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

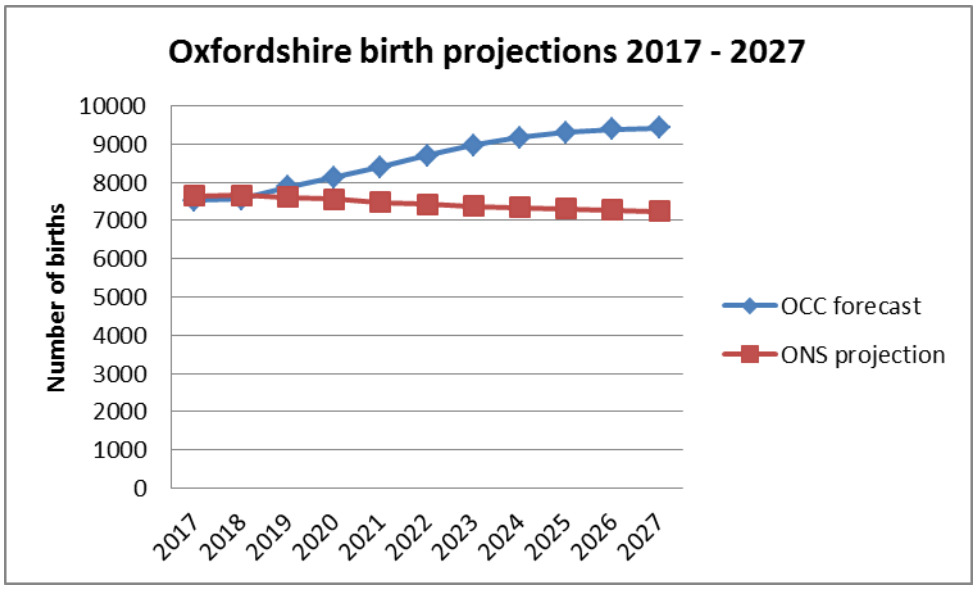
4.1 Current and future demand for maternity services

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



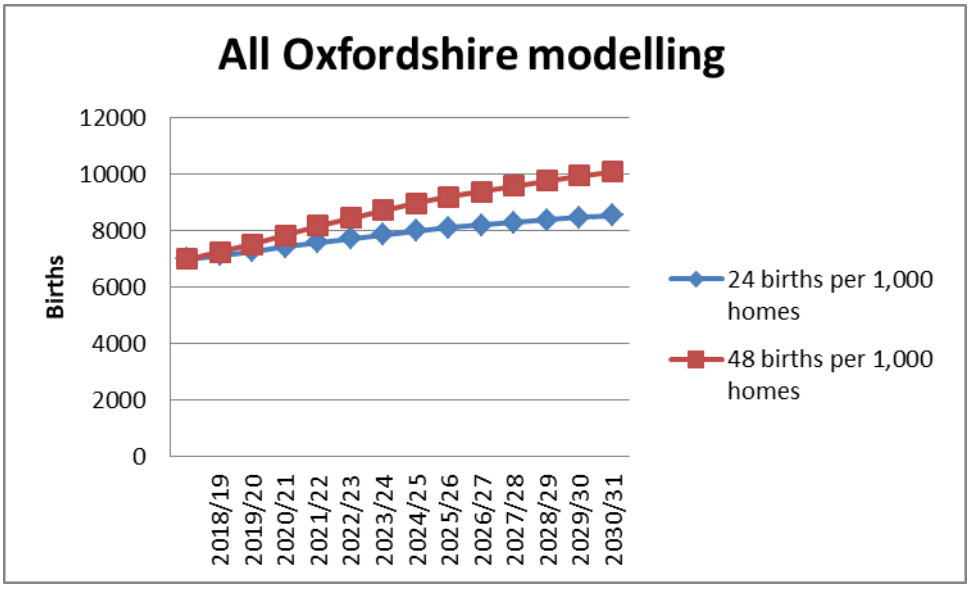
[1] Oxfordshire County Council housing-led population forecasts published August 2019

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:

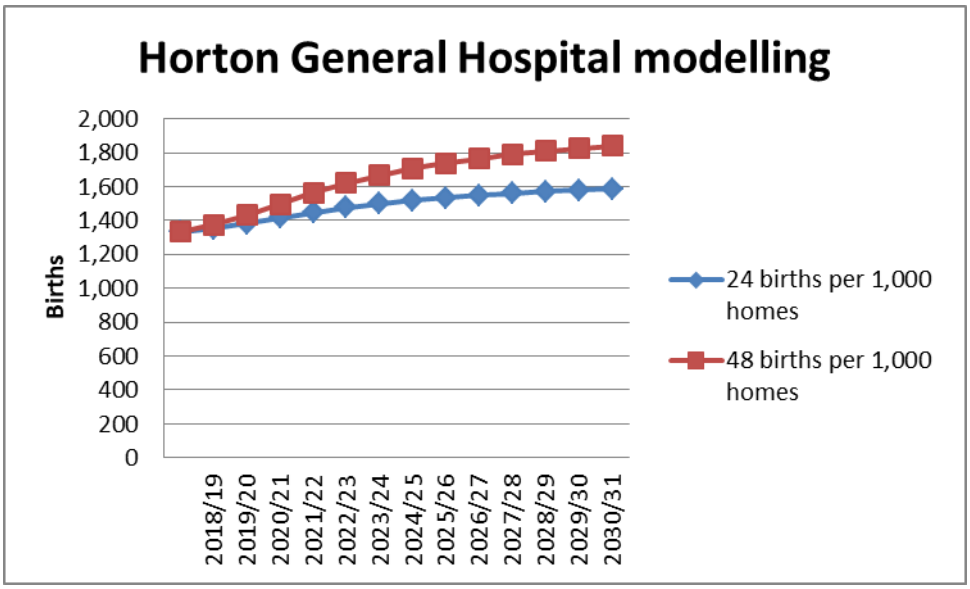
Diagram 2: Modelling the impact of housing growth on births for all Oxfordshire (GP registered population)



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).

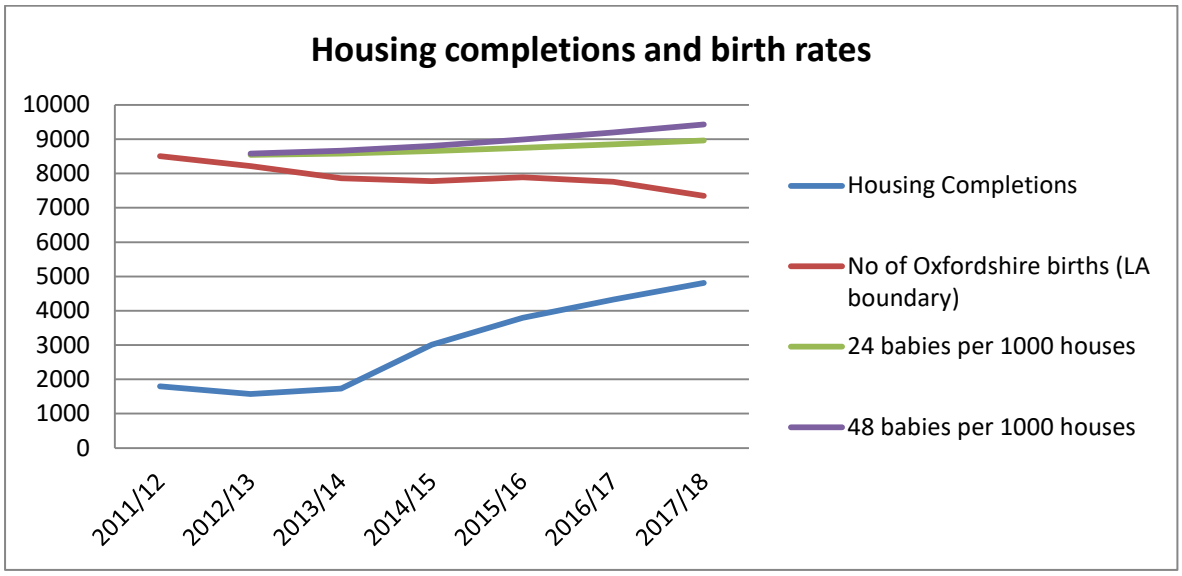
4.1.3 Historical trends in birth numbers

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.

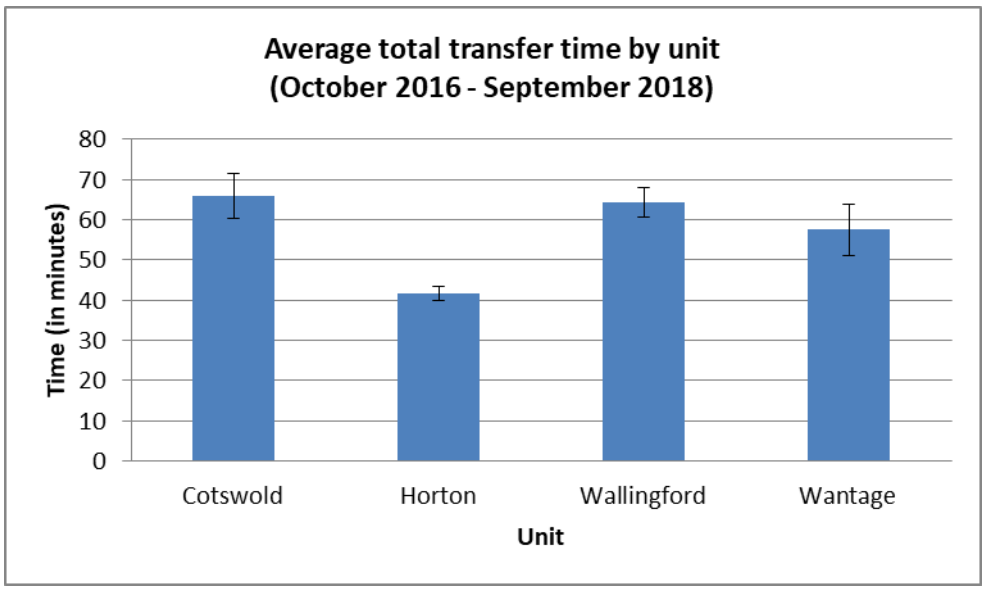
It is clear from the travel analysis that was undertaken as part of the original consultation process and the additional information from the survey that increased travel time, and in particular its variability, has a negative impact on those women who would have chosen to use the Horton obstetric service. 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