1. Background

The FWC requested additional information in support of the OBC for expanding the Neonatal Unit and this document is provided as an addendum to the OBC. In particular the Committee wished to be provided with additional information to demonstrate why the only two options presented in the OBC were do nothing and the recommended £6.8m capital scheme and to be appraised of other options considered during the development of the OBC.

Options that were considered are summarised in this table and detailed below;

Long List Options	Comment	Short list
Do nothing		Yes
Reduce demand	Considered and rejected as an option as having only a marginal impact on capital costs; being contrary to a national service guarantee and; would result in a loss of income of £2.6m	No
Alternative location	Considered and rejected as unable to identify an alternative that provided sufficient space while retaining co-location with the labour ward. Although not costed in any detail, the cost for creating a new maternity and neonatal unit on the site would have been of a magnitude that would not be economically viable.	No
Future proofing	Considered and rejected as growth beyond capacity included in the OBC is unlikely in the medium term. Future proofing would require expansion of the maternity service and the costs would be considerably greater than that required for the alternative location option above	No
Preferred option		Yes

2. Considered options not in the OBC

Option to reduce demand

If it is accepted that do nothing is not a viable option, then the feasibility and impact of reducing demand is a consideration. The only potential methodology to achieve this would be to 'cap' the number of women booking into our maternity service.

Feasibility

It should first be recognised that it is a national guarantee that women have a choice of where to receive their maternity care and give birth (*Maternity Matters, Choice, access and continuity of care in a safe service DH 2007*). Notwithstanding this, the most feasible option would be to restrict access

to women who live outside of our immediate catchment area. This accounts for approximately 450 deliveries per year, driving about 54 admissions to the neonatal unit (12% rate of births).

There would remain the risk that women would choose to have their ante and post natal care in their local area but still elect to present to our maternity service at the time of the birth. We would have little or no control over this.

Even this level of cap would have minimal impact upon cot requirements in the neonatal unit as 54 admissions would on average equate to 295 cot days at the ITU/HDU levels of care, or less than one cot even at 85% occupancy.

Capital cost impact

Keeping to the existing 20 cot capacity would reduce the space required by 73m^2 (9m^2 for 1 SCBU cot and 16m^2 x 4 for HDU cots). However, ensuring that the existing cot capacity and unit facilities are compliant with current space standards would still require a unit that has 610.5m^2 of floor space, an increase of 238.5m^2 from the current space.

The potential capital cost saving would be approximately £220k on the floor space and further £150k for medical services pendants and other equipment.

Neither the existing dental department (160m^2) nor the outpatients' area (200m^2) would alone provide sufficient space and it would be necessary to derogate the equivalent of 2 compliant HDU and 1 SCBU cot spaces if the outpatients' area alone were to be used.

Impact on income

It is possible to model the impact on trust income from capping births, based upon average pathways. A reduction of 450 births would reduce income by £2.6m per annum, as detailed in the following table;

Income analysis for 450 bookings	
Maternity	
Antenatal Pathway	£ 855,217
Delivery Pathway	£ 1,481,745
Postnatal Pathway	£ 135,772
Excess bed days	£ 7,384
Maternity total	£ 2,480,118
Neonatal	
Neonatal cot days	£ 70,711
Chargeable neonatal spells	£ 17,353
Excess cot days	£ 7,401
Neonatal total	£ 95,465
Grand total	£ 2,575,583

Option for an alternative location

Neonatal unit

This option was considered and dismissed as the project team were unable to identify an alternative 600m^2 plus of floor space in proximity to the maternity unit and moving both the maternity and neonatal units to a new location was not considered to be an economically viable option. As an example, breaking the current adjacency of the maternity unit to the operating theatres would require the creation of an obstetric operating theatre and ancillary rooms within the relocated maternity unit.

Dental Department and Outpatients

Careful consideration was given to the options available for relocating the dental and outpatients departments and the option proposed in the OBC was favoured because this retains access from the main hospital and a 2 storey building can be created without the need for additional passenger lift access. In addition, the location offers access to service infrastructure, such as power and drainage. This was balanced against the additional costs of fire protection measures necessary for a building in the proposed location.

As part of the continual space review across the estate options to reconfigure or relocate specific areas to accommodate growth or new initiatives are considered on an on-going basis. Therefore potential alternative locations have already been scoped. These are more distant to the main hospital building and additional service infrastructure costs alone would cost approximately £500k. Dependent upon actual location a further £400k might be required for changes to road layouts and parking.

Option to future proof capacity

The project team did consider potential growth beyond that allowed for in the OBC and cot capacity was discussed with the Neonatal Network Manager. It was agreed that based upon current clinical good practice 25 cots would be sufficient to cater for up to 5,000 births.

Based upon current activity patterns there is no evidence to show that this number of births is likely to be exceeded in the medium term. That level of activity would require a step change in the entire maternity and neonatal service e.g. a much enlarged maternity unit – antenatal ward; labour ward; birthing centre; post natal ward and; an additional (second) obstetric operating theatre. On current projections it would be difficult to justify the level of capital investment that would be required to create such a unit. The case for change now has already been made in the OBC.

3. Further points raised by the FWC

Financial viability

The OBC has adopted the cautious approach of including a Capital Optimism Bias of 20% and also prudent income plan. As already stated, increasing the number of cots does not necessarily mean that more activity will follow as cot use is based upon the volume of maternity activity.

A key driver here is patient satisfaction and service quality – women will choose to have their babies in a unit that has a good reputation. The proposed capital scheme will likely have a beneficial impact upon the reputation of our service with a consequent increase in market share. But the caveats detailed above have to be considered.

The loss of existing income from capping maternity activity outweighs the costs of the preferred option.

Outpatient proposal

At the very least the scheme will have to replace capacity lost to the dental and gynae/antenatal outpatient areas. It is noted in the OBC that the Outpatients Programme Board will be asked to assess whether a straight move of the two displaced departments into the new facility is the best option, or whether a wider review of outpatient facility use is desirable. Either way, the capacity must be maintained at the very least, recognising the Trust's need to manage outpatient demand and meet its financial and RTT plans

The Project Team recognised the need to address some significant environmental issues with the two departments directly impacted by the proposed scheme, but were of the opinion that the wider outpatients estates strategy was not sufficiently well developed to incorporate into this OBC without compromising the need to address the neonatal unit issues in a timely manner. Should the wider outpatient's estates strategy be developed before commencing the neonatal programme suitable amendments could be made?

Viability of dental services

The Trust's business plan sees the continuation of dental services provided by the Trust, covering the current level of service. The specialty has previously not been profitable (more correctly, not making a positive contribution to Trust overheads) and action has been to make it so through a combination of increased capacity and cost reduction. During 2016/17 capacity was increased and in 2017/18 the cost of shared services with Queen Victoria Hospital FT is being reviewed (primarily visiting medical staff).

Income to dental services has been adversely affected for many years by chronic lack of capacity in a small department with an ageing infrastructure. The current department is inappropriate for the delivery of specialist dental services as required by current commissioning. The department has also been on the Trust risk register for several years in respect of on-going privacy and dignity issues for

patients arising from the configuration of the clinical space, which cannot be resolved within the current arrangement.

A new remodelled department with appropriate facilities for modern hospital dentistry will enable the department to resolve the privacy and dignity issues, improve patient experience and service the large (<40%) increase in demand across all dental specialties since 2013, while making the service financially sustainable.

Performance is subject to monitoring through performance review; however there is no case to cease dental services.

Commitment to the scheme

Following the Executive Team workshop to review the Annual Plan, development of the Neonatal Unit was included as a strategic priority *(2.15 - Re-develop the neonatal unit to ensure sufficient capacity is available for the needs of the local population whilst also meeting quality requirements).*

The physical space for cots in the neonatal unit has been a concern for some time and has in the past been cited as a contributory factor in 2 infection outbreaks. While these risks have been successfully mitigated the growth in demand and capacity limitations has called into question the on-going viability of the current arrangements. As well as the clearly demonstrated adverse impact upon women and families there is a significant impact upon staff in the neonatal unit; midwives and obstetricians.

It is the view of the Executive team that these issues have now reached the level of concern that warrants the significant capital investment proposed over other competing priorities in the Trust. It is further the view of the WACH Division that the remedy proposed cannot wait beyond the timescales set-out in the OBC.