Trust Board
Minutes of the Extraordinary Trust Board meeting held in public on Wednesday 31 August 2016 at 15:00 in Tingewick Hall, John Radcliffe Hospital

Present: Dame Fiona Caldicott FC Chairman
Dr Bruno Holthof BH Chief Executive
Professor Sir John Bell JB Non-Executive Director
Dr Tony Berendt TB Medical Director
Mr Paul Brennan PB Director of Clinical Services
Mr Alisdair Cameron AC Non-Executive Director
Mr Christopher Goard CG Non-Executive Director
Professor David Mant DM Non-Executive Director
Mr Mark Power MP Director of Organisational Development and Workforce
Ms Maria Moore MMO Interim Chief Finance Officer
Mr Geoff Salt GS Vice-Chairman, Non-Executive Director
Mr Andrew Stevens AS Director of Planning & Information
Ms Catherine Stoddart CS Chief Nurse
Ms Eileen Walsh EW Director of Assurance
Mr Peter Ward PW Non-Executive Director

In attendance: Professor Stephen SK Divisional Director, Children’s and Women’s Kennedy
Dr Eleri Adams EA Consultant Neonatologist
Dr Veronica Miller VM Consultant Obstetrician
Miss Maria Crawford MC Corporate Governance Manager

Apologies Mrs Anne Tutt AT Non-Executive Director

The minutes are produced in the order of the agenda

TB2016/08/01 Apologies and declarations of interest
Apologies for absence had been received from Mrs Anne Tutt, Non-Executive Director.
No declarations of interest were made.

TB2016/08/02 Chairman's Business

The Chairman explained that the Board had decided to convene an extraordinary meeting to consider the current safety of maternity services at the Horton General Hospital, on a temporary basis. She stated that the Board considered that the situation had reached the point of needing a top level emergency review, which had necessitated the short notice meeting. The Chairman thanked everyone who had contributed their views in recent weeks including staff, the public, the District Council, MPs and Trust governors.
She confirmed that the single issue to be considered related to maternity services at the Horton General Hospital, and the extent to which a current, safe service could be maintained in the short term. She confirmed that the details formed the basis of the report before the Board on the contingency plan for maternity and neonatal services ("the Report") which had been made available in advance of the meeting. Broadly speaking, if the Board could not guarantee that the safety of the service could be maintained, there would be a decision to withdraw some of the services on a temporary basis. It was important to note that the decision was not a permanent one, nor was this step a permanent solution but would be subject to review and monitoring by the Board.

The Chairman noted that Oxfordshire Clinical Commissioning Group [OCCG] would also be conducting a wider strategic consultation later in the year regarding services at the Horton General Hospital, including maternity services, which would provide a further opportunity for stakeholders to feed in views. She noted that the Board had a duty continually to monitor patient safety, and confirmed that the Board understood that decisions taken at this meeting could be subject to heightened scrutiny, including judicial review.

The Chairman explained that while it was a meeting held in public, it was not a meeting in which the public could participate. Given the complexity and importance of the issues, no questions from the public would be taken at this meeting. Should there be interruptions or disturbances she would be forced to exclude the public and continue elsewhere in a private session. She asked that all mobile telephones be turned off, and that there should be no filming other than the official filming by the Trust.

She welcomed three clinical members to the meeting: Professor Stephen Kennedy, Dr Eleri Adams and Dr Veronica Miller.

**TB2016/08/03 Obstetric and neonatal services at Horton General Hospital**

The Chairman asked the Director of Clinical Services (PB) to highlight key points in his Report to provide the context for the discussion.

Key points highlighted were:

- Horton General Hospital had one of the smallest obstetric units in the country (with 1466 births last year) and its middle grade rota training recognition had been withdrawn in 2013. This had resulted in a challenge to maintain the service and it was noted that many smaller units in similar situations across the country had switched to midwifery-led units (MLUs). However, an intervention by the University to create a Clinical Research Fellow role had initially been a great success, and an 8 doctor rota had been created, allowing a continued provision of services.

- Recruitment difficulties began in the middle/back end of 2015 and became progressively worse to the point that it has not been possible to recruit sufficient doctors for the October 2016 programme. Professor Stephen Kennedy, speaking as Head of the University Department had confirmed just before Christmas 2015 that the programme for 2016 was no longer viable.
The clinical team had looked at a wide range of options and decided to attempt to create a 9 doctor rota, rotating from the John Radcliffe to the Horton General Hospital. Unfortunately a series of resignations, and instances where those being offered posts did not take them up (as described in detail in the Report) meant that, in spite of a number of recruitment efforts, the unit only will only have 3 doctors in post as at the beginning of October 2016, one of whom has resigned and is due to leave during October, leaving just 2 posts out of the intended 9, filled.

A further recruitment drive via the British Medical Journal [BMJ] closed on Friday 26 August and two doctors have been invited to interview, but it is currently unknown if they would attend, or be offered posts.

One of the difficulties to be faced was the fact that there was a general vacancy rate of around 25% in the Thames Valley in training grade posts, and it was likely that doctors would choose first to take posts in units which offered a larger number of births, providing more experience and training opportunities towards consultant roles.

It is not possible simply to move existing trainee doctors from the John Radcliffe to the Horton General Hospital to cover this, as the Horton is not able to take trainees of that level, and in addition removal of those doctors would cause closure of services at the John Radcliffe.

The Chairman asked the Director of Clinical Services if he could confirm her understanding of what he was telling the Board, which was that from the beginning of October 2016 the Horton Hospital would not be able to staff the middle grade rota and that therefore the Obstetric unit would not be safe. The Director of Clinical Services confirmed that as it was a doctor-led service, without doctors to staff the rota, the service would be unsafe.

Mr Alisdair Cameron, Non-Executive Director asked for more detail about the impact of continuing beyond October if all possible resources were employed, including locums and doctors from the John Radcliffe Hospital. The Director of Clinical Services explained that the service at the John Radcliffe was a tertiary service, backed up by intensive and high dependency neonatal care and that higher risk women must remain at the John Radcliffe, which needed itself to be fully staffed to avoid increasing safety risks at the JR. The Horton General Hospital did not have the infrastructure to provide this kind of intensive and high dependency neonatal care, so capacity could not be transferred from the John Radcliffe to the Horton General Hospital. In addition, the posts at the Horton General Hospital were not training recognised and therefore middle grade doctors at the John Radcliffe could not be re-deployed at the Horton General Hospital. The alternative of deploying consultant level staff to the Horton from the JR would also increase the risk of safety issues arising at the JR.

Efforts had been made to attract locums, using a number of locum agencies (as well as via adverts in NHS Jobs and the BMJ), and offering the post to middle grade and above, but with no success.
In response to a further question from Mr Cameron, the Director of Clinical Services confirmed that if the Trust were to try to maintain the current service with the available resources described above, from October, then he would expect that more mothers and babies would be harmed.

Mr Geoff Salt, Vice-Chairman and Non-Executive Director, reflecting questions posed at the recent public meeting in Banbury and via other forums, asked for further assurance that everything possible had been done in the efforts to recruit. There had been suggestions that doctors from the John Radcliffe could join the rota at the Horton General Hospital, for example for half a day or a day a week. The Director of Clinical Services explained that to maintain the service at the Horton General Hospital required a 24/7 resident rota, and that this plan simply did not provide enough cover. Also if doctors were deployed from the John Radcliffe Hospital, there would be a need to close part of the access to the obstetric unit at the John Radcliffe. This is therefore not an option.

The Chief Executive asked the clinical team to describe the recruitment efforts in more detail, and the Director of Organisational Development and Workforce (MP) explained that the net had been widely cast on a national and international level. Where there had been interest, applicants’ skills had often not met the minimum requirements. In an attempt to attract candidates a pay premium had been offered, pitched as a range, and for the right calibre of applicant, the resultant salary being offered could be as much as, or beyond that of an entry level consultant salary, at over £76,000.

Further to a request from Mr Peter Ward, Non-Executive Director, the Director of Organisational Development and Workforce explained that the salary broke down into:

- A base salary in the range £38,000-£47,700
- A pay premium of 50%
- A banding supplement of £5000, to reflect the intensity of the rota
- Additional financial assistance to overseas applicants to cover the cost of visas etc

Confirmation was given that recruitment efforts would not stop, and efforts would be redoubled to continue to try to recruit, in response to Mr Ward’s second question about what else could be tried to achieve effective recruitment, with a view to making sure that this is only a temporary arrangement.

Mr Christopher Goard, Non-Executive Director noted that the posts had been offered on a one year contract and wondered what feedback had been received from applicants, and whether more flexibility and/or a longer term contract might have made the posts more attractive. Dr Veronica Miller confirmed that feedback had been received and that most commonly, when a post had been offered, but not taken up, it was because they had opted to take up positions at units which offered a busier environment and more experience. This was despite the Horton General Hospital making clear in the job plan that the role would include experience within a busier unit too. She explained that a one year contract was standard for middle grade roles as typically junior doctors do not want to be tied down. The Chief
Executive noted that the length of contract was however something which could be
looked at again if that was an issue.

Action: BH

The Medical Director reminded the Board of his responsibilities for clinical
governance and as the Responsible Officer for Medical Revalidation and pointed out
the importance of the Horton General Hospital attracting the right kind of doctors who
can work independently and know how to function safely within an environment such
as the Horton, and indeed within the NHS environment. He had personally reviewed
all applications and was clear that the recruitment decisions made had been
reasonable. He pointed out that a large number of applicants came from overseas,
requiring Tier 2 visas. Such applicants would require extensive support to ensure
they would be able to practice safely and required additional rigour on recruitment to
ensure not only that recruitment was achieved, but that the necessary competencies
were present, where training had been undertaken within a different system.

The Chairman invited further questions on recruitment or safety.

Mr Alisdair Cameron, Non-Executive Director, asked whether there was evidence of
any measurable impact on safety elsewhere in the NHS when people had tried to be
more flexible on the use of locums and the experience required, in order to bring in
extra resource. Dr Veronica Miller explained that it was well recognised in national
reports that an overreliance on short term locums and temporary staff within a
maternity team, can cause harm, and put mothers and babies at significant and very
serious risk. It has also been proven to be dangerous to attempt to continue to
deliver high risk births in an area with insufficient skilled doctor cover, this leads to
significant mortality.

Mr Peter Ward, Non-Executive Director then sought assurance that should a low-risk
birth deteriorate (and indeed two concurrently), under any new arrangement, that
there would be robust and resilient processes and transport in place to manage this.
The Director of Clinical Services said that, should the decision be taken to
temporarily change the service to an MLU, the numbers expected would be one to
two deliveries per day in an MLU. Further to discussions with the South Central
Ambulance Service (SCAS), a dedicated ambulance would be stationed at the
Horton MLU 24/7, staffed not by a paramedic, but by an emergency care assistant.
As is normally the case on such a transfer, a midwife would travel to the John
Radcliffe with the mother. The Community Midwifery Service would provide the back
up should another woman need to give birth at the MLU at the same time. Should
the midwife become concerned about moving the mother and if the matter was
considered life-threatening, SCAS had agreed that ambulance control would
prioritise such a clinician-authorised call over other 999 calls. The woman's partner
would be able to travel in the ambulance. Ambulance crews had confirmed that, in
their experience, travel time between the Horton General Hospital and the John
Radcliffe was known to be between 30 and 38 minutes with blue lights.

The Medical Director drew attention to the fact that there were already rigorous
protocols followed by midwives in connection with the progression of births and the
management of risk. It was noted that typically transfer rates nationally were in the
order of about 20% for second births – the rate being higher for first births. There are clear protocols to manage that risk.

The Director of Assurance sought absolute confirmation from the clinical colleagues present that in their view it would be potentially unsafe to continue to have an obstetric unit at the Horton General Hospital from the beginning of October. The Director of Clinical Services and his clinical colleagues present confirmed that to be the case. The Director of Assurance wanted absolute assurance that there is nothing else that could be done to maintain a safe service, based on the current conditions. The Director of Clinical Services further reconfirmed that there were insufficient doctors at the John Radcliffe and Horton General Hospital to maintain a resident, safe service on both sites.

In response to Professor David Mant’s enquiry about whether a successful recruitment initiative launched now could deliver the necessary doctors by 3 October 2016, the Director of Clinical Services explained that given the number of applicants requiring Tier 2 visas and/or not registered at the GMC, the process would not be fast enough.

Having ascertained there were no further questions about the safety of the service from early October, the Chairman asked the Board to vote on whether it considered the continuation of the services of the Obstetric Unit at the Horton General Hospital beyond 3 October 2016 to be unsafe.

The Board voted unanimously on a show of hands that the continuation of the services of the Obstetric Unit at the Horton General Hospital was unsafe beyond 3 October 2016.

The Chairman explained that the discussion would now focus on what could be offered from the beginning of October 2016. The Director of Clinical Services explained that the evidence, both nationally and internationally was that for low risk women, a midwifery-led unit (MLU) was safe and indeed that the outcomes for babies were the same as in doctor-led obstetrics units, but with the benefit of fewer medical interventions. He went on to outline the proposal for a temporary MLU, as set out in detail in the Report, as follows:

- an MLU would be established at the Horton General Hospital on a temporary basis;
- there would be a 24/7 ambulance stationed there, with an emergency care assistant;
- a combined pre-birth and breech screening clinic would be offered at the Horton General Hospital at 36 weeks to further manage the risks to mothers and babies, to achieve both a medical and midwifery review;
- all existing ante and post-natal care services would be maintained at the Horton General Hospital, so that women could choose where to have that care.

He further noted that there was capacity in Northampton and South Warwickshire and that some women may choose to use their services instead (the number of over boundary women using the Horton General Hospital service was relatively low, at less than 1 a day, mainly from Northampton).
The Chief Executive relayed the message from a public meeting held in Banbury on Thursday 25 August that there was public concern about the general safety of an MLU, and he asked the clinical colleagues present to describe any evidence which might provide reassurance in this regard. Dr Veronica Miller reiterated that significant and robust studies had shown that not only were the outcomes and safety at MLUs comparable with that of obstetric units, but that they in fact offered benefits to mothers with fewer medical interventions such as forceps, episiotomies and Caesarean sections. Further, she explained that MLUs are backed by the Royal College for Obstetricians and Gynaecologists, and the NICE Intrapartum Care Guidelines and that trusts were in fact encouraged to offer the choice of an MLU as something positively beneficial for low risk women. Even if some women do not want to deliver in an MLU, choice is encouraged.

Mr Christopher Goard, Non-Executive Director asked whether there was any national evidence about the risks of transfer, and how this would be managed. Professor Stephen Kennedy sought to reassure the Board by explaining that the Trust already has experience of running MLUs across the county as a safe service with protocols in place to manage transfers. The national evidence was as Dr Veronica Miller had described, such that MLUs were as safe as an obstetric unit and offered a better experience for low-risk mothers.

While accepting the evidence, and noting that they had agreed earlier that a temporary cessation was necessary, Professor David Mant sought further assurances that arrangements for transfer would be in place to minimise safety risks that will occur even in low risk pregnancies. Dr Eleri Adams explained that she was a Consultant Neonatologist and described in response the existing pathways and protocols at the MLUs already running in Oxfordshire to manage safety risks. These emergency transfers have arisen approximately twice per year. The protocols have been proven to work effectively with no difference in the outcomes for babies born in obstetric units, where mothers were low risk to start with.

Professor Sir John Bell, Non-Executive Director asked how the risks set out in the risk register would be managed in the transition to an MLU, particularly with reference to communication and the resultant expanded demand for the John Radcliffe Obstetrics Centre. The Chief Nurse explained that they already had expert midwives following established protocols, but would in addition be providing further training for obstetric emergencies. Letters had and would continue to go out to women and GPs explaining the choices available, and advising women to seek advice from their midwives about the best location for them. In respect of the capacity at the John Radcliffe, in recognition of the potential for temporary closure, some immediate work has been undertaken to increase obstetric and neonatal capacity. At the proposed Horton MLU, the plan is that within the transition period, there would be 24 hour midwife cover in addition to the community midwives, and there would be weekly reviews to ensure that the planned cover was proving adequate.

In response to a further question from Professor Bell, the Chief Nurse explained that more beds and specialist equipment were being made available at the John Radcliffe neonatal facilities. This was purposefully not at the Horton General Hospital as there was significant evidence including the Morecambe Bay report, that if there was a
Special Care Unit on the site of an MLU, lines become blurred and this increased risks and mortality. The Chief Nurse was confident that the Special Care Unit provided by the John Radcliffe Hospital would be able to cope with the increased activity. The Chief Nurse also clarified for the Director of Assurance that while normal practice at an MLU was for the Community Midwifery Service to provide an on call midwife to go into the MLU with the mother, at the Horton there would be 24 hour resident midwife staffing in addition.

Mr Christopher Goard, Non-Executive Director queried whether the temporary break in provision of obstetric services would impact other services at Horton General Hospital, such as paediatrics and SCBU, and also wanted to understand what it would involve to reinstate the service. The Director of Clinical Services advised that the proposal would be to close the Special Care Unit alongside the obstetric service, for the reasons given by the Chief Nurse. He assured the Board that there would be no impact on paediatric services, where there is still 24/7 resident paediatric provision. In terms of restoring the Special Care Service, two special care nurses who have resigned would need to be replaced as part of reinstatement of the unit.

The Medical Director stated that it was important for the Board to understand and note that the development of the plan and proposals by the clinical services team had been undertaken separately to the risk assessment, which had been undertaken by himself, the Chief Nurse and the Director of Assurance. He pointed out that the risk assessment was necessarily a dynamic document which could change as risks were added and ratings adjusted over time. There has been separation of the development of the plan and the risk assessment process.

Professor David Mant stated that he was keen that the cessation proved temporary, and wanted to know how the Board could ensure that the service could be later restored. The Director of Clinical Services explained that they would continue with their recruitment efforts and would look at tenure of the posts, further to the comments made earlier in the meeting. Adverts were placed in the BMJ, NHS Jobs and social media, plus international contacts in the EU. He did remind the meeting however of the 24% vacancy rate for training grade vacancies nationally and that that Brexit had had a further impact, meaning that the market available to them was primarily the UK and outside the EU. Recruitment efforts would however continue and interviews.

[A box of signatures was delivered to the Chairman by a member of the public, who also spoke.] The Chairman reminded the public gallery that if there were any further interruptions or disturbances she would be forced to adjourn the meeting.

Mr Salt reiterated the point that he wanted the temporary cessation to be as short as possible and sought further assurance that everything possible to attract candidates would be done. The Chief Executive said that given the shortage of candidates, efforts would be made to ensure that the package was attractive in terms of both the financial compensation and the duration of the contract. He also recognised that they would need to increase efforts in the search outside the UK, and outside the EU, as an international recruitment, and offer the necessary visa support and training (with the post also offering the opportunity to also work at the John Radcliffe Hospital). MPs have asked what can be done to make this more attractive to work here. Housing help had been offered by the local community. He noted that if the
posts could have their training post registration restored that would be ideal, but it was unfortunately unlikely. Should the Board have further ideas, he stressed that the Executive would be keen to hear them.

Action: BH

Mr Peter Ward, Non-Executive Director explained that there were anxieties in rural areas for those with no car about the extra distance to the John Radcliffe Hospital, with limited public transport options, or about the parking difficulties for those with cars. The Director of Clinical Services undertook to look at the issue for those needing to travel the extra distance to the John Radcliffe Hospital, and in particular situations where babies need to stay for a longer period in the special care unit.

Action: PB

The discussion moved to the impact on gynaecology further to a question from the Director of Assurance. Dr Stephen Kennedy highlighted that part of the contingency plan was that all elective Caesarean sections would move to the gynaecology theatres, creating more space on the labour ward. The resultant loss of 7 lists in gynaecology would be covered by the establishment of a temporary mobile theatre at the Horton General Hospital. He confirmed that this was reversible after the end of the temporary cessation of obstetric care at the Horton General Hospital.

The Chairman invited further questions on the proposal for the temporary establishment of an MLU at the Horton General Hospital from October.

In response to a question from the Director of Organisational Development and Workforce, the Director of Clinical Services confirmed that from the moment that recruitment activities were successful, it would take 8 weeks to remobilise and restore the obstetric unit.

The Medical Director wanted to ensure that the Board understood that the benefits of an MLU in general terms were not a matter of opinion, but supported and promoted in NICE Guidance.

As there were no further questions, the Chairman asked the Board to vote on the temporary establishment of an MLU at the Horton General Hospital.

Carried unanimously on a show of hands, the Board approved the temporary establishment of an MLU at Horton General Hospital from 2 October.

The Director of Planning and Information stressed that there would remain a total commitment to engage with local populations, including as part of the Oxfordshire-wide Transformation Programme.

At the request of the Director of Assurance, the Chairman formally acknowledged the receipt of a petition from the ‘Save the Horton’ campaigners during the meeting, and stressed that the approval in terms of the cessation of obstetric care at the Horton General Hospital was for a temporary cessation.

The Board approved the Report on the Contingency Plan for Maternity and Neonatal Services.
TB2016/08/04 Any other business

There was no further business.

TB2016/08/05 Date of the next meeting

A meeting of the Board to be held in public will take place on Wednesday, 14 September 2016 at 10.00 in the Training Room at the Horton General Hospital.

Signed ……………………………………………………………………………………

Date ……………………………………………………………………………………..