Horton Joint Health Overview & Scrutiny Committee
Thursday, 19 September 2019
Banbury Town Hall, Banbury

ADDENDA

5. Responding to the IRP and Secretary of State recommendations (Pages 1 - 80)

The paper accompanying this item is attached as an addenda to the papers on the 16th of September

6. Chairman's Report (Pages 81 - 100)

Chairman's report addenda attached.

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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 Horton Joint HOSC meeting 19 September 2019

At the November 2018 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 have been completed. Oxfordshire Clinical Commissioning Group (OCCG) has now published the paper that summarises the work undertaken to address the recommendations of the SoS/IRP with recommendations on the provision of obstetric services. These recommendations will be discussed at the OCCG Board meeting on 26 September.

OCCG and OUH representatives will be attending the Horton Joint HOSC meeting on 19 September to listen to any further comments of members to inform the Board discussion.

Where possible, questions will be answered; however, it is important to note that no decisions have yet been made, and will not be made, until the OCCG Board meeting on 26 September.

Louise Patten, Chief Executive, Oxfordshire CCG

Dr Bruno Holthof, Chief Executive, Oxford University Hospitals NHS Trust

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Oxfordshire
Clinical Commissioning Group

OXFORDSHIRE CLINICAL COMMISSIONING GROUP BOARD

Date of Meeting: 26 September 2019	**Paper No: 19/54**

Title of Paper:

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

Paper is for: (please delete tick as appropriate)	**Discussion**	✓	**Decision**	✓	**Information**	

Conflicts of Interest (please delete tick as appropriate)	
No conflict identified	✓
Conflict noted: conflicted party can participate in discussion and decision	
Conflict noted, conflicted party can participate in discussion but not decision	
Conflict noted, conflicted party can remain but not participate in discussion	
Conflicted party is excluded from discussion	

Purpose and Executive Summary:
Staff from the Clinical Commissioning Group and Oxford University Hospitals NHS Foundation Trust have been working together to address the recommendations from the Independent Reconfiguration Panel into the OCCG proposals on a permanent change to Obstetric services.

At every key stage, this work has been presented to the Horton Joint Health Overview and Scrutiny Committee (Horton Joint HOSC), in order for them to oversee progress and contribute to the methodology and approach.

The Board was updated at the July 2019 meeting and agreed that the two highest scoring options from the option appraisal should be reviewed in more detail. This paper provides the outcome of this more detailed review and is presented for decision making.

Engagement: clinical, stakeholder and public/patient:
There has been a comprehensive workstream covering engagement in this work. This has included clinicians, service users and their partners and wider stakeholders. A variety of approaches have been used including publishing all information on the CCG website; commissioning a service user survey; stakeholder events and involvement of stakeholder representatives in key activities (commissioning the survey partner and identifying the areas to cover) and the scoring panel.

Financial Implications of Paper:
This paper includes the detailed costings of the two options.

Action Required:
The Board is asked to:

1. **Agree** that it is assured the work plan presented to the Horton Joint HOSC to cover all IRP requirements has had ongoing oversight through presentation of the work back to the HOSC and that the plan has been delivered and the Board has received the information required to support decision making.

2. **Confirm** the decision made in August 2017 to create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the John Radcliffe Hospital and establish a Midwife Led Unit (MLU) at the Horton General Hospital, for the foreseeable future.

3. **Note** that the decision is for the 'foreseeable future' rather than a statement of permanency. This is because we now have a framework, agreed by the Oxfordshire Health and Wellbeing Board, that states an ongoing commitment by the CCG and all health & care partners to regularly review population health and care needs and change services as appropriate to meet that need, all co-produced with local stakeholders. This approach will ensure that if population or other factors change significantly then the need for obstetric services can be reviewed.

4. **Agree** to work with OUH on an implementation plan to improve mothers' and partners' experience and enhance access to maternity services (particularly for the population in the Horton catchment area) by introducing:

    a. A dedicated hotline for women in labour and their families to navigate the site and use priority parking in an emergency. This is in addition to current work to address travel and parking issues at the John Radcliffe Hospital site.
    b. An expansion of services available at the Horton MLU or virtually to enable women to receive most of their maternity care closer to home; and increased facilities for birth partners to stay overnight at the John Radcliffe Hospital.
    c. Better information for women on the choice of options available, including joint working and strengthening links with South Warwickshire Foundation Trust to ensure Warwick Hospital is an attractive option.

5. **Note** that it is important for women, their families and healthcare staff that we finalise and implement this decision to remove uncertainty and enable us to plan for the future of Horton General Hospital and actively pursue the opportunity of capital investment.

6. **Agree** to work closely with the OUH and local stakeholders to further develop the masterplan for the Horton General Hospital, ensuring it includes high quality, flexible clinical space that could be used for different services over

time, including obstetric services if circumstances demand.

7. **Agree** to actively pursue with OUH the need for significant capital investment in the Horton Hospital, in clear recognition that this can improve recruitment and ensures the site is fit for its future as a thriving 21st century hospital for the whole of North Oxfordshire and beyond.

OCCG Priorities Supported (please delete tick as appropriate)	
	Operational Delivery
✓	Transforming Health and Care
	Devolution and Integration
	Empowering Patients
✓	Engaging Communities
✓	System Leadership

Equality Analysis Outcome:
A full Integrated Impact Assessment was undertaken as part of the work for Phase 1 of the Oxfordshire Transformation Programme and this has been used to inform this piece of work.

Link to Risks: AF28; Workforce and AF32; Use of Resources

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Date of Paper: 16 September 2019

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

1. Introduction

In August 2017, the Oxfordshire Joint Health Overview and Scrutiny Committee (Oxfordshire JHOSC) referred the Oxfordshire Clinical Commissioning Group (OCCG) proposals on a permanent change to Obstetric services to the Secretary of State for Health and Social Care (SoS). The Secretary of State received advice from the Independent Reconfiguration Panel (IRP). The IRP concluded that further work was required locally and their advice has been accepted by the SoS. In summary this asked for OCCG to undertake a more detailed appraisal of the options, specifically:

- A consideration of what is desirable for the future of maternity and related services and all those who need them across the wider area of Oxfordshire and beyond.
- All potential activity from the area served by Oxfordshire services (particularly South Warwickshire and South Northamptonshire)
- Views of mothers, families and staff who have been involved in the temporary arrangements
- Addressing all the recommendations from the Clinical Senate report of 2016
- What dependency, if any, exists between these services and other services
- Review of the options appraisal with stakeholders before a final decision is made.

"Whatever option eventually emerges, it should demonstrate that it is the most desirable for maternity services across Oxfordshire and all those who will need them in the future." [IRP letter to Secretary of State 09.02.2018]

In line with the IRP recommendations, the three Local Authorities (Northamptonshire County Council, Oxfordshire County Council and Warwickshire County Council) that considered the proposal to be a substantial change in NHS services agreed to form a Joint Overview and Scrutiny Committee; the Horton Joint Health Overview and Scrutiny Committee (Horton Joint HOSC) held its first meeting in September 2018.

The Horton Joint HOSC has met regularly in public, with key personnel from OCCG and the Oxford University Hospitals NHS Trust (OUH) in attendance. This has provided regular opportunities to feed back at key stages, ensuring the work remained in scope and on track.

2. Scope of work and agreed plan

The agreed areas of work within this scope were agreed with the Horton Joint HOSC and are summarised below. These three broader areas encompass the areas highlighted by the IRP/SoS listed in Section 1 above.

1. *Current and future demand for maternity services:* To work closely with neighbouring CCGs to ensure we have a full understanding of the population size and future housing/population growth for Oxfordshire and surrounding

areas. Northamptonshire and Warwickshire are key populations as well as the whole of Oxfordshire and flow from other counties to the John Radcliffe unit (the IRP was clear that the options must be the most desirable for the whole of the Oxfordshire population and wider population that access services in Oxfordshire). This enables modelling of potential market size (number of births) and ability to test market share (including testing this in the survey undertaken).

2. *Taking a fresh look at the options:* To thoroughly review the options presented in the August 2017 Decision Making Business Case (DMBC) and to include any additional options identified to identify whether there is a feasible staffing model to maintain obstetric services at the Horton General Hospital.

3. *Service co-dependencies:* To clarify the potential co-dependencies of services linked to the presence (or absence) of obstetric services at the Horton General Hospital, specifically how this may affect the sustainability of other specialties. A key area is to test viability of the anaesthetic rota.

At the November 2018 meeting, the Horton Joint HOSC confirmed that in the opinion of the Committee the proposed approach and plan (outlined above) would address the recommendations of the Secretary of State/Independent Reconfiguration Panel. The full plan is available here.

3. Delivering the Plan

A core project group with representation (clinical and managerial) from OUH and OCCG has been meeting on a regular basis to drive forward the work programme. The project group has worked closely with the NHS in bordering counties (South Warwickshire CCG, South Warwickshire NHS Foundation Trust, Nene CCG and Northampton General Hospital NHS Trust).

At key points in the programme members of the project team met with the Royal College of Obstetricians and Gynaecologists (RCOG) as a means of obtaining an external viewpoint on the staffing models proposed.

All elements of the plan have been delivered to time and progress has been reported regularly to the Horton Joint HOSC at key stages, to ensure the work continued to meet their expectations of delivery within the agreed scope.

The OCCG Board received an update paper (available here) at the July meeting which provided an overview of the work undertaken and the outcome of each work stream. A summary of the work undertaken to deliver the requirements of the SoS/IRP, as agreed with the Horton Joint HOSC, is set out in Table 1 below.

The work streams that made up this overall work programme ran concurrently and are summarised in the July OCCG Board paper, with links to the detailed work that is all in the public domain and available on our website here.

In undertaking a fresh look at the service model options, the work included a comprehensive scoring methodology that involved key stakeholders. Two options scored very closely and significantly higher than any other; (Option Ob6) a single

obstetric unit at the John Radcliffe Hospital (with MLU at the Horton) and (Option Ob9) two obstetric units both with Midwifery-Led Units (MLU) alongside.

In presenting these findings to the Horton Joint HOSC, the committee agreed that the detailed work up should be focussed on these two options, in terms of modelling what will be required for delivery – in particular, what would be needed to mitigate the weaknesses for each (e.g. to improve patient choice and experience in the single obstetric unit model; and to improve deliverability and sustainability for the two obstetric units with alongside MLUs). It is this information alongside a fuller financial analysis of the two options that is included in this paper.

Table 1: A summary of the outcomes of the work undertaken to deliver the scope agreed with HOSC and the requirements of the SoS/IRP

Area of scope agreed with HOSC	**SoS/IRP Requirement**	**Work undertaken**	**Link to work**
1. <u>Current and future demand for maternity services:</u> To work closely with neighbouring CCGs to ensure we have a full understanding of the population size and future housing/population growth for Oxfordshire and surrounding areas. Northamptonshire and Warwickshire are key populations as well as the whole of Oxfordshire and flow from other counties to the John Radcliffe unit (the IRP was clear that the options must be the most desirable for the whole of the Oxfordshire population and wider population that access services in Oxfordshire). This enables modelling of potential market size (number of births) and ability to test market share (including testing this in the survey undertaken).	A consideration of what is desirable for the future of maternity and related services and all those who need them across the wider area of Oxfordshire and beyond.	Work stream 2 Service description; described the full maternity pathway including key performance indicators and the service available to mothers and their partners.	Paper available here presented at Stakeholder Event and then to Horton HOSC February 2019. Key elements of this are highlighted in section 4.1.5 of this paper.
	All potential activity from the area served by Oxfordshire services (particularly South Warwickshire and South Northamptonshire).	Full analysis, by practice, of where mothers had come from prior to 2016 temporary closure. Work stream 4 Size and share of the market; includes modelling based on housing growth in all relevant geographies and possibilities of changing market share.	Presented to Horton HOSC September 2018 and available here in Appendix 4 Births Analysis. Paper available here presented at Stakeholder Event and then to Horton HOSC February 2019. Overview included in update paper here to OCCG Board in July 2019 and informs section 4.1 of this paper.
	Views of mothers, families and staff who have been involved in the temporary arrangements.	Work stream 1 Engagement OCCG commissioned Pragma to undertake a survey, focus groups and interviews to provide insight into the experience of families that have used maternity services during the time of the temporary closure of obstetric services at	Findings presented at Stakeholder Event and then to Horton HOSC June/July 2019. The report is available here. Overview included in update paper here to OCCG Board in July 2019 and informs section 4.2 of this

		the Horton. Stakeholders were involved in the selection of Pragma and in the design of the survey. Staff engagement is undertaken as part of operational management within the Trust.	paper. The Maternity Directorate continue to engage all staff in service delivery. There are regular staff meetings and briefings during which staff are encouraged to share good news and to raise any safety concerns regarding service provision. The Maternity service has a high engagement with the NHS Staff Survey and holds 'Listening into Action' events on a monthly basis, chaired by the Director of Midwifery and open to all staff. There is also a monthly newsletter which is emailed to all staff and contains service updates, any concerns raised and celebration of successes by individuals and teams.
3. *Taking a fresh look at the options:* To thoroughly review the options presented in the August 2017 Decision Making Business Case (DMBC) and to include any additional options identified to identify whether there is a feasible staffing model to maintain obstetric services at the Horton General Hospital.	Addressing all the recommendations from the Clinical Senate report of 2016.	Following receipt of the recommendations from the Clinical Senate these were reviewed and implemented by OCCG and OUH. OCCG has attended two further Clinical Senate meetings (May 2018 and June 2019) to report on this programme of work	The position at September 2018 (all actions completed and closed) was reported to the HOSC in Appendix 6 of the paper available here The Clinical Senate has confirmed to NHSE that all the 2016 recommendations have been met. Their letter is attached as Appendix 1.
	What dependency, if any, exists between these services and other services.	Work stream 3 Work undertaken by the South East Coast Clinical Senate has reviewed the dependency for co-location of clinical services. The full report is available here, the full co-dependency grids are shown on pages 30-32.	The following was reported to the HOSC in September 2018 (in Appendix 3 of the paper presented which is available here). This report highlights that provision of A&E (pages 34-37), acute medicine (pages 37-38) and paediatrics (see pages 49-52) are not dependent on the provision of an obstetric service on the same site. This has been seen in practice locally in that all these services

			have continued to be run from the Horton General Hospital since the temporary closure of the obstetric service in October 2016. The Obstetric Anaesthetic rota at the Horton was independent of the other anaesthetic rotas for vital services such as trauma or the resuscitation team. The absence of obstetrics should therefore not impact on the provision of anaesthetics for other vital services at the Horton General going forward. Conversely the provision of obstetrics is dependent on the co-location of neonatal services, anaesthetics and critical care.
2. *Taking a fresh look at the options:* To thoroughly review the options presented in the August 2017 Decision Making Business Case (DMBC) and to include any additional options identified to identify whether there is a feasible staffing model to maintain obstetric services at the Horton General Hospital.	Review of the options appraisal with stakeholders before a final decision is made.	Work stream 6 Option Appraisal.	The options to be reviewed were agreed with Horton HOSC and the list has been published on the OCCG website. It was also presented at the first Stakeholder event. This is available here. The information used by the scoring panel was shared and the main pack is available here with additional information shared also available here (in 18 June section). The outcome of the appraisal process was shared at the second Stakeholder Event and with the Horton HOSC June/July 2019. The paper is available here. Overview included in update paper here to OCCG Board in July 2019.

4. Summary of the work undertaken within the three areas of scope

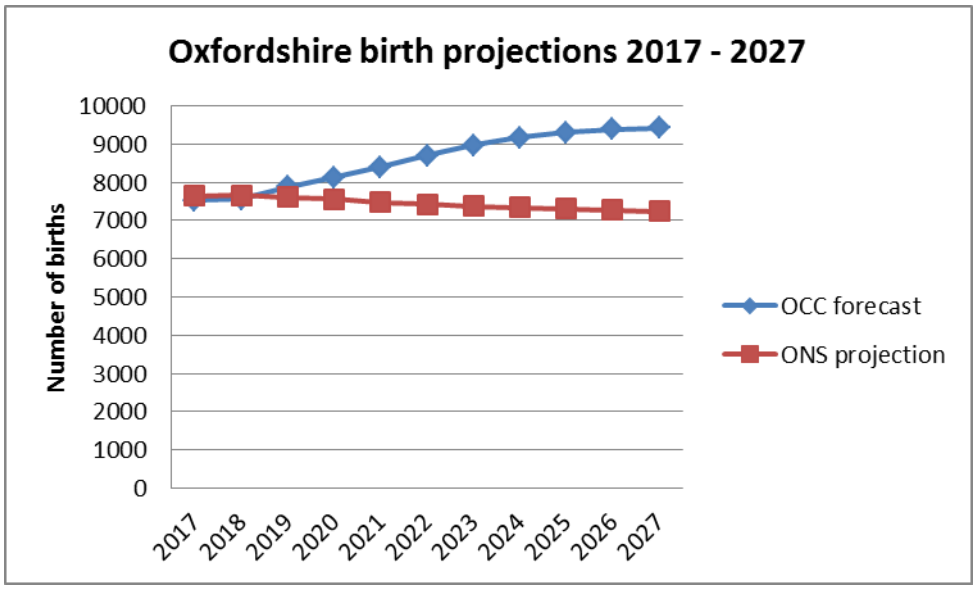
4.1 Current and future demand for maternity services

4.1.1 Birth projections

Predicting the number of births with any degree of certainty is particularly difficult given the many and varying factors that can affect the birth rate. The Office of National Statistics (ONS) makes population projections, including projecting the number of births, based on population data and assumed age related fertility rates. Given the historical reduction in the fertility rate nationally, the ONS projections for 2016 – 2026 are based on the assumption that women will have fewer children and therefore predicts a decrease in births in Oxfordshire during that period.

Oxfordshire County Council (OCC) carries out its own forecasting that takes into account local housing growth. The most recent forecasts produced by OCC predict a 20% increase in births across Oxfordshire by 2027[1]. Diagram 1 below shows the variation in the ONS and OCC forecasts.

Diagram 1: Oxfordshire Birth projections



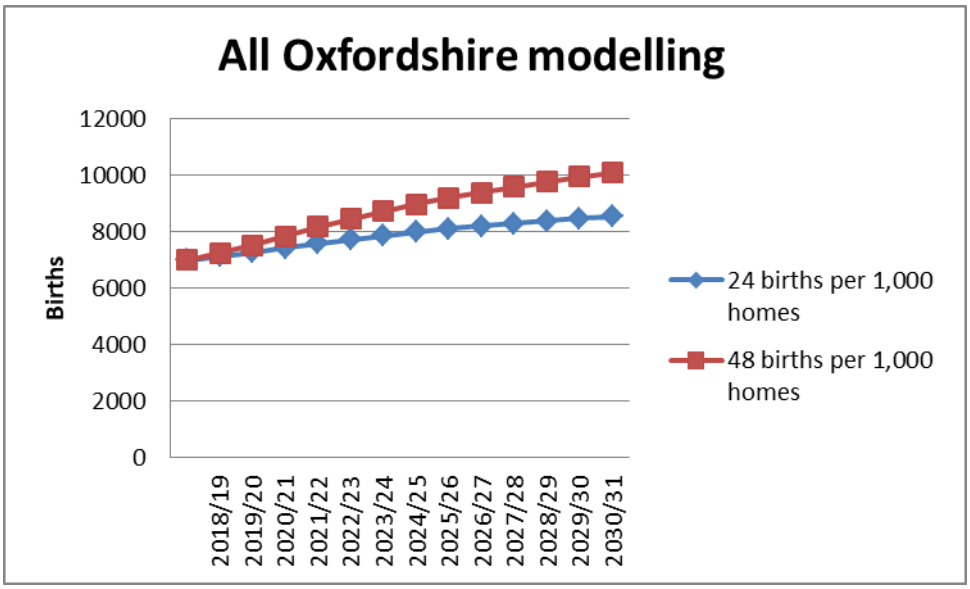
[1] Oxfordshire County Council housing-led population forecasts published August 2019

4.1.2 Potential impact of housing growth

The birth rate in 2017 suggested an estimate of 24 births per 1,000 households so this was used to model the impact of the housing growth on births. There is a view that housing growth is a bigger driver of growth in the birth rate than is used in current modelling so a second projection has been undertaken applying a birth rate of 48 births per 1,000 households for new housing (i.e. double the 2017 birth rate).

Applying these two models to give birth projections for the total Oxfordshire (GP registered) population is shown in Diagram 2 below:

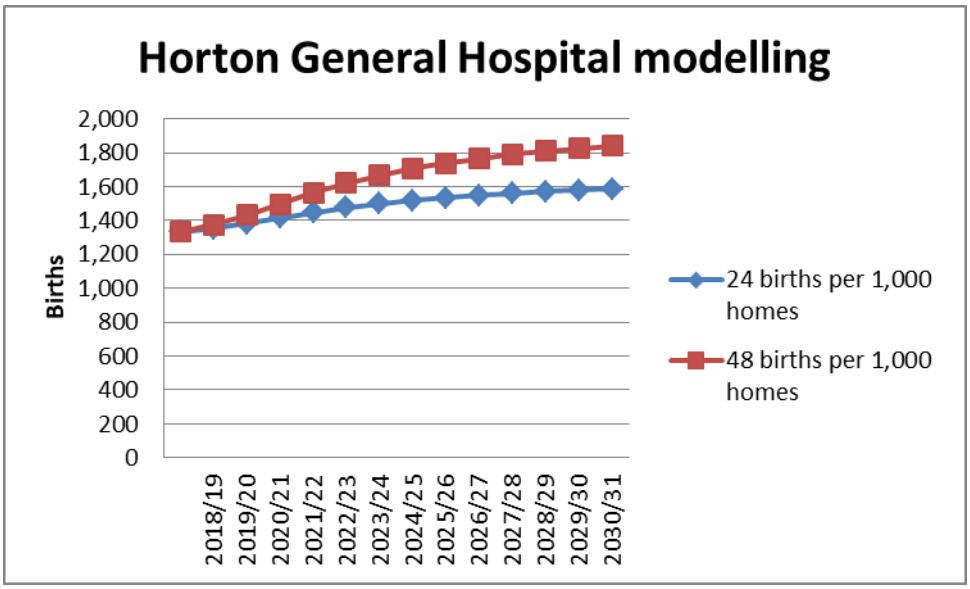
Diagram 2: Modelling the impact of housing growth on births for all Oxfordshire (GP registered population)



This modelling gives a range in total births for Oxfordshire of between 8,553 and 10,099 by 2030/31. This is an increase of between 22% and 44% over the period.

The catchment population for the Horton General Hospital comes from Oxfordshire, south Northamptonshire and south Warwickshire. Our analysis of where the mothers who used the Horton Obstetric Unit before closure came from indicated that there was a “main” and “wider” catchment. The main catchment area includes practices in and around Banbury in north Oxfordshire, the practice in Chipping Norton and practices in Brackley and Byfield in south Northamptonshire. The wider catchment area includes practices in Shipston, Kineton and Fenny Compton (south Warwickshire), Bicester practices, other West Oxfordshire (Charlbury, Woodstock), Witney, Eynsham and surrounds and Kidlington and Islip. The two different rates have been used to model potential increase in births for the Horton catchment areas (main and wider) on the basis of current flow. This is shown in Diagram 3 below.

Diagram 3: Modelling the impact of housing growth on births for Horton General Hospital catchment area



Using the current catchment and distribution of births this modelling gives a range in total births for the Horton General Hospital of between 1,586 and 1,835 by 2030/31. This is an increase of between 19% and 38% over the period.

We also modelled a shift in flow from the wider Horton General Hospital catchment and applied that percentage to the increased number of births. This gave a revised baseline for HGH births of 1,760 and an upper limit in 2030/31 of 2,148 (24 births per 1,000 houses) to 2,536 (48 births per 1,000 houses). To achieve this level of births at Horton General Hospital requires a significant shift (at least doubling) in current patient flows from Bicester, Woodstock, Witney and Kidlington areas and the birth rate for all new housing developments to be double the current birth rate. This is summarised in Table 2 below.

Table 2: February 2019 modelling an increase in share of the market and share of additional births at HGH

	Baseline HGH		Shift towards HGH	Revised	Additional births per 1,000 homes by 2030/31		Total potential births at HGH by 2030/31	
	Births	%HGH		Baseline	24	48	24	48
Banbury practices	617	81%	81%	617	115	230	732	847
Brackley and Byfield	177	73%	73%	177	21	42	198	219
Practices around Banbury	110	59%	75%	141	0	0	141	141
Chipping Norton	54	41%	55%	72	20	40	92	112
Shipston, Kineton and Fenny Compton	53	28%	40%	75	53	106	128	181
Bicester practices	134	24%	50%	283	95	190	378	473
Other West Oxfordshire (Charlbury, Woodstock)	25	23%	50%	54	9	18	63	72
Witney, Eynsham and surrounds	25	6%	30%	132	53	106	185	238
Kidlington and Islip Practices	9	3%	30%	82	22	44	104	126
Other	128			128				
TOTAL	1,332			1,760	388	776	2,148	2,536

In the survey that was undertaken women were asked to indicate whether they would have used an obstetric unit at the Horton General Hospital if this had been available. These results have been analysed by postcode and these expressed preferences have been used to model the potential for increasing births at the Horton General Hospital. This is shown in Table 3 below.

Table 3: Modelling an increase in share of the market and share of additional births at HGH based on preferences expressed in survey

	Births %HGH	% in model	Postcodes	% Survey	Revised baseline (survey)	Additional births per 1,000 homes by 2030/31		Total potential births at HGH by 2030/31	
						24	48	24	48
Banbury practices	81%	81%	OX16	92%	703	132	264	835	967
Brackley and Byfield	73%	73%	NN11 &13	93%	224	27	54	251	278
Practices around Banbury	59%	75%	OX15 &17	93%	175	0	0	175	175
Chipping Norton	41%	55%	OX7	42%	55	15	30	70	85
Shipston, Kineton and Fenny Compton	28%	40%	CV	50%	94	66	106	131	200
Bicester practices	24%	50%	OX25-27	40%	226	76	190	152	416
Other West Oxfordshire (Charlbury, Woodstock)	23%	50%	OX7&20	42%	45	9	18	54	63
Witney, Eynsham and surrounds	6%	30%	OX28&29	20%	55	36	71	91	126
Kidlington and Islip Practices	3%	30%	OX5	0%	0	0	0	0	0
Other					128				
TOTAL					1,705	361	733	2,066	2,438

For the areas closer to Banbury there is a very strong preference (>93%) for using an obstetric unit at the Horton General Hospital; these percentages have been used in the modelling but are higher than would be seen as there is a proportion of women who would need to be supported by the specialist services at the John Radcliffe Hospital. Conversely the preference expressed from the wider catchment area is generally less than our February 2019 modelling assumptions. This modelling gave a revised baseline for potential number of births at the Horton General Hospital of 1,705 and an upper limit in 2030/31 of 2,066 (24 births per 1,000 houses) to 2,438 (48 births per 1,000 houses).

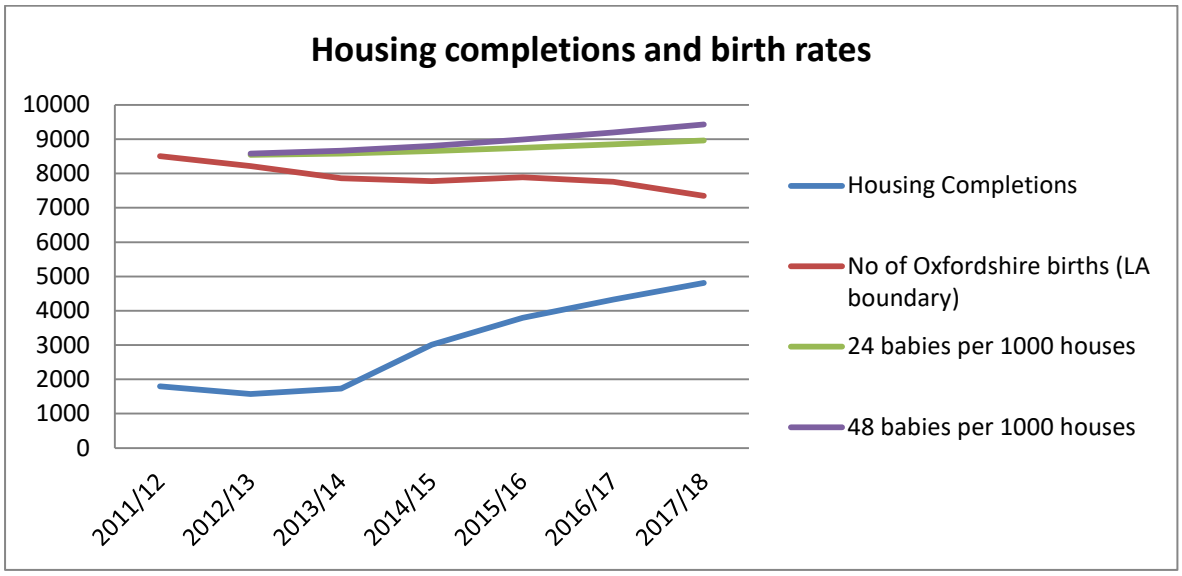
4.1.3 Historical trends in birth numbers

This modelling with a stronger emphasis of the impact of housing growth on birth rate can only give an indication of what might happen and needs to be looked at in the context of what has happened. It is interesting to consider the birth rate in Oxfordshire compared to the net housing growth across the County. Diagram 4 below shows the net housing completions reported by the district councils[2] plotted against the number of recorded Oxfordshire births[3] for the past seven years.

[2] Figures extracted from each District Council's Annual Monitoring reports for the given years. Graph shows combined total completions for Oxfordshire.

[3] Birth numbers are for calendar rather than financial year and are for Oxfordshire Local Authority (rather than CCG) area.

Diagram 4: Net housing completions and the number of recorded Oxfordshire births



The graph shows that despite a significant increase in the number of housing completions from 2013/14 onwards it appears that this has had little impact on the birth rate. In fact the birth rate has instead shown a steady decline from 2011.

The graph also shows what the predicted birth rate would have been had our modelling been applied to the birth rate in 2011. The model based on the assumption of 24 babies per 1,000 houses built projected a birth rate of 8,964 by 2017/18 and the model of 48 babies per 1,000 houses was 9,426; this equates to an over-projection of 1,612 and 2,074 births respectively.

The recent decline in births is not unique to Oxfordshire. The latest statistical bulletin from ONS released on 1 August 2019 highlights that births are dropping across the country. The ONS Lead Statistician summarised;

"Our analysis of births in England and Wales in 2018 paints a picture of decreases and some record lows. The birth rate was the lowest ever recorded, when births are measured as a proportion of the total population. The total fertility rate stood at 1.70 children per woman, lower than all years except 1977 and 1999 to 2002. The proportion of live births to non-UK mothers fell for the first time since 1990. The stillbirth rate reached the lowest level recorded for the second year running. There were 657,076 live births last year, the fewest since 2005 and a drop of almost 10% since 2012."

At a more local level, table 4 below shows surrounding counties all mirror the national picture with declining births from 2012. This highlights declining activity across the BOB footprint and the Horton catchment area.

Table 4: Percentage birth rate change since 2012 for Oxfordshire and surrounding counties

County	Percentage change in birth rate from 2012
Northamptonshire	-6.4%
Warwickshire	-5.4%
Buckinghamshire	-5.5%
West Berkshire	-17%
Oxfordshire	-10.4%

4.1.4 Current and future demand summary

The birth rate is not as stable and predictable as may be expected. Whilst an increase in housing is an important consideration for assessing current and future demand on services, recent history has shown little correlation with the birth rate.

Birth data over recent decades shows that the birth rate can, and has been, effected by social, economic, political and cultural factors; the post war 'baby boom', the dip in births during recessions, the increase in birth rate due to migration are all such examples. It is difficult to pinpoint more recent factors that have affected the birth rate but it would appear that the birth rate in Oxfordshire (and nationally) is currently falling.

4.1.5 Describing maternity services fit for the future

This work described the full maternity pathway and service available to mothers and their partners, including key performance indicators, in order to understand the quality of services offered to service users across the wider area of Oxfordshire and beyond.

The Maternity services provided by OUH are recognised nationally as delivering safe care with good outcomes for mothers and their babies. The Maternity services are rated "Good" by the CQC (2017) and a recent CQC maternity survey (2018) reported "Labour and delivery care" as "Better than most trusts".

OUH was one of the few trusts in the UK to be declared 100% compliant in all 10 safety action plans of the NHSLA National Maternity Incentive Scheme introduced at the beginning of 2018. The Trust has, as required submitted its declaration for 2019; this provides evidence that the 10 safety standards have been met and the final outcome will be confirmed by the NHSLA in October 2019.

Outcomes have continued to improve over the last 3 years. The Trust reports marked improvement in rates in the serious outcome measures for maternity including from 2014-2018.

- Still birth and perinatal death at term
- Significant brain damage to term babies.
- Unexpected admissions of term babies to special care units.

The improvement in outcomes has been achieved by ensuring as many women as possible are seen early in their pregnancy. Women have an extensive clinical risk

assessment away from the hospital by the community midwives and the GPs. The community midwife then coordinates the appropriate care and ensures low risk women have access to quality antenatal care (including regular clinical review, scans and on-going risk assessment the majority of which takes place in settings across the county). This includes new screening programmes and a choice to deliver in midwife-led settings. Those women who are identified as having increased risks or complex pregnancies are seen in the appropriate obstetric or specialist clinics (which are run at both the John Radcliffe Hospital and Horton General Hospital). This is in line with the Better Births Agenda and with the relevant NICE guidelines.

The Long Term Plan builds on the momentum from the Better Births and National Maternity Transformation Programme and continues to focus on improving the outcomes mentioned above as well as improving the quality of service provided throughout the whole maternity pathway for women. The Oxfordshire Local Maternity System is focussed on delivering key aspects of the transformation agenda including improving continuity of carer, digitalising personalised care plans and promoting the voice of service users through the recently established Oxfordshire Maternity Voices Partnership (a patient feedback forum run by women who have recently experienced maternity care in Oxfordshire). A new Perinatal Mental Health Service has been commissioned by OCCG and is provided by Oxford Health NHS Foundation Trust. Work is ongoing to embed this new service across Oxfordshire to support women from preconception through to one year postnatal.

4.2 A fresh look at the service model options

4.2.1 Outcome of Option appraisal

The work undertaken to deliver the agreed plan involved agreeing a long list of options. The full long list included 14 options, of which 3 were discarded (in agreement with the Horton Joint HOSC and stakeholders). The remaining options (in the end 12 options were reviewed as Ob2a 2 units with fixed consultants had a variant-option) were reviewed and scored by the scoring panel, consisting of three stakeholder representatives (Chairman of the Community Partnership Network and the Co-Chair of Maternity Voices Partnership. A representative from Keep the Horton General participated in the scoring panel discussion but did not submit individual scores), four clinical representatives from OUH (Chief Medical Officer, Clinical Director for Maternity, Director of Midwifery and Senior Midwife) and three members of the CCG (Deputy Locality Clinical Director for North Oxfordshire, Director of Governance and Head of Children's Commissioning) Once the criteria weightings (which were developed through involvement of all stakeholders who attended the first Stakeholder Workshop on 22 February 2019) were applied this thorough process resulted in two options scoring very closely and significantly higher than any of the other options.

The two options with highest scores were:

1. Ob9: 2 obstetric units, one at the John Radcliffe Hospital and one at the Horton General Hospital, both with an alongside MLU. This includes a hybrid rota (24 hour cover provided by middle grades and resident consultants) medical staffing model at the Horton Obstetric Unit. Total weighted score 243.70
2. Ob6: Single obstetric service at John Radcliffe Hospital (with MLU at the Horton). Total weighted score 243.59

Whilst the two favoured options are near equal on total weighted score, the two unit option scored more highly on patient and carer experience; access; patient choice and consultant hours on the labour ward. On the other hand the single unit option scored more highly on deliverability and sustainability; cost and providing a stronger platform for delivering on the national strategies (this is shown in Table 5 below). This highlights that there are several competing factors to balance when making decisions about service options.

It is important to note that this process included testing whether other potential options exist that could prove to be an alternative viable option for re-introducing obstetrics to the Horton General Hospital. These possible options were explored, described and scored; stakeholder feedback was that whilst none of these options scored highly, including these options had been a valuable exercise. None of the alternative options scored as high as the two above. In particular the lowest scoring model was Ob1: the 2016 model (resident medical cover provided by 9 Trust appointed middle grade doctors) that the OUH was trying to recruit to when the temporary closure occurred.

Table 5: The scores agreed by the Scoring Panel for the top two options

	Ob6: Single obstetric service at JRH	Ob9: 2 obstetric units both with alongside MLU
1. Clinical outcomes	2.00	2.00
2. Clinical effectiveness and safety	3.00	3.00
3. Patient and carer experience	2.00	4.00
4. Distance and time to access service	2.00	4.00
5. Service operating hours	3.00	2.00
6. Patient choice	2.00	3.00
7. Delivery within the current financial envelope	3.00	2.00
8. Rota sustainability	3.00	1.00
9. Consultant hours on the labour ward	2.00	3.00
10. Recruitment and retention	2.00	2.00
11. Supporting early risk assessment	2.00	2.00
12. Ease of delivery	2.00	1.00
13. Alignment with other strategies	4.00	2.00

4.2.2 Working up the two highest scoring options

It was agreed with the Horton Joint HOSC that these two options should be worked up in more detail to provide further information to inform the Board's decision. In doing this we have also recognised that some of the other options (for example, Ob11 Horton has regained accreditation for training and Ob10 doctors in training at the John Radcliffe Hospital spend 8 hours a week at the Horton unit) provide additional scope for widening the pool of doctors available to fill the posts.

The Trust has undertaken a thorough review of the two options and the paper attached as Appendix 2 has been agreed by the Trust Board. This covers what needs to be done to address the lower scoring criteria for each option. The overview for each of the two options in this section is developed from the work undertaken to deliver the agreed plan and the additional detail provided by the OUH in Appendix 2. The criteria used in the option appraisal were grouped into five categories: quality, access (including choice), finance, workforce and deliverability and the two options are presented under these headings.

A Option Ob6: Single Obstetric Unit at the John Radcliffe Hospital

A1 Description of model

This option assumes there would be a single obstetric unit based at the John Radcliffe Hospital (the same service that has been running on a temporary basis since October 2016 and an MLU at the Horton General Hospital.

The staffing at the obstetric unit at the John Radcliffe Hospital 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 the John Radcliffe Hospital. The MLU at the Horton General Hospital would be developed to offer a wider range of services as a "maternity hub" which would be supported by having midwifery staffing on-site 24/7 and retention of the on-site ambulance dedicated to maternity services.

A2 Quality (safety, clinical outcomes and patient experience)

The work undertaken indicated that this option, whilst delivering safe and effective services (both options scored the same for clinical outcomes and clinical effectiveness and patient safety based on being fully staffed) with good outcomes, it has impacted the experience of women and their partners in the Horton catchment area. This option has been running on a temporary basis since October 2016 and has demonstrated that it provides safe, effective services for all women and babies. There has been a continued improvement in outcomes and in particular a reduction in the most serious negative outcomes. However, this option has a negative impact on patient experience for those women and their partners from the Horton catchment area. This was heard clearly in the presentations made by individual women to the Horton Joint HOSC in December 2019 and in the survey undertaken as part of this work.

The full survey report is available here and a small extract is included in Appendix 3. The summary of the patient journey on page 1 of Appendix 3 gives a candid view of the single obstetric unit option and the impact on experience. Page 2 summarises the experience of antenatal service which indicates that the antenatal care being provided under this model scores well and that Cherwell residents are more satisfied with all aspects of antenatal care than service users as a whole. Conversely the majority of respondents from Cherwell and South Northamptonshire agreed or strongly agreed with almost all the positive statements about OUH maternity services – with the exception of three elements of post-natal care: ease of people travelling to visit; ability of children to come and visit; and ease of parking for visitors which is shown on page 3 of Appendix 3.

A3 Access including choice

The information this section is derived from our work on Travel and Access as part of work stream 5 and a more detailed paper is available here.

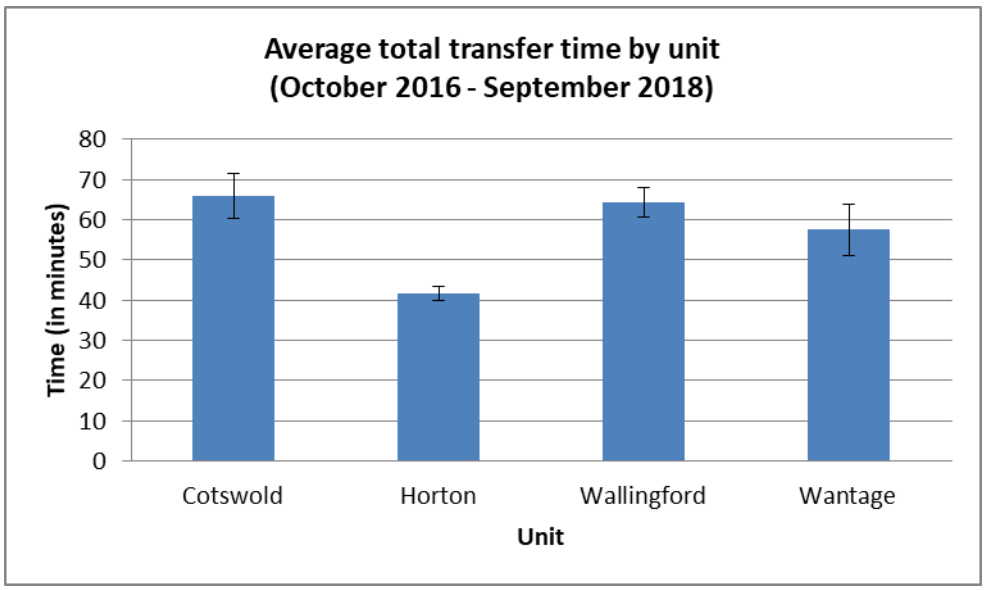
It is clear from the travel analysis that was undertaken as part of the original consultation process and the additional information from the survey that increased travel time, and in particular its variability, has a negative impact on those women who would have chosen to use the Horton obstetric service. With an obstetric unit at the Horton General Hospital the majority of the catchment areas could access an obstetric service within 30 minutes but without the service at the Horton this increases to up to 50 minutes (average car journey time). There are other areas of Oxfordshire (parts of West Oxfordshire, South Oxfordshire and Vale of the White Horse district council areas) that have similar access issues which would not be improved by having the service at the Horton General Hospital.

Our review of two years data about total transfer times (this includes the time waiting for the ambulance to arrive) from the Oxfordshire MLUs to the obstetric unit at the John Radcliffe Hospital is summarised below. Table 6 contains the mean, median and interquartile range and the mean transfer times are then shown in the graph in diagram 5 below.

Table 6: Transfer times from MLUs to John Radcliffe Hospital from October 2016 to September 2018

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

Diagram 5: Average total transfer time from each MLU to obstetric services



The MLU at the Horton General Hospital has the lowest average total transfer time (42 minutes) given the shorter time women wait for an ambulance. From the data we have there is nothing to indicate that the increased travel distance and time (for women and their families to travel to services) and transfer times (the time taken for an ambulance transfer from an MLU to an obstetric service) is unsafe or has been linked to adverse outcomes for a mother or her baby. Comparison of median transfer times from the Oxfordshire MLUs to the John Radcliffe obstetric service is in line with the national findings of the Birthplace Study.[4]

The comprehensive survey undertaken indicated that the women and their partners using services value the support and care from clinical staff and highlighted many positive aspects about the services. For example the survey indicated that there was a net positive response to questions on choice (this included questions on: Level of choice of where to give birth; Support received to choose; On reflection the choice made) both at total population level and when broken down by District Council Area. In the Horton catchment area the net positive response to questions on choice was lower (and was negative for residents of south Northamptonshire) than for other areas of the county; this is included on page 4 of the extract from the survey that is in Appendix 2.

Some of this impact on experience can be mitigated through the Trusts' proposals to increase ante and postnatal services at the Horton especially the maternity assessment service. The Trust has indicated that the following will be put in place to mitigate the impacts on the women and their families affected by the closure of the Horton obstetric unit. These mitigating actions suggested by the Trust seek to specifically address some of the lower scoring points raised in the survey.

[4] The Birthplace cohort study: Key findings found at here

- An expansion of services available at the Horton MLU to create a maternity hub which would include:
    - An expanded maternity assessment unit (MAU) to include reduced fetal movement assessments and early labour assessments, allowing between 5-10 women per day to be reviewed closer to home. The dedicated ambulance would also cover transfers from the MAU if required.
    - Refurbishing the second floor of the current unit to open more specialist ante-natal and post-natal outpatient clinics, including an expansion of the mental health clinics; the new diabetes clinic; and, possibly (subject to clinical appropriateness) a pre-term labour clinic.
    - Expanding telemedicine between the Horton and the John Radcliffe, with new equipment to allow consultants to remotely review monitoring of fetal wellbeing.
- In addition to ongoing work to address travel and parking issues at the John Radcliffe site, look to set up a dedicated hotline for women in labour and their families to navigate the site and use priority parking in an emergency.
- Increased facilities for partners to stay overnight at the John Radcliffe Hospital
- Complete recruitment to the new case loading team for vulnerable women which will provide service across the county focused on areas of need.
- Better information for women on the choice of options available, including joint working and strengthening links with South Warwickshire Foundation Trust to ensure that is an attractive option.

In line with national policy under both options the maternity services available to the Oxfordshire, south Northamptonshire and Warwickshire population offer all four choices for place of birth; home, freestanding MLU, alongside MLU or obstetric unit.

A4 Cost

The Trust has modelled the costs of the two options based on the staffing models. A summary of this is included in this paper and a more detailed analysis is in Appendix 4. The CCG agreed with the Trust that the current year (2019/20) represents Ob6 the single obstetric unit and the costs for this are £37,492,609 (more detail is given in table 8 below and in Appendix 3).

Capital investment; whatever decision is made the Trust has indicated that the current facilities at the Horton General Hospital need to have significant capital investment as the building does not meet current standards. Investment and redesign of the facilities would take time but could contribute to recruitment.

A5 Workforce

The service currently being delivered to the population (single obstetric unit) has demonstrated that it can be safely and sustainably staffed and maximises use of the scarce skills and experience of the staff. The retention rate of midwives has improved and the OUH has been able to successfully recruit into vacancies and shift fill rates are enabling the Trust to maintain all four choices for place of birth.

A6 Deliverability

Since October 2016 the Trust has shown it can deliver Ob6, the single obstetric service at the John Radcliffe Hospital, that it is safe, of high quality and meets the needs of the population and has provided a good foundation to improve outcomes and deliver the national policy agenda to continue to reduce adverse outcomes.

B Option Ob9 Two obstetric units with alongside MLUs (hybrid medical staffing model for Horton unit)

B1 Description of model

This model assumes there are two separate obstetric services; one at the John Radcliffe Hospital and one at the Horton General Hospital (both with an alongside MLU) with separate staffing arrangements including separate doctor rotas at both sites. The service at the Horton unit would be delivered by a hybrid rota of middle grade doctors and consultants providing the 24/7 presence on site. The service at the John Radcliffe unit would be delivered, as now, by doctors in training and consultants.

B2 Quality (safety, clinical outcomes and patient experience)

Both options scored the same for clinical outcomes and clinical effectiveness and patient safety based on being fully staffed. This option scored better on patient experience, particularly for women in the catchment area of the Horton General Hospital.

B3 Access including patient choice

With an obstetric unit at the Horton General Hospital the majority of the catchment areas could access service within 30 minutes but without the service at the Horton this increases to up to 50 minutes (average car journey time). Opening an obstetric unit at the Horton gives an additional location for choice of an obstetric birth and an AMLU which increases access for the catchment area in the north of the county and south Warwickshire and south Northamptonshire. It does not increase access for the rest of the county.

B4 Cost

This work has been undertaken considering the service provided by the Trust and based on the staffing required to open a second unit. The CCG agreed with the Trust that the current year (2019/20) represents Ob6 the single obstetric unit and then for Ob9 the 2 unit option the forecast outturn for births 2019/20 are split in the same ratio between the two units as occurred in 2015/16. A summary of this is included in this paper and a more detailed analysis is in Appendix 4.

Table 7: Births at the Oxford University Hospitals NHS Trust

Births occuring at OUH	2015/16	2019/20 forecast - Ob6 single obstetric unit at JR	Ob9 2 units*
Horton	1,411	160	1,060
John Radcliffe	6,394	6,900	6,000
Other	534	440	440
TOTAL	8,339	7,500	7,500

* This is assuming 2019/20 number of births split between places of birth as per 2015/16.

Table 8: Costs of providing the two options

	2019/20 forecast Ob6 Single obstetric unit at JR	Ob9 2 units	Change to costs between 2019/20 forecast and second Obstetric unit
Horton	2,006,968	9,463,357	7,456,390
John Radcliffe	35,485,641	32,623,566	- 2,862,075
Other - excluded as no inpatient services			-
TOTAL COST	37,492,609	42,086,924	4,594,315

The main drivers of increased cost between the one and two unit options are summarised in Table 9 below. As can be seen the main elements of the increased cost are the additional obstetric staff required and the requirement co-location of a dedicated anaesthetic rota and a neonatal service.

Table 9: Drivers of cost differences between the two options:

Cost split	2019/20 forecast Ob6 Single obstetric unit at JR	Ob9 2 units	Change to costs between 2019/20 forecast and second Obstetric unit	Notes
Consultants	2,178,141	3,839,531	1,661,390	Additional posts required for second Obstetric unit 6WTE
Non consultant medical	2,022,920	3,466,220	1,443,300	Additional posts required for second Obstetric 24/7 rota 17WTE
Anaesthetics	-	430,000	430,000	Additional posts required for second Obstetric 24/7 rota 9WTE
Midwives and MSWs	7,636,420	8,107,434	471,014	Additional posts required for second Obstetric 24/7 rota, including reductions at the JR site 35TWE
Neonatal nurses	-	652,000	652,000	Additional posts required for additional SCBU, no reductions on JR site 12WTE
Other staff	1,908,590	2,067,789	159,199	Includes additional A&C posts to support additional consultant posts
TOTAL PAY	**13,746,071**	**18,562,975**	**4,816,904**	
Ambulance	360,449	-	- 360,449	Horton based ambulance not required for second Obstetric unit
Other Non Pay	2,044,660	2,182,520	137,860	Additional non pay expenditure for second Obstetric unit for equipment and other non variable costs
TOTAL NON PAY	**2,405,109**	**2,182,520**	**- 222,589**	
Indirect costs	4,323,385	4,323,385		No change to indirect costs
CNST - Maternity and Maternity incentive element	12,263,715	12,263,715	-	No change to CNST premium
Depreciation and Amortisation	992,465	992,465	-	No change to depreciation and amortisation - assumed no additional capital works
Other overheads	3,761,864	3,761,864	-	No change to overheads
TOTAL OVERHEADS	21,341,429	21,341,429	-	
TOTAL COST	**37,492,609**	**42,086,924**	**4,594,315**	

Capital investment; whatever decision is made the Trust has indicated that the current facilities at the Horton General Hospital need to have significant capital investment as the building does not meet current standards. Investment and redesign of the facilities would take time but could contribute to recruitment.

B5 Workforce

The OUH was asked to consider what would be required to implement this option and consider how it could be delivered.

- Obstetric workforce; the Trust would need to recruit up to an additional 9 obstetricians (3 middle grade and 6 consultants) in an area that has significant workforce shortages so this would require time (18 months to 2 years) to have a fully staffed rota and a significant amount of staff time (HR and the service) committed to it on an ongoing basis. An additional 5 junior doctors would be required to enable a rota of 8 (there are currently 3 junior doctors available for the Horton Unit via the GP Vocational Training Scheme). This would need them to undertake the following
    - Appointment of dedicated clinical leads for the Horton unit
    - Adopting a hybrid rota in which consultants participate in the middle grade rota
    - Establishing dedicated international recruitment streams, taking up some of the national schemes that have been piloted elsewhere and setting up local rotation schemes
- The OUH would seek training accreditation for the unit which would increase the routes for recruitment (in both Macclesfield and Barrow-in-Furness the hybrid rotas included 2 Specialist Trainees in the middle grade numbers) but would not provide all the staff required.
- Midwifery workforce – 46 WTE would be required to open the unit (for births numbers up to 1,500); of this 11 would transfer from the John Radcliffe Unit (on the basis that there would be a reduction in the numbers of births occurring here) but that still requires recruitment of an additional 35 staff
- Recruitment of additional neonatal nurses to staff the required second SCBU would also be challenging. Overall there is a shortage of neonatal nurses and there are vacancies at the John Radcliffe unit so it would be extremely challenging to recruit the additional 12 nurses required.
- There is a current national shortage of Anaesthetists. OUH also experiences these workforce challenges, with gaps in the rota which are difficult to fill on a sustainable basis. If organised on the same basis as previously, require 2-3 WTE additional consultants would be required at the Horton. The Trust would want to examine if there are any ways to deploy innovative workforce models to achieve the standards with a different staff mix, given the overall shortages of Anaesthetists, locally and nationally.

The Trust view is that even with a significant investment of time to support increased recruitment activity and a range of options to source staff they remain concerned about the sustainability of the rota and thus the safety of the service in this option.

B6 Deliverability

There are risks to being able to deliver all that is required to safely and sustainably open a second unit and this could not be achieved quickly. These are particularly related to factors that are not wholly within the control of the local health system such as the availability of workforce and significant capital investment. As highlighted in the workforce section the Trust remains concerned that the rota would not be sustainable and that this would provide difficulties in delivering a safe service.

4.2.3 Learning from other small units

The Project team looked at how NHS Trusts across the country manage the challenge of safe obstetric care in units with small numbers of births. The aim was 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. The criteria adopted for selecting units to approach was:

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

Thirteen hospitals across the country were contacted and information gathered about the size of the unit, their staffing model and training accreditation. In addition, the local campaign group, Keep the Horton General, did a similar piece of work and shared this with OCCG and the Horton Joint HOSC.

Of the thirteen hospitals contacted the future is uncertain for four. Two important differences between OUH and many of the other trusts were highlighted through this work. The first related to training accreditation – many of the small units have maintained their training accreditation. The second related to the difference in scale between the John Radcliffe Hospital and the Horton General Hospital. Most of the other small hospitals were either stand alone or paired with another hospital of similar size.

Representatives from OUH and OCCG visited Barrow-in-Furness and Macclesfield. The purpose of these visits was to be able to see how these units ran, to discuss operational delivery with clinical staff and to see what learning could be used locally. It must always be remembered that each unit has its own local circumstances that have contributed to the development of services in the area which may mean some aspects are not directly translatable to the Oxfordshire system. For example Furness hospital meets the NHS criteria to be defined as of a remote unit (over 10% of the population served must be more than 60 minutes from the second closest provider; for Furness hospital 61% of its population is more than 60 minutes from the next closest hospital putting it as fourth most remote hospital); the CCG allocation formula includes an adjustment for unavoidably small hospital provision in remote areas. In addition there has been significant investment in new facilities and additional revenue investment to support it.

These visits confirmed that the model we are looking at for a second obstetric unit at the Horton is the right one. Both the Macclesfield and Barrow-in-Furness units use hybrid models with some consultants taking part in the resident on-call middle grade rota. Both units had seven middle grade posts (of which two were doctors in training) and the rest were Trust appointments most of whom had been working there for many years. Consultants were also included in the middle-grade resident on-call rota so both units were running hybrid rotas as we have also described. Both units had experienced difficulties in recruiting to middle grade vacancies that had occurred recently. Another important point for medical staffing at both these units was the presence of another (SHO level) tier of resident doctors who were able to support the middle grade doctors if, for example, there was a need to perform an emergency caesarean section out-of-hours; this is also built into the medical staffing models proposed for Ob9.

As part of the exploration into staffing small obstetric units we attended the RCOG Nuffield Trust Workshop in July 2019. This was a national meeting with representatives from at least 20 units from across the United Kingdom. OUH presented the incentives that had been introduced to aid the recruitment of trust grade doctors which were well received by the group.

5. Discussion

It is clear from all the work undertaken that an obstetric unit with an alongside MLU would be an ideal option for people living in the Horton catchment area in a system with unlimited resources (workforce and finance). The Board will need to consider the balance of the various factors; the criteria used in the option appraisal were grouped into five categories: quality, access (including choice), finance, workforce and deliverability.

In considering the options it is necessary to bear in mind that the birth (and place of birth) is only part of the pathway. In terms of improving outcomes for women and their babies' factors such as increasing support earlier in pregnancy, risk assessment, targeting input and maximising antenatal and postnatal care closer to home are also very important.

The IRP indicated that "Whatever option eventually emerges, it should demonstrate that it is the most desirable for maternity services across Oxfordshire and all those who will need them in the future." This must be borne in mind when comparing the various factors as, at the time of temporary closure the Horton accounted for 17% of OUH births (1,411 of 8,339) and 15% (1,029 of 7,007) of the births for Oxfordshire CCG residents. For the main catchment area of the Horton General Hospital unit (practices in and around Banbury in north Oxfordshire, the practice in Chipping Norton and practices in Brackley and Byfield in south Northamptonshire) 72% (958 of 1,324) births took place at the Horton obstetric unit.

Overall, Oxfordshire receives one of the lowest allocations per 1,000 head of population in England at £1,535 (2019/20), 12.4% less than the national average allocation. Furthermore, the amount allocated to Oxfordshire is 1.19% less than the target allocation resulting in a reduction of funding of £13.7m. The needs assessments which determine the allocations imply that the healthier population of Oxfordshire will require 12.4% (based on actual allocation) less treatment than the

national average - i.e. activity needs to be 12.4% less than the national average levels.

It is clear that there is a significant cost implication (£4.6m) to the Oxfordshire health system in running a second obstetric unit. If a second unit were to be supported this resource would need to be prioritised from any increase in OCCG's allocation or from reductions in funding in other service areas. In maternity services this would reduce the ability to support the wider pathway and impact on all women using the service. If additional investment is made in maternity services this either reduces investment opportunities or overall investment in other service areas which impacts on the whole Oxfordshire population. Given pressure on resources it is not clear that this level of increased cost in maternity services would be a high priority in order to increase access for some the population.

The work undertaken looking at the projected number of births and modelling two different scenarios for the impact of housing growth gives ranges for increasing the number of births that might take place at a second obstetric unit based at the Horton General Hospital. All modelling work has assumed no fall of birth rate even though we have seen a drop of just over 10% since 2012. This would indicate that the model that includes a birth rate of 48 births per 1,000 new homes is unlikely to be realistic. Having a larger number of births taking place at a second unit does increase the viability of the unit and reduce the excess costs associated with it. However the modelling has indicated that the assumptions required to get to a level of 2,000 births by 2030/31 requires at least the birth rate to remain the same and for there to be a significant shift in women from the wider catchment area choosing the Horton unit or for there to be a doubling in the birth rate for residents of all planned new housing.

The workforce challenges continue to blight the ability of OUH to support the expansion of clinician numbers required to support a further obstetric unit at the Horton General Hospital. OUH's current experience of workforce challenges mean they continue to raise concerns about sustainability of such a service and therefore the potential clinical risk.

Linked to recruitment and retention is the state of the current Horton General Hospital buildings. It is important to note that many of the Horton buildings are old and need significant capital investment if the hospital is to be fit for the future. It is widely believed by commissioners, the provider and stakeholders that a new build or a significant upgrade is not only long overdue but necessary, regardless of the option outcome. OUH are clear that buildings that are fit for purpose can enhance recruitment and retention of staff; future builds with flexible clinical areas will allow for changes in services to match local needs, in line with our planning framework.

6. Recommendations

The Board is therefore asked to:

1. **Agree** that it is assured the work plan presented to the Horton Joint HOSC to cover all IRP requirements has had ongoing oversight through presentation of the work back to the HOSC and that the plan has been delivered and the Board has received the information required to support decision making.

2. **Confirm** the decision made in August 2017 to create a single specialist obstetric unit for Oxfordshire (and its neighbouring areas) at the John Radcliffe Hospital and establish a Midwife Led Unit (MLU) at the Horton General Hospital, for the foreseeable future.

3. **Note** that the decision is for the 'foreseeable future' rather than a statement of permanency. This is because we now have a framework, agreed by the Oxfordshire Health and Wellbeing Board, that states an ongoing commitment by the CCG and all health & care partners to regularly review population health and care needs and change services as appropriate to meet that need, all co-produced with local stakeholders. This approach will ensure that if population or other factors change significantly then the need for obstetric services can be reviewed.
4. **Agree** to work with OUH on an implementation plan to improve mothers' and partners' experience and enhance access to maternity services (particularly for the population in the Horton catchment area) by introducing:

    a. A dedicated hotline for women in labour and their families to navigate the site and use priority parking in an emergency. This is in addition to current work to address travel and parking issues at the John Radcliffe Hospital site.
    b. An expansion of services available at the Horton MLU or virtually to enable women to receive most of their maternity care closer to home; and increased facilities for birth partners to stay overnight at the John Radcliffe Hospital.
    c. Better information for women on the choice of options available, including joint working and strengthening links with South Warwickshire Foundation Trust to ensure Warwick Hospital is an attractive option.

5. **Note** that it is important for women, their families and healthcare staff that we finalise and implement this decision to remove uncertainty and enable us to plan for the future of Horton General Hospital and actively pursue the opportunity of capital investment.

6. **Agree** to work closely with the OUH and local stakeholders to further develop the masterplan for the Horton General Hospital, ensuring it includes high

quality, flexible clinical space that could be used for different services over time, including obstetric services if circumstances demand.

7. **Agree** to actively pursue with OUH the need for significant capital investment in the Horton Hospital, in clear recognition that this can improve recruitment and ensures the site is fit for its future as a thriving 21st century hospital for the whole of North Oxfordshire and beyond.

Index of Appendices (available as separate documents)

Appendix 1: 2019.09 Letter from Clinical Senate to NHS England

Appendix 2: Oxford University Hospitals NHS Trust view on what is required to deliver the two highest scoring options

Appendix 3: Extract from Pragma Voice of the Service User

Appendix 4: Costing Information for the two options

Thames Valley Clinical Senate

David Radbourne
Director of Strategy and Transformation
NHS England & Improvement, South East

Via email

NHS England South Central
Jubilee House
5510 John Smith Drive
Oxford Business Park
Oxford, OX4 2LH

9th September 2019

Dear David,

Oxfordshire Transformation Plans – Maternity

At its last Council meeting on 18 June 2019, the Thames Valley Clinical Senate received a presentation from Catherine Mountford, Director of Governance at Oxfordshire Clinical Commissioning Group (OCCG) providing an update on OCCG's Transformation Plans for Maternity Services across Oxfordshire. This follows from the early review of the phase 1 of OCCG's Transformation Plans that the Senate had undertaken with an outcome report published in November 2016. This report contained a number of recommendations in relation to maternity services.

Subsequently, following NHSE Stage 2 assurance of the plans and a three-month period of public consultation, OCCG made a decision in August 2017 to close permanently the maternity unit at the Horton Hospital. The Oxfordshire Health Overview and Scrutiny Committee (HOSC) referred OCCG's decision to the Secretary of State who asked the Independent Review Panel (IRP) for advice. In its report published in February 2018, the IRP recommended that, before the CCG implemented its decision, OCCG should carry out a more detailed appraisal of the options in particular factoring in population growth in the wider catchment area and then reviewing available options with stakeholders.

OCCG also needed to:

- address any outstanding issues from the Senate early review,
- learn from the experiences of mothers, families and staff who had been affected during the time of the temporary closure,
- review and confirm staffing models for midwife-led units,
- review interdependencies with other services, and
- work closely with the HOSC.

A joint HOSC 'Horton HOSC' was set up between Oxfordshire, Warwickshire and Northamptonshire. The Senate Council was told that OCCG had been reporting to the Horton HOSC as they worked through the review of the plans and their implementation.

The Council also heard that OCCG had now completed a detailed review of staffing models, including considerations of the potential future birth rate of Oxford and the wider catchment area. There had also been a detailed mother-and-partner survey inviting individuals who had given birth between

October 2016 and September 2018 to take part. In addition, OCCG had organised a stakeholder event in February 2019.

A further stakeholder workshop had taken place on Friday 14 June 2019, where OCCG provided all attendees with an information pack. This information pack was shared with the Council for reference. It included the different options available for maternity services and for the Horton site in particular. Each option was scored and weighted at the workshop. The Council was told that two distinct options scored the highest on the day. Catherine Mountford informed the Council that OCCG's next steps would be to consider which options would be presented to the Horton HOSC in July, with the aim for a decision to be made by the OCCG Board in September.

On the basis of the information shared with the Senate Council, the Council felt that OCCG had addressed the recommendations made by the Senate Council in November 2016 and subsequently those made by the IRP in February 2018. The Senate considered that OCCG had worked closely with and reported regularly to the Horton HOSC and, therefore, there had already been continuous scrutiny and assurance both of the process and of the transformation plans themselves. The Senate Council suggested that it could provide further review of the two options that had scored the highest by considering the feasibility of each implementation plan or reviewing the weighting used in the scoring methodology. Another option, should OCCG wish for further assurance, would be to refer their plans to a different senate within a similar geography and obtain their views.

I hope that this summary is helpful to NHS England and NHS Improvement, and OCCG in progressing the local transformation plans for maternity services.

Yours sincerely,

Dr Jane Barrett, Senate Chair
Thames Valley Clinical Senate

Oxford University Hospitals
NHS Foundation Trust

Obstetrics services in Oxfordshire: Oxford University Hospitals overview of what it would take to deliver the two highest scoring models from the options appraisal.

Introduction and Executive Summary

1. Over the last year, Oxford University Hospitals (OUH) has worked closely to support the Oxfordshire Clinical Commissioning Group (OCCG)'s process to look again at options for obstetrics in Oxfordshire, following the recommendations of the Independent Reconfiguration Panel. In the options appraisal undertaken as part of this process, two models were scored most highly by the stakeholder panel:
   - Option Ob9: Two Obstetric Units both with alongside Midwife-Led Unit (MLU)
   - Option Ob6: Single Obstetric Unit at the John Radcliffe Hospital

2. Both these models have different strengths and weaknesses. OCCG has asked OUH to set out its views on what it would take to deliver each of the two models, including addressing the issues identified during the options appraisal. This paper sets out those views.

3. Two Obstetric Units, both with alongside MLUs, should provide greater patient choice and improve patient experience of maternity services for women in the Horton catchment area. In an ideal world, without workforce or financial constraints, this model would be very attractive. However, in reality, it is very difficult to implement. To deliver it safely and sustainably would require a new approach to workforce, untested in the medium to long-term; additional revenue and capital funding; and substantial support from other organisations. The Trust does not have sufficient evidence to be sure if the new approach to workforce would overcome ongoing and severe recruitment and retention challenges, particularly in relation to obstetric doctors, nor if the necessary external support would be forthcoming. For this reason, OUH cannot fully mitigate risks to rota sustainability – and our Board, clinicians and managers remain highly concerned about the risks to patient safety as a result of rota gaps; and the Trust's ability to ensure a safe, quality service in the short, medium and long-term under this model.

4. The model of a Single Obstetric Unit at the John Radcliffe has been temporarily in place since 2016 and has been proven to provide a safe, quality service, with improving outcomes and positive overall feedback from patients (including in North Oxfordshire, South Northamptonshire and South Warwickshire). But there has been a detrimental impact on patient choice and experience for some women in the Horton catchment area in using maternity services, particularly vulnerable women, due to the increased distance to travel to access obstetric services at the John Radcliffe. Delivering this model, whilst addressing the issues identified, would require: more joined-up, tailored information on choice for women in the Horton catchment area; improved patient and visitor access to the John Radcliffe site; expansion of the MLU into a 'maternity hub' providing a wider range of ante-natal and post-natal care (including for vulnerable women); and building in flexibility

to respond to long-term population changes. However, the suggested actions can never fully mitigate the need for women living in North Oxfordshire, South Warwickshire and South Northamptonshire who want an obstetric-led birth to travel further and longer to do so, nor the risk this may negatively impact on some of their experiences of maternity care.

5. Once the OCCG Board has made its decision, the Trust stands ready to work together on implementation – including the production of any relevant business cases and quality impact assessments required under the selected model. When there is greater certainty over the future model for obstetrics, whichever model is selected, OUH is keen to press ahead with developing its wider vision for the Horton as a thriving 21st century district general hospital for North Oxfordshire and beyond, including submitting a business case for significant investment to develop the site.

6. This paper will now examine what it would take to deliver each of the options in turn.

Option Ob9: Two Obstetric Units both with alongside MLU

7. Compared to a single obstetric unit at the John Radcliffe, the stakeholder panel scored this option:
   - more highly than the single obstetric unit on 'patient and carer experience'; 'distance and time to access service'; 'patient choice'; 'consultant hours on the labour ward';
   - the same on 'clinical outcomes' and 'clinical effectiveness and safety' (assuming workforce challenges are overcome); 'recruitment and retention'; and 'supporting early risk assessment';
   - less well on 'service operating hours'; 'delivery within the current financial envelope'; and 'ease of delivery'; and
   - significantly less well on 'rota sustainability' and 'alignment with other strategies'.

Areas of strength

8. Oxford University Hospitals view is that 2 obstetric units with alongside MLUs would be an ideal option for people living in the Horton catchment area, in a system with unlimited resources and no workforce shortages. Whilst the choice of an Obstetric Unit with alongside Midwife-Led Unit is available at both the John Radcliffe (23 miles from the Horton General) and Warwick Hospital (22 miles from the Horton General Hospital), this model would widen the number of places where this choice is available and reduce the distance and travel time to access obstetric services for women in North Oxfordshire, South Northamptonshire and South Warwickshire.

9. The patient survey conducted by OCCG suggests that this option would reduce the increased anxiety around the choice of birth location currently experienced by women in North Oxfordshire and South Northamptonshire. It should also mitigate some of the difficult experiences reported by women and their families when accessing obstetric

services at the John Radcliffe – whilst these are a small proportion of overall births at OUH and we cannot comment on the individual cases, it still very important to the Trust to address the issues these experiences raise. The Trust is grateful to the women and their families who shared their stories.

10. This model would be likely to improve patient experience and choice for some women in the Horton catchment area. According to the patient survey, 24% of women surveyed would choose Banbury as their ideal location to give birth (74% of Cherwell respondents and 97% of South Northamptonshire respondents). When reflecting on their experience, 75% of women surveyed who live 'far' from an obstetric unit would have chosen the same place to give birth, versus 84% of those who live 'near' to an obstetric unit. (Although, it should be noted that, even if there was an obstetric unit with alongside MLU at the Horton General Hospital, some of these women may still choose to give birth elsewhere and some would still need to give birth at a specialist centre.) Local councillors, community groups and campaign organisations in North Oxfordshire, South Warwickshire and South Northamptonshire feel very strongly that obstetrics services should be available at the Horton.

Overcoming challenges and mitigating risks

11. This section sets out what it would take for Oxford University Hospitals to overcome the risks and challenges identified by the scoring panel on sustainability, affordability and alignment with other strategies.

A. <u>Rota sustainability</u>

Workforce challenges across the NHS and at OUH

12. Across the NHS, there are severe workforce shortages. In 2018, the Kings Fund, Nuffield Trust and Health Foundation published a joint briefing that highlighted:
    - There are over 100,000 vacancies across NHS Trusts (1 in 11 posts). The greatest challenge is in nursing and midwifery with 36,000 vacancies (1 in 8 posts).
    - Based on current trends, they project that the gap between staff needed and the number available could reach 250,000 by 2030. If the emerging trends of staff leaving the workforce early continues and the pipeline of newly trained staff and international recruits does not rise sufficiently, the worst case scenario is a gap of more than 350,000 by 2030.
    - International recruitment can be a useful short-term initiative but is not a long-term solution and global competition for trained healthcare staff is high. The World Health Organisation looked at demand across 31 of its member countries and projected that by 2030, all countries could experience shortfalls of 50,000 midwives, 1.1m nurses and 750,000 doctors.

According to the Royal College of Midwives, as of summer 2019, the NHS in England is short of the equivalent of 2,500 full time midwives.

13. Oxford University Hospitals suffers from these workforce challenges alongside the rest of the NHS. These difficulties are exacerbated by the high cost of living compared to other areas of the country, coupled with a national pay scale. OUH also operates in a highly competitive job market: unemployment in Oxfordshire (including in Banbury) is low and there are relatively good transport links (to London, Birmingham and elsewhere) from both the North and the South of the County which opens up a wider jobs market. London Trusts are able to offer London weighting which is not available for staff in Oxfordshire. Some Trusts within commuting distance of Oxford and Banbury are able to offer outer–London weighting which OUH is not funded to do. OUH is very reliant on international staff – around 1 in 8 of our workforce are EU citizens, rising to 1 in 5 nurses – and is therefore vulnerable to uncertainties created by Brexit.

14. In summer 2019, the OUH vacancy rate is 1,250 – around 10 percent of staff, including 600 nursing posts. The Trust has ambitious targets to grow substantive staffing by nearly 4 per cent in 2019-20 by reducing turnover, further international recruitment and doubling apprenticeships. OUH will be looking at: expanding international recruitment, where we can leverage the Oxford brand (although the Trust faces fierce national and global competition); developing better career pathways for OUH staff to improve retention; and improving the Oxfordshire 'offer' on housing and transport. OUH continues to lobby nationally for additional funding to pay our staff 'Oxford weighting' but have not yet been successful.

15. Within the Trust, the Horton General Hospital also suffers from the same workforce shortages as the rest of the NHS. The Horton has some advantages such as:
    - Lower housing costs
    - Easier travel to work with fewer traffic difficulties than in Oxford; and
    - Higher levels of staff engagement, according to analysis of staff survey results.

16. However, there are other challenges that make the Horton equally difficult to recruit to. For example:
    - Whilst the cost of housing is lower in Banbury than in Oxford, it is still considerably higher than the UK average.
    - Employment levels in North Oxfordshire are high; and travel links to London and Birmingham (and to other NHS Trusts e.g. in Warwickshire, Buckinghamshire and Berkshire) are as good, if not better than the rest of the county so there is a very competitive job market.
    - Clinical teams at the Horton are often required to operate fairly independently and required to take serious decisions on the level of risk for their patients, which can make the experience more stressful. This also means that OUH often needs more senior doctors, nurses, midwives and managers to work at the Horton who have a

broad range of skills and are comfortable working independently and experienced in making judgements on risk levels. These posts are in high demand nationally and are particularly difficult to recruit to.

- Some candidates are interested in the more specialist clinical and research opportunities that are not always available at the Horton. In order to address this issue, the Trust is looking to expand the amount of research conducted at the Horton and try to build time at specialist sites - within OUH or elsewhere - to job plan but that time away has to be covered and, therefore, the more time away is built in, the more additional staff need to be recruited. It also means additional travel for staff, which negates one of the positive aspects of working at the Horton.
- The lack of training posts restricts the supervisory elements of some jobs at the Horton, which make also them less attractive from a career development perspective.

Obstetric workforce challenges to date

17. Nationally, there has been a shortage of obstetricians over the past few years. According to the Royal College of Obstetrics & Gynaecology Update on Workforce Recommendations (2018):
    a. 9 out of 10 obstetric units report a gap in their middle-grade rota, which can affect job satisfaction, postgraduate training, quality of care and staff wellbeing.
    b. A 30% attrition rate from the Obstetrics & Gynaecology training programme is typical, further compounded by a loss at transition from training to consultant grade posts.
    c. 54% of those on the Obstetrics & Gynaecology Specialist Register are international medical graduates with 14% from the EEA.

18. OUH had to temporarily close the Horton obstetrics unit in 2016 because the Trust could not secure the workforce required to operate a safe and sustainable service. The service had experimented with a model of 8 clinical fellows but this was not sustainable as they could not devote enough time to both running a safe service at the Horton and meeting their contractual commitments on clinical research. When it closed, the service was dependent on locum doctors and, despite very intensive efforts, the Trust was not able to recruit enough middle grade obstetric doctors to sustain a safe service. In addition to the general challenges in obstetric staffing, these posts are particularly hard to recruit to – because the obstetric doctors need to be able to operate independently, these are senior roles and people qualified to do it are in high demand and can take their pick of roles. In the OUH experience, these people choose units with the highest benefit to their careers and the chance to develop the broadest range of skills. The Horton Unit cannot provide all those competitive advantages.

19. Since 2016, OUH has made continuous, intensive efforts to recruit 9 middle grade obstetric doctors for the Horton, including:
    - Offering a very competitive package, including £5000 per annum additional salary; paying for visas for the applicant and family, including the health surcharge (also

worth £5000); and, on the suggestion of HOSC, offering a relocation package of up to £8000.

- Making the jobs as attractive as possible, including (on the advice of the Royal College) offering time in the job plans at the John Radcliffe to develop specialist skills and the opportunity to participate in RCOG ATSM skills modules on Advanced Labour Ward Practice, Advanced Antenatal Practice and Early Pregnancy. OUH has tested this package with other Trusts and are reassured that it is very competitive. The only additional suggestion made was introducing CESR (see below).
- Running around 20 recruitment processes (with 2 more live at the moment, at various stages), sifting over 300 applications; conducting over 30 interviews and offering positions to 20 people. Since 2016, OUH estimates that the Horton Medical Recruitment campaigns have nominally cost the Trust approximately £33,000 and taken around 200 hours of Consultant time; and 285 hours of HR specialists' time.
- Being open to suggestions from Cherwell District Council and other local representatives to additional offers to attract staff – if they comply with national frameworks and legal duties.
- On the suggestion of HOSC, engaging an international recruitment agency. In January 2019, OUH commenced working with a specialist medical staff agency who submitted just two overseas CV's but both doctors were not appointable against the job description, person specification and required competencies. This Agency subsequently informed the Trust they were unable to find candidates who satisfied the competencies. OUH is building up expertise in international recruitment and an aggressive effort in this area would be required for this option to be successful (see below).

20. Despite these efforts, OUH has been unable to attract close to the 9 substantive doctors needed to re-open the Unit under the 2016 workforce model. The highest number in post at any one time has been 5 people – however, once at that number, almost immediately one of the people in post decided to move on. The Trust experiences high levels of turnover in obstetrics - over the last 5 years, 29 doctors have voluntarily moved on from OUH: 7 consultants, 4 specialty doctors and 18 registrars. People leave for a variety of reasons but mainly for career development or for personal/family reasons. Due to national shortages, the obstetric profession is very competitive and experienced doctors are very much in demand. OUH has multiple examples of our experienced doctors being recruited elsewhere.

21. Similarly, when an obstetrician is made an offer to work at OUH, often their home Trust (or another Trust to which they have also applied) will match or better the OUH offer and they decide to stay put or go elsewhere, often to places with a lower cost of living. Some also change their mind for family or personal reasons. Of the 20 doctors offered positions since 2016: 9 both accepted an offer and attended the induction programme, 8 of which would have been experienced enough to start work at the Horton General immediately.

However, only 4 of these 8 have been retained (2 of whom have just started). The other 4 accepted alternative career opportunities over time.

22. HOSC have previously questioned the drop off ratio between the number of applications received (300) and shortlisted candidates (30), leading to 20 offers. This is not unusual. As a comparison, in the 6 months between 1 February 2019 and 31 July 2019, 8 Emergency Medicine Fellows were shortlisted from 52 applications and 15 Anaesthetic Specialty Doctors and Fellows shortlisted from 121 applications.

23. When OUH has strengthened the package available – for example, by paying for visas or offering a relocation package, we do see an increase in the number of applications. Sadly, we do not usually see an increase in the quality of applicants. As these clinicians will be working without supervision, they have to have considerable experience to be able to safely practice at the Horton. The Trust is confident in the fairness and scrupulousness of our processes. OUH shortlist only on the basis of candidates being able to demonstrate they have the key experience and skills in the job description - and we have not changed our approach during this time period. The Trust is happy to be flexible in our approach where possible but, of course, we will not compromise the standards required to provide a safe and quality service for patients.

24. The recruitment and retention experience above has been confirmed by the results of the options appraisal and the views of the stakeholder panel, which scored the 2016 model the lowest of all options. This process has enabled the Trust to explore different possible workforce models to make an obstetric unit with alongside MLU at the Horton deliverable in a safe and sustained way.

Preferred workforce model - obstetricians

25. OUH clinicians and HR experts tested the theoretical possibility of constructing a rota for all the workforce options in the long list agreed with HOSC. For all except one option, we were able to theoretically construct a rota that complies with national rules. The table in Annex 1 sets out the additional obstetric doctors that would be required for each of the different workforce models. However, actually being able to fill such rotas sustainably is much more challenging.

26. Working with OCCG, and taking into account findings from the report compiled by 'Keep the Horton General' campaign group, the Trust has sought to learn from other smaller units. There are c13-14 units in England, which are rated good or outstanding by the CQC and have under 2200 births per year. OCCG's research suggests that not all of these Units are in a similar position to the Horton (often much more rural, with further travel distances to the next nearest Unit and not part of such large or specialist Trusts). OUH's discussions with these Units – through visits, calls and workshops - indicate that, whilst they are proud of the services they provide to patients, workforce is a continuous

challenge. These units are managing, in the majority of cases, to maintain their rotas but the ongoing difficulties in recruitment and retention (particularly of obstetricians and sometimes also of paediatricians) and the subsequent risks to patient safety is a constant concern. The Trust has drawn on learning from these Units in developing possible workforce models and potential new approaches.

27. Learning from other smaller units, the model which seems to work best is a 'hybrid rota'. This involves recruiting a higher number of consultants who also participate in the middle grade rota. As there are fewer shortages at consultant level, this helps mitigate recruitment challenges and increases sustainability. This model was the highest scored by the stakeholder panel. The balance between consultants and middle grade doctors can change as set out below, but the most common ratio in other smaller units seems to be c8 consultants and c7 middle grade doctors. There is also a question of whether the hybrid rota should be just for the Horton General or pooled across the John Radcliffe and the Horton. The hybrid rota just for the Horton General scored more highly in the options appraisal and is more in line with other smaller units. The table below sets out the relationship between number of middle grade doctors and number of consultants under the hybrid model to meet rota requirements.

No. Middle trust grades	**No. consultants**
9	5
8	6.6
7	**8.2**
6	9.8
5	11.4
4	13
3	14.6
2	16.2
1	17.8
0	20

28. The current recruitment gaps are set out in annex 2, based on the preferred hybrid rota model at 8.2 consultants and 7 middle grade doctors, for the Horton General only. This assumes no further attrition from current rates. These are:
    - Consultants: add 3.2 to funded establishment then need to recruit 6.2 additional to fill gaps.
    - Middle grade Trust doctors: reduce funded establishment by 2 then need to recruit 3 additional to fill gaps.
    - Junior doctors: based on BMA guidance, add 8 junior doctors to the rota. We currently have 3 junior doctors available for the Horton Unit via the GP Vocational Training Scheme. OUH would reapply through the Deanery for accreditation for training junior doctors via the General Medical Council and Health Education England (HEE) Thames Valley. Depending on how many trainees the Trust was allocated, gaps would need to

be filled through direct recruitment of junior grade Trust doctors. This is a more expensive option than training doctors –but is a much easier role to recruit than middle grades.

29. As under the 2016 model, the majority of consultants would be obstetricians and gynaecologists who could also support elective gynaecology lists and outpatient clinics at the Horton. Employing joint obstetric and gynaecological consultants will also mean they would be trained to undertake the obstetric emergency surgery that requires gynaecological expertise, 24/7 if needed. The Trust would need to more fully explore what additional support might be needed to ensure this can be done safely in the Horton unit. These consultants would need to be passionate about and dedicated to prioritising the development of a really quality, safe and sustainable Obstetric Unit and alongside MLU at the Horton, alongside their gynaecology work.

30. As part of this model, OUH could consult with the Deanery on the option for trainees to spend up to 8 hours at the Horton. OUH would never be comfortable that reopening a Unit that relied on using trainees in this way to stay open would be a sustainable future option. But redeploying trainees at the Horton would be likely to increase the attractiveness of the middle grade posts to applicants. The Trust would be concerned that we would need to backfill the trainees' time at the John Radcliffe, so we would need to ensure this would not jeopardise the overall obstetric service for Oxfordshire. As above, the Trust would rather pursue reaccreditation and the allocation of training grade doctors from the Deanery. Not securing the full 8WTE training doctors/junior Trust grade doctors under the hybrid model would mean having to recruit more middle grade doctors to cover the role, which is extremely difficult or more consultants which is very expensive.

Sustainability of workforce model

31. One of the key challenges with this model is not just the initial recruitment, but the ongoing sustainability of the workforce. If the Trust cannot be confident that we can sustainably staff the rotas, then OUH clinicians and managers cannot be confident in providing a safe service to patients and we cannot maintain an Obstetric Unit. It would be completely wrong to re-open an obstetric unit at the Horton, only to have to close it again because it is not possible to fill the rotas sustainably and patient safety risks are too high.

32. One piece of learning from previous experience in obstetrics; some other Horton services; and other smaller units - is the importance of dedicated, local clinical leadership in rebuilding a service that is sustainable for the future. For this option to work, OUH will need to recruit a dedicated clinical lead for the new Unit, based at the Horton and, possibly also a dedicated Head of Horton Midwifery.

33. Given the overall shortages in obstetrics middle grade doctors in particular, and learning from other small units, it is highly unlikely rota sustainability can be achieved with a

standard approach to recruitment and retention. OUH and OCCG have discussed with the Royal College and consulted with other Trusts and to pursue this model would involve looking at some or all of the following innovative options for the new Unit. All of these options take 1-2 years to set up; incur additional costs for which the Trust would need funding support above the £4.6m already described in the finance section; and will require considerable clinical and administrative support and focus to set up. The costs and resource are summarised below and set out in detail in Annex 3. Some of these initiatives are untested in the medium to long-term - and OUH cannot know if they would be individually or collectively successful in securing the required workforce levels, given the difficulties in recruiting and level of turnover we experience in obstetrics.

34. The options to consider are set out below with the length of time to set up and the costs attached. Most options will take 1-2 years to put into place and, if we recruited one doctor through each scheme, we estimate it would cost between £200,000 and £250,000 and would require support from a small, dedicated recruitment team. More detail on each of these is set out in Annex 3.
    - CESR Fellowship Rotation posts: 1 year and c£20,000
    - Research Fellow posts: 1 year and c£105,000 (tried before and did not work as roles did not allow enough time for research and practice)
    - Medical Training Initiative placements: 1.5yrs and c£10,000 per doctor
    - Associate Specialist Grade: 1.5yrs, c£11,500 plus c£17,000 per doctor
    - Multiple international recruitment agencies: 1.5 years, c£9500 plus c£34,500 per doctor
    - Ongoing partnership with international health organisation: 1.5yrs , £20,000 plus £3200 per doctor
    - Step In, Step Out – potential RCOG pilot, more information needed.

35. To implement the above proposed options, the Trust would initially need to have a dedicated Medical Staffing Talent Specialist (approx. Band 6) working on this project to set up the service and then would need continued additional resource (probably reducing to 0.5 of a Band 6) to ensure there was regular recruitment initiatives, drives and flow of doctors to sustain the service. From the estimated time above, the Medical Staffing team would also initially need one dedicated Medical Staffing Recruitment Assistant (Band 4) releasing the advertisements, assisting the shortlisting, setting up interviews, co-ordinating with other partnership Trust's, agencies and overseas units (probably dropping to 0.5 in the longer term). This excludes any additional resources needed for other new clinical and non-clinical staff to support the service. The level of HR effort and cost required to staff this unit would be significant vs other specialties.

Midwifery recruitment

36. The below table shows the additional staffing required to run an obstetric unit at the Horton hospital. It shows the midwifery staffing levels required for 1000-1500 births and

1500-2000 births. These staff would be required to provide antenatal, intrapartum and postnatal inpatient care. The current staff required to cover outpatient and community services are not included in the below. The service is currently funded to recruit the number of additional midwifery staff for 1000-1500 births and so could begin this immediately.

Midwifery Staff	**Birth numbers**	
	1000-1500	**1500-2000**
Band 8 Matron	1	1
Band 7 Manager	1	1
Band 7 Coordinators	5.15	5.15
Band 6 Midwives	18.61	21.18
Band 5 Preceptee Midwives	4.58	4.58
Band 4 Maternity Assistant Practitioner *	5.15	5.15
Band 3 Maternity Support Workers	7.5	10.5
Band 2 Maternity Support Workers	3	3

**Dependent on the staffing model, the Band 4 Maternity Assistant Practitioner is second assistant in theatre and required during caesarean sections.*

37. Overall at OUH, we continue to face pressures on midwifery recruitment and retention. Historically, midwife recruitment and retention of staff has been successful in the north of the county due to lower costs of living than in Oxford city and surrounding areas. OUH is broadly confident we could recruit sufficient midwives to staff the Horton service – although this may put more pressure on recruitment for the rest of the maternity services across Oxfordshire.

Neo-natal nursing recruitment

38. OUH would need 12 neo-natal nurses to open up the Level 1 SCBU with 8 cots at the Horton required to reopen an obstetric unit. Nursery nurse support would also be required. Administrative and clerical staff would be shared with paediatrics services.

39. Overall, there is a national shortage of neo-natal nurses. At present, there is a high level of vacancies at the John Radcliffe, despite intensive recruitment and retention efforts. Any of the current neo-natal nurses moving to the Horton would also need to be backfilled at the John Radcliffe. We could look at dedicated international recruitment of neo-natal nurses at an approximate cost of £10,000 per post but this is a competitive area. It would be extremely challenging to sustainably staff the SCBU sustainably, given the pressure on

neo-natal nurse recruitment. Nursery nurses are relatively easy to recruit, although turnover is high.

Anaesthetic recruitment and other theatre staff

40. There is a current national shortage of Anaesthetists. OUH also experiences these workforce challenges, with gaps in our rota which we find it difficult to fill and on current projections it will take us more than 3 years to sustainably fill our existing workforce gaps. In addition, almost 20% of our anaesthetists are over the age of 55 therefore this represents another challenging ask for us to replace this proportion of our workforce over the next 5 years. Across the Trust we are examining additional international recruitment options and other incentives in order to speed up this process – particularly with the general national shortage in this field. When an obstetric unit previously operated at the Horton General Hospital, to meet required standards the Trust needed to operate a full on-call rota. If organised on the same basis as previously, that would require us to recruit 2-3 WTE additional consultants at the Horton. The Trust would want to examine if there are any ways to deploy innovative workforce models to safely achieve the standards with a different staff mix, given the overall shortages of Anaesthetists, locally and nationally.

41. OUH will also need to recruit additional theatre staff to support an obstetric theatre at the Horton: this is another area where we face shortages across the Trust as a whole and have found it difficult to recruit.

B. <u>Affordability</u>

42. Our financial analysis indicates that to re-open an obstetric unit with an alongside MLU, operating the preferred workforce model described above will cost £4.6m more per year to the local health system, compared to the current, temporary model. This money will need to be found from within the existing funding envelope for Oxfordshire health and care.

43. Our previous condition assessment report for the Horton maternity block indicates it needs significant investment. Whatever decision the CCG makes on the future of obstetrics, we will need capital investment in the maternity unit. For this option, the investment will be more immediate and significant. Current safety standards mean we would not be able to simply re-open the existing obstetric theatre facility but would need to update it. We will also need to create the space for both an obstetric unit and an alongside MLU, whereas we have only previously operated one or the other. Based on the potential future birth projections for the obstetrics unit, we would also need to build in capacity for the unit to grow in the future. We will also need to make sure there is enough space for current and future maternity outpatient clinics we currently run. This means we require a new build unit. We would expect such a unit would be attractive to

women and increase the numbers choosing to give birth at the Horton and be an attractive environment for staff to come and work in.

44. OUH commissioned an estimate from external consultants (based on accepted methodology and benchmarks) on the capital investment required for a new build obstetrics unit alongside a midwife-led unit at the Horton. The estimate for a stand-alone, new build unit is between c£40-45m. OUH would need to submit a business case to the Department of Health & Social Care for this capital investment, either just for obstetrics or as part of a wider business case for capital to redevelop the Horton site. There is currently no open process for capital investment bids and we do not know the timeline for the next round. We would also need to consider if there are other ways of raising some of the capital needed for investment – for example, philanthropic donations.

C. <u>Support from partners and national organisations.</u>

45. In order to open an obstetric unit with an alongside midwifery led Unit, we will need support from a number of our system partners and national organisations. This includes:
    - Our Local Maternity System (LMS) in Buckinghamshire, Oxfordshire and Berkshire West – and also the Local Maternity Systems for Northamptonshire and Coventry & Warwickshire: our LMS will need to be supportive of the potential to extend the catchment area of the Horton and be comfortable about the impact on other services in the area of more women from wider geographies choosing to give birth at the Horton. We will also need their support to implement the learning from other smaller units to develop the Horton as a beacon of good practice in certain areas. This could build on existing strengths or current plans: such as early risk assessment; supporting women who would like low intervention births; or working with vulnerable women to support them before and after labour.
    - The Deanery, HEE and the GMC – to support the reaccreditation of the Horton for trainees and help fund and support some of the innovative new workforce models.
    - The Royal College of Obstetrics & Gynaecology – to prioritise the Horton for the piloting of new and innovative schemes to address workforce challenges; and to develop the Horton as a beacon of good practice. We may also need support from other Royal Colleges on workforce shortage areas.
    - The Department of Health & Social Care, HM Treasury, NHS England/Improvement and the BOB Integrated Care System to approve the business case for capital investment required for the Horton Unit and make it a priority against other requests for capital.
    - The Oxfordshire Clinical Commissioning Group and the wider Oxfordshire system to make the additional funding available.

46. Given the trade-offs required for some of these external organisations to provide the support above; the need to consider the impact on other providers and services; and the formal processes which need to be conducted to make some of these decisions, OUH is not

currently in position to know whether the necessary support from all these organisations would be forthcoming.

Summary on option 9b) 2 joint obstetric units with alongside MLUs:

47. To implement this model would require OUH to adopt a new hybrid rota and put in place a package of innovative new approaches to recruitment and retention. These approaches would take 1-2 years to put into place and require considerable resource from clinicians and HR specialists. Even then, we cannot be certain they would be successful in enabling us to successfully fill our rotas. 2 joint obstetric units with alongside MLUs would cost an addition £4.6 million per year in additional funding, plus £40-45m capital investment for a new build. OUH will also need support from a range of local and national partners, which we do not know will be forthcoming.

48. The OUH view is that this model would be likely to improve the patient choice and experience of maternity services for women in the Horton catchment area and it is strongly supported by local councillors, community groups and campaign organisations. However - because of the uncertainty over whether the approaches suggested would be successful in overcoming recruitment and retention challenges - the OUH Board, clinical leads and managers continue to be highly concerned about the risks to patient safety of unfilled rotas and therefore the sustainability of service provision under this model in the short, medium and longer term.

Option Ob6: Single Obstetric Unit at the John Radcliffe Hospital

49. Compared to reopening an obstetric unit with an alongside midwifery-led unit at the Horton General Hospital, the stakeholder panel scored this option:
    - More highly on alignment with other strategies, ease of delivery, rota sustainability, delivery within the financial envelope and service operating hours;
    - The same on clinical outcomes and clinical effectiveness and safety; and on recruitment and retention.
    - Less well on consultant hours on the labour ward and patient choice
    - Significantly less well on distance and time to access service and patient and carer experience.

Areas of strength

50. This model has been in operation since 2016, in response to the need to temporarily close obstetric services at the Horton, and is proven to provide safe, quality services overall for the population of Oxfordshire and surrounding areas within the current financial envelope. It fits with the Local Maternity System strategy. The description of the services we offer, previously outlined in papers to HOSC, is attached at Annex 4. Women are able to choose an obstetric-led birth at the John Radcliffe (or Warwick Hospital); an alongside

midwifery-led unit at the John Radcliffe (or Warwick Hospital); a freestanding midwifery-led unit (at the Horton General, Chipping Norton, Wantage and Wallingford); or a Home Birth. Ante-natal and Post-natal care is also offered at the Horton General, including scans, blood test and support clinics.

51. The Maternity services provided by OUH are recognised nationally as delivering safe care with good outcomes for mothers and their babies. In 2019, CQC rated OUH maternity services as 'Good' both overall as a Trust and at the John Radcliffe. (The Horton General was also rated 'Good' for maternity but this inspection dates back to 2014.) The annual CQC maternity survey of patients for 2018 rates OUH services as above average for labour and birth and in line with average for other areas.

52. In the patient survey carried out in response to the IRP recommendations, feedback on the maternity care provided by the Trust is positive overall with common words to describe our services including 'professional', 'excellent', 'good', 'helpful', 'friendly', 'reassuring' and 'positive'. OUH maternity services had a net satisfaction score for all elements, with the exception of parking cost, with particularly positive ratings for the quality of ante-natal care; cleanliness and hygiene during labour and post-natal care; and the competence of healthcare staff. The majority of respondents from Cherwell and South Northamptonshire agreed or strongly agreed with almost all the positive statements about OUH maternity services – with the exception of three elements of post-natal care: ease of people travelling to visit; ability of children to come and visit; and ease of parking for visitors.

53. The Trust reports marked improvement in rates in the serious outcome measures for maternity (still birth and perinatal death at term; significant brain damage to term babies; unexpected admissions of term babies to special care units) including from 2014-2018. OUHFT was one of the few trusts in the UK to be declared 100% compliant in all 10 safety action plans of the NHSLA National Maternity Incentive Scheme introduced at the beginning of 2018. This information is all included in the service description in Annex 4, previously provided to the HOSC.

54. Whilst midwifery recruitment and retention are still an ongoing challenge, many of the most severe workforce difficulties outlined in the first section are not applicable to this model – the Trust would not require additional obstetricians, neo-natal nurses and anaesthetic staff (the harder to recruit professions) under this model. Extensive engagement with staff has led to improving retention and reducing turnover in midwifery and the Trust has appointed of a new, permanent Director of Midwifery from September. Through these efforts, we have increased our shift cover and fill rates, enabling us to maintain all areas of service provision throughout this year. These improvements give OUH clinicians and managers confidence that this model can be sustainably provide a safe, quality service; and overall good experience for patients.

Overcoming challenges and mitigating risks

55. This section sets out what it would take for Oxford University Hospitals to overcome the challenges identified by the scoring panel on patient choice; distance and time to access service; and patient/carer experience.

A. Better, tailored information for women in the Horton catchment area on the choice of options available, across both Oxfordshire and surrounding counties

56. The patient survey shows that, whilst there is a net positive satisfaction score of 41% in the choice of where to give birth, there is only a net positive of 12% for Cherwell residents responding and net negative satisfaction score of -2% for South Northamptonshire residents. 68% of Cherwell service users (82% in S. Northamptonshire) feel that the temporary closure of the obstetric unit at the Horton impacted their decision of where to deliver and 59% in Cherwell and S. Northamptonshire feel it impacted their overall experience. Another obstetric unit with an alongside MLU in Oxfordshire does not increase the range of choices open to women – both of these exist at the John Radcliffe and Warwick Hospital. It does, however, offer an additional choice of locations at which these services are available in our local area and reduces time and distance to travel. 75% of service users in Cherwell and 93% in S. Northamptonshire said they would have preferred to give birth at the Horton if obstetric services had been available. However, there is also a net positive satisfaction score of 48% and 64% for Cherwell and South Northamptonshire for, on reflection, the choice made on where to give birth. 79% overall, 66% of Cherwell residents and 68% of South Northamptonshire residents would have chosen the same place to give birth.

57. The patient survey gives a net satisfaction rating of 48% across Oxfordshire for the support received in choosing where to give birth – 30% net satisfaction for Cherwell residents and 36% net satisfaction for South Northamptonshire. Feedback from the survey/focus groups and from the stories we heard from women and their families throughout this process indicates that many women in Oxfordshire and South Northamptonshire do not necessarily view the Warwick Hospital as a good choice for them, despite the fact that it offers an obstetric unit with alongside MLU, within a shorter travel time than Oxford for many in the Horton catchment area.

58. To make this model work, OUH would need to do more with our colleagues at South Warwickshire Foundation Trust and other hospitals in the surrounding area to improve information for women about this option. The two Trusts would need to build on work already done with women on communications, to jointly refresh our patient information to provide specifically tailored information on choice for women in the Horton catchment area that covers options in both Oxfordshire and Warwickshire together. OUH would work with patients, including organisations such as Maternity Voices to examine the best ways to provide helpful information – for example, the Trust website is already being updated OUH could include videos and information about Oxfordshire and South

Warwickshire care options. A new mobile phone app is also in development to help women with maternity journey.

B. Improving patient and visitor access to the John Radcliffe site.

59. In the patient survey, residents of all council areas disagreed that it was easy for visitors to park and for other children to visit. Cherwell and S. Northamptonshire residents reported significantly less satisfaction with ease of visitor travel. The CCG analysis shows that whilst travel times to the John Radcliffe are around the same from the Horton catchment area as the rest of the county, the distance and time to services has increased for residents of that area, compared to when the Horton obstetric unit was open, as more of them have to travel to the John Radcliffe for some of their care.

60. Traffic congestion coming into Oxford and particularly around the Headington area is a well-known issue with consequent effect on travel to the Oxford hospital sites. This affects all services, not just maternity. OUH is working to improve overall access to the John Radcliffe, whilst also mindful of our environmental responsibilities to promote sustainable travel and help improve air quality. Actions to date include relocating the majority of our administrative staff to a new site at Cowley to reduce the need for staff travel onto the John Radcliffe site; encourage staff and patients to use public transport where possible; and moving some services into the community and up to the Horton General.

61. OUH are keen to move much more activity closer to home where possible, particularly if we are successful in securing capital to develop the Horton site. The Trust will begin to install Automatic Number Plate Recognition at the John Radcliffe this winter, which should lead to improved flow of traffic around our sites, quicker access and exit from our car parks, and more convenient payment methods. OUH is also looking to apply for permission to consolidate our ground level car parks into a multi-story car park. The Trust will continue to investigate various internal and external measures to ease the pressure on parking at the John Radcliffe and is committed to working with local partners involved to improve the patient access experience. However, these issues continue to be very difficult to resolve and access and parking difficulties are likely to persist for some time, despite the Trust's best efforts.

62. There is a particular issue if women in labour have difficulties accessing the site in private transport at peak times. OUH indicatively estimates that this could apply to up to 5 of total John Radcliffe births a day (although this number is not reflected in our feedback and complaints). To mitigate the risk for these women, OUH would need to look at setting up a dedicated hotline for women and their families who are trying to access the site through private transport in an emergency. The hotline would advise women in an emergency situation on how to navigate the site, including deploying security teams if necessary; and direct them to available priority parking places.

63. The transfer times are comparable to the other MLUs across Oxfordshire due to the presence of the dedicated ambulance (and in line with median travel times in the findings of the national Birth place cohort study). OUH would need OCCG to continue to pay for this dedicated ambulance in order to maintain transfer times under this service model.

64. The patient survey provided clear feedback that the ability of partners to stay overnight at the John Radcliffe would improve the experience for mothers, particularly first time mothers. This was the number 1 improvement priority identified. OUH has already taken recent action to expand these options – we have increased the number of family rooms and our new single rooms have drop down beds for partners to stay. For women in four-bedded single sex bays, OUH could look at creating a partners rest room with convertible chairs that would allow partners to stay overnight at the end of the ward. For families with babies in the Neonatal Intensive Care, the Ronald McDonald facilities at the John Radcliffe site are increasing from the 17 current bedrooms to a new Ronald MacDonald House on-site with 62 bedrooms. This will be opening in the Summer 2020.

65. OUH is also responding to feedback that most women wish to have their postnatal care as soon as possible after birth. The OUH service has developed enhanced recovery pathways to allow women a safe and quicker discharge home after all births, including women who have had caesarean sections. Feedback from user representative groups has been positive. The Trust will continue to focus on this area and would look to expand post-natal care available at the Horton General (see below). This should mean that more women stay less time at the John Radcliffe which would help address some of the impact of concerns on visitor access.

C. <u>An expansion of services available at the Horton MLU or virtually to enable women to receive the majority of their maternity care closer to home.</u>

66. The main action required under this option is to increase the antenatal and postnatal services available at the Horton, or virtually, enabling women in North Oxfordshire, South Warwickshire and South Northamptonshire to receive the majority of their maternity care closer to home.

67. The Trust already offers antenatal and postnatal care at the Horton, including: blood tests, scans, a perinatal mental health clinic and an enhanced breast feeding service (including an overnight stay with midwife support if required). The patient survey showed that Cherwell residents rate their ante-natal care particularly highly. 64% of Cherwell residents had their scans at the Horton; and 55% had blood tests. 42% were able to have an appointment with an obstetrician/gynaecologist at the Horton. OUH would look to increase these percentages.

68. To make this model work better for the residents of the Horton catchment area, OUH would need to build on the current MLU and outpatient clinics to create a maternity hub which would include:
    - An expanded maternity assessment unit (MAU) to include reduced fetal movement assessments and early labour assessments, allowing between 5-10 women per day to be reviewed closer to home. The dedicated ambulance could also cover transfers from the MAU, if required.
    - Refurbishing the second floor of the current unit to open more specialist ante-natal and post-natal outpatient clinics, including an expansion of the mental health clinics; the new diabetes clinic; and, possibly (subject to clinical appropriateness) a pre-term labour clinic.
    - Expanding telemedicine between the Horton and the John Radcliffe, with new equipment to allow consultants to remotely review monitoring of fetal wellbeing. The Trust would also like to look at expanding telemedicine further to women in their own homes to allow remote monitoring – for example on blood sugar levels for those with gestational diabetes.

69. Throughout this process, there have been particular concerns raised around vulnerable women. OUH has secured funding to set up a case loading team for vulnerable women, which will provide them with a named midwife providing 1-2-1 continuity of care throughout their pregnancy, including in labour. This will also allow the Trust to respond to some of the concerns in the patient survey around continuity of care. OUH is currently recruiting to this team and once in place, they will be able to work with vulnerable women across the county, including in the Horton catchment area to help ensure their needs are addressed. OUH would need to also look at developing outreach clinics to local communities, working with Primary Care Networks, to particularly target areas in the Horton catchment area where women may be high-risk, working with community groups.

70. The Trust has met with representatives from South Warwickshire Foundation Trust and agreed to explore ways to allow women who require obstetric led care to access more of their antenatal care at a local level. This will focus on the Ultrasound Scan provision, the possibility of consultant antenatal clinics at the Horton and providing local maternity assessment including some pathways e.g. screening for gestational diabetes and decreased foetal movements. This ambition would not be easy to realise and would require detailed work between the two Trusts across two different Local Maternity Systems.

71. During this process, concerns have also been raised about the effects of increased anxiety in pregnancy on mothers and babies. There is evidence that women with a diagnosed General Anxiety Disorder can suffer from poorer outcomes if they do not receive support. As part of the booking process and throughout pregnancy, OUH screens for a variety of mental health issues, including General Anxiety Disorder and depression. Our clinicians and managers make sure women who are diagnosed with mental health issues get the

help they need – for example, from community mental health services, Oxford Parent Infant Project, Infant Parent Psychology Support, Talking Spaces or our internal OUH services if appropriate. These services are largely provided locally in the community. There is a general increase in the proportion of women presenting with mental health issues but OUH screening is not identifying more women with previously undiagnosed mental health issues and there no greater rise in the North Oxfordshire population than elsewhere. OUH continues to monitor these issues closely.

72. The Trust would need to make some short-term capital investment at the Horton MLU to create the expanded maternity hub. We would expect that to be deliverable within usual capital planning. In the longer-term, under this model, the Trust would need more significant investment to refurbish/build a new freestanding midwifery-led unit. External consultants estimate that a full refurbishment on the existing footprint would be c£17-18m. OUH would incorporate this into the business case we intend to submit for the redevelopment of the Horton site. As set out above, there is currently no open process for capital investment bids and we do not know the timeline for the next round. And, as above, the Trust would also need to consider if there are other ways of raising some of the capital needed for investment – for example, philanthropic donations.

D. <u>Long-term flexibility to respond to changing population and demographics</u>

73. The CCG's population growth estimates demonstrate considerable variation in projections of the future birth rate, depending on the rate of housebuilding and its impact on demographics. That analysis does not yet include an estimate of the impact on population growth from the Oxford-Cambridge ARC which is not yet in local plans. Growth in population over the last few years has not translated into increased birth rates - since 2010, Oxfordshire has seen an 18% decrease in births.

74. However, if the upper estimates of the population growth and birth rate projections do materialise over the next 5-10 years, additional obstetric capacity would be required in Oxfordshire. In that case, under the population health planning framework agreed by the Health & Wellbeing Board, the CCG would need to review the model for obstetrics. If the single obstetric unit model is selected in this current process - and if OUH can secure capital to redevelop the overall Horton hospital site – it would be sensible to build flexibility into the design of the site, so it is possible to re-open an obstetric unit in the future.

Summary on Option 6) single obstetric unit at the John Radcliffe Hospital

75. To address the issues identified with this model, OUH would need to: work with South Warwickshire Foundation Trust and other local providers to provide joint, comprehensive and tailored information on choices for women in the Horton catchment area; improve patient and visitor access to the John Radcliffe site; expand the range of

antenatal and postnatal care that can be accessed at the Horton MLU, so women can receive the majority of their maternity care close to home; and build in flexibility to respond to long-term population growth, if possible.

76. The OUH Board, clinicians and managers are confident in the safety and quality of the service provided through this model over the past 3 years, which has positive feedback from patients, including those within the Horton catchment area, and the independent inspectorate. However, the suggested actions can never fully mitigate the need for women living in North Oxfordshire, South Warwickshire and South Northamptonshire who want an obstetric-led birth to travel further and longer to do so – and we recognise this may have a negative impact on some of their experiences of maternity care.

Overall conclusion

77. At request of OCCG, OUH has set out what it would take to deliver each of the highest scoring options for obstetrics in Oxfordshire. Once the OCCG Board has made its decision, the Trust stands ready to work together with commissioners, other stakeholders and our patients on implementation – including the production of any relevant business cases and quality impact assessments required under the selected model.

78. This has been a valuable process, including the opportunity to engage with a range of stakeholders and gain feedback on OUH maternity services, including ideas for improvement. The Trust is keen for the local Maternity Voices Partnerships to review the full patient survey and identify whether there are other actions we should consider to improve patient experience.

79. More broadly, the Trust has an exciting vision for the future of the Horton as a thriving, 21st century district general hospital for the population of North Oxfordshire and beyond. In order to make this vision a reality, whichever, model of obstetrics is selected, we need to develop a strong business case to the Secretary of State for Health & Social Care and HM Treasury for the significant investment required. Throughout this process, there have been real positives from engaging closely with local stakeholders to shape thinking – OUH is keen to continue building relationships and working together to take this vision forward. We hope we will benefit from the strong support of Health and Wellbeing Board partners and also our local MPs, councillors and community in making our compelling case for investment in the future of the Horton.

Appendix 2 Response from OUH

Annex 1: Number of obstetric doctors required for each of the workforce options considered by the stakeholder panel

Option number	Consultant obstetricians	Middle grade doctors	Tier 1 doctors	Associate specialists MSW	Total additional staff required
Ob1 – 2 obstetric units, 2016 model	20 (15 JR 5 HGH)	29 (9 HGH 20 JR)	15 (JR) 3 (HGH)	4 (HGH)	0
Ob2a – 2 obstetric units, fixed consultant	38 (total) 15 (JR) 23 (HGH)	20 (JR)	15 (JR)		18 consultants
Ob2a (as above, with Tier 1 support)	35 (total) 15 (JR) 20 (HGH)	20 (JR)	15 (JR) 9 (HGH)	Or 6 (HGH)	15 consultants 9 tier 1 doctors or 6 Ass MSW
Ob2b – 2 obstetric units, rotating consultants	30 (total) 32.4 (total) if no tier 1 support	20 (JR)	15 (JR) 9 (HGH)	Or 6 (HGH)0	10-12.5 consultants but would need to have further specialist training
Ob2c – fixed, combined consultant and middle grade	**20-40 (total) 15 (JR) 5-20 (HGH) 5-23 if no tier 1 support)**	**20 (JR) 0-9 (HGH)**	**15 (JR) +/- 9 (HGH)**	**+/- 6 (HGH)**	**Up to 23 new consultants. Depending on ratio would have to consider some requiring further specialist training**
Ob2d – rotating combined consultant and middle grade	21-33	20-28	15 (JR) 9-1	3-6	Up to 13 new consultants but actually would be difficult to cover all the specialties and provide structured training for ST6/7 e.g. SST the SST
Ob6 – single obstetric unit	16	20	15	0	0 current temporary reconfiguration

Appendix 2 Response from OUH

Annex 2: Summary of recruitment at the Horton General required to achieve both highest scoring options.

Doctors currently in post[1]				Required						Gap (need to recruit at HGH)		
Consultants	Middle grade	Junior doctors		Consultants		Middle grade		Junior doctors		Consultants	Middle grade	Junior doctors
				JR	HG	JR	HG	JR	HG			
Currently 17 are in post[2] This includes 2 recruited to work at HGH	Currently 22 are in post This includes 4 recruited to work at HGH.	Currently 12 are in post This includes 0 recruited to work at HGH	**Two obstetric units[3]**	15[4]	8	20[4]	7	15[4]	8	6	3	8
			Single obstetric unit	16	0	20	0	15	0	N/A	N/A	N/A

Current in post[1]					Required				Gap to recruit at HGH	
Midwives		Neo-natal nurses			Midwives		Neo-natal nurses		Midwives	Neo-natal nurses
JR	HGH	JR	HGH		JR	HGH	JR	HGH		
270.6	9.04	Currently 109.6 are in post. This includes 5 who were originally part of the HGH establishment		**Two obstetric units**	269[5]	38[6]	121	12	16.5	7-12[7]
				Single obstetric unit	285.5[5]	11	121	0	0[8]	0

1- As at September 2019.
2 - Consultants at the JR include 9 specialist obstetricians who must stay at JR to manage complex cases.
3 – With alongside MLUs, operating a hybrid rota. This means a mix of consultants and middle grade doctors with more consultants covering some duties usually covered by middle grade doctors. This is beneficial if middle grade doctors are in short supply. The calculation in the table above is considered to be the most feasible mix of consultants (8.2) and middle grade doctors (7) but this could be flexed depending on success in recruiting.
4 - The number of consultants required at the JR will not change significantly with an obstetric unit being open at the HGH. The minimum number of consultants required on a ward is related to the number of births that take place and because the JR has a large number of births and offers care for women with complex needs they must have more consultants available.
5 - Based on Birthrate recommendations
6 – Depending on whether catering for 1000-1500 births or 1500–2000 births
7 – Nurses who were formerly part of the Horton establishment would need to be consulted on whether they want to move back up to the Horton unit. Any nurses who did choose to move back up would need to be backfilled at the John Radcliffe.
8 – We may need to recruit additional midwives for the Horton to provide the expanded services described in our mitigations above, which we need to work through in more detail, depending on the design and roll-out of services. As described, in the main paper, the Trust has found it easier to recruit midwives for the Horton compared to other staff groups.

Annex 3 – Detailed options for new recruitment and retention initiatives

Obstetrics and Gynaecology CESR Fellowship Rotation Posts
Similar to the Orthopaedic CESR rotation posts, the Trust would partner with other Obs & Gynae departments in the UK and form rotational posts that attract candidates who want to complete a fellowship prior to being appointed as a Consultant. Due to the shortage of Obstetrics and Gynaecology doctors, there are no guarantees that we would find other Trust's interested in forming a partnership and there is no knowledge of whether this would be attractive enough to senior trainees. The rotations would need to be fixed to meet the immigration requirements should candidates require a visa and each Trust is required to pay for a new visa as the doctor rotates around the different Trusts which adds a cost pressure to the partnering Trusts and the doctor. However, this initiative was most strongly recommended to OUH by other smaller units and would be the most likely initiative to try first. Approx timescales: 6 months to formalise a relationship, documentation, create rotations and advertise. Interview and notice period would take approx. 5 months. Total – 11-12 moths <u>Costs of implementation</u> Regular meetings with the partner organisation to set-up the rotation - £1,797.00 (1 week Consultant time) Advertisement costs – BMJ - £700.00 Joint shortlisting and interviewing - £8,986.00 Recruitment and administration of the rotations - £500.00 Total Set-Up Fees: £11,283.00 Visa if rotating for 1 years - £1,199.00 per trainee, per hospital Total for 6 candidates - £7,194.00 Overall total approx: £19,177.00
Obstetrics and Gynaecology Research Fellow Posts
Similar to Gastroenterology, the Trust would advertise a year in advance for Obs and Gynae Research Fellow posts. The post would have a 'job plan' that outlines particular time for research activities. This does impact on service delivery and would require a greater number of 'other' roles or doctors to cover the duties. Start dates would be in 12 months' time therefore this option does not provide an immediate solution to vacancies. But once recruited, they should be ready to work at the Horton straight away. The Trust tried operating a clinical fellow model before at the

Horton and it was not sustainable so the Trust will need to work with the University and the potential candidates to overcome the issues experienced previously.

Costs of Implementation

Advertisement costs BMJ - £700.00
Shortlisting and interviewing - £8,986.00
Recruitment - £400.00
Increased number of doctors to sustain the rota - £94,264.00 (2 additional doctors required)
Total cost: £104,350.00

Obstetrics and Gynaecology Medical Training Initiative (MTI) placements

The MTI scheme allows International Medical Graduates (IMGs) to come to the UK for a maximum of two years to train within the National Health Service (NHS). The expectations of IMGs in terms of their performance and targets should be based on the same standards as UK trainees at ST2 level initially, until, with support from the hospital, they move to ST3–4 level for the majority of their placement. During the placement, IMGs follow a similar assessment process to UK trainees.

This type of placement would require robust training and the candidates would not be at the level to work autonomously therefore this would require a greater Consultant/registrar presence and clear training plans which as cost and recruitment implications. If the level of complexity is not available, the Trust could risk not giving the adequate training/education that is required for these posts.

We have heard mixed reports from Trusts that have used this model and we know that the Royal College are working on refreshing the scheme to tackle some of the issues raised – but it is not certain that the quality of candidates required for the Horton would be secured through this route. We can mitigate this through placing candidates in the John Radcliffe for their first year and, if they reach the required level of competency, they would move to the Horton for their second year.

Each placement costs £2,500.00, the cost of supporting these roles would need to be factored into this option.

Timescales: 3 months for appointment into the role. And then up to 12 months at the John Radcliffe developing the required competencies and experience required to fill a Horton post.

Costs of Implementation

Cost of the placement - £2,500.00

Senior support, supervision and training opportunities - £6,740.00
Recruitment – £400.00

Total cost: £9,640.00 per doctor

Associate Specialist Grade

The Associate Specialist grade closed in 2008 but as a Foundation Trust there is the option to re-create this type of role which may increase the volume of applicants. An Associate Specialist is normally a permanent appointment and attracts a salary of £54,764.00 to £90,147.00. An associate specialist is required to have:

a. full registration with the General Medical Council;
b. served for a minimum of four years in the registrar or staff grade and/or specialty doctor grade and/or in the clinical and/or senior clinical medical officer grades, at least two of which have been in the appropriate specialty. Equivalent service is also acceptable, with the agreement of the relevant College or Faculty Regional Adviser and the Regional Postgraduate Dean;
c. have completed 10 years medical work (either a continuous period or in aggregate) since obtaining a primary medical qualification which is (or would at the time have been) acceptable by the GMC for full, limited or temporary (but not provisional) registration. Placement on the overseas list will not by itself count towards the qualifying period.

A robust business case would need to be written which outlines the difference between appointing an Associate Specialist or appointing a Consultant as the level of experience and the expectations for this role is that the individual works autonomously. Nationally, the BMA and NHS Employers are re-looking at the Associate Specialist contract but no timescales are known to date.

There are wider Trust/system implications as if the Trust commences an Associate Specialist contract in Obs and Gynae at the Horton, this will give wider requests for the same to be adopted.

To move this forward the Trust would need to create its own Associate Specialist Terms and Conditions of Service, obtain legal advice, Trust Management Executive and Board approval before discussing with system partners to ensure we do not destabilise their Obs and Gynae services then commence negotiations with the British Medical Association. This could take approx. 8 months.

The difference between the two salary scales are:

Specialty Doctor - £39,060.00 to £72,840.00
Associate Specialist - £54,764.00 to £90,147.00

The Trust would then commence advertising, shortlisting and appointing candidates who come forward. Candidates would then serve 3 months' notice.

Approx total: 1.5 years.

Costs of Implementation

Creation of Trust Associate Specialist Terms and Conditions - £475.00
Lawyers review the Trust Associate Specialist Terms and Conditions - £600.00
LNC and BMA agreement - £1000.00
Advertisement – BMJ - £700.00
Shortlisting and interviewing - £8,986.00
Increased salary payments – approx £17,000.00 per annum per doctor

Total cost of implementation: £11,761.00
Total additional cost of 6 doctors as Associate Specialists and implementation: £113,761.00

Engage multiple overseas recruitment agencies to recruit on our behalf

This approach to recruitment could give a wider and more diverse pool of applicants. From the experience of recruiting a small number of doctors from overseas into the Emergency Department and from overseas nurse recruitment, it is better for overseas recruits to start as a cohort onto a bespoke induction with induction lasting approx. 2/3 weeks. The Trust would need to assign each overseas recruit with a clinical and educational supervisor and for this to remain in place for 12/18 months dependent on experience.

The cost of a visa is £1,199.00 per annum and the Trust can sponsor for a maximum period of 3 years initially as a total cost of £3,199.00 per person.

The Trust's attempts to date to recruit middle grade obstetricians through international recruitment have not been successful. In Emergency Medicine (another shortage occupation where suitable candidates are limited) overseas recruitment did not provide the volume of recruitment required for the number of vacancies and this is not a reliable method for staffing a whole unit on a regular basis.

There are increased costs associated with overseas recruitment of 40% of the candidates' basic salary (approx. £16,000.00) as a one-off agency cost and a consideration for time spent shortlisting, inducting, supervising etc would need to factored in. The doctor would not be able to work independently until ready and from the experiences in the Emergency Department this has taken approx. 8 months.

Potential timescales: Advertising, obtaining interested candidates, shortlisting and interviewing – 5 months
Arranging the visa – 3 months
Notice, travel, accommodation and induction – 1/2 months
Training/supervision – 8 months

Total: 1.5 years

Costs of Implementation

Agency costs plus £3,199.00 per person
Shortlisting and Interviewing - £8,986.00
Recruitment - £400.00
Backfill whilst undergoing training - £24,794.00 per overseas doctor
Training/supervision - £6,740.00

Total cost per doctor - £34,733.00 (Excluding their salary)
If 6 doctors and implementation - £217,784.00

Obstetrics and Gynaecology Step in, Step Out Training Opportunities

The NHS Long Term Plan provides a step change in health and provides a focus on changing models of working. The plan includes a section about the health, wellbeing and morale of doctors and proposes changes to training programmes.

Royal Colleges are looking to pilot programmes called 'Step In, Step Out' which enables trainees to take a 12 month break from their training to help reduce burnout. To increase applicants the Trust could offer 'step out' placements at the Horton which may be an attractive place to work during a step out phase. However, as the positions at the Horton require our middle grade doctors to operate more independently and take judgements on the level of risk involved with patients, these roles could also be perceived as challenging – it will depend on the views of the individuals involved.

As this scheme is in its infancy, this will not generate large volume regular candidate applications but it could be implemented in addition to other schemes.

Link with an International Obstetric Unit

If the Trust could link with an international unit in places such as Australia, Malta or India, placements could be offered for doctors to rotate between two/three countries and experience Obstetrics and Gynaecology in more diverse settings.

This would require some exploration, relationship building, creation of the rotations, learning opportunities and induction prior to advertising these roles but would provide

a regular rotation of talent to the Horton.

The Trust would need to ensure the rotating doctors have regular supervision and support through-out their time at the Trust which will require additional senior resource to support this initiative.

This initiative is dependent on finding an International unit that wants to pair with the Trust and candidates who are interested in rotating to the countries we pair with. The long-term sustainability of this option is unsure as it often depends on individual clinical leads establishing strong relationships which can then suffer if people move on.

It would be likely to take 1.5-2 years to establish a relationship and to see doctors start to arrive at OUH via this route.

Costs of implementation

Regular meetings with the overseas partners to set-up the rotations - £7,188.00
Advertisement costs – BMJ and overseas journals - £3500.00 (cost could be shared with other parties)
Joint shortlisting and interviewing - £8,986.00
Recruitment and administration of the rotations - £1,000.00
Total Set-Up Fees: £20,674.00

Visa if rotating for 1 years - £1,199.00 per trainee, per hospital
Travel costs - £2,000.00 per trainee
Total for 6 candidates - £19,194.00

Overall total approx: £39,868.00

Annex 4: Description of the Maternity Services (previously provided to HOSC)

Background

The Maternity services in Oxfordshire are provided by Oxford University Hospitals NHS Foundation Trust (OUHFT). As well as providing community midwifery and intrapartum care to Oxfordshire women, OUHFT provides tertiary care for women and babies across the Thames Valley region. The service delivers between 7500-8000 babies per year. Around 12% of these births are referred from outside Oxfordshire into the regional centre.

The Maternity services are recognised nationally as delivering safe care with good outcomes for mothers and their babies. These outcomes have continued to improve over the last 3 years.

The Maternity services are rated "Good" by the CQC. (2017)

The recent CQC maternity survey (2018) reported "Labour and delivery care" as "Better than most trusts"

The trust reports marked improvement in rates in the serious outcome measures for maternity including from 2014-2018.

- Still birth and perinatal death at term **(Figure 1)**
- Significant brain damage to term babies. **(Figure 2)**
- Unexpected admissions of term babies to special care units. **(Figure 3)**

OUHFT was one of the few trusts in the UK to be declared 100% compliant in all 10 safety action plans of the NHSLA National Maternity Incentive Scheme introduced at the beginning of 2018.

To enable women to make appropriate choices and provide effective personalised care there must be consistent quality of service and assessment of individual risk. There are robust, evidence- based, national standards of care for women with more complex pregnancies so that safer care is delivered by specialised or dedicated services e.g. twin clinic or and Diabetic clinics (see list of NICE guidance in appendix).

The improvement in outcomes has been achieved by ensuring as many women as possible are seen early in their pregnancy. Women have an extensive clinical risk assessment away from the hospital by the community midwives and the GPs. The community midwife then coordinates the appropriate care and ensures low risk women have access to quality antenatal care. This includes new screening programmes and a choice to deliver in midwife-led settings. Those women who are identified as having increased risks or complex pregnancies are seen in the appropriate obstetric or specialist clinics. This is in line with the Better Births Agenda and with the relevant NICE guidelines.

Appendix 2 Response from OUH

Figure 1

	No. pregnancies with EDD Oct 14-Oct 16	No. pregnancies with EDD Oct 16-Oct 17	Percentage change
No. pregnancies	14328	6522	
No. PNM	47 (0.32%)	17 (0.26%)	-19%
PNM>/= 36 weeks	31 (0.22%)	6 (0.09%)	-59% (p=0.04)
SGA detection	35%	62%	

PNM adjusted Perinatal Mortality is the number of deaths in babies who are born over 24 weeks with no congenital abnormalities. This includes still births and early neonatal deaths (7 days of life).

Figure 2

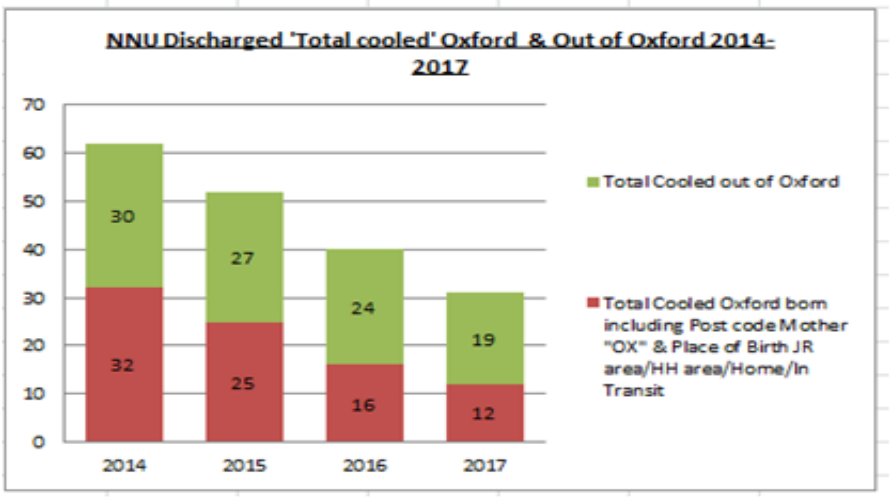
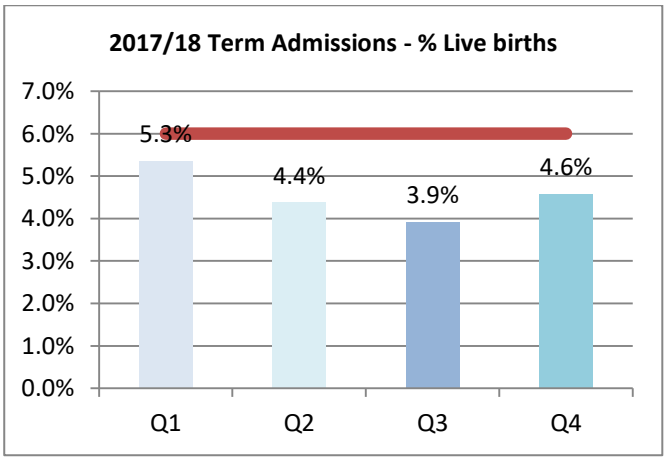


Figure 3



The national target is to be below 5.3%.

<u>Community Midwifery Teams</u>

Appendix 2 Response from OUH

Women receive care from one of eight Community Midwifery Teams across Oxfordshire in conjunction with their GP plus Obstetrician or Specialist if required. This way the women receive personalised care which is coordinated by a small team of midwives.

All antenatal care for low risk women is provided by a team of midwives who are supported by Maternity Support Workers (MSWS). The community midwives run the home birth service, support the free standing midwifery units (FMLU) and the alongside midwife led unit (AMLU) these services are described further under intrapartum care section.

Community midwives from OUHFT also provide care for women in Brackley, Northamptonshire.

The community midwives provide a comprehensive range of additional services:

- Antenatal Education classes
- Teenage support groups
- Saplings group for vulnerable women.
- Mindfulness sessions
- Infant feeding workshops
- 24 hour on-call triage service

The community midwives also co-ordinate the woman's postnatal care plan. In the first postnatal week women are reviewed at home or in nearby clinic settings and are able to access a wide range of other clinics in local settings including breastfeeding support, neonatal examination and neonatal hearing screening.

This service design supports the "hub and spoke" model to provide care closer to the family.

Antenatal Ultrasound Service

All pregnant women in Oxfordshire are offered a routine dating scan at around 12 weeks and a further anomaly screening scan at 20 weeks. OUHFT is the only trust in the country to offer a new screening programme to detect babies whose growth is poor later in pregnancy. This includes a 36 week growth scan for all women and additional growth scans for women whose pregnancies are higher risk.

The Ultrasound scans for this service are based at both the HGH and the JR.

Obstetric Care

Women who have been identified as requiring support from an Obstetrician are referred to Consultant led Antenatal clinics. These are situated both at the HGH and the JR. This includes clinics for women who fall into these categories:

- Already have a medical condition for example Asthma

- Have had a problem in a previous pregnancy
- Develop problems during their pregnancy
- Have risk factors that may lead to an increase in complications during labour
- Have complex social issues that require multiagency support
- Require perinatal mental health support.

Specialist Antenatal Services (Fetal Medicine and Maternal Medicine)

Fetal medicine

These services are provided by a team of accredited sub-specialist Fetal and Maternal Medicine doctors and specialist midwives. The unit is based at the John Radcliffe Hospital and offers diagnosis and treatment of complications which may arise in unborn babies, including:

- Detailed ultrasound scanning (in the first, second and third trimesters) including fetal heart scans
- Provision of rapid fetal karyotyping by amniocentesis, Chorionic Villus Sampling (CVS) service and amniocentesis.
- The treatment of pregnancies with rhesus disease and other causes of severe fetal anaemia requiring in-utero transfusion of the baby
- Diagnosis and management of feto-fetal transfusion (twin-twin transfusion syndrome) syndrome
- Diagnosis and management of abnormal invasive placentae

Maternal Medicine

There are also specialist ante natal clinics for pregnant women with any pre-existing medical disorder in addition to severe pregnancy-specific medical disorders. These are provided by a multidisciplinary teams consisting of accredited sub-specialist Fetal and Maternal Medicine doctors, Obstetric Physicians, Specialist midwives, Anesthetists, Cardiologists, Endocrinologists and other specialists. The specialist clinics include

- Multi-disciplinary cardiac clinic
- Specialist Diabetic clinics
- High risk maternal medicine clinics for women with serious preexisting medical conditions and high blood pressure/severe preeclampsia/HELLP syndrome

Intrapartum care

Midwife led care

The maternity service offers all four choices for place of birth; home, freestanding MLU, alongside MLU or obstetric unit. The options are discussed with the woman and an explanation given about what services are available in each maternity setting. It is important

that the woman is aware that she can change her mind about where she wishes to give birth at any time in her pregnancy.

Oxfordshire has three permanent Freestanding Midwife Led Units (FMLUs) in Wallingford, Wantage and Chipping Norton. Community midwives are based in the FMLUs and provide antenatal and postnatal care in the FMLU, at the GP surgery or in the woman's home. Intrapartum care is provided either in the FMLU or in a woman's home. Two of the FMLU's are closed overnight and the workload for the evening and night is coordinated by a Maternity Support Worker based in one of the FMLU's. The MSW contacts the on call midwives to care for a woman in labour. If the woman is planning to birth in one of the FMLU's the midwife will meet the woman at the unit. This service is provided in line with the 'hub and spoke' model being developed in other services; it is based in the community and provides a range of services for women and their families. The planned home birth rate is 2 - 3%.

A decision was taken by Oxfordshire CCG in August 2017 to permanently close the Consultant Led Unit at the Horton General Hospital in Banbury. This decision was part of a wider consultation that was then subject to a Judicial Review, which found in favour of OCCG. The obstetrics decision specifically was referred to the Independent Reconfiguration Panel which recommended that OCCG undertaken further work locally before making their decision. The Horton Obstetric Unit currently remains shut on a temporary emergency closure, due to safety concerns arising from a lack of obstetric staff to fill the required rota, and is operating as a fourth Freestanding Midwife Led Unit.

Alongside Midwifery Led Unit (Spires)

The alongside midwifery unit is on level 7 at the John Radcliffe Hospital. Low risk women can deliver here from all over Oxfordshire.

Obstetric led delivery unit

This is based at the John Radcliffe Hospital. There are a full range of services including the anaesthetic and neonatal support required to run a tertiary level department caring for very high risk and complex maternity cases.
Women from Oxfordshire who require general obstetric care and low risk women who choose to deliver in an obstetric led unit may also deliver in one of the following neighbouring units

- Warwick Hospital, Warwickshire
- Stoke Mandeville Hospital, Buckinghamshire
- Northampton General Hospital, Northampton
- Royal Berkshire Hospital, Reading
- Great Western Hospital, Swindon

Further information about this service and the neighbouring units can be found here
www.cqc.uk/publications/surveys/maternity-services-survey-2018

www.ouh.nhs.uk/women/maternity/default.aspx
www.swft.nhs.uk/our-services/adult-hospital-services/ma
www.buckshealthcare.nhs.uk/birthchoices/contact-us.htm
www.northamptongeneral.nhs.uk/Services/Our-Clinical-Services-and-Departments/Obstetrics-and-Gynaecology/Maternity/Maternity.aspx
http://www.royalberkshire.nhs.uk/wards-and-services/maternity.htm
https://www.gwh.nhs.uk/wards-and-services/a-to-z/maternity-services/where-should-i-have-my-baby/delivery-suite-at-the-great-western-hospital/

Neonatal services

Neonatal care forms a key part of the NHS maternity service. It is part of the routine service for all women and their newborn babies. Neonatal Critical care provides an emergency service and ongoing support for babies and their families when a baby is born very prematurely, becomes sick or develops a medical problem.

Since 2011 the Neonatal services in the UK are designated by NHS England. They consist of 3 levels of care.

The Oxford Newborn Care Unit is a Neonatal Intensive Care Unit (NICU Level 3). It is the only designated NICU (Level 3) in Thames Valley and therefore provides intensive care for all babies born in Thames Valley region.

The Oxford NICU also provides high dependency care (HDU, medium level of care, level 2) e.g. non-invasive respiratory support or parental nutrition (TPN) and special care (non-complex and requiring no respiratory support level 1) for all babies in Oxfordshire.

Prior to closure of Horton Special Care Unit, only babies in North Oxfordshire needing the lowest level of care (Level 1 non-complex and requiring no respiratory support) would be looked after at the Horton Hospital the rest were transferred to the John Radcliffe Hospital.

- There are 16 Intensive Care beds, 13 High Dependency beds, 21 Special Care beds (total 50 beds) currently in use at JR. In addition, 10-12 babies per day requiring additional care are looked after on the postnatal wards (transitional care patients).
- There are approximately 980 admissions per year.
- A Neonatal Regional Transport service operates from NICU, using a specialist ambulance to transfer patients 24 hours/ day to JR for intensive care and repatriation back to their local units. This service shares ambulance provision with the Paediatric Critical Care Retrieval service which also operates from the same site. The service transfers around 500 babies per year.
- The NICU is both a tertiary medical and tertiary surgical and cardiology referral unit. Cardiology and surgical teams have multiple contacts with the unit on a daily basis. Where patients are extremely ill, surgery will take place on the neonatal unit.

- The NICU also provides care for neonates requiring the input of other surgical specialties including neurosurgery, urology, ENT and plastic surgery and other specialist medical specialties such as respiratory, endocrine and neurology
- The neonatal teams work closely with obstetric and fetal medicine colleagues to provide a smooth transition from fetal to neonatal life, they also work closely with the palliative care team at Helen House.

Number of Births

This is the number of births including still births and includes women who have been transferred into OUHFT from other trusts in the region.
The JR figures include births in the alongside midwifery led unit, Wallingford MLU, Wantage MLU and home births of women from central and southern GP practices. The Horton General figures include births from Chipping Norton MLU and home births of women from GP practices north of the county.

Year April to March	Total births OUHFT	JR	HGH	comments
2010/2011	9033	7300	1869	
2011/2012*	8045	6644	1401	*data issues
2012/2013	8598	6841	1760	
2013/2014	8315	6721	1594	
2014/2015	8401	6734	1667	
2015/2016	8497	6890	1608	
2016/2017	8665	7128	933	
2017/2018	7497	7172	325	

Births Before Arrival (BBA).

These are unplanned births at home or on the way to a unit including in an ambulance. The transit figures include women who are aiming to deliver at the freestanding units as well as the hospital based obstetric unit.

	All Transit BBAs	All BBAs (exc on maternity sites)	Total	Transit North	BBAs North	Total
2014	**14**	**35**	**49**	**2**	**14**	**16**
2015	**5**	**17**	**22**	**2**	**5**	**7**
2016	**6**	**14**	**20**	**2**	**1**	**3**
2017	**20**	**29**	**49**	**3**	**9**	**12**

2018	**15**	**38**	**53**	**5**	**6**	**11**

	Total BBA OUHFT	**Total BBA HGH catchment**
2014	**49**	**16**
2015	**22**	**7**
2016	**20**	**3**
2017	**49**	**12**
2018	**53**	**11**

References

NICE CG192 Antenatal and Postnatal Mental Health (2015)
NICE NG3 Diabetes in Pregnancy from Pre-conception to postnatal care. (2015)
NICE CG 132 Caesarean section (2012)
NICE CG102 Hypertension in Pregnancy Diagnosis and Management (2011)
NICE CG70 Induction of Labour (2011)
NICE CG 25 Preterm Labour and Birth (2015)
NICE CG 129 Multiple Pregnancy Antenatal Care Twins and Triplets (2015)
NICE CG 110 Pregnancy and complex social factors (2010)
NICE PH27 Weight management before, during and after pregnancy (2010)
Better Births Improving Outcomes of Maternity Services in England: A five year forward view: The National Maternity Review 2016.

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Summary (3 / 4)

SUMMARY

Service user journey

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Antenatal care:

- The quality of care received at the antenatal stage of the journey is generally rated highly by service users (receiving a net satisfaction score of 78%) and this is consistent across different council areas
- Parking availability and choice of location receive low rating scores (-8% and 21% net satisfaction scores respectively)
- The Horton is being used for routine antenatal care by Cherwell residents; for example, 42% of Cherwell residents that had a hospital appointment with a consultant attended the Horton for the appointment

Labour & Birth:

- Nearly half, 47%, of service users were moved during their labour and half of service users identified at least one incident during their labour, with a shortage of staff and parking difficulties occurring most often
- Cleanliness (net satisfaction score 77%) and staff competence (net satisfaction score 72%) are scored highly whereas staff availability (net satisfaction score 40%), continuity of care (net satisfaction score 38%) and parking practicalities (net satisfaction score 19% for availability and -16% for cost) are rated poorly by service users

Postnatal care:

- Service users rated cleanliness and hygiene highly (net satisfaction score 74%) in postnatal care, but were least satisfied with the continuity of care (net satisfaction score 20%) and emotional support received (30%)

Notes: There were just 9 service user responses from Stratford-upon-Avon so throughout the report, these responses are counted in the totals but not shown separately

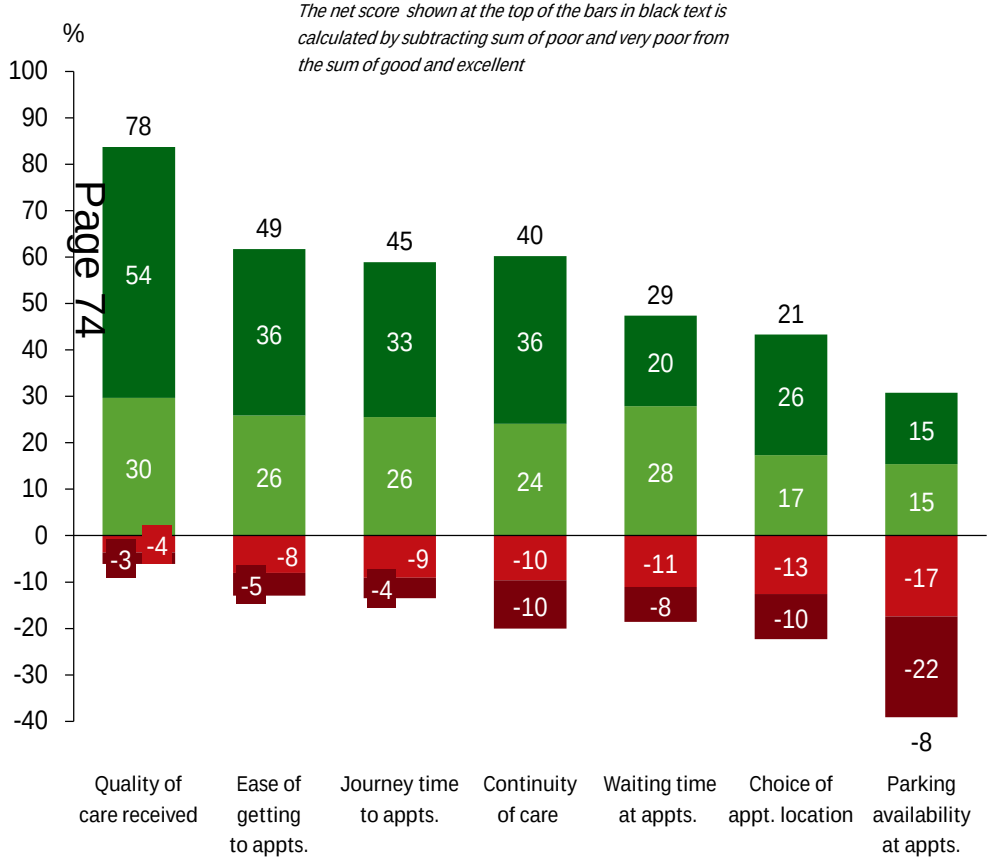
The quality of antenatal care is highly rated by service users. Cherwell is particularly well-regarded for continuity of antenatal care

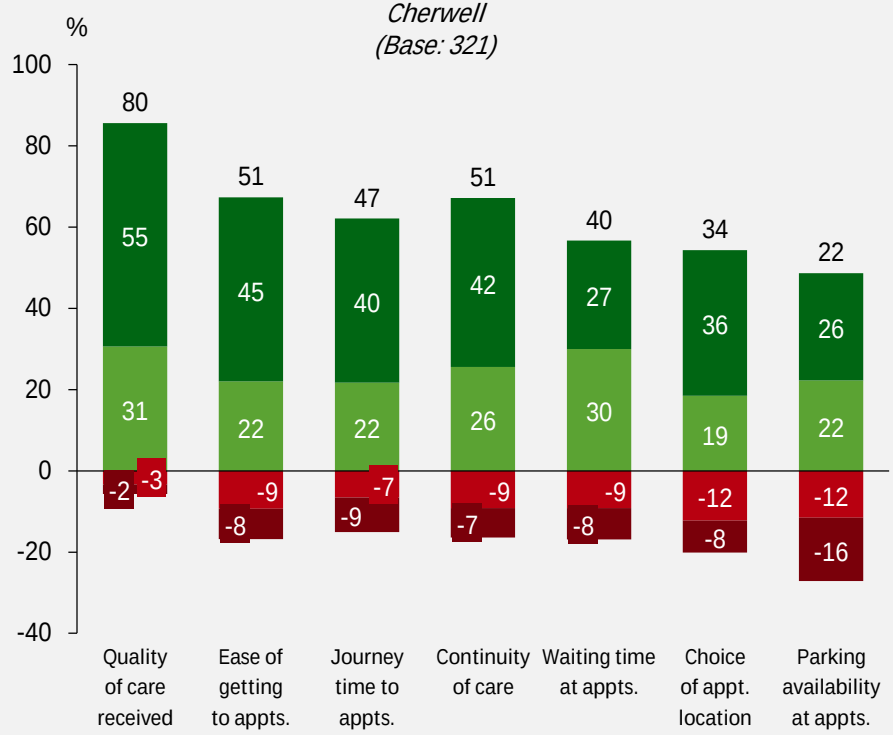
Antenatal care

Very Poor | Poor | Good | Excellent

Q. Thinking about your experience of antenatal care during your most recent pregnancy, please rate each of the following
Base: All service users (1,013)

The net score shown at the top of the bars in black text is calculated by subtracting sum of poor and very poor from the sum of good and excellent





Source: Pragma Maternity Services Online Survey March 2019

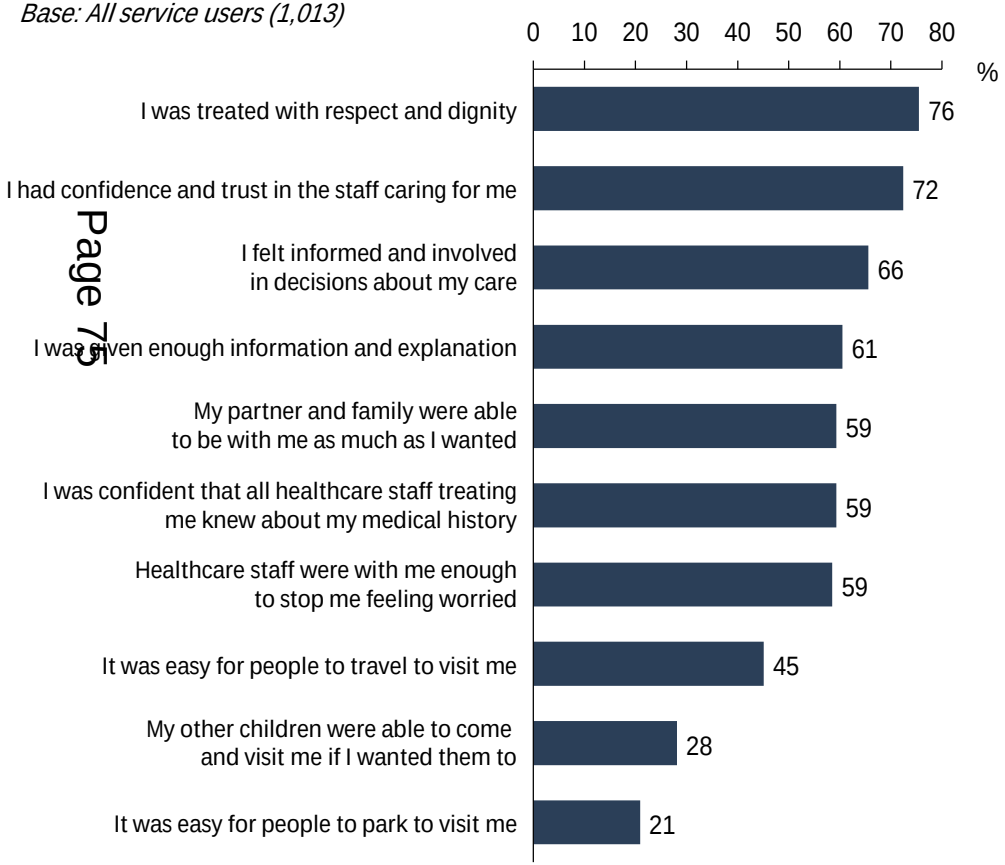
Notes: There were just 9 service user responses from Stratford-upon-Avon so throughout the report, these responses are counted in the totals but not shown separately. Bases will therefore not always add to the total

When asked about their postnatal experiences, residents of all council areas disagreed that it was easy for visitors to park and for other children to visit. Cherwell and South Northamptonshire residents reported significantly less satisfaction with ease of visitor travel

Postnatal care

Q. Thinking about your experience and the care you received after giving birth, please indicate the extent to which you agree with each of these statements on a scale of 1 to 5 where 1 is strongly disagree and 5 is strongly agree. % strongly agree + agree

Base: All service users (1,013)



% of service users selecting strongly agree + agree by area					
Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northam-ptonshire
(321)	*(191)*	*(163)*	*(148)*	*(118)*	*(63)*
76%	74%	73%	79%	74%	77%
69%	70%	73%	77%	75%	75%
63%	66%	62%	77%	66%	55%
59%	58%	62%	65%	58%	63%
57%	64%	59%	63%	52%	57%
59%	59%	55%	60%	64%	67%
57%	57%	58%	62%	57%	61%
32%	58%	48%	54%	41%	27%
26%	34%	31%	25%	24%	23%
21%	19%	26%	18%	20%	18%

Source: Pragma Maternity Services Online Survey March 2019

Notes: There were just 9 service user responses from Stratford-upon-Avon so throughout the report, these responses are counted in the totals but not shown separately. Bases will therefore not always add to the total

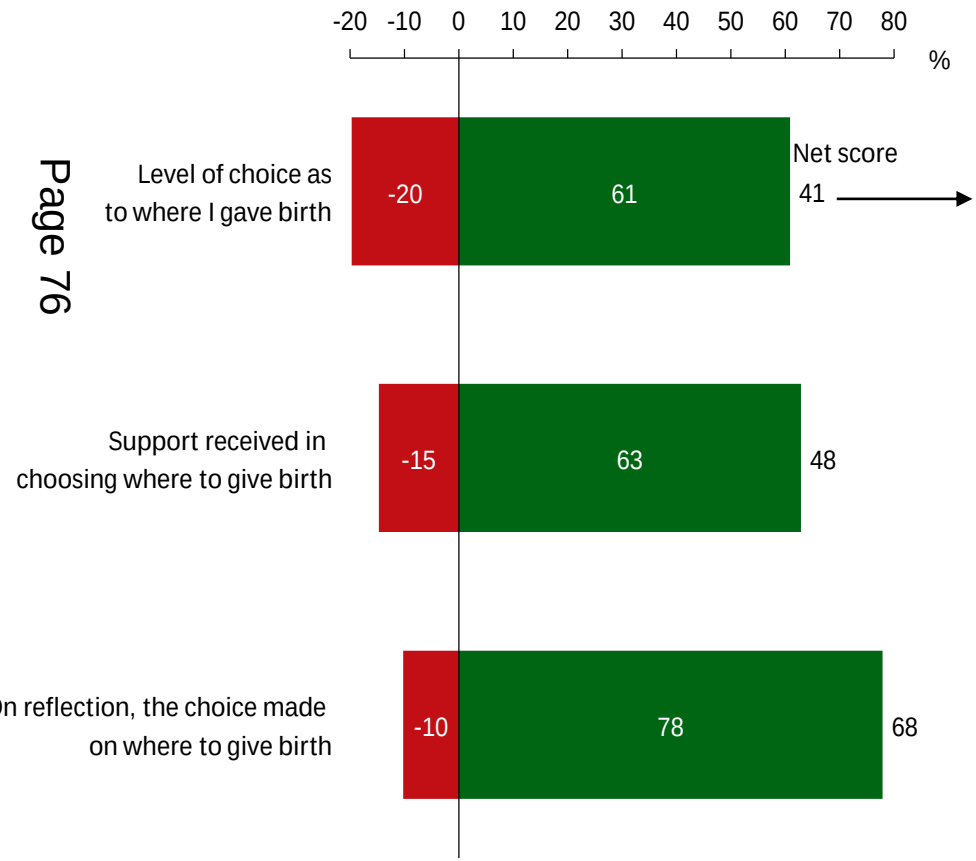
At a general level, those living further from obstetric services have lower levels of satisfaction with the choice available to them. By area, dissatisfaction is most profound for Cherwell and South Northamptonshire, indicating impact of the Horton downgrade on service perceptions

Decision-making

Decision Making | Satisfaction

Not satisfied Satisfied

Q. How satisfied were you with the following factors? Please rate on a 1-5 scale, with 5 being highly satisfied
Base: All service users (1,013)



Net score (sum of highly satisfied + satisfied minus very dissatisfied + dissatisfied)							
Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northam-ptonshire	*Near obstetrics*	*Far from obstetrics*
(321)	*(191)*	*(163)*	*(148)*	*(118)*	*(63)*	*(461)*	*(574)*
12%	54%	45%	62%	60%	-2%	49%	35%
30%	52%	47%	63%	64%	36%	53%	45%
48%	75%	71%	82%	68%	64%	72%	64%

Source: Pragma Maternity Services Online Survey March 2019

Notes: There were just 9 service user responses from Stratford-upon-Avon so throughout the report, these responses are counted in the totals but not shown separately. Bases will therefore not always add to the total

Appendix 4 Costing Information for 2 options
Analysis of one vs two Obstetric units at OUH - Summary

Number of Births

	2015/16	2019/20 forecast	Ob9 2 units*
Horton	1411	160	1060
John Radcliffe	6394	6900	6000
Other	534	440	440
TOTAL	8339	7500	7500

Total cost of Maternity inpatient services

	2019/20 forecast Ob6 Single obstetric unit at JR	Ob9 2 units	Change to costs between 2019/20 forecast and second Obstetric unit
Horton	2,006,968	9,463,357	7,456,390
John Radcliffe	35,485,641	32,623,566	- 2,862,075
Other - excluded as no inpatient services			-
TOTAL COST	37,492,609	42,086,924	4,594,315

The drivers of increased cost between the one and two unit options are:

Cost split	2019/20 forecast Ob6 Single obstetric unit at JR	Ob9 2 units	Change to costs between 2019/20 forecast and second Obstetric unit	Notes
Consultants	2,178,141	3,839,531	1,661,390	Additional posts required for second Obstetric unit 6WTE
Non consultant medical	2,022,920	3,466,220	1,443,300	Additional posts required for second Obstetric 24/7 rota 17WTE
Anaesthetics	-	430,000	430,000	Additional posts required for second Obstetric 24/7 rota 9WTE
Midwives and MSWs	7,636,420	8,107,434	471,014	Additional posts required for second Obstetric 24/7 rota, including reductions at the JR site 35TWE
Neonatal nurses	-	652,000	652,000	Additional posts required for additional SCBU, no reductions on JR site 12WTE
Other staff	1,908,590	2,067,789	159,199	Includes additional A&C posts to support additional consultant posts
TOTAL PAY	**13,746,071**	**18,562,975**	**4,816,904**	
Ambulance	360,449	-	- 360,449	Horton based ambulance not required for second Obstetric unit
Other Non Pay	2,044,660	2,182,520	137,860	Additional non pay expenditure for second Obstetric unit for equipment and other non variable costs
TOTAL NON PAY	**2,405,109**	**2,182,520**	**- 222,589**	
Indirect costs	4,323,385	4,323,385		No change to indirect costs
CNST - Maternity and Maternity incentive element	12,263,715	12,263,715	-	No change to CNST premium
Depreciation and Amortisation	992,465	992,465	-	No change to depreciation and amortisation - assumed no additional capital works
Other overheads	3,761,864	3,761,864	-	No change to overheads
TOTAL OVERHEADS	21,341,429	21,341,429	-	
TOTAL COST	**37,492,609**	**42,086,924**	**4,594,315**	

Horton Maternity Unit new build capital expenditure proposals

	Option 1 - New build 4090m2	Option 2 - New build 4380m2	Option 3 - New build 4673m2	Option 4 - Refurbishment of current building
Initial capital costs	£40,000,000	£42,000,000	£45,000,000	£17,100,000
Revenue costs (indicative additional annual costs for depreciation and PDC - from first year of operation)	£3,100,000	£3,300,000	£3,500,000	£1,300,000

Note:
Horton Maternity Unit Net Book Value as at 31st January 2019 - £957,000

Analysis of one vs two Obstetric units at OUH - Assumptions

Area	Assumptions
Activity (actual)	Births as reported in SLAM for all commissioners for the relevant financial year
Activity (forecast)	Forecast births for each scenario as agreed with Veronica Miller, Clinical Director for Obstetrics, July 2019

		Assumptions by site	
	Cost type	**JR**	**Horton**
Expenditure - Pay	Consultants	No reduction in JR consultant posts	Additional posts required for second Obstetric unit 6 WTE
	Non consultant medical	No reduction in JR non consultant medical staffing posts	Additional posts required for second Obstetric 24/7 rota, 17 WTE
	Midwives	Midwife posts reduced in line with the number of births at the JR site, ratio of midwives to births remains constant	Additional posts required for second Obstetric 24/7 rota, 29 WTE
	HCAs	HCA posts reduced in line with the number of births at the JR site, ratio of midwives to births remains constant	Additional posts required for second Obstetric 24/7 rota, 6 WTE
	Admin and Management	No reduction in medical secretaries for JR consultants	Additional A&C posts to support additional Horton based consultant posts
	Theatre staffing	No reduction in JR Theatre staffing	No additional theatre posts required - delivered by Horton based midwives and MSWs
	Anaesthetists	No reduction in JR Obstetrics Anaesthetics	Additional posts required for second Obstetric 24/7 rota, 9 WTE
	SCBU Horton	No reduction in JR Neonatal unit pay	SCBU Horton in line with costs in 2016/17, plus inflation.
Expenditure - Non Pay	Drugs	Drugs costs variable based on births - variable cost estimated at £70 per delivery	Drugs costs variable based on births - variable cost estimated at £70 per delivery
	Other Non Pay	Other Non Pay based on 19/20 costs in scenario 1. Other Non Pay based on 15/16 and 16/17 costs in scenario 2a-2d.	Other Non Pay based on 19/20 costs in scenario 1. Other Non Pay based on 15/16 and 16/17 costs in scenario 2a-2d.
	Internal recharges	Assumed to be fixed for all scenarios	Assumed to be fixed for all scenarios
	Ambulance	N/A	Ambulance not required with second Obstetric unit
	SCBU Horton	No reduction in JR Neonatal unit non pay	SCBU Horton in line with costs in 2016/17, plus inflation
Overheads	Indirect costs	2018/19 PLICS Q4, JR Maternity and Obstetrics inpatients. Assumed to be fixed for all scenarios. Excludes CNST costs.	2018/19 PLICS Q4, Horton Maternity and Obstetrics inpatients. Assumed to be fixed for all scenarios. Excludes CNST costs.
	CNST - Maternity and Maternity incentive element	CNST Maternity element 2019/20 - assumed no change to total premium - split based on numbers of births on each site per scenario.	CNST Maternity element 2019/20 - assumed no change to total premium - split based on numbers of births on each site per scenario.
	Depreciation and Amortisation	2018/19 PLICS Q4, JR Maternity and Obstetrics inpatients. Assumed to be fixed for all scenarios.	2018/19 PLICS Q4, Horton Maternity and Obstetrics inpatients. Assumed to be fixed for all scenarios. No capital investment for Horton Maternity included.
	Other overheads	2018/19 PLICS Q4, JR Maternity and Obstetrics inpatients. Assumed to be fixed for all scenarios.	2018/19 PLICS Q4, Horton Maternity and Obstetrics inpatients. Assumed to be fixed for all scenarios.

Costing data for one and two unit options by site

ACTIVITY - BIRTHS ONLY		2019/20 forecast Ob6 Single obstetric unit at JR 1920 forecast	Ob9 2 units Total births as per 1819 actuals plus 900 HH less 900 JR
Total OUH births		**7500**	**7500**
Total John Radcliffe		**6900**	**6000**
Total Horton births		**160**	**1060**
Total MLU/home births		**440**	**440**

OUH MATERNITY - costs for births		1920 forecast (£)	Total births as per 1819 actuals plus 900 HH less 900 JR (£)
Expenditure	**TOTAL**	**37492609**	**42086924**
Pay	**TOTAL PAY**	**13746071**	**18562975**
	Consultant	2178141	3839531
	Non consultant medical	2022920	3466220
	Midwives	7636420	8107434
	HCAs	1619160	1612220
	Admin and Management	235870	402009
	Theatres and ST&T	53560	53560
	Anaesthetists	0	430000
	SCBU Horton	0	652000
Non Pay	**TOTAL NON PAY**	**2405109**	**2182520**
	Drugs	524190	493000
	Other Non Pay	1295830	1361880
	Internal recharges	224640	294640
	Ambulance	360449	0
	SCBU Horton	0	33000
Overheads	**TOTAL OVERHEADS**	**21341429**	**21341429**
	Indirect costs	4323385	4323385
	CNST - Maternity and Maternity incentive element	12263715	12263715
	Depreciation and Amortisation	992465	992465
	Other overheads	3761864	3761864

		1920 forecast (£)	Total births as per 1819 actuals plus 900 HH less 900 JR (£)
Expenditure	**JR**	**35485641**	**32623566**
Pay	**TOTAL PAY**	**12905591**	**11807969**
	Consultant	2178141	2178141
	Non consultant medical	2022920	2022920
	Midwives	6999880	6086852
	HCAs	1415220	1230626
	Admin and Management	235870	235870
	Theatres and ST&T	53560	53560
	Anaesthetists	0	0
	SCBU Horton	0	0
Non Pay	**TOTAL NON PAY**	**1999210**	**1798120**
	Drugs	524190	482000
	Other Non Pay	1250380	1091480
	Internal recharges	224640	224640
	Ambulance	0	0
	SCBU Horton	0	0
Overheads	**TOTAL OVERHEADS**	**20580840**	**19017477**
	Indirect costs	4140691	4140691
	CNST - Maternity and Maternity incentive element	11985784	10422421
	Depreciation and Amortisation	921169	921169
	Other overheads	3533196	3533196

		1920 forecast (£)	Total births as per 1819 actuals plus 900 HH less 900 JR (£)
Expenditure	**HORTON**	**2006968**	**9463357**
Pay	**PAY**	**840480**	**6755005**
	Consultant	0	1661390
	Non consultant medical	0	1443300
	Midwives	636540	2020582
	HCAs	203940	381594
	Admin and Management		166139
	Theatres and ST&T	0	0
	Anaesthetists	0	430000
	SCBU Horton	0	652000
Non Pay	**TOTAL NON PAY**	**405899**	**384400**
	Drugs	0	11000
	Other Non Pay	45450	270400
	Internal recharges	0	70000
	Ambulance	360449	0
	SCBU Horton	0	33000
Overheads	**TOTAL OVERHEADS**	**760589**	**2323952**
	Indirect costs	182694	182694
	CNST - Maternity and Maternity incentive element	277931	1841294
	Depreciation and Amortisation	71296	71296
	Other overheads	228668	228668

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Horton Health Overview and Scrutiny Committee.
19th September 2019

Chairman's Report:
Addenda

1. Introduction

1.0 The Horton Health Overview and Scrutiny Committee (HOSC) was formed as a mandatory joint committee between Oxfordshire, Northamptonshire and Warwickshire County Councils under Regulation 30 (5) Local Authority (Public Health, Health and Well-being Boards and Health Scrutiny) Regulations 2013, for the purposes of the specified consultation on consultant-led obstetric services at the Horton General Hospital (HGH). The committee first met in September 2018 to exercise its delegated health scrutiny powers, namely:

a) Make comments on the proposal consulted on
b) Require the provision of information about the proposal
c) Require the member or employee of the relevant health service to attend before it to answer questions in connection with the consultation.
d) Refer to the Secretary of State only on the consultation of consultant-led obstetric services at the Horton General Hospital where it is not satisfied that the following have been met:

- Regulation 23(9)(a) – consultation on any proposal for a substantial change or development has been adequate in relation to content or time allowed
- Regulation 23(9)(b)- a decision has been taken without consultation and it is not satisfied that the reasons given for not carrying out consultation are adequate
- Regulation 23(9)(c) - the decision is not in the best interests of the health service or local residents;

1.1 Throughout the last twelve months, the Horton HOSC has met on seven occasions to scrutinise the proposals of Oxfordshire Clinical Commissioning Group (OCCG) and Oxford University Hospitals Foundation Trust (OUH) to respond to the recommendations of the Secretary of State and Independent Reconfiguration Panel (IRP).

1.2 The Horton HOSC has expressed some concerns over a number of issues which relate to the health scrutiny regulation throughout the process of scrutinising the process and proposals for obstetrics at the HGH. The following outlines some additional information for the committee on those issues to consider in its scrutiny of the final proposal which will be set out by OCCG at the committee meeting of the 19th of September 2019.

2. Chairman's Response

2.0 As Chairman of Horton HOSC I was given site of the board paper only on Sunday 15th September 2019, via email, at 16.10, under embargo until 10am on Monday 16th September to allow me to prepare a Chairman's report to be circulated with the paper.

2.1 The following is a brief response to the board paper compiled in the time allowed. These are my initial thoughts as the Chairman that I would like the committee to consider in their deliberations and debate of the CCG paper. I believe this should include contemplation of the option this committee has of referring the OCCG decision (should it be agreed at their Board meeting on the 26th of September) to Secretary of State for Health and Social Care.

Process and information

2.2 The report to go the CCG Board is very disappointing. It is clear from the outcome that that OCCG and OUH believe that the response from the Secretary of State requiring further consultation was one of process, not engagement with a different outcome. The impression given is that the CCG and Trust believe that simply going through a 'tick-box' exercise and presenting the results of their work to HOSC at every stage would be enough to nullify any grounds for referral on process or decision.

2.3 Let me make it absolutely clear that at no point as the Horton HOSC 'signed off' on the outputs of the workstreams. Something that a reading of the minutes confirms. This committee has provided scrutiny as the process has developed, but at no point has the committee indicated it's satisfaction with the execution process the CCG set out in its plan to address the Secretary of State and IRP recommendations. In-fact, a reading of the minutes would give quite a different perspective. Whilst the committee did approve the overall process for the CCG to follow, I am sure members will be in agreement that the execution of that has been less than satisfactory.

2.4 The committee has frequently found the responses from both the CCG and the (OUH) trust to be evasive, unnecessarily complicated, and not in the spirit of cooperation that one would expect. The committee's health scrutiny powers mean it can require the provision of information about proposals; at times, I believe some of the responses to the committee have tested the limit of believability and have eroded the trust the committee has in the process. For example, at our meeting on 4th July 2019, in response to a question on staffing numbers, Dr Veronica Miller (OUH, Clinical Director, Maternity), stated that a staffing model requiring Doctors to work across both sites on a trust-wide basis would require more Doctors than models which would require the two sites at the Horton and the John Radcliffe to recruit separately on a site specific basis. Members were sufficiently surprised by the answer that the question was clarified so there could be no confusion at which point the answer was repeated.

2.5 Another example of evasiveness with the committee's requests for information is the eight months it took to provide financial data. Information promised in November 2018 was delayed, then inadequately provided in April 2019 before comparable

information was provided in July 2019. The committee's request for additional information on finances remains unfulfilled. The committee remain perplexed on how such a simple request could have taken such a long period of time and illustrates that engagement with the committee has been inadequate. These are just two examples of the many incidents which have made the scrutiny process excruciating and more difficult than It needs to be.

2.6 Given that scrutiny of difficult topics is effective elsewhere in the system, the actions taken here give the impression of an evasive and 'blocking' approach adopted by the Trust. I interpret this lack of a fully inclusive process as the CCG and (OUH) trust as having pre-determined the outcome of this process, that they have been working towards.

2.7 Similarly, when a topic has become 'too difficult' to deal with, the CCG and Trust have just dropped this from our discussions, not bringing it to further scrutiny meetings. Again, there have been a number of examples on this, but for example, I am sure that members will agree that the committee has still not resolved the questions it had around the recruitment process. The table below also highlights other open questions:

Meeting Date	Issue	Action	Provided or complete Y/N	Notes
28-Sep-18	Clinical view	Provide a clinical view on the acceptability of the quoted transfer times (30-120 minutes) from the Horton Hospital to the JR;	N	Not provided
28-Sep-18	Patient flow	Provide an overview of the data on mothers who have ***chosen*** to go to other hospitals because of the situation at the Horton and where those hospitals were;	N	At meeting of 25th of February 2019, the committee received information on pre-closure information on births from practices. The post-closure information was not provided.
26-Nov-18	Recruitment and retention	Share the report findings of Birthrate plus	N	Not provided
25-Feb-19	Population growth	Provide information on the extent to which the increase in the number of births and sustained housing growth across Oxfordshire would put another pressure on the John Radcliffe (rather than just the Horton)	N	Not provided to date
25-Feb-19	Transfer and travel times	In travel and transfer modelling- to add a minimum of four minutes to the times if there was not an ambulance on site to reflect what the transfer times would be with a usual ambulance	N	Not provided to date
25-Feb-19	Recruitment and retention	Provide a breakdown of the numbers of Doctors needed if the John Radcliffe and Horton Hospitals was an integrated site	Partially	Information presented at the committee's meetings of the 11th of April and the 4th of July which partially answered the question. Further request made at July meeting to present the information in a clear way. No further information provided to date.

Meeting Date	Issue	Action	Provided or complete Y/N	Notes
11-Apr-19	Options	To re-visit the weighting process to be both visible and transparent in order to give more confidence on the scoring for the committee- take it away to look at the process and how to share with and involve the Committee in it.	N	Not delivered
04-Jul-19	Recruitment and retention	To better explain what the staffing numbers are required for running across the two sites separately and two units run in an integrated way (as an urgent request between meeting)	N	Not provided to date
04-Jul-19	Financial flow	To include tariffs and to index to percentage of income/expenditure on the financial information provided. This is to understand the changes in birth rates (alongside tariffs) and therefore the income which has been gain or lost accordingly.	N	Not provided to date

2.8 Of these, the most concerning is the issue around re-visiting the weighting process. Despite a commitment from the OUH Chief Executive, Dr Bruno Holthof, to both revisit the weighting process and share this with committee, and to provide the weightings with Nick Graham, Oxfordshire County Council's Director of Law and Governance, this did not take place. There was no further communication with the committee re the weighting process and the weighting where only shared with Nick Graham (a week) after the process had been completed.

2.9 This is not a process which gives either the public or the committee confidence. It illustrates that the CCG and OUH have not provided information to the committee in accordance with the requirements of health scrutiny powers set by Regulation 30 (5) Local Authority (Public Health, Health and Well-being Boards and Health Scrutiny) 2013.

Interests of the local population

2.10 The unilateral decision to stop Consultant Led Maternity Services at the Horton as an emergency and temporary measure was purported to be on safety grounds. It is incredulous that the Trust has now engaged in a campaign to make any resumption of services appear to be cost prohibitive. Taken in insolation, this could be perhaps understood, if not accepted, but it again builds on the view that the trust have been working to a pre-determined outcome.

2.11 This brings me on to the assessment of other small units. Part of a full assessment of options should, according to NHSE guidance[1] include a clear clinical evidence base. This evidence-base has not been scrutinised by the committee and was only initiated at the behest of the committee. It should not be for the committee and Keep The Horton General (KTHG) to do the work for OCCG and the (OUH) trust. If there was genuine interested in exploring all possible options for the successful running of small units, this should have had a far greater significance in the work-streams. Instead, to conduct it at this late stage with such little investigation, again, does not give confidence in the system. The committee is particularly concerned that as soon it was announced that we would be conducting our own investigation, the response back was one of hearsay against other NHS trusts from both the CCG and the OUH, who suggested that other trusts might not be complaint and might lie or stretch the truth in their responses to the committee. This is not the response of an organisation engaging in the public process.

2.12 With regards to the recruitment of staff, the CCG and the Trust simply refused to bring this back for fuller examination but I would make the following observations:

- The committee does not accept that the Trust is doing all it can to recruit the necessary staff numbers. We fail to see how the internationally recognised brand of Oxford University leads to difficulties in this area, yet the OUH can recruit for other difficult areas.
- The committee remains unconvinced by arguments put forward that suggest a trust-wide model would require higher numbers of staff and is not viable.

[1] https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf

Afterall, this approach is adopted by the trust in other areas, such as Gynecology.

- The Trust's plans for the Horton, as already agreed by the board, allegedly require moving around 60,000 out-patient appointments to the Horton. So either the staff can work across a trust or they cannot. Further, it is simply incredulous to ask the committee to believe that the trust can find staff for such a high level of outpatient appointments, but will struggle for less than 2,000 births a year. I believe there has been a lack of genuine engagement in making recruitment to staff an obstetric unit at the Horton.

2.13 The information contained within Appendix 1 of this addenda outlines that the issue of genuinely and effectively addressing workforce at the HGH and maternity staffing at the OUH is a long standing one. The trust appears not to have sufficiently and aggressively tackled the recruitment and retention of staff, at this world-leading institution.

2.14 It also appears that the trust wishes to simply ignore the work of the public survey for the Horton Catchment area which found that:

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

2.15 The figures above clearly illustrate evidence to support that the decision of the CCG and OUH is not in the best interests of the health service or local residents (Regulation 23(9)(c) of the Local Authority (Public Health, Health and Well-being Boards and Health Scrutiny) Regulations 2013).

2.16 The responses from the (OUH) trust to the findings of the public survey work have been very disappointing; they have simply dismissed the legitimate claims of Mothers that deciding where to give birth causes them anxiety. The committee has found many pieces of peer-reviewed clinical research (listed in Appendix 2 in this paper) highlighting the negative links between anxiety in pregnancy and the effects on the baby. In some cases, these can be long-lasting and not immediately apparent. The most recent example of this was a study of 3,626 Finnish women which concluded:

> *"Children whose mothers experienced stress or moderate stress while pregnant were three times more likely to develop a personality disorder by the time they reached the age of 30. Meanwhile, children whose mothers experienced severe prenatal stress were 10 times more likely to develop a personality disorder."*

2.17 Furthermore, the OUH and CCG have simply dismissed the legitimate experiential evidence presented to the Horton HOSC where Mothers (and their families) describe terrifying birthing experiences caused by needing to transfer between the HGH and JR. The committee heard during its meeting of the 19th of December

2018, several cases where women had harrowing experiences because obstetric services were not available at the HGH. At no point has the Trust responded effectively to these experiences; they have simply said that cases are dealt with through their complaint systems. Their argument has been that because the experiences had not been at a threshold to trigger their 'clinical incident' procedures, the experiences were not considered as incidents. This ignores the link between mental and physical health in the maternity and postnatal pathways- which is a key focus of the NHS Long Term Plan. The following from the Birth Trauma Association[2] shows that whilst harrowing birth experiences, may not constitute a 'clinical incident', they have serious and chronic impacts on women, their babies and their families.

About 30,000 women a year, according to the most recent research, experience birth trauma in the UK. Instead of being joyful and happy, the experience of giving birth has been frightening…… Witnessing someone else's trauma can also be traumatic, so partners can experience Post Traumatic Stress Disorder (PTSD) too.

What is the impact of birth trauma?

PTSD is a distressing experience for anyone. For women experiencing the condition after giving birth, there are additional factors that make it particularly difficult:

- *Women with birth trauma often find it hard to bond with their baby. After a traumatic birth, it's not unusual for the mother and baby to be separated, either because the mother is ill or the baby is. Sometimes women give birth by caesarean section under general anaesthetic and are not present for their baby's birth. Women who have experienced this early separation often mourn the loss of those important early moments with their baby. Sometimes they feel guilty, and that they have let the baby down. Many feel a sense of distance from their baby, and tell us they're "going through the motions" of motherhood without feeling the overwhelming love that most mothers report. Others go to the other extreme and become overly-anxious about their baby, watching over it constantly and refusing to let other people even hold the baby.*
- *Reminders of the birth, such as a visit to the hospital, or even the sight of another woman with a newborn baby, can trigger flashbacks. For this reason, many women with birth trauma avoid contact with the hospital, or with medical professionals, or with new mothers. This is worrying because it means women may miss important medical appointments or stay away from mother-and-baby groups, leading to them becoming isolated.*
- *PTSD can make people extremely anxious and irritable, leading to relationship difficulties. When a woman has birth trauma, it can feel to those around her as if she is a completely different woman. Frequently, partners don't understand why the woman feels this way and think she should be able to just snap out of it, leading to further deterioration in the relationship. Friends and family also tend to advise women that they should "move on", or change the subject by making*

[2] https://www.birthtraumaassociation.org.uk/

comments such as, "But you have a lovely baby" leading to women feeling even more isolated.

- *Many women who have had a traumatic birth suffer from painful and distressing physical symptoms, sometimes as a result of tearing or other obstetric damage (see "A word about physical birth trauma" below). This can make an already difficult situation even worse.*
- *A traumatic birth can make women reluctant to try for another baby, so many women with birth trauma stop at one child. A subsequent pregnancy can also reawaken the trauma of the first birth.*

2.18 The summary provided above is backed by a body of clinical evidence[3] which at no time has been considered through the deliberations of the CCG and OUH on the clinical impact of having no obstetric unit at the HGH. This not only demonstrates that the consultation on any proposal for a substantial change or development has been adequate in relation to content (as stated in the 2013 regulation 29(9)(a), but that the proposals are also not in the best interests of the health service or local residents (Regulation 23(9)(c)).

Chairman's Recommendations to Horton HOSC

2.19 In summary, both in terms of process and outcome, it is my belief that this has not been a case in which the public can have confidence in the independence and robustness of the process. The committee will want to consider if the proposed decision will be in the best interests of the local population that this committee represents.

2.20 In 2016 the (OUH) trust made a decision to close Consultant Led Maternity Services at the Horton as an emergency and temporary measure which was purported to be on safety grounds. The information presented in this addenda suggests that instead of genuinely engaging in how obstetrics could be sustainable at the HGH, the impression has been one that a process has been followed, to reach a pre-determined outcome and to justify making this decision permanent. As such, I do not believe the committee's views will be genuinely heard by the CCG at their Board meeting on the 26th of September and I therefore recommend to the committee that if decisions are taken at that meeting, as per the board paper, that the committee agree to refer the decision to the secretary of state on the following grounds:

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

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

[3] https://www.birthtraumaassociation.org.uk/for-health-professional/research

2.21 Further, my concern is that the CCG and OUH have not followed the IRP advice which is something the committee will want to explore in any further referral of the decision to the Secretary of State:

- Whilst the CCG and OUH have heard from expectant mothers, contrary to the IRP advice they have not 'Learnt from the experience of mothers, families...'. a telephone call for priority parking is a disgraceful response as a solution and only serves to illustrate the trivial perspective of both the CCG and the trust on the experiences of the population of the Horton Catchment area.
- We cannot see, when weighted vs the evidence from public engagement, that there is anyway in which the solution which has emerged is in anyway 'the most desirable for Maternity services across Oxfordshire and all those who desire them in the future'
- Whatever the CCG present to the board, as outlined above, the committee unanimously believes that the CCG has not worked together to create a vision for the future that sustains confidence amongst local people and users of service.

2.22 Additionally, three of the points for referral from the original referral are still valid:

- The needs of local people have not changed and the arguments set out in the 2008 IRP judgement still apply
- The population of North Oxfordshire is set to grow
- There are ongoing issues with travel and access from the Horton to the JR for expectant mothers

2.23 In summary, there is sustainable demand for the Horton catchment area, the need of local people have not changed and the issues around traffic and parking capacity at the John Radcliffe will not change, there will be traffic and parking issues for many years to come (see Appendix 3 for just a few examples of planned road works), especially with the increased demand on that site from around Oxfordshire.

Appendix 1: Workforce

1.0 One of the Horton HOSC's areas of most close scrutiny has been that of the recruitment and retention of staff. The issue of most concern for the committee has been that the OUH have not sufficiently or effectively tackled the recruitment of the numbers and appropriate levels of Doctors to staff a rota which could see obstetrics be provided at the Horton General Hospital (HGH). The following highlights some of the information which illustrates how the several issues around management of people, including staffing support, recruitment, retention and succession planning has been a long-standing one for the OUH. The evidence from the following substantiates the Horton HOSC committee's concerns about the approach hitherto taken to recruitment of Doctors to staff obstetrics at the HGH.

1.1 Back in 2014, a CQC Inspection report of Maternity at the Horton[4] (May 2014) highlighted that there were "*good and safe staffing levels*" (p52), however it also stated the Trust had experienced difficulty in recruiting to medical posts in maternity and that there was a lack of succession planning at the HGH at the time. It stated:

"Most practice was in line with national guidelines. There were concerns about the lack of support for newly qualified midwives which may impact on care delivery. The labour delivery suite had been without a manager and there was a lack of succession planning. The service was well-led. There were clinical governance strategies and regular meetings which looked at development of the service. Staff felt supported within the ward and units; however, they told us they felt disconnected from the wider organisation".

Source: Maternity at the Horton[5] (May 2014)

1.2 It also stated the following, highlighting the models OUH was exploring at the time, which the Horton HOSC has heard are not viable:

The quality and audit paper from 2013 showed the trust was working with the University of Oxford and its partners in the community (including GPs and the Community Partnership Network) to formulate proposals to maintain a full obstetric service at the Horton. The proposed model involved joint clinical and research posts to support the obstetric roster. Staff and patients were passionate about keeping the local facility and had full support from the local community. The trust board members had engaged with the local community about the transfer of some services to Oxford".

Source: Maternity at the Horton[6] (May 2014)

1.3 The above quotes and the CQC report illustrated that in 2014, staffing levels were safe and although they were stretched, different ways of working and creative

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

management was deployed to maintain safe staffing levels. It does however show that the issues clearly needed proactive management.

1.4 The following quotes from a CQC maternity inspection in 2019 highlights how the same workforce issues remain in 2019, even with the Horton closed. This demonstrates that the workforce issue has not been solved through the closure of obstetrics at the HGH:

" Not all services always had enough nursing staff, with the right mix of qualification and skills, although they were working hard to remedy this. The Midwifery service did not have the planned numbers of midwifery and nursing staff which impacted on the women's choice. Staff worked flexibly to provide a safe service although there was not enough midwifery staffing to reach the Royal College of Obstetricians and Gynaecology (RCOG) recommended midwife ratio of 1:28"…….

…."The service met the Royal College of Obstetricians and Gynaecologists (RCOG) recommended obstetric consultant staffing levels but were shorter for their lower grades and relied on locum cover to cover the service"….

…"The trust must ensure there are sufficient numbers of suitably qualified, competent skilled and experienced staff to meet the needs of the service, both midwifery and medical".

Source: CQC Inspection report on OUH[7] (June 2019)

1.5 A Maternity staffing report[8] to the OUH Board in May 2019 recommended an increase in the maternity staffing resources for the Trust. It stated the following:

"This paper is to advise the Board the recommendations from BirthRate Plus and to support additional funding to increase maternity staffing levels.
In 2018, the Berkshire, Oxfordshire and Buckinghamshire Local Maternity System (BOB LMS) commissioned an external review of maternity staffing using the recognised BirthRate Plus tool (NICE 2015).

Birthrate Plus (BR+) is a framework for workforce planning and strategic decision-making and has been in variable use in UK maternity units for a significant number of years. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour.

The report recommends an increase in the midwifery staffing establishment to provide comprehensive package of care for approximately 7700 to 7800 births predicted for 2019-2020 in the hospital and community setting".

Source: Maternity staffing report[9] (May 2019)

[7] CQC Inspection Report on OUH. https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ4273.pdf
[8] Report to OUH Board on Maternity Staffing, May 2019. https://www.ouh.nhs.uk/about/trust-board/2019/may/documents/TB2019.58b-appendix.pdf
[9] Report to OUH Board on Maternity Staffing, May 2019. https://www.ouh.nhs.uk/about/trust-board/2019/may/documents/TB2019.58b-appendix.pdf

1.6 Having stated the requirement for additional maternity staffing, the report goes on to state the following:

It is recognised that there is a national shortage of midwives and although OUHFT is successful with recruitment, retention is challenging due to the cost of living in Oxford. Adding to this the new midwives cannot be recruited until they qualify in September. This means they are not available to work until mid-October after induction etc.

Source: Maternity staffing report[10] (May 2019)

1.7 The above quotes demonstrate the acknowledgement of OUH of the need to invest in their maternity workforce; this is despite of the known problems of national shortages in maternity workforce and the local cost of living issues.

3.1 The committee has identified through its scrutiny that there is a disparity between the focus and regard on the HGH, as a smaller county general hospital when compared with the tertiary and specialist centre that is the John Radcliffe in Oxford. This following information illustrates the effect of the disparity between the two sites on the HGH staffing. It substantiates committee's concerns about the lack of focus on recruitment of Doctors to staff obstetrics at the HGH.

3.2 In 2014, the CQC report on the Horton highlighted the staffing view of the workforce management issues at the HGH at the time. The following quote indicates a feeling that HGH-based staff did not feel equally regarded as staff at the JR. It states:

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

Source: Maternity at the Horton[11] (May 2014, p57)

3.3 The above was written in 2014, the temporary closure of obstetrics at the HGH was undertaken in 2016, (announced in July 2016 and enacted in October 2016) due to a number of resignations. The Horton HOSC committee has heard that there is a necessity to have specialist Doctors based at the JR because of the tertiary services provided there. The above quote powerfully how the nature of the services at the JR created a disparity between staff at the two OUH Trust obstetric sites and indicates that the success and focus on specialist provision creates a perceived "neglect" of the HGH.

[10] Report to OUH Board on Maternity Staffing, May 2019. https://www.ouh.nhs.uk/about/trust-board/2019/may/documents/TB2019.58b-appendix.pdf

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

3.4 The CQC Inspection report on OUH[12] (June 2019) reported concerns about the facilitates at the HGH. The CQC stated and recommended the following regulatory actions:

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

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

Source: CQC Inspection report on OUH[13] (June 2019)

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

Appendix 2: Anxiety and stress in Pregnancy

3.5 The Horton HOSC has heard that there is an increased level of anxiety and concern amongst Mother-to-be around the HGH catchment area since obstetrics has been temporarily closed. The committee asked whether there are any impacts of anxiety during pregnancy, the following outlines a small selection of the research related to anxiety during pregnancy. This includes an outline of the positive impacts of reduced anxiety on the birthing process.

Research on impacts of stress (or reduced stress) in pregnancy

Issue	Source	Summary
Stress hormones in Mother are reflected in amniotic fluid	Sarkar P, Bergman K, Fisk N.M, O'Connor T.G and Glover V (2007) Ontogeny of foetal exposure to maternal cortisol using midtrimester amniotic fluid as a biomarker. Clinical Endocrinology, Vol 66, No 5.	Stress experienced by a woman during pregnancy may affect her unborn baby as early as 17 weeks after conception, with potentially harmful effects on brain and development. Higher levels of cortisol (stress hormone) in the mother's blood is reflected in higher levels in the amniotic fluid.
How anxiety in Pregnancy impacts on the foetal brain	Anxiety During Pregnancy: How Does it Affect the Developing Fetal Brain? MGH, Center for Women's Mental Health (2011) https://womensmentalhealth.org/posts/anxiety-during-pregnancy-how-does-it-affect-the-developing-fetal-brain/	The reported study shows that pregnancy anxiety is related to specific changes in brain morphology. High levels of anxiety at 19 weeks of pregnancy were correlated with the volume reductions in several regions of the brain, including the prefrontal, lateral temporal and premotor cortex, medial temporal lobe and cerebellum. The regions most affected by high levels of anxiety are important for cognitive performance, social and emotional processing and auditory language processing.
Link of maternal anxiety to increased rates of ADHD	Van den Bergh B.R.H and Marcoen A (2004) High Antenatal Maternal Anxiety Is Related to ADHD Symptoms, Externalizing Problems, and Anxiety in 8- and 9-Year-Olds. Child Development. Volume 75, No 4	Maternal anxiety levels early in pregnancy -- during the 12th and 22nd week of pregnancy -- were strongly linked to ADHD in the children. Even after adjusting for child's gender, parents' educational level, smoking during pregnancy, birth weight, and postnatal maternal anxiety, prenatal anxiety (at 12 to 22 weeks) turned out to be a significant independent predictor of ADHD.
Link of maternal stress to personality disorders in children	Brannigan R, Tanskanen A, Huttunen M.O, Cannon M, Leacy F.P and Clarke M.C (2019) The role of prenatal stress as a pathway to personality disorder: longitudinal birth cohort study. The British Journal of Psychiatry. Vol 190.	Exposure to stress during gestation increases the odds of personality disorder (by three fold) in offspring, independent of other psychiatric disorders. These results suggest the assessment of maternal stress and well-being during pregnancy may be useful in identifying those at greatest risk of developing personality disorder, and highlight the importance of prenatal care for good maternal mental health during pregnancy.

Issue	Source	Summary
Link between maternal stress in pregnancy and foetal (neuromuscular and motor) development	Grace T, Bulsara M, Robinson M and Hands B (2015) *The Impact of Maternal Gestational Stress on Motor Development in Late Childhood and Adolescence: A Longitudinal Study. Childhood Development. Vol 87, No 1.*	Study showed a negative correlation between the effect of maternal stress on neuromuscular and motor development in offspring.
Depression in pregnancy leads to anti-social behaviour in teenagers	Hay D.F, Pawlby S, Waters C.S, Perra O and Sharp D (2010) Mothers' Antenatal Depression and Their Children's Antisocial Outcomes. Childhood Development, Vol 81, No 1.	Depression in pregnancy significantly predicted violence in adolescence, even after adjusting (controlling) for the family environment, the child's later exposure to maternal depression, the mother's smoking and drinking during pregnancy, and parents' antisocial behavior. Mothers with a history of conduct problems were at higher risk to become depressed in pregnancy, and the offspring of depressed women had a greater chance of becoming violent by age 16.
Lack/denial of delivery choice exacerbates tokophobia (pathological fear of childbirth)	Hofberg K and Brockington I (2000) *Tokophobia: an unreasoning dread of childbirth. A series of 26 cases*. Br J Psychiatry. 2000 Jan;176:83-5. https://www.ncbi.nlm.nih.gov/pubmed/10789333	Pregnant women with tokophobia (pathological fear of childbirth) who were refused their choice of delivery method suffered higher rates of psychological illness than those who achieved their desired delivery method.
Impact of maternal stress in pregnancy and impact on child development	Davis E.P and Sandman C.A (2010) The Timing of Prenatal Exposure to Maternal Cortisol and Psychosocial Stress Is Associated With Human Infant Cognitive Development. Child Development, Vol 81, No 1.	The consequences of prenatal maternal stress for development were examined in 125 full-term infants at 3, 6, and 12 months of age. Maternal cortisol (stress hormone) and psychological state were evaluated 5 times during pregnancy. Exposure to elevated concentrations of cortisol early in gestation was associated with a slower rate of development over the 1st year and lower mental development scores at 12months. Elevated levels of maternal cortisol late in gestation, however, were associated with accelerated cognitive development and higher scores at 12 months. Elevated levels of maternal pregnancy-specific anxiety early in pregnancy were independently associated with lower 12-

Issue	Source	Summary
		month mental development scores. These data suggest that maternal cortisol and pregnancy-specific anxiety have programming influences on the developing fetus.
Extended benefits of anxiety on children	O'Connor T. G, Ben-Shlomo Y, Heron J, Adams J and Glover V (2005). Prenatal Anxiety Predicts Individual Differences in Pre-Adolecent Children. Biological Psychaitry 58: 211-217.	Analysis of stress hormone levels (cortisol) in 10 year old children suggested that fetal exposure to prenatal maternal stress or anxiety affects a key part of their babies developing nervous system.
Impacts of reduced stress perinatal on birth		
Reduction in length of labour using hypnosis	Harmon T.M, Hynan M.T and Tyre TE (1990) *Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education.* The Journal of *Consulting and Clinical Psychology*. Volume 58, Number 5, Pages 525-30.	First time Mother hypnosis for childbirth clients, had an average of 4.5 hours of active labour, compared to 9 hours the average of 9 hours.
Reduction in length of labour using hypnosis	Jenkins M.W and Pritchard M.H (1993) *Hypnosis: Practical applications and theoretical considerations in normal labour.* British Journal of Obstetrics and Gynaecology. Volume 100, Number 3, Pages 221-226.	Findings showed a reduction in labour with first time Mothers of 3 hours and by 1 hour for Mothers in subsequent births.
Reduction in medication use	Bobart, V. and Brown, D.C. (2002). *Medical Obstetrical Hypnosis an Apgar Scores and the Use of Anaesthesia and Analgesia during Labor and Delivery*. Hypnos, 29(3), pp.132-139.	Study reported a decrease in the use of medication during labour. Epidurals were used by 97% of the non-hypnosis group and by only 38% of the hypnosis group. Analgesia was used by 75% of the non-hypnosis group, and by only 5.5% of those using hypnosis. 2.7% of the non-hypnosis group had a drug free birth compared with 61% of the hypnosis group. Baby Apgar scores were also significantly higher in the group using hypnosis.

Issue	Source	Summary
Use of intervention	Harmon, T.M., Hynan, M.T. and Tyre, T.E., 1990. *Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education.* Journal of Consulting and Clinical Psychology, 58(5), p.525.	reported that a higher than average 81% of first time mums using hypnosis, delivered spontaneously without the use of caesarean, forceps or venteuse.
Reduction in post-partum depression	McCarthy P (1998) *Hypnosis in obstetrics*. Australian Journal of Clinical and Experimental Hypnosis. Volume 26, Pages 35-42.	After providing 600 women with a 30 minute hypno-birthing session, the study found a virtual absece of postpartum depression compared to an average of 10-15%
Reduction in post-partum depression	Harmon, T.M., Hynan, M.T. and Tyre, T.E., 1990. *Improved obstetric outcomes using hypnotic analgesia and skill mastery combined with childbirth education.* Journal of Consulting and Clinical Psychology, 58(5), p.525.	Reported a reduced incidence of postnatal depression in women who had been taught hypnotic analgesia for childbirth.

Appendix 3: Planned works on the HGH/JR travel route

3.1 An issue of serious concern to the Horton HOSC committee has been the travel distance and time between the HGH and the JR to enable safe transfer of women in emergency situations. The committee has heard evidence of the travel and transfer times and understand road conditions at the time of day in question influences the exact travel/transfer time.

3.2 The following list highlights the minor roadworks planned which are likely to exasperate the travel situation. This does not include the travel and traffic disruption which would occur should the Oxford to Cambridge arc road be approved and developed across the area.

- Combined safety scheme at Hennef Way approach and return to Southam Rd roundabout – sections of antiskid and remarking roundabout – timings TBC
- Surface dressing at A4260 Steeple Aston duals to Hopscroft Holt – (forecast to be finished in July 2019, but it's still active)
- Carriage way resurfacing from Old Parr Road to Farmfield Road (A4260) – timings TBC
- Traffic lights for various roadworks on A4260- from 12 Aug – 6 Sept
- Traffic lights for various roadworks from Bucks County Council on A41/B4100 from 14 Jan – 18 Oct 2020
- Traffic lights for various roadworks on Wendlebury Road, Chesterton (B4100) 8 Jul – 4 Oct 2019
- Access to Headington Roadworks –due to be completed in September 2019