HORTON GENERAL HOSPITAL

FUTURE SERVICE CONFIGURATION

CLINICAL WORKING GROUP

CHILDREN'S SERVICES

Recommendations from the Working Group
May 2007

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Appendices

1. Introduction and background

During the summer of 2006 the Trust consulted formally on service changes at the Horton General Hospital arising from the Strategic Review and the Performance Improvement and Cost Reduction Programme. The consultation proposals on Children's services, maternity, gynaecology and neonatal services arose from the previous work of the North Oxfordshire Paediatric Task Force (2003/4) and the Oxford Radcliffe Hospitals Strategic Review (2004-6).

Formal consultation closed on Friday 13 October 2006. Results were analysed by NSM research.

4,273 responses were received. Over two thirds of responses were in the form of a standard letter published in the Banbury Guardian. Of the remaining 31% (1,368) there were 16 responses from staff and staff groups, 124 responses on behalf of organisations and external groups and 1,228 individual responses from members of the public, where these 1,368 responses are grouped together in what follows they are described as 'non-standard' responses.

The overwhelming majority of respondents to the consultation were opposed to the proposed changes. Their objections to the proposed changes fell into 12 major areas of concern. These are listed in the table below with the percentage in each category of respondent raising that issue in their response. Alongside the percentages the ranking of that issue for that group of respondents is given.

The figures in the 'total' column are dominated by those issues cited in the standard public letter: overall opposition to the cuts; concerns about ambulance transfers of very sick people – particularly mothers and children – and the risks of injury and death; concern about access to services, travel and transport to Oxford; the importance of the Horton to the local community and the prospect of population growth in the area; and the role of the Horton in managing major incidents.

For other groups, the top three issues were overall opposition to the cuts, concerns about access to services and worries about risks to patients. It is of note that underlying many people's anxieties about risks to patients was concern about the time and distance involved in transfers of seriously sick patients to the John Radcliffe. Similarly, the single most frequently cited reason for objecting to the proposed change to maternity services was due to the risks and discomfort of transferring women in a late stage of labour.

Category of respondent	Total	Public Standard letter	Public Individual letter	Organ-isation	Staff / staff groups
Number (*= rank)	4413	3045	1228	124	16
Opposed to cuts overall	94% (1)*	100%	81% (1)*	84% (1)*	75% (1=)*
Objection based on risk to patients	91% (3)	100%	75% (3)	40% (3)	75% (1=)
Objection based on concerns about ambulance transfers	80% (7=)	100%	37% (8)	25% (6)	56% (3=)
Objection based on concerns about public transport / access to services	92% (2)	100%	76% (2)	54% (2)	56% (3=)
Objection based on recruitment / training	1% (12)	0%	2% (12)	10% (10)	44% (8=)
Opposed to changes in children's services specifically	83% (5=)	100%	47% (5)	22% (8)	44% (8=)
Opposed to changes in Maternity services / loss of SCBU specifically	83% (5=)	100%	46% (6)	24% (7)	50% (6=)
Opposed to changes in emergency services specifically	5% (10)	0%	14% (10)	16% (9)	44% (8=)
Objection based on population growth	88% (4)	100%	65% (4)	31% (4=)	50% (6)

Objection based on response to major incidents	80% (7=)	100%	39% (7)	9% (11)	19% (11=)
Objection based on importance of Horton to community / town	73% (9)	94%	29% (9)	7% (12)	19% (11=)
Criticisms of the consultation process	4% (11)	0%	12% (11)	31% (4=)	56% (3=)

The flavour of some of the key responses is illustrated in the extracts below:

1.1. The North Oxfordshire & South Northamptonshire GP Forum stated

'We remain opposed to the proposals on the grounds of safety, sustainability and the reduction in access to basic healthcare and choice for our patients, which will affect especially the most vulnerable. We have little confidence in the process of 'consultation' and the spirit in which it has been conducted.'

1.2. The Oxfordshire Health Overview and Scrutiny Committee response stated:

'the HOSC believes that the Trust's main proposals relating to services for children, babies and maternity services would lead to a reduction in the standards of healthcare available to people in the north of the county and that they are potentially unsafe. They run counter to national policy on localising healthcare and are contrary to the principles identified when the Horton Hospital was amalgamated into the Oxford Radcliffe Hospitals Trust.'

1.3. The HOSC called either for the Trust to abandon its proposals or for an independent examination of the Trust's proposals:

'The HOSC calls upon the Trust either to abandon the proposals, except for those that would improve services at the Horton, or to call upon an independent organisation such as the independent reconfiguration Panel (IRP) to examine the proposals in detail and report publicly.'

1.4. The response from the Cherwell District Council stated:

'The majority of the proposals contained in the Oxford Radcliffe Hospitals NHS Trust (ORH) consultation document significantly downgrade many of the core services at the Horton General Hospital (HGH) particularly in the area of women and children's services and trauma and emergency services.

'These services are the very services which were identified following a detailed public enquiry by Arthur Davidson QC in October 1996 as essential to be maintained to meet the need of the local 'Banburyshire' population.'

1.5. The Oxfordshire PCT expressed broad support for the proposals although this was conditional upon satisfactory reassurance or resolution of a number of important but detailed points mainly to do with mitigating the risks around the proposals.

Post Consultation process

The Trust Board decided on 26 October 2006 to seek agreement with the Oxfordshire HOSC and Oxfordshire PCT on a process to shape the Trust's proposals over the following few months, with the help of stakeholders and partners and independent clinical experts to

- look again at issues affecting the paediatric, maternity and gynecology services, and the Special Care Baby Unit, at the Horton General Hospital, including staffing and training problems.
- address concerns raised by the public, by GPs and others, including risk factors, transport issues, population growth, and the impact on vulnerable sections of the population.
- consider new ideas and suggestions which have emerged during the consultation, and look at associated risks.
- submit revised proposals to the Board of the Trust.

The focus for this work was to be on the proposals for maternity, gynaecology, neonatal services and Children's services.

GPs and others had raised concerns about the consultation process, they had said that they had 'little confidence in the consultation process and the spirit in which it was conducted'. It was essential that the post-consultation process was open and inclusive and addressed these concerns.

The working groups

Two working groups were established to look at each of:

- Children's services
- Maternity, gynaecology and neonatal services

The groups were independently chaired by Pam Garside and included representatives from among GPs, ORH doctors, nurses and midwives from Banbury and Oxford in paediatrics, obstetrics, midwifery, SCBU, anaesthetics, gynaecology, neonatology, the emergency department. The groups were clinically driven, agreed their own terms of reference, methods of working and agendas. They were supported by Trust managers and independent experts Professor Sir Alan Craft (paediatrics) and Suzanne Cunningham (Midwifery) who attended meetings of the working groups. Dr Nick Naftalin (obstetrics) was available to support the maternity, gynaecology and neonatal working group.

The Oxfordshire PCT also participated in both groups.

The working groups agreed that the key themes to be examined in the post consultation process were:

- the role of recruitment and training and the case for change – in particular the ability of the Trust in the future to consistently staff the services with doctors with the appropriate level of experience and qualifications
- whether the alternative models proposed are 'safe', i.e. have an acceptable level of clinical risk
- patient transport and access to the John Radcliffe Hospital

Among other important issues which would be looked at were:

- the effect of forecast population growth on demand
- the needs of deprived and vulnerable sections of the population
- the strategic context including the implications for, and of, the plans of nearby general hospitals, and evidence of what is happening elsewhere

Each working group met 10 times between January and May including a joint session to consider transport issues. They met with postgraduate dean twice and received reports on training and staffing issues from Sir Alan Craft and Dr Nick Naftalin. Sir Alan Craft also attended a meeting of the working group and a meeting with the Post Graduate Dean. The working groups undertook detailed risk assessments of the current service, consultation proposals and a variety of alternative and enhanced models. And they considered emergency transport, access issues, social and demographic factors and evidence from elsewhere in the UK, including alternative models elsewhere.

2. Children's services - the case for change – staffing, recruitment and training

The working group considered evidence presented in the Trust's briefing document on staffing recruitment and training issues. The working group received an independent report on this from Professor Sir Alan Craft and met with the Postgraduate Dean on two occasions with additional feedback from separate meetings and correspondence. The working group discussed these issues extensively at its first meeting on 5 January, on 31 January and 7 March at specially convened meetings with the Postgraduate Dean and again on 22 March.

At its first discussion on the topic the working group concluded that the current model is not sustainable:

> 'that the current pattern of staffing is unlikely to be sustainable in the future in view of the history of staffing and future changes.
>
> 'that the Horton General Hospital will be unlikely to attract training recognition for senior middle grade doctors or to retain recognition for juniors under the current service configuration in the medium to longer term.'
>
> (extract from agreed working group minutes 5 January)

This conclusion was reached on the basis of the impact of the European Working Time Directive (EWTD), changes to junior doctors hours, changes to training under 'Modernising Medical Careers' (MMC) and changes to immigration rules. These taken together made posts in smaller hospitals with relatively low levels of activity unsuitable for training – particularly out of hours - and at the same time reduces the pool of doctors available who might be willing and competent to take up non-training middle grade posts.

The group considered that alternative ways of staffing a 24 hour paediatric service should be looked at either using non-training grades or by exploring the possibility of creating training-approved posts by rotating staff across both the John Radcliffe and The Horton hospitals.

The group accepted that staffing the Horton paediatric service had been problematic at some times in the recent past.

The group accepted that the proposals to change the service were not financially driven but driven by clinical issues and the need to be confident that the service could be staffed appropriately.

3. **Social and demographic factors and the plans of neighbouring hospitals**

The working group considered a paper on demographics, social issues, the management of major incidents and the impact of the plans of neighbouring hospitals at its meeting on 7 February. The group concluded:

- that the forecast increases in population and the higher potential increases were not sufficient to make a material difference to the viability of the current model of service.
- that no further investigation into population growth needed to be undertaken
- that the Trust had adequately investigated the plans of neighbouring hospitals and had provided sufficient assurance that at the present time there are no plans to close services at neighbouring hospitals which would result in substantially increased demand at the Horton.
- that the Trust's proposals represented a reasonable response to levels of deprivation in Banbury. This included:
    - ~ the shuttle bus proposal;
    - ~ increased levels of community paediatric nursing to provide a 7 day service extending into the evenings;
    - ~ discretionary provision of taxis for parents without other means of transport needing to take their child to the JR out of hours.
- that it would be for those responsible for the major incident plan to make appropriate adjustments in the light of any changes which were ultimately agreed.

(extracts from agreed working group minutes 7 February)

4. Options for maintaining a 24/7 service

The working group considered a number of options for maintaining a 24 hour, 7 day a week service in the light of difficulties around training recognition. These were as follows:

1. An inpatient service staffed by
    - a Horton rota of consultants resident on call or a combination of consultants and non-training middle grade staff resident on-call
    - a combined general paediatric consultant rota including resident on-call from the Horton and on-call from home for the John Radcliffe
    - middle grade trainees in a combined rota with the John Radcliffe with consultants on call from home
2. A 24 hour paediatric observation and assessment unit based in the Emergency Department and staffed by middle grade trainees in a combined rota with the John Radcliffe with a consultant on call from home
3. A nurse delivered out-of hours service consisting of either
    - A 6 bed children's ward staffed by two paediatric nurses, **or**
    - A 6 bed paediatric observation area adjacent to the Emergency Department supervised by a paediatric nurse based in ED.

The group concluded that staffing a 24/7 inpatient service with consultants resident on call out of hours, **or** a combination of consultants and non-training middle grade posts, **or** a combined general paediatric rota including resident on call at the Horton and on call from home at the JR would not be sustainable because such posts would have a very high proportion of working hours resident on call with low workload and would be unattractive to consultants, and middle grades, and that middle grades of the appropriate calibre willing to take non-training posts, are unlikely to be available.

At least one member of the working group felt that in the event that the maternity, gynaecology and neonatal working group concluded that a consultant-led obstetric service was sustainable at the Horton the possibility of running a consultant staffed 24/7 paediatric service to support this should be revisited.

In terms of the proposed models involving middle grade posts in a rotation with Oxford, Professor Sir Alan Craft and The Post-Graduate Dean had advised that they would be unlikely to attract training recognition because of significant dilution of the training experience. The Post Graduate Dean had also advised that middle grade posts combining work in the Horton ED out of hours with a

paediatric observation and assessment unit would be unsuitable for paediatric training and would be unlikely to attract training recognition. (working group minutes 7 March)

The group was advised and agreed that a nurse-led out of hours service would not reduce risk and would potentially be difficult to staff.

'A review of where this model had been tried elsewhere had indicated that the vast majority of places which had considered it had rejected it on the grounds that there were insufficient numbers of patients in small units to justify it. Out of two places which had tried to implement the model one was withdrawing it because the nurses running the unit were bored, it was not considered a good place to work and there had been problems with staff turnover (Bishop Auckland).'

(working group minutes 4 April)

It was noted that in the absence of a nurse-led overnight service it would still be necessary to provide a nurse with paediatric training and experience or Registered Children's nurse to care for children presenting and waiting in ED out of hours.

5. Ambulatory* options

The model proposed in the consultation document was described as follows:

- consultant led ambulatory service at the Horton 12 hours/day, 5 days/week plus 3 hours Saturday morning (or 8 hours/day, 5 days/week),
- rapid assessment and diagnostics, day-observation beds, specialist outpatients and day case surgery,
- inpatient service based in Oxford,
- enhanced community paediatric nursing,
- enhanced skills / resources in Emergency Department,
- improved transport and emergency transfer arrangements

During the course of the post-consultation process the working group has considered the following enhancements:

- enhanced emergency transfer and transport arrangements
- further upgrading of staffing, paediatric skills, associated training, and resources in the Emergency Department
- creation of an appropriate environment within ED for the treatment of children and those awaiting transfer out of hours
- rapid response paediatrician on-call from John Radcliffe or home out of hours
- transition arrangements including public information and education programme
- changes to the opening hours of the ambulatory unit
- further resources into community nursing
- helipad at the Horton

*Note: An Ambulatory Unit is the term used to describe day service with no inpatient admissions

6. **Transport**

A special session was held on 31 January to consider emergency patient transport and non emergency access. The meeting was attended by senior representatives of the South Central Ambulance Service.

The following specification was agreed

- ambulance to respond to an emergency call within 8 minutes for class A and within 19 minutes for class B. Other transfers by negotiation. All out of hours transfer to be treated as A or B.
- transfer times 25-40 minutes for class A, 40-50 minutes class B.
- drive-by protocol except for agreed exceptions

Further work was later done to define the care pathways for emergencies with the ambulance service. These were risk assessed and:

'Overall the risks were assessed across a range of clinical scenarios as the same or better than the current service'

(extract from agreed minutes 17 April)

The following are extracts from the minutes of the meeting on 31 January:

'Overall the group felt that the figures presented on numbers of transfers represented a reasonable planning assumption with a caveat over the number of gynae patients needing transfer for assessment, seasonality in paeds and higher numbers of emergency transfers in labour than estimated. These numbers are to be reviewed and shared with the ambulance service re current funding and ability to support any shifts in activity. However, the ambulance service would need to be able to cope with significant fluctuations (the numbers they are working to assume the need for 0.4 ambulance which they have rounded up to a full time ambulance). They are prepared to monitor the service and adjust provision of resources in the event that the outturn was in fact a higher number of transfers than had been planned for. The Ambulance service gave reassurance on both these points.'

'It was agreed that ambulance protocols were needed to ensure effective care and that these would need to be understood, agreed and applied by hospital clinicians, the ambulance service and crews, and GPs.'

(extracts from working group minutes 31 January)

The working group also discussed non-emergency transport for patients, relatives and carers, visitors and staff and the following proposal in particular:

- Shuttle bus proposal for non emergency patients, visitors, carers and relatives, and staff 07.00 to 18.00 or 07.00 – 22.00 every 2 hours each way.

'The Shuttle bus proposal was discussed and the group overall felt this was both an appropriate and an essential response to the service changes. It would help address issues of concern for the public, for patients and for staff.'

(extract from working group minutes 31 January)

Most of the group felt that the ambulance service would be able to make an appropriate and timely response under the new arrangements. However, a minority of members of the working group had some reservations about this based on past and current experience and recommended a rigorous monitoring of response times and a process of real-time resolution, should this new arrangement not be successful.

The working group also discussed the possibility of creating a Helipad at the Horton to facilitate air ambulance transfers.

'In most cases the helicopter would be no quicker than a blue light ambulance journey and could take longer. It is also very difficult to treat a patient in transit in a helicopter which is cramped, less stable and very noisy.'

(extract from working group minutes 31 January)

The working group felt that this would not materially reduce clinical risks and should not therefore be included in the group's recommendations.

7. Risk Assessments

The working groups undertook risk assessments for

- the current model (as a benchmark),
- the current model in two years time (when the staff it is possible to recruit may have a lower level of skills or less experience),
- the ambulatory model as presented in the consultation document,
- an enhanced ambulatory model with additional safeguards in the ED and a paediatrician on call.
- a consultant delivered model (assuming staff could be recruited to the posts),
- the ambulatory model with a nurse led out of hours service

Three specific clinical scenarios were considered which were representative of the risks presented by a range of situations

- a severely ill child needing resuscitation / immediate intervention eg circulatory failure, meningococcal septicaemia
- moderately unwell child with potential to deteriorate eg asthma, croup
- GP needing a second opinion for a slightly unwell child eg bronchiolitis – borderline admission, stable pneumonia

For each clinical scenario and for each model

- the management plan was described
- the key risk mitigating factors were identified

Risks were assessed on likelihood and severity of an adverse outcome due to

- delay in diagnosis or wrong diagnosis
- delay in immediate response (eg resuscitation) or inadequate immediate response
- delay in definitive treatment or inadequate definitive treatment

An overall risk of poor outcome was then derived

Risk was assessed on the basis of

- likelihood (how often something may happen), a scale of 1-5
- severity (how serious a typical outcome would be if it did happen), a scale of 1-5

Overall risk was calculated by multiplying likelihood score by severity score resulting in an overall scale 1-25

- 1-3 Low
- 4-6 Acceptable
- 8-12 Undesirable

- 15-25 Unacceptable

Note: overall scores limited to multiples of 1-5 x 1-5 hence some scores in the range 1-25 are 'missing'.

For all clinical scenarios the *severity risk* arising from any of the three causes (diagnosis, immediate response, and definitive treatment) was the same for all models.

The differences between the models therefore resulted from differences in the group's assessment of the *likelihood* of an adverse outcome resulting from one of: delay in diagnosis or misdiagnosis, delay in or inadequate immediate response, or delay in or inadequate definitive treatment.

The tables below show the composite or total risk score calculated by multiplying likelihood by severity. The differences relate to differences in likelihood rather than severity. Please note that scores have been given for 'in hours and 'out of hours'

Risk assessment: summary of results: current model

	Severely ill child	Moderately unwell child	GP / second opinion
Delay in or misdiagnosis	5 in hours	4 in hours	4 in hours
	10 out of hours	8 out of hours	4 out of hours
Delay in or inadequate immediate response	5 in hours	5 in hours	2 in hours
	10 out of hours	10 out of hours	2 out of hours
Delay in or inadequate definitive treatment	5in hours	4 in hours	2 in hours
	10 out of hours	8 out of hours	2 out of hours
Overall risk	5 in hours	4.3 in hours	2.6 in hours
	10 our of hours	8.6 out of hours	2.6 out of hours
	Undesirable ooh		Acceptable /low

The current model was assessed as having an undesirable level of risk in the case of the severely ill or moderately unwell child mainly due to the possibility of delay in diagnosis or delay in immediate response out of hours.
For the GP requiring a second opinion the risk was assessed as acceptable

Risk assessment: summary of results: current model in two years

	Severely ill child	Moderately unwell child	GP / second opinion
Delay in or misdiagnosis	5 in hours	4 in hours	6 in hours
	10 out of hours	12 out of hours	6 out of hours
Delay in or inadequate immediate response	5 in hours	5 in hours	4 in hours
	15 out of hours	15 out of hours	4 out of hours
Delay in or inadequate definitive treatment	5 in hours	4 in hours	4 in hours
	15 out of hours	12 out of hours	4 out of hours
Overall risk	5 in hours	4.3 in hours	4.6 in hours
	13.3 out of hours	13 out of hours	4.6 out of hours
	Undesirable ooh		Low

The risks of the current model 'in two years time' would be the same as the current model apart from the fact that it is likely to become increasingly difficult to recruit staff of equivalent experience and expertise. It was assumed that middle grade staff if they could be found would be less skilled and less experienced than current middle grades

The group raised its assessment of the likelihood of an adverse outcome out of hours resulting in an overall assessment on the borderline between undesirable and unacceptable for the seriously ill or moderately unwell child. The risk of delay or inadequate immediate or definitive treatment for a severely ill child was assessed as unacceptable.

There could also be a real likelihood of an unplanned emergency closure of the service if staff could not be recruited which would be very risky for patients as no safeguards would be in place, this is not reflected in the risk assessment.

Risk assessment: summary of results: consultant delivered model

The risks of the consultant delivered model were assessed as the same as the current model provided the service could be staffed with consultants of the appropriate level of expertise and experience. However, many on the working group felt this would not be the case and there could be a real likelihood of an unplanned emergency closure of the service which would be very risky for patients as no safeguards would be in place

Risk assessment: summary of results: nurse–led out of hours service

The group felt that a nurse-led out of hours service would not significantly decrease the risks compared with the ambulatory service and could potentially increase risk. However, it was recognised that without this, the Emergency Department would need to meet the requirement for a paediatric trained nurse to be on site out of hours another way.

Risk assessment: summary of results: ambulatory model

	Severely ill child	Moderately unwell child	GP / second opinion
Delay in or misdiagnosis	5 in hours	4 in hours	2 in hours
	10 out of hours	8 out of hours	4 out of hours
Delay in or inadequate immediate response	5 in hours	5 in hours	2 in hours
	10 out of hours	10 out of hours	4 out of hours
Delay in or inadequate definitive treatment	5 in hours	4 in hours	2 in hours
	15 out of hours	16 out of hours	4 out of hours
Overall risk	5 in hours	4.3 in hours	2 in hours
	11.7 out of hours	11.3 out of hours	4 out of hours
	Undesirable / unacceptable ooh		Acceptable / Low

Risk assessment: summary of results: ambulatory model enhanced

	Severely ill child	Moderately unwell child	GP / second opinion
Delay in or misdiagnosis	5 in hours	4 in hours	2 in hours
	10 out of hours	8 out of hours	4 out of hours
Delay in or inadequate immediate response	5 in hours	5 in hours	2 in hours
	10 out of hours	10 out of hours	4 out of hours
Delay in or inadequate definitive treatment	5 in hours	4 in hours	2 in hours
	10 out of hours	12 out of hours	2 out of hours
Overall risk	5 in hours	4.3 in hours	2 in hours
	10 out of hours	10 out of hours	3.3 out of hours
	Undesirable ooh		Acceptable / Low

The risks of the ambulatory model differ from those in the current model out of hours only and specifically relate to delays in providing definitive treatment to a severely ill or moderately unwell child leading to an overall assessment of 'unacceptable'. This is moderated in the enhanced ambulatory model by the availability of a rapid response paediatrician on-call for emergency situations. This will reduce the risk of delay or inadequate treatment for a severely ill child or moderately unwell child. (See below)

Without a paediatrician on site out of hours it is essential that the Emergency Department staff, supported by other staff available at the Horton out of hours, are able to diagnose and manage sick children who may present at the Horton Emergency Department or who may be brought by ambulance in a critically ill condition. In both the ambulatory and enhanced ambulatory model it is intended that the resources, training and experience of staff in the Emergency Department out of hours are increased by the addition of one consultant; the upgrading of out of hours staff to include a middle grade emergency doctor rather than an SHO or Foundation year 2; and the presence of at least one clinician with advanced paediatric life support training in the Emergency Department at all times. There remained some concerns about the ability to recruit the proposed staff to the Emergency Department in view of the pressures identified in paediatrics and obstetrics. However, the group agreed to proceed on the basis that these were less in ED and the Trust would be able to staff the service.

The working group emphasised that the risk assessments for the ambulatory and enhanced ambulatory models were valid only to the extent that the full package of recommended enhancements (including staffing) were made to the Emergency Department.

Risk assessment: summary of results: comparison of models

	current	Current in two years	ambulatory	Enhanced ambulatory
Severely ill child	5 in hours	5 in hours	5 in hours	5 in hours
	10 out of hours	13.5 out of hours	11.7 out of hours	10 out of hours
Moderately unwell child	4.3 in hours	4.3 in hours	4.3 in hours	4.3 in hours
	8.6 out of hours	13 out of hours	11.3 out of hours	10 out of hours
GP needing second opinion	2.6 in hours	4.6 in hours	2 in hours	2 in hours
	2.6 out of hours	4.6 out of hours	4 out of hours	3.3 out of hours

Risk assessment: what the working group concluded

The working group concluded the following on the basis of the risk assessment work done:

- the current model is not 'risk-free'
- the main risks relate to the management of out-of-hours emergencies
- 'doing nothing' is likely to increase risks over time
- a consultant –led model or doing nothing will both increase the risk of an unplanned temporary closure of the service if it cannot be staffed
- addition of a nurse-led overnight service does not change the risks around the service
- the Enhanced Ambulatory model offers the **lowest achievable** level of risk and that the residual risk is at an acceptable level

8**. What is happening elsewhere**

The Working Groups considered evidence from elsewhere to inform their conclusions. The Groups were presented with the following:

- ORH: Findings from the "Paediatric Taskforce";
- IRP: Findings from the Independent Reconfiguration Panel recommendations for North Tees & Hartlepool and for Calderdale & Huddersfield;
- review of service plans for women and children in the Greater Manchester, East Cheshire, High Peaks region
- review of changes to the service configuration of small hospitals;
- review of hospitals with emergency departments but no paediatric inpatient beds;
- solutions suggested by the "Keep the Horton General" Campaign Group";

This material was presented in a document ("Strategic Context – part 2") on 22nd March 2007 and the group was invited to consider:

- whether there were further examples that the Trust should review or whether the Trust had conducted a comprehensive examination of what was happening elsewhere?
- whether the Trust's proposals were going with or against the flow?
- whether there were examples of comparable places which had managed to retain their paediatric and/or obstetric services and whose service models could provide a relevant and appropriate model for consideration?

The following conclusions can be drawn:

1. The reconfiguration of paediatric inpatient services to ambulatory care often goes hand in hand with reconfiguration of obstetric services to midwifery-led care. This is because a hospital with a relatively low number of births generally has a relatively low level of paediatric activity, so both the services become difficult to staff. In addition, an admitting obstetric service cannot exist without an out-of-hours paediatrician.
2. Only one hospital (Ashington) is known to have maintained SCBU (and hence obstetrics) without 24/7 paediatric cover through the use of ANNPs. This was not considered a deliverable model for the Horton.
3. Changes to paediatric services appear to be driven either by recruitment difficulties (staffing out-of-hours doctor rotas) or cost implications (cost of

maintaining EWTD-compliant rotas on more than one site) or both. (Note: for the Trust the driver is recruitment and staffing issues and the proposed ambulatory model will in fact cost more than the current service)

4. The majority of hospitals with an ambulatory paediatric model (i.e. no out-of-hours resident paediatric cover) which retain an unselected Emergency Department, have a consultant paediatrician on-call from home or an admitting hospital within 30 minutes.
5. Two hospitals had staffed 24/7 paediatric sessions using a consultant-delivered model (e.g. Salisbury and the Royal Free in London). Neither was regarded as comparable with the Horton General Hospital, being larger and busier.
6. One small hospital is known to sustain its paediatric rota using clinical research "fellows" – the Frenchay Hospital in Bristol. This is a specialist unit in its own right, as well as being in close proximity to a range of academic and medical institutions in Bristol. This is not comparable with the situation in Banbury.

This research reinforced the working group's view that:

- a 24/7 paediatric inpatient services cannot be retained at the Horton General Hospital
- An ambulatory paediatric model should be enhanced by the addition of an on-call paediatric consultant for emergencies

9. Outline costings

The working group viewed outline costings for the proposed enhancements and noted that the cost of the proposed ambulatory service with enhancements would be greater than the current service by of the order of £450,000 including the cost of enhanced transport services.

The working group notes that the proposals were 'demonstrably not a cost saving exercise' (working group minutes 17 April).

The group noted that there would also be capital costs for example for creating a suitable area for children in ED but that these were not yet available.

The outline costs are reproduced in appendix 4. These show that excluding transport and capital the additional cost of the paediatric ambulatory model is in the order of £219,000 per annum. However these costings are indicative only. The precise way in which the recommendations of the working group might be delivered are yet to be finalised and this may mean that costs vary upwards or downwards. In particular the cost for provision of a paediatric trained nurse on site at all times is based on one model which may not in fact represent best value. An alternative for example would be to have a rota comprising dual trained ED and paediatric nurses.

10. Recommendations

The Children's services working group makes the following recommendations:

In the light of the evidence regarding the ability to provide a safe and sustainable 24 hour paediatric service, the service should be reconfigured as follows:

- consultant led ambulatory service at the Horton 12 hours/day 10.00 – 22.00, 5 days/week plus session (3-4 hours) Sunday morning (Sunday morning was considered better than Saturday morning as more central to the weekend) .
- integrated general paediatric consultant rota with Oxford
- rapid assessment and diagnostics, 6 x day-observation beds, specialist outpatients and day case surgery,
- inpatient service and out of hours assessment based in Oxford
- extended availability of community paediatric nursing from 18.00 to 22.00 weekdays and extended hours on weekends and bank holidays
- compliance with the RCN recommendation to have a Registered Children's Nurse or nurse with training and experience of children's care on duty where children are cared for

Emergency transfer and transport arrangements should be put in place as follows:

- ambulance to respond to an emergency call within 8 minutes for class A and within 19 minutes for class B. Other transfers by negotiation
- transfer times 25-40 minutes for class A, 40-50 minutes class B.
- drive-by protocol with agreed exceptions
- shuttle bus proposal for non emergency patients, visitors, carers and relatives, and staff 07.00 to 18.00 or 07.00 – 22.00 every 2 hours each way.
- discretionary taxis for parents or carers of a child transferred to Oxford out of hours
- a helipad would not materially reduce clinical risks and should not therefore be included in the group's recommendations

In the absence of on-site paediatric services, the way to produce the lowest possible risk to children out of hours is to implement the following enhancements to the Emergency Department which should be regarded as a complete package. The risk assessments demonstrated that some children seen in the ED "out of hours" and at weekends will be less safe in the absence of available paediatricians, but that the risks can be reduced to an acceptable level by enhancing the staffing of the ED as follows before Paediatric services are reconfigured.

- additional consultant in Horton ED
- middle grade doctor available in ED at all times, in particular out of hours
- rapid response paediatrician on-call from John Radcliffe or home out of hours, telemedicine link with Oxford
- all senior nurses in ED trained in advanced paediatric life support, clinician with APLS training available in ED at all times,
- nurses with paediatric training on site out of hours
- Staff available for paediatric transfers as required

The group would also strongly recommend that the Emergency Department is configured in such a way as to meet the Children's NSF requirements for an area that is physically separated (out of sight and sound) from adults.

Other recommendations of the working group concerned the transition arrangements. In particular:

- Transition arrangements should include a public information and education programme to advise parents and the public about the new service and what to do with a sick child out of hours.

This is important because it will encourage parents and carers to make use of the children's service at the Horton when it is available and to take sick children directly to Oxford out of hours. In other places it has been found that people adjust to the opening hours of the children's service and fewer children are brought in the out of hours period, recognising that there will always be some who need assessment / treatment and/or admission out of hours.

At least one member of the working group felt that the recommendation for an enhanced ambulatory model was an acceptable way forward but only if maternity was to become midwife-led and recruitment for the Emergency Department is viable and sustainable in the long term.

The key *changes* recommended to the Trust's original proposals are as follows:

- weekend opening of ambulatory unit on Sunday instead of Saturday morning
- drive-by protocol with agreed exceptions
- shuttle bus proposal for non emergency patients, visitors, carers and relatives, and staff 07.00 to 18.00 or 07.00 – 22.00 every 2 hours each way
- rapid response paediatrician on-call from John Radcliffe or home out of hours (generally within 30 minutes), telemedicine link with Oxford

- all senior nurses in ED trained in advanced paediatric life support, clinician with APLS training available in ED at all times,
- a registered children's nurse or nurses with paediatric training and experience on site out of hours
- staff available for paediatric transfers as required
- the Emergency Department configured in such a way as to meet the Childrens' NSF requirements for an area that is physically separated (out of sight and sound) from adults
- a public information and education programme to advise parents and the public about the new service and what to do with a sick child out of hours.

APPENDIX 4

Costing for the proposed changes to the Horton General Hospital Women's & Children's services*

CHILDREN'S SERVICES	Financial change	Variance in cost from current service			Notes
		Pay	Non-pay	Total	
Paediatric consultants JRH+HGH	From £663,000 to £840,000	£177,000		£177,000	Currently 5 individuals across the Trust, but with on-call and sub-specialists cover at JR, this is equivalent to 6 WTEs. Increase to 8 wte.
Paediatric consultants emergency on-call for HGH		£6,000		£6,000	A consultant on-call from home out-of-hours for Horton
Paediatric junior doctors JRH+HGH	A reduction of £290,000	-£290,000		-£290,000	Reduction of 5.3 wte. This will provide junior doctors at the HGH to support the Consultant running the ambulatory day unit
Nursing for HGH ambulatory service (M-F)	From £531,000 to £117,000	-£414,000		-£414,000	From 16.75 WTE to 3.9 WTE. The HGH ambulatory Unit will be staffed by two Band 5 nurses, 12 hours Monday to Friday (3.9 WTE at £30K including on-costs and enhancements)
Nurse for JRH wards	An additional £240,000	£240,000		£240,000	An additional 8 WTE. The JRH ward nursing will be increased to manage the additional admitted children. Any staff transferred to use inter-hospital shuttle bus (8 WTE at £30K including on-costs and enhancements)
Paediatric secretarial	A reduction of £18,000	-£18,000		-£18,000	Reduce from 2.7 WTE to 2 WTE
Emergency Dept. consultants HGH	An additional cost of £100,000	£100,000		£100,000	Currently 1 individual working 1.4 WTE, who will reduce to 1.2 WTE. Create an additional post who will work 1.2 WTE, therefore need new funding for 10 PAs
Emergency Dept. junior doctors	An additional cost of £205,000 less £40,000	£165,000		£165,000	An additional 3 WTE. This will increase the Middle Grade doctors from 5 to 8 (£205K less a saving of £40K currently incurred on locum cover). This provides a full 24-hour middle grade rota supported by a 16 hours a day F2 trainee

Paediatric-trained nurse at HGH		£154,000		£154,000	Additional 4.23 WTE Band 6 nurse. Additional nursing to provide a paediatric-trained nurse at HGH when ambulatory unit is not open
Emergency department nurse training	Additional cost of £9,000		£9,000	£9,000	Based on up to 18 nurses each year receiving training in paediatric advance life support techniques.
Children's Community Nursing	An additional cost £70,000 + £20,000 travel	£70,000	£20,000	£90,000	An additional 2 WTE. The county-wide service will function until 22:00 hours rather than until 18:00 five days a week. Weekends and public holidays will run for 8 hours not 5 hours each day. Travel costs assume £10,000 per nurse
CHILDREN'S SUB-TOTAL		**£190,000**	**£29,000**	**£219,000**	

*IMPORTANT NOTE:
These costings are indicative only. The precise way in which the recommendations of the working group might be delivered are yet to be finalised and this may mean that costs vary upwards or downwards. In particular the cost for provision of a paediatric trained nurse on site at all times is based on one model which may not in fact represent best value. An alternative for example would be to have a rota comprising dual trained ED and paediatric nurses.
In addition these costings do not include the capital costs of providing the dedicated children's area in the ED.

WOMEN'S SERVICES	Financial change	Variance in cost from current service			Notes
		Pay	Non-pay	Total	
Horton O&G consultants	Saving of £172,000	-£172,000		-£172,000	Reduce from 4 wte to 2.5 wte. Based on 11.5 PA posts
JRH O&G consultants	Cost of £172,000 plus £7,000 travel costs	£172,000	£7,000	£179,000	Increase from 5 WTE to 6.5 WTE. A consultant on-call from home out-of-hours for Horton
Middle grades	Unquantified saving on on-call costs at HGH	£0		£0	No change from 11 wte
Horton midwives, MCAs and admin staff	Saving £1309,000. Cost £79,000 travel + £5000 training	-£1,279,000	£81,000	-£1,198,000	Reduce from 40.2 to 17 wte midwives and from 15.6 to 9.8 MCAs/admin. Includes 1 wte on-call midwife at Horton for out-of-hours ambulance transfers, assuming 2 out of 3 days a transfer is required.
JRH midwives, MCAs and admin staff	An additional £829,000	£829,000		£829,000	An additional 19 midwives and 13 MCAs and admin staff
JRH anaesthetic nurse	An additional cost of £102,000	£102,000		£102,000	Increase from 0.6 wte to 4.1 wte
JRH Transitional care	An additional £424,000 plus £29,000 travel costs	£424,000	£29,000	£453,000	Two midwives and 2 MCA/Nursery Nurse relocate from obstetric ward per shift. Additional 11.6 nurses/midwives plus 5.8 MCAs
JRH housekeeping	An additional £15,000	£15,000		£15,000	An additional 1 wte
Horton transfer of SCBU	Saving of £468000	-£468,000		-£468,000	Reduce by 15.4 wte
JRH neonatal medical staff	An additional £125,000	£125,000		£125,000	Additional 1.3 wte
Neonatal community nurse	An additional £30,000	£40,000	£10,000	£50,000	Additional 1 wte. To match existing 1 wte in rest of county. Assumes £10,000 travel costs
Horton gynaecology inpatient facility closes	A saving of £374,000 pay and £17,000 non-pay	-£374,000	-£17,000	-£391,000	Saving on existing budget
New Horton Gynaecology Day Unit with emergency clinic	£126,000 pay and 15,000 non-pay	£126,000	£15,000		Additional 1.3 wte Band 6, 2.6 Band 5, 1.3 Band 2. Assumes secretarial/admin staff to be reorganised to also take on day ward support role. Open 5 days a week, 8 hours a day. 40 D/C, plus 5 Med. Terms. plus clinic

Gynae/surgical ward nurses	Additional £60,000 plus £8,000 non-pay	£60,000	£8,000	£68,000	This assumes up to two overnight beds on a Women's surgical ward available for limited number of overnighting gynaecology patients (up to 4 per week)
WOMEN'S SUB-TOTAL		**-£400,000**	**£133,000**	**-£267,000**	

TRUST-WIDE OVERHEADS	Financial change	Variance in cost from current service			Notes
		Pay	Non-pay	Total	
Ambulance transfers	An additional cost of £111,000		£200,000	£200,000	An additional ambulance resource during the out-of-hours period at a cost of up to £111,000, (also to add in £89,000 for obstetric service changes)
Unsocial hours taxi service	Based on a contracted price of £70 per round trip		£18,200	£18,200	At times where there is no inter-hospital shuttle service, no private transport and no suitable public transport, the Emergency Department nurse will authorise this taxi for a relative
Inter-hospital shuttle service (staff, visitors)	An additional £115,000		£115,000	£115,000	Shuttle would leave HGH every 2 hours, with a return from the JRH every two hours. If shuttle ran from 08:00 to 20:00 every day, there is a saving of up to £30,000
TRUST-WIDE OVERHEADS SUB-TOTAL		**£0**	**£333,200**	**£333,200**	

GRAND TOTAL (RECURRENT EXPENDITURE)		**-£210,000**	**£495,200**	**£285,200**	
One-off expenditure					
Awareness campaign for public and GPs	Plus £10000 in Children's costings	£4,000	£16,000	£20,000	£4,000 salary costs and £6,000 advertising included in the Children's costings

Appendix 5

List of Working Group Members

Chair
Ms Pam Garside, Judge Business School, University of Cambridge

Clinicians
Sister Michelle Brock, Emergency Department, Horton
Dr Janet Craze, Consultant Paediatrician
Dr Grizelda George, Consultant, Emergency Department, Horton
Dr Harold Hin, Hightown Surgery, Banbury, nominated by the North Oxfordshire and South Northamptonshire GP Forum
Sister Clare Hunt, Children's Ward, Horton
Dr Shelley Segal, Consultant Paediatrician, Horton/JR
Dr Justin Sims, Consultant Paediatrician, Horton
Dr David Skinner, Consultant, Emergency Department
Ms Vanessa Sloane, Deputy Directorate Manager, Children & Clinical Genetics
Dr Anne Thomson, Consultant Paediatrician and Directorate Chair
Dr Graham Walker, Lead Consultant Anaesthetist, Horton
Mr Rob Way, Nurse Consultant, Emergency Department
Dr Jonathan Williams, Horsefair Surgery, Banbury, nominated by the North Oxfordshire and South Northamptonshire GP Forum

PCT
Ms Emma Tidy, Deputy Director of Commissioning, Oxfordshire PCT
Dr John Walton, Member of Clinical Executive, Oxfordshire PCT

Expert Advisers attending one or more sessions of the working group
Dr Michael Bannon, Postgraduate Dean
Professor Sir Alan Craft, Professor of Child Health
Mr John Nichols, Regional Director, South Central Ambulance Trust

ORH Observers and administrative support
Ms Julia Clarke, Director of Strategic Review
Mr Raj Gokani, Directorate Manager, Children's Services
Mr Richard Jones, Director
Ms Nicola Joyce, Project Administrator
Dr David Lindsell, Divisional Chairman
Ms Jo Paul, Director of Operations