NHS Oxfordshire Clinical Commissioning Group

OXFORDSHIRE COUNTY COUNCIL

healthwatch Oxfordshire

Horton Joint Health Overview & Scrutiny Committee
Wednesday, 19 December 2018

ADDENDA

4. Committee to hear the views of interested parties (Pages 1 - 134)

Attached are the following documents:

- NHS England South (South Central) – Service Reconfiguration Assurance
- Royal College of Midwives (RCM) – 'Response to Horton HOSC's consultation
- RCM - 'Position Statement'
- RCM – Standards for Midwifery services in the UK'
- Submission from Healthwatch Northamptonshire and South Northamptonshire & Daventry maternity survey highlights
- Royal College of Obstetricians & Gynaecologists (RCOG) – 'Response to Horton HOSC invitation
- RCOG – 'Providing quality care for women – Workforce'
- RCOG – 'Workforce Report 2017'
- RCOG – 'Workforce Report – Update on workforce recommendations and activities.'
- South Warwickshire CCG – 'Horton General Hospital Obstetric Unit position statement
- South Warwickshire CCG – Appendix 1a – Births Analysis report'
- South Warwickshire CCG – Appendix 1b – Births Analysis
- Responses from Primary Care
- General responses

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NHS England - Service Reconfiguration Assurance

Horton HOSC meeting, Town Hall, Banbury

19 December 2018

What this presentation covers:

1. NHS policy framework for 'service change'
2. NHS England's role in service change
3. Legal framework for NHS service change
4. NHSE Assurance - key principles and process; the assurance 'tests' for service change, Stage1 and Stage 2 panels
5. Role of the Clinical Senate in service reconfiguration assurance
6. NHS England - assurance decision-making thresholds
7. NHS England guidance
8. Discussion of the Q's from Horton HOSC

Information in this presentation has been summarised from NHS England's guidance "Planning, assuring and delivering service change" 2018. For further details, refer to this guidance which is available at:
https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

Policy framework for ‘service change’

In October 2014, NHS England published the *NHS five year forward view* (Forward View). This key policy document sets out a vision of how NHS services need to change to meet the current and future health needs of the population.

The policy

- focuses on the need for the NHS to place far greater emphasis on: prevention, integration of services, reduction of health inequalities, and putting patients and communities in control of their health;

- sets out an expectation that, through Sustainability and Transformation Partnerships (ICSs), clinical commissioners and their partners will think creatively about how to achieve the vision.

NHS England's role in service change

NHS England's role is to **support NHS commissioners and their local partners,** including providers, **to develop clear, evidence based proposals for service change, and –** where it is agreed that a service change is 'substantial' **- to undertake assurance to ensure that commissioners and partners can progress, with due consideration for the government's four tests of service change and NHS England's test for proposed bed closures.**

Although there is **no single accepted, legal definition of 'substantial' service change** it is generally understood to involve a significant shift in the way front line health services are delivered, usually encompassing **a change to the geographical location** where services are delivered; a proposal to '**decommission'** a service; or if a large number of patients will be affected.

(See page 10 of NHSE's Guidance https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/)

Legal framework (1)

Clinical Commissioning Groups (*and NHS England, if NHS England are directly commissioning services*) are under a **statutory duty regarding public involvement and consultation**, set out in:

- **s.13Q NHS Act 2006 (as amended by the *Health and Social Care Act 2012*)** for NHS England; and
- **s.14Z2 NHS Act 2006** for Clinical Commissioning Groups

Consultation with local authorities – *Local Authority (Public Health, HWB and Health Scrutiny) Regulations 2013*

- *a*pplies to "substantial development"
- confers legal power of referral to Secretary of State for Health and Social Care (*separate from Judicial Review*) where
  - consultation is perceived as inadequate
  - proposals for service change are considered to be not in the interests of health services in the area.

Legal framework (2)

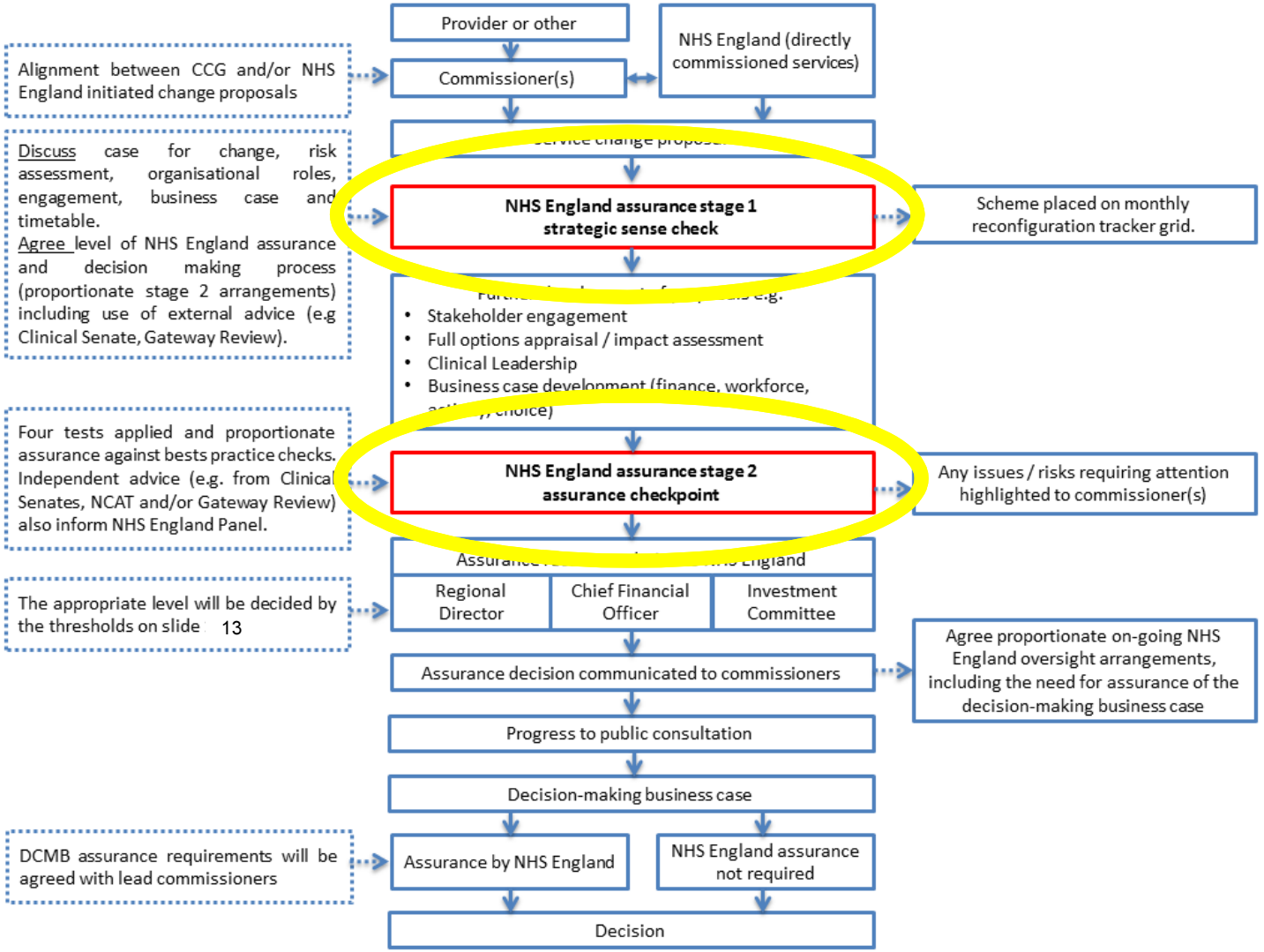
Clinical Commissioning Groups have a statutory duty to

- exercise their commissioning functions consistently with the objectives in the Government's **Mandate** and to act in accordance with the requirements of relevant regulations, such as Procurement, Patient Choice and Competition Regulations, **CCG Improvement and Assurance Framework** and guidance from **NHS Improvement.**
- consider relevant **Joint Strategic Needs Assessments** and **Joint Health & Wellbeing Board Strategies** (section 116B of the Local Government and Public Involvement in Health Act 2007) as part of the decision-making process. In light of the legal duty to consider JSNA and JHWS, there is an expectation that proposals will demonstrate a clear alignment to the JSNA and JHWS.
- comply with the Equality Act 2010 regarding the **public sector equality duty** ('PSED') and the **duty to reduce health inequalities**, and duties under the NHS Act 2006 (as amended by the HSCA 2012). Service change proposals and communications should be appropriate and accessible to meet the needs of diverse communities.

NHSE Assurance process – key principles

- **The objective** of service change should be to achieve a fundamental improvement in the quality and sustainability of services, in a way that gains the support of patients, staff and the public.
- **Proposals require commissioner ownership, support and leadership** (even if change is initiated by a provider organisation) so that proposals align with commissioning intentions. Where services are commissioned by two or more commissioners, it is essential that proposals align with each organisation's commissioning intentions. All proposals **need to be supported by the relevant STP/ICS**.
- It is important that NHS England/NHS Improvement undertake a **robust and consistent assurance process,** to ensure that all parts of the NHS are working together, and to provide confidence to patients, staff and the public.
- Assurance of proposals should be **undertaken in advance of formal public consultation**.
- Service change assurance requirements **should not place an additional burden on CCGs**, as these are requisite for a well-managed change.
- The assurance process aims to help organisations progress complex reconfiguration programmes. The application of a 'best practice' approach also helps to **mitigate risk of challenge**.

The Assurance Process



Tests for Service Change

FOUR TESTS FOR SERVICE CHANGE

1.Strong public and patient engagement

2. Consistency with current and prospective need for patient choice

3. Clear, clinical evidence base

4. Support for proposals from clinical commissioners

NHS ENGLAND'S FIFTH TEST

Plans to significantly reduce hospital bed numbers, NHS England will expect commissioners to be able to evidence that they can meet one of the following three conditions:

Demonstrate sufficient alternative provision, such as increased GP or community services, is being put in place alongside or ahead of bed closures, and that the new workforce will be there to deliver it	Show that specific new treatments or therapies, such as new anti-coagulation drugs used to treat strokes, will reduce specific categories of admissions	Where a hospital has been using beds less efficiently than the national average, that it has a credible plan to improve performance without affecting patient care (for example in line with the Getting it Right First Time programme)

Stage 1 - The Strategic Sense Check

A strategic sense check is a formal discussion between commissioners leading the change and NHS England at the appropriate level (usually the local office / Regional team). NHS England will explore the case for change and the level of consensus for change; ensure a full range of options are being considered and that potential risks are identified and mitigated. The alignment between the proposed changes and local STP or ICS, other key partners and neighbouring organisations will also be explored.

Areas of focus can include:

Organisational roles/impact	Likely resource requirements, including support requirements	The role clinical networks, Senates and specialised commissioning might offer in providing advice, guidance and assurance	Capital and estates implications (involving NHS Improvement and NHS England's Project Appraisal Unit where appropriate)
The level of stakeholder involvement and sign up	Inter-relationships between CCG and/or NHS England initiated change proposals and alignment of these elements (including a lead commissioner for assurance purposes)	Choice and competition implications of the proposals	Clinical quality, other non-financial and financial parameters for defining and appraising options (involving NHS England's strategic finance team where appropriate)

By this point, engagement with NHS Improvement should have commenced and, if capital is likely to be required, discussions with the relevant NHS England and NHS Improvement finance teams should have begun.

The strategic sense check will agree NHS England's expectations in terms of assurance and the use of a best practice approach. The use of external independent advice, e.g. from Clinical Senate and/or Project Appraisal Unit, will be agreed at this stage. Any particular issues to be included in terms of reference for these reviews will also be specified.

Stage 2 - Assurance Checkpoint

This stage is a more detailed assurance of proposals undertaken by NHS England, the scope of which will reflect the agreement made at the strategic sense check. NHS England may decide to establish an assurance panel to discharge its assurance responsibilities. The Panel would be formed by NHS England staff suitably qualified to consider evidence submitted against the five key tests plus financial deliverability, affordability and value for money and to advise on the additional checks.

NHS ENGLAND PANEL

Contributions from NHS Improvement, HEE, Clinical Senates, specialised commissioning and other experts may be sought.

NHS England will want to assure:

- strategic alignment of the proposals within the STP/ICS
- current and future provision of directly commissioned services;
- change proposals from neighbouring health systems and the delivery of national priorities

Support for proposals from providers and other commissioners impacted to a significant degree by the proposals will be tested as part of the assurance process and, where relevant, letters of support may be required as part of the assurance evidence.

Recommendation to the appropriate decision making forum within NHS England

The role of Clinical Senates

The purposes of the Clinical Senates are to:

- Support commissioners to make the best decision about healthcare for their populations
- Bring together a range of health and social care professionals, with patients, to take an overview of health and healthcare for local populations
- **Provide a source of strategic, independent clinical advice and leadership on how services should be designed to provide the best overall care and outcomes for patients**
- **Provide clinical advice to inform the NHS England reconfiguration assurance process**

As commissioners and transformation programmes work to reconfigure services, Clinical Senates can provide them with independent clinical advice to enable them to demonstrate compliance with the Four Tests* for Service Change (**particularly Test 3 – *Clear Clinical Evidence Base***) and the Fifth Test regarding **changes in bed numbers**.

**See Slide 9 for a description of the Tests*

The role of Clinical Senates (2)

In addition to making recommendations to NHS England regarding compliance with Test 3 *Clear Clinical Evidence Base,* there are a range of '**best practice**' checks for service change proposals which include ensuring that the proposals provide:

- a clear articulation of patient and quality benefits;
- evidence that the clinical case fits with national best practice; and
- an options appraisal that includes consideration of a network approach, cooperation and collaboration with other sites and / or organisations.

The process is as follows:

- Proposal is developed by the commissioner - documentation/evidence is submitted to the Senate
- The Senate convenes an external expert panel – ensuring no conflicts of interest
- The commissioner documentation is reviewed and Key Lines Of Enquiry are developed
- The Panel meets to review the evidence and produce recommendations for NHSE

NHS England assurance – Decision Making Thresholds

1. The Investment Committee Turnover > £500m

- Capital value > £100m
- Requires transition or transaction support > £20m from NHS England funds
- Provider in tier 4 NHSI's Single Oversight Framework (was special measures)

2. Chief Financial Officer Turnover > £350m

- Capital value > £50m
- Requires transition or transaction support from NHS England
- Distressed health economy / success regime

3. The Regional Director (NHS South East – Anne Eden) will oversee assurance for all schemes beneath these thresholds

Guidance

NHS England Guidance includes 'good practice' advice on

- developing proposals, business cases, public involvement and consultations;
- the Government's 'four tests' for reconfiguration; NHS England's 5th test for bed closures;
- a summary of relevant legislation (including legal duties on public involvement and consultation with local authority health scrutiny);
- how service reconfiguration proposals will be supported and assured by NHS England;
- governance for schemes involving multiple commissioning organisations

By following this guidance, and appropriately and effectively involving local diverse communities, local authorities, key stakeholders and expert advisors (for example from Clinical Senates), commissioners may reduce the risk of their service changes being referred to the Secretary of State, Independent Reconfiguration Panel or challenged by judicial review.

Questions from Horton HOSC

NHS England/Thames Valley Clinical Senate is asked to discuss:

1. Summary of the NHS Assurance process and timescales
2. The progress OCCG and OUHFT have made on addressing the Thames Valley Clinical Senate recommendations
3. The capacity of the JR (and other obstetric units as appropriate) to absorb additional births as a result of the closure of obstetrics at the Horton General Hospital/
4. The work which has been undertaken on recruitment and retention of staff at OUHFT.
5. How important an obstetric unit at the Horton General Hospital is for the local area?
6. Acceptable NHS England standards for travel and transfer times for women in labour to obstetric services.
7. The draft long-list options (dated 29th Nov 2018) for an obstetric unit at the Horton General Hospital?.
8. What are the most important criteria when making an assessment on future options? What weight should they be given when assessing options?
9. The impact for strategic provision of maternity services of the closure of an obstetric unit at the Horton General Hospital.
10. What do you think would be the impact of a permanent closure?
11. The NHS England position on how purdah impacts the process of engagement and consultation on changes to service provision. In particular; why is this seen as precluding such activity?

THE ROYAL COLLEGE OF MIDWIVES

Promoting · Supporting · Influencing

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

17th December 2018

Dear Councillor Fatemian

Thank you for your letter of 29th November to our Chief Executive Gill Walton and for the invitation to speak at the Horton HOSC meeting on Wednesday 19th December. I will be representing the RCM at that meeting and look forward to discussing the proposals for the future of services at the Horton.

In advance of this meeting, I set out in this letter, the RCM's views on the proposals for services at the Horton and, in particular, our response to the questions outlined in your letter.

I thought it would be helpful to begin with an explanation of the RCM's approach to responding to proposals for reconfiguring maternity services. As set out in the attached position statement, we believe that proposals for merging or reconfiguring maternity services should:

- Be supported by a robust and evidence-based case for change.
- Ensure that women are able to choose where to give birth, including the options of giving birth at home or in a midwife led unit (MLU).
- Include information, in a variety of formats, about all the available maternity facilities.

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- Demonstrate alignment between the proposed model(s) of care and the needs of women and babies, staffing and skill mix levels, the demographic profile of the local population and case mix.
- Maximise the opportunity for women to have continuity of carer from the person who is caring for them.
- Encourage multi-professional working and learning.
- Ensure that there is sufficient capacity to deliver services in the new or modified settings.
- Include robust arrangements for the safe and timely referral and transfer of women and babies to more specialist services, when these are required.

Options for an obstetric unit at the Horton General Hospital

Of the options listed, if there is no improvement in efforts to recruit middle grade doctors to the Horton (and accordingly no restoration of training accreditation) then the RCM's preferred option would be option Ob4 (single obstetric service at JRH).

The standalone MLU at the Horton achieved 200 births in its first year, which provides a good basis for its future. Although latest statistics indicates a slight fall (190 births in the last year) this is reflective of an overall reduction in birth numbers in Oxfordshire. Ideally, standalone MLUs should be achieving 400 or more births a year; we are therefore pleased that there are plans to promote the MLU in order to increase the number of women that access services there.

If the recruitment and training issues affecting medical staffing are resolved, then the RCM would in principle support option Ob7 (two obstetric units both with an alongside MLU). We regard option Ob7 as preferable to the other options that are based on two obstetric units, as none of these explicitly commit to also having MLUs on site. It should be noted that while the RCM supported the temporary reconfiguration of maternity services, we have always been concerned about the distance that women in Banbury have to travel to attend the maternity unit at the JRH. Restoring obstetric services to the Horton will benefit those women who would not be eligible to access care from a standalone MLU, but we must stress that this will only be a realistic option if there is a significant improvement in the recruitment of middle grade doctors and the restoration of training accreditation.

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The RCM would also like the Horton HOSC to give consideration to the option for women to give birth at home, which appears to have been overlooked in all of the options listed. As part of the transformation of maternity services in England, commissioners and providers are meant to ensure that women are offered choice of a birth in hospital, in a midwife-led unit and also birth at home. The best way of enabling this option to be available to women is to develop a service model based on:

- An organisational commitment to support the home birth service.
- Employing sufficient numbers of competent and appropriately educated midwives.
- Ensuring that the woman knows at least one of the midwives attending her home birth and that she has her contact details.
- Clear and agreed standards for the transfer of women from home, in case of delays or complications.

Work undertaken on recruitment and retention of staff at OUHFT

Based on Dr Veronica Miller's report on midwifery and medical staffing recruitment, while the recent recruitment drive for midwives appears to have been successful, we note that maternity services are predicting staffing shortfalls for next year and that this is likely to be confirmed by the Birthrate Plus assessment (the initial findings of which are already indicating a shortage of midwives for the workload and acuity of the women attending the JRH). The question then is not whether OUH is able to recruit midwives to posts but whether its funded establishment accurately reflects the number of midwives needed to deliver a safe and good quality service.

On medical staffing, the report does not appear to offer many grounds for optimism that the Trust can achieve a significant turnaround in recruiting more obstetric staff. While the present shortages persist it is difficult to see how obstetric services can be restored at the Horton.

Acceptable and safe midwifery staffing levels for an obstetric unit

The RCM recommends adherence to the NICE safe staffing guideline for midwives working in maternity settings as the most appropriate guidance for determining what are acceptable and safe midwifery staffing levels. The key recommendation within the guideline is that there are sufficient midwives to provide every woman in established labour with one-to-one care from a midwife. This must always be calculated on the total number of clinical whole time equivalent (wte) midwives required exclusive of specialist and managerial roles.

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This will include allowing uplift to account for:

- Sickness absence, maternity leave and study leave.
- Continuous professional development.
- Training required to maintain competency in providing safe maternity care.
- The supervisory and managerial duties of senior midwives.

It is absolutely essential that implementation of the guideline is underpinned by a systematic workforce strategy and use of a recognised workforce planning tool for determining the total number of midwifery and MSW staff required. This will vary from maternity service to maternity service and will depend on a range of variables, such as models of care, configuration of services, case mix, length of stay in acute settings and competency levels of maternity support workers.

All services will be subject to peaks and troughs in demand throughout the year, so workforce planning will need to be augmented by acuity tools and escalation plans in order to ensure that services respond promptly to sudden fluctuations in activity or changes to staffing levels (caused for example by unexplained absences). Whilst the labour ward should be safely staffed at all times, this should not be at the expense of other areas, such as community or home birth services.

The RCM strongly recommends using Birthrate Plus to undertake workforce planning for midwifery services, as this is the only recognised national tool for calculating midwifery staffing levels. Birthrate Plus provides a robust and proven methodology, based on the minimum quality standard of providing one-to-one care in labour, and has been endorsed by NICE.

In line with the recommendations in Better Births, and the current maternity transformation programme in England, the RCM recommends that staffing levels should not only be based on women receiving one-to-one care in labour but should also be sufficient to ensure that models of service delivery based on continuity of carer can be developed.

Benefits and challenges for midwives providing care in small obstetric units

While there is little evidence to say what the optimum size of an obstetric unit should be, it is likely that units undertaking more than 8,000 births a year may require staffing by two teams of obstetricians. The RCM also believes that maternity units undertaking fewer than 6,000 births a year are more likely to facilitate an environment in which care is personalised and woman-centred.

While we recognise that the smallest maternity units (particularly those undertaking fewer that 2,500 births a year) face challenges in terms of attracting sufficient numbers of trained medical staff to make them viable, it should also be recognised that the closure of small units will have an impact on the capacity of neighbouring units. In addition there is a strong case (recognised within Better Births, the report of the national maternity review in 2016) for retaining small maternity units in remote and rural settings in order to avoid a situation where women and families are required to travel long distances to access their nearest services.

Accordingly, if the future of an obstetric unit is subject to review, consideration should be given to:

- The impact that a closure would have on local women, particularly in terms of the time and distance that they would then need to travel in order to access neighbouring maternity services.
- The capacity of neighbouring units to absorb the additional activity resulting from the closure of the unit.
- Whether, particularly in the case of smaller obstetric units, arrangements can be made with a larger unit for referral of women and the interchange of staff
- Establishing a midwifery-led service on the site of the obstetric unit.

It is unlikely that small obstetric units will be able to provide care to the most high risk women, so there must be adequate plans in place to ensure that these women are able to access appropriate care from specialist maternity services. It is therefore vital that smaller obstetric units undertake continuous, dynamic and robust risk assessment for all women, that there is appropriate signposting to the most appropriate setting of care and that this is all underpinned by excellent stabilisation and transfer services[i].

Examples of innovative practice which allows smaller obstetric units to be run and staffed, safely and sustainably

The examples that the Committee are interested in probably relate more to innovative practice in obstetric staffing than midwifery, and may therefore be one that the RCOG is better qualified to answer. Having said, that the RCM is aware of the case of West Cumberland Hospital (WCH) in Whitehaven - another small obstetric unit (1200 births a year), where the RCOG had recommended the incorporation of new ways of working as a means of sustaining the unit.

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This included adopting a networked approach, within which WCH was linked to the nearest obstetric unit at Carlisle and the tertiary service at Newcastle. This model was seen as facilitating the amalgamation of medical staffing structures through the rotation of consultants between Whitehaven and Carlisle. This networked approach was also seen as beneficial in terms of addressing skills preservation and updating, CPD requirements and improving team working and communication (which could be extended over time to paediatric and anaesthetic services).

Comparison of alongside and standalone MLUs

Whilst alongside and standalone MLUs have distinctive characteristics and facets, it is worth emphasising that they also share much in common. The principles and evidence for the provision of care are much the same for both types of MLU – both provide care to healthy women with straightforward pregnancies during labour and following birth. And both provide care that is as safe as in obstetric units for low risk women, including women expecting their first babies[ii]. It should be noted in any case that all births, wherever they take place, carry some risk – however small – and the key issue here is informed choice for women. Women who birth in MLUs are more likely to have a normal birth, to have access to water for pain relief and to successfully establish breastfeeding.

There is no recommended minimum or maximum level of activity for MLUs, whether alongside or standalone. For both models, staffing levels and skill mix should align with the number of women birthing in the MLU and with antenatal and postnatal activity – in order to ensure that the MLU is financially viable. Selection criteria and practice guidelines for MLUs should be agreed by the multi-disciplinary team and audited on a regular basis.

Alongside MLUs can provide a most cost effective and efficient use of the midwifery and MSW workforce, as they can be deployed flexibly within the whole service, particularly during times of peak activity. Alongside units should be staffed by a midwife-led team and supported by strong local leadership. They should offer sufficient capacity to meet the needs of the majority of low risk women and deploy a flexible staffing model in order to ensure that it can remain open even during times of high pressure on the acute unit.

Alongside units should be physically distinct from the delivery suite. Simply putting up a dividing curtain on a ward is not sufficient in itself to qualify it as an alongside MLU.

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The proximity of alongside units to obstetric services offers is an obvious advantage in situations where a woman may need to be transferred to obstetric care. On the other hand there are anecdotal concerns that 'risk-creep' can occur in standalone units i.e. because there is quick access to obstetric services, staff in alongside units may develop a higher tolerance to 'deviation' from the normal pathway than that which would be tolerated in community settings.

Standalone MLUs offers increased choice for some women as well as additional capacity, particularly when the nearest maternity unit is experiencing peaks in demand. Standalone MLUs are not just there for the birth but also provide antenatal and postnatal care, including for women who birth elsewhere. In some areas hospital obstetricians attend and run their clinics in the birth centre, thereby reducing the need for women to travel to the obstetric unit. While standalone units are by definition separate to an obstetric service, there is no reason why they cannot be co-located with other health and social care services, such as children's services, physiotherapy, health visiting, dentistry, GP and practice nurses.

There may be a strong case for commissioning a standalone MLU if an obstetric unit is due to close or if the nearest alongside MLU is a significant distance from the local community. Consideration should therefore be given to providing antenatal and postnatal care at the standalone unit for women at all risk levels.

Standalone units will not be right for everyone. Women cannot be offered all available pain relief in standalone MLUs and so a hospital setting may be more appropriate if the woman wants to be in a location where all the choices of pain relief are readily available. In areas of high deprivation, a standalone unit might not be considered to be viable if a significant proportion of childbearing women may be deemed to be at high risk, and therefore not likely to meet the criteria for birthing at a standalone unit[iii].

Summary of clinical standards for midwifery which would be important for assessing the safety of an obstetric service

Crucial reports and strategic reviews about the quality of maternity care in different parts of the UK have consistently identified that improvements should be underpinned by implementation of existing evidence-based clinical standards.

The RCM standards for midwifery services in the UK cite 55 standards all of which cover safety in some way. The standards can be found here: https://www.rcm.org.uk/sites/default/files/RCM%20Standards%20for%20Midwifery%20Services%20in%20the%20UK%20A4%2016pp%202016_12.pdf

The RCM has identified six key themes for service delivery:

- Clinical governance.
- Communication.
- Staffing.
- Education and accountability.
- Family-centred care.
- Care and the birth environment.

Key measurement criteria are suggested for each standard, along with an example of at least one suggested source of evidence that could be used to evaluate implementation.

The RCM would draw the Committee's attention to the following standards in particular:

- Standards 6 and 7: High quality midwifery services nurture and develop a trusting relationship with the women and families that they serve. They work in collaboration with all key stakeholders in the provision of maternity care and engage proactively with service users, ensuring that feedback is responded to in a timely manner and that their views are sought when any significant changes to systems are proposed. They foster a culture of learning and supportive work practices amongst professional colleagues and are open and transparent in response to an investigation of any critical incidents.
- Standard 8: Midwifery is defined as "skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views and working in partnership with women to strengthen women's own capabilities to care for themselves".
- Standard 9: A midwifery model of care assumes that pregnancy, birth and the postnatal period are normal life events for a woman and her baby.

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It is woman-centred and based on strong evidence that continuity of carer in monitoring and promoting the physical, psychological and social well -being of the woman and family throughout the childbearing cycle is critically important. A midwifery model of care provides the woman with individualised education, counselling and antenatal care, and continuity of care during labour, birth and the immediate postpartum period and ongoing support during the postnatal period. The midwife plays a central role in co-ordinating care and linking with other health and social care professionals and voluntary sector organisations providing services for childbearing women (adapted from International Confederation of Midwives 2011).

- Standard 10: This definition clearly places the midwife in a central position in both providing care and communicating with other family members, providers and clinicians. The care from a midwife will take place in many diverse settings and as such requires midwives to be adaptable and versatile.
- Standards 11 to 14: Midwifery care should take place within services which are organised to provide evidence-based guidance for midwives and in systems that validate and regularly review policies, guidelines and protocols. Services should use systems to continuously audit and monitor clinical activity and are reviewed regularly as part of the governance arrangements and adhere to professional standards for documentation, record keeping and data information storage. They should address the requirements of national guidelines and policies with particular regard to improving health and reducing health inequalities.

The RCM hears from women all over the UK about their birth experiences and they often report greater levels of satisfaction with midwifery units than receiving care in traditional labour wards. The care they receive is often more personal and they are less likely to experience medical interventions, such as caesarean sections. The RCM has always stressed that women need to make their decision about where they give birth based on the best possible evidence about the risks and benefits of all places of birth including home, midwife led units or in a consultant led obstetric unit. This is why it is so important that midwives have the time to discuss all the options about place of birth with women.

The other possible issue is that if the woman's circumstances change during the pregnancy such as anticipating themselves or their baby risk developing complications, they will then be advised to labour and give birth in hospital anyway. In addition, women are free to change their mind at any point if they wish to receive care elsewhere.

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I hope that you find this information to be helpful and I look forward to attending the meeting on Wednesday.

Yours sincerely

Gabby Dowds-Quinn
Regional Officer
Royal College of Midwives

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[i] It should be noted that women who need to be transferred from an alongside MLU usually do so further on into their labour, than women who have decided to have their baby in hospital. It should also be stressed that the vast majority of transfers are not urgent and are conducted in planned and very controlled circumstances.

[ii] The Birthplace study in 2011, which was the definitive study of the safety of place of birth for women in UK settings, found that midwife led care, for women at low risk of complications, was as safe as a hospital birth, as well as reducing intervention rates. This is one of the key reasons that NICE amended its guidelines on the subject. The study also covered freestanding midwife led units.

[iii] Only those women without risk factors fit the criteria for birth in a standalone MLU. These women would need to give consent, including understanding the distance to hospital if a transfer is needed.

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Position Statement
Reconfigurations

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RCM position

Proposals for merging or reconfiguring maternity services should:

- be based on a robust and evidence-based case for change
- ensure that women are able to choose where to give birth, including at home or in a midwifery unit
- provide women and families with information, in a variety of formats, about all of its maternity facilities
- align staffing and skill mix levels with the needs of women and babies, the chosen model of care, the demographic profile of the local population and case mix
- maximise the opportunity for women to have continuity in the person who is caring for them
- encourage multi-professional working and training
- ensure that there will be sufficient physical capacity to deliver services in the new or modified settings
- include robust arrangements for the safe and rapid referral and transfer of women and babies to more specialist services when they are needed.

Background and Context

Home births

Home births must be offered to women as a guaranteed service to underpin their choices, and the best way of doing this is to have a service model that is underpinned by:

- organisational commitment to support the service, regardless of clinical activity within the acute provider setting
- sufficient numbers of appropriately educated and competent midwives
- ensuring that the woman knows at least one of the midwives attending her home birth and has her contact details
- clear and agreed standards for the transfer of women from home in case of complications.

Midwifery units

- There is no recommended minimum or maximum level of activity for midwifery units (MUs). Staffing levels and skill-mix should align with the number of women birthing in the MU, and with antenatal and postnatal activity, in order to ensure that the MU is financially sustainable.
- Selection criteria and practice guidelines for MUs should be agreed by the multi-disciplinary team and audited on a regular basis.
- There may be a strong case for commissioning a freestanding midwifery unit (FMU) if an obstetric unit is due to close or if the nearest obstetric service with an alongside midwifery unit (AMU) is a significant distance from a local community. Consideration should be given to providing antenatal and postnatal care at the FMU for women at all risk levels.
- While FMUs are by definition separate to an obstetric service, there is no reason why they cannot be co-located with other health and social care services.
- AMUs should be staffed by a midwife-led team and supported by strong local leadership. They should offer sufficient capacity to meet the needs of the majority of low risk women and deploy a flexible staffing model in order to ensure that the AMU remains open even during times of high pressure on the acute unit. They should be physically distinct from the delivery suite.

Obstetric units

- There is no recommended minimum or maximum level of activity for an obstetric unit. However:
  - units undertaking more than 8,000 births a year may require staffing by two teams of obstetricians.
  - units undertaking fewer than 2,500 births a year may have difficulty in attracting sufficient numbers of trained medical staff to make them viable.
- If the future of an obstetric unit is subject to review, consideration should be given to:
  - the impact that closure will have on the time and distance that women will have to travel to their next nearest service.
  - the capacity of neighbouring units to absorb the additional activity that will result from the closure of the unit.
  - whether, for smaller obstetric units, arrangements can be made with a larger unit for referral of women and interchange of staff
  - establishing a midwifery-led service on the site of the obstetric unit.
- The closure of a hospital A&E department and associated emergency services should not automatically lead to a decision to close the remaining obstetric unit without first exploring alternative ways of managing women at expected risk.

Workforce issues

- Midwifery staffing levels should be sufficient to ensure that models of service delivery based on continuity of carer can be developed and that all women can receive one to one care in labour.
- The labour ward should be safely staffed at all times but this should not be achieved at the expense of other areas, such as community or home birth services.
- On the effectiveness of 24/7 consultant labour ward cover, a review of evidence by the National Perinatal Epidemiology Unit (NPEU) concluded that such a model appears to be viable only in large urban hospitals.

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The RCM standards for midwifery services in the UK

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Background

Crucial reports and strategic reviews about the quality of maternity care in different parts of the UK have consistently identified that improvements should be underpinned by implementation of existing evidence-based clinical standards (for example see 1, 2, 3, 4 and 5).

The RCM identified that to deliver compassionate, well-led, professional evidence-based midwifery care which maximises midwives' contributions to improving quality also required midwifery service standards within a framework which could be used by service providers, commissioners and RCM members.

The Royal College of Midwives (The RCM)

A small project team was tasked with developing The RCM Standards for midwifery services in the UK. The team developed the standards using a pragmatic review of the evidence available and through consensus informed by views, comments and suggestions on draft outputs from respondents amongst those listed in Appendix 1.

Published: September 2016

Format of report

Section 1

Section 1 covers principles of standards for high quality midwifery services which were used as the basis for developing the standards.

Section 2

Section 2 sets out statements and standards presented under six key themes for service delivery:

- clinical governance
- communication
- staffing
- education and accountability
- family-centred care
- care and the birth environment.

Key measurement criteria are suggested for each standard, along with an example of at least one suggested source of evidence that could be used to evaluate implementation.

The standards are addressed to service providers and commissioners and also to midwives for attention and action.

Contextual references for Section 1 are listed at the end of the report along with a bibliography for Section 2.

Section 1
Principles for high quality midwifery services

High quality midwifery services nurture and develop a trusting relationship with the women and families that they serve. They work in collaboration with all key stakeholders in the provision of maternity care and engage proactively with service users, ensuring that feedback is responded to in a timely manner and that their views are sought when any significant changes to systems are proposed. They foster a culture of learning and supportive work practices amongst professional colleagues and are open and transparent in response to an investigation of any critical incidents. (6 and 7)

Midwifery is defined as "Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum throughout pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstances and views and working in partnership with women to strengthen women's own capabilities to care for themselves". (8)

A midwifery model of care assumes that pregnancy, birth and the postnatal period are normal life events for a woman and her baby. It is woman-centred and based on strong evidence that continuity of carer in monitoring and promoting the physical, psychological and social well being of the woman and family throughout the childbearing cycle is critically important. A midwifery model of care provides the woman with individualised education, counselling and antenatal care, continuity of care during labour, birth and the immediate postpartum period and ongoing support during the postnatal period. The midwife plays a central role in co-ordinating care and linking with other health and social care professionals and voluntary sector organisations providing services for childbearing women (adapted from International Confederation of Midwives 2011). (9)

This definition clearly places the midwife in a central position in both providing care and communicating with other family members, providers and clinicians. The care from a midwife will take place in many diverse settings and as such requires midwives to be adaptable and versatile. (10)

Midwifery care should take place within services which are organised to provide evidence-based guidance for midwives and in systems that validate and regularly review policies, guidelines and protocols. Services should use systems to continuously audit and monitor clinical activity and are reviewed regularly as part of the governance arrangements and adhere to professional standards for documentation, record keeping and data information storage. They should address the requirements of national guidelines and policies with particular regard to improving health and reducing health inequalities. (11-14)

Section 2
Key themes, statements and standards for midwifery services

Theme 1: Clinical Governance

Standard Statement:
Planning and organising of midwifery services takes place under midwifery leadership and through multi-disciplinary collaboration which supports a high quality clinical governance framework that delivers personalised maternity services.

Standard	Measure	Example of evidence sources
1. There must be multi-professional input into the development of evidence-based guidelines, policies and procedures that are relevant to clinical practice in midwifery care and subject to regular review.	Evidence of membership of policy and guideline development groups.	Local arrangements and written clinical protocols.
2. There should be a multi-disciplinary steering / management group responsible for oversight of clinical care, which meets at least quarterly with published minutes and is directly accountable to the service provider's clinical governance body.	Evidence of membership and governance of steering / management group responsible for oversight of clinical care.	Local arrangements for written terms of reference and minutes.
3. There should be structures that facilitate open, transparent, respectful, non-hierarchical professional communication.	Evidence of structures that facilitate professional communication.	Staff survey. Minutes of perinatal mortality meetings.
4. There must be clear referral and communication pathways for the transfer of care between professionals and sites.	Evidence of referral and communication pathways.	Local arrangements and written protocols. Regional arrangements and written protocols.
5. There should be clear role profiles to support effective team working.	Evidence of role profiles.	Job descriptions.
6. There must be a written risk management policy, including trigger incidents, adverse incident reporting and multi-professional review.	Evidence of risk management policy.	Local arrangements and written clinical protocols.

Standard	Measure	Example of evidence sources
7. There must be a process for feeding back promptly, honestly and transparently to women and families when things go wrong and involving them as they wish in any review or inquiry.	Evidence of duty of candour policy.	Local arrangements and written clinical protocols.
8. There must be a process to ensure that all critical incidents, including all perinatal deaths, are thoroughly reviewed by a multi-disciplinary group including service user representation and independent peers.	Evidence of process for reviewing all critical incidents.	Local arrangements and written clinical protocols.
9. There must be a process of rapid dissemination of learning from such reviews to facilitate multi-disciplinary learning.	Evidence of process for dissemination of learning.	Local quality accounts. Shared learning summaries.
10. There must be effective collaborative partnership working with the local and national maternal, neonatal and child health services.	Evidence of collaborative partnership working.	Local arrangements for local data collection.
11. There should be senior midwifery representation on the local Maternity Services Liaison Committee (MSLC) and the service provider's clinical governance body.	Evidence of membership of the local MSLC and the service provider's clinical governance body.	Local arrangements and written minutes of meetings.
12. Systems must be in place to ensure electronic collection, reporting and transfer of information regarding activity, performance and outcomes of care which support midwives and other clinical staff to have access to the relevant data to assess and improve outcomes.	Evidence of systems for collection, reporting and transfer of information.	Local arrangements and written policy.
13. Personal and team practice audit should take place linked to evidence-based guidance, reflection and practice change.	Evidence of personal and team practice audit.	Local arrangements and local data collection.
14. There must be an agreed care plan based on an individual woman's health and needs assessment that is reviewed regularly.	Evidence of individual care plan.	Local arrangements for woman held maternity notes.

Theme 2: Communication

Standard Statement:
Midwives must have the ability to communicate effectively with all members of the maternity team, other professionals, women receiving care and their family members. They should ensure that all information relevant to the care pathway is accessible, aids decision making and assists communication.

Standard	Measure	Example of evidence sources
15. There should be processes and systems, including IT, that support good communication in all elements of care.	Documented processes and systems for communication.	Local arrangements and local written clinical policy. Local data collection.
16. There should be formal communication and referral pathways for midwives with general practitioners, health visitors, laboratory services, emergency services, acute and primary care trusts and other health and social care networks.	Documented communication and referral pathways.	Local arrangements and local written clinical policy. Regional arrangements and written policy.
17. There should be protocols on the content and format of written communication, in particular about transfer of care between professionals.	Documented protocols on content and format of written communication.	Local arrangements and written clinical policy.
18. Women and their families should be actively encouraged to express their preferences and supported to make choices, share decisions and take responsibility for their own health care.	Evidence about women and their families active involvement in decision making.	Local data from national survey of women's experiences.
19. Women should be offered the opportunity to talk about their birth experiences and to ask questions about the care they received. This may continue beyond the six week postnatal period.	Evidence that women are offered opportunities to talk about their experiences and ask questions.	Local review and investigation of complaints. Local data from survey of women's experiences.
20. Documentation must be to a standard expected by the professional regulator and organisation's / employer's systems.	Evidence of documentation.	Local information systems.
21. The named professional responsible for the woman's care must be documented at all stages and most importantly when transfer of care takes place.	Evidence of documentation.	Local arrangements for woman held maternity notes.

Theme 3: Staffing

Standard Statement:
Safe staffing levels of midwives and support staff are maintained, reviewed and audited at least six monthly.

Standard	Measure	Example of evidence sources
22. Staffing establishments should be calculated according to a recognised workforce planning tool that ensures women have continuity of carer and one to one care from a midwife in labour.	Documented process for calculating staffing establishments.	Local arrangements and written clinical policy. Quality accounts.
23. There should be an appropriate skill mix that supports safe delivery of midwifery care that meets the needs of women in all environments.	Documented process for calculating skill mix.	Local arrangements and written clinical policy. Quality accounts.
24. The organisational leadership structure should reflect the philosophy of care, provide expert advice at board level to support the staff in the working environment.	Documented organisational leadership structure.	Local arrangements and written clinical policy.
25. An appropriately skilled and competent workforce must be maintained.	Documented process for monitoring workforce competency.	Local arrangements and written clinical policy.
26. New staff in all care environments must have access to induction and preceptorship.	Documented process for induction and preceptorship.	Local arrangements and written clinical policy.
27. Performance management appraisals should be undertaken for each member of the maternity team at least annually.	Evidence of annual performance management appraisals.	Local arrangements and written clinical policy. Staff survey.
28. Good morale and culture should be demonstrated through evidence from staff surveys, rates of sickness, absence and staff retention.	Evidence about morale and culture.	Staff survey. Local HR records.
29. A leadership style should be demonstrated to exist at all levels which assures engagement of all staff in the success of the organisation and supports staff in a way which maximises their contribution to high quality care.	Evidence about leadership style.	Staff survey.
30. Staff should have a safe working environment and culture that provides space which enables and supports them to take adequate rest, comfort and meal breaks.	Evidence of the working environment.	Local arrangements and written HR policy.

Theme 4: Education and professional accountability

Standard Statement:
Midwives have a personal accountability for continuing professional development and life-long learning. The system they work in should provide a positive learning culture with opportunities to fulfil these responsibilities.

Standard	Measure	Example of evidence source
31. Employers must provide time and opportunities for all midwives to maintain professional development in line with revalidation.	Evidence of continued professional developments.	Staff survey. Local arrangements and written policy.
32. Each staff member should undergo a staff performance review annually, which identifies development needs.	Evidence of annual staff performance review.	Staff survey. Local arrangements and written policy.
33. There must be a framework for effective accessible clinical supervision.	Evidence of clinical supervision.	Local arrangements and written policy.
34. All maternity staff should have access to courses and activities for workforce development and team building.	Evidence of workforce development and teambuilding.	Local arrangements and written policy. Local data collection.
35. There must be structures in place for the development and provision of the role of a sign off mentor for student midwives and of preceptors for newly qualified midwives.	Evidence of mentorship and preceptorship.	Local arrangements and written policy. Local data collection.
36. The culture of working environments should actively encourage learners and learning.	Evidence of working environment that encourages learners and learning.	Local arrangements and written policy. Local data collection.
37. Midwives and support staff should undertake multi-disciplinary training and participate in a regular clinical skills programme that is appropriate within the context of care environment.	Evidence of multi-disciplinary training.	Local arrangements and written policy. Local data collection.

Theme 5: Family-centred care

Standard statement:
Care is accessible, responsive and provided in partnership with women and their families, respecting their diverse needs, preferences and choices and in collaboration with other organisations whose services impact on family wellbeing.

Standard	Measure	Example of evidence sources
38. The model of midwifery care must be family centred and responsive to the cultural, emotional and physical aspects of pregnancy and birth.	Evidence about family-centred care.	Local arrangements and written clinical policy. Local data from national survey of women's experiences. Patient experience survey. Local data collection.
39. All midwifery services should be planned on the basis of high quality information about local population needs.	Evidence about service planning.	Local arrangements and written policy. Local data collection.
40. There should be effective partnership working across communities, including local authorities and the voluntary sector, providing pathways of care with access to social care agencies.	Evidence of partnership work.	Local arrangements and written policy. Local data collection.
41. There should be a structure that addresses the requirements of the relevant children and young people's legislation which includes safeguarding policies and collaboration with the relevant local networks.	Evidence of structure that addresses requirements of children's and young people's legislation.	Local arrangements and written policy. Local data collection.
42. There should be evidence that the local MSLC or other such structures embed user involvement to develop and improve services.	Evidence of user involvement to develop and improve services.	Local arrangements and written policy. Local data collection. Quality account.
43. Experiences of women and their family must be used to drive continuous improvement of care.	Evidence of feedback from service users.	Local review and investigation of complaints.
44. Women must be fully involved in all aspects of their care enabling them to be at the centre of decision making throughout.	Evidence about women's active involvement in decision making.	Local data from national survey of women's experiences. Local arrangements and written clinical policy.
45. Women must have access to the right information that facilitates direct access to care and midwives without unnecessary delay at any stage in the care pathway.	Evidence about information offered to women.	Local data from national survey of women's experiences. Local arrangements and written clinical policy. Local review of serious incident investigations.
46. Women should be introduced to all healthcare professionals involved in their care and made aware of their roles and responsibilities.	Evidence that women are introduced to all healthcare professionals.	Local arrangements and written clinical policy. Local data collection. Survey of women's experiences.
47. Women and their families' rights must be consistently respected throughout the care pathway, including their right to decline particular aspects of care and their right to privacy, dignity, autonomy and equality.	Evidence that women and their families rights are respected.	Local arrangements and written clinical policy. Survey of women's experiences. Local review and investigation of complaints.

Theme 6: Care and the birth environment

Standard statement:
Care is provided in a chosen, comfortable, clean, safe setting that promotes the wellbeing of women, families and staff, respecting women's needs, preferences and privacy. The physical environment supports normality and compassionate care.

Standard	Measure	Example of evidence sources
48. Maternity services should ensure women have access to midwifery care in all birth settings including midwifery units and home births.	Evidence of women's access to all birth settings.	Local arrangements and written clinical policy. Local published information. Local data from national survey of women's experiences.
49. There must be clear, evidence-based guidelines and policies supporting women's access to antenatal and postnatal care in different care environments.	Documentation of guidance and policies.	Local arrangements and written clinical policy.
50. The design of the environment for care must be led by the needs of women and their families and should contribute to relationship building between women and those caring for them.	Evidence about women's active involvement in design of the environment.	Local arrangements and written clinical policy.
51. All care environments must protect and promote women's privacy and dignity, respecting their human rights.	Evidence about privacy and dignity in care environments.	Local arrangements and written clinical policy. Survey of women's experiences. Local review and investigation of complaints.
52. Consideration should be given to the efficiency, effectiveness and sustainability when planning care environments.	Evidence about sustainable planning of care environments.	Local arrangements and written clinical policy. Local data collection.
53. There should be facilities that include space for furnishing and storage of equipment commensurate with normal birth and effective midwifery practice.	Evidence about space for storage of equipment.	Local arrangements and written clinical policy. Local data collection. Local incident reporting, review and action.
54. There must be appropriate private, sound proofed environments for families experiencing a loss in pregnancy, stillbirth or neonatal death that enables partners to stay with women throughout their hospital stay.	Evidence of an appropriate environment for bereaved families.	Local arrangements and written clinical policy. Local data collection. Survey of women's experiences.
55. The impact of the environment whatever the complexity of the care should be recognised, assessed and any concerns identified acted upon.	Evidence of assessment of impact of environment.	Local arrangements and written clinical policy. Local review and investigation of complaints.

Appendix 1
Project team and advisors involved in developing this report

Project team

Cathy Warwick, (sponsor) Chief Executive, The Royal College of Midwives

Louise Silverton, (co-sponsor) Director of Midwifery, The Royal College of Midwives

Helen Rogers, (project lead) Director, The Royal College of Midwives Wales

Mervi Jokinen, (project team) Practice and Standards Professional Advisor, The Royal College of Midwives

Jane Munro, (project team) Quality and Audit Development Advisor, The Royal College of Midwives

Rona McCandlish, (project team) Guideline and Development Advisor, The Royal College of Midwives

Geraldine Butcher, Consultant Midwife, Ayrshire Maternity Unit

Elizabeth Margaret Susan Davies, Consultant Midwife, Abertawe Bro Morgannwg University Health Board

Mary Ross-Davie, Educational Project Manager, Maternal Health NHS Education for Scotland

Kathryn Gutteridge, Consultant Midwife, Clinical Lead for Low Risk Care, Sandwell and West Birmingham Hospitals, NHS Trust

Margaret Rogan, Consultant Midwife, Belfast Health and Social Care Trust

RCM advisory forum members

Billie Hunter, Royal College of Midwives Professor of Midwifery, Cardiff University

Carmel McCalmont, Head of Midwifery (retired), University Hospitals Coventry and Warwickshire NHS Trust

Carole Garrick, Associate Director / Head of Midwifery, Western Sussex Hospitals NHS Foundation Trust

Chelsea Thomas, Midwife, President, Cardiff Midwifery Society

Chloe Pearson, Student Midwife, Edinburgh Napier University

Corina Casey-Hardman, Head of Midwifery, Bridgewater Community Healthcare NHS Trust

Donna Ockenden, Independent Advisor – Healthcare, Midwife

Gill Walton, Director of Midwifery, Portsmouth Hospitals NHS Trust

Helene Marshall, Director, Scottish Multi-professional Maternity Development Programme

Jenny Cleary, Clinical Midwife, Whittington NHS Foundation Trust

Jude Jones, Student Midwife, University of Salford

Justine Craig, Head of Midwifery, Ninewells Hospital and Medical School, Dundee

Kerry Evans, Research Midwife, Nottingham Universities Hospitals

Susan Lewallen, Advanced Maternity Support Worker, Kingston NHS Foundation Trust

Kuldip Bharj, Associate Professor and Senior Lecturer in Midwifery, University of Leeds

Lucia Rocca, Lecturer in Midwifery, City University London

Nicky Berry, Associate Nurse Director / Head of Midwifery and General Manager for Women's and Children's Services, NHS Borders

Patti Paine, Divisional Director of Nursing and Midwifery, Worcestershire Acute Hospitals NHS Trust

Scott Johnston, Head of Midwifery, Imperial College Healthcare NHS Trust

Sue Way, Associate Director for Employer Engagement (Health), Bournemouth University

Yvonne Bronsky, Local Supervising Authority Midwifery Officer, NHS Glasgow

Zoe Boreland, Head of Midwifery, South Eastern Health and Social Care Trust Northern Ireland

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healthwatch Northamptonshire

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12 December 2018

Re. Horton Joint Health, Overview and Scrutiny Committee meeting, 19 December

Dear Cllr Fatemian,

Thank you for the invitation to provide feedback to the HOSC on 19 December. We would like to provide this written submission to the committee.

We have not heard much from members of the public of Northamptonshire about obstetric services at The Horton so are unable to comment directly on the questions highlighted in your letter. However, we do have concerns about closure of services at this hospital and the impact on residents of South Northamptonshire who would struggle to travel to Northampton or Oxford, especially if reliant on public transport in rural areas. In particular, we have heard:

- there is insufficient public transport to Northampton from certain villages in South Northamptonshire;
- travelling to Oxford by public transport from the south of Northamptonshire can take one and a half hours or more, depending on connections and traffic, which can be tiring for people having to make frequent visits;
- there is feeling amongst residents that there is a lack of viable alternatives to The Horton.

Last year we conducted a survey of the experiences of maternity services in Northamptonshire. The full report is available at http://www.healthwatchnorthamptonshire.co.uk/MaternityReport2017.

Of the 534 parents we spoke to, 63 lived in postcode areas near to Banbury (NN7, NN11, NN12, NN13, OX17) but we do not know how many used obstetric services at The Horton. We have extracted the most relevant results from these 63 people in the attached document.

One comment from a resident of NN13 referred to The Horton:

> "The Horton hospital being a MWL [midwife led unit?] is worrying. It would be best to have consultants on site. Also to have 24 hour monitoring there too."

Finally, we would be happy to help promote the public engagement survey and events via our membership and networks.

Yours sincerely,

Dr David N Jones
Chair
Healthwatch Northamptonshire

cc. Healthwatch Oxfordshire, Healthwatch Warwickshire, Nene CCG Localities Manager, South Northamptonshire Health and Wellbeing Forum.

Royal College of Obstetricians and Gynaecologists: Response to Horton HOSC Invitation

Dear Ms Shepherd,

Thank you for your email and the information provided in relation to the 19th December meeting of the Horton Health and Overview Scrutiny Committee. Please accept my apologies for the delay in responding.

I am writing to clarify the RCOG's position with regard to local maternity reconfiguration matters. Whilst the RCOG provides national guidance on issues such as safe staffing and maternity safety, it does not comment on matters of local reconfiguration where it has not been explicitly commissioned to do so. Having now reviewed the terms of the meeting scheduled for the 19th, the RCOG is not appropriately informed to comment on the local issues affecting the Oxfordshire CCG and obstetric service. The RCOG promotes the principle that standards of care must be maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time and is clear that any solution must be tailored to local need. We therefore wish to decline the invitation to contribute to this particular meeting on this occasion.

I would like to use this opportunity to highlight our most recent activity regarding workforce, Providing Quality Care for Women – O&G Workforce report here and our latest work on Workforce from 2017 report and 2018 Workforce .

I do hope that your meeting next week results in a positive outcome for women and their babies.

With best wishes,

Lesley Regan
Professor Lesley Regan MD DSc FRCOG FACOG

President Royal College of Obstetricians and Gynaecologists

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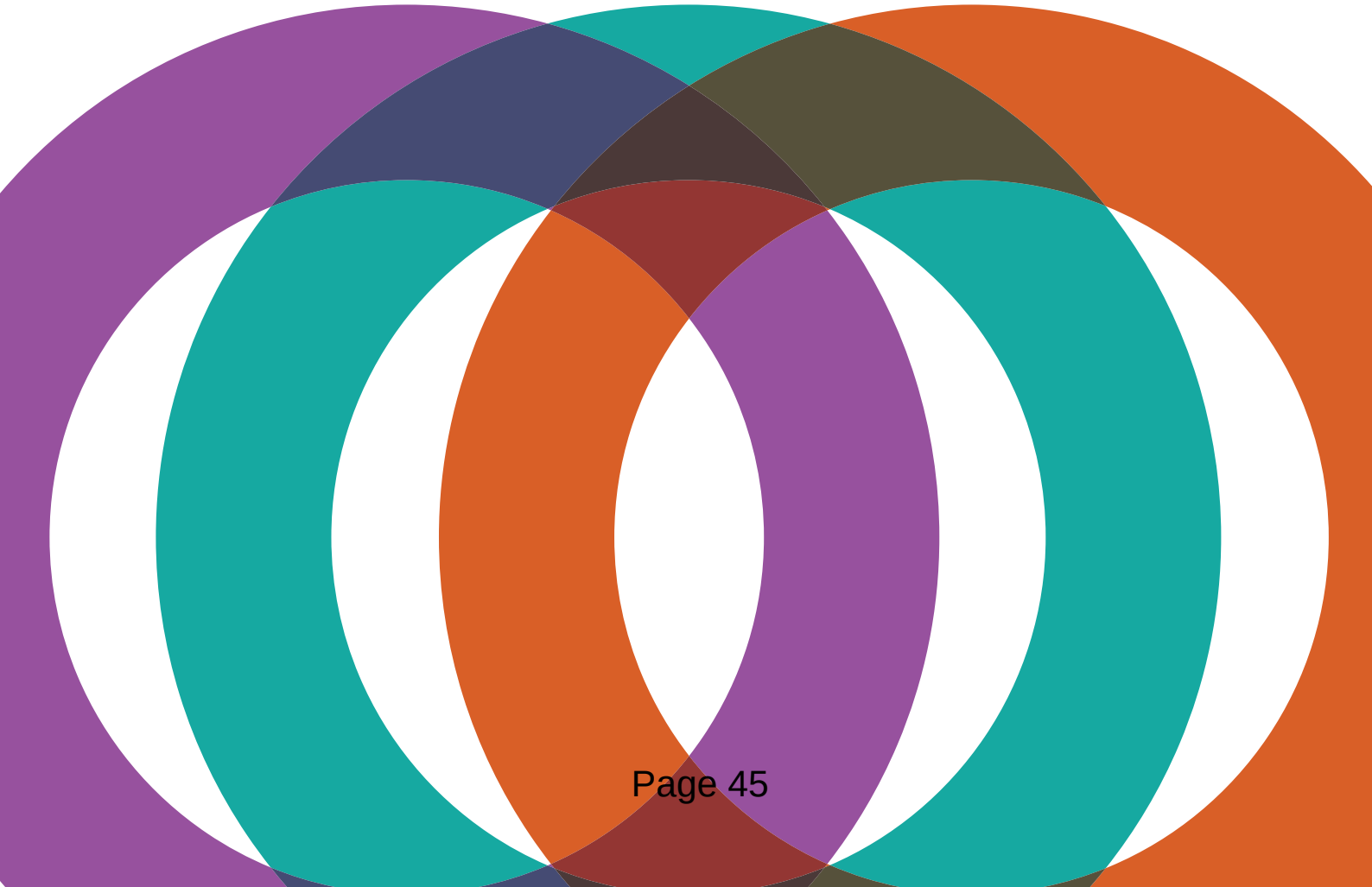
Royal College of Obstetricians & Gynaecologists

PROVIDING QUALITY CARE FOR WOMEN

OBSTETRICS AND GYNAECOLOGY WORKFORCE



PROVIDING QUALITY CARE FOR WOMEN

OBSTETRICS AND GYNAECOLOGY WORKFORCE

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Providing quality care for women: obstetrics and gynaecology workforce

Executive summary

IN 2015, THE RCOG ESTABLISHED the Safer Women's Health Care working party to consider the different workforce models required to ensure safe obstetrics and gynaecology care. This report addresses the difficulties being experienced in providing sufficient medical workforce in obstetrics and gynaecology to safely staff UK units. Units are reporting difficulties in identifying staffing solutions to address the gaps in middle grade rotas. Guidance is required for service leads, who have responsibility for ensuring safe patient care. This report provides the opportunity to update previous guidance within the *Safer Childbirth* report in light of subsequently published evidence.

It is recognised that there is huge variability of service provision around the country in terms of workload complexity, geography and current middle grade staffing. For this reason there is no single staffing model which is suitable for all UK units. The RCOG presents a summary of the issues and suggests solutions, especially around consultant working out-of-hours. Within obstetrics it is no longer possible to make recommendations about hours of consultant presence on the labour ward based on number of deliveries because of the diversity of consultant contracts and working practices.

KEY MESSAGES

- **Delivery of a high quality and safe service for women at all times is imperative.**
- **All members of the multidisciplinary team must have the appropriate competencies to deliver high quality care.**
- **Appropriate consultant presence should maximise training opportunities, with a balance between direct and indirect supervision.**
- **The expansion of resident consultant working needs to be monitored.**

Executive summary

RECOMMENDATIONS FROM THIS REPORT

RECOMMENDATION 1

All units need to ensure a locally agreed, safe and sustainable solution to address workforce issues to manage care in both obstetrics and gynaecology.

RECOMMENDATION 2

Safe service delivery can only be achieved with safe staffing levels in both maternity and gynaecology units.

RECOMMENDATION 3

All solutions should take into account the national issue of lack of availability of middle grade doctors leading to recurrent rota gaps.

RECOMMENDATION 4

Workforce solutions must optimise training opportunities and accommodate the changing needs of trainees at different stages of their careers.

RECOMMENDATION 5

All solutions should allow for multidisciplinary training, development of quality services and good clinical governance.

RECOMMENDATION 6

All units should have consultant labour ward presence during working hours Monday to Friday, with the intention to extend this to every day of the week.

RECOMMENDATION 7

Resident consultant working within a hybrid rota is recommended to ensure appropriate medical staffing. In most units, this will involve all consultants working in a hybrid rota with some out-of-hours shifts.

RECOMMENDATION 8

Remodelling job plans to include evening and weekend daytime working must be considered in order to maintain equity among the consultant team. Involving only newly recruited consultants in resident working can be divisive.

RECOMMENDATION 9

Culture change within the profession is needed since a contribution to resident working will be required throughout a consultant's career.

RECOMMENDATION 10

Resident consultants must be treated equally to non-resident consultants by all staff.

RECOMMENDATION 11

The RCOG's standards for job descriptions and job plans should be used by all units to help implement the above recommendations.

RECOMMENDATION 12

The RCOG must explore novel methods for assessing work intensity and out-of-hours staffing levels in both obstetrics and gynaecology.

RECOMMENDATION 13

The RCOG should develop a repository of good medical workforce models that are available to all.

RECOMMENDATION 14

Units must ensure that high standards of care are maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time.

Providing quality care for women: obstetrics and gynaecology workforce

Introduction

THE MANAGEMENT OF PATIENTS in the specialty of obstetrics and gynaecology is hugely rewarding and the dedicated staff who work within this field provide quality care to women. However, the ability to provide care is increasingly under strain as there are difficulties in providing medical staffing for our services, as well as rising service expectations and financial restrictions. In 2015, RCOG Council established a working party to review the issues, explore options and suggest solutions to address future provision of high quality care in the UK. This work was aligned with reviews of both the maternity and standards for gynaecology care. This report addresses the immediate issues of the medical workforce required to provide safe patient care.

Feedback from Clinical Directors, Heads of Schools and trainees is highlighting identical issues relating to gaps in the middle grade rotas and the difficulty ensuring the balance between service and training. This situation is not anticipated to change. While ensuring safe maternity services is paramount, it is recognised that gynaecology services, especially emergency gynaecology services, must also be appropriately staffed. As a profession we must ensure that consultants' skills and expertise are valued, and that careers continue to be professionally rewarding.

In planning future care, clinicians and managers must take into account the views of patients around their concerns and choices of care. This requires exploration of women's perspectives on the issues of quality of care, care provider and location of care for both obstetrics and gynaecology.

In undertaking this work, the RCOG has become aware of a number of successful initiatives that are being developed across the breadth of the UK. We will establish a repository that Fellows and Members can access in the future.

In planning future care, clinicians and managers must take into account the views of women around their concerns and choices of care

2 The staffing problem

REDUCTION IN THE NUMBER OF AVAILABLE MIDDLE GRADE DOCTORS

IN A SURVEY of Heads of Schools in 2014 it was estimated that there were gaps in middle grade rotas approximately 30% of the time, and that this was fairly consistent across the country. Trainee rota gaps occur for various reasons, including out of programme time for research or subspecialty training; maternity leave; less than full-time (LTFT) working; and long-term sickness. The specialty remains appealing as a career and 100% of year 1 training posts (ST1) are filled. However, as a specialty with a large proportion of female trainees, there is a concomitant high rate of maternity leave and LTFT working. This results in a reduced available middle grade workforce.

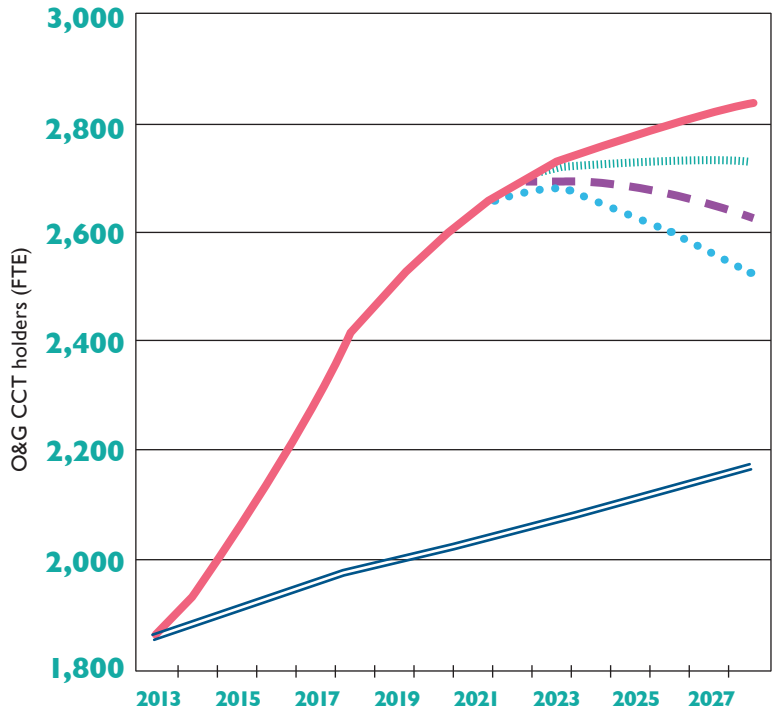
In addition, over the last decade the ability to recruit alternative non-training middle grade staff has been reducing due to specialty training changes, financial drivers and immigration regulations.

The award of a Certificate of Eligibility for Specialist Registration (CESR) to many staff grade doctors, who have demonstrated equivalent training, qualifications and experience to doctors who have completed a General Medical Council (GMC)-approved programme, has resulted in them vacating the middle grade rota to take up substantive consultant posts. Data from the last RCOG censuses[1-3] show that there has been a steady decline in the number of staff grade (218 in 2011, 169 in 2013) and associate specialist doctors (177 in 2011, 140 in 2013).

Locum doctor appointments have historically filled gaps in rotas. However, feedback from clinical directors is that the pool of locum staff has diminished considerably, making it extremely difficult to manage a compliant middle grade rota.

Going forward it is anticipated that rota gaps will persist in all units. The need to develop a more sustainable workforce solution is essential and immediate and has been the driving force behind the introduction of many resident consultant posts.

FIGURE 1: PRINCIPAL PROJECTION FOR O&G CCT HOLDERS AND ILLUSTRATIVE OPTIONS FOR REDUCING TRAINING NUMBERS, ENGLAND



Source: CfWI system dynamics model of the O&G CCT holder workforce for England.[5]

CHART KEY

- Demand - principal projection
- Supply - 5% per year (cumulative) reduction from 2015 to 2017
- Supply - 10% per year (cumulative) reduction from 2015 to 2017
- Supply - 15% per year (cumulative) reduction from 2015 to 2018
- Supply - principal projection

2 The staffing problem

EFFECT ON TRAINEE EXPERIENCE

Obstetrics and gynaecology units, which rely extensively on trainees to deliver the acute out-of-hours service at middle grade level, often struggle to sufficiently protect training opportunities when gaps in the rota occur. Trainees may feel pressurised into covering additional shifts and under such circumstances have reported both undermining and a poorer overall training experience.[4] Increased contribution by trainees to the out-of-hours rota, primarily covering obstetrics, reduces their availability for elective daytime training and ability to gain experience in elective and urgent gynaecology work during the day.

REQUESTS TO INCREASE TRAINEE NUMBERS

Requests to consider increasing the number of specialty obstetric and gynaecology trainees to address the deficient numbers of available middle grade doctors have been considered. A workforce analysis undertaken by the Centre for Workforce Intelligence (CfWI) highlights that there is likely to be an oversupply of obstetrics and gynaecology trainees gaining their Certificate of Completion of Training (CCT) – i.e. those who have completed the specialist training programme and are eligible to apply for a consultant post – by 2028 (see Figure 1).[5] In coming to their conclusions, a number of factors were taken into account: 24/7 consultant presence, attrition from the specialty and an increased retirement age. In light of the cost of postgraduate training and the fact that there is no requirement to increase the number of CCT holders, there is no support for increasing training numbers. The CfWI report suggests that a reduction in the number of training posts is required to prevent significant overproduction of CCT holders. However, the RCOG believes that, if this policy were to be adopted, the crisis in the middle grade workforce would intensify.

Obstetrics and gynaecology units rely extensively on trainees to deliver the acute out-of-hours service at middle grade level

3 Potential workforce solutions

IN ATTEMPTING to ensure safe middle grade staffing, various solutions have been suggested which may be an option for some units. However, all of the options have their limitations and none presents a sustainable solution for all UK units. It is important not only to address the need to have a doctor who is a senior decision-maker available to provide the service, but also to ensure a high quality of care is prioritised. The RCOG promotes the principle that standards of care must be maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time.

SUGGESTED WORKFORCE SOLUTIONS

EMPLOY MORE LOCUM DOCTORS

The pool of locum doctors in the UK has diminished considerably due to changes in immigration rules and training programme structures. While locum doctors can provide a workforce solution, there are concerns about the expense. Locum doctors often work short-term contracts with minimal notice periods, which means they may be unfamiliar with the unit, its guidelines and practices. In these situations it is difficult to ascertain an individual's competency level without close direct supervision and difficult to ensure that appropriate emergency skills training is up to date. Team working suffers as members of staff are unaware of each other's levels of clinical ability, and consequently there is a detrimental effect on patient safety. Locum doctors are therefore not considered a viable, sustainable option for long-term safe patient care.

THEY SAY

"We had permanent gaps in the registrar rota because the deanery couldn't fill the training posts. It was difficult to get long-term locums and we advertised many times without success. The locum agency costs were extremely large and it was decided to have two posts at York with prospective cover by using the money spent on locums and reducing a trust-funded registrar post. This meant the registrars had to cover Wednesday to Sunday nights and weekend days.

"Resident consultants are still cheaper than a locum spend of £400,000 per year, which was the main reason for us considering and implementing this role."

EMPLOY TRUST GRADE DOCTORS

The number of trust doctor posts has increased considerably from 2011 to 2013 (260 in 2011, 382 in 2013), but the RCOG censuses[1-3] show a significant number of vacancies in these posts. Despite the increase in numbers, the gaps in middle grade rotas remain. Recruitment to these posts is difficult as there is no pool of available suitably trained doctors and no UK preparatory training pathway. Generally, recruitment is of overseas doctors and, without a change in UK immigration regulations, it is anticipated that recruitment of trust grade doctors will become even more difficult. Although the UK vote to leave the EU will have implications for immigration regulations, no change will happen in the short term and the nature and timeline of any changes is currently unknown.

INCREASE THE NUMBER OF MEDICAL TRAINING INITIATIVE (MTI) POSTS

The MTI scheme has been developed to allow international medical graduates to train in the NHS for a maximum of two years. As new entrants to UK practice, these doctors require significant supervision and assessment before being able to work independently on middle grade rotas. The RCOG administers this scheme and the number of appointable applicants currently almost matches the number of posts, which has remained stable at approximately 50 per year for the last three years. MTI doctors can only work in the UK for two years and therefore need to be recurrently recruited. There are strict regulations about who is appointable to maximise patient safety. While it may be possible to increase recruitment of MTI applicants and improve the opportunities for overseas doctors, there are limitations. Increasing the number of posts might simply result in unfilled MTI posts. While MTI recruitment may help

3 Potential workforce solutions

workforce numbers, it is not felt that this is a sustainable solution for UK services.

APPOINT RESEARCH FELLOWS OR VISITING DOCTORS FROM OVERSEAS

In a minority of units, it may be possible to recruit research fellows or visiting foreign doctors to contribute to the middle grade rota. The units able to do this are likely either to be in London or to be tertiary centres with a strong academic profile. Conversely, if research fellow recruitment to major academic centres is from the UK trainee doctor pool, this compounds the workforce issues in other less academic units – this is already being noticed, creating a two-tier system of units and potentially making units seem 'unattractive'.

CREATE POST-CCT TRAINING POSTS

Some units are advertising specialised post-CCT training posts with middle grade on-call duties. The current GMC-approved specialty training programme does not require additional post-CCT training, as a CCT holder should have all the necessary competencies to become a consultant. However, some individuals wish to develop more specialised skills in a specific area of practice and will opt to take on these roles for a short period of time. The *Shape of Training* report[6] proposes post-CCT credentialing; it is possible that components of advanced and subspecialty training could be undertaken after CCT but before taking up a consultant post. If credentialing is approved by the GMC, such post-CCT training post holders could make a contribution to the out-of-hours rota. To date, national terms and conditions have not been developed for these roles; this would be required if post-CCT training were to become a standard part of medical career development.

OTHER HEALTHCARE PROFESSIONALS

While healthcare professionals such as gynaecology specialist nurses, advanced midwife practitioners or physician associates can and do make a valuable contribution to service delivery, they cannot act in the role of senior decision-maker for emergency care in either obstetrics or gynaecology and hence are not able to fully contribute to the middle grade rota. Additionally, the midwifery and nursing professions have their own workforce issues, and further role development would require expansion of their workforce.

RESIDENT CONSULTANTS

In many units, 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, i.e. a hybrid rota. There are reports of units where this is working well, but also of units where resident consultants are unhappy.

CONCLUSIONS

The options for addressing middle grade rota gaps by employing alternative middle grade doctors are largely short-term solutions, have risks around them and could be costly.

The RCOG believes that, having considered all of the options above, it is evident that resident consultants will be part of any sustainable solution to current workforce difficulties. Therefore, there is a need to determine how best this should be implemented to ensure safe care for women and professional satisfaction for consultants.

The report explores this issue further, with the aim of providing a workforce solution that would ensure sustainable, safe services. The working party captured data on current arrangements for resident consultant working, then analysed this information to determine what is working well and what is a source of discontent. This was then used to develop proposals for resident consultant job descriptions and job plans. Further detail is provided in the following chapters.

Standards of care must be maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time

4 Exploring out-of-hours consultant working

The introduction of hybrid rotas …has been necessary to ensure staff with the appropriate competencies are available

WHEN ADDRESSING STAFFING of obstetrics and gynaecology units, clinical leaders prioritise safe patient care to ensure availability of sufficient staff and appropriate senior decision-makers. The RCOG promotes high standards of patient care and provides guidance to help clinicians to deliver this.

CONSULTANT PRESENCE ON LABOUR WARD

The Hospital at Night study published in 2005[7] demonstrated that the level of activity in obstetrics is the same throughout the 24-hour period, and recommended that the level of cover should be the same throughout the 24-hour period, seven days a week. The RCOG's *Safer Childbirth* report[8] included recommendations regarding staffing levels on the labour ward based on the number of deliveries within a unit, with particular emphasis on delivering a consultant-based service. The rationale for these recommendations had its foundation in the drive to improve obstetric outcomes, motivated by the increasing rates of obstetric intervention and increased perinatal mortality at night. In England, these recommendations were incorporated into Clinical Negligence Scheme for Trusts (CNST) standards and thus there was the financial impetus to effect change, albeit slowly. Some units were able to use the recommendations as a lever to increase staffing levels; however, others were criticised for failing to meet the standard. While it is generally agreed that consultant presence is beneficial in terms of improved management and training, there is less agreement on the direct benefit to women in labour and a lack of evidence to support the necessity for a model of 24-hour resident consultant presence on the labour ward in the interest of women's outcomes.[9]

Many units may still wish to increase the amount of consultant presence on their labour ward for a variety of reasons. In light of the current available evidence, fixed levels for consultant labour ward presence for different sizes of units cannot be justified. However, it is strongly recommended that all consultant-led maternity units should have a minimum labour ward consultant presence during working hours Monday to Friday, with the aim of extending this to every day of the week to provide the same quality of service over seven days, in line with the aims of NHS England's seven-day service standards.[10] This level of consultant presence is felt necessary for service development, multidisciplinary training and clinical governance throughout the working day, seven days a week.

The focus, however, should change from meeting arbitrary levels of consultant presence to ensuring there are appropriate numbers of staff, with the appropriate competencies, available at all times. In many units, the introduction of hybrid consultant rotas as a result of middle grade rota gaps has been necessary to ensure staff with the appropriate competencies are available; as a consequence, the number of hours of consultant presence on the labour ward has also increased.

CONSULTANT PRESENCE FOR EMERGENCY GYNAECOLOGY SERVICES

In considering the availability and level of competency of the appropriate workforce, the seniority of decision-maker required and the frequency of surgical input are relevant. It is important to recognise that, while National Confidential Enquiry into PeriOperative Deaths (NCEPOD)[11] data do not recommend undertaking surgical procedures overnight, this is not applicable in obstetrics as there is a need to have an obstetrician available and able to perform a caesarean section at all times. In contrast, the NCEPOD data suggest that most urgent gynaecological surgery should wait until the next working day.

The provision of high quality emergency gynaecological services is very important. These services often suffer lower staffing levels than emergency obstetrics services as obstetrics is prioritised. However, emergency gynaecology

THEY SAY

"We have a hybrid rota with 11 consultants currently providing resident cover two nights per week. The remaining eight consultants cover weekdays. We all share weekends."

4 Exploring out-of-hours consultant working

The difficulty of staffing medical rota gaps, with the consequent effect of compromising safe service provision, has been growing more profound

patients can require immediate care, resuscitation and surgery. It remains problematic to provide guidance on staffing levels for gynaecology as there is less uniformity of service provision depending upon associated services, e.g. access to emergency theatre, availability of early pregnancy assessment units, provision of anaesthetic staff. It is recognised that emergency gynaecology patients are likely to wait longer as a result of reduced middle grade doctor availability, with decisions on patient care being delayed. This needs to be addressed by clinicians and managers.

In considering how to address safe staffing levels, it is crucial that both obstetrics and gynaecology care is considered. It is inappropriate to develop a solution that only addresses the provision of labour ward cover.

This report is about identifying an acceptable, safe and sustainable solution to a current and ongoing problem of filling the middle grade rota gap. It is not about 24/7 consultant presence nor about meeting a set number of hours of consultant presence.

DEVELOPING SUSTAINABLE SAFE SERVICES

The difficulty of staffing medical rota gaps, with the consequent effect of compromising safe service provision, has been growing more profound, and there are limited alternative non-consultant staff solutions. As set out in Chapter 3, there are possible middle grade staffing options that can be explored to address the shortage of middle grade workforce; however, none is sustainable and most are not suitable for the majority of units within the UK.

THEY SAY

"We have one night which is covered on site by a consultant with a junior doctor (old style SHO level) for 12 hours from 9pm to 9am. On the other nights and weekends we have a traditional on-call system with a registrar and an SHO on site."

THEY SAY

"Initially we started as four PA residents on-call which was not leaving much time for anything else. We reduced to 2.25 with two consultants sharing one resident and one non-resident post, which is a much nicer option."

Faced with a persisting staffing crisis, alternative strategies must be considered. Discussion is required to decide whether the current number of maternity units in the UK is sustainable or if there is a need to reconfigure services. This requires greater implementation of the network principles outlined in *High Quality Women's Health Care*.[12] The issues of patient choice, staff requirements, intensity of workload, geography and how services are delivered over the totality of a seven-day week also need to be explored. This work will be taken forward by the RCOG as part of a wider programme of work initiated by the Safer Women's Health Care working party.

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. In many hospitals hybrid rotas are being developed, with some resident consultants working some nights and a traditional 'consultant on-call from home' on the other nights.

Each unit should determine the workforce required to provide a sustainable, safe, high quality service for both obstetrics and gynaecology. It is clear that no single solution will be applicable to all UK units and, ultimately, local solutions will need to be developed. The service model may need to change over time if the workload or number of middle grade doctors changes.

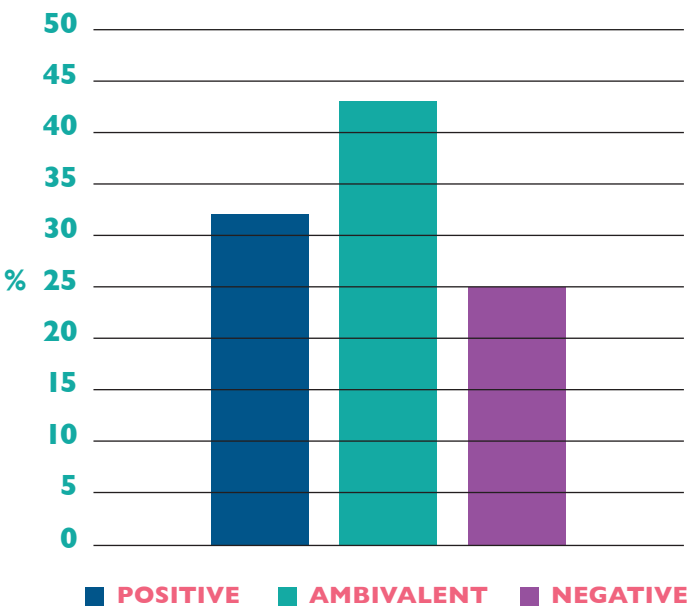
There are currently insufficient avenues for sharing information about local solutions that work well. The RCOG should develop a repository of good practice examples that can be shared and made available to all.

5 The impact of resident consultant posts

TO DATE, IMPLEMENTATION of resident consultant working has not necessarily occurred in a planned strategic way, but rather as a necessary response to immediate workforce issues. The number of consultant posts with resident working out-of-hours (evenings or nights) is increasing. Resident consultant posts represent a new way of working and it is important for the future of the specialty that such posts are developed appropriately. While these posts are working well in some units, in other units resident consultants are feeling frustrated and disillusioned.

While resident consultant working is inevitable for many units, there are issues which need to be resolved. To identify and explore these in more detail, a survey of resident consultants was undertaken to identify the perceived benefits and the problems faced by individuals in these posts. A survey of trainees was also carried out to assess what their expectations of a future consultant post were. Several units that have established resident consultant posts were also approached and asked to describe their experience and the benefits and disadvantages for their service.

FIGURE 2 – OVERALL ATTITUDES TO RESIDENT CONSULTANT WORKING



The results are described here, with more detailed accounts provided in the Appendix. Figures 2–4 provide detail from the analysis, and anonymised comments provide some additional context.

SYNOPSIS OF RESULTS FROM THE SURVEY OF RESIDENT CONSULTANTS

Clinical Directors of approximately 200 units in the UK were contacted by the RCOG in July 2015. Of 85 Clinical Directors who responded, 25 had some consultants contributing to the resident out-of-hours rota. The Clinical Directors were asked to disseminate a survey to all resident consultants working in their unit. The aim of the survey was to identify the perceived benefits and the issues faced by individuals in resident consultant posts.

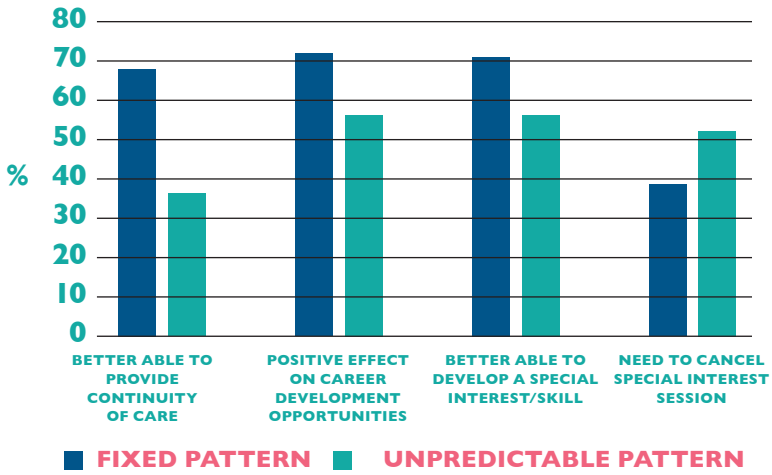
135 resident consultants responded. The key messages from this survey were:

- Resident consultants were spread across units of all sizes
- An average job plan for a resident consultant had 10.5 PAs, consisting of 5.5 in-hours direct clinical care, 3.0 out-of-hours direct clinical care and 2.0 SPAs
- Almost half the respondents were working on the same tier of the rota as middle grade staff out-of-hours, i.e. 'filling rota gaps'
- Almost half the respondents said colleagues had made them feel 'more junior' and this was associated with a feeling of discontent
- Almost half felt they did not receive the same career development opportunities as non-resident colleagues
- Most felt resident consultant working improved quality of service, patient safety and training (see Figure 3)
- Opinions varied on the impact of resident consultant working on work-life balance
- Concerns about earlier 'burnout' were expressed
- Single fixed nights with a predictable rota were viewed positively
- A system where all consultants make some contribution to the out-of-hours rota was viewed positively

5 The impact of resident consultant posts

FIGURE 3 – PERCEPTIONS OF THE IMPACT OF RESIDENT CONSULTANT WORKING

FIGURE 4 – PERCEIVED EFFECT OF FIXED PATTERN VERSUS UNPREDICTABLE SHIFT PATTERN



THEY SAY

"I prefer my pattern of resident work as it is not too onerous and gives me more flexibility in terms of my free time. I am never required to be 'on-call' from home and weekend work is relatively infrequent. I also prefer to be directly involved in supervising care than doing this from home in such a high-risk unit."

THEY SAY

"I don't mind being resident. In fact, I enjoy being involved directly in teaching, training and supervising trainees. The gynae and delivery suite staff also feel much more supported. The majority of women feel very satisfied being reviewed by a consultant out-of-hours. This also reduces the inpatient admission rate."

From the feedback received it is evident that single nights, and a predictable pattern, seemed better than blocks of nights for work-life balance, continuity of care and professional development (see Figure 4).

Being made to 'feel junior' was more strongly associated with a negative overall view of resident consultant working than any of the other aspects assessed. Consultants who worked with fewer junior staff were much more likely to report that they were made to feel junior to their non-resident colleagues.

If resident consultants are working on the same rota as middle grade doctors, this may affect staff

THEY SAY

"It's sometimes difficult to explain that, although I am second on-call, I am a consultant on-call."

THEY SAY

"As none of the non-resident consultants took up a resident consultant role there is, I feel, some snobbery and divide between the two groups, which I feel is wrong. A case in point is the resident consultant carries a bleep when on-call, but the non-resident while on labour ward, on-call during the day doesn't, which displays inequity."

5 The impact of resident consultant posts

perceptions of them, i.e. there may be a tendency for other staff (consciously or unconsciously) to equate them with middle grade doctors. Some units have a second consultant on-call from home, who may be viewed/view themselves as more senior than the resident consultant. To change this perception would require all consultants (including the most senior) to carry out some resident consultant shifts. This would send out a strong message to all staff that level of seniority is not determined by resident or non-resident working.

SYNOPSIS OF RESULTS FROM THE SURVEY OF NORTHERN DEANERY TRAINEES

The RCOG working party also wanted to assess the opinion of future consultants. A questionnaire was emailed to all Health Education England (HEE) Northern Region trainees in June 2015, exploring their views of resident consultant working. 60 trainees responded. 45 (75%) anticipated working resident nights as part of their consultant job, and 36 (60%) were happy with this concept. 26 (43%) felt that resident consultant working would allow better opportunities for training (19 – 32% – were unsure). 38 (63%) felt that resident consultant working would result in better safety and outcomes for patients.

THEY SAY

"I think resident consultant posts can easily cause resentment if it is not expected of the majority of consultants or if it is assumed that only very new consultants will take part. This can lead to more of a sense of a 'junior/ senior' consultant divide. The resident consultant atmosphere in this hospital is pleasant, mostly because the older, more experienced consultants (even our clinical director!) agreed to take part."

THEY SAY

"There does not seem to be any divide between a resident consultant and senior registrar in our unit – we do the job of both, which is frustrating and busy at night. There is also an unspoken divide between the resident and non-resident consultants."

The responses from both of the surveys described above are similar to those reported in a survey of staff from Heartlands Hospital, where 75% felt that patient safety would be improved and 52% felt that training of junior doctors would be improved by increased consultant presence.

EXPERIENCE OF UNITS WITH ESTABLISHED RESIDENT CONSULTANT POSTS

In several units with established resident consultant posts, individuals also volunteered to describe their experience and the benefits and disadvantages for their service. The RCOG is keen to gather more information that will be useful to those developing new rota models. The submissions provided for this report are available in the Appendix. It is proposed that the RCOG should further explore methods for assessing staffing levels out-of-hours, encompassing both obstetrics and gynaecology. Future work should focus on the number of staff with the appropriate competencies to provide safe patient care.

75% of all Northern Deanery trainees anticipated working resident nights as part of their consultant job

6 Supporting a change of culture

Senior clinical leadership can help change the culture within units

PROVISION OF HIGH-QUALITY care is critical and requires a sustainable, engaged workforce willing to work together in multidisciplinary teams. Those in senior leadership positions are responsible for ensuring safe medical staffing levels for both elective and emergency work; however, this requires all consultants to contribute to providing solutions to ensure obstetrics and gynaecology patients receive the highest quality of care. Senior clinical leadership can help change the culture within units.

From the analysis of potential middle grade staffing options, it is recognised that providing a safe, high-quality service will require a proportion of out-of-hours care to be delivered by resident consultants sharing slots on the rota with junior doctors (i.e. filling middle grade rota gaps). These rota changes should be developed in a predictable and planned way. It also needs to be acknowledged that, while this is a significant change in the way in which consultant obstetricians and gynaecologists work, consultant status and responsibilities remain the same.

It is important to understand that resident consultant working does not necessarily equate to always working night shifts. Rotas can (and should) be developed whereby some consultants contribute to resident out-of-hours shifts in the evenings or during the day at weekends. This allows **all** consultants to contribute, while recognising that they are not all able to work night shifts.

A number of issues need to be addressed in order to ensure sustainability of resident consultant working, as set out in this chapter.

MAKING RESIDENT CONSULTANT POSTS PROFESSIONALLY SATISFYING

It is important for staff retention and, hence, service provision that individuals find work professionally rewarding. In terms of consultant work, this relates to the clinical and non-clinical work that they provide. Resident consultants should have a job description that clearly reflects the need for service commitment but also includes planned sessions for professional development.

During normal working hours, there must be appropriate professional development opportunities for consultants to develop clinical services and take on leadership roles, governance responsibilities, medical education and research within units. This is essential for the development of individuals as well as for the future leadership of the NHS. Resident consultants need to ensure that they in turn shoulder their share of clinical and managerial consultant responsibilities (governance, complaints, risk management), which will require the appropriate allocation of time for these activities – known as supporting professional activities (SPA) – in their job plans. There must be equal opportunities for career progression, but a recognition that career progression does not equate to moving to non-resident status.

Resident consultants must have their own caseload of inpatients and outpatients for whom they have responsibility. Patients want continuity of care, and job plans must be organised to ensure this occurs. Job plans with a fixed weeknight duty enable consultants to hold a regular clinic on days when they are not on duty (not necessarily every week) and also ensure the fixed resident shift does not impinge on a clinic or operating list if timetabled appropriately.

If job plans include a set of consecutive nights with blocks of time off, cross-cover arrangements need to be in place to ensure there is regular, consistent consultant cover for both inpatients and outpatients. This can be achieved through a buddying or partnership system, where consultants are paired. Consultants working in pairs facilitate patient management when a consultant is off following resident night shifts as well as reducing the need to cancel elective work during annual leave. For specialist obstetrics or gynaecology services, clearly defined joint working or pairing is particularly important, as both consultants will have the specialist knowledge and skills to continue to provide specialist care for women when their paired consultant is away.

In determining the pattern of resident working, it is important to maximise continuity of patient care. Predictable patterns of work, with single nights rather than blocks of nights, and appropriate time off before and after night shifts were viewed positively in the RCOG survey. Such patterns of working facilitate continuity of patient care, as well as increasing the ability of the consultant to

6 Supporting a change of culture

Preferred patterns of working may vary over the course of a consultant's career, with resident working offering the benefit of predictable time off

undertake specialist sessions or operating lists on a regular basis.

ENSURING CULTURAL COHESIVENESS OF THE UNIT

In units where resident consultant working is successful, senior members of the department have led by example and taken on resident consultant shifts out-of-hours. This leadership dispels the perception that working as a resident consultant equates to being a more junior consultant, and sends out a strong message to other members of the multidisciplinary team.

It is recognised that there may be reluctance among non-resident consultants to move to resident working. However, such consultants may prefer to contribute in a planned and coordinated way to evening or daytime weekend resident shifts, rather than finding themselves repeatedly and unexpectedly on-call overnight with no resident middle grade doctor.

It is also recognised that preferred patterns of working may vary over the course of a consultant's career, with resident working offering the benefit of predictable time off during the day, which may be valued by those with children and those with commitments to daytime external activities (e.g. regional or national roles). In addition, many consultants find it more difficult to undertake resident night work as they grow older.

In some units the frequency of consultant involvement in clinical activity overnight may be so great that it may be safer from a patient perspective, and preferable to the consultant, to be resident with appropriate, timetabled time off the following day, rather than being non-resident and expected to work a normal day after working a busy night on-call. These units may be the larger, busier units, or may be smaller units with a large proportion of locums or inexperienced junior staff.

It is important that there are transparent and clear job planning processes applicable to all consultants. This will ensure that individuals are treated fairly and hence improve cohesion. The process for changing the pattern of out-of-hours working should be agreed within each unit. As an increasing number of units have resident consultant posts, it is important that each unit agrees its own process. Once appointed to a consultant post in a hospital, a consultant should not then need to reapply for another consultant post in the same unit if they wish to change their working pattern. This should be managed through the job planning process. Equally, there should not be a guarantee that a resident consultant will automatically move into a non-resident post at any specified point.

It is inappropriate to fix a particular age at which resident night work should cease. This is firstly because age is a protected characteristic (i.e. it is illegal to discriminate against someone because of their age); secondly because some older consultants may find that working resident nights with time off during the day suits their lifestyle; and thirdly because some units may encounter a situation where a large proportion of the consultant body is of a very similar age and cannot provide the service if a cohort of consultants cease resident shifts at the same time. Changes in a consultant's pattern of work may need to be made to accommodate any relevant health issues.

CONSULTANT SKILLS FOR RESIDENT WORKING

Out-of-hours resident consultants will most often be working in lieu of a middle grade doctor, and will be expected to perform the duties of such a doctor while working on the labour ward or managing gynaecology emergencies. Concern has been expressed that some consultants may have lost basic skills if they have worked for many years in a supervisory capacity rather than being 'hands on'. If these consultants are to begin to work without a middle grade doctor on a resident shift, they will need to deliver basic medical skills as well as emergency obstetrics and gynaecology skills.

Competencies will include, but are not limited to:

- Basic medical skills: ability to site intravenous (IV) access, basic cardiopulmonary resuscitation (CPR), use of IT support (as per local policies), prescribing drugs/IV fluids, requesting and interpreting laboratory and other diagnostic tests
- Obstetric skills: amniotomy, application of fetal scalp electrode, fetal scalp blood sampling, manual removal of placenta, non-rotational forceps and ventouse, familiarity and skills in both managing all acute emergencies (e.g. maternal collapse, major haemorrhage, acute fetal compromise/ intrauterine fetal resuscitation, severe pre-eclampsia and eclampsia, etc.)
- Gynaecological skills: including surgical management of gynaecological emergencies (evacuation of retained products of conception, Bartholin's abscess) and initial assessment and management of critically ill patients

6 Supporting a change of culture

Individual practitioners will need to highlight where they may require training/re-training in certain of the above skills. Senior clinicians may feel they require specific re-training in the basic medical and IT skills required to work as a practitioner involved in hands-on service delivery out-of-hours. Re-skilling, particularly in obstetric skills (including obstetric emergencies), may be facilitated by attendance at an appropriate course such as MOET (Managing Obstetric Emergencies and Trauma). Additionally, unit 'skills and drills' sessions offer opportunities to train as an integral part of the multidisciplinary team.

BENEFITS FOR TRAINING

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.

As trainees approach the end of training, they need to have the opportunity to work in an emergency setting without constant direct supervision, in order to further develop their self-confidence, prioritisation, decision-making and leadership skills. Senior trainees also need the chance to supervise and train those more junior to themselves. In many units, hybrid rotas have been developed where some nights are covered by resident consultants, and others by non-resident consultants. Hybrid rotas have the benefit of providing direct consultant supervision on some nights, while giving trainees the opportunity to work more independently, with indirect supervision, on other nights. 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. In Peterborough, a model of 'consultant-delivered care' has been introduced, with a measurable improvement in training (see Appendix).

PLANNING SERVICES AND ENSURING APPROPRIATE STAFFING (INCLUDING SECOND ON-CALL)

When planning obstetrics and gynaecology service provision, consideration needs to be given not only to out-of-hours cover but also to how elective work and inpatient cover is provided, and how continuity of care is ensured for both inpatients and outpatients. Units may need to expand the number of consultant posts to implement resident consultant working consequent to the reduced availability of middle grade doctors. An increased number of consultants can reap benefits for other aspects of service provision, with more consultants available to cover inpatient wards, a more consultant-delivered service in outpatients and a larger team of consultants to share educational, managerial and governance roles.

Since the majority of the emergency workload overnight originates in the labour ward, it is possible that resident consultants may not be immediately available for out-of-hours gynaecology emergencies. Depending on the level of activity in a unit, a second non-resident consultant may be needed to provide advice about gynaecology emergencies, and may also be needed as the extra pair of hands in either obstetrics or gynaecology situations. These situations are not uncommon. Therefore, it should be recognised that the number of doctors readily available should not be reduced with the implementation of resident consultant posts.

In planning emergency medical staffing, the skills of individual consultants also need to be taken into account in determining the appropriate number of consultants required to provide emergency cover. The need for a second on-call consultant to support the resident consultant must be considered not only to accommodate times of heavy workload but also to ensure appropriate skills are available for possible complicated surgery (e.g. gynaecology emergencies). This must be a planned and resourced service to ensure patient safety.

Appropriate consultant presence should maximise training opportunities

7 Standards and job descriptions for resident consultant posts

TO ADDRESS the workforce issues discussed in this report, increased numbers of resident consultant posts are required. It is likely that, in the future, almost all consultant posts will include an element of resident working out-of-hours.

Careful job planning for all consultants within the unit and considerate timetabling of all activities is necessary to ensure resident consultants are not disadvantaged compared with their non-resident consultant colleagues. Units that do not provide attractive job plans will struggle to recruit and retain consultants. A high turnover of staff is not only costly, but also demoralising for other colleagues. It results in poor continuity of care for patients and poor continuity in any management roles that the consultant may have accepted.

Job plans for resident consultants must include sufficient time to enable consultants to maintain and develop specialist clinical skills; lead and develop clinical services; and take on academic, managerial and external roles, such as RCOG or NHS responsibilities. There should be an expectation that resident consultants will shoulder these responsibilities, but they need to be supported with resources and time in job plans.

With some systems of working, particularly if sets of consecutive nights are worked, SPA sessions and clinical administration time will be lost. As consultants will be expected to complete their non-clinical or administrative tasks, dedicated time needs to be allocated in another part of the job plan as these essential activities should not be undertaken in a consultant's own time. Careful timetabling and job planning for the whole unit is necessary to ensure appropriate patient care and professional development opportunities. Rotas can become extremely complex, with little flexibility for taking leave if too many restrictions are in place or the frequency of out-of-hours shifts is too great. The current consultant contracts in England and Scotland place restrictions on the number of out-of-hours PAs.

Adequate cross-cover by other consultants for annual and professional leave should be included when rotas are designed for resident consultants. It is not appropriate to assume that trainees will cover consultant leave, as this will reduce their training opportunities for both daytime and night-time work. It is important to ensure trainees have appropriate levels of supervision for both emergency and elective work.

Consultants who work a mixture of resident and non-resident working would still attract the on-call supplement of between 3% and 8% of the consultant's salary, depending on the frequency of the on-call work. Hybrid rotas are therefore more costly than full-shift rotas; however, they are much cheaper and safer than recurrent payments to locum doctors.

Taking into account the feedback received from the survey of resident consultants, the survey of trainees and communications with Clinical Directors, on the next page are the RCOG's proposed standards for job descriptions and job plans. The aim is to ensure that consultant posts in the future provide appropriate opportunities for continuing professional development, and give post-holders enough time to take on leadership responsibilities. Only posts meeting these standards will be given RCOG approval.

Job plans for resident consultants must include sufficient time to enable consultants to maintain and develop specialist clinical skills

7 Standards and job descriptions for resident consultant posts

The weekly job plan should include a timetable which enables the consultant to maintain continuity of patient care with his/her caseload of patients

RCOG STANDARDS FOR CONSULTANT JOB DESCRIPTIONS

The following should be stated explicitly in the job description:

- That the post provides appropriate opportunities for professional development
- That the post-holder has a defined caseload (potentially shared with another consultant) and takes consultant responsibility for those patients, including their clinical management and for addressing any serious untoward incidents, complaints or claims
- A clear description of what is expected of the resident consultant when they are on duty, i.e. physical presence and involvement in clinical decisions and presence for certain procedures
- A clear description of the junior staff support while working out-of-hours, and whether the consultant will be expected to perform the same tasks as a middle grade doctor in addition to the decision-making, prioritisation and leadership role expected of a consultant
- The amount of time off before and after a night duty, when this should be taken, and whether it is paid or unpaid
- The arrangements for covering the consultant's leave, and also the arrangements for covering leave of the other doctors working on the same rota
- That the way in which the rota is organised for all consultants is fair and transparent
- That the post-holder will also have non-clinical consultant responsibilities, e.g. for teaching, audit, governance, educational supervision, quality improvement and management
- That the entitlement to study leave and professional leave will be the same for all consultants working in the unit
- That there is no expectation that the post would automatically progress to being a non-resident consultant post
- That there is a process in place for consultants to agree changes in their pattern of work
- That the post-holder will have appropriate secretarial support and office facilities

RCOG STANDARDS FOR CONSULTANT JOB PLANS

The weekly job plan should include:

- No more than three PAs worked out-of-hours
- At least one core SPA (mandatory training, appraisal, audit/quality improvement projects and RCOG CPD requirements)
- At least one further SPA for personal development (special interest clinic, leadership role etc.)
- An appropriate amount of specified clinical administration time, commensurate with that of other consultants in the department
- A timetable that enables the consultant to maintain continuity of patient care with his/her caseload of patients
- A regular timetable of work with fixed sessions (clinics and operating lists) and predictable out-of-hours duties with predictable time off
- Time off before and after night shifts that does not impinge on clinical care, clinical administration or professional development sessions
- Recognition of displaced SPA time (i.e. if a SPA session is lost due to time off before or after a night shift, either this should be re-provided in the job plan, or SPAs should be added which can be worked flexibly)
- Subspecialty posts should have at least two PAs for subspecialty activities

8 Managing the transition

WHILE MOST trainees accept that, in the future, they will work resident shifts as a consultant, the profession is currently in a period of transition. Many units have developed hybrid rotas involving a mixture of resident and non-resident consultants, with older consultants who have been in post longer working in non-resident posts and the new appointees working in resident posts. Therefore, at present, this perpetuates the perception of non-resident consultant posts being more senior, and resident consultant posts being more junior. In some hospitals established consultants have chosen to work as resident consultants, and this move has helped shift the culture and perception of this way of working and should be encouraged.

Various models for resident consultant working have been developed and there is no set model that is applicable to all units. Determining the most appropriate model will be influenced by the workload and complexity of the local service provision, the trainee complement of the unit, the age spread of the consultant workforce and individual consultants' characteristics.

Some suggested models involve a gradation of the amount of resident work undertaken during a consultant's career (diminishing in amount with time). While such models appear appealing, they may be difficult to sustain in practice if several consultants are appointed within a short time frame; if a consultant with health problems (which preclude night time work) is appointed; or if a more experienced consultant is recruited, as it may not be clear where they 'slot' in. Equally, models where all consultants undertake exactly the same amount of resident working are also difficult to sustain in practice, as some consultants may reach a point where they are unable to work overnight due to health reasons.

One solution to these issues is to have patterns of working where all consultants contribute to the resident consultant out-of-hours rota, with some contributing during the evenings or during the daytime at weekends. Hybrid rotas incorporate the facility to change between the different patterns of working at different times in a consultant's career. The need for changes in consultants' patterns of working must be recognised.

During the transition period it is likely that many different models of working will be developed, and the agreements reached with organisations about how to manage changes to working patterns are likely to vary. The standards suggested in this document are designed to help local negotiations and promote consistency between organisations.

During the transition period it is likely that many different models of working will be developed, and agreements reached with organisations about how to manage changes to working patterns are likely to vary

9 Summary and recommendations

It is likely that the next decade will be a period of transition to a system where the majority of consultants perform some 'hands on' resident consultant duties

THIS REPORT FOCUSES on how to ensure, in a predictable manner, proper levels of clinically appropriate medical staff at all times in an era of reduced working hours and reducing trainee availability. It proposes that the only sustainable solution to address middle grade rota gaps involves some resident consultant working in most units. This requires a permanent change to our way of working and an alteration to historic perspectives of what constitutes a consultant post. Patient safety is paramount within both obstetrics and gynaecology. The need to ensure labour ward cover must not be at the expense of gynaecology service provision.

Resident consultant posts must be developed appropriately, and should have equal responsibilities and engender the same respect as traditional non-resident consultant posts. Resident consultant posts need to be professionally satisfying and sustainable, with clearly defined opportunities for career development and progression. As with any other consultant post, career progression will involve taking on management or leadership roles, but will not necessarily be defined by moving to non-resident on-call.

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.

RECOMMENDATIONS

1. **All units need to ensure a locally agreed, safe and sustainable solution to address workforce issues to manage care in both obstetrics and gynaecology.**
2. **Safe service delivery can only be achieved with safe staffing levels in both maternity and gynaecology units.**
3. **All solutions should take into account the national issue of lack of availability of middle grade doctors leading to recurrent rota gaps.**
4. **Workforce solutions must optimise training opportunities and accommodate the changing needs of trainees at different stages of their careers.**
5. **All solutions should allow for multidisciplinary training, development of quality services and good clinical governance.**
6. **All units should have consultant labour ward presence during working hours Monday to Friday, with the intention to extend this to every day of the week.**
7. **Resident consultant working within a hybrid rota is recommended to ensure appropriate medical staffing. In most units, this will involve all consultants working in a hybrid rota with some out-of-hours shifts.**
8. **Remodelling job plans to include evening and weekend daytime working must be considered in order to maintain equity among the consultant team. Involving only newly recruited consultants in resident working can be divisive.**
9. **Culture change within the profession is needed since a contribution to resident working will be required throughout a consultant's career.**
10. **Resident consultants must be treated equally to non-resident consultants by all staff.**
11. **The RCOG's standards for job descriptions and job plans should be used by all units to help implement the above recommendations.**
12. **The RCOG must explore novel methods for assessing work intensity and out-of-hours staffing levels in both obstetrics and gynaecology.**
13. **The RCOG should develop a repository of good medical workforce models that are available to all.**
14. **Units must ensure that high standards of care are maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time.**

Glossary

ASSOCIATE SPECIALIST DOCTOR
A doctor who is appointed to a permanent position but is not a consultant. The title 'associate specialist doctor' is usually conferred upon staff grade doctors after several years' experience.

ADVANCED MIDWIFE PRACTITIONER
A senior midwife with clinical experience who extends their role beyond the accepted normal sphere of practice.

CCT
Certificate of Completion of Training. This is gained on successfully completing the postgraduate training programme and allows the doctor to submit their name to the General Medical Council (GMC) Specialist Register and be appointed to consultant posts.

CESR
Certificate of Eligibility for Specialist Registration. This allows doctors who have not completed a GMC-approved training programme to be on the GMC Specialist Register.

COMPETENCY
The knowledge, clinical skills and attitudes developed by doctors as they progress through a curriculum. Within the obstetrics and gynaecology curriculum, competencies need to be attained at a defined level to progress to the next year of training.

CREDENTIALING
A process which provides formal recognition of competences (which include knowledge, skills and performance) through an approved training programme in a defined area of practice. This is not a formal GMC-recognised process within medicine at the time of writing this document.

DIRECT SUPERVISION
During training, doctors require supervision by experienced doctors or other trained healthcare staff to develop their skills. Direct supervision means that the experienced trainer must observe the procedure the junior doctor is performing.

GYNAECOLOGY SPECIALIST NURSE
A nurse with additional specialist skills allowing practice in a defined area of gynaecology.

HYBRID ROTA
A rota that involves both middle grade doctors and consultants, with some out-of-hours shifts undertaken by resident consultants. Consultants may undertake some shifts resident and some non-resident. Different models will be developed in different units depending on geography, acuity, complexity and workload.

INDIRECT SUPERVISION
Indirect supervision means that the experienced trainer does not physically oversee the procedure the junior doctor is performing, but must be easily accessible to support the junior doctor.

MIDDLE GRADE ROTA
A rota staffed by doctors who have attained the required competencies to undertake out-of-hours work (within labour ward and emergency gynaecology settings) but still require support from consultants. Usually, these doctors are in training; however, some some will be in non-training posts.

NTN TRAINEES (ST1–7)
Trainees with a national training number (NTN) who are in a GMC-recognised training programme. The obstetrics and gynaecology training programme is 7 years in length, with each year given a number from ST1 to ST7, with ST1 being the most junior.

OUT-OF-HOURS
There are many different definitions of out-of-hours working. In this document, out-of-hours includes evenings, weekend daytimes, bank holiday daytimes and nights.

Glossary

PHYSICIAN ASSOCIATE
A new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision. The role is therefore designed to supplement the medical workforce, thereby improving patient access.

POST-CCT TRAINING POST/FELLOWSHIP
Posts developed by boards and trusts to offer specialised training in a specific area of practice. These doctors will have already completed the obstetrics and gynaecology training programme.

RESEARCH FELLOW
An academic trainee, who can be pre- or post-CCT.

REGISTRAR
A trainee doctor between ST3 and ST7 in the obstetrics and gynaecology training programme.

RESIDENT CONSULTANT
A consultant delivering a service directly to patients out-of-hours and remaining on site for the duration of the shift.

ROTA GAP
Occurs when a member of the medical team involved in the rota to provide patient care is not available. This can be temporary because of sickness or longer term, where the vacancy cannot be filled.

SECOND ON-CALL
The clinician who provides support to the clinician providing immediate first-line clinical cover.

SENIOR DECISION-MAKER
An individual with expertise within the specific clinical field who has the necessary skills and competencies to take responsibility for clinical decision-making.

SENIOR HOUSE OFFICER (SHO)
For the purposes of this document, it is recognised that SHO posts are filled by ST1–2 obstetrics and gynaecology trainees, GP trainees, foundation year doctors and staff grade doctors.

SPA
Supporting professional activities. These are activities that underpin clinical care and include training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.

SUBSPECIALTY
These are subspecialties of main areas of medical practice. Within obstetrics and gynaecology this applies to gynaecological oncology, reproductive medicine, urogynaecology and maternal–fetal medicine.

TRUST DOCTOR OR TRUST GRADE DOCTOR, STAFF GRADE, NON-TRAINING MIDDLE GRADE STAFF
Doctors working in the NHS in non-training posts at an equivalent level to either a registrar or consultant.

WORKING HOURS
In this document, ‘working hours’ denotes weekday daytime working hours. There is wide variation in different units and it would be inappropriate to set an exact timeframe for all to follow.

Appendix

This Appendix provides a number of examples of resident working in practice.

PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST

Mr Stephen Havenga FRCOG, Consultant Obstetrician and Gynaecologist and Associate Clinical Director for Maternity

We are a large district general hospital with 5000 deliveries. We have 12 full-time O&G consultants, one part-time senior consultant who does only obstetrics and no nights, and another part-time senior consultant who does only fertility (no obstetrics) and no nights. We have seven middle grade trainees from the HEE East of England Deanery and seven junior doctors – a mixture of FY2s, ST1s and GPSTs.

We have always provided good training but were getting persistently negative feedback from trainees about teaching, supervision and undermining. Also, we weren't able to offer many of the ultrasound modules. Our labour ward resident hours were on average about 60 hours/week. Furthermore, we had a rather critical RCOG review visit, which was prompted by a number of serious untoward incidents. Among the review's recommendations were that we were too busy and needed more juniors and a second middle grade on-call tier, but also that we should consider splitting the daytime consultants' O&G cover. We worked up a radical investment appraisal and business case, funded by our rapidly rising delivery rate, to increase our labour ward cover and improve the training opportunities for our trainees. The aim was to recruit four more consultants, and we were lucky enough to eventually appoint four excellent colleagues at one interview.

Our night/weekend rota is now 1:12, which is not too onerous. We all agreed, as part of the deal, to extend our daytime resident shift to 21:30, seven days per week, which means we now provide 13 hours x 7 days = 91 hours per week of labour ward resident cover per week. The consultant on night call starts their on-call at 17:00, having done their normal day job, stays for the 20:00 handover round with day/night registrar and juniors, and then remains on site until 21:30 at the earliest, or later if busy. Weekends start at 08:30 and finish in the same way at 21:30 on both days, and the consultant is resident for that entire shift. Consultants are free to swap out and split their weekends if they choose, which many do.

However, the biggest change came in the daytime cover arrangements. Our rota coordinators constructed a rota that uniquely had a lot of the daytime labour ward middle grade cover provided by 'consultant-delivered care'. All four of the new consultants formed part of the team providing this cover and they joined three more senior colleagues (five years in post), and since then another much more senior colleague has begun taking part, making a total of eight out of 12 colleagues providing this service. Most enjoy the role and it is much appreciated by the patients, the midwives and, of course, the trainees, who are freed up to attend the gynaecology outpatient department, theatre and other training sessions, often as supernumerary, so that they can be taught and trained properly. Our trainees get a large component of gynaecology operating. They tend to do most of the 17:00 to 20:00 labour ward registrar cover in return.

Furthermore, the four new appointees now provide the bulk of the gynaecology consultant on-call morning cover, on a sessional basis. This is separate from the obstetric consultants' rota, which is run on a weekly basis as a 'consultant of the week'. Each morning one of them attends the main handover on the labour ward, then they see all the gynaecology patients on the ward and any emergencies, attend the emergency gynaecology ambulatory unit (EGAU)/early pregnancy assessment unit (EPAU), and they also provide a training ultrasound list, run in parallel with the sonographers. They are also available to attend the emergency department with trainees, for teaching purposes. New pathways have been created to allow for more transfer of clinically stable gynaecology emergency patients from the emergency department to the EGAU, so that they can be scanned and assessed 'in-house'.

This single development, i.e. of the scanning component, has allowed us to meet all the requirements to provide the curriculum and practical training/competencies for the

intermediate gynaecology/early pregnancy scanning modules. The four new colleagues also provide internal cover for the gynaecology consultant on-call sessions and also cross-cover the abortion service in rotation.

Needless to say, this new arrangement has vastly improved trainee satisfaction and, to our great pride, we came fourth in the country for overall post satisfaction in the last GMC survey. This is a huge improvement for us. We have also made other improvements in the educational domain by creating more teaching sessions on Thursday mornings, run by the trainees, with consultant attendance, perinatal meetings every Tuesday lunchtime, a gynaecology morbidity meeting every month, and we have also set up an educational faculty with attendance by all trainees and clinical and educational supervisors.

Although our new colleagues don't have fixed general gynaecology clinics in the main, they each have a special interest session, e.g. one does a colposcopy clinic, two have an alternate week outpatients hysteroscopy session, and the fourth has a labour ward skills and drills session. They also all do an antenatal clinic. In addition, one is labour ward lead, one is EGAU/EPAU/TOP and gynaecology governance lead, the third is postnatal care lead, and the fourth is medical student lead, so they all have fulfilling SPA sessions and lead roles. They are all gynaecology scan-trained and they can all do laparoscopic ectopic pregnancies, ovarian cystectomies etc. on the emergency rota. As senior colleagues we are happy to provide support during daylight hours or at night, and this is often needed. One slight downside is their major operating experience may be slightly reduced, so we encourage them to join us every couple of weeks or so in our elective gynaecology operating theatres to go through a day case list, or abdominal or vaginal hysterectomy, or laparoscopically assisted vaginal hysterectomy or total laparoscopic hysterectomy, for example, to keep up their surgical skills.

I know this arrangement may not work for everyone, but it certainly has for us. Our one ongoing problem is the lack of a second on-call middle grade tier, which at 5000 deliveries we really should have – we have tried many times to recruit staff grades/trust doctors but have had very little success. On the strength of our excellent GMC survey feedback, the East of England Training Programme Director promised us two more registrar posts last year, and this was all costed and funded by the trust. We did put together a plan to provide a consultant resident service 24/7, but we worked out this would have cost the trust eight more consultants and the trust would not fund it, hence the lack of middle grade cover is now sitting as a major risk on the corporate risk register.

This new arrangement has vastly improved trainee satisfaction and, to our great pride, we came fourth in the country for overall post satisfaction in the last GMC survey

We have used this system and have found it works well, with most of us being called less once we have gone home and the labour ward feeling much more organised to the midwifery staff

DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST

Dr Janet Ashworth FRCOG, Consultant Obstetrician

We introduced resident consultant posts at the time I started with the trust in 2003. The posts have metamorphosed and now been entirely altered.

In 2003 we delivered 4500–4800 and had a two-tier registrar rota. All the consultants did joint O&G and covered both on-call. I and three others were appointed to do one night a fortnight, not prospectively covered, from 17:00 to 09:00, with time off in the daytime prior and the day following the night. The rest of the time we worked normal full-time and we took part in the general 1:9 on-call rota with prospective cover. When we were resident, there was no second tier registrar and another consultant colleague was nominally on-call from home to provide support if needed. The aim of the posts was to accommodate a middle-grade rota that was compliant with the European Working Time Directive. As our deliveries steadily increased and increasing numbers of our consultant colleagues became solely obstetrics or gynaecology focused, it became clear that we could no longer sustain only having one trainee at night, especially when the resident was a sole obstetrician and the on-call consultant a gynaecologist, so after one to two years we reinstated two trainees on the night and evening shifts. Over time some of my colleagues moved unit and others ceased doing resident nights, while other new appointees joined the resident team on the same basis as I had.

By 2013, we were delivering around 6300 and only some weekday nights were covered by a resident consultant. We had split the on-call rota into obstetrics and gynaecology a few years before, and the on-call obstetrician was purely nominal, never being called in. I for one had a markedly increased daytime role, which was untenable with missing two days a fortnight. Those of us who did resident nights were rarely called out of bed (we have a resident consultant on-call room) after 23:00, and on the nights when there was no resident consultant, the on-call consultant was mostly in till at least 21:00. We found that by staying most of the evening, most patients had plans in place and the unit tended to run well.

We wanted to ensure that all weekdays had a minimum of consultant evening cover, restore equality to consultant job plans across the department (some of us were doing much more out-of-hours work, which was also less well rewarded under the new contract) and ensure that there was contracted consultant presence for some time over the weekend. We therefore agreed as a group of obstetricians providing obstetric cover that the person on-call for the night would stay until 22:00 as a minimum, as well as a minimum of eight hours at the weekend (ideally four hours each day). This was felt reasonable. This would mean that all of these sessions were also prospectively covered, as the on-call cover was.

We have used this system since November 2013 and have found it works well, with most of us being called less once we have gone home and the labour ward feeling much more organised to the midwifery staff. We are in the process of appointing to two new obstetric posts. Our trust wanted us to bias the job plan of these posts to include more out-of-hours work, but as a department we have resisted this, as we felt it would be divisive and not conducive to appointing and retaining good colleagues. Hence we have all agreed to increase our out-of-hours resident commitment further to commence at 08:00 (rather than 09:00) on weekdays in our duty week, and to commit to 16 hours minimum resident per weekend. This is in return for a guaranteed day off on Monday after a weekend on-call (now felt essential) and doing slightly less frequent on-call with our new appointments (it will be just under 1:7 on-call).

YORK DISTRICT HOSPITAL

Mr James Dwyer FRCOG, Clinical Director and Mr Adrian Evans FRCOG, Consultant Gynaecologist

We have 3400 deliveries, and we had permanent gaps in the registrar rota. It was difficult to get long-term locums and we advertised many times without success. The locum agency costs were extremely large and it was decided to have two consultant posts at York with prospective cover by using the money spent on locums and reducing a trust-funded registrar post. This meant the registrars covered Wednesday to Sunday nights and weekend days. Since then, we have had a retirement and used this replacement post to provide further resident consultant cover such that the registrars no longer do Wednesday nights. This increases the amount of time they are present during the day and thus helps their training.

The resident consultant posts are cheaper than the locum spend of £400,000 per year, which was the main reason for us considering and implementing this role. They also allow the non-resident consultants to continue providing sessions the days following their own on-call on Monday, Tuesday and Wednesday night so it keeps the department ticking over from that point of view. It is very likely that sessions will be lost from the non-residents as we are increasingly being called in to help overnight, as I am sure most units are experiencing.

There have been some barriers. One concern is that we may get a different level of person applying, but we have not found this to be the case. In our recent appointment, we had over 30 applications for two resident posts, of which we shortlisted eight and five accepted interview.

With fewer trainees and less access to long-term locums, the only solution is to increase the amount of resident consultant posts – this means instead of a registrar not as well as in our unit.

Overall, we have worked hard on the job timetable to allow the resident consultants good access to the same opportunities as the non-resident. We could have filled the posts with trust-appointed post-CCT specialists who would not be under the same terms and conditions, but we thought it better to increase the number of consultants.

The more recently appointed consultants may need more support. When on-call, I come in at 22:00 to do a personal ward round with the new resident consultants, as it helps us get to know each other better and for me to provide support. There are many ways this presence is valuable as it is also a chance to discuss a wide variety of topics and give general support.

There are still things we need to evolve but it is a reasonable system. I know there is a degree of frustration that may creep in if no specialist skills are developed and we need to look at this more closely in future.

One of the main problems we have with the current system relates to how our pension is calculated and moving away from the best year out of their last three would be an advantage to this model.

We have worked hard on the job timetable to allow the resident consultants good access to the same opportunities as the non-resident

Appendix

Resident consultant working was initially introduced to increase from 60 to 98 hours labour ward presence and we identified that we would need three new consultants as otherwise job plans would not be sustainable or attractive

LUTON AND DUNSTABLE UNIVERSITY HOSPITAL

Miss Kathy Waller MRCOG, Consultant Obstetrician and Gynaecologist, and Mr Malcolm Griffiths FRCOG, Consultant Obstetrician and Gynaecologist

We are a unit of 5200 deliveries with a level 3 neonatal intensive care unit. We first proposed a 24/7 consultant rota in 2002 in our department. We saw it as a way of expanding consultant numbers, offering a more consultant-delivered service and providing an opportunity for building up subspecialty teams. We didn't succeed due to a lack of vision and finance. The push later came as a result of RCOG and Clinical Negligence Scheme for Trusts targets and pressure from our primary care trusts and clinical commissioning groups to meet some service targets.

Resident consultant working was initially introduced to increase from 60 to 98 hours labour ward presence and we identified that we would need three new consultants as otherwise job plans would not be sustainable or attractive. The business plan was then accepted by the executive team. We then arranged a consultant away day and circulated seven different potential consultant rotas beforehand for comments.

One suggestion from a very newly appointed colleague was that we should recruit new junior consultants to provide the cover. It was decided that we didn't want to bring about a junior/senior consultant split. We'd expected that at some stage that we'd be working as a resident consultant. We felt that the idea of having experienced on-site consultants would be good for patient safety and training. Once one person pitched in with their 'offer', two colleagues also chose, for personal reasons, to opt in. We then appointed some more new consultants, some of them sharing our rota and some not. At that time we had a full complement of trainees, so medical staffing arrangements were the same as during the daytime.

All existing consultants were given the option to become resident consultants and many chose to do so, working one resident night every four weeks (paid four PAs overnight). Three new consultants were appointed with one also on the same pattern, and two jobs planned for 26 resident nights per year. We have had no difficulties with recruitment to these posts and have appointed some excellent colleagues. No one has left the resident consultant posts since they commenced in June 2010.

More recently we've had the same problem that other units are facing of too few middle grade doctors. We've now appointed two locum consultants who work resident shifts in place of the senior registrar. We see this (sadly) as inevitable but less positive.

In contrast, a similar system (appointing new consultants to work in place of senior trainees, but without full support) has been happening in parallel for several years with our neonatologists. There it's turned out very differently – the people appointed all ultimately aim to move off resident nights and we have had a steady progression from resident consultants to non-resident (or less resident) as new posts have been created or when there are retirements. We've also had a number who have left (locum and non-locum resident consultants) for substantive posts elsewhere.

I really prefer the resident commitment. I really hate being on-call from home. You will know the feeling when you get called at night about a case, you wonder whether you should go in anyway, you lie awake for a while and then soon after you've gone back to sleep the senior midwife rings to say they did need you after all. When you are resident you are there any way! I love it. I am afraid that they may try to take away my full team and I'll be reduced to acting as a 'senior registrar' – I don't think at my age I could cope with that!

The deanery has always commended us for this particular initiative as the trainees think it so valuable.

In summary, the most important points are: colleagues agree the rota together; the resident consultant did not replace the senior registrar; senior colleagues in the department have led by example; it is excellent for teaching and training and encouraged by the deanery; trainees like it; and there has to be a consultant on-call room.

From a personal point of view, the rota is very family friendly; staying up at all night is becoming more difficult as I get older (now 50+, as are others); and re-scheduling clinics and theatres can be a pain and advance planning is essential.

Appendix

SAINT MARY'S HOSPITAL MANCHESTER

Dr Sarah Vause FRCOG, Consultant in Fetal and Maternal Medicine and Deputy Clinical Head of Division

In 2010–11, maternity and paediatric services in Greater Manchester were reconfigured, leading to a significant increase in the number of women delivering at Saint Mary's Hospital (currently 9000 women per year). The increased number of deliveries made the 'consultant on-call from home' model unsustainable. There was therefore a desire from the consultant body to change the way of working, but with the proviso that whatever new system was adopted had to deliver benefits for both patients and consultants.

Planning a 24/7 consultant presence obstetric service was a protracted and difficult process, which took over four years to achieve. We developed nine different models before we found one which was acceptable to consultants and affordable for the trust. A number of factors had to be balanced to achieve a sustainable model. This included balancing daytime work for consultants to give them both experience and professional development opportunities, as well as enough time off. It was felt to be important that there should be equity across consultants, with all consultants participating in resident out-of-hours work. It was also felt that there must be equity in status and responsibility with none of the consultants being viewed as more senior than others, and all taking a fair share of management and governance roles. All the consultants contributed to the development of the new system, and although discussions were at times robust, it was an amazing piece of teamwork.

The staffing model arrived at required the appointment of an additional 10 consultants, 26 in total. Consultants are divided into two groups. One group undertakes night shifts. Each of the 16 consultants on the night rota undertake 13 weeknights per year together with three weekends per year (Friday, Saturday and Sunday nights). This represents a total of 23 resident nights per year and accounts for 2.2 PAs per week. The second group (10 consultants) undertakes weekend daytime and evening out-of-hours labour ward shifts to make up their out-of-hours duties (1.9 PAs per week). It is predominantly (but not exclusively) newer consultants who work night shifts, with the older consultants, who had previously worked a traditional non-resident on-call, now working the resident weekend daytime and weekday evening shifts in the labour ward. The advantage of this model is that consultants can continue to contribute to the resident out-of-hours rota until retirement.

Other benefits have been that the increased number of consultants can now provide more support to the inpatient wards, triage and the antenatal assessment unit. Two consultants are now allocated to each antenatal clinic providing cross-cover for leave, and therefore better continuity of care for women attending specialist clinics.

The new 24/7 consultant presence model of working was introduced on 1 September 2014. Although formal evaluation is not yet possible, initial data suggest that the new system is improving relevant clinical outcomes; that most consultants feel their overall quality of life is either better or different, but not worse; and that training for most junior doctors has improved. There are some concerns about whether the most senior trainees will be able to develop leadership and prioritisation skills, and some concerns that we don't see each other as often as we would like due to numbers and timetabling. We have been working in this way for almost a year now, and overall it feels as though it has definitely been a change for the better.

Each of the 16 consultants on the night rota undertake 13 weeknights per year together with three weekends per year (Friday, Saturday and Sunday nights)

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Royal College of Obstetricians & Gynaecologists

Obstetrics and Gynaecology Workforce Report 2017

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Introduction

The changing demographics and expectations of both the women using obstetrics and gynaecology (O&G) services and those delivering them need to be understood together, in order to respond to workforce needs effectively. This report provides an update for RCOG members and sets out next steps for the College and what is needed from the membership to support this.

The College remains committed to improving women's health, and a strong and sustainable workforce is critical to achieving this

The Royal College of Obstetricians and Gynaecologists (RCOG), together with the profession, needs to continue engaging with workforce planners to define the expectations of the current and future workforce in a way that is inclusive and supportive of a healthy work–life balance, while having an honest discussion about what we can deliver to women with the workforce available. This will be crucial in not only attracting doctors but also retaining and nurturing them within our profession. This is a critical issue in terms of long-term stability of the workforce and one in which the College will continue to actively engage.

The College remains committed to improving women's health, and a strong and sustainable workforce is critical to achieving this. This report outlines the challenges facing the O&G profession and the commitments the College is making to address them. It also describes opportunities for members of the College to get involved in this work by sharing successful methods they have used to address their own workforce challenges, which can then be communicated to the wider membership.

Key messages

- UK O&G services are being delivered safely but the pressure is rising on all staff involved
- To manage obstetric and gynaecology care, units must address workforce issues in a safe and sustainable way
- 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 (*NMPA 2017*)
- A 30% attrition rate from the O&G training programme is typical, varying from 29% to 37% (*HEE/GMC*)
- 15.4% of trainees think about leaving O&G once a month or more (*Trainee Attrition Survey 2017*)
- Consultant presence in a unit should be based not only on the numbers of births, but also on the complexity of the O&G workload and the case mix of a department
- Providers should explore alternatives to 24/7 consultant presence if they are as effective and more financially sustainable
- Resident consultant working may be needed in many units so there are suitable numbers of doctors with the appropriate competencies
- Consultants who work resident shifts out-of-hours should get parity of responsibility and professional development opportunities
- All on call consultants in a unit should work towards providing a similar on call work pattern taking into account local job plans

This report provides an update for RCOG members and sets out next steps for the College and what is needed from the membership to support this.

RCOG Actions

- Pro-actively work with Health Education England and equivalent agencies in the devolved nations, to model a workforce of the future that has the right number of specialist staff to deliver safe O&G services
- Mitigate against high attrition rates by lobbying workforce planners to:
    - Recruit new trainees so the full time equivalent (FTE) output of Certificate of Completion of Training (CCT) holders in run-through specialty training remains stable and gaps caused by less than full time working can be plugged
    - Consider further rounds of recruitment at later stages of training, i.e. ST3 or beyond
    - Improve flexibility for trainees to step off and then return to the programme
- Develop and support specialty doctors through skill acquisition, continuing professional development (CPD) and a supervision/appraisal structure, improving the retention of these valued staff
- Promote RCOG criteria for approval of new consultant posts. These give newly appointed consultants a job plan that enables them to provide continuity of care, develop professionally and have an appropriate work–life balance. It includes job plans with no more than 3-4 PAs for resident out-of-hours work.
- Set up a working party to take into account the needs of consultants who are considering retirement, including the impact of their activities on more junior consultants

There are opportunities for members of the College to get involved in this work by sharing successful methods they have used to address their own workforce challenges, which can then be communicated to the wider membership.

The changing nature of the O&G workforce.

A message from Mary Ann Lumsden

Over the past few years there have been concerns expressed, by workforce planners, of our specialty training an excess of O&G consultants. However, the RCOG is not aware of any regions in the UK where this seems to be the case; instead, we're witnessing a worrying trend in middle-grade rotas with 88% of units reporting gaps (*Source: National Maternity and Perinatal Audit 2017*).

Rota gaps put an immense pressure not only on teams but also on an individual's ability to deliver safe services, something which our members are doing – but at what cost? Safe services are being delivered at the cost of our doctors' wellbeing, educational opportunities and job satisfaction, which is leading some to leave the profession altogether. High trainee attrition rates together with changes in the visa rules, an increase in less than full time (LTFT) working, maternity and paternity leave, and 'retire and return schemes' are creating rota gaps. Although workforce planners may take account of trainee attrition there is not enough consideration of these other factors in their modelling. Rota gaps cannot be filled with trainees alone and consideration must also be given to other health care professionals of all types who contribute to the delivery of women's health care.

It is essential that we communicate this message to planners and decision makers to ensure we have the workforce required to deliver O&G services going forwards. At the end of 2016 we established a Workforce Task Group to determine a strategy to better support and advocate for the profession. The group's first priority was to confirm the number and type of roles that provide O&G services as well as their working patterns. It was essential to get this right as all future work and modelling would rely on an accurate foundation and database of workforce data.

Where data already existed this was reviewed and sense checked to ensure it was being interpreted in the correct manner. Where data were missing the task group took steps to capture and analyse it, ensuring it was representative of what the profession told us they were experiencing.

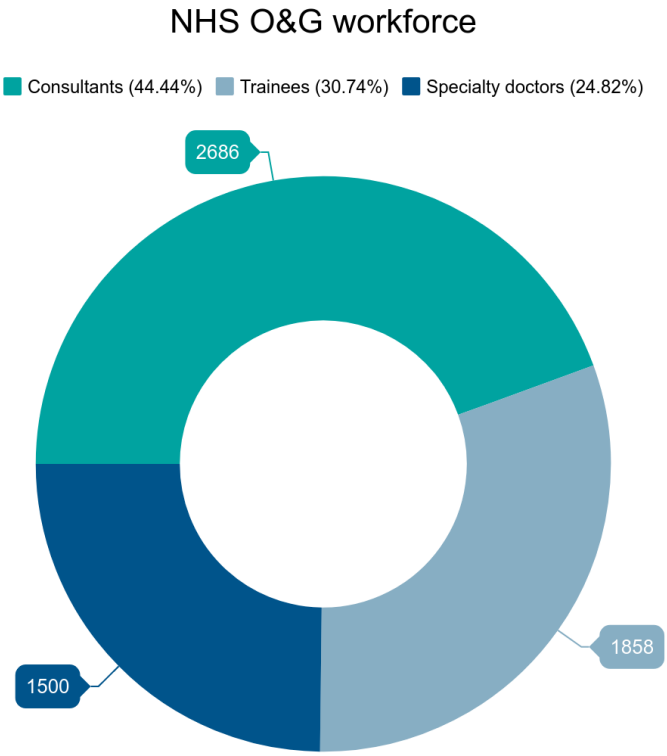
Rota gaps put an immense pressure not only on teams but also on an individual's ability to deliver safe services, something which our members are doing – but at what cost?

Many discussions have taken place with workforce planners over the past 12 months to improve their understanding of the O&G workforce and how it operates. The RCOG has also represented the profession on a number of working parties including Health Education England's Maternity Workforce Steering Group, part of the Maternity Transformation Programme. Discussions have led to a greater understanding among planners and a willingness to work together on future modelling.

The Workforce Task Force is committed to continue working with planners, decision makers and the profession to address these challenges and to retain our highly valued workforce.

Mary Ann Lumsden
Senior Vice President
Strategic Development
Chair, Workforce Task Group

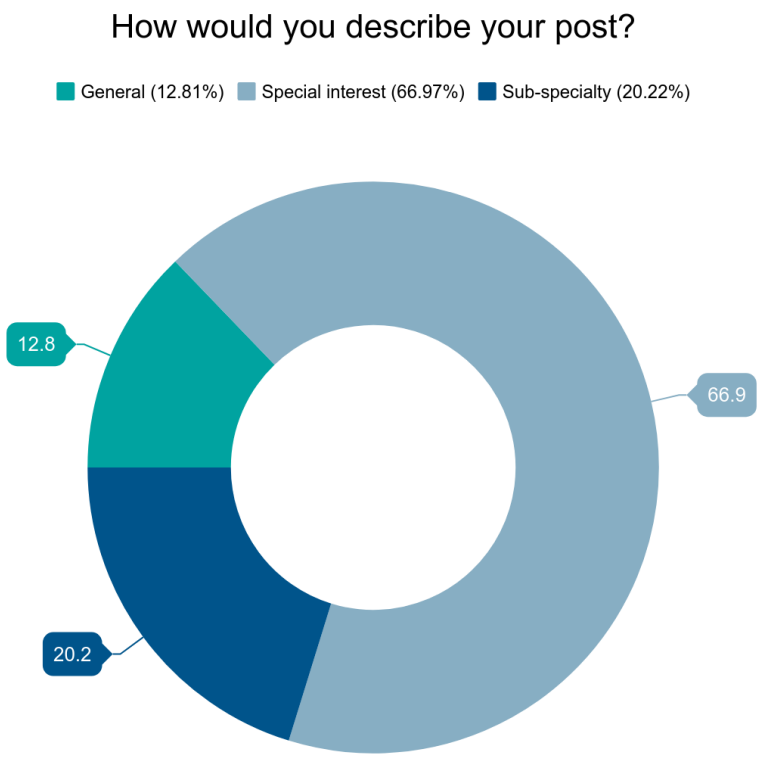
The O&G profession



NHS Digital; NI DoH; NHS Scotland; StatsWales: RCOG ePortfolio; NHS Sources

RCOG Members around the UK

England	1550
Northern Ireland	65
Scotland	150
Wales	70



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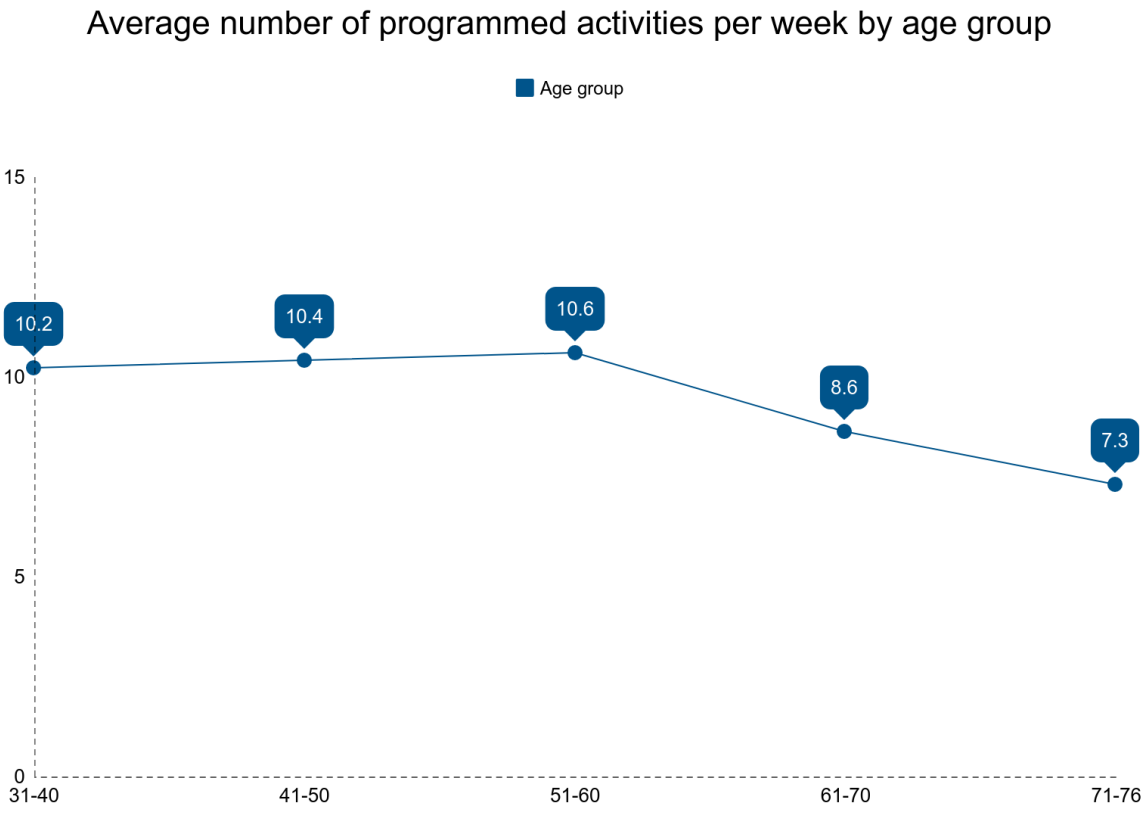

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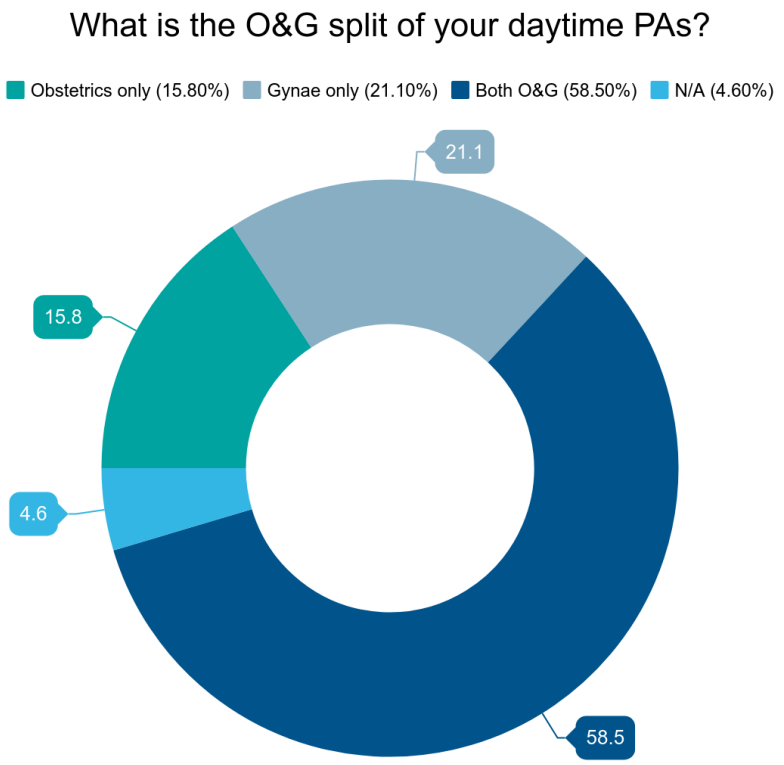

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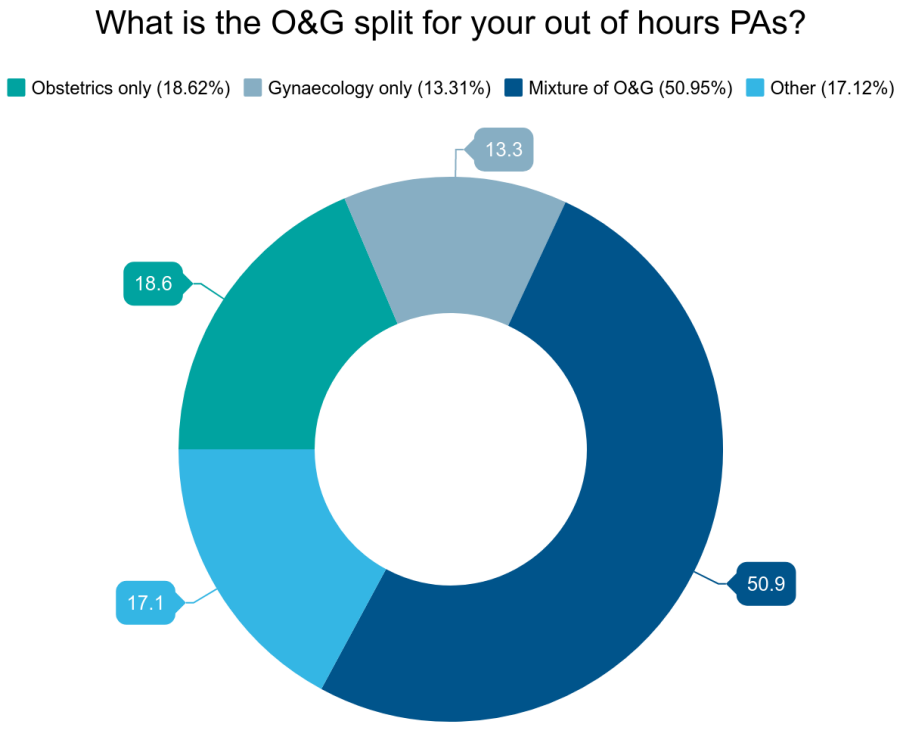

RCOG Workforce Survey, 2016

Workforce challenges - Trainee attrition

GMC data show a significant number of trainees who start the O&G training programme but do not finish. An attrition rate of 30% in any region is not unusual, with rates ranging from 29% to 37% (*HEE/GMC*).

Recent RCOG trainee surveys show that:

- 75% have considered leaving O&G since the start of specialty training.
- 89% have at some point felt low in mood, depressed or anxious since starting specialty training
- 19% report feeling this way at least monthly
  (Trainee Attrition Survey 2017)

The factors behind this high trainee attrition rate include:

- Rota gaps
- More out-of-hours working
- Poor work–life balance
- Less supervision
- Fewer training experiences

These are also challenges for the wider workforce that will result in changes to the O&G consultant role of the future. For some it is becoming a less attractive prospect, especially for more junior consultants.

Workforce challenges - Rota gaps

88% of obstetric units reported a gap in their middle-grade rota (*NMPA 2017*).

Locums

83% of units reported requiring locum cover to staff their middle-grade rotas in the previous three months (*NMPA 2017*).

Locums are an important and valued part of the workforce. However, at a time of NHS austerity, relying on locums to cover gaps is an expensive use of budgets. Reliance on locums to deliver services could also lead to inconsistency in service delivery as locums are often unfamiliar with local systems and need time to acclimatise. This impacts on team work and, potentially, patient safety.

A more sustainable and efficient option would be to address the reasons for the gaps being there in the first place.

	Number of units in each response category (excluding units which responded a proportion was unknown)		
Proportion of the middle-grade rota in the last 3 months which was entirely unfilled, filled by a locum or filled by a consultant	entirely unfilled	filled by a locum	filled by a consultant
0%	93 (57%)	28 (17%)	95 (58%)
1 to 5%	25 (15%)	27 (16%)	44 (27%)
6 to 10%	24 (15%)	38 (23%)	10 (6%)
11 to 25%	12 (7%)	54 (33%)	12 (7%)
26 to 50%	5 (3%)	17 (10%)	1 (1%)
More than 50%	4 (2%)	2 (1%)	2 (1%)
Total (excluding unknown)	163 (100%)	166 (100%)	164 (100%)
Overall proportion entirely unfilled, filled by a locum or filled by a consultant (excluding unknown)	70 (43%)	138 (83%)	69 (42%)
Unknown	22	19	21

(NMPA 2017)

Options for addressing workforce challenges

Rota gaps are caused by several factors. The Workforce Task Group quickly realised that there is not a single solution. A work stream was set up to explore and address this complexity. It also aimed to find ways to assess both the extent of the problem and possible solutions.

Below are recommendations that the Workforce Task Group believe will make the biggest impact in terms of addressing rota gaps. Other options considered by the group can be viewed in Appendix 1.

Maintain and increase the flexibility of the O&G training programme

Currently, if a trainee leaves the specialty programme, or works part-time, their post cannot be replaced. Recruitment in England is currently only allowed at ST1 level and doctors taking up these posts must have worked in O&G for less than 24 months.

A recalculation of the number of posts required is needed alongside the reality of budget reductions. There are certainly workforce concerns of training an excess of specialists who cannot find consultant posts, but currently recruitment is not taking into account the loss of available staff due to attrition, more maternity and paternity leave and increasing part-time work patterns, as well as the increasing diversity of O&G services.

The RCOG proposes allowing a hybrid model of recruitment, maintaining run-through posts from ST1 but allowing alternatives as well. Options would include recruitment at ST3 or later as well admitting more doctors into ST1 to replace those working LTFT or out of programme, recognising that there is significant attrition in the first two years. The model chosen would depend on the needs of local schemes and the availability of applicants at different stages of training. Recruitment at ST3 or later would replace trainees who had left the scheme and so would not increase the overall number of doctors being trained for future consultant posts.

An increase in flexibility of numbers would allow trainees time out of training for research,

specific skill acquisition, global health work and family commitments, and would improve retention. Training schemes should be able to factor this into their recruitment numbers, with slight expansion, in order to allow out of programme activities more readily.

Increased support for specialty doctors (SAS, Staff grade, Trust, etc.)

There is currently a large workforce of doctors who are not on training schemes or in consultant positions but who provide an invaluable service to O&G departments. It is important to have middle-grade posts that are not dependent on gaining a CCT, but these doctors must be offered appropriate career development with support, appraisal, training and CPD.

Specialty doctors tend to have long-standing experience in O&G, often running clinics and theatre lists alone. However, the turnover of doctors in these posts can be very high depending on the type of post, with around 15% leaving the substantive workforce in any given year. Data from HEE show that a further 10–12% move into either consultant posts or postgraduate training, but there is no further information on where they go.

Active interventions to retain, reskill and upskill these experienced staff would increase workforce supply.

Increased resident consultant working

Faced with growing pressures due to middle-grade rota gaps, many units have introduced resident consultant working out-of-hours. In some units this has been successful, but in others newly appointed consultants have felt undervalued, resentful and disillusioned. In order to maintain a safe service, some resident consultant working will probably be necessary in most units.

The RCOG's 2016 report *Providing Quality Care for Women: Obstetrics and Gynaecology Workforce* set out recommendations to support resident consultant working as part of the solution to rota gaps.

For resident consultant roles to be successful, they must be professionally satisfying with opportunities and support equal to non-resident roles. An RCOG survey of resident

consultants in 2015 highlighted the importance of a predictable work pattern, a defined case-load, opportunities for professional development and the sharing of clinical and managerial consultant responsibilities in the development of a successful resident post. A job plan allowing for improved work life balance was deemed essential. The requirement for all or most consultants to contribute in some way to resident out-of-hours work was also viewed positively; this did not need to be overnight, but could be out-of-hours work in the evenings or during the day at weekends.

In the past, recommendations have been made about the amount of resident consultant presence required for units with various numbers of deliveries. It is now accepted that these figures did not take into account all the necessary evidence. The emphasis should now be placed on providing safe care for women 24/7, and having the appropriate number of doctors with the appropriate skills available. Each individual unit should decide the best way for them to provide this care, based on their knowledge of their workload and case mix. However, in view of the significant rota gap issue it is likely that in many units this will involve some resident consultant working.

Redeployment of retiring consultants

As consultants near the age of retirement, many may consider either reducing their number of sessions or being re-employed on a part-time basis with an adapted job plan ('retire and return'). Many wish to reduce their night-time on-call commitment but have skills which can still be used in the department, particularly conducting clinics, ward rounds, time on labour ward or daytime emergency gynaecology sessions, elective theatre lists and teaching. They could also provide some out-of-hours cover in the evenings or during the daytime at weekends. Without removing training opportunities, they could free up time for other consultant staff to contribute to activities in both O&G.

What next?

The RCOG will continue to work closely with workforce planners and decision makers to address workforce challenges and ensure the profession has the correct number and skill mix to continue to deliver safe O&G services now and in the future.

A number of initiatives are also under way to better support and equip the profession to work within such a challenging environment; to safeguard the welfare of our doctors; to ensure satisfying job plans and career prospects; and, ultimately, to retain more highly skilled doctors within the specialty.

RCOG initiatives

Welfare of the Workforce

The Welfare of the Workforce group, a sub-group of the RCOG's Workforce Task Group, was set up to help the profession in terms of culture, job plans and career development. As well as assessing and confirming the current situation, the group has been developing guidance and recommendations (outlined above) to empower and support doctors to manage workforce challenges more effectively.

Trainee attrition

The group recently surveyed all O&G trainees to find out the proportion considering leaving the training programme and their reasons why. As a follow-up to the survey, the researchers have formed trainee focus groups in all 16 health education authorities in the UK to offer ideas for solutions to the issues that the survey has raised.

New consultants

As well as the recommendations (outlined above) to ensure resident consultant roles are professionally satisfying, the group also recommends that resident working patterns continue to be assessed through data collection and audit and that the RCOG explore novel methods for assessing work intensity and out-of hours staffing levels in both O&G. Model job plans will be held at RCOG for units to look at and inform the creation of their own plans.

The group is also exploring how the College can help new consultants feel better supported, equipped and confident to carry out their roles, particularly the non-clinical aspects of their work. Ideas currently being explored include extending the reach of the RCOG's annual Newly Appointed Consultants meeting by making more content available online. A number of new consultants have already taken the initiative of setting up online and local groups to act as peer-to-peer support networks. The RCOG will be raising awareness of such groups and providing support, in the form of a toolkit, to others also wishing to set up a local group.

Return to work

For those doctors who take time out of practice for maternity/paternity leave or out of

programme experience, returning to the workplace can be a daunting prospect. It is essential that such individuals are up to date on the latest guidance and practices to ensure a seamless and satisfying transition back into work. The Welfare of the Workforce group is therefore exploring an accelerated return to work initiative (courses and web access) that will be available to doctors looking for support and information to get themselves back up to speed.

Future Models of Care

The Future Models of Care group, a sub-group of the RCOG's Workforce Task Group, was set up to assess the workforce needed to deliver O&G services in the next 5-15 years, to propose different workforce models to attempt to mitigate gaps between supply and demand and to highlight the risks posed by identified gaps.

The group is working very closely with HEE to assess and model workforce demand, and is also developing a tool to assess acuity/intensity of O&G workload in a unit with the aim of using this to identify how many tiers of staff are needed.

Supporting Our Doctors

A Supporting Our Doctors Task Group has been established to prevent, minimise and manage workplace stress experienced by doctors. Outputs include a service to support doctors and their employers to manage more workplace conduct and practice challenges locally.

The group is working closely with the GMC to ensure fair, efficient and effective fitness to practice investigations that benefit both doctors and their patients. The group has also collaborated on guidance for doctors who receive notification from the GMC of a complaint against them, advising them of what to do next.

The group will also be providing support and information on how to manage workplace challenges and ensuring doctors are aware of all the support services and resources available to them, either from the College or further afield.

Get involved

The RCOG has been working closely with the membership, through focus groups and surveys, to understand the extent and nature of their workforce challenges and to develop meaningful and sustainable solutions, and is keen that all members have the opportunity to input into this important area of work.

- Do you have an example of how to support a specialty doctor?
- Are you a Clinical Director who has had colleagues who have 'retired and returned'?
- Do you have examples of how you have filled rota gaps?

If you have ideas or feedback, particularly if you have examples of approaches that are working well in your trust, then we want to hear from you. Please contact workforce@rcog.org.uk to register your interest and we'll contact you to capture your feedback.

Appendix 1.

Additional options considered for addressing middle-grade rota gaps

As well as the recommendations outlined in the report for addressing rota gaps, the Workforce Task Group also considered a number of other options. None of those listed below were considered long-term, sustainable solutions; however, combined with the main recommendations, they may prove useful to some trusts in addressing their rota gaps.

Trust-funded specialty posts

Clinical fellows

Clinical fellow posts are created to attract doctors to spend one to two years gaining a specific skill, and to fill the rota gaps. These posts may attract trainees (who are unable to get sufficient training time in their own posts) to take out of programme experience/training (OOPE/T). However, this may leave further gaps in their own rotas, which the RCOG does not encourage.

Post-CCT fellows

Some trusts have created post-CCT positions with middle-grade on-call responsibilities. Some trainees may initially prefer to take a post which does not have consultant responsibilities and they may suit a CCT holder who is adding further skills to their portfolio. However, these posts may not be easily appointed to as most CCT holders are likely to be looking for a consultant post, unless they are keen to develop new, specialist skills. These jobs may also potentially create an unacceptable sub-consultant tier.

Trust fellows

The trust grade includes a large skill mix of doctors with often creatively designed job descriptions. Some have chosen to leave training, possibly because of failure to pass the MRCOG exam. Others may have been unable to gain a training number or come from a different country with too much O&G experience to apply at ST1. Trusts, individually or within a region, could offer training and appraisal on an individualised basis.

Despite there being an increase in numbers of trust grade doctors from 2011 to 2013, there are still significant vacancies in these posts. These doctors may not be sufficiently trained to take up a middle-grade position, and there is no UK training pathway available to them, apart from that offered at a trust level which differs in quality around the country. Current immigration regulations within the UK make recruitment of overseas doctors difficult. For these reasons, this is not a long-term solution.

Research fellows

Teaching trusts are able to ask doctors studying for research doctorates to work on the on-call rota. However, being on-call may also take time away from a research fellow's research.

Middle-grade locums

There is a diminishing number of middle-grade staff available to work as locums. Also, there is risk attached to the use of short-term locums as they are not familiar with departmental working patterns, guidelines and the multidisciplinary team. In addition, locums are a costly resource.

Expanding the number of MTI doctors

This scheme is administered by the RCOG, but determined at a national level by HEE. MTI trainees are employed at ST3 level for two years, but must be supervised, or on the SHO rota, for the first few months to familiarise themselves with UK practice. They are in the UK to gain both training and the MRCOG and must be appropriately supervised and supported. There is a current limit on the number of visas that can be issued to support MTI doctors. As a single initiative, the scheme will be unlikely to be able to expand sufficiently to replace vacancies on the middle-grade rotas. An increase in MTI placements would be a welcome development, particularly as O&G remains popular and is consistently filled each year.

There is also potential to expand this scheme for more senior doctors (above ST3) where more experienced doctors from overseas, who already have MRCOG, could undertake further more specialist training.

Offer training schemes to other countries

UK training in O&G is internationally recognised as being of a high standard, only allocating

CCT once trainees have a wide range of experience. Where deaneries have the capacity to offer additional training schemes, these could be used by trainees from another country on a formalised basis.

HEE is considering letting departments use their trust-funded posts to offer training to overseas doctors who bring their own funding with them. There would be a concern if the RCOG were not able to select and interview these doctors, particularly if they were coming for a period of up to seven years. It would be important for the training to reflect the skills needed to be taken back to the trainees' countries of origin. It would also need to be ensured that trainees recruited from other countries are integrated into an education and appraisal structure.

A potential group of doctors is European CCT holders who gain less practical experience during their shorter training programme, but who may have acquired skills of particular benefit to UK practice e.g. greater familiarity with ultrasound. There is an option to recruit European CCT holders to a level between ST3 and ST7 (depending on their practical experience) and offer them UK structured training but without the need for assessment for CCT, as they already hold it.

Develop other health professionals to provide middle-grade duties

It is unlikely that staff who are not medically trained would be able to take over the duties of an O&G registrar, which are wide ranging and include both specialised surgical skills, acute emergency management and general medical knowledge.

The development of nurse specialists in specific roles such as colposcopy and outpatient hysteroscopy already occurs and should be expanded. This could free up middle-grade time for on-call duties etc. but it must not remove sufficient training opportunities for trainees. The use of physician associates for specific operative roles or specialised clinics will be explored but they would be unable to replace the multiskilled role of O&G middle-grade staff, particularly on-call. Again, access to training opportunities for O&G trainees should not be reduced.

The current crisis and shortfall in nursing and midwifery staff far outweighs the shortfall in

medical staffing and so is not a short- to medium-term solution. The Royal College of Midwives has provided the following statement on this point.

"The RCM accepts that the boundary between midwifery skills and medical skills is not inflexible and that some midwives may develop particular skills in order to sustain continuity of carer, allow more women to benefit from midwifery care at home or in midwifery units or otherwise to improve the care available to women and babies. Good examples of this are perineal repair, cannulation, examination of the new born and undertaking six-week postnatal examination. However this is about adapting the midwife's role to accommodate women's requirements, it is not about advancing skills.

The RCM does not however endorse the extension of the midwife's role into obstetric, nursing or other spheres of practice where this does not demonstrably improve the quality of or access to midwifery expertise. Whilst the RCM accepts that NHS organisations wish to maximise the flexibility of their workforce, it is not acceptable to permanently alter midwifery roles to compensate for staffing shortages or changes in doctors roles. We do not believe this kind of response solves the fundamental problem of medical shortages but merely moves the problem onto another profession."

Develop GPs with an extended role (GPwER)

There is discussion between RCGP and NHSE about a credentialed programme to develop GPs with an extended role (GPwER) in women's health. If this is not formalised shortly, trusts could develop their own local schemes, recruiting GPs to provide specific skills such as work in antenatal care or emergency gynaecology, which would free up middle-grade time for on-call duties. Again, it must not remove training opportunities for current trainees nor access to 'first on-call' doctors for clinics. However, general practice also has major recruitment and workforce issues, which need to be factored into any plans. That said, these opportunities may be attractive to some GPs and help retain individuals in the workforce.

There are a group of GPs who initially trained in O&G, some leaving after achieving their MRCOG. They would be an ideal group to work with on a sessional basis, with a specific skill and appropriate CPD. The salary scale for this grade of doctor – previously known as clinical assistants – needs to be clarified nationally. It would need to be equivalent to the pay for a GP locum session.

www.rcog.org.uk/workforce2017

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Royal College of Obstetricians & Gynaecologists

O&G Workforce Report 2018

Update on workforce recommendations and activities

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Introduction

Professor Mary Ann Lumsden
Senior Vice President, Strategic Development
Chair, Workforce Task Group

Ensuring the obstetrics and gynaecology (O&G) workforce is equipped and supported to deliver the highest levels of care to women and girls is a key strategic priority for the RCOG. In 2017 we published our first O&G Workforce Report outlining the challenges facing our profession and the action needed to address them.

Over the past 12 months we have been engaging with key stakeholders including workforce planners and government bodies to ensure the concerns of our profession are heard and, most importantly, understood. Although there is more work to be done we are already beginning to see these discussions bear fruit.

At an average of 30%, attrition from the O&G training programme is one of the highest of any specialty. Understanding why this is the case so we can reduce and mitigate further attrition has been a key priority for us over the past year. Focus groups with trainees explored the reasons many had considered leaving the training programme as well as their suggestions on how best to improve experiences going forward. Among the causes are poor work-life balance, bullying and undermining and the absence of a team structure.

One of our first achievements was the reintroduction of recruitment at ST3 in England. Although this doesn't address all of our rota gap issues it does help to plug gaps created by trainees leaving the specialty training programme in years one and two.

Many doctors will at some point in their career choose to take time out, whether to gain valuable experience elsewhere, to explore research and training opportunities or to raise and support their families. Returning after a period of absence can be daunting, with some choosing not to return at all. To address this we have launched a Return to Work Toolkit to bring doctors up to date with developments and changes in practice.

Another significant step has been the establishment of an SAS/Trust Doctor Advisory Group, led by a new SAS/Trust Doctor Lead. The role that SAS and Trust doctors play in delivering O&G services, and their range of skills and competencies, is pivotal but often little understood – especially by workforce planners.

This means that SAS/Trust Doctors are not receiving the professional development opportunities and career support they need, leading to attrition and the

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Introduction

unnecessary loss of much needed and valued skills from the workforce. The new advisory group will be making recommendations on how to address this.

Using data captured through our annual workforce surveys we have been helping to shape maternity workforce strategies.

It is now acknowledged that as a specialty we are not heading towards an oversupply of O&G consultants, something that workforce planners had previously mooted but not something the vast majority of us can relate to in our daily practice.

In addition it is also now understood that the majority of doctors in our specialty do both obstetrics and gynaecology, which must be factored into both maternity and gynaecology workforce planning models if we are to accurately predict the number of doctors required to provide these services, now and in the future.

Thank you to everyone involved in our work to date and to those who continue to provide us with valuable insights through our annual workforce surveys.

The information you provide is essential to our work and is making a real and tangible difference to the lives of many within our profession and not least to the women we serve.

Key messages

The welfare of the O&G workforce is at the centre of delivering the best care for our patients. The RCOG acknowledges that, like many other specialties, we are experiencing workforce shortages in response to increasing demands on the service.

The RCOG believes that one of the most effective ways to address shortages and improve the quality of care for patients, is to improve the welfare of the workforce. This means addressing bullying and undermining in the workplace, but it also means celebrating talent and success and providing our doctors with rewarding career opportunities as well as addressing the low morale of many of our workforce particularly the trainees.

The RCOG calls on policymakers, regulators and NHS leaders to develop a long-term plan to address workforce welfare. The College invites leaders to come together to agree how this can be achieved.

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Key workforce stats

- 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[1]
- A 30% attrition rate[2] from the O&G 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[3] . The impact on this group of doctors of the UK's exit from the EU together with the availability of visas for medics is unknown
- O&G services rely on the significant contribution of SAS (Specialty and Associate Specialist) doctors and Trust doctors, however there is a significant turnover among this group with around 12% leaving the NHS workforce in England each year[4]
- Although the majority (63%) of doctors provide both O&G services, 20% provide services in gynaecology only[5] , which must be factored into workforce planning
- O&G trainees report more undermining behaviour than any other medical specialty[6] and 64% of consultants say they have experienced or witnessed consultants being bullied[7]
- Clinical negligence claims in obstetrics account for 10% of the volume but 48% of the total value of payouts[8]

Key workforce messages

- Workforce planners predict an increased number of consultants will be required on top of the projected supply by 2021[9]
- Developing and retaining talent is vital for the safe delivery of O&G services. This will also have a huge positive economic impact for the NHS
- Within the profession there are many examples of successful teams and working practices. We must celebrate their success and learn from them
- There is a human cost associated with the culture of blame within the NHS, which is not fully understood (both the cost to doctors and to patients and their families)

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The O&G Workforce

Royal College of Obstetricians & Gynaecologists

At the centre of delivering the highest levels of care to women and girls

O&G services are delivered by:

2600 Consultants

63% of consultants provide both O&G services. 20% Provide gynaecology only

1800 Trainees

30% Attrition from the training programme

1000 SAS/Trust

12% leave the NHS in England each year

54% of O&G doctors are international medical graduates

Obstetric units report a gap in their middle grade rota

Demographics

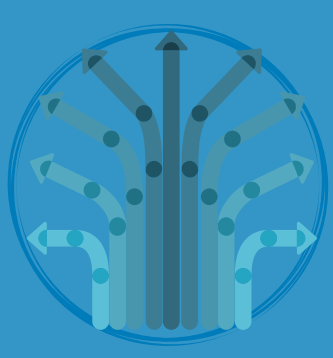
55% of the total workforce are female

80% of all trainees are female

40% on the specialist register are 45-54yrs

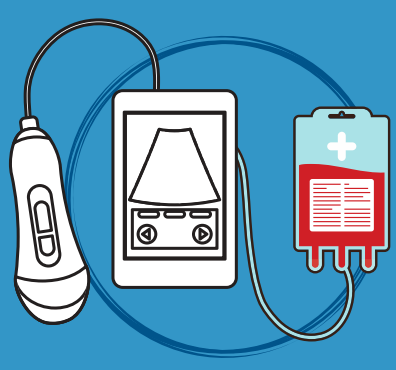
30% approaching retirement age within next 5 years

Working in O&G is a stimulating and rewarding career



Varied career paths available

Improving women's healthcare throughout their lives



Versatility - a mix of medicine and surgery

For some, it can come with its challenges

Disproportionate rates of litigation

Difficult to maintain work/life balance

High rates of bullying and undermining

The data within this infographic are from multiple sources and organisations. Visit rcog.org.uk/workforce2018 for a full list of references.

The O&G Workforce

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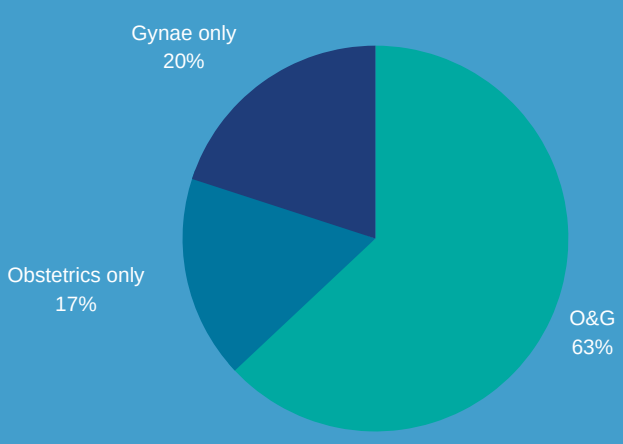
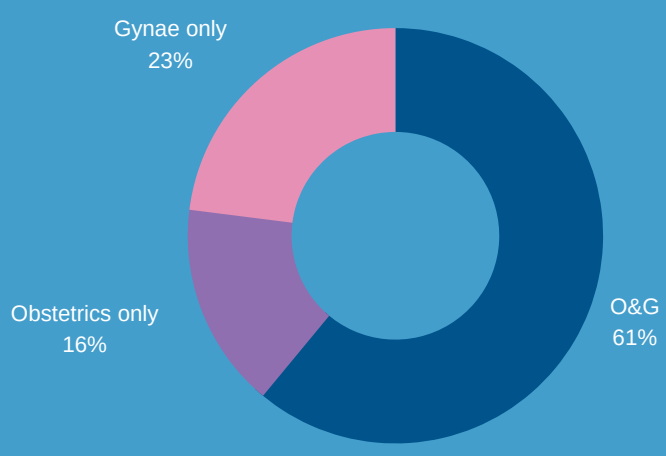
Consultants

Consultants provide a mix of O&G services

O&G split of daytime PAs:

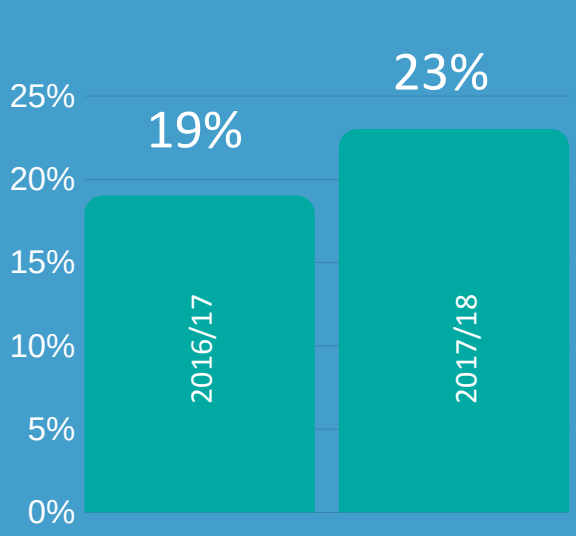


O&G split of out of hours activities:

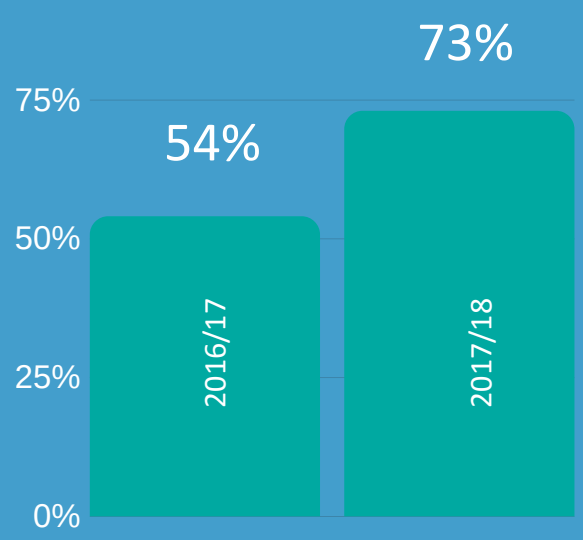


Resident consultant out of hours working is increasing

Job plans requiring resident consultant out of hours working



OOH including after midnight



Twilight/weekend day shifts only

78%

of consultants are aware of gaps in the trainees rota when on duty

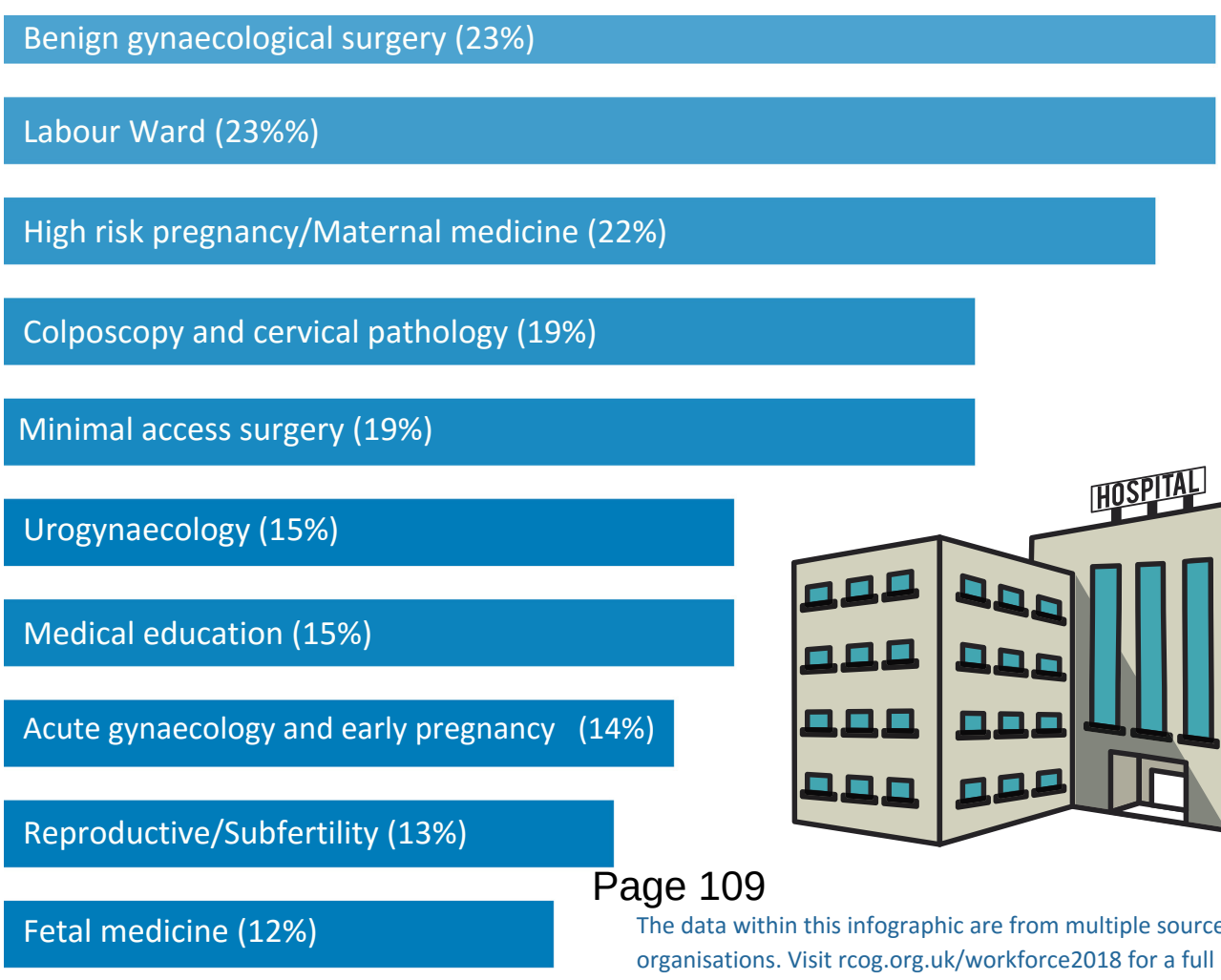
87%

of consultants have SAS/Trust doctors supporting their rotas

11

The median number of PAs in a consultant's job plan

Top 10 areas of special interest/sub-specialty:



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The O&G Workforce

Royal College of Obstetricians & Gynaecologists

Trainees

UK training in O&G requires a minimum of 7 years of specialty training (ST1–ST7). There are currently 1,800 doctors on the O&G specialty training programme.

100%

of trainees are aware of rota gaps at their level in their current unit

35-49%

of trainees have explored leaving medicine entirely

30%

Average attrition rate from the O&G training programme

52% of trainees have so far taken time out of their training

1/3 approximately of trainees are intending to work resident out of hours as a consultant

2/3 approximately of trainees wish to do both O&G with the remaining third evenly split between the two

29% Feel obliged to work more than their contracted hours

81% of trainees would recommend their training placement

81%

80% of trainees are female

Trainees report more undermining behaviour than any other specialty

Educational supervision is highly rated

Obstetrics training is more highly rated than gynaecology

LTFT are more satisfied with their training than full time

The data within this infographic are from multiple sources and organisations. Visit rcog.org.uk/workforce2018 for a full list of references.

The O&G Workforce

Royal College of Obstetricians & Gynaecologists

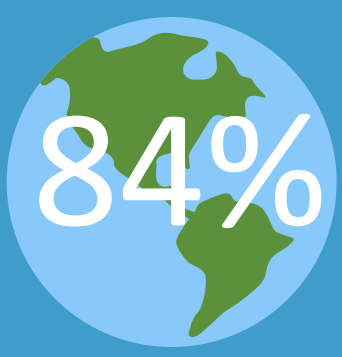
SAS/Trust Doctors

Specialty and associate specialist (SAS) doctors are permanent posts where the doctor has at least four years of postgraduate training, two of those being in a relevant specialty.

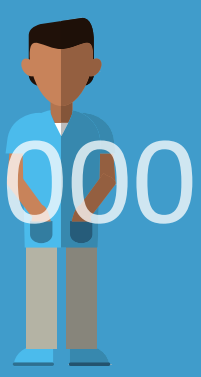
Trust doctors are employed directly by trusts and their contracts aren't subject to national terms and conditions. They can be employed at any level.

SAS and trust doctors work alongside trainees and consultants, working resident on-call rotas, running clinics and plugging rota gaps.

67% of SAS/Trust doctors are female



84% qualified outside of the UK



Estimated number of SAS/Trust doctors working in O&G

Most SAS/Trust doctors have been qualified for over 15 years

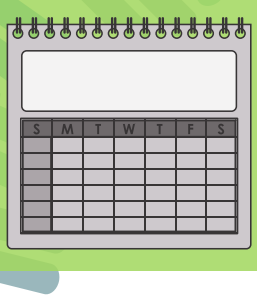
80%

of SAS/Trust doctors work in both obstetrics and gynaecology

75%

say they work at a 'middle grade' level

Virtually all SAS/Trust Doctors work is within the NHS



Majority of SAS/Trust Doctors work full time

12%

Leave the NHS in England each year

31%

Have explored the option of leaving medicine entirely

of SAS/Trust doctors do resident out of hours second on-call

Anticipate doing this for the rest of their careers

Nearly 25% of SAS/Trust doctors have CESR and nearly 50% are currently working towards CESR

The data within this infographic are from multiple sources and organisations. Visit rcog.org.uk/workforce2018 for a full list of references.

Activities to Address Workforce Challenges

Update on O&G Workforce Report 2017 Recommendations

Maintain and increase the flexibility of the O&G training programme

In the O&G Workforce Report 2017 we recommended a hybrid model of recruitment into the O&G training programme to replace the increasing number of doctors working less than full time (LTFT) or out of programme. This approach also recognises the significant attrition that occurs in the first two years of the programme.

Health Education England (HEE) recognised the need to address these challenges and agreed to implement recruitment at ST3 (previously recruitment was only possible at ST1) in England. This was introduced in 2018 with 219 individuals applying, of whom 87% were offered posts.

Increased support for SAS/Trust doctors[10]

Specialty and Associate Specialist (SAS) and Trust doctors provide an invaluable service to O&G departments, with many performing highly specialist roles such as running clinics and theatre lists, but with a narrower remit compared with consultants. However, the turnover of doctors in these posts is approximately 12%[11], resulting in the loss of valuable and much needed skills from the O&G workforce. Anecdotal evidence suggests that many leave the workforce due to a lack of career development, professional support and recognition of skills.

The Workforce Task Group has recognised the need to engage with and understand the needs of the SAS/Trust doctor workforce better. In January 2018 the College's workforce survey was also sent to SAS and Trust doctors in membership to gain a better understanding of their working patterns, areas of interest and career aspirations as well as the workplace challenges they face. This information is being used to inform our future working.

In addition the College has begun advocating for interventions to retain, reskill and upskill SAS doctors. In March 2018 the RCOG appointed a new SAS/ Trust doctor Lead, Dr Laura Hipple, who for the first time is a full voting member of Council.

The lead represents SAS and Trust doctors on a number of RCOG committees as well as at external groups, including the Academy of Medical Royal Colleges' SAS group and a new SAS development and

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retention group that has been set up by HEE. The Lead also chairs a new RCOG SAS/Trust Doctor Advisory Group, which was established to provide further advice on issues affecting these doctors.

Find out more about the SAS/Trust Doctor Advisory Group here: http://bit.ly/SASTrustGroup

Increased resident consultant working

The increasing pressure brought about by middle grade rota gaps is leading to more units introducing resident consultant working out of hours. This is successful in many units and for some consultants. However others, especially newly appointed consultants, are expressing frustration citing unpredictable work patterns, lost professional development opportunities and a lack of management support from consultant colleagues.

Each individual unit needs to decide the best way to provide safe care for women based on their knowledge of their work load and case mix, which in many cases will require some resident consultant working as one of the possible options.

RCOG's 2016 report Providing Quality Care for Women: The Obstetrics & Gynaecology Workforce contains standards for resident consultant role descriptions and job plans to ensure post holders can take advantage of professional development and leadership opportunities.

The RCOG has also produced job planning principles that encourage a transparent, departmental approach to job planning linked to the developmental objectives of the new appointee as well as to the wider department.

This includes a provision that time off before and after night shifts is clear in the job plan and do not impinge on clinical care, nor on professional development. You can read more about the principles of good job planning and download a template person specification for an O&G consultant here: http://bit.ly/jobplanning

Redeployment of retiring consultants

There is concern among job planners that, due to workplace pressures, consultants in the future may start to retire earlier than is currently the case. This would lead to the loss of much needed specialist skills and leadership support and have a detrimental impact on more junior colleagues.

To explore ways to retain these consultants and their skills in a way that is professionally satisfying and supports a positive work-life balance, the Workforce Task Group has established a working party to make recommendations on and take account of the needs of consultants considering retirement. This working party will report back on activities early in 2019.

If you'd like to contribute to this working party please contact us workforce@rcog.org.uk.

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Other activities and initiatives

Maternity workforce planning

The RCOG sits on HEE's Maternity Workforce Steering Group, Work Stream 5 of the Maternity Transformation Programme. HEE were tasked with delivering the vision set out in Better Births, this includes the provision of maternity services based on the future needs of women and babies and the workforce required to deliver them.

Through the Maternity Workforce Steering Group the RCOG has been advising on the composition of the O&G workforce and the services it provides, as well as the challenges and threats to the continuity of safe care. We have worked directly with workforce planners to ensure that their modelling is based on accurate workforce data including the number and types of roles that provide maternity services as well as their working patterns.

As a result of this work the Maternity Workforce Strategy - Transforming the Maternity Workforce, signed off as part of the Maternity Transformation Programme in June 2018, contains a more accurate reflection of O&G workforce numbers together with a set of recommendations to address the challenges it faces, now and in the future.

Only 12 to 18 months ago workforce planners were predicting a potential oversupply of O&G consultants and there was concern that training places could be reduced. As a result of our conversations, HEE is now estimating a potential undersupply and is working closely with the RCOG to mitigate this and other risks to the delivery of safe services. Recommendations and actions from the strategy include:

- Future Workforce Planning: Work with the RCOG to assess the workforce needed to deliver O&G services over the next 5 to 15 years, including an assessment of acuity
- Understanding attrition: The RCOG will sit on a Medical Workforce Steering Group to improve our understanding of the reasons people leave the profession
- Redesigning the consultant model for the future: Working with the RCOG and other bodies, develop a future consultant model which addresses growing subspecialisation and changing work expectations at different career stages. The RCOG will consult with its members to ensure that proposals are informed and fit for purpose
- Developing the role of SAS and Trust doctors: The RCOG will sit on a newly established SAS Doctors Development Group to coproduce a workforce strategy for SAS doctors; areas of focus will include education, professional development and career structure
- New role of obstetric physician: HEE will fund the development of an additional training pathway for obstetric physicians, with plans to pilot this for both established consultants and doctors in training in 2018/19

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Reducing attrition from the O&G training programme

In 2017 a member of the Workforce Task Group, Dr Heidi Stelling, conducted a survey and focus groups among O&G trainees to understand their reasons for considering leaving the training programme. The survey, completed by over 500 trainees, showed that factors behind attrition were:

- Poor work-life balance
- Rota gaps
- More out-of-hours working
- Less supervision
- Fewer training experiences

The survey findings are being shared with Heads of Schools and others involved in training to help shape and improve trainee experiences going forward. This is likely to involve an improved team structure, which could address some of their major concerns.

You can read more about the survey findings in our O&G magazine article 'Retaining Our Workforce' from Summer 2018 here: http://bit.ly/retainingworkforce.

Training Evaluation Form

The Training Evaluation Form (TEF) is an annual survey conducted by RCOG to gather feedback from trainees on their training experience enabling the College to monitor and improve the quality of training. The TEF survey results, including trust level data, are now available to view on the College website for the first time. Key findings from the 2018 survey include:

- 81% of trainees would recommend their training placement
- Obstetrics training is more highly rated than gynaecology
- There is wide deanery variation in some areas such as satisfaction with gynaecology training
- Satisfaction with regional teaching continues to improve
- LTFT trainees are more satisfied with their training than full time
- Reported rates of undermining behaviour are unchanged
- Educational supervision is highly rated with top performing units showing extremely positive feedback
- 29% of trainees felt obliged to work more than their contracted hours with wide deanery variation. Increasing obligation correlated with a reduction in satisfaction in the working environment and overall satisfaction with training

TEF awards have also been introduced and recognise the achievements of highly performing units in obstetrics, gynaecology, professional development and overall performance. Feedback from these units, along with recognised

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national quality standards for education and training, is being used to produce RCOG national quality criteria which will be published alongside the new curriculum. This will enable units to benchmark their provision against best practice.

The feedback from highly performing units has also been disseminated to schools and is available on the College website for others to view and apply, where relevant, in their own units.

Return to work support

Returning to the workplace after a period of absence (parental leave, out of programme experience, etc.) can be very daunting. Many doctors have expressed concerns that they may have lost clinical skills and not be up to date with developments and changes in practice. Funded by a grant from HEE, the RCOG has developed a Return to Work Toolkit to support O&G doctors returning to work after a period of absence.

The toolkit builds on successful courses already running at a regional level and provides information that can be easily accessed by those returning to work as well as those supporting these individuals.

The toolkit is relevant to trainees, consultants and SAS/Trust doctors and also contains guidance to enable regions to develop and run their own return to work courses.

The toolkit was put together by a senior trainee, Dr Sukhera Furness, who built on the work of other successful initiatives in this area. Utilising resources such as this toolkit the RCOG is encouraging all trusts to adopt a consistent approach to supporting doctors back into the workplace after a period of absence.

This is essential if we are to retain much needed and valued talent and mitigate further workforce attrition.

The toolkit is available here: http://bit.ly/ReturntoworkOG

Increased support for new consultants

Making the transition from trainee to consultant can be an overwhelming and often lonely experience. The RCOG has been working with a group of new consultants to develop resources and networks to ensure new consultants feel better supported, equipped and confident to carry out their roles.

This includes refreshing the annual Newly Appointed Consultants meeting, which has been renamed #NEXTSTAGE – Transitioning to Being a Consultant, to include more focus on the non-clinical aspects of consultant roles, including effective leadership, management and team working.

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Also in development is a New Consultants' Toolkit for those wishing to set up a local peer group network.

The toolkit will contain a template programme, suggested speakers and contacts as well as useful resources.

#NEXTSTAGE - Transitioning to Being a Consultant, takes place on Tuesday 22 January 2019. Find out more: http://bit.ly/NextstageOG

Find out more about our work with the new consultants in our O&G magazine article 'Supporting New Consultants' from Summer 2018 here: http://bit.ly/SupportConsultants

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Supporting our Doctors

Dr Alison Wright
Vice President, UK & Global Membership
Chair, Supporting our Doctors Task Group

As the professional body for the O&G profession, there is an important role for the College to play in better supporting doctors, and their employers, manage workplace challenges.

The RCOG's Supporting our Doctors Task Group was established in 2017 and aims to:

- Advocate for improved workplace cultures including a nationally recognised and consistent approach to resolving disputes
- Understand the workplace issues faced by doctors, including contributory factors, and seek to mitigate them
- Set a strategy and coordinated approach for supporting doctors (and their employers) with their training and work-place based conduct and practice challenges
- Collaborate with likeminded organisations that provide services to doctors in difficulty to raise awareness of and sign post to support resources available outside the RCOG
- Formalise links and establish respective roles with regulatory, indemnity and other relevant national bodies
- Develop and promote tools, resources and services to effectively manage work-place challenges, including a peer to peer support programme

Below is an update on the group's work and achievements to date.

Peer to Peer Support Service

There is now an enquiry form on the website for members who are experiencing difficulties in the work place and would like to speak to someone about the options available to them. A panel of members from the Supporting our Doctors Task Group, who have previous experience of supporting doctors, review the enquiries and provide one to one pastoral support. All enquiries are treated as strictly private and confidential.

Expert Opinion Service

The task group are piloting a service that provides doctors and their employers with an expert opinion on how best to manage a complaint or conduct issue and the options available to them. The aim is to facilitate the resolution of complaints at a local level, minimise the number of suspensions and referrals to GMC and ultimately keep more doctors in work, where appropriate.

Find out more about the support services available here: http://bit.ly/SupportServicesOG

Good complaint handling and local resolution

The Supporting our Doctors Task Group is advocating for a more consistent, open and progressive approach to complaints handling. The group has identified five core principles it believes should underpin a good complaint handling process:

- Inclusion: Exclusion should be a last resort having demonstrated that no other realistic and acceptable work can be offered, e.g. limiting an area of practice or teaching
- Peer support: Doctors should be encouraged to support and speak to colleagues experiencing difficulties
- Timeliness: Complaint handling and investigations must be completed in a timely manner
- Competency: Training for everyone handling and investigating complaints
- Equality: A nationally recognized and applied framework for complaint handling, to ensure parity and consistency across the profession

To support the 'Competency' principle the task group is aiming to run an event in 2019 on how best to handle complaints and resolve disputes locally. The event will be aimed at managers and anyone who could be potentially involved in complaints handling processes.

Burnout

As part of the RCOG's 2017/18 workforce survey we included questions to assess the impact that workforce challenges are having on doctors' wellbeing and ability to deliver safe services.

The intention is to secure evidence that supports our workforce advocacy and lobbying activities supporting the need to improve workplace conditions. The results are being analysed and will be published early in 2019.

Bullying and undermining

Undermining and bullying behaviour has long been recognised as a problem in O&G. Trainees report more undermining behaviour than any other medical specialty[12] and 64% of consultants say they have experienced or witnessed consultants being bullied[13] .

The RCOG has developed a network of Workplace Behaviour Champions to support trainees and SAS/Trust doctors respond to bullying and undermining behaviour, and our Peer to Peer Support Service (see above) is available to help consultants who experience similar issues.

The RCOG is also collaborating with other Colleges and healthcare bodies, as well as government organisations and charities, to understand and address the systemic issues having an adverse effect

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on workplace cultures and good team working. This also includes sourcing and promoting examples of good practice.

In September 2018 the RCOG jointly hosted a meeting with the Royal College of Surgeons of Edinburgh (RCSEd) to provide clinicians and managers with anti-bullying strategies. The day also included workshops to explore practical aspects of anti-bullying strategies in the workplace.

This is the second anti-bullying and undermining event run by the RCOG and RCSEd with the first one taking place in February 2018. The day was extremely well received and will be followed by a further event at the RCOG on 4 April 2019.

View the RCOG's Undermining and Bullying Toolkit and other resources: http://bit.ly/2HpoWMx

Get Involved

The RCOG is keen that all members and trainees have the opportunity to input into our workforce activities.

- Do you have examples of how you have successfully addressed rota gaps?
- Have you undertaken initiatives to improve trainees' experiences?
- What professional development opportunities do you provide to SAS and Trust doctors?
- What training and support is provided within your trust for managing disputes?
- How does your trust make resident consultant roles more satisfying?
- Do you provide retire and return opportunities?

If you have ideas or feedback, particularly if you have examples of approaches that are working well in your trust, then we want to hear from you. Please contact workforce@rcog.org.uk

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References

1) The National Maternal and Perinatal Audit 2017

2) NHS Electronic Staff Records and General Medical Council data

3) General Medical Council 2018

4) NHS Electronic Staff Records

5) RCOG O&G Workforce Survey 2018

6) GMC National Training Survey

7) Shabazz T, Parry-Smith W, Oates S, et al. Consultants as victimes of bullying and undermining: a survey of Royal College of Obstetricians and Gynaecologists consultant experiences. BMJ Open 2016

8) NHS Resoultion Annual Report and Accounts 2017/18

9) Maternity Workforce Strategy - Transforming the Maternity Workforce 2018. Health Education England

10) Specialty and Associate Specialist (SAS) doctors have at least four years of postgraduate training, with at least two of these in a relevant specialty. These doctors are not on a training scheme or in consultant positions but they are employed on a nationally agreed contract and have exactly the same appraisal and revalidation requirements as consultants. Trust Grade Doctors have a variety of titles and are employed on local contracts often on a short term basis. Some of these doctors will have stepped out of the O&G training programme for a period of time to pursue a special interest.

11) NHS Electronic Staff Records

12) GMC National Training Survey

13) Shabazz T, Parry-Smith W, Oates S, et al. Consultants as victimes of bullying and undermining: a survey of Royal College of Obstetricians and Gynaecologists consultant experiences. BMJ Open 2016

Infographic references

'Number of consultants, trainees and SAS/Trust Doctors' - NHS Digital, NI DoH, NHS Scotland, StatsWales, RCOG Training ePortfolio

'O&G Specialist Register' - GMC O&G Specialist Register

'Trainees report more undermining behaviour than any other specialty' - GMC National Training Survey

'90% of obstetric units report a gap in their middle rota' - NMPA 2018

'Consultants provide a mix of O&G services' - RCOG Consultant Workforce Survey 2017/18

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'Average 30% attrition rate from the training programme' - GMC/Health Education England

'80% of all trainees are female' - RCOG Training Evaluation Form 2018

'The O&G Workforce - Consultants' - RCOG Consultant Workforce Survey 2017/18

'The O&G Workforce - Trainees' - RCOG Trainees Workforce Survey 2017/18

'The O&G Workforce - SAS/Trust Doctors' - RCOG SAS/Trust Doctor Workforce Survey 2017/18

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South Warwickshire Clinical Commissioning Group

HORTON GENERAL HOSPITAL OBSTETRIC UNIT POSITION STATEMENT

December 2018

Introduction

1.1 This position statement has been prepared in response to a formal request to NHS South Warwickshire CCG (the 'CCG') on the 5th December 2018 by the Chair of the Horton Health Overview and Scrutiny Committee (HOSC).

1.2 The CCG would like to confirm that the CCG has been engaged in the process to date. The CCG has supported Oxfordshire CCG (OCCG) in compiling the required information on demographic growth and birth numbers.

1.3 The information provided by the CCG was used by OCCG in its Birth Analysis Report; this report was included in the papers submitted for the inaugural Horton HOSC meeting on the 28th September 2018.

Strategic Context

2.1 The CCG has recently undertaken engagement on Maternity and Paediatric Services with its neighbouring CCGs in Coventry and Warwickshire to identify the underpinning characteristics that our population would want to see in Maternity and Paediatric services. We have shared the key messages and our approach with OCCG and we will continue to share progress as we develop these further through public and stakeholder engagement that will take place in early 2019.

2.2 At this stage the characteristics are in draft and therefore they may be subject to change following further engagement. However, from previous experience, we anticipate that any changes will be on emphasis and not a significant change to the actual characteristics.

2.3 With the above caveats in mind, these are the characteristics that the CCG will be using to transform Maternity and Paediatric services with its partners in Coventry and Warwickshire:

DRAFT Key Characteristics created from the Maternity and Paediatric Engagement	
Prevention	The ability to improve Health and Wellbeing is predicated on services ensuring prevention is central to all delivery.
Environment	Care is delivered in an appropriate, safe, clean and supportive environment;, such as those in the acute, community, independent and voluntary sector.
Person centred	Care is delivered with compassion, empathy and

care	understanding of the individual's needs, wishes and history; individuals feel listened to and respected.
Access	People received timely access to services and they are given the information; advice and guidance needed to make informed choices about their care and are transitioned smoothly between services/professionals when necessary.
Empowered and supported workforce	Staff work in an environment that enables and encourages collaboration, across organisations, disciplines and boundaries; staff receive ongoing training and support to enable them to deliver the quality of care patients expect; the workforce is bolstered through recruitment and training to ensure they are able to deliver continuity of person-centred care.
Communication, advice and guidance	Communication to, with and from families should be consistent, accessible and family-friendly; information should be up-to-date, available in a variety of formats and languages; advice and guidance should be consistent between professionals and organisations
Integration of services (joined up / aligned)	Providers need to work together across all organisations, including the independent and voluntary sector, to reduce duplication, deliver a seamless service and address, as appropriate and professional boundaries at a strategic and an operational level.

2.4 In addition to the characteristics developed through engagement with the population and workforce the Coventry and Warwickshire Commissioners (CCGs and Local Authority) have identified characteristics that they want in Maternity and Paediatric Services:

- Deliverability;
- Timeliness and Predictability;
- Sustainability and affordability;
- Evidence based/aligned to national policies and standards

2.5 Whilst the implementation of the characteristics is focused on the Coventry and Warwickshire system the CCG will be seeking assurance from the appropriate lead commissioners (in this case OCCG) that the services delivered to its population outside of the Coventry and Warwickshire footprint are designed in a way that delivers these characteristics so as to ensure equity for its population.

Impact of Changes at the Horton General Hospital Obstetric Unit

3.1 The Horton HOSC asked the CCG three specific questions. The CCG has utilised the Birth Analysis Report in its response; for ease of reference this report has been appended to this Position Statement. The CCG has responded to each of these in turn.

1. ***How important an obstetric unit at the Horton General Hospital is for your organisation, residents and your local area?***

   As demonstrated in Table 2a, the vast majority (86%) of CCG births took place at SWFT in the pre-change period. In the same period, 2% of births took place at the Horton General Hospital. With 56 births during the 12 month pre-change period we therefore had c 1 birth per week at the Horton General Hospital.

   Therefore, in the context of our current birth rate of c.2,600, changes to the obstetric unit at the Horton General Hospital will not have a significant impact to our population overall.

   However, for the CCG population for whom this is the closest and preferred obstetric unit, the services are extremely important. We therefore want to ensure that the impact upon those people is understood and recognised as part of the OCCG process.

2. ***What has been the impact and experience for your organisation, residents and your local area of the closure of an obstetric unit at the Horton General Hospital?***

   There has been no impact to the CCG directly. In terms of the impact on our system, SWFT have been able to absorb the changes that resulted from the temporary closure. SWFT have made a separate submission that provides the appropriate assurance to Horton HOSC that they have, and will continue to, absorb activity that previously would have been managed at the Horton General Hospital.

   In terms of our population who are most likely to be impacted by a permanent closure, we are working with OCCG to make sure they are appropriately engaged in the next phase of engagement that is planned so that we understand the impact on their experience.

   The CCG has not received any complaints or negative feedback about the temporary closure from any of its population.

3. ***What do you think would be the impact of a permanent closure?***

   At this stage, based on the information available, we do not believe that a permanent closure would have any further impact than that already observed during the temporary closure.

End of Report

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Births Analysis Report

Birth information for Oxfordshire, South Warwickshire, Nene and Corby CCGs for the periods 1 October 2015 to 31 March 208 (30 June 2018 for Nene and Corby) has been analysed. This is considered in three periods relative to the temporary closure of the obstetrics unit at the Horton General Hospital:

- Pre change period: 1/10/2015 through to 30/09/2016
- Post change Period 1: 1/10/2016 through to 30/09/2017
- Post change Period 2: 1/10/2017 through to 31/03/2018 (30 June 2018 for Nene and Corby CCGs. This was then extrapolated to give a full year forecast outturn.

The following information is presented in the tables in the spreadsheet:

- Tables 1-4: Total births (numbers and percentage distribution) by location for Oxfordshire, South Warwickshire, Nene and Corby CCGs.
- Tables 5-8: Births (numbers and percentage distribution) by location for the practices in Oxfordshire, South Warwickshire, Nene and Corby CCGs who had women giving birth at the Horton Hospital pre the temporary closure of the obstetric unit.

Overview of practices whose patients accessed obstetric services at the Horton General Hospital

- 49 practices from Oxfordshire CCG had some women giving birth at Horton prior to the temporary closure of the obstetric unit. 14 of these practices had a minimum of 10 births at the Horton and accounted for 80% of this activity and these were:
    - 12 practices in Cherwell District Council Area:
        - Banbury – Windrush Surgery, West Bar Surgery, Woodlands Surgery, Horsefair, Hightown
        - Bicester – Montgomery House Surgery, Bicester Health Centre, Alchester Medical Group
        - Village Practices – Deddington Health Centre, Wychwood Surgery, Cropredy, Bloxham
    - 2 practices in West Oxfordshire District Council Area
        - Chipping Norton Health Centre and The Charlbury Medical Centre
- The 6 practices (listed below) from South Warwickshire CCG used the Horton General Hospital. Of these the majority of births (86%) came from Shipston Medical Centre and Fenny Compton Surgery
    - Avonside Health Centre
    - Fenny Compton Surgery
    - Hastings House Medical Centre
    - Kineton Surgery
    - Rother House Medical Centre
    - Shipston Medical Centre
- For Nene and Corby CCGs births at the Horton General Hospital came from the 9 practices listed below. The majority (78%) of these came from

Springfield Surgery, Brackley Medical Centre and Abbey House Medical Practice.

- Danetre Medical Practice
- Springfield Surgery
- Greens Norton and Weedon Medical Practice
- Towcester Medical Centre
- The Brook Health Centre
- Brackley Medical Centre
- Brackley Health Cetnre
- Byfield Medical Centre
- Abbey House Medical Practice.

Key Messages

- Total numbers of births for Oxfordshire residents have decreased; for South Warwickshire have increased and have held steady for Nene and Corby.
- In the year before the temporary closure of the obstetric unit 15% of the births for Oxfordshire residents, 2% of the births for South Warwickshire residents and 3% of the births for Nene and Corby residents occurred at the Horton General Hospital.
- During the temporary closure of the obstetric unit 2% of the births for Oxfordshire residents, occurred at the Horton General Hospital
- For Oxfordshire residents the births moved to the John Radcliffe Hospital and Warwick Hospital.
- For South Warwickshire patients the shift was to Warwick Hospital.
- For Nene and Corby patients the shift was evenly split between Northampton and the John Radcliffe Hospital.

Combined births data for Oxfordshire, South Warwickshire and Nene and Corby (Northamptonshire) CCGs

Table 1a Oxfordshire - numbers

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Home Births OUH (2)	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	1,029	5,333	1	0	2	619	23	7,007
Post Change Period 1	Oct-16 to Sep-17	140	5,885	2	0	99	552	25	6,703
Post Change Period 2	Oct-17 to Mar-18 (1)	138	5,876	2	0	84	504	30	6,634

Table 1b Oxfordshire - percentage distribution by site

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Home Births OUH (2)	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	15%	76%	0%	0%	0%	9%	0%	100%
Post Change Period 1	Oct-16 to Sep-17	2%	88%	0%	0%	1%	8%	0%	100%
Post Change Period 2	Oct-17 to Mar-18 (1)	2%	89%	0%	0%	1%	8%	0%	100%

Table 2a South Warwickshire - numbers

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Home Births OUH (2)	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	56	12	0	0	2,041	278	0	2,387
Post Change Period 1	Oct-16 to Sep-17	1	13	0	0	2,257	276	0	2,547
Post Change Period 2	Oct-17 to Mar-18 (1)	0	16	0	0	2,300	296	0	2,612

Table 2b South Warwickshire - percentage distribution by site

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Home Births OUH (2)	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	2%	1%	0%	0%	86%	12%	0%	100%
Post Change Period 1	Oct-16 to Sep-17	0%	1%	0%	0%	89%	11%	0%	100%
Post Change Period 2	Oct-17 to Mar-18 (1)	0%	1%	0%	0%	88%	11%	0%	100%

Table 3a Nene and Corby - numbers

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Home Births OUH (2)	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	212	85	4,407	3,243	0	257	0	8,204
Post Change Period 1	Oct-16 to Sep-17	35	221	4,452	3,232	0	254	0	8,194
Post Change Period 2	Oct-17 to Mar-18 (1)	21	223	4,583	2,991	0	300	0	8,118

Table 3b Nene and Corby - percentage distribution by site

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Home Births OUH (2)	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	3%	1%	54%	40%	0%	3%	0%	100%
Post Change Period 1	Oct-16 to Sep-17	0%	3%	54%	39%	0%	3%	0%	100%
Post Change Period 2	Oct-17 to Mar-18 (1)	0%	3%	56%	37%	0%	4%	0%	100%

Table 4a TOTAL - numbers

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Home Births OUH (2)	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	1,297	5,430	4,408	3,243		1,154	23	15,555
Post Change Period 1	Oct-16 to Sep-17	176	6,119	4,454	3,232		1,082	25	15,088
Post Change Period 2	Oct-17 to Mar-18 (1)	159	6,115	4,585	2,991		1,100	30	14,980

Table 4a TOTAL - percentage distribution by site

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Home Births OUH (2)	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	8%	35%	28%	21%	0%	7%	0%	100%
Post Change Period 1	Oct-16 to Sep-17	1%	41%	30%	21%	0%	7%	0%	100%
Post Change Period 2	Oct-17 to Mar-18 (1)	1%	41%	31%	20%	0%	7%	0%	100%

(1) Activities are Projected to Full Year for Comparison (for OCCG and South Warwickshire this is based on FOT from 6 months data, for Nene/Corby CCGs this is based on FOT from 9 months data)

(2) Activities do not include Home Births where there was no contact with an Acute Provider

(3) Birth activity is identified by HRG codes. This is the best proxy measure but please be mindful some of the underlying information may not reflect it is fully related to Births

Births data for Oxfordshire, South Warwickshire and Nene and Corby (Northamptonshire) CCGs for practices that used Horton obstetric unit

Table 5a Oxfordshire - numbers

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	1,029	4,041	0	0	2	342	5,414
Post Change Period 1	Oct-16 to Sep-17	140	4,689	2	0	99	300	5,230
Post Change Period 2	Oct-17 to Mar-18 (1)	138	4,708	1	0	84	309	5,240

Table 5b Oxfordshire - percentage distribution by site

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	19%	75%	0%	0%	0%	6%	100%
Post Change Period 1	Oct-16 to Sep-17	3%	90%	0%	0%	2%	6%	100%
Post Change Period 2	Oct-17 to Mar-18 (1)	3%	90%	0%	0%	2%	6%	100%

Table 6a South Warwickshire - numbers

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	56	11	0	0	339		406
Post Change Period 1	Oct-16 to Sep-17	1	10	0	0	442		453
Post Change Period 2	Oct-17 to Mar-18 (1)	0	8	0	0	460		468

Table 6b South Warwickshire - percentage distribution by site

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	14%	3%	0%	0%	83%	0%	100%
Post Change Period 1	Oct-16 to Sep-17	0%	2%	0%	0%	98%	0%	100%
Post Change Period 2	Oct-17 to Mar-18 (1)	0%	2%	0%	0%	98%	0%	100%

Table 7a Nene and Corby - numbers

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	211	16	531	2	0	48	808
Post Change Period 1	Oct-16 to Sep-17	35	206	551	1	0	77	870
Post Change Period 2	Oct-17 to Mar-18 (1)	21	207	569	0	0	63	860

Table 7b Nene and Corby - percentage distribution by site

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	26%	2%	66%	0%	0%	6%	100%
Post Change Period 1	Oct-16 to Sep-17	4%	24%	63%	0%	0%	9%	100%
Post Change Period 2	Oct-17 to Mar-18 (1)	2%	24%	66%	0%	0%	7%	100%

Table 8a TOTAL - numbers

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	1,296	4,068	531	2		390	6,287
Post Change Period 1	Oct-16 to Sep-17	176	4,905	553	1		377	6,012
Post Change Period 2	Oct-17 to Mar-18 (1)	159	4,923	570	0		372	6,024

Table 8a TOTAL - percentage distribution by site

Period Name	Period	Horton General	John Radcliffe	Northampton	Kettering	Warwick	Other hospitals	Total Births (3)
Pre Change Period	Oct-15 to Sep-16	21%	65%	8%	0%	0%	6%	100%
Post Change Period 1	Oct-16 to Sep-17	3%	82%	9%	0%	0%	6%	100%
Post Change Period 2	Oct-17 to Mar-18 (1)	3%	82%	9%	0%	0%	6%	100%

(1) Activities are Projected to Full Year for Comparison (for OCCG and South Warwickshire this is based on FOT from 6 months data, for Nene/Corby CCGs this is based on FOT from 9 months data)

(2) Activities do not include Home Births where there was no contact with an Acute Provider

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Responses from Primary Care

Chairman, Oxfordshire Local Medical Committee

The following is a personal view which has not discussed with others in the LMC:

"Overall Oxfordshire has workforce shortages and inadequate resources (like the NHS in general) that cannot deliver the perfect gold standard local NHS Medical staffing is the key issue and despite the apparent belief (that OUH have not tried hard enough) amongst those against the maternity changes, I do believe that there are not enough staff of sufficient quality out there.

At a past HOSC, the medical lead for OUH was convincing in her evidence based belief that incurring travel time was a safer option than diluting maternity services in both Oxford and Banbury. I support this view which is in keeping with the joint OUH/ICCG position of looking at Oxon maternity services in general."

View of GP in Banbury, supplied by LMC:

"So far the GPs at my practice haven't noticed much negative feedback from patients about the change to maternity at the Horton, even against the background of OUH planned care being as bad as it is (as is much of the rest of the country). There has been the occasional horror story in the Banbury Guardian, but even those have been few and far between, which is saying something (the BG has been unremittingly hostile to the maternity change). I've even seen a primip planning to deliver there, which is somewhat new."

To answer the questions:

1. What has been the impact and experience for your services of the closure of an obstetric unit at the Horton General Hospital?

   Response: *Pretty minimal, really.*

2. Information on the experience of the patients and GPs involved in maternity care since the closure of the obstetric unit at the Horton General Hospital?

   Response: *Pretty minimal, really.*

3. The draft long-list options (dated 29th Nov 2018) for an obstetric unit at the Horton General Hospital?

   Response: *The draft list was too long and included options that should never have been publicly discussed, such as GPs doing C sections.*

4. Any examples you are aware of innovative practice from a GP perspective which allows small obstetric units to be run and staffed, safely and sustainably.

Response: *No. To be honest, the less maternity work GPs do, the happier I'll be. It's yet another set of clinical risks for which GPs are increasingly less prepared and trained.*

5. Summary of the clinical standards for GP's which would be most important in assessing the safety of an obstetric service? What weight should these standards be given when assessing options for provision of services in future?

   Response: *Clinical outcomes, including accessibility to regular maternity appointments, evidence of clearly planned and followed pathways for development of complications in pregnancy and delivery, robust assessment and learning from significant events, and good after care including breastfeeding support.*

6. What do you think would be the impact of a permanent closure?

   Response: *Assuming you mean permanent closure of consultant care and continuation as a midwife led unit, relatively little impact. Closure of the MLU would be catastrophic.*

GP Practice Manager (Warwickshire):

The only issue for us has been a reduction in choice for local women about where they have their baby.

British Medical Association, Industrial Relations Officer:

Nothing to add.

General Responses Received

Cllr Surinder Desi:

Cllr Rose Stratford and Cllr Surinder Dhesi did a dummy test run from Horton Hospital to John Radcliffe Hospital at 2:30 and it took about 30 minutes in a flashing ambulance car. Traffic congestion has increased and when you get to the John Radcliffe Hospital you can never find parking place and then you are panicking because you have not got any change. The John Radcliffe Hospital could not cope with the increased activity with births they had to send some babies to the Horton and to other Hospitals. Banbury and Bicester have grown considerable since the last census in population and we need a obstetric led service locally.

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