Notice of Meeting Public Document Pack

Horton Joint Health Overview & Scrutiny Committee

Monday, 25 February 2019 at 10.30 am

The Town Hall, Banbury Town Council, Bridge Street, Banbury OX16 5QB

Membership

Chairman - Councillor Arash Fatemian
Deputy Chairman -

Councillors:	Sean Gaul	Wallace Redford	Sean Woodcock
	Kieron Mallon	Barry Richards	Adil Sadygov
	Neil Owen	Alison Rooke	
Co-optees:	Dr Keith Ruddle		

Notes: ***Date of next meeting:*** *11 April 2019*

What does this Committee review or scrutinise?

- Any matter relating to the planning, provision and operation of health services in the area of its local authorities.
- Health issues, systems or economics, not just services provided, commissioned or managed by the NHS.

How can I have my say?

We welcome the views of the community on any issues in relation to the responsibilities of this Committee. Members of the public may ask to speak on any item on the agenda or may suggest matters which they would like the Committee to look at. **Requests to speak must be submitted to the Committee Officer below no later than 9 am on the working day before the date of the meeting.**

For more information about this Committee please contact:

Chairman	-	Councillor Arash Fatemian Email: arash.fatemian@oxfordshire.gov.uk
Policy & Performance Officer	-	*Samantha Shepherd Tel: 07789 088173* *Email: Samantha.shepherd@oxfordshire.gov.uk*
Committee Officer	-	*Julie Dean Tel: 07393 001089* *Email: julie.dean@oxfordshire.gov.uk*

Yvonne Rees
Chief Executive

February 2019

About the Horton Health Overview & Scrutiny Committee

Health Services are required to consult a local authority's Heath Overview and Scrutiny Committee about any proposals they have for a substantial development or variation in the provision of health services in their area. When these substantial developments or variations affect a geographical area that covers more than one local authority, the local authorities are required to appoint a Joint Health Overview and Scrutiny Committee (HOSC) for the purposes of the consultation.

In response to the Oxfordshire Clinical Commissioning Group's proposals regarding consultant-led maternity services at the Horton General Hospital, the Secretary of State and Independent Reconfiguration Panel (IRP) have advised a HOSC be formed covering the area of patient flow for these services. The area of patient flow for obstetric services at the Horton General Hospital covers Oxfordshire, Northamptonshire and Warwickshire.

The County Councils of Oxfordshire, Northamptonshire and Warwickshire have therefore formed this joint committee.

What does this Committee do
The purpose of this mandatory Horton Health Overview and Scrutiny Committee across Oxfordshire, Northamptonshire and Warwickshire is to:

a) Make comments on the proposal which is the subject of the consultation
b) Require the provision of information about the proposal, as necessary
c) Require any member or employee of the relevant health service to attend before it to answer questions in connection with the consultation.
d) Determine whether to make a referral to the Secretary of State on the consultation of consultant-led obstetric services at the Horton General Hospital where it is not satisfied that:
    - Consultation on any proposal for a substantial change or development has been adequate in relation to content or time allowed (NB. The referral power in these contexts only relates to the consultation with the local authorities, and not consultation with other stakeholders)
    - That the proposal would not be in the interests of the health service in the area
    - A decision has been taken without consultation and it is not satisfied that the reasons given for not carrying out consultation are adequate

NB The Committee's duration is expected to last only as long as necessary for the matters above to be considered. Responsibility for all other health scrutiny functions and activities remain with the respective local authority Health Scrutiny Committees.

If you have any special requirements (such as a large print version of these papers or special access facilities) please contact the officer named on the front page, giving as much notice as possible before the meeting

A hearing loop is available at County Hall.

AGENDA

1. Apologies for Absence and Temporary Appointments

2. Declarations of Interest - see guidance note on the back page

3. Minutes (Pages 1 - 24)

To approve the minutes of the last two meetings held on 26 November 2018 and 19 December 2018 (**HHOSC3**) and to receive information arising from them.

4. Petitions and Public Address

5. Responding to the IRP and Secretary of State recommendations (Pages 25 - 70)

10:45

Oxfordshire Clinical Commissioning Group (OCCG) and the Oxford University Hospitals Foundation Trust (OUH) will report back to the Committee on progress with regard to the following (**HHOSC5**): (**TWO REPORTS TO FOLLOW**)

- Travel and transport
- Clinical model
- Housing growth and population
- Update on engagement work – stakeholder event and survey

6. Chairman's Report (Pages 71 - 72)

11:55

The report (**HHOSC6**) gives an update on the activity of the Committee between meetings.

Declarations of Interest

The duty to declare…..
Under the Localism Act 2011 it is a criminal offence to
(a) fail to register a disclosable pecuniary interest within 28 days of election or co-option (or re-election or re-appointment), or
(b) provide false or misleading information on registration, or
(c) participate in discussion or voting in a meeting on a matter in which the member or co-opted member has a disclosable pecuniary interest.

Whose Interests must be included?
The Act provides that the interests which must be notified are those of a member or co-opted member of the authority, **or**

- those of a spouse or civil partner of the member or co-opted member;
- those of a person with whom the member or co-opted member is living as husband/wife
- those of a person with whom the member or co-opted member is living as if they were civil partners.

(in each case where the member or co-opted member is aware that the other person has the interest).

What if I remember that I have a Disclosable Pecuniary Interest during the Meeting?.
The Code requires that, at a meeting, where a member or co-opted member has a disclosable interest (of which they are aware) in any matter being considered, they disclose that interest to the meeting. The Council will continue to include an appropriate item on agendas for all meetings, to facilitate this.

Although not explicitly required by the legislation or by the code, it is recommended that in the interests of transparency and for the benefit of all in attendance at the meeting (including members of the public) the nature as well as the existence of the interest is disclosed.

A member or co-opted member who has disclosed a pecuniary interest at a meeting must not participate (or participate further) in any discussion of the matter; and must not participate in any vote or further vote taken; and must withdraw from the room.

Members are asked to continue to pay regard to the following provisions in the code that *"You must serve only the public interest and must never improperly confer an advantage or disadvantage on any person including yourself"* or *"You must not place yourself in situations where your honesty and integrity may be questioned…..".*

Please seek advice from the Monitoring Officer prior to the meeting should you have any doubt about your approach.

List of Disclosable Pecuniary Interests:
Employment (includes"*any employment, office, trade, profession or vocation carried on for profit or gain*".), **Sponsorship, Contracts, Land, Licences, Corporate Tenancies, Securities.**

For a full list of Disclosable Pecuniary Interests and further Guidance on this matter please see the Guide to the New Code of Conduct and Register of Interests at Members' conduct guidelines. http://intranet.oxfordshire.gov.uk/wps/wcm/connect/occ/Insite/Elected+members/ or contact Glenn Watson on **07776 997946** or glenn.watson@oxfordshire.gov.uk for a hard copy of the document.

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
Kathy Hall. OUH

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. Kathy 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. Kathy 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 Chairman introduced the item stating that 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 the 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 – including a response from Local Councillor Surinder Dhesi
- 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;
- She was very concerned regarding travel times as the length of journey could be very unpredictable due the heavy traffic, accidents, inclement weather etc. Parking charges were high at the John Radcliffe. The results of her travel survey had gleaned 400 responses with the average time taken to travel and park being 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 which was very supportive;
- Lady B – birth started as low risk, rushed to John Radcliffe for a C section in a naked state with the midwife holding the baby's head to avoid death – she got to the John Radcliffe in time because it was a Sunday morning. It could have been a different outcome during a weekday or in Saturday traffic. She had serious post trauma issues afterwards as a result;
- Lady C – transferred to John Radcliffe 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 Bladon which was equidistant from the John Radcliffe and the Horton Hospitals, which in turn 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 keep 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 took 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 in the field of 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 was 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.

In response to a question asking which specific areas of best practice had the NHSE highlighted to the CCG, Bennet Low stated 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. As far as the interests of patients was concerned, NHSE would be looking at the CCG to provide clinically safe and sustainable options for the population – 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 ensured that the independent evidence of its analysis was evaluated effectively, he stated that the Senate and the Royal Colleges were a good way to do this.

In conclusion, 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 each 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 found it necessary 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 at 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.

Katie Randall (via email)

She gave birth to her child in August 2016, just prior to the Hospitals being downgraded. The hospital experience she had received there was 'exceptional', she felt 'cared for 100% of the time and when things were not going to plan (it was found necessary to give her an epidural), the Hospital was in control'. She stated that she could not imagine how traumatic this would have been if she had had to transfer between hospitals, being in such pain. The changes in hospital care since then had been one of the greatest contributing factors to her and her husband not having a second child. She was upset to think that other women are not able to experience the same care as she had during one of the most crucial moments of their lives.

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 that 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 Access 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.

High Steward of Banbury, Sir Tony Baldry

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.
- 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 birth 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 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 .....

Oxfordshire
Clinical Commissioning Group

Responding to Secretary of State letter following referral of the permanent closure of consultant-led maternity services at the Horton General Hospital

Paper for the Joint OSC meeting 25 February 2019

At the November meeting the Horton Joint Health Overview and Scrutiny Committee (Horton Joint OSC) confirmed that in the opinion of the Committee the proposed approach and plan outlined would address the recommendations of the Secretary of State/Independent Reconfiguration Panel. The full plan is available here.

The work streams are progressing to plan and in line with our timetable the papers presented today include updates in the following areas:

Work stream 1 – Engagement

Work stream 2 – Service description

Work stream 4 – Size and share of the market (activity and population modelling)

Work stream 5c – Travel and access

Work stream 6 – Option appraisal, the final draft of the long list is included, this has been updated to address the comments received at the last meeting of the Horton Joint OSC.

The information being presented here will be shared and discussed at the first Stakeholder event being held on 22 February 2019. A verbal update from this event will be given to HOSC members.

HOSC members are asked to review the information presented for all work streams and highlight if there are any other aspects that should be explored.

Louise Patten, Chief Executive, Oxfordshire CCG
Dr Bruno Holthof, Chief Executive, Oxford University Hospitals NHS Trust

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Oxfordshire
Clinical Commissioning Group

DRAFT
Horton Joint Health and Overview Scrutiny Committee

Date of Meeting: 25 February 2019

Title of Paper: Update on Workstream 1: Engagement

Purpose: To provide an update on the Engagement Workstream, particularly focussed on:

- Survey for women who have used maternity services since the temporary closure of obstetrics at the Horton General Hospital.
- Stakeholder events planned for February and June

Senior Responsible Officer: Catherine Mountford, Director of Governance, Oxfordshire Clinical Commissioning Group

Introduction
The purpose of the Engagement Workstream is

- To ensure that the programme of work to address the requirements as set out by the Secretary of State is undertaken with stakeholders in an open and transparent way
- To seek feedback from mothers and families in Oxfordshire and the bordering areas in the north of the county who have given birth since the temporary closure of the Horton obstetric unit on 1 October 2016.

Information being used in the programme is being shared on the OCCG website. A new section was set up at the start of the programme and is accessible with one click from the OCCG home page. A link is provided to an archive page with material, documents and reports used previously to ensure all stakeholders and members of the public can access information they need easily.

The two main areas of work currently being addressed within this workstream are the survey and focus groups and the stakeholder events.

Survey and focus groups
A survey is planned to help us understand the experience of women who have used maternity services since the temporary closure of the obstetric service at the Horton General Hospital. The survey will gather information from women in the following groups:

- Women in Oxfordshire who give birth in Oxfordshire
- Women who live in Oxfordshire who give birth outside Oxfordshire
- Women who live outside Oxfordshire who give birth in Oxfordshire
- Women who live outside Oxfordshire, in the catchment area of the Horton, and give birth at an obstetric unit outside Oxfordshire

It is estimated that approximately 16,000 women will be invited to participate in the survey.

A working group was established to oversee this work with representation from the Horton HOSC, the Keep the Horton General campaign group, Oxford University Hospitals and OCCG. A procurement process was followed to appoint a company with sufficient experience and expertise to design and conduct the survey and focus groups. Two organisations were shortlisted and Pragma was selected.

The survey questions have been developed using feedback from the group. Drafts of the survey have been shared with the group and the comments, suggested changes and general feedback has been used in refining the final version of the survey.

The survey questions are designed to encourage women and their partners to share their experience about using services, what worked well, what could be improved and how they may have been impacted by changes. The key issues of travel, transport and distance all feature highly in the survey as well as feedback on choices.

The survey is being tested before launching which is planned for 25 February 2019.

The survey will be hosted by Pragma and all responses will be anonymous.

To ensure confidentiality, the invitation letter will be sent to women from NHS organisations rather than Pragma

In addition to letters being sent directly to women, publicity through the local media and social media is planned.

It is important to gather experience from as many women as possible. It is also important that the sample of women who complete the survey are representative of the population in terms of where they live, their age, ethnicity and other demographic factors. We will monitor the responses as they arrive to ensure we address any further publicity correctly to encourage those under-represented to participate.

Within the survey, women will be asked if they would be prepared to share their experience in more detail by attending a focus group or participating in a one-to-one interview. This will help to explore some issues in more depth.

The results of the survey will be analysed and a report produced that will be published.

Engagement Events

Two events are being organised to engage wider stakeholders in the work of the programme. These events will be facilitated by independent external professionals who will also write up reports on each.

The first event will take place on 22 February 2019. This event will consider information including evidence and data relevant to the criteria. All information will be published in advance of the event and most it is being presented to the Joint HOSC on 28 February 2019. Participants will then focus on considering the criteria to be used for assessing options and deciding on a weighting to apply.

The process for weighting the criteria will involve each participant scoring each criterion depending on how important they believe it to be. The scores will be collected and will be used to finalise the scores for each option.

The second stakeholder event will take place in June to consider the outcome of the option appraisal.

At the second workshop the scores will be shared and participants will have an opportunity to reflect on the results. More details for the content of this workshop will be made available nearer the time.

Stakeholders

The stakeholders for this work are identified in the Engagement Plan previously discussed and agreed with HOSC. Invitations to the stakeholder events were drawn up from the full list illustrated in the table below.

Members of the new Joint OSC
Members of the local authorities: • Cherwell District Council • Stratford on Avon District Council • South Northamptonshire District Council • West Oxfordshire District Council • Warwickshire County Council • Northamptonshire County Council • Oxfordshire County Council • Banbury Town Council
Local MPs: • Victoria Prentis MP for Banbury • Andrea Leadsom MP for south Northamptonshire • Nadhim Zahawi MP for Stratford-on-Avon • Robert Courts MP for Witney • Chris Heaton Harris MP for Daventry
Members of the Community Partnership Network
Keep the Horton General campaign group (KTHG)
Healthwatch Oxfordshire Healthwatch Northamptonshire Healthwatch Warwickshire
Groups that support women and families during pregnancy and childbirth including: • NCT • La Leche League • Maternity Voices • Banbury Sunshine Centre
GPs in north Oxfordshire, south Northamptonshire and south Warwickshire
NHS organisations: • Nene CCG (Northamptonshire) • South Warwickshire CCG • Oxford University Hospitals NHS Foundation Trust (OUH) • South Warwickshire NHS Foundation Trust • Northampton General Hospital NHS Foundation Trust • South Central Ambulance Service NHS Foundation Trust • East Midlands Ambulance Service NHS Foundation Trust
Professional bodies: • Local Medical Committees • Royal College of Obstetricians • Thames Valley Clinical Network
Staff working in maternity services in Oxfordshire, Northamptonshire and Warwickshire

Responding to Secretary of State letter following referral of the permanent closure of consultant-led maternity services at the Horton General Hospital

Work Stream 4 Size and share of the market (activity and population modelling)

1. Introduction

a) The purpose of this work stream is to collate and analyse activity and develop activity projections that take into account population growth for areas that access services in Oxfordshire. This incorporates analysis of the current and future demand for services at the Horton General Hospital (HGH), including an assessment population growth as a result of future housing and growth plans.
   - Get full understanding of shift in location for births from 12 month pre-change period (01.10.15 to 30.09.16) to 24 month post temporary closure period (01.10.16 to 30.09.18) for Oxfordshire residents and for Warwickshire and Northamptonshire practices that are significant users of Oxfordshire services (currently based on 18 months data being updated)
   - SCBU/neonatal activity – please see paper on service description
   - Work with District Councils to look at future housing and population growth and consider what this might mean for numbers of births
   - Undertake some sensitivity analysis to vary population share of births that take place at different sites to give an indication of the size of shift required to increase the numbers of births at the Horton General Hospital to over 2,500.

Completion of this work will be demonstrated by presentation of past activity and projections based on District Council provided housing growth figures with any assumptions identified.

This paper is presented as a draft for discussion and comments are particularly invited on:

- Are all main geographical areas included in the analysis?
- Is the modelling clear?
- Are the assumptions about a shift of baseline towards the Horton General Hospital by geography reasonable? Should other options be modelled?

2. Summary of level of births by practice groups prior to temporary closure of Horton obstetric service

From 1 October 2015 to 30 September 2016 there were 1,307 births at the HGH to mothers from Oxfordshire, south Northamptonshire or south Warwickshire. This was the last full 12 month period prior to the temporary closure of the obstetric services.

Table 1 below shows by groups of practices the births that took place in the 12 months prior to the temporary closure of the obstetric unit at HGH.

Table 1 – Birth distribution for practices in HGH catchment area

	Birth numbers		Birth per cent	
	HGH	Other	HGH	Other
Banbury practices	617	147	81%	19%
Brackley and Byfield	177	64	73%	27%
Practices around Banbury	110	78	59%	41%
Chipping Norton	54	77	41%	59%
Shipston, Kineton and Fenny Compton	53	135	28%	72%
Bicester practices	134	431	24%	76%
Other West Oxfordshire (Charlbury, Woodstock)	25	82	23%	77%
Witney, Eynsham and surrounds	25	415	6%	94%
Kidlington and Islip Practices	9	265	3%	97%
Other	103			
TOTAL	1,307	1,694		

This table has grouped practices that had significant flow to HGH or are deemed to be within a wider catchment where it may prove attractive for greater numbers to use the HGH if the service was re-established. Those included in other contain many practices where the numbers of births occurring at the HGH were only 1 or 2 and accounted for less than 1% of the practice births (this group includes some of the south Northamptonshire and south Warwickshire practices).

For the rest of the analysis and discussion in this paper the practices are considered in two groups:

Group 1: HGH main catchment area (Banbury practices, Brackley and Byfield, Practices around Banbury and Chipping Norton)

Group 2: HGH wider catchment area (Shipston, Kineton and Fenny Compton, Bicester practices, Other West Oxfordshire (Charlbury, Woodstock), Witney, Eynsham and surrounds and Kidlington and Islip)

3. What we knew in 2017

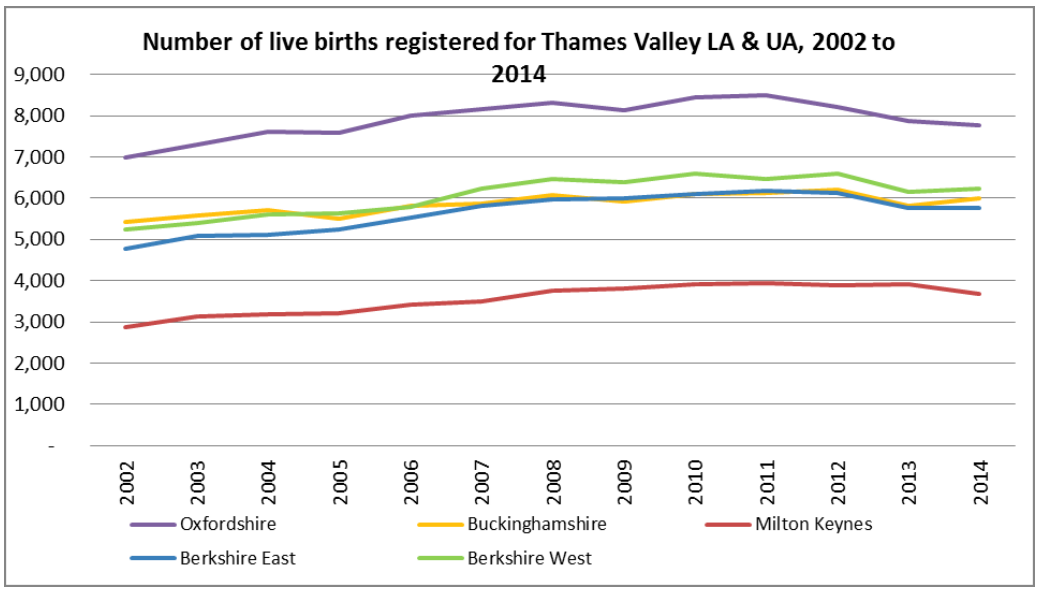
The data presented in 2017 was based on the review undertaken by the Thames Valley Strategic Clinical Network.[1]

The report included work reviewing historic birth trends and undertaking projections. The following information is taken from the report (for Oxfordshire this is based on the County Council area which covers a slightly different population than the CCG is responsible for).

3.1 Historic Trends

Figure 1 depicts the number of live births across Thames Valley over the last 12 years. Within the TVSCN there has been a 15% increase in the number of live births from 2002 to 2014.

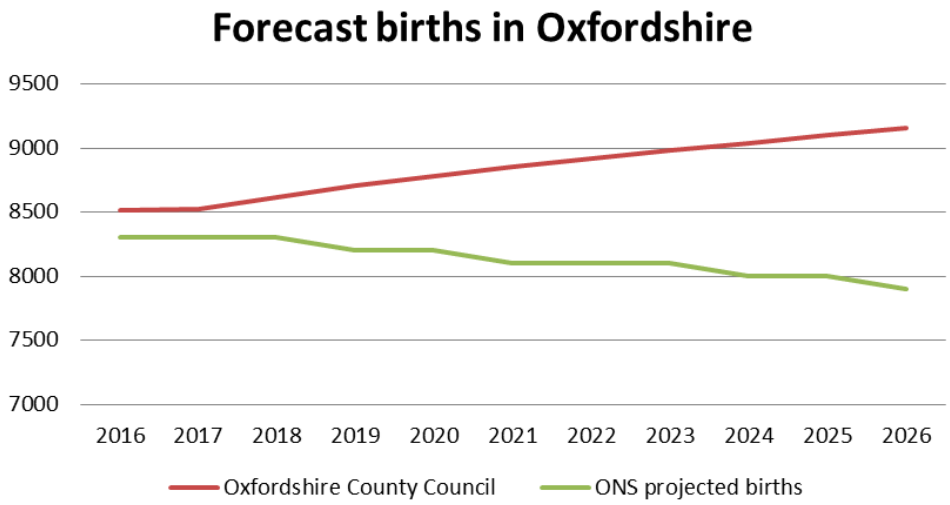
Figure 1 Number of Live births across Thames Valley SCN 2002-2014



3.2 Projections

The work undertaken by the SCN projected number of births in each council area including additional births as a result of housing growth and resulting population growth. The graph below shows the difference between the ONS projections for changes in numbers of births (a decrease) and those forecast by the County Council taking into account housing growth which show an 8% increase over the 10 years from 2016.

[1] TVSCN Maternity Capacity and Future planning Report; Conclusion Paper June 2016



3.3 Recent trends (based on CCG data)

Table 2 below shows the actual births from 2013/14 to 2018/19 based on the CCG registered population. As can be seen this shows that numbers of births rose to maximum of 6,937 in 2015/16 and then has decreased again.

Year	Number of births
2013/14	6,430
2014/15	6,287
2015/16	6,937
2016/17	6,853
2017/18	6,478
2018/19 (extrapolated from 9 months data)	6,599

4. Housing growth

The most recent housing growth figures have been obtained from Cherwell District Council[2], West Oxfordshire District Council[3] South Northamptonshire District Council[4], Stratford-upon-Avon District Council[5]. The full analysis used can be found in Appendix 1; the District Council present the date slightly differently and the following data has been included/excluded:

	Included	Excluded
Cherwell District Council	Deliverable (available, suitable and achievable sites) Specific developable sites	Remaining allocation
South Northamptonshire District Council	All from Appendix 4 Major sites Minor sites Windfalls	
West Oxfordshire District Council	All from Appendix 2 Large commitments Local plan allocations	
Stratford-Upon-Avon District Council	Under construction Initial site works commenced Outline permission Permission not started Resolution to grant	Expired No permission Stalled

A summary of this is shown on the next page with Table 2 containing data for the HGH main catchment area and Table 3 containing data for the wider catchment area.

[2] Cherwell District Council Annual Monitoring Report 2018 and appendices (December 2018)
[3] West Oxfordshire District Council Housing Land Supply Position Statement (November 2018)
[4] South Northamptonshire District Council Housing Land Report 2018 (April 2018)
[5] Stratford-upon-Avon District Council Housing Sites Spreadsheet 2011-2031 position at 31 March 2018

Table 2 Planned Housing growth in HGH main catchment area

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	TOTAL
Cherwell District Council (Banbury area)	526	656	921	923	695	551	460	390	317	253	117	117	52	5,978
West Oxfordshire District Council (Chipping Norton area)	196	114	100	73	75	75	100	100	100	100	150	150	173	1,506
South Northamptonshire District Council (Brackley area)	155	170	218	202	192	86	40	40	40	40	30	0	0	1,213
TOTAL	877	940	1,239	1,198	962	712	600	530	457	393	297	267	225	8,697

Table 3 Planned Housing growth in HGH wider catchment area

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31	TOTAL
Cherwell District Council (Bicester area)	365	618	688	807	838	845	809	620	575	555	455	425	311	7,911
Cherwell District Council (Other area)	347	473	387	232	238	211	180	180	180	180	180	150	133	3,071
West Oxfordshire District Council (Woodstock, Bladon and Charlbury)	81	98	90	97	95	75	80	50	50	50	0	0	0	766
West Oxfordshire District Council (Witney, Eynsham and surrounds)	249	477	473	789	695	777	730	645	620	595	558	445	345	7,398
Stratford-Upon-Avon District Council (all except Alcester, Bidford-on-Avon, Henley-in-Arden, Southam, Stratford-on-Avon and Studley)	530	846	686	649	502	538	485	240	200	200	200	200	200	5,476
TOTAL	1,572	2,512	2,324	2,574	2,368	2,446	2,284	1,735	1,625	1,580	1,393	1,220	989	24,622

5. Modelling increase in births from housing growth

As highlighted in section 3.2 Oxfordshire County Council has forecast the expected number of births taking into account the planned housing growth (see page 41 of TVSCN Maternity Capacity and Future planning Report; Conclusion Paper June 2016). This methodology uses the number of new estimated women (in-house forecast) in each age group in a given year and the expected age-fertility rates for that age group in that year. This was for the whole of the county and indicated a rise in births of 641 from 8,514 in 2016 to 9,155 in 2026; using these estimates would only predict an increase of about 200 births by 2026 for the Oxfordshire part of the Horton catchment. The CCG is working with the Public Health team to determine whether it is possible to apply this more sophisticated methodology to provide birth projections for the population in the Horton catchment area.

Much of the previous analysis has been undertaken at County level and for this work it is important to be able to consider housing growth in particular locations. Therefore a very simple approach to modelling the increase in births from housing growth has been used which gives an estimate based on births per 1,000 households. If this is based on current birth rate this is about 24 births per 1,000 houses. Often new housing developments attract a higher proportion of younger people so a second projection has been undertaken applying a birth rate of 48 births per 1,000 homes for the new housing (that is double the current birth rate). These assumptions have been applied to the housing growth in the main and wider HGH catchment areas. A summary of this is shown on the next page with Table 4 containing data for the HGH main catchment area and Table 5 containing data for the wider catchment area. These assumptions give upper estimates to the number of additional births there may be in the catchment area as they assume all residents of the new housing are new to Oxfordshire.

Table 4 Estimate of increased numbers of births from Planned Housing growth in HGH main catchment area

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Births at 24 per 1,000 houses	21	23	30	29	23	17	14	13	11	9	7	6	5
Cumulative increase current birth rate	21	44	73	102	125	142	157	169	180	190	197	203	209
Births at 48 per 1,000 houses	42	45	59	58	46	34	29	25	22	19	14	13	11
Cumulative increase double birth rate	42	87	147	204	250	285	313	339	361	380	394	407	417

Table 5 Estimate of increased numbers of births from Planned Housing growth in HGH wider catchment area

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25	2025/26	2026/27	2027/28	2028/29	2029/30	2030/31
Births at 24 per 1,000 houses	38	60	56	62	57	59	55	42	39	38	33	29	24
Cumulative increase current birth rate	38	98	154	216	272	331	386	428	467	504	538	567	591
Births at 48 per 1,000 houses	75	121	112	124	114	117	110	83	78	76	67	59	47
Cumulative increase double birth rate	75	196	308	431	545	662	772	855	933	1,009	1,076	1,134	1,182

As can be seen from these tables, the highest upper estimate of additional births (by 2031) for the wider HGH catchment area is between 800 (current birth rate) and 1,599 (double birth rate). It would not be expected on current flows (and because some mothers will need specialised services) that all these births would take place at the HGH.

Table 6 below models a shift in flow from the wider HGH catchment and applies that percentage to the increased number of births. This gives a revised baseline (as of now) for HGH births of 1,760 and an upper limit in 2031 of 2,148 (current birth rate) to 2,536 (double birth rate). To achieve this level of births at HGH requires a significant shift (at least doubling) in current patient flows from Bicester, Woodstock, Witney and Kidlington areas and the birth rate for all new housing developments to be double the current birth rate.

Table 6 – Modelling an increase in share of the market and share of additional births at HGH

	Baseline HGH		Shift towards HGH	Revised	Additional births per 1,000 homes by 2030/31	
	Births	%HGH		Baseline	24	48
Banbury practices	617	81%	81%	617	115	230
Brackley and Byfield	177	73%	73%	177	21	42
Practices around Banbury	110	59%	75%	141	0	0
Chipping Norton	54	41%	55%	72	20	40
Shipston, Kineton and Fenny Compton	53	28%	40%	75	53	106
Bicester practices	134	24%	50%	283	95	190
Other West Oxfordshire (Charlbury, Woodstock)	25	23%	50%	54	9	18
Witney, Eynsham and surrounds	25	6%	30%	132	53	106
Kidlington and Islip Practices	9	3%	30%	82	22	44
Other	128			128		
TOTAL	1,332			1,760	388	776

The proposed shifts are given as examples and are estimated using a combination of the following factors:

- It is unlikely that more than 80% of births even from practices in the main catchment area would take place at HGH as some mothers would choose an MLU or would need to give birth in the specialist centre. Therefore where the proportion of births at the HGH was over 70% this was not increased.
- For other areas the size of the potential shift was estimated based on proximity to HGH relative to another hospital and baseline flow.

For the revised baseline position the increase in market share for the HGH shifts 428 births from other hospitals (mostly the John Radcliffe Hospital and a few from Warwick Hospital) to the HGH; this would not be deemed to be significant against the overall number of births at these hospitals.

6. Conclusions and next steps

Given the assumptions used the numbers modelled give an upper limit to the numbers of births that may occur at an obstetric unit at the HGH. We are working with the County Council to review these predictions against their modelling that takes into account new housing, age breakdown and fertility rates.

The number of births in a unit is one factor that contributes to the ability to have a sustainable and safe staffing model. The options identified to be taken forward into the option appraisal include a variety of different staffing models and we are also linking with the Royal College of Obstetricians and Gynaecologists and collecting information from other small units around the country to see if there are other potential staffing models.

Catherine Mountford
Director of Governance, Oxfordshire CCG
14.02.19

Responding to Secretary of State letter following referral of the permanent closure of consultant-led maternity services at the Horton General Hospital

Work Stream 5c Travel and access

1. Introduction

The purpose of this work stream is to understand the range of travel times for services and the impact (in terms of increased travel time) on these of the temporary closure of the obstetric services from the Horton General Hospital. This will differentiate between travel times (defined as the time taken for women and their families to travel to services) and transfer times (defined as the time taken for an ambulance transfer from a Midwife led Unit (MLU) to an obstetric service)

- Travel times; previous analyses to be reviewed and reissued to identify if any further work is required.
- Transfer times
    - Using the information collected over the period of the temporary closure of the obstetric service at the Horton General Hospital a review of transfer times between the Horton MLU and the other three Oxfordshire MLUs and the John Radcliffe will be undertaken. If possible these will be set in the context of national data.
    - An independent clinical view on the acceptability of transfer times will be sought.
    - The processes enacted when there are multiple demands on the dedicated ambulance or severe traffic delays will be summarised.

Completion of this work will be the development of clear information that is used within the option appraisal process.

It is important to note that there have always been some women who would travel to Oxford from the Banbury area and further afield. Women who need the care of specialist services because existing health conditions or other issues that might mean additional specialist support is needed would always need to attend an obstetrics unit in a specialist hospital like the JR. They would be identified early in pregnancy and plans would be made during the pregnancy to ensure they could travel safely. Other women chose to have their baby in Oxford despite having a local obstetric unit in Banbury.

Many of these women would have travelled to Oxford in their own car but others would have needed to travel by ambulance, some will have transferred as an emergency from the Horton to Oxford to ensure they had the specialist care needed.

2. Travel Times

2.1 Sources of information

Work was undertaken during 2017 to analyse and understand the impact on travel and access for women and their families if there was not an obstetric service at the Horton General Hospital (HGH).

This analysis was detailed and included consideration of time of day (peak and off-peak) of the week which impacted on travel time because the traffic conditions vary. The analysis is presented as maps that illustrate how travel time is affected by distance and time of travel.

It was acknowledged that the changes to obstetric services would mean many women and their families would need to travel further for some aspects of their care and the travel times would vary.

This work is still relevant today and is based on standard methodologies for calculating travel times. In addition to the travel times, the impact of parking was also investigated. The congestion on the JR site was highlighted and a survey was conducted by Healthwatch Oxfordshire to gather evidence about availability of parking and delays that could add to travel times.

The work commissioned by Oxfordshire Clinical Commissioning Group resulted in a number of reports that have been published and remain available on OCCG website including:

- Hospital car parking survey conducted by Mott MacDonald
- Healthwatch travel survey
- Integrated Impact Assessment
- Baseline travel analysis
- Travel analysis

These documents can be found here:
http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents

The Integrated Impact Assessment Final Report provided more detailed analysis of the direct impact of changes including the increased travel time (particularly relevant for maternity services are pages 30-32, 39-40 and 69-78; these have been saved as a standalone document and are included at Appendix 1).

In addition

2.2 What this tells us

We know that the changes to obstetric services have meant most people from the Banbury area need to travel further for some of their care. The analysis we have done demonstrates the how the travel time varies and how this impacts on different groups within the community. It is not just the distance to travel, it is also the traffic conditions that affect the time taken for the journey. Rush hour traffic and roadworks all contribute to longer journeys.

The information from the travel confirms that removal of the obstetric service from the HGH results in an increase in journey times. With services at the HGH the majority of the catchment area could access the hospital within 30 minutes and with the HGH this increases to up to 50 minutes (average car journeys). It is understood that one important consideration is the variation in journey times and the CCG is working with the County Council to get an understanding of this variation from the Banbury area to the John Radcliffe Hospital.

It is also clear that the need to have time to find a car parking space adds to the overall experience and journey time.

These factors have an impact on patient experience and this will be considered as part of the appraisal of options where access and experience will be considered alongside the other factors.

Victoria Prentis MP undertook a travel survey #BanburytoJR which highlighted the same issues of increased travel time and time to park.

3. Transfer Times

3.1 *Managing Transfer from an MLU to an obstetric unit*

Some women need to be transferred during labour or soon after birth because of problems that have developed. If these problems are serious or life-threatening, the transfer will be conducted with a blue light ambulance to ensure minimum time to reach the expertise needed.

Being transferred by ambulance from an MLU is not unusual and happens at every MLU. The decision about whether to transfer in these circumstances is taken by the midwife attending the woman and she/he will take into account the distance and time it will take for a transfer.

In Oxfordshire ambulance transfers are classified as ‘time critical’ and ‘non-time critical’. The decision as to whether a transfer is classified as time critical depends on the reason for transfer and the urgency of the clinical problem.

- **Time critical transfers** where the safety of the mother or baby is at risk, these are extremely rare and can be subdivided into those where a blue light transfer is required and those where there is a need for urgent medical review to avoid a poor outcome for either mother or baby.
- **Non-time critical** are when further monitoring or treatment is required for either the mother or baby because there is a potential for risk to occur

3.2 Transfer rates and times from Oxfordshire MLUs 1 October 2016 – 30 September 2018

The transfer data from 1 October 2016 to 30 September 2018 for all the Oxfordshire MLUs has been analysed to look at transfer numbers, rates and time taken for transfer.

3.2.1 Reason for transfer and transfer rates

Women are transferred from MLUs for a variety of factors - for example, the identification of new onset risk factors during birth such as slow progress, meconium stained liquor or suspicion of fetal distress; or maternal choice on pain relief; or, post-birth complications or if the baby requires further assessment or additional monitoring. A safety first culture is operated and if there are concerns, midwives will explain these to the patient and arrange a transfer. Midwives will be in close contact with the obstetricians at the John Radcliffe at all times to discuss options and ensure they are making the best decision for the mother and baby concerned.

The Table below shows the timing of the transfer during labour or in the 4 hours following birth for the 358 women who were transferred over the 2 year period.

Table 1 Transfers broken down by unit and stage of transfer October 2016 to September 2018

Stage of transfer	Cotswold Chipping Norton	Horton Banbury	Wallingford	Wantage	TOTAL
First stage	29	79	40	7	155
Second stage	15	14	13	7	49
Third stage	8	25	11	4	48
Post natal	10	23	10	3	46
Newborn	9	27	21	3	60
TOTAL	71	168	95	24	358

Table 2 below shows the transfer rates for each of the MLUs over the two year period.

Table 2 Births and Transfer rates October 2016 to September 2018

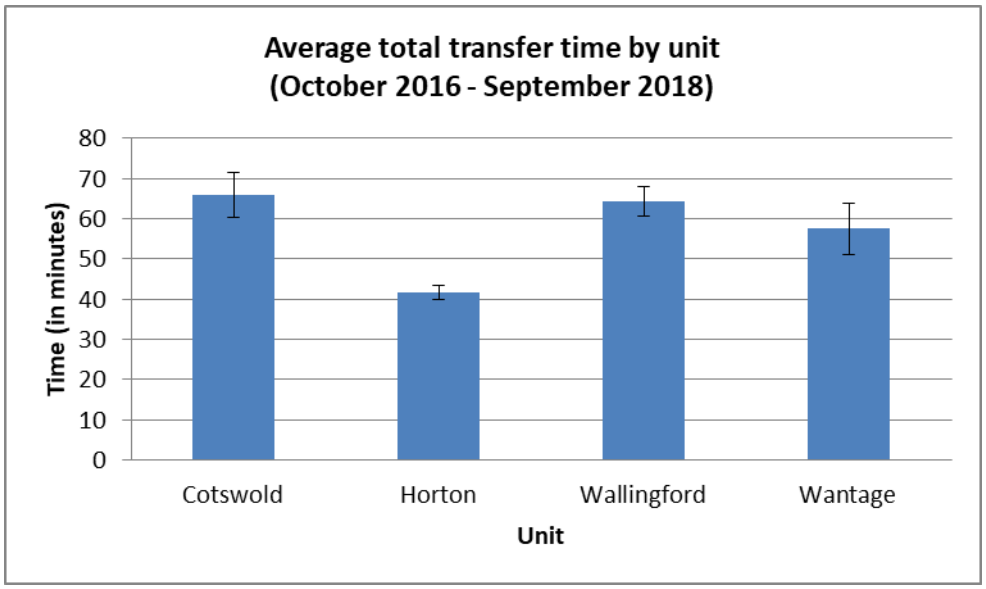
	Cotswold Chipping Norton	Horton Banbury	Wallingford	Wantage	TOTAL
Planned	224	460	393	92	1169
Births	180	370	337	78	965
Transfers	71	168	95	24	358
Transfer rate	32%	37%	24%	26%	31%

3.2.2 Transfer times

The data presented here shows the average total time for transfer (this includes the time waiting for the ambulance to arrive and the journey time). Table 3 contains the mean, median and interquartile range and the mean transfer times are then shown in the graph below.

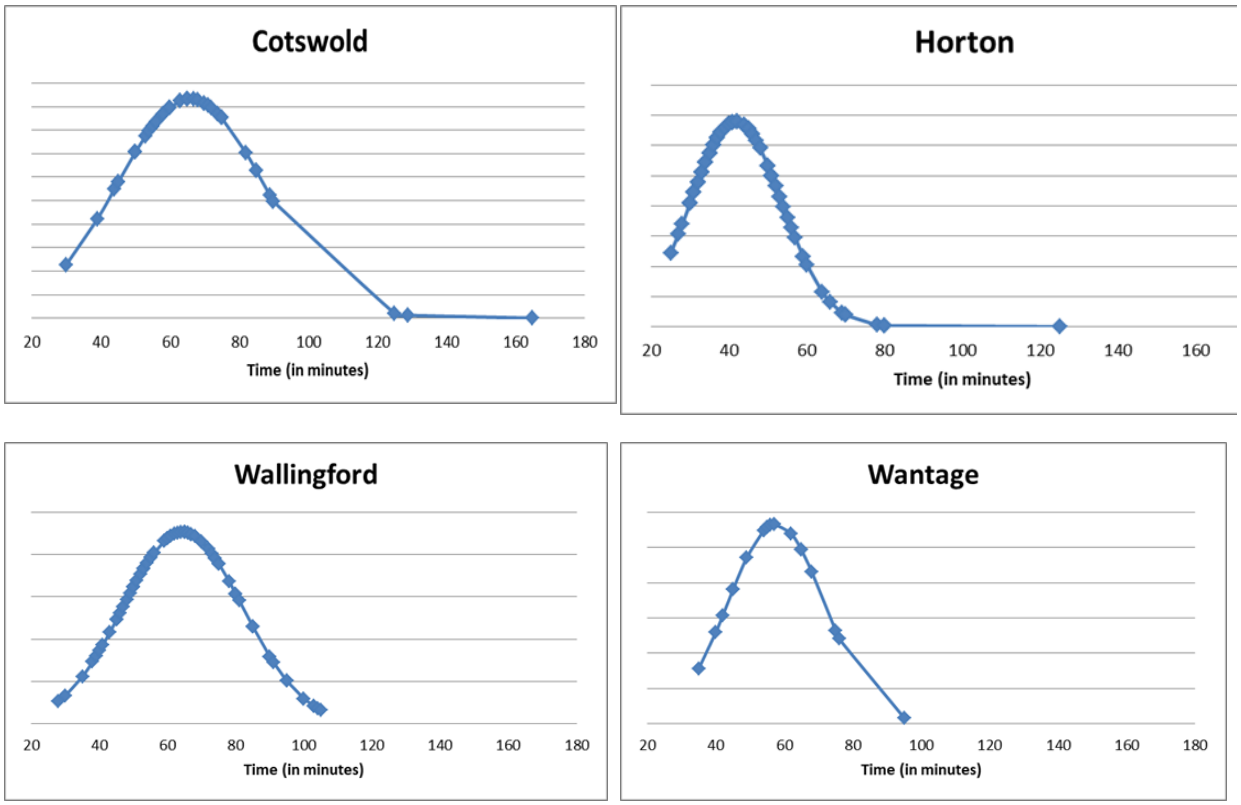
Table 3 – Transfer times from MLUs to John Radcliffe Hospital from October 2016 to September 2018

	Cotswold Chipping Norton	Horton Banbury	Wallingford	Wantage
Mean (minutes)	66	42	64	58
Median (minutes)	60	40	62	55
Interquartile range (minutes)	55 - 72	35 - 45	53 - 75	45 - 65



The Cotswold unit has the highest average total transfer time of 66 minutes. The Horton has a lower average total transfer time (42 minutes) given the shorter time women wait for an ambulance

Distribution curves for each unit showing all recorded total transfer times (i.e. where both the call to arrival and travel time in the ambulance were both recorded).



The longest total transfer time across all of Oxfordshire's MLUs was 165 minutes from the Cotswold unit (135 minutes from call to arrival and 30 minutes travel time). This was a non-time critical transfer. Four transfers took longer than 2 hours in total – one from the Horton (this was due to an ambulance breaking down en route and contact between the ambulance crew and the hospital was maintained throughout until the transfer could be resumed) and three from the Cotswold unit.

3.3 Clinical view on acceptability of transfer rates and times

3.3.1 National context

The Birthplace cohort study, conducted in 2011, collected data on over 64,000 'low-risk' births in England, including 28,000 planned 'low-risk' midwifery unit births in both FMLUs and Alongside MLUs (AMLUs)[1].

The key findings from the study [2] were:

- For women in their first pregnancy who planned birth in a FMLU, the transfer rate during labour or immediately following delivery was 36%.

[1] NPEU Birthplace cohort study (2011).
[2] Extract from 'The Birthplace cohort study: Key findings' found at website

- For women having a second or subsequent baby, the transfer rate was 9%.

There have been a number of practice and guidance changes in the 6 years since the Birthplace cohort study was published. Most notably this includes guideline changes regarding the thresholds for admission and transfer criteria for women in labour and following the birth: for example, recognition and early management of suspected sepsis and an increase in observations required for newborn babies.

It is also worth acknowledging the changing profile of pregnant women due to: a) increased maternal age - around 50% of women having their first baby aged 40 years or over are transferred ; b) the increase in women with a raised body mass index (BMI), and c) the fact that the population is generally less fit/healthy. These factors mean that women are more likely to have pregnancy-related complications, particularly delay in labour and postpartum haemorrhage.

In the Birthplace study, two thirds of the 53 FMLUs studied were between 20-40km from the nearest obstetric hospital with a median transfer time of 60 minutes (interquartile range 45-75 minutes). Most transfers from MLUs to the John Radcliffe Hospital are made via ambulance with the accompanying midwife; however, it is possible for women to be taken by their birthing partner in their own vehicle if the woman and her partner so wish and it is clinically appropriate. Midwives have a guide to review the most suitable mode of transport for transfers depending on clinical presentation.

The distances from each of the MLUs to the John Radcliffe Hospital are as follows:

- Cotswold – 20.2 miles / 32.5km
- Wallingford – 17.5 miles / 28km
- Wantage – 19 miles / 30.5km
- Horton – 23.2 miles / 37km (and 22 miles/35.4km to Warwick Hospital)

From the total transfer time data analysed the median transfer times for all the MLUs in Oxfordshire were in line with those of the Birthplace study.

3.3.2 Local arrangements

The Birthplace study found that

- For planned births in freestanding midwifery units and alongside midwifery there were no significant difference in adverse perinatal outcomes compared with planned birth in an obstetric unit.
- Women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more 'normal births' than women who planned birth in an obstetric unit.

OUH has provided services from MLUs for many years and midwifes staffing these units are trained to support women in labour including careful monitoring of the progress of labour and the incidence of any complications. There are agreed protocols and thresholds for transfer set to ensure the safety of mother and baby.

The midwives link with the receiving obstetric unit to agree the need and urgency of a transfer and continued communications would also occur between the ambulance crew and receiving unit if the clinical situation changed.

Transfers from the Cotswolds, Wantage and Wallingford midwife led units are provided by South Central Ambulance Service (SCAS). There is a dedicated Ambulance at the Horton MLU which is provided by another provider but dispatched via SCAS. At the Horton HOSC evidence session on 19 December 2018 representatives from SCAS confirmed that all decisions are clinically based and that all factors are taken into account, on an individual patient basis, to balance speed and comfort. When clinically indicated it is safe to transfer the mother and paramedics are trained to support women in labour and would be accompanied by a midwife.

OUH reviews all transfers on a continual basis and any potential concerns or issues would be investigated

4. Conclusions and next steps

From the data we have there is nothing to indicate that the increased travel distance and time (for women and their families to travel to services) and transfer times (the time taken for an ambulance transfer from a Midwife led Unit (MLU) to an obstetric service) is unsafe. Comparison of median transfer times from the Oxfordshire MLUS to the JR obstetric service is in line with the national findings of the Birthplace study. The Public Health Wales Observatory Research Evidence Review (2015) "did not find conclusive evidence to support a causal link between increasing distance, or the time, required to travel from mother's residence to maternity services and adverse birth outcomes"[3].

As stated earlier this analysis of travel and transfer times and the impact on mothers and their families will inform the option appraisal process.

The HOSC is asked to comment on the information requested and identify if there is any further analysis that should be undertaken.

Catherine Mountford
Director of Governance, Oxfordshire CCG
14 February 2019

[3] p.23;Research Evidence Review: Impact of Distance/Travel Time to Maternity Services on Birth Outcomes;1 October 2015; Public Health Wales Observatory

4 Travel and access impacts

This chapter identifies travel and access impacts, which could potentially be experienced as a consequence of implementing the proposals. The chapter presents impacts for blue light ambulance as the journeys by patients for the services assessed would typically be made by this mode of transport; impacts for private car and public transport are included in appendix F. Impacts have been identified through quantitative journey time analysis, as well as a desk review. Detailed analysis by an equality group is included within the equality chapter (chapter 5). Appendix C provides heat maps for changes in travel times and appendix F provides a further breakdown of the changes in travel times.

Travel and access analysis has been undertaken on the basis of available current patient activity for the phase one services. Activity data, rather than population data, has been used so as to provide as accurate picture as possible about the potential impacts for patient journey times and to understand the potential volume of patients which would require longer trips. Data have been analysed at two levels, defined as:

- Overall patient activity: this refers to the number of patients who have accessed services within Oxfordshire CCG, regardless of whether they are resident in Oxfordshire or have come from outside Oxfordshire to access services.
- Oxfordshire patient activity only: this refers to the number of patients who have accessed services within Oxfordshire CCG and are resident in Oxfordshire.

This report has utilised thresholds of 30 and 60 minutes to report on the travel impacts. This allows for a consistent baseline upon which to record the differences between option configurations. Further details of the travel impact for additional travel time bands can be seen in appendix F.

4.1 Ambulatory care

Travel and access impacts have not been assessed for ambulatory care. This is because patients will continue to receive care at an AAU at their local hospital site, or because ongoing ambulatory care will be delivered in or closer to patients homes.

4.2 Critical care services

Analysis for the change to critical care services has not been assessed for travel and access impacts. This is due to the low volumes of patients receiving level 3 critical care.

4.3 Maternity

The tables below highlight the difference in travel times for maternity patients accessing hospitals for the baseline position and under a future scenario with obstetric-led maternity care removed from HGH. Residents living in the north of the county, namely Banbury and Chipping Norton and the surrounding areas, will need to travel further for their care.

The change to maternity services will not affect all patients. The HGH would move from providing 18 per cent of OUHFT's births to 6 per cent under the proposals in Phase One. The remaining 6 per cent (496) of births would be delivered at HGH at the on-site MLU.

4.3.1.1 Quantitative analysis of journey time impacts: overall patient activity

Based on current maternity patient activity data, 73 per cent of maternity patients can access obstetric-led maternity services by blue light within 30 minutes and 93 per cent within 60 minutes. Should obstetric-led maternity services not be provided at the HGH in future, 52 per cent of patients would be able to able to access obstetric-led maternity services within 30 minutes and 93 per cent within 60 minutes.

Table 5: Blue light ambulance journey time to obstetric-led maternity services: baseline - including services at the HGH (all patients)

	Travel time – blue light (baseline - including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	3,515	2,205	2,692	1,786	543	20	772
Percentage of patients reaching maternity services in journey time range	30%	19%	23%	15%	5%	0%	7%
Cumulative percentage	30%	50%	73%	88%	93%	93%	100%

Source: SUS SEM

Table 6: Blue light ambulance journey time to obstetric-led maternity services: without services at the HGH (all patients)

	Travel time - blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,798	1,540	2,676	3,809	910	19	781
Percentage of patients reaching maternity services in journey time range	16%	13%	23%	33%	8%	0%	7%
Cumulative percentage	16%	29%	52%	85%	93%	93%	100%

Source: SUS SEM

4.3.1.2 Quantitative analysis of journey time impacts: Oxfordshire patient activity only

Based on current maternity patient activity data, 79 per cent of patients resident in Oxfordshire can access obstetric-led maternity services by blue light within 30 minutes and 100 per cent within 60 minutes. Should obstetric-led maternity services not be provided at the HGH in future, 57 per cent of patient's resident in Oxfordshire would be able to access obstetric-led maternity services within 30 minutes and 100 per cent within 60 minutes.

Table 7: Blue light ambulance journey time to obstetric-led maternity services: baseline – including services at the HGH (Oxfordshire resident patients only)

	Travel time – blue light (baseline - including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patient's resident in Oxfordshire reaching maternity services in journey time range	3,515	2,073	2,636	1,742	469	0	0
Percentage of patient's resident in Oxfordshire reaching maternity services in journey time range	34%	20%	25%	17%	4%	0%	0%
Cumulative percentage	34%	54%	79%	96%	100%	100%	100%

Source: SUS SEM

Table 8: Blue light ambulance journey time to obstetric-led maternity services: without services at the HGH (Oxfordshire resident patients only)

	Travel time - blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,798	1,532	2,641	3,679	785	0	0
Percentage of patients reaching maternity services in journey time range	17%	15%	25%	35%	8%	0%	0%
Cumulative percentage	17%	32%	57%	92%	100%	100%	100%

Source: SUS SEM

4.4 Planned care services

Travel analysis on the impact of the changes to planned care services has not been possible for this IIA. To robustly assess the impacts on planned care services at the HGH, requires a greater level of disaggregation of the patient data than has been available. However, it is likely that travel times will be reduced for patients using these services, given the additional capacity being proposed at the HGH.

4.5 Stroke services

Stroke services for Oxfordshire will be centralised in the JRH. Direct conveyance of all appropriate Oxfordshire patients to the HASU at the JRH will be supported by the roll out of countywide early supported discharge to improve rehabilitation and outcomes. Residents living in the north of the county, namely Banbury and Chipping Norton and the surrounding areas, will have longer journeys to access care.

4.5.1.1 Quantitative analysis of journey time impacts: overall patient activity

Based on current stroke patient activity data, 71 per cent of patients can access stroke services by blue light ambulance within 30 minutes and 98 per cent within 60 minutes. Should stroke services not be provided at the HGH in future, 55 per cent of patients would be able to able to access stroke services within 30 minutes and 98 per cent within 60 minutes.

5.2.2.1 Maternity

The tables below highlight the travel times to obstetric-led maternity services for maternity patients within one of the scoped-in equality groups; baseline journey times are compared with the future proposal.

Table 14: Percentages able to reach obstetric-led maternity services in 30 minutes or less by blue light ambulance

Group	Baseline percentage able to reach obstetric-led maternity services by blue light ambulance in 30 minutes or less (including services at HGH)	Future percentage able to reach obstetric-led maternity services by blue light ambulance in 30 minutes or less (without services at HGH)	Difference
Overall – all patient activity	**73%**	**52%**	**-20pp change**
Oxfordshire patients only	**79%**	**57%**	**-22pp change**
Women aged 15-44 (all patients)	74%	52%	-22pp change
Women aged 15-44 (Oxfordshire patients only)	79%	57%	-22pp change
BAME (all patients)	86%	64%	-22pp change
BAME (Oxfordshire patients only)	92%	68%	-24pp change
Most deprived quintile (all patients)	99%	59%	-40pp change
Most deprived quintile (Oxfordshire patients only)	100%	59%	-41pp change

Source: SUS SEM

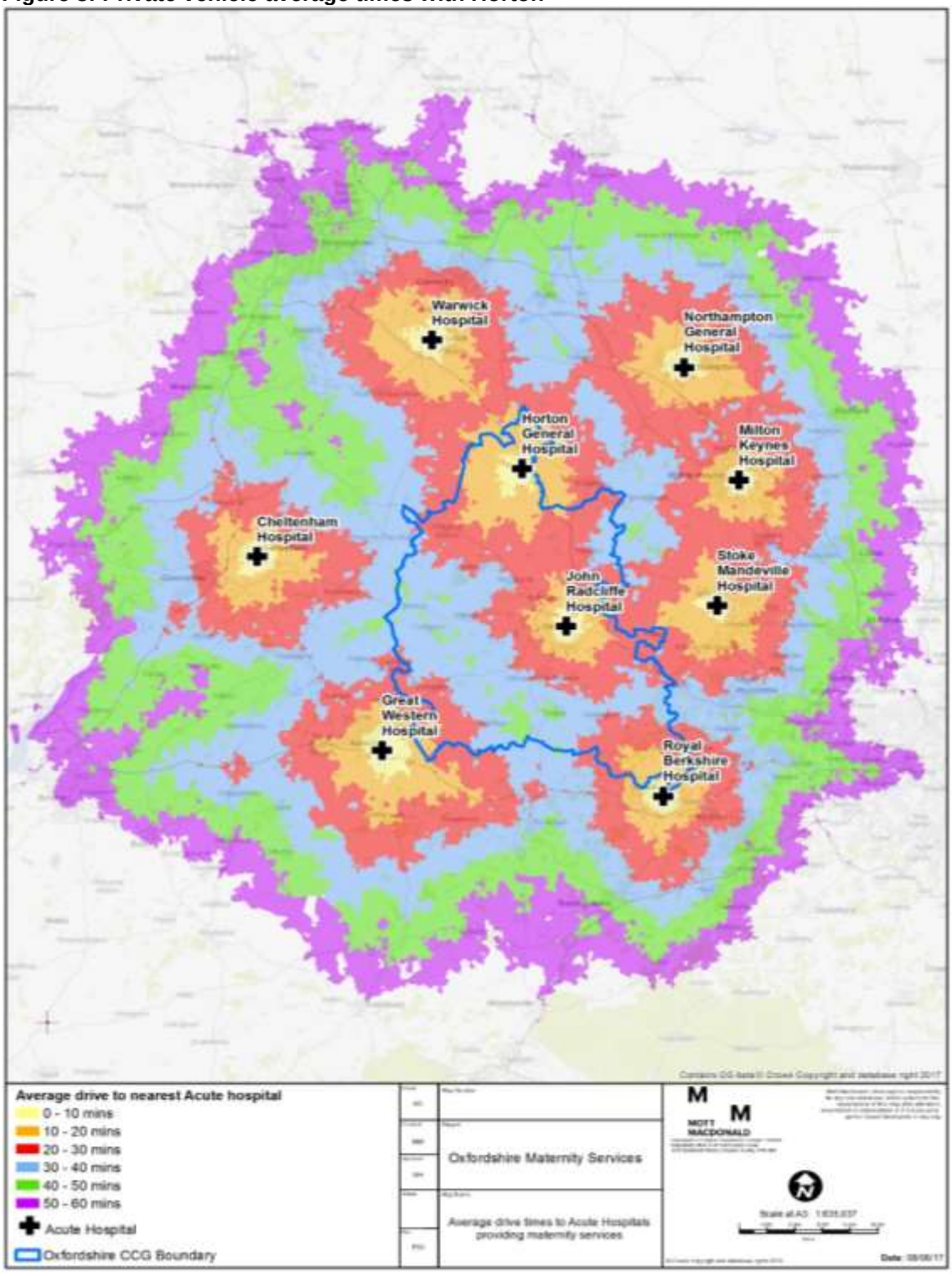
Table 15: Percentage able to reach obstetric-led maternity services in 60 minutes or less with by blue light ambulance

Group	Baseline percentage able to reach obstetric-led maternity services by blue light ambulance in 60 minutes or less (including services at HGH)	Future percentage able to reach obstetric-led maternity services by blue light ambulance in 60 minutes or less (without services at HGH)	Difference
Overall – all patient activity	**93%**	**93%**	**No change**
Oxfordshire patients only	**100%**	**100%**	**No change**
Women aged 15-44 (all patients)	93%	93%	No change
Women aged 15-44 (Oxfordshire patients only)	100%	100%	No change
BAME (all patients)	94%	94%	No change
BAME (Oxfordshire patients only)	100%	100%	No change
Most deprived quintile (all patients)	99%	99%	No change
Most deprived quintile (Oxfordshire patients only)	100%	100%	No change

Source: SUS SEM

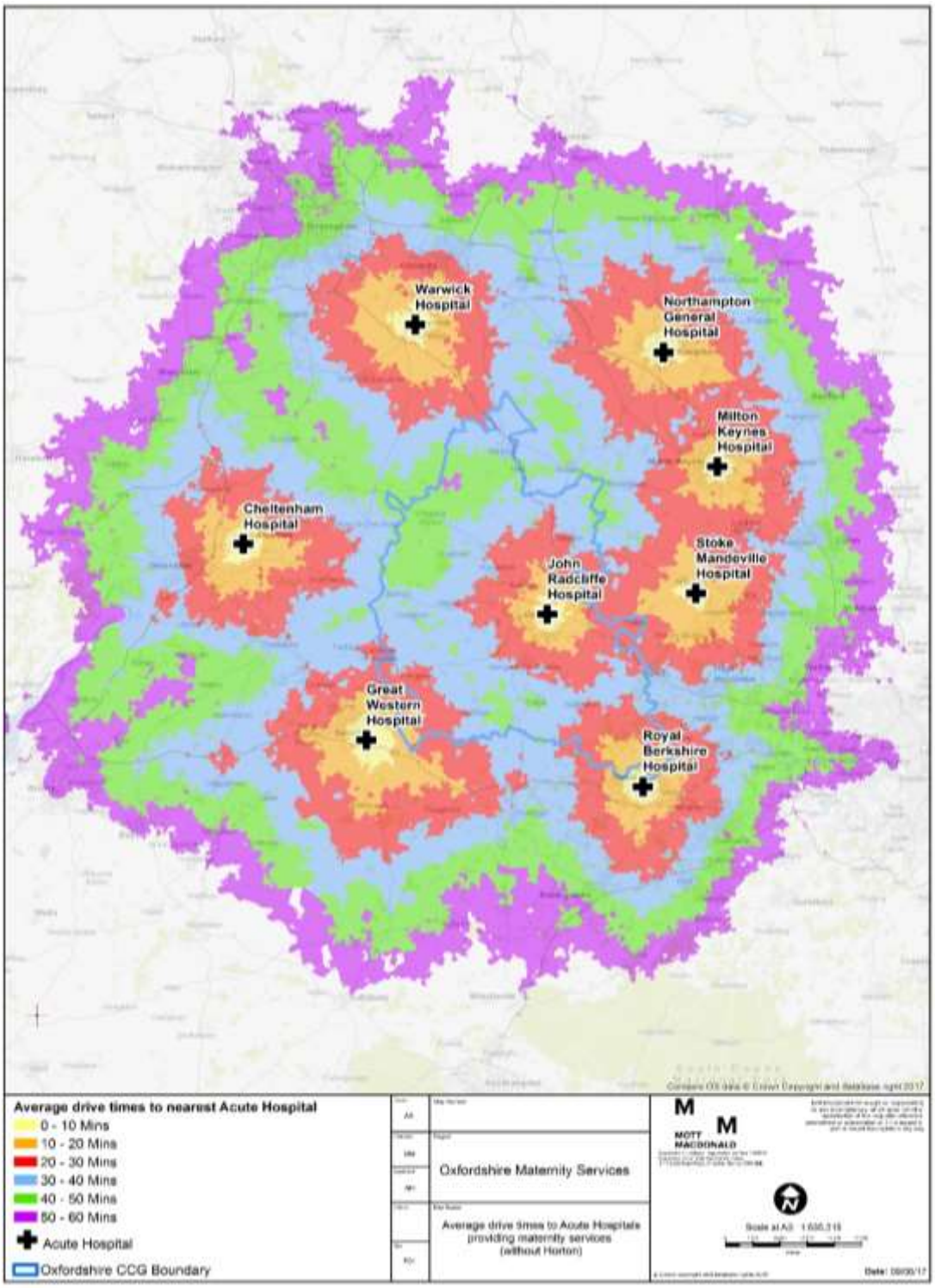
- There is a 40 percentage point reduction in patients from deprived communities being able to reach these services within 30 minutes (by blue light ambulance), compared to a 20 percentage point reduction for the population overall. The change is due to the removal of the HGH as an option, the higher concentration of deprived communities (compared to other protected characteristic groups) in the Banbury area and the longer distances that could be involved in transporting a patient to the JRH.
- Women aged 15-44 will have the lowest percentage of patients who can access maternity services within 30 minutes by blue light (52 per cent - using activity data from all patients); these percentages are in line with access for the overall population.

Figure 8: Private vehicle average times with Horton



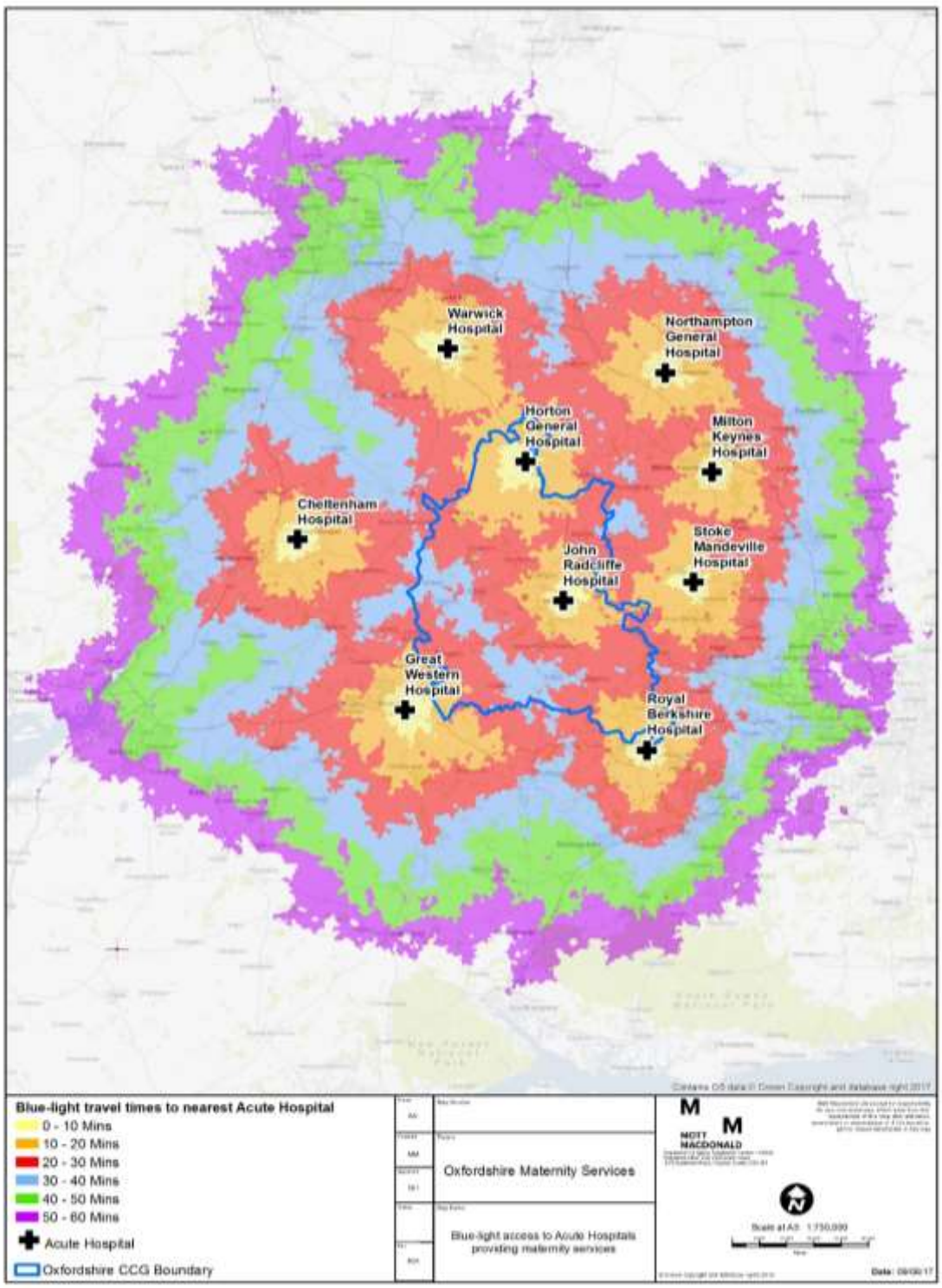
Source: Data provided by the CSU

Figure 9: Private vehicle average times without Horton



Source: Data provided by the CSU

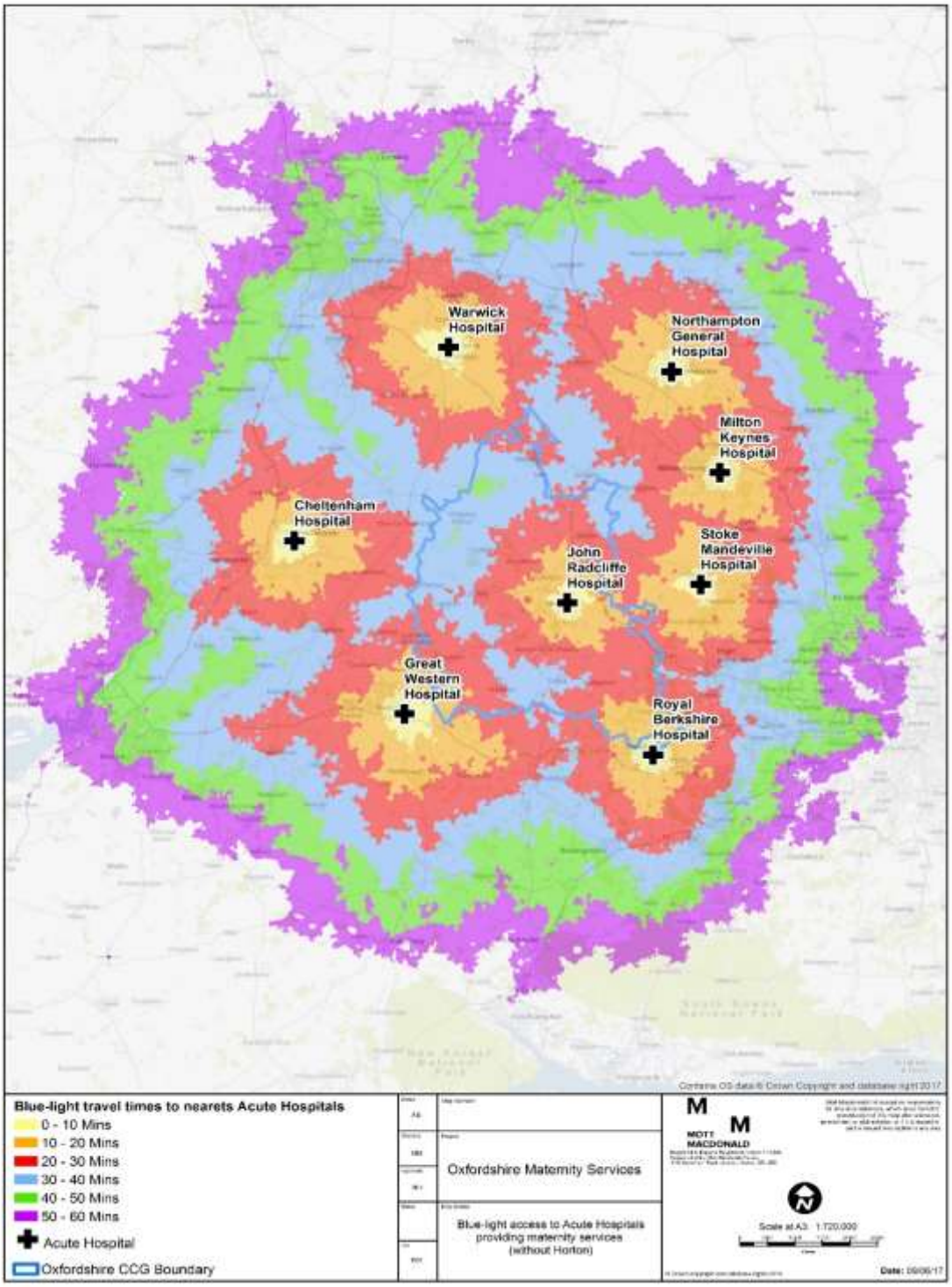
Figure 10: Blue light access with Horton[66]



Source: Data provided by the CSU

[66] Modelling has been done on the basis of pick up to destination both at non peak and peak times.

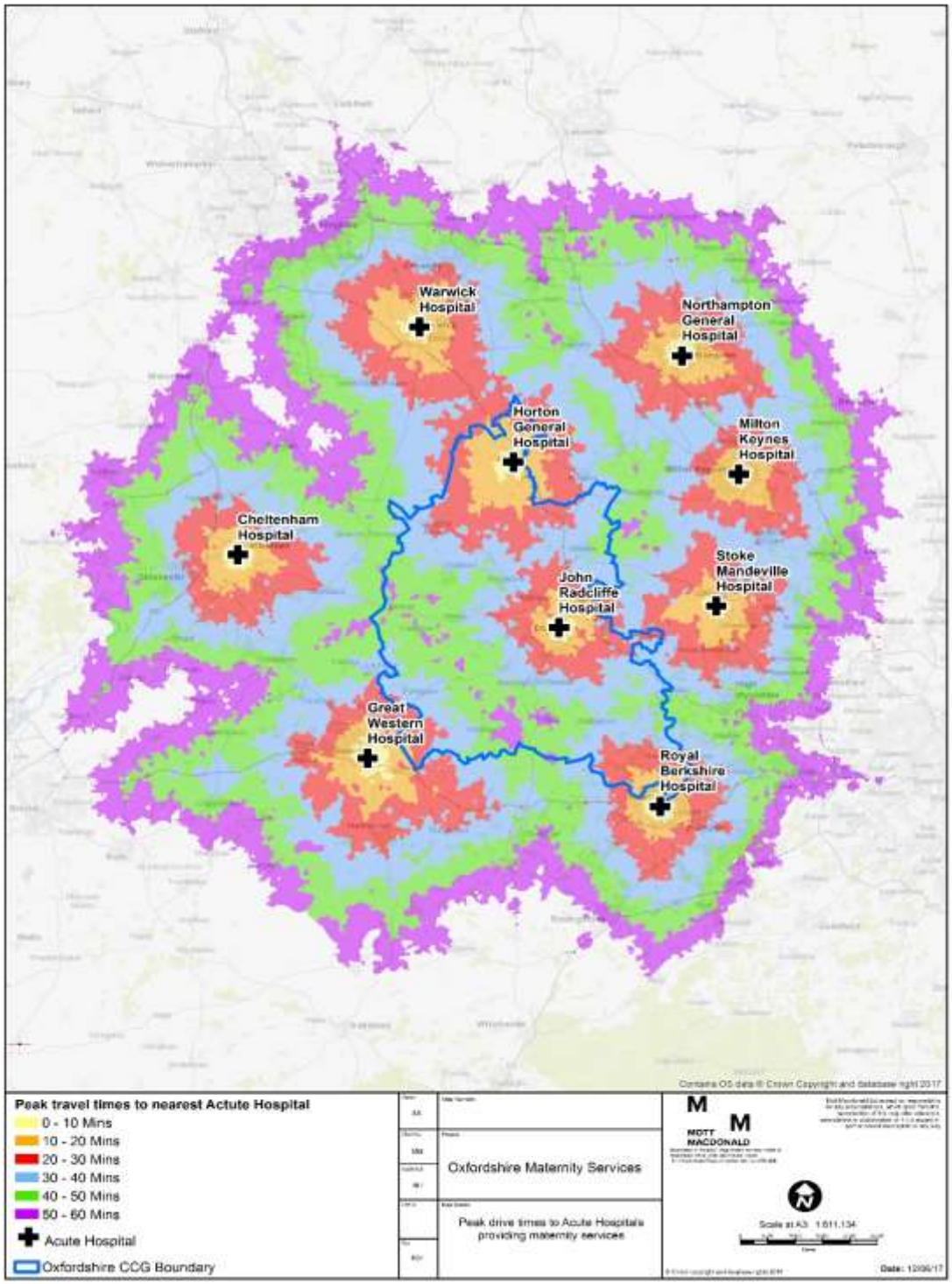
Figure 11: Blue light access without Horton[67]



Source: Data provided by the CSU

[67] Modelling has been done on the basis of pick up to destination both at non peak and peak times.

Figure 14: Private vehicle peak times with Horton



Source: <Insert Notes or Source>

Figure 18: Private vehicle peak times without Horton

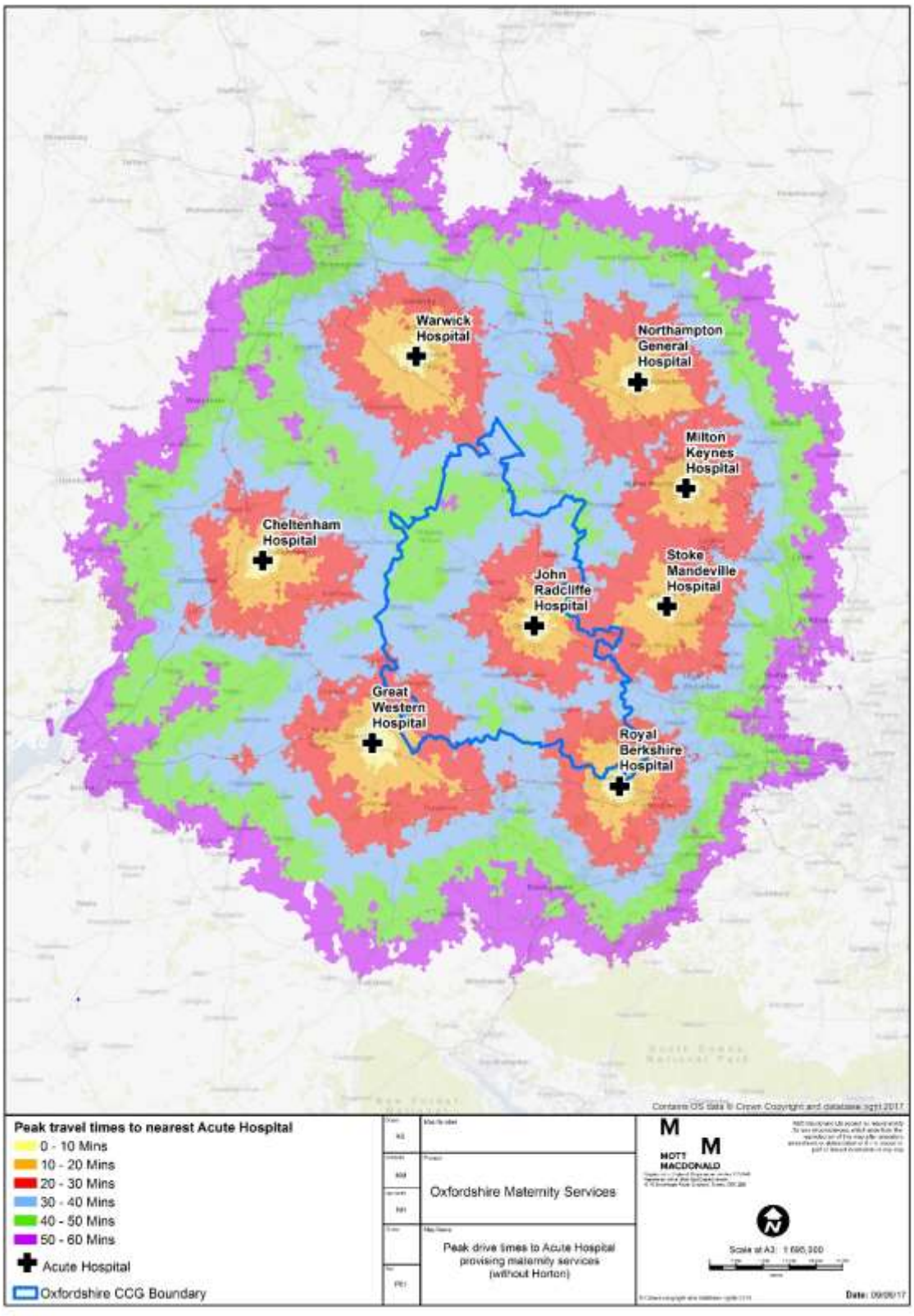
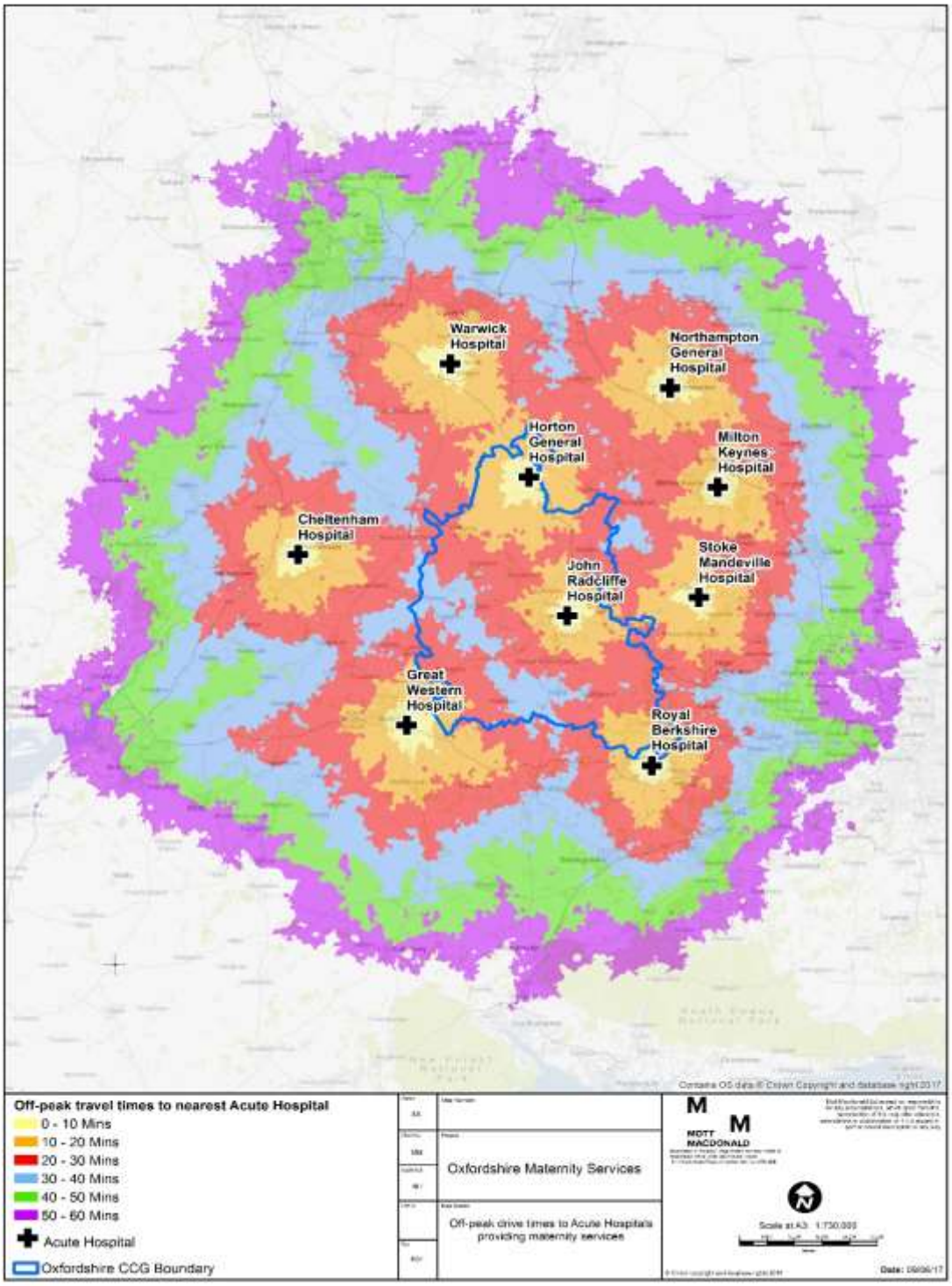


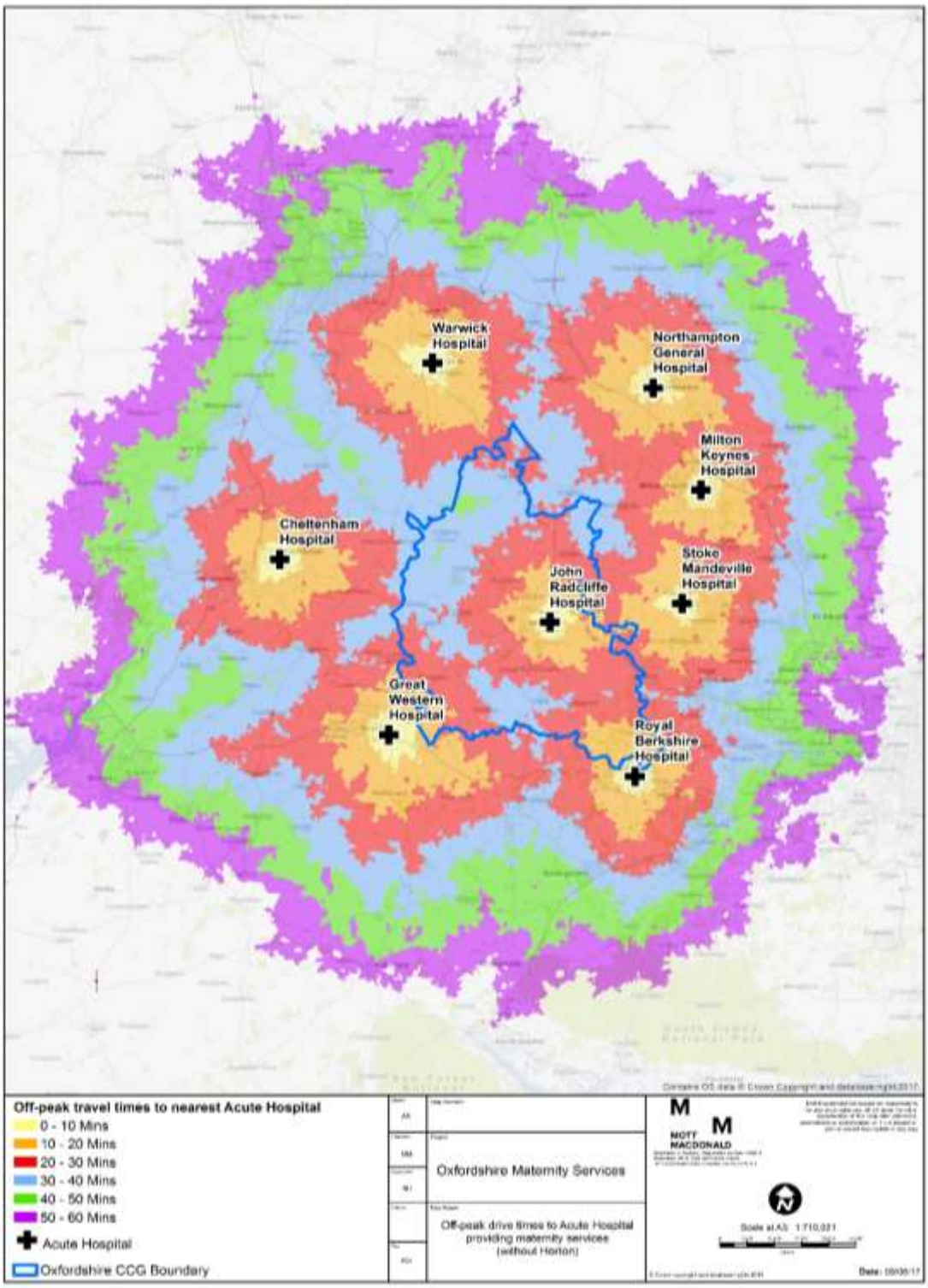
Figure 15: Private vehicle off-peak times with Horton



Source: Data provided by the CSU

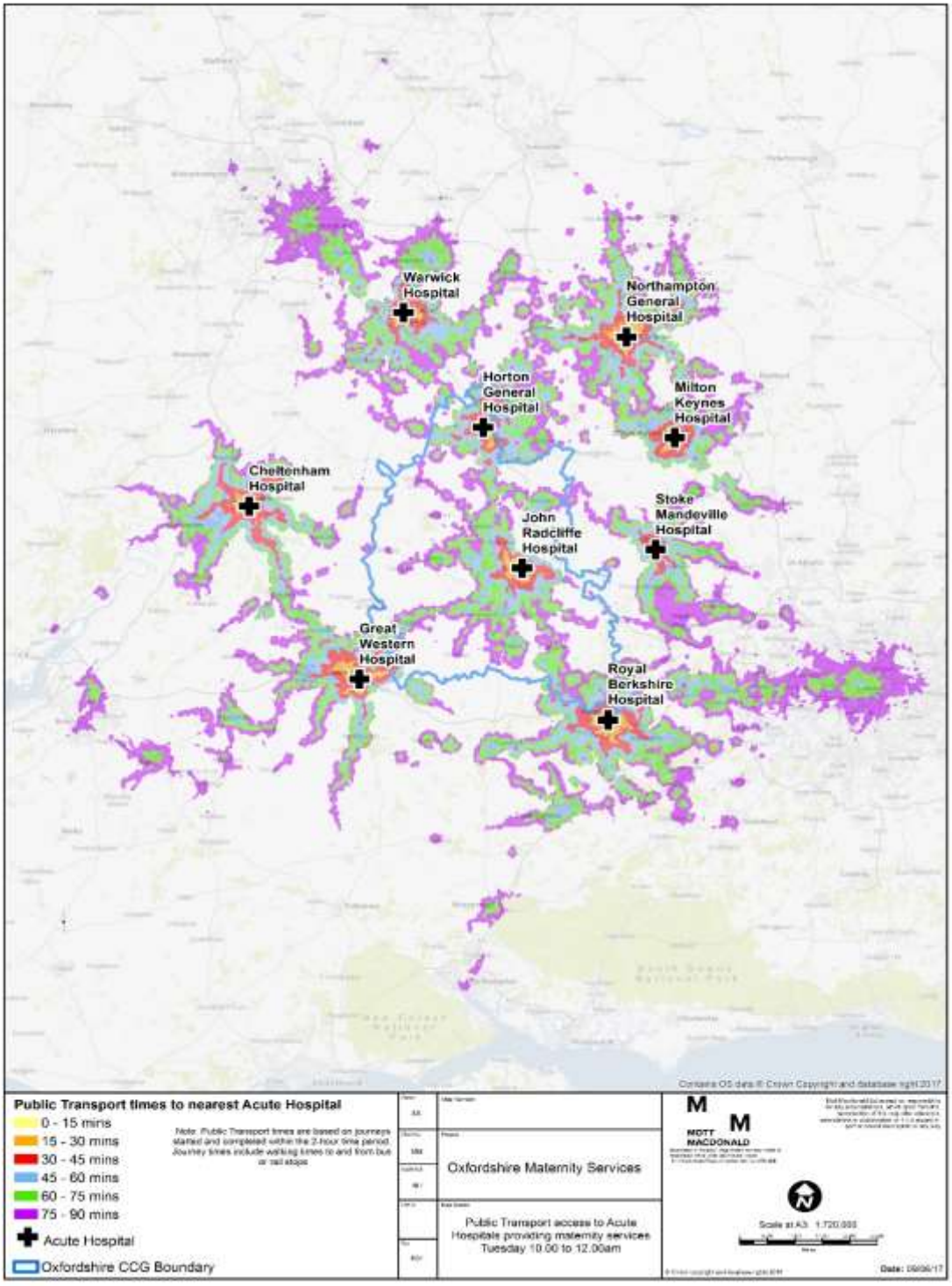
Source: Data provided by the CSU

Figure 19: Private vehicle off-peak times without Horton



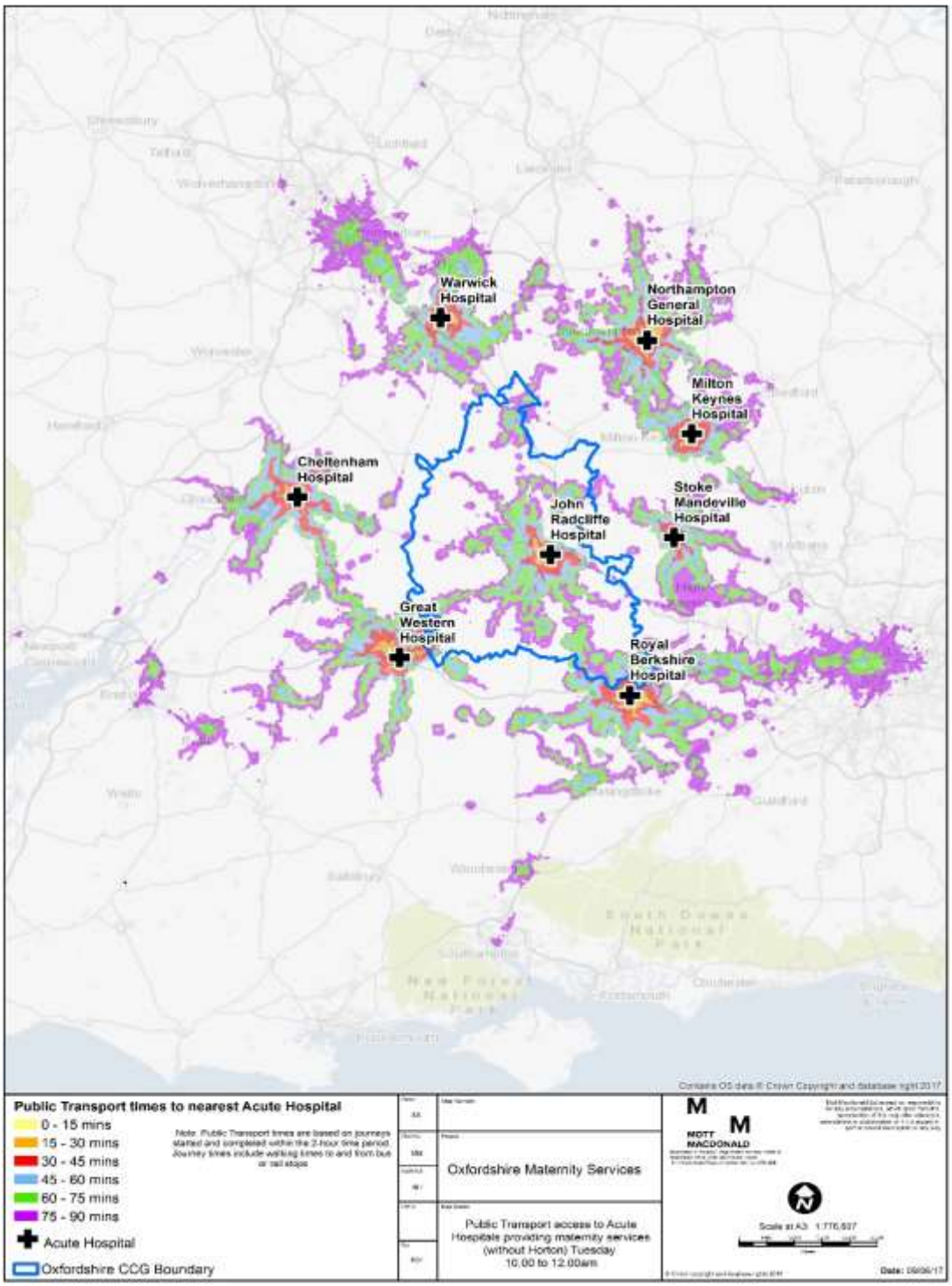
Source: Data provided by the CSU

Figure 12: Public transport Tuesday 10am-12am with Horton – (e.g. access to antenatal services)



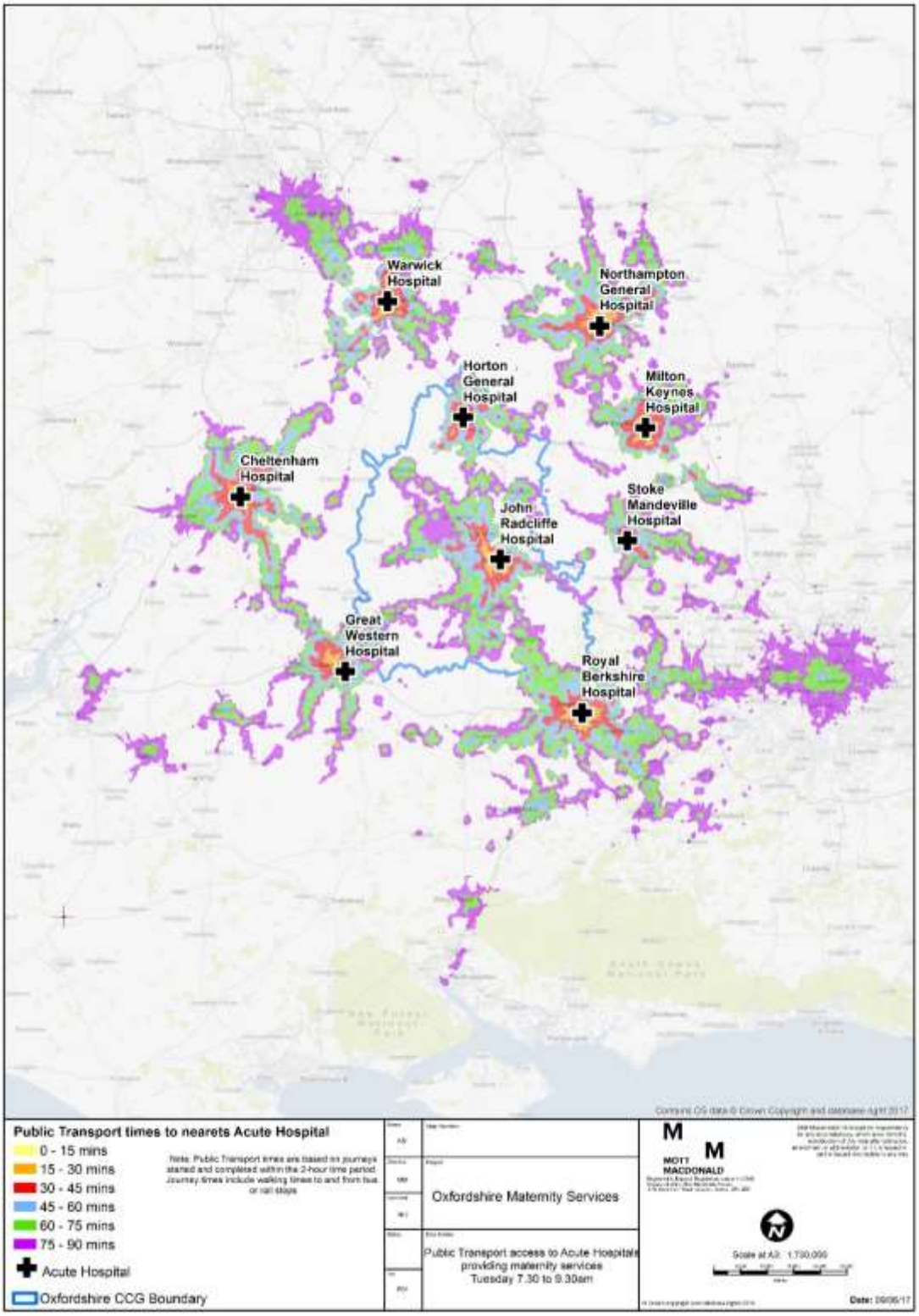
Source: Data provided by the CSU

Figure 13: Public transport Tuesday 10am-12am without Horton – (e.g. access to antenatal services)

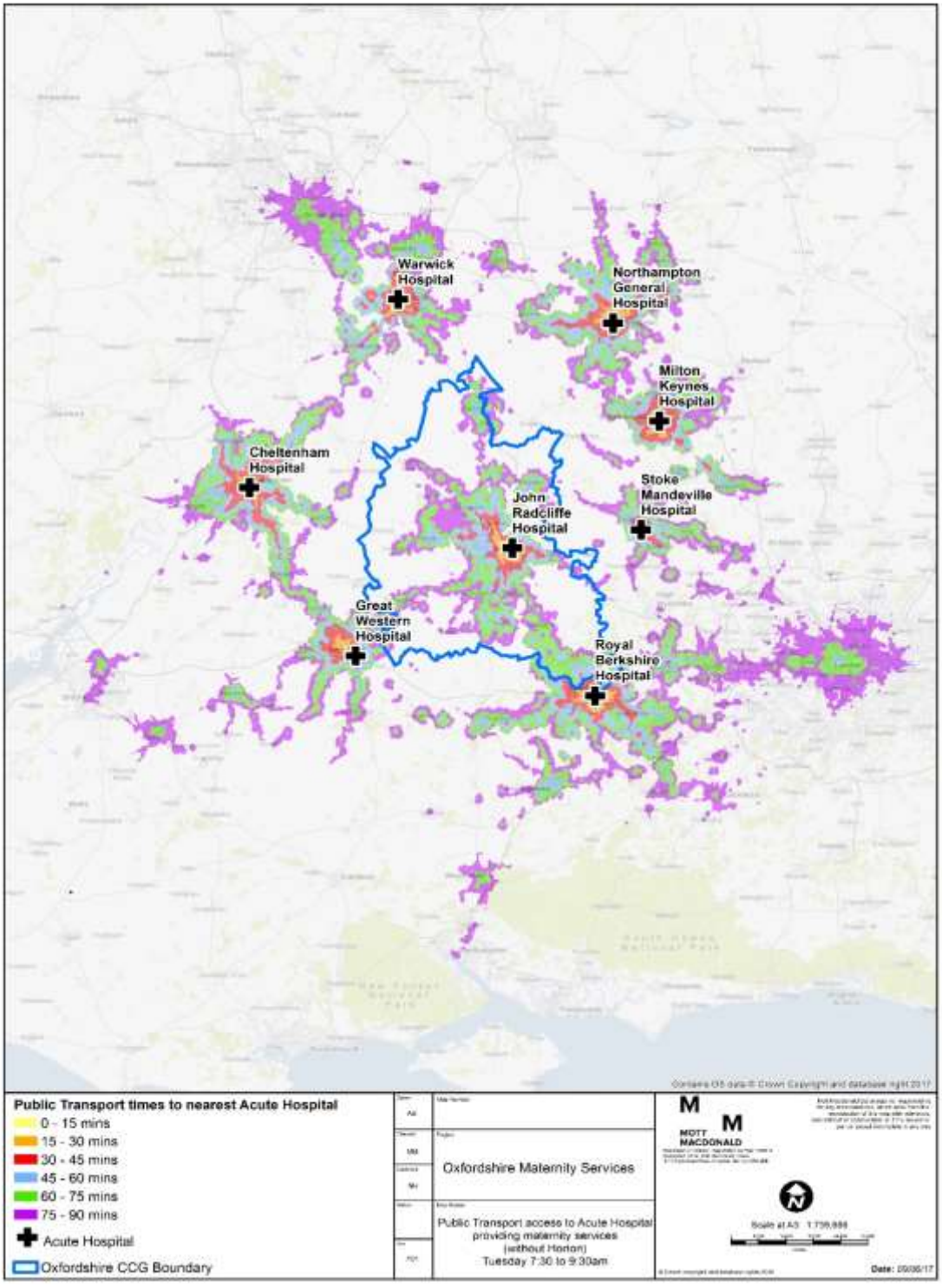


Source: Data provided by the CSU

Figure 17: Public transport Tuesday 7.30-9.30 without Horton
Figure 16: Public transport Tuesday 7.30-9.30 with Horton



Data provided by the CSU


Warwick Hospital
Northampton General Hospital
Milton Keynes Hospital
Cheltenham Hospital
John Radcliffe Hospital
Stoke Mandeville Hospital
Great Western Hospital
Royal Berkshire Hospital
Public Transport times to nearest Acute Hospital
0 - 15 mins
15 - 30 mins
30 - 45 mins
45 - 60 mins
60 - 75 mins
75 - 90 mins
Acute Hospital
Oxfordshire CCG Boundary
Oxfordshire Maternity Services
Public Transport access to Acute Hospital providing maternity services (without Horton)
Tuesday 7:30 to 9:30am
MOTT MACDONALD

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Options for obstetric provision – Final long list at 29.11.2018

Types of options

The long list of options focuses on staffing models to try and identify a sustainable staffing model. The options listed are based on different staffing models at the HGH, which would impact on the staff rotas at the John Radcliffe Hospital (JRH) to a greater or lesser extent depending on the model. The list of options assumes that obstetric provision at the JRH is always provided by consultants and doctors in training.

All the options listed would ensure safe cover during the out of hours period (evening, overnight and weekends) by including as a minimum, a Consultant on-call and a suitably qualified doctor on site. This is a requirement of all obstetric units.

Types of doctors

For the purposes of these options 'doctors in training' are those learning to become an obstetrician but who are not yet approved onto the Speciality Register (which is required to practise as a Consultant in the NHS). Doctors in training work alongside qualified doctors under their supervision.

Middle grade doctors are those who have attained the required competencies to undertake out-of-hours work within labour ward and emergency gynaecology settings but who still require support from consultants. There is a shortage of middle grade doctors and difficulties in recruiting to vacant posts at the HGH led to the temporary closure of the obstetric unit. These doctors are not in training.

Consultants are doctors who have trained to the highest level. The support and advice of a consultant must be available at all times.

The HGH is not approved for training obstetric doctors (this is a decision made by the Deanery in 2012). For this reason, all long list options assume that there are no doctors in training at the HGH. It also assumes that in line with current practice, Consultants at the HGH are both obstetrics and gynaecology but Consultants at the JRH are only obstetricians.

Further information on the training required to become a Consultant Obstetrician can be found here.

Alongside Midwifery Unit

Almost all Obstetric units nationally now have an alongside midwifery unit (AMU). The purpose of these units is to offer women the choice of giving birth in a dedicated midwifery unit, with dedicated maternity staffing but with the option to easily access obstetric care if required (e.g for epidural). For options Ob1-Ob8 in the table below it is assumed that there will continue to be a single AMU in Oxfordshire.

VERSION CONTROL

Date	Details	Version	Contributor
26/09/2018	Version presented to Horton Joint OSC	1.0	CM
26/11/2018	Revision to address Horton Joint OSC input	1.1	Project Group
29/11/2018	Final version amended to address Horton Joint OSC comments. All identified options have been included with additional columns added to indicate whether on short list and if not why.	2.0	CM

Option number	Option Title	Description	Shortlist Y or N	Comments
Ob1	**2 obstetric units – (2016 model)**	This means a separate obstetric service at JRH and HGH with separate staffing arrangements including separate doctor rotas at both sites. The service at the HGH will be delivered by middle grade doctors and consultants and the service at the JRH will be delivered by doctors in training and consultants.	Y	
Ob2a	**2 obstetrics units – fixed consultant**	This means a separate obstetric service at JRH and HGH with separate staffing arrangements including separate doctor rotas at both sites. The service at HGH will be consultant delivered (no middle grade doctors) and the service at the JRH will be provided by doctors in training and consultants.	Y	
Ob2b	**2 obstetrics units – rotating consultant**	This means a separate obstetric service at JRH and HGH but with one consultant rota covering both units (i.e. consultants would work at both sites) and doctors in training will only be at the JRH. The service at the HGH will be consultant delivered with no middle grade doctors.	Y	
Ob2c	**2 obstetrics units – fixed combined consultant and middle grade**	This means a separate obstetric service at JRH and HGH with separate staffing arrangements and separate rotas but using consultants and middle grades at both sites (i.e doctors only work at one site). At the JRH this will be doctors in training, middle grades and consultants. At the HGH this will be consultants and middle grades on a single rota that requires 24/7 resident medical cover with a consultant on-call.	Y	
Ob2d	**2 obstetrics units – rotating combined consultant and middle grade**	This means a separate obstetric service at JRH and HGH but with one doctor rota with both consultant and middle grade doctors covering both units and doctors in training at the JRH only (i.e. this means doctors would work at both sites).	Y	
Ob3	**2 obstetrics units – external host for HGH**	This means there would be a unit at JRH and HGH but the unit at HGH would be managed by a different NHS Trust from outside Oxfordshire.	Y	
Ob4	**50 / 50 split of non-tertiary births**	This option increases the number of births at the HGH by making sure that all non-complex births for Oxfordshire women are split equally between the JRH and HGH.	N	This option was predicated on increasing activity, however regardless of activity a viable work force model is required. Work stream 4 on activity and population growth incorporates a sensitivity analysis which will identify what sort of shifts need to take place to increase the proportion of births that occur at the HGH. Increasing activity is a factor that needs to be considered for all options.
Ob5	**2 obstetrics units – elective (planned)**	This option increases the number of births at the HGH and means there would be a unit at JRH and a unit at HGH. All planned caesarean sections for Oxfordshire women would take place at the HGH.	Y	This option is reliant on one of the staffing models from the other options
Ob6	**Single obstetric service at JRH**	This means one unit based at the JRH. This means there would be an MLU at the HGH. The staffing at the obstetric unit would be provided by consultants and doctors in training. Other clinical services to support complex (tertiary) obstetrics and level 3 neonatal services will also be provided at JRH.	Y	

Ob7	**Single obstetric service at HGH**	This means one unit based at the HGH. It means there would be an MLU at the JRH. The staffing at the obstetric unit would be provided by consultants and middle grades. Other clinical services to support complex (tertiary) obstetrics and level 3 neonatal services would also be required at the HGH. This would mean no training doctors for obstetrics in Oxfordshire. The Deanery would be approached to review accreditation for HGH.	N	This is discarded as the provision of a specialist services for the wider geography served needs to be co-located with other services (such as neonatal intensive care, paediatric surgery), have strong and close links with the University of Oxford research departments and be centrally located with respect to the geography served. This requires that these services need to be maintained in Oxford.
Ob8	**Rural and remote services option**	This means there would be obstetric units at the JRH and HGH and the staffing model at the HGH would be specialist GPs (local GPs given extra training to be able to perform caesarean sections) with access to on-call support from the JRH.	N	The catchment population served by the Horton General Hospital would not be defined as remote and therefore this would not be a preferred model.
Ob9	**2 obstetric units both with alongside MLU**	This means a separate obstetric service at JRH and HGH (both with an alongside MLU) with separate staffing arrangements including separate doctor rotas at both sites. The service at the HGH will be delivered by middle grade doctors and consultants and the service at the JRH will be delivered by doctors in training and consultants.	Y	
Ob10	**2 obstetric units – doctors in training at JR spend 8 hours a week at Horton**	This means there would be obstetric units at the JRH and HGH. The staffing at the obstetrics unit at the HGH would be provided by consultants with support from JR based doctors in training.	Y	
Ob11	**2 obstetric units; HGH unit has regained accreditation for doctors in training**		?	This option is subject to reviewing what it would take to regain accreditation at the HGH.

Horton Health Overview and Scrutiny Committee.
25 February 2019

Chairman's Report

1. Maternity survey – Provider appointment

1.0 As part of the Oxfordshire Clinical Commissioning Group (OCCG) and Oxford University Hospitals NHS Trust (OUH) response to address the outcome of the referral to the Secretary of State a number of workstreams were established. Workstream 1 specifically deals with Engagement, and as part of that workstream the OCCG and OUH set about capturing patient experiences since the closure of the Horton obstetric unit on 1 October 2016. Horton HOSC members were invited to take part in a working group to aid the design of the survey and appoint a provider to conduct the survey.

1.1 The working group is made up of officers from; OCCG, OUH, Oxfordshire County Council (OCC), councillors and a co-opted member from the Horton HOSC and a representative from the Keep the Horton General Campaign. The group met on 22nd November to discuss what the survey needed to capture and to design the scoring criteria for bids. Companies were invited to bid for the work in early December.

1.2 Four bids were received and these were collated in mid-December and scored by the members of the group. The top two bids scored closely and were invited to present their bids to the group and answer further questions, at a meeting on 14th December. The session was useful to understand the approach the two companies would take. It was also useful to gauge their level of understanding around the sensitivities of the undertaking the survey, and the technical aspects of ensuring views are captured sufficiently. After the session Pragma were the preferred bidder and appointed as the provider.

1.3 Pragma attended the Horton HOSC meeting on 19th December, to hear patient views and experiences.

1.4 The working group met with Pragma on 18th January 2019 for a project kick off meeting. Discussions were held around more detailed aspects of the survey and clarification was given around areas that Pragma required. Pragma also presented a timeline for the work and an overview of what the survey would contain. This was generally well received by the group, with a few amendments discussed. It was also clarified that the survey will contain contact details directing survey responders to support if they need it.

1.5 The survey will be issued to all women that gave birth within the two-year period from the closure of the obstetrics unit at the Horton Hospital in October 2016, to October 2018. It will be sent to all those in Oxfordshire, and those in the Horton catchment area in South Northamptonshire and South Warwickshire. The survey will also contain the option to capture partner experiences, should they wish to also share anything. Each individual will be sent a letter with a unique code to be able to access the survey. They will then have the option to share personal data with Pragma, should they wish to be considered for a focus group or one-to-one session.

1.6 Pragma will gather deeper qualitative data from the focus groups and one-to-one sessions. The intention is to run four focus groups, with up to 6 people invited to each. Up to 8 individual one-to-one sessions will be offered, should anyone wish to share a particularly difficult experience outside of a focus group.

1.7 Pragma have shared the draft survey with the working group which has been passed around for comment. The survey is intended for launch mid-Feb, with OCCG, OUH and OCC co-ordinating communications to advertise the survey and try and encourage as many relevant people to respond as possible. The focus groups are scheduled to take place during March.

1.8 Pragma are intending on feeding back the results of the survey on 30 April 2019.