasive respiratory support or parental nutrition (TPN) and special care (non-complex and requiring no respiratory support level 1) for all babies in Oxfordshire.

Prior to closure of Horton Special Care Unit, only babies in North Oxfordshire needing the lowest level of care (Level 1 non-complex and requiring no respiratory support) would be looked after at the Horton Hospital the rest were transferred to the John Radcliffe Hospital.

- There are 16 Intensive Care beds, 13 High Dependency beds, 21 Special Care beds (total 50 beds) currently in use at JR. In addition, 10-12 babies per day requiring additional care are looked after on the postnatal wards (transitional care patients).
- There are approximately 980 admissions per year.
- A Neonatal Regional Transport service operates from NICU, using a specialist ambulance to transfer patients 24 hours/ day to JR for intensive care and repatriation back to their local units. This service shares ambulance provision with the Paediatric Critical Care Retrieval service which also operates from the same site. The service transfers around 500 babies per year.
- The NICU is both a tertiary medical and tertiary surgical and cardiology referral unit. Cardiology and surgical teams have multiple contacts with the unit on a daily basis. Where patients are extremely ill, surgery will take place on the neonatal unit.

- The NICU also provides care for neonates requiring the input of other surgical specialties including neurosurgery, urology, ENT and plastic surgery and other specialist medical specialties such as respiratory, endocrine and neurology
- The neonatal teams work closely with obstetric and fetal medicine colleagues to provide a smooth transition from fetal to neonatal life, they also work closely with the palliative care team at Helen House.

Number of Births

This is the number of births including still births and includes women who have been transferred into OUHFT from other trusts in the region.
The JR figures include births in the alongside midwifery led unit, Wallingford MLU, Wantage MLU and home births of women from central and southern GP practices. The Horton General figures include births from Chipping Norton MLU and home births of women from GP practices north of the county.

Year April to March	Total births OUHFT	JR	HGH	comments
2010/2011	9033	7300	1869	
2011/2012*	8045	6644	1401	*data issues
2012/2013	8598	6841	1760	
2013/2014	8315	6721	1594	
2014/2015	8401	6734	1667	
2015/2016	8497	6890	1608	
2016/2017	8665	7128	933	
2017/2018	7497	7172	325	

Births Before Arrival (BBA).

These are unplanned births at home or on the way to a unit including in an ambulance. The transit figures include women who are aiming to deliver at the freestanding units as well as the hospital based obstetric unit.

	All Transit BBAs	All BBAs (exc on maternity sites)	Total	Transit North	BBAs North	Total
2014	14	35	49	2	14	16
2015	5	17	22	2	5	7
2016	6	14	20	2	1	3
2017	20	29	49	3	9	12

Appendix 2 Response from OUH

2018	**15**	**38**	**53**	**5**	**6**	**11**

	Total BBA OUHFT	**Total BBA HGH catchment**
2014	**49**	**16**
2015	**22**	**7**
2016	**20**	**3**
2017	**49**	**12**
2018	**53**	**11**

References

NICE CG192 Antenatal and Postnatal Mental Health (2015)
NICE NG3 Diabetes in Pregnancy from Pre-conception to postnatal care. (2015)
NICE CG 132 Caesarean section (2012)
NICE CG102 Hypertension in Pregnancy Diagnosis and Management (2011)
NICE CG70 Induction of Labour (2011)
NICE CG 25 Preterm Labour and Birth (2015)
NICE CG 129 Multiple Pregnancy Antenatal Care Twins and Triplets (2015)
NICE CG 110 Pregnancy and complex social factors (2010)
NICE PH27 Weight management before, during and after pregnancy (2010)
Better Births Improving Outcomes of Maternity Services in England: A five year forward view: The National Maternity Review 2016.