Guide – Maternity

The plan intends to make removal of HGH consultant led maternity to the JR in Oxford, permanent. The temporary closure was forced on the Horton for want of five middle grade obstetric doctors to replace five clinical research fellows whose posts were removed by the Post Graduate Dean in 2012.

The JR obstetric unit, according to PCBC p72, was short of 62 hours' clinical cover in 2016. It is difficult for the OUHFT to recruit to Oxford because of the extremely high cost of living in and around the city. The Co-incidentally, the Oxford University Hospitals Foundation Trust (OUHFT) has since benefited from five Horton Obs-Gynae consultants and the middle grades recruited thus far for when the Horton CLU reopens (5 as of March). The JR clearly benefits from the Horton's staff but we believe it is safer for this population to have the benefit of those specialists designated for this hospital, and for greater ease of facilities for expectant mothers at the JR.

Trust claims to have worked hard to recruit internationally for the obstetric vacancies at Banbury. Offers by a cohort of experienced Ugandan specialists to take up vacant positions – effected through Horton staff and Keep the Horton General – in a bid to avert the October crisis, were rejected by the trust. Recruitment since then has received significant interest but no 'takers' because of the downgrading cloud hanging over the Horton. Those appointed to 'Horton' positions have been adopted by the JR team. No evidence has been presented publically that the Trust has actively attempted to recruit from the Indian subcontinent despite the fact that the majority of foreign doctors working in the UK hail from India.

The document claims that "irrespective of the numbers of births, OUHFT would not have enough doctors to staff the [Horton's obstetric] unit. This makes it unsafe for current and future demand and an unviable option for the future." This is absolutely unproven and is totally counter to the claim that the Trust has made, since July 2016, that it is committed to retaining a consultant-led unit (CLU) at the Horton. What the c50 applications received for the advertised nine posts (now deemed necessary to run the CLU safely) does demonstrate is that doctors really do want to live and work in Banbury - even during the threat of downgrade to the hospital.

The Thames Valley Strategic Clinical Network Review's analysis said there will be an 8% increase in births in the next decade. (p72) This includes assumptions about housing growth

but the plan deliberately omits Banbury as one of the rapidly growing housing areas in the PCBC appraisal of major development. The review said Oxfordshire is 'at capacity' in delivering 6,000 women in its CLUs and 'work is needed to increase capacity'. The PCBC calculates Oxfordshire's expected births at c8,500. While Midwife only units (MLUs) are to be considered in Phase 2 of the OTP, it is clear this number cannot be managed at the JR which is bursting at the seams with its current c6,000 births.

Sharing the 8,500 between the JR and the Horton makes absolute sense as it would allow the Banbury hospital to regain training accreditation- and thus have no problem staffing the unit - and ease pressure at the JR. Many of the 2,500 births needed to satisfy that training recognition, if not all, would come from the Banburyshire/W Oxon catchment. That capacity should be created at the Horton General Hospital to provide equitable access to consultant-supervised births.

With the clear intention of closing the Chipping Norton midwife-only unit (MLU), the Horton is in more need than ever of its obstetrics to ensure choice and safe provision of maternity care for a rapidly growing population.

The PCBC professes there are 'more complex pregnancies' needing specialist care. This reinforces the case for retention of the Horton obstetric unit still further.

The Oxfordshire Transformation Plan enthuses over bringing more patients to the Horton and saving travel to Oxford. It makes equal sense for the few specialist doctors to be based in an obstetric unit in Banbury than many hundreds of mothers going to the JR. An increase in complex pregnancies highlights the need for more obstetric units, not fewer, giant ones.

Obstetrics (the largest Horton department) allows other services including anaesthetics, paediatrics and A&E to be maintained. This is one of the reasons it is impossible to run public consultation in two parts as all the Horton's core, acute services are interdependent.

The Horton has always acted as a safety valve for the JR for maternity, paediatrics, trauma and A&E. Frequently, when the JR has had no capacity patients/expectant mums have been diverted to Banbury. Other hospitals have also had the security of knowing they could transfer patients to the Horton. Without Banbury's CLU, expectant mothers (and other patients) could have to travel as far as Warwick, Northampton etc for obstetric care. If

those overburdened units are also full, having absorbed deliveries from other closed DGH departments, fatalities are inevitable. We are aware of the JR's CLU being at capacity on numerous occasions, with women labouring in waiting areas and delivering in side rooms because there was no space for them in birthing suites or on wards.

With every extra mile a mother's right to patient choice diminishes and the risk of complication increases.

Banbury contains three of the most deprived wards in Europe. This fact means that a significant proportion of pregnancies are higher risk.

The Independent Reconfiguration Panel (IRP) in 2008 decreed that Banbury (25+m from the JR) was too far to humanely or safely transfer sick patients, adult and children or mothers in labour. The only thing that has changed since is the population/catchment has increased markedly, is planned to grow rapidly and traffic/congestion has got much worse, as evidenced by Oxfordshire County Council's entreaties. Oxford City Council has said it will not countenance changes to allow more traffic because of the effect on residents, making centralisation appear an impossible exercise.

The OTP, by design part of the Sustainability and Transformation Plan for Bucks, Oxon and Berks West (BOB), ignores the needs of one third of the catchment of the Horton – those living in south Northants and south Warks whose communities have always relied on Banbury and its services.

According to recent figures the MLU in Banbury has delivered 60 babies. 40% of deliveries were transferred to Oxford, as births in progress or with complications after delivery. To attain agreement for the temporary removal of obstetrics, the OUHFT paid for a dedicated, private ambulance which is supposed to be parked outside the unit 24/7. The OUHFT has intimated this will not continue after consent is given for a permanent MLU. That leaves expectant mothers no confidence in giving birth so far from specialist. Claims in the PCBC that women have better outcomes in MLUs contradicts the fact that only 6% of women (nationally) choose to give birth in an MLU and even then we know transfer rates are 40%. And we know that Banburyshire GPs will not advise their patients to give birth at the Horton General. They are wholeheartedly against removal of the CLU.

The OTP fails to be honest with stakeholders about the considerable risk to babies and women in an MLU who experience unexpected complications eg requiring a C-Section, gynae surgery or a blood transfusion. For every 1000 babies born in Britain 2.9 are stillborn.

How will the JR cope if it experiences many more births than anticipated, if fewer births take place at the MLU at the Horton than predicted, as is happening? As that unit is staffed by only one on-call midwife, with an assistant, this is a real possibility. KTHG is receiving reports of midwifery staff going off on long term stress leave, suffering unacceptable stress and overwork, and junior midwives being left in charge without adequate support too soon after qualification because of the impossible pressure on the JR birthing unit.

We are aware of one needless tragedy associated with the removal of CLU from Banbury. Scarcely three weeks after the Horton's maternity unit was temporarily downgraded, a baby was born deaf and blind as a result of having been in distress during labour. The mother could not be transferred to the JR because their obstetric unit was at capacity. The baby is surviving via tube feeding. Another baby was delivered in an ambulance en route to JR. We have unconfirmed reports of a baby being delivered on the hard shoulder of the M40.

OUHFT claims that CLUs experiencing fewer than 2500 births a year are unsafe because training doctors do not see a sufficient number or variety of complex cases to maintain their skill and experience. This attitude isn't shared on the continent: eg In Germany most obstetric units experience far fewer than 2500 births per year – the threshold for training accreditation at a British unit. The average number of births in German hospitals is 900 a year; 2500 births+ is a very large unit and 6000 births would be considered folly. Many training doctors prefer smaller units because they allow more one to one time with patients.

Prior to 2015, birth figures for the Horton were higher than the 1466 that year- over 1700 in 2014. OUHFT claims "number of births at the Horton has continued to decline". This was because OUHFT altered the rules eg expectant mums with high BMI, are diabetic or expecting twins (that previously delivered at the Horton) were compelled to go to the JR. It is worth noting that the RCOG itself concedes "the number of births in a unit does not necessarily reflect the number of complex cases requiring consultant input".

OUHFT acknowledges "the outcomes reported by both units (Horton/JR) are similar". So there was absolutely nothing wrong in terms of safety with the Horton's birth outcomes as a smaller obstetric unit.

Training status at the CLU was withdrawn in 2013. The RCOG raised the threshold from 1500 to 2500 births which had a direct effect on HGH. This discretionary threshold shows a worrying disconnect between the healthcare needs of tens of thousands of people and the decisions of those with the power to confer training status. Depending on the Deanery, policy and procedure on training status can vary. This inconsistency is borne out when one considers that there is a number of hospitals with fewer births than the Horton which have retained training status in spite of this, e.g. Barnstaple, Aberystwyth, Dumfries.

The Postgraduate Dean has said that training status for the Horton could be re-conferred if the unit reached 2000 births per year. This is less than 400 more births a year than were taking place before the Trust changed the protocols and removed almost all complicated births to the JR, and would be achievable within the next few years, given the development and population increase expected.

OUHFT has demonstrated it is not difficult to allocate significant numbers of expectant mothers to a particular hospital where there is a will, so one obvious solution is for this arrangement to work in reverse. This would a) increase the numbers of births at the Horton resulting in it regaining eligibility for training status, b) ease the burden on the JR which will otherwise be the sole enormous obstetric centre for the whole of Oxfordshire, if the OTP is approved.

The inevitable outcome is the JR becomes an over-stretched 'birth factory', struggling to cope with demand, compromised by delivering poor birth experiences for vast numbers of women.