Oxford Radcliffe Hospitals NHS
NHS Trust

Performance Improvement and Cost Reduction Programme

June 2006

Part 2
The Horton Hospital

Foreword

As the NHS receives increased funding, it is reasonable to ask why some parts of the country – including Oxfordshire – are in financial difficulty and faced with the need to cut costs by large amounts.

The extra resources made available to the Oxford Radcliffe Hospitals (ORH) in recent years have meant improvements in patient care, reduced waiting lists and waiting times, new hospital facilities, and the availability of new and often more expensive drugs. They have also meant better pay for our doctors, nurses and other staff – particularly important to us if we are to attract and retain staff in a part of the country with a high cost of living. In short, increased resources have enabled the ORH to deliver more, modernise its services, and build for the future of Oxfordshire's healthcare.

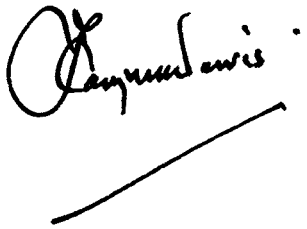
There is, however, a substantial gap between the money needed to run local services at their present cost and activity levels, and the funding currently available to the NHS in Oxfordshire. As a county, we receive 85% of the national average funding for NHS services, placing us among the lowest funded regions in the country. This is based on the relative health of the population, and means that (for example) inner city areas with higher levels of illness and deprivation receive higher levels of funding. At the same time, the NHS in Oxfordshire has to plan for a high cost of living, and has a population which is arguably more knowledgeable and demanding of its health services than some other areas of the country.

Oxfordshire's hospitals have greatly increased their efficiency in recent years, and are working hard to provide the most for the money available. According to official Department of Health figures, the ORH is now one of the most cost-efficient acute teaching trusts in England. In the future, under a system in which money follows the patient at an agreed national rate, there is no reason why the ORH should not be in a strong financial position each year.

For now, however, the gap remains. As the range of services and our efficiency has increased, so has demand. In 2002/03, for example, we treated 71,200 emergency inpatients – by 2005/06 this had risen to 91,500. Day cases and treatments have risen from 56,700 to 77,000 in the same time – an increase of 37%. Similar increases have occurred in most areas of our work.

Whilst the funding level for Oxfordshire will doubtless continue to be debated, the amount available is unlikely to change in the near future. We must therefore provide the best possible care for the local population within the present funding, which this year is £33 million less than required by current cost and activity levels.

This document therefore sets out proposals agreed by the ORH Board to reduce our costs by this amount. It is in two parts: **Part 1** deals with how we propose to improve our efficiency and performance and work with patient groups, key stakeholders and staff to implement these plans, and **Part 2** is the formal consultation document on options for changes in services at the Horton Hospital in Banbury. We hope that you will provide us with comments and feedback on both elements, but particularly in relation to **Part 2**. Further details of how you can contribute are included in both parts of the document.



Trevor Campbell Davis
Chief Executive

Part 2: The Horton Hospital

This part of the document outlines the changes to some of the Horton Hospital's services that the ORH is now considering. **The options are presented for formal public consultation.** The changes being put forward for consultation have been driven primarily by clinical considerations. In particular, we need to make sure that the services are safe, that they are of the highest possible quality, and that the staff who provide them can be trained properly and safely supervised. Crucially, we must also make sure that all the ORH's clinical services are sustainable for the foreseeable future.

In addition to consulting patients and the public about these changes, we will continue discussing options with our commissioners, local GPs, other NHS organisations and stakeholders.

Staffing issues are a key consideration; in this small hospital the volume of activity in some specialties is so low, particularly at night, that medical posts are not suitable for training, and, with loss of training recognition, recruitment then becomes problematic. This makes it more difficult to maintain clinical skills and, ultimately, the quality of service will deteriorate.

The work by the ORH Strategic Review has involved large number of clinicians and highlighted the need to apply the principles and themes emerging from this work in all services. It is important that the clinical services across Oxfordshire and the Trust's sites are managed and delivered by a single team of clinicians, with a common approach. In many instances, the medical staff will work in both Banbury and Oxford, allowing the services and the medical teams to strengthen the links to the benefit of patient care across the Trust.

This will ensure that consistently high standards are applied and skills are maintained, with doctors, and where appropriate nurses and midwives, gaining experience of both routine and more complex cases. For patients who need to be transferred between the hospitals, continuity of care will be improved and all patients will have equal access to the specialist expertise available within the Trust.

The Strategic Review has highlighted the fact that demand for healthcare is rising as a result of demographic factors, medical advances, new treatments and rising patient expectations. The ORH now needs to consider how best to meet these demands and whether new service models are available.

The ORH has a responsibility to deliver services in the most cost-effective manner in order to provide the maximum amount of healthcare. In an increasingly constrained financial environment, the ORH faces difficult decisions when balancing the benefits of maintaining services against the impact of increasing cost pressures.

To meet the immediate financial pressures (as explained in **Part 1** of this document), the Trust is bringing forward consultation on strategic changes which might otherwise have been made over a period of one to three years. The work done by the Strategic Review in understanding the factors impacting on all the Trust's clinical and other services, and how best to meet the challenges of the changing health service environment, has provided the Trust with a clear and consistent framework for the proposals now being put forward for the Horton Hospital.

The vision

In the ***Emerging Themes*** document of the Strategic Review we set out a vision for the Horton Hospital as a modern local hospital which was based on:

- high quality services for the local population;
- seamless links to the specialist services provided across the Trust;
- improved care pathways for patients needing to be transferred for specialist treatment whenever these cannot be provided locally;
- greater collaboration between primary and secondary care providers, with appropriate links to specialist services;
- establishing an innovative model for the hospital which leads the way for others of similar size;
- ensuring that being part of the Oxford Radcliffe Hospitals benefits patients served by the Horton Hospital, and that the Horton contributes to the purpose and objectives of the Trust as a whole.

In subsequent discussions, this vision was extended to include:

- provision of state-of-the-art diagnostic investigations across the widest possible range of imaging techniques;
- delivery of all routine elective and day case surgery for the population of North Oxfordshire, South Northamptonshire and parts of Warwickshire.

This vision was developed by a working group which included clinicians and managers at the Horton Hospital and representatives from primary care, including GPs, from the north of the county.

The pressures

The Horton Hospital is valued by the population it serves and the staff who work there. It provides services to the people of north Oxfordshire, south Northamptonshire and parts of Warwickshire, and hence plays a major part in delivering services locally. However, as indicated in ***Emerging Themes*** and explained at public meetings since, small acute hospitals across the country are subject to a number of pressures which make some services difficult to sustain, and could lead to a change in way services are provided in the smaller acute hospitals. These pressures are largely driven by the fact that the minimum volume of activity required to provide some services safely and cost-effectively is increasing. There are two main sources of pressure contributing to this problem.

First, there are increasing restrictions on the hours that doctors can work:

- Reduced working hours for junior doctors (as a result of the European Working Time Directive – EWTD) means that more doctors are required to make up a full rota.
- Rotas where the doctor is resident in the hospital require a minimum of seven doctors to run them with one doctor on each night.
- These reduced hours worked by each doctor mean that, in low volume services, the trainee doctor does not see enough patients to develop and maintain clinical skills. This can lead to withdrawal of training recognition which makes recruitment of middle grade doctors of consistently good quality extremely difficult.
- At consultant level, doctors are increasingly unwilling to work on-call rotas of less than one-in-four nights on-call, which means that a minimum of five are required to run an on-call service such as obstetrics or paediatrics, where emergencies can arise at any time. Services with more onerous on-call requirements are increasingly difficult to recruit to.

Second, pressures arise from the increasingly specialist nature of our clinical services, with doctors treating specific disease groups or specific parts of the body. General surgery is an excellent example; general surgeons now cover a very wide range including upper gastrointestinal surgery, colorectal surgery, endocrine surgery, breast surgery, and vascular surgery.

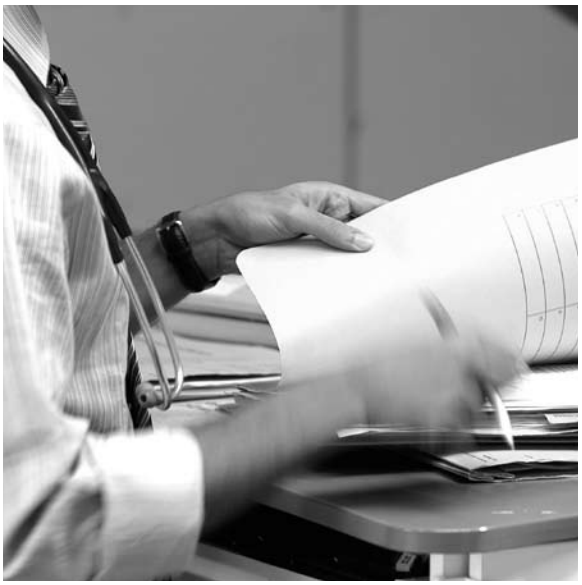
Consultants in paediatrics now have specialist interests in, for example, oncology, neurology, infectious diseases, diabetes and gastroenterology. This specialisation, of course, increases the skills available to patients, but makes it more expensive to provide the full range of the specialist services in a hospital with a modest level of activity.

These pressures mean that some Horton services, in particular services for women and children, and emergency surgery and trauma services, are not clinically sustainable in their current configuration.

The strategy

Having considered the pressures on small acute hospitals, the Strategic Review developed a strategy for the Horton based on:

- Maintaining the core of the hospital – the emergency department and acute general medicine.
- Improving care for the older person, including provision of intermediate care beds, at the Horton Hospital to enable patients to recover locally, with local rapid access to assessment and diagnostic services, such as x-ray and CT.
- Expanding the amount of routine elective surgery, particularly day case surgery, done at the Horton, so that it provides the majority of this work for the population of North Oxfordshire, South Northamptonshire and parts of Warwickshire.
- Continuing to deliver the majority of emergency surgery in scheduled daytime emergency operating lists at the Horton Hospital, with rapid access to theatres in Oxford for the few cases that cannot wait until the next working day.
- Improving access to the fullest range of diagnostic tests and equipment which can be provided cost-effectively in Banbury, including access to MRI via the ISTC.
- Providing maternity services at the Horton Hospital in a new configuration linked with the Women's Centre in Oxford.
- Providing services for children in a consultant-led Horton Children's Day Centre, as part of a new integrated children's service covering all of Oxfordshire.
- Increasing access to the many specialist services provided by the Trust, with as many as possible being delivered through clinics at the Horton.
- Integrating services across the Trust so that they are delivered to consistently high standards, by a single team of clinicians, with a common approach, ensuring equal access to the generalist and specialist expertise of the Trust for all its patients.



The Local Hospitals Project sponsored nationally by the NHS Confederation was established to consider the appropriate configuration of services for small local hospitals in view of the pressures facing them. It has recently reported, and the report confirms the Strategic Review's findings that the core of the local hospital is its emergency department and acute general medicine. The project specifically considered the services which are essential in any hospital with an emergency department. The report states that it is not considered essential to have emergency general surgery, trauma, paediatrics and obstetrics on site to support a full emergency department service, provided they are available within a local network and that there is access to specialist and surgical advice.

The Horton Hospital has an important contribution to make to the training of medical students and junior doctors in its busy specialties. This aspect of training during daylight hours has been acknowledged during 'training recognition visits' by various Royal Colleges.

Following this consultation, the future configuration of the Hospital will be agreed and a development plan will be drawn up setting out the investment in the infrastructure which will be put in place at the Horton Hospital to support the delivery of the strategy in suitable buildings.

The proposals

The Strategic Review has developed proposals to address the pressures described above, while at the same time enhancing the quality and range of services provided at the Horton. We have also considered where economies can be made without affecting patient care, thereby releasing resources for other priorities and to meet growing demand.

Options for consultation are presented for the following services:

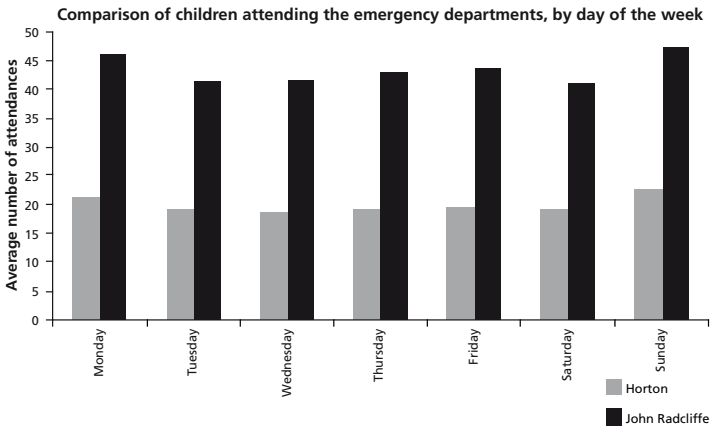
- Services for children and the newborn
- Maternity
- Gynaecology
- Emergency general surgery and trauma
- Elective surgery and, in particular, day case surgery
- Emergency department
- Care of the older person
- Specialist services
- Laboratory medicine and pathology services

Services for children and the newborn

For some years, particularly following the withdrawal of training recognition for middle grade trainees in paediatrics (including neonates), it has been difficult to maintain a full middle grade rota at the Horton Hospital. There have been periods when the service has not been fully staffed, and others where cover has been maintained only by a series of very short-term locum posts (sometimes of only one or two weeks at a time). This has seriously affected the continuity of care and may have contributed to a significantly higher number of admissions for minor complaints relative to the catchment population, when compared to the John Radcliffe Hospital.

Paediatric Admissions	Horton	John Radcliffe
General paediatric admissions a year	1,845 (5 per day)	3,208 (nearly 9 per day)
Out-of-hours admissions a year	339 (nearly 1 per night)	967 (nearly 3 per night)
Percentage of patients admitted for less then 24 hours	40%	30%
Average length of stay	1.9 days	2.5 days

It is likely that training recognition for SHOs (Senior House Officers) could also be withdrawn because of the low intensity of workload and poor exposure to a spectrum of acutely and chronically sick children and neonates. The volume of activity out-of-hours is very low, raising concerns about the maintenance of skills, particularly for staff participating in resident on-call rotas. On average, four children arrive at the emergency department out-of-hours (21:00 to 09:00), with one of these being admitted to the ward. Doctors participating in the out-of-hours rota will have reduced daytime sessions, which further reduces their opportunity to maintain clinical skills.



The current model of staffing the paediatric service out-of-hours is not working. The tightening of EWTD, the withdrawal of training recognition, the high cost of employing consultants and staff grades to be resident at night, and the low exposure out-of-hours to acceptable activity levels, all make this option unworkable in the medium to long-term.

We have spent the last two years consulting internally with staff, externally with paediatric professionals, and locally with stakeholder groups. There is a recognition amongst all the clinical professionals (including retired Horton paediatricians and the Royal College of Paediatrics & Child Health) that things have to change. This is tempered by a strong desire amongst local stakeholders that things should continue as they are.

Just 10% of all attendances by children at the emergency department are out-of-hours – around three attendances per night. 85% of attendees are treated by emergency department staff without reference to a paediatrician. Fewer than seven children a week are admitted out-of-hours.

If we were to try to maintain the overnight service, this would require us to implement a mixed staffing model which would include some consultants and some middle grades being resident in the hospital at night. We would need to recruit an additional two consultants willing to participate in what is likely to be considered an unrewarding and unattractive job.

This model is not achievable in the short-term and is not sustainable in the medium to long-term. Furthermore, it increases the cost of the service provision (it would cost an additional £433,000 each year) and does not achieve the strategic objective of establishing an integrated service across the county.

We have therefore considered two options:

C1. Children's Day Centre with extended opening hours

C2. Children's Day Centre with normal opening hours

C1. Children's Day Centre with extended opening hours

In this model, the current arrangements would be replaced by a Children's Day Centre open for an extended 12 hour day Monday to Friday and three hours on Saturday morning. The suggested weekday opening hours are 09:00 to 21:00 or 10:00 to 22:00.

During the weekend, there are on average 42 children attending the Horton emergency department, of which six may require assessment by a paediatrician. Weekend sessions have been considered and a three-hour Saturday morning session has been proposed because this may allow for some urgent referrals from GP practices and for review of patients attending paediatric rapid access clinics on a Friday. However, the workload on a Sunday is so small that an additional session (and the impact on the consultant rotas) is not a feasible option.

The service would be led and largely delivered by a consultant paediatrician, who would also form part of a wider, integrated, general paediatric service across Oxfordshire. The vast majority of sick children would continue to be seen and treated in Banbury during the opening hours of the Children's Day Centre.

The Children's Day Centre would provide GPs with rapid access to paediatric assessment and diagnosis, with six daytime observation beds. This would run alongside general paediatric and specialist outpatients clinics seeing over 3,000 children annually, together with a range of paediatric day case work such as ENT and oral surgery.

Children requiring overnight admission would be admitted to the new Oxford Children's Hospital which opens in early 2007. The evidence shows that typically between three and five beds would be required for children previously admitted overnight to the Horton Hospital. This capacity has been identified as being available in the Oxford Children's Hospital.

The Horton emergency department already manages the majority of children without reference to paediatricians. However, in this option we would enhance the paediatric skills of the emergency department staff to reduce further the need for children to be transferred to Oxford. The clinicians would have direct telephone access to the duty paediatrician in Oxford. Children requiring urgent paediatric review outside the opening hours of the Horton Children's Day Centre would be referred to the Oxford Children's Hospital.

The evidence shows that we would expect to transfer up to two children per night – one for paediatric assessment and another for admission. This has been discussed with the Ambulance Service, who are able to provide this transfer service to the required specification and have given an indicative cost. Out-of-hours, there will occasionally be a child who is collected by an ambulance in the community; in this case they would be taken direct to Oxford. Examples of urgent or emergency cases requiring urgent transfer to Oxford include major trauma, meningococcemia and acute bronchiolitis.

We anticipate being able to offer taxi transportation for the immediate parent/guardian of a child who requires ambulance transfer to Oxford.

Since paediatricians would no longer be available out-of-hours under this proposal, it would be necessary to have a more experienced middle grade doctor or Specialist Registrar in the emergency department out-of-hours. A second emergency department consultant would be needed to support any increased workload and staff training, and a clinician (doctor or nurse) with advanced paediatric life support (APLS / PALS) training will need to be available at all times in the emergency department.

We have agreed with the Primary Care Trust how we could enhance the community children's nursing service, extending availability from 18:00 up until 22:00, plus longer hours at weekends and public holidays. This children's nursing support at home would reduce the need for hospital admission and facilitate the earlier return home of any child admitted to hospital.

This model achieves the strategic objective of establishing a service integrated across the Trust, with a single general paediatrics rota; it provides a clinically safe local service for children in Banbury; is sustainable in the long-term; and it makes a modest contribution to the Trust's requirement to deliver services more cost-effectively. This model is slightly cheaper than current practice, giving a saving of £85,000 each year. To provide an additional three-hour session on a Sunday morning would cost £45,000, reducing the savings to £40,000 each year.

C2. Children's Day Centre with normal opening hours

The Trust has also considered how it would provide a Children's Day Centre service for eight hours a day (rather than the extended period), opening from 10:00 to 18:00 for instance, without the weekend sessions. All other features remain the same as in option C1.

This model achieves the strategic objective of establishing an integrated service across the Trust; provides a clinically safe local service for children in Banbury; is sustainable in the long-term; and makes a significant contribution to the Trust's requirement to deliver services more cost-effectively leading to a saving of £417,000 each year.

Maternity services

The Horton Hospital currently offers a maternity service consisting of routine obstetric admissions and a low-risk midwifery service. It is supported by a small special care baby unit (SCBU) looking after the newborn or prematurely born babies.

With fewer than 1,600 deliveries each year, the Horton Hospital maternity unit is the ninth smallest in the country (out of 150 units). The same staffing issues apply as in the low volume paediatric services; the on-call rotas are difficult to manage with small numbers of doctors, the volume of work is insufficient to retain training accreditation or for doctors to maintain clinical skills, and the jobs can be unattractive and difficult to recruit to.

An additional constraint on small units with an obstetric-led service is the requirement to have an experienced anaesthetist available at all times for the labour ward. This means that there must be an anaesthetist resident on site whose sole responsibility is the maternity service. Currently, the Horton Hospital has a single trainee anaesthetist available on site out-of-hours who covers all specialities, including the emergency department, ward emergencies, intensive care and the maternity service. This trainee is supported by a consultant on-call from home. This does not meet the requirements of the NHS Clinical Negligence Scheme for Trusts (CNST). To meet CNST standards, the ORH would need to put in place a new tier of experienced anaesthetists at night. These posts would be unattractive and difficult to fill, and also represent a significant cost increase in the order of £400,000 to £600,000 each year.

Furthermore, the Royal College of Obstetricians and Gynaecologists has indicated that it is unlikely to renew training recognition for obstetric trainees unless activity is increased (likely to need to increase to 2,500 births a year). The expected population growth in Cherwell Vale of 13% over 20 years will increase the number of births by about 12 each year. In principle, it is also possible to increase activity by transferring 1,000 births from the Oxford Women's Centre to the Horton. In practice, this would prove very difficult to achieve, as it would require women from just north of Oxford, and from the city itself, choosing to have their baby in Banbury.

Even if additional activity meant that training recognition could be maintained, the Royal College of Obstetricians and Gynaecologists has said that it would require a second tier of obstetric doctors to be resident at night to maintain adequate supervision of training. This would add £350,000 to £420,000 to the annual cost of the service.

The introduction of a Children's Day Centre to replace the current children's service would mean that paediatricians are no longer available at the Horton out-of-hours, and would not therefore be able to provide medical cover for the SCBU. In this situation, in order to retain the SCBU, we would need to train and employ a tier of advanced neonatal nurse practitioners (ANNPs). There is a national shortage of this group of staff and it does not appear that this will change in the next few years. It is also felt that due to the low level of activity and complexity of cases at the Horton, these ANNP posts would be unattractive to these highly skilled nurses, and, even if they were to rotate with Oxford, it may prove difficult to maintain their skills. The Trust currently has vacancies for ANNPs in the neonatal unit in Oxford which it cannot fill. The annual cost of this tier of ANNPs would be £360,000.

This model is not achievable in the short-term and is not sustainable in the medium to long-term. Furthermore, it increases the cost of service provision by an additional £1.1 million to £1.4 million each year.

Recognising these difficulties, the following options have therefore been considered:

M1. Maintain the midwifery-led service, with obstetric-led service centralised in Oxford

M2. An enhanced midwifery-led service, with obstetric-led service centralised in Oxford

M1. Maintain the midwifery-led service, with obstetric-led service based in Oxford

The Strategic Review has recognised that many women who are fit and healthy and have uncomplicated pregnancies, would prefer to have a natural delivery supported by a midwife in a 'low tech' environment without medical intervention.

This option proposes maintaining the midwifery-led service at the Horton Hospital, together with obstetric-led antenatal clinics during the day. Obstetric-led deliveries would be based in the Women's Centre at the John Radcliffe Hospital.

Evidence from other small maternity units that have gone through the same change suggests that, while there is initially a substantial drop in the number of midwifery-led births, this number increases again over time. We have estimated that we would expect the maternity unit to cater for 610 births rising to over 700 in five years.

We estimate that, of the 1,500 to 1,600 births each year, in the first year some 450 women would deliver at the Horton and 900 would deliver in Oxford (this includes 160 women who may need to be transferred to Oxford during pregnancy or labour). Between 200 and 300 women may choose to book their deliveries outside Oxfordshire.

The option would require ten additional maternity beds in the Women's Centre; appropriate physical space is available for this. There is sufficient theatre provision at the Women's Centre, but we would need to provide three additional delivery rooms. The SCBU babies would be accommodated by the expansion of the neonatal unit already planned, and establishment of a transitional care unit (for babies who require to stay in hospital but do not need to be separated from their mothers).

By definition, a midwifery-led maternity service would not deliver babies likely to require special care. Therefore no SCBU would be required in Banbury.

The additional requirement for ambulance transfers has been discussed with the Ambulance Service and is included in the costings. Mothers would have the reassurance of rapid transfer to the Oxford Women's Centre should they need medical intervention at any time during the pregnancy, labour and delivery.

This model provides a clinically safe local service for low-risk births in Banbury, is sustainable in the long-term, and makes a contribution to the Trust's requirement to deliver services more cost-effectively, giving with an annual saving of £167,000.

M2. An enhanced midwifery-led service with obstetric-led service based in Oxford

The Horton Hospital already has an award-winning midwifery service, and in this model option M1 would be developed further to create a modern birthing centre. Such a facility would include upgraded delivery rooms and a birthing pool. The antenatal/postnatal single rooms would have en suite facilities, comfortable large beds, facilities for a partner to stay, and a home-from-home atmosphere. In addition, there would be access to holistic therapies such as massage and aromatherapy in labour. Care would continue to be delivered by groups of midwives working together to offer personalised care and continuity, so that women get to know a group of three or four midwives, one of whom will deliver their baby.

Mothers would have the reassurance of rapid transfer to the Oxford Women's Centre should they need medical intervention at any time during the pregnancy, labour or delivery.

As with option M1, this model provides a clinically safe local service for low-risk births in Banbury, is sustainable in the long-term, and makes the same contribution to the Trust's requirement to deliver services more cost-effectively. The additional capital costs of developing the new environment have yet to be fully assessed.

Gynaecology

Gynaecology and obstetrics are often delivered by the same group of consultants, although nationally there is a trend towards consultants specialising in either gynaecology or obstetrics.

With changes in surgical techniques, more than 70% of gynaecological surgery is now performed as a day case. In terms of emergency surgical procedures, the vast majority are undertaken during daylight hours, as recommended by the National Confidential Enquiry into Patient Outcome and Deaths – NCEPOD ("The institution of daytime lists for emergency operating has been a major improvement in the quality of care delivered to surgical patients" NCEPOD).

Horton: Average theatre operations per month (Weekdays)

Time	Gynaecology	Obstetrics
08:00 to 17:59	**74.5**	**17.0**
18:00 to 21:59	0.5	1.7
22:00 to 01:59		2.0
02:00 to 07:59	0.2	3.7
18:00 to 07:59	**0.7**	**7.4**
TOTAL	**75.2**	**24.4**

Horton: Average theatre operations per month (Weekends)

Time	Gynaecology	Obstetrics
08:00 to 17:59	**2.3**	**2.3**
18:00 to 21:59	0.5	1.0
22:00 to 01:59		0.8
02:00 to 07:59		1.2
18:00 to 07:59	**0.5**	**3.0**
TOTAL	**2.8**	**5.3**

Each month there are, on average, a total of 3.5 gynaecological patients who go to theatre out-of-hours (i.e. between the hours of 18:00 and 08:00 on weekdays and throughout the weekend). If the obstetric service is transferred to Oxford, the low levels of gynaecological work would mean that it is not feasible to maintain a junior doctor and consultant rota at night. Not only would this be expensive, but the level of activity would not be sufficient to maintain skills and keep training recognition.

The following option has been considered:

G1. Increase day case gynaecology at the Horton, centralising emergency and inpatients in Oxford

There are currently 1,200 day case gynaecological admissions at the Horton and 376 elective inpatients, of which approximately 200 a year (4 per week) require surgical intervention and overnight admission. These four cases each week would be undertaken at the Oxford Women's Centre, allowing the gynaecology ward at the Horton to be closed. Any day case patient who unexpectedly needs to stay overnight would be admitted to the Horton main surgical ward, or transferred to Oxford if required clinically.

While there are 384 emergency admissions, very few procedures are carried out at night (three per week). The majority of patients referred for emergency surgery are operated on the same day or the next working day in scheduled emergency operating lists. Most of these are able to be discharged on the same day as surgery. If a patient unexpectedly needs to stay overnight, she would be admitted to the main surgical ward at the Horton, or transferred to Oxford if required clinically.

More day case gynaecology can be done at the Horton by expanding the service from three to five theatre sessions per week. In addition to the current gynaecological day case workload, a further 20 patients requiring day case surgery, who are currently admitted to Oxford, would in the future be admitted to the Horton. These patients would be accommodated within facilities released by transferring (orthopaedic) day cases to the ISTC.

The current Horton gynaecology clinics would continue with the provision of three weekly outpatient clinics, an early pregnancy clinic (Monday-Friday) and colposcopy clinics. It is hoped to introduce a new hysteroscopy clinic.

Gynaecological cancer services across the county will shortly be located on the Churchill site in the new Cancer Centre.

This reconfiguration of gynaecology services would provide a safe local service for the majority of routine gynaecology patients at the Horton (day case and emergency), is sustainable in the long-term, and makes a contribution to the Trust's requirement to deliver services more cost-effectively, giving a saving of £400,000 each year by closing the gynaecology inpatient ward.

Emergency general surgery and trauma

In line with best national practice, very little emergency surgery of any kind is undertaken at night at the Horton Hospital. Most emergencies arising during the night have their surgery safely deferred until the next morning, when there is a scheduled theatre list for emergency general surgery and trauma.

Horton: Average theatre operations per month (Weekdays)

Time	General Surgery	Ophthal-mology	Oral Surgery	Plastic	Trauma	Urology	Uncoded	Total
08:00 to 17:59	**79.8**	**38.8**	**21.3**	**13.0**	**25.7**	**35.2**	**27.0**	**240.8**
18:00 - 21:59	2.2				0.8		6.2	9.2
22:00 - 01:59	0.2				0.2		1.2	1.6
02:00 - 07:59							0.2	0.2
18:00 to 07:59	**2.4**	**0.0**	**0.0**	**0.0**	**1.0**	**0.0**	**7.6**	**11.0**
TOTAL	**82.2**	**38.8**	**21.3**	**13.0**	**26.7**	**35.2**	**34.6**	**251.8**

Horton: Average theatre operations per month (Weekends)

Time	General Surgery	Ophthal-mology	Trauma	Uncoded	Total
08:00 to 17:59	**1.5**	**1.2**	**0.5**	**10.8**	**14.0**
18:00 - 21:59	0.5		0.7	1.3	2.5
22:00 - 01:59			0.2	0.3	0.5
02:00 - 07:59				0.2	0.2
18:00 to 07:59	**0.5**	**0.0**	**0.9**	**1.8**	**3.2**
TOTAL	**2.0**	**1.2**	**1.4**	**12.6**	**17.2**

Emergency general surgery is currently delivered at the Horton Hospital by four general surgeons. Making the consultant on-call rota sustainable in the medium to long-term would require the appointment of two additional general surgeons at an annual cost of £200,000.

The requirements of EWTD have meant that in the past the junior doctor rotas for general surgery and trauma have been combined. This means that on some nights there is no resident surgical doctor and, conversely, on other nights, there is no resident trauma doctor, leading to concerns about clinical safety. The level of activity at night is very low, making it impossible to make workable and sustainable out-of-hours rotas in either speciality.

Trauma, by definition, is an emergency or urgent service. It is currently provided by the same clinicians who provide the orthopaedic service. The opening of the Independent Treatment Centre (ISTC) on the Horton site in August 2006 will mean that all adult orthopaedic patients in North Oxfordshire will be admitted to that unit and not to Trust facilities. This has implications for the trauma service.

It is intended that the trauma and orthopaedic surgeons will work part of their time in the ISTC and part of their time at the Horton Hospital providing the trauma service.

In the medium to long-term, it will not be possible for the same trauma and orthopaedic surgeon to be both on-call for his/her elective orthopaedic patients in the ISTC and on-call for emergency trauma patients in the Horton Hospital. Therefore, in order to maintain an emergency out-of-hours trauma service at the Horton, we would have to put a separate on-call tier of trauma surgeons in place. However, the level of activity out-of-hours is very low; only 2 cases a month go to theatre at weekends and between the hours of 18:00 and 08:00 Monday to Friday. This level of cover would require the appointment of an additional trauma surgeon at a cost of £100,000 a year.

Furthermore, to stabilise the resident junior doctor rota, we would need to appoint two additional junior doctors at a cost of £100,000 a year.

This model is not sustainable in the medium to long-term. In addition, it increases the annual cost of service provision by an additional £400,000.

The following option has been considered:

E1. Continuation of daytime emergency general surgery and trauma, with transfer of out-of-hours patients to the John Radcliffe Hospital

In this model, the emergency theatres would be closed to new patients at 18.00 hours on Monday to Friday, but would continue to operate on any patients already taken to theatre up until full closure at 20:00. Over the weekend, the emergency theatres would close on Friday evening and re-open at 08:00 on Monday morning. During this period, any patient for whom surgery is essential and cannot wait until the next working day, would be transferred to Oxford.

For all of the surgical specialities (excluding gynaecology, obstetrics and orthopaedics), each month there are, on average, a total of 11 patients who go to theatre between the hours of 18:00 and 08:00 (equivalent to three each week), and 17 patients at weekends (equivalent to four each weekend).

During the week, nine of these patients go to theatre between 18:00 and 22:00. A significant proportion of these patients would be either emergency patients who could go to theatre earlier in the day, or elective patients whose operations have overrun during the day. When the ISTC opens in August 2006, there will be additional capacity to undertake these operations during the working day. At the weekends, there are 14 patients per month being operated on between 08:00 and 18:00 and three patients per month going to theatre between 18:00 and 08:00. Many of the patients being operated on during the day are elective or urgent procedures that could wait until the normal week.

We estimate that between eight and 16 patients a month would require transfer to Oxford for emergency surgery that cannot wait until the next working day. The remaining patients would be operated on at the Horton Hospital on the next working day in scheduled emergency operating sessions, as recommended by NCEPOD.

Patient safety would be maintained by protocols jointly agreed with the ambulance service, whereby any patient in the community who is assessed by the GP or paramedic as likely to need immediate surgical intervention out-of-hours would be taken directly to the John Radcliffe Hospital; a similar protocol is already in place for emergency vascular or neurosurgery patients, who are always transferred immediately to Oxford.

Out-of-hours, the Horton emergency department will have direct telephone access or telemedicine link to Oxford for surgical advice. The intensive care facility at the Horton Hospital will remain to provide support for any critically ill patients out-of-hours.

A patient arriving at the Horton Hospital, and being assessed as needing surgery that cannot wait until the morning, would be transferred by ambulance to Oxford. Patients not requiring immediate surgery would stay at the Horton Hospital overnight, under the care of the Hospital at Night medical team (an experienced acute general medicine doctor and an experienced emergency department doctor with access to surgical advice in Oxford), until a surgeon was available to assess them the following morning.

For surgical inpatients who have had their operation at the Horton Hospital, a consultant surgeon would be on call out-of-hours.

Postoperatively, patients transferred under these circumstances would return to the Horton Hospital to recover as soon as they were clinically stable.

This reconfiguration of emergency trauma and emergency general surgery provides a safe service for the majority of patients having emergency surgery the next day in scheduled emergency lists; it provides rapid access to emergency surgery in Oxford for those patients who cannot wait until the next working day; it is sustainable in the long-term; and it makes a contribution to the Trust's requirement to deliver services more cost-effectively, giving a saving of £380,000 a year by the removal of out-of-hours theatre cover.

Elective surgery and day case procedures

Around 55% of all elective surgery for the population of north Oxfordshire is carried out at the Horton Hospital and, for routine procedures, this is a much higher proportion. Complex surgery such as cancer surgery, heart surgery, neurosurgery and transplantation is only available in major centres with the necessary supporting services, and is offered in Oxford.

As part of the reconfiguration of surgical services, additional elective surgery, particularly day case surgery, can be transferred from Oxford to the Horton Hospital. This can include additional gynaecology, endocrine, ophthalmology, ENT, general, vascular, urological and colorectal surgery, as well as related endoscopic investigations and treatments.

This additional surgical activity would replace the orthopaedic work which is to transfer to the ISTC in August 2006.

Emergency department

The very busy emergency department at the Horton Hospital is led by a single consultant. An additional consultant would be appointed, and the two Horton consultants would form part of a fully integrated service across Oxfordshire's two emergency departments.

In the context of proposed changes to out-of-hours children's services and emergency adult surgery, two further changes would be required in the Emergency Department. The out-of-hours doctor should be upgraded to middle grade (SpR equivalent), and a clinician (doctor or nurse) with advanced paediatric life support (APLS/ PALS) training should always be present in the department. A third consultant might be required in the medium-term to support any increased workload and staff training.

This model achieves the strategic objective of establishing an integrated service across the Trust; it provides a clinically safe service for patients requiring emergency care; and is sustainable in the long-term. This enhancement to the service has an additional cost of £230,000 each year.

Care of the older person

The care of the older person is a recognised national priority and has been given prominence by the Strategic Review. The frail elderly, who often have a number of conditions, account for a large proportion of hospital admissions, occupy a significant number of hospital beds and tend to stay in hospital longer. Older people are also the group for whom care close to home is most important, to enable them to keep in contact with friends and family.

The Strategic Review has recommended that care of the older person is given a greater degree of priority and, in particular, that the service at the Horton Hospital should be enhanced with:

- A rapid assessment and diagnosis service,
- an enhanced acute stroke service, and
- an enhanced rehabilitation service.

In addition, it has been agreed with primary and social care that, once patients are no longer acutely ill and do not require the facilities and expertise available in the acute hospital, they could recover in more appropriate environments designed and staffed to meet their rehabilitation and recovery needs.

Discussions are now taking place on how and where intermediate care beds should be provided in the county, and PCTs may consult on any proposed changes later in the year. One option would be to provide this facility for the north of the county on the Horton Hospital site. This would consolidate many services for the elderly locally on the same site, with the many advantages and economies of scale that this brings with it.

Specialist services

The Trust already provides a wide range of specialist clinics at the Horton. The current services include:

Specialist consultant clinics:	**Nurse Specialists in:**
Anticoagulation	Breast care
Audiology	Palliative care
Chemotherapy (Brodey Centre)	Stomatherapy
Children's cardiology, diabetes and neurology	Urology
Dermatology	Diabetes
Diabetes & endocrinology	Respiratory
Haematology	Pain
Nephrology (renal)	
Neurology	
Optometry	
Orthoptics	
Palliative care (also at Katherine House)	
Sexual health/genito-urinary medicine (at Orchard Health Centre)	

The Trust has identified additional chemotherapy sessions and a thyroid service as new specialist clinics which can be provided at the Horton. Where services cannot be provided locally, as in the case of specialist surgery or specialist diagnostics (e.g. cancer, cardiac), there will be streamlined access to specialist services in Oxford, with appropriate follow-up at the Horton.

Laboratory medicine and pathology services

Currently, the Horton Hospital has microbiology, haematology and biochemistry laboratory services on site.

The microbiology service is run out-of-hours as a single county-wide service based in the John Radcliffe Hospital. Economies of scale can be achieved by extending this to include the working day. If this service continues at the Horton Hospital, there would need to be an immediate upgrading of the laboratory, at a cost of £75,000, in order to maintain the required national accreditation standard.

The continued provision of haematology and biochemistry services at the Horton Hospital will be essential to support the emergency department and to ensure test results are available within four hours. Subject to maintaining this level of service, the out-of-hours arrangements are under review and future developments may include 'point-of-care' testing and revised on-call arrangements.

The option for consultation is therefore:

L1. Consolidation of microbiology into a single county-wide service based at the John Radcliffe Hospital

It is proposed to base the microbiology service at the John Radcliffe Hospital. Samples would be transported from the Horton in three scheduled transport runs during the day and by courier for urgent tests and out-of-hours.

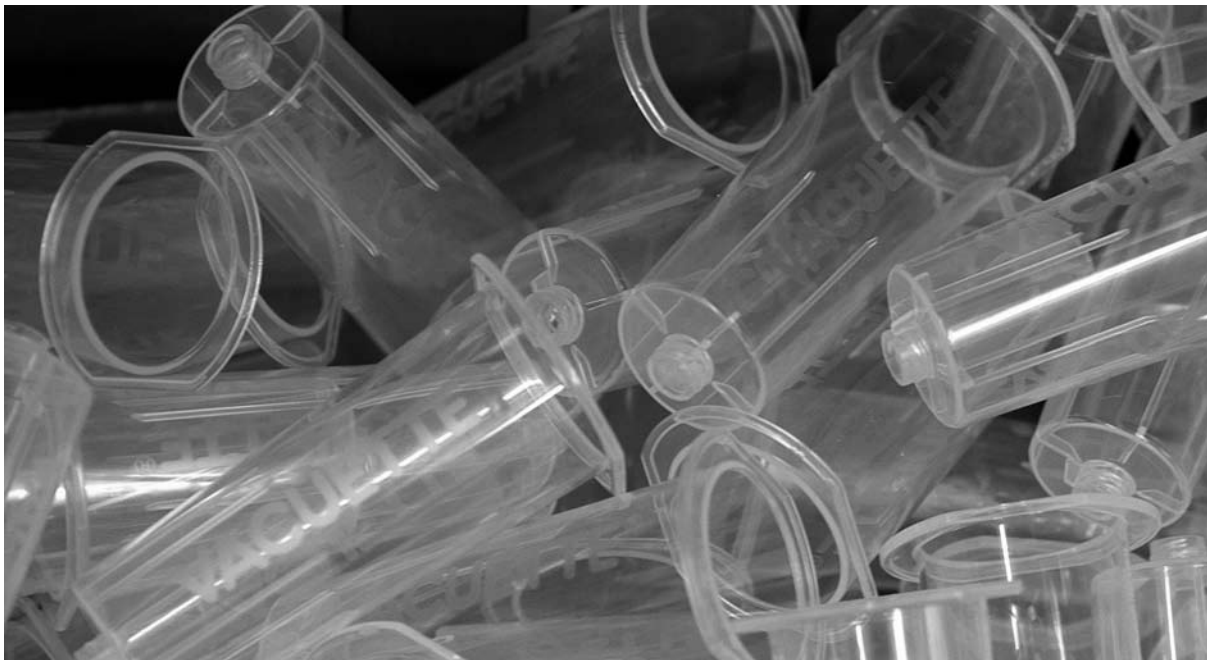
The proposal would not affect the care of patients with suspected meningitis or delay the commencement of their treatment. These patients are already successfully supported out-of-hours by the laboratory at the John Radcliffe Hospital.

Infection control services at the Horton would be provided by an infection control nurse based at the Horton Hospital, supported up by the infection control consultant based in Oxford.

The centralisation of the service would result in annual savings of £30,000.

Summary of options for service change at the Horton Hospital

Options	Reason	Savings	Cost
Children's services C1. Children's Day Centre with **extended** opening hours (inpatients in Oxford Children's Hospital) C2. Children's Day Centre with **normal** opening hours (inpatients in Oxford Children's Hospital)	Current service not clinically sustainable. Future costs avoided: £433,000	£85,000 £417,000	
Maternity services M1. Maintain the midwifery-led service, (Obstetric-led deliveries at Oxford Women's Centre.) M2. An enhanced the midwifery-led service (Obstetric-led deliveries at Oxford Women's Centre)	Current service not clinically sustainable. Future costs avoided: £1.1 - £1.4 million	£167,000	Capital cost being assessed
Gynaecology G1. Increase day case gynaecology at the Horton (consolidate emergency and inpatients in Oxford)	Medical staffing is directly linked to obstetric service	£400,000	
Emergency general surgery and trauma E1. Continuation of emergency general surgery and trauma in daytime scheduled emergency theatre lists, with out-of-hours and weekend emergency general surgery and trauma transferred to the John Radcliffe Hospital	Current out-of-hours service not clinically sustainable. Future costs avoided: £400,000	£380,000	
Elective surgery and day case procedures Transfer of some elective surgery from Oxford	Full provision of these services for North Oxfordshire residents in Banbury		Being evaluated
Emergency Department Additional consultant presence and out-of-hours cover Higher grade resident out-of-hours cover Enhanced paediatric life support skills	Service enhancement to meet modern standards		£230,000
Care of the older person A rapid assessment and diagnosis service An enhanced acute stroke service An enhanced rehabilitation service Intermediate care beds on site	Service enhancement		Being evaluated
Specialist services Continuation of current services plus some enhancements	Improved access to specialist expertise		Being evaluated
Laboratory medicine and pathology services L1. Consolidation of the microbiology service into a single county-wide service based at the John Radcliffe Hospital	Cost savings Future costs avoided: £75,000	£30,000	



Glossary and abbreviations

ANNP	Advanced Neonatal Nurse Practitioners. Part of the nursing profession, but with advanced skills that allow them to act in the capacity of a junior doctor without direct supervision.
CNST	Clinical Negligence Scheme for Trusts. Part of the NHS Litigation Authority and handles clinical negligence claims against NHS bodies.
EWTD	European Working Time Directive. Sets limits that staff can work, in hours per week.
HCA/ MCA	Health Care Assistant and Midwifery Care Assistant. Non-qualified auxiliary staff.
Midwifery-led care	Maternity services, including deliveries, which are provided by midwives.
NCEPOD	National Confidential Enquiry into Patient Outcome and Death. Established with government funds in 1988 to review clinical practice and to make recommendations to improve the quality of the delivery of care. This is done by undertaking confidential surveys covering many different aspects of medical care and making recommendations for clinicians and management to implement.
Neonatal HDU	Neonatal High Dependency Unit. A facility for looking after newborn babies who require what is known as Level 2 critical care. It is commonly available in larger general hospitals with an obstetric-led maternity service.
NICU	Neonatal Intensive Care Unit. A facility for looking after newborn babies who require what is known as Level 3 critical care. This is the highest level of critical care service and is provided in specialist tertiary hospitals.
Obstetric-led care	Maternity services, including deliveries, which are provided by obstetricians.
PA	Programmed Activities. Used to describe the equivalent of a ½-day working session for a consultant.
SCBU	Special Care Baby Unit. A facility for looking after newborn babies who require Level 1 critical care. This is the basic level of critical care service if a baby is too sick to be on the maternity ward or in a transitional care unit. It is commonly available in small to large hospitals with an obstetric-led maternity service, but never provided in a midwifery-led care unit.
SHO	Senior House Officer. A junior doctor in training.
SpR	Specialist Registrar. A middle grade doctor in training.
WTE	Whole Time Equivalent. A way of describing a full-time role. The role may be staffed by more than one person, or by someone working part-time. (1 WTE = the equivalent of a full-time person; 0.5 WTE = the equivalent of a person working half-time.)

The consultation process

The following section describes the process that the ORH will follow in consulting with the public on the options now under consideration for service changes at the Horton Hospital.

The aim of the consultation process is:

- To create a mutual understanding of the issues and challenges facing the organisation;
- To provide sufficient information on the options being considered;
- To enable others to contribute to the decision-making process by providing opportunities for comment, discussion and debate;
- To be open and accountable.

Our duty to consult

The Trust has a duty under the Health and Social Care Act (2001) to involve and consult patients and the public in relation to planning, proposals and decisions affecting the provision of health services.

Section 11 of the Act requires:
"Public involvement in consultation.

It is the duty of every body to which this section applies to make arrangements with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are, directly or through representatives involved in and consulted on –

- The planning of the provision of those services,
- The development and consideration of proposals for changes in the way those services are provided, and
- decisions to be made by that body affecting the operation of those services."

Regulation 4 of the Local Authority (Overview Scrutiny Committees Health Scrutiny Functions) Regulations 2002 (the 2002 Regulations) give guidance to County Council Health Overview and Scrutiny Committees as to the types of proposals for variation of health services that require public consultation. Regulation 4 of the 2002 Regulations provides:

"Subject to the following provisions of this Regulation, where a local NHS body has under consideration any proposal for a substantial development of the health service in the area of the local authority, or for a substantial variation in the provision of such service, it shall consult the Overview and Scrutiny Committee of that authority."

To prepare for consultation on ORH proposals, discussions have been held with the Chairs of Overview and Scrutiny Committees, the ORH Patient and Public Involvement Forum, with the Local Medical Committee, with local partner NHS organisations including the Primary Care Trusts, and internally with trades unions and through normal management routes.

The process and timetable

The Trust Board has agreed the options contained in the paper as the basis for a formal 90 day consultation process. The means of consultation include the following:

- Publication of this document on the ORH website www.oxfordradcliffe.nhs.uk and circulation to staff and external stakeholders.
- Media briefings.
- A series of meetings at which members of the Trust Board and relevant managers and clinicians present the proposals to stakeholders, including the Oxfordshire Health Overview and Scrutiny Committee and the Patient and Public Involvement Forums.
- A series of meetings to be held in public will be arranged, at which the proposals can be explained and discussed. Meetings will be arranged in Oxford, Bicester, and Banbury (and perhaps in South Warwickshire and South Northamptonshire). Full information on dates and locations will be circulated through media briefings and by postings on the ORH website www.oxfordradcliffe.nhs.uk
- Internal meetings with a range of staff groups, including with the Local Staff Negotiation and Consultation Committee, will also be held throughout the period.

Key stakeholders include:

- The Joint Health Overview and Scrutiny Committee, the ORH Patient and Public Involvement Forum (PPIF), and Members of Parliament.
- Local Authority Councillors and officers, and Parish Councils.
- Patient groups throughout Oxfordshire, including (as examples) the Horton User Group, the Keep Horton General Campaign, the ORH Patient Panel, and other patient groups.
- All staff
- Oxford University and Oxford Brookes University.
- Staff side union representatives
- Partner NHS organisations, including all commissioning PCTs, and acute Trusts within the Thames Valley and beyond, the Local Specialist Commissioning Group and the Oxfordshire Commissioning Board.
- Other Patient and Public Involvement Forums within Oxfordshire including the Cherwell Vale and NOC PPIFs.

The formal consultation will start on Tuesday 6 June, running until Monday 4 September 2006.

Comments can be sent in writing and by email to horton.consultation@orh.nhs.uk

Acknowledgements will be sent to those replying to the consultation. (However, it will not always be possible to respond directly to points made in individual responses).

All comments received will be recorded and brought together into a single document for the Trust Board to consider when it makes its final decision on which options are to be implemented. A summary of the comments and any key themes will be published on our website at the end of the consultation period, together with the paper to be considered by the Board.

As some options result in a reduced workforce, a parallel process will be underway to ensure that the appropriate steps in line with agreed Trust policies are taken to safeguard the interests of potentially affected staff.

If there are any questions about this consultation, these should be addressed to:

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email: horton.consultation@orh.nhs.uk