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

Paper for the Joint OSC meeting 4 July 2019

Work stream 5a – Workforce analysis.

1. Introduction

This paper brings together several sections of the Information Pack shared with members of the Scoring Panel. More information including the detail of the calculations and the generated rotas are available in the pack, published on OCCG website here.

This paper includes the following:

- Careers in obstetrics and gynaecology
- Workforce planning in obstetrics
- Summary of obstetric staffing numbers required to support each option
- Non-obstetric workforce requirements
- Recruitment and retention of the obstetric workforce

2. Careers in Obstetrics and Gynaecology

Obstetrics is the area of medicine that looks after mothers and their babies before, during and after birth.

Gynaecology is the area of medicine that covers female reproductive health outside of pregnancy. This includes reproductive and fertility medicine as well as sexual and reproductive health. The common link is women's health: before, during and after the reproductive years.

Doctors who choose to work in this speciality have combined training both in obstetrics and gynaecology and the majority of consultants are Consultant Obstetricians and Gynaecologists. Some consultants having undertaken additional higher training are recognised as experts in a particular field. They are known as Consultants with Subspecialist training. At this point they are usually either Consultant Obstetricians or Consultant Gynaecologists.

2.1 Training to become a Consultant Obstetrician and Gynaecologist

For the purposes of these options "doctors in training" are those learning to become an Obstetrician and Gynaecologist but who are not yet approved onto the Speciality Register (which is required to practise as a Consultant in the NHS). Doctors in training, also known as 'Junior Doctors', work alongside consultants under their supervision.

The newly qualified doctor finishes University and then works for 2 years in a foundation scheme developing general clinical skills under supervision, in this period they are known as FY1s and FY2s (FY - Foundation Year).

After this foundation period, the doctor can then apply for a 7 year speciality training scheme. To advance in their speciality career, the doctors have to gain clinical experience and be assessed as competent in specific clinical skills.as well as passing professional exams. So for example in Obstetrics and gynaecology to move from a level of year 3 specialist training (ST3) to year 4 (ST4) a doctor would be expected to demonstrate they can safely deliver a baby by forceps or perform a basic emergency caesarean section independently and have passed part 1 the RCOG membership exam.

Specialist trainees in years 4 and 5 (ST4-5) can work more independently but require supervision for more complex cases. In year 6 and 7 (ST6-7) there is the opportunity for sub speciality training in a more defined area of obstetrics and gynaecology. When a doctor successfully completes training they are awarded a **Certificate of Completed Training** and can be added to the Specialist Register. They are now able to work as a consultant in Obstetrics and Gynaecology. Some doctors who have trained outside the NHS can apply to get on to the Specialist Register by applying for a **Certificate of equivalent specialist registration (CESR).**

2.2 Medical teams in Obstetrics

To run a service a team of doctors is required. This is usually led by a consultant and made up of 3 tiers:

- **Tier 1** is made up of qualified doctors with general clinical skills but fairly new to the speciality .e.g. FY2/CT2/ST1-3/General Practice Trainees
- **Tier 2:** Doctors who are clinically competent to perform routine speciality clinical duties but require further supervision for complex cases. E.g. ST4-7/Trust grade doctors/Subspecialty trainees and associated speciality doctors
- **Tier 3:** Consultants who are on the Specialist Register. In large specialist Hospitals, there are some consultants who are experts in a specialist field and have skills beyond that of a general obstetrician.

2.3 Number of medical staff required to run a service

This depends on the size and type of maternity service. A small unit with less complex cases and fewer deliveries happening over a period of time will require different resources that a large busy unit with specialist services and a higher foot fall through delivery suite.

Doctors are not just required to assist the labour ward but to attend women who are inpatients or present through Emergency Department and the Maternity assessment units.

A smaller unit may require 2 doctors to be present with as a larger unit may require 3 with consultants on call from home. Traditionally the recommended numbers are as below from Safer Births 2007 however it is recognised that other models of care can be used for very small units which have less than 1500/deliveries per year. The recommendations with regards to the number of hours of consultant presence should be agreed at a local level. A minimum of 40 hours is recommended for all obstetric units and in larger units such as the JR this could be up to 168 hours.

The local arrangement is currently for 114 hours at the John Radcliffe Hospital and 40 hours at the Horton General Hospital.

Births/year	Resident doctor	Total (including on call consultant at home and gynaecology)
<2500	2	3
2500-4000	3	4
4000-6000	4	5
>6000 (may have split service)	4	6

3 Work force planning in Obstetrics.

3.1 Junior and middle grade doctors

The rotas described will be compliant with the 2016 contract introduced in England for GP trainees and trainees in hospital posts approved for postgraduate medical/dental education Maximum average 48 hour working week (reduced from 56) with doctors who opt out of the WTR capped at maximum average of 56 working hours per week. This includes the following:

- Maximum 72 hours' work in any seven day period (reduced from 91).
- Maximum shift length of 13 hours (reduced from 14 hours).
- Maximum of five consecutive long (>10 hours) shifts (reduced from seven) with minimum 48 hours rest after a run of five consecutive long shifts (up from 11 hours rest).
- Maximum of four consecutive night shifts (reduced from seven) with minimum 46 hours rest after a run of either three or four consecutive night shifts (up from 11 hours rest).
- Maximum of four consecutive long, late evening shifts (>10 hours finishing after 11pm) with minimum 48 hours rest after four consecutive long, late evening shifts (up from 11 hours rest).
- No doctor should be rostered to work more frequently than one weekend in two (a slightly different definition of weekends applies to F2 doctors for one rotation only).
- Maximum eight consecutive shifts with 48 hours' rest after eight consecutive shifts (reduced from 12 consecutive shifts), apart from low-intensity non-resident on-call rotas, for which a 12-day maximum applies.
- No more than three rostered on-calls in seven days except by agreement, with guaranteed rest arrangements where overnight rest is disturbed.
- Maximum 24-hour period for on call which cannot be worked consecutively except at weekends or by agreement that it is safe to do so.
- Work rostered following on-call cannot exceed 10 hours, or 5 hours if rest provisions are expected to be breached.

3.2 Consultant Job plans

This is in line with the BMA recommendations for consultant resident on call duties and with the RCOG workforce report 2017.

- A consultant will not work more than 3 PAs/week of out of hours duties.

- In order to provide continuity of a specialist tertiary service, these specialist consultants will work no more than 2.2 PAs/week of out of hours service.

4. Summary of obstetric staffing numbers required to support the options for obstetric provision

Option number	Number of consultant obstetricians	Number of middle grade doctors	Number of tier 1 doctors	Associate specialists MSW	Total additional staff required	Paper ref no.
Ob1	20 (15 JR 5 HGH)	29 (9 HGH 20 JR)	15 (JR) 3 (HGH)	4 (HGH)	0	Papers 1-10
Ob2a	30 (total) 15 (JR) 20 (HGH)	20 (JR)	15 (JR)	4 (HGH)	15 consultants	Papers 10-11
Ob2a (with Tier 1 support)	30 (total) 15 (JR) 15 (HGH)	20 (JR)	15 (JR) 9 (HGH)	0	10 consultants 9 tier 1 doctors	Paper 11
Ob2b	30 (total) 32.4 (total) if no tier 1 support	20 (JR)	15 (JR) 9 (HGH)	Or 6 (HGH)0	10-12.5 consultants but would need recruit subspecialist consultants rather than general consultants	Paper 12
Ob2c	20-40 (total see table in paper 13)) 15 (JR) 5-20 (HGH see table in paper 13)) 5-23 if no tier 1 support)	20 (JR) 0-9 (HGH)	15 (JR) +/- 9 (HGH)	+/- 6 (HGH)	See Table in paper 13.	Paper 13
Ob2d	21-33 (see table in paper 15)	20-28 (see table In paper 15)	15 (JR) 9-1	3-6	See Table in paper 15	Papers 14,15
Ob6	16	20	15	0	0 current temporary reconfiguration	
Ob10	20	30	15 (JR) 9-1(HGH)	3-6	1 Trust grade.	Paper 16
Ob 11	20	30	15 (JR) 9-1 (HGH)	3-6 (HGH)	1 middle grade Same as above as limited by post 2016 contract. May be easier to recruit into	Paper 16

Note: All papers referred to in this table are available in the Information Pack published on the OCCG website here.

5. Non-obstetric workforce requirements to open an obstetric unit at the Horton

This paper provides an overview of the other staffing required to re-open the Horton Obstetric unit. For the purpose of the option appraisal scoring it should be assumed that the funding for this level of staffing is within the baseline budget of services so would not differentiate between options in the scoring process under the finance criterion. However as staffing two obstetric units requires more staff than one unit in areas where there are national workforce challenges this could be considered in scoring the ease of deliverability criteria.

5.1 Anaesthetic staff

To safely run / reinstate an obstetric service, the Trust would need to staff a minimum of a 12 WTE on call rota. Part of the issue will be to find enough elective daytime work for all the consultants to have 12 on the on call rota. A purely non-resident rota cannot be run at the Horton as there are only four CT1 junior trainees and a few specialty doctors of CT2+ / ST3 level (to prop up the junior rota) and the nature of the workload requires someone of ST5+ experience / training to safely have a non-resident consultant covering.

There are currently 9 of the 12 consultants/associate specialists required in post so the Trust is currently short for the out of hours cover. That is in addition to the daytime sessions currently provided (equivalent to 9-5 cover on weekdays). The present resident on-call rota was started about 10 years ago on the understanding / expectation of increasing consultant numbers to allow a 1:16 rota. The current workforce plan still includes 12 not 16 consultants. At the time existing staff went up to 13.5+ PA job plans, expecting to drop back to 10 once enough staff were recruited; this expansion in staffing has not happened and there are vacancies in the core establishment.

The Directorate are planning to recruit again for these posts and the job plans will include Oxford lists but the job market is challenging. The last time the Trust was recruiting Consultant anaesthetists there were three applicants for three posts but only one met the requirement and was appointed.

5.2 Midwives

The tables below summarises the midwifery staffing required to re-open the HGH obstetric unit and includes

- Current staffing at the Horton
- What staff would be needed if it opened with the previous numbers of deliveries occurring at the Horton General Hospital
- The current gap

In- Patient Services-Midwives	Current WTE	Required WTE	Gap WTE
Band 8A Midwives	0	1	1
Band 7 Manager	0	1	1
Band 7 Coordinator	2.77	5.52	2.75
Band 6 Midwives	2.88	19.87	16.99
Band 5 Midwives	0	2.94	2.94
Total Midwives	5.65	30.33	24.68

In- Patient Services-MSW	Current WTE	Required WTE	Gap WTE
Band 3 MSW-	2.93	7.42	4.49
Band 2 MSW	1.22	2.89	1.67
Total MSW	4.15	10.31	6.16

Out-Patient Services-Midwives	Current WTE	Required WTE	Gap WTE
Band 7 Manager	1.6	1.6	0
Band 6 Midwives	2.61	3.52	0.91
Total Midwives	4.21	5.12	0.91

Out-Patient Services-MSW	Current WTE	Required WTE	Gap WTE
Band 3 MSW	3.2	3.2	0
Total MSW	3.2	3.2	0

Theatre Team	Current Team	Required Team	Gap Team
24h hour resident theatre team	0	3	3
Total	0	3	3

Midwife recruitment is challenging nationally as well as locally. The Trust keeps its approach to recruitment and retention under review and is implementing the following:

5.3 Recruitment

- Recruitment open days
- An agreed uplift in the number of midwives to be recruited
- Continue to actively advertise for midwives throughout the year
- Work with Oxford Brookes University to recruit student midwives due to qualify in 2019
- Training six Assistant Practitioners (band 4) to support midwives
- Reviewing new roles i.e. Discharge Coordinators, Recovery Nurses, Obstetric Nurses etc.
- Offering Midwifery Apprenticeships
- International recruitment to India in March 2019 for Obstetric Nurses
- Flexible working opportunities
- Considering flexible working packages for midwives wishing to retire and return
- Working with the Berkshire, Oxfordshire and Buckinghamshire Local Midwifery System to review workforce planning and initiatives across the Thames Valley

5.4 Retention

- Proactive exit interview with an emphasis on what would support individuals to stay
- Promotion of flexible working opportunities
- Offering further training opportunities for staff
- Working with the wider Trust to look at incentives to recruit and retain staff
- Review Preceptorship package

5.5 Neonatal nurses

A level one Special Care Baby Unit requires the following in order to meet BAPM standards.

One Neonatal Nurse for every four patients, however you cannot leave one Registered Nurse (RN) on their own so you will need two RN's on a shift, so could staff up to eight cots with the resource. To staff 24 hours a day with two RNs requires an establishment of 10.3 WTE. RNs (this would include the sister in charge of the unit). There may be up to three RNs who would transfer from the JR and the remaining posts would need to be recruited to.

Recruitment of neonatal nurses is challenging not just in Oxfordshire but nationally. The Trust has a rolling advert and there is at present a specialist course at Brooks University.

5.6 Other staff

One ward clerk would also be required.

6. Recruitment and retention of the obstetric workforce

The work undertaken on modelling the rotas for the various obstetric workforce models and included in this pack has indicated that the determining factor is the number of doctors required to provide a 24/7 safe staffing level. Learning so far from other smaller obstetric units suggests that medical staffing is also the largest challenge for them. To implement any of the models requires us to recruit doctors (at minimum to fill current vacancies and for some models additional doctors, particularly consultants, would be required).

The national picture for the obstetric workforce shows that there are several challenges. The latest report from the Royal College of Obstetricians and Gynaecologists (RCOG) "O&G Workforce Report 2018" (available here) highlights the following;

- 9 out of 10 obstetric units report a gap in their middle-grade rota, which can affect job satisfaction, postgraduate training, quality of care and staff wellbeing
- A 30% attrition rate from the training programme is typical, further compounded by a loss at transition from training to consultant grade posts
- 54% of those on the O&G Specialist Register are international medical graduates with 14% from the EEA
- O&G services rely on the significant contribution of Specialty and Associate Specialist (SAS) doctors and Trust doctors, however there is a significant

turnover among this group with around 12% leaving the NHS workforce in England each year

- Although the majority (63%) of doctors provide both O&G services, 20% provide services in gynaecology only
- Workforce planners predict an increased number of consultants will be required on top of the projected supply by 2021

6.1 Consultants

The Trust is not fully staffed at consultant level (in November there were five vacancies). Filling these posts will have some difficulty and any of the models that have a large increase in consultant staff will be very difficult to recruit to especially as in these models consultants are required to undertake resident on-call work. Consultants at the Horton General Hospitals would probably largely be consultants in obstetrics and gynaecology (as is the model in other small units) and therefore there also needs to be capacity for the daytime surgical work. It would be important to focus on the benefits of working in a local unit with a defined catchment that can be forward looking in implementing the community hub model of "Better Births" and working in partnership with the specialist services provided by the same Trust at the John Radcliffe Hospital.

6.2 Middle grade doctors (Doctors in training/Speciality and Associate Specialist and Trust Doctors)

The RCOG confirmed that most obstetric services need to supplement their trainees with other doctors in order to have sustainable rotas. Information we have received from other small units indicates that their middle grade rotas have other doctors as well as doctors in training on them.

Following previous advice from the RCOG and input from the HOSC, the Trust has put in place several measures to make the middle grade doctor post as attractive as possible, including:

- additional salary allowance in recognition of shortage post
- generous relocation allowance
- time at the John Radcliffe to maintain and develop skills and the opportunity to participate in more specialist projects to help career development
- using an international agency to test the market for doctors at this level
- rolling recruitment advert

Through these methods, we have managed to recruit between two and five middle grade doctors at any one time, who want to work at the Horton. We have not come close to sustainably recruiting nine.

The RCOG has highlighted some further options for recruiting middle grade doctors which included:

- Trust Doctors are employed directly by trusts and their contracts aren't subject to national terms and conditions. This is the type of role that the OUH have been trying to recruit too and on its own has not enabled nine doctors to be in post.
- Medical training initiative (MTI) doctors from overseas who are qualified and competent at ST3 and come to train and get their RCOG specialist

accreditation. For the first year these doctors would not be able to provide the resident on-call service at the Horton so a 2-3 year on-going programme would be required with one year solely at the John Radcliffe and then 1-2 years supporting the Horton rota. This programme is in very early development so we would be piloting a new approach and we do not therefore have evidence on how successful it would be.

- We could run a dedicated sponsorship scheme, making connections with specific maternity units in a small number of international markets where there is good supply of obstetricians and we believe we could make a competitive offer. We would then set up some form of rotation scheme with the specific Unit. More testing of appropriate markets and Units would be required.
- Piloting a 'Step Away and Step Back' scheme for experienced doctors who are considering leaving the profession but who would be willing to work on the middle grade rota in a smaller unit for some time, in return for changes to working patterns e.g. to go part-time. We would need to ensure any doctors under this scheme had enough support on hand and are able to provide appropriate out of hours cover.
- Re-introducing trainees in order to allow for supervision opportunities which are positive for career development. Our models include using the maximum 8 hours that trainees can spend in units without training accreditation. If we do re-open the Unit, we can then re-apply for training accreditation. This may make it more attractive for consultants and middle grade doctors.

These options increase the potential pool for recruiting the middle grades required but the RCOG acknowledged that all of these could not be implemented instantly would require time to fully adopt in order to be confident of having a sustainable rota and this approach was new and not fully operational in another unit. Making a success of pool of staff drawn from such a variety of sources as suggested above will require strong governance, leadership and support to be in place. It is essential that any staffing model is sustainable over time and is fully in line with national guidance.

Glossary

BAPM	British Association of Perinatal Medicine
BMA	British Medical Association
CESR	Certificate of equivalent specialist registration
CT	Core Trainee. A doctor in training but not yet in a specialty.
EEA	European Economic Area
FY	Foundation Year (i.e. FY1 – Foundation Year 1, FY2 – Foundation Year 2)
HGH	Horton General Hospital
HOSC	Health Overview and Scrutiny Committee
JR	John Radcliffe Hospital
MTI	Medical training initiative
MSW	Maternity Support Worker
MTI	Medical Training Initiative
O&G	Obstetrics and Gynaecology
OUH	Oxford University Hospitals NHS Foundation Trust
PA	Programmed Activity. A timetabled value of four hours (or three hours if the PA is undertaken in premium time) of Consultant time.
RCOG	Royal College of Obstetricians and Gynaecologists
Resident	The consultant stays in the hospital while covering emergency duties in case their direct presence is needed.
RN	Registered Nurse
SAS	Specialty and Associate Specialist Doctors
ST	Specialty Trainee. The number denotes the year of training e.g. ST3 is a junior doctor in their third year of specialty training.
SpR or STR	Specialist Registrar.
TCS	Terms and Conditions. NHS Employers negotiates nationally on behalf of employers with the NHS trade unions on national terms and conditions of service (TCS) and pay arrangements.
Tertiary	Highly specialised service. Consultants from surrounding hospitals make ‘tertiary’ referrals to the JR for specialised obstetric care.
WTE	Whole time equivalent (e.g. someone working 3 days per week would be 0.6 WTE)
WTR	Working Time Regulations