Public Document Pack

Horton Joint Health Overview & Scrutiny Committee
Friday, 27 November 2020

ADDENDA

7. Responding to the IRP and Secretary of State recommendations (Pages 1 - 200)

Attached is the referral from this Committee to the Secretary of State, together with supporting documents; the response of the Secretary of State; a further letter to the Secretary of State from the Chairman of this Committee; advice sought on the prospect of a judicial review on the Secretary of State's decision and a recommendation on next steps.

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Horton Health Overview and Scrutiny Committee
27th November 2020

Secretary of State Referral Cover Report

1.0 Referral

1.1 The Horton HOSC met on 19th September 2019 when it unanimously agreed to refer the CCG Board decision to create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the John Radcliffe Hospital and establish a Midwife Led Unit (MLU) at the Horton General Hospital, for the foreseeable future, back to the Secretary of State on the following two requirements:

- Regulation 23(9)(a) – consultation on any proposal for a substantial change or development has adequate in relation to content.
- Regulation 23(9)(c) - the decision is not in the best interests of the health service or local residents.

1.2 The referral letter was sent to the Secretary of State on 2nd December 2019. A copy of the letter and associated supporting evidence has been included as Appendix 1 to this report:

Number	Information
Appendix 1	Referral letter
Appendix 1a	Minutes of the Horton HOSC (from Sept 2018 to Sept 2019 – including DRAFT minutes of the meeting held on 19th Sept 2019)
Appendix 1b	Obstetric-Led Unit Research conducted by a) HHOSC and b) Keep the Horton General Campaign Group
Appendix 1c	Condition Report on the Horton General Hospital, as presented to the Community Partnership Network
Appendix 1d	Text file copy of the email sent to Nick Graham on 10th June 2019 regarding the weighting of options
Appendix 1e	Appendix 2 of the Chairman's report Addenda from 19th September, highlighting the research on impacts of anxiety in pregnancy

2.0 Response

2.1 A response to the referral letter was received on 15th September 2020, this has been included as Appendix 2. It notes the Secretary of State's conclusion that it did not constitute a valid referral.

2.2 The Chairman wrote back to the Minister on 22nd September 2020, urging them to reconsider and pass the matter on to the Independent Reconfiguration Panel. A copy of this letter is included as Appendix 3.

3.0 Judicial Review

3.1 Advice has been sought on the prospect of a judicial review on the Secretary of State's decision. Detailed information on this advice and recommended next steps have been included as Appendix 4.

Date: 2nd December 2019
Our Ref: OJHOSC/SoS/HortonMat3

OXFORDSHIRE COUNTY COUNCIL

Horton Joint Health Overview and Scrutiny Committee
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Rt Hon Matt Hancock MP
Secretary of State for Health and Social Care
Department of Health and Social Care
9th Floor
39 Victoria Street
London
SW1H 0EU

Dear Secretary of State,

Re: Referral of the closure of consultant-led maternity services at the Horton General Hospital for the foreseeable future

Following a previous referral to your predecessor on the same subject in August 2017, namely the decision taking by the Oxfordshire Clinical Commissioning Group (OCCG) to permanently close consultant-led maternity services at the Horton General Hospital in Banbury ('the Horton'), you suggested that further action was required before a final decision was made and you directed the work that the CCG and Oxfordshire Joint Health and Overview Scrutiny Committee (OJHOSC) should undertake.

Unfortunately, it is with the deepest and most profound regret that I am writing to you again following a meeting of the Horton Health Overview and Scrutiny Committee (HHOSC) held on Thursday 19th September 2019. At that meeting, the HHOSC unanimously agreed to refer the Oxfordshire Clinical Commissioning Group's (OCCG) proposal to close consultant-led maternity services at the Horton General Hospital in Banbury ('the Horton') for the foreseeable future to you, as the Secretary of State for Health, should the OCCG Board agree the proposals at its meeting on Thursday 26th September 2019. Despite the unanimous view of the committee and the strongest urging to postpone or not make this decision, the proposal *was regrettably* subsequently agreed by the Board, therefore the HHOSC makes this referral pursuant to Regulation 23(9)(a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

<u>Background</u>

In 2006 the then Oxford Radcliffe Hospitals NHS Trust (ORH) proposed moving inpatient paediatric and gynaecology services, consultant-led maternity services and the Special Care Baby Unit from the Horton in Banbury to the John Radcliffe Hospital (JR) in Oxford. The Committee scrutinising these proposals (OJHOSC) believed that the changes were not in the interests of people in the north of the county and referred the matter to the Secretary of State, who supported this view.

On 18 February 2008, The Independent Reconfiguration Panel (IRP) issued advice to ORH concerning Pediatric Services, Obstetrics, Gynecology and the Special Care Baby Unit at the Horton. In summary these recommendations were as follows:

1. The IRP considered the Horton Hospital to have an important role for the future in providing local hospital based care to people in the north of Oxfordshire and surrounding areas. It did however state, the Horton would need to change to ensure its services remained appropriate, safe and sustainable.

2. The IRP did not support the Oxford Radcliffe Hospitals (ORH) NHS Trust's proposals to reconfigure services in pediatrics, obstetrics, gynecology and the special care baby unit (SCBU) at Horton Hospital. The IRP did not consider that they would provide an accessible or improved service to the people of North Oxfordshire and surrounding areas.

3. The Oxfordshire Primary Care Trust (PCT) was to carry out work with the ORH NHS Trust to set out the arrangements and investment necessary to retain and develop services at the Horton Hospital. Patients, the public and other stakeholders were to be fully involved in this work. South Central Strategic Health Authority (SHA) was tasked with ensuring that a rigorous and timely process was followed.

4. The PCT was to develop a clear vision for children's and maternity services within an explicit strategy for services for North Oxfordshire as a whole.

5. The ORH was to do more to develop clinically integrated practice across the Horton, John Radcliffe and Churchill sites as well as developing wider clinical networks with other hospitals, primary care and the independent sector.

The Independent Reconfiguration Panel advised that the Trust and the PCT were to invest in, retain and develop services at the Horton, as it considered the Hospital was to have an important future role in providing local care to people in North Oxfordshire and the surrounding areas.

ORH maintained consultant-led maternity services at the Horton supported by a training programme for junior doctors working in obstetrics. However, in 2012 post graduate obstetric training accreditation at the Horton was withdrawn. This was predominantly due to the low numbers of births at the Hospital, which meant limited exposure to complex cases, failures in providing suitable and satisfactory supervision and training, and the difficulties experienced in recruiting sufficient numbers of middle grade doctors.

The Trust then developed a Clinical Research Fellow programme to support consultant-led provision, but they reported that national recruitment shortages in obstetric posts led to a reduction in applications which made it unviable. The programme closed in December 2015 and a rotational middle grade rota was created to staff the obstetrics unit.

In September 2016 OJHOSC was informed that ORH, now known as Oxford University Hospitals Foundation Trust (OUHFT) were intending to temporarily close consultant-led maternity services at the Horton from 3rd October 2016, as they were unable to adequately staff the unit in a safe and sustainable manner.

OJHOSC held a further meeting in September 2016 to scrutinise OUHFT's contingency plan for continuing Maternity and Neonatal services at the Horton. This included evidence of the Trust's efforts to maintain consultant-led maternity services and a discussion about the impact of temporarily closing the obstetrics unit and the associated risks. Assurances were given by the Trust that they planned to reopen the unit by March 2017 on the strength of an action plan to recruit more consultants.

The Committee (OJHOSC) was also keen to establish that a decision to temporarily close consultant-led maternity services at the Horton General Hospital would not pre-determine the outcome of the Oxfordshire Health and Care Transformation (OTP) Phase 1 consultation. The consultation included a proposal to move obstetric services, the Special Care Baby Unit and emergency gynaecology inpatient services permanently to the JR, whilst maintaining midwife-led maternity services at the Horton.

To monitor the situation carefully the Committee requested regular updates on the status of consultant-led maternity services at the Horton, the number of women transferred to the JR in labour, and the recruitment of obstetricians.

The Trust's update on performance of maternity services at the Horton, dated 23 December 2016, stated that they would not have enough experienced and skilled medical staff in post to reopen the unit in March 2017 as planned. Therefore, at its meeting on 2 February 2017, OJHOSC believed that the material grounds for not referring the matter had changed, i.e. the Trust's recruitment plan had failed, and the closure would be longer than envisaged. The Committee considered nothing further could be gained by discussions at a local level and referred the matter to you under Regulation 23(9)(b) of the 2013 Regulations.

Your predecessor subsequently wrote to the committee confirming that this matter had been passed to the IRP for initial review who later agreed that this no longer constituted a temporary closure.

At a further meeting on 7 March 2017, OJHOSC undertook detailed scrutiny of the proposals being put forward for acute services in the Phase 1 Transformation consultation (running 16 January – 9 April 2017). These were focused on:

- Changing the way hospital beds are used and increasing care closer to home in Oxfordshire
- Planned care (planned tests and treatment and non-urgent care) at the Horton General Hospital
- Acute stroke services in Oxfordshire
- Critical care (help with life-threatening or very serious injuries and illnesses) at the Horton General Hospital
- Maternity services at the Horton General Hospital including obstetrics and the Special Care Baby Unit

As part of the meeting the committee heard many passionate appeals from campaign groups, residents, district councils and MPs in the north and west of the county and surrounding areas (including Victoria Prentis MP (Banbury), Robert Courts MP (Witney) and The Rt Hon Andrea Leadsom MP (South Northamptonshire)) for consultant-led maternity services at the Horton to continue, as this would otherwise mean a downgrading of the Hospital. The concerns raised in this meeting formed the basis of OJHOSC's formal response to the consultation and recommendations for the OCCG, which was submitted on 13 March 2017.

In relation to the maternity proposal the committee felt that the separation of proposals for obstetric services from those for midwife-led units (MLUs) painted an ambiguous picture for the future of maternity services in the county. In particular, the inclusion of example options for Chipping Norton MLU in the Phase 1 consultation document led to confusion and uncertainty about the future of this service and caused unnecessary public anxiety.

The Committee recommended that the OCCG:

- Take immediate action to clarify the proposals for maternity services in the north of the county as a whole in the Phase 1 consultation, or develops an alternative approach to consulting on these proposals;
- Present a comprehensive appraisal of options for maintaining obstetric services at the Horton, including the potential for an obstetrics rota between the JR and the Horton;
- Provide specific answers to:
    - the numbers of mothers transferred from the Horton to the JR during the temporary closure,
    - travel times from the Horton to the JR for these mothers, and
    - the future of ambulance support at the Horton for mothers needing to be transferred.

It was agreed that a special meeting of the OJHOSC with OCCG would be held once the OCCG had an opportunity to respond to the committee's concerns.

The committee next met with the OCCG on 22 June 2017 to review the outcomes of the consultation and members were concerned that a considerable amount of additional analysis was to be completed before the OCCG Board would make final decisions on the Phase 1 proposals at its 10 August 2017 meeting. In relation to the proposal for obstetric services at the Horton, the committee was keen to see the OCCG address options for the future of these services in its report to the Board, as well as the outcomes of the JR travel and parking analyses. The committee agreed to meet again with the OCCG, after their decision-making business case was published for the Board meeting on 10 August, to review the final proposals being put forward.

At a special meeting on 7 August 2017 for the committee (OJHOSC) to scrutinise the final Phase 1 proposals being put forward for decision, the committee heard from numerous speakers, including MPs, about their grave concerns regarding the impact of the Phase 1 proposals. This predominantly focused on the impact of permanently withdrawing consultant-led maternity services at the Horton. Following robust questioning of OCCG and OUHFT representatives the committee did not believe it had seen a strong enough case for meeting the needs of expectant mothers in the absence of consultant-led services in the north of the county.

The committee strongly opposed the proposal to create a single specialist obstetric unit at the JR and establish a permanent midwife-led service at the Horton and resolved that, should OCCG Board ratify the proposal at its 10 August Board meeting, it would refer the matter to the Secretary of State on the grounds that it was not in the best interests of local residents and the health service.

OJHOSC had engaged extensively with the OCCG prior to decisions on Phase 1 of the OTP being made, in an effort to exhaust all other alternatives before a referral to the Secretary of State. However, OCCG had openly stated that it was only interested in detailed discussions once a decision had been made, refusing to address the committee's concerns that the closure was predicated on staffing shortages, despite OUHFT having filled seven of the nine vacant consultant posts since the temporary closure of the unit. The committee also felt that the OCCG had failed to engage fully with local partners, such as Cherwell District Council, to explore offers of investment and measures to help with schooling, housing, and cost of living expenses through the use of incentives for example, to attract sufficiently skilled staff.

Following a decision by the OCCG Board on 10 August to agree the proposal to stop consultant-led maternity services at the Horton, the OJHOSC referred the decision to the Secretary of State under Regulation 23(9)(a) and (c) for the following reasons:

I. **The needs of local people have not changed, and the arguments set out in the 2008 IRP judgement still apply.** The committee heard passionately from many members of the pubic, local campaign groups, local politicians, local councils, former Horton doctors, local MPs, the clergy, and Healthwatch Oxfordshire. There was unanimous opposition to the proposals for maternity services in Phase 1 of the OTP and the committee was yet to see any evidence (let alone evidence of a compelling nature) of any change in the fundamental needs of mothers in North Oxfordshire and the surrounding areas since 2008.

   The committee accepted that there were difficulties recruiting and retaining suitably qualified staff to maintain an obstetric unit at the Horton but did not consider this just cause for removing a service when the needs of local people had not fundamentally changed.

   Whilst staff retention may be harder than it had been previously, the Trust had demonstrated that it could successfully recruit to the specialist posts, despite the cloud of uncertainty hanging over the unit. The committee was also disappointed to hear that the OCCG had not fully engaged with local partners who put forward alternative options for maintaining an obstetric service at the Horton. Moreover, the OCCG had not presented the committee with any options for maintaining obstetric services at the Horton, as requested in OJHOSC's response to the Phase 1 consultation.

II. **The population of North Oxfordshire is set to grow.** The population in North Oxfordshire had grown since 2008 and was (and still is) set to grow substantially in the coming years, further justifying the need for a consultant-led maternity service in the north of the county.

By its own admission, the OCCG was looking at a 5-year plan, whereas local authorities in the area are planning for much longer timescales, including up to 2031. Even using conservative estimates for birth rates and housing growth (especially as North Oxfordshire has to take on a supply of housing from Oxford), the number of births at the Horton under a consultant led-service was expected to grow. Given that before the temporary closure the Horton accounted for a fifth of births in Oxfordshire (and this number excludes the surrounding areas which the Horton also serves), the committee felt that not only did the need for consultant-led maternity at the Horton still exist, but only focusing on a 5-year plan and concentrating all consultant-led births for the county at the John Radcliffe, weakened resilience and did not in any away adequately consider the population growth in the north of the country.

Moreover, consultant-led services at the JR will have to cope with the impact of population growth in the south of the county, which had already seen an increase that is double the national average. The proposed plans would put enormous pressure on consultant-led services at the John Radcliffe site.

III. **Ongoing issues with travel and access from the Horton to the JR for expectant mothers**. The integrated impact assessment commissioned by the OCCG indicated that a change in consultant-led maternity services would mean that only 52% of mothers could access obstetric-led maternity services within 30 minutes, compared with 72% if a unit remained at the Horton. The committee had major concerns about transport difficulties between Banbury and Oxford, particularly at peak travel times and in inclement weather. This includes both emergency transport for patients and public transport for patients and relatives.

Whilst a dedicated ambulance had been stationed at the Horton during the temporary closure to transport high risk mothers in labour to the JR, the future of this provision was unclear. OJHOSC had already heard anecdotal evidence of mothers' poor experience travelling between the Horton and the JR, and the pressures on the JR affecting waiting times for women in labour.

Furthermore, the OCCG commissioned parking and travel analyses confirmed that there are acute problems with access and parking at the JR site compared to very few issues at the Horton. The qualitative feedback that Healthwatch Oxfordshire gathered indicated that patient travel and parking times at the JR are between 45 and 75 minutes. The committee was particularly concerned that little detail had been shared about planned investments in parking and access to manage the volume of additional patients at the hospital.

IV. **The lack of a clear picture for countywide maternity services as a result of the two-phased consultation.** The impact of permanently removing the obstetric unit at the Horton on maternity services as a whole, including the Chipping Norton, Wallingford and Wantage midwifery-led units, was not clear in the Phase 1 consultation. Furthermore, the committee did not believe it has been adequately consulted. Despite trying to be as flexible as possible, the OCCG allowed limited time for detailed examinations of plans once these had been fully developed. The response from the OCCG has been that OJHOSC should only be involved in detailed discussions once a decision had been made and not before.

On 7th March 2018, your predecessor wrote to the OJHOSC accepting the advice of the IRP in full and set out the following:

I. That further action is required locally before a final decision is made about the future of maternity services in Oxfordshire.

II. That there should be a more detailed appraisal of the options that should incorporate the findings of the latest Clinical Senate Review considering the temporary Horton MLU and dedicated Ambulance Service.

III. Equally important, that there is an opportunity to learn from the experience of Mothers, their families, and staff who have now been involved in the temporary arrangements for more than a year

IV. This work should also address all the recommendations of the original Clinical Senate Report from 2016 and the implementation issues that have been left outstanding, in particular how antenatal care is organised and how recommendations to address travel and parking issues will be carried through in practice.

V. Whatever option eventually emerges, it should demonstrate that it is the most desirable for maternity services across Oxfordshire and all those who will need them in the future.

VI. That further detailed work on Obstetric Options at the Horton is required, in parallel, the dependency that exists between those options and other services can be taken into account. Both pieces of work would benefit from a further external review from a clinical senate to provide assurance and confidence to stake holders.

VII. Consultation about the future of services, on whatever scale, should take account of patient flows, and not be constrained by administrative boundaries

VIII. It is self-evidently in the interests of the health service locally, that all stakeholders should feel they have been involved in the development of the proposals for change. If this was not true of the past, the CCG must ensure that it is so moving forward.

IX. This requires renewing a joint commitment to learn from recent experience, work together better and create a vision of the future that sustains confidence amongst local people and users of services.

X. The proposals also included a recommendation from the Secretary of State, that a joint oversight and scrutiny committee be formed covering a wider area.

Following these recommendations, a number of actions were taken by both sides. Firstly, a programme of work, including a workshop with all local health partners to help reset and renew the relationship between providers, commissioners, and the scrutiny in Oxfordshire.

Secondly, heeding the advice above, a scrutiny committee was formed specifically to scrutinise the programme of work brought forward by the CCG and the Trust to address the recommendations. This was approved by Oxfordshire, Northamptonshire, and Warwickshire County Councils, and health scrutiny powers on consultant-led maternity service at the Horton, including the power of referral, were delegated to this committee.

The Horton Health Overview and Scrutiny Committee (HHOSC) commenced work in September 2018. It has met seven times at regular intervals to scrutinise the workstreams undertaken by the CCG and the Trust and has also met to hear first-hand the experiences of staff and expectant mothers and their families. I enclose a fuller account of the committee workings as part of the supporting papers.

However, despite best efforts on both sides, the committee finds itself in the deeply regrettable and sadly avoidable position of having to refer the matter for consideration by yourself and the IRP yet again, for the following reasons.

1. Regulation 23(9)(a) – consultation on any proposal for a substantial change or development has been adequate in relation to content

2. Regulation 23(9)(c) - the decision is not in the best interests of the health service or local residents;

Reg 23(9)(a) Inadequate consultation

First of all, it is the view of the committee that the decision-making process has not been robust because the content of consultation on the proposal for substantial change has not been adequate. Meaningful consultation or engagement should be a process in which all stakeholders have confidence and, as per the views expressed by your predecessor, one that takes into account the opportunity to learn from the experience of mothers, their families, and staff who have now been involved in the temporary arrangements for more than a year. The committee welcomed the approach adopted by the Trust in their engagement and throughout the process, members of the public, mothers and their families felt as though the research approach provided a forum for engagement that had been previously been lacking. Furthermore, this was not limited by administrative boundaries as had previously been the case.

However, for this to be adequate consultation, this needs to be done with an open mind, not simply to fulfil and satisfy a recommendation from the Secretary of State. The committee accepts that this time around, there has been much more of a willingness to engage with the scrutiny process from the outset and this is to be welcomed. However, there is still much left to be desired from the journey we have been on.

I want to start by dispelling the narrative implicit in the CCG Board Papers that somehow going through of the process of engagement is any way either a measure of the quality of that engagement and/or of constitutive of proper engagement. The committee certainly did not feel that the content of the consultation was sufficiently comprehensive, and it is the view of the committee that the process was brought to an artificial and premature end. The CCG dispute this, but the fact that there are still outstanding questions which required an addendum for their Board papers the day before the Board decision and after the final planned HHOSC committee meeting, further serves to underline this point.

On more than one occasion the CCG were asked if they wished to postpone the decision-making timeline because the committee felt that further scrutiny was still required. The answer was a very firm negative which is unfortunate, as an extended timeline may have enabled fuller scrutiny of the issues the committee feels are outstanding.

I wish to make it absolutely clear that at no point has the Horton HOSC 'signed off' on the outputs of the workstreams. This committee gave its endorsement of the programme plan at the outset and it has provided scrutiny as the process has developed, but at no point has the committee indicated it's satisfaction with the execution of the process the CCG set out in its plan to address the Secretary of State and IRP recommendations. I would also argue that any impartial observer to those meetings, and a reading of the minutes (see enclosed document number 1) would confirm the committee's perspective. Whilst the HHOSC did approve the overall process for the CCG to follow, the execution of that process has been less than satisfactory. The primary source of the committee's dissatisfaction is the incomplete and lack of information contained within the CCG and Trust's consultation with the committee.

The committee has frequently found the responses from both the CCG and the (OUH) Trust to be evasive, delayed, and incomplete which did not engender the spirit of cooperation that the committee had anticipated. The committee was on occasion assumed not to have the capacity to fully understand technical proposals and solutions; the committee firmly rejects this was the case.

The committee's health scrutiny powers mean it can require the provision of information about proposals; an example of evasiveness with the committee's requests for information is the eight months it took to provide financial data. Information promised in November 2018 was delayed, then inadequately provided in April 2019 before comparable information was provided in July 2019. The committee's request for additional information on finances remains unfulfilled when it met in September 2019 to consider the CCG Board recommendations. At no point before September 2019 did the committee receive any information on the capital implications of the options being considered. The committee remain perplexed on how such a simple request could have taken such a long period of time and could have missed such a critical part of the options. This illustrates that content of the engagement with the committee has been inadequate.

I would ask you to consider in which other public sector organisation, at either a local or a national level, would it be acceptable for such a simple request for information to be delayed for such a long period of time? These are just some examples of the incidents which have made the scrutiny process excruciating and more difficult than it needs to be. Similarly, when a topic has become 'too difficult' to deal with, the CCG and Trust have simply dropped this from our discussions, not bringing it to further scrutiny meetings, and then presenting the answer in the final decision-making papers as a ‘fait accompli’.

Given that scrutiny of difficult topics is effective elsewhere in the system locally, and that we work so well as a system since the last time I wrote to your department on this matter, the actions taken here give the impression of an evasive and ‘blocking’ approach. The committee therefore interprets this lack of a fully inclusive process as the CCG and (OUH) Trust as having undertaken a mandated process to deliver a previously-determined outcome. The perception left amongst committee members is that evidence was sought to reaffirm its argument (and preferred solution) for a single obstetric model at the JR.

The committee notes that NHS England has signed off on the CCG’s process of addressing the 2018 IRP recommendations based on the information presented to them by the CCG. In itself this is a deeply flawed process. As NHSE’s (South Central) Director of Assurance and Delivery himself stated at the HHOSC meeting of the 19th of December 2018; NHSE is the regulator, assuring the process and does not comment on whether the decision is right or wrong. NHSE do not make a judgement on whether the NHS Test of impact on patient choice, have been met- only that it has been considered. At the meeting in December 2018, NHSE acknowledged their original assurance of OCCG and OUHFT proposals for obstetrics for Oxfordshire should have been more encompassing of the wider population and cognisant of what the wider options should be. The committee would have welcomed engagement by NHSE in their assessment; this was completely absent and neither did NHSE feel it necessary to inform the HHOSC of the outcome of its assessment. Given the circumstances we now find ourselves in, I therefore seek your independent assessment of these issues and assurances. Quantity of meetings and following process is not in itself a measure of quality, which is what appears to be the implication from NHSE and the CCG Board papers submitted.

The committee maintains that the process was brought to an artificial and arbitrary end, means that there has not been the opportunity for effective scrutiny in all areas and there are still many unanswered questions. The two most prominent areas are recruitment and finance; but the committee also has outstanding concerns over the assessment criteria and weightings.

Recruitment

Information provided for scrutiny

On the subject of recruitment, as previously noted, the committee welcomed the early engagement on the recruitment process. However, when the subject became an area of significant challenge by the committee, the specific questions asked were avoided and deferred. Despite pledges from the Trust to bring back further information before the committee next met; a report was only presented with the CCG Board papers. An example of this was the detailed explanation of the substantive staffing numbers for the final options; the committee did not have an opportunity to comprehensively scrutinise this before the CCG Board decision.

The committee remains unconvinced by arguments put forward that suggest a trust-wide model would require higher numbers of staff and is not viable. After all, this approach is adopted by the trust in other areas, such as Gynecology. The Trust's plans for the Horton, as already (as part of the OTP) agreed by the CCG Board, and supported by OJHOSC, allegedly require moving between 60,000 to 90,000 outpatient appointments to the Horton. So surely it is the case that either the staff can work across a trust or they cannot. Further, it is unfathomable that the Trust can plan on the basis of recruiting staff for such a high level of outpatient appointments but will struggle for less than 2,000 births a year.

The committee accepts that there are difficulties recruiting and retaining suitably qualified staff to maintain an obstetric unit at the Horton. However, it does not feel that options have been fully exhausted and nor does it consider it is sufficient grounds for removing a service when the needs of local people have not fundamentally changed. Whilst staff retention may be harder than it has been in the past, the Trust has demonstrated that it can successfully recruit to the specialist posts, despite a cloud of uncertainty hanging over the Horton unit.

Workforce solutions

In 2014 a CQC report on the Horton highlighted the staff view that HGH-based staff did not feel equally regarded as staff at the JR. It states:

> *"The staff felt the lack of senior management on site over the two years prior to our inspection had caused them to feel neglected by the trust. They felt bed closures and transfer of care to Oxford were due to financial reasons and not with patient care in mind. The staff felt there was no overall cooperation or coordination on site because most senior staff were based in Oxford. The management structure had also impacted on communication with the John Radcliffe Hospital. Staff said morale on site was poor and felt they could not openly discuss their concerns".*
>
> **Source: Maternity at the Horton**[1] **(May 2014, p57)**

The HHOSC committee has heard that there is a necessity to have specialist Doctors based at the JR because of the tertiary services provided there. The above quote powerfully illustrates how the nature of the services at the JR created a disparity between staff at the two OUH Trust obstetric sites and indicates that the perceived "neglect" of the Horton. The resignations which led to the temporary closure of obstetrics at the Horton in 2016 is perceived by the committee as a consequence of a lack of aggressive action by OUH to tackle the management and staff perception issues highlighted in 2014.

From the information the committee has seen through this process, it still does not accept that the Trust is doing all it can to recruit the necessary staff numbers and resolve the 'two-tier' feelings of staff. We fail to see how the internationally recognised brand of Oxford University leads to difficulties in this area, yet the OUH can recruit for

[1] CQC Quality Inspection Report. Horton General Hospital. May 2014. https://www.cqc.org.uk/sites/default/files/new_reports/AAAA0572.pdf

other difficult areas. Given the successful recruitment of five doctors in a process which could be improved and with an uncertain future for the Horton.

The committee accepts that there is shortage of a number of posts nationally, and that the OUH have staff shortages locally, but this is not an insurmountable issue, especially when you consider the good will involved and willingness of key local stakeholders such as Cherwell District Council, to engage and support on this issue in any way they can. HHOSC is of the opinion that there can be a solution on this issue and there is genuine willingness from all stakeholders to make this happen. It is the belief of the committee that this issue is not as difficult as the Trust maintains and needs direction from yourself to resolve the issue.

Small unit research

Research undertaken by Keep the Horton General campaign and the committee's own investigation of smaller units confirms that units with low birth numbers can be staffed and sustained. The reintroduction of training accreditation, which units with fewer births than the Horton have maintained would further help the recruitment situation. The committee feels as though the research and understanding of models in other small units did not feature sufficiently highly in the CCG and Trust's search for innovative solutions and several questions (such as training accreditation) remained unanswered through the process. Instead of aggressively pursuing innovative solutions to a small unit challenge, the CCG and Trust have often been perceived by the committee to be ignoring solutions from elsewhere and to have sought out barriers which confirm their small unit and recruitment challenge. I would ask to you to also consider the Keep the Horton General and committee's own work on small unit models and staffing submitted as supporting evidence (see enclosed document number 2).

For the reasons explained, the committee remains surprised on how the workforce workstream has been dealt with through this process. In addition, HHOSC has learned that despite the uncertainties hanging over the future of maternity services at the hospital, the Trust were still able to recruit five doctors to fill the positions. According to the Trust, feedback from potential recruits to the Horton, is that they are allegedly put-off by the large number of 'Save our Horton' banners displayed around Banbury. These are provided by Keep The Horton General campaign group with the blessing of both Oxfordshire County Council and Cherwell District Council as the relevant local authorities. This apparent observation, which the Trust must have been aware of for some time, has not been shared with the committee, or the any local stakeholders, until the final publication of papers and the HHOSC's latest meeting. Only with the publication of the CCG Board papers did the committee and the wider community, including local councils and the Keep the Horton General group, who have worked tirelessly on protecting the future of the hospital, learn about this issue that could have been easily resolved. The committee remains confused as to why this was not raised by the CCG and OUHFT sooner as it could have led to a swift and positive resolution.

Finance

There is a significant issue outstanding around the finance workstream. Time and again, OUHFT have maintained that the decision would not be a financial one at no point, did the scrutiny of costs required for the resumption of services feature as part of the HHOSC's programme of work. As a result, the committee found it astounding that the CCG Board papers featured a discussion around capital costs that made the business case for the resumption of obstetric-led maternity services prohibitively expensive.

The committee has heard repeatedly that the resumption of obstetric led services is one on safety grounds, not on financial grounds. HHOSC was very surprised to see costs in the board papers of £17m for the provision of suitable facilities for obstetric led services at the Horton with an alongside MLU. This is all the more surprising as in a study commissioned by the Trust and presented to the Community Partnership Network (a non-decision-making stakeholder engagement forum), in December 2018, the cost of refurbishing the entire Horton site was put at £10m. Please see enclosed document, number 3.

Related to the capital costs, a CQC Inspection report in June 2019 reported concerns about the maternity facilitates at the Horton; it recommended the following regulatory actions:

For most part, the service had suitable premises. The main exception was the Horton MLU where the birthing rooms required refurbishment. Walls in the delivery rooms had exposed plaster and a faded general appearance…..

- *The trust should review the maintenance contract for the Horton General hospital maternity led unit and ensure the environment and equipment meets agreed standards (see below).*
- *The trust should ensure medicines are stored securely and at the correct temperatures.*
- *The trust should ensure maternity service guidelines are reviewed against current best practice or national guidance.*
- *The service should investigate complaints within in the time frames detailed in its own complaints policy.*

Source: CQC Inspection report on OUH[2] (June 2019)

The estate concerns around the Horton maternity services is perceived by the committee as a consequence of a lack of investment by OUH to actively pursue the re-opening of obstetrics at the Horton or maintain that estate for a potential re-opening. The result of this approach now appears to be an increased capital cost to ensure the estate is fit-for-purpose for the options presented. The committee has not had sufficient information to effectively scrutinise the capital investment aspect of the options.

Because of the inadequate information available to the HHOSC on capital costs and the conflicting reports from other sources highlighting wildly different capital investment figures, the committee questions the validity of the figures presented to the CCG Board for its decision. The committee regrets both the introduction of this topic only at the end of the decision-making process despite previous statements to the contrary and the lack of time for effective scrutiny to address the many issues and

[2] CQC Inspection Report on OUH. https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ4273.pdf

unanswered questions that remain on this topic. This reinforces the committee's view that the content of the consultation with the committee has been inadequate.

As highlighted by the examples outlined; despite a much better working relationship and a genuine willingness from the CCG and OUHFT to engage, the committee believes that the scrutiny process itself remains unfilled.

Assessment criteria and weighting

The HHOSC has expressed concerns about the transparency of the options weighting process. In particular the shortlisting of staffing options to decide which to explore further leaves a lot to be desired. When these where first presented to the committee, a number of concerns where expressed to the Trust about how the options had been chosen and the weightings applied. Despite a commitment from the OUH Chief Executive, Dr Bruno Holthof, to revisit the weighting process and share this with committee, and to provide the weightings with Nick Graham, Oxfordshire County Council's Director of Law and Governance before they had been applied, this did not take place.

There was no further communication with the committee re the weighting process and the weighting were only shared with Nick Graham (a week) after the process had been completed. To this day, the CCG maintain that the weightings criteria were shared with the Director of Law and Governance on the 7th June, however the email trail clearly shows that this was the 10th June (see enclosed document, number 4). As a result, the committee has no confidence in how these criteria have been selected and as a result, cannot assure the public.

This is important because the CCG and Trust have been perceived as effectively creating an opaque bias in how the criteria have been selected and the weightings applied. By their own admission, there should have been more transparency in the process, and this was clearly not the case. Selection of criteria for assessment are always going to be a political issue, and given the process, the selection of the criteria, the involvement of those selecting the criteria (heavily weighted in favour of medical personnel from the Trust), this is not a process in which, as per your direction, the committee, local people and service users have confidence in.

The points above, highlight reasons why the committee believes content of the consultation has been inadequate. It is the view of HHOSC that had content been comprehensively provided and the due process been followed as planned, a different decision would have been reached.

Reg 23(9)(c) Interests of the health service or local residents

Notwithstanding the points above, HHOSC also do not believe the decision to be in the best interests of the residents of Oxfordshire and the wider Horton Catchment area for the following reasons.

The needs of local people.

Firstly; the needs of local people have not materially changed and the arguments set out in the 2008 IRP judgement still apply. Over the last year, the committee has taken compelling and passionately expressed evidence from many members of the pubic, mothers, local campaign groups, local politicians, local councils, former Horton doctors, local MPs, and Keep the Horton General campaign group. There is unanimous opposition to the proposals for maternity services and the decision taken by OCCG. Their own extensive survey which has since been discarded shows a clear preference for an obstetric service in the Horton Catchment area.

Whilst the committee accept the guidance given by the IRP that each referral is treated on its own merits, throughout this extensive process, the committee has yet to see any evidence that is of a remotely compelling nature to demonstrate the fundamental needs of mothers in the Horton Catchment areas have changed since 2008. Specifically, as highlighted above, in 2008 the IRP did not support the then Oxford Radcliffe Hospitals (ORH) NHS Trust's proposals to reconfigure services in pediatrics, obstetrics, gynecology and the special care baby unit (SCBU) at Horton Hospital. The IRP did not consider that they will provide an accessible or improved service to the people of North Oxfordshire and surrounding areas. HHOSC has not seen any evidence to suggest anything to the contrary, in fact, our own investigations and the CCG survey show the opposite

There is nothing fundamentally different with the decision made in 2017 or the earlier decision in 2008. Your office and the IRP on both occasions were not convinced by the reasons stated and we would ask you to ponder that as nothing of substance has changed, why would you consider any different now.

Views and experiences of Mothers

This process has not been about finding a way to maintain obstetric led maternity services at all costs, but rather the best service provision for Oxfordshire. Yet the reality of the matter is that there are no winners from the decision taken at the CCG board meeting. This is a deterioration of services for the Horton catchment area who lose an obstetric-led maternity service and a deterioration of services for mothers in Oxfordshire due to the resulting increased pressure on the JR.

HHOSC held a session to hear first-hand from mothers and expectant mothers in December 2018 and the committee is grateful to all those who came and shared some very powerful and moving testimony. This testimony highlighted some of the many problems that having a single led obstetric service brings. From the added stress levels in deciding where to give birth, to issues around travel and parking, to the difficulties facing elder siblings and partners, and most importantly, the added stress to mothers during the birthing process itself. The promised mitigation measures suggested by the Trust are, in the view of the committee, quite frankly, an insult and are items which should have been implemented a long time ago. They are also bordering on the impractical. I ask you to imagine that in the rush to hospital to give birth, trying to locate the right telephone number to call and wait for someone to direct you to the appropriate place to park. Aside from the obvious difficulties for such a course of action for a mother in labour, either alone or accompanied by a partner or family member, this is also bordering on the use of dangerous and illegal advice given how it will distract from driving.

It is clear from the patient engagement workstream, that the overwhelming majority of residents are not only in favour of an Obstetric-led service at Horton, but those in the Horton Catchment area have a much lower satisfaction rating for the provision of maternity services:

- 74% of Cherwell mothers and 97% of South Northamptonshire mothers would have preferred to have given birth in Banbury
- The net satisfaction scores (subtracting the % of those dissatisfied from those satisfied) for mothers giving birth in Cherwell is 12% and for South Northamptonshire -2%
- Deciding on where to give birth causes anxiety for 33% of Cherwell mothers and 28% of those in South Northants

Additionally, on this issue, the committee is concerned by the increased anxiety levels for mothers from the Horton Catchment area. As previously noted, the CCG's own survey showed that deciding on where to give birth causes anxiety for 33% of Cherwell mothers and 28% of those in South Northants. HHOSC found the initial response to these figures from the trust as dismissive which was regretful. HHOSC is also concerned about the possible links between anxiety during pregnancy and the impact this can have on development in later life for babies. HHOSC disagreed with the response provided, and we have included our own research on this (see enclosed document, number 5). This largely an unknown area and the committee is concerned of the potential longer term impacts these increased anxiety levels can have on the population of the Horton catchment area. Not withstanding this point, it is not desirable that the decision taken by the Trust and the CCG leads to increased anxiety levels for expectant mothers from the Horton catchment area.

Whilst the Trust acknowledges that in an ideal world it would provide two obstetric led units, it is effectively holding a veto over the process in its assessment of what can be resourced, rendering any public, patient and stakeholder engagement as meaningless. HHOSC believes that the Trust will continue to disregard patient experience as a significant indicator of quality provision until they are directed to do you by your office.

Travel and access

As with the previous occasion on which we wrote to your office. The committee has major concerns about transport difficulties between Banbury and Oxford, particularly at peak travel times and in inclement weather. This includes both emergency transport for patients and public transport for patients and relatives. To date, the only official survey of travel times remains that conducted by Victoria Prentis, MP for Banbury and the Trust continue to base assumptions on google maps.

Leaving aside the obvious issues with this methodology, the fact remains that since we last wrote to you on this topic, new road works around the permanency of increased development in the area around the John Radcliffe have led to increased travel times. The already worsened traffic situation is only likely to increase as there is further development in the vicinity of the JR and North Oxfordshire and this remains a very real, albeit incredibly inconvenient situation for the Trust.

During the closure, a dedicated ambulance has been stationed at the Horton to transport high risk mothers in labour to the JR. The CCG recently confirmed the future of this provision. Whilst this is very welcome development, HHOSC asks you to consider the absurdity of this and the lengths the Trust will go to support a pre-determined conclusion.

To say nothing of the extra costs this brings, or the opportunity cost of having that ambulance provision in general service, this further underlines the point that the experiences of mothers have been discarded. The committee heard a number of quite troubling accounts of mothers being transferred by ambulance and the additional stress this brings to what should be a positive experience. Most notably, these included partners having to follow in their own transport / via public transport, with no knowledge of the health of the mother; travelling in the ambulance but the having no provision to return home, and having to make alternative arrangements for elder siblings.

HHOSC has already heard anecdotal evidence of mothers' poor experience travelling between the Horton and the JR, and the pressures on the JR affecting waiting times for women in labour and the work from the survey further underlines this point. The Chief Executive of the Trust, Dr Bruno Holtholf, indicated on another matter (the contract for PET CT scanning on which coincidently I also wrote to your office in my position as OJHOSC Chair in May 2019), that the OUH do not consider access a priority in its measurement of quality. This was clearly a deciding factor in the trust not originally being awarded the contract for PET CT scanning and is clearly one of the motivations behind this decision. HHOSC believes that like patient experience, the Trust will continue to disregard access as a significant indicator of quality provision until directed to so.

Furthermore, the previous OCCG commissioned parking and travel analyses confirmed that there are acute problems with access and parking at the JR site compared to very few issues at the Horton. The qualitative feedback that Healthwatch Oxfordshire gathered indicates that patient travel and parking times at the JR are between 45 and 75 minutes. These travel surveys are now two years old and has not taken account of increase in population and car ownership during that time.

Whilst the Trust has discussed measures that can be both implemented immediately such as automatic number plate recognition and a priority parking area for pregnant mothers which can be accessed via telephone call, alongside more long-term measures such as increasing parking capacity, the fundamental problems remain.

On the former, these are measure that should have been implemented a long time ago for all mothers, not just those in the Horton Catchment. On the latter, the local planning authority, Oxford City Council, maintain that they will not allow an increase in parking spaces as the JR which means any application will be denied, as has been the case previously.

For the reasons highlighted on travel and access, HHOSC do not believe the decision to have a single obstetric unit at the JR to be in the best interests of the residents of Oxfordshire and the wider Horton Catchment area; whether that be for the immediate or foreseeable future.

Foreseeable future

The CCG have maintained that this decision is not a permanent decision, but rather one for the foreseeable future. They have also committed to an annual review to assess the situation. Whilst this mitigation would be welcome in the worst-case scenario that you decide to confirm the decision made by the CCG, HHOSC remains deeply sceptical.

Despite pushing the CCG to outline the criteria which would trigger the resumption of obstetric led maternity services, they have to date refused to do so. The committee accepts that this is not simply a matter of number of births but is concerned by the lack of transparency over what would constitute the CCG to restart an obstetric led service at the Horton site. Without this criterion being laid out, the 'foreseeable' future will become an indefinite period of suspended animation for obstetric services which would make the decision taken permanent in all but in name.

<u>Summary</u>

It is quite clear from the points above that the decision taken is not in the best interests of either the Horton catchment area or Oxfordshire. Contrary to your direction:

I. Whilst there has been patient engagement, there has been no demonstrable measure of learning from the experience of mothers, their families, and staff who have now been involved in the temporary arrangements for more than a year.

II. The work has not addressed the implementation issues that have been left outstanding, more particularly how antenatal care is organised and how recommendations to address travel and parking issues will be carried through in practice. HHOSC also remains concerned about some of the antenatal and pre-birthing measures suggested and their viability. Especially given that in the past, on a number of occasions, the MLU's around the county, including that of the Horton, have been closed down with midwives directed to the JR to mitigate staff shortages. Thus, rendering no choice on location for women giving birth and further exasperating the travel and accessibility issues highlighted above.

III. It **cannot be** demonstrated that the option is in any way the most desirable for maternity services across Oxfordshire and all those who will need them in the future.

IV. All stakeholders **do not feel** they have been involved in the development of the proposals for change. If this was not true of the past, the CCG must ensure that it is so moving forward.

V. The vision of the future, especially the opaque status of suspended animation and the lack of clarity around financing is not one that sustains confidence amongst local people and users of services.

I would also ask you to consider the following. Back in 2008, the IRP directed the Oxfordshire Primary Care Trust (PCT) was to carry out work with the ORH NHS Trust to set out the arrangements and investment necessary to retain and develop services at the Horton Hospital. The PCT was to develop a clear vision for children's and maternity services within an explicit strategy for services for North Oxfordshire as a whole.

The ORH was to do more to develop clinically integrated practice across the Horton, John Radcliffe and Churchill sites as well as developing wider clinical networks with other hospitals, primary care and the independent sector. The Independent Reconfiguration Panel advised that the Trust and the PCT were to invest in, retain and develop services at the Horton, as it considered the Hospital to have an important future role in providing local care to people in North Oxfordshire and the surrounding areas.

This direction has clearly been ignored over the past 11 years. Further, the supposed issue around staffing is entirely an issue of the Trust's own making. There was no issue with staffing models until the Trust announced its Phase 1 STP decisions in 2016 which called for no obstetric led service at the Horton. A decision which you and the IRP have subsequently indicated was wrong. This decision prompted a number of doctors to resign, given the uncertain future of the service, leading to the temporary closure on safety grounds and the creation of a frankly unnecessary recruitment problem which was of the Trust's own causing, whilst at the same time neglecting to invest anywhere on the Horton site and removing the training accreditation from the Horton site for obstetrics.

The Trust has, in various iterations, systematically ignored the recommendations of the IRP, previous Secretaries of State, and the CQC and is presenting an argument on manufactured safety grounds to finally achieve a long-held goal of removing obstetric led services from the Horton site.

The committee does not accept that the Trust is doing all it can to recruit the necessary staff numbers. We fail to see how the internationally recognised brand of Oxford University leads to difficulties in this area, yet the OUH can successfully recruit for other difficult to staff areas.

The HHOSC has resolved to continue and to engage with key stakeholders and the CCG and the Trust to work on a positive vision for the long-term future of the Horton Hospital. We welcome the steps made towards positive meaningful engagement. However, we do not accept that is it a binary choice and to embrace this positive vision requires accepting a deterioration in service provision for obstetrics.

Allowing the CCG and Trust to put the future of maternity into suspended animation with no clear gateways for review does no justice to the existing and future population of North Oxfordshire, south Warwickshire and south Northamptonshire. This would also set a precedent for trusts up and down the country to avoid transparent review of service changes.

I appreciate this referral is very detailed and raises many points in support of the difficult decision taken by the committee, but I would also ask you to consider the following dilemma. The CCG and Trust maintain that this is a decision taken on recruitment grounds for the foreseeable future. Despite the opacity around what conditions would have to be met to reinstate obstetric led services at the Horton, presumably, if this is a genuine commitment and not simply a strategy to avoid referral and or direction from your department, there are local conditions which would result in the re-introduction of obstetric-led services. If that is the case, then the Trust must have a solution for the recruitment and staffing issues. So why not implement it now? Surely delaying the decision does not magically solve any potential recruitment and staffing problems. Either the commitment to the foreseeable future is not genuine, or there must be a plan to solve the alleged recruitment issues. The alternative being the point maintained above, that the committee feels these issues can be resolved.

The relationship between health partners and scrutiny is overall in a much more positive place than when I last had to write to you on this topic, and on other topics, the decision-making process and the scrutiny of those decisions is one that does inspire public confidence. The committee also welcomes the decisions taken to safeguard the future of A&E and Pediatric services. However, none of this takes away from the pertinent points and quite valid reasons for referral outlined above.

This referral to your department is not taken lightly and was always viewed by the committee as an option of last resort. It is however backed by the constituent councils that the HHOSC represents, OJHOSC as its parent committee, and all locally elected representatives, regardless of political persuasion. A motion deploring this decision and welcoming and supporting the referral has been unanimously passed at Cherwell District Council and received overall support (by 52 votes to 0, with 1 abstention) at Oxfordshire County Council. It represents the united views of the wider Horton Catchment area and is supported by all the local surrounding MPs, including your cabinet colleagues. As stated, we now find that despite best efforts on both sides, the committee regrettably refers the matter for consideration by yourself and the IRP again, for the following reasons.

1. Regulation 23(9)(a) – consultation on the proposal for a substantial change has been adequate in relation to content

3. Regulation 23(9)(c) - the decision is not in the best interests of the health service or local residents;

As such, we strongly urge you to consider referring the decisions made and directing the Trust on the clear direction they need to take for the future of the Horton site. As local representatives at all tiers of government, we stand ready to work with Health partners on a positive future vision for the Horton site and recognise the implementation of that. However, we reject the option that it is a binary choice between obstetric led services and a positive vision for the Horton and no amount of new hospital buildings, facilities or services will change a long-held political ambition from the Trust, unless there is direction from your department. In short, the recent mammogram announcement is welcome but does not in anyway detract from the substantive issues set out in this letter.

Let us work together, starting afresh with your decision, and embark on a positive vision for the future of obstetric services in North Oxfordshire, begin recruitment immediately and lift cloud of uncertainty surrounding the Horton site.

I look forward to hearing your response.

Best regards,

Cllr Arash Ali Fatemian
Chair of Horton HOSC on behalf of the committee and the residents of the Horton Catchment Area

ENCLOSED DOCUMENTS

1. Minutes of the Horton HOSC (from Sept 2018 to Sept 2019- including DRAFT minutes of the meeting held on the 19th of September 2019, to be agreed at the committee's next meeting).
2. Obstetric-Led (small) Unit Research conducted by a) HHOSC and b) Keep the Horton General Campaign Group.
3. Condition Report on the Horton General Hospital, as presented to the Community Partnership Network.
4. Copy of the email sent to Nick Graham on the 10th of June 2019 regarding the weighting of options.
5. Appendix 2 of the Chairman's Report Addenda from the 19th of September 2019, highlighting the research on impacts of anxiety in pregnancy.

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HORTON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Friday, 28 September 2018 commencing at 2.00 pm and finishing at 3.55 pm

Present:

Voting Members:

Councillor Fiona Baker
Councillor Arash Fatemian
District Councillor Sean Gaul
Councillor Kieron Mallon
District Councillor Neil Owen
District Councillor Barry Richards
Councillor Alison Rooke
District Councillor Sean Woodcock
Councillor Mark Cargill (In place of Councillor Wallace Redford)

Co-opted Member: Dr Keith Ruddle

Officers:

Whole of meeting: Strategic Director of Resources; Director of Law & Governance, Julie Dean and Katie Read (Resources)

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.

1/18 ELECTION TO CHAIRMAN
(Agenda No. 1)

Councillor Arash Fatemian was elected as Chairman of the Joint Committee.

1/18 ELECTION OF DEPUTY CHAIRMAN
(Agenda No. 2)

Councillor Fiona Baker was elected Deputy Chairman of the Committee.

1/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 3)

Cllr Mark Cargill attended in place of Cllr Wallace Redford.

1/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 4)

Cllr Sean Gaul declared a personal interest on account of his wife being in employment for an Oxfordshire Health Service employer. Cllr Arash Fatemian also declared a personal interest by virtue of his child being born at the maternity Unit at Horton Hospital.

1/18 PETITIONS AND PUBLIC ADDRESS

The following requests to speak at Agenda Item 7 had been agreed:

- Jenny Jones-Claydon – as a member of the public;
- Keith Strangwood – as Chairman of ‘Keep the Horton General’ campaign Group
- Cllr Andrew McHugh – Cabinet Member for Health, Cherwell District Council

<u>Jenny Jones – Claydon</u>

Jenny Jones spoke as an informed member of the public with more than 10 years’ experience attending meetings associated with the Horton Hospital. She stated her view that the list of options was incomplete. She stated that when the Oxfordshire Joint Health Overview & Scrutiny Committee was addressed in August 2017, she had indicated that the General Medical Council would allow each of the obstetrics trainees from the John Radcliffe Hospital to work 8 hours per week at the Horton. It was her view that no attention had been given to this by the CCG. She asked that this be included as an additional option.

With regard to the engagement plan to consider the options, it was her view that responses to questions from the public on the website contained so much ‘spin’, adding that this was not a substitute for face-to-face dialogue. She pointed out that the CPN Plan was non-statutory, asking that OUH and the CCG do not use this non-statutory status as reasons not to answer questions.

<u>Keith Strangwood</u>

Keith Strangwood pointed out that the obstetrics unit had now been closed for two years. He made reference to some individual cases of mothers who had given birth which he had personally sent to the members of the Committee, and stated that there were many more cases to follow.

He also made reference to certain information currently in the media that this Committee did not have the power to refer again to the Secretary of State, which was not the case, but that there would be no concrete decisions made by this Committee until May 2019. He expressed a hope that this matter be not ‘pushed into the long grass again’ as the mental stress this had caused had been substantial.

He urged the Committee to opt for option 9 in the paper, it being the only viable one in his view.

Cllr Andrew McHugh

Cllr McHugh expressed his concern that, in his view, a safe maternity service could not be delivered at the Horton on the grounds that it had proved impossible to recruit sufficient staff, this having been under threat since before 2008. He referred to the high living costs in the County and the costs of housing, albeit these were lower in the Banbury area. He made reference to a report produced by the Royal College of Nursing which suggested that the recruitment of obstetricians and gynaecologists was set to improve which should attract candidates for employment at the hospital. Cllr McHugh stated that Cherwell District Council believed that a safe and efficient obstetrics service given at the Horton Hospital would lead to a vibrant future for the hospital, whilst leaving the complex cases to the John Radcliffe Hospital. He pledged that Cherwell District Council would work collaboratively with the OCCG to re-establish an obstetrics service at the Horton. In conclusion he urged the Committee to approve option 9.

1/18 TERMS OF REFERENCE
(Agenda No. 5)

The Committee’s Terms of Reference (HHOSC6) were before the Committee for approval.

The Chairman pointed out that, by virtue of the agreed Terms of Reference, the Joint Committee held the full powers of referral to the Secretary of State without the need for the decision to be referred back to each Council for approval. In addition, substitutes had been allowed at the request of Warwickshire County Council.

In response to a question from Cllr Cargill, the Chairman explained that the numbers of representatives on the Joint Committee from each Council was in proportion to the percentage of births at the Horton Maternity Hospital for the last full year.

The Committee **RESOLVED** to approve the Terms of Reference.

1/18 REFERRAL TO THE SECRETARY OF STATE
(Agenda No. 6)

The Chairman presented the background to the referral by the Oxfordshire Joint Health Overview & Scrutiny Committee and outlined the Secretary for Health and Independent Reconfiguration Panel recommendations (HHOSC7).

The Joint Committee noted the report.

1/18 RESPONDING TO THE RECOMMENDATIONS: A PROPOSED APPROACH
(Agenda No. 7)

The Chairman welcomed the following representatives to the meeting:

- Chris Panel – Northamptonshire General Hospital
- Sue Lloyd – Obstetrics/Gynaecology – Northamptonshire General Hospital
- Anne Hargrove – South Warwickshire
- Lou Patten, Sarah Adair, Veronica Miller and Catherine Mountford - Oxfordshire Clinical Commissioning Group
- Kathy Hall and Sarah Randall – Oxford University Hospitals Foundation Trust

Lou Patten gave a brief overview of the situation from the OCCG's perspective, stressing that Accident & Emergency and Paediatrics services would remain at the Horton and the OCCG was espousing a main focus on planning services, rather than buildings, in order to give a vibrant future for the Horton. The future service planning was linked to a growing population and its growing health and care needs which would lead to, over time, service change at the Horton. She added that, at this meeting, the OCCG intended to share the draft plan and to glean the Joint Committee's views and comments on the scope of the work and to identify if anything was missing, having learned the lessons from the Secretary of State's comments in relation to the referral. It was anticipated that there would be monthly updates to the Committee, as well as HOSC meetings, on how work was progressing.

Sarah Adair spoke of the CCG's plans for stakeholder involvement and a patient experience workstream, to be conducted in an open and transparent way. The CCG would be seeking the views of women and families who had used maternity services across Oxfordshire, including people in north Oxfordshire who had used the obstetric unit at the Horton. These views would be brought into a report to be used in an options appraisal to list the final options.

Veronica Miller stated that a report would be produced describing what maternity services currently look like, to include information from the ten community midwife teams, the four freestanding Midwife-Led Units, the Spires Unit alongside the John Radcliffe Hospital and the main obstetric delivery suite and the tertiary unit at the John Radcliffe Hospital. This would also include information on regional referrals across Oxfordshire, the neo-natal unit at the John Radcliffe Hospital and the transitional care facilities for families. She added that there was close working in place with Warwick Hospital, where mothers were given options for where they wished to deliver their babies. Referrals were accepted from other authorities and a border was shared with Northamptonshire. Sarah Adair added that the paediatric, urgent care team in Accident & Emergency would also be included.

Catherine Mountford added that very detailed information on activity and population modelling had been received and shared, including statistics on, for example, where mothers had given birth and, if the obstetrics service had been needed, where these mothers had come from. Analysis had not yet commenced on information received regarding housing growth for surrounding areas. The CCG aimed to have a full list of all potential options and would work with this Committee to determine the method of appraisal.

Questions asked by members of the Committee and responses received, were as follows:

When asked if the ambitious timescales should be revised, Lou Patten responded that the workstreams would be scoped out in the next four weeks, after which realistic timescales would be determined.

A member expressed his frustration at the need for information and data to support yet another consultation. Lou Patten responded that the IRP had made clear that there was a need for an additional specification focusing on key groups and staffing. Information and data gathered would be added to what was already known.

A member spoke of his concern at the ambulance transfer times from the Horton to the John Radcliffe Hospital, the maximum time of two hours being too long and the range too high. He raised his concern also about how long the temporary ambulance arrangement at the Horton Hospital would be in place. Veronica Miller responded that the Banbury to Oxford and Oxford to Banbury had now been recognised as a good road for travel. Over the last two years there had not been an increase in poor outcomes. The member responded that this statement did not take into account the range of travel time which was 40 minutes to 2 hours, and did not take into account incidents on the road. Also, the temporary arrangement with the Ambulance Trust to keep an ambulance at the Horton in readiness for emergency journeys to Oxford, could be withdrawn at any time. Veronica Miller responded that transfer times were monitored. The focus was on outcomes and over the last two years there had not been an increase in poor outcomes. In response to a question about whether this non-increase could be related to other mothers being diverted to other hospitals, Lou Patten stated that average transfer times would be revisited, together with contingency plans for weather warnings/accidents and where mothers went for alternatives.

A member expressed her concern that the same attention with regard to consultation and engagement was not paid to Northamptonshire residents. The data provided was based on today's population, but the local plans had been produced up to 2031. Cherwell and South Northamptonshire were aware of population growth up to the next 12 years. Two thousand houses were scheduled to be built in Brackley, some of which had already been built and people were waiting to move in. Population growth is not for the future, it is happening now. Catherine Mountford responded that the CCG was in possession of all the population growth information up to 2031 and what that entailed.

A member commented that the public had to be able to put its trust in this consultation and she was keen for the voices of local people to be heard, as they were the local experts. There was also a need for the whole of Oxfordshire, South Northamptonshire and Warwickshire to be taken into account when considering the number of suites available, to reflect, practically, the number of people who could utilise the units. For example, if there were more births recorded in the Spires birthing Unit, this would affect people from across all the counties. Lou Patten responded that the number of suites in Midwife-Led Units (MLU) would be included. The consultation would have a definite focus on local voices and, in light of the comments today on travel times and contingency planning, these would be reviewed. She wanted to ensure that people were aware that the CCG had a very strong clinical vision for Oxfordshire.

The Chairman stated the importance of the CCG making the distinction between transfer times (in an ambulance) and travel times for a person not in an ambulance.

In response to concern from a member of the Committee, Lou Patten stated that the CCG would consider the impact on the family of extended transfer times and multiple demands on the dedicated ambulance.

A South Warwickshire member expressed his concern about cross-border co-operation between authorities and his belief that this should be looked at nationally. Lou Patten responded that Oxfordshire CCG was keen to ensure that South Warwickshire was appropriately engaged in the options and their analysis. He asked also why there was a recruitment problem at the Horton. Veronica Miller responded that there had been successful recruitment at the Horton, but it was a very competitive market and there was limited opportunity to further careers at the Horton. Staff saw other opportunities and went elsewhere. She added that the retention of doctors had been a problem nationally. Sarah Randall added that OUH would be transparent about rotas and recruitment/retention practices across professions. In response to a further statement that if prospective applicants felt that the Horton offered security of tenure, then perhaps more people would apply there for jobs, Veronica Miller responded that job stability was available to applicants as the terms of contract offered 2 years plus of job tenure. In terms of midwife numbers, Sarah Randall reported that there was currently a shortage of 39 midwives. However, due to the ongoing recruitment campaign, by December it was anticipated that an additional 40 would be coming to Oxfordshire.

A member of the Committee commented on the importance of ensuring west Oxfordshire population housing and growth data was contained within the options, as there was no mention of it in the papers. He also asked the CCG to consider market share, not just market size, for example, to take account of an increased number of births as a proportion of the population (sensitivity analysis). He also advocated the views of the Royal College on the possibility and viability of options. Lou Patten agreed to refine option 4, with market share in mind and to seek the views of the Royal College.

A Committee member asked whether the options presented would give mothers a choice about where to give birth, expressing also a wish to see an assessment of which options were safe. Lou Patten responded that the scoping of each option would include an assessment of safety.

Lou Patten was asked how cost-effective was the transfer of money out if Oxfordshire to neighbouring county trusts; and could it lead to the Horton's Midwife Led Unit (MLU) being under threat? She replied that money followed the patient and patients exercised their choice. She undertook to share statistics in relation to this. A member asked a further question as to whether the fall in numbers of mothers choosing the

Horton was due to concern on their part of a possible two hour journey to Oxford in the event of complications – and would this lack of demand pose a threat to the viability of the MLU? Veronica Miller replied that there was a national drive to establish MLU's in local environments. She assured the Committee that demand would increase once the future plans were known. Lou Patten added also that there were other people coming to Oxfordshire which helped the figures. She undertook to share the statistics on this matter with the Committee also.

A member made reference to the Shrewsbury & Telford NHS Maternity Unit experience which was currently in the media. Veronica Miller stated that the contributing factors were awaited. She stressed the importance of proper risk assessment and good communication policies between free-standing Midwife -Led Units and Obstetric Units.

The Chairman stated that it was unclear what was in or out of the scope and a detailed look at the survey was required before publication, together with more clarification on the engagement period and the consultation period. He asked if there was any weighting behind the criteria for appraisal of the options. Lou Patten undertook to share the details of the survey and the weighting of options. Moreover, she stated that there would be full transparency on the appraisal process, which was likely to be a two - stage process. She added that the IRP recommendations were about further engagement and the need for consultation would be dependent on the outcome of the options appraisal and engagement.

It was suggested by a member that the CCG might consider accepting views from the public via the 'Keep the Horton General' in order to maintain the anonymity of the people giving their opinions. A further suggestion was for mothers to give their evidence via a third party. Lou Patten agreed that this was reasonable and they were welcome to testify before this Committee in this manner.

A further suggestion for the consultation with stakeholders was for the CCG to consider who else they might like to talk to, for example, with future mothers.

A member suggested that the CCG be requested to indicate how the data would be tested and analysed to assess the need in a robust way, including where families had or were being diverted to other hospitals. It also needed to include information on the impact of demand should the Horton become a centre of excellence. In response to a question, Catherine Mountford assured the Committee that the outcome of the work to involve stakeholders in the development of proposals would be taken through the Clinical Senate.

On the conclusion of the questions the Committee **AGREED** the following:

(a) at a meeting of the joint Committee to be arranged in early/mid-November 2018 the CCG and OUH will share the following:

   (i) a more detailed scope for each of the proposed workstreams and a realistic timetable for completion;
   (ii) a review of transfer times between the Horton and John Radcliffe Hospitals for mothers needing obstetric interventions and the contingency plans for when

there are multiple demands on the dedicated ambulance or severe traffic delays, etc;

(iii) a clinical view on the acceptability of the quoted transfer times (30-120 minutes) from the Horton Hospital to the JR;

(iv) an overview of the data on mothers who have ***chosen*** to go to other hospitals because of the situation at the Horton and where those hospitals were;

(v) analysis of the current and future demand for services at the Horton, including an assessment population growth as a result of future housing and growth plans;

(vi) a comprehensive engagement plan that demonstrates a focus on the voices of local people and gives sufficient attention to mothers in Northamptonshire and Warwickshire;

(vii) further refinement of the options (particularly option 4) to take account of the population share of births, as opposed to just the size – i.e. some sensitivity analysis.;

(viii) an overview of the cost of patients going out-of-county vs. the income received from patients coming to the Horton;

(ix) the questions in the proposed survey before this is sent out;

(x) detail about the options appraisal process and any weighting of the appraisal criteria; and

(xi) further information about the approach to recruitment and retention of midwives and doctors at the Horton.

(b) an 'opinion-evidence gathering meeting' will be held in December 2018 for the Horton HOSC to hear the views of key stakeholders, the public and interested parties in order to inform the Committee's future scrutiny of CCG and OUH plans. The Committee agreed to initially invite the following witnesses (this is not an exhaustive list):

- The Local Medical Committee
- District Councils
- Healthwatch (across Oxfordshire, Warwickshire and Northamptonshire)
- Royal Colleges
- NHS England
- Thames Valley Clinical Senate
- Interested professionals (e.g. midwives, obstetric trainee doctors, middle-grade doctors, consultants)
- The Ambulance Service
- Mothers / families who are or have been affected by the loss of obstetric services at the Horton
- Campaign groups

1/18 FUTURE MEETINGS

(Agenda No. 8)

It was **AGREED** that the next meeting would be in November 2018, there would be an evidence gathering meeting in December 2018 and a possibility of further meetings in January and April.

.... in the Chair

Date of signing ....

HORTON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Monday, 26 November 2018 commencing at 2.00 pm and finishing at 3.18 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair Councillor Fiona Baker (Deputy Chairman) District Councillor Sean Gaul Councillor Kieron Mallon District Councillor Neil Owen Councillor Wallace Redford District Councillor Barry Richards Councillor Alison Rooke District Councillor Sean Woodcock
Co-opted Members:	Dr Keith Ruddle
Officers:	
Whole of meeting	Strategic Director for People and Director of Public Health; Julie Dean and Sam Shepherd (Resources)

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.

10/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

All members were in attendance.

11/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

There were no declarations of interest.

12/18 MINUTES
(Agenda No. 3)

The Minutes of the meeting held on 28 September 2018 (JHO3) were approved and signed as a correct record subject to the following:

Minute 5/18

- Correction to the first paragraph of the of the section headed Jenny Jones relating to the obstetrics trainees
- The final sentence of the second paragraph of the section headed Jenny Jones to read:

  “She pointed out that the CPA was non-statutory, asking that OUH and the CCG do not use this non-statutory status as a reason not to answer questions.

Minute 8/18

The list of representatives be corrected to read

Anna Hargrave, Chief Transformation Officer, South Warwickshire CCG
Veronica Miller, OUH; and
??

13/18 PETITIONS AND PUBLIC ADDRESS
(Agenda No. 4)

The following request to speak at Agenda Item 7 had been agreed:

- Keith Strangwood – as Chairman of ‘Keep the Horton General’ campaign Group

Keith Strangwood referred to option 5 in Appendix 5 on the long list of options that had been submitted to the September meeting. He queried why this had been removed from the current list of options. He noted that there was no mention in the papers before the committee of the loss of income from Warwickshire and South Northamptonshire. He made reference to hundreds of individual cases of mothers which had been sent to Members and he expressed the hope that they had had an opportunity to consider these. He went on to detail an individual case as an example of the experiences of mothers giving birth. He highlighted that buildings needed to be part of the consideration of options. Mr Strangwood further commented on issues within the papers and queried whether the current staffing levels at the John Radcliffe Hospital and the Horton Hospital provided a safe level of care. The Chairman responded that the information on income into and out of county was one of the areas that the Committee was expecting a response on.

14/18 RESPONDING TO THE IRP AND SECRETARY OF STATE RECOMMENDATIONS
(Agenda No. 5)

At its last meeting the Joint Committee asked the Oxfordshire Clinical Commissioning Group (OCCG) and the Oxford University Hospitals Foundation Trust (OUH) for the following information for consideration at this meeting:

- A revised programme plan for addressing the recommendations of the Secretary of State.

- A comprehensive engagement plan that demonstrates a focus on the voices of local people and gives sufficient attention to mothers in Northamptonshire and Warwickshire.
- Further information about the approach to recruitment and retention of midwives and doctors at the Horton.

The Chairman welcomed the following representatives to the meeting: -

Richard Bailey, NHS Nene CCG and NHS Corby CCG
Sarah Breton, Head of Commissioning, OCCG
Ally Green, Head of Communications, OCCG
Kathy Hall, OUH
Anna Hargrave, Chief Transformation Officer, South Warwickshire CCG
Veronica Miller, OUH
Catherine Mountford, Director of Governance, OCCG
Louise Patten, Chief Executive, OCCG

Catherine Mountford presented the report, drawing attention to the table setting out how points raised at the meeting in September were to be addressed. She also drew attention to paragraph 3.6.3 that proposed that 2 options be removed. The paper gave a more detailed scope for the work and a realistic timeline. Responding to the points raised by Mr Strangwood she clarified that the original option 5 had been omitted from the updated options list by mistake and should be included giving 10 options in all. There was specific work on finance included in the workstreams.

Ally Green presented the draft engagement plan set out at Appendix 1 which had been further developed using the useful feedback at the previous meeting. She referred to a small workgroup that had met to discuss what information was wanted from the survey. A decision on the company to deliver the survey would be made in December.

The Chairman thanked representatives for the work undertaken and the greater detail included in the paper. Referring to the timescale he noted that the final Board decision was scheduled for September 2019. He understood the need to ensure that the work was done properly but would like to see it progress quicker. He found the table useful and hoped that there would be no further delays.

During discussion the following points were made:

- Members expressed disappointment that the review of transfer times requested for this meeting was not available and was included in a future workstream instead. This was a vital question for local residents and it was hoped that the work could be progressed and come back quickly.
- A member queried when the CQC report of the maternity unit at the John Radcliffe Hospital (JR) would be available. Kathy Hall advised that the report was expected in January.
- Members queried the timeline and in particular challenged the delay due to local elections. Catherine Mountford indicated that the position on election purdah was the result of clear instruction from NHS England.

- A member who had attended the work group commented that it had been a good meeting looking at the patient survey. They had looked at the criteria and had not set the questions although he was clear that the survey should get at the whole patient experience. He referred to the patient experiences included in the information supplied to members by the KeepThe Horton General campaign group and asked that the survey reach such a fine - grained level of detail and include red flag incidents.
- There was support from a member for training accreditation who expressed the view that there was no magic number that made training viable but instead it was about support and supervision. If options were revisited he hoped that training be included.
- When looking at point (b) on page 12 there should be consideration of how mothers going into labour at night and without their own transport would get to the JR. Catherine Mountford confirmed that time of day and access to transport would be included in workstream 5c.
- Asked whether given staffing issues at the JR Option 4 on page 34 of the papers was viable, Veronica Miller accepted that staffing was a national challenge. Choices had to be made about where to place staff to provide care. Recruitment continued. However, she stressed that there was the capacity to run a safe service at the JR.

The Chairman in moving the recommendations commented that the original option 5 was to be included, that it had been confirmed that there was flexibility to add options if the training model was considered, that focus groups would be flexible and take account of sensitivities. The Chairman added that in agreeing the timeline it should be clear that this represented the maximum time it should take and not a minimum and he hoped that a decision would be possible before September 2019.

The Horton Joint Health Overview and Scrutiny Committee **AGREED** to:

- Confirm that in the opinion of the Committee the proposed approach and plan outlined will address the recommendations of the Secretary of State/Independent Reconfiguration Panel.
- Confirm that the Engagement plan presented is comprehensive and allows for full engagement in the work streams and appraisal process.
- Note and endorse the revised timeline which has extended to ensure fuller engagement throughout the work streams as requested by the Horton Joint OSC and the period of political restriction prior to the local elections.
- Note the revised timeline would indicate that further meetings of the Horton Joint OSC for the proposed gateways should be held in February and June 2019 (previously January and April 2019)
- Agree that the priority now is for OCCG and OUH to proceed to implement the plan.

15/18 MIDWIFERY AND MEDICAL STAFFING RECRUITMENT AT OXFORD UNIVERSITY HOSPITALS NHS TRUST (OUH)
(Agenda No. 6)

Veronica Miller presented the paper that summarised current and past efforts to increase recruitment of midwifes and obstetricians.

During discussion the following points were made:

- A member asked whether enough was being doing on retention and that if people recognised that it was a great place to work and live recruitment and retention would improve. Kath Hall in noting that turnover was down undertook to provide a note.
- Members referred to an offer from Cherwell and South Northants District Councils to put a package together and queried whether OUH had actively engaged with the councils. Kathy Hall advised that they had spoken with Cherwell District Council on recruitment fairs, for advice on housing markets and on access to affordable lettings. She undertook to go back to the District Councils to discuss this matter further.
- Responding to a query about recent shortlisting where nothing further had happened Veronica Miller assured members that the delay had been down to illness but that all those shortlisted were still coming to interview. None had been lost.
- Referring to the number of applications received, against those shortlisted and appointed a member questioned whether the correct criteria were being set. A member also queried at the drop off in the percentage of successful appointments and hoped that this was not intentional. Veronica Miller explained that nothing had changed and that it was important to appoint to set criteria.
- Members referred to the closure of local units in order to transfer staff to the JR and were advised that this was a normal response to demand and had happened over a number of years.
- Members explored the local picture on recruitment compared with the national position and noted that Oxfordshire was successful in recruiting from overseas compared to the picture nationally.
- A member querying whether the JR was short staffed asked for information on numbers of neonatal nurses before the closure and the number of cots and maternity nurses at JR. Veronica Miller stated that this information while not available at the meeting could be obtained. Veronica Miller added that they were running a safe unit with excellent outcomes and they were proud of the care provided.
- Members discussed the impact of recruitment and retention and leadership on the issue on staff morale levels and were advised that morale was a national problem.
- A Member highlighted a survey by Oxfordshire Healthwatch and queried whether the Committee would see that information. Kath Hall stated that there was an ongoing official NHS staff survey with results in the New Year.

In noting the paper the Horton Joint Overview and Scrutiny Committee asked for the following further information to meeting following the evidence gathering in December:

- An information note on retention
- Detailed information on numbers of neonatal nurses.
- Detailed analysis of the recruitment process for doctors
- Share the report findings – Birthrate plus
- Information on discussions with Cherwell District Council on a formal package of measure to attract applicants.

.... in the Chair

Date of signing 2018

HORTON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Wednesday, 19 December 2018 commencing at 10.00 am and finishing at 5.25 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	Councillor Fiona Baker (Deputy Chairman) District Councillor Sean Gaul Councillor Kieron Mallon District Councillor Neil Owen Councillor Wallace Redford District Councillor Barry Richards Councillor Alison Rooke District Councillor Sean Woodcock
Co-opted Members:	Dr Keith Ruddle

Officers:

Whole of meeting	J. Dean and S. Shepherd (Resources); R. Winkfield (Adult Social Care)

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting together with two schedules of addenda tabled at the meeting and agreed as set out below. Copies of the agenda, reports and schedule are attached to the signed Minutes.

16/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

The Chairman welcomed all to the meeting and thanked everybody for giving up their time to come along and give their views to the Committee.

There were no apologies for absence.

17/18 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

There were no declarations of interest.

18/18 PURPOSE AND OUTLINE OF THE MEETING
(Agenda No. 3)

The purpose of this meeting was to inform the Committee's future scrutiny of proposals by hearing the views of all those with an interest in proposals to permanently change obstetric services at the Horton General Hospital. The purpose also was to ensure the recommendations of the Secretary of State and the Independent Reconfiguration Panel (IRP) were comprehensively addressed.

During the day the Committee hoped to hear from all those interested, including the following:

- MPs and local councillors
- Healthwatch organisations in the area
- NHS England
- Relevant commissioners and providers of services across the area in question (for example, the Ambulance services)
- Mothers/families who have been affected, and will be affected, by proposals
- Campaign Groups

The Committee had received the written views from the following organisations prior to the meeting (these were attached to the Addendas for the meeting):

- NHS England South (South Central) – Service Reconfiguration Assurance
- Royal College of Midwives (RCM) – 'Response to Horton HOSC's consultation'
- RCM – 'Position Statement'
- RCM – 'Standards for Midwifery services in the UK'
- Submission from Healthwatch Northamptonshire and South Northamptonshire & Daventry maternity survey highlights
- Royal College of Obstetricians & Gynaecologists (RCOG) – 'Response to Horton HOSC invitation'
- RCOG - 'Providing quality care for women – Workforce'
- RCOG – 'Workforce Report 2017'
- RCOG – 'Workforce Report – Update on workforce recommendations and activities'.
- South Warwickshire CCG – 'Horton General Hospital Obstetric Unit position statement'
- South Warwickshire CCG – Appendix 1a – 'Births Analyst report'
- South Warwickshire CCG – Appendix 1b – 'Births Analysis'
- Responses from Primary Care
- General responses
- Fringford Parish Council – response
- South Warwickshire Foundation Trust – response
- 'Options for Obstetric Provision – final long list as at 29 November 2018'.

19/18 COMMITTEE TO HEAR THE VIEWS OF INTERESTED PARTIES
(Agenda No. 4)

The following people/organisations came along to give their views to the Committee:

Victoria Prentis MP for Banbury and North Oxfordshire (speaking also on behalf of the Rt. Hon. Jeremy Wright MP for Kenilworth and Southam, Warwickshire)

- Spoke on behalf of her 90k constituents on the basis that there was no political difference on this issue;
- Building of new housing in the Banbury area averaged 3 houses per day and the Horton dealt with one third of all Oxfordshire's Accident & Emergency cases – the Horton's services were necessary to the north of Oxfordshire given also the rise in population;
- She remained anxious for the future of maternity as patient safety was of the utmost importance – 20% of mothers were being transferred from the Midwife - Led Unit (MLU) in the Horton to the John Radcliffe Hospital, Oxford;
- Efforts to re-open the Obstetric Unit had not been taken up by the Trust for over two years. There was a need to probe exactly how the recruitment process was progressing. Those at higher risk were transferring during labour to Northampton/Warwick and Oxford hospitals and enduring a very uncomfortable car journey – and some did not own a car – some areas in her constituency were included in the highest level of deprivation in the area;
- Very concerned regarding travel times – length of journey could be very unpredictable due the heavy traffic, accidents, inclement weather etc. and parking charges high at JR. Results of her travel survey had gleaned 400 responses – average time taken to travel and park was 120 minutes – which would not be a very pleasant experience for women in the final stages in labour;
- She read out some short extracts from some shared experiences from women who had contacted her:
- Lady A - she had stayed two nights in an Oxford hotel, at a high cost, to ensure that she could be close to the JR - she found care was not personal and rather like a 'conveyor belt' – in contrast the MLU at the Horton was very supportive;
- Lady B – birth started as low risk, rushed to JR for a C section in a naked state with the midwife holding the baby's head to avoid death – she got to the JR in time because it was a Sunday morning. It could have been a different outcome in weekday or Saturday traffic. She had serious post trauma issues afterwards as a result;
- Lady C – transferred to JR and on the way haemorrhaged due to retained placenta – this was very uncomfortable – her view that the Horton needed to be a fully functioning hospital as Oxford was too far away;
- Lady D – sent to Oxford after her waters broke. She was told that if she felt like pushing she must pull over and call an ambulance. On arrival there were no beds available at the JR and the delivery suite was full, but she eventually delivered in the suite with 15 minutes to spare. No cots were

available until five hours later. Additional staff had been brought in, including midwives from the Horton.

Victoria Prentis MP concluded by asking the Committee to urge the CCG and the Oxford University Hospitals NHS Foundation Trust (OUH) to 'think outside the box' as Oxford was too far away for Banbury mothers in labour.

Councillor Andrew McHugh, speaking as Cabinet Member for Health, Cherwell District Council (CDC), also for Councillor Barry Wood, Leader of CDC, and also as Chairman of the Oxfordshire Health & Wellbeing Board's Health Improvement Board:

- Wished to pick up on the theme he addressed at the last meeting in relation to the offer CDC had made to the OUH/CCG to assist in the recruitment of neo-natal and midwives at the Horton, this offer had been repeated to Jane Carr, Executive Director of Wellbeing, CDC & South Northamptonshire DC. Whilst it was understood that it was not possible to accept CDC's offers of financial inducements, the offer to become a strategic partner with the Trust to deliver key worker housing and to assist with housing on a temporary or permanent basis in the Banbury area still stood;
- OUH had told him that housing issues were not a factor in relation to the lack of applicants for jobs which was unfortunate as this might have persuaded potentially good candidates to apply.

The Chairman commented that the evidence so far was that whatever the Trust did with regard to the recruitment of obstetricians had not been successful.

Councillor McHugh responded that:

- the evidence pointed to the need to revisit the Trust's recruitment campaign. He understood that the Trust had received welcome news of well - motivated applicants from the African sub - continent. He reminded the Committee that Victoria Prentis MP had promised to help with problems suitable applicants had with visas;
- CDC had also offered to form a partnership with the OUH in the development of key worker housing to be situated in the grounds of the Horton Hospital;
- He pointed out that there were nine other units in the country with less than 2k births and offering an Obstetric service, in similar circumstances to the Horton, of which six had been rated as good and one in Gateshead, with 1,826 births, rated as outstanding. All were able to recruit and retain staff and keep their status;
- Failing to re-open the obstetric unit was counter to Health & Wellbeing Board priorities;
- The relationship between CDC and the trust had improved during the last twelve months. As Chairman of the Community Partnership Network he had worked constructively with his health partners on healthy place making and CDC stood ready to do its part to work with the Trust.

Councillor McHugh was asked what objections the Trust had to date with CDC's proposals for ways in which staff could be attracted to the Horton, given the Trust's lack of enthusiasm to date. He responded that the Trust had rejected the principle of 'golden hellos' to successful applicants because it might then have to look at introducing a bonus scheme which did not necessarily feature as a way forward – Councillor McHugh added that it had been accepted that the Trust was genuinely not able to accept offers financial inducements. However, the offer from CDC to assist with housing still stood and it wished to explore all options. CDC may be able to offer transition housing and it had also looked at operating as a strategic partner to the Trust to develop derelict buildings on the site

The Chairman stated that the Committee would have the opportunity to consider this further at a future meeting.

Councillor Ian Hudspeth spoke as a local member whose boundaries were shared (residents in the Middle Barton area who associated with the Horton General Hospital), as the Leader of Oxfordshire County Council and in his capacity as Chairman of the Oxfordshire Health & Wellbeing Board. A common thread of all these was to provide the best medical facilities as local as possible for residents. He made the following points:

- He personally lived in Bladen which was equidistant from the John Radcliffe and the Horton Hospitals, which was a reason to be looking to support the Horton Hospital to receive the best facilities. As local member he understood that there needed to be more than one central hospital for maternity facilities;
- Just as the Royal Berkshire Hospital attracted people from the south of the county, and the Great Western Hospital attracted people living in Shrivenham, then the Horton attracted people from Warwickshire and South Northamptonshire. The Horton was situated in a clear location to do so;
- There were 25k people coming to live in the north of Oxfordshire by 2021 and 22k in the Didcot area. He suggested that there was a massive pressure on facilities in the John Radcliffe and it was important that, besides providing the best services for the people of Banbury and its environs, consideration be given to provide the best medical facilities elsewhere to relieve that pressure. He therefore asked why consideration could not be given by all system leaders to the relocation of the Horton to a more convenient location, such as on the motorway network, where facilities such as obstetrics could be offered.

Councillor Jacqui Harris addressed the Committee on behalf of Stratford District Council and the residents of Warwickshire. She also spoke on behalf of Rt. Hon. Jeremy Wright MP for Kenilworth and Southam and Nadhim Zahawi MP for Stratford-upon Avon. She asked the Committee to ensure that it continued to take into account the cross – border issues and also kept account of any strategic issues. She pointed out that there had been a silence in respect of Warwickshire issues when the matter had originally been consulted on and referred to the Secretary of State. The Committee had a main core role to scrutinise cross border issues and to ask meaningful, probing and detailed questions of the impact on Warwickshire. She offered her support to this.

She referred to the submissions before the Committee from Warwickshire and asked that it takes up the issues contained in them on behalf of Stratford District Council, or to include the Council in a more collaborative approach.

At the request of the Committee, Cllr Harris undertook to provide the Committee with the statistics in relation to the increase in births of those patients attached to the 6 primary care practices in south Warwickshire and the 9 in the north.

NHS England South (South Central) – Bennet Low, Director of Assurance & Delivery and Frances Fairman, Head of Community. They directed the Committee's attention to the presentation entitled 'NHS England – Reconfiguration Assurance' (attached to the Addenda), which explained NHS England's role, legal framework and key principles and process in relation to Assurance for NHS service change; and the role of the Clinical Senate in service reconfiguration assurance. They thanked the Committee for the questions supplied beforehand, the vast majority of which were not their responsibility to answer. The CCG's role was as clinically - led local commissioners and they were responsible for seeking the answers to questions on options. They identified any options or issues for engagement with NHSE. The NHSE was the regulator, giving initial support in finding best practice and to assure the process. It did not comment on whether the decision was right or wrong, any failings would be around CCG governance. The Senate reviewed the clinical case for the options in an independent way.

Their timeline was variable, from simple 'one-off' meetings with very little to do, to a very lengthy time period (possibly 18 month/2 years) before the CCG would be ready to embark on their consultation. Bennet Low stated that NHSE had completed the assurance of the changes in this process. However, now that the CCG is responsible to the IRP, stage two checkpoint would have to be re-visited after the CCG had been through the senate process. The CCG was aiming for the Board to make the final decision in September. NHSE would then complete its refresh of the whole process to ensure that the CCG had met the time-line they set out.

As a result of a question asking which specific areas of best practice had the NHSE highlighted to the CCG, Bennet Low responded that they usually put areas in touch with similar reconfigurations. They undertook to come back to Committee with specific examples of best practice received.

A member of the Committee asked how the NHSE squared the circle in respect of a reduction in choice (as in the removal of the obstetric service). Their response was that, as part of the stage 2 process, the NHSE wanted the CCG to fully consider the impact of choice in its consideration of the options, as part of their engagement with the public. Tests did not necessarily need to demonstrate an increase in choice – they just needed to consider the impact of choice.

A member pointed out that when revisiting Oxfordshire there was also a need to revisit the full population flow from Warwickshire and Northamptonshire also, together with the impact of what services would remain at the Horton as well as the impact on the John Radcliffe Hospital.

Bennet Low was asked for clarity on the role NHSE had – he responded that it did not have a say in the model, as the CCG was a clinically-led organisation, but it had legal and regulatory duties and could impose legal proceedings if a CCG failed to comply with its legal and statutory duty. He was asked if the NHSE considered it acceptable if the CCG had considered, but then decided that a reduction in choice was the best way forward. Bennet Low responded that the NHSE would look at the way the CCG had considered it, for example, how it had engaged with organisations such as HOSC. It balanced clinical information with the financial aspect of services also. In the interests of patients, NHSE would be looking at the CCG to provide clinically safe and sustainable options for the population – and to have gone through the process - and, where necessary, to engage to bring in the required expertise to create the long list of options.

He was also asked if the NHSE provided advice if a Trust was experiencing recruitment problems – he responded that the OUH was frequently in touch with recruitment advisers.

In response to a question about how NHSE ensure that the independent evidence of its analysis is evaluated effectively? He responded that the Senate and the Royal Colleges were a good way to do this.

Finally, a member asked now that the CCG was in a follow-up to the IRP, what did it say about the NHSE's assurance the first time? They responded that the process was fine for what they were looking at the time, but that process should have been more encompassing of the wider population and cognisant of what the wider options should be.

The Committee AGREED to thank both for their attendance and for the presentation and invited to return to a future Committee when there were proposals on the table in order to provide information on the assurance process.

Lisa Greenhalgh

Told the Committee that during her first pregnancy she had been diagnosed with complications and referred to the John Radcliffe Hospital, although she lived only 5 minutes from the Horton Hospital. She was discharged from the JR and went home. A little later she acted on advice from the John Radcliffe after she experienced a problem, to go to the Horton where she was treated for the problem and given antibiotics.

She was now pregnant again, and had been diagnosed with the same complication, but this time had been informed that it was not an option to give birth at the Horton. The labour had not been scheduled and she was concerned that she would have to allow potentially 40 - 60 minutes to get to Oxford, depending on the time of day, and then 40 minutes to get the car parked. This was not practical in her view.

She had therefore decided to also register to give birth at Brackley Hospital as she could get there quicker and park more easily. Now she was not unsure of what would happen on the day, which caused her some anxiety, it depended on the time of day she went into labour. This had resulted in taking the practical option of making use of the resources of two hospitals in two counties to plan her labour. She had two sets of appointments and two birth plans.

Mary Treadwell O'Connor

Informed the Committee that she had aimed to give birth at the Horton, but her care required that she be transferred by emergency ambulance to the John Radcliffe Hospital. Her experience on arrival had not been as she hoped due to a lack of available equipment being ready and a lack of support for breast feeding, due to staff being very busy. Her postnatal care given at the Horton was positive following her discharge. She attended follow-up care at the John Radcliffe, which, in her view, could have taken place at the Horton.

A mother (anonymous)

Told the Committee that she had given birth to her first child at the Horton in 2014, when consultant care was still available. Her baby had been born by emergency 'c' section and unfortunately was born with her cord around her neck, and was not breathing. It was her view that her daughter potentially would not have been alive if a transfer to the John Radcliffe had been found to be necessary, and if she had not had the support of the obstetrician at the Horton. Her second baby's birth had been at the John Radcliffe, due to her having contracted a temperature. This was not an emergency and her birthing experience had been satisfactory, as was her postnatal care.

Megan Field

Informed the Committee that she had attended the Horton for the birth of her first child at which her pre-natal care had been 'excellent'. However, due to dehydration she had to be transferred to the John Radcliffe at the end of her labour. She questioned why the midwives were not permitted to administer IV fluids at the Horton. The care she received at the John Radcliffe on her arrival and during the birth had been 'excellent', but her post-natal care had not been so good due to staff being so busy. Her second baby had been born at the Horton where she had received 'exceptional' pre-birth and post-birth care. It was her view that the Horton maternity should be consultant – led and that every woman in Oxfordshire should have an opportunity to have a good experience.

Sarah Squires

Described the care she received at the Horton when the hospital was still consultant – led as 'exceptional'. She was thankful for this as her labour was long and she had an emergency forceps delivery. For her second birth she had chosen the nearer Warwick Hospital, rather than the John Radcliffe due to the A34 being risky and her husband did not drive. She travelled to the hospital for pre-natal check-ups by train, which proved costly and she had to take a substantial time off work. Care provided by

Warwick Hospital was ‘good’. As a result of pre - eclampsia she was admitted to the Horton before she was full-term for, safety reasons due to the distance from Warwick Hospital. She underwent an emergency ‘c’ section at the Horton. Her husband arrived in time for the birth, which would not have been possible if she had given birth at Warwick. She concluded by stating her view that, although she was aware of the shortage of obstetricians, she felt that the care of mothers and their babies came first as a necessity.

Clare Hathaway

Told the Committee that her first baby had been born at the Horton and her second at the John Radcliffe. As she was aged over 40 for both she was under the consultant’s care. She pointed out her view that there was now 1 in 25 mothers giving birth over the age of 40 and the demand for consultant care had risen, and was rising. She expressed her concern at the population growth within the Banbury area and also in relation to the length of the journey to the John Radcliffe, which, in her case was never under one hour. Emotionally she felt supported at the Horton, for example, with breast feeding. At the John Radcliffe there had been no support offered. It was her view that efforts in the recruitment of obstetrician recruitment had been ‘insufficient’ and, she felt that as a consequence, negligence case would only increase costs to the NHS, thus causing a false economy.

Beth Hopper

Informed the Committee that, due to health issues, she was referred to the John Radcliffe. It was necessary to attend each time she suffered an episode which proved to be a high cost in relation to travel and parking. At 22 weeks it was necessary to remain in hospital due to the distance being too great from her home. It was her view that long stays in hospital puts one at risk both physically and mentally. When she went into early labour there was no room available for her husband to stay, neither could he get to the hospital in time for the baby’s birth due to the queue in the car park. Due to staff shortages it proved difficult to get food and water.

Unfortunately, her baby daughter died. It took six hours for her to be given another bed in a ward away from new born babies.

It was her view that the distance to the John Radcliffe was too great, and the mother and family experience was not taken into account. Many of her friends had chosen to give birth at Warwick Hospital for these reasons.

Emma Barlow

Told the Committee that, after a ‘perfect’ previous birthing experience at the Horton, her next involved an emergency ‘blue-light’ journey to the John Radcliffe. She was in great pain, positioned on all-fours, with the midwife holding the baby’s head off her cervix, to prevent strangulation. Her partner and family were unable to visit, due to the distance. No support was offered for breastfeeding until 4 days after the birth. She added that she and her partner hoped for other children but she would want a planned ‘C’ section in light of her former experience. She and her partners had also decided to wait until the children were old enough to be left with another family before trying for another child.

The experiences of Sarah Ayre were read out to the Committee

Her first 2 children were born at the Horton which was a 'lovely and easy experience from start to finish'. Both labours were very quick. She had given birth recently to a third child at the John Radcliffe Hospital and her experience had included hours in travelling and parking time (for example, one time it had taken 2 hours and 45 minutes parking time) and it was always busy in the waiting room. She had been blue-lighted to the John Radcliffe at one point in her pregnancy, which had taken 32 minutes in the middle of the day, which was due to her baby's slow heart - beat. Just prior to her delivery date she was found to require consultant care which caused her stress that treatment could not be given closer to home. The stress and anxiety she had felt due to the downgrade of maternity care at the Horton had affected her greatly during her pregnancy and she voiced her concern that women living in the Banbury area might think twice about being checked over at the John Radcliffe.

She cited some cases which 'Keep the Horton General' campaign had documented during the previous IRP investigation, stating that the points made then applied equally well now. She implored the Committee to refer the downgrade once more to the Secretary of State for reversal.

Councillor Eddie Reeves.

Spoke of 'Banburyshire being an inconvenient reality', in that nothing had sufficiently changed which would lead to a permanency of service for mothers. He himself had benefited from treatment given at the Horton, which in his view, gave good service as a local general hospital and he saw no reason why future generations should suffer. It was his view the qualitative experiences, and meaningful evidence of real people should not be ignored by the NHS, and the fact that this had remained a genuine concern for three counties, was important. He added that the centralisation of care was not in the best interests of the patients and he welcomed the recent decision to keep Accident and Emergency and paediatrics in the north of the county. The reinstatement of a full maternity service, to include obstetric care, was also required. Moreover, the risk of having to travel by blue light to an 'increasingly impenetrable John Radcliffe' was, in his opinion, too great. He concluded by stating that this Committee needed to send out a clear message to the CCG and the Trust to consider this and act upon it.

Adjourned for lunch 12.39 pm
Reconvened at 1.15 pm

South Central Ambulance Service NHS Foundation Trust

Mr John Black – SCAS Medical Director and Member of the Trust Board and Mr Ross Cornett – SCAS Oxfordshire Acting Head of Operations attended the meeting.
Barry Richards declared a non-pecuniary interest

Mr Black and Mr Cornett responded to questions:

- Responding to a question about an acceptable transfer time for the waiting ambulance at the Horton to the JR, Mr Cornett advised that the decision would be clinically based on each occasion. The figures the Committee had received did not differentiate between cases transferred under blue - light or not. He added that sometimes speed would not be best for the patient. Mr Black added that the focus was on clinical risk.
- They had looked at the critical incident reporting system for transfers and no significant transfer incidents had been reported for maternity. Asked about incidents involving sub-contractors Mr Black confirmed that in the event of a serious incident it would still come through SCAS. Asked about serious incidents after transfer but due to a delay in transfer Mr Black advised that it was possible that they would not have this information in their figures and that it might be held by OUHT. The Chairman noted that this was a question to ask the Trust.
- Members were reminded of the transfer data included in the CCG paper to the Committee in September.
- Mr Cornett confirmed that based on his experience if the patient was stable and comfortable then it could take 2 hours to transfer to the JR if traffic was bad. However, he stressed that this would only happen where it was clinically appropriate not to transfer under blue - light. Asked whether it was safe Mr Cornett stressed that the panel of clinicians were tried and experienced. He was confident of their ability to make safe judgements on transfers. Mr Black added that transfers were not done in isolation but would involve the midwife.
- Questioned about the impact of the temporary ambulance being withdrawn Mr Black confirmed that the figures they had were door to door. The mean response time for Category 1 calls was 7 minutes.
- Mr Cornett, responding to a comment from a member that they had heard harrowing stories about transfers that the SCAS seemed unaware of, undertook to look into it. Mr Black added that there were numerous ways to raise concerns.
- Mr Black, asked whose decision it would be to withdraw the temporary ambulance replied that OUHT were the commissioners. He would expect SCAS to be involved and there was a very comprehensive modelling process. They wanted all patients to have the best medical care and the services to achieve world class outcomes. They were used to adapting to changing transfer pathways. They worked closely with commissioners and were well aware of the national issues and worked to provide the best use of all resources.

<u>High Steward of Banbury, Sir Tony Baldry</u>

Sir Tony Baldry commented that in recent years by default each County area was tending to have a single general hospital nut that in Oxfordshire the geography was not suitable for that. For centuries Banbury had been a sizeable market town and until mid - 1990's Banbury had been at the centre of its own health area. He stated that it was at least an hour journey time from Banbury to the JR and that taking away the consultant led maternity care took away choice. The choice of a maternity led unit was not a real choice. Given the not insignificant risk of transfer in labour it was not surprising that the numbers choosing the Horton had decreased. He thought it difficult to see that the recommendations of the 2007 review would be overturned. It was about redirecting funding with those living in North Oxfordshire, South

Warwickshire and parts of Northamptonshire at a disadvantage. The maternity services provided would be significantly worse.

Councillor Tony Ilott, Banbury Town Council

Councillor Tony Ilott spoke highlighting the housing growth in the Banbury area and particularly in his Ward of Hardwick. Traffic congestion was not getting better and would be made worse by the numbers of people coming to live in Banbury. He commented on the lack of parking at the JR where it had taken him 20 minutes to find a parking space on a recent visit. People should not be expected to travel for 90 minutes from Banbury to the JR when in pain, frightened and unsure what was going on.

Royal College of Midwives(RCM)

Gabby Dowds - Quinn and Linda Allen

- Commented that any reconfiguration should be robust and evidence based with a focus on evidence based clinical safety.
  - Whilst supporting the temporary closure the RCM had always been concerned at the transfer times to Oxford. If it was possible to achieve the necessary middle grade doctors with training and recruitment, then the Option with 2 obstetric units with an MLU would benefit their work. Otherwise if there was no improvement in recruiting of middle range doctors then Option 6 with a single obstetric unit at the JR was preferable.
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- Noted that the home birth option had been overlooked.
- Referred to the national recruitment picture noting that they were not attracting new people and that older midwives were retiring.
- Commented that staffing needed to be adequately funded and explained how modelling took place using Birth Rate Plus, a recognised national tool. There was no evidence to suggest the ideal size of unit. Some smaller units were successful.
- Explored the role of an MLU by reference to the 2011 and 2013 Birthplace Study. The MLU can be part of the community hub. It is as safe as a hospital-based service but is not suitable for all women. The numbers using the Horton MLU had reduced and there would be publicity to attract its use. There was evidence of greater satisfaction levels with MLUs than traditional labour wards.
- Stated that women need to have a choice based on the best possible evidence and that it be open for them in consultation with their midwives to change their minds at any point.

Gabby Dowds - Quinn and Linda Allen responded to questions:

- Asked about incidents where birth was considered low risk but then at the very last stage complications develop meaning a transfer is necessary Ms Allen that usually there was time to transfer and take action because of the monitoring that takes place.

- On transfers she noted that there was no evidence that transfers had not been done appropriately.
- Responding to a suggestion that recruitment was being controlled to support the argument for closure Gabby indicated that there was no problem recruiting midwives to the MLU at Banbury. It was suggested that it would be helpful to see the West Cumberland model on network staffing.

The Chairman indicated that it was helpful to hear their views first hand and that any information they could provide on the viability of smaller units would be helpful.

Testimonies

The following experiences were read out by Julie Dean:

Dora Miodek

Her pregnancy was high risk and therefore delivered at the John Radcliffe. On the occasion when her waters broke she walked to the train station and then caught the bus on her own. The train was full and she was not offered a seat. It was a ‘very difficult’ experience as she suffered from anxiety issues.

Emma Austin

Gave birth at the John Radcliffe in the evening and it had taken 40 minutes to travel there by car. Had it been in the daytime she would have had her baby in the car. Her baby was in the special baby care unit for 7 weeks. After a week her partner had to go back to work as they could not afford for him to be off work. She had also to take her daughter to school each day. There followed a 90 minute trip for her and her two year old to the John Radcliffe each day to see her baby in the special baby care unit. Some days it would take up to an hour to find a parking space, even with a parking permit. Taking this into account, and the travelling time, and the need to return home by 3pm to pick up her daughter from school, she was only spending approximately two hours a day with her newly born baby. As a result the bonding process was not taking place, and she was unable to feed him his bottle, as times were not conducive. During the two hours she was there, she had to express milk due to him having a milk allergy, but it had proved impossible to express a sufficient amount because she needed to bond more with him, and have skin to skin contact. Her baby then caught sepsis and was in a critical condition within a matter of hours. She nearly lost him and was not able to be at the hospital all the time during this time. It had proved to be a long and traumatic seven weeks. If the baby had been at the Horton she would have been able to spend more time with him, hence to increase the bonding experience and also to spend more time with him when he was so ill.

She had given birth to another baby prematurely in 2016 and he was in the Horton’s special care baby unit. She was very aware, from first - hand experience, of the difference it made to bother her and her baby’s care. She could spend more time with him, they bonded and she was much more emotionally and physically stable.

Lorraine Squire

Had her baby at the John Radcliffe, leaving three children at home. She had experienced a ‘dreadful’ journey home for 40 minutes following her ‘c’ section, ‘which put her back on her recovery’.

Julie Wells

Told the Committee that she had given birth to her first child at the Horton and the care and birthing experience she had received was ‘fantastic’. He had spent the night following the birth in hospital in order for the midwives to be sure her baby was feeding well.

The experience she had in April 2018 with her second birth was very different. During her pregnancy she had experienced anxious thoughts about whether it would be necessary to give birth at the John Radcliffe. At 8 months into her pregnancy her health problems required her to do so. She gave birth to a son at 8 months, who, due to breathing problems was cared for in the special baby care unit. All her family worked, and, as a consequence, her husband was unable to travel to the John Radcliffe, park and then drive back in order to look after their older child. Her husband was only able to visit them on one occasion in 5 days. Despite the ‘very good’ care she received at the John Radcliffe, this resulted in ‘loneliness and depression’. She and her partner were considering having a third child but, as a geriatric mother she would be required to give birth at an alternative hospital. She concluded that it would be ‘a great relief’ to know that the Horton was able to cater for her. Moreover, to receive the care she had in 2014 would make the birth of their final child ‘a true joy’.

Charlotte Bird read out the experiences of **Julie and Daniel Neil** and of **Laura Bourne** that illustrated the difficulties and additional distress caused by a transfer during labour and calling for the retention of a local maternity service.

Taiba Smith

Gave birth at the Horton Hospital in 2014 by emergency caesarean section. She had a positive experience of childbirth and received good care from the midwives who knew her and whom she trusted. The postnatal experience was also good.

It was necessary for her to be under the care of a consultant for her second pregnancy in 2015. Travel to the John Radcliffe was ‘especially traumatic’ as some days the journey had taken over 2 hours which meant her husband had to stay behind to pick up her daughter. It was stressful experience because she was seeing doctors and midwives whom she did not know and had not built up trust in. She lost the baby when she was 6 months pregnant and she had gone through the majority of that experience on her own. She felt that had she received the care closer to home they would have felt differently about the situation looking back. She became resistant to fall pregnant again, the main issue being that she would have to attend appointments on her own due to childcare.

Eventually she became pregnant again and had her second daughter at Warwick Hospital. She paid a high sum for a doula to attend the labour as her birthing partner so as not to leave her daughter without either her husband or herself. This experience affected her and her husband greatly. He had missed out on the scans and appointments for the baby who is not here now.

The downgrade therefore affected their lives both before and after the birth. She had experienced it from both perspectives, from before the downgrade and after. It not only affected expectant mothers but also their families. It was a lonely experience. She also expressed her concern as a long-term taxpayer who was denied the local care she deserved.

Videos

At this point the Committee viewed two videos, one from Victoria Prentis, MP looking at the traffic congestion and parking problems at the JR and the other from Sophie Hammond referring to the care she had received at the Horton when full maternity services had been available and contrasting that with the current situation.

Sophie Hammond

Mrs Hammond referred to her experience when suffering complications during child birth. It had left her with doubts about the care currently available. Child care is a risky business and needs the immediate attention of a qualified team when things go wrong. She stated that since the downgrading of the Horton to an MLU there was mounting evidence that the JR was unable to cope. She referred to a survey where 95% of women responding would prefer to give birth at the Horton if the obstetric unit was restored. She referred to the accounts given by mothers and provided to the Committee and hoped that they provided a damning indictment of the current position and evidence of the betrayal of the health needs of women.

Kayleigh Jayne Carter

Mrs Carter described her experience of using the MLU and JR during problems with her pregnancy, labour and care afterwards. She contrasted the faultless service she had received at the Horton compared to the problems encountered at the JR and commented that the staff at the MLU must find it frustrating to be able to attend only the low risk births.

Nadine Thorne

Mrs Thorne described her experience of the JR and that it had been busy but ok. Her concern had been that her husband after not sleeping for 36 hours had then to go back to Banbury on his own. There had been delays in some aspects of her care including delays in her release due to a lack of midwives but she stressed that generally the care she had received had been ok.

Roseanne Edwards with Kathleen Nunn and Haifa Varju

With Roseanne Edwards two mothers, affected by the downgrade of maternity services at The Horton, related their experiences. The distance made it difficult to receive visitors and one mother had paid for hotel accommodation in Oxford prior to the birth so worried was she about travel to the hospital from Banbury. Mrs Edwards added that she had a dossier of similar experiences that she could refer to the Committee if they wished.

Keith Strangwood

Keith Strangwood, read out a detailed statement from Abigail Smith a mother who during pregnancy had been transferred to the JR from the Horton MLU. Due to a need for monitoring she had been kept in the JR. The staff had been brilliant, but she had seen that they were rushed with missed observations. She had been kept in for some days and then induced. The staff were stretched which had led to failures in some aspects of care including: 24 hours with no food; the time it took for various procedures including the time it took to be stitched following the birth; not being given the chance to see her baby before being moved to the wards. She highlighted the problems for her family of being so far from Banbury. It was difficult to visit and travel and parking costs were greater than to Banbury.

Mr Strangwood questioned where Lou Patten and Dr Bruno Holthof and governors of the Trust were as they were not present to hear the evidence being presented. Mr Strangwood also asked that a decision be reached quicker than next September.

The Chairman, indicated that Catherine Mountford had been attendance all day and that other representatives of the Trust had also attended.

The Chairman read out the statement of Robert Courts MP

Mr Courts was unable to attend the meeting and declared his opposition to the ongoing downgrade of the maternity service to a midwife-led unit (MLU). He therefore requested that a number of points be made for the Committee to take into consideration.

His concern for his constituents living in rural areas who would first go to the Horton Hospital for the immediate help they needed, to then be transferred to the John Radcliffe, should their risk levels increase. He was very much afraid that this would lead to loss of life. He stated that it was imperative that the right services be in the right areas to help those who needed them the most;

His opposition to the permanent downgrade of the Horton MLU status, and given the uncertainty of the Chipping Norton MLU, the Oxfordshire CCG needed to take action to ensure local residents had access to the maternity services they needed.

It was his view that the CCG needed to work with other local authorities to address the recruitment issue, which played a significant role in the challenges currently faced. Moreover, more could be done to recruit medical staff in Oxfordshire as a whole, and the CCG and the Trust must work with Cherwell District Council to try to solve this issue at the Horton, in particular.

Georgina Orchard

Mrs Orchard described the positive experience of having her first baby at The Horton. Ante natal care was a very positive experience.

Vicki Gamble

Due to the requirements for extra tests at the John Radcliffe, she had decided to go to the John Radcliffe for the birth. She was sent home to Banbury but soon after started the journey back to the John Radcliffe when her contractions became regular. She could not let the maternity unit know of her arrival due to the telephone being permanently engaged. Her baby daughter arrived in the car on the hard shoulder of the M40. The ambulance team contacted the hospital to tell them that she was coming in for midwifery attention. The care she received in the delivery suite was good but having her daughter on route was not the safe birth she had planned. She and her husband had chosen the John Radcliffe due to the higher risks and had the risks been realised the situation could have been worse.

Having heard all the first-hand accounts made at the meeting, the Chairman thanked all the speakers, Banbury Town Hall for the accommodation, the Committee Members and Keep the Horton General for encouraging those who came forward to give their testimonies. He also thanked the representatives from the OCGG and the OUH for their attendance throughout the meeting in order to hear the testimonies.

.... in the Chair

Date of signing ....

HORTON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Monday, 25 February 2019 commencing at 10.30 am and finishing at 11.55 am

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	District Councillor Neil Owen Councillor Wallace Redford District Councillor Barry Richards District Councillor Sean Woodcock
Co-opted Members:	Dr Keith Ruddle

Officers:

Whole of meeting	Sam Shepherd and Julie Dean (Resources)

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting together with a schedule of addenda tabled at the meeting and agreed as set out below. Copies of the agenda, reports and schedule are attached to the signed Minutes.

1/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Councillor Sean Gaul, Councillor Kieron Mallon, Councillor Alison Rooke and Councillor Adil Sadygov.

2/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 2)

The Chairman, Councillor Arash Fatemian, declared a personal interest in Agenda item 5 on account of his former employment with Pragma.

3/19 MINUTES
(Agenda No. 3)

The Minutes of the last two meetings held on 26 November 2018 and 19 December 2018 were before the Committee for approval and signature.

It was **AGREED** that the Minutes for 19 December 2018 be carried over to the next meeting on 11 April 2019 for approval, in order that the maximum number of Committee members could be present to agree them.

The Minutes of the meeting held on 26 November 2018 were approved and signed as a correct record. There were no matters arising.

4/19 PETITIONS AND PUBLIC ADDRESS

(Agenda No. 4)

The following request to speak at Agenda Item 5 had been agreed from
Councillor Andrew McHugh – as Cabinet Member for Health and Wellbeing, Cherwell District Council

He re-stated the wish of Cherwell District Council (CDC) to see obstetrics re-established at the Horton Hospital and offered CDC as a strategic partner to work with the Trust and/or the CCG to help ensure that this was achieved.

Councillor McHugh welcomed the Trust's decision to embark on a recruitment programme in South Asia. He had become aware, from a reliable source, that there were a number of highly trained, highly motivated and highly suitable candidates in both nursing and medical roles. He understood that the campaign in South Asia had been focusing almost exclusively on recruiting nursing and midwifery staff. If this was the case, he felt that this might call into question the seriousness of the Trust in trying to recruit doctors for obstetric posts at the Horton. He suggested that the Committee re-visit the commitment of the Trust in relation to this.

He stated that he had attended a stakeholder engagement event, organised by the CCG, concerning options for the Hospital. He felt it was well organised, and was pleased to see that the CCG had taken on board the points raised by Councillor Hudspeth at the 19 December meeting of this Committee. He had suggested that there could be a re-drafting of the catchment areas for the future obstetric service. Councillor McHugh pointed out that the CCG report before the Committee today included CCG projections for additional births based on predicted housing growth. These predictions predicted between 800 and 1600 additional births per year by the year 2031 in an expanded Horton catchment area. He wished to emphasise to the Committee that these projections were based on current District Council projections and did not factor in any additional growth that was likely to come with the Oxford-Cambridge arc. He added that what he thought the projections showed was that it would be possible to establish two mutually supportive obstetric services – one at the Horton and one at the John Radcliffe, sharing the 8.5k (approximate) births per year.

Another point raised at the stakeholder engagement meeting was that the John Radcliffe had spare capacity. He refuted this, pointing out he had understood from reliable sources that the system was under stress, the system that, in order to deal with pressures of demand, had had to close the midwife-led unit at the Horton, in order to redeploy midwives to the John Radcliffe. It was his view that two obstetric units would be able to mutually support each other to balance out the peaks and troughs in demand in the two locations.

He informed the meeting that the purpose of the stakeholder day was to review the criteria by which the various options for obstetrics in Oxfordshire would be compared. There were 14 separate criteria covering domains of quality of care, access, affordability and value for money, workforce and ease of implementation. He pointed out his belief that one domain had been ignored which was deprivation and health inequality. The CCG had responded that health inequalities was covered in the first two domains. He reported that he was unconvinced of this, stating that one of the reasons why he wanted the obstetric service to be maintained at the Horton was in order that a service could be delivered to the women and families of the deprived areas in Banburyshire and West Oxfordshire (he was not disputing that the 11 wards in Oxford and Abingdon were also in the first or second decile for multiple indices of deprivation, but these were within easy reach of the John Radcliffe Hospital. The remaining wards were situated in Banbury). Councillor McHugh reminded the Committee that the link between deprivation and poor health outcomes was clear. Numerous studies had reinforced this link, more specifically in obstetrics, a possible link between deprivation and more severe maternofetal morbidity had been identified in the work of Convers et al, published in the friend journal Gynaecology, Obstetrics and Fertility in April 2012.

He concluded that any future decision on obstetrics across Oxfordshire that did not see the reintroduction of an obstetric service at the Horton would be embedding and formalising health inequalities for the deprived communities of Ruscote and Grimsbury. He believed it essential for openness and transparency that the effect of each of the options before the Committee on deprived communities in Banbury and surrounding area was assessed alongside the other 14 criteria. He requested the Committee to scrutinise this.

5/19 RESPONDING TO THE IRP AND SECRETARY OF STATE RECOMMENDATIONS

(Agenda No. 5)

The Oxfordshire Clinical Commissioning Group (OCCG) and the Oxford University Hospitals Foundation Trust (OUH) were present to report on progress with regard to the following workstreams:

- Travel and Transport
- Clinical Model
- Housing Growth and Population
- Engagement Work – Stakeholder events and Survey

The Chairman welcomed the following representatives to the meeting:

- Louise Patten, Chief Executive, OCCG
- Catherine Mountford, Director of Governance, OCCG
- Ally Green, Head of Communications, OCCG
- Veronica Miller, Clinical Director, Maternity, OUHFT
- Kathy Hall, Director of Strategy, OUHFT
- Professor Meghana Pandit, Medical Director, OUHFT
- Sarah Breton, Head of Maternity Commissioning, OCCG
- Anna Hargrave, South Warwickshire CCG

Louise Patten introduced this item stating that the primary concern of this update was that of the visionary work taking place by Cherwell District Council and the ongoing work of the revised Oxfordshire Health & Wellbeing Board (HWB). The CCG had established a Stakeholder Group which aimed to look at potential need, and what needed to be put in place. Over time, this would be looked at from a local perspective. She reported that the first Stakeholder Group event, which had very recently taken place on 22 February 2019, had been well attended and had been presided over by a neutral Chair. There was a good mix of representatives across the table, including people from Warwickshire and Northamptonshire. It had proved to be a good opportunity to give information, and to discuss the weighting of the criteria, which had previously been shared with this Committee. She undertook to provide more information on the discussions which had taken place, at the next meeting of this Committee.

Ally Green took the Committee through the first part of the report (HHOSC5) which concentrated on the engagement regime (agenda pages 27-30), the two main areas of work being the survey and focus groups and two stakeholder events. The survey, which was due to be launched immediately following this meeting, was to aid understanding of the experiences of women who had used the maternity services since the temporary closure of the obstetric service at the Horton. The stakeholder group was holding two events with the aim of engaging wider stakeholders in the work of the programme. Both events would be facilitated by an independent, external professional who would also write up the reports on each.

Ally Green reported orally on the first event to which some elected members had attended. The second event was planned to take place in June 2019. The purpose of the first event was to consider information, including evidence and data relevant to the criteria, most of which was included within the papers for this Committee. Participants were asked to focus on considering the criteria to be used for addressing options and deciding on a weighting to be applied. The scores from this would be collated and used to finalise the scores for each option. The aim of the second event was to consider the outcomes of the option appraisal.

She further reported that the survey had been launched at the same event, which was an integral part of the programme. The planning of the survey would be undertaken by the OCCG, together with some members of the group who helped appoint the engagement supplier (including Keep the Horton General Campaign Group). Pragma had been the engagement supplier appointed to work on it. There had been many comments on, and feedback given, on the questions to be used for the survey, with a view to their refinement. The areas it covered were;

- The planning of the birth, including the choices available to women;
- The experience of the women during labour;
- The experience of women during post labour; and
- Transport.

She added that the survey would be very detailed and there was a need to get it right for it to be a platform to be tested. Details of the work would be shared with the local media in order to attract as many responses as possible.

Catherine Mountford then took the Committee through the remaining workstreams contained in the paper ie. workstream 4 on activity and population modelling in relation to the size and share of the market (pages 31 – 40): workstream 5c Travel and Access (pages 41 – 65) and the options for obstetric provision (page 67 – 70). This paper was presented to the Committee as a draft for discussion and comments were particularly invited on:

- Were the assumptions about the shift of baseline towards the Horton by geography reasonable? and
- Should other options be modelled?

<u>Questions and Responses received, together with comments from Committee members</u>

- A member commented that it was pleasing to see work on housing growth but asked about the increase in the number of births and sustained housing growth across Oxfordshire. Wouldn't this put another pressure on the John Radcliffe rather than just the Horton? Louise Patten undertook to take this away and to bring a response back to the Committee;

- With regard to pages 31-33, tables 6 and 14 – what are your thoughts about the decline in ambulance response times in Oxfordshire from 79% to 59%? Are you comfortable with this? – Catherine Mountford responded that the statistics were based on calculations of changes in time. The CCG had balanced various factors when arriving at these. She also commented that the CCG was not particularly happy with the decline in ambulance response, but there was a requirement to look at all factors, including the need to provide a safe service;

- In response to a comment that the Trust was prioritising staffing issues over where its patients were, Veronica Miller stated that it was very important to deliver services to those women who were in need of the services. The Trust had been told nationally to try to reach a target of 80% of babies delivered on site. The Trust had improved the numbers of women able to access the service whilst increasing the baby survival rate. She appreciated that the Trust must provide care, but it was more important that delivery was in the right place. The Chairman, in answer to this, asked if the Trust should make travel times longer for the most deprived, or should it find a way to deliver where the most deprived were?

- A member asked if the CCG/Trust were looking to justify their preferred way forward via a survey, in the face of all the harrowing experiences told to the Committee at its meeting on 19 December? Ally Green commented that she understood this point of view because she was aware that increasingly, surveys were being called upon to forge a way forward. However, the IRP had requested that this be undertaken as an exercise in reviewing the problems. The CCG was inviting all women to come forward to tell of their birthing experiences since the Obstetrician Service had ceased at the Horton. What the Committee needed to know was that the results were not as predicted. There was an assumption that many women would not respond to the survey and it had been recognised that there would be a need on the part of the CCG to give extra encouragement to them. In addition to this, Pragma, an independent company who had been appointed to undertake the survey, had been tasked with analysing the outcomes, to ensure confidence in the capturing of the experiences of women. If this was not reached, then there were plans to hold focus groups and/or 1:1 interviews. To add to this, the stakeholder group had requested that some members of the 'Keep the Horton General' Campaign Group look at the survey beforehand in order to make arrangements more robust than previously;

- A member directed the Committee's attention to Table 3, page 46, in relation to Midwife Led Units (MLU). With regard to the Cotswold Unit, the South Central Ambulance Service (SCAS), when they attended the meeting on 19 December, advised the Committee to add a minimum of four minutes to the times if there was not an ambulance on site. This should be reflected in the data. Catherine Mountford stated that this could be reflected going forward – these were statistics from the last few years;

- A member reminded the representatives present that, at the 19 December 2018 Horton HOSC meeting, SCAS were unable to answer the questions relating to patient experience and transfer times because they did not provide the dedicated ambulance at the Horton. A member commented that the figures on ambulance transfer times which compared the Horton to other MLU's was not comparing like with like because of the dedicated ambulance. It was the Committee's view that Category A response times should be shown if the dedicated ambulance was not available. Catherine Mountford responded to say OCCG could present figures which included what the transfer times would be with a usual ambulance. A member stressed the importance of including the practical experience of patients using the ambulances;

- A member commented on the importance of ensuring the capture of experiences of those people who were deprived and difficult to get to groups. Moreover, that the detailed level of responses included in the survey would not just cover Oxfordshire, but the other Local Authorities involved also;

- It was also hoped that reasonable rises in birth rate statistics, up to 2k, to 2031 would be used when the option analysis was reached. Also, when revisiting training status, it would be ensured that the options were flexible enough to allow creative thinking. There were 34 small units across the county, each with less than 2k births. Of these, 10 were using hybrid models and some had retained their training status. In his view, the OUH was capable of sustaining these units. He hoped for a good, objective look. Veronica Miller agreed that a look at all small units was important and Kathy Hall would be including all of those units with smaller birth numbers. She had met with the Royal College of Obstetricians who were exploring a number of different models. In response to a question asking if this would be undertaken by the Trust, Kathy Hall responded that OUH would do the work with the Royal College providing independent guidance, and would bring this back to the Committee an analysis of the list of units which had 2k births or less and their training status.

- A member asked for clarification in relation to the recruitment policy, asking who was the Trust recruiting for, the John Radcliffe or the Horton Hospital; and where were the current post holders working during the closure of the of the Obstetric Services at the Horton? Veronica Miller responded that it was for the Horton, to support the Obstetric Unit and they were currently working at the John Radcliffe Hospital. She stated that she had taken on board the opinion of the Committee that the Trust was advertising for a job that was not there. The Committee felt that this could give the wrong impression, would feed into the narrative and lead to a pre-determined outcome. Kathy Hall stated that previously, Obstetrics were asked to go to other placements for good practice. She also felt that, to have an independent person looking at it was a very good suggestion, and the Trust would be more than happy to do this. She reminded the Committee that this was part of the workstreams not being reported on at this meeting;

- The Chairman queried when the financial analysis would be available. Catherine Mountford stated that this had been a complex piece of work and more information would come to the next meeting;

- A member declared his acceptance that the Trust had a recruitment problem which had led to Obstetrics having to close, but he was still not able to understand how a Trust with an international brand, as the John Radcliffe Hospital had, was unable to recruit to this service. The Oxfordshire Joint Health Overview & Scrutiny Committee (HOSC) at a recent meeting, had heard how the Trust was recruiting nurses from all over the world, why not obstetricians? He had been led to believe that eminently qualified American doctors were wanting to come over to this country to work. He asked if obstetricians would still leave their posts if there was more of a momentum to undertake Trust - based recruitment only? Professor Meghana Pandit responded that Obstetricians faced a very high-density clinical specification and there were more obstetricians dropping out of training than any other clinical specification. She added that the OUH was trying to be as creative as possible in order to attract people to work including a training regime which involved several units, including educational training and clinical support etc. To date the Trust had been unable to appoint 9 or 10 suitable candidates all in one go, which would lead to ongoing recruitment. It had been made clear to candidates that once the Trust got to that number of appointments, then it would enable them to make the transition to their place of employment which would be the Horton;

- In relation to the challenges facing the Trust regarding recruitment, Louise Patten undertook to take a look at the smaller units operating in other parts of the country, in particular at those smaller units in places outside of London. She also referred to the moves from Oxfordshire to be considered for similar London weighting. The Chairman added that, on the other side of the coin, a clinician could very easily live within 5/10 miles of the hospital in places which were cheaper to live. This could be explored. Kathy Hall stated that the Trust was keen to explore all options, including some of the suggestions made by the Committee. She added that the Trust was in conversation with Cherwell District Council and had engaged with the Community Network Partnership giving updates. The Trust did genuinely want to work with all, with a view to engaging the right people with the right skills. The Chairman welcomed this, stating again that it required a bigger shift, rather than relying on the John Radcliffe Hospital branding. He asked Veronica Miller if there was now a sufficiency of staff working at the John Radcliffe to be able to move over to the Horton, to which she replied there were not. He asked if there was a means by which the current obstetricians could have their contracts extended in order to cover work at the Horton (which could lead to a number of births returning to the Horton)? Veronica Miller responded that there was an issue concerning the coverage of obstetric units nationally. The skills of those at the John Radcliffe differed to the skills required the Horton and rotas would be affected – it was an accreditation issue. She added that the Trust was looking to increase the number of doctors training and qualifying in this area, adding that perhaps the John Radcliffe could work at gaining a reputation in the ability to train doctors in this area in order to satisfy the need. Veronica Miller reminded the Committee that this was an issue for the Royal College of Obstetricians & Gynaecology to address, not the Trust. Primarily there was a necessity to provide a safe service. She assured the Committee that the Trust would be exploring and covering all issues and options in its quest to bring the Obstetrician training back at the Horton.

- In response to a question about what numbers were needed if the John Radcliffe and Horton Hospitals was an integrated site, Veronica Miller explained that this needed to be looked at in depth as it was not straightforward, and indeed very complex. Different tiers were involved. She was also asked if two Obstetric Units with no Special Baby Care Unit would be viable. She responded that was not as straightforward as it seemed as there would be a need to look at the statistics in depth. She assured the Committee that this would be covered in depth in the options;

- A member made a plea for flexibility when looking at the ways in which it could be done, in the interests of the patients and public. If there were consultants working at two different sites, it would be about using a number of different methods. The Royal Sussex Hospital Trust, in Brighton was a good example of this. Catherine Mountford responded that the CCG was doing this work and discussions were taking place with the Royal College of Obstetricians and Gynaecologists. She added that one of the options was to ask another provider to undertake it. A provider session with hospitals in Oxfordshire, Northamptonshire and Warwickshire was to be set up to discuss possible models.

The Committee asked if the work which remained still matched with the planned timescale. Catherine Mountford stated that the decision-making meeting was on course to take place in September 2019, but this depended upon the NHS Assurance process. The meeting planned to take place on 11 April could go ahead and confirmation would be given for the 24 June 2019 meeting in due course.

All representatives were thanked for their attendance.

6/19 CHAIRMAN'S REPORT
(Agenda No. 6)

The Chairman’s report was received.

.... in the Chair

Date of signing ....

HORTON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 11 April 2019 commencing at 2.00 pm and finishing at 3.30 pm

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair Councillor Kieron Mallon District Councillor Neil Owen Councillor Wallace Redford District Councillor Barry Richards Councillor Alison Rooke District Councillor Sean Woodcock
Co-opted Members:	Dr Keith Ruddle
Officers:	
Whole of meeting	J. Dean and S. Shepherd (Resources); R. Winkfield (Adult Social Care)

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting and agreed as set out below. Copies of the agenda and reports are attached to the signed Minutes.

7/19 ELECTION OF A DEPUTY CHAIRMAN
(Agenda No. 1)

Councillor Wallace Redford was elected Deputy Chairman of the Committee for the duration of the Municipal year 2018/19.

8/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 2)

Apologies were received from Councillors Sean Gaul and Adil Sadygov.

9/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 3)

There were no declarations of interest submitted.

10/19 MINUTES
(Agenda No. 4)

The Minutes of the meetings held on 19 December 2018 and 25 February 2019 were approved and signed as a correct record (HHOSC4).

There were no matters arising.

11/19 PETITIONS AND PUBLIC ADDRESS
(Agenda No. 5)

The Chairman had agreed a request to address the Committee in relation to Agenda Item 6 from Charlotte Bird, representing ‘Keep the Horton General’ campaign.

12/19 RESPONDING TO THE IRP AND SECRETARY OF STATE RECOMMENDATIONS
(Agenda No. 6)

Prior to consideration of this item the Committee was addressed by Charlotte Bird, from ‘Keep the Horton General’ campaign group (KTHG) who was speaking on behalf of Sophie Hammond also of KTHG.

She informed the Committee that investigations carried out by KTHG had found that, despite the information given to this Committee that hospitals could no longer be registered as a training centre for obstetricians if they had less than 3,500 births per year, this information was false. To date the Group had found other hospitals with births amounting to this figure who were operating with obstetricians. She informed the Committee that KTHG would be offering a paper to the Committee’s next meeting, which would include data on this. It would also be offering viable options for a viable and sustainable unit at the Horton.

The Chairman welcomed the following Health representatives to the Committee:

- Dr Bruno Holthof, Chief Executive, Oxford University Hospitals Foundation Trust (OUH) attending on behalf of Louise Patten, Chief Executive Officer, Oxfordshire Clinical Commissioning Group (OCCG);
- Veronica Miller, Clinical Director, Maternity, OUH
- Kathy Hall, Director of Strategy, OUH
- Catherine Mountford, Director of Governance, OCCG
- Ally Green – Head of Communications, OCCG
- Kate Barker, Deputy Director, Strategy & Planning, Northamptonshire CCG (NCCG)

Survey

Catherine Mountford introduced the report HHOSC6 stating that, in relation to engagement, the largest area to update the Committee on was the survey, which was currently live and open. Ally Green highlighted the following:

- to date 958 women had been surveyed and 450 partners had also completed the section which invited them to give their views;
- Pragma who had been appointed to run the survey were very pleased with this response to date and hoped to reach a thousand respondees in what was a very lengthy survey;
- Three focus groups for women to discuss their experiences had been planned, the first of which had taken place that morning in Wantage and there would be two in Banbury. There had been plans to run a focus group for partners only, but there had been insufficient interest. Instead partners would be involved via a slightly different way which would still be a means of gathering in depth information on their perspective;
- The second event was taking place in June. Information on these events were available on the front page of the OCCG website in date order to encourage use and to raise awareness.

The Chairman asked if there was any information on how many of the people who had responded to the survey lived within the Horton catchment area and how many lived outside of it. Ally Green responded that Pragma was looking at the geographical spread against the baseline and was satisfied that there was a reasonable spread across the geographical area. A member of the Committee stated that some of the invitations had been sent out from GP practices based in South Northamptonshire and Warwickshire. He urged the CCG to ensure that there was a robust response from these areas which would look both ways and similarly from hard to reach areas. Catherine Mountford responded that they had a catch-up call with Pragma the following week to see if there were any additional areas that they needed to focus on to encourage a response – or even to give additional time to. She extended her thanks to KTHG for promoting the survey. Kate Barker also assured the Committee that they were doing all they could to ensure a good response from South Northamptonshire and South Warwickshire - and had sent the letters out from their GP practices in good time. Ally Green added that PRAGMA was monitoring this and, as a result, it had raised concerns about the demographic spread. Fewer Polish and Eastern European communities had responded. To remedy this the CCG had published advertisements in Polish and had sought the help of community workers in Banbury who had gone out to groups to encourage people to respond. Ally Green added that a website link was also available with screening questions.

In response to a question asking if OCCG had a bank of full data, or was everything received added to information which had been gleaned in the past? Ally Green stated that OCCG was not discounting all that had been received over a period of time. She added that the Secretary of State for Health had requested that public opinion be gathered across the area in order for views to be fully understood. Kathy Hall added that OUH had also gathered data on patient experience for various exercises and surveys.

Recruitment

Veronica Miller introduced this section explaining that the staffing required depended upon the size of the service. The John Radcliffe Hospital was a tertiary centre, looking at complex foetal medicine. 15 doctors who were starting out on their training were required, but only 12 were in post. She also highlighted the complexity of this, due to factors such as maternity leave etc. and it rotated frequently. She added that qualified doctors in training had to pass core competencies for the additional skills that were required to do the job. Doctors who had reached year 4 and above were competent to work alone. As they became more experienced by the end of 7 years, they were exposed to more complex cases and thus received more training and additional experience. At the end of year 6 – 7 they undertook specialist training and focused on becoming specialist consultants, which took a further 2 years. Some became specialist consultants, some general consultants. Gynaecology specialists, were requested to attend certain sessions which were speciality – based. Thus, if one was looking at different models of how to run these services there was a need to look at different tiers of staffing. Rules had changed, and doctors no longer undertook shift patterns of the past. The rules for new doctors specified that they had to be compliant with junior doctor conditions of service. This was different for trust grade doctors. Kathy Hall added that workforce modelling would be included as part of the assessment of all options. She told the Committee that the rules had changed since 2016 to ensure compliance with junior doctors' service. Terms and Conditions of Service were expected to be followed.

Comments and questions from Members, and responses received, were as follows:

- A member commented that the IRP advice given in 2018, stipulated that 7 doctors were needed, to the required 9 and currently there were 2 in post, asking what had happened to the other five? – Veronica Miller explained that this accorded with the drop-out rate nationally, which amounted to a 30% attrition rate. The Royal College of Obstetricians and Gynaecology had opened up another entrance level to the profession at stages 3 and 4. This had led to some doctors entering the national trainee scheme at stage 4. Of these, most had taken up consultant posts elsewhere. Also, some had already been working their notice. Kathy Hall pointed out that this breakdown had been provided in a previous paper – and offered to circulate it again.
- A member made a plea to start with a clean sheet, which would very helpful as it was easy to build in a set of assumptions. In a short time, the Committee would be looking at a set of options, together with models and practices elsewhere and innovative practice required a fresh approach. In this respect, it was also important for the Committee to understand the details of different models and practices elsewhere, in relation to clinical viability. This would include, for example, practices at Harrogate and Lancaster;
- A member commented that it had proved helpful to use clinical research fellows as a temporary plugging solution from 2012 for 3 to 4 years. In response to a question about whether this particular option was totally out of the question, Veronica Miller stated that the option of running solely on clinical fellows had been taken off, adding that no details of this were available as they related to the running of academic programmes. However, staffing was being looked at, and different health specialities were also under investigation. She emphasised that this option was not being discounted totally, but in reality, with the numbers in question, running it exclusively with clinical research fellows was not a robust way of

managing it. She added that it was also too difficult to find sufficient numbers of people of the required calibre.

Financial Analysis

Catherine Mountford, in introducing this section of the report, pointed out that the OCCG had both looked at, and noted, that they and OUH had erroneously provided tables showing differing calendar and financial years.

A member commented that valuable data from current and previous years was missing which would have provided a comparison with which to study how far birth rates had dropped and the associated decline in income for the Trust. This had been asked for at a number of occasions by this Committee. Catherine Mountford agreed that there was a need to provide historical information in relation to the commissioning spend for the same period. She undertook to bring those workstreams together for the next meeting of Committee. She clarified that OCCG had presented the Committee with information as the work, based on current activity flows, had been completed on catchment populations and housing growth.

Kathy Hall added that there was a need to show the Committee the difference between specific services in order to give a more complete picture. This would include a breakdown of all the figures.

Dr Holthof stated that OUH wanted to provide an excellent service regardless of the money, adding that skilled professionals across all services in Oxfordshire had a tough time in Oxfordshire. The biggest challenge was how to ensure that enough patients were treated, with insufficient numbers of staff to do so. A member commented that the Committee still needed to be convinced that efforts were being made to make maternity services more attractive at the Horton, for women to feel that they wanted to give birth there.

Option Appraisal Process

Catherine Mountford, in introducing this section of the report which outlined the option appraisal process, emphasised that CCG wanted this to be as open and transparent as possible. She added that weighted scorings would not be the only part of the decision, an engagement exercise would also be undertaken on a written proposal and recommendation. She asked if the Committee would like to look at the engagement exercise.

A member enquired why would the scoring exercise be undertaken without a decision on the weightings? Ally Green explained that the weighting had already been completed at the first stakeholder event in February 2019. The scorings would be collated by an external team and the weightings would be applied afterwards.

A member put forward the view that the manner in which the weighting was determined would then determine the outcome. Catherine Mountford responded that this was the reason why stakeholders were involved in the weighting activity, and OCCG and OUH had not taken part in the activity. Kathy Hall added that this process was based on good practice.

Whilst the Committee agreed with the concept of separating the weighting from the scoring, it felt that this was rife with potential problems, such as it being an invisible process. Somebody had to judge on the process of deciding which was important, how it compared with the others and then to make judgements – and this was not a mechanical art. Judgement would then have to be made on whatever was decided made sense. It also depended upon who put the evidence and data together, there being issues of nuance. It was suggested that this should not be the only process.

Dr Holthof also agreed that whilst separation was good, the weighting process should be both visible and transparent in order to give more confidence on the scoring. Moreover, the weighting would impact on the overall assessment of options. There was thus a need to take another look at the process and on how to resolve the influencing of the weighting. Catherine Mountford **AGREED** to take it away to look at the process and how to share with, and involve the Committee in it. There were 13 categories. She **AGREED** at the request of the Chairman, that once it had been decided about how the weighting process would be undertaken, then this would be shared with the Head of Legal at OCC, Mr Nick Graham, in order to keep the integrity of the process.

The Committee then **AGREED** to request Sam Shepherd to seek independent advice of the possibility of the timing, costs and feasibility of appointing independent consultants to clinically evaluate the options.

With regard to the transparency of the evidence and the scoring, Catherine Mountford reported that these would be published and taken to the stakeholder event and then to the next meeting of this Committee. This would be presented in a formative stage prior to their submission to NHSE to undergo the assurance process. The Chairman requested that there be a transparency about the process, as the Committee had substantial concerns about the option appraisal process. Catherine Mountford responded that the option appraisal was important but was not the only part of the process.

A member asked why the scoring panel had not included any clinical input, to which Catherine Mountford stated that this could be considered as part of the assurance process.

The Chairman stated that a significant amount of work was to be provided at the June meeting, and, in light of the need for this information to be more substantive, he advised Health representatives to consider the Committee's meeting date of the 24 June to be provisional only. There was a strong possibility that the meeting would take place during early to mid - July in order to give sufficient time for a fuller and frank discussion.

Dr Holthof was asked by the Chairman whether he could honestly say that the quality of service provision for women giving birth at the Horton was improved by not having an Obstetric service? He responded that OUH took all decisions on the principles of quality and safety, adding that it was not about money. The Trust wanted to provide a safe service and this was the biggest concern for staff. Veronica Miller added that if the Trust had continued with the numbers of doctors it had, it would have been an unsafe service and a worsened patient experience. Catherine Mountford quoted the three elements of quality as defined by national NHS for quality outcomes which were clinical effectiveness, safety and patient experience.

A member asked if the process of doing the options analysis and the weighting would be fruitless if the workforce options were not sustainable? Kathy Hall responded that the Trust felt it was important to look at the different workforce models to see if there were different ways of doing it.

In response to a question, Kathy Hall confirmed that the options would involve multiple sites. Dr Holthof re-iterated that safety trumped everything else – and it was therefore important that agreement was reached on the options and weighting processes, as money would not enter into it. If safety could be guaranteed, then other options would be looked, if not, then the service at the Horton could not be provided.

The Chairman thanked all for attending.

.... in the Chair

Date of signing ....

HORTON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 4 July 2019 commencing at 2.00 pm and finishing at 4.32 pm

Present:

Voting Members: Councillor Arash Fatemian – in the Chair

Councillor Hannah Banfield
District Councillor Sean Gaul
Councillor Kieron Mallon
District Councillor Neil Owen
Councillor Wallace Redford
Councillor Alison Rooke

Officers:

Whole of meeting: Robert Winkfield, Adult Social Care Strategy Manager; Sam Shepherd, Senior Policy Officer; Martin Dyson, Policy and Performance Officer; sue Whitehead, Law & Governance

The Scrutiny Committee considered the matters, reports and recommendations contained or referred to in the agenda for the meeting [, together with a schedule of addenda tabled at the meeting/the following additional documents:] and agreed as set out below. Copies of the agenda and reports [agenda, reports and schedule/additional documents] are attached to the signed Minutes.

13/19 ELECTION TO CHAIRMAN FOR THE 2019/20 COUNCIL YEAR
(Agenda No. 1)

'It was proposed by Councillor Wallace Redford, seconded by Councillor Kieron Mallon and it was

AGREED: that Councillor Arash Fatemian be elected Chairman for the Municipal Year 2019/20.

14/19 ELECTION TO DEPUTY CHAIRMAN FOR THE 2019/20 COUNCIL YEAR
(Agenda No. 2)

'It was proposed by Councillor Arash Fatemian, seconded by Councillor Kieron Mallon and it was

AGREED: that Councillor Wallace Redford be elected Deputy Chairman for the Municipal Year 2019/20.

15/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 3)

Apologies were received on behalf of Councillor Adil Sadygov, Councillor Sean Woodcock and Dr Keith Ruddle.

16/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE
(Agenda No. 4)

Councillor Arash Fatemian stated that he was a former employee of Pragma but that this had been over 4 years ago.

17/19 MINUTES
(Agenda No. 5)

Subject to the following amendments the Minutes of the meeting held on 11 April 2019 were approved and signed as a correct record:

Page 2 – Minute 12/19. The second paragraph was corrected to reflect that the information referred to had been given not to this Committee but to a separate meeting at St Mary's.

Page 6 2nd paragraph – Reference to Catherine Mountford to be corrected to read Dr Holthof.

18/19 PETITIONS AND PUBLIC ADDRESS
(Agenda No. 6)

Jenny Jones, Keep The Horton General, spoke on behalf of Sophie Hammond referring to the research and subsequent paper that had been submitted to this Committee as an addenda. Ms Jones highlighted page 3 of the papers referring to the example of Furness and Lancaster. The data clearly showed how hybrid rotas are being made to work. Training accreditation had been awarded trust wide rather than to the individual hospitals

She was encouraged that OUH had welcome the paper. Ms Jones was Further encouraged that using international agencies was being considered. Ms Jones addressed the concerns and obstacles referred to in the OUH paper.

19/19 RESPONDING TO THE IRP AND SECRETARY OF STATE RECOMMENDATIONS
(Agenda No. 7)

At the last Meeting, the Joint Committee asked Oxfordshire Clinical Commissioning Group (OCCG) and the Oxford University Hospitals Foundation Trust (OUHFT) to report back, in line with their timetable on the progress with the following information for consideration at this Meeting:

(a) Report on the survey conducted (independent consultant, Pragma to present);

(b) Workforce Analysis;
(c) Financial Analysis;
(d) Options Appraisal and Outcome;
(e) Review of small units;
(f) Next steps

The following attendees were present: Anna Hargrave, South Northants OCCG; Rosalie Wright; Lou Patten, OCCG; Catherine Mountford, CCG; Ally Green, OCCG; Veronica Miller, OUH; Kathy Hall, OUH; Sarah Breton, OCCG; Helen Mills, Pragma and a further representative of Pragma.

(a) Helen Mills introduced the report on the survey detailing the methodology used in the research.

Ally Green highlighted comparisons and detailed the statistics within the paper setting out the conclusions drawn. Ms Mills added that overall anxiety for mothers to be peaked during labour and giving birth. Reference was made to the 2016 Review and the hierarchy of improvements that matched their own work. The priorities matched the improvements suggested by the focus groups and interviews. Issues around parking were coming through strongly.

Ms Mills went on to refer to the position with regard to The Horton. Before the changes locally it had been the default choice. The closure had increased anxiety with families weighing up the fact of using the Midwife Led Unit at The Horton against the distance to the John Radcliffe Hospital.

Representatives responded to questions from Members:

- The quantitative data presented was truly robust. Where qualitative data was included the quotes were chosen to represent the points made. Referring to the word bubbles on page 30 of the report Members noted that the word ‘Care’ could be taken in two ways. It was accepted that some interpretation of the qualitative data was necessary.
- Responding to points that the vast majority of women in the local area would choose The Horton if there was an obstetrics unit available Ms Mountford caveated the information available. It was true for certain areas and when breaking it down it was necessary to be cautious as the numbers may be at low levels.
- Asked to distil their perspective on the work done Ms Mountford stated that the maternity experience was very individual. The changes at The Horton had impacted differently at different stages of pregnancy. Decision-making was impacted. Anxiety around the decision-making had increased.
- The research was a unique opportunity to be able to survey people following the changes but before the final decision was made. It would be helpful going forward.
- Asked about the impact of mother’s anxiety on the unborn child members were advised that the issue of anxiety was taken very seriously, and the Trust was supportive.

During discussion members considered the information provided and expressed concern at the spikes in anxiety levels for pregnant women evidenced in the research. The Chairman in noting the anxiety levels stated that the Committee remained to be convinced that outcomes could be used as a measure of success.

(b) Veronica Miller and Rosalie Wright introduced the paper setting out the workforce analysis.

Representatives responded to questions:

- OUH offered rotations to staff and considered where staff wanted to work. There were some keen to work at The Horton. At the moment there were less opportunities to work in the North of the County due to the lower number of births.
- Asked about their response to the offer from Cherwell District Council (CDC) to discuss key worker housing Ms Hall stated that they were willing ready and open to working with CDC. T was a question of waiting for planned developments to take place.
- Ms Mountford explained that in terms of staffing numbers they had taken the best model for Option Ob9. This was a delivery model option rather than straight staffing.
- Responding to the query from Jenny Jones that KTHG be invited to the RCOG event Kathy Hall indicated that it was not in their gift but that they would ask on their behalf.
- A member sought assurances that the very best processes to secure successful recruitment were being employed including the use of professional consultancy where appropriate. He referred to a successful NHS Conference in Manchester with several consultancies. The Committee was advised of the range of approaches being used. It was suggested by the Chairman that the member share with Sam Shepherd the details of the successful recruitements

As a result of questions on what additional staffing would be needed for the hybrid model there was a short adjournment for more detailed information to be provided. It was stressed that this detailed information was publicly available and the paper to the Committee had sought to draw out the main points.

During discussion of the additional information Veronica Miller advised that more staff were needed to run a rota across two sites in an integrated staffing model than was needed to run two sites independently of one another. Kathy Hall added that a rota which just works for the smaller unit was better than using a rota across the trust as a whole. After lengthy discussion of the numbers involved Lou Patten recognising that the method of displaying the information was currently not clear undertook to make the information clearer and to circulate it between meetings.

(d) Catherine Mountford introduced the Options Appraisal and Outcome paper highlighting the 2 options that they saw as being better than any others and worth taking forward.

During discussion the Chairman suggested that the top 4 were worth taking forward. The Chairman expressed disappointment that the Committee had not been included in the weighting process as had been agreed. He further expressed disappointment that it had been agreed to keep them blind but to share them with Nick Graham, as the County Council's Monitoring Officer. This was not done before the scoring and did not encourage a feeling that there was transparency or engender trust. The Chairman was not suggesting that they had been changed and Catherine Mountford apologised that they had been sent late but that they had not seen them until after the event. Ms Mountford added that two units and options 11 and 10 were not mutually exclusive.

(e) Sarah Breton introduced the work on small units. Ms Breton highlighted that where there were successful small units there were two small units in an area. Oxfordshire was very different having one unit having a very large number of births and any second unit having possibly a very small number of births. They had made contact with Furness with a view to a visit. The Chairman suggested that if the decision was taken to fully back two units then the smaller unit would be able to broaden its catchment and be not so small.

(c) Ms Mountford presented the contents of the finance paper. The Chairman queried whether it was possible to index the figures given the birth rate changes. Ms Mountford replied that there had been massive changes I the way figures were collated. The Chairman stressed that that proportionality was not sufficient, and he would like to see like for like figures to be able to understand the potential loss of income. Ninety-seven percent of mother to be in South Northants would have chosen The Horton and that would bring in income. Lou Patten undertook to see what it was possible to do.

Following consideration of each of the papers the Committee considered next steps. It was **AGREED**:

(a) To note the work completed and the outcome of the option appraisal process;
(b) Note that OCCG and OUH will be working on pulling together the findings from the Horton HOSC workstreams and any additional information into papers for the CCG meeting in September
(c) that the Horton HOSC arrange a date significantly in advance of the CCG Board paper
(d) that representatives of other small obstetric units be invited to attend the Committee, to give evidence of how they work to achieve their aims and retain their training accreditation, at a date to be arranged but in sufficient time for any findings to be considered as part of the OCCG meeting.

20/19 **CHAIRMAN'S REPORT**
(Agenda No. 8)

The Chairman's report was noted and the information considered as part of the previous item.

.... in the Chair

Date of signing 2019

HORTON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

MINUTES of the meeting held on Thursday, 19 September 2019 commencing at 6.15 pm and finishing at 8.58 pm

Present:

Voting Members: Councillor Arash Fatemian – in the Chair

Councillor Hannah Banfield
Councillor Rebecca Breese (replacing Councillor Adil Sadygov)
District Councillor Sean Gaul
Councillor Kieron Mallon
District Councillor Neil Owen
Councillor Wallace Redford
Councillor Sean Woodcock

Co-opted Members: Dr Keith Ruddle

Officers:

Whole of meeting: Robert Winkfield, Adult Social care Strategy Manager; Sam Shepherd, Senior Policy Officer; Sue Whitehead, Law & Governance

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21/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS
(Agenda No. 1)

Apologies were received from Councillor Alison Rooke and Councillor Adil Sadygov (Councillor Rebecca Breese substituting).

22/19 MINUTES
(Agenda No. 3)

Subject to the following corrections the Minutes of the meeting held on 4 July 2019 were approved and signed as a correct record:

Page 3 - Jessica Williams to be added as the further Pragma representative referred to amongst the attendees.

Page 3, Item (a) 2nd paragraph – Reference to 'Ally Green' to be corrected to read 'Jessica Williams'.

Page 3, Item (a) 3rd paragraph – Second sentence to be amended to read: 'Data indicated that the closure had led to higher levels of anxiety in the Horton General catchment area with families weighing up the fact of using the Midwife Led Unit at The Horton against the distance to the John Radcliffe Hospital.'

Page 3, Item (a) second bullet point – Reference to 'Ms Mountford corrected to read 'Ms Mills'.

Page 3, Item (a) third bullet point – Fourth sentence to be corrected to read: 'Anxiety around the decision-making was higher in the Horton General Hospital catchment.

23/19 PETITIONS AND PUBLIC ADDRESS
(Agenda No. 4)

The Chairman had agreed the following requests to address the meeting:

Victoria Prentis MP
Cllr Eddie Reeves
Rt Hon Sir Tony Baldry DL
Cllr Andrew McHugh
Cllr Rosie Herring - SNC
Cllrs Jacqui Harris – SDC (did not attend)
Keith Strangwood, Chairman KTHG

Victoria Prentis MP

Victoria Prentis MP thanked the members of the Committee for their efforts and thanked mothers for their powerful evidence to the Committee.

Speaking for the whole area Victoria Prentis MP stated that they were furious at the recommendations but would not give up. Needs in the area had not diminished since 2008 and there had been population growth and increased traffic congestion. It was not that local people distrusted the service offered at Oxford but simply that it was too far away. She expressed shock that her traffic survey was the only one available and highlighted the experience of people travelling on average 1 hour 40 minutes to The John Radcliffe Hospital (JR) whilst in labour.

Victoria Prentis MP was encouraged by the suggestion of an annual review (chaired by herself) and by discussions on working together to apply for funding for essential rebuilding. She expressed her displeasure that over the last three years no applications had been made.

Councillor Eddie Reeves

Councillor Eddie Reeves, County Councillor for Banbury Calthorpe, which included the Horton Hospital, stated that this was the fourth time he had spoken in the last two years and there had not been a lot of change in that time. The de facto downgrading of The Horton was on the cards. The public consultation given the manner of it was consultation only in a very elastic sense. What remained as a fact was the geography of the area. The Committee had heard the harrowing testimonies in December and Councillor Reeves felt that the OCCG and OUHT had not engaged meaningfully with the evidence. The cynicism felt by local people due to past experience had not been addressed.
Local people believed that poor administrative decisions were being presented as good clinical decisions. He asked that no-one be under any illusion about the strength of feeling. It had not abated.

Sir Tony Baldry DL

Sir Tony Baldry DL, speaking against the recommendations made a number of points:

- He urged the Committee to refer the decision back to the Independent Reconfiguration Panel. He referred back to the decision of the Independent Reconfiguration Panel in 2008 which had not supported the Trust's proposals to reconfigure paediatric, gynaecological and obstetric services because they failed to provide an accessible or improved service for local people. Since then nothing had changed except the growth in the population in the area.
- He questioned what type of provision the Horton Hospital was now providing. Was it a general hospital or a hospital at all or was it just a random collection of services. In 2008 it had been described as a General Hospital but looking now it would not necessarily be considered the case. He asked the Trust and OCCG to set out the vision for the Hospital and the services to be provided.
- In not applying for funds during this period the local community were effectively being punished for their opposition to the proposals.

Councillor Andrew McHugh

Councillor Andrew McHugh, Cherwell District Councillor for Adderbury, Bloxham and Bodicote, expressed his devastation at the recommendations set out in the paper to the OCCG Board on 26 September 2019. He had been hoping that the change in Leadership in OCCG and OUH would have led to break in the Oxford centric approach and the start of place-based services.

As a member of Cherwell District Council executive and the Oxfordshire Health and Well-Being Board he had been pleased to work with the Trust and with the CCG in order to help secure the health system that I, and the vast majority of North Oxfordshire and surrounding district residents, feel we need. At the Cherwell Community Partnership Network, the CCG had spoken of its 'Population Health and Care Needs Framework'. This document outlined the way in which the CCG would engage with communities to identify population health and care needs now and in the future. It talks about an approach that is open and transparent with high levels of engagement to develop future models of care to meet identified need.

Mr McHugh stated that he had embraced this Framework in good faith. At times, he had felt uneasy with what I was being asked to do. He took part in the scoring panel for the options appraisal for Horton obstetrics. I was uneasy because if as part of the scoring panel, it was shown that having two obstetric departments was unfeasible, he would be seen as guilty of finishing off Horton Obstetrics. He had been surprised and delighted when the weighted scores of the scoring panel showed option 9- two separate obstetric departments, one at the Horton, one at the JR to be the best option, albeit by a narrow margin.

With regard to difficulties in recruitment Councillor McHugh stated that the Trust had told him that the presence of the KTHG banners around Banbury had created a negative impression that resulted in some good candidates choosing not to proceed with their application following a site visit. If this is the case that could have been easily remedied by the Trust and the CCG announcing their newfound faith and confidence in the two obstetric department option. If that had been announced, it would have been very easy to create the right "civic atmosphere" to attract the brightest and the best. Councillor McHugh announced concern at the open-ended nature that the proposals for maternity at the Horton were for the foreseeable future. At the very least the decision needed to be revisited on an annual basis.

Councillor McHugh added that the CCG paper talked about developing a plan for the Horton including flexible clinical space that could possibly be used for obstetric services as well as other services. He was pleased to report that he had this afternoon, seen some evidence of The OUH starting to move towards meeting that commitment.

If the trust of the people of Banburyshire was to be rebuilt evidence of good faith was needed. Dates, plans, contracts tendered, work started were required.

Whilst welcoming the offer of a redeveloped Horton he would continue to fight to ensure that obstetrics are a part of that redevelopment.

Councillor Rosie Herring

Councillor Rosie Herring, South Northamptonshire District Councillor for Danvers and Wardoun expressed disappointment but not surprise at the recommendations in the paper. She welcomed that the door had been left open for services to resume at some time in the future. The Horton Hospital wa an asset for the whole Trust. Councillor Herring referred to the opportunities in place for mothers to visit the JR in advance of their labour, but this service was massively oversubscribed. The hot line referred to should go further with a holding site available for mothers to come in early. Councillor Herring welcomed the facilities making it possible for fathers to stay but there was a need to put provision in place so that they were not expected to drive home, with mother and baby once discharged unless fit to do so.

There was no reference to the ambulance currently sited at the Horton in case of emergency transfer being retained and she assurance on this point.

Councillor Herring welcomed recommendations 6 and 7 but queried who would monitor this. It should be part of someone's job description to monitor and report regularly to the Oxfordshire Joint Health Overview & Scrutiny Committee. In addition the engagement with mother's should be an ongoing commitment.

Keith Strangwood

Keith Strangwood, Chairman of the Keep the Horton General (KTHG) commented that the contents of the report were expected.

Referring to the report detail Mr Strangwood:

- Stated that the annex quoted 46 midwifes were needed to reopen unit. The unit was previously being run by 29 in total at 5 per shift. not the 46 that the report states are needed. This was confirmed by a ex midwife at time of temporary closure
- Noted that refurbishment of the maternity block is quoted in the report at a cost of £17.1 million. Yet in December 2018, a GK condition report requested by the OUH quoted £10.3 million for the whole Horton site, with the maternity block part costing £1.3 million. At a CPN meeting in June 2015 Paul Brenan ex OUHFT confirmed that if the SOSH/HHOSC decided Obstetrics had to be returned, the finances would be found to do so.
- Stated the report also quoted that obstetrics at the Horton would cost £9.463.357 per annum to supply. When the unit was running prior to closing in 2016. it was costing £2.3 million PA. The report also stated that only a MLU service would currently cost £2.6 million, £300k more than the full Obstetrics unit was costing in 2016
- Queried the level of estimated births if a Obstetrics unit was returned to Horton (1060 per year as set out in the annex table 7). He commented that in the last year of a full Obstetrics service Horton delivered 1466 babies.
- Highlighted that from the figures quoted for overall births there is a decrease of around 500 overall, choosing to give birth at neighbouring trusts. This constitutes a f loss of income to the OCCG.

In addition, Mr Strangwood noted the importance of the reinstatement of the training accreditation to reinstating Obstetrics at the Horton.

Mr Strangwood argued that the data needed to be independently verified before being presented to the OCCG Board. He noted that having always been told that it was not about money that now seemed to be the main point.

Mr Strangwood thanked the Horton HOSC for their work and suggested that the matter must again be referred to the Secretary of State for Health requesting a full Independent Reconfiguration panel review. The report stated that since the downgrade of Horton to MLU, it had been proven to provide safe quality services overall. He referred to specific examples where the people involved would not agree.

24/19 RESPONDING TO THE IRP AND SECRETARY OF STATE RECOMMENDATIONS
(Agenda No. 5)

The Committee had before them the report to the OCCG Board on 26 September 2019 and supporting appendices.

The following attendees were at the table: Lou Patten, Chief Executive OCCG; Dr Bruno Holthof, Chief Executive OUH and Professor Meghana Pandit, Medical Director, OUH. In addition, Veronica Miller, OUH and Catherine Mountford, OCCG came to the table to respond to specific points made.

The following statements were made and are set out in full:

Lou Patten

'At the start of this programme the IRP asked OCCG to do three things:

1. To fully understand current and future demand for maternity services, taking into account housing/population growth across the wider area of north Oxfordshire, south Northamptonshire and south Warwickshire.
2. To take a fresh look at the options, to thoroughly review the options previously included and to include any additional options identified.
3. To clarify any potential co-dependencies of services linked to obstetrics at the Horton.

In delivering this programme we have worked with stakeholders including those from north Oxfordshire, south Warwickshire and south Northamptonshire. We have been open and shared information publicly at every stage. We set out our plan at the outset, agreed by the Joint HOSC, and have reported progress at every one of your seven previous meetings.

The process has been thorough and complicated at times as we have got into the complex detail of staffing models, recruitment, patient experience, clinical safety and national guidance.

OCCG have received written confirmation from NHSEI that they are assured that the process we have followed has delivered what was asked of us and this letter is published on OCCG website.

We have seen the JHOSC Chair's addendum in response to our published Board paper and note several areas that require clarification or correction; whilst we may have the opportunity to go through this today, we have prepared a written response that will be passed to the Chair today and made available on our public website on Friday morning.

Most importantly, I need to ask that one particular point is retracted immediately about smaller hospitals that suggested other hospitals might lie or stretch the truth. I don't believe this was accurately reported.

Oxfordshire Clinical Commissioning Group understands the recommendation set out in our Board paper will be hugely disappointing for all those who want to see obstetrics return to the Horton. However, although a recommendation has been made, a final decision is still to be discussed and made by the OCCG Board on 26 September.

It is really important for the JHOSC to note that the recommended option if agreed will be a very different decision to that taken by the CCG Board in 2016. There are a number of differences that I wish to point out.

- In March 2018 the CCG Board overturned the decision to consult on the removal of A&E and Paediatrics; these services will stay at the Horton. System Leaders agreed that the Horton provides a significant suite of services to the people of Banbury & surrounding areas and that this was to be built on rather than taken away. We continue our commitment to building a strong future for the Horton General Hospital.
- Another key difference is that this recommendation to the OCCG Board is not for a permanent closure of obstetrics. The recommendation is that at this point in time, because of the balance of the sustainability and therefore clinical safety, the recommendation has to be to maintain closure at present.
- I wish to remind JHOSC members that we have set in stone with the HWB, supported by the Oxfordshire HOSC, a process for reviewing our population health and care needs at regular intervals, so that this decision can be reviewed if critical factors change.
- How can such critical factors change?
    - Well, in terms of the current birth rate, whilst it is dropping at present, it may well increase with the proposed housing developments. We need to watch this carefully, together.
    - In terms of changes to recruitment and retention, our learning from this process is that the current state of the Horton estate does not lend itself to encouraging clinicians to work there. Having a hospital that is fit for purpose would significantly enhance our opportunities to encourage staff to come and work here, and – regardless of the Board decision, we must unite our voices in asking for significant capital investment to ensure we have flexible clinical space that is fit for the 21st century.
    - National changes to training could result in an increase in in the number of qualified obstetricians in the country.
    - In the event of any of these factors changing, then together, as part of an integrated health and care partnership (for which we have been officially recognised) we can review this decision as that may be enough to tip the balance in favour of a more sustainable service being delivered.

We understand the frustrations, but I want to finish by stating that we have learnt much from this engagement experience. We believe it has been a robust, open and transparent process which has gathered a wide range of information, views and feedback from the people who matter most. We are keen to ensure we continue an open and ongoing dialogue with local stakeholders about health needs and local services in the future.'

Professor Meghana Pandit

'I have been asked to share my clinical perspective and be available to answer questions particularly on clinical outcomes, safety and medical staffing

- I want to start by reassuring everyone that providing a clinically safe service for patients is the Trust's number 1 priority. Our experience of running the single obstetric model over the past two years, demonstrates that this service can be run safely and sustainably. The CQC rated our service good in their report early this year.

- Clinical outcomes are improving: The number of still births has fallen every year since 2016 as a percentage of births. The number of babies with poor outcomes (moderate to severe brain damage) has also steadily fallen.

- Whilst the patient feedback during this process has given us very valuable input on where our service needs to improve, it is also positive overall about the care our patients receive – including women from this area.

- Cherwell residents were particularly positive about ante-natal care, a good proportion of which is delivered from the Horton. For example, over half of women have had scans and bloods at the Horton and we operate a range of antenatal and postnatal clinics here such as perinatal mental health and breast feeding support.

<u>On the two obstetric unit model:</u>

- As you have heard before and can see from the paper, the NHS faces ongoing and severe workforce challenges, nationally and locally, in obstetrics, anaesthetics and neo-natal nursing.
- Staffing clinical rotas in line with rules – rightly in place to ensure patient and staff safety – is complex and challenging.
- I hope Members will see from the papers we have looked hard at options to address these challenges. But we cannot be certain of success and we would need support from other organisations to deliver, which may not be forthcoming.
- Therefore, even with these mitigations, we remain highly concerned that we could not sustainably staff the required rotas for a Horton obstetrics unit and therefore could not guarantee to run a safe service for patients.

<u>On a single obstetric model</u>

- As I said at the start, we feel confident that the single obstetric model can provide a safe, sustainable service, given present challenges. However, we recognise the negative impact on patient choice and experience for women in this area that have been raised through this process.
- Patient stories that were heard as part of this process were difficult to hear, as some of them were so far from the experience we would all want to have. We are grateful to the women and their families who have shared their stories and we found the patient survey to be immensely valuable. We are very committed to acting on feedback to improve services.
- Our suggested actions on the single obstetric unit model around increasing the amount of ante-natal and post-natal care at the Horton; improving patient

information; and doing what we can to improve access to the John Radcliffe site are based on this feedback.
- But, if the CCG's recommendation is accepted, we would do everything we can to work with local partners such as Maternity Voices, women and their partners to minimise any negative impacts from the longer distance to travel.

I want to reassure people that the Trust's absolute top priority is to ensure a safe service for all our patients.

Dr Bruno Holthof

'Thank members of the committee and the people in the trust and CCG who have worked hard behind the scenes. I want to thank particularly the clinicians who have worked on this project.

- I know people locally will be disappointed by the CCG's recommendation. I am also disappointed. We don't have enough anaesthetists, band 5 nurses and workforce is, after clinical safety, our number one priority.
- We have a new Prime Minister and new Secretary of State who have committed funding for hospitals. We as a trust are committed to rebuilding the Horton. It is important that we work with the local community to agree what services and buildings we want at the Horton. We have committed to expanding the emergency department, increasing the scanning, more day cases and other services.
- While legal proceedings were on going, we were advised not to apply for funding but since those were concluded we have applied for funding. We will shortly appoint advisors to work with us on this.
- I confirm that as I have said to this Committee before and as our Medical Director has just said, providing a clinically safe service is my number one priority.
- I note the CCG's recommendation that this decision would be for the foreseeable future and should be reviewed if circumstances (birth rate, workforce availability, capital availability) change.
- I hope people will acknowledge that the Trust with the CCG has put in a lot of time and effort to this process, exploring all the options. We are grateful for all the ideas and challenge from the HOSC and local community and campaign groups, which have encouraged us to look at different models.
- Whatever decision the CCG Board makes, the Trust is committed to working with local partners and the community to make our maternity services as good as possible for our patients.
- I want to talk more broadly about the Horton General Hospital. It is a hugely important part of Oxford University Hospitals and we want to invest in its future – working with the community. We really value the way that the Horton is treasured by the local residents of what is sometimes known as 'Banburyshire'.
- We share your desire to see expansion of the services that we provide here and to improve or rebuild buildings. New facilities will help give certainty to staff and the community on our commitment to the Horton – and should help improve recruitment and retention.
- The Trust is keen to press ahead with developing a masterplan for the Horton site and to make a compelling business case to government for significant

capital investment in the Horton. We hope we will have the community's support and engagement in doing that.

- Our local MP and local Cherwell councillors – Councillor Wood and Councillor McHugh - have made it clear to us they wish to see tangible actions to demonstrate our commitment. The Trust will therefore immediately proceed with initial phases of master planning the Horton site at our own cost. Expert external advisors will be appointed to support us on this by the end of September.
- We will be keen to arrange an early meeting between the Trust, local system leaders and our advisors to ensure we are capturing local aspirations for the site from the start of the process.
- And, if the CCG Board accepts the recommendation, we will build in flexibility so that an obstetric unit can be opened at the Horton in the future if circumstances demand.'

Dr Holthof, responding to a point made by the speakers about lack of application for funding confirmed that they had been advised that they would be unsuccessful whilst there were on-going legal proceedings. Once ended they had applied.

Councillor Arash Fatemian thanked Lou Patten, Professor Pandit and Dr Holthof for their opening statements. Responding to the request made by Lou Patten to retract the statement in his addenda as referred to in her statement above the Chairman stated that that was his current understanding, but he was happy to discuss outside the meeting and to retract the comment if proved in error.

The Chairman in his opening remarks referred to the possible position in 2 years' time where needs have changed, and a growing demand meant that there was a wish to reinstate maternity services. The process to scope and apply for funding would be lengthy. He feared that it would be similar to the position with Wantage Community Hospital and that the concept of only closing for the foreseeable future not being permanent did not stack up. Responding Lou Patten stressed that the current proposals were very different to permanent closure. The position would be modelled on a regular basis. They would work proactively to redevelop the Horton and it was still a working hospital. It would continue to have its services reviewed for the needs of the population.

Councillor Fatemian referred to the meeting of Oxfordshire Joint Health Overview & Scrutiny Committee and comments made there by Dr Holthof in relation to the PET CT scanner item. The Chairman stated that Dr Holthof had commented that the Trust did not see accessibility as an issue of quality and that access was not an important factor. Dr Holthof responded that the Trust strategy was about endorsing the place-based model and they would endorse any initiative that ensured people were diagnosed and treated locally. They were committed to keeping patients as local as possible and were developing new strategies including using new technologies to achieve this.

Representatives responded to questions from Members:

- Asked what population growth in numbers or percentage would trigger the reinstatement of services Lou Patten advised that it was not a simple question of numbers but a complex issue. Growth would be cross referenced with local complexity with factors such as maternity flows, local demographics and workforce

issues. On demographic issues they were able to track patients using registered patient lists in order to map demographic trends. She referred to the suggestion that the position would be looked at on a regular basis. The Chairman commented that if there was not clarity on the criteria it would not rebuild trust.
- Responding to the point that by encouraging mothers to go to Warwick or Gloucester it was perpetuating the reason (of low birth numbers) for closure Lou Patten explained that this was something that could be tracked.
- It was confirmed that the current ambulance at the Horton in case of emergency would be retained if the proposals were accepted.

During discussion Members made the following points:

- A member commented that it was a good piece of work by the Trust looking at the population projections. However even with higher numbers it seemed to him that the trigger point had to be the ability to have a sustainable workforce.
- A member highlighted that the piece of work undertaken by Pragma had been impressive. It was a substantial piece of work that was not mentioned in the main paper to the OCCG Board.
- A co-opted member (who had no vote on this Committee) who had been part of the Stakeholder Group looking at options scoring commented that it was regrettable that he had not seen the weighting nor how they were applied. The criteria had been presented to them by OCC. He expressed some concern that it was possible depending on the criteria and weighting to build in bias. It was an important issue when relying on the type of scoring used with an option coming out on top but not doing it based on deliverability and workforce issues. Lou Patten replied that they had used best practice and had been supported by the Consultation Institute. The weighting had been sent to Councillor Fatemian, to Nick Graham, Monitoring officer and published on the web site. The intention was to reduce the options to take forward. There had been two options everyone had agreed were worth taking forward and then the next stage was safety and sustainability. The Chairman stated that in his view information had not been shared as agreed. Lou Patten disagreed.
- A member highlighted the prominence of cost and deliverability in the report. He had been on the Committee since it had begun and costs had not featured since the initial discussion due to the difficulty in getting answers to financial questions. It was troubling to find out the cost implications at this late stage and it was suggested that this revealed the agenda that lay behind the proposals. In response Dr Holthof stressed that safety was the key driver over finance. Cost was one of the criteria and they had looked at cost rather than revenue. Lou Patten added that OCCG had a responsibility to consider financial implications as holders of the public purse.
- Responding to a member who raised discrepancies in the cost of Option 9 in the report (which had come top of the scoring) compared to figures in a conditions survey Dr Holthof undertook to look at the document. It was noted that refurbishment costs would be markedly different to rebuilding costs.
- A member referred to the second paragraph of page 29 and sought clarification whether it meant that that costs were an issue, that should a second maternity unit be funded it would have an impact on other maternity and wider provision and that it would not be a priority for funding. Lou Patten explained that they were constantly trying to balance a finite budget and it would be for discussion.

- A member noted that he had raised the issue of recruitment at previous meetings. The report gave him no confidence that there had been a robust recruitment campaign as there was a lack of evidence. He could suggest that it was convenient for there to be the current shortages. The Committee was advised that the Board paper was an overview and the Board had already considered detailed work on this matter. Professor Pandit detailed the efforts made to recruit staff, including the steps taken and the use of specialist HR staff. Dr Holthof added that they had absolutely carried out international recruitment. The fact was that there were not enough doctors and nurses.
- A member questioned the practicality of steps set out in 4(a) and (b) to improve the experience for mothers and birth partners to the JR. He sought assurance that the provision for birth partners to stay overnight would not be removed when the space came under pressure. Lou Patten replied that that was about oversight to ensure that provision was effective. The emergency parking was already successfully in place at the JR.
- Concern was expressed that with regard to recommendation (c) that this still entailed a long journey of 20-25 miles. It was queried whether there were journey times from Banbury to Warwick. It was also queried whether it was known if there were any capacity issues. It was suggested that the Warwick hospital could face similar problems to the Horton as services were likely to be focussed on the Coventry and Warwick Hospital site. It was queried what work had been done on this to ensure future proofing of the preferred option.
- It was suggested that retaining mothers in the County who were being encouraged to look elsewhere would increase income. The Trust already had an attractive option and that was the Horton General Hospital if that would only be realised and services funded. Lou Patten commented that it was best practice to ensure mums had all the information to make an informed choice. Option 4 (c) was about strengthening links to other hospitals in the area. The work they had done had helped them to understand that the Trust's borders were not borders for mums.
- A member queried the information contained in Tables 7 and 8 of the report. He queried whether a second maternity unit would not attract more mothers making the per baby cost of the two-unit model less. Catherine Mountford commented that the modelling took into account the catchment of the Horton at the time but that it would be monitored. It was noted that if a second unit was not opened it would be difficult to assess how many additional births it would attract. Catherine Mountford indicated they would look at the number of births in Banbury and the surrounding area. Currently the birth rate was going down.

There was a brief adjournment at 8.19 pm with the Committee reconvening at 8.25 pm.

Discussion continued:

- Anaesthetists and gynaecologists had been successfully rotated and it was queried why this was not possible in obstetrics. Professor Pandit explained that 8 of the current 16 doctors worked on very complex cases. If they were to rotate it would reduce the specialist capacity. Others could be rotated but there would be a need for additional doctors to create the model which went back to the staffing issue.
- There was some discussion over the impact of mother's anxiety on the unborn baby and the continuing impact this could have on the child with issues such as

social, emotional or behavioural difficulties, ADHD and complications at birth. This would have an implication in terms of continuing NHS care. It was queried how this cost had been factored in to the model. Professor Pandit recognised that women could be worried from the beginning of pregnancy, to the birth and beyond. She accepted the anxiety over maternity services and about labour. This general anxiety and stress were not the same as a clinical diagnosis. The Trust did provide support. The mental health of women was a national issue and the Trust was expanding its services to support women.

- A member referred to the suggestions from Councillor Herring and noted that the Oxford to Cambridge arc was not referenced in the report. For mother in South Northants a lot of the anxiety was simply travelling down the A43/M40. There was an issue for mothers who having made that journey were turned away because they were too early in their labour. It was queried whether there was scope to improve the implementation plan. Dr Pandit undertook to look at what was possible.

Following the discussion, the Chairman highlighted the addenda setting out his response to the proposals presented. He stated that in his opinion the unsustainability of the Horton was of the Trust's own making. Doctors resigned when news got out that the Horton was to be permanently downgraded. This led to its temporary closure. Members supported this view of the current position.

The Chairman commented that the starting point was the geography of the Horton General Hospital catchment. Lou Patten declined to respond to a question as to whether the residents of the area would be better served if the Horton became another Trust.

The Chairman thanked the OCCG and OUH for their attendance. He drew attention to the comments and recommendations set out in the Chairman's report addenda and highlighted that the question for the Committee was whether it was satisfied with the adequacy of the consultation. Whether the scrutiny had been artificial given the reliance in the OCCG paper on finance and cost. For adequate consultation to take place it must take genuine account of mother's views and experience. If the response is always to be 'that we can't do that' then the Chairman questioned the point of the exercise.

The Chairman stated that he did not believe that the proposals in the OCCG paper would be in the best interests of local people in the Horton catchment area. The proposals did not improve services and there were issues of accessibility and choice. The Committee had not been convinced by the workforce issues feeling that where there was a will then a way would be found. It had been possible to recruit 4 doctors despite the difficulties. The Chairman suggested that if the Trust was able to deal with an expected 60,000 to 90,000 emergencies then it should be possible to plan for 1500 births. The workforce issues were surely similar across all services.

Referring to the proposals to enhance the user experience at the JR the Chairman suggested that rather than a response to concerns raised by the IRP these were improvements that should already be in place. Provisions such as emergency parking were not just applicable to maternity services, The Chairman proposed the recommendations contained in the addenda but proposed an additional recommendation. He referred to points 6 and 7 in the OCCG paper that suggested that partners work together to develop a masterplan for the Horton General Hospital and to pursue capital investment. In light of this the Chairman proposed that the Horton Joint Health Overview & Scrutiny Committee continued to meet and accepts in good faith that partners are genuine in working to improve Horton General Hospital and that we will continue to meet to hold OUH and OCCG and others to account in the development and implementation of the positive vision for the future of the Horton General Hospital.

It was:

AGREED: (nem con)

(a) That if decisions are taken at the meeting of the OCCG Board, as per the board paper, to refer the decision to the secretary of state on the following grounds:

I. The Horton HOSC is not satisfied with the adequacy of the content of the consultation (Regulation 29(9)(a)).

II. The Horton HOSC believes the proposal would not be in the interests of the health service in this area (the latter being the cross-boundary area represented by the Horton HOSC) (Regulation 23(9)(c).

The detail of this referral to be based on the comments in the above minutes and the additional information as set out in the Chairman's addenda.

(b) that the Horton Joint Health Overview & Scrutiny Committee continue to meet and accepts in good faith that partners are genuine in working to improve Horton General Hospital and that the Committee will continue meet to hold OUH and OCCG and others to account in the development and implementation of the positive vision for the future of the Horton General Hospital.

25/19 CHAIRMAN'S REPORT

(Agenda No. 6)

The Chairman's report and addenda were noted and the information and recommendations considered as part of the previous item.

.... in the Chair

Date of signing 2019

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Horton HOSC CLU Responses

At the meeting of the 4th July 2019 Horton HOSC it was agreed to: "invite representatives of other small obstetric-led units to give evidence of how they work to achieve their aims and retain their training accreditation before the September CCG Board meetings."

The Horton HOSC has written out to 25 Trusts. The basis of the research undertaken by Keep the Horton General was used to inform the work of the Horton HOSC, specifically helping to highlight Trusts to contact. A list of questions were devised to inform committee members of each Trust's approach to; the model of provision for maternity services, staffing models, birthing stats, size of the area served and distances travelled, the training accreditation and level it is held at, and whether they have experienced any challenges maintaining the accreditation.

Responses were received from the following NHS Trusts (individual responses from each Trust are included in Appendix 1 below):

Name of Trust	Corresponding pages:
North Cumbria University Hospitals NHS Trust	2 – 4
Northumbria Healthcare NHS Foundation Trust	5 – 9
Nottingham University Hospitals NHS Trust	10 – 11
United Lincolnshire Hospitals NHS Trust	12 – 13

Unfortunately all the trusts declined to speak to the committee, some either via the return letter, or when contacted to arrange a potential time slot to speak.

We also had a response from University Hospitals of Leicestershire NHS Trust, who were unable to answer the questions as they were under considerable time pressures.

The names of all NHS Trusts contacted are included in Appendix 2.

Appendix 1 – NHS Trust Responses

NHS
North Cumbria
University Hospitals
NHS Trust

Head of Midwifery & Gynaecology's Office
Maternity Department
Cumberland Infirmary
Infirmary Road
CARLISLE
Cumbria
CA2 7HY

Direct Tel: 07787690001
Email: jane.anderson@ncuh.nhs.uk

Our Ref: JA/BR

Date: 27/08/19

Samantha Shepherd
Senior Policy Officer
Horton Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Dear Samantha,

Re: Horton Health and Overview Scrutiny Committee - CLU review

Please see below for responses to questions submitted for the Horton Health & Overview Scrutiny Committee for the CLU review. I hope that you find our responses of some use:

1. **Name of the Trust**

   North Cumbria University Hospitals NHS Trust.

2. **What is the model of provision for maternity services?**

   X 2 Consultant-led Units with alongside Midwifery-led Units
   X 1 Midwifery-led Unit

3. **What staffing model do you use? (please include information on numbers of staff and rotas, numbers of vacancies and how they are managed, and how you approach recruitment.)**

   Birthrate Plus is used for Midwifery workforce planning.
   New models of integrated care are being planned in line with Better Births.

4. **What are the number of births for the last 3 years (delivered in the different settings)?**

	2016/17	2017/18	2018/19
CIC	1680	1585	1592
PBC	27	17	30
WCH	1278	1212	1114
Total	**2985**	**2814**	**2736**

CIC = Cumberland Infirmary, Carlisle (Consultant Led Unit)
PBC = Penrith Birth Centre (Midwifery Led Unit)
WCH = West Cumberland Hospital (Consultant Led Unit)

5. **How do you measure your clinical quality and outcomes? What has been your performance in the last three years against these outcomes?**

   Clinical quality and outcomes measured via dashboards;
   Measured against national standards eg RCOG, NICE recommendations and regional standards.
   These are reviewed at monthly Joint Core Governance Meeting – themes and trends extracted and audited.

6. **What is the size of the area you serve? (i.e. how far / long do people have to travel to get to the unit)**

   - *Large rural geographical location with remote areas*
   - *63.5 people per km/sq*
   - *From West Cumberland Infirmary to Cumberland Infirmary 48 miles – slow A road*
   - *From West Cumberland Infirmary to Penrith Birth Centre 44 miles – A road with some dual carriageway*
   - *From Penrith Birth Centre to Cumberland Infirmary 20 miles – motorway*

   The region is visited by large numbers of tourists and this, together with large farming communities, adds time to journeys.

   Public transport consists of train and bus services, however, the networks are poor.

7. **Do you still hold your training accreditation status? and if so, how long have you held it? And have there been any challenges maintaining that?**

   Training accreditation is held at both Consultant-led sites.

8. **Is the training accreditation held at a trust level, or on an individual unit basis?**

   Individual Unit

9. **Do you capture information on patient experience? (if so, what are satisfaction levels for example?)**

   Patient satisfaction is captured by surveys both nationally biased and Trust led – in general satisfaction levels are good.

   The patients generally belong to communities that are passionate with regard to their local services and support them well.

10. **Do you capture any feedback from staff that are being trained in a smaller unit? (if so, are you able to share any feedback received please?)**

    Unsure as to what this question refers.

11. **Would you be able to either attend the Horton HOSC meeting, or Skype into the meeting to be able to discuss with members of the HOSC?** (The meetings take place in Banbury Town Hall, Oxfordshire and the next Horton HOSC meeting is likely to take place in either the first or second week of September – please could you let us know ASAP if you are able to attend, or speak to the committee, so we can plan in accordingly)

    Apologies, Head of Midwifery unable to attend as will be away on leave, contact made with Martin Dyson to this effect.

Yours sincerely,

Jane Anderson
<u>HEAD OF MIDWIFERY & GYNAECOLOGY</u>

Northumbria Healthcare
NHS Foundation Trust

Trust Management
North Tyneside General Hospital
Rake Lane
North Shields
Tyne and Wear
NE29 8NH

(0191) 293 2730

Ref: MD/TC

15 August 2019

Cllr Arash Fatemian
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee
Oxford County Council
Horton Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Dear Cllr Fatemian

HORTON HEALTH AND OVERVIEW SCRUTINY COMMITTEE – CLU REVIEW

Thank you for your letter dated 24 July 2019 which outlines the work you are undertaking around the viability of small Consultant-led Obstetric Units and inviting Northumbria Healthcare NHS Foundation Trust to participate in this work.

I have enclosed our response to the questions provided and hope that this information is useful to you.

Unfortunately due to annual leave and other commitments we are unable to provide representation at the Horton HOSC meeting planned for September 2019.

Yours sincerely

MARION DICKSON
Executive Director of Nursing and Midwifery on behalf of and in the absence of Sir James Mackey, Chief Executive

Enc

cc Marion Dickson, Executive Director of Nursing and Midwifery
Lynn Tilley, Acting Head of Maternity

Questions:

1. **Name of the Trust**
   Northumbria Healthcare NHS Foundation Trust

2. **What is the model of provision for maternity services?**
   Northumbria provide an Obstetric-led service at the Northumbria Specialist Emergency Care Hospital, including a Pregnancy Assessment Unit, a Birth Centre for low and high risk pregnancies, and an Ante-natal / Postnatal ward for inpatient stays.

   In addition to the main Unit we have three freestanding Midwifery-led Units (MLUs). Low risk women are offered birth in these Units. The MLUs provide Antenatal care for all women with Consultant Outreach Antenatal clinics.

   The MLUs in Alnwick and Berwick are open seven days per week but not across 24 hours. On-call Midwives are available out of hours to support birth in the MLU or at home. There is no inpatient Postnatal stay in these MLUs.

   Teams of Community Midwives provide Antenatal and Postnatal care and support the Home Birth Service.

   Antenatal clinics are held in a variety of locations including GP practices, Children's centres and Trust base sites (Wansbeck General Hospital and North Tyneside General Hospital).

3. **What staffing model do you use? (please include information on numbers of staff and rotas, numbers of vacancies and how they are managed, and how you approach recruitment.)**

   Staff levels are calculated in accordance with Birth Rate Plus methodology. However it is acknowledged that the freestanding MLUs are over-established based on this methodology; however they are appropriate to ensure sustainable service provision.

   The Northumbria is currently established to 71.29 WTE Midwives and 27.69 WTE Nursing Assistants.

   Alnwick MLU (Hospital and Community) is currently established to 4.44 WTE Midwives and 2.03 WTE Nursing Assistants.

   Berwick MLU (Hospital and Community) is currently established to 4.05 WTE Midwives and 1.76 WTE Nursing Assistants.

   Hexham MLU (Hospital and Community) is currently established to 17.48 WTE Midwives and 8.13 WTE Nursing Assistants.

Wansbeck Community Midwifery is currently established to 17.68 WTE Midwives. North Tyneside Community Midwifery is currently established to 20.31 WTE Midwives.

Vacancies for Midwives is managed pro-actively through a rolling programme of recruitment. An automatic advert goes live on alternate months with interviews arranged for the next month so that vacancy is filled as it is released. This has proven to be a very successful programme.

Nursing Assistant posts are advertised as required and is infrequent as the vacancy rate has been low historically.

4. What are the number of births for the last 3 years (delivered in the different settings)?

Site	Apr 16 - Mar 17	Apr 17- Mar 18	April 18 - Mar 19
Northumbria	3125	3047	3027 births
Alnwick	37	34	15
Berwick	9	10	15
Hexham	81	63	55
Home Birth	42	46	38

5. How do you measure your clinical quality and outcomes? What has been your performance in the last three years against these outcomes?

We have a performance dashboard in line with RCOG recommended metrics which is reviewed and discussed monthly at our Operational Board; any emerging themes or trends are identified and actions agreed. We also contribute to a regional dashboard which allows us to compare performance with other local providers.

The metrics demonstrated below are not exhaustive.

	Apr 16-Mar 17	Apr 17-Mar 18	April 18-Mar 19
Spontaneous vaginal delivery	65.5%	60.1%	63.1%
Caesarean Section rate (combined elective and emergency)	31.0%	30.8%	27.3%
Instrumental vaginal delivery rate	8.1%	9.1%	13.1%
Intrapartum transfer from an MLU to the Northumbria	13.6%	11.6%	13.5%

6. **What is the size of the area you serve? (i.e. how far / long do people have to travel to get to the unit)**

   Northumbria covers a large geographical area with a combination of rural and urban areas. The distances that women travel to access services will vary depending on their proximity to their local Unit or the Obstetric Unit in the Northumbria Hospital.

   As an example women may travel in excess of 52 miles from Berwick to the Northumbria site (approximately an hour).

7. **Do you still hold your training accreditation status? and if so, how long have you held it? And have there been any challenges maintaining that?**

   Please can you clarify which training accreditation this refers to.

8. **Is the training accreditation held at a trust level, or on an individual unit basis?**

   Unable to provide this information.

9. **Do you capture information on patient experience? (if so, what are satisfaction levels for example?)**

   We collect patient experience information from a number of sources but is not limited to:

   - The CQC Maternity Survey,
   - A real time patient experience survey completed twice a month by our Patient Experience Team; reported monthly to our Operational Board.
   - Friends and family test
   - Through complaints monitoring
   - Feedback from clinical incident investigation meetings
   - Birth reflection service

   Patient satisfaction levels are generally very good.

10. **Do you capture any feedback from staff that are being trained in a smaller unit? (if so, are you able to share any feedback received please?)**

    No we do not routinely collect information on training from other providers.

11. **Would you be able to either attend the Horton HOSC meeting, or Skype into the meeting to be able to discuss with members of the HOSC?** (The meetings take place in Banbury Town Hall, Oxfordshire and the next Horton

HOSC meeting is likely to take place in either the first or second week of September – please could you let us know ASAP if you are able to attend, or speak to the committee, so we can plan in accordingly)

Unfortunately we are not able to participate in the discussion due to annual leave.

On behalf of the members of the Joint Horton Health Overview and Scrutiny Committee, thank you very much for taking the time to provide answers to the questions above. It will provide invaluable support in being able to perform effective scrutiny over the process taking place in Banbury.

Contact Officers:

If you have any queries with the form, please contact either:
Sam Shepherd – Samantha.shepherd@oxfordshire.gov.uk, 07789 088173
Martin Dyson – martin.dyson@oxfordshire.gov.uk, 07393 001252

Questions:

1. **Name of the Trust**

Nottingham University Hospitals

2. **What is the model of provision for maternity services?**

   2 Obstetric units, community midwifery provision and co-located midwifery led birthing unit

3. **What staffing model do you use? (please include information on numbers of staff and rotas, numbers of vacancies and how they are managed, and how you approach recruitment.)**

   For midwifery staffing, Birth rate plus is used

4. **What are the number of births for the last 3 years (delivered in the different settings)?**

5.

financial Year /Numbers	Obstetric Unit	Birth centre/midwifery led unit	Home birth
16/17	7,928	1,543	81
17/18	6,983	1,198	77
18/19	7,514	1,140	73

6. **How do you measure your clinical quality and outcomes? What has been your performance in the last three years against these outcomes?**

   We have a maternity dashboard and we benchmark/gap analyse against national data

7. **What is the size of the area you serve? (i.e. how far / long do people have to travel to get to the unit)**

   We cover Nottingham and mid/south Nottinghamshire.

8. **Do you still hold your training accreditation status? and if so, how long have you held it? And have there been any challenges maintaining that?**

   Yes – we are a university teaching hospital – unsure of timeframe

9. **Is the training accreditation held at a trust level, or on an individual unit basis?**

   Trust

10. **Do you capture information on patient experience? (if so, what are satisfaction levels for example?)**

    Yes – high satisfaction rates

11. **Do you capture any feedback from staff that are being trained in a smaller unit? (if so, are you able to share any feedback received please?)**

    We do not capture this data

12. **Would you be able to either attend the Horton HOSC meeting, or Skype into the meeting to be able to discuss with members of the HOSC?** (The meetings take place in Banbury Town Hall, Oxfordshire and the next Horton HOSC meeting is likely to take place in either the first or second week of September – please could you let us know ASAP if you are able to attend, or speak to the committee, so we can plan in accordingly)

Unable to commit currently

1. **Name of the Trust**

   United Lincolnshire Hospitals NHS Trust

2. **What is the model of provision for maternity services?**

   Provide obstetric services at Pilgrim Hospital, Boston and Lincoln County with antenatal provision at Grantham Hospital. This provision is supplemented by ultrasound provision at Skegness and Gainsborough.

3. **What staffing model do you use? (please include information on numbers of staff and rotas, numbers of vacancies and how they are managed, and how you approach recruitment.)**

   Full obstetric and anaesthetic rotas on each site in accordance with RCOG guidance.

   Midwifery staffing levels in accordance with Birthrate Plus. Moving towards a mixture of hospital and community continuity of carer models

4. **What are the number of births for the last 3 years (delivered in the different settings)?**

Lincoln County Hospital	Pilgrim Hospital	Home Births	Grantham MLU
2016/2017 = 3266	2016/2017 = 1874	2016/2017 = 217	58
2017/18 = 3108	2017/18 = 2040	2017/18 = 158	Closed
2018/2019 = 2943	2018/2019 = 1738	2018/2019 =	Closed

5. **How do you measure your clinical quality and outcomes? What has been your performance in the last three years against these outcomes?**

   Through the maternity dashboard. Reducing Stillbirth rate on both sites. LCH has better clinical outcomes than PHB in terms of IOL and CS rate

6. **What is the size of the area you serve? (i.e. how far / long do people have to travel to get to the unit)**

   Lincolnshire large rural area with poor transport infrastructure. No motorways and only approx. 23 miles of dual carriage way. Absence of public transport for some residents on a Sunday. Each site 40 miles apart. Coastal area has higher deprivation levels. QIA and EQIA support the continuation of both sites

7. **Do you still hold your training accreditation status? and if so, how long have you held it? And have there been any challenges maintaining that?**

Yes – not reporting any red flags in the GMC trainee survey. Midwifery training due to commence in Lincolnshire in Autumn. Challenge is maintaining Paediatric Training and the domino impact on obstetrics

8. **Is the training accreditation held at a trust level, or on an individual unit basis?**

   Individual site level

9. **Do you capture information on patient experience? (if so, what are satisfaction levels for example?)**

   Wide range including: FFT, CQC Survey, Maternity Voice Partnership, Neonatal Voice Partnership, Public Engagement Events as a Trust or in partnership with Lincolnshire Better Births, Social Media activities – surveys etc.

10. **Do you capture any feedback from staff that are being trained in a smaller unit? (if so, are you able to share any feedback received please?)**

    No – not currently – intend to be part of the RCOG rural obstetric work programme

11. **Would you be able to either attend the Horton HOSC meeting, or Skype into the meeting to be able to discuss with members of the HOSC?** (The meetings take place in Banbury Town Hall, Oxfordshire and the next Horton HOSC meeting is likely to take place in either the first or second week of September – please could you let us know ASAP if you are able to attend, or speak to the committee, so we can plan in accordingly)

    Yes

    (MD - When we wrote back to them to confirm a convenient potential time to discuss with the committee, they confirmed that they did not intend to speak to the committee and were only providing a written response)

Appendix 2 – List of NHS Trusts contacted

Trust	Hospital
County Durham and Darlington NHS FT	Darlington Memorial Hospital
Doncaster and Bassetlaw Teaching Hospitals NHS FT	Bassetlaw District General Hospital
Dorset County Hospital NHS Foundation Trust	Dorset County Hospital, Dorchester
East Cheshire NHS Trust	Macclesfield District General Hospital
Epsom and St Helier University Hospitals NHS Trust	Epsom General Hospital
Epsom and St Helier University Hospitals NHS Trust	St Helier Hospital
Gateshead Health NHS FT	Queen Elizabeth Hospital, Gateshead
Harrogate and District NHS FT	Harrogate District Hospital
James Paget University Hospitals NHS FT	James Pagett Hospital
North Cumbria University Hospitals NHS Trust	Cumberland Infirmary, Carlisle
Northern Devon Healthcare NHS Trust	North Devon District Hospital, Barnstaple
North Lincolnshire and Goole NHS FT	Princess of Wales Hospital
North Lincolnshire and Goole NHS FT	Scunthorpe General Hospital
North West Anglia NHS FT	Hinchingbrooke Hospital
Northumbria Healthcare NHS FT	Northumbria Specialist Emergency Care Hospital
Nottingham University Hospitals NHS Trust	Nottingham City Hospital
Salisbury NHS Foundation Trust	Salisbury Hospital
United Lincolnshire Hospitals NHS Trust	Pilgrim Hospital (District Hospital), Boston
University Hospitals of Leicester NHS Trust	Leicester Royal Infirmary
University Hospitals of Morecambe Bay NHS FT	Furness General Hospital, Barrow in Furness
University Hospitals of Morecambe Bay NHS FT	Royal Lancaster Infirmary
Western Sussex Hospitals NHS FT	Worthing Hospital
Wye Valley NHS Trust	County Hospital, Hereford
Yeovil District Hospital NHS FT	Yeovil District Hospital
York Teaching Hospital NHS Foundation Trust	Scarborough Hospital

Benchmarking of Small Obstetric Units: Research into Training Accreditation, Staffing Models, Obstetric Recruitment Issues and Initiatives, and Doctor/Trainee Rotation

Produced by Keep The Horton General, June 2019

Keep The Horton General has collated data between March and June 2019 relating to the ways in which other small Consultant-Led Units nationally sustain their obstetric services. In 2016 Prof Stephen Kennedy said at the public consultation meeting in St Mary's Church, Banbury:

> *In 2012, the people who look after training made the decision that the Horton could no longer be a centre recognised for training, principally because of too few deliveries [taking place]. The training rules and regulations, which are applied throughout the country -not just in Banbury, but for every training centre across the country- decreed that if you were too small; if you had too few deliveries, then you could no longer be a training centre. It made sense…because to acquire sufficient skills and knowledge to be able to practise obstetrics safely it was decided that a hospital had to have at least 3500 births [per year].*[1]

Evidence KTHG has obtained invalidates this claim that the Horton had too few deliveries to be a safe obstetric unit with training accreditation, as numerous other hospitals are managing just that.

The IRP report of 2008, when maternity services in Banbury were last threatened, made several key recommendations. Point 5 in the report advocated greater clinical integration between the units:

> *The ORH must do more to develop clinically integrated practice across the Horton, John Radcliffe and Churchill sites as well as developing wider clinical networks with other hospitals, primary care and the independent sector.* [2]

Rotation of consultants would avoid this "loss of skills" Prof. Kennedy referred to, and rotation of trainees would be of benefit to them as a less busy unit gives more time for discussion of cases with consultants.

The following paper analyses the raw data and statistics we have researched, for circulation in time for the June 2019 HHOSC meeting. This information has been formulated with the input of expert clinicians and considers some of the options for an obstetric service at the Horton which have either been omitted in the past or dismissed out of hand, and we believe, demonstrate a viable and sustainable future for an obstetric unit at the Horton.

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[1] Prof. Stephen Kenney, Recorded transcript of Public engagement meeting, St Mary's Church, Banbury, August 2016

[2] *Advice on Changes Proposed By The Oxford Radcliffe Hospitals Nhs Trust To Paediatric, Obstetrics, Gynaecology And The Special Care Baby Unit At The Horton General Hospital In Banbury*, Independent Reconfiguration Panel, 2008, p. 4 Available online: http://www.keepthehortongeneral.org/docs/IRPreport.pdf

What we did:
KTHG began by using the Office for National Statistics' most recently available Births by Communal Establishment spreadsheet (for 2015/16) to identify smaller Consultant Led Units (units which had fewer than 2500 deliveries). 29 open Consultant Led Units with between 1000 and 2500 births per year were contacted to ascertain basic data including:

- birth data from 2014-18
- whether the unit has obstetric training accreditation[3]
- the number of consultants employed at the unit
- permutation of staffing rotas
- whether hybrid rotas are in use[4]

27 units responded to this FOI request.

More recently, KTHG sent an FOI request to every Hospital Trust with CLU/s in England and Wales to ascertain:

- how many non-training middle grade doctors were employed at their CLUs
- whether they have any vacancies for non-training middle grades, registrars (middle grades in training), and consultants, and if so, how many for each
- whether they have experienced any difficulties in recruiting obstetricians and if so, at which level
- whether they utilise any recruitment initiatives beyond advertising to recruit to posts, and details of these
- whether they offer any incentives in order to attract/retain doctors
- whether any special recruitment initiatives or incentives used are successful

A small number of Trusts have more than one CLU under their jurisdiction. Where this was the case, we sent separate FOI requests to them to identify:

- the deanery they come under for RCOG training
- whether training accreditation was awarded at a Trust level, or to the specific sites
- whether consultants, registrars, non-training middle grades or trainees rotated between sites, and if so, whether this was for elective (clinic) work, or for acute or emergency work.

Comment on the Small CLUs

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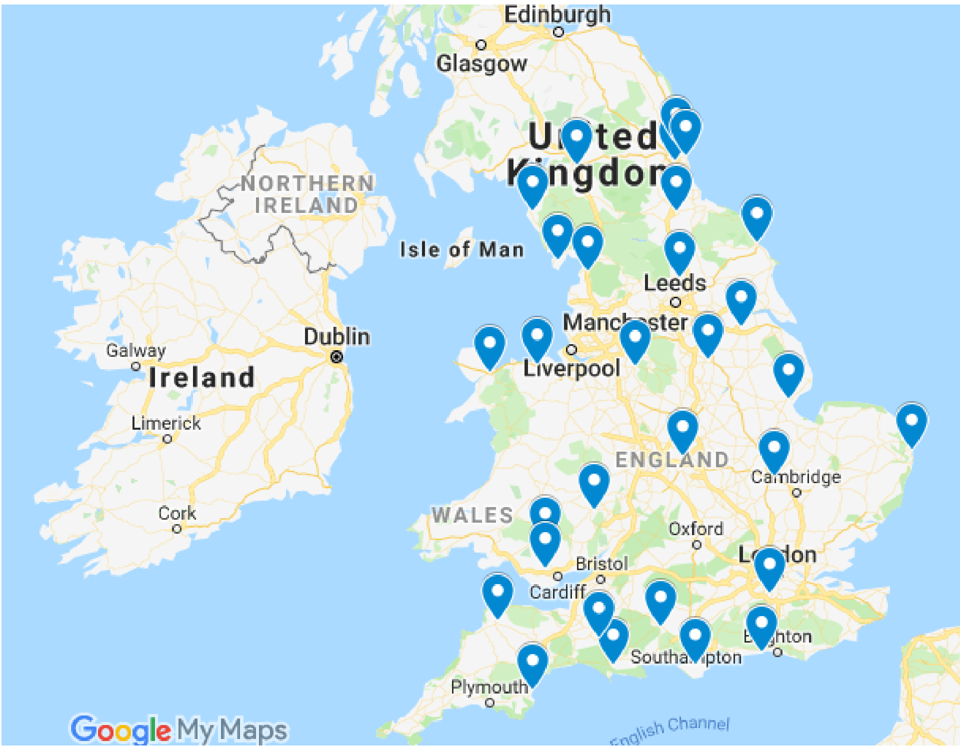
[3] RCOG Training for registrars/middles grades, not general training for Junior Doctors

[4] In recent years, hybrid rotas have been developed where resident consultants cover some slots on a middle grade rota, with other slots covered by middle grade doctors with a non-resident consultant. They are often necessary to ensure there are enough staff with the necessary competencies on shifts. As a result, their use requires more consultant hours than traditional rotas. The RCOG concludes in its 2016 paper, *Obstetrics and Gynaecology Workforce,* that they are the only long-term sustainable staffing solution to middle-grade rota gaps. The paper explains "It is likely that the next decade will be a period of transition from a system where consultants are predominantly non-resident when on-call, to a system where the majority of consultants perform some 'hands-on' resident out-of-hours duties. Resident consultant working does not necessarily mean night shift working: evenings and/or weekend daytime working are alternative options that can be considered as part of a hybrid model, which also has the potential to improve out-of-hours training. Embracing resident consultant working will allow the profession to move forward in a positive and equitable way for all consultant staff and for the benefit of patients" Available online: https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/ogworkforce.pdf

The 27 small units which responded to KTHG are distributed fairly evenly across the country. A map showing the geographical spread of the units is below:



Training Accreditation:
23 of the 27 small units responding confirmed that they have training accreditation. This equates to 85%. The mean annual birth rate for these hospitals was 1687 deliveries based on 2016 figures (the most recent ones where we had data for all the hospitals). This is virtually identical to the 2014-15 birth rate at the Horton General Hospital (1667), before the siphoning of more complex cases off to the John Radcliffe affected the birth rate in Banbury.

Fig. 2 The small units with training accreditation:

Hospital	2016 births	On CCG's List?
Furness General Hospital, Barrow in Furness	1067	No
Yeovil District Hospital	1471	No
North Devon District Hospital, Barnstaple	1530	No
Prince Charles Hospital, Merthyr Tydfil	1553	No
Scarborough Hospital	1558	No
Bassetlaw District General Hospital	1610	Yes
Epsom General Hospital	1679	Yes
Cumberland Infirmary, Carlisle	1702	No
County Hospital, Hereford	1718	No
Macclesfield District General Hospital	1743	Yes
Scunthorpe General Hospital	1832	Yes
Pilgrim Hospital (District Hospital), Boston	1874	No

Queen Elizabeth Hospital, Gateshead	1905	Yes
Dorset County Hospital, Dorchester	1908	Yes
Harrogate District Hospital	1928	Yes
Royal Lancaster Infirmary	1971	Yes
Princess of Wales Hospital, Bridgend	2031	No
Ysbyty Gwynedd	2060	No
Darlington Memorial Hospital	2099	Yes
James Pagett Hospital	2159	No
Hinchingbrooke Hospital	2230	Yes
Salisbury Hospital	2346	Yes
Worthing Hospital	2371	No

Case Study on a pair of small CLUs:

The CLUs belonging to Morecambe Bay NHS FT were very interesting for several reasons, though only Lancaster seems to have been investigated by the OCCG in its own research.

- Both Furness General Hospital and Lancaster Royal Infirmary have training accreditation, despite the annual birth rate being approximately 1100 and 1900 respectively.
- Both hospitals use Hybrid rotas, where consultants fill gaps in the middle-grade rotas, though due to 48 miles' distance between sites, no rotation of consultants or middle-grades takes place.
- Impressively, the Trust was highly commended by the RCOG in 2017 for professional development, and in 2018 for its standard of training. (These accolades would appear to refute entirely Stephen Kennedy's statement that hospitals with fewer than 3500 births don't provide enough experience for training doctors to acquire the skills they need.)
- The Trust comes under the North West Deanery, and training accreditation has been awarded to *the Trust itself* rather than being site-specific. This is significant because FGH is the smallest CLU with training accreditation we could find nationally, and its status would appear to be protected by this accreditation being trust-wide, where for instance, St Mary's Hospital in Newport, IOW, similarly experiencing around 1100 births per year does not have training accreditation.

It was clear from our dealings with the Morecambe Bay Trust that it is highly supportive of both its CLUs and the staff there, and extremely proud of its award-winning training standards. We feel that the OUHFT and OCCG could benefit greatly from their example. This is especially pertinent given the reference to the potential use of hybrid rotas at the Horton in the minutes from the OCCG's board meeting of 10th August 2017:

The Lay Member Public and Patient Involvement believed that sufficient evidence around the workforce issues had not been presented and a hybrid rota should have been given more consideration. Clinical Lead for Obstetrics *informed the Board that, having spoken to the Royal College, she was told that the hybrid rota was 'unaffordable in small units', such as the Horton.*[5]

Clearly this is not borne out by hospitals such as Furness General Hospital.

Training Accreditation Status:

Six hospital Trusts from four different deaneries confirmed that their training accreditation had been awarded to the Trust as a whole, rather than to the specific units. Three are in the north of England, each with at least one small CLU. The other three belong to the same deanery; London and South East. This highlights 1) that there is not a consistent approach to the awarding of training accreditation nationwide, and 2) that it is an accepted practice of Postgraduate Deans elsewhere to award training accreditation Trust-wide (seemingly regardless of birth numbers of the small CLUs). This also means the way in which training accreditation is awarded directly impacts equality outcomes and patient choice. At the time of writing, Frimley Health Trust, the only other multi-CLU Trust in our Deanery, Thames Valley, has not yet responded on how its training accreditation is awarded. If it is Trust-wide, this would be an important precedent in making the case for OUHFT being treated similarly.

Trust	Hospital	Location	Deanery	2015 births
University Hospitals of Morecambe Bay NHS Foundation Trust	Furness General Hospital,	Barrow-in-Furness	North West	1069
University Hospitals of Morecambe Bay NHS Foundation Trust	Royal Lancaster Infirmary	Lancaster	North West	1979
County Durham & Darlington NHS Foundation Trust	University Hospital North Durham	Durham	North East	3088
County Durham & Darlington NHS Foundation Trust	Darlington Memorial Hospital	Darlington	North East	2214
Northern Lincolnshire and Goole NHS Foundation Trust	Scunthorpe General	Scunthorpe	Yorkshire & Humber	1869
Northern Lincolnshire and Goole NHS Foundation Trust	Princess of Wales Hospital, Grimsby	Grimsby	Yorkshire & Humber	2227
Lewisham and Greenwich NHS Trust	University Hospital	Lewisham	London and South	3958
Lewisham and Greenwich NHS Trust	Queen Elizabeth Hospital	Woolwich	London and South	4366
Epsom and St Helier University Hospitals NHS Trust	Epsom Hospital	Epsom	London and South	1974
Epsom and St Helier University Hospitals NHS Trust	St Helier Hospital	Carshalton	London and South	2962
King's College Hospital NHS FT	King's College Hospital	Denmark Hill	London and South	4726

[5] *Minutes, Oxfordshire Clinical Commissioning Group Board Meeting: 10th August 2017*, p.12 Available online: https://www.oxfordshireccg.nhs.uk/documents/meetings/board/2017/08/2017-08-10-Oxfordshire-Clinical-Commissioning-Group-Minutes-FINAL.pdf

King's College Hospital NHS FT	Princess Royal University Hospital	Orpington	London and South	4788

Fig. 3: the NHS Trusts to which Training Accreditation has been awarded at Trust Level

Use of Hybrid Rotas:

OUHFT does not currently use hybrid rotas, however, 5 of the 26 small units from 4 separate Trusts which we contacted confirmed they use Hybrid rotas, shown overleaf. This equates to 19%.

The RCOG concludes in its 2016 guidance *Obstetrics and Gynaecology Workforce*, that Hybrid rotas (i.e. ones using resident consultants) are likely to be the only long-term solution to gaps in middle-grade staffing:

> *The issue of ensuring appropriate obstetrics and gynaecology medical staffing levels in most UK units is immediate. In most hospitals the solution is likely to include resident consultant working, with consultants and the middle grade junior doctors jointly staffing the slots on the out-of-hours rota, i.e. a hybrid rota… It is evident that resident consultants will be part of any sustainable solution to current workforce difficulties.*[6]

Hospital	2016 births	Number of obs/gynae consultants currently employed (Mar 2019)	NHS Trust
Furness General Hospital, Barrow in Furness	1067	6 Obstetric/ Gynae Consultants	University Hospitals of Morecambe Bay NHS Foundation Trust
Royal Lancaster Infirmary	1971	11.46 Obstetric/Gynae Consultants	University Hospitals of Morecambe Bay NHS Foundation Trust
Scarborough Hospital	1558	7 Obstetric/Gynae Consultants + 1 P/T Gynae	York Teaching Hospital NHS Foundation Trust
Ysbyty Gwynedd	2060	12 Obstetric/Gynae consultants	Betsi Cadwaladr University Health Board
Salisbury Hospital	2346	10 Obstetric/Gynae Consultants	Salisbury NHS Foundation Trust

Fig. 4: the Small CLUs currently using Hybrid rotas

Given that, as KTHG understands, the catalyst for the withdrawal of training accreditation from the HGH in 2012 was the complaint from trainees that they were not getting sufficient out-of-hours supervision, it is worth bearing in mind that the RCOG-recommended implementation of Hybrid rotas would have a preventative effect on situations like this because of increased consultant presence:

[6] *Obstetrics and Gynaecology Workforce,* RCOG, 2016. Available online: https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/ogworkforce.pdf

For the majority of trainees, increased resident consultant presence provides a concomitant increase in the opportunities for training. Resident consultants should demonstrate equal commitment to training out-of-hours as within working hours. The time a trainee spends covering emergency duties in both obstetrics and gynaecology is more likely to be directly supervised by a consultant who is resident. For junior trainees, this is particularly valuable for clinical skills acquisition in the emergency setting, with better opportunities for workplace-based assessments, constructive feedback and delivery of the RCOG training curriculum. For senior trainees, it allows the more technically challenging clinical skills to be learnt in a safe environment. Appropriate consultant presence should maximise training opportunities and the skill of the trainer is to achieve the appropriate balance between direct and indirect supervision… Therefore, a hybrid rota should not necessarily be seen as a compromise, but may actually be a preferred solution to both workforce and training issues.[7]

The RCOG mentions in its 2016 paper an intention to collate examples of good practice which can be shared for the benefit of Trusts looking for information resources and support in this field.

Given that Hybrid rotas have been in existence since before the HGH was temporarily downgraded, the Trust ought to have explored seriously the option of employing resident consultants in Hybrid rotas as an alternative to downgrading the CLU, and KTHG believes that a thorough, independent exploration of this option ought to be requested by HHOSC.

Even with the requirement for greater consultant presence to compensate for middle-grade rota gaps, the research KTHG has done into how smaller units are staffed suggests that the information pack submitted to the options-scoring panel appears to overstate the workforce requirement for running a hybrid rota. For example, page 119 (Section 5 Paper 13) of the information pack contains the claims plus the statement that it is the model currently adopted by other small units in the UK. On the same page, the OUH claims that running 5 middle grades would require 11.4 consultants. A direct comparison can be made with the Hybrid rota at Scarborough (around 1500 births per year), which uses 5 ST3-5 (middle grades) and 1 ST2 (only Tier 1 not to work alone) and 7 obstetrics/gynae consultants plus 1 part-time gynae consultant. Salisbury Hospital is somewhat busier, averaging between 2200-2400 births per year, but also only has 10 consultants and 7 registrars contributing to their hybrid rota.

Another issue is that although the OUH rota gives ST3-5s it has claimed separately that only ST4 and above could work at the Horton. Yet each of the small units using Hybrid rotas have the more junior grades contributing to rotas.

Hospital	2016 births	Permutation of doctors used in 2018
Furness General	1067	6 Consultants, 2 Higher, 2.3 Junior, 5 SAS grade. (WTE)

[7] *Obstetrics and Gynaecology Workforce,* RCOG, 2016, p.18 Available online: https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/ogworkforce.pdf

Hospital, Barrow in Furness		
Royal Lancaster Infirmary	1971	11.7 consultants, 4.6 Higher, 7 Junior, 0 SAS grade. (WTE)
Scarborough Hospital	1558	7 consultants + 1 x P/T Gynae, 5 x ST 3-5s & 1 x ST1 all on run through training for obs and gynae, plus 2 staff grades.
Ysbyty Gwynedd	2060	Tier 3 Consultants: 1 in 7 weekdays 1 in 10 weekends, Middle grades and Tier 2 resident consultants: 1 in 9 days, Junior (tier 1): 1 in 8 days.
Ysbyty Glan Clwyd	1986	Tier 3 Consultants: 1 in 7 weekdays 1 in 10 weekends, Middle grades and Tier 2 resident consultants: 1 in 8 days, Junior (tier 1): 1 in 8 days.
Salisbury Hospital	2346	9/10 Consultants, 7 middle grades and 5 ST1/2s

Fig. 5: Hybrid rota permutations at small CLUs

The number of middle-grade doctors employed at the smaller units has also proved interesting, given that we were told to reopen the Horton, 9 WTE (whole time equivalent) non-training middle grades would be needed. For instance, Pilgrim Hospital in Boston, Lincolnshire (c.1900 births per year) employs 7 consultants and 8 middle grades. Worthing Hospital averages 2400 births per year but has 9 consultants, and 7 registrars, like Salisbury.

Rotation of Doctors within Multi-CLU Trusts

8 out of 11 Multi-CLU Hospital Trusts we were able to acquire data from confirmed that consultants rotate between sites. Interestingly, North Cumbria NHS Hospitals Trust said that 5 of their 10 consultants rotate between Whitehaven and Carlisle, despite the units being 35 miles apart. 6 of the 11 Trusts confirmed that registrars rotate between sites.

Staffing Problems and Use of Recruitment Programmes Beyond Advertising for Posts:

We asked the following, by FOI request, of the Trusts (Health Boards in Wales) to which the 157 obstetric units in England and the 12 obstetric units in Wales belong:

- how many non-training middle grade doctors were employed at their CLUs
- whether they have any vacancies for non-training middle grades, registrars (middle grades in training), and consultants, and if so, how many for each
- whether they have experienced any difficulties in recruiting obstetricians and if so, at which level
- whether they utilise any recruitment initiatives beyond advertising to recruit to posts, and details of these
- whether they offer any incentives in order to attract/retain doctors
- whether any special recruitment initiatives or incentives used are successful

Around 1/3 of Trusts which responded to our national FOI request confirmed that they had middle grade vacancies at the time of reply, which is in line with the RCOG's findings in their research for *Obstetrics and Gynaecology Workforce* from 2016. When asked if they had experienced difficulty recruiting obstetricians in recent years, 1/3 of the Trusts answered in the affirmative. Interestingly, though the majority were taking positive steps to counter this trend, a significant minority of Trusts didn't appear to have any additional measures in place beyond advertising, in terms of either targeted recruitment programmes or incentives, to remedy this situation. While there certainly are more vacancies than there are middle grade doctors in the UK to fill them, the varying efforts of different Trusts having trouble recruiting suggests that some are simply fatalistic and not sufficiently pro-active in their efforts. It seems old-fashioned and laissez-faire to be relying on adverts when so many hospitals are competing for a small pool of doctors.

The recruitment initiatives we learned about are described below.

RCOG's Medical Training Initiative Scheme

Around half of the Hospital Trusts responding to us said they had signed up to the RCOG's Medical Training Initiative (MTI) Overseas Doctors Scheme. The programme is open to doctors of the equivalent experience of ST2-4, and the RCOG summarises the scheme on its website as follows:

> *The MTI scheme allows International Medical Graduates (IMGs) to come to the UK for a maximum of two years to train within the NHS. IMGs benefit greatly from the knowledge, skills and techniques learned within the NHS and can use them to improve the level of patient care in their home country on their return. In addition, UK hospitals who provide a placement for IMGs benefit from increased workforce capacity and the skills and knowledge that IMGs can share with their UK colleagues.*[8]

The hospitals using the MTI scheme typically recruited between one and three doctors in training this way, and all of them felt that its implementation has been successful. While the use of the MTI scheme is not a panacea for the nationwide staffing issues with middle-grades, as part of a holistic, proactive approach to sustaining the necessary clinical competencies alongside options such as Hybrid rotas, it could be useful.

Other Overseas Training Partnerships:

Leeds University Hospitals Trust explained that as well as being part of the RCOG's MTI scheme, they have a regular arrangement with the College of Physicians and Surgeons in Pakistan which provides two doctors in non-training middle grade posts.

Overseas Agency Recruitment

Several Trusts responding to our request explained that they had utilised agencies for overseas recruitment. Names of agencies were not typically given, though the company Remedium Ltd was mentioned in one response. All those who mentioned using agencies to fill vacancies claimed they had recruited successfully for these positions.

Incentives/Benefits Packages as a Means of Attracting Doctors

[8] https://www.rcog.org.uk/en/careers-training/working-in-britain-for-non-uk-doctors/medical-training-initiative-mti-scheme/

Four hospital Trusts told us they offered incentives or supplements for newly appointed obstetricians. Examples include:

- Relocation expenses paid
- Staff benefits e.g. salary sacrifice schemes available, home electronics, cycle to work scheme and lease cars
- £3,000 paid to middle grades on commencement of employment
- Discounted on-site nursery facility
- Free gym membership
- Additional training opportunities

Conclusion:

From this research, which a small number of volunteers for KTHG have compiled in their spare time, it is evident that there are avenues for creating a sustainably resourced obstetric unit at the Horton, of which no exploration has been demonstrated (e.g. use of overseas recruitment programmes, the RCOG's MTI scheme), or which have been dismissed prematurely as being unviable without showing any evidence for this (e.g. Trust management claiming that there's no point using Hybrid rotas as they're too expensive, despite them being proven by the RCOG to be cheaper than alternatives such as using locums).

The IRP report in 2008 directed that, in the interests of patient safety, every possible effort to sustain a CLU at the Horton should be made. Individuals we have spoken to at other small obstetric units have spoken of the hard work which has gone into maintaining training accreditation and their pride at the success of this, for example at Morecambe Bay Hospital Trust. Our obstetrician contact at Pilgrim Hospital in Boston, Lincolnshire, commented that "the Trust and Consultant obstetricians have together worked very hard to maintain training accreditation here". Reflecting on this research, it strikes us that the the issues small CLUs face which threaten their sustainability needn't be insurmountable if there is the will and ingenuity to overcome them within Hospital Trusts.

GK Transformation

OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

Horton Hospital Condition Survey

Ref: R/1986.02
March 2017

CONTENTS

1 INTRODUCTION

1.1 Background

The Oxford University Hospitals NHS Foundation Trust had a number of concerns about the condition of its estate at the Horton Hospital. In advance of any redevelopment planning the Trust was keen to develop an authoritative assessment of its Horton Hospital estate that would identify any risks associated with the building being below condition B and thereby help to inform the development of an affordable and sustainable estates strategy going forward. The Trust therefore requested a condition survey to be undertaken.

The approximate area of the Hospital is 29,000m2.

The Horton has approx. 230 beds.

The condition survey focused on the Physical condition (Fabric and M&E) and statutory compliance of the Horton Hospital, identifying any areas that are below condition B.

The survey covered the Trust's Horton hospital site only and did not include any other aspects of a six facet survey, i.e. quality, space utilisation, functional suitability, environmental management or a Disability Access Audit.

1.2 Terms of Reference

The key objectives of this condition survey were to develop a comprehensive assessment of the Horton Hospital estate that includes;

- a summary report setting out the findings in relation to the condition survey
- a schedule of each department/floor of each building detailing condition, quality and costs to bring up to Condition B
- a schedule of the main assets, plant and infrastructure and an assessment of its condition and costs to bring up to standard
- a schedule detailing all areas of non-compliance with statutory standards

1.3 Overview

The Foundation Trust's estate is an important financial asset and one of a number of key enablers of modern healthcare delivery.

The standard of the physical environment impacts directly on the Patient experience and indirectly on staff to enable them to deliver quality care.

The Care Quality Commission [CQC] guidance for compliance states that health organisations should ensure against the risk associated with unsafe or unsuitable premises by means of;

- Suitable design and layout.
- Adequate maintenance of its premises and grounds.

The purpose of this report is to identify the key operational estates risks within the Horton Hospital and estimate the costs, where practicable, to remedy.

The findings of the report can be used to help inform decision making about the future development of the Horton Hospital by highlighting key estate risks and where they reside. An estimate of cost for remedy of reported defects is also provided.

- This report sets out the findings of a recently undertaken survey of the estate that risk assesses the hospitals buildings, engineering systems and infrastructure.

- The survey was carried out by GK Transformation (GKT) during the last quarter of 2016. GKT have worked closely with Trust Operational Estates Managers at Horton hospital in the development of this document.

- Department of health Guidance for '**A risk based methodology for establishing & managing Estate backlog**' has been used to structure the Condition Appraisal.

2 METHODOLOGY AND SUMMARY OF SURVEY FINDINGS

2.1 Physical Condition Methodology

The assessment is based on the Department of Health's guidance and methodology and appraises the condition of the Horton Hospital buildings. Any component part of a building that is evaluated to be below a satisfactory condition [condition B] for its intended operation is given a **cost** to remedy and a **risk rating** to help with setting priorities for investment.

The assessment is built up by building block and covers all the main building components, engineering elements and plant requirements.

The appraisal brings together, in one place, the estimated investment needs of the estate for the buildings it plans to continue to occupy over the next five to ten-year period.

The appraisal is risk-assessed to enable high and significant risks to be quickly identified and prioritised.

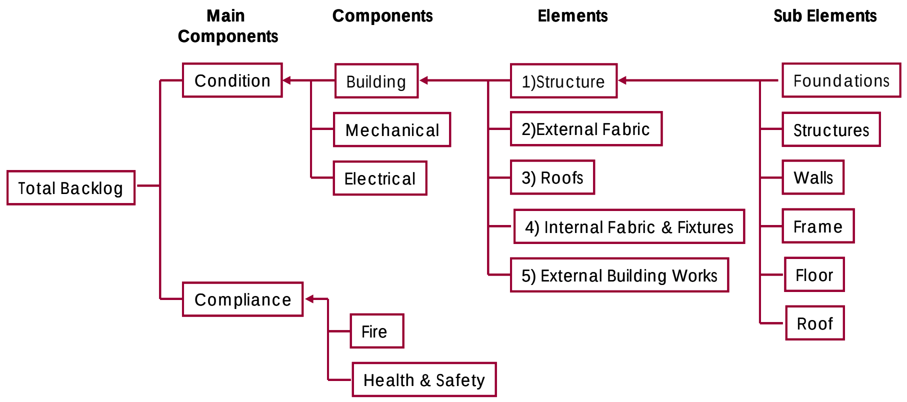
The risk assessment uses a 5 x 5 matrix for severity and likelihood [see Appendix 1: Risk Assessment 5 X 5 Matrix] and follows DH guidance on the need to separate degrees of investment into low, moderate, significant and high risk following a local risk assessment.

The results are held in an excel spreadsheet. Each building has its own sheet where defects are described, risk rated, a remedy stated with an estimate of cost for implementation. These Excel sheets are shown in Appendix 2.

The appraisal highlights key risks and overall investment needs to bring the facility back into a satisfactory condition. The appraisal does not grade any space function or utilisation factors but mention may be made where there are significant shortfalls in space standards from current practice.

The appraisal can be used to highlight operational risk and the development of an Estate Strategy for the future use of the site.

Risk Adjusted Backlog Process



Notes:

a. Each building on a site is assessed for condition and statutory compliance by sub elements. Condition includes all building and engineering components, plant an infrastructure items.

b. They are ranked A – D in accordance with DoH Estates definitions. Costs are assessed to bring elements back up to B standard where they fall below this ranking.

c. Sub elements below B are then risk assessed and categorised as either low, moderate, significant or high. A risk matrix that assesses consequence and probability is used for this process.

d. The “bottom-up” approach enables investment needs to be readily re-assessed to take account of future site development and planned changes to the estate asset base. In turn, this helps to formulate future estate strategy proposals and the likely impact on the investment profile of the estate of any proposed change.

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The Department of Health requires Trusts to produce a risk adjusted backlog figure from the following algorithm:

$$\text{High \& Significant Risk Cost} + \frac{\text{Moderate and Low Risk Cost}}{\text{Remaining Average Life of Buildings}} = \text{Risk Adjusted Backlog}$$

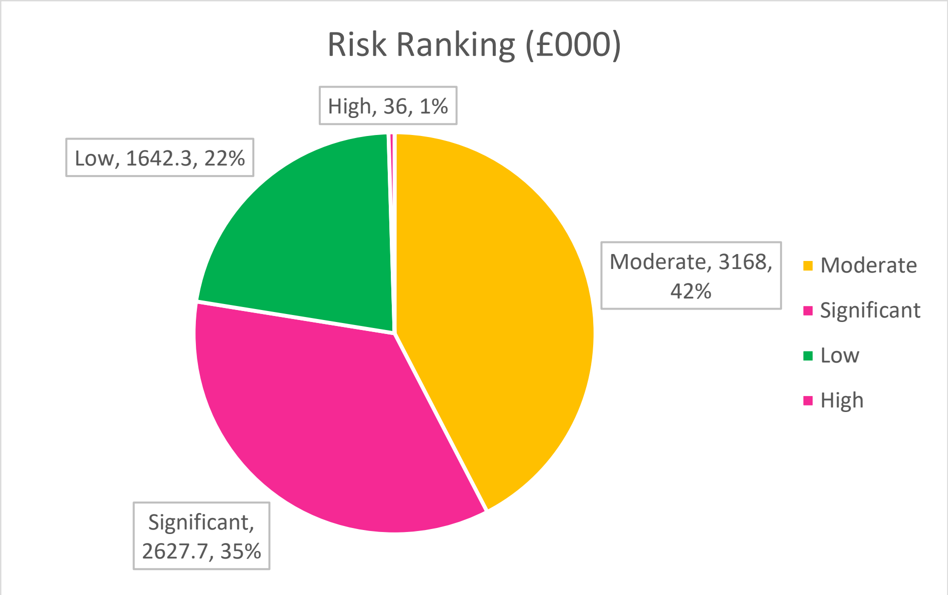
The remaining lives are derived from the District Valuer’s report on the value of the estate.

2.2 Summary of Findings

The estimated total investment for bringing the Trusts estate back up to Condition B [satisfactory] on a like-for-like basis is some **£7.4million**. This estimate does not include professional and design fees, VAT, scaffolding and other access and decant costs. Where practicable, the costs do include replacement and repair to current technical standards.

The Hospital's estimated Risk adjusted Backlog is some **£2.9m,** based on an average remaining life of 15/20 years.

The survey findings are categorised as per the Department of Health's methodology into four risk ratings; High, Significant, Moderate and Low. (See Chart Below)



This estimate of **£7.4m** is a significant increase from the Trusts last reported ERIC (Estates Return Information Collection) of **£2.7**million

The estimate of £7.4 M includes £2m of Asbestos risk which has not have been included in the ERIC return as it is strictly speaking not a maintenance backlog issue.

The asbestos is however a large risk to the Trust Estate both operationally and to future development plans. It is recommended that for local Trust Reports based on risk the asbestos is included.

Highest risks, other than Asbestos, are the hospital's ventilation systems, Electrical systems and Safe Structures.

3 ANALYSIS OF SURVEY RESULTS

3.1 Overview of Hospital

Horton Hospital is a small Acute Hospital in Banbury and is part of a much larger estate managed and operated by Oxford University Hospitals NHS Foundation Trust. The hospital comprises of approximately **30,700 m^2** of buildings (including the Treatment Centre- 5000m2) spread over a **9.9 hectare** site located close to the centre of Banbury, 30 miles north of Oxford. The Hospital serves local and Oxford based patients.

The Hospital has approximately 200 beds, 4 main theatres, an Emergency Department, OPD (circa 100,000 attendances), Renal Services, CCU and Clinical and Non clinical Support Services.

The Hospital was originally built in the late 1800's and has had a number of subsequent phases of building between the 1940's and 1980's (some constructed with the Oxford Method of building).

Subsequent late 80's buildings are the Medical Block and the Children's ward was added in the 90's. The newest building constructed on site is the Treatment Centre which is a 3 storey tradition built facility which was, until recently, independently operated. The Hospital shares the site with Local Mental Health Trust and there are also some small independently run residential buildings on site.

The site drawing below shows the age profile of the hospitals buildings.

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Age Profile By Building

Year Built	Block No.	Age (years)
1862 - 1882	Blocks 01-07	150 years
1942	Blocks 09-14	75 years
1947	Blocks 15-18	70 years
1957	Blocks 19-25	60 years
1967	Blocks 30-35	50 years
1970	Blocks 36-38	47 years
1982	Blocks 40-44	35 years
1988	Blocks 56-59	29 years
1991 - 1992	Blocks 60-62	25 years
1995 - 1996	Blocks 64-65*	22 years
2011	Block 69	6 years

Notes

Denotes: Blocks 10 & 15 vacant and awaiting demolition. OPD Portacabin adjacent to Block 42 is dilapidated & requires decommissioning/removal.

Age Profil by Building
Site Plan as Existing
Horton General Hospital

Oxford University Hospitals
NHS Foundation Trust NHS

3.2 Survey Results and Analysis

The bottom line cost estimate for remedying identified defects is in the order of £7.4 million. This excludes VAT, associated fees, decant and enabling works, all of which can add a further 40% to this figure.

The £7.4 million includes a sum of £2 million for Asbestos risk to reflect the significant presence of the material on site. The risk is currently operationally managed but restricts development needs and maintenance requirements due to no or limited access.

The table below splits the estimated £7.4 million investment requirement into Risk bands (High, Significant, Moderate and Low) against Building and Engineering elements.

The investment needs are shown in descending order of the total expenditure.

Safe structures (includes Asbestos) is the greatest amount at 28% of the total

This is followed by External fabric at 15%, Ventilation at 12.5%, Infrastructure at 12% and Electrical Systems at 8%

These 5 elements equate to some 80% of the overall requirement.

Further detail of the element defect and remedy is available from the survey sheets in Appendix 2.

Element	Low £000	Moderate £000	Significant £000	High £000	Grand Total £000
20. Safe structures		1,200	875		2,075
02. External Fabric	139	860	100		1,099
09. VENTILATION SYSTEMS	225	70	650		945
04. Internal fabric and fittings	687	123	67	6	883
13. ELECTRICAL SYSTEMS	260	80	502	30	872
03. Roofs	70	405			475
06. ENERGY CENTRE SYSTEMS	200		210		410
11. LIFTS & HOISTS		220			220
01. Structure		90	28		118
05. External fabric and fittings	20	80	15		115
17. Passive fire precautions	2	15	89		106
07. HEATING SYSTEMS	30	25	0		55
08. HOT & COLD WATER SYSTEMS			45		45
12. FIXED PLANT and EQUIPMENT			20		20
25. Access standards	8		5		13
15. COMMUNICATION SYSTEMS			10		10
19. Fire safety culture			10		10
14. ALARMS & DETECTION SYSTEMS			3		3
24. Energy measures	1				1
	1,642	**3,168**	**2,628**	**36**	**7,474**

High and Signiant risks can also be broken down against individual risk scores as below.

Element	Risk Score				
	12	15	16	20	Grand Total
	£000	£000	£000	£000	£000
01. Structure			28		28
02. External Fabric	90		10		100
04. Internal fabric and fittings	65		2	6	73
05. External fabric and fittings			15		15
06. ENERGY CENTRE SYSTEMS	130	80			210
08. HOT & COLD WATER SYSTEMS			45		45
09. VENTILATION SYSTEMS	650				650
12. FIXED PLANT and EQUIPMENT	20				20
13. ELECTRICAL SYSTEMS	20		482	30	532
14. ALARMS & DETECTION SYSTEMS			3		3
15. COMMUNICATION SYSTEMS	10				10
17. Passive fire precautions	23		66		89
19. Fire safety culture			10		10
20. Safe structures	415		460		875
25. Access standards	5				5
Grand Total	**1,428**	**80**	**1,120**	**36**	**2,664**

The above tables show the cost of remedying defects by risk and estate element but it is useful to look at risk items against location.

The table below shows risk against building cluster blocks.

Total expenditure by location is analysed and also the risks within each location.

This analysis can greatly assess priorities and to help ensure higher rated risks are focussed on.

	Description	Low £000	Moderate £000	Significant £000	High £000	Grand Total £000
a	Victorian Bldgs.	52	137	3		192
b	OPD	63	225	73		361
c	1942 Bldgs.	83	130	6		218
f	Medical Block	488	513	35		1,036
g	Childrens /Physio	40	9	27		76
h	Theatres	67	130	500		697
i	Boiler / workshp.	2				2
k	X Ray	35		62		97
l	E.Dept.	76	70	25		171
m	CCU / OT	14		26	6	46
n	E Ward/DSU	68	5	11		84
o	Maternity	224	73	614		911
p	Pathology	46	214	26		285
q	Chapel	2	17			19
r	Women's Day	47	26	2		75
s	Restaurant/Kit	7	87			94
t	Stores / linen	18		1		19
u	League of F	5	2			7
v	Corridors	1	110	8		119
w	Post Grad	67	60			127
z	Infrastructure	240	1,360	1,210	30	2,840
Grand Total		**1,642**	**3,168**	**2,628**	**36**	**7,474**

Key areas are Infrastructure, CCU, Theatres and Maternity

A comparative unit cost of investment needs per building can be analysed by dividing the total investment per building by its area; investment (or backlog) per m^2 (gross internal area - GIA). The site plan below has banded these rates into 4 groups.

The purple coloured buildings have the highest £ rate/ m2, at over £300.00 m^2.

The Maternity, Theatres & OPD fall into this bracket.

At the other end of the scale, buildings coloured blue have an investment rate of less than £50.00 per m^2 The Treatment Centre and new Endoscopy Unit are examples.

The Median value for all the site buildings is £152.00 per m^2

Investment

£/m² by Cluster

0 - 49	£/m²
50 - 149	£/m²
150 - 299	£/m²
300+	£/m²

Median = 152 £/m²

Buildings to be Demolished

Notes:

- Median rate across the site = 152 £/m².
- Shows Maternity, Theatres & Out Patients as the areas requiring the highest rate of investment per m².

Investment by £/m² Ratings
Site Plan as Existing
Horton General Hospital

Oxford University Hospitals NHS Foundation Trust NHS

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4 SITE BUILDING AND SERVICES NOTES

This section briefly describes the estate component elements and includes site photographs

4.1 Roads & Car Parks

The internal hospital site roads overall appear to be in good condition with the exception of a few minor repairs required around the site.

There are 3 main road entrances to the site; 2 off Oxford road and the other off Hightown Road. There is a perimeter road to the back of the site which links the west Oxford road entry point to Hightown road in the east. A small amount of car parking is available off the eastern Oxford Road entrance, around the original Hospital buildings.

This Car park and those off Hightown Road serve the Maternity, Treatment Centre and Medical Block and are in good condition and well- marked out. The overflow car park to the staff parking areas is unsurfaced, without any markings. The condition of the internal roads is good. The hospitals energy centre and supply hub are located in the western part of the site and can be served without the need of dragging traffic through the site. There is a small surfaced car park to the Post Grad and Training Centre.

Car parking appears to be well utilised but adequate for the Hospitals current needs. Future traffic demands will require assessment, once service delivery plans are known for the site but there are opportunities to rationalise and supplement the existing arrangements.

Paved areas are generally good around the site, except where they have been driven over or parked on, which has caused cracked and broken paving. Some internal courtyard paving stones require to be cleared of leaves, particularly to formal fire escape areas. (Adjacent to Block64)

4.2 Grounds Security

Site boundaries are generally sound and in good condition and secure, as far as they can be in a publicly-accessible site.

Site security cameras did not form part of the survey but are an important deterrent to crime and vandalism. The site entrances are generally ‘open’ and individual buildings have controlled access.

4.3 Foul and Surface Water Drainage Systems

The drainage system operates satisfactorily other than occasional blockages due to misuse. The surface drainage to the back of the site is dependent on soakaway systems which are undersized. This results in ponding of surface water during periods of heavy rainfall. Any reconfiguration of the hospital will need to take this shortfall into account. The external drains generally appear to be in reasonable condition and of adequate capacity.

4.4 Roofs and Gutters

There is a variety of pitched and flat roofs on site which vary in their age but most appear to be in a reasonable condition.

The exceptions to this are the flat roofs to the Maternity Block (30), the flat roofs above the main link corridor where they have not already been replaced, the asbestos sheet roof to Central stores area (25) and pitched roof to the former gatehouse(5). The flat roofs to the older former wards vary in their condition but are all subject to patch repairs (11,12,13,14,16&19)


Main Spine Corridor Roof


Asbestos Roof Panels to Supplies

The Maternity Block has 3 main areas of flat roof, all of which are showing signs of deterioration due to the age of the buildings and having had patch repairs done to leaks in the past.

The main flat roof needs to be renewed within the next 3 years and lightweight roofing lights taken out and roofed over to remove the associated risks of people falling through them.

Access to the roof areas are by the external fire escape and then vertical ladders which are secured by gates kept locked.


Main Maternity Roof


Maternity Lower Roof

Unprotected External Fire Escape Stair

4.5 Structural Issues

4.5.1 Maternity Building (30)

The concrete framed building suffers from spalling to the fascia and soffit panels where insufficient concrete cover to the reinforcement bars occurs. The Trust estates team have carried out the requisite structural surveys and raked off any loose material and treated the steelwork that is exposed to prevent further corrosion. Nonetheless, this is an on-going problem and results in the building looking very unsightly. The first floor soffits represent a potential risk to passing pedestrians from falling debris although this is minimised by rigorous inspection by the estates team. Any future use of the 50 year old building should allow for these areas to be fully stripped back, cleaned and re-clad or re-rendered and decorated as a minimum.

Maternity Elevation

The older 1942 single brick wall structures with flat roofs are all beyond their life expectancy. The buildings vary in condition and are occupied by administrative and support functions. These buildings are not worth investing in and should be planned to be replaced over the next 3 years.

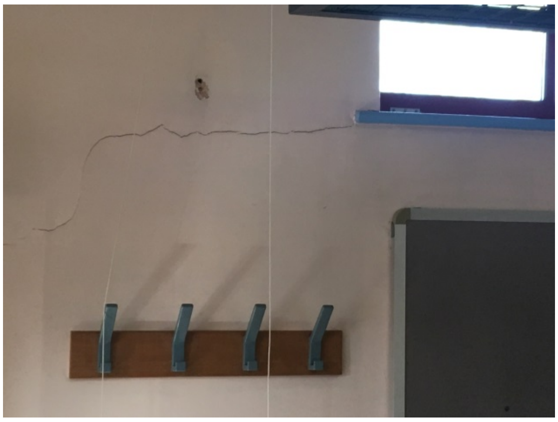
The Victorian Buildings to the south frontage of the site date from an earlier period, 1862-1882, but are of better architectural quality than the 1940's structures. The Hospital borders a Conservation area and it is likely that the core of these buildings will need to be retained. They are not suitable for any clinical care functions.


Victorian Buildings


1942 Buildings

4.5.2 Physio/Occupational Health (61)

The first floor gable end has several cracks. These may have been caused by the building settling after the extension was built to the Children's ward below. Further inspection/investigation is required to check the stability and that it is not progressive.


Crack to Gable Wall, Therapy Department

4.5.3 Records storage/Gatehouse (5)

There is some evidence of settlement/subsidence to the Hightown Road elevation which may need remedial action, subject to structural report findings.

4.5.4 Oxford Method Buildings

Cladding panels showing signs of de-lamination of coating and peeling, particularly at low level. Immediate action is needed to treat and re-protect. In the longer term the buildings could be re-clad.
(Blocks;36,32,41,37,25)

Oxford Building Cladding

4.5.5 Accessibility

A specialist Access Audit was not carried out as part of this survey and is something that will need further consideration as the Hospital develops in the future. Buildings should be fully accessible, to the standards set out in BS 8300, Building Regulations(Part M).

We recommend that the Trust commissions a comprehensive audit of accessibility within the site at an appropriate time.

The Double door access from the Medical Block via the link to the main buildings are difficult to negotiate for people with walking problems and should be replaced, preferably with automatic door sets providing adequate draught lobbies. This has been included in the backlog costings.

4.5.6 Modular and Temporary Buildings

There only a few of these type of buildings on the site. The OPD Portacabin is in very poor condition and at the end of its life. It should be decommissioned and removed from site.

OPD Portacabin in Poor Repair

4.5.7 Upgrading and Redecoration

The general décor is subject to a rolling programme dependent on available funding but 5 & 7 year cyclical external and internal painting are usually adopted as best practice. Areas that receive more wear may require more frequent redecoration; main entrances, corridors etc.
There are some Wards and parts of OPD which are now in need of redecoration.

Floor finishes are subject to periodic replacement for example, the corridor areas have recently been re-floored. The Medical Building requires new floor finishes to ward areas within the next few years.

4.5.8 Fire Safety

A full fire survey was not undertaken as part of the survey but it is understood that all Fire risk assessments are in place and the site is managed accordingly. The Fire alarm is L1 compliant

Fire drawings were displayed for escape routes but these did not include compartmentation walls. It is understood that the Trust fire lead person has full compartmentation drawings and this aspect forms part of the risk assessments.

The survey did identify external fire-escape stairs that were not protected, some escape routes clogged with leaves and one adjacent to the Pathology block that was locked. It was also noted that fire doors in several places were aged and/or damaged. Backlog items have been included in the investment figures


Maternity external fire escape


Fire doors requiring replacement


Integrity between door and overhead glass panel

4.5.9 Asbestos

Asbestos management is proactively managed and the presence of significant amounts restricts further development in areas such as the Radiology department. Asbestos is managed satisfactorily but exists in floors, walls and ceilings.

The Trust has an 'asbestos policy' which sets out responsibilities and procedures and from the evidence seen this is being followed.

The survey investment sums include a figure of £2million as part of Infrastructure costs, split at £400,000 per annum over 5 years to progressively remove the asbestos from site.

4.5.10 Windows

Glazing is a mix of single and double glazing units, age and frame type.

The Medical Block has single glazed metal framed units which are subject to complaints about comfort and draughts, particularly in patient areas.

Maternity first floor windows are weak strength PVC units with top lights that exceed the maximum opening distance of 100mm

In general, the survey has included all single glazed areas for renewal.

Lightweight roof lights to Pathology and Maternity flat roof areas should be removed and appropriately roofed over or upgraded to required standards.

Maternity Roof and Roof Lights

4.5.11 Access and Edge Protection

Access to roofs is in most cases controlled by key. This applies to the highest roofs. Where access is by vertical ladder, most locations can only be accessed by passing through a controlled door.

Roof protection is generally well provided although the escape stair from the main spine roof near Pathology requires roof protection as a matter of urgency.

Lack of Edge Protection

4.6 Engineering Infrastructure

4.6.1 Plant Rooms

Generally, plant rooms are in clean and tidy condition. Most plant has been well maintained on a day-to-day basis reflecting good levels of planned and reactive maintenance performed by competent people.

4.6.2 Energy Centre

The energy centre provided low pressure hot water from four boilers. Three are relatively new and do not require any investment other than routine maintenance for the foreseeable future. The fourth boiler is approaching the end of its life and a replacement should be planned. Advantage can also be taken at the same time to remove the now ageing chimney structure which will not be required for modern plant using ultra low sulphur fuel.

The boilers provide a single heat source for a site wide constant temperature heating system. This system originally fed a number of blending stations in order to modulate the heating flow temperatures depending on heat demand. The majority of these blending stations are now not in use and require replacement.

The two oil storage tanks are showing signs of advanced external and internal corrosion. The two tanks have both been decommissioned and vented and there is now only one tank in use the remaining tank should be removed from site (£55k estimate) and consideration be given to providing a small reserve tank to enable maintenance to be carried out to the remaining tank (£25k estimate).

The heat distribution pumps are dated and very energy inefficient. These should also be considered for replacement.

The Trust may wish to consider combining these issues into a single energy centre upgrade or to consider a broader scheme to upgrade the energy infrastructure as part of a carbon reduction initiative.

DEFECT ITEM	LOCATION	REMEDY	RANK	£000	Consqn	Likelyhd	Risk Sc
Boiler Plant	Energy Centre	Replace & Remove Chimney	B(C)	200	3	2	6
Heating Pumps	Energy Centre	Replace with Modern Equivalent	B(C)	20	3	2	6
Energy Distribution	Site Sectional Heating Stations (7 of.)	Replace with Modern Equivalent	C	100	4	3	12
Energy Distribution	Block 2 Sectional Heating Stations	Replace with Modern Equivalent	C	30	4	3	12

Boilers are generally operated at a fixed temperature to supply heat to constant temperature circuits, variable temperature heating circuits, through three-port valves, and primary supplies to hot water generation. Many of the three port valve blending stations controlling the heating circuits to departments have been bypassed or are not working. The absence or age of, control systems means that the plant runs at below optimum efficiency.

Hot water generation for the major users is by plate heat exchangers with large centralised buffer vessels to provide resilience at times of high demand. Buffer vessels of this type do require maintenance and regular monitoring due to legionella risk and the Trust may wish to consider if they could be removed.

4.6.3 Steam Distribution

There is a small steam generation and steam distribution system on site limited to the provision of steam supplies for autoclaves in pathology and SSD. The heat losses from the distribution system will render this system very inefficient. The system is however in good condition and should be serviceable for at least five years (therefore not identified in backlog 5 year plan). If autoclave facilities are to be retained, the Trust might consider local steam generation being specified when autoclaves are replaced.

4.6.4 Water Systems

This report does not cover a detailed survey of water systems other than to identify where major plant replacement is required. With the exception of a lack of blending valves to wash hand basins, there were no significant defects identified in the domestic hot and cold water distribution systems. However, the Trust should also refer to the water risk assessments carried out under the HTM04-01 series of documents.

4.6.5 Ventilation Plant

The majority of the ventilation plant within the hospital is at or beyond its expected life. There are several areas where plant is performing poorly.

Main concerns are:
Operating theatres ventilation does not comply with current (nor previous) design guidance. A recirculation system is employed with bespoke ultra clean systems. This is dependent on all supply air being h.e.p.a filtered and routine microbiological testing. This varies significantly from all recognised standards and should not be seen as good practice. Additionally, the systems are well beyond their normal expected life.

Ventilation plant serving general ward areas do not comply with current standards and are close to the end of their expected life cycle.

Maternity theatre plant is well beyond its expected life and is in an advanced state of dilapidation. The air distribution system within the theatre will not give adequate flow distribution within the space.

Because of age, the majority of other air handling units on site do not comply with current standards.

It was noted that there was no forced ventilation within CCU which contravenes current HBN 04.02 and HTM guidance.

Dept/level.	Sub Element	Defect	Remedy
Maternity	Ventilation Plant	Numerous compliance issues	Replace AHU and ancillary equipment
Mortuary	Air Handling Units: External	In an advanced state of dilapidation	Remove/Replace if required
X-Ray	Air Handling Units: External	Exceeded life expectancy	Replace
Theatres	Air Handling Units: Internal	Non-compliant	Replace
EAU/Laburnum & Amb Plant Room	Ventilation Plant	Rowan Day Unit Supply & Extract AHU: non-compliant	Replace
EAU/Laburnum & Amb Plant Room	Ventilation Plant	Ambulatory Care Unit Dirty Extract AHU: non-compliant	Replace
EAU/Laburnum & Amb Plant Room	Ventilation Plant	EAU & Laburnum Supply AHU: non-compliant	Replace
EAU/Laburnum & Amb Plant Room	Ventilation Plant	EAU & Laburnum Clean & Dirty Extract AHUs: non-compliant	Replace
EAU/Laburnum & Amb Plant Room	Ventilation Plant	Laburnum side rooms Supply AHU: exceeded life expectancy	Replace
EAU/Laburnum & Amb Plant Room	Ventilation Plant	Oak & Juniper Supply AHU: non-compliant	Replace
EAU/Laburnum & Amb Plant Room	Ventilation Plant	Oak & Juniper Clean & Dirty Extract AHUs: non-compliant	Replace
A&E	Air Handling Units : Internal	AHU exceeded life expectancy	Replace
Women's Day Case Unit	Ventilation Plant	Colposcopy room has no mechanical ventilation	Install system in order to provide a positively pressured environment

4.6.6 Medical Gas Systems

The majority of medical gas plant and distribution is to an acceptable standard with much of the central plant having recently been replaced. The Oxygen VIE is a single unit with bottled back up and this represents a single point of failure. The Trust should consider a second VIE located appropriately in accordance with HTM 02.01.

4.6.7 Lifts and Hoists

Most of the 6 lifts appear to be in reasonable condition and the AE report does not identify any significant issues. However, 2 lifts were identified as being problematic and should be considered for replacement:

Dept./level.	Sub Element	Defect	Remedy
EAU/Laburnum & Amb Ground Floor	Passenger Lift	Breaks down frequently/not suitable for Hospital Beds.	Replace with new Bed Lift.
Kitchen	Goods Lift	1 out of 2 lifts fail from time to time	replace with new goods lift.

4.6.8 Electrical Infrastructure

The site is supplied at High Voltage with an internal HV interconnector. There is some doubt relating to the fault current carrying capacity of this interconnector which appears undersized. This requires further investigation by an appropriately qualified engineer. With this exception, the HV infrastructure appears to be in acceptable condition and has been subject to review by the Trust's Authorising Engineer (HV).

There are a number of concerns with the LV infrastructure, particularly main distribution and section boards. There is an investment need of some £310,000 (exc. fees, vat and temporary supplies etc.) to upgrade aged and failing switchgear. The following summarises the requirements:

Dept/level.	Sub Element	Defect	Remedy
A-Sub LV Switchgear	Electrical Main Distribution	Malfunctioning Switch & Now Exceeded Life Expectancy	Replace
B-Sub LV Switchgear	Electrical Main Distribution	Now Exceeded Life Expectancy	Replace
Main DB & change-over panel	Switchgear	Now Exceeded Life Expectancy	Replace
X-Ray DB (Radiology Corridor)	Switchgear	Now Exceeded Life Expectancy	Replace
Medical Block Main Switchgear	Switchgear	Now Exceeded Life Expectancy	Replace
Pathology Lower - main DB & change-over panel	Switchgear	Now Exceeded Life Expectancy	Replace
Pathology Upper – Section-board	Switchgear	Non Compliant & Now Exceeded Life Expectancy	Replace
Old Theatre Block - Uncontrolled Switchgear	Switchgear	Now Exceeded Life Expectancy & Discrimination?	Replace
Under Block 2 - Electrical Switch Room	Switchgear	Now Exceeded Life Expectancy	Replace

Generators are in satisfactory condition but should be maintained and tested in accordance with HTM 06 01 part B to ensure continuing reliability.

4.6.9 Electrical Systems

A number of installations within buildings require minor works. The exception is the maternity building which falls far short of current requirements and requires a full replacement of the electrical installation.

4.6.10 Telecoms and Data Systems

Voice and data systems were not reviewed as part of this survey, so no observations can be made about operational and strategic issues.

4.6.11 Lighting

Lighting is old in some buildings through the site but is generally being replaced over time when resources become available.
Improvements can be made at 3 levels: 1) Illumination 2) Aesthetics and 3) Carbon efficiency.

The Trust should develop a planned replacement programme, based on cost reduction and lighting improvement.
There is considerable evidence for carbon saving, increased service life and improved effectiveness of lighting using modern T5 and LED luminaries, which are particularly suitable for use with lighting controls.

Emergency lighting is provided to escape routes, and this appears to be adequate. However, Lighting Guide 2; Hospitals and health care buildings, (CIBSE/SLL) notes that emergency lighting is also required for areas over 60 M2, toilets over 8 M2 or with no external windows, lifts, and plant rooms. This provision is for safety reasons, and appears to be generally absent.

4.6.12 Pressure Systems

Pressure vessels are few due to the engineering systems deployed, but are all subject to an Authorising Engineer report and Insurance inspections.

4.6.13 Energy Conservation

Whilst energy saving advice is not the direct remit of this report, there are a lot of references in the text above to backlog improvements which might impact on energy consumption.

Summarising:-

- Building fabric standards vary and though there is not a lot of opportunities for insulation, cavity walls and roof-spaces must be treated. Improving windows, external insulation of flat roofs and general draught-proofing will pay for themselves.

- Standards of insulation on pipes and ducts, and hot and cold plant surfaces, vary from adequate to poor. Failed insulation should be replaced, inadequate insulation should be upgraded, and uninsulated components should be insulated.

- The Building Management System is not sufficiently comprehensive. Automatic control with plant and utilities monitoring is a useful energy management tool. The BMS should be extended both in the area it covers and its functionality. The survey has not included these costs as Backlog.

- There is very little energy recovery from ventilation systems. This is mostly because of their age, and the configurations do not lend themselves to retrofitting. For new plant, though, energy recovery should be a key consideration. Where heat extracted cannot be used in the supply, then there may be other places it could be used. An integrated approach should be adopted where feasible.

- The use of heat pump technologies such as the Colt 'Caloris' system, which will integrate effectively with other systems and can be closely controlled.

- Older lighting could be replaced with operational savings. The pay-back times need to be considered when deciding on priorities

5 CONCLUSIONS

The scale of the investment required to remedy the estate risks and to put back into a satisfactory condition has been assessed at some £7.4 million (Ex VAT, Fees, Enabling works)

The Risk Adjusted figure for Critical backlog is some **£2.9** million.

This is significantly higher than previously reported figures of £2.7million with a risk adjusted figure of £1.4 million. (ERIC 2015/16)

High risk items are less than 1% of those identified and represent £60,000.00 requirement for CCU ventilation systems and £300,000.00 urgent infrastructure works to electrical systems.

Significant risk items amount to £2.6 million of required investment. The main areas are Theatre ventilation systems, the Maternity building and infrastructure requirements.

Moderate risk items total some £3.1 million and **Low risk** some £1.6m.

The survey investment sums can be spread over a 5 year period and the table below indicates a possible pattern of expenditure.

In practice, a judgement needs to be made on where best to target expenditure to minimise risk but also to reflect any emergent development plans for the site.

- The former Nurses Home and old Theatre blocks are scheduled for demolition and these works have not formed part of this appraisal. Early demolition of these areas will reduce operational risk as well as opening up the site to further development opportunities.

- The single storey, flat roofed 1942 structures have exceeded their life expectancy and further investment is folly.

- Infrastructure investment includes £2million for Asbestos risk but this is not likely to be expended until the need arises to redevelop areas where disturbing asbestos is inevitable; Radiology Department for example.

- The first floor of the Maternity block is currently unoccupied, and the survey has identified nearly a £1 million of risk in the building, some of which will need to be expended prior to any clinical reuse of the facility. The building is 50 years old and has some structural problems and upgrade requirements. The future continued use of the building will need to be considered.

The Treatment Centre has not formed part of this appraisal but when it reverts back to Trust control it will have a key impact on the rest of the development plans for the site.

Treatment Centre (GIA-5000m^2)

The Medical block is nearly 30 years old and a significant building on site. The wards are undersized for multiple bedded areas compared to modern space standards (HBN 04). The four bedded bays are tight on space and management of patients is compromised by this. An investment need of just over a £1 million investment need has been identified by this survey.

Medical Block (GIA-4566m^2)

The existing Theatres has 4 undersized theatres (34m2 compared to modern standard of 50m2) and although serviceable with further investment ,their size my restrict their type of use.

The table below provides an initial indicative spread of expenditure which will need to be adjusted to take account of the above issues and future planning needs for the site.

Cluster	Investment Year							
	Block	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23	Grand Total
A	1-5+22&23	3	3	2.5	95		88	191.5
B	21		31	47	48	27	207.5	360.5
C	11-19	2.5	28		105	2.5	80	218
F	56	60	41	225	610	70	30	1,036
G	61	12	24			28	12	76
H	41&42		535		25	107	30	697
I	34&40				2			2
K	38		12	50	35			97
L	57	8	60	25	70	7.5		170.5
M	37		32		8	6		46
N	32	10	21		30	22.8		83.8
O	30	342	330.2	95	59	25	60	911.2
P	36	12.5	50		35	97.5	90	285
Q	62				7		12	19
R	64		33		25	16.5		74.5
S	58		7	80	7			94
T	25		1			18		19
U	68				2		5	7
V	35		9		25		85	119
W	7		2		65		60	127
Z	Infrastruct	160	850	450	530	400	450	2,840
Grand Total		**610**	**2,069.2**	**974.5**	**1,783**	**827.8**	**1,209.5**	**7,474**

Appendix 1: Risk Assessment 5 X 5 Matrix

SCORE RANGE	RISK RANKING
1 – 6	LOW
7 – 10	MODERATE
11 – 16	SIGNIFICANT
17 -25	HIGH

	PROBABILITY OF FAILURE				
Rating	**1**	**2**	**3**	**4**	**5**
Failure Descriptors	**RARE**	**UNLIKELY**	**POSSIBLE**	**LIKELY**	**CERTAIN**
	None or minimal remedial action required and/or new/ recent upgrade. Estimated time to failure may be circa > 10 yrs	Normal wear and tear. Sound, operationally safe and exhibits only minor deterioration. Estimated time to failure may be circa < 10 yrs.	Reasonable physical damage / deterioration. Reassignment of life may be acceptable based on technical tests or residual robustness. Estimated time to failure may be circa < 5 yrs.	Major physical damage / deterioration. Failure apparent / assessed as imminent or unacceptable built environment. Not appropriate to reassign life. Estimated time to failure may be circa < 1 yr.	Failure occurred unacceptable built environment. Not appropriate to reassign life. Estimated time to failure may be circa < 6 months.

	SEVERITY										
	Rating	**Descriptor**	**Health & Safety**	**Environment**	**Business**	**Operational / building / engineering element**	**Fire / Statutory** Complies with mandatory fire safety requirements and statutory legislation.	**Fire / Statutory** Complies with mandatory fire safety requirements and Statutory safety legislation with minor deviations of a non-serious nature.	**Fire / Statutory** Known contravention of one or more requirements – which falls short of "B".	**Fire / Statutory** Dangerously below "B".	**Fire / Statutory** Dangerously below "B".
POTENTIAL CONSEQUENCES	**1**	**INSIGNIFICANT**	No injury/ breach of guidance procedures	No or minimal impact breach of guidance / procedures.	Unlikely cause of complaint. Litigation remote. Minimal reputation loss / limited awareness within organisation.	Minimal or no impact. Minimal or No disruption.	**1**	**2**	**3**	**4**	**5**
	2	**MINOR**	Minor injury (first aid or self-treatment. Breach of legal requirement.	Breach of legal requirement.	Possible complaint. Litigation unlikely. Loss of reputation (widespread internal awareness).	Localised Impact. Disruption to normal Services.	**2**	**4**	**6**	**8**	**10**
	3	**MODERATE**	Moderate injury / health statutory obligations. Improvement notice issued.	Single breach of legal requirements. Improvement notice issued.	Possible complaint. Possible litigation. Loss of reputation. National paper reporting.	Moderate Impact. Moderate disruption to Normal services.	**3**	**6**	**9**	**12**	**15**
	4	**MAJOR**	Major / significant injury or long-term incapacity / disablement. Prohibition notice issued.	Multiple breaches of legal requirements. Prohibition notice issued.	Litigation expected. Loss of reputation. National reporting.	Major / significant Impact. Severe disruption To normal services.	**4**	**8**	**12**	**16**	**20**
	5	**CATASTROPHIC**	Fatality and / or permanent disability. Prosecution.	Multiple breach of legal requirement. Prosecution.	Litigation certain. National adverse publicity.	Critical impact. Service closure.	**5**	**10**	**15**	**20**	**25**

Appendix 2: Survey Spreadsheets

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
2	Audiology & Cardiac Rehab	a	Cardiac Rehab	03. Roofs	Flashings	Damage/blistering to parapet/flasing details.	Repair locally.	B(C)		40	5	8	3	3	9
2	Audiology & Cardiac Rehab	a	Cardiac Rehab	02. External Fabric	Windows	Single glazed timber sash windows.	Replace with Double Glazed units.	C		40	3	20	3	3	9
2	Audiology & Cardiac Rehab	a	Audiology	04. Internal fabric and fittings	Internal Decoration	plaster & paintwork flaking.	Replaster skim & decorate.	C		7	3	2	2	2	4
2	Audiology & Cardiac Rehab	a	Audiology	04. Internal fabric and fittings	Ceilings	Suspended ceiling tiles naged throughout.	Replace with new ceiling tiles	D		40	2	1.5	3	2	6
2	Audiology & Cardiac Rehab	a	Audiology	04. Internal fabric and fittings	Floor screed and coverings	Internal Manhole seals & floor coverings failed.	replace with new double sealed manhole & floor finish.	C		15	2	1	3	2	6
3	Cedar Ward	a	Cedar Ward	02. External Fabric	Windows	Single glazed timber windows.	Replace with UPVC Double Glazed units.	C		40	3	35	3	3	9
4	Training / Management / Senior Nurses	a	First Floor	02. External Fabric	Windows	Single glazed metal windows.	Replace with UPVC Double Glazed units.	C		40	3	20	3	3	9
4	Training / Management / Senior Nurses	a	First Floor	17. Passive fire precautions	Fire escape routes	Break glass to round side of doctors mess.	install break glass to other side of door.	D			1	1	4	4	16
5	Occupational Health / X-Ray Records	a	Whole Building	02. External Fabric	Walls & Finishes	vegetation penetrating brickwork & roof	strip back and cut out	C		80	5	5	3	2	6
5	Occupational Health / X-Ray Records	a	Whole Building	02. External Fabric	Walls & Finishes	mortar joints breaking away	repoint locally	C		80	5	15	3	2	6
5	Occupational Health / X-Ray Records	a	Whole Building	02. External Fabric	Windows	Single glazed timber sash windows deteriorating.	Replace with Double Glazed units.	C		40	5	20	3	3	9

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
5	Occupational Health / X-Ray Records	a	Whole Building	02. External Fabric	External Doors	Non insulated timber painted doors deteriorating.	Replace with insulated doors	C		30	5	6	3	3	9
5	Occupational Health / X-Ray Records	a	Whole Building	03. Roofs	Flashings	Damage/blistering to parapet/flashing details.	Repair locally.	B(C)		40	5	4	3	3	9
5	Occupational Health / X-Ray Records	a	Whole Building	13. ELECTRICAL SYSTEMS	Wiring Systems - Protection	loose wiring/cabling exposed, trip hazards, etc	install appropriate containment	D		25	1	2	4	4	16
7	PGEC	w	PGEC	02. External Fabric	Windows	Single glazed timber windows deteriorating.	Replace with UPVC Double Glazed units.	C		40	3	60	3	3	9
7	PGEC	w	PGEC	03. Roofs	Flashings	Flashings to flat roof deteriorating.	Replace/redo flashings locally	D		20	3	5	3	2	6
7	PGEC	w	PGEC	03. Roofs	Roof coverings	Roof coverings made from Asbestos	Remove & replace with new tiles.	C		20	5	60	2	2	4
7	PGEC	w	PGEC	03. Roofs	Rain Water Goods	guttering blocked - full of debris	clean/tidy up guttering.	C		20	1	2	2	2	4
11	Finance & Information	c	Finance & Information	02. External Fabric	Windows	Single glazed metal windows.	Replace with UPVC Double Glazed units.	C		40	3	30	3	3	9
11	Finance & Information	c	Finance & Information	14. ALARMS & DETECTION SYSTEMS	Fire Alarm System	No detection side 5 offices.	Install fire detection interfaced with fire alarm.	D		25	0	2.5	4	4	16
12	Consultants & Secretaries	c	Consultants & Secretaries	02. External Fabric	Windows	Single glazed metal windows.	Replace with UPVC Double Glazed units.	C		40	3	30	3	3	9
13	Medical Records	c	Medical Records	17. Passive fire precautions	Fire signs	Inadequate means of escape signage.	Install Means of escape signage to BS.	D			1	1	4	4	16
13	Medical Records	c	Medical Records	17. Passive fire precautions	Fire stopping	No Fire stopping to compartment walls where services pass.	Fire stop locally	D			1	2	4	4	16

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Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
14	Porters & HK	c	Porters & HK	02. External Fabric	Windows	Single glazed timber windows.	Replace with UPVC Double Glazed units.	C		40	3	18	3	3	9
14	Porters & HK	c	Porters & HK	03. Roofs	roof coverings	Leak to 1 room & corridor when rains	Make good roof locally	C		20	1	25	3	3	9
17	Pre-Admissions	c	Pre-Admissions	02. External Fabric	Windows	Single glazed timber windows.	Replace with UPVC Double Glazed units.	C		40	3	7	3	3	9
17	Pre-Admissions	c	Pre-Admissions	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)		30	4	2.5	3	2	6
18	SSD Store	c	SSD Store	02. External Fabric	External Timber / PVCu Detail	pre-fab timber extension with inadequate insulation	Clad externally with modern materials.	C		80	5	40	2	2	4
18	SSD Store	c	SSD Store	02. External Fabric	Windows	Single glazed timber windows.	Replace with UPVC Double Glazed units.	C		40	3	10	3	3	9
19	Resuscitation Nurse Training	c	Resuscitation Nurse Training	02. External Fabric	External Timber / PVCu Detail	Timber shed construction.	Clad externally with modern materials.	C		80	5	40	2	2	4
19	Resuscitation Nurse Training	c	Resuscitation Nurse Training	02. External Fabric	Windows	Single glazed timber windows & doors	Replace with UPVC Double Glazed units.	C		40	3	10	3	3	9
21	OPD & Brodey Centre	b	The Brodie Centre	04. Internal fabric and fittings	Sanitary Ware	Incompliant dishwasher	Replace with new	B(C)	1998	30	2	1	3	2	6
21	OPD & Brodey Centre	b	OPD	01. Structure	Walls	Major cracking to high level walls - structural walls	To be checked by Structural Engineer	D	1997	80	1	15	4	4	16
21	OPD & Brodey Centre	b	OPD	01. Structure	Walls	Inadequate sound protection to Clinic Rooms	Overboard, plaster, skim & decorate.	C		80	5	12.5	4	4	16
21	OPD & Brodey Centre	b	OPD	01. Structure	Floor	Timber floor deflating/buckling.	Replace with new timber flooring locally.	C		80	5	90	3	3	9

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
21	OPD & Brodey Centre	b	OPD	02. External Fabric	Windows	Single glazed timber & metal windows.	Replace with UPVC Double Glazed units.	C		40	3	40	3	3	9
21	OPD & Brodey Centre	b	OPD	02. External Fabric	External Timber / PVCu Detail	pre-fab timber extension dilapidating	Clad externally with modern materials.	C		80	5	80	4	2	8
21	OPD & Brodey Centre	b	OPD	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)		30	4	27	3	2	6
21	OPD & Brodey Centre	b	OPD	04. Internal fabric and fittings	Floor screed and coverings	Carpet installed to Clinical Areas	Replace with vinyl	B(C)	1997	15	5	25	2	2	4
21	OPD & Brodey Centre	b	OPD	04. Internal fabric and fittings	Sanitary Ware	Incompliant dishwasher	Replace with new	B(C)	1997	30	2	1	3	2	6
21	OPD & Brodey Centre	b	OPD	04. Internal fabric and fittings	Internal Decoration	Decoration deteriating	Redecorate/reseal wall finishes.	C		5	1	1	2	2	4
21	OPD & Brodey Centre	b	OPD	25. Access standards	Internal accessibility	Doors & frame non-contrasting as required.	Replace/repaint door frames.	C			3	8	2	2	4
21	OPD & Brodey Centre	b	OPD	07. HEATING SYSTEMS	Controls	Faulty TRVs (estimated 100.of)	Replace	D	1995	15	1	15	2	5	10
21	OPD & Brodey Centre	b	OPD	08. HOT & COLD WATER SYSTEMS	Ancillary Equipment - Valves / Controls	No mixing valves installed (30.of)	Fit valves	C		20	2	45	4	4	16
25	Stores & Linen	t	Stores & Linen	02. External Fabric	Windows	Single-glazed metal windows have exceedeed their life expectancy	Replace	C	1967	40	4	18	2	2	4
25	Stores & Linen	t	Stores & Linen	17. Passive fire precautions	Fire signs	Limited fire signage installed	Install additional signage including appropriate lighting	C	1950	n	1	1	4	3	12
22	Pharmacy	a	Pharmacy	02. External Fabric	Windows	Single Glazed with draughts & water ingress	Replace with Double Glazed	C		40	3	6	3	3	9

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Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
							units.								
22	Pharmacy	a	Pharmacy	03. Roofs	Roof Lights	Water tight issues.	Replace Rooflights & redo flashings	D		20	0	3	3	3	9
22	Pharmacy	a	Pharmacy	04. Internal fabric and fittings	Floor screed and coverings	Defected floors temporarily taped up.	Replace & make good.	C		15	3	12	3	2	6
22	Pharmacy	a	Pharmacy	04. Internal fabric and fittings	Internal Decoration	Damaged walls, plaster & paint.	Replaster, Paint & Install Protection	C		7	5	15	3	2	6
22	Pharmacy	a	Pharmacy	04. Internal fabric and fittings	Unit Furniture	shelving & benching damaged/scuffed throughout.	Replace with new laminate faced fittings.	C		40	5	15	3	3	9
30	Maternity	o	Maternity	02. External Fabric	Walls & Finishes	High level perimeter concrete ringbeam breaking away exposing reinforcing bars.	Reinstate locally & install cladding panels.	C	1967	80	1	80	4	3	12
30	Maternity	o	Maternity	02. External Fabric	Windows	No restrictors installed to Clinical Areas.	Install proprietary restrictor to openable windows	D	1967	40	1	5	4	4	16
30	Maternity	o	Maternity	02. External Fabric	Windows	Single Glazed with draughts & water ingress	Replace with Double Glazed.	C	1967	40	3	8	3	3	9
30	Maternity	o	Maternity	03. Roofs	Rain Water Goods	No mesh cover protection to internal RWP at Roof Level.	Install mesh protection.	D	1967	20	0	1	3	2	6
30	Maternity	o	Maternity	03. Roofs	Roofcoverings - Flat	Showing signs of age & bowing throughout.	Replace in near future	B(C)	1967	40	3	5	3	3	9
30	Maternity	o	Maternity	03. Roofs	Flashings	Damage/blistering to parapet/flasing details.	Repair locally.	B(C)	1967	40	3	5	3	3	9
30	Maternity	o	Maternity	04. Internal fabric and fittings	Internal Decoration	plaster & paint breaking away.	replaster, Skim & decoration	D	1967	7	5	30	3	2	6

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
							required.								
30	Maternity	o	Maternity	04. Internal fabric and fittings	Internal Decoration	Wall paint spec unsuitable & flaking to Theatre	Repaint with suitable spec.	D	1967	7	1	5	3	2	6
30	Maternity	o	Maternity	04. Internal fabric and fittings	Floor screed and coverings	timber skirtings to clinical areas	replace/cover with coved/set in PVC skirting.	C	1967	15	2	10	2	2	4
30	Maternity	o	Maternity	04. Internal fabric and fittings	Floor screed and coverings	Defected floors temporarily taped up.	Replace & make good.	C	1967	15	1	25	3	2	6
30	Maternity	o	Maternity	04. Internal fabric and fittings	Internal Doors	Timber painted doors damaged/unsealed.	replace with laminate faced doors	C	1967	30	3	30	2	3	6
30	Maternity	o	Maternity	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)	1967	30	4	25	3	2	6
30	Maternity	o	Maternity	04. Internal fabric and fittings	Sanitary Ware	Step up/non accessible type showers.	Replace with new walk-in/wet showers.	B(C)	1967	30	1	15	4	2	8
30	Maternity	o	Maternity	04. Internal fabric and fittings	Unit Furniture	painted timber fittings damaged/scuffed to clinical areas.	Replace with new	C	1967	40	5	30	3	3	9
30	Maternity	o	Maternity	13. ELECTRICAL SYSTEMS	Internal lighting	Dated light fittings with low lux.	Replace with new fittings.	C	1967	15	2	85	2	3	6
30	Maternity	o	Maternity	17. Passive fire precautions	Fire escape routes	Door détentes to Corridors failed.	Install new to interface with fire alarm.	D	1967		0	1.5	4	3	12
30	Maternity	o	Maternity	17. Passive fire precautions	Fire escape routes	External Fire Escape Staircase rusting/unsealed.	Repaint with appropriate paint protection.	C	1967		0	2	2	2	4
30	Maternity	o	Maternity	17. Passive fire precautions	Fire escape routes	External Fire Escape Staircase not partially covered to B Regs.	Install new partially covering enclosure.	D	1967		0	7.5	4	4	16

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Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
30	Maternity	o	Maternity	17. Passive fire precautions	Fire compartmentation	Fanlight above Fire doors non fire rated.	Install FR panel/glazing.	D	1967		0	8	4	3	12
30	Maternity	o	Maternity	17. Passive fire precautions	Fire doors	Door smoke seals dilapidated.	Reseal/relip doors/frames.	D	1967		1	10	4	4	16
30	Maternity	o	Maternity	19. Fire safety culture	Fire evacuation plans	Inadequate Means of Escape Signage to Ground Floor	Install FE Signage & illuminated signs.	D	1967		1	10	4	4	16
30	Maternity	o	Maternity	20. Safe structures	Glazing standards	Unstable/unsafe UPVC framework to first floor.	Replace with FENSA approved windows & frames.	D	1967	40	1	50	4	4	16
30	Maternity	o	Maternity	20. Safe structures	Working at height management	No barrier protection to Roof Lights - Hazard	Install barrier protection.	D	1967		1	5	4	3	12
30	Maternity	o	Maternity	20. Safe structures	Working at height management	No barrier protection/enclosure to part Roof.	Install barrier protection.	D	1967		1	10	4	4	16
30	Maternity	o	Maternity	25. Access standards	Accessibility of building entrances	Inadequate barrier matting to Main Entrance.	Install new primary & secondary barrier matting.	C	1967		1	5	4	3	12
30	Maternity	o	Maternity	24. Energy measures	Insulation	AC pipework on roof insulation perished	Replace insulation	B(C)	2003	12	3	1	2	2	4
30	Maternity	o	Maternity	09. VENTILATION SYSTEMS	Ventilation Plant	Numerous compliance issues	Replace AHU and ancilliary equipment	C	1967	20	1	100	4	3	12
30	Maternity	o	Maternity	07. HEATING SYSTEMS	Heat Emitters	No guard on cast iron radiators (2.of 1st floor)	Install low surface teperature covers	C	1967	30	1	0.2	4	3	12
30	Maternity	o	Maternity	07. HEATING SYSTEMS	Heat Emitters	Cast iron radiators exceeded life expectancy (17.of 1st floor)	Replace with contemporary alternatives	B(C)	1967	30	1	10	1	2	2

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
30	Maternity	o	Maternity	13. ELECTRICAL SYSTEMS	Wiring Systems	Non-compliant: imited number of sockets and no UPS/IPS to SCBU	Rewire the building	C	1967	25	0	300	4	4	16
30	Maternity	o	Maternity	17. Passive fire precautions	Fire escape routes	External Stairs are slip-hazard and rusting	Repaint and install cover	B(C)	1967		3	10	4	2	8
30	Maternity	o	Maternity	04. Internal fabric and fittings	Sanitary Ware	Non-compliant (22.of 1st Floor)	Replace	D	2000	30	0	22	4	3	12
32	'E' Ward & Day Case / Surgery	n	Day Case Unit	02. External Fabric	Walls & Finishes	Defected Paint finishes and unsealed timber façade.	Redecoration to External timber façade.	C		80	1	10	3	2	6
32	'E' Ward & Day Case / Surgery	n	Day Case Unit	04. Internal fabric and fittings	Floor screed and coverings	Unsealed set in pvc skirts.	Replace and reseal.	C		15	0	10	3	2	6
32	'E' Ward & Day Case / Surgery	n	Day Case Unit	04. Internal fabric and fittings	Internal Doors	Scuffed/damaged & unsealed.	Relip, repaint or replace doors.	C		30	3	20	2	3	6
32	'E' Ward & Day Case / Surgery	n	Day Case Unit	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	D		30	4	12.8	3	2	6
32	'E' Ward & Day Case / Surgery	n	Day Case Unit	04. Internal fabric and fittings	Sanitary Fittings	No grabs rails to Patient Bathroom/Showers.	Install new grab rails	D	N/A	30	1	5	3	2	6
32	'E' Ward & Day Case / Surgery	n	Day Case Unit	17. Passive fire precautions	Fire doors	Defected Smoke seals to Fire Doors.	Reseal & replip doors	D		30	1	5	4	2	8
32	'E' Ward & Day Case / Surgery	n	Day Case Unit	04. Internal fabric and fittings	Sanitary Ware	Wash hand basin is non-compliant (1.of)	Replace	C	1996	30	1	1	4	3	12
32	'E' Ward & Day Case / Surgery	n	Day Case Unit	13. ELECTRICAL SYSTEMS	Internal lighting	Exceeded life expectancy	replace	C	1996	15	4	10	2	2	4
32	'E' Ward & Day Case / Surgery	n	Day Case Unit	15. COMMUNICATIO N SYSTEMS	Nurse Call System	Exceeded life expectancy	replace	C	1971	15	3	10	4	3	12

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
36	Pathology	p	Pathology Lab	13. ELECTRICAL SYSTEMS	Internal lighting	Exceeded life expectancy	Replace with contemporary equivalent	C	1995	15	1	10	2	2	4
36	Pathology	p	Mortuary	09. VENTILATION SYSTEMS	Air Handling Units : External	In an advanced state of delapidation	Remove/Replace if required	Dx	1995	15	1	25	2	2	4
35	Main Corridors	v	Main Corridor	02. External Fabric	External Doors	Main Entrance doors defected timber - non insulated.	Replace with double glazed insulated doors.	C		30	1	1	2	2	4
35	Main Corridors	v	Main Corridor	03. Roofs	Roofcoverings	Roof deteriorating/buckling	Replace with new in sections.	B(C)		20	5	85	3	3	9
35	Main Corridors	v	Main Corridor	03. Roofs	Rain Water Goods	Gutter require cleaning throughout hospital.	Clean gutters	B(C)		20	3	25	3	3	9
35	Main Corridors	v	Main Corridor	17. Passive fire precautions	Fire stopping	Fire Stopping throughout failed by services	infill/fire stop with intumescent foam or boarding.	D			1	8	4	4	16
36	Pathology	p	Pathology	02. External Fabric	External Timber / PVCu Detail	UPVC Pannelling timber extension dilapidating	Clad externally with modern materials.	C		80	5	80	4	2	8
36	Pathology	p	Pathology	02. External Fabric	Windows	Single glazed metal windows.	Replace with UPVC Double Glazed units.	C		40	3	30	3	3	9
36	Pathology	p	Pathology	03. Roofs	Roofcoverings	Roof deteriorating/buckling	Replace with new throughout	B(C)		20	4	75	3	3	9
36	Pathology	p	Pathology	03. Roofs	Roof Lights	Rooflights rusting/deteriorating	replace with new with flashings	B(C)		20	4	20	3	3	9
36	Pathology	p	Pathology	20. Safe structures	Working at height management	No barrier protection to Roof Lights - Hazard	Install barrier protection.	D			1	10	4	3	12
36	Pathology	p	Pathology	04. Internal fabric and fittings	GF Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)		30	4	2.5	3	2	6

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Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
36	Pathology	p	Pathology	04. Internal fabric and fittings	GF Floor screed and coverings	Carpet installed to Clinical Areas	Replace with vinyl	B(C)		15	5	7	2	2	4
36	Pathology	p	Pathology	04. Internal fabric and fittings	GF Floor screed and coverings	Open risers to staircase	infill - max. 100mm open risers.	C		15	5	2	4	2	8
36	Pathology	p	Pathology	04. Internal fabric and fittings	Body Store Floor screed and coverings	Flooring to Slide Store Room dilapidated.	replace with new	D		15	3	5	4	2	8
36	Pathology	p	Pathology	02. External Fabric	1st fl External Doors	cracks to external fire escape.	infill & reseal door	C		30	5	1	2	2	4
36	Pathology	p	Pathology	03. Roofs	1st flRoof Lights	Glare and water tight issues.	Replace with new & make good.	D		20	0	2	3	3	9
36	Pathology	p	Pathology	17. Passive fire precautions	Fire escape routes	No balustrading protection to fire escape route.	install balustrading where required	D			1	5	4	4	16
36	Pathology	p	Pathology	17. Passive fire precautions	Fire escape routes	External Fire Escape Staircase not partially covered to B Regs.	Install new partially covering enclosure.	D			0	7.5	4	4	16
36	Pathology	p	Pathology	17. Passive fire precautions	Fire escape routes	No lighting to fire escape	Install new emergency lighting	D			0	3	4	4	16
37	'F' Ward / CCU / OT	m	CCU	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)		30	4	6	3	2	6
37	'F' Ward / CCU / OT	m	CCU	04. Internal fabric and fittings	Internal Doors	Timber painted doors damaged/unsealed.	replace with laminate faced doors	C		30	3	8	2	3	6
37	'F' Ward / CCU / OT	m	CCU	17. Passive fire precautions	Fire signs	Means of escape singage misleading	install appropriate directions signage.	D			1	2	4	4	16
37	'F' Ward / CCU / OT	m	CCU	17. Passive fire precautions	Fire exits	Fire exit behind bed bay	Reposition centrally to	D			1	4	4	3	12

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Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
							room away from bed bay								
37	'F' Ward / CCU / OT	m	CCU	04. Internal fabric and fittings	Sanitary Ware	Non-compliant (6.of)	Replace	C	1996	30	1	6	5	4	20
37	'F' Ward / CCU / OT	m	CCU	12. FIXED PLANT and EQUIPMENT	UPS Systems	Not present	Install	C		15	1	20	4	3	12
38	Radiology	k	Radiology	02. External Fabric	Walls & Finishes	Leak/Water ingress adjacent to electrical cabling	Make good RWP, Seal externals	D		80	1	5	4	4	16
38	Radiology	k	Radiology	04. Internal fabric and fittings	Floor screed and coverings	Defected floors damaged/temporarily taped up.	Replace & make good.	C		15	1	7	4	3	12
38	Radiology	k	Radiology	13. ELECTRICAL SYSTEMS	Internal lighting	Dated light fittings with low lux.	Replace with new fittings.	C		15	3	35	2	3	6
38	Radiology	k	X-Ray	09. VENTILATION SYSTEMS	Air Handling Units : External	Exceeded life expectancy	Replace	B(C)	2005	15	2	50	4	3	12
40	Workshop	i	Workshop	03. Roofs	Flashings	Flashings deteriorating	make good/redo flashings locally.	B(C)		20	3	2	3	2	6
41	Theatres	h	Theatres	03. Roofs	Roof Lights	Rooflights rusting/deteriorating	replace with new with flashings	B(C)		20	4	25	3	3	9
41	Theatres	h	Theatres	03. Roofs	Roofcoverings	Roof deteriorating/buckling	Replace with new throughout	B(C)		20	4	75	3	3	9
41	Theatres	h	Theatres	04. Internal fabric and fittings	Internal Doors	Timber painted doors damaged/unsealed.	replace with laminate faced doors	C		30	3	25	2	3	6
41	Theatres	h	Theatres	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)		30	4	7	3	2	6
41	Theatres	h	Theatres	04. Internal fabric and fittings	Internal Decoration	Wall paint spec unsuitable & flaking to Theatre	Repaint with suitable spec.	D		7	1	20	3	2	6

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Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
41	Theatres	h	Theatres	04. Internal fabric and fittings	Unit Furniture	timber fittings damaged/scuffed to clinical areas.	Replace with new laminate faced units.	C		40	5	30	3	3	9
41	Theatres	h	Theatres	04. Internal fabric and fittings	Floor screed and coverings	Defected floorsdamaged/temporarily taped up.	Replace & make good.	C		15	1	15	3	2	6
41	Theatres	h	Theatres	09. VENTILATION SYSTEMS	Air Handling Units : Internal	Non compliant	Replace	C	1982	25	1	500	4	3	12
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	02. External Fabric	Automatic Doors	Non automated single glazed Doors	Install automated double glazed doors	C	1987	15	3	40	3	3	9
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	02. External Fabric	Windows	Single Glazed with draughts	Replace with Double Glazed.	C	1987	40	3	130	3	3	9
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	02. External Fabric	External Doors	Single Glazed with draughts	Replace with Double Glazed.	C	1987	30	3	50	3	3	9
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	03. Roofs	Rain Water Goods	Damage to Gutter.	Replace with new & make good.	D	1987	20	0	1	3	3	9
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	03. Roofs	Roofcoverings - Pitch	Damage to Fascia & Roof Tiles.	Replace with new & make good.	D	1987	40	0	1	3	3	9
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	04. Internal fabric and fittings	Internal Decoration	Damaged walls, plaster & paint.	Replaster, Paint & Install Protection	C	1987	7	1	15	3	2	6
56	EAU/Laburnum & Ambulatory	f	EAU/Laburnum & Amb Ground Floor	04. Internal fabric and fittings	Floor screed and coverings	timber skirtings to clinical areas	replace/cover with coved/set in PVC skirting.	B(C)	1987	15	2	35	3	2	6

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
	Care														
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	04. Internal fabric and fittings	Floor screed and coverings	Defected floors temporarily taped up.	Replace & make good.	C	1987	15	1	5	4	3	12
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	04. Internal fabric and fittings	Door Furniture	Door lever handles dropped/failed.	Replace with new lever handles.	D	1987	15	0	8	2	3	6
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)	1987	30	4	15	3	2	6
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	04. Internal fabric and fittings	Unit Furniture	Hardwood Staff Base damaged/scuffed throughout.	Replace with new	B(C)	1987	40	5	15	2	2	4
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	07. HEATING SYSTEMS	Heating Pumps	No overhead door heaters to Entrance Lobby Doors.	Install overhead door heaters.	C	1987	15	3	10	3	3	9
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	11. LIFTS & HOISTS	Passenger Lift	Breaks down frequently/not suitable for Hospital Beds.	Replace with new Bed Lift.	B(C)	1987	30	2	140	3	3	9
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	13. ELECTRICAL SYSTEMS	Internal lighting	Dated light fittings with low lux.	Replace with new fittings.	B(C)	1987	15	3	60	2	3	6
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	17. Passive fire precautions	Fire escape routes	Door détentes to Corridors in Wards broken.	Install new to interface with fire alarm.	D	1987		0	4	4	3	12

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Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Ground Floor	17. Passive fire precautions	Fire doors	Door smoke seals dilapidated.	Reseal/relip doors/frames.	D	1987		0	3.5	4	4	16
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	02. External Fabric	Windows	Single Glazed with draughts	Replace with Double Glazed.	C	1987	40	3	120	3	3	9
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	03. Roofs	Roof Lights	Glare and water tight issues.	Replace with new & make good.	D	1987	20	0	15	3	3	9
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	04. Internal fabric and fittings	Floor screed and coverings	timber skirtings to clinical areas	replace/cover with coved/set in PVC skirting.	B(C)	1987	15	2	50	3	2	6
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	04. Internal fabric and fittings	Floor screed and coverings	Defected floors temporarily taped up.	Replace & make good.	C	1987	15	1	15	4	3	12
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	04. Internal fabric and fittings	Door Furniture	Door lever handles dropped/failed.	Replace with new lever handles.	D	1987	15	0	20	2	3	6
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)	1987	30	4	15	3	2	6
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	04. Internal fabric and fittings	Sanitary Ware	Step up/non accessible type showers.	Replace with new walk-in/wet showers.	B(C)	1987	30	1	6	4	2	8
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	04. Internal fabric and fittings	Unit Furniture	Hardwood Staff Base damaged/scuffed throughout.	Replace with new	B(C)	1987	40	5	15	2	2	4

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Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	13. ELECTRICAL SYSTEMS	Internal lighting	Dated light fittings with low lux.	Replace with new fittings.	B(C)	1987	15	3	60	2	3	6
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	17. Passive fire precautions	Fire escape routes	Door détentes to Corridors in Wards broken.	Install new to interface with fire alarm.	D	1987		0	4	4	3	12
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb First Floor	17. Passive fire precautions	Fire doors	Door smoke seals dilapidated.	Reseal/relip doors/frames.	D	1987		0	3.5	4	4	16
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Plant Room	09. VENTILATION SYSTEMS	Ventilation Plant	Rowan Day UnitSupply & Extract AHU: non-compliant	Replace	C	1987	20	3	50	2	2	4
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Plant Room	09. VENTILATION SYSTEMS	Ventilation Plant	Rowan Day UnitDirty Extract AHU: non-compliant	Replace	C	1987	20	3	10	2	2	4
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Plant Room	09. VENTILATION SYSTEMS	Ventilation Plant	Mulberry & Laburnum Supply AHU: non-compliant	Replace	C	1987	20	3	30	2	2	4
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Plant Room	09. VENTILATION SYSTEMS	Ventilation Plant	Mulberry & Laburnum Clean & Dirty Extract AHUs: non-compliant	Replace	C	1987	20	3	20	2	2	4
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Plant Room	09. VENTILATION SYSTEMS	Ventilation Plant	Laburnum side rooms Supply AHU: exceeded life expectancy	Replace	C	1995	20	4	20	2	2	4
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Plant Room	09. VENTILATION SYSTEMS	Ventilation Plant	Oak & Juniper Supply AHU: non-compliant	Replace	C	1987	20	3	30	2	2	4

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
56	EAU/Laburnum & Ambulatory Care	f	EAU/Laburnum & Amb Plant Room	09. VENTILATION SYSTEMS	Ventilation Plant	Oak & Juniper Clean & Dirty Extract AHUs: non-compliant	Replace	C	1987	20	4	20	2	2	4
57	Accident & Emergency	l	A&E	02. External Fabric	Automatic Doors	Non automated Doors to Ambulance not working.	Repair/Replace.	C		15	1	10	4	3	12
57	Accident & Emergency	l	A&E	04. Internal fabric and fittings	Internal Decoration	Damaged walls, plaster & paint.	Replaster, Paint & Install Protection	C		7	1	15	3	2	6
57	Accident & Emergency	l	A&E	04. Internal fabric and fittings	Floor screed and coverings	timber skirtings to clinical areas	replace/cover with coved/set in PVC skirting.	B(C)		15	2	25	3	2	6
57	Accident & Emergency	l	A&E	04. Internal fabric and fittings	Floor screed and coverings	Defected floors temporarily taped up.	Replace & make good.	C		15	1	15	4	3	12
57	Accident & Emergency	l	A&E	04. Internal fabric and fittings	Door Furniture	Door lever handles dropped/failed.	Replace with new lever handles.	D		15	0	8	2	3	6
57	Accident & Emergency	l	A&E	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)		30	4	7.5	3	2	6
57	Accident & Emergency	l	A&E	04. Internal fabric and fittings	Unit Furniture	Furniture to clinical areas are damaged/scuffed.	Replace with new.	B(C)		40	1	20	2	2	4
57	Accident & Emergency	l	A&E	09. VENTILATION SYSTEMS	Air Handling Units : Internal	AHU exceeded life expectancy	Replace	C	1992	25	3	70	3	3	9
58	Kitchen / Restaurant	s	Kitchen	02. External Fabric	External Doors	non insulated timber doors damaged/broken	replace with new fully insulated secure doors.	C		30	1	2	2	3	6
58	Kitchen / Restaurant	s	Kitchen	04. Internal fabric and fittings	Door Furniture	Door lever handles dropped/failed.	Replace with new lever handles.	D		15	1	5	2	3	6
58	Kitchen / Restaurant	s	Kitchen	11. LIFTS & HOISTS	Goods Lift	1 out of 2 lifts fail from time to time	replace with new goods lift.	C		30	2	80	3	3	9

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Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
58	Kitchen / Restaurant	s	Restaurant	03. Roofs	Roof Lights	Water tight issues.	Reseal flashings & redecorate.	D		20	3	7	3	3	9
61	Childrens Ward / Physiotherapy	g	Ground - Childrens Ward	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)	1991	30	4	25	3	2	6
61	Childrens Ward / Physiotherapy	g	Ground - Childrens Ward	04. Internal fabric and fittings	Sanitary Ware	Step up/non accessible type showers.	Replace with new walk-in/wet showers.	B(C)	1991	30	1	9	4	2	8
61	Childrens Ward / Physiotherapy	g	First Floor - Physiotherapy	04. Internal fabric and fittings	Floor screed and coverings	Carpet installed to Clinical Areas	Replace with vinyl	B(C)	1991	15	5	12	2	2	4
61	Childrens Ward / Physiotherapy	g	First Floor - Physiotherapy	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)	1991	30	4	3	3	2	6
61	Childrens Ward / Physiotherapy	g	First Floor - Physiotherapy	05. External fabric and fittings	Walls	Major cracking to external walls to interior	To be checked by Structural Engineer	D	1991	40	1	15	4	4	16
61	Childrens Ward / Physiotherapy	g	First Floor - Physiotherapy	17. Passive fire precautions	Fire escape routes	External Fire Escape Staircase not partially covered to B Regs.	Install new partially covering enclosure.	D	1991		0	12	4	4	16
62	Chapel & Bereavement Suite	q	Chapel	02. External Fabric	Windows	Cracked timber windows frames	replace with new	B(C)	1993	40	5	2	2	2	4
62	Chapel & Bereavement Suite	q	Chapel	03. Roofs	Roof Lights	Water tight issues.	Reseal flashings & redecorate.	D	1993	20	3	7	3	3	9
62	Chapel & Bereavement Suite	q	Chapel	03. Roofs	Roof Lights	single glazed.	replace with double glazing	B(C)	1993	20	5	5	3	3	9
62	Chapel & Bereavement Suite	q	Chapel	03. Roofs	Roofcoverings	Roof build up of debris & missing tiles	clean & tidy roof, replace tiles where necessary	B(C)	1993	20	5	5	3	3	9

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
64	Womans Day Unit	r	Women's Day Case Unit	02. External Fabric	Windows	Poorly insulated double glazed sash windows	Replace with new Double Glazed.	C	1995	40	3	8	3	3	9
64	Womans Day Unit	r	Women's Day Case Unit	03. Roofs	Roofcoverings - Pitch	Leak to ceiling/roof adjacent to Entrance doors	Flashings to Roof valley to be relooked.	C	1995	40	3	7	3	3	9
64	Womans Day Unit	r	Women's Day Case Unit	04. Internal fabric and fittings	Sanitary Ware	Incompliant clinical wash basin & taps	Replace with new	B(C)	1995	30	4	16.5	3	2	6
64	Womans Day Unit	r	Women's Day Case Unit	04. Internal fabric and fittings	Sanitary Ware	Step up/non accessible type showers.	Replace with new walk-in/wet showers.	B(C)	1995	30	1	6	4	2	8
64	Womans Day Unit	r	Women's Day Case Unit	04. Internal fabric and fittings	Sanitary Ware	Janitorial type sink to Dirty Utility	Replace with slop hopper to HTM.	B(C)	1995	30	3	3	2	2	4
64	Womans Day Unit	r	Women's Day Case Unit	04. Internal fabric and fittings	Internal Doors	Entrance doors damaged, Fire Resistance integrity lost.	Replace with new	C	1995	30	1	2	4	4	16
64	Womans Day Unit	r	Women's Day Case Unit	04. Internal fabric and fittings	Unit Furniture	Dilapidated units to clinical areas	replace with new laminated faced units	C	1995	40	3	7	2	3	6
64	Womans Day Unit	r	Women's Day Case Unit	04. Internal fabric and fittings	Sanitary Ware	Non-compliant	Replace	C	95	30	1	5	3	3	9
64	Womans Day Unit	r	Women's Day Case Unit	09. VENTILATION SYSTEMS	Ventilation Plant	Colposcopy room has no mechanical ventilation	Install system in order to provide a positively pressured environment	D		20	1	20	3	2	6
68	League of Friends	u	League of Friends	02. External Fabric	External Timber / PVCu Detail	Timber shed construction.	Clad externally with modern materials.	C		80	5	5	2	2	4
68	League of Friends	u	League of Friends	02. External Fabric	Windows	Single glazed timber windows & doors	Replace with UPVC Double Glazed units.	C		40	3	2	3	3	9

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
99.1	Energy Centre	z	Energy Centre	06. ENERGY CENTRE SYSTEMS	Fuel Supply / Storage / Distribution	Now Exceeded Life Expectancy	Replace	D	1978	30	1	80	3	5	15
99.1	Energy Centre	z	Energy Centre	06. ENERGY CENTRE SYSTEMS	Boiler Plant	Now Exceeded Life Expectancy	Replace & Remove Chimney	B(C)	1978	25	1	200	3	2	6
99.1	Energy Centre	z	Energy Centre	07. HEATING SYSTEMS	Heating Pumps	Now Exceeded Life Expectancy	Replace With Modern Equivalent	B(C)	1978	15	5	20	3	2	6
99.1	Energy Centre	z	Site Sectional Heating Stations (7 of.)	06. ENERGY CENTRE SYSTEMS	Energy Distribution	Now Exceeded Life Expectancy	Replace With Modern Equivalent	C	1967	30	3	100	4	3	12
99.1	Energy Centre	z	Block 2 Sectional Heating Stations	06. ENERGY CENTRE SYSTEMS	Energy Distribution	Now Exceeded Life Expectancy	Replace With Modern Equivalent	C	1967	30	3	30	4	3	12
99.2	Electrical Infrastructure	z	A-Sub LV Switchgear	13. ELECTRICAL SYSTEMS	Electrical Main Distribution	Malfunctioning Switch & Now Exceeded Life Expectancy	Replace	D	1971	25	0	80	4	4	16
99.2	Electrical Infrastructure	z	B-Sub LV Switchgear	13. ELECTRICAL SYSTEMS	Electrical Main Distribution	Now Exceeded Life Expectancy	Replace	D	1971	25	0	50	4	4	16
99.2	Electrical Infrastructure	z	Main DB & change-over panel	13. ELECTRICAL SYSTEMS	Switchgear	Now Exceeded Life Expectancy	Replace	C	1971	25	1	30	4	4	16
99.2	Electrical Infrastructure	z	X-Ray DB (Radiology Corridor)	13. ELECTRICAL SYSTEMS	Switchgear	Now Exceeded Life Expectancy	Replace	C	1971	25	1	20	4	4	16
99.2	Electrical Infrastructure	z	Medical Block Main Switchgear	13. ELECTRICAL SYSTEMS	Switchgear	Now Exceeded Life Expectancy	Replace	B(C)	1987	25	5	30	4	2	8

Block Number	Block Name	Cluster	Dept/level.	Element	Sub Element	Defect	Remedy	Cond Rank	Year Installed	Life Cycle	Yrs. before work	Cost £,000	Conseq	Likelihood	Risk Score
99.2	Electrical Infrastructure	z	Pathology Lower - main DB & change-over panel	13. ELECTRICAL SYSTEMS	Switchgear	Now Exceeded Life Expectancy	Replace	C	1987	25	1	20	4	3	12
99.2	Electrical Infrastructure	z	Pathology Upper - Sectionboard	13. ELECTRICAL SYSTEMS	Switchgear	Non Compliant & Now Exceeded Life Expectancy	Replace	C	1987	25	1	20	3	3	9
99.2	Electrical Infrastructure	z	Old Theatre Block - Uncontrolled Switchgear	13. ELECTRICAL SYSTEMS	Switchgear	Now Exceeded Life Expectancy & Discrimination?	Replace	Dx	1967	25	0	30	5	4	20
99.2	Electrical Infrastructure	z	Under Block 2 - Electrical Switch Room	13. ELECTRICAL SYSTEMS	Switchgear	Now Exceeded Life Expectancy	Replace	C	1967	25	2	30	3	3	9
99.3	Asbestos	z	Site wide	20. Safe structures	Asbestos management	ACM very high priority	Remove	Cx	1965		1	400	4	4	16
99.3	Asbestos	z	Site wide	20. Safe structures	Asbestos management	ACM High priority	Remove	Cx	1965		2	400	4	3	12
99.3	Asbestos	z	Site wide	20. Safe structures	Asbestos management	ACM Medium priority	Remove	Cx	1965		3	400	4	2	8
99.3	Asbestos	z	Site wide	20. Safe structures	Asbestos management	ACM Moderate priority	Remove	Cx	1965		4	400	4	2	8
99.3	Asbestos	z	Site wide	20. Safe structures	Asbestos management	ACM Low Priority	Remove	Cx	1965		5	400	4	2	8
99.4	Roads, pathways and car parks	z	General repairs	05. External fabric and fittings	Roads / Car Parks	General deterioration	Repair	C	1950		2	20	2	2	4
99.4	Roads, pathways and car parks	z	Nort Car Park	05. External fabric and fittings	Roads / Car Parks	Unserfaced	Provide finishing surface and markings	D	2000	30	1	80	3	3	9

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GK Transformation

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From: Graham, Nick - Law & Governance
Sent: 11 June 2019 17:05
To: Shepherd, Samantha - Corporate Services
Subject: Fwd: Criteria Weighting Process
Attachments: OCCG - Workshop 1 results.pdf

Can we discuss?

Nick Graham
Director of Law & Governance
Oxfordshire County Council
01865 323 910
07850 342986

From: Saffron Pineger <Saffron.Pineger@freshwater.co.uk>
Sent: Monday, June 10, 2019 5:41:45 PM
To: Graham, Nick - Law & Governance
Subject: FW: Criteria Weighting Process

Dear Nick,

As Catherine suggested, I enclose a copy of the weighted criteria for the options appraisal process for
Oxfordshire CCG.
Do let me know if you have any questions at all.

Best wishes,
Saffron

Saffron Pineger
Director

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From: MOUNTFORD, Catherine (NHS OXFORDSHIRE CCG)
[mailto:catherine.mountford@nhs.net]
Sent: 07 June 2019 09:46
To: NICK.GRAHAM@OXFORDSHIRE.GOV.UK
Cc: Saffron Pineger <Saffron.Pineger@freshwater.co.uk>
Subject: FW: Criteria Weighting Process

Dear Nick

The Horton HOSC asked that we send you a copy of the weighted criteria for our options appraisal
process to ensure the integrity of the process. I have copied in Saffron from Freshwater who will send
this to you as I have not seen the outcome of the exercise.

If you have any queries please do not hesitate to contact me.

Best wishes

Catherine

Catherine Mountford | Director of Governance | Oxfordshire Clinical Commissioning Group |
Jubilee House | 5510 John Smith Drive | Oxford Business Park | Cowley | Oxford OX4 2LH | tel:
01865 336705 | fax: 01865 337094 | email: catherine.mountford@.nhs.net |
web: www.oxfordshireccg.nhs.uk

From: PATTEN, Louise (NHS BUCKINGHAMSHIRE CCG)
Sent: 07 June 2019 09:43
To: Cllr Arash Ali Fatemian
Cc: Shepherd, Samantha - Corporate Services; MOUNTFORD, Catherine (NHS OXFORDSHIRE CCG)
Subject: Criteria Weighting Process

Dear Arash

At the last Horton HOSC you asked for us to provide more information on the Criteria Weighting Process. As you know we have external expert support on the engagement work and this has included input from the Consultation Institute to ensure we are using best practice. The weighting was undertaken at our stakeholder event with input from a wide range of individuals. In terms of considering the importance of the different criteria we need the views from a range of stakeholders not only women using the service to think about these services in the context of the whole county and other services.

As requested we will send a copy of the weighted criteria to Nick Graham.
Kind Regards,

Lou
Louise Patten RGN BSc DN MBA
Chief Executive Officer
NHS Buckinghamshire CCG

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Appendix 2: Anxiety and stress in Pregnancy

3.1 The Horton HOSC has heard that there is an increased level of anxiety and concern amongst Mother-to-be around the HGH catchment area since obstetrics has been temporarily closed. The committee asked whether there are any impacts of anxiety during pregnancy, the following outlines a small selection of the research related to anxiety during pregnancy. This includes an outline of the positive impacts of reduced anxiety on the birthing process.

Research on impacts of stress (or reduced stress) in pregnancy

Issue	Source	Summary
Stress hormones in Mother are reflected in amniotic fluid	Sarkar P, Bergman K, Fisk N.M, O'Connor T.G and Glover V (2007) Ontogeny of foetal exposure to maternal cortisol using midtrimester amniotic fluid as a biomarker. Clinical Endocrinology, Vol 66, No 5.	Stress experienced by a woman during pregnancy may affect her unborn baby as early as 17 weeks after conception, with potentially harmful effects on brain and development. Higher levels of cortisol (stress hormone) in the mother's blood is reflected in higher levels in the amniotic fluid.
How anxiety in Pregnancy impacts on the foetal brain	Anxiety During Pregnancy: How Does it Affect the Developing Fetal Brain? MGH, Center for Women's Mental Health (2011) https://womensmentalhealth.org/posts/anxiety-during-pregnancy-how-does-it-affect-the-developing-fetal-brain/	The reported study shows that pregnancy anxiety is related to specific changes in brain morphology. High levels of anxiety at 19 weeks of pregnancy were correlated with the volume reductions in several regions of the brain, including the prefrontal, lateral temporal and premotor cortex, medial temporal lobe and cerebellum. The regions most affected by high levels of anxiety are important for cognitive performance, social and emotional processing and auditory language processing.
Link of maternal anxiety to increased rates of ADHD	Van den Bergh B.R.H and Marcoen A (2004) High Antenatal Maternal Anxiety Is Related to ADHD Symptoms, Externalizing Problems, and Anxiety in 8- and 9-Year-Olds. Child Development. Volume 75, No 4	Maternal anxiety levels early in pregnancy -- during the 12th and 22nd week of pregnancy -- were strongly linked to ADHD in the children. Even after adjusting for child's gender, parents' educational level, smoking during pregnancy, birth weight, and postnatal maternal anxiety, prenatal anxiety (at 12 to 22 weeks) turned out to be a significant independent predictor of ADHD.
Link of maternal stress to personality disorders in children	Brannigan R, Tanskanen A, Huttunen M.O, Cannon M, Leacy F.P and Clarke M.C (2019) The role of prenatal stress as a pathway to personality disorder: longitudinal birth cohort study. The British Journal of Psychiatry. Vol 190.	Exposure to stress during gestation increases the odds of personality disorder (by three fold) in offspring, independent of other psychiatric disorders. These results suggest the assessment of maternal stress and well-being during pregnancy may be useful in identifying those at greatest risk of developing personality disorder, and highlight the importance of prenatal care for good maternal mental health during pregnancy.

Issue	Source	Summary
Link between maternal stress in pregnancy and foetal (neuromuscular and motor) development	Grace T, Bulsara M, Robinson M and Hands B (2015) *The Impact of Maternal Gestational Stress on Motor Development in Late Childhood and Adolescence: A Longitudinal Study. Childhood Development. Vol 87, No 1.*	Study showed a negative correlation between the effect of maternal stress on neuromuscular and motor development in offspring.
Depression in pregnancy leads to anti-social behaviour in teenagers	Hay D.F, Pawlby S, Waters C.S, Perra O and Sharp D (2010) Mothers' Antenatal Depression and Their Children's Antisocial Outcomes. Childhood Development, Vol 81, No 1.	Depression in pregnancy significantly predicted violence in adolescence, even after adjusting (controlling) for the family environment, the child's later exposure to maternal depression, the mother's smoking and drinking during pregnancy, and parents' antisocial behavior. Mothers with a history of conduct problems were at higher risk to become depressed in pregnancy, and the offspring of depressed women had a greater chance of becoming violent by age 16.
Lack/denial of delivery choice exacerbates tokophobia (pathological fear of childbirth)	Hofberg K and Brockington I (2000) *Tokophobia: an unreasoning dread of childbirth. A series of 26 cases*. Br J Psychiatry. 2000 Jan;176:83-5. https://www.ncbi.nlm.nih.gov/pubmed/10789333	Pregnant women with tokophobia (pathological fear of childbirth) who were refused their choice of delivery method suffered higher rates of psychological illness than those who achieved their desired delivery method.
Impact of maternal stress in pregnancy and impact on child development	Davis E.P and Sandman C.A (2010) The Timing of Prenatal Exposure to Maternal Cortisol and Psychosocial Stress Is Associated With Human Infant Cognitive Development. Child Development, Vol 81, No 1.	The consequences of prenatal maternal stress for development were examined in 125 full-term infants at 3, 6, and 12 months of age. Maternal cortisol (stress hormone) and psychological state were evaluated 5 times during pregnancy. Exposure to elevated concentrations of cortisol early in gestation was associated with a slower rate of development over the 1st year and lower mental development scores at 12months. Elevated levels of maternal cortisol late in gestation, however, were associated with accelerated cognitive development and higher scores at 12 months. Elevated levels of maternal pregnancy-specific anxiety early in pregnancy were independently associated with lower 12-

Issue	Source	Summary
		month mental development scores. These data suggest that maternal cortisol and pregnancy-specific anxiety have programming influences on the developing fetus.
Extended benefits of anxiety on children	O'Connor T. G, Ben-Shlomo Y, Heron J, Adams J and Glover V (2005). Prenatal Anxiety Predicts Individual Differences in Pre-Adolecent Children. Biological Psychaitry 58: 211-217.	Analysis of stress hormone levels (cortisol) in 10 year old children suggested that fetal exposure to prenatal maternal stress or anxiety affects a key part of their babies developing nervous system.
Impacts of reduced stress perinatal on birth		
Reduction in length of labour using hypnosis	Harmon T.M, Hynan M.T and Tyre TE (1990) *Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education.* The Journal of *Consulting and Clinical Psychology*. Volume 58, Number 5, Pages 525-30.	First time Mother hypnosis for childbirth clients, had an average of 4.5 hours of active labour, compared to 9 hours the average of 9 hours.
Reduction in length of labour using hypnosis	Jenkins M.W and Pritchard M.H (1993) *Hypnosis: Practical applications and theoretical considerations in normal labour.* British Journal of Obstetrics and Gynaecology. Volume 100, Number 3, Pages 221-226.	Findings showed a reduction in labour with first time Mothers of 3 hours and by 1 hour for Mothers in subsequent births.
Reduction in medication use	Bobart, V. and Brown, D.C. (2002). *Medical Obstetrical Hypnosis an Apgar Scores and the Use of Anaesthesia and Analgesia during Labor and Delivery*. Hypnos, 29(3), pp.132-139.	Study reported a decrease in the use of medication during labour. Epidurals were used by 97% of the non-hypnosis group and by only 38% of the hypnosis group. Analgesia was used by 75% of the non-hypnosis group, and by only 5.5% of those using hypnosis. 2.7% of the non-hypnosis group had a drug free birth compared with 61% of the hypnosis group. Baby Apgar scores were also significantly higher in the group using hypnosis.

Issue	Source	Summary
Use of intervention	Harmon, T.M., Hynan, M.T. and Tyre, T.E., 1990. *Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education.* Journal of Consulting and Clinical Psychology, 58(5), p.525.	reported that a higher than average 81% of first time mums using hypnosis, delivered spontaneously without the use of caesarean, forceps or venteuse.
Reduction in post-partum depression	McCarthy P (1998) *Hypnosis in obstetrics*. Australian Journal of Clinical and Experimental Hypnosis. Volume 26, Pages 35-42.	After providing 600 women with a 30 minute hypno-birthing session, the study found a virtual absece of postpartum depression compared to an average of 10-15%
Reduction in post-partum depression	Harmon, T.M., Hynan, M.T. and Tyre, T.E., 1990. *Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education.* Journal of Consulting and Clinical Psychology, 58(5), p.525.	Reported a reduced incidence of postnatal depression in women who had been taught hypnotic analgesia for childbirth.

Department of Health & Social Care

Edward Argar MP
Minister of State for Health

39 Victoria Street
London
SW1H 0EU

020 7210 4850

Cllr Arash Ali Fatemian
By Email: arash.fatemian@oxfordshire.gov.uk

Dear Arash,

15th September 2020

Decision by the OCCG to continue with the closure of consultant-led maternity service at the Horton General Hospital for the foreseeable future

I'm writing to thank you for your letter of 2 December 2019, to Secretary of State (SofS) for Health and Social Care, concerning Oxfordshire Clinical Commissioning Group's (OCCG) decision to continue the closure of consultant-led maternity services at the Horton General Hospital in Banbury for the foreseeable future. I would like to apologise for the delayed response, this is due to the work on Covid-19.

Maternity and related services at the Horton have been the subject of referrals to the SofS and the Independent Reconfiguration Panel (IRP) in 2008 and 2017. The IRP provided advice and recommendations on these referrals to the then SofS for Health which were accepted in full.

After careful consideration of the information presented in your letter, in relation to the relevant legislation (the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013), SofS has concluded that it does not constitute a valid referral under the regulations as there does not appear to be a substantial variation or development in the health service since the last referral in 2017.

The consultant-led unit has been closed since October 2016 as the unit could not be adequately staffed in a safe and sustainable manner. The decision of the OCCG is to continue the closure and keep it under review annually and maintaining a midwife-led unit at the Horton.

I hope this reply is helpful.

Yours ever,

Edward Argar

EDWARD ARGAR

Horton Joint Health Overview and Scrutiny Committee
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OX1 1ND

Contact: Sam Shepherd, Policy Team Leader
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Date: 22 September 2020
Our Ref: OJHOSC/SoS/HortonMat3

Rt Hon Edward Argar MP
Minister of State for Health
Department of Health and Social Care
9th Floor
39 Victoria Street
London
SW1H 0EU

Dear Minister,

Re: Referral of the closure of consultant-led maternity services at the Horton General Hospital for the foreseeable future

I thank you for your letter dated the 15th of September 2020 further to our representations dated 2nd December 2019.

I am however deeply concerned that you have misunderstood the issues at hand and failed to take due account of the new evidence submitted. I urge you to urgently reconsider your initial assessment and pass the matter to the Independent Reconfiguration Panel (IRP) for their detailed assessment against the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. You are respectfully reminded that although this is at the discretion of the Secretary of State, the decision on the validity of a referral must be based upon a comprehensive re-evaluation of all relevant and pertinent evidence.

Your letter suggests that the Horton Health Overview and Scrutiny Committee (HHOSC) referral from December 2019 is not a valid referral because a substantial variation has not occurred since 2017. This statement not only fails to recognise the pre-2017 existence of obstetric services at the Horton General Hospital (HGH), but it contradicts the judgements of the IRP and your predecessors. It also misses the very point of having a process and legislation around health variation and scrutiny, where since 2017 new evidence has been submitted to a new and fully representative HOSC. In December 2019 the Horton HOSC deemed a further referral necessary. I can only hope that the pressures of the pandemic have not afforded you the time and capacity to fully digest and understand the issues at hand.

The substantial variation in question physically occurred in 2016 when Oxford University Hospitals mis-leadingly badged the closure of obstetrics at the HGH as 'temporary'. Your letter indicates an acceptance of that closure as the baseline state in relation to this referral; I strongly refute this because up until 2017 obstetric services had been provided at the HGH for many years. Your initial understanding of this situation fails to acknowledge the baseline state as the Horton Hospital **with** obstetric services.

To add evidence to my assertion that the baseline state in this case is a HGH with obstetric services, the IRP advice in 2018 was to undertake further local action. If at that point substantial variation had not been deemed to have taken place, then the ensuing recommendations of the IRP would not have been necessary. As it was; the variation was deemed substantial and the IRP was very clear in determining the local actions required. The referral of December 2019 is therefore a response to, and in connection with, the substantial variation which took place before 2017. The 2019 referral is part of the same process recommended by the IRP, which we have followed in good faith.

It is clear from confirmation by the IRP in 2018 and through the evidence we have provided that due process was not followed in 2016/17; there was a mis-leading 'temporary' closure at that time to create what you are inaccurately viewing as the baseline. Had due process been followed around consultation for substantial variation in 2017, again; the IRP would not have deemed further local action necessary and we would not have created a new, fully representative HOSC committee and engaged for a two-year period with those actions. Due process was left wanting and we believe this to still be the case.

In specific response to your statement that the obstetric unit has been closed since 2016 on the grounds it could not be adequately staffed in a safe and sustainable manner, the committee considered new evidence in its work throughout 2018/19 that suggests:

- There was a disparity between the way in which staff (and the estate) at the two Oxford University Hospital Foundation Trust obstetric sites were dealt with. This "neglect" of the Horton potentially led to the resignations which then caused the problem with 'safely and sustainably' staffing the unit. A detailed examination of this assertion by the IRP would help determine whether investment in the HGH and its staff could, as we believe, make it a safe and sustainable place to work.

- The committee heard a number of offers for help with recruitment (such as that made by Cherwell District Council); none of which were aggressively pursued. An IRP examination would help determine whether all opportunities have been fully exhausted or whether, as we believe; more could be done to recruit a safe and sustainable workforce.

- There are several examples of how units with small birth numbers (and therefore with similar training accreditation challenges to the HGH) pursued innovative solutions to their workforce challenges. The committee heard how these solutions were ignored and instead, barriers sought out to confirm the HGH small unit, training and recruitment challenge. We ask that the IRP be given the opportunity to consider the new evidence found on small unit models and staffing submitted as supporting evidence to the 2019 referral.

Having now followed the IRP and Secretary of State advice for more than two years, we find ourselves in an unprecedented position where the passing of time seems to be justification to forget the history of this case. A new baseline has been arbitrarily and unjustifiably drawn as a means of dismissing our referral. The challenges of a pandemic are real and felt by us all, but I urge you not to allow pressures within the system created by Covid-19 to allow the legislative framework of this country to be by-passed.

We are currently reviewing our position in light of the continued reluctance to consider evidence-based representation around our concerns. I am sure other well-financed parties with an interest in this matter, will also consider their next steps should the final decision of the Secretary of State be to disregard his own previous advice and that of the IRP and not pass this on for detailed examination. I therefore call upon you to please remove any doubt of the validity of this referral by requesting that the IRP undertake a detailed review of the facts of this long fought and complex local issue. It is respectfully suggested that in doing so, the Secretary of State can ensure that our local people are provided with a detailed explanation of the decision-making rationale based upon our representations to date. The people of north Oxfordshire, South Northamptonshire and Warwickshire deserve comprehensive consideration of this important issue.

I look forward to hearing your response.

Best regards,

Cllr Arash Ali Fatemian
Chair of Horton HOSC on behalf of the committee and the residents of the Horton Catchment Area

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Horton HOSC Judicial Review Advice Request

Purpose

1. In September 2019, Oxfordshire Clinical Commissioning Group (OCCG) took a decision to confirm an earlier decision (from 2017) to have a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the John Radcliffe Hospital and establish a Midwife Led Unit (MLU) at the Horton General Hospital, for the foreseeable future.

2. Following the OCCG decision, the Horton Joint Health Overview and Scrutiny Committee (HOSC) submitted a referral to the Secretary of State for Health and Social Care on the 2nd of December 2019. The Secretary of State briefly replied on the 15th of September 2020 to say he did not consider the referral to be valid. The Chairman of the Horton HOSC then wrote an additional letter in reply. No response has yet been received.

3. This paper sets out what a Judicial Review is, and the advice received on a potential Judicial Review of the Secretary of State's decision. It makes a recommendation to the Horton HOSC on the next steps.

Judicial review

4. Judicial Review is the procedure by which the courts examine the decisions of public bodies to ensure that they act lawfully and fairly. On the application of a party with sufficient interest in the case, the court conducts a review of the process to assess the validly of the decision. Judicial Review is a remedy of last resort. Although the number of Judicial Review claims has increased in recent years, it can be difficult to bring a successful claim and the court may refuse permission to bring a claim, if an alternative remedy has not been exhausted. A claimant should therefore explore all possible alternatives before applying for Judicial Review.

5. The grounds for Judicial Review are constantly evolving but those which are currently available can be categorised under four heads:

Illegality – arises when a decision maker has either misdirected themselves in law, exercises powers wrongly or acted beyond their powers.

Irrationality- relates to a situation where a decision is so unreasonable, that no reasonable authority could have come to that decision (Wednesbury Unreasonableness).

Procedural unfairness- relates to a situation where a decision maker failed to consult or give reason and or has failed to comply with the principles of natural justice.

Legitimate expectation- A public body may have by its actions or statements or by the requirement to act in a certain way, have given rise to a legitimate expectation.

Making a Judicial Review application

6. The making of a claim for Judicial Review is governed by a Pre-Action Protocol which sets out the process with a view to avoiding unnecessary litigation. It recommends that a good time before making an application, a letter before claim should be sent to the defendant. The correspondence sets out the issues and sets out whether they can be narrowed, or litigation avoided. The defendant will be given 14 days in which to respond. If the claimant is satisfied with the response, the matter is concluded. If the Claimant is not, then proceedings must be issued within 3 months of the of the date upon which the grounds for the claim first arose.

Remedies

7. Judicial Review offers the following remedies:

A Quashing Order that sets aside the decision.

A Mandatory Order requiring the public body to carry out its legal duties.

A Prohibiting Order restraining the public body from acting beyond its legal powers.

Typically, a claimant would seek a quashing order, together with a mandatory order directing the public body to take a decision in accordance with the court's judgement.

Closure of consultant-led maternity services at the Horton General Hospital for the foreseeable future

8. The Minister of State for Health responded on 15th September 2020 to detailed representations made on 2nd December 2019. The Horton HOSC responded by way of correspondence dated 22nd of September 2020 seeking further clarification of the basis upon which the decision-making process undertaken by the Minister of State for Health, the Rt HON Edward Argar MP.

9. The response requested a reconsideration of the initial assessment and a request that the matter be passed to the Independent Reconfiguration Panel for detailed assessment against the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013. The argument presented are based upon the premise that the Minister of Health had misunderstood the issues at hand and did not take account of the new evidence submitted. A request for a detailed explanation of the decision-making rationale based upon representations to date has been requested. To date, there has been no response to the correspondence of the 22nd September.

10. Having considered the issue of whether the Horton HOSC has the power to issue proceedings by way of Judicial Review against the Secretary of State, the view taken is that it does not have such power because such action is beyond the terms of reference. In order to initiate such action, the Horton HOSC would be required to have in place the agreement of the member authorities, who would in turn need to consider and agree the decision to initiate proceedings. Further to which, as health overview committees derive their powers from Full Council, this is an issue that would need to be considered by Full Council and would be dependent upon Monitoring Officer and Chief Financial Officer advice.

11. The process for bringing a Judicial Review would require the appointment of Queen's Counsel with specialist expertise in public administrative and medical law. A pre-action protocol letter will need to be drafted and served with a view to issuing proceedings within 3 months of the 15th September 2020. The pre-action protocol letter will need to set out the basis of the claim, the reason for bringing the claim and the remedy that is sought.

12. The claim will elaborate upon the various premises set out in the correspondence of the 22nd September, and reiterating that the decision making was flawed because all the evidence was not taken into account, and or, that it was not given sufficient credence, resulting in the decision contained within the correspondence of the 15th September being unreasonable.

13. Council will be required to attain a provisional advice as to the merits of potential claim for Judicial Review. It is anticipated that an initial advice will cost in the region of £6,000. It is difficult to assess the likely cost to be incurred in pursuing the matter with it being recommended that a contingency fund of £80,000 be set aside together with a further allowance of the same, should the case be unsuccessful and we are required to pay costs. This figure may vary depending on the approach adopted by the various parties.

14. Advice on a Judicial Review

Summary

The following advice has been sought from the Head of Legal Services at Oxfordshire County Council.

- **a.** The prospect of success in the contemplated Judicial Review is considered to be below 30% with there being a significant legal and evidential hurdles in pursuing a claim.

- **b.** The costs to benefit balance proves unviable with a prospect of success determination being below 30% and estimated total costs to be in the region of £80,000 in bringing a Judicial Review claim. It is anticipated that the Secretary of State's (SofS) costs is likely to be equal to, if not exceed, our cost estimate. In light of the low chance of success, it is highly probable that the SofS will seek to and succeed in recovering their legal costs.

c. The advent of Covid-19 has placed a significant amount of pressure upon the Administrative Courts system with there being inherent delays across the entire judicial system. It is anticipated that by the time the matter is brought before the Administrative Court for a final hearing, the suggested annual review will shortly after, afford a further opportunity to petition the SofS.

Background to the advice

a. Following a meeting of the Horton Health Overview and Scrutiny Committee (HHOSC) held on Thursday 19th September 2019, the HHOSC referred the Oxfordshire Clinical Commissioning Group's (OCCG) proposal to close consultant-led maternity services at the Horton General Hospital in Banbury ('the Horton') for the foreseeable future to the SofS for Health. The referral being made pursuant to Regulation 23(9)(a) and (c) of the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013. On 2nd December 2019, the Chair of Horton HOSC on behalf of the committee and the residents of the Horton Catchment Area, wrote to the SofS for Health and Social Care, the Rt Hon Matt Hancock MP further to a previous referral in August 2017.

b. The issues relating to obstetric services at the Horton have a long and complex history. In 2006 the then Oxford Radcliffe Hospitals NHS Trust (ORH) proposed moving inpatient paediatric and gynaecology services, consultant-led maternity services and the Special Care Baby Unit from the Horton in Banbury to the John Radcliffe Hospital (JR) in Oxford. It being felt that this was in the interest of people in the North of the county, the matter having been referred to the SofS.

c. In February 2008, The Independent Reconfiguration Panel (IRP) issued advice to ORH concerning Paediatric Services, Obstetrics, Gynaecology and the Special Care Baby Unit at the Horton together with a set of recommendations. The IRP advised that the Trust and the PCT were to invest in, retain and develop services at the Horton, as it considered the Hospital was to have an important future role in providing local care to people in North Oxfordshire and the surrounding areas. ORH maintained consultant-led maternity services at the Horton supported by a training programme for junior doctors working in obstetrics.

d. In 2012 post graduate obstetric training accreditation at the Horton was withdrawn due to the low numbers of births at the hospital, which meant limited exposure to complex cases, failures in providing suitable and satisfactory supervision and training, and the difficulties experienced in recruiting sufficient numbers of middle grade doctors. The Trust then developed a Clinical Research Fellow programme to support consultant-led provision, but they reported that national recruitment shortages in obstetric posts led to a reduction in applications which made it unviable. The programme closed in December 2015 and a rotational middle grade rota was created to staff the obstetrics unit.

e. In September 2016 OJHOSC was informed that ORH, now known as Oxford University Hospitals Foundation Trust (OUHFT) were intending to temporarily_close consultant-led maternity services at the Horton from 3rd October 2016, as they were unable to adequately staff the unit in a safe and sustainable manner. Assurances were given by the Trust that they planned to reopen the unit by March 2017 on the strength of an action plan to recruit more consultants. This did not occur with a referral to the SofS being made under Regulation 23(9)(b) of the 2013 Regulations. The IRP subsequently reviewed the matter who were of the view that this no longer constituted a temporary closure.

f. In March 2017, OJHOSC scrutinised proposals for acute services in the phase 1 Transformation consultation running from 16th January - 9th April 2017 which formed the basis of a formal response to the consultation and recommendations for the OCCG, submitted that month. A series of meeting took place in the intervening months which culminated in a decision by the OCCG Board on 10th August 2017, agreeing a proposal to stop consultant-led maternity services at the Horton, the OJHOSC referring the decision to the SofS under Regulation 23(9)(a) and (c). In March 2018, the SofS wrote to the OJHOSC accepting the advice of the IRP in full and set out 10 broad categories of compliance and further exploration.

g. The HHOSC commenced work in September 2018, having undertaken a number of regular meetings to explore the issues raised. A decision was taken to refer the matter for consideration by the SofS and the IRP, for the following reasons.

  i. Regulation 23(9)(a) – consultation on any proposal for a substantial change or development has been inadequate in relation to content, and
  ii. Regulation 23(9)(c) - the decision is not in the best interests of the health service or local residents.

h. Extensive and detailed arguments were submitted in relation to both grounds which addressed concern centred around recruitment, finance, assessment criteria, weighting, needs of local people, views and experiences of mothers, travel, access and the implications for the foreseeable future. The arguments presented were detailed, clear and evidenced with the necessary information having been presented in support.

Legal Analysis

a. The information was presented to the SofS in the form of a letter dated the 2nd December 2019, addressed to the Rt Hon Matt Hancock MP. Following a number of failed attempts to secure a reply, a response having been received by way of a letter dated 15th September 2020 from the Rt Hon Edward Argar MP. It is this letter that forms the subject matter of a subsequent challenge.

b. I considered this response and was asked to add additional comments upon the draft response from the HHOSC Chairman to the SofS. The intention being to place emphasis on the need for elaboration of the basis of the decision together with the evidence taken into account. The SofS has to date not responded to the correspondence of 22nd September 2020. In the absence of a response, I will consider further the letter of 15th September 2020.

c. The decision letter of 15th September states as follows:

" After careful consideration of the information presented in your letter, in relation to the relevant legislation (the Local Authority (Public Health, Health and Wellbeing Board and Health Scrutiny) Regulations 2013 the SofS has concluded that it does not appear to be a substantial variation or development in the health service since the last referral in 2017.

The consultant-led unit has closed since October 2016 as the unit could not be adequately staffed in a safe and sustainable manner. The decision of the OCCG is to continue the closure and keep it under review annually and maintain a midwife-led unit at the Horton."

It is worthy of note that the SofS makes clear that careful consideration of information presented was undertaken which informed his conclusion that there did not appear to be a substantial variation or development.

d. In considering the bringing of a claim to review the decision of the SofS, one would need to issue proceedings in the Administrative Courts by way of a Judicial Review claim. It has been suggested in some quarters that the decision of the SofS is subject to Judicial Review. It is important to recognise that this is the most draconian of measures only to be used as a last resort. The grounds upon which a claim may be brought will relate to the decision. The decision being to keep the matter under review in the first instance, distinct from expressing an alternative view, or in the alternative, deciding to refer the matter to the IRP. The decision letter further concludes that the arguments submitted do not constitute a valid referral under the regulations, there not appearing to be a substantial variation or development in the health service since 2017.

e. It is worthy of note at this juncture that the references are subjective and within the realm of the SofS's discretion. The conclusions drawn and the subsequent decision arrived at is based upon the SofS's assessment of the information presented, with the outcome being that they do not fulfil the referral criteria. I re-iterate my concerns as to the subjective nature of the assessment, the failure by the SofS to articulate the thought process and the factors taken into account, further detracting from the ability to bring a claim for Judicial Review. These factors although inconvenient from an assessment perspective do not detract from my opinion that this will prove a high hurdle to overcome and interrogate before the Administrative Courts.

f. Preliminary considerations in deciding whether the decision was reviewable would be to consider whether account has been taken of all the relevant considerations. Although I cannot account for the actual decision-making process, for the reasons outlined above, I can conclude the arguments submitted in the letter dated 15th September were most detailed, comprehensive and well-articulated. The evidence submitted represented a comprehensive analysis of evidence, data and opinion. Although the SofS does not articulate specific consideration of evidence or the points submitted, reference is made to "*After Careful consideration of the information presented in your letter…".* I think it likely that a High Court Judge sitting in an Administrative Court will be satisfied that the presentation and reference to *"careful consideration*" will be sufficient to show that the relevant evidence had been taken into account. The argument that the SofS should have articulated their consideration of the evidence is weak with the reference to having "*carefully considered*" being sufficient to undermine a claim for Judicial Review. I note the presiding cases of <u>Tesco Stores Ltd v. Secretary of State for the Environment [1995] I WLR 759 and R (Khan) v. Newham London Borough Council [2005] QB 37.</u>

g. The second consideration is in relation to the rationality argument, i.e. whether the SofS acted rationally in deciding to keep matters under annual review. I note the historical context of the decision-making process at local level, the various facets to the decision-making process with the decision to continuing to review annually not being irrational or out of kilter with previous approaches. More information would have been useful to understand how the decision was made and the factors that informed the decision-making process. Regardless, they do not in my opinion undermine the rationality of the decision itself.

h. A challenge must be based upon an unreasonable decision (Wednesbury Unreasonableness) which is difficult to establish. Despite criticism of the test in <u>R(Daly) v. Secretary of State for the Home Department [2001] 1 AC 532</u>, at 549 (per Lord Cooke of Thorndon) and <u>R (Association of British Civilian Internees: Far East Region) v. Secretary of State for Defence [2003] QB 1397</u> at 1413 9 per Dyson LJ) , the courts are still very reluctant to find a decision was Wednesbury unreasonable. <u>(Bromley London Borough Council v. Greater London Council [1983] 1 AC 768).</u> This is particularly the case where the decision maker is an expert and I would further suggest a government minister, judgement the court would be unwilling to substitute with their own, save for the most exceptional case of blatant unreasonableness <u>R (Great North Eastern Railway Ltd) v. Office of Rail Regulation [2006] EWHC 1942.</u>

i. The proportionality of the decision-making process is a significant element of the decision itself and again I do not believe that the decision to review annually is disproportionate in the current circumstances. Lord Greene, <u>Associated Provincial Picture Houses Ltd v Wednesbury Corporation [1948] I KB 223 HL</u>. The concept of proportionality involves a balancing exercise between the legitimate aims of the state on one hand, and the protection of the individual's rights and interests on the other. The test is whether the means employed to achieve the aim correspond to the importance of the aim, and whether they are necessary to achieve the aim. The decision was made in the midst of a once in a lifetime pandemic with there being unprecedented strains on all aspects of the health and social care framework. In the absence of a vaccine, tectonic pressures on the health system and with no end in sight in the autumn of 2020, I do not believe that it is disproportionate to review on an annual basis. I would in fact argue that the economic impact remains uncertain together with the impact that it will have on population distribution. These are of course arguments to be proposed with it being reasonably foreseeable that a broader view of the health provision landscape being taken into account. In the absence of a response, the position of the SofS is unknown. I would suggest that a carefully crafted explanatory statement further elaborating upon the above heads in support of the letter dated the 15th September would significant undermine a claim for Judicial Review.

j. In determining the possibilities of success, I would as a practitioner of public administrative law with experience of Judicial Review, conclude that the chances of success are significantly below 30%. In the absence of an opinion that would estimate chances of success to be in the region of 75% or above, I would strongly advise again the issue of a claim in the Administrative Court for Judicial Review.

k. I am further cognisant of the cost to benefit ratio with the time for issue a Judicial Review, i.e. 3 months from the decision itself, rapidly running short. I am further mindful of the absence of compliance with the Pre-Action Protocol provisions which will place the Council at significant risk of costs, with there being limited time in which to issue proceedings and comply with the protocol. With the complexity of the issue at hand, the delay in response by the Secretary of State and increased demand with dealing with the Covid-19 pandemic; the legal service (like many other services within the Council), has only now had an opportunity to provide and share the legal opinion on the Judicial Review Path.

Courts and Covid-19

a. Administrative Court Office publishes guidance on measures for Judicial Review applications for immediate or urgent action, subsequently updated to cover non-urgent claims and actions.[i] What is apparent from the new guidance is that some processes, particularly in relation to non-urgent Judicial Review claims, initially may take longer such as the consideration of an application for permission to apply for Judicial Review on the papers and the hearings of non-urgent business which may take longer to come on. It is unclear the likely length of delay, but it is by all indications significant.

Recommendation

15. When the decision was made by Oxfordshire Clinical Commissioning Group on the 26th September 2019, the CCG Board:

- ***Confirmed*** *the decision made in August 2017 to create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the John Radcliffe Hospital and establish a Midwife Led Unit (MLU) at the Horton General Hospital, for the foreseeable future.*

- ***Noted*** *that the decision is for the 'foreseeable future' rather than a statement of permanency. This is because OCCG have a framework, agreed by the Oxfordshire Health and Wellbeing Board, that states an ongoing commitment by the CCG and all health & care partners to regularly review population health and care needs and change services as appropriate to meet that need, all co-produced with local stakeholders. This approach will ensure that if population or other factors change significantly then the need for obstetric services can be reviewed.*

16. It is the above decision[1] which the Horton Health Overview and Scrutiny Committee referred to the Secretary of State on the 2nd of December 2019.

17. A recommendation is made below, in light of the following factors:

a) Legal advice provided (and presented in this report) on the likelihood of success of a Judicial Review against the Secretary of State;
b) Considering it is now 14 months past the OCCG decision which described the decision as one for the 'foreseeable future' and would be subject to review, described as an 'annual' review by the Secretary of State's office letter dated 15th September;
c) There has been a fundamental shift in significant factors related to the provision of all health and care services from the Covid-19 epidemic.
d) Despite the impact of Covid-19, this issue remains a significant priority for the residents and patients of north Oxfordshire, south Northamptonshire and south Warwickshire.

18. It is therefore **RECOMMENDED that the Horton HOSC:**

RECOMMEND to the OCCG Board**:**

a) That OCCG undertake the review referred to in their decision paper of the 26th September 2019 and as reflected as an annual review by the Secretary of State letter dated the 15th of September 2020.
b) The review is required to be undertaken as a matter of urgency.

[1] 2019-09-26-Paper-19-54-Maternity-Services.pdf (oxfordshireccg.nhs.uk)

[i] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/926002/RCJ_Administrative_Court_Information_for_Court_Users.pdf