Notice of Meeting Public Document Pack

Horton Joint Health Overview & Scrutiny Committee

Thursday, 11 April 2019 at 2.00 pm

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
	Keiron Mallon	Barry Richards	Adil Sadygov
	Neil Owen	Alison Rooke	
Co-optees:	Dr Keith Ruddle		

Notes: ***Date of next meeting:*** *24 June 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

April 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. Election of a Deputy Chairman

To elect a Deputy Chairman for the Joint Committee.

2. Apologies for Absence and Temporary Appointments

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

4. Minutes (Pages 1 - 28)

To approve the minutes of the meetings held on 19 December 2018 and 25 February 2019 (**HHOSC4a and b**) and to receive information arising from them.

5. Petitions and Public Address

6. Responding to the IRP and Secretary of State Recommendations (Pages 29 - 52)

14.20

The CCG and OUHFT to report back to the Horton HOSC on the progress with the following:

- Engagement update (Ally Green, Head of Communications)
- Work on other small units (Sarah Breton, Head of Maternity Commissioning)
- Finance overview (Catherine Mountford, Director of Governance)
- Proposed approach to option appraisal (Catherine Mountford, Director of Governance)
- Current obstetric staffing (Veronica Miller, Clinical Lead for Maternity)
- Appropriate authorisations and competencies for obstetric trainees (Veronica Miller, Clinical Lead for Maternity)

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 Wednesday, 19 December 2018 commencing at 10.00 am and finishing at 5.25 pm

Present:

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

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

16/18 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

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

There were no apologies for absence.

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

(Agenda No. 2)

There were no declarations of interest.

18/18 PURPOSE AND OUTLINE OF THE MEETING

(Agenda No. 3)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Councillor McHugh responded that:

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

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

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

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

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

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

meaningful, probing and detailed questions of the impact on Warwickshire. She offered her support to this.

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

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

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

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

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

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

A member pointed out that when revisiting Oxfordshire there was also a need to revisit the full population flow from Warwickshire and Northamptonshire also, together

with the impact of what services would remain at the Horton as well as the impact on the John Radcliffe Hospital.

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

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

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

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

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

Lisa Greenhalgh

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

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

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

Mary Treadwell O'Connor

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

A mother (anonymous)

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

Megan Field

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

Sarah Squires

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

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

Clare Hathaway

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

Beth Hopper

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

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

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

Emma Barlow

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

decided to wait until the children were old enough to be left with another family before trying for another child.

The experiences of <u>Sarah Ayre</u> 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.

<u>Councillor Eddie Reeves.</u>

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

Adjourned for lunch 12.39 pm
Reconvened at 1.15 pm

<u>South Central Ambulance Service NHS Foundation Trust</u>

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 care is a risky business and needs the immediate attention of a qualified team when things go wrong. She stated that since the downgrading of the Horton to an MLU there was mounting evidence that the JR was unable to cope. She referred to a survey where 95% of women responding would prefer to give birth at the Horton if the obstetric unit was restored. She referred to the accounts given by mothers and provided to the Committee and hoped that they provided a damning indictment of the current position and evidence of the betrayal of the health needs of women.

Kayleigh Jayne Carter

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

Nadine Thorne

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

Roseanne Edwards with Kathleen Nunn and Haifa Varju

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

Keith Strangwood

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

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

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

The Chairman read out the statement of Robert Courts MP

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

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

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

It was his view that the CCG needed to work with other local authorities to address the recruitment issue, which played a significant role in the challenges currently faced. Moreover, more could be done to recruit medical staff in Oxfordshire as a

whole, and the CCG and the Trust must work with Cherwell District Council to try to solve this issue at the Horton, in particular.

Georgina Orchard

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

Vicki Gamble

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

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

..... in the Chair

Date of signing .....

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HORTON JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE

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

Present:

Voting Members:	Councillor Arash Fatemian – in the Chair
	District Councillor Neil Owen
	Councillor Wallace Redford
	District Councillor Barry Richards
	District Councillor Sean Woodcock
Co-opted Members:	Dr Keith Ruddle
Officers:	
Whole of meeting	Sam Shepherd and Julie Dean (Resources)

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

1/19 APOLOGIES FOR ABSENCE AND TEMPORARY APPOINTMENTS

(Agenda No. 1)

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

2/19 DECLARATIONS OF INTEREST - SEE GUIDANCE NOTE ON THE BACK PAGE

(Agenda No. 2)

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

3/19 MINUTES

(Agenda No. 3)

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

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

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

4/19 PETITIONS AND PUBLIC ADDRESS

(Agenda No. 4)

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

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

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

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

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

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

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

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

(Agenda No. 5)

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

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

The Chairman welcomed the following representatives to the meeting:

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

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

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

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

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

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

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

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

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

Questions and Responses received, together with comments from Committee members

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

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

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

- A member asked if the CCG/Trust were looking to justify their preferred way forward via a survey, in the face of all the harrowing experiences told to the Committee at its meeting on 19 December? Ally Green commented that she understood this point of view because she was aware that increasingly, surveys were being called upon to forge a way forward. However, the IRP had requested that this be undertaken as an exercise in reviewing the problems. The CCG was inviting all women to come forward to tell of their birthing experiences since the Obstetrician Service had ceased at the Horton. What the Committee needed to know was that the results were not as predicted. There was an assumption that many women

would not respond to the survey and it had been recognised that there would be a need on the part of the CCG to give extra encouragement to them. In addition to this, Pragma, an independent company who had been appointed to undertake the survey, had been tasked with analysing the outcomes, to ensure confidence in the capturing of the experiences of women. If this was not reached, then there were plans to hold focus groups and/or 1:1 interviews. To add to this, the stakeholder group had requested that some members of the 'Keep the Horton General' Campaign Group look at the survey beforehand in order to make arrangements more robust than previously;

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

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

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

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

work with the Royal College providing independent guidance, and would bring this back to the Committee an analysis of the list of units which had 2k births or less and their training status.

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

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

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

- In relation to the challenges facing the Trust regarding recruitment, Louise Patten undertook to take a look at the smaller units operating in other parts of the country, in particular at those smaller units in places outside of London. She also referred to the moves from Oxfordshire to be considered for similar London weighting. The Chairman added that, on the other side

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

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

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

The Committee asked if the work which remained still matched with the planned timescale. Catherine Mountford stated that the decision-making meeting was on course to take place in September 2019, but this depended upon the NHS Assurance

process. The meeting planned to take place on 11 April could go ahead and confirmation would be given for the 24 June 2019 meeting in due course.

All representatives were thanked for their attendance.

6/19 CHAIRMAN'S REPORT

(Agenda No. 6)

The Chairman's report was received.

..... in the Chair

Date of signing .....

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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 11 April 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. The attached paper provides an update on the Engagement work stream to date.

Work stream 5a – Workforce analysis. We will provide a summary of the current obstetric workforce at the Oxford University Hospitals (OUH) and the different training grades and requirements for training. The detailed work on the modelling is underway and will be presented at the June meeting.

Work stream 5b – Financial analysis. The attached paper provides the baseline financial position for OCCG (spend by provider) and OUH (income by commissioner).

Work stream 6 – Option appraisal, proposed approach for discussion with the Committee.

Other items of interest

Work stream 5c – Travel and Transfer; following the discussion at the HOSC Evidence Day held in December we are preparing a briefing that outlines definitions and a description of NHS incident reporting and its application to ambulance transfers. As part of this both South Central Ambulance Service and OUH have been asked to confirm whether there have been any reported incidents linked to ambulance transfers from any Midwife Led Unit to the John Radcliffe.

At the February meeting we highlighted that we would be reviewing other small units. We have attached a paper summarising the units we are planning to contact and our proposed approach.

The current position with recruitment to the obstetric Trust grade positions is that the candidate who accepted our offer of employment in December is due to start in April now their pre-employment checks (including right to work) have cleared. They will be working at the John Radcliffe for the time being, although supporting clinics at the Horton as appropriate. We have made offers to 4 people from our January/February

round. 1 has declined for personal reasons and the pre-employment checks for the other 3 candidates are being progressed. Two CVs have been received from the international agency but both are not appropriate as they do not have the ability to perform tasks independently, we are working with the agency to identify further candidates. We have not included wider material on workforce (other than mentioned under 5a above), as this will be a key focus at the June HOSC meeting.

HOSC and CPN members have previously demonstrated interest in discussing staff engagement survey results for OUH maternity services. OUH welcomes this interest and would be happy to discuss at a future session. Survey results at this level are not published and HOSC members will understand that we will need to make sure that the anonymity of responses is protected. The full feedback at Directorate level is still being analysed, disseminated and discussed with staff and so OUH are unable to present information at this HOSC but are happy to do so at a future date.

Forward look for Horton HOSC meeting on 24 June

In line with the project plan all other work is in hand and the following will be presented at the June meeting:

Work stream 1- Engagement; The final update will summarise the work undertaken and include the report of the survey and focus groups.

Work stream 3 – Future Vision for the Horton; as the Committee is aware the Health and Wellbeing Board agreed the proposed new approach to planning for population health and care needs. This approach is being rolled out to the local 'Banburyshire' area and will incorporate further discussions on the future vision for the Horton General Hospital. The approach includes setting up a Stakeholder Group to co-produce the services design, based on a population needs analysis, before future proposals for changes to local health services are brought forward; work is in hand to build on the Community Partnership Network to take this forward.

Work stream 5 – Options Work up; the outcome of the workforce and financial analysis will be part of the information presented with this work stream.

For completeness the following pieces of work will be included with the final reports:

Work stream 2 – Service description (as presented to the February Horton HOSC meeting)

Work stream 4 – Size and Share of the Market (as presented to the February Horton HOSC meeting)

Action requested

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.

In particular the HOSC members are asked to consider the proposed options appraisals process:

- Highlight if anything else should be considered as part of the process
- Comment on the membership of the scoring panel
- Indicate whether they wish to take up the offer of having an observer at the panel day

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: 11 April 2019

Title of Paper: Update on Workstream 1: Engagement

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

- Survey and focus groups for women who have used maternity services since the temporary closure of obstetrics at the Horton General Hospital.
- Stakeholder event
- Website and access to information about the programme

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.

The three main areas of work currently being addressed within this workstream are the survey and focus groups, the stakeholder events and access to information.

Survey

The planned survey is now underway 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 is gathering information from women registered with any Oxfordshire GP practice and those practices in south Northamptonshire and south Warwickshire in the catchment area for the Horton General Hospital.

Approximately 14,000 women have been invited to participate in the survey. The majority of invitations were sent by Oxford University Hospitals Foundation Trust who provide the maternity services in Oxfordshire. Some invitations have been sent by GP practices in south Oxfordshire, south Northamptonshire and south Warwickshire to women who have used maternity services in Warwickshire, Wiltshire and Berkshire.

Social media and the local media have been used to help raise awareness about the survey. Women can follow the instructions in their invitation letter or visit the website directly to complete 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 hosted by Pragma and all responses are anonymous.

It is important to gather experience from as many women as possible. At the time or writing this paper, more than 800 women have completed the survey and more than 300 partners have completed the additional section for them. The survey will close at 9.00am on Monday 15 April and further publicity will be organised to encourage as many women as possible to complete the survey before the closing date.

A target number of completed surveys has not been set although 1,000 responses would allow a good degree of confidence in the results. The advice received by the working group was that the balance across respondents was more important than

setting a single target number. This means we have been working hard to encourage responses from across Oxfordshire, south Warwickshire and south Northamptonshire as well as looking at the demographic spread of responses (in terms of ethnicity, deprivation, age etc.). In analysing the survey responses, there may need to be some additional work to weight responses appropriately so that the views and experience from these different groups are appropriately accounted for.

We have been monitoring the responses as they arrive to ensure we address any further publicity correctly to encourage those under-represented to participate. For example, community workers have been reaching out to various community groups to encourage and support their participation in the survey and social media posts have been translated to Polish to encourage more participation from this community.

Focus Groups

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 issues in more depth.

Three focus groups have been organised and women are currently being recruited to participate:

- Mums in Banbury and surrounding area
- Mums in south Oxfordshire area
- Pregnant women in Banbury and surrounding area

The questions from the survey will be used to help structure the discussion at the focus groups. The specific areas of discussion will depend on the experience of the women and partners who attend and there is flexibility in the approach to ensure relevant data is gathered.

In addition, individual interviews are being arranged with women and partners who have expressed a preference for this and have more complex stories to share.

The results of the survey, focus groups and interviews will be analysed and a report produced that will be published in May 2019.

Engagement Events

Two events are described in the project plan that are intended to ensure the engagement of 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 took place on 22 February. This event was focused on considering the criteria to be used for assessing options and weighting them. Information was

shared at the event to help all participants understand the data and evidence being used within the programme. The presentation and other materials from the event are available here (see listing for 22 February, Stakeholder Workshop 1).

The process for weighting the criteria involved each participant applying a weighting to each criteria depending on how important they believed the criteria to be. These were collected at the end of the event and are being held by the facilitators.

The second stakeholder event will take place on 14 June after the scoring and weighting has been completed. At the second workshop the scores will be shared along with an explanation of why the panel assigned the scores. Participants will then have an opportunity for discussion and to provide any further feedback on the scores. More details for the content of this workshop will be made available nearer the time.

For a full list of stakeholders, please refer to the Engagement Plan agreed with the Joint OSC and published on the OCCG website here.

Access to information

A commitment was made at the start of the project to make public all project documentation including papers, presentations, data and any other information being used. A new section on the OCCG website, here, was set up at the start of the programme and is accessible with one click from the OCCG home page to make it easy to find.

The information is organised in date order so the most recent documents are available at the top of the list.

A link is also 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.

Ally Green
Head of Communications and Engagement

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

Work Stream 5c Financial Analysis

1. Introduction

Within the NHS there are national tariffs for hospital based activity and this is then the "price" that commissioners pay providers for these services.

This paper provides an overview of the amount spent by Oxfordshire CCG on maternity services for a 12 month period (split by provider) and the income received by the Oxford University Hospitals NHS Foundation Trust (OUH) for 2017/18 (split by commissioner). The income received by the provider as well as providing the budget for direct service provision (for example in this case the budget for obstetricians and midwives and other services) must also cover all support services (for example diagnostic services, catering, portering, laundry) and Trust overheads. An analysis of cost for the OUH is not provided in this paper.

2. Commisioning spend on maternity

The table below shows the amount spent by Oxfordshire CCG by provider for births (costs of ante and postnatal care would be in addition to this) during the calendar year 2018.

Provider	Total spend £
Oxford University Hospitals	20,730,769
Royal Berkshire Hospital (Reading)	542,042
Great Western Hospitals (Swindon)	311,262
South Warwickshire NHS Foundation Trust (Warwick)	191,804
Buckinghamshire Health Care (Aylesbury)	81,450
Frimley Health	10,103
TOTAL	21,867,430

3. Income received by Oxford University Hospitals NHS Trust for maternity services

Commissioner	Antenatal £	Postnatal £	Birth £	Total £
Oxfordshire CCG	11,495,594	1,937,591	19,612,819	33,046,004
Northamptonshire CCG	508,181	101,937	836,281	1,446,400
Buckinghamshire CCG	472,850	47,543	717,334	1,237,728
Armed Forces	189,708	27,761	293,603	511,072
Berkshire West CCG	206,143	23,286	274,460	503,889
Milton Keynes CCG	74,306	12,457	140,119	226,883
Wessex			206,143	206,143
Berkshire East CCG	65,427	7,517	121,379	194,324
Gloucestershire CCG	50,383	3,705	73,515	127,604
Swindon CCG	37,992	5,462	63,582	107,036
South Warwickshire CCG	34,195	5,887	52,635	92,717
Wiltshire CCG	14,844	1,544	17,457	33,845
Bedfordshire CCG	5,895	926	22,629	29,451
Hertfordshire CCG	9,999	1,163	10,869	22,031
Non-contracted activity	63,841	9,807	114,938	188,586
TOTAL	13,229,361	2,186,589	22,557,765	37,973,741

4. Commentary

This information only provides a very high level overview of the funding flows for maternity services. The following can be noted:

- For Oxfordshire registered mothers most activity (95%) takes place in Oxfordshire
- The majority of income (87%) for maternity services for OUH comes from Oxfordshire CCG
- There is a greater flow of income into OUH from CCGs outside Oxfordshire than Oxfordshire CCG pays to other providers for Oxfordshire mothers who give birth outside the county. This is consistent with the OUH being the specialist provider for the Thames Valley and wider areas

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

Work Stream 6 Option Appraisal Process

The proposed approach to undertaking the option appraisal process is outlined in this paper.

1. Proposed Process

Friday 3 May - All panel members sent evidence packs (includes option descriptions, criteria descriptors, scoring matrix, workforce information, finance information, maternity survey report etc)

Panel members individually score all options (0-4 scale) against all criteria.

By 9 am Monday 13 May individual members of panel return scores for collation

Week beginning 20 May (date to be confirmed) all day panel event to come to consensus scores.

- Panel day will have Independent Chair, supported by Freshwater.
- Observers (invitations to be sent to Horton HOSC, MP's offices and Cherwell, South Northamptonshire and Stratford-on-Avon District Councils)
- After arriving at consensus score then weighting applied
- Final product of day scored and weighted list of options

2. Short list of options

Final short list as shared with Horton HOSC at February meeting (attached as Annexe 1).

3. Criteria

The agreed criteria and definitions are as shared at Stakeholder event (attached as Annexe 2). The participants at the event contributed to weighting of these criteria but the weighting will not be shared with panel members until after the scoring has been undertaken.

There was discussion about the addition of a criterion to do with reduction in inequalities. After further consideration our view is that additional criteria should not be added. The most important aspects of work to reduce inequalities is to focus on prevention to minimise the potential for adverse outcomes. In terms of this work that reduction in inequalities will be addressed through other criteria and in particular through:

- Clinical outcomes
- Patient and carer experience
- Distance and time to access services

In addition the relevant information from the Integrated Impact Assessment undertaken by Mott MacDonald from Phase 1 will be presented to the CCG Board alongside the outcome of the option appraisal as part of the decision making process.

4. Scoring Panel

It is proposed that the Scoring Panel should include stakeholder representatives as well as NHS staff. The following representation (subject to confirmation and availability) is suggested:

Oxfordshire Clinical Commissioning Group: Director of Governance, Head of Children's Commissioning; Locality Clinical Director or Deputy for North Oxfordshire Locality

Oxford University Hospitals NHS Foundation Trust: Clinical Director for Maternity, Medical Director, Head of Midwifery, a representative from the Horton MLU

Stakeholder representatives (to be asked if they wish to participate): Maternity Voices (user representative); Chair of Community Partnership Network (stakeholder representative of the Horton catchment area), Keep the Horton General (user representative). Healthwatch have been asked what role they would like to have (either on the scoring panel or observer).

South Warwickshire and Nene CCGs have confirmed that they support the proposed approach.

5. Post scoring

As previously reported to the Horton HOSC the output from the scoring panel will then be shared as follows:

14 June 2019 Stakeholder Event 2

1. Share the weighted scores with stakeholders
2. Present the reasons why the panel assigned the scores
3. Facilitate discussion to produce qualitative feedback on the scores

24 June 2019 Horton HOSC

The output of the scoring panel plus feedback from stakeholders from the event will be shared with the Horton HOSC for feedback.

The outputs from the Horton HOSC will form part of the submission to NHSE to complete the Assurance process.

26 September 2019

Once all these steps have been completed the output will form part of the final report will be presented to the OCCG Board for decision.

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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.

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Criteria definitions

Area	Criteria	What do we mean?
Quality of care criteria	1. Clinical outcomes	The service model contributes to the improvement in outcomes in line with Better Births; this includes improvement against the serious outcome measures of: • Stillbirth and perinatal death at term • Significant brain damage to babies born at term • Unexpected admissions of babies born at term to special care units Achieve the aims of the Department of Health mandate to reduce poor maternal and neonatal outcomes by 20% by 2020 and 50% by 2030 to implement recommendations from Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE).
	2. Clinical effectiveness and safety	The service model enables and promotes service delivery in line with guidance from the National Institute for Clinical Excellence (NICE) and interventions which are proven to be effective in improving safety and outcomes. Risk assessment takes place throughout pregnancy to ensure the woman is supported in the right services. Women should be informed of risks and be supported to make decisions which would keep them as safe as possible.
	3. Patient and carer experience	In line with Better Births the service supports personalised care, centred on the woman her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information. This includes: • Every woman should be supported to develop a personalised care plan with her midwife and • other health professionals which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses.

		• Unbiased information should be made available to all women to help them make their decisions and develop their care plan. • Women should be able to make decisions about the support they need during birth and where they would prefer to give birth.
Access criteria	4. Distance and time to access service	Impact on population average travel times (blue light, off-peak car, peak car and public transport) considering both 'planned' journeys and 'transfers' from midwife-led units.
	5. Service operating hours	Ability of model to support seven day working across all sites with flexibility to move staff resources to meet service needs.
	6. Patient choice	Ability to maintain patient choice of location of care. Women should be able to make decisions about the support they need during birth and where they would prefer to give birth whether this is at home, in a midwife-led unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option.
Affordability and value for money criteria	7. Delivery within the current financial envelope	The service can be provided within the national tariff (so as the numbers of pregnancies and births increase, the income received by hospitals increases).
Workforce criteria	8. Rota sustainability	Enough medical and other clinical staff are employed so the rota can be maintained and if gaps occur these can be easily filled on a short term basis by locum staff.
	9. Consultant hours on the labour ward	The model enables the increase of dedicated consultant hours of presence on the obstetric labour ward to facilitate the recommendations of the Each Baby Counts report.
	10. Recruitment and retention	Job plans for medical and other clinical staff are attractive and have a good chance of attracting and retaining suitably qualified candidates.
	11. Supporting early risk assessment	All women are consistently and effectively screened and medically risk-assessed by their GP as early as possible in pregnancy.

Deliverability criteria	12. Ease of delivery	Ease and timeliness of being able to introduce the model, considering factors such as time required for recruitment, any capital development required, impact on other services.
	13. Alignment with other strategies	Alignment with other national and local strategies (eg Better Births, NHS Long Term Plan) and provides a flexible platform for the future.

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Small obstetric units, models of working and learning for Oxfordshire.

Background

Oxfordshire Clinical Commissioning Group and Oxford University Hospitals NHS Foundation Trust has been looking at how NHS Trusts across the country manage the challenge of safe obstetric care in units with small numbers of births. The aim is to use any learning, particularly around medical staffing, training accreditation and safety to inform the appraisal of options for the unit at the Horton General Hospital.

Joint Health Overview and Scrutiny Committee members are requested to:

a) Note the work underway
b) Comment on the criteria used to identify units
c) Identify if there are units that do not meet our criteria but that the Committee believes provide exceptionally relevant examplesthat we should consider

Scope

There has been a reduction in the number of small obstetric units operating across the country since 2015. However, there are still a number of small units that manage less than 2200 births, either as part of a larger NHS Trust with a larger obstetric unit or more commonly as the only obstetric unit in that NHS Trust.

A selection of these units is now being looked at to see what lessons can be learned. The criteria adopted for selecting the units are:

- Less than 2200 deliveries
- Good or outstanding CQC rating
- Comparable or better CQC women's survey outcome
- Not currently under review/reconfiguration

The current key lines of enquiry being pursued include:

- Medical staffing models
- Training accreditation status
- Collaboration with other NHS Trusts
- Safety and outcomes

The small units currently being investigated are listed in appendix 1 (these were identified from the National Maternity Perinatal Audit (NMPA) organisational report 2017.

Alignment with other work

We understand that members of Keep the Horton General are undertaking a review of small units and we have asked if we can share approaches and information.

Appendix 1

- Hereford Central Hospital
- Bassetlaw Hospital
- Gateshead Hospital
- Scunthorpe General Hospital
- Dorset County Hospital
- Harrogate General Hospital
- Macclesfield General Hospital
- Darlington General Hospital
- Royal Lancashire General Hospital
- George Elliot General Hospital
- Salisbury General Hospital
- St Hellier General Hospital
- Worthing Hospital