PROPOSAL FOR A BUSINESS CASE

MAINTAINING MATERNITY THEATRE SERVICES AT THE HORTON MATERNITY UNIT FOR OUGHFT ROUTINE ELECTIVE CAESAREAN SECTIONS

1. Introduction

1.1. The Horton General Hospital (HGH) is much needed and supported by the people of North Oxfordshire and its neighbouring counties. A significant and crucial element of HGH is the Obstetric Led Horton Maternity Unit (HMU). This service is accessed by Oxfordshire, Warwickshire and Northamptonshire residents and provides a crucial Obstetric led service for women and their families during the antenatal, intrapartum and postnatal periods. HMU also houses a Day Assessment Unit, various antenatal clinics and an Ultrasound Department. It provides specialist support to the neighbouring Cotswolds’ Birthing Unit in Chipping Norton as required on transfer in and in the event of an emergency, and on a weekly basis provides beds and staff to cover shortfalls in the John Radcliffe’s Women’s Centre (JRH) capacity. It also currently operates a level 1 Special Care Baby Unit (SCBU) with the capacity to care for up to 7 neonates.

2. Background

2.1 Since 2008 and the decision of the Independent Reconfiguration Panel (IRP) to maintain Obstetric Led Services at HMU, very little has been attempted by Oxford University Hospital Foundation Trust (OUHFT) to maximise birth rate, utilize training potential, improve recruitment of middle grade doctors and maintain the necessary buildings at HMU. The Birth rate has fallen from 1,723 in 2012/2013 to 1466 in 2015/2016. This drop can be attributed to the intentional transfer to the JRH of the majority of high risk women accessing HMU from Spring 2015, after the change in policy on whom could deliver at HMU. This change was instigated with no consultation with HMU staff and with no change in either Midwifery staffing, Obstetric cover, Anaesthetic cover or Paediatric cover. Birth rate nationally has otherwise risen at 0.4% since 2014 according to the Office for National Statistics.

2.2 A Contingency Plan was announced by OUHFT in full on Friday 26th August 2016 as a temporary measure to cover the failure by OUHFT to recruit sufficient middle grade doctors to staff HMU. At the OUHFT Extraordinary Board Meeting (EBM) on Wednesday 31st August, it was voted by all board members that as part of the Contingency Plan, Consultant Led Obstetric Services will cease and the HMU will become a Midwife Only Unit (MOU) from 3rd October 2016. This Contingency Plan has been agreed on by members of the OUHFT board as a temporary measure to ensure a safe service at HMU whilst the recruitment of middle grade doctors is accelerated.

2.3 The Contingency Plan on page 6, point 6.1, highlights that one of the considerations for planning is that the JRH can expect 1000 more births per year after HMU becomes an MOU. No explanation is given within the Contingency Plan as to how this figure has been calculated. Staff at the JRH have already expressed concerns to management about existing staffing levels, sickness levels and infrastructure for the present birth rate at the JRH, before the extra predicted 1000 per year: 19 per week, expected from 3rd October 2016. This proposal was developed in response to these concerns.
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3. Options Considered within the Contingency Plan

3.1 Only two options were presented to the OUHFT Board at the EBM on 31st August 2016; to shut down HMU fully or to ‘downgrade’ to a MOU.

3.2 The Contingency Plan states on page 5, point 5.5.3, that the option of complete closure was not supported as, unlike the middle grade doctor rota, it is possible to sustainably staff an MOU so no justification for a full withdrawal of the service.

3.3 The Contingency Plan therefore outlined the proposal to downgrade HMU to an MOU, touching on areas such as training, facilities and staffing. The Board members voted, based on the issue of patient safety, on information provided within the Contingency Plan. The Plan only presented one viable option, that due to the failure to recruit middle grade doctors to staff HMU as it currently operates, an MOU was the only acceptable temporary measure.

3.4 It would appear no other models of service provision have been considered by OUHFT for HMU or presented to the Board for their consideration at any time.

4. HMU as an MOU

4.1 Taking into account recent research as publicised in NHS England’s National Maternity Review “Better Births” (Feb 2016) it is recognised that only 6% of women select a stand-alone MOU as their place of birth. Stand-alone refers to the fact that the Unit is not adjacent to an Obstetric Led Unit like The Spires at JRH. Based on HMU’s delivery rate as stated in 2.1 above, this statistic would therefore predict only approximately 88 women will choose to deliver at HMU if operating as a MOU. This equates to less than 7 births per month. This figure is supported by the table seen on page 8, point 2.1.3 of the Contingency Plan, published by OUHFT on 26th August 2016. As discussed in point 15.5 further on in this proposal, 40% of women transfer from an MOU to an Obstetric Led Unit for varying reasons. Birth rate therefore for MOU could therefore be as low as 61 per year, approximately 1-2 births per week.

4.2 Based on the predicted 6% birth rate of 88 per year, HMU as an MOU will not represent the best use of OUHFT resources. Concerned Midwifery staff believe the OUHFT Board will be presented with a report that will reflect this within several months and the decision to close HMU fully will be made, with The Cotswolds Birthing Unit in Chipping Norton used as the MOU for the North of Oxfordshire, providing adequate choice in the eyes of OUHFT, to women and their families in line with NICE guidance CG190 – Choosing Planned Place of Birth. This predicted closure will disrupt staff and service users once more and so a third option is presented within this proposal which will run in addition to the temporary MOU option. It is believed this proposal will save OUHFT money, utilize and maintain current systems of operation and ensure the swift and smooth reopening of HMU once middle grade doctors are employed and ultimately ensure patient safety and service user satisfaction.

4.3 This option will also help to repair the public perception of OUHFT as displayed by service users locally at the recent public meeting held in St Mary’s Church, Banbury on Thursday 25th August. It may also help to recruit and retain staff at the HGH throughout this turbulent period.

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5. A Third Option

5.1 AS acknowledged in the Contingency Plan, on page 9, point 2.3.1 ‘a major challenge facing OUHFT ... is the availability at the JRH of emergency theatre time, post-operative recovery beds, anaesthetists and theatre staff.’ The Contingency Plan also states 1 in 10 women have an elective Caesarean section (ELSCS) in Delivery Suite theatres at the JRH, approximately 80 per month, and 1 in 3 have a surgical procedure in the same theatres, approximately 25 women per month.

5.2 The proposal;

All ELSCS to be performed at the Maternity theatre at HMU for the period of the HMU downgrade and for review at the point in which the Consultant Led Unit is reinstated. This proposal may be a catalyst for long term consideration of service provision across both sites within Maternity Services.

This proposal puts forward for a third option for the OUHFT Board’s immediate consideration. This proposal, whilst needing further specialist input, outlines an option to the Board that will maintain Theatre Services at HMU, eradicating concerns over staffing, availability of beds at JRH, weekend gynaecology theatre lists at JRH and Delivery Suite theatre availability at JRH, as acknowledged in the Contingency Plan.

5.3 This proposal asks for the OUHFT Board to consider that the majority of ELSCS except for the exceptionally high risk, such as major placenta praevia which would require additional specialist support in the event of an emergency, to be undertaken 7 days a week in the theatre at HMU separate from, but in addition to, the MOU model: 2 lists, am and pm, offering a 9am-5pm Theatre service for the undertaking of up to 4 ELSCS per day, potentially 28 per week.

5.4 This proposal outlines considerations needed in relation to;

- Facilities
- Staffing – all specialities
- SCBU
- Access
- Overall Benefits to OUHFT

6. Facilities

6.1 There is an existing fully operational and functional Maternity theatre at HMU negating the expense and short term upheaval of hiring and running a mobile operating Theatre at JRH as proposed in the Contingency Plan.

6.2 Inadequate detail within the Contingency Plan presented to the Board on location of proposed portable theatre, how patients will be transported to and from this area and what extra staffing requirements this will demand, plus no mention of procurement and costs associated, deem the Contingency Plan for the mobile theatre option inadequate.
6.3 Within HMU, Rooms 4 and 5 on Delivery Suite can be utilised as both admission and immediate post-operative recovery rooms as current practice at HMU for ELSCS already supports.

6.4 Within HMU Postnatal Ward, bays 14, 15 and 16, a total of 12 beds and 12 cots, can be maintained as fully functioning during the temporary status change to a MOU, with side rooms 10 and 11 on the Postnatal Ward maintained for any isolating needs such as infectious diseases as per current OUHFT protocols.

6.5 This proposal therefore requires no expensive costs to be incurred for the movement of equipment or any relevant lengthy stock take process, as per the Contingency Plan to be undertaken. All maintenance and appropriate cleaning, safety checks and infection control protocols will remain the responsibility of the Midwives on shift throughout the period of downgrade to an MOU, to ensure smooth transition once middle grade doctors are in post.

7. Midwives

7.1 The Contingency Plan states the downgraded Midwife Only Unit (MOU) will be staffed 24/7 with 1 Midwife and 1 Maternity Support Worker (MSW), with support from Community on call Midwives as required, from 3rd October 2016. We propose no change in this staffing model for the purposes of the MOU.

7.2 However, Community Midwives on call in North Oxfordshire already cover Homebirth provision, the Midwife Only Unit in Chipping Norton – Cotswolds’ Birthing Centre, and the John Radcliffe Women’s Centre. By staffing HMU as a Midwife Only Unit with additional support available from Midwives from the Maternity theatre, places no further strain or reduction on Homebirth provision on the Community teams by reducing the need to call community Midwives into the MOU.

7.3 The Contingency Plan’s proposal on staffing requirements necessitates many long serving HMU staff members, having never worked in any other Unit, to be moved against their wishes to the JRH to work. This has caused much upset and unrest with several experienced members of staff preparing to resign. Much like SCBU, where 2 nurses have resigned, OUHFT cannot allow such collateral damage in staffing if their claims to have this as a temporary provision are to be believed. This proposal would assist to avoid this.

7.4 The reputation of OUHFT as an employer amongst Midwives across both hospitals is poor with a low percentage attained in the staff questionnaire last year – ‘would you recommend staff to work here’, efforts must be employed by OUHFT to improve recruitment and retention, not worsen it. The resignation of further Maternity staff will make the return to an Obstetric Led Unit at HMU impossible. None of the current staff have received any reassurances from Maternity Management that their jobs are secure at HMU once the temporary measure is lifted.
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7.5 Band 7 Midwives at HMU are trained to assist at all categories of Caesarean section, unlike their JR counterparts and as they are potentially suggested by OUHFT Maternity managers as the main compliment of MOU staffing when the downgrade becomes effective on the 3rd October 2016, our proposal would support the retention of all Band 7 Midwives currently employed at HMU to staff the MOU. This will also enable the smooth and safe return of Obstetric Led services to HMU and all relevant rotated staff, once middle grade doctors are in post.

7.6 All levels of HMU Midwives, unlike their JR counterparts, are trained to be scrub nurses at all categories of Caesarean sections and are experienced in providing 1:1 recovery care post-operation and will require no further training for this proposal.

7.7 The Contingency Plan suggests 6.5 WTE Midwives are required to staff HMU as a MOU 24/7. A further 26 WTE Midwives would be required to staff Maternity Theatres and Postnatal Ward safely for this proposal to be effective, based on all staff working long shifts.

7.8 **1 Midwife** to be utilized as a scrub nurse 9am – 5pm (once list complete to move to Postnatal Ward to provide post-operative care and support/break relief to Postnatal Ward Midwife)

**1 Midwife** for recovery bay on Delivery Suite and to receive baby in theatre (opportunity for this to also be Band 4 Maternity Assistant Practitioner as proposed for JRH Post-Operative Bay, once all patients moved to the Postnatal Ward they can provide relief cover for all staff on MOU to have breaks)

**1 Midwife** to cover the Postnatal Ward, required only for post-operative patients (Current Postnatal Ward Manager for HMU can be used within the staffing Monday – Friday day shifts in a further attempt to maintain sufficient management input, staffing management issues such as sickness and aid the smooth transition back to an Obstetric Led Service once middle grade doctors in post.)

7.9 Those Midwives already on rotational programmes can continue with rotation to the JRH for the period of the temporary downgrade as per their existing agreements with Maternity Management. This reduces the number of staff predicted to resign from the OUHFT due to being forced to work at the JRH. Approximately 4 WTE Midwives work over both sites on a rotational basis. There would be no requirement to continue using bank or agency midwives as is current practice due to the high level of vacancies.

7.10 However, in the Contingency Plan in relation to the high level of vacancies, it is stated that 24 Midwives have been recruited by OUHFT and start at the JRH in October 2016. Therefore, Horton Midwives are not required to staff the JRH during the temporary time frame of the Contingency Plan if the plan’s claims on staffing are correct and so any staff not required for this proposal or the staffing of the MOU, would be best placed in Banbury and Bicester Community areas with consideration given to them providing the on call service for the MOU overnight due to their knowledge of the area and HMU.
7.11 Staffing for Maternity Theatre and MOU

<table>
<thead>
<tr>
<th>Potential Capacity</th>
<th>Staff required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day Shift – Theatre/Recovery</td>
<td>4 ELCS</td>
</tr>
<tr>
<td>Day Shift - MOU</td>
<td>1 MLC</td>
</tr>
<tr>
<td>Day Shift - Postnatal Ward/Recovery Ward</td>
<td>8 ELCS</td>
</tr>
<tr>
<td>Night Shift – MOU</td>
<td>1 MLC</td>
</tr>
<tr>
<td>Night Shift - Postnatal Ward</td>
<td>8 ELCS</td>
</tr>
</tbody>
</table>

7.12 This proposal, bringing all routine ELSCS to HMU, should also assist with reducing the sickness levels and rate of resignations from the JRH based staff due to overwork and the stress connected to the Contingency Plan, and any further loss of medical staff at HGH and the JRH for the same reasons. The anxieties voiced by all staff across both sites may lead to a further retention problem for OUHFT and in turn may lead to increased reliance on bank staff (increased cost), increased job adverts (increased cost) and potentially increased error and litigation rates (increased cost).

7.13 Maintaining the majority of the Midwifery staffing and all the Maternity Support Workers at HMU to staff Maternity theatre, the MOU and the Postnatal Ward, will also negate the expense to be incurred by OUHFT for the petrol/travel expenses staff who have been told will need to move to JRH, can claim. For some this is a forced 113-mile round trip per shift as opposed to a 70-mile round trip currently.

8. Maternity Support Workers

8.1 This proposal would require retention of all MSWs currently employed by OUHFT at the HMU to work either within the MOU, the Maternity theatre at HMU or the Postnatal Ward. Current levels of experience would mean none of the MSWs would require further training for this.
Consideration should be given as part of this proposal to the Band 3 MSWs covering Maternity Theatre and the Post-Operative Bay throughout the day shifts at HMU during the temporary service change. All HMU Band 3 MSWs were trained at great expense to OUHFT last year to enable them to assist at all categories of Caesarean section. They can be considered experienced “runners” for the Maternity theatre with the option to assist if required and can provide much needed postnatal care individualised to maternal needs such as breastfeeding.

9. Maternity Assistant Practitioners

9.1 OUHFT employ 2 Band 4 Maternity Assistant Practitioners across both HMU and the JRH, who are trained to work as a scrub Nurse in all categories of Caesarean section. They are able to recover post-operative patients immediately following an ELSCS and so can be deployed over the day shifts Monday-Sunday to provide this care.

10. Theatre staff

10.1 Dedicated Theatre nurses and Operating Department Practitioners (ODP) already cover a 24/7 rota for HMU Maternity theatre in the event of an emergency whilst an Obstetric Led Service.

10.2 To assist in maintaining this service and to ensure staff satisfaction and skills remain up to date within Maternity, and to ensure the smooth transition once middle grade doctors are in post, this on call rota can be reduced from a 24/7 on call system, saving the OUHFT money throughout the downgrade period, and utilised to cover a 9am-5pm, 7 days a week rota.

11. Obstetrician and Gynaecologist Cover

11.1 As noted in the Contingency Plan on page 17, point 8.2.1, 5 WTE Consultants have combined Obstetrics and Gynaecology service commitments at HMU currently. These consultants would be able to provide the specialist cover for ELSCS lists 9am-5pm Monday-Sunday as part of this proposal and so should remain at HMU for the duration of the temporary downgrade.

11.2 The two middle grade doctors remaining at HMU as noted on page 17, point 8.2.1, of the Contingency Plan, will not be required to redeploy to JRH therefore offering a further 2 WTE doctors to cover the ELSCS lists. 7 WTE in total. Alongside this the two GP trainees mentioned on page 18, point 8.2.2, would be able to remain at the HMU for one day a week instead of transferring to the JRH, and can assist at ELSCS, providing further hands on support for this proposal.

11.3 This in turn supports the Contingency Plan’s requirement that 3 WTE Obstetric Consultants cover the Antenatal Clinics remaining at HMU as per page 18, point 8.2.1.
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11.4 It is recognised that the training opportunity afforded by this proposal for HMU, for ST1 – ST3 trainees currently in post at the JRH, is also a firm beneficial consideration, enabling trainees to learn without the ramifications of on call commitments.

12 Anaesthetics

12.1 Not unlike the Theatre staff, a 24/7 second on call rota is currently in place for Anaesthetists at HMU as detailed in the Contingency Plan on page 18, and they already provide efficient 24/7 cover for Maternity, both for elective and emergency work.

12.2 By centralising the ELSCS work at HMU Maternity theatre during the HMU temporary downgrade to a MOU, the 24/7 cover by Anaesthetists can remain in place with cover 9am-5pm for the Theatre list provided and an on call emergency rota for any post-operative reviews deemed necessary as a first point of call by Midwifery staff on the Postnatal Ward outside of Theatre list time frames.

12.3 Most ELSCS post-operative reviews are centred on pain relief management and can be efficiently managed by skilled Midwifery staff supported by an Anaesthetic review overnight on an on call basis. Consultant Anaesthetists at HMU are residency posts and so no increase in on call cover is required for the purpose of this proposal.

12.4 This proposal would save OUHFT petrol/transport costs claimed by staff by sending HGH Anaesthetists to the JRH as suggested in the Contingency Plan to support an increase in Theatre lists at JRH.

12.5 This proposal would also eliminate any necessary lengthy negotiations with HGH Anaesthetists on being transferred to the JRH, possibly against their wishes due to the added commute, its impact on safety due to fatigue and any associated concerns centred around covering the JRH on calls, therefore retaining staff and maintaining staff satisfaction.

13 Paediatrics

13.1 Paediatricians currently cover a 24/7 Resident Consultant on call for HMU and SCBU. Sufficient Paediatric doctors are employed currently within OUHFT at the HGH to cover this. With the move to an MOU the demand on their skills and time 24/7 will no longer be required. Proposing therefore a 24/7 on call rota for ELSCS neonates as required will not add any further strain to their rota. Paediatricians are not required to routinely attend elective Caesarean sections as immediate neonate input is provided by the Midwives.

13.2 This proposal does however recognise the need for further specialist advice and input from HGH Consultant Paediatricians and the Thames Valley and Wessex Neonatal Operational Delivery Network in respect of maintaining an on call service 24/7 for Maternity theatre and SCBU.
14 Special Care Baby Unit

14.1 There is a recognised clinical need to maintain a Special Care Baby Unit (SCBU) as part of this proposal, when undertaking ELSCS cases due to the minimal risks to neonates from ELSCS.

14.2 It was acknowledged by the OUHFT Board at the EBM on 31st August 2016 that 2 SCBU nurses had already tendered their resignations to OUHFT therefore already making the reinstatement of a SCBU, once middle grade doctors are in post, an additional challenge for OUHFT.

14.3 To prevent further collateral damage from additional SCBU staff resignations, a SCBU is proposed to support the Maternity Theatre at HMU as part of this proposal. Suggestions have been received from current staff that this can be staffed by 1 Band 6 Nurse and 1 Nursery Nurse per shift day and night, meaning 6.5 WTE of both roles will be required to remain in post, and not moved to JRH for the time of the temporary downgrade. Ensuring again staff satisfaction and retention.

14.4 SCBU equipment would not be required to be redeployed to the JRH as stated in the Contingency Plan, thus again saving OUHFT transportation costs due to the proposed temporary closure.

14.5 It is appreciated that due to the timescale employed to draft this business case, it is important that further clinical input is sought to finalise the provision of a SCBU as recognition is given to the points raised on page 13 of the Contingency Plan, point 4.3.7, that an MOU does not require a SCBU as could lead to confusion and delays in appropriate transfers. However, a Maternity Theatre will require this infrastructure.

14.6 The Spires at the JRH is an MOU and they do not experience any such issues with a Level 3 Unit on site and so consideration must be given to the expertise and skills of the Midwives proposed to staff HMU MOU and the requirement to follow the strict protocols in place, across all OUHFT’s MOUs in relation to escalating concerns relating to newborn babies.

14.7 HMU SCBU have provided regular support to the JRH, accepting transfers of newborn babies for transitional care (TC) for locally placed families, this much needed support can be maintained if fair consideration is given to this proposal. As per the Contingency Plan on page 13, point 4.3.8 this totalled 52 babies last year with an average length of stay as 5.6 days.

14.8 Over the years HMU SCBU has received considerable donations from the public and service users and this has been regularly used to purchase much needed equipment and to furnish and support the Family Room. This is an area in which immediate family with babies on SCBU can stay for any period of time to improve patient outcomes. Public dissatisfaction has already been openly voiced at the suggestion by OUHFT, within the Contingency Plan, that HMU SCBU equipment is moved to the JRH for the period of the temporary downgrade. This proposal will prevent this.

15 Gynaecology Services
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15.1 With emergency beds and recovery beds fully utilized at JRH as stated on page 9, point 2.3.4 of the Contingency Plan, discussion about extending lists at the JRH for Gynaecology procedures to cover weekends, has been proposed. By maintaining a Maternity theatre at HMU this will alleviate the need for any disruption to lists at the JRH, thus ensuring no possible further fines for missed targets due to over stretched theatre lists, or the need to procure a mobile Theatre for the duration of the temporary downgrade.

15.2 This proposal also prevents further pressure on multi-disciplinary staff for extra Theatre lists, including the suggestion of weekend lists at the JRH, improving again the recruitment and retention of OUHFT staff across both sites.

16 Access

16.1 The Contingency Plan on page 14, point 5.4.1 acknowledges the need to minimise transfer times, yet does not state clearly what these times are. Currently this is recorded by South Central Ambulance Services (SCAS) as being a minimum average of 45 minutes. This is in conflict with the 30 - 38 minutes suggested at the OUHFT Board meeting on the 31st August 2016, as length of time for transfer between HMU and the JRH.

16.2 The transfer time is clearly acknowledged as an important issue by OUHFT as in the Contingency Plan, page 14, point 5.4.1, it is stated that current negotiations are underway to obtain an ambulance stationed outside the MOU 24/7, at an approximate cost of 1 million a year. “Better Births” (Feb 2016) states that 40% of women transferred from an MOU to an Obstetric Led Unit last year and so deeper consideration should have been given to this issue.

16.3 This proposal will not impact on the Midwifery staff’s requirement within the MOU to adhere to the stringent OUHFT escalation protocols for transfer to the JRH from any MOU within Oxfordshire, yet acknowledges the continuing concerns surrounding the issue of time and distance for a transfer in any emergency scenario.

16.4 This proposal does however provide much needed immediate Midwifery support from within the building in an emergency scenario, ensuring the efficient triage and transfer, unlike the staffing levels outlined in the Contingency Plan for the MOU, as previously mentioned in point 7.1 of this proposal. This immediate support is key in an emergency scenario to ensure positive outcomes for women and their families.
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#### 17 Overall Benefits

| Saving OUHFT money | 1. Utilise HMU Maternity Theatre and equipment  
|                    | 2. No need to hire Mobile Theatre at JRH  
|                    | 3. No requirement for inventory or movement of equipment from HMU to JRH then return transportation when reopened  
|                    | 4. No need to pay petrol costs for all staff displaced to JRH for the term of the downgrade  
| Patient Satisfaction | 1. HMU scored higher in CQC report than JRH  
|                      | 2. Smaller ward/recovery environment  
|                      | 3. Better midwife to patient ratio at HMU  
|                      | 4. Improved postnatal care outcomes in line with “Better Births.”  
|                      | 5. Quicker more efficient discharge home experience  
| Staff Satisfaction | 1. Maintaining majority of staff at HMU in any capacity will prevent further resignations  
|                    | 2. Maintaining staff at HMU will improve staff and management relationships  
|                    | 3. No movement of MDT required, greater staff satisfaction  
|                    | 4. Happy staff = safe care  
| Returning to Obstetric Led | 1. Maintaining staffing, equipment and Theatre will ensure a smooth transition once this temporary downgrade is complete and middle grade doctors are in post  
| Restore Faith | 1. Working towards restoring service user’s faith in OUHFT county wide and across county boundaries.  

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17.1 Other service providers like Warwick and Northampton have been contacted on a shop floor level. Impromptu discussions had with Midwives from these hospitals contradict fully each of their Management’s view, suggesting that these hospitals will be able to accept the increase in births the Contingency Plan will create for them. This point was not explored fully in the Contingency Plan, with no appendix detailing any appropriate correspondence with these Hospitals, therefore offering no reassurance to service users.

18 Things to Consider

18.1 In the unlikely event that a patient may need to return to Theatre outside of Theatre list time frame due to a post-operative complication arising, consideration must be given to either:

The continuance of an emergency team for Maternity Theatre at HMU 24/7 as is presently in place, for the duration of the temporary downgrade

OR

The immediate transfer by ambulance to the JRH if considered an emergency with the on call midwife from community called as per the Contingency Plan for the MOU, for the temporary cover of the Postnatal Ward whilst a Midwife accompanies the patient on a transfer to the JRH.

A review/audit is suggested on routine ELSCS cases returning to Theatre within the immediate first 48 hours post-operative, to fully review risk.

18.2 Patient satisfaction and safety is key to this proposal and so full and frank immediate consultation is required with Paediatric, Obstetric and Anaesthetic Leads across both sites.

18.3 Discussions around distance to travel for women opting for an ELSCS from Oxford or the South of Oxfordshire needs to be offset by the distance women from the rural North of Oxfordshire will have to travel when attending the JRH. Parking and road infrastructure around the HMU make the HGH considerably easier to access than the JRH – patient appointment letters for JRH already warn of allowing an hour for parking. This is not the case at HMU. Parking is also considerably cheaper at HGH than at the JRH.

18.4 Patient satisfaction – Whilst on Postnatal Ward at HMU post-operative patients will enjoy a better staff to patient ratio. This is significantly less than that currently seen for post-operative patients at JRH in Observation Area, Level 5 and Level 6. Important areas of care such as breastfeeding support and subsequent postnatal outcomes, as per “Better Birth” review of postnatal services will be significantly improved and this will also impact on
perinatal mental health, also a driving factor in current Maternity care provision. The HMU scored significantly higher in the CQC report against the JRH in this area.

19 Summary

This proposal will ultimately

- Save OUHFT money
- Improve recruitment and retention of all staff across both sites
- Prevent the displacement of equipment from HMU to the JRH
- Maintain SCBU and Ward areas in preparation for the end point of the temporary downgrade
- Best utilize current HGH working practices whilst providing the JRH with support
- Maternity theatre and associated staffing at HMU will be maintained
- Ensure higher staff satisfaction across both sites leading to better care outcomes for patients
- Alleviate pressure for Theatre time and beds at the JRH
- Enable the timely smooth return to Obstetric Led services at HMU once OUHFT have recruited sufficient middle grade doctors.

Overall, this proposal is centred around a safer and quality assured service for all OUHFT patients by dedicated and highly trained HGH and JRH staff with skills maintained, staffing retained across all areas and a securer, more encompassing future for HMU and the wider HGH.
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NB. Please note that due to the limited timescale involved in drafting this business case it has not been possible to submit appropriate appendix as supporting evidence.

The author would recommend that this proposal is considered alongside the existing Contingency Plan dated 26th August 2016 and more poignantly, the National Maternity Review commissioned by NHS England “Better Births” (Feb 2016). Special attention to be paid to areas highlighting postnatal care and long term outcomes for women and their babies.