Horton HOSC CLU Responses

At the meeting of the 4th July 2019 Horton HOSC it was agreed to: "invite representatives of other small obstetric-led units to give evidence of how they work to achieve their aims and retain their training accreditation before the September CCG Board meetings."

The Horton HOSC has written out to 25 Trusts. The basis of the research undertaken by Keep the Horton General was used to inform the work of the Horton HOSC, specifically helping to highlight Trusts to contact. A list of questions were devised to inform committee members of each Trust's approach to; the model of provision for maternity services, staffing models, birthing stats, size of the area served and distances travelled, the training accreditation and level it is held at, and whether they have experienced any challenges maintaining the accreditation.

Responses were received from the following NHS Trusts (individual responses from each Trust are included in Appendix 1 below):

Name of Trust	Corresponding pages:
North Cumbria University Hospitals NHS Trust	2 – 4
Northumbria Healthcare NHS Foundation Trust	5 – 9
Nottingham University Hospitals NHS Trust	10 – 11
United Lincolnshire Hospitals NHS Trust	12 – 13

Unfortunately all the trusts declined to speak to the committee, some either via the return letter, or when contacted to arrange a potential time slot to speak.

We also had a response from University Hospitals of Leicestershire NHS Trust, who were unable to answer the questions as they were under considerable time pressures.

The names of all NHS Trusts contacted are included in Appendix 2.

Appendix 1 – NHS Trust Responses

Head of Midwifery & Gynaecology's Office
Maternity Department
Cumberland Infirmary
Infirmary Road
CARLISLE
Cumbria
CA2 7HY

Direct Tel: 07787690001
Email: jane.anderson@ncuh.nhs.uk

Our Ref: JA/BR

Date: 27/08/19

Samantha Shepherd
Senior Policy Officer
Horton Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Dear Samantha,

Re: Horton Health and Overview Scrutiny Committee - CLU review

Please see below for responses to questions submitted for the Horton Health & Overview Scrutiny Committee for the CLU review. I hope that you find our responses of some use:

1. **Name of the Trust**

   North Cumbria University Hospitals NHS Trust.

2. **What is the model of provision for maternity services?**

   X 2 Consultant-led Units with alongside Midwifery-led Units
   X 1 Midwifery-led Unit

3. **What staffing model do you use? (please include information on numbers of staff and rotas, numbers of vacancies and how they are managed, and how you approach recruitment.)**

   Birthrate Plus is used for Midwifery workforce planning.
   New models of integrated care are being planned in line with Better Births.

4. **What are the number of births for the last 3 years (delivered in the different settings)?**

	2016/17	2017/18	2018/19
CIC	1680	1585	1592
PBC	27	17	30
WCH	1278	1212	1114
Total	**2985**	**2814**	**2736**

CIC = Cumberland Infirmary, Carlisle (Consultant Led Unit)
PBC = Penrith Birth Centre (Midwifery Led Unit)
WCH = West Cumberland Hospital (Consultant Led Unit)

5. **How do you measure your clinical quality and outcomes? What has been your performance in the last three years against these outcomes?**

   Clinical quality and outcomes measured via dashboards;
   Measured against national standards eg RCOG, NICE recommendations and regional standards.
   These are reviewed at monthly Joint Core Governance Meeting – themes and trends extracted and audited.

6. **What is the size of the area you serve? (i.e. how far / long do people have to travel to get to the unit)**

   - *Large rural geographical location with remote areas*
   - *63.5 people per km/sq*
   - *From West Cumberland Infirmary to Cumberland Infirmary 48 miles – slow A road*
   - *From West Cumberland Infirmary to Penrith Birth Centre 44 miles – A road with some dual carriageway*
   - *From Penrith Birth Centre to Cumberland Infirmary 20 miles – motorway*

   The region is visited by large numbers of tourists and this, together with large farming communities, adds time to journeys.

   Public transport consists of train and bus services, however, the networks are poor.

7. **Do you still hold your training accreditation status? and if so, how long have you held it? And have there been any challenges maintaining that?**

   Training accreditation is held at both Consultant-led sites.

8. **Is the training accreditation held at a trust level, or on an individual unit basis?**

   Individual Unit

9. **Do you capture information on patient experience? (if so, what are satisfaction levels for example?)**

   Patient satisfaction is captured by surveys both nationally biased and Trust led – in general satisfaction levels are good.

   The patients generally belong to communities that are passionate with regard to their local services and support them well.

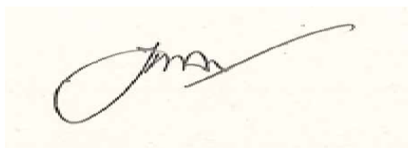
10. **Do you capture any feedback from staff that are being trained in a smaller unit? (if so, are you able to share any feedback received please?)**

    Unsure as to what this question refers.

11. **Would you be able to either attend the Horton HOSC meeting, or Skype into the meeting to be able to discuss with members of the HOSC?** (The meetings take place in Banbury Town Hall, Oxfordshire and the next Horton HOSC meeting is likely to take place in either the first or second week of September – please could you let us know ASAP if you are able to attend, or speak to the committee, so we can plan in accordingly)

    Apologies, Head of Midwifery unable to attend as will be away on leave, contact made with Martin Dyson to this effect.

Yours sincerely,



Jane Anderson
<u>HEAD OF MIDWIFERY & GYNAECOLOGY</u>

Northumbria Healthcare
NHS Foundation Trust

Trust Management
North Tyneside General Hospital
Rake Lane
North Shields
Tyne and Wear
NE29 8NH

(0191) 293 2730

Ref: MD/TC

15 August 2019

Cllr Arash Fatemian
Chairman Oxfordshire Joint Health Overview & Scrutiny Committee
Oxford County Council
Horton Joint Health Overview and Scrutiny Committee
County Hall
New Road
Oxford
OX1 1ND

Dear Cllr Fatemian

HORTON HEALTH AND OVERVIEW SCRUTINY COMMITTEE – CLU REVIEW

Thank you for your letter dated 24 July 2019 which outlines the work you are undertaking around the viability of small Consultant-led Obstetric Units and inviting Northumbria Healthcare NHS Foundation Trust to participate in this work.

I have enclosed our response to the questions provided and hope that this information is useful to you.

Unfortunately due to annual leave and other commitments we are unable to provide representation at the Horton HOSC meeting planned for September 2019.

Yours sincerely

MARION DICKSON
Executive Director of Nursing and Midwifery on behalf of and in the absence of Sir James Mackey, Chief Executive

Enc

cc Marion Dickson, Executive Director of Nursing and Midwifery
Lynn Tilley, Acting Head of Maternity

Questions:

1. **Name of the Trust**
   Northumbria Healthcare NHS Foundation Trust

2. **What is the model of provision for maternity services?**
   Northumbria provide an Obstetric-led service at the Northumbria Specialist Emergency Care Hospital, including a Pregnancy Assessment Unit, a Birth Centre for low and high risk pregnancies, and an Ante-natal / Postnatal ward for inpatient stays.

   In addition to the main Unit we have three freestanding Midwifery-led Units (MLUs). Low risk women are offered birth in these Units. The MLUs provide Antenatal care for all women with Consultant Outreach Antenatal clinics.

   The MLUs in Alnwick and Berwick are open seven days per week but not across 24 hours. On-call Midwives are available out of hours to support birth in the MLU or at home. There is no inpatient Postnatal stay in these MLUs.

   Teams of Community Midwives provide Antenatal and Postnatal care and support the Home Birth Service.

   Antenatal clinics are held in a variety of locations including GP practices, Children's centres and Trust base sites (Wansbeck General Hospital and North Tyneside General Hospital).

3. **What staffing model do you use? (please include information on numbers of staff and rotas, numbers of vacancies and how they are managed, and how you approach recruitment.)**

   Staff levels are calculated in accordance with Birth Rate Plus methodology. However it is acknowledged that the freestanding MLUs are over-established based on this methodology; however they are appropriate to ensure sustainable service provision.

   The Northumbria is currently established to 71.29 WTE Midwives and 27.69 WTE Nursing Assistants.

   Alnwick MLU (Hospital and Community) is currently established to 4.44 WTE Midwives and 2.03 WTE Nursing Assistants.

   Berwick MLU (Hospital and Community) is currently established to 4.05 WTE Midwives and 1.76 WTE Nursing Assistants.

   Hexham MLU (Hospital and Community) is currently established to 17.48 WTE Midwives and 8.13 WTE Nursing Assistants.

Wansbeck Community Midwifery is currently established to 17.68 WTE Midwives. North Tyneside Community Midwifery is currently established to 20.31 WTE Midwives.

Vacancies for Midwives is managed pro-actively through a rolling programme of recruitment. An automatic advert goes live on alternate months with interviews arranged for the next month so that vacancy is filled as it is released. This has proven to be a very successful programme.

Nursing Assistant posts are advertised as required and is infrequent as the vacancy rate has been low historically.

4. **What are the number of births for the last 3 years (delivered in the different settings)?**

Site	Apr 16 - Mar 17	Apr 17- Mar 18	April 18 - Mar 19
Northumbria	3125	3047	3027 births
Alnwick	37	34	15
Berwick	9	10	15
Hexham	81	63	55
Home Birth	42	46	38

5. **How do you measure your clinical quality and outcomes? What has been your performance in the last three years against these outcomes?**

We have a performance dashboard in line with RCOG recommended metrics which is reviewed and discussed monthly at our Operational Board; any emerging themes or trends are identified and actions agreed. We also contribute to a regional dashboard which allows us to compare performance with other local providers.

The metrics demonstrated below are not exhaustive.

	Apr 16-Mar 17	Apr 17-Mar 18	April 18-Mar 19
Spontaneous vaginal delivery	65.5%	60.1%	63.1%
Caesarean Section rate (combined elective and emergency)	31.0%	30.8%	27.3%
Instrumental vaginal delivery rate	8.1%	9.1%	13.1%
Intrapartum transfer from an MLU to the Northumbria	13.6%	11.6%	13.5%

6. **What is the size of the area you serve? (i.e. how far / long do people have to travel to get to the unit)**

   Northumbria covers a large geographical area with a combination of rural and urban areas. The distances that women travel to access services will vary depending on their proximity to their local Unit or the Obstetric Unit in the Northumbria Hospital.

   As an example women may travel in excess of 52 miles from Berwick to the Northumbria site (approximately an hour).

7. **Do you still hold your training accreditation status? and if so, how long have you held it? And have there been any challenges maintaining that?**

   Please can you clarify which training accreditation this refers to.

8. **Is the training accreditation held at a trust level, or on an individual unit basis?**

   Unable to provide this information.

9. **Do you capture information on patient experience? (if so, what are satisfaction levels for example?)**

   We collect patient experience information from a number of sources but is not limited to:

   - The CQC Maternity Survey,
   - A real time patient experience survey completed twice a month by our Patient Experience Team; reported monthly to our Operational Board.
   - Friends and family test
   - Through complaints monitoring
   - Feedback from clinical incident investigation meetings
   - Birth reflection service

   Patient satisfaction levels are generally very good.

10. **Do you capture any feedback from staff that are being trained in a smaller unit? (if so, are you able to share any feedback received please?)**

    No we do not routinely collect information on training from other providers.

11. **Would you be able to either attend the Horton HOSC meeting, or Skype into the meeting to be able to discuss with members of the HOSC?** (The meetings take place in Banbury Town Hall, Oxfordshire and the next Horton

HOSC meeting is likely to take place in either the first or second week of September – please could you let us know ASAP if you are able to attend, or speak to the committee, so we can plan in accordingly)

Unfortunately we are not able to participate in the discussion due to annual leave.

On behalf of the members of the Joint Horton Health Overview and Scrutiny Committee, thank you very much for taking the time to provide answers to the questions above. It will provide invaluable support in being able to perform effective scrutiny over the process taking place in Banbury.

Contact Officers:

If you have any queries with the form, please contact either:
Sam Shepherd – Samantha.shepherd@oxfordshire.gov.uk, 07789 088173
Martin Dyson – martin.dyson@oxfordshire.gov.uk, 07393 001252

Questions:

1. **Name of the Trust**

Nottingham University Hospitals

2. **What is the model of provision for maternity services?**

   2 Obstetric units, community midwifery provision and co-located midwifery led birthing unit

3. **What staffing model do you use? (please include information on numbers of staff and rotas, numbers of vacancies and how they are managed, and how you approach recruitment.)**

   For midwifery staffing, Birth rate plus is used

4. **What are the number of births for the last 3 years (delivered in the different settings)?**

5.

financial Year /Numbers	Obstetric Unit	Birth centre/midwifery led unit	Home birth
16/17	7,928	1,543	81
17/18	6,983	1,198	77
18/19	7,514	1,140	73

6. **How do you measure your clinical quality and outcomes? What has been your performance in the last three years against these outcomes?**

   We have a maternity dashboard and we benchmark/gap analyse against national data

7. **What is the size of the area you serve? (i.e. how far / long do people have to travel to get to the unit)**

   We cover Nottingham and mid/south Nottinghamshire.

8. **Do you still hold your training accreditation status? and if so, how long have you held it? And have there been any challenges maintaining that?**

   Yes – we are a university teaching hospital – unsure of timeframe

9. **Is the training accreditation held at a trust level, or on an individual unit basis?**

   Trust

10. **Do you capture information on patient experience? (if so, what are satisfaction levels for example?)**

    Yes – high satisfaction rates

11. **Do you capture any feedback from staff that are being trained in a smaller unit? (if so, are you able to share any feedback received please?)**

    We do not capture this data

12. **Would you be able to either attend the Horton HOSC meeting, or Skype into the meeting to be able to discuss with members of the HOSC?** (The meetings take place in Banbury Town Hall, Oxfordshire and the next Horton HOSC meeting is likely to take place in either the first or second week of September – please could you let us know ASAP if you are able to attend, or speak to the committee, so we can plan in accordingly)

Unable to commit currently

1. **Name of the Trust**

   United Lincolnshire Hospitals NHS Trust

2. **What is the model of provision for maternity services?**

   Provide obstetric services at Pilgrim Hospital, Boston and Lincoln County with antenatal provision at Grantham Hospital. This provision is supplemented by ultrasound provision at Skegness and Gainsborough.

3. **What staffing model do you use? (please include information on numbers of staff and rotas, numbers of vacancies and how they are managed, and how you approach recruitment.)**

   Full obstetric and anaesthetic rotas on each site in accordance with RCOG guidance.

   Midwifery staffing levels in accordance with Birthrate Plus. Moving towards a mixture of hospital and community continuity of carer models

4. **What are the number of births for the last 3 years (delivered in the different settings)?**

Lincoln County Hospital	Pilgrim Hospital	Home Births	Grantham MLU
2016/2017 = 3266	2016/2017 = 1874	2016/2017 = 217	58
2017/18 = 3108	2017/18 = 2040	2017/18 = 158	Closed
2018/2019 = 2943	2018/2019 = 1738	2018/2019 =	Closed

5. **How do you measure your clinical quality and outcomes? What has been your performance in the last three years against these outcomes?**

   Through the maternity dashboard. Reducing Stillbirth rate on both sites. LCH has better clinical outcomes than PHB in terms of IOL and CS rate

6. **What is the size of the area you serve? (i.e. how far / long do people have to travel to get to the unit)**

   Lincolnshire large rural area with poor transport infrastructure. No motorways and only approx. 23 miles of dual carriage way. Absence of public transport for some residents on a Sunday. Each site 40 miles apart. Coastal area has higher deprivation levels. QIA and EQIA support the continuation of both sites

7. **Do you still hold your training accreditation status? and if so, how long have you held it? And have there been any challenges maintaining that?**

Yes – not reporting any red flags in the GMC trainee survey. Midwifery training due to commence in Lincolnshire in Autumn. Challenge is maintaining Paediatric Training and the domino impact on obstetrics

8. **Is the training accreditation held at a trust level, or on an individual unit basis?**

   Individual site level

9. **Do you capture information on patient experience? (if so, what are satisfaction levels for example?)**

   Wide range including: FFT, CQC Survey, Maternity Voice Partnership, Neonatal Voice Partnership, Public Engagement Events as a Trust or in partnership with Lincolnshire Better Births, Social Media activities – surveys etc.

10. **Do you capture any feedback from staff that are being trained in a smaller unit? (if so, are you able to share any feedback received please?)**

    No – not currently – intend to be part of the RCOG rural obstetric work programme

11. **Would you be able to either attend the Horton HOSC meeting, or Skype into the meeting to be able to discuss with members of the HOSC?** (The meetings take place in Banbury Town Hall, Oxfordshire and the next Horton HOSC meeting is likely to take place in either the first or second week of September – please could you let us know ASAP if you are able to attend, or speak to the committee, so we can plan in accordingly)

    Yes

    (MD - When we wrote back to them to confirm a convenient potential time to discuss with the committee, they confirmed that they did not intend to speak to the committee and were only providing a written response)

Appendix 2 – List of NHS Trusts contacted

Trust	Hospital
County Durham and Darlington NHS FT	Darlington Memorial Hospital
Doncaster and Bassetlaw Teaching Hospitals NHS FT	Bassetlaw District General Hospital
Dorset County Hospital NHS Foundation Trust	Dorset County Hospital, Dorchester
East Cheshire NHS Trust	Macclesfield District General Hospital
Epsom and St Helier University Hospitals NHS Trust	Epsom General Hospital
Epsom and St Helier University Hospitals NHS Trust	St Helier Hospital
Gateshead Health NHS FT	Queen Elizabeth Hospital, Gateshead
Harrogate and District NHS FT	Harrogate District Hospital
James Paget University Hospitals NHS FT	James Pagett Hospital
North Cumbria University Hospitals NHS Trust	Cumberland Infirmary, Carlisle
Northern Devon Healthcare NHS Trust	North Devon District Hospital, Barnstaple
North Lincolnshire and Goole NHS FT	Princess of Wales Hospital
North Lincolnshire and Goole NHS FT	Scunthorpe General Hospital
North West Anglia NHS FT	Hinchingbrooke Hospital
Northumbria Healthcare NHS FT	Northumbria Specialist Emergency Care Hospital
Nottingham University Hospitals NHS Trust	Nottingham City Hospital
Salisbury NHS Foundation Trust	Salisbury Hospital
United Lincolnshire Hospitals NHS Trust	Pilgrim Hospital (District Hospital), Boston
University Hospitals of Leicester NHS Trust	Leicester Royal Infirmary
University Hospitals of Morecambe Bay NHS FT	Furness General Hospital, Barrow in Furness
University Hospitals of Morecambe Bay NHS FT	Royal Lancaster Infirmary
Western Sussex Hospitals NHS FT	Worthing Hospital
Wye Valley NHS Trust	County Hospital, Hereford
Yeovil District Hospital NHS FT	Yeovil District Hospital
York Teaching Hospital NHS Foundation Trust	Scarborough Hospital

Benchmarking of Small Obstetric Units: Research into Training Accreditation, Staffing Models, Obstetric Recruitment Issues and Initiatives, and Doctor/Trainee Rotation

Produced by Keep The Horton General, June 2019

Keep The Horton General has collated data between March and June 2019 relating to the ways in which other small Consultant-Led Units nationally sustain their obstetric services. In 2016 Prof Stephen Kennedy said at the public consultation meeting in St Mary's Church, Banbury:

> *In 2012, the people who look after training made the decision that the Horton could no longer be a centre recognised for training, principally because of too few deliveries [taking place]. The training rules and regulations, which are applied throughout the country -not just in Banbury, but for every training centre across the country- decreed that if you were too small; if you had too few deliveries, then you could no longer be a training centre. It made sense…because to acquire sufficient skills and knowledge to be able to practise obstetrics safely it was decided that a hospital had to have at least 3500 births [per year].*[1]

Evidence KTHG has obtained invalidates this claim that the Horton had too few deliveries to be a safe obstetric unit with training accreditation, as numerous other hospitals are managing just that.

The IRP report of 2008, when maternity services in Banbury were last threatened, made several key recommendations. Point 5 in the report advocated greater clinical integration between the units:

> *The ORH must do more to develop clinically integrated practice across the Horton, John Radcliffe and Churchill sites as well as developing wider clinical networks with other hospitals, primary care and the independent sector.* [2]

Rotation of consultants would avoid this "loss of skills" Prof. Kennedy referred to, and rotation of trainees would be of benefit to them as a less busy unit gives more time for discussion of cases with consultants.

The following paper analyses the raw data and statistics we have researched, for circulation in time for the June 2019 HHOSC meeting. This information has been formulated with the input of expert clinicians and considers some of the options for an obstetric service at the Horton which have either been omitted in the past or dismissed out of hand, and we believe, demonstrate a viable and sustainable future for an obstetric unit at the Horton.

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[1] Prof. Stephen Kenney, Recorded transcript of Public engagement meeting, St Mary's Church, Banbury, August 2016

[2] *Advice on Changes Proposed By The Oxford Radcliffe Hospitals Nhs Trust To Paediatric, Obstetrics, Gynaecology And The Special Care Baby Unit At The Horton General Hospital In Banbury*, Independent Reconfiguration Panel, 2008, p. 4 Available online: http://www.keepthehortongeneral.org/docs/IRPreport.pdf

What we did:
KTHG began by using the Office for National Statistics' most recently available Births by Communal Establishment spreadsheet (for 2015/16) to identify smaller Consultant Led Units (units which had fewer than 2500 deliveries). 29 open Consultant Led Units with between 1000 and 2500 births per year were contacted to ascertain basic data including:

- birth data from 2014-18
- whether the unit has obstetric training accreditation[3]
- the number of consultants employed at the unit
- permutation of staffing rotas
- whether hybrid rotas are in use[4]

27 units responded to this FOI request.

More recently, KTHG sent an FOI request to every Hospital Trust with CLU/s in England and Wales to ascertain:

- how many non-training middle grade doctors were employed at their CLUs
- whether they have any vacancies for non-training middle grades, registrars (middle grades in training), and consultants, and if so, how many for each
- whether they have experienced any difficulties in recruiting obstetricians and if so, at which level
- whether they utilise any recruitment initiatives beyond advertising to recruit to posts, and details of these
- whether they offer any incentives in order to attract/retain doctors
- whether any special recruitment initiatives or incentives used are successful

A small number of Trusts have more than one CLU under their jurisdiction. Where this was the case, we sent separate FOI requests to them to identify:

- the deanery they come under for RCOG training
- whether training accreditation was awarded at a Trust level, or to the specific sites
- whether consultants, registrars, non-training middle grades or trainees rotated between sites, and if so, whether this was for elective (clinic) work, or for acute or emergency work.

Comment on the Small CLUs

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[3] RCOG Training for registrars/middles grades, not general training for Junior Doctors

[4] In recent years, hybrid rotas have been developed where resident consultants cover some slots on a middle grade rota, with other slots covered by middle grade doctors with a non-resident consultant. They are often necessary to ensure there are enough staff with the necessary competencies on shifts. As a result, their use requires more consultant hours than traditional rotas. The RCOG concludes in its 2016 paper, *Obstetrics and Gynaecology Workforce,* that they are the only long-term sustainable staffing solution to middle-grade rota gaps. The paper explains "It is likely that the next decade will be a period of transition from a system where consultants are predominantly non-resident when on-call, to a system where the majority of consultants perform some 'hands-on' resident out-of-hours duties. Resident consultant working does not necessarily mean night shift working: evenings and/or weekend daytime working are alternative options that can be considered as part of a hybrid model, which also has the potential to improve out-of-hours training. Embracing resident consultant working will allow the profession to move forward in a positive and equitable way for all consultant staff and for the benefit of patients" Available online:
https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/ogworkforce.pdf

The 27 small units which responded to KTHG are distributed fairly evenly across the country. A map showing the geographical spread of the units is below:

Training Accreditation:

23 of the 27 small units responding confirmed that they have training accreditation. This equates to 85%. The mean annual birth rate for these hospitals was 1687 deliveries based on 2016 figures (the most recent ones where we had data for all the hospitals). This is virtually identical to the 2014-15 birth rate at the Horton General Hospital (1667), before the siphoning of more complex cases off to the John Radcliffe affected the birth rate in Banbury.

Fig. 2 The small units with training accreditation:

Hospital	2016 births	On CCG's List?
Furness General Hospital, Barrow in Furness	1067	No
Yeovil District Hospital	1471	No
North Devon District Hospital, Barnstaple	1530	No
Prince Charles Hospital, Merthyr Tydfil	1553	No
Scarborough Hospital	1558	No
Bassetlaw District General Hospital	1610	Yes
Epsom General Hospital	1679	Yes
Cumberland Infirmary, Carlisle	1702	No
County Hospital, Hereford	1718	No
Macclesfield District General Hospital	1743	Yes
Scunthorpe General Hospital	1832	Yes
Pilgrim Hospital (District Hospital), Boston	1874	No

Queen Elizabeth Hospital, Gateshead	1905	Yes
Dorset County Hospital, Dorchester	1908	Yes
Harrogate District Hospital	1928	Yes
Royal Lancaster Infirmary	1971	Yes
Princess of Wales Hospital, Bridgend	2031	No
Ysbyty Gwynedd	2060	No
Darlington Memorial Hospital	2099	Yes
James Pagett Hospital	2159	No
Hinchingbrooke Hospital	2230	Yes
Salisbury Hospital	2346	Yes
Worthing Hospital	2371	No

Case Study on a pair of small CLUs:

The CLUs belonging to Morecambe Bay NHS FT were very interesting for several reasons, though only Lancaster seems to have been investigated by the OCCG in its own research.

- Both Furness General Hospital and Lancaster Royal Infirmary have training accreditation, despite the annual birth rate being approximately 1100 and 1900 respectively.
- Both hospitals use Hybrid rotas, where consultants fill gaps in the middle-grade rotas, though due to 48 miles' distance between sites, no rotation of consultants or middle-grades takes place.
- Impressively, the Trust was highly commended by the RCOG in 2017 for professional development, and in 2018 for its standard of training. (These accolades would appear to refute entirely Stephen Kennedy's statement that hospitals with fewer than 3500 births don't provide enough experience for training doctors to acquire the skills they need.)
- The Trust comes under the North West Deanery, and training accreditation has been awarded to *the Trust itself* rather than being site-specific. This is significant because FGH is the smallest CLU with training accreditation we could find nationally, and its status would appear to be protected by this accreditation being trust-wide, where for instance, St Mary's Hospital in Newport, IOW, similarly experiencing around 1100 births per year does not have training accreditation.

It was clear from our dealings with the Morecambe Bay Trust that it is highly supportive of both its CLUs and the staff there, and extremely proud of its award-winning training standards. We feel that the OUHFT and OCCG could benefit greatly from their example. This is especially pertinent given the reference to the potential use of hybrid rotas at the Horton in the minutes from the OCCG's board meeting of 10th August 2017:

The Lay Member Public and Patient Involvement believed that sufficient evidence around the workforce issues had not been presented and a hybrid rota should have been given more consideration. Clinical Lead for Obstetrics

informed the Board that, having spoken to the Royal College, she was told that the hybrid rota was 'unaffordable in small units', such as the Horton.[5]

Clearly this is not borne out by hospitals such as Furness General Hospital.

<u>Training Accreditation Status:</u>

Six hospital Trusts from four different deaneries confirmed that their training accreditation had been awarded to the Trust as a whole, rather than to the specific units. Three are in the north of England, each with at least one small CLU. The other three belong to the same deanery; London and South East. This highlights 1) that there is not a consistent approach to the awarding of training accreditation nationwide, and 2) that it is an accepted practice of Postgraduate Deans elsewhere to award training accreditation Trust-wide (seemingly regardless of birth numbers of the small CLUs). This also means the way in which training accreditation is awarded directly impacts equality outcomes and patient choice. At the time of writing, Frimley Health Trust, the only other multi-CLU Trust in our Deanery, Thames Valley, has not yet responded on how its training accreditation is awarded. If it is Trust-wide, this would be an important precedent in making the case for OUHFT being treated similarly.

Trust	Hospital	Location	Deanery	2015 births
University Hospitals of Morecambe Bay NHS Foundation Trust	Furness General Hospital,	Barrow-in-Furness	North West	1069
University Hospitals of Morecambe Bay NHS Foundation Trust	Royal Lancaster Infirmary	Lancaster	North West	1979
County Durham & Darlington NHS Foundation Trust	University Hospital North Durham	Durham	North East	3088
County Durham & Darlington NHS Foundation Trust	Darlington Memorial Hospital	Darlington	North East	2214
Northern Lincolnshire and Goole NHS Foundation Trust	Scunthorpe General	Scunthorpe	Yorkshire & Humber	1869
Northern Lincolnshire and Goole NHS Foundation Trust	Princess of Wales Hospital, Grimsby	Grimsby	Yorkshire & Humber	2227
Lewisham and Greenwich NHS Trust	University Hospital	Lewisham	London and South	3958
Lewisham and Greenwich NHS Trust	Queen Elizabeth Hospital	Woolwich	London and South	4366
Epsom and St Helier University Hospitals NHS Trust	Epsom Hospital	Epsom	London and South	1974
Epsom and St Helier University Hospitals NHS Trust	St Helier Hospital	Carshalton	London and South	2962
King's College Hospital NHS FT	King's College Hospital	Denmark Hill	London and South	4726

[5] *Minutes, Oxfordshire Clinical Commissioning Group Board Meeting: 10th August 2017*, p.12 Available online: https://www.oxfordshireccg.nhs.uk/documents/meetings/board/2017/08/2017-08-10-Oxfordshire-Clinical-Commissioning-Group-Minutes-FINAL.pdf

King's College Hospital NHS FT	Princess Royal University Hospital	Orpington	London and South	4788

Fig. 3: the NHS Trusts to which Training Accreditation has been awarded at Trust Level

Use of Hybrid Rotas:
OUHFT does not currently use hybrid rotas, however, 5 of the 26 small units from 4 separate Trusts which we contacted confirmed they use Hybrid rotas, shown overleaf. This equates to 19%.

The RCOG concludes in its 2016 guidance *Obstetrics and Gynaecology Workforce*, that Hybrid rotas (i.e. ones using resident consultants) are likely to be the only long-term solution to gaps in middle-grade staffing:

> *The issue of ensuring appropriate obstetrics and gynaecology medical staffing levels in most UK units is immediate. In most hospitals the solution is likely to include resident consultant working, with consultants and the middle grade junior doctors jointly staffing the slots on the out-of-hours rota, i.e. a hybrid rota… It is evident that resident consultants will be part of any sustainable solution to current workforce difficulties.*[6]

Hospital	2016 births	Number of obs/gynae consultants currently employed (Mar 2019)	NHS Trust
Furness General Hospital, Barrow in Furness	1067	6 Obstetric/ Gynae Consultants	University Hospitals of Morecambe Bay NHS Foundation Trust
Royal Lancaster Infirmary	1971	11.46 Obstetric/Gynae Consultants	University Hospitals of Morecambe Bay NHS Foundation Trust
Scarborough Hospital	1558	7 Obstetric/Gynae Consultants + 1 P/T Gynae	York Teaching Hospital NHS Foundation Trust
Ysbyty Gwynedd	2060	12 Obstetric/Gynae consultants	Betsi Cadwaladr University Health Board
Salisbury Hospital	2346	10 Obstetric/Gynae Consultants	Salisbury NHS Foundation Trust

Fig. 4: the Small CLUs currently using Hybrid rotas

Given that, as KTHG understands, the catalyst for the withdrawal of training accreditation from the HGH in 2012 was the complaint from trainees that they were not getting sufficient out-of-hours supervision, it is worth bearing in mind that the RCOG-recommended implementation of Hybrid rotas would have a preventative effect on situations like this because of increased consultant presence:

[6] *Obstetrics and Gynaecology Workforce,* RCOG, 2016. Available online: https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/ogworkforce.pdf

For the majority of trainees, increased resident consultant presence provides a concomitant increase in the opportunities for training. Resident consultants should demonstrate equal commitment to training out-of-hours as within working hours. The time a trainee spends covering emergency duties in both obstetrics and gynaecology is more likely to be directly supervised by a consultant who is resident. For junior trainees, this is particularly valuable for clinical skills acquisition in the emergency setting, with better opportunities for workplace-based assessments, constructive feedback and delivery of the RCOG training curriculum. For senior trainees, it allows the more technically challenging clinical skills to be learnt in a safe environment. Appropriate consultant presence should maximise training opportunities and the skill of the trainer is to achieve the appropriate balance between direct and indirect supervision… Therefore, a hybrid rota should not necessarily be seen as a compromise, but may actually be a preferred solution to both workforce and training issues.[7]

The RCOG mentions in its 2016 paper an intention to collate examples of good practice which can be shared for the benefit of Trusts looking for information resources and support in this field.

Given that Hybrid rotas have been in existence since before the HGH was temporarily downgraded, the Trust ought to have explored seriously the option of employing resident consultants in Hybrid rotas as an alternative to downgrading the CLU, and KTHG believes that a thorough, independent exploration of this option ought to be requested by HHOSC.

Even with the requirement for greater consultant presence to compensate for middle-grade rota gaps, the research KTHG has done into how smaller units are staffed suggests that the information pack submitted to the options-scoring panel appears to overstate the workforce requirement for running a hybrid rota. For example, page 119 (Section 5 Paper 13) of the information pack contains the claims plus the statement that it is the model currently adopted by other small units in the UK. On the same page, the OUH claims that running 5 middle grades would require 11.4 consultants. A direct comparison can be made with the Hybrid rota at Scarborough (around 1500 births per year), which uses 5 ST3-5 (middle grades) and 1 ST2 (only Tier 1 not to work alone) and 7 obstetrics/gynae consultants plus 1 part-time gynae consultant. Salisbury Hospital is somewhat busier, averaging between 2200-2400 births per year, but also only has 10 consultants and 7 registrars contributing to their hybrid rota.

Another issue is that although the OUH rota gives ST3-5s it has claimed separately that only ST4 and above could work at the Horton. Yet each of the small units using Hybrid rotas have the more junior grades contributing to rotas.

Hospital	2016 births	Permutation of doctors used in 2018
Furness General	1067	6 Consultants, 2 Higher, 2.3 Junior, 5 SAS grade. (WTE)

[7] *Obstetrics and Gynaecology Workforce,* RCOG, 2016, p.18 Available online: https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/ogworkforce.pdf

Hospital, Barrow in Furness		
Royal Lancaster Infirmary	1971	11.7 consultants, 4.6 Higher, 7 Junior, 0 SAS grade. (WTE)
Scarborough Hospital	1558	7 consultants + 1 x P/T Gynae, 5 x ST 3-5s & 1 x ST1 all on run through training for obs and gynae, plus 2 staff grades.
Ysbyty Gwynedd	2060	Tier 3 Consultants: 1 in 7 weekdays 1 in 10 weekends, Middle grades and Tier 2 resident consultants: 1 in 9 days, Junior (tier 1): 1 in 8 days.
Ysbyty Glan Clwyd	1986	Tier 3 Consultants: 1 in 7 weekdays 1 in 10 weekends, Middle grades and Tier 2 resident consultants: 1 in 8 days, Junior (tier 1): 1 in 8 days.
Salisbury Hospital	2346	9/10 Consultants, 7 middle grades and 5 ST1/2s

Fig. 5: Hybrid rota permutations at small CLUs

The number of middle-grade doctors employed at the smaller units has also proved interesting, given that we were told to reopen the Horton, 9 WTE (whole time equivalent) non-training middle grades would be needed. For instance, Pilgrim Hospital in Boston, Lincolnshire (c.1900 births per year) employs 7 consultants and 8 middle grades. Worthing Hospital averages 2400 births per year but has 9 consultants, and 7 registrars, like Salisbury.

Rotation of Doctors within Multi-CLU Trusts

8 out of 11 Multi-CLU Hospital Trusts we were able to acquire data from confirmed that consultants rotate between sites. Interestingly, North Cumbria NHS Hospitals Trust said that 5 of their 10 consultants rotate between Whitehaven and Carlisle, despite the units being 35 miles apart. 6 of the 11 Trusts confirmed that registrars rotate between sites.

Staffing Problems and Use of Recruitment Programmes Beyond Advertising for Posts:

We asked the following, by FOI request, of the Trusts (Health Boards in Wales) to which the 157 obstetric units in England and the 12 obstetric units in Wales belong:

- how many non-training middle grade doctors were employed at their CLUs
- whether they have any vacancies for non-training middle grades, registrars (middle grades in training), and consultants, and if so, how many for each
- whether they have experienced any difficulties in recruiting obstetricians and if so, at which level
- whether they utilise any recruitment initiatives beyond advertising to recruit to posts, and details of these
- whether they offer any incentives in order to attract/retain doctors
- whether any special recruitment initiatives or incentives used are successful

Around 1/3 of Trusts which responded to our national FOI request confirmed that they had middle grade vacancies at the time of reply, which is in line with the RCOG's findings in their research for *Obstetrics and Gynaecology Workforce* from 2016. When asked if they had experienced difficulty recruiting obstetricians in recent

years, 1/3 of the Trusts answered in the affirmative. Interestingly, though the majority were taking positive steps to counter this trend, a significant minority of Trusts didn't appear to have any additional measures in place beyond advertising, in terms of either targeted recruitment programmes or incentives, to remedy this situation. While there certainly are more vacancies than there are middle grade doctors in the UK to fill them, the varying efforts of different Trusts having trouble recruiting suggests that some are simply fatalistic and not sufficiently pro-active in their efforts. It seems old-fashioned and laissez-faire to be relying on adverts when so many hospitals are competing for a small pool of doctors.

The recruitment initiatives we learned about are described below.

RCOG's Medical Training Initiative Scheme

Around half of the Hospital Trusts responding to us said they had signed up to the RCOG's Medical Training Initiative (MTI) Overseas Doctors Scheme. The programme is open to doctors of the equivalent experience of ST2-4, and the RCOG summarises the scheme on its website as follows:

> *The MTI scheme allows International Medical Graduates (IMGs) to come to the UK for a maximum of two years to train within the NHS. IMGs benefit greatly from the knowledge, skills and techniques learned within the NHS and can use them to improve the level of patient care in their home country on their return. In addition, UK hospitals who provide a placement for IMGs benefit from increased workforce capacity and the skills and knowledge that IMGs can share with their UK colleagues.*[8]

The hospitals using the MTI scheme typically recruited between one and three doctors in training this way, and all of them felt that its implementation has been successful. While the use of the MTI scheme is not a panacea for the nationwide staffing issues with middle-grades, as part of a holistic, proactive approach to sustaining the necessary clinical competencies alongside options such as Hybrid rotas, it could be useful.

Other Overseas Training Partnerships:

Leeds University Hospitals Trust explained that as well as being part of the RCOG's MTI scheme, they have a regular arrangement with the College of Physicians and Surgeons in Pakistan which provides two doctors in non-training middle grade posts.

Overseas Agency Recruitment

Several Trusts responding to our request explained that they had utilised agencies for overseas recruitment. Names of agencies were not typically given, though the company Remedium Ltd was mentioned in one response. All those who mentioned using agencies to fill vacancies claimed they had recruited successfully for these positions.

Incentives/Benefits Packages as a Means of Attracting Doctors

[8] https://www.rcog.org.uk/en/careers-training/working-in-britain-for-non-uk-doctors/medical-training-initiative-mti-scheme/

Four hospital Trusts told us they offered incentives or supplements for newly appointed obstetricians. Examples include:

- Relocation expenses paid
- Staff benefits e.g. salary sacrifice schemes available, home electronics, cycle to work scheme and lease cars
- £3,000 paid to middle grades on commencement of employment
- Discounted on-site nursery facility
- Free gym membership
- Additional training opportunities

Conclusion:

From this research, which a small number of volunteers for KTHG have compiled in their spare time, it is evident that there are avenues for creating a sustainably resourced obstetric unit at the Horton, of which no exploration has been demonstrated (e.g. use of overseas recruitment programmes, the RCOG's MTI scheme), or which have been dismissed prematurely as being unviable without showing any evidence for this (e.g. Trust management claiming that there's no point using Hybrid rotas as they're too expensive, despite them being proven by the RCOG to be cheaper than alternatives such as using locums).

The IRP report in 2008 directed that, in the interests of patient safety, every possible effort to sustain a CLU at the Horton should be made. Individuals we have spoken to at other small obstetric units have spoken of the hard work which has gone into maintaining training accreditation and their pride at the success of this, for example at Morecambe Bay Hospital Trust. Our obstetrician contact at Pilgrim Hospital in Boston, Lincolnshire, commented that "the Trust and Consultant obstetricians have together worked very hard to maintain training accreditation here". Reflecting on this research, it strikes us that the the issues small CLUs face which threaten their sustainability needn't be insurmountable if there is the will and ingenuity to overcome them within Hospital Trusts.