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