Information Pack

to support the Scoring Panel in the option appraisal of obstetric models

This pack contains a mixture of draft information and other information already published.

All information will be published in advance of the Stakeholder meeting on 14 June.

Contents list

Section 1

Section 1:

Introduction

Thank you for partaking in this Oxfordshire Clinical Commissioning Group scoring panel. The scoring panel forms an important part of the option appraisal process for the future of maternity services at the Horton General Hospital.

This pack contains a paper copy of the information needed to score the options.

A blank scoring sheet is included in the pack and an additional copy has been included on a large sheet to make it easier for you to record your notes and scores against each criteria for each option. It is important that you complete the score sheet and return one copy to us no later than **5pm on Monday 27 May 2019**. If at all possible, please complete and send the version sent by email. If this is not possible, you can post it to us (see address details below).

Please use the guidance below to complete your scoring sheet.

Scoring the options

Please refer to Section 2 for the scoring guide, for detailed information on:

- Definitions of each score value from 0-4
- Which criteria we request to be scored as a minimum requirement
- Examples of what each score value might look like for each of the 11 options

The scoring sheet table in Section 3 lists the 11 options across the top row. The 13 criteria you should use to score each option are listed vertically down the left hand side.

Using the scoring guide, and the information provided to you in the remaining sections, please assign a value between 0-4 for each option in the table.

Some of the boxes on the scoring sheet are coloured grey. You do not need to provide a score in these boxes. This is because the criteria in the boxes relating to these options is a duplicate of criteria you will score for other options on this sheet.

More detail relating to this, and how all options will be appraised in the same way, will be explained, discussed and agreed on the day of the scoring panel.

If you have any thoughts or comments relating to this, or any other element of the scoring process, please make a note of these and bring these notes on the day of the scoring panel for open discussion with all members of the panel and its independent chair.

Please remember to fill in your name on the sheet in the space provided.

Please save and return this document to us no later than 5pm on Monday 27 May May 2019, by:

- Email: Attached in Excel format to ally.green@nhs.net
- Post: Ally Green, Oxfordshire Clinical Commissioning Group, Jubilee House, 5510 John Smith Drive, Oxford Business Park, Cowley, Oxford, OX4 2LH

Please note that if you are returning your scoring sheet in the post, it needs to be sent in time to arrive by the deadline of 5pm on Monday 27 May 2019.

If you choose to send a handwritten copy of your score sheet in the post, you might like to keep a copy so you can refresh your memory and use it to refer to on the day the panel meets.

Scoring panel day

On the day of the scoring panel, each panel members' individual scores will be discussed and a consensus agreed upon for each score.

The scoring panel day is being held on **Monday 3 June 2019** at:

Banbury Town Hall, Bridge Street, Banbury, OX16 5QB

The day will be highly productive and in order to ensure we have enough time to complete the group scoring exercise for each option, we request that you hold **9:00am – 5:00pm** in your diaries. If we complete the exercise before 5:00pm, we will of course finish early.

Refreshments and lunch will be provided.

We have already been in touch to ascertain your availability to join this panel and are very grateful for your time.

If you have any questions regarding the scoring process, please contact Ally Green on:

Email: ally.green@nhs.net

Phone: 07973 743606

Section 2

Oxfordshire
Clinical Commissioning Group

Section 2

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

Work Stream 6 Option Appraisal Process

Scoring guide

Oxfordshire Clinical Commissioning Group (OCCG) uses a five point scale and the generic descriptions are:

Assessment	Interpretation	Score
Deficient	Unanswered or unacceptable response.	0
Limited	A limited answer that does not meet the stated requirement in one or more areas, or one that provides little detail or evidence.	1
Acceptable	A satisfactory answer meeting the stated requirement with a sufficient level of detail and evidence.	2
Good	A good answer, either exceeding the stated requirement, or providing a more detailed answer, with strong evidence.	3
Excellent	An excellent answer, either exceeding the stated requirement, or exceptionally detailed and/or innovative, with particularly strong evidence.	4

All panel members are welcome to individually score all criteria but at a minimum please could individuals ensure they cover the following. At the panel scoring day all panel members will participate in discussion and agreement of scores for all criteria.

	OCCG representatives	OUH representatives	Stakeholder representatives
1. Quality: clinical outcomes	✔	✔	✔
2. Quality: clinical effectiveness and safety	✔	✔	✔
3. Quality: patient and carer experience	✔	✔	✔
4. Access: distance and time	✔	✔	✔
5. Access: service operating hours	✔	✔	
6. Access: patient choice	✔	✔	✔
7. Finance: within current envelope	✔	✔	
8. Workforce: rota sustainability	✔	✔	
9. Workforce: consultant hours on the labour ward	✔	✔	
10. Workforce: recruitment and retention	✔	✔	
11. Workforce: supporting early risk assessment	✔	✔	
12. Deliverability: ease of delivery	✔	✔	
13. Deliverability: alignment with other strategies	✔	✔	

The table below has been produced to support the individuals who are participating in the scoring panel and indicates the sorts of things you may wish to consider to help you score the individual criteria for each of the options. The suggestions focus on the areas where there may be differences (such as in workforce the main factor is sufficient obstetric staffing). If there are other factors you wish to take into account please do so but keep a note of this and your rationale for scoring as this is what we will discuss (with a focus on areas that panel members have scored differently) on the day of the scoring panel so that we can reach a consensus.

Acronyms for table on next page:

DH	Department of Health
NICE	National Institute for Health and Care Excellence
FMLU	Freestanding Midwife Led Unit
AMLU	Alongside Midwife Led Unit
OCCG	Oxfordshire Clinical Commissioning Group
OUH	Oxford University Hospitals
HGH	Horton General Hospital
JR	John Radcliffe Hospital
WTE	Whole Time Equivalent (2 people working half of a week each would be 1WTE)
DMBC	Decision Making Business Case

	Score 0	Score 1	Score 2	Score 3	Score 4
1. Quality: clinical outcomes	Progress in reducing poor maternal outcomes is stalled or worsens. Worsens inequalities in outcomes.		Maintains current levels of improvement to deliver DH mandate to reduce poor maternal and neonatal outcomes by 20% by 2020 and 50% by 2030. Supports reduction in inequalities in outcomes.	Improves rate of improvement on delivery of DH mandate Accelerates reduction in inequalities in outcomes	
2. Quality: clinical effectiveness and safety	The service is vulnerable and fails to meet minimum service standards at all time		All minimum service standards are met consistently (NICE, risk assessments)	Service exceeds/performs better than England average against service standards	
3. Quality: patient and carer experience	The service model does not support personalised care, centred on the woman her baby and family based around their needs		The service supports personalised care, centred on the woman her baby and family based around their needs – use key themes from survey report	The service provides exceptional personalised care - use key themes from survey report	
4. Access: distance and time	Majority of services are centralised Median travel time and distance to place of birth for transfer (from MLU to Obstetric unit) are greater than the parameters of the Birthplace study (median travel time 60 minutes; maximum distance 40km) Increases inequalities in access to services for lower socio-economic groups		Ante and post-natal services are provided locally Median travel time and distance to place of birth for transfer (from MLU to Obstetric unit) are greater than the parameters of the Birthplace study (median travel time 60 minutes; maximum distance 40km)	Some specialised services are provided at community hubs Median travel time and distance to place of birth for transfer (from MLU to Obstetric unit) are better than the parameters of the Birthplace study (median travel time 60 minutes; maximum distance 40km). Reduces inequalities in access to services for lower socio-economic groups	
5. Access: service operating hours	Service regularly needs to redeploy staff so that one or more choices of places to give birth are affected frequently (once a week/month?)		Service supports seven day working across all sites and only occasionally needs to move staff and reduces choices of place to give birth	Service rarely or never needs to redeploy staff so all choices of places to give birth are almost always/always available	
6. Access: patient choice	One or more of service options for place of birth are missing		Full range of service options for place of birth (home, FMLU, AMLU, obstetric service) are available in at least one location in the county	There is more than one location available within the county for some/all of the service options for place of birth	
7. Finance: within current envelope	Obstetric staffing costs are more than current budget		Obstetric staffing can be provided within current budget	Obstetric staffing required costs less than current budget	
8. Workforce: rota sustainability	Significant gaps in rota cannot be filled by locums leading to regular difficulties in staffing and closures of units.		Occasional gaps in rota that are easily covered by locums so all service maintained	Rota internally sustainable with minimal need for short term locum cover	
9. Workforce: consultant hours on the labour ward	Consultant hours on labour ward reduced from baseline		Staffing enables baseline consultant hours on labour ward of HGH – 40 hours per week and JR – 114 hours per week	Ability to increase Consultant hours on labour ward	
10. Workforce: recruitment and retention	Inability to recruit or high turnover means that need to be advertising and recruiting obstetricians on a continual basis		Majority of obstetric posts can be recruited to with high likelihood of retention	No problems recruiting or retaining obstetric staff of required grades	
11. Workforce: supporting early risk assessment	Risk assessment not consistently and effectively delivered		Risk assessment as now	Funding released to recruit additional 3.85 WTE midwives (as per DMBC) to support ante natal care	
12. Deliverability: ease of delivery	Factors affecting delivery (eg recruitment, capital investment, finance) are mostly not within the control of the local health service		Factors affecting delivery (eg recruitment, capital investment, finance) are mostly within the control of the local health service	Factors affecting delivery (eg recruitment, capital investment, finance) are all within the control of the local health service	
13. Deliverability: alignment with other strategies	Is counter to national (Better Births, Long Term Plan) and local strategies and reduces flexibility		Aligns to national and local strategies	Expedites delivery of major elements of national and local strategies and provides a flexible platform for the future	

Options for obstetric provision – Final long list at 29.11.2018

Types of options

The long list of options focuses on staffing models to try and identify a sustainable staffing model. The options listed are based on different staffing models at the HGH, which would impact on the staff rotas at the John Radcliffe Hospital (JRH) to a greater or lesser extent depending on the model. The list of options assumes that obstetric provision at the JRH is always provided by consultants and doctors in training.

All the options listed would ensure safe cover during the out of hours period (evening, overnight and weekends) by including as a minimum, a Consultant on-call and a suitably qualified doctor on site. This is a requirement of all obstetric units.

Types of doctors

For the purposes of these options 'doctors in training' are those learning to become an obstetrician but who are not yet approved onto the Speciality Register (which is required to practise as a Consultant in the NHS). Doctors in training work alongside qualified doctors under their supervision.

Middle grade doctors are those who have attained the required competencies to undertake out-of-hours work within labour ward and emergency gynaecology settings but who still require support from consultants. There is a shortage of middle grade doctors and difficulties in recruiting to vacant posts at the HGH led to the temporary closure of the obstetric unit. These doctors are not in training.

Consultants are doctors who have trained to the highest level. The support and advice of a consultant must be available at all times.

The HGH is not approved for training obstetric doctors (this is a decision made by the Deanery in 2012). For this reason, all long list options assume that there are no doctors in training at the HGH. It also assumes that in line with current practice, Consultants at the HGH are both obstetrics and gynaecology but Consultants at the JRH are only obstetricians.

Further information on the training required to become a Consultant Obstetrician can be found here.

Alongside Midwifery Unit

Almost all Obstetric units nationally now have an alongside midwifery unit (AMU). The purpose of these units is to offer women the choice of giving birth in a dedicated midwifery unit, with dedicated maternity staffing but with the option to easily access obstetric care if required (e.g for epidural). For options Ob1-Ob8 in the table below it is assumed that there will continue to be a single AMU in Oxfordshire.

VERSION CONTROL

Date	Details	Version	Contributor
26/09/2018	Version presented to Horton Joint OSC	1.0	CM
26/11/2018	Revision to address Horton Joint OSC input	1.1	Project Group
29/11/2018	Final version amended to address Horton Joint OSC comments. All identified options have been included with additional columns added to indicate whether on short list and if not why.	2.0	CM

Option number	Option Title	Description	Shortlist Y or N	Comments
Ob1	**2 obstetric units – (2016 model)**	This means a separate obstetric service at JRH and HGH with separate staffing arrangements including separate doctor rotas at both sites. The service at the HGH will be delivered by middle grade doctors and consultants and the service at the JRH will be delivered by doctors in training and consultants.	Y	
Ob2a	**2 obstetrics units – fixed consultant**	This means a separate obstetric service at JRH and HGH with separate staffing arrangements including separate doctor rotas at both sites. The service at HGH will be consultant delivered (no middle grade doctors) and the service at the JRH will be provided by doctors in training and consultants.	Y	
Ob2b	**2 obstetrics units – rotating consultant**	This means a separate obstetric service at JRH and HGH but with one consultant rota covering both units (i.e. consultants would work at both sites) and doctors in training will only be at the JRH. The service at the HGH will be consultant delivered with no middle grade doctors.	Y	
Ob2c	**2 obstetrics units – fixed combined consultant and middle grade**	This means a separate obstetric service at JRH and HGH with separate staffing arrangements and separate rotas but using consultants and middle grades at both sites (i.e doctors only work at one site). At the JRH this will be doctors in training, middle grades and consultants. At the HGH this will be consultants and middle grades on a single rota that requires 24/7 resident medical cover with a consultant on-call.	Y	
Ob2d	**2 obstetrics units – rotating combined consultant and middle grade**	This means a separate obstetric service at JRH and HGH but with one doctor rota with both consultant and middle grade doctors covering both units and doctors in training at the JRH only (i.e. this means doctors would work at both sites).	Y	
Ob3	**2 obstetrics units – external host for HGH**	This means there would be a unit at JRH and HGH but the unit at HGH would be managed by a different NHS Trust from outside Oxfordshire.	Y	
Ob4	**50 / 50 split of non-tertiary births**	This option increases the number of births at the HGH by making sure that all non-complex births for Oxfordshire women are split equally between the JRH and HGH.	N	This option was predicated on increasing activity, however regardless of activity a viable work force model is required. Work stream 4 on activity and population growth incorporates a sensitivity analysis which will identify what sort of shifts need to take place to increase the proportion of births that occur at the HGH. Increasing activity is a factor that needs to be considered for all options.
Ob5	**2 obstetrics units – elective (planned)**	This option increases the number of births at the HGH and means there would be a unit at JRH and a unit at HGH. All planned caesarean sections for Oxfordshire women would take place at the HGH.	Y	This option is reliant on one of the staffing models from the other options
Ob6	**Single obstetric service at JRH**	This means one unit based at the JRH. This means there would be an MLU at the HGH. The staffing at the obstetric unit would be provided by consultants and doctors in training. Other clinical services to support complex (tertiary) obstetrics and level 3 neonatal services will also be provided at JRH.	Y	

Ob7	**Single obstetric service at HGH**	This means one unit based at the HGH. It means there would be an MLU at the JRH. The staffing at the obstetric unit would be provided by consultants and middle grades. Other clinical services to support complex (tertiary) obstetrics and level 3 neonatal services would also be required at the HGH. This would mean no training doctors for obstetrics in Oxfordshire. The Deanery would be approached to review accreditation for HGH.	N	This is discarded as the provision of a specialist services for the wider geography served needs to be co-located with other services (such as neonatal intensive care, paediatric surgery), have strong and close links with the University of Oxford research departments and be centrally located with respect to the geography served. This requires that these services need to be maintained in Oxford.
Ob8	**Rural and remote services option**	This means there would be obstetric units at the JRH and HGH and the staffing model at the HGH would be specialist GPs (local GPs given extra training to be able to perform caesarean sections) with access to on-call support from the JRH.	N	The catchment population served by the Horton General Hospital would not be defined as remote and therefore this would not be a preferred model.
Ob9	**2 obstetric units both with alongside MLU**	This means a separate obstetric service at JRH and HGH (both with an alongside MLU) with separate staffing arrangements including separate doctor rotas at both sites. The service at the HGH will be delivered by middle grade doctors and consultants and the service at the JRH will be delivered by doctors in training and consultants.	Y	
Ob10	**2 obstetric units – doctors in training at JR spend 8 hours a week at Horton**	This means there would be obstetric units at the JRH and HGH. The staffing at the obstetrics unit at the HGH would be provided by consultants with support from JR based doctors in training.	Y	
Ob11	**2 obstetric units; HGH unit has regained accreditation for doctors in training**		?	This option is subject to reviewing what it would take to regain accreditation at the HGH.

Section 3

	A
1	**Section 3: NHS Oxfordshire Clinical Commissioning Group scoring panel: draft scoring sheet**
2	
3	**Introduction**
4	
5	This document lists the **12** options for the future of obstetric-led maternity services at the Horton General Hospital and the 13 criteria against which you are being asked to score these options.
6	Your input will help us understand how each of the options meets the criteria, by scoring each option with a number between 0-4, with zero being low and four being high.
7	
8	Oxfordshire Clinical Commissioning Group (OCCG) uses a five point scale and the generic descriptions are:
9	**0** - Deficient: Unanswered or unacceptable response
10	**1** - Limited: A limited answer that does not meet the stated requirement in one or more areas, or one that provides little detail or evidence.
11	**2** - Acceptable: A satisfactory answer meeting the stated requirement with a sufficient level of detail and evidence.
12	**3** - Good: A good answer, either exceeding the stated requirement, or providing a more detailed answer, with strong evidence.
13	**4** - Excellent: An excellent answer, either exceeding the stated requirement, or exceptionally detailed and/or innovative, with particularly strong evidence.
14	
15	**Scoring the options**
16	Please assign a value of between 0-4 for each of the options listed below. If you need any further help, please ask one of our facilitators.
17	Please refer to Section 2 in your information pack for details of each option and for guidance on what each scoring value between 0-4 represents.
18	Some of the boxes on the scoring sheet are coloured grey. You do not need to provide a score in these boxes. This is because the criteria in the boxes relating to these options is a duplicate of criteria you will score for other options on this sheet.
19	

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
20	**Panel member name:**														
21	**Criteria**	**Options**													
22		Ob1: 2 obstetric units – (2016 model)	Ob2a (i): 2 obstetrics units – fixed consultant	Ob2a(ii): 2 obstetric units - tier 1 support	Ob2b: 2 obstetrics units – rotating consultant	Ob2c: 2 obstetrics units – fixed combined consultant and middle grade	Ob2d: 2 obstetrics units – rotating combined consultant and middle grade	Ob3: 2 obstetrics units – external host for HGH	Ob5: 2 obstetrics units – elective (planned)	Ob6: Single obstetric service at JRH	Ob9: 2 obstetric units both with alongside MLU	Ob10: 2 obstetric units – doctors in training at JR spend 8 hours a week at Horton	Ob11: 2 obstetric units; HGH unit has regained accreditation for doctors in training		
23	1. Clinical outcomes														
24	2. Clinical effectiveness and safety														
25	3. Patient and carer experience														
26	4. Distance and time to access service														
27	5. Service operating hours														
28	6. Patient choice														
29	7. Delivery within the current financial envelope														
30	8. Rota sustainability														
31	9. Consultant hours on the labour ward														
32	10. Recruitment and retention														
33	11. Supporting early risk assessment														
34	12. Ease of delivery														
35	13. Alignment with other strategies														
36	**Score**														

Section 4

Oxfordshire CCG

Maternity services: Voice of the service user
SUMMARY

18 / 742

V2

8 May 2019

NHS
Oxfordshire
Clinical Commissioning Group

Prepared for

Oxfordshire CCG

Prepared by

Pragma Consulting

Disclaimer

This report was commissioned by Oxfordshire CCG to gather feedback on maternity services

Any observations, analyses, comments, conclusions and recommendations are those of the authors, and are made in good faith based on information reported to us and the information we had access to. We cannot, however, give any warranties or guarantees as to the accuracy or appropriateness of the content thereof, and the information in this report.

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Contents

Summary (1 / 4)

Summary

Project background

- Pragma has completed a programme of research to capture feedback from users of maternity services in Oxfordshire and neighbouring south Northamptonshire and south Warwickshire
- We conducted an online survey as well as qualitative research (focus groups and in-depth interviews) to understand service user experiences of maternity services at each stage of the journey through pregnancy, labour and postnatal care

Decision making

- Parents feel a high level of responsibility in the decision making process, anxious to select the best option and to balance risk and choice
- There is mixed understanding of services and facilities available at each type of site, highlighting scope to improve information provision
- While there is variation in preferences and priorities - depending upon outlook and circumstances - there is a broad hierarchy of needs for service users when choosing where to give birth:
    1. Risk management is the most important and is illustrated by the importance that is placed on having doctors and medical facilities on site
    2. Practicality (getting to place of birth) and comfort are also important (comfort especially for first-time mothers)
    3. Costs associated with travel and parking are the least important factors
- If the service user feels there is no obvious solution which provides a balance of all three, significant anxiety can result, with service users seeking advice and often keeping their options open or changing their mind
- Comparing service users by geography, those living in Cherwell are least satisfied with their level of choice about where to give birth. They are also, retrospectively, least satisfied with choice they made

Summary (2 / 4)

Summary

Ideal maternity experience

- Service users recognise that childbirth is inherently unpredictable and that the journey does not always follow a fixed plan
- There are common themes around the _ideal_ maternity journey; service users prioritise **feeling safe**, **continuity of care**, and **access to support networks** – **all of which serve to reduce anxiety**
- Anxiety levels generally increase during labour and birth. Stress can impact birth experience, stall labour and change outcomes, and can cause lasting emotional damage
- The feedback received from service users highlighted a number of key areas to focus on in order to reduce anxiety throughout the journey:
  - **Continuity of care**: seeing familiar professionals throughout and medical notes being passed on to the relevant people
  - **Staff availability:** timely access to staff, providing attentive and effective care
  - **Information**: relevant information easily accessible in a central source
  - **Manageable logistics**: convenience of location, travel and parking
  - **Partners staying overnight**: emotional support when most needed

Better Births

- In 2016, Better Births, a National Maternity Review, was published and outlined priorities for maternity services in the UK. Our survey results echo the priorities outlined in their recommendations:
  - 31% of all service users selected the opportunity for partners to stay after the birth as one of their top 3 improvements to their overall experience, 30% selected more available staff, 25% more consistency in healthcare staff and 24% easier / cheaper car parking
  - Partners of service users had similar priorities; 41% selected the opportunity for partners to stay after the birth, 31% easier / cheaper car parking, 23% more available staff and 19% facilities nearer home to reduce travelling time

Summary (3 / 4)

SUMMARY

Service user journey

Antenatal care:

- The quality of care received at the antenatal stage of the journey is generally rated highly by service users (receiving a net satisfaction score of 78%) and this is consistent across different council areas
- Parking availability and choice of location receive low rating scores (-8% and 21% net satisfaction scores respectively)
- The Horton is being used for routine antenatal care by Cherwell residents; for example, 42% of Cherwell residents that had a hospital appointment with a consultant attended the Horton for the appointment

Labour & Birth:

- Nearly half, 47%, of service users were moved during their labour and half of service users identified at least one incident during their labour, with a shortage of staff and parking difficulties occurring most often
- Cleanliness (net satisfaction score 77%) and staff competence (net satisfaction score 72%) are scored highly whereas staff availability (net satisfaction score 40%), continuity of care (net satisfaction score 38%) and parking practicalities (net satisfaction score 19% for availability and -16% for cost) are rated poorly by service users

Postnatal care:

- Service users rated cleanliness and hygiene highly (net satisfaction score 74%) in postnatal care, but were least satisfied with the continuity of care (net satisfaction score 20%) and emotional support received (30%)

Summary (4 / 4)

SUMMARY

Reflections on Choice

- At a total level, 79% of service users would have chosen the same place to give birth, This decreases to 66% of Cherwell residents
- Oxford Spires offers service users an opportunity to balance choice and risk, with medical intervention on-site if required. More service users would prefer to give birth at both Oxford Spires and the Horton than end up delivering there. In contrast, more service users end up delivering at the Obstetric Unit at the JR than would have chosen to do so

Perceived impact of temporary closure of Horton's consultant-led maternity care

- Women living in Banbury and surrounding areas feel that previously, the Horton would have been the default choice for women nearby. The closure of consultant-led care removes an obvious choice for them. This impacts anxiety levels for Cherwell and South Northamptonshire service users, who report feeling more anxious at the point of deciding where to give birth
- This anxiety centres around concerns relating to emotional support, journey time, parking and risk of transfer
- Partners of service users are also feeling the impact of changes at the Horton with Cherwell residents rating ease of visiting and choice of locations lower than other council areas
- We heard individual cases where service users felt their experience had been negatively impacted by the changes to provision in Banbury
- The options for service users in Banbury include Warwick, The Spires and The Cotswold Birth Centre but service users highlight different challenges with each, with none considered an equivalent alternative
- When asked to select their ideal geographical location to give birth, 24% of all service users selected Banbury at a total level, i.e. all survey respondents. This increases to 74% of Cherwell residents and 97% of S. Northamptonshire residents
- The awareness of changes to maternity services at the Horton is highest in Cherwell and S. Northamptonshire; 75% of service users in Cherwell and 93% in S. Northamptonshire would have preferred to give birth at the Horton if obstetric services had been available vs. 30% of all service users
- 68% of Cherwell service users (82% of S. Northamptonshire and 24% of all service users) feel that the temporary closure of the obstetric unit at the Horton had an impact on their decision of where to deliver

Contents

Pragma has completed a programme of research to capture feedback from users of maternity services in Oxfordshire and neighbouring south Northamptonshire and south Warwickshire

Project Background

- On 1st October 2016, the obstetric unit at the Horton General Hospital in Banbury was temporarily closed on safety grounds because of staff. In August 2017, following a period of uncertainty, the Oxfordshire Clinical Commissioning Group (OCCG) decided that the obstetric unit should be permanently closed. The decision to remove Consultant-led services and make Horton General a Midwife-Led Unit (MLU) was not supported by the joint Health Overview and Scrutiny Committee (JHOSC) and was subsequently referred to the Secretary of State
- An independent report delivered in March 2018 ruled that further action be required before a final decision is made about the future of maternity services in Oxfordshire, i.e. to appraise options, balancing the needs of the population (locality of services and specialised care provision) with the sustainability of staffing and the best use of finite NHS resources
- As part of this process, Pragma were commissioned to undertake a programme of research to engage and capture feedback from users of maternity services in Oxfordshire and neighbouring south Northamptonshire and south Warwickshire.
- This document is the output of that programme of research

Our methodology included an online survey among service users, focus groups and in-depth interviews

Methodology

Online survey

- Women in relevant areas of Oxfordshire, south Northamptonshire and south Warwickshire who had given birth since October 1st 2016 were sent a letter inviting them to take part in an online survey
- The link to the survey was also publicised through local and social media to encourage participation and as a back-up in case of lost letters. The survey could be completed on mobile, desktop or laptop devices
- There was an optional section at the end of the survey for partners to complete
- Letters were sent to 13,637 women; 1,035 completed the survey and 436 partners completed the optional section
- Open-ended questions were included in the survey and quotations from these have been used in the report to illustrate feedback from service users

Focus groups

- Survey service users were asked if they would like to opt-in to be considered to take part in further research in order to gather more detailed feedback from users of maternity services. A recruitment process through local baby groups, nurseries and children's centres was also launched to recruit pregnant women
- A selection of women that opted-in were invited to take part. 20 participants signed up and attended one of 3 groups:
  - One held in Banbury with pregnant women
  - One held in Banbury with mothers who had given birth since October 2016
  - One held in Wantage with mothers who had given birth since October 2016

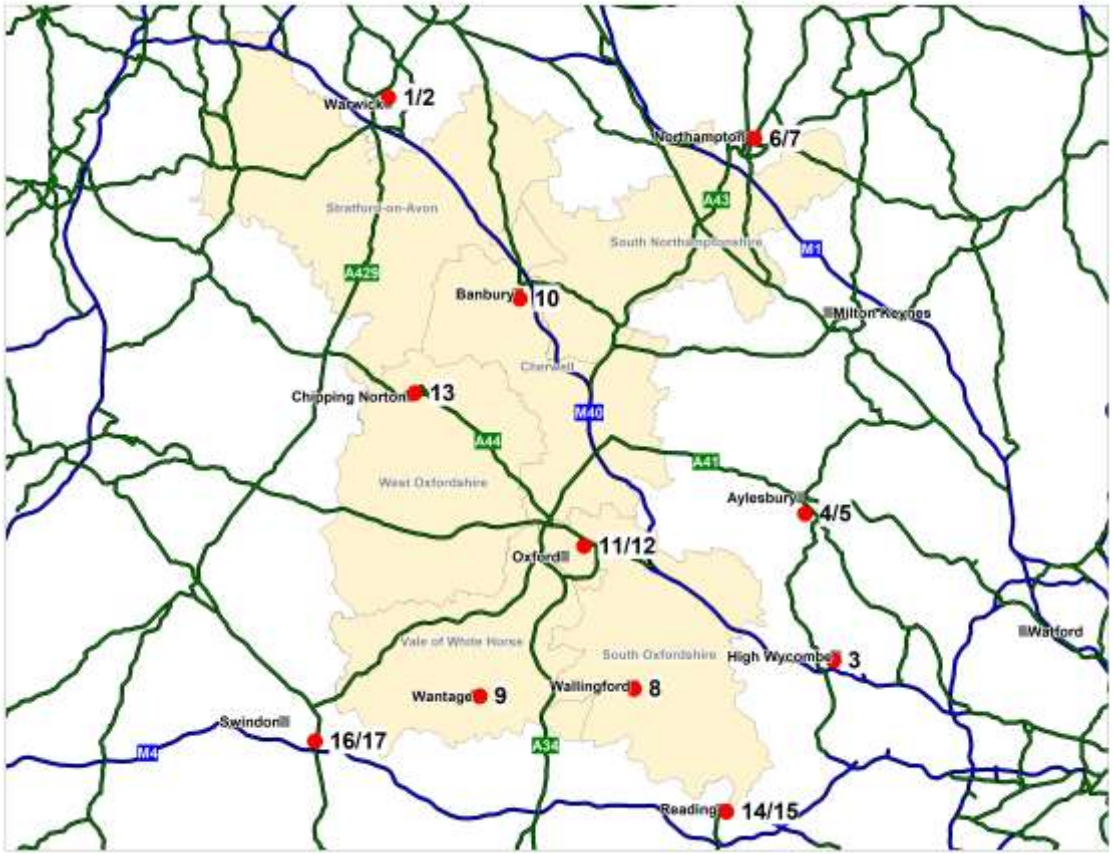
In-depth interviews

- Survey service users had the choice of whether to opt-in for a focus group or for an in-depth interview
- In-depth interviews were carried out either in person or over the phone
- Partners were also invited to attend / join the call
- 8 participants, including 2 partners shared their experiences

Notes: 1. Service users in South Northamptonshire and Stratford Upon Avon were included in the mail out and response rates were assessed as a total of the mailout . There were just 9 service users from Stratford-upon-Avon so this break is not shown throughout this report . As such, bases will not always sum to all service users

The catchment includes a range of options where women can give birth…

Catchment



Reference number	Location
1	Obstetric Unit, Warwick Hospital
2	Bluebell Birth Centre, Warwick Hospital
3	Wycombe Birth Centre, Wycombe Hospital
4	Obstetric Unit, Stoke Mandeville Hospital
5	Aylesbury Birth Centre, Stoke Mandeville Hospital
6	Obstetric Unit, Northampton General Hospital
7	Barratt Birth Centre, Northampton General Hospital
8	Wallingford Maternity and Birthing Centre
9	Wantage Maternity Unit
10	Horton Midwife Led Unit, Banbury
11	Obstetric Unit, John Radcliffe Hospital
12	Oxford Spires Midwife Led Unit, John Radcliffe Hospital
13	Cotswold Birth Centre, Chipping Norton
14	Obstetric Unit, Royal Berkshire Hospital
15	Rushey Midwife Led Unit, Royal Berkshire Hospital
16	Obstetric Unit, Great Western Hospital
17	White Horse Birth Centre, Great Western Hospital

…and the uptake of service users that give birth at each location varies by council area

Location Of Delivery

Q. …and which of these places did you actually give birth at?
Base: All service users (1,013)

Actual birth location		Resident in which council area					
	Total	Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northam-ptonshire
	(1,013)	*(321)*	*(191)*	*(163)*	*(148)*	*(118)*	*(63)*
Obstetric Unit, JR	66%	62%	73%	60%	69%	72%	57%
Oxford Spires Midwife Led Unit, JR	17%	13%	23%	13%	18%	19%	14%
Horton MLU, Banbury	6%	16%	-	-	-	-	27%
Wallingford Maternity and Birthing Centre	4%	-	-	19%	1.0%	-	-
Home birth	3%	3%	3%	3%	5%	4%	0.8%
Obstetric Unit, Warwick Hospital	2%	4%	-	-	-	-	-
Wantage MLU	0.6%	-	-	-	4%	-	-
Obstetric Unit, Royal Berkshire Hospital, Reading	0.5%	-	-	3%	-	-	-
Cotswold Birth Centre, Chipping Norton	0.5%	-	-	-	-	4%	-
Rushey Midwife Led Unit, Royal Berkshire Hospital	0.4%	-	-	2%	-	-	-
White Horse Birth Centre, Great Western Hospital	0.4%	-	-	-	3%	-	-
Obstetric Unit, Great Western Hospital	0.1%	-	-	-	0.6%	-	-
Obstetric Unit, Northampton General Hospital	0.1%	-	-	-	-	-	1.3%
Bluebell Birth Centre, Warwick Hospital	0.1%	0.2%	-	-	-	-	-
Obstetric Unit, Stoke Mandeville Hospital	-	-	-	-	-	-	-
Aylesbury Birth Centre, Stoke Mandeville Hospital	-	-	-	-	-	-	-
Wycombe Birth Centre, Wycombe Hospital	-	-	-	-	-	-	-
Barratt Birth Centre, Northampton General Hospital	-	-	-	-	-	-	-
Other	0.1%	0.2%	-	-	-	-	-
In transit	0.2%	0.6%	-	-	-	0.8%	-

Source: Pragma Maternity Services Online Survey March 2019

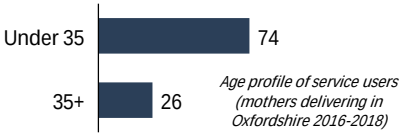
The survey data has been statistically weighted to reflect the demographics of the actual audience profile, in order to provide an accurate and representative view of the population

Data Weighting

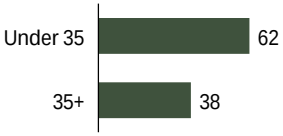
- The survey on maternity services was open for all eligible participants to complete. Inevitably, the response rates achieved varied across different subgroups of the data e.g. more older mothers completed the survey. If we used the actual data, without weighting, the groups where more mothers responded would be over represented
- Weighting involves:
  - Comparing the profile of the survey sample with that of the actual population, using information provided by OCCG, the census and government estimates
  - Discrepancies which would impact the accurate reflection of the population, are corrected by applying a weighting so that underrepresented groups get a larger weight and those in over represented groups get a smaller weight
  - The weighted data used in this report will accurately represent the population, allowing accurate conclusions to be drawn and comparisons to be made

Age

Make up of wider population (%)



Response rates of survey (%)



More older mothers responded to the survey, data was weighted to ensure voice of all ages accurately represented

Location[1]

Make up of wider population (%)

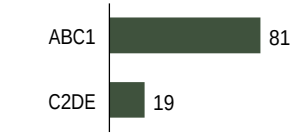
Response rates of survey (%)

More mothers in Cherwell responded to the survey, data was weighted to ensure that the voice of residents from all regions accurately represented

Social grade

Make up of wider population (%)

Response rates of survey (%)

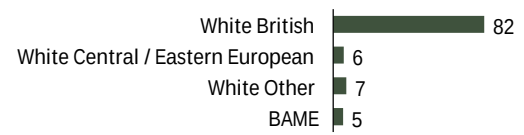


More mothers from higher social grades responded to the survey, data was weighted to ensure that the voice of those from all social grades accurately represented

Ethnicity

Make up of wider population (%)

Response rates of survey (%)



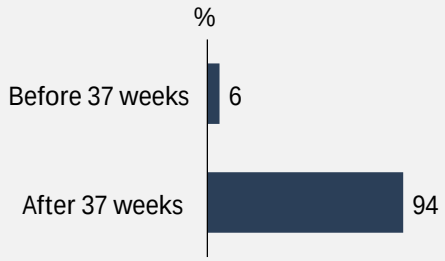
Response rates were broadly in line with the wider population and important Central / Eastern European group not separated in census so weighting was not applied

Notes: 1. Some service users live in South Northamptonshire and Stratford Upon Avon. Although not shown on this slide as there is no representative data, response rates were assessed as a total of the mailout and weighted appropriately. There were just 9 service users from Stratford-upon-Avon so this break is not shown in this report. As such, bases will not always sum to all service users

We captured detail about service users' pregnancies, births and lifestyles to support comparisons across different groups

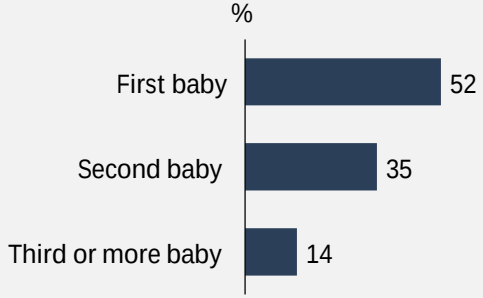
Profile Of Survey service users

Delivery

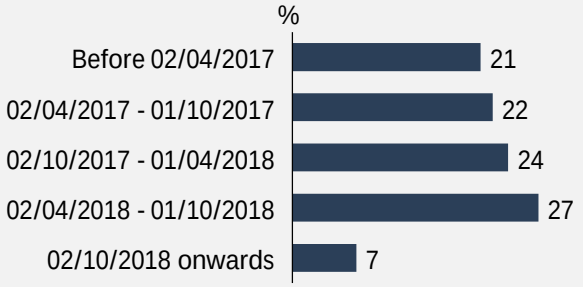


Premip vs Multip

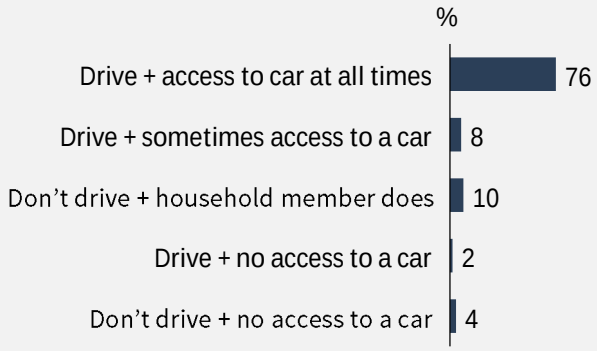
1% or 10 service users had twins rather than a single baby



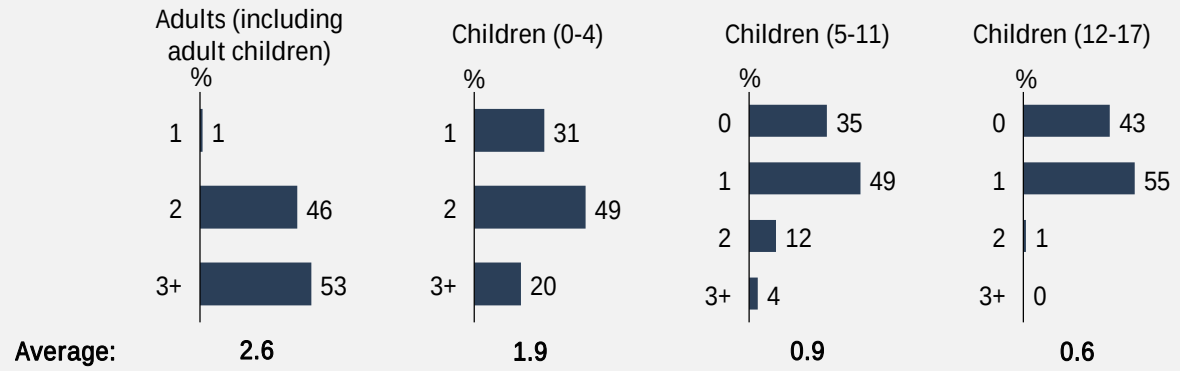
Date of delivery



Access to a car



Household make up

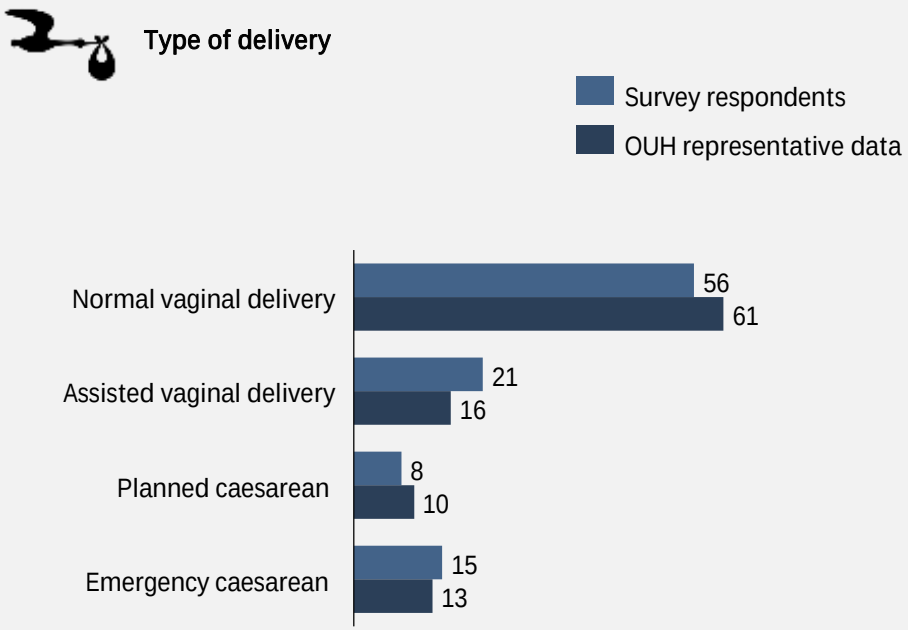


Source: Pragma Maternity Services Online Survey March 2019

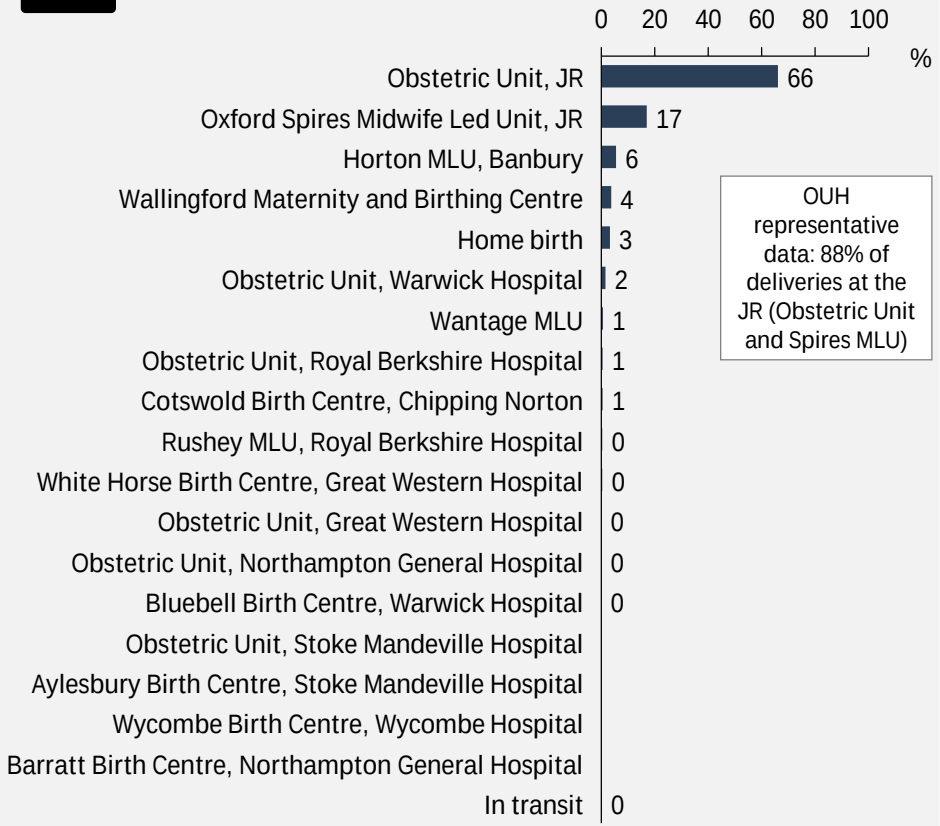
This provides confidence that a broad range of representative views are included

Profile Of Survey service users

Type of delivery



Place of delivery



Source: Pragma Maternity Services Online Survey March 2019

The survey and focus groups / in-depth interviews asked women about their experiences of using maternity services at each stage of the journey through pregnancy and birth. Partners were also asked about their experiences

Research Structure

Throughout this report we include direct verbatim and quotations to illustrate specific points of view. These are sourced from free response boxes on the survey, focus groups and in-depth interviews. Many comments focus on opportunities to improve, therefore gravitate towards negative aspects of experience. Please consider these in balance with the quantitative data from the survey

Contents

Parents feel a high level of responsibility in the decision making process, anxious to select the best option and to balance risk and choice

"There was no choice unless I chose to disregard medical opinion."

Service User, South Northamptonshire

"It's left to us almost to assess the level of risk that we're willing to tolerate. And the level of anxiety that we're willing to tolerate around birth which feels unequal in terms of what's available throughout the country."

Pregnant Service User, Banbury

"I had really fixed on going to the JR but I work almost opposite the JR and I knew what the traffic was like. It was keeping me awake at night. I decided that I would go to the Horton as it would be more comfortable and then that was keeping me awake at night. I just did not know what to do; I was absolutely terrified."

Service User, Banbury

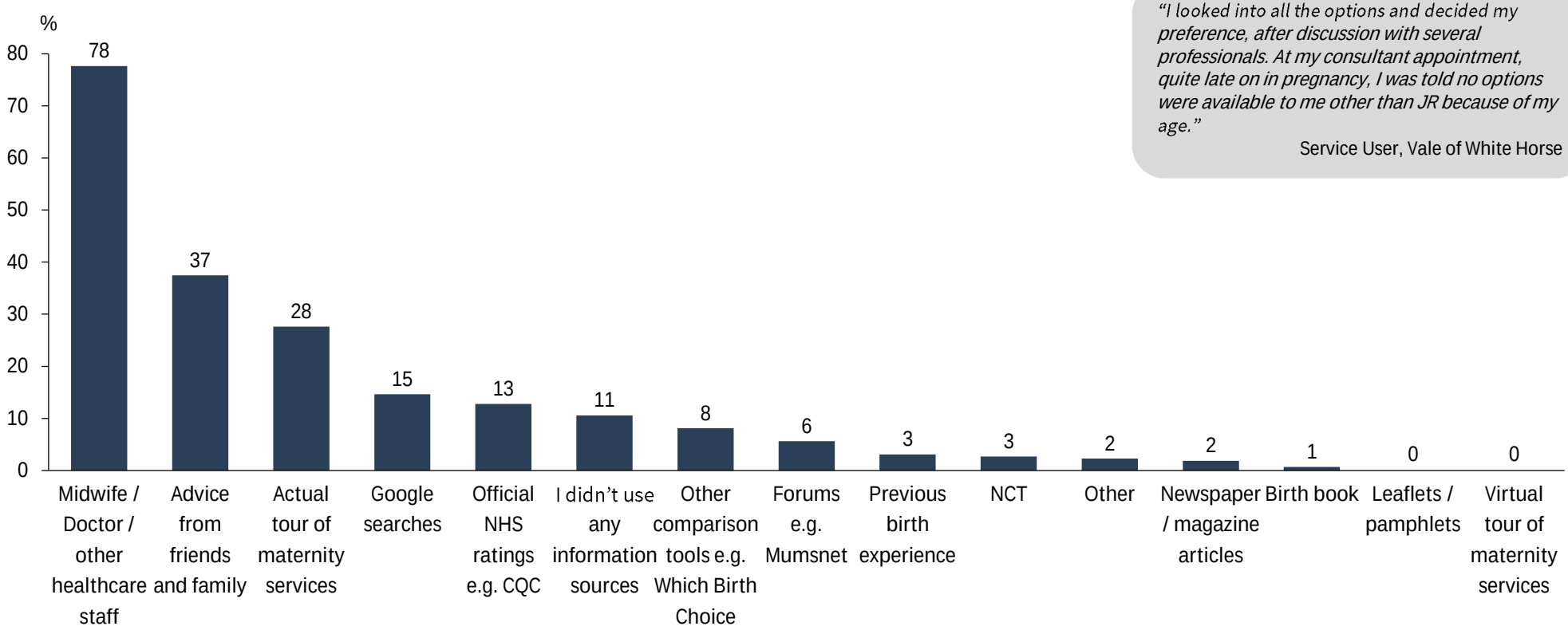
Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

Healthcare professionals are the main source of information for users of maternity services. Many felt that a central information resource on maternity services, e.g. a website, would be an extremely helpful reference point

Decision-making

Q. Which of the following information sources did you use when making your decision about where to give birth?

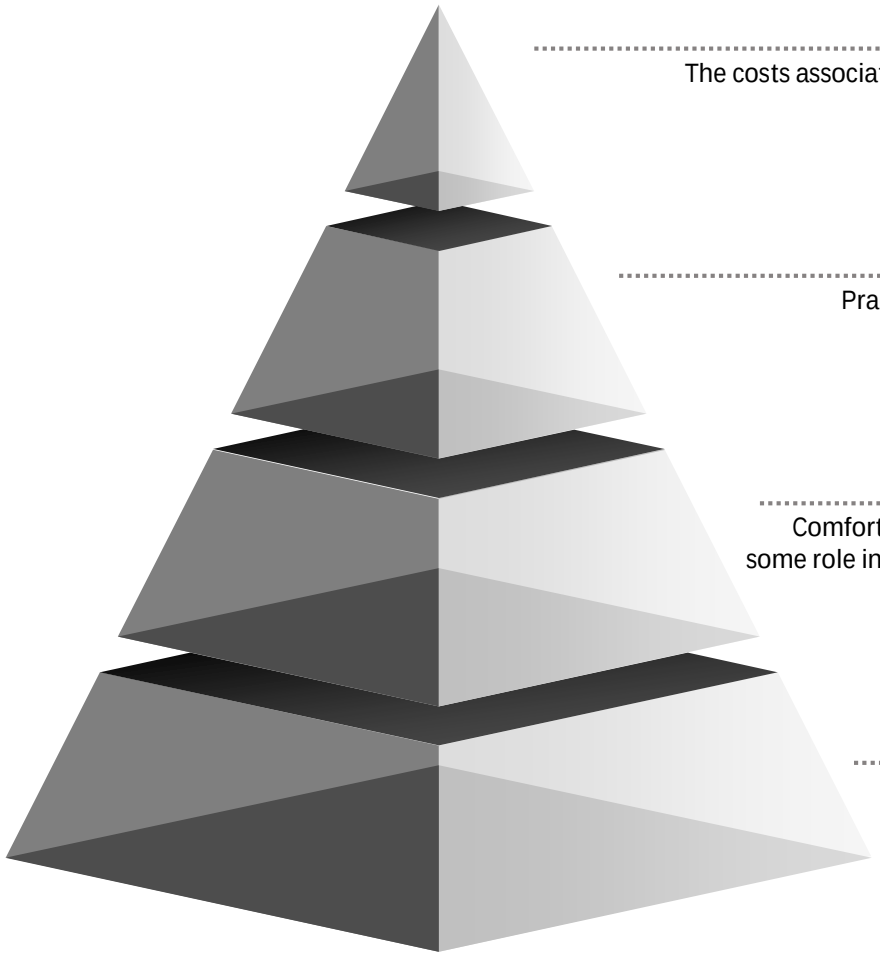
Base: All service users (1,013)



> *"I looked into all the options and decided my preference, after discussion with several professionals. At my consultant appointment, quite late on in pregnancy, I was told no options were available to me other than JR because of my age."*
>
> Service User, Vale of White Horse

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

There is a broad hierarchy of needs for service users that is built on minimising risk



Associated Costs

The costs associated with travel and parking are not key to decision making

Practicality

Practical elements such as travel to place of birth are important decision factors

Comfort

Comfortable surroundings and environment play some role in decision making, especially for first-time parents

Risk Management

Minimising risk to prioritise a good outcome is the fundamental element of decision making

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

While some expecting mothers favour a more natural experience and minimal intervention, the reassurance of knowing there is medical support on hand is an important consideration

Decision Making | Key Selection Criteria

Risk Management

"When I first gave birth, there was a slight complication so now I'm really anxious…I'd really like to have doctors around."

Pregnant Service User, Banbury

"It's not about me, it's about my baby being in the safest place available."

Pregnant Service User, Banbury

"I felt incredibly supported at The Spires. It was very positive and natural, I was in the birth pool. I also felt supported by the doctors when it did turn into a bit more of an emergency."

Service User, Wantage

Comfort

"Comfortable surroundings and environment is quite important. Everyone has a view of what makes it comfortable, it doesn't matter whether it's hospital, home or midwife, as long as you're comfortable otherwise labour just doesn't happen."

Service User, Wantage

"A private room might be important for your first child. Your second, you realise all your dignity goes out the window!"

Pregnant Service User, Banbury

Practicality

"I was so worried about hubby not making it to the birth or being unable to visit due to lack of parking."

Service User, Oxford

"The closer I was getting to my due date, all I was thinking was that I wanted to be close to home. I really didn't want to travel."

Pregnant Service User, Banbury

Associated Costs

"You don't have babies every week so I don't really care about the cost of parking."

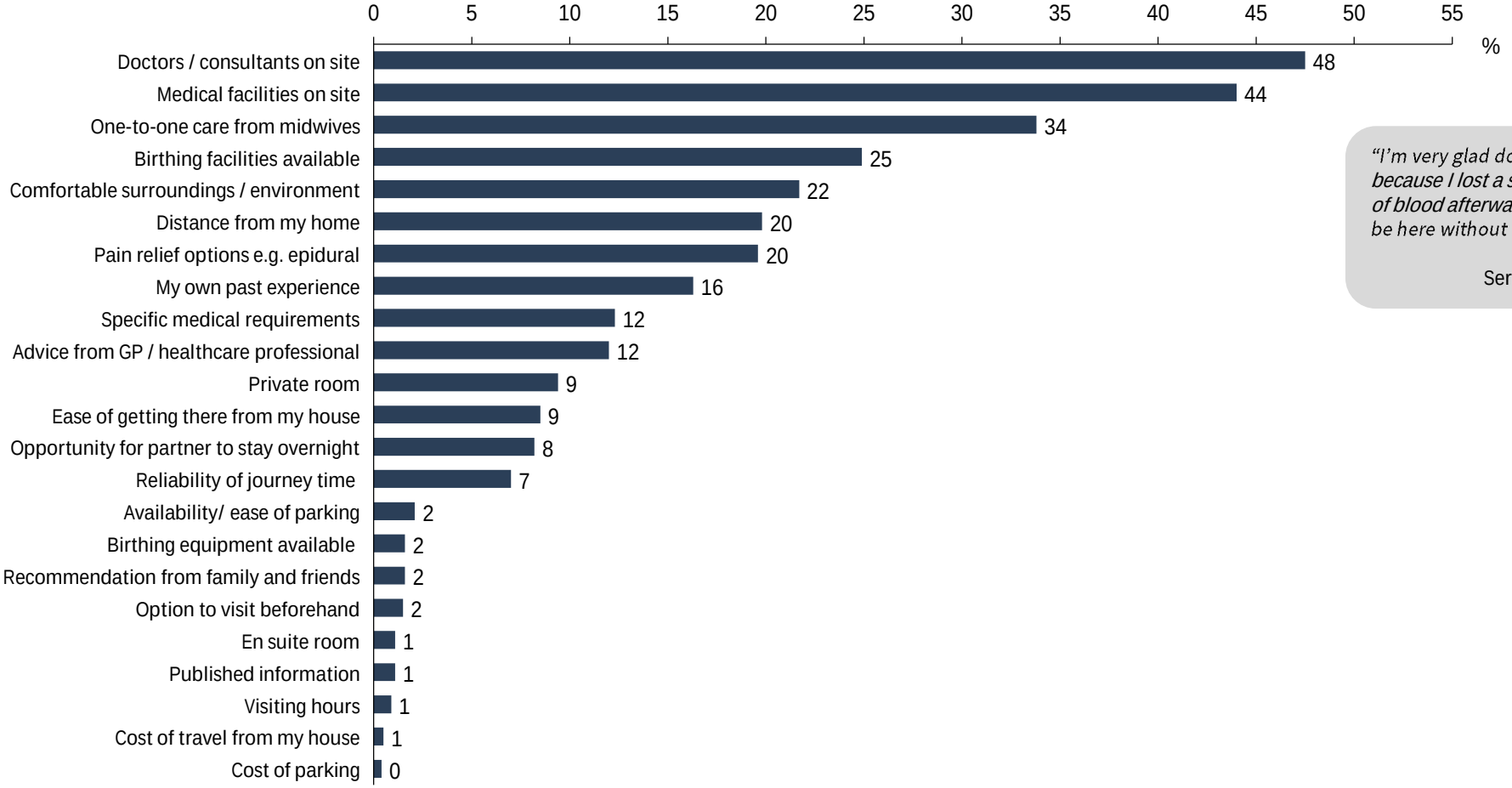
Pregnant Service User, Banbury

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

Overall, having doctors and medical facilities on site if they are needed are the most important factors to service users

Q. And from this list, what were the top three most important things to you in making your decision?

Base: All service users (1,013)



"I'm very glad doctors were around because I lost a significant amount of blood afterwards so I might not be here without that."

Service User, Wantage

Source: Pragma Maternity Services Online Survey March 2019

Notes: The percentage shows the number of service users who selected the factor as one of their top 3 most important things

Preferences and priorities vary depending on outlook and circumstances. Cherwell residents prioritise practicalities and first time mothers place more emphasis on comfort factors.

Decision Making | Key Decision Factors

Q. And from this list, what were the top three most important things to you in making your decision?
Base: All service users (1,013)

	All service users	Cherwell	First time mother	Given birth before
	(1,013)	(321)	(523)	(490)
Doctors / consultants on site	48%	42%	48%	47%
Medical facilities on site	44%	44%	45%	43%
One-to-one care from midwives	34%	30%	35%	33%
Birthing facilities available	25%	26%	31%	19%
Comfortable surroundings / environment	22%	20%	23%	21%
Distance from my home	20%	28%	17%	22%
Pain relief options e.g. epidural	20%	18%	23%	17%
My own past experience	16%	10%	1%	32%
Specific medical requirements	12%	10%	12%	13%
Advice from GP / healthcare professional	12%	12%	10%	14%
Private room	9%	5%	14%	5%
Ease of getting there from my house	9%	14%	7%	10%
Opportunity for partner to stay overnight	8%	7%	11%	6%
Reliability of journey time	7%	14%	7%	7%
Availability/ ease of parking	2%	5%	2%	2%
Birthing equipment available	2%	1%	2%	2%
Recommendation from family and friends	2%	1%	2%	1%
Option to visit beforehand	2%	1%	2%	1%
En-suite room	1%	0%	2%	1%
Published information	1%	0%	2%	1%
Visiting hours	1%	2%	1%	1%
Cost of travel from my house	1%	2%	0%	1%
Cost of parking	0%	1%	-	1%

Source: Pragma Maternity Services Online Survey March 2019

Notes: The net score is calculated by subtracting net unimportance (very unimportant + unimportant) from net importance (important + very important)

Service users were broadly aware of what was offered at each location, although there are some examples of misunderstandings

Q. Which of the following services did you understand to be available at each location?
Base: Various; all service users considering location, see table

	Caesarean delivery	Forceps delivery	Ventouse suction cup	Intravenous drip	Baby heartbeat monitoring	Epidural	Injection of painkillers	Gas and air	TENS machine	Water / birthing pool	Specialist treatment for newborns
Obstetric Unit, JR (720)	96%	95%	90%	92%	95%	98%	89%	97%	61%	62%	92%
Oxford Spires MLU, JR (561)	12%	21%	21%	20%	49%	17%	47%	97%	76%	95%	23%
Horton MLU (223)	4%	23%	16%	14%	56%	10%	40%	97%	71%	90%	5%
Home birth (109)	0%	6%	4%	2%	19%	-	25%	80%	77%	80%	4%
Cotswold Birth Centre (105)	0%	9%	8%	7%	45%	0%	41%	96%	75%	95%	3%
Wallingford Maternity and Birthing Centre (104)	0%	10%	11%	8%	32%	0%	35%	95%	83%	95%	2%
Obstetric Unit, Warwick Hospital (60)	91%	91%	81%	90%	91%	91%	85%	91%	78%	77%	87%
Wantage Maternity Unit (41[1])	0%	9%	11%	4%	38%	0%	24%	92%	75%	91%	0%

Source: Pragma Maternity Services Online Survey March 2019

Notes: 1. Low base, indicative only

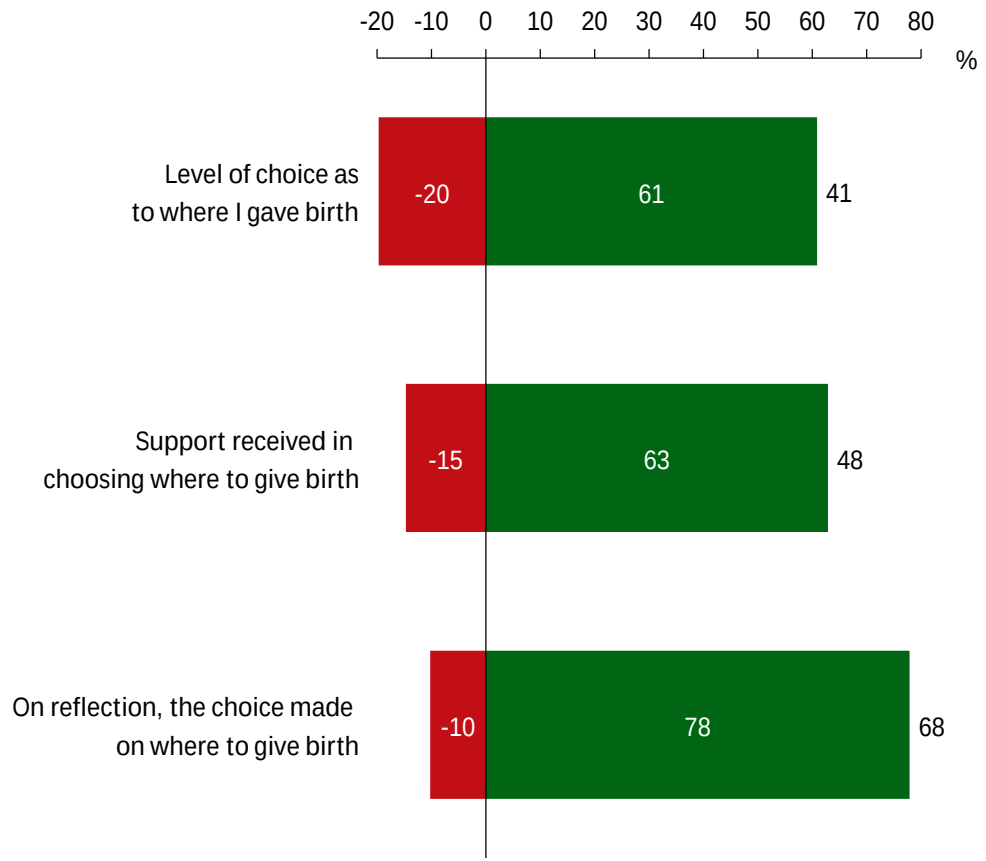
Service users in Cherwell have the lowest levels of satisfaction with the level of choice available to them. They are also, retrospectively, least satisfied with choice they made

Decision-making

Decision Making | Satisfaction

Not satisfied Satisfied

Q. How satisfied were you with the following factors? Please rate on a 1-5 scale, with 5 being highly satisfied
Base: All service users (1,013)



Net satisfaction score by area					
Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northam-ptonshire
(321)	*(191)*	*(163)*	*(148)*	*(118)*	*(63)*
12%	54%	45%	62%	60%	-2%
30%	52%	47%	63%	64%	36%
48%	75%	71%	82%	68%	64%

Source: Pragma Maternity Services Online Survey March 2019

Notes: The net score is calculated by subtracting net unimportance (very unimportant + unimportant) from net importance (important + very important)

Contents

While recognising that pregnancy and childbirth is inherently unpredictable, there are many common themes around an *ideal* maternity services journey

"A birth flow plan would actually be a much better way to describe it. A decision tree. Preference is a much better word than plan because a plan can leave you quite disheartened if things change."

Service User, Banbury

Continuity of care: healthcare professionals and notes

"It was amazing continuity of care . The midwife knew exactly what was going on with me and she remembered random facts that weren't important at all . She was really lovely."

Service User, Banbury

Feeling safe

"My midwife made me feel safe and cared for. Without her, it would have been a very different experience. The process of labour and birth was long and scary but she made it better."

Service User, Oxford City

Access to support network (partner, family)

"I guess we're having to think very much about what support we have around us, family and friends wise, in terms of having that time away."

Service User, Wantage

Informed choices – in control

"You should be able to have a conversation about your care and you have a right to say yes or no to things."

Service User, Banbury

No unnecessary stress / anxiety

"You just don't need that added stress because it can be stressful already and you don't want stress on the baby and yourself."

Service User, Banbury

A package of care that follows the patient

"I was living in Warwickshire when I fell pregnant, but was about to move to Northamptonshire. I thought this was handled really well and I didn't have to have duplicate tests or scans."

Service User, South Northamptonshire

Doctors / intervention on hand, IF required

"I didn't want the cascade of intervention. As soon as we turned up at the JR that was it…monitoring and probes on her head and drips."

Service User, Wantage

Control of the controllable

"The care I received during labour was great. The breech team made me feel very special and in control

Service User, Cherwell

Communication / information as things develop

"The staff at the JR for my induction and while I was giving birth were fabulous….they made me feel at ease, explained everything fully and let me make my own choices."

Service User, Vale of White Horse

Understanding of needs

"Midwives and the health visitors need to do their own handover and talk to each other. When the health visitor comes they say 'I've already spoken to your midwife and I understand you had a vaginal delivery and know what you need.'"

Service User, Wantage

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

When asked for spontaneous descriptors, service users generally describe their experience with words that are broadly positive

Journey | Birth Experience

Q. Overall, what 3 words would you use to describe your experience of the maternity services during this recent pregnancy and birth? *Base: All service users (1,035)*

The size of the words is determined by the number of times the words were mentioned

Source: Pragma Maternity Services Online Survey March 2019

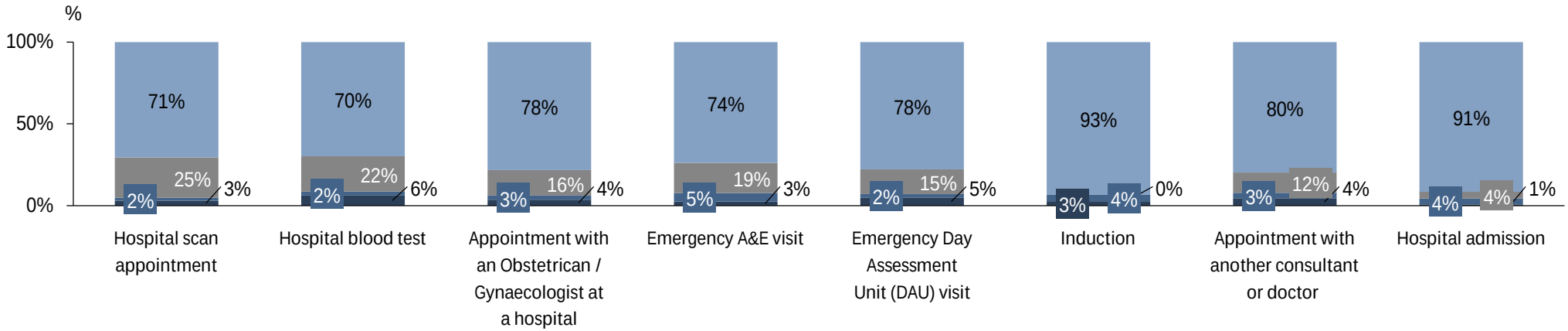
Antenatal services are provided across a range of locations and the Horton tends to be used for routine care by Cherwell residents

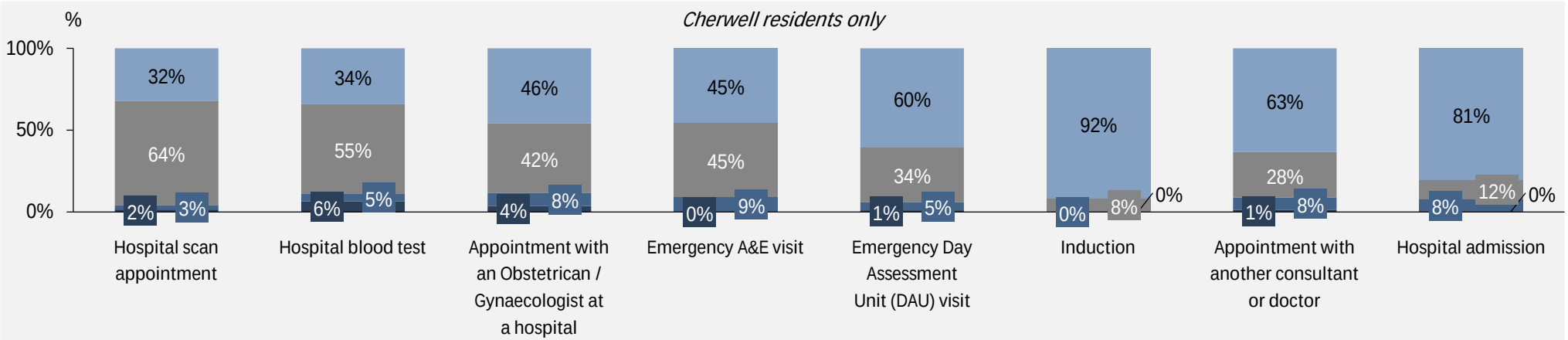
Antenatal care

Journey | Antenatal Care | Facilities Used | Location

Q. For each of the services you selected in the previous question, please select where you went for these appointments from the drop down lists

Base: All service users who used service / facility





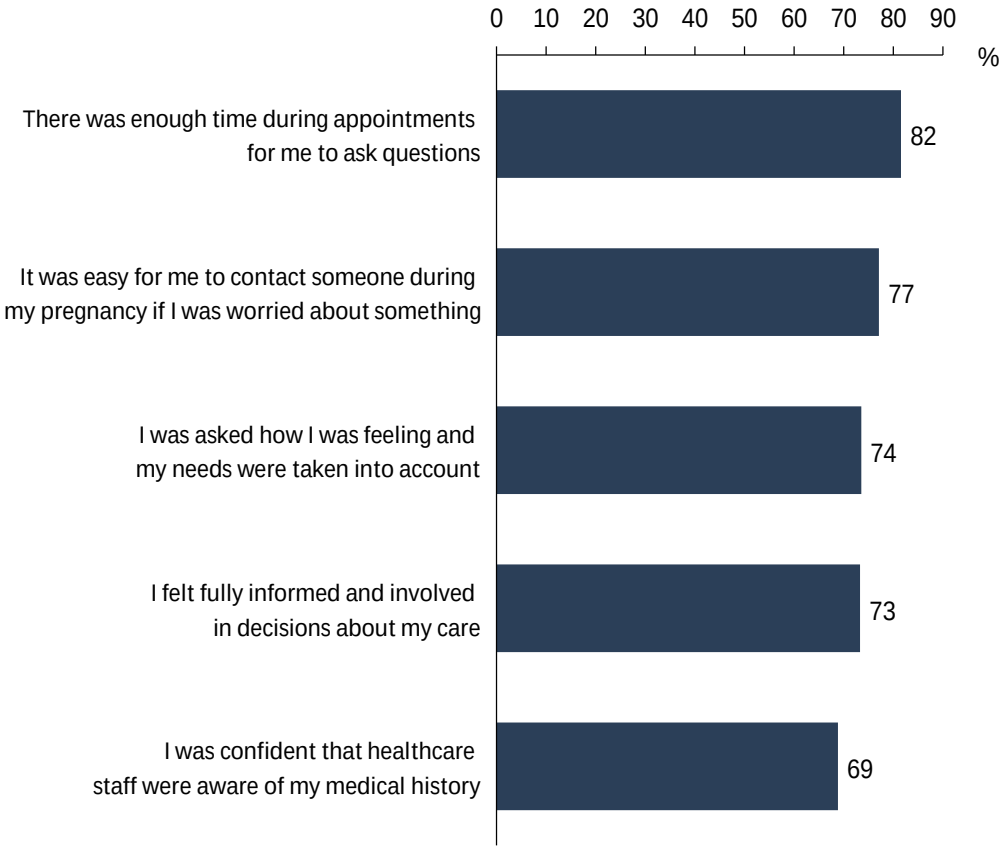
Source: Pragma Maternity Services Online Survey March 2019

Service users across different council areas have a similar quality of antenatal experience

Journey | Antenatal Care | Statements

Q. Thinking about your experience of antenatal care during your most recent pregnancy, please indicate the extent to which you agree with each of these statements, % strongly agree + agree

Base: All service users (1,013)



% of service users selecting strongly agree + agree by area					
Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northam-ptonshire
(321)	*(191)*	*(163)*	*(148)*	*(118)*	*(63)*
79%	82%	80%	80%	85%	88%
74%	74%	78%	82%	85%	69%
72%	73%	71%	77%	74%	81%
70%	73%	71%	78%	78%	76%
67%	72%	64%	72%	68%	69%

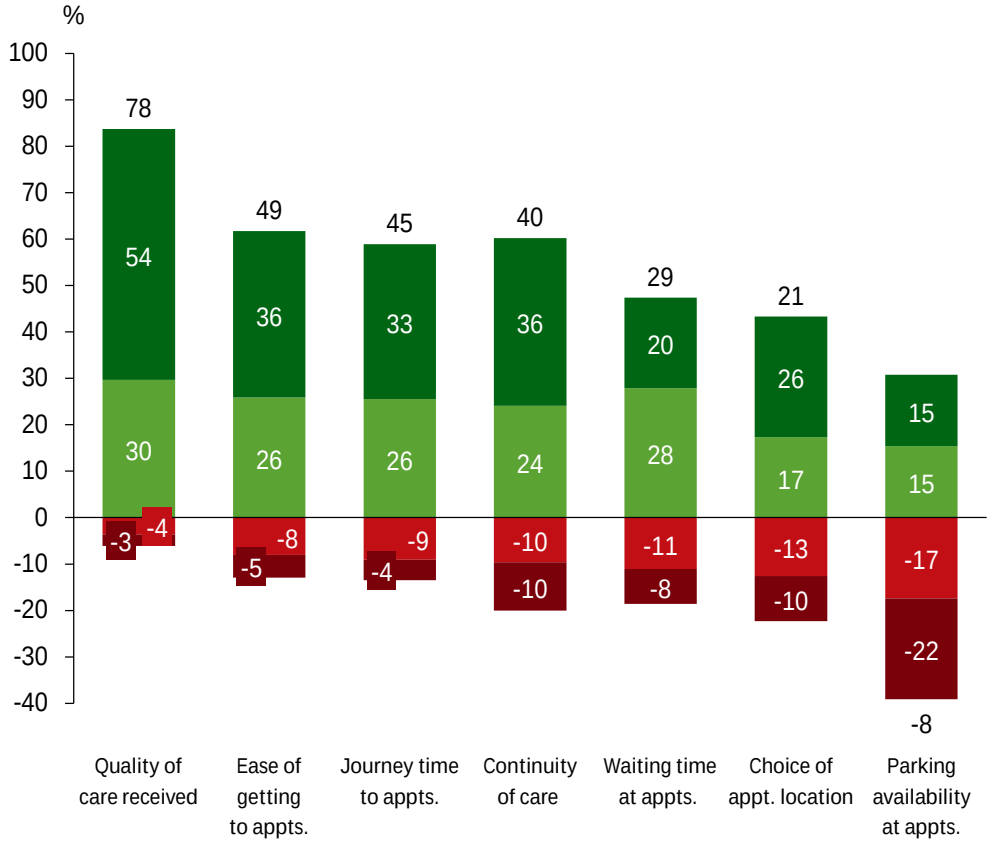
Source: Pragma Maternity Services Online Survey March 2019

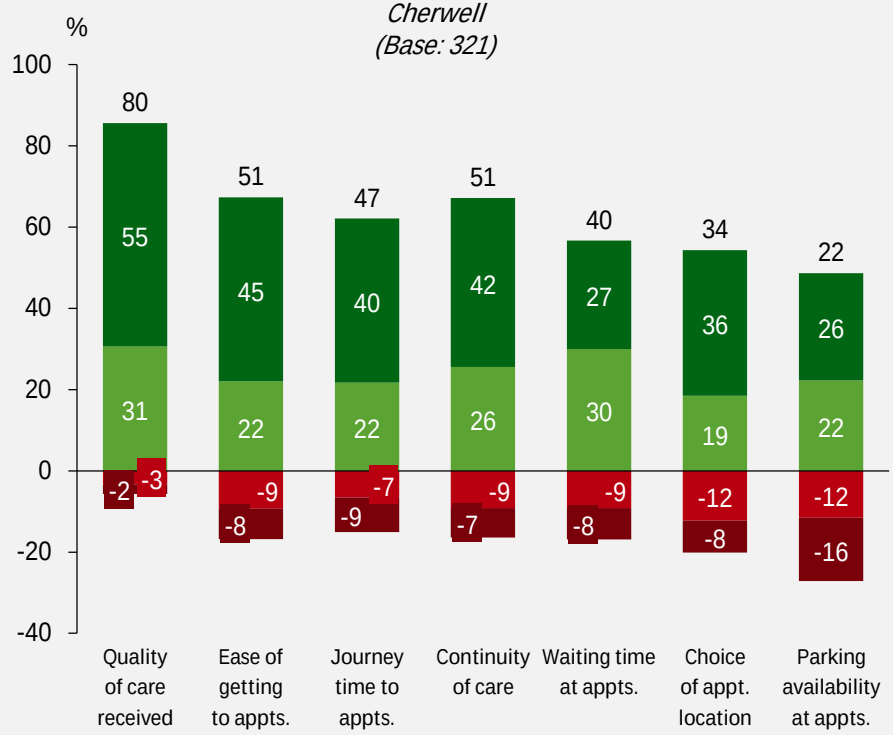
The quality of antenatal care is highly rated by service users. Cherwell is particularly well-regarded for continuity of antenatal care

Antenatal care

Very Poor | Poor | Good | Excellent

Q. Thinking about your experience of antenatal care during your most recent pregnancy, please rate each of the following
Base: All service users (1,013)





Source: Pragma Maternity Services Online Survey March 2019

Notes: The net score is calculated by subtracting sum of poor and very poor from sum of good and excellent

Feedback from service users across the catchment area regarding antenatal care can be grouped into themes around continuity of care, choice of location, information and logistics

Antenatal care

"Appointments were either unreasonably long or stupidly short with no time to ask questions. It was hard to get hold of anyone to help with advice or questions about my pregnancy."
Service User, Cherwell

"For antenatal appointments, one clinic I was visiting on a weekly basis had wait times of 1-2 hours. It would have helped if my different appointments could have been better scheduled so I didn't have to go back several times a week. With two medical issues during pregnancy, I felt that communication between different teams was non-existent which led to stress and confusion."
Service User, West Oxfordshire

"My care was inconsistent as I rarely saw the same midwife twice during my antenatal care."
Service User, Oxford City

"In all the times I went to hospital, I didn't see the same doctor twice. They didn't have time to read my notes, each time they'd come in and ask what happened and for my history. Then you think 'Did I forget to tell them something? Will this have affected my care?'"
Service User, Banbury

- Information
- Continuity of care
- Location
- Logistics: travelling and finding parking

"I had a lot of tests as I was higher risk, I was often sent to the JR for these and then they would say "you could have had this done at the Horton." That was frustrating as I was taking a whole day off work for appointments. Why can't more routine appointments be pushed to the Horton?" Service User, Banbury

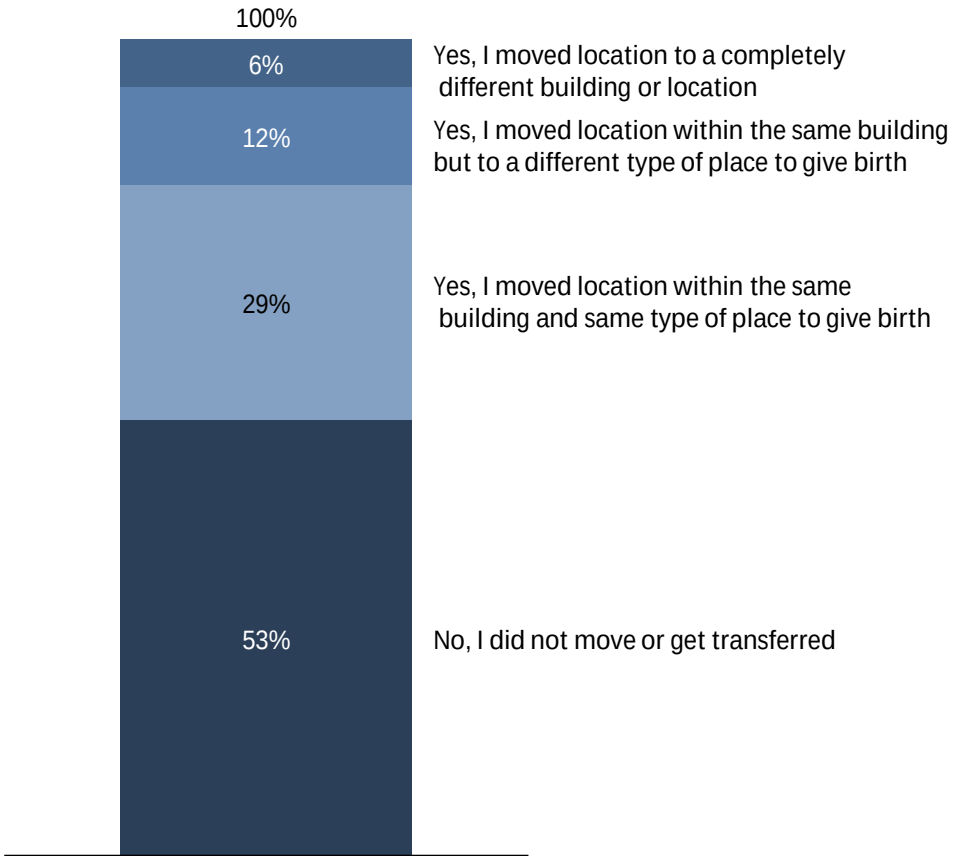
"Every scan appointment at the JR was so stressful trying to get parked and it takes even longer to go by bus."
Service User, West Oxfordshire

"Accessing appointments at the JR is a nightmare due to traffic and parking, even though we only live a few miles away."
Service User, Oxford City

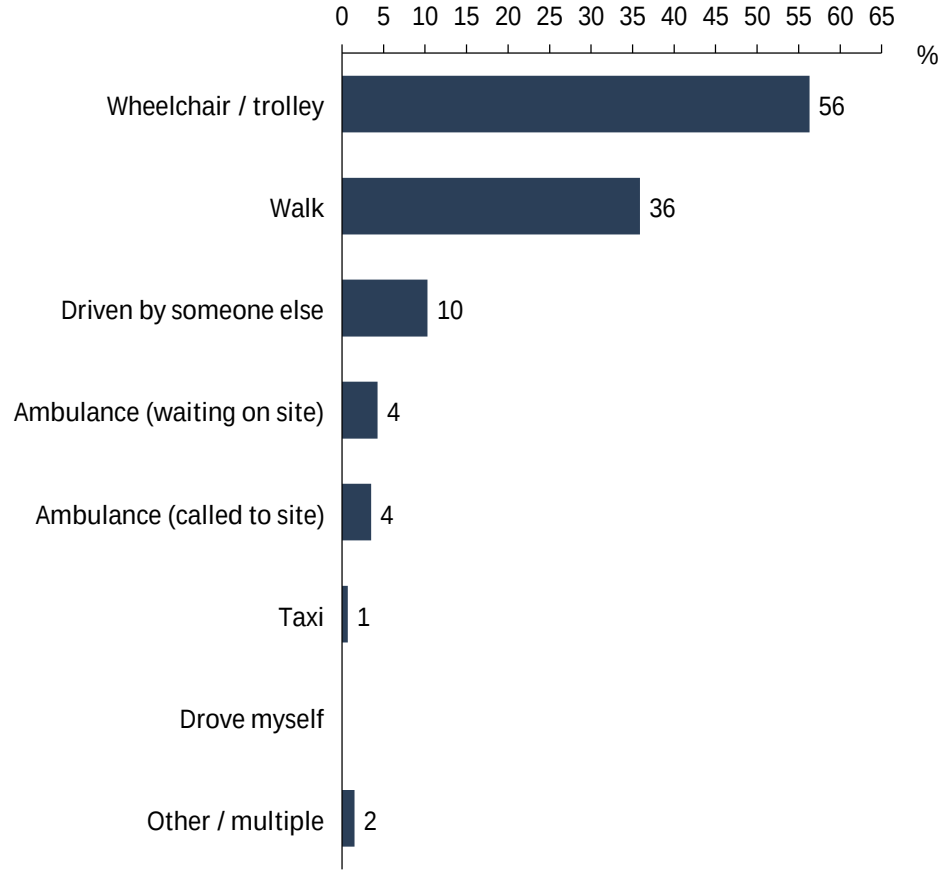
Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

47% of service users were moved during their labour, with wheelchair / trolley being the most common mode of transport

Q. Did you move location or get transferred during your labour?
Base: All service users (1,013)



Q. What mode of transport was used for your transfer during labour?
Base: All service users who transferred during labour (479)



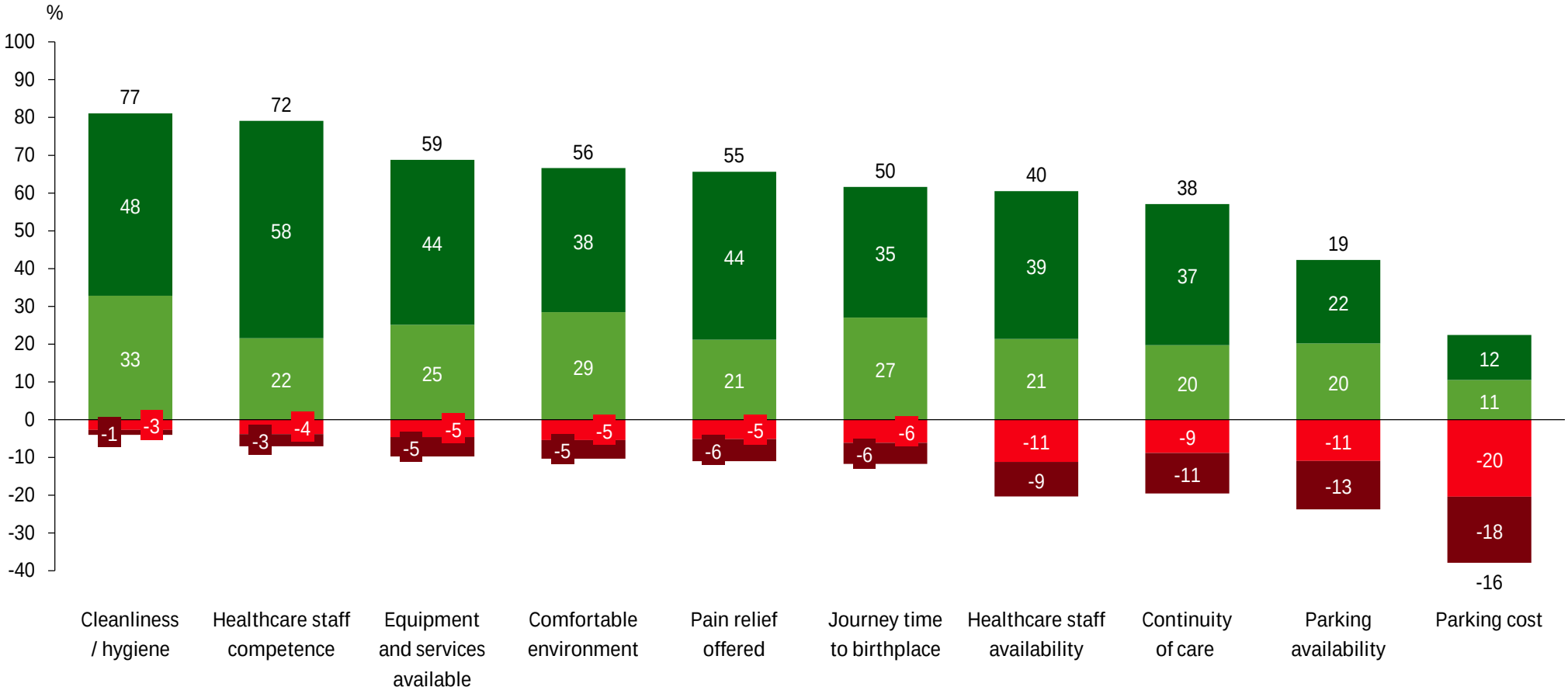
Source: Pragma Maternity Services Online Survey March 2019

Service users rate cleanliness and healthcare staff competence very highly but give lower overall scores to parking, continuity of care and staff availability

Journey | Labour & Birth | Ratings

Q. Thinking about your experience of labour and birth, please rate each of the following

Base: All service users (1,013)



Source: Pragma Maternity Services Online Survey March 2019

Notes: The net score is calculated by subtracting sum of poor and very poor from sum of good and excellent

During labour, the majority of women were satisfied with the level of partner involvement, and felt confident in staff and treated with respect and dignity. There is room to improve areas such as patient transfers and medical history awareness

Q. Thinking about your experience during labour and birth, please indicate the extent to which you agree with each of these statements. % strongly agree + agree
Base: All service users (1,013)

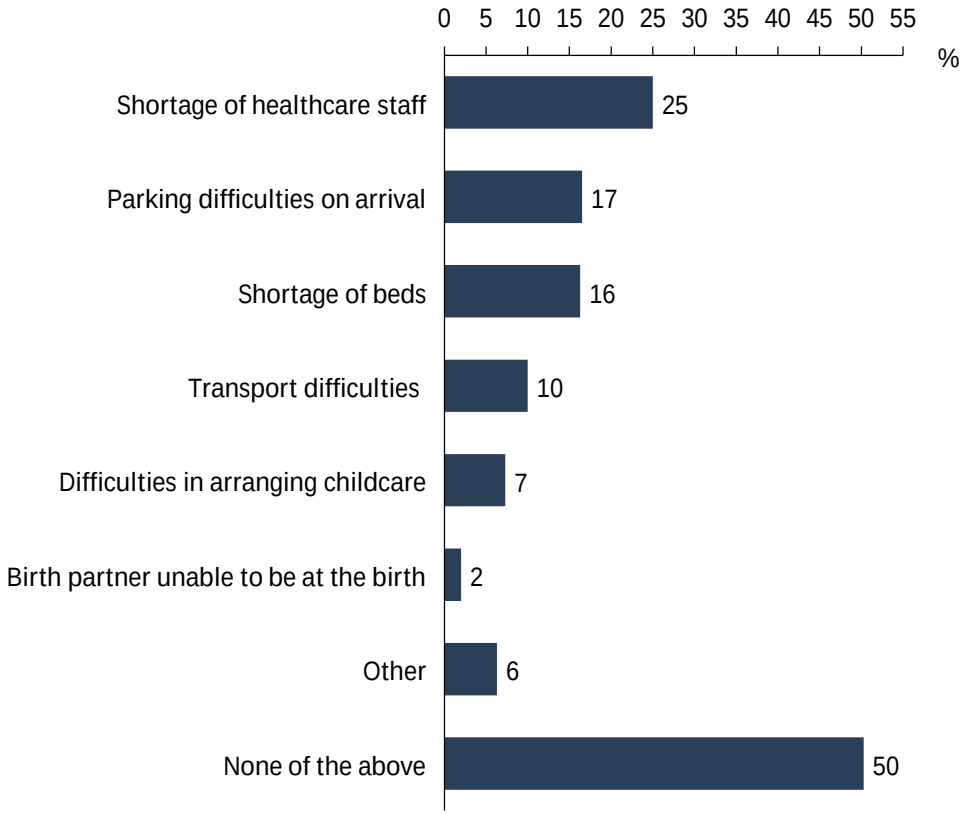
% of service users selecting strongly agree + agree by area					
Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northam-ptonshire
(321)	*(191)*	*(163)*	*(148)*	*(118)*	*(63)*
82%	92%	81%	89%	85%	85%
80%	80%	80%	88%	81%	84%
79%	76%	81%	84%	80%	80%
66%	72%	74%	79%	77%	72%
68%	73%	75%	72%	69%	64%
65%	71%	70%	66%	68%	71%
62%	70%	66%	66%	67%	63%
61%	64%	61%	63%	67%	52%
59%	60%	60%	62%	59%	61%

Source: Pragma Maternity Services Online Survey March 2019

Notes: 1. Only asked to those service users who were transferred (479)

Half of service users identified at least one negative aspect of their labour, with a shortage of staff and parking difficulties most cited

Q. Did any of the following apply to you and your most recent experience of giving birth? Multiple choice
Base: All service users (1,013)



% of service users by area					
Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northam-ptonshire
(321)	*(191)*	*(163)*	*(148)*	*(118)*	*(63)*
27%	25%	20%	26%	27%	29%
24%	14%	18%	7%	14%	22%
18%	18%	13%	16%	14%	22%
20%	4%	6%	4%	11%	19%
12%	3%	11%	5%	7%	5%
4%	1%	2%	0%	1%	6%
7%	4%	5%	7%	7%	11%
42%	52%	53%	58%	51%	43%

Source: Pragma Maternity Services Online Survey March 2019

Feedback from service users across the catchment area regarding labour and birth can be grouped into themes around staff availability, continuity of care, feeling safe and logistics

Labour & Birth

Journey | Labour & Birth

"I was induced and then I was left because the JR was overstretched. And then my baby came within a minute of someone answering the buzzer."
Service User, Banbury

"I had to wait for free space at Spires. I just made it in the wheelchair before giving birth on the chair itself."
Service User, Oxford City

"There were no midwives available for my home birth. I was too far in labour to travel so an ambulance attended."
Service User, Cherwell

Staff availability / burden on JR

Continuity of care

Feeling safe and listened to

Logistics: travelling and finding parking

"When we arrived at hospital with regular contractions the midwife on the triage unit said they had no beds on maternity ward and no staff. Once a bed was found and two midwives called in from home (splitting the night shifts between them) all went well, though not much continuity in care due to having 3 midwives in 12 hours."
Service User, Oxford City

"I had difficulties in getting pain relief and difficulties convincing staff that I was in labour and about to push the baby out!" Service User, Vale of White Horse

"Suddenly, it all kicked off and I felt really not listened to. I wanted a midwife to say, 'yes you are in labour, yes this is fine, let's transfer you to somewhere where you can have the baby'. But instead it was, 'no, no, don't worry you are fine, don't worry, it will be okay.'"
Service User, Banbury

"There was heavier traffic than usual as I went into labour during rush hour. I was worried we wouldn't get to hospital. Then. the midwife didn't seem to have anyone to hand over to at end of her shift to continue my care so she stayed."
Service User, West Oxfordshire

"I was pacing the corridors in tears thinking is my husband going to get here in the rush hour? Is he going to get parked or miss the birth?" Service User, Wantage

"I was in full labour, contractions a few minutes apart, and had to walk myself into the hospital while my partner parked." Service User, West Oxfordshire

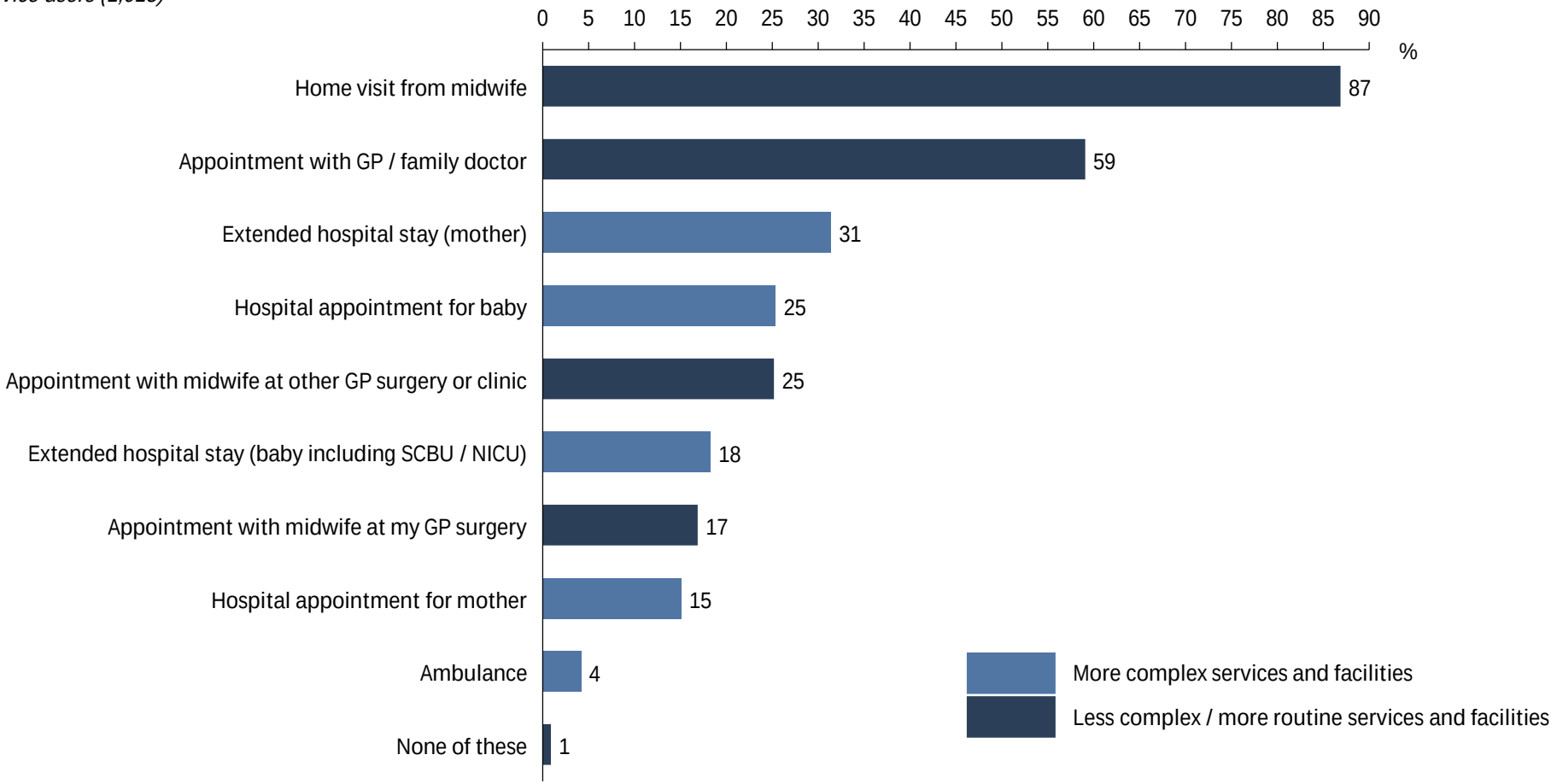
Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

Postnatally, the most used services were home visits from the midwife and appointments with the GP

Postnatal care

Q. Which of the following services and medical facilities did you use after your most recent birth? Please think about both immediately after giving birth and in the few weeks afterwards

Base: All service users (1,013)

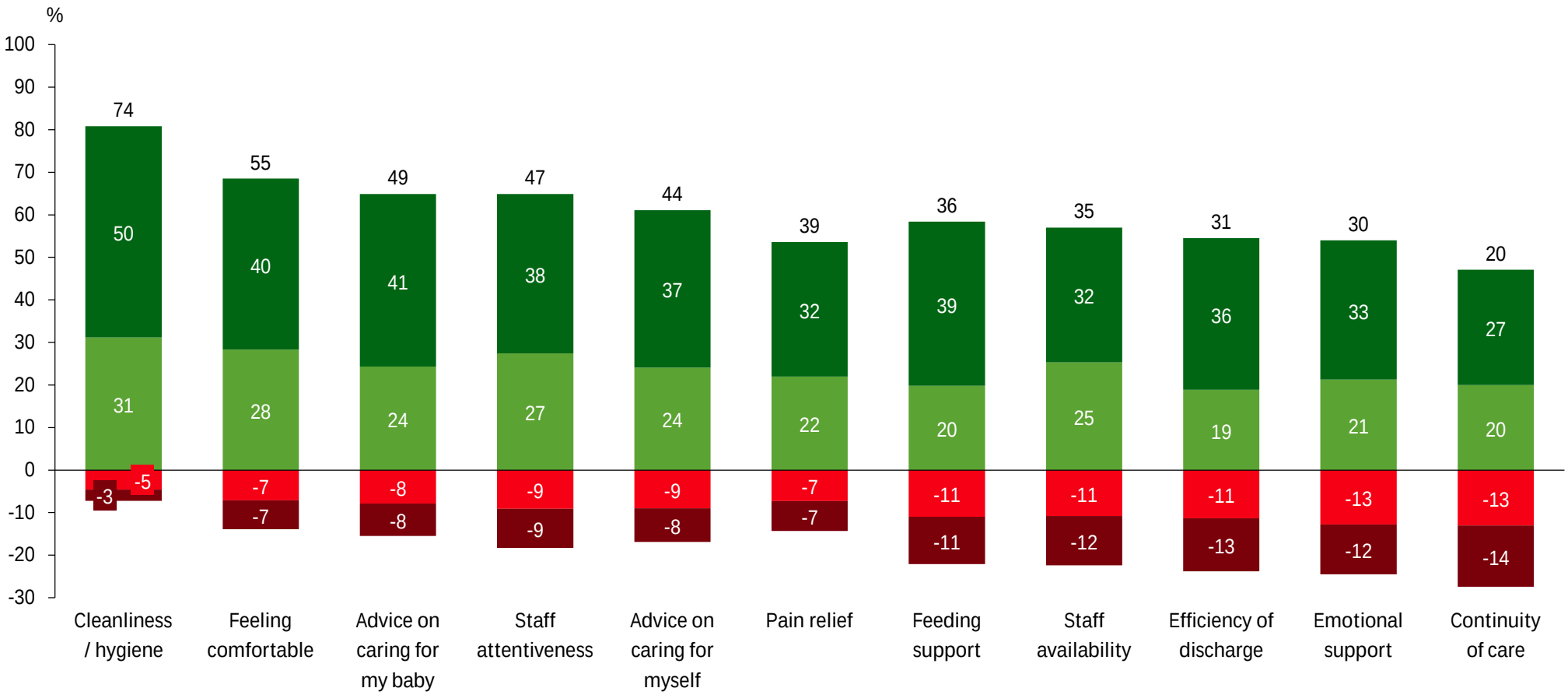


Source: Pragma Maternity Services Online Survey March 2019

Cleanliness and hygiene was highly rated, but service users were least satisfied with the continuity of care and emotional support received

Journey | Postnatal Care | Ratings

Q. Thinking about your experience and the care you received after giving birth, please rate each of the following
Base: All service users (1,013)



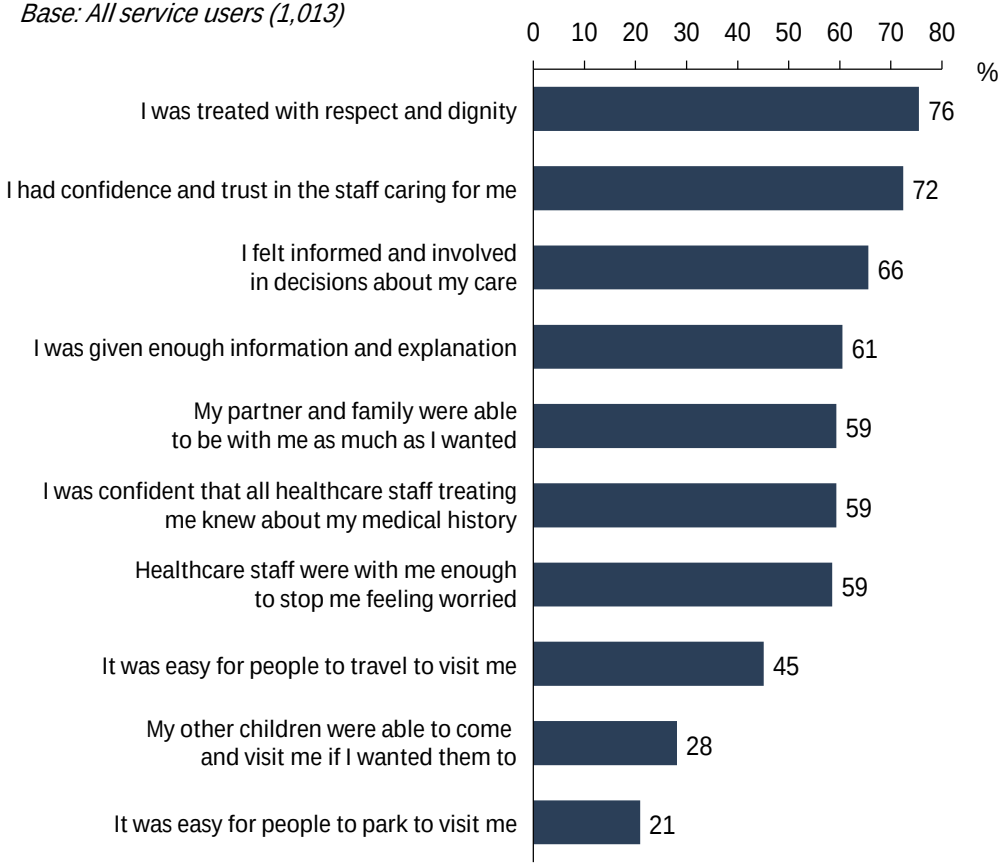
Source: Pragma Maternity Services Online Survey March 2019

Notes: The net score is calculated by subtracting sum of poor and very poor from sum of good and excellent

When asked about their postnatal experiences, residents of all council areas disagreed that it was easy for visitors to park and for other children to visit. Cherwell and S. Northamptonshire residents reported significantly less satisfaction with ease of visitor travel

Q. Thinking about your experience and the care you received after giving birth, please indicate the extent to which you agree with each of these statements on a scale of 1 to 5 where 1 is strongly disagree and 5 is strongly agree. % strongly agree + agree

Base: All service users (1,013)



% of service users selecting strongly agree + agree by area					
Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northam-ptonshire
(321)	*(191)*	*(163)*	*(148)*	*(118)*	*(63)*
76%	74%	73%	79%	74%	77%
69%	70%	73%	77%	75%	75%
63%	66%	62%	77%	66%	55%
59%	58%	62%	65%	58%	63%
57%	64%	59%	63%	52%	57%
59%	59%	55%	60%	64%	67%
57%	57%	58%	62%	57%	61%
32%	58%	48%	54%	41%	27%
26%	34%	31%	25%	24%	23%
21%	19%	26%	18%	20%	18%

Source: Pragma Maternity Services Online Survey March 2019

Feedback from service users across the catchment area regarding postnatal care can be grouped into themes around staff availability, continuity of care, partners staying overnight and logistics

Postnatal care

Journey | Postnatal Care

"With the medical knowledge and expertise in the theatre at the JR, I wouldn't want to be anywhere else, but they're just so overstretched on the wards after, that's where it goes downhill." Service User, Banbury

"The staff were really caring but you could see they were really struggling to cope with the workload. It also took almost 24 hours to be discharged." Service User, Oxford City

"The ward at the JR was overrun and the staff simply didn't have the time to be as engaged as I'm sure they would like to have been. My son and I both had infections. It seemed no one had an overview of our drugs monitoring schedules which meant that virtually every hour overnight one or other of us needed some input from midwives." Service User, Vale of White Horse

Staff availability / burden on JR

"I was very poorly after the birth. I remember lying there and I couldn't get to my baby. I felt so very guilty about it. I just don't remember holding him. I couldn't get to him because my husband had gone home." Service User, Wantage

"I saw so many people afterwards and they are asking the same questions over and over again and I just hated it." Service User, Banbury

Continuity of care

Partner staying overnight

"It was hard for me having to leave my partner and poorly baby just a few hours after she was born. I couldn't return until 9am the next day." Partner of Service User, Cherwell

Logistics: travelling and finding parking

"My husband was told he couldn't stay…so he drove home. I was really worried about him driving home so tired." Service User, Banbury

"I was stressing as much about parking at the JR as I was about actually giving birth there." Service User, Wantage

"Traveling to the JR is not easy, wherever you are traveling from, but I felt extra anxious due to local roadworks." Service User, Vale of White Horse

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

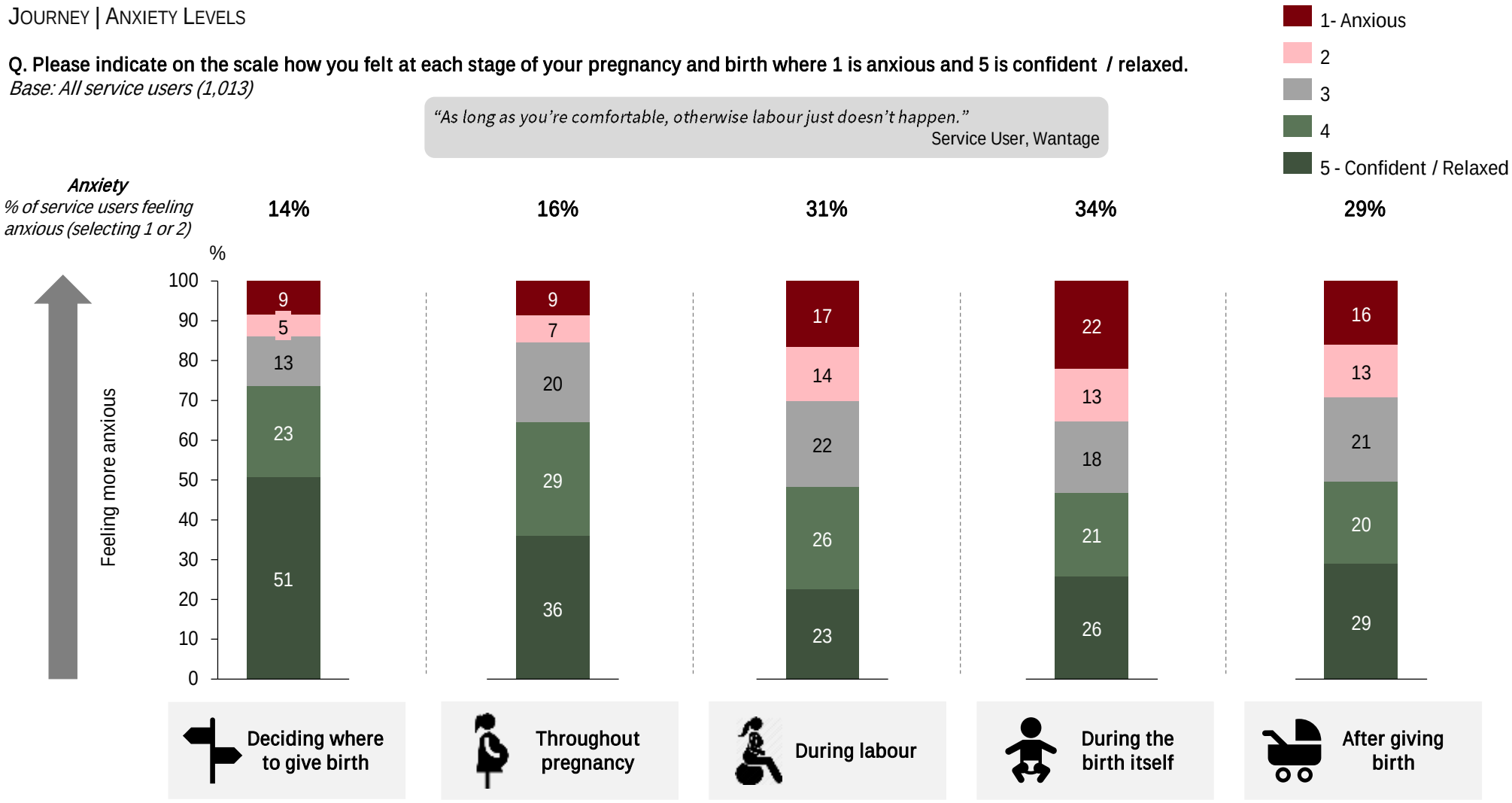
Stress and anxiety impact birth experience, can stall labour and change outcomes, and can cause lasting emotional damage. Anxiety levels increase significantly during the labour and birth periods

Reflections

Journey | Anxiety Levels

Q. Please indicate on the scale how you felt at each stage of your pregnancy and birth where 1 is anxious and 5 is confident / relaxed.
Base: All service users (1,013)

> *"As long as you're comfortable, otherwise labour just doesn't happen."*
> Service User, Wantage

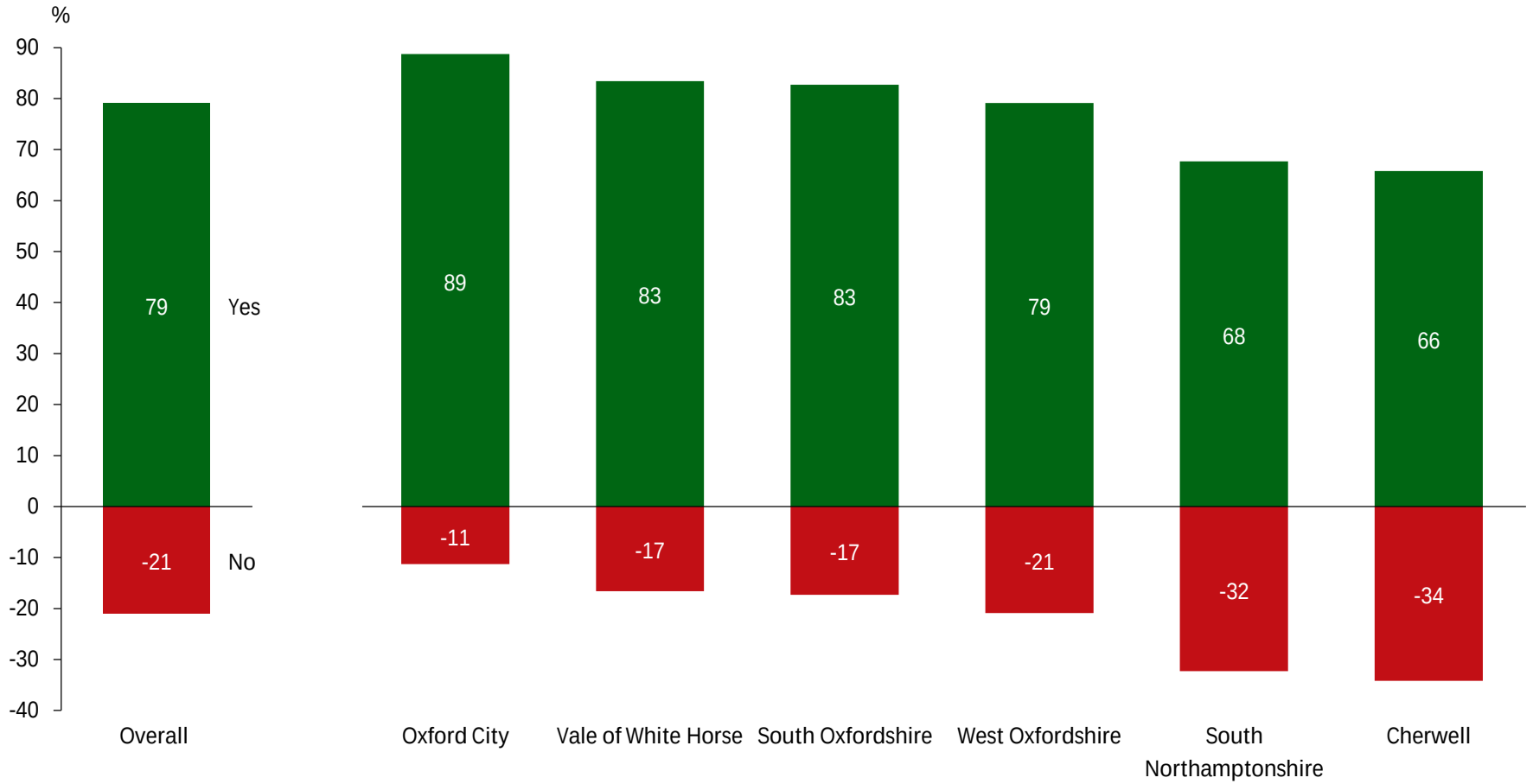


Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

On reflection, 79% of service users would have chosen the same place to give birth. Cherwell residents are least likely choose the same place to give birth

Q. Reflecting on your experience, would you have chosen the same place to give birth?

Base: All service users (1,013)

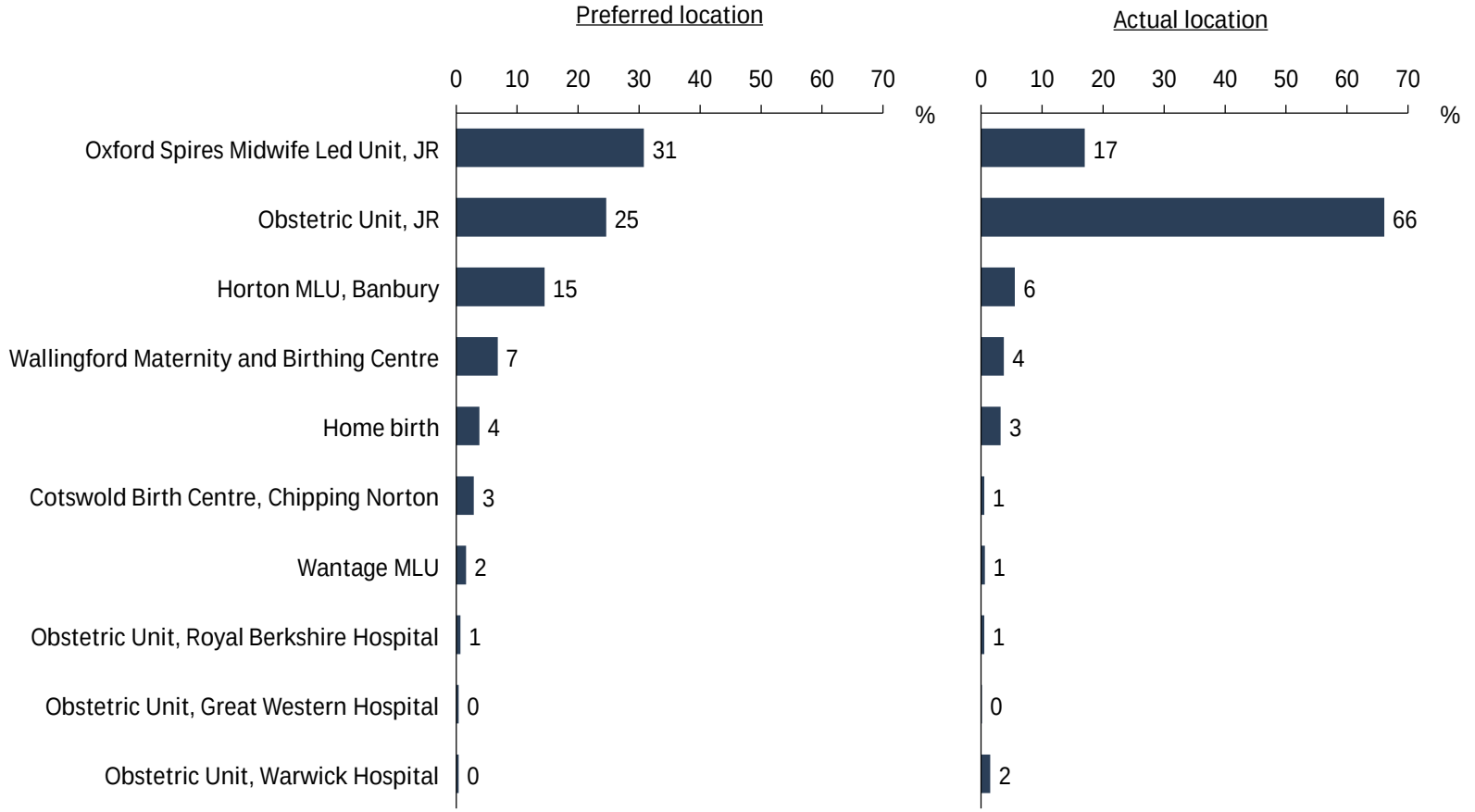


Source: Pragma Maternity Services Online Survey March 2019

More service users would prefer to give birth at both Oxford Spires and the Horton than end up delivering there. In contrast, more service users end up delivering at the Obstetric Unit at the JR than would have chosen to do so

Reflections

Q. ...and which of those places would you have preferred to have given birth at?
Q. ...and which of these places did you actually give birth at?
Base: All service users (1,013)



'Conversion' between preferred and actual location
0.55
2.69
0.38
0.54
0.84
0.17
0.38
0.71
-
-

Source: Pragma Maternity Services Online Survey March 2019

Contents

In 2016, Better Births, a National Maternity Review was published and outlined priorities for maternity services in the UK

1. **Personalised care,** centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.

2. **Continuity of carer,** to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions.

3. **Safer care,** with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong.

4. **Better postnatal and perinatal mental health care,** to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family.

5. **Multi-professional working,** breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies.

6. **Working across boundaries** to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed.

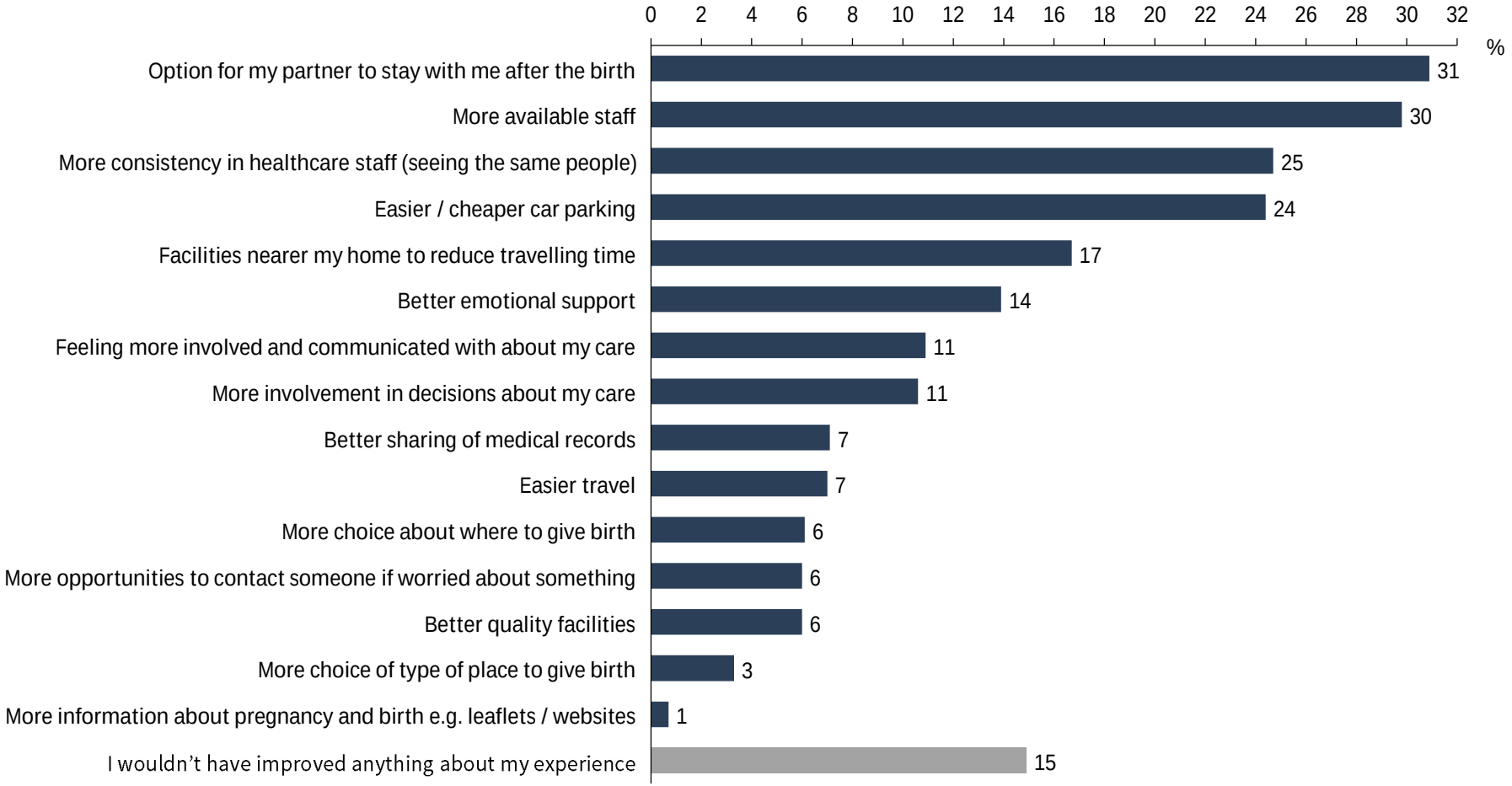
Source: Better Births 2016

The improvements suggested by service users also feature many of the priorities outlined in Better Births

Reflections

Q. How could your overall experience have been improved? Please select up to 3 reasons

Base: All service users (1,013)



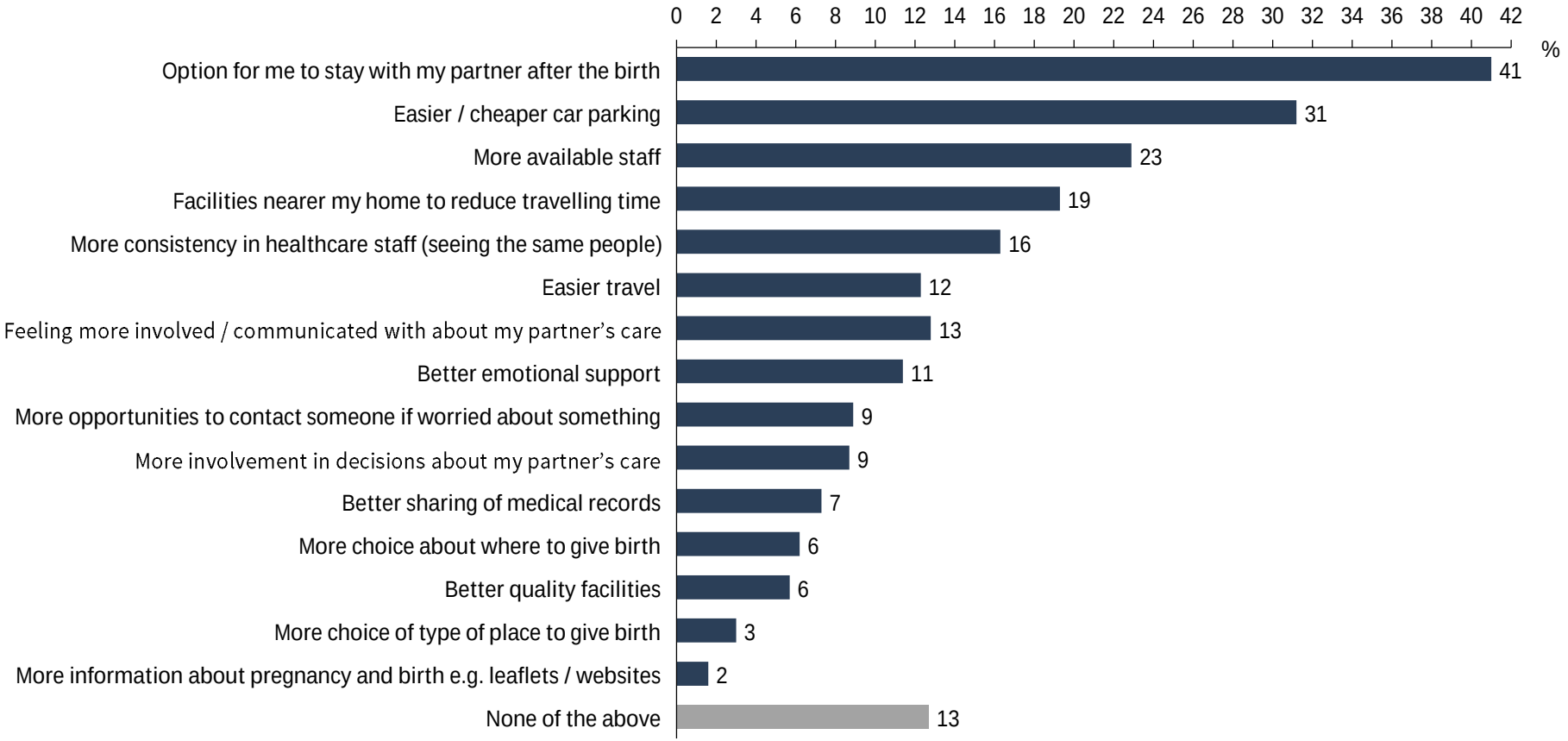
Source: Pragma Maternity Services Online Survey March 2019

Partners of service users cite similar areas for improvement, but with greater emphasis on practical improvements around parking and accessibility

Partner loop

Q. How could your overall experience have been improved? Please select up to 3 reasons

Base: All partners (436)



Source: Pragma Maternity Services Online Survey March 2019

These priorities also match the improvements suggested in the focus groups and interviews

Reflections

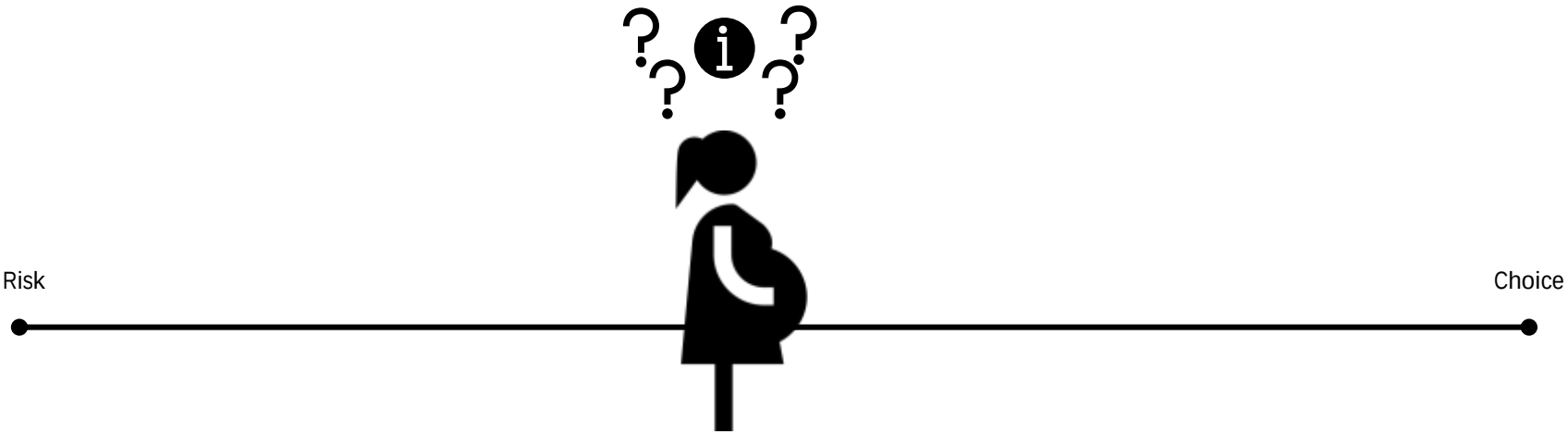
Impact & Improvements | Qualitative Improvements

Partner allowed to stay after the birth	*"The main thing I would change is partners staying. He was told at 9pm that he had to go. It certainly affected how I felt about our family unit in the early days."* Service User, Wantage
	"Better communication between the community midwife and the hospital team about the pathway I was on and being kept aware of what's going on. I was in hospital for 3 days before I saw a consultant. That makes a difference as a patient, you want the information and to know the plan." Service User, Banbury
Feeling safer, more supported and with more available staff	*"It was so busy in the JR, it felt a bit like being on a conveyor belt."* Service User, Cherwell
	"I think the midwives should work in a small team and then the mums should get to know those midwives and at least have then a friendly face." Service User, Wantage
Better continuity of care	*"When you were actually able to get someone into the room to help you, you had to explain everything. Having the same midwife would have helped massively. My wife was kept in hospital initially because her heart rate was so erratic, I think it was the stress'."* Partner of Service User, Banbury
	"It was extremely difficult for me to see my partner and toddler which affected his bond with my baby. Travel was over an hour and parking the same." Service User, Cherwell
Logistics	*"Visiting hours should be in the morning and then the evening rather than just afternoon and evening. With traffic, it was impossible for my husband and other child to visit me."* Service User, South Northamptonshire
More joined up communication and access to records	*"The best things about the blue folder is all the information about the appointments and what to expect. Those won't necessarily be available in such an easy access format if they move to electronic records."* Service User, Wantage
	"When you're going through pregnancy and birth, particularly the first time, it's quite scary and daunting. Videos or virtual tours of places you can give birth would be really helpful to let people visualise the kind of place you might go." Service User, Wantage
More information to support decision making and care	*"I had to sign a release form for my partner during a difficult birth. I still do not fully understand what I was signing for. A clearer explanation pre birth of some possible outcomes or contingencies to make the fathers aware would be beneficial."* Partner of Service User, Vale of White Horse
	"I had great support with breastfeeding but I don't think I knew anything about where to get support beforehand . You need it all written down and pinned to the fridge – it's Monday at 7am, who can I talk to?" Service User, Wantage

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

The Horton was previously the default choice for many women living nearby, yet the closure of consultant-led care has made it as a more difficult decision with greater perceived risk

Reflections



Temporary closure of consultant-led care at Horton General Hospital

"I needed a 2.5 hour repair job after my first baby, what would have been the choice if that had happened with this one? Guidelines say that women have a choice, I didn't feel like I had a choice as I wanted medical facilities."
Service User, Banbury

"There's a general sense of anxiety and uncertainty now around the birthing options. A few years ago, we assumed that we would give birth at our local hospital."
Service User, Banbury

"Feeling safe, feeling like you have a nest. It all feels like it's been shifted down our priorities because of what's happened at the Horton. This time around, I'm thinking risk management, practicality management, how am I going to make this work in a way that is not going to impact me, my baby and my family."
Service User, Banbury

"After 2 hours at the Horton, the baby's heartbeat kept going dangerously low. Then it turned serious and that's when you realise there is nothing here. It's alright having a birthing pool and a radio and lights but we didn't think about what happens when things get serious because it was our first one. All the midwife had was a stethoscope and a mirror."
Partner of Service User, Banbury

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

Cherwell residents express more negative words than all service users, reflecting the practical challenges with the distance travelled and the resulting anxiety

Q. Overall, what 3 words would you use to describe your experience of the maternity services during this recent pregnancy and birth? *Base: All service users (1,035)*

The size of the words is determined by the number of times the words were mentioned

Exclusive words in the top 20
(when all words are ranked by number of mentions, which words are unique in the top 20)

Key position differences

All service users (1,035)

Positive
Informed
Safe

Cherwell residents (329)

Scary
Disappointed
Far

Source: Pragma Maternity Services Online Survey March 2019

Individual service user journeys highlighted incidences where the closure of the Horton obstetrics had a direct negative impact upon either the service user experience and / or resulted in increased risk (1/3)

This slide outlines the story of a single journey of a service user

- Errors with care pathway in community services and communication
- High blood pressure discovered during appointment at the Horton after reduced movements - Ambulance transfer to JR
- 2 week stay in hospital followed by emergency caesarean section at 2 months premature
- 6 week stay in SCBU – presented challenges for visiting and sibling childcare increasing journey anxiety
- Baby now healthy

"I had absolutely no choice whatsoever, it was 'this is a medical emergency,' and 'our way or no way,' and there was very little information."

"My husband missed the birth as it was an emergency. I had a two week inpatient stay with a two year old, a 40 minute drive and very limited visiting hours. Not having access to that support was distressing. I felt like a prisoner and cried with relief when I finally left."

"They don't let you off the unit until your blood pressure is stable so I couldn't even go to the local park with my toddler. They should have an arrangement so you can see other children. It's the human cost of organisational things."

"The care was very good at the JR but I was traumatised by it all – it was such a shock and so sudden."

"You can't take a 2 year old to SCBU, we were only able to visit every other day."

"If she'd been in SCBU in Banbury, it would have been so much easier."

"It was the worst experience of my life."

"Have to give information to the patient, if anyone had mentioned pre-eclampsia at any point, I would have monitored it. But they didn't."

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

Individual service user journeys highlighted incidences where the closure of the Horton obstetrics had a direct negative impact upon either the service user experience and / or resulted in increased risk (2/3)

This slide outlines the story of a single journey of a service user

- Stillbirth at JR at 23 weeks following history of miscarriages
- High levels of anxiety around travel and parking at JR for appointments and visiting
- Financial impact associated with distance from loss of earnings, parking and fuel costs
- Distance from home reduced access to support network limiting visits from partner and parents and intensified patient anxiety and sense of isolation

"I rang my husband [after they told me I had lost the baby], who had to drive over which took him ages because it was 9 in the morning. He rang me really upset from the car park, because he was queuing and couldn't find anywhere to park."

"I was driving around for ages and you just end up getting more and more stressed, fighting over spaces…it's whoever can get there first."

"I went in for a routine appointment and drove and did park and ride. I left my house at 11 and got back at 5, so it's a whole day."

"The financial effect this has had on us has been an added extra to the anxiety. Last year I lost hundreds if not over a thousand pounds in loss of earnings for both of us, fuel, parking and transport costs."

"I was on an antenatal ward. A lot of people didn't know what had happened… people were speaking to me as if I was still expecting'."

"The Horton [where she had been treated for a previous miscarriage] had a homely feel, it's a much smaller place with fewer patients. It was not a nice thing to happen, but it was still a good experience. At the JR, they are overworked and you feel guilty asking for anything."

"Every person I saw said something different, it felt like I was on a conveyor belt.'

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

Individual service user journeys highlighted incidences where the closure of the Horton obstetrics had a direct negative impact upon either the service user experience and / or resulted in increased risk (3/3)

This slide outlines the story of a single journey of a service user

- Transfer from Horton to JR during labour due to baby's slowing heartbeat
- Hour wait as on call midwife went straight to JR, resulting in Horton midwife having to travel in ambulance
- Epidural at the JR, followed by overnight stay
- During follow up, confused for another patient
- Baby now healthy

Decision-making

"We chose the Horton as I was keen to get to the hospital as quickly as possible, we live one minute away."

"I work at the JR so I did consider it."

"The closer it was getting to my due date, the more I was thinking 'I just want to be close to home.'"

Antenatal care

"We got there [at the Horton] and the room was lovely, a lovely birthing room, with a pool and gas and air, and I was having the time of my life. It started off really well."

"They made us very aware there was only one midwife there… we asked 'what if two people came in, in labour?' She said she'd have to deal with them both."

"All she had [the midwife] was a mirror and a stethoscope."

"It was fine when it was all going well, but when we realised we needed actual serious help… there is no help."

"When we went into the JR I realised just how little there is at the Horton. It was like this IS a hospital, it was a massive thing of relief."

Labour & Birth

Postnatal care

"I stayed in overnight, the midwife who looked after me after was incredible – she helped me to get [baby] to latch on and feed and to get me into the shower."

"It was very daunting, I've got a brand new being and they just pull the curtain around us and say goodnight."

Reflections

"We want the Horton to stay open, we want to use the facilities, we thought 'if we use it, maybe we can encourage others to use it.'"

"I would now advise anyone not to go there, and don't waste your time [with the Horton]."

"I can't knock the JR with anything, the experience was great."

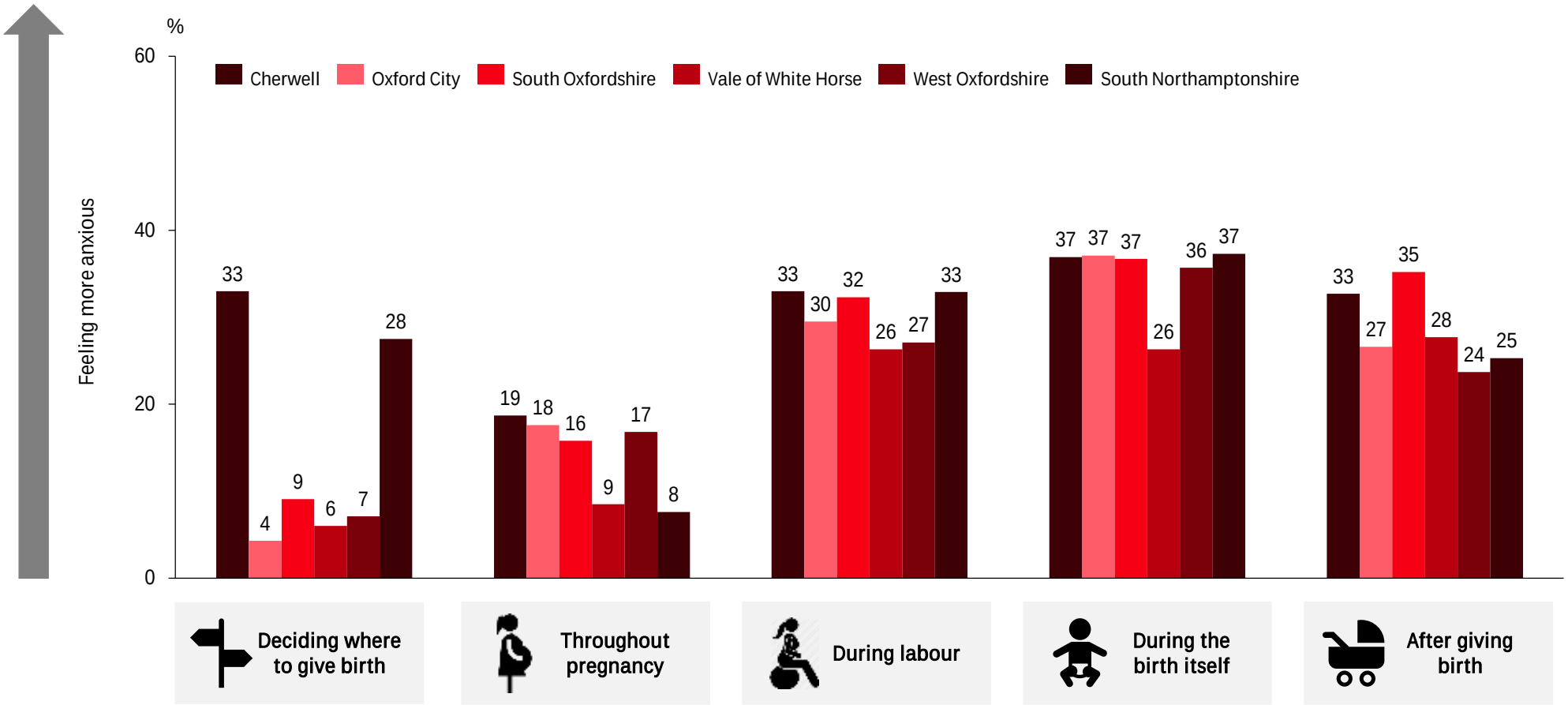
Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

On reflection, those in Cherwell and S. Northamptonshire report higher levels of anxiety when deciding where to give birth

Reflections

Q. How did you feel at each stage of your pregnancy where 1 is anxious and 5 is confident? ***% of service users feeling anxious (selecting 1 or 2)***

Base: Cherwell (321), Oxford City (191), South Oxfordshire (163), Vale of White Horse (148), West Oxfordshire (118), South Northamptonshire (63), Stratford Upon-Avon (9)



Source: Pragma Maternity Services Online Survey March 2019

Feedback from service users in the Banbury area can be grouped into themes around emotional support, travel time, parking and risk of transfer

Reflections

"There was the fear of being transferred and something going wrong." Service User, Banbury

"I don't want to be in the later stages of labour in an ambulance." Service User, Banbury

"I had to follow an ambulance to Oxford at 6am after 8 hours of labour. I can't imagine how my wife felt doing that without me." Partner of Service User, Cherwell

3 women who answered the survey gave birth in transit, 1 from West Oxfordshire and 2 from Cherwell

"My daughter was in special care. My in-laws had to travel from Cornwall and watch my older child. We couldn't visit her as much as we would've liked and she didn't have a great a deal of contact in the early weeks of her life. Having her closer to hand in Banbury would've made it easier."
Service User, Banbury

"It would have been wonderful to have my baby at the Horton, as I did with my first two babies. It's close to where I live so family can pop in to visit."
Service User, Banbury

- Risk associated with transfer
- Emotional support / visiting
- Parking
- Travel time

"I almost missed my child's birth because of parking at the JR." Partner of Service User, Cherwell

"The financial effect this has had on us has added hugely to my anxiety…last year I lost hundreds, if not thousands of pounds in loss of earnings for both of us, fuel, parking and transport costs."
Service User, Banbury

"You don't want to have to travel a long distance or think about how you are going to get there. Having to decide if you are going to get there in time and can you park…you just don't need that added stress on the baby or yourself.
Service User, Banbury

"I cannot imagine myself having contractions and driving to Oxford, being stuck in traffic." Service User, Banbury

"My partner had to travel quite fast; we got to one set of traffic lights and my waters broke and her head was coming out." Service User, Banbury

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

Partners of service users are also feeling the impact of changes at the Horton with Cherwell residents rating ease of visiting and choice of locations lower than other council areas

Partner loop

Q. Thinking about your recent experience during your partner's pregnancy and birth, please rate each of the following from your own perspective on a scale of 1 to 5 where 1 is very poor and 5 is excellent

Base: All partners (436)

		Net score (sum of good and excellent minus sum of poor and very poor)					
	Total	Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northam-ptonshire
	(436)	*(149)*	*(74)*	*(67)*	*(59)*	*(55)*	*(28)* *low base, indicative only*
Staff attentiveness	**53%**	45%	70%	46%	57%	61%	23%
Staff availability	**41%**	32%	53%	30%	54%	45%	18%
Ease of visiting	**34%**	12%	63%	32%	46%	29%	7%
Continuity of care	**28%**	22%	41%	21%	28%	40%	13%
Choice of locations (for appointments and for labour)	**27%**	10%	43%	33%	48%	19%	-9%
Travel times (for appointments, birth and afterwards)	**25%**	6%	69%	32%	41%	-6%	-27%
Ease of childcare for siblings (if applicable)	**6%**	8%	-1%	2%	7%	22%	-3%
Ease of parking (for appointments, birth and afterwards)	**-11%**	-12%	-4%	-22%	1%	-16%	-16%

Source: Pragma Maternity Services Online Survey March 2019

Notes: The net score is calculated by subtracting sum of poor and very poor from sum of good and excellent

Other options for service users in Banbury include Warwick, The Spires and The Cotswold Birth Centre. Each of these alternatives comes with issues / challenges which limit their appeal

Reflections

Warwick

"Because I said I was going to go to Warwick, the Horton wouldn't deal with me, they wouldn't do any scans…it's sort of disappointing because you think I haven't done this... They give you Warwick likes it an option, but when you take it as an option they make it hard for you."
Service User, Banbury

"I chose Warwick purely on logistics, not for care or medical reasons."
Service User, Banbury

As an alternative to the Horton, Warwick is generally chosen due to logistical benefits. Service users report issues around joined-up care between trusts

Spires, JR

"I liked knowing that the hospital was just downstairs." Service User, Wantage

"I was pulled out of a birthing pool in the Spires at 8cm dilated as the unit was closed due to staff shortages." Service User, Cherwell

"And on the day that I went into labour, I rang them up and they said no, Spires is closed. We've got no staff. It's the summer. It's been closed all August. "
Service User, Wantage

The Spires is rated highly due to its ability to give MLU benefits alongside the wider medical expertise of the JR but there are issues around closures

Cotswold Birth Centre, Chipping Norton

"We're ringing the door bell and the phone – no answer, total panic and chaos. We're in the car park for an hour or more waiting."
Service User, Banbury

"I was tempted by CBC as it seemed lovely and travel and parking would be easier. The peace of mind knowing there were specialist doctors available without being carted off to another hospital was the reason I chose the JR." Service User, Cherwell

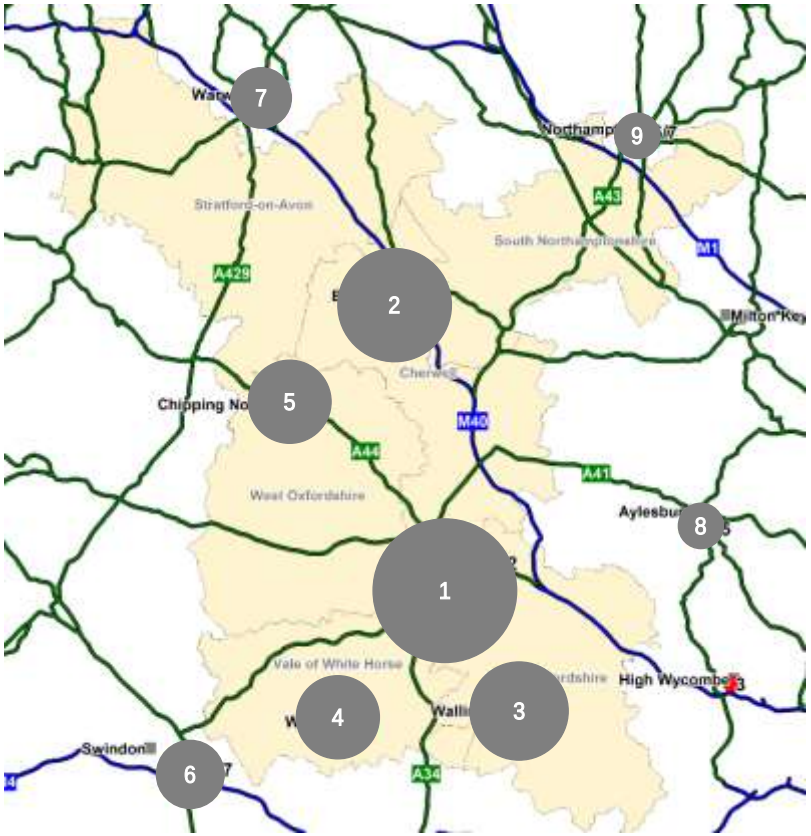
The Cotswold Birth Centre also received some negative feedback about closures

Source: Pragma Maternity Services Online Survey March 2019 , Pragma Qualitative Research April 2019

When asked to select their ideal geographical location to give birth, 24% of all service users selected Banbury…

Reflections

Q. Imagine your ideal place to give birth could be located anywhere on this map below, where would you select? *Base: All service users (1,013)*



1. Oxford: 50%
2. Banbury: 24%
3. Wallingford: 11%
4. Wantage: 5.1%
5. Chipping Norton: 5.1%
6. Swindon: 0.7%
7. Warwick: 0.5%
8. Aylesbury: 0.1%
9. Northampton: 0.1%

"I would choose to give birth at my home": 4.3%

Source: Pragma Maternity Services Online Survey March 2019

…which increases to 74% of Cherwell residents

Reflections

Q. Imagine your ideal place to give birth could be located anywhere on this map below, where would you select? *Base: All service users (1,013)*

Ideal birth location	% of service users by area					
	Cherwell	Oxford City	South Oxfordshire	Vale of White Horse	West Oxfordshire	S. Northamptonshire
	(321)	*(191)*	*(163)*	*(148)*	*(118)*	*(63)*
Oxford	21%	95%	33%	59%	55%	1%
Banbury	74%				2%	97%
Wallingford			56%	5%		
Chipping Norton	3%	0.5%			34%	
Wantage			5%	28%		
Swindon				3%	2.%	
Warwick	0.2%					
Aylesbury			0.4%			
Northampton						1%
Choose home birth	2.1%	4.8%	6%	4%	8%	1%

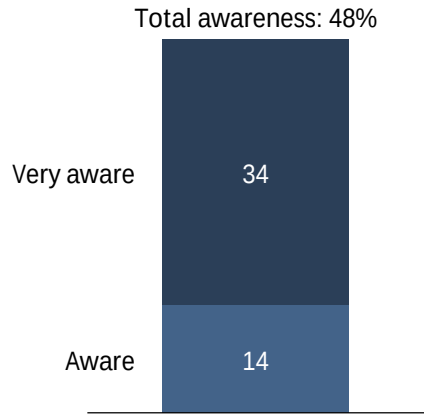
Of all survey service users who live in Cherwell, 74% selected Banbury as their ideal geographical location to give birth

Source: Pragma Maternity Services Online Survey March 2019

The awareness of changes to maternity services at the Horton is highest in Cherwell and S. Northamptonshire

Reflections

Q. To what extent are you aware of the recent change to maternity services at the Horton General Hospital in Banbury involvin g the temporary closure of consultant-led care? *Base: All service users (1,013)*



Council area	% Very aware + aware
Cherwell	81%
Oxford City	33%
South Oxfordshire	24%
Vale of White Horse	30%
West Oxfordshire	49%
South Northamptonshire	92%

Source: Pragma Maternity Services Online Survey March 2019

Notes: Council area bases: Cherwell (321), Oxford City (191), South Oxfordshire (163), Vale of White Horse (148), West Oxfordshire (118), S. Northamptonshire (63)

75% of service users in Cherwell and 93% in S. Northamptonshire would have preferred to give birth at the Horton if obstetric services had been available

Reflections

Q. Had the Horton obstetric service been available as an option to you, would you have preferred to give birth there? *Base: All service users (1,013)*

Net score: -40%

Council area	% Yes
Cherwell	75%
Oxford City	3%
South Oxfordshire	3%
Vale of White Horse	1%
West Oxfordshire	21%
South Northamptonshire	93%

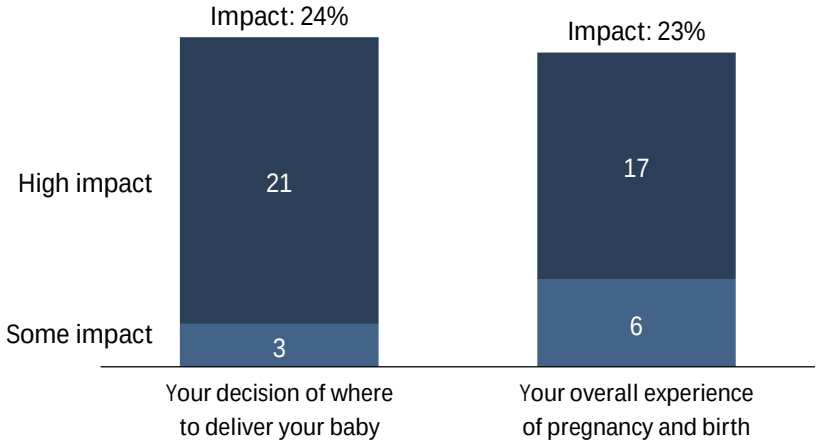
Source: Pragma Maternity Services Online Survey March 2019

Notes: Council area bases: Cherwell (321), Oxford City (191), South Oxfordshire (163), Vale of White Horse (148), West Oxfordshire (118), S. Northamptonshire (63)

68% of Cherwell service users (82% in S. Northamptonshire) feel that the temporary closure of the obstetric unit at the Horton impacted their decision of where to deliver and 59% in Cherwell and S. Northamptonshire feel it impacted their overall experience

Reflections

Q. To what extent did the temporary closure of the obstetrics unit at Horton General Hospital impact...: *Base: All service users (1,013)*



Council area	% Impact on decision	% Impact on experience
Cherwell	68%	59%
Oxford City	3%	7%
South Oxfordshire	2%	4%
Vale of White Horse	0%	6%
West Oxfordshire	13%	14%
South Northamptonshire	82%	59%

Source: Pragma Maternity Services Online Survey March 2019

Notes: Council area bases: Cherwell (321), Oxford City (191), South Oxfordshire (163), Vale of White Horse (148), West Oxfordshire (118), S. Northamptonshire (63)

Section 5

Section 5: Index of papers

Paper 1	HGH Middle grade rota 8 person
Paper 2	HGH Middle grade rota 9 person
Paper 3	HGH FY2/CT/GPVTS rota 9 person
Paper 4	pre 2016 ST 4-5 9 person rota
Paper 5	ST 4-5 9 person rota non-compliant
Paper 6	ST 4-5 10 person rota compliant
Paper 7	ST 6-7 rota pre 2016
Paper 8	ST 6-7 rota 9 person compliant
Paper 9	JR FY2/ST1-2/GPVTS 14 rota compliant
Paper 10	JR Consultant cover 114 hours and tertiary service
Paper 11	24 hour consultant cover for labour ward at HGH and 114 hours at JR plus JR on call and specialist services
Paper 12	HGH 24 hour consultant cover for labour ward at HGH and 114 hours at JR plus JR on all and specialist services (single pool)
Paper 13	HGH hybrid rota consultants and middle grade doctors
Paper 14	All OUHFT Consultants and middle grades with on call at JR plus 114 hours JR cover plus a mixture of on call and resident at HGH
Paper 15	Combined ST3-7 covering both JR and HGH
Paper 16	St 4-5 covering both sites with ST 6/7 at JR

Section 5: Obstetric Workforce Models

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

Option number	Number of consultant obstetricians	Number of middle grade doctors	Number of tier 1 doctors	Associate specialists MSW	Total additional staff required	Paper ref no.
Ob1	20 (15 JR 5 HGH)	29 (9 HGH 20 JR)	15 (JR) 3 (HGH)	4 (HGH)	0	Papers 1-10
Ob2a	35 (total) 15 (JR) 20 (HGH)	20 (JR)	15 (JR)	4 (HGH)	15 consultants	Papers 10-11
Ob2a (with Tier 1 support)	35 (total) 15 (JR) 20 (HGH)	20 (JR)	15 (JR) 9 (HGH)	0	10 consultants 9 tier 1 doctors	Paper 11
Ob2b	30 (total) 32.4 (total) if no tier 1 support	20 (JR)	15 (JR) 9 (HGH)	Or 6 (HGH)0	10-12.5 consultants but would need recruit subspecialist consultants rather than general consultants	Paper 12
Ob2c	20-40 (total see table in paper 13)) 15 (JR) 5-20 (HGH see table in paper 13)) 5-23 if no tier 1 support)	20 (JR) 0-9 (HGH)	15 (JR) +/- 9 (HGH)	+/- 6 (HGH)	See Table in paper 13.	Paper 13
Ob2d	21-33 (see table in paper 15)	20-28 (see table In paper 15)	15 (JR) 9-1	3-6	See Table in paper 15	Papers 14,15
Ob6	16	20	15	0	0 current temporary reconfiguration	
Ob10	20	30	15 (JR) 9-1(HGH)	3-6	1 Trust grade.	Paper 16
Ob 11	20	30	15 (JR) 9-1 (HGH)	3-6 (HGH)	1 middle grade Same as above as limited by post 2016 contract. May be easier to recruit into	Paper 16

Careers in Obstetrics and Gynaecology

Introduction

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

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

Doctors who choose to work in this speciality have combined training both in obstetrics and gynaecology and the majority of consultants are *Consultant Obstetricians and Gynaecologists*.

Some consultants having undertaken additional higher training are recognised as experts in a particular field. They are known as *Consultants with Subspecialist training*. At this point they are usually either *Consultant Obstetricians* or *Consultant Gynaecologists*.

Training to become a Consultant Obstetrician and Gynaecologist

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

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

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

Specialist trainees in years 4 and 5 (ST4-5) can work more independently but require supervision for more complex cases. In year 6 and 7 (ST6-7) there is the opportunity for sub speciality training in a more defined area of obstetrics and gynaecology. When a doctor successfully completes training they are awarded a **Certificate of Completed Training** and can be added to the Specialist Register. They are now able to work as a consultant in Obstetrics and Gynaecology

Some doctors who have trained outside the NHS can apply to get on to the Specialist Register by applying for a **Certificate of equivalent specialist registration (CESR).**

Medical teams in Obstetrics

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

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

Number of medical staff required to run a service

This depends on the size and type of maternity service.

A small unit with less complex cases and fewer deliveries happening over a period of time will require different resources that a large busy unit with specialist services and a higher foot fall through delivery suite.
Doctors are not just required to assist the labour ward but to attend women who are inpatients or present through Emergency Department and the Maternity assessment units.

A smaller unit may require 2 doctors to be present with as a larger unit may require 3 with consultants on call from home. Traditionally the recommended numbers are as below from Safer Births 2007 however it is recognised that other models of care can be used for very small units which have less than 1500/deliveries per year. The recommendations with regards to the number of hours of consultant presence should be agreed at a local level. A minimum of 40 hours is recommended for all obstetric units and in larger units such as the JR this could be up to 168 hours.
The local arrangement is currently for 114 hours at the John Radcliffe Hospital and 40 hours at the Horton General Hospital.

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

Work force planning in Obstetrics.

Junior and middle grade doctors

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

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

<u>Consultant Job plans</u>

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

- A consultant will not work more than 3 PAs/week of out of hours duties.
- In order to provide continuity of a specialist tertiary service, these specialist consultants will work no more than 2.2 PAs/week of out of hours service.

Glossary for Section 5 papers

CT	Core Trainee. A doctor in training but not yet in a speciality.
FY	Foundation Year (i.e. FY1 – Foundation Year 1, FY2 – Foundation Year 2)
GPVTS	General Practice Vocational Training Scheme. The route to training of UK General Practitioners on completion of the Foundation Year Programme.
HGH	Horton General Hospital
JR	John Radcliffe Hospital
PA	Programmed Activity. A timetabled value of four hours (or three hours if the PA is undertaken in premium time) of Consultant time.
Resident	The consultant stays in the hospital while covering emergency duties in case their direct presence is needed.
SARD	The computer programme used to develop rotas for doctors in training that are compliant with the 2016 contract.
ST	Specialty Trainee. The number denotes the year of training e.g. ST3 is a junior doctor in their third year of specialty training.
SpR or STR	Specialist Registrar.
TCS	Terms and Conditions. NHS Employers negotiates nationally on behalf of employers with the NHS trade unions on national terms and conditions of service (TCS) and pay arrangements.
Tertiary	Highly specialised service. Consultants from surrounding hospitals make ‘tertiary’ referrals to the JR for specialised obstetric care.
WTE	Whole time equivalent (e.g. someone working 3 days per week would be 0.6 WTE)
WTR	Working Time Regulations

Oxford University Hospitals NHS Trust, horton, Obstetrics and gynaecology, Middle Grade 8 person rota, F1, Resident. No monitoring.

Band 1A (Based on template only)

Steps through the banding flowchart:

- New Deal Compliant
- Average work 48 hours a week or less
- Work pattern is a full shift, partial shift or hybrid
- 1 weekend in 4 or more frequent (1 in 4.00)

Note: The band of a rota may change if monitored hours of work are different to those suggested by the theoretical work pattern. It is particularly important to remember this if a theoretical work pattern is close to the limits of a particular payband. Differences between calculated prospective cover and actual work done by doctors to cover absent colleagues can also cause a variance between theoretical and monitored bands.

Template - No Prospective Cover

New Deal Analysis

Item	Actual	Target	Comments
Average weekly hours of duty	47:45	56:00	
Average weekly hours of work	47:45	56:00	
Longest duty period	12:30	14:00	
Shortest off duty	11:30	08:00	
Longest 'off duty' period	76:00	62:00	
Next longest 'off duty' period	72:00	48:00	
Maximum consecutive duty days	9	13	
62+48 hr. breaks every 28 days	OK		

European Working Time Directive Analysis

Item	Actual	Target	Comments
Average weekly hours of work	47:45	48:00	
Starting each Monday, a 35 hour continuous rest in 7 days or a 59 hour continuous rest in 14 days	OK		
11 hrs continuous rest in any 24 hour period	OK		

Availability of normal days (Based on template only)

In a 52 week period, doctors are available during normal hours on 199 days
This reduces to 139 assuming that 60 of these days will be taken as leave

This is equivalent to 2.67 days per week.

See the paper "The European Working Time Directive 2009" by Yasmin Ahmed-Little and Matthew Bluck in "The British Journal of Health Care Management" 2006, Vol. 12, No. 12 for details of the calculation and its implications.

Template work pattern

Wk	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	A: Night 21:00 09:00	A: Night 21:00 09:00	A: Night 21:00 09:00	A: Night 21:00 09:00	Zero Hours		

Full Group Analysis

Wk	Mon	Tue	Wed	Thu	Fri	Sat	Sun
2	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00		
3	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00		
4	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Zero Hours	A: Night 21:00 09:00	A: Night 21:00 09:00	A: Night 21:00 09:00
5	Zero Hours	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00		
6	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Zero Hours	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00
7	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00		
8	C: Floater 08:30 17:00	C: Floater 08:30 17:00	C: Floater 08:30 17:00	C: Floater 08:30 17:00	C: Floater 08:30 17:00		

Template normal working days

Normal Week	Start	End	Rest	Hours	Num of Diary Cards	Ave Start	Ave End	Ave Rest	Ave Hours
Mon	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00
Tue	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00
Wed	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00
Thu	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00
Fri	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00

Template on call duties

Name	Intensity	Resident	Start	End	Rest	Hours	Num of Diary Cards	Ave Start	Ave End	Ave Rest	Ave Hours
A: Night	Full Shift	Yes	21:00	09:00	00:00	12:00	0				
B: Long Day	Full Shift	Yes	08:30	21:00	00:00	12:30	0				
C: Floater	Full Shift	Yes	08:30	17:00	00:00	08:30	0				

Cover Analysis

Monday

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
	1	1	1	1	1	1	1	1	1	6	6	6	6	6	6	6	6	1	1	1	1	1	1	1

Tuesday

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1																								
2																								
3																								

Full Group Analysis

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
4																								
5																								
6																								
7																								
8																								
	1	1	1	1	1	1	1	1	1	7	7	7	7	7	7	7	7	1	1	1	1	1	1	1

Wednesday

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
	1	1	1	1	1	1	1	1	1	6	6	6	6	6	6	6	6	1	1	1	1	1	1	1

Thursday

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
	1	1	1	1	1	1	1	1	1	6	6	6	6	6	6	6	6	1	1	1	1	1	1	1

Friday

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1																								
2																								
3																								
4																								
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Saturday

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Sunday

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Oxford University Hospitals NHS Trust, horton, Obstetrics and gynaecology, Middle grade 9 Person rota, STR, Resident. No monitoring.

Band 1B (Based on template only)

Steps through the banding flowchart:

- New Deal Compliant
- Average work 48 hours a week or less
- Work pattern is a full shift, partial shift or hybrid
- Less than 1/3 of duty hours outside 7am to 7pm Mon-Fri (.253) and less than 1 weekend in 4 (1 in 4.50)

Note: The band of a rota may change if monitored hours of work are different to those suggested by the theoretical work pattern. It is particularly important to remember this if a theoretical work pattern is close to the limits of a particular payband. Differences between calculated prospective cover and actual work done by doctors to cover absent colleagues can also cause a variance between theoretical and monitored bands.

Prospective Cover Calculations

Prospective cover for: Duties outside normal hours.

Leave: SPR - 50 days/annum for 9 doctors = 450 days/annum

Total leave to be covered for the group = 450 days/annum
Between 9 doctors this is 50 days/annum each (10 wks/annum each)

The normal working week = 40:00 per week.
Cover to be provided for all out of hours duties = 06:53 per week. (Total Duty hrs - Normal week hrs)
Each doctor must cover 6.889 x 50 / (365 - 50) hours/week
This gives an average 1.093 hours/week for prospective cover.

New Deal Analysis

Item	Actual	Target	Comments
Average weekly hours of duty	47:59	56:00	
Average weekly hours of work	47:59	56:00	
Longest duty period	12:30	14:00	
Shortest off duty	11:30	08:00	
Longest 'off duty' period	76:00	62:00	
Next longest 'off duty' period	72:00	48:00	
Maximum consecutive duty days	9	13	
62+48 hr. breaks every 28 days	OK		

European Working Time Directive Analysis

Item	Actual	Target	Comments
Average weekly hours of work	47:59	48:00	
Average hours (before adjustments)	46:53		
Starting each Monday, a 35 hour continuous rest in 7 days or a 59 hour continuous rest in 14 days	OK		
11 hrs continuous rest in any 24 hour period	OK		

Availability of normal days (Based on template only)

In a 52 week period, doctors are available during normal hours on 206 days
This reduces to 146 assuming that 60 of these days will be taken as leave

This is equivalent to 2.81 days per week.

See the paper "The European Working Time Directive 2009" by Yasmin Ahmed-Little and Matthew Bluck in "The British Journal of Health Care Management" 2006, Vol. 12, No. 12 for details of the calculation and its implications.

Template work pattern

Wk	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	A: Night 21:00 09:00	A: Night 21:00 09:00	A: Night 21:00 09:00	A: Night 21:00 09:00	Zero Hours		
2	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00		
3	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00		
4	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Zero Hours	A: Night 21:00 09:00	A: Night 21:00 09:00	A: Night 21:00 09:00
5	Zero Hours	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00		
6	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Zero Hours	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00	B: Long Day 08:30 21:00
7	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00		
8	C: JR Clinical 08:30 17:00	C: JR Clinical 08:30 17:00	C: JR Clinical 08:30 17:00	C: JR Clinical 08:30 17:00	C: JR Clinical 08:30 17:00		
9	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00	Stnd Day 09:00 17:00		

Template normal working days

Normal Week	Start	End	Rest	Hours	Num of Diary Cards	Ave Start	Ave End	Ave Rest	Ave Hours
Mon	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00
Tue	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00
Wed	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00
Thu	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00
Fri	09:00	17:00	00:00	08:00	0	00:00	00:00	00:00	00:00

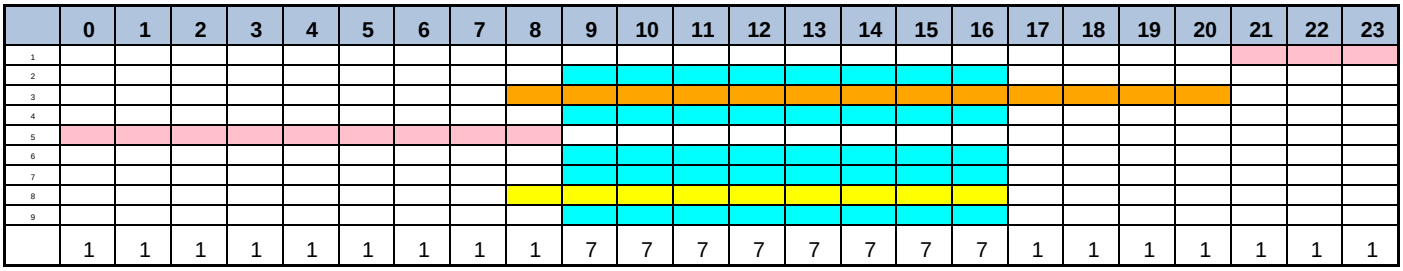
Template on call duties

Name	Intensity	Resident	Start	End	Rest	Hours	Num of Diary Cards	Ave Start	Ave End	Ave Rest	Ave Hours
A: Night	Full Shift	Yes	21:00	09:00	00:00	12:00	0				
B: Long Day	Full Shift	Yes	08:30	21:00	00:00	12:30	0				
C: JR Clinical	Full Shift	Yes	08:30	17:00	00:00	08:30	0				

Cover Analysis

Monday

Full Group Analysis



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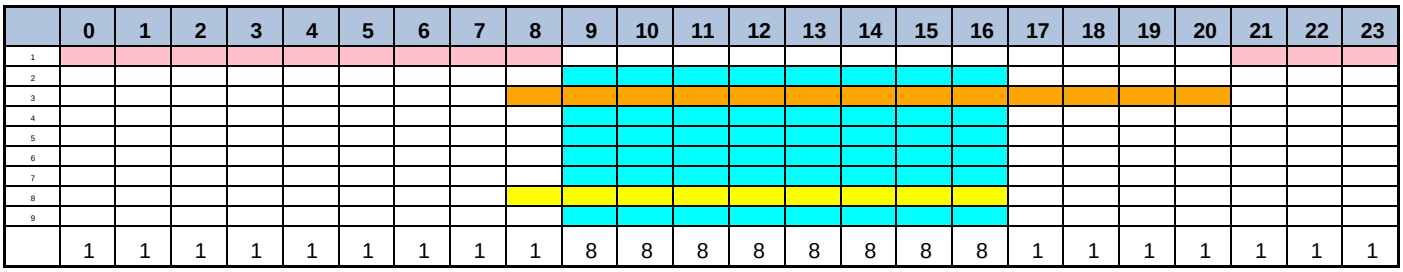
Tuesday



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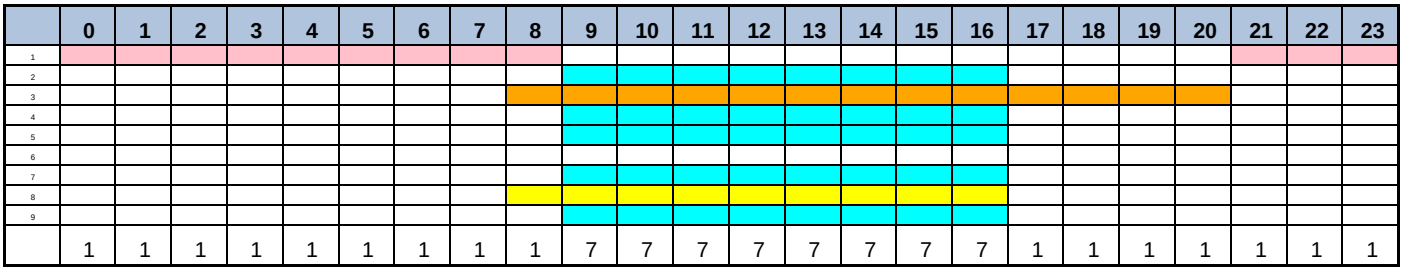
Wednesday



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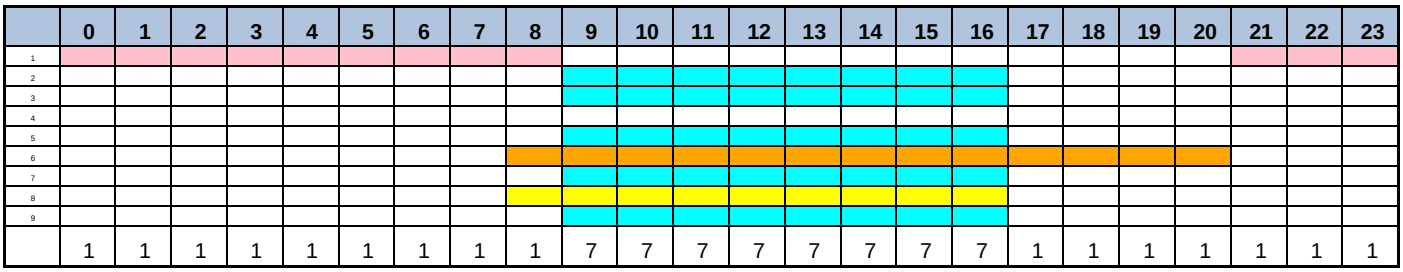
Thursday



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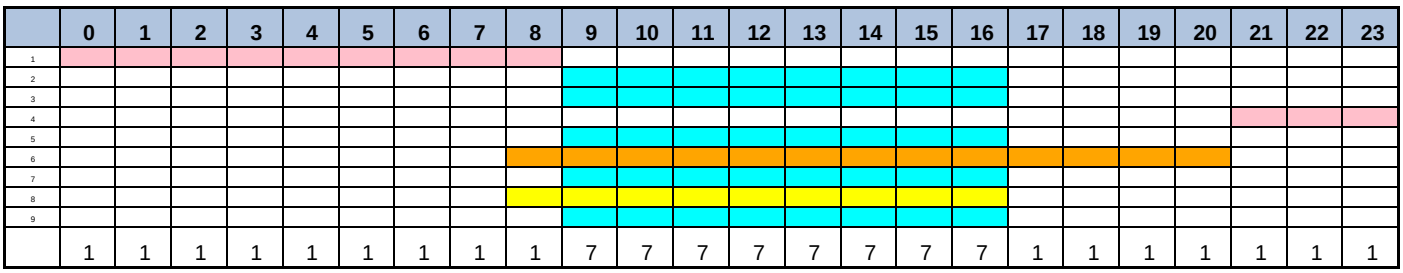
Friday



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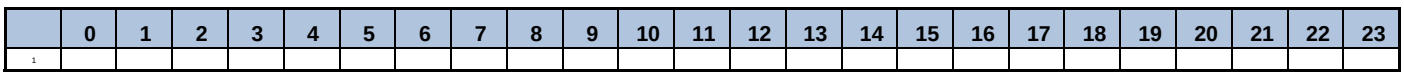
Saturday



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Full Group Analysis

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Basic details

Site: Horton

Specialty: Obstetrics and gyna

Name: Obs FY2/CT Horton

Grade: F2

On Call Dr.s: 0

Leave Entitlement: 27

Number of weeks: 9

○ Draft ○ Live ○ Archive

Standard Duties

(Click a time below to edit. You can also use the 'Tab' key to quickly navigate through times)

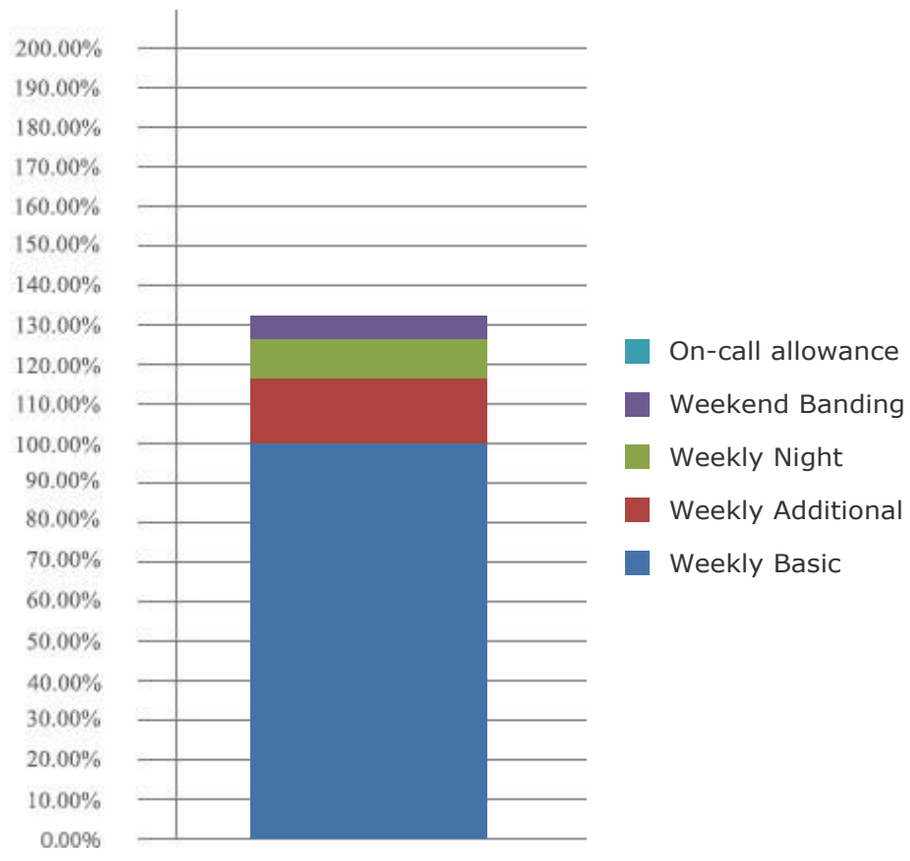
Short Name	Start	End
Mo	08:00	17:00
Tu	08:00	17:00
We	08:00	17:00
Th	08:00	17:00
Fr	08:00	17:00

	Duty Name	Code	Start	End	Intensity	Low Intensity	Day1 12am-7am	Day1 7am-5pm	Day1 5pm-9pm	Day1 9pm-12am	Day2 12am-7am	Day2 7am-5pm	Day2 5pm-9pm	Day2 9pm-12am	Resident	
○	Long Day	A	13:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
○	Nights	B	20:00	08:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
○	Weekend Day	C	08:00	17:00	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
	Zero Hours	0	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	
	Standard Duty	S	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	

Week No.	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	13:00 - 20:30	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
2	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
3	08:00 - 17:00	13:00 - 20:30	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
4	08:00 - 17:00	08:00 - 17:00	13:00 - 20:30	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
5	13:00 - 20:30	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30
6	00:00 - 00:00	00:00 - 00:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
7	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	13:00 - 20:30	13:00 - 20:30	13:00 - 20:30
8	00:00 - 00:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
9	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00

Pay Breakdown:

	Without adjustment	With leave /adjustment	With adjustment / rounding
Average Hours	46.56	46.74	46.75
Weekly Additional	6.56	6.74	6.75
Weekly Night	9.72	10.85	11.00
Weekend Banding	6.00%	6.00%	6.00%
Availability Allowance	N/A	N/A	N/A



Indicative salaries for this rota (2017-18)

Note that indicative salaries below are based on the Pay and Conditions Circular (M&D) 1/2017, and do not include any London weighting or Flexible Pay Premia.

Nodal Point	Basic salary	Basic earned	Additional rostered	Night rate hours	Weekend allowanc	Availability allowan	Total salary
FY1	£26,614	£26,614	£4,492	£2,708	£1,597	£0	£35,411
FY2	£30,805	£30,805	£5,199	£3,135	£1,849	£0	£40,988
CT1/CT2	£36,461	£36,461	£6,153	£3,710	£2,188	£0	£48,512
CT3	£46,208	£46,208	£7,798	£4,702	£2,773	£0	£61,481
ST1/SpR1 – ST2/SpR2	£36,461	£36,461	£6,153	£3,710	£2,188	£0	£48,512
ST3/SpR3 – ST8/SpR8	£46,208	£46,208	£7,798	£4,702	£2,773	£0	£61,481

Indicative salaries for this rota (2018-19)

Note that indicative salaries below are based on the This Pay and Conditions Circular (M&D) 3/2018 replaces Pay and Conditions Circular (M&D)1/2017 originally published on 27 March 2017 and updated on 22 March 2018

Nodal Point	Basic salary	Basic earned	Additional rostered	Night rate hours	Weekend allowanc	Availability allowan	Total salary
FY1	£27,146	£27,146	£4,581	£2,763	£1,629	£0	£36,119
FY2	£31,422	£31,422	£5,303	£3,198	£1,886	£0	£41,809
CT1/CT2	£37,191	£37,191	£6,276	£3,785	£2,232	£0	£49,484
CT3	£47,132	£47,132	£7,954	£4,796	£2,828	£0	£62,710
ST1/SpR1 – ST2/SpR2	£37,191	£37,191	£6,276	£3,785	£2,232	£0	£49,484
ST3/SpR3 – ST8/SpR8	£47,132	£47,132	£7,954	£4,796	£2,828	£0	£62,710

2016 CONTRACT COMPLIANCE

Rule	Result	Analysis
1. No more than 72 hours actual work have been undertaken, in any working pattern, in any period of 7 consecutive calendar days. **Please be advised that the Terms & Conditions refer to this as any seven day period, midnight to midnight, and not as 72 hours within any rolling 168 hour period.**	64.50	RULE: OK
2. No shift (other than an on-call duty period) should be rostered to exceed 13 hours in duration.	0	RULE: OK
3. No more than 5 long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) can be worked consecutively.	4	RULE: OK
4. No more than 4 night shifts of any length can be rostered or worked consecutively. A night shift is defined as any shift where a minimum of three hours of rostered work falls into the period between 23:00 and 06:00.	0	RULE: OK
5. On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days, may be agreed locally where both the employer and the doctor agree that it is safe and acceptable to both parties to do so and where such an on-call pattern would not breach any of the other limits on working hours or rest.	0	RULE: OK
6. Where 5 long shifts are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
7. Where either 3 or 4 night shifts are rostered or worked consecutively, there must be a minimum 46 hour rest period after.	47.50	RULE: OK
8. Where 8 days are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
9. No doctor shall be rostered for work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 week in 2. Doctors paid at nodal point 2 are exempt from the requirements of the above paragraph for one placement during their foundation year. For these doctors, there is a requirement not to be rostered for shifts starting at any time between 00.01 on a Saturday and 23.59 on a Sunday at a frequency of greater than 1 week in 2.	2.00	RULE: OK Frequency is 1 in 4.5(2 weekend work in 9 weeks)(standard TCS), And 1 in 4.5 (2 Weekends in 9 weeks)(nodal point 2 rule)
10. Where shifts exceeding 10 hours finish after 2300, no more than 4 such shifts can be worked consecutively.	0.00	RULE: OK
11. Where 4 shifts exceeding 10 hours finishing after 23:00 are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
12. There must be no more than 3 on-call duty periods in 7 days, unless it is mutually agreed at a local level	0	RULE: OK
13. The day following an on-call duty period must not be rostered to last longer than 10 hours. Where it is expected that rest requirements will not be met on all occasions, rostered duty must not exceed 5 hours	0.00	RULE: OK
14. Whilst on-call a doctor must get 8 hours rest per 24 hours, of which 5 must be continuous between 2200 and 0700	0.00	RULE: OK
15. Doctors should not be rostered for more than an average of 48 hours of actual work per week, unless they have opted out of WTR in which case they should not exceed an average of 56 hours of actual work per week.	46.74	RULE: OK
16. A maximum of 8 shifts of any length can be rostered or worked on 8 consecutive days. Where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of work on each day, and no more than 3 episodes of work on each day, then such duty is defined as 'low intensity'. In such a 'low intensity' working pattern the 8 day limit will not apply and a maximum of 12 days can be rostered or worked consecutively.	7	RULE: OK
17. Pattern should not contain fixed leave	0	RULE: OK

WORKING TIME REGULATIONS (WTR) COMPLIANCE

Rule	Result	Analysis
1. No doctor to work more than an average of 48 hours per week (unless they have opted out of the WTR).	46.74	RULE: OK
2. Daily rest of 11 consecutive hours in each 24 hour period.	0	RULE: OK
3. Starting each Monday, either: • a 35 hour continuous rest period in 7 days • a 59 hour continuous rest period in 14 days • two 35 hour continuous rest periods in 14 days	0	RULE: OK

Full Group Analysis

Section 5 Paper 4

Oxford University Hospitals NHS Trust, John Radcliffe, Obstetrics and gynaecology, Final StR 3 - 5 Rota - E-Rostering, SPR, Resident.

Band 1B (Based on template only)
Steps through the banding flowchart:
- New Deal Compliant
- Average work 48 hours a week or less
- Work pattern is a full shift, partial shift or hybrid
- Less than 1/3 of duty hours outside 7am to 7pm Mon-Fri (.293) and less than 1 weekend in 4 (1 in 4.50)

Note: The band of a rota may change if monitored hours of work are different to those suggested by the theoretical work pattern. It is particularly important to remember this if a theoretical work pattern is close to the limits of a particular payband. Differences between calculated prospective cover and actual work done by doctors to cover absent colleagues can also cause a variance between theoretical and monitored bands.

Template - No Prospective Cover

New Deal Analysis

Item	Actual	Target	Comments
Average weekly hours of duty	48:00	56:00	
Average weekly hours of work	48:00	56:00	
Longest duty period	12:30	14:00	
Shortest off duty	11:30	08:00	
Longest 'off duty' period	239:30	62:00	
Next longest 'off duty' period	75:00	48:00	
Maximum consecutive duty days	8	13	
62+48 hr. breaks every 28 days	OK		

European Working Time Directive Analysis

Item	Actual	Target	Comments
Average weekly hours of work	48:00	48:00	
Starting each Monday, a 35 hour continuous rest in 7 days or a 59 hour continuous rest in 14 days	OK		
11 hrs continuous rest in any 24 hour period	OK		

Availability of normal days (Based on template only)

In a 52 week period, doctors are available during normal hours on 149 days
There are 30 days of leave built into the pattern
It is assumed that an additional 30 days of leave will be taken to make 60 in total
This reduces the normal days to 119 in the 52 weeks

This is equivalent to 2.29 days per week.

See the paper "The European Working Time Directive 2009" by Yasmin Ahmed-Little and Matthew Bluck in "The British Journal of Health Care Management" 2006, Vol. 12, No. 12 for details of the calculation and its implications.

Template work pattern

Wk	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	B: St3-5 night 20:00 08:30	B: St3-5 night 20:00 08:30	B: St3-5 night 20:00 08:30	B: St3-5 night 20:00 08:30	Zero Hours		
2	Leave	Leave	Leave	Leave	Leave		
3	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00		
4	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	B: St3-5 night 20:00 08:30	B: St3-5 night 20:00 08:30	B: St3-5 night 20:00 08:30
5	Zero Hours	Zero Hours	A: St3-5 late 13:00 20:30	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00		
6	Stnd Day 08:00 17:00	A: St3-5 late 13:00 20:30	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00		
7	A: St3-5 late 13:00 20:30	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00		
8	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	A: St3-5 late 13:00 20:30	D: St3-5 WD 08:00 20:30	D: St3-5 WD 08:00 20:30
9	Stnd Day 08:00 17:00	Zero Hours	Stnd Day 08:00 17:00	A: St3-5 late 13:00 20:30	Stnd Day 08:00 17:00		

Template normal working days

Full Group Analysis

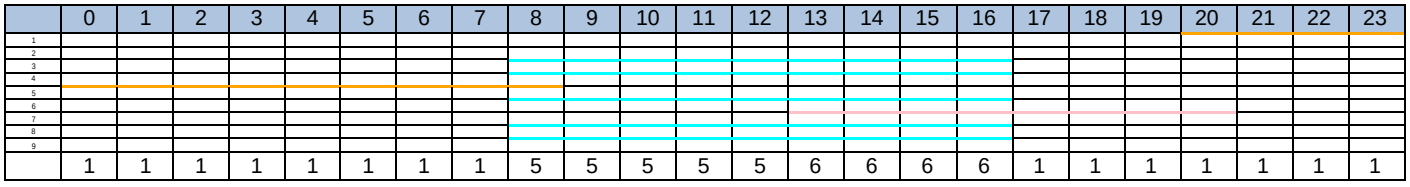
Normal Week	Start	End	Rest	Hours	Num of Diary Cards	Ave Start	Ave End	Ave Rest	Ave Hours
Mon	08:00	17:00	00:00	09:00	10	07:56	16:38	00:12	08:42
Tue	08:00	17:00	00:00	09:00	11	08:21	17:17	00:19	08:56
Wed	08:00	17:00	00:00	09:00	13	08:23	17:10	00:20	08:47
Thu	08:00	17:00	00:00	09:00	13	07:57	17:25	00:17	09:28
Fri	08:00	17:00	00:00	09:00	11	08:24	17:09	00:15	08:45

Template on call duties

Name	Intensity	Resident	Start	End	Rest	Hours	Num of Diary Cards	Ave Start	Ave End	Ave Rest	Ave Hours
A: St3-5 late	Full Shift	Yes	13:00	20:30	00:00	07:30	5	13:00	20:40	00:05	07:40
B: St3-5 night	Full Shift	Yes	20:00	08:30	00:00	12:30	15	20:00	08:44	00:17	12:44
C: standard day	Full Shift	Yes	09:00	17:00	00:00	08:00	0				
D: St3-5 WD	Full Shift	Yes	08:00	20:30	00:00	12:30	3	08:00	20:55	00:00	12:55

Cover Analysis

Monday



	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
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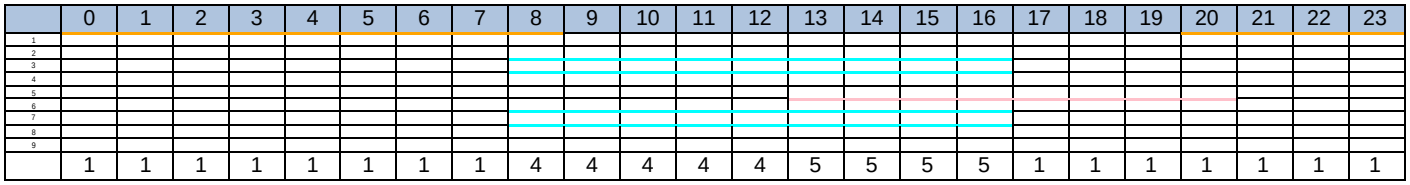
Tuesday



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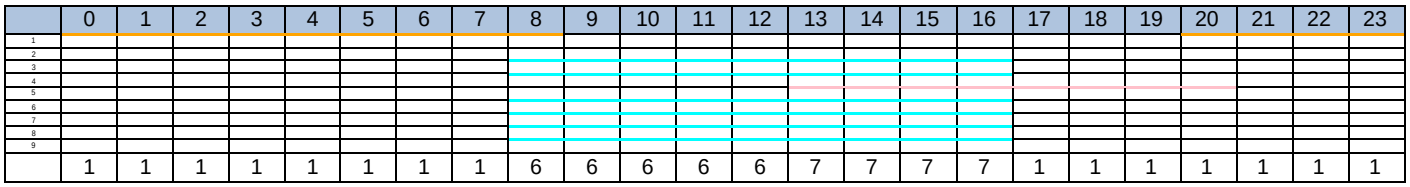
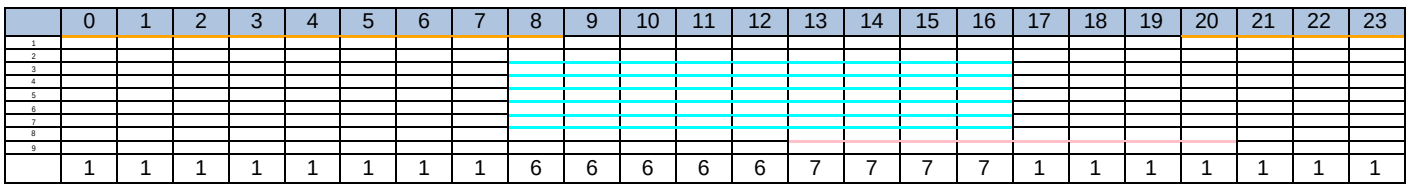
Wednesday



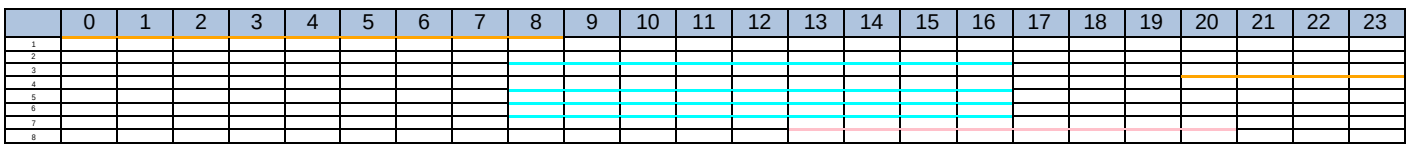
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
	1	1	1	1	1	1	1	1	6	6	6	6	6	7	7	7	7	1	1	1	1	1	1	1

Thursday



	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
	1	1	1	1	1	1	1	1	6	6	6	6	6	7	7	7	7	1	1	1	1	1	1	1

Friday



	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23

Full Group Analysis

9																								
	1	1	1	1	1	1	1	1	5	5	5	5	5	6	6	6	6	1	1	1	1	1	1	1

Saturday

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1																								
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3																								
4																								
5																								
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7																								
8																								
9																								
	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Sunday

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
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2																								
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9																								
	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Analysis Of Pattern : Obs & Gynae ST3 Senior Rota (DRS4 ID:#26898, Analysis Date: 09/04/2019) **Section 5 Paper 5**

Basic details

Site: John Radcliffe

Specialty: Obstetrics and gyna

Name: Obs & Gynae ST3 Senior Rota

Grade: SPR

On Call Dr.s: 9

Leave Entitlement: 32

Number of weeks: 9

○ Draft ○ Live ○ Archive

Standard Duties

(Click a time below to edit. You can also use the 'Tab' key to quickly navigate through times)

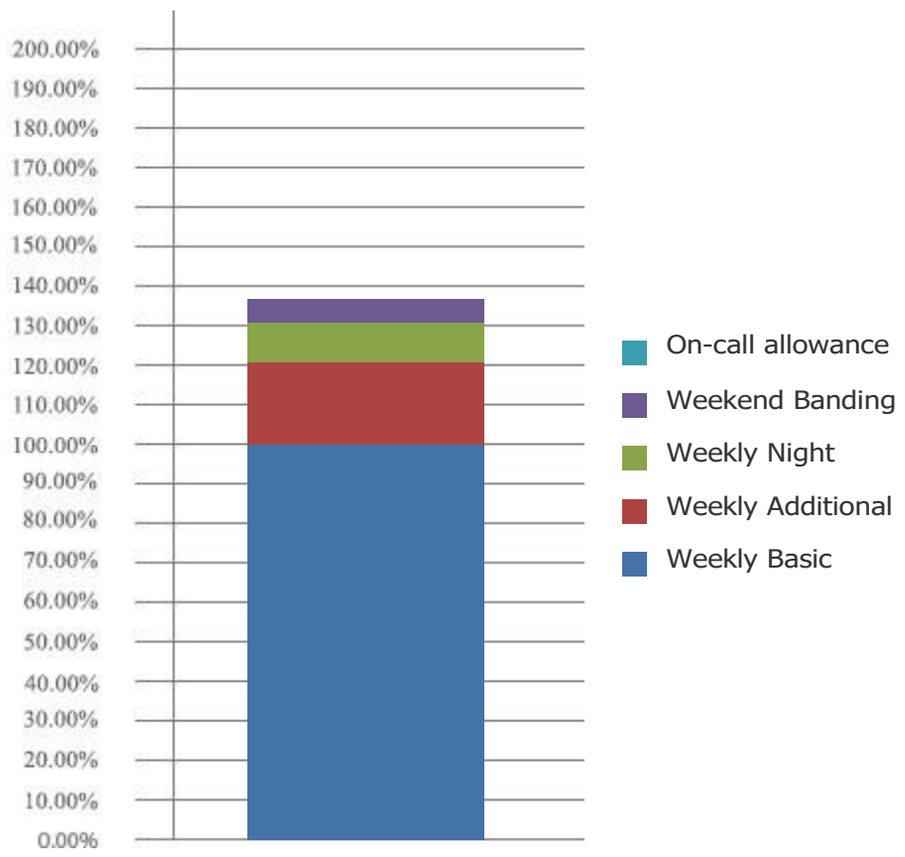
Short Name	Start	End
Mo	08:00	17:30
Tu	08:00	17:30
We	08:00	17:30
Th	08:00	17:30
Fr	08:00	17:30

	Duty Name	Code	Start	End	Intensity	Low Intensity	Day1 12am-7am	Day1 7am-5pm	Day1 5pm-9pm	Day1 9pm-12am	Day2 12am-7am	Day2 7am-5pm	Day2 5pm-9pm	Day2 9pm-12am	Resident	
○	St3-5 late	A	13:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
	St3-5 night	B	20:00	08:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00		
○	standard day	C	09:00	17:00	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00		
	St3-5 WD	D	08:00	20:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00		
○	Zero Hours	0	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	
○	Standard Duty	S	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	

Week No.	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
2	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
3	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
4	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30
5	00:00 - 00:00	00:00 - 00:00	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
6	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
7	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
8	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	08:00 - 20:30	08:00 - 20:30
9	00:00 - 00:00	00:00 - 00:00	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00

Pay Breakdown:

	Without adjustment	With leave adjustment/adjustment	With adjustment / rounding
Average Hours	48.33	48.45	48.50
Weekly Additional	8.33	8.45	8.50
Weekly Night	9.72	11.09	11.25
Weekend Banding	6.00%	6.00%	6.00%
Availability Allowance	N/A	N/A	N/A



Indicative salaries for this rota (2017-18)

Note that indicative salaries below are based on the Pay and Conditions Circular (M&D) 1/2017, and do not include any London weighting or Flexible Pay Premia.

Nodal Point	Basic salary	Basic earned	Additional rostered	Night rate hours	Weekend allowanc	Availability allowan	Total salary
FY1	£26,614	£26,614	£5,656	£2,770	£1,597	£0	£36,637
FY2	£30,805	£30,805	£6,547	£3,206	£1,849	£0	£42,407
CT1/CT2	£36,461	£36,461	£7,748	£3,795	£2,188	£0	£50,192
CT3	£46,208	£46,208	£9,820	£4,809	£2,773	£0	£63,610
ST1/SpR1 – ST2/SpR2	£36,461	£36,461	£7,748	£3,795	£2,188	£0	£50,192
ST3/SpR3 – ST8/SpR8	£46,208	£46,208	£9,820	£4,809	£2,773	£0	£63,610

Indicative salaries for this rota (2018-19)

Note that indicative salaries below are based on the This Pay and Conditions Circular (M&D) 3/2018 replaces Pay and Conditions Circular (M&D)1/2017 originally published on 27 March 2017 and updated on 22 March 2018

Nodal Point	Basic salary	Basic earned	Additional rostered	Night rate hours	Weekend allowanc	Availability allowan	Total salary
FY1	£27,146	£27,146	£5,769	£2,825	£1,629	£0	£37,369
FY2	£31,422	£31,422	£6,678	£3,270	£1,886	£0	£43,256
CT1/CT2	£37,191	£37,191	£7,904	£3,871	£2,232	£0	£51,198
CT3	£47,132	£47,132	£10,016	£4,905	£2,828	£0	£64,881
ST1/SpR1 – ST2/SpR2	£37,191	£37,191	£7,904	£3,871	£2,232	£0	£51,198
ST3/SpR3 – ST8/SpR8	£47,132	£47,132	£10,016	£4,905	£2,828	£0	£64,881

2016 CONTRACT COMPLIANCE

Rule	Result	Analysis
1. No more than 72 hours actual work have been undertaken, in any working pattern, in any period of 7 consecutive calendar days. **Please be advised that the Terms & Conditions refer to this as any seven day period, midnight to midnight, and not as 72 hours within any rolling 168 hour period.**	70.50	RULE: OK
2. No shift (other than an on-call duty period) should be rostered to exceed 13 hours in duration.	0	RULE: OK
3. No more than 5 long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) can be worked consecutively.	4	RULE: OK
4. No more than 4 night shifts of any length can be rostered or worked consecutively. A night shift is defined as any shift where a minimum of three hours of rostered work falls into the period between 23:00 and 06:00.	0	RULE: OK
5. On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days, may be agreed locally where both the employer and the doctor agree that it is safe and acceptable to both parties to do so and where such an on-call pattern would not breach any of the other limits on working hours or rest.	0	RULE: OK
6. Where 5 long shifts are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
7. Where either 3 or 4 night shifts are rostered or worked consecutively, there must be a minimum 46 hour rest period after.	52.50	RULE: OK
8. Where 8 days are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
9. No doctor shall be rostered for work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 week in 2. Doctors paid at nodal point 2 are exempt from the requirements of the above paragraph for one placement during their foundation year. For these doctors, there is a requirement not to be rostered for shifts starting at any time between 00.01 on a Saturday and 23.59 on a Sunday at a frequency of greater than 1 week in 2.	2.00	RULE: OK Frequency is 1 in 4.5(2 weekend work in 9 weeks)(standard TCS), And 1 in 4.5 (2 Weekends in 9 weeks)(nodal point 2 rule)
10. Where shifts exceeding 10 hours finish after 2300, no more than 4 such shifts can be worked consecutively.	0.00	RULE: OK
11. Where 4 shifts exceeding 10 hours finishing after 23:00 are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
12. There must be no more than 3 on-call duty periods in 7 days, unless it is mutually agreed at a local level	0	RULE: OK
13. The day following an on-call duty period must not be rostered to last longer than 10 hours. Where it is expected that rest requirements will not be met on all occasions, rostered duty must not exceed 5 hours	0.00	RULE: OK
14. Whilst on-call a doctor must get 8 hours rest per 24 hours, of which 5 must be continuous between 2200 and 0700	0.00	RULE: OK
15. Doctors should not be rostered for more than an average of 48 hours of actual work per week, unless they have opted out of WTR in which case they should not exceed an average of 56 hours of actual work per week.	48.45	WARNING! opt-out will be required
16. A maximum of 8 shifts of any length can be rostered or worked on 8 consecutive days. Where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of work on each day, and no more than 3 episodes of work on each day, then such duty is defined as 'low intensity'. In such a 'low intensity' working pattern the 8 day limit will not apply and a maximum of 12 days can be rostered or worked consecutively.	7	RULE: OK
17. Pattern should not contain fixed leave	0	RULE: OK

WORKING TIME REGULATIONS (WTR) COMPLIANCE

Rule	Result	Analysis
1. No doctor to work more than an average of 48 hours per week (unless they have opted out of the WTR).	48.45	WARNING! – Opt-out will be required
2. Daily rest of 11 consecutive hours in each 24 hour period.	0	RULE: OK
3. Starting each Monday, either: • a 35 hour continuous rest period in 7 days • a 59 hour continuous rest period in 14 days • two 35 hour continuous rest periods in 14 days	0	RULE: OK

Analysis Of Pattern : Obs (DRS4 ID:#62013, Analysis Date: 09/04/2019) **Section 5 Paper 6**

Basic details

Site: John Radcliffe

Specialty: Obstetrics and gyna

Name: Obs

Grade: SPR

On Call Dr.s: 0

Leave Entitlement: 32

Number of weeks: 10

○ Draft ○ Live ○ Archive

Standard Duties

(Click a time below to edit. You can also use the 'Tab' key to quickly navigate through times)

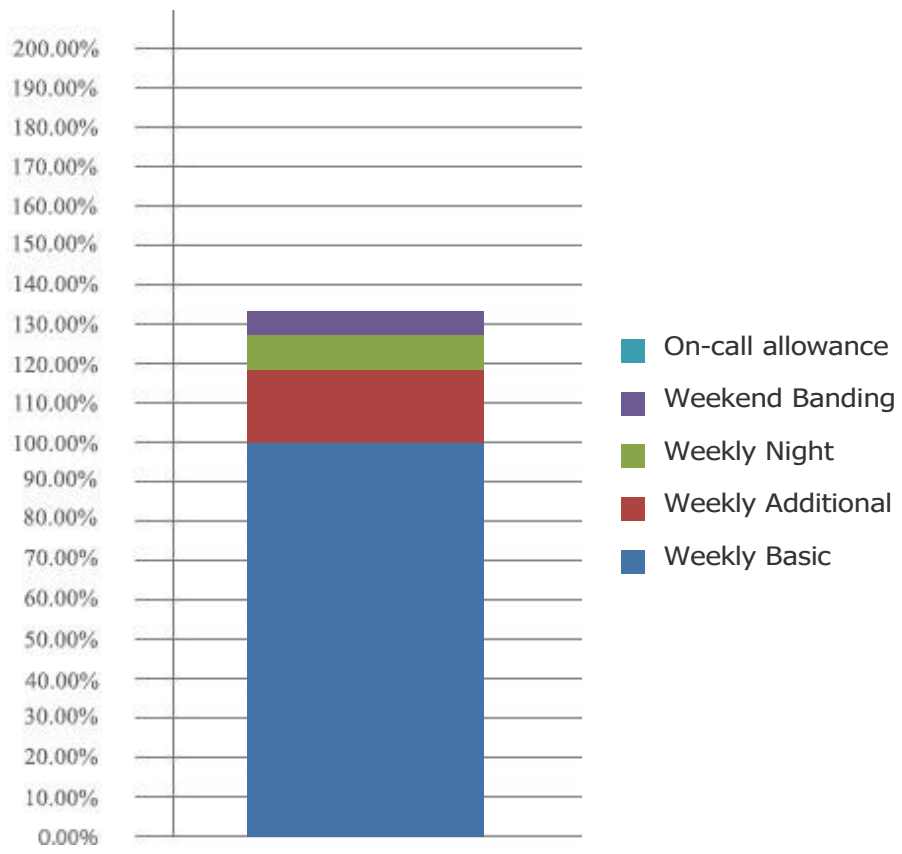
Short Name	Start	End
Mo	08:00	17:30
Tu	08:00	17:30
We	08:00	17:30
Th	08:00	17:30
Fr	08:00	17:30

	Duty Name	Code	Start	End	Intensity	Low Intensity	Day1 12am-7am	Day1 7am-5pm	Day1 5pm-9pm	Day1 9pm-12am	Day2 12am-7am	Day2 7am-5pm	Day2 5pm-9pm	Day2 9pm-12am	Resident	
○	St3-5 late	A	13:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
	St3-5 night	B	20:00	08:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
○	standard day	C	09:00	17:00	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
	St3-5 WD	D	08:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
○	Zero Hours	0	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	
○	Standard Duty	S	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	

Week No.	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
2	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
3	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
4	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30
5	00:00 - 00:00	00:00 - 00:00	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
6	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
7	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
8	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	08:00 - 20:30	08:00 - 20:30
9	00:00 - 00:00	00:00 - 00:00	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
10	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00

Pay Breakdown:

	Without adjustment	With leave /adjustment	With adjustment / rounding
Average Hours	47.30	47.27	47.50
Weekly Additional	7.30	7.27	7.50
Weekly Night	8.75	9.98	10.00
Weekend Banding	6.00%	6.00%	6.00%
Availability Allowance	N/A	N/A	N/A



Indicative salaries for this rota (2017-18)

Note that indicative salaries below are based on the Pay and Conditions Circular (M&D) 1/2017, and do not include any London weighting or Flexible Pay Premia.

FY1	£26,614	£26,614	£4,991	£2,462	£1,597	£0	£35,664
FY2	£30,805	£30,805	£5,776	£2,850	£1,849	£0	£41,280
CT1/CT2	£36,461	£36,461	£6,837	£3,373	£2,188	£0	£48,859
CT3	£46,208	£46,208	£8,664	£4,275	£2,773	£0	£61,920
ST1/SpR1 – ST2/SpR2	£36,461	£36,461	£6,837	£3,373	£2,188	£0	£48,859
ST3/SpR3 – ST8/SpR8	£46,208	£46,208	£8,664	£4,275	£2,773	£0	£61,920

Indicative salaries for this rota (2018-19)

Note that indicative salaries below are based on the This Pay and Conditions Circular (M&D) 3/2018 replaces Pay and Conditions Circular (M&D)1/2017 originally published on 27 March 2017 and updated on 22 March 2018

FY1	£27,146	£27,146	£5,090	£2,512	£1,629	£0	£36,377
FY2	£31,422	£31,422	£5,892	£2,907	£1,886	£0	£42,107
CT1/CT2	£37,191	£37,191	£6,974	£3,441	£2,232	£0	£49,838
CT3	£47,132	£47,132	£8,838	£4,360	£2,828	£0	£63,158
ST1/SpR1 – ST2/SpR2	£37,191	£37,191	£6,974	£3,441	£2,232	£0	£49,838
ST3/SpR3 – ST8/SpR8	£47,132	£47,132	£8,838	£4,360	£2,828	£0	£63,158

2016 CONTRACT COMPLIANCE

Rule	Result	Analysis
1. No more than 72 hours actual work have been undertaken, in any working pattern, in any period of 7 consecutive calendar days. **Please be advised that the Terms & Conditions refer to this as any seven day period, midnight to midnight, and not as 72 hours within any rolling 168 hour period.**	70.50	RULE: OK
2. No shift (other than an on-call duty period) should be rostered to exceed 13 hours in duration.	0	RULE: OK
3. No more than 5 long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) can be worked consecutively.	4	RULE: OK
4. No more than 4 night shifts of any length can be rostered or worked consecutively. A night shift is defined as any shift where a minimum of three hours of rostered work falls into the period between 23:00 and 06:00.	0	RULE: OK
5. On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days, may be agreed locally where both the employer and the doctor agree that it is safe and acceptable to both parties to do so and where such an on-call pattern would not breach any of the other limits on working hours or rest.	0	RULE: OK
6. Where 5 long shifts are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
7. Where either 3 or 4 night shifts are rostered or worked consecutively, there must be a minimum 46 hour rest period after.	52.50	RULE: OK
8. Where 8 days are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
9. No doctor shall be rostered for work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 week in 2. Doctors paid at nodal point 2 are exempt from the requirements of the above paragraph for one placement during their foundation year. For these doctors, there is a requirement not to be rostered for shifts starting at any time between 00.01 on a Saturday and 23.59 on a Sunday at a frequency of greater than 1 week in 2.	2.00	RULE: OK Frequency is 1 in 5.0(2 weekend work in 10 weeks)(standard TCS), And 1 in 5.0 (2 Weekends in 10 weeks)(nodal point 2 rule)
10. Where shifts exceeding 10 hours finish after 2300, no more than 4 such shifts can be worked consecutively.	0.00	RULE: OK
11. Where 4 shifts exceeding 10 hours finishing after 23:00 are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
12. There must be no more than 3 on-call duty periods in 7 days, unless it is mutually agreed at a local level	0	RULE: OK
13. The day following an on-call duty period must not be rostered to last longer than 10 hours. Where it is expected that rest requirements will not be met on all occasions, rostered duty must not exceed 5 hours	0.00	RULE: OK
14. Whilst on-call a doctor must get 8 hours rest per 24 hours, of which 5 must be continuous between 2200 and 0700	0.00	RULE: OK
15. Doctors should not be rostered for more than an average of 48 hours of actual work per week, unless they have opted out of WTR in which case they should not exceed an average of 56 hours of actual work per week.	47.27	RULE: OK
16. A maximum of 8 shifts of any length can be rostered or worked on 8 consecutive days. Where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of work on each day, and no more than 3 episodes of work on each day, then such duty is defined as 'low intensity'. In such a 'low intensity' working pattern the 8 day limit will not apply and a maximum of 12 days can be rostered or worked consecutively.	7	RULE: OK
17. Pattern should not contain fixed leave	0	RULE: OK

WORKING TIME REGULATIONS (WTR) COMPLIANCE

Rule	Result	Analysis
1. No doctor to work more than an average of 48 hours per week (unless they have opted out of the WTR).	47.27	RULE: OK
2. Daily rest of 11 consecutive hours in each 24 hour period.	0	RULE: OK
3. Starting each Monday, either: • a 35 hour continuous rest period in 7 days • a 59 hour continuous rest period in 14 days • two 35 hour continuous rest periods in 14 days	0	RULE: OK

Full Group Analysis

Section 5 Paper 7

Oxford University Hospitals NHS Trust, John Radcliffe, Obstetrics and gynaecology, Final StR 6 - 7 Rota - E-Rostering, SPR, Resident.

Band 1B (Based on template only)
Steps through the banding flowchart:
- New Deal Compliant
- Average work 48 hours a week or less
- Work pattern is a full shift, partial shift or hybrid
- Less than 1/3 of duty hours outside 7am to 7pm Mon-Fri (.293) and less than 1 weekend in 4 (1 in 4.50)

Note: The band of a rota may change if monitored hours of work are different to those suggested by the theoretical work pattern. It is particularly important to remember this if a theoretical work pattern is close to the limits of a particular payband. Differences between calculated prospective cover and actual work done by doctors to cover absent colleagues can also cause a variance between theoretical and monitored bands.

Template - No Prospective Cover

New Deal Analysis

Item	Actual	Target	Comments
Average weekly hours of duty	48:00	56:00	
Average weekly hours of work	48:00	56:00	
Longest duty period	12:30	14:00	
Shortest off duty	11:30	08:00	
Longest 'off duty' period	239:30	62:00	
Next longest 'off duty' period	75:00	48:00	
Maximum consecutive duty days	8	13	
62+48 hr. breaks every 28 days	OK		

European Working Time Directive Analysis

Item	Actual	Target	Comments
Average weekly hours of work	48:00	48:00	
Starting each Monday, a 35 hour continuous rest in 7 days or a 59 hour continuous rest in 14 days	OK		
11 hrs continuous rest in any 24 hour period	OK		

Availability of normal days (Based on template only)

In a 52 week period, doctors are available during normal hours on 150 days
There are 30 days of leave built into the pattern
It is assumed that an additional 30 days of leave will be taken to make 60 in total
This reduces the normal days to 120 in the 52 weeks

This is equivalent to 2.31 days per week.

See the paper "The European Working Time Directive 2009" by Yasmin Ahmed-Little and Matthew Bluck in "The British Journal of Health Care Management" 2006, Vol. 12, No. 12 for details of the calculation and its implications.

Template work pattern

Wk	Mon	Tue	Wed	Thu	Fri	Sat	Sun
1	A: St6-7 late 13:00 20:30	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00		
2	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	A: St6-7 late 13:00 20:30	D: St6-7 WD 08:00 20:30	D: St6-7 WD 08:00 20:30
3	Stnd Day 08:00 17:00	Zero Hours	Stnd Day 08:00 17:00	A: St6-7 late 13:00 20:30	Stnd Day 08:00 17:00		
4	B: St6-7 night 20:00 08:30	B: St6-7 night 20:00 08:30	B: St6-7 night 20:00 08:30	B: St6-7 night 20:00 08:30	Zero Hours		
5	Leave	Leave	Leave	Leave	Leave		
6	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00		
7	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	B: St6-7 night 20:00 08:30	B: St6-7 night 20:00 08:30	B: St6-7 night 20:00 08:30
8	Zero Hours	Zero Hours	A: St6-7 late 13:00 20:30	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00		
9	Stnd Day 08:00 17:00	A: St6-7 late 13:00 20:30	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00	Stnd Day 08:00 17:00		

Template normal working days

Full Group Analysis

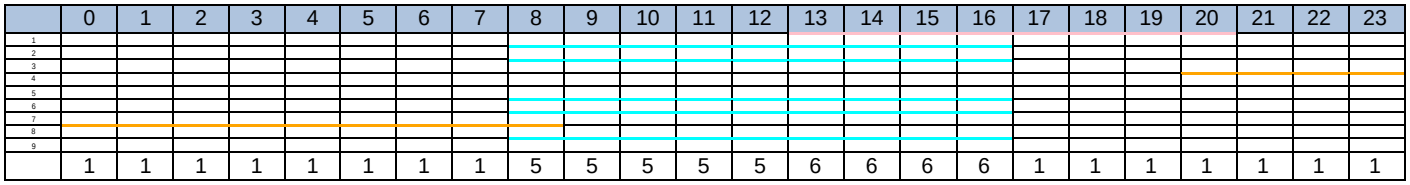
Normal Week	Start	End	Rest	Hours	Num of Diary Cards	Ave Start	Ave End	Ave Rest	Ave Hours
Mon	08:00	17:00	00:00	09:00	9	07:58	17:12	00:12	09:14
Tue	08:00	17:00	00:00	09:00	6	07:55	17:20	00:20	09:25
Wed	08:00	17:00	00:00	09:00	10	07:57	17:36	00:14	09:39
Thu	08:00	17:00	00:00	09:00	11	07:57	17:34	00:22	09:37
Fri	08:00	17:00	00:00	09:00	11	07:54	17:22	00:24	09:28

Template on call duties

Name	Intensity	Resident	Start	End	Rest	Hours	Num of Diary Cards	Ave Start	Ave End	Ave Rest	Ave Hours
A: St6-7 late	Full Shift	Yes	13:00	20:30	00:00	07:30	3	13:00	19:20	00:00	06:20
B: St6-7 night	Full Shift	Yes	20:00	08:30	00:00	12:30	12	20:20	08:38	00:01	12:18
C: standard day	Full Shift	Yes	09:00	17:00	00:00	08:00	0				
D: St6-7 WD	Full Shift	Yes	08:00	20:30	00:00	12:30	4	08:00	20:30	00:00	12:30

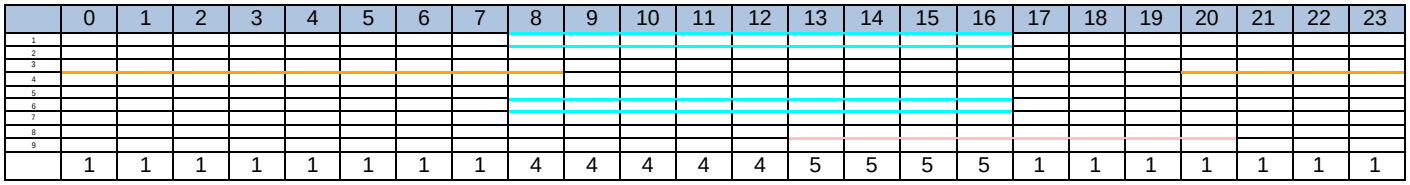
Cover Analysis

Monday



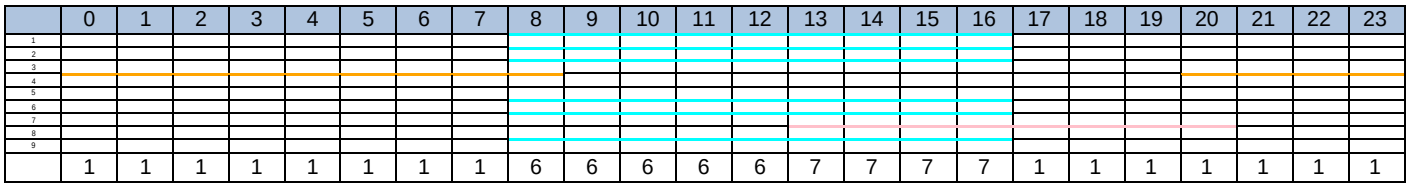
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
	1	1	1	1	1	1	1	1	5	5	5	5	5	6	6	6	6	1	1	1	1	1	1	1

Tuesday



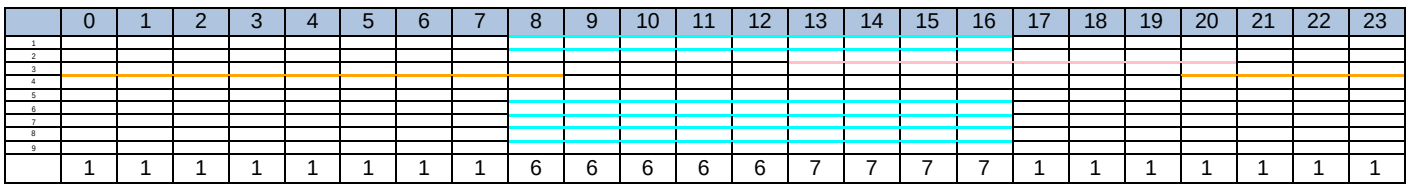
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
	1	1	1	1	1	1	1	1	4	4	4	4	4	5	5	5	5	1	1	1	1	1	1	1

Wednesday



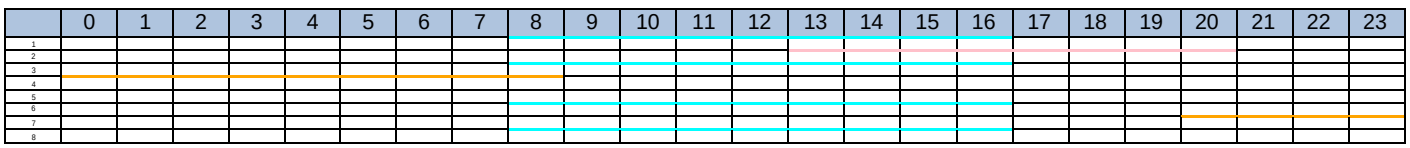
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
	1	1	1	1	1	1	1	1	6	6	6	6	6	7	7	7	7	1	1	1	1	1	1	1

Thursday



	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
	1	1	1	1	1	1	1	1	6	6	6	6	6	7	7	7	7	1	1	1	1	1	1	1

Friday



Full Group Analysis

9																								
	1	1	1	1	1	1	1	1	5	5	5	5	5	6	6	6	6	1	1	1	1	1	1	1

Saturday

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Sunday

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1																								
2																								
3																								
4																								
5																								
6																								
7																								
8																								
9																								
	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1

Basic details

Site: John Radcliffe

Specialty: Obstetrics and gyna

Name: Obs & Gynae Senior Rota ST6

Grade: SPR

On Call Dr.s: 9

Leave Entitlement: 32

Number of weeks: 9

○ Draft ○ Live ○ Archive

Standard Duties

(Click a time below to edit. You can also use the 'Tab' key to quickly navigate through times)

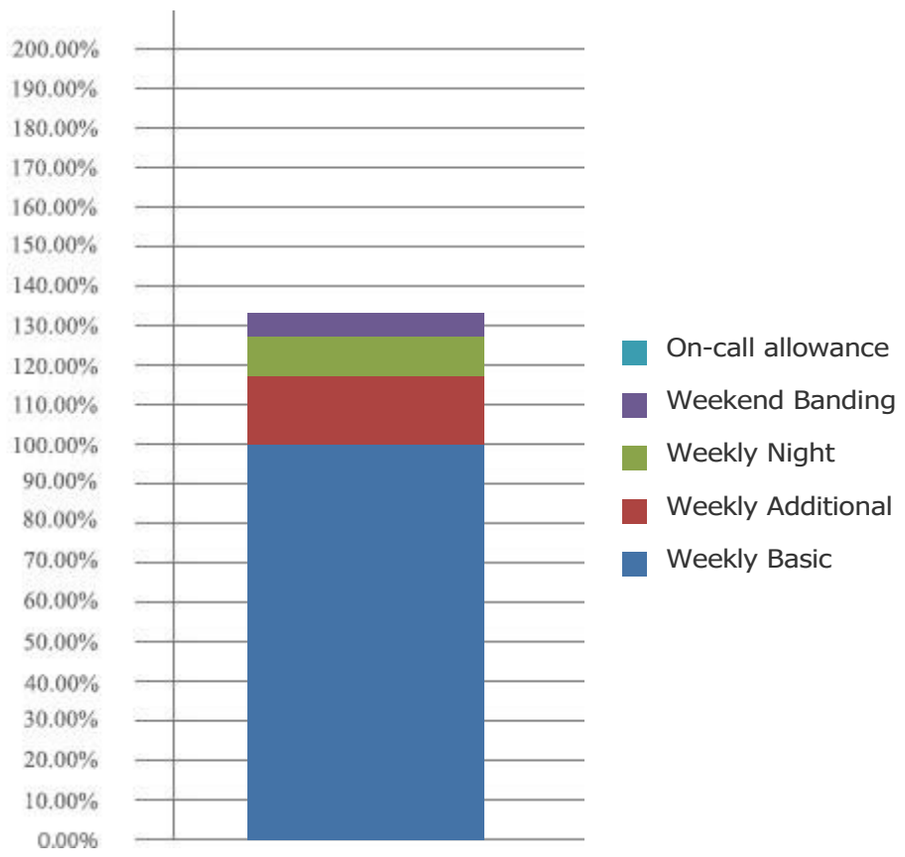
Short Name	Start	End
Mo	08:00	17:00
Tu	08:00	17:00
We	08:00	17:00
Th	08:00	17:00
Fr	08:00	17:00

	Duty Name	Code	Start	End	Intensity	Low Intensity	Day1 12am-7am	Day1 7am-5pm	Day1 5pm-9pm	Day1 9pm-12am	Day2 12am-7am	Day2 7am-5pm	Day2 5pm-9pm	Day2 9pm-12am	Resident
○	St6-7 late	A	13:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑
	St6-7 night	B	20:00	08:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	
○	standard day	C	09:00	17:00	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	
	St6-7 WD	D	08:00	20:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	
○	Zero Hours	0	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--
○	Standard Duty	S	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--

Week No.	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	13:00 - 20:30	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
2	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	13:00 - 20:30	08:00 - 20:30	08:00 - 20:30
3	00:00 - 00:00	00:00 - 00:00	08:00 - 17:00	13:00 - 20:30	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
4	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
5	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
6	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
7	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30
8	00:00 - 00:00	00:00 - 00:00	13:00 - 20:30	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
9	08:00 - 17:00	13:00 - 20:30	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00

Pay Breakdown:

	Without adjustment	With leave /adjustment	With adjustment / rounding
Average Hours	46.67	46.90	47.00
Weekly Additional	6.67	6.90	7.00
Weekly Night	9.72	11.09	11.25
Weekend Banding	6.00%	6.00%	6.00%
Availability Allowance	N/A	N/A	N/A



Indicative salaries for this rota (2017-18)

Note that indicative salaries below are based on the Pay and Conditions Circular (M&D) 1/2017, and do not include any London weighting or Flexible Pay Premia.

Nodal Point	Basic salary	Basic earned	Additional rostered	Night rate hours	Weekend allowanc	Availability allowan	Total salary
FY1	£26,614	£26,614	£4,658	£2,770	£1,597	£0	£35,639
FY2	£30,805	£30,805	£5,391	£3,206	£1,849	£0	£41,251
CT1/CT2	£36,461	£36,461	£6,381	£3,795	£2,188	£0	£48,825
CT3	£46,208	£46,208	£8,087	£4,809	£2,773	£0	£61,877
ST1/SpR1 – ST2/SpR2	£36,461	£36,461	£6,381	£3,795	£2,188	£0	£48,825
ST3/SpR3 – ST8/SpR8	£46,208	£46,208	£8,087	£4,809	£2,773	£0	£61,877

Indicative salaries for this rota (2018-19)

Note that indicative salaries below are based on the This Pay and Conditions Circular (M&D) 3/2018 replaces Pay and Conditions Circular (M&D)1/2017 originally published on 27 March 2017 and updated on 22 March 2018

Nodal Point	Basic salary	Basic earned	Additional rostered	Night rate hours	Weekend allowanc	Availability allowan	Total salary
FY1	£27,146	£27,146	£4,751	£2,825	£1,629	£0	£36,351
FY2	£31,422	£31,422	£5,499	£3,270	£1,886	£0	£42,077
CT1/CT2	£37,191	£37,191	£6,509	£3,871	£2,232	£0	£49,803
CT3	£47,132	£47,132	£8,249	£4,905	£2,828	£0	£63,114
ST1/SpR1 – ST2/SpR2	£37,191	£37,191	£6,509	£3,871	£2,232	£0	£49,803
ST3/SpR3 – ST8/SpR8	£47,132	£47,132	£8,249	£4,905	£2,828	£0	£63,114

2016 CONTRACT COMPLIANCE

Rule	Result	Analysis
1. No more than 72 hours actual work have been undertaken, in any working pattern, in any period of 7 consecutive calendar days. **Please be advised that the Terms & Conditions refer to this as any seven day period, midnight to midnight, and not as 72 hours within any rolling 168 hour period.**	68.50	RULE: OK
2. No shift (other than an on-call duty period) should be rostered to exceed 13 hours in duration.	0	RULE: OK
3. No more than 5 long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) can be worked consecutively.	4	RULE: OK
4. No more than 4 night shifts of any length can be rostered or worked consecutively. A night shift is defined as any shift where a minimum of three hours of rostered work falls into the period between 23:00 and 06:00.	0	RULE: OK
5. On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days, may be agreed locally where both the employer and the doctor agree that it is safe and acceptable to both parties to do so and where such an on-call pattern would not breach any of the other limits on working hours or rest.	0	RULE: OK
6. Where 5 long shifts are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
7. Where either 3 or 4 night shifts are rostered or worked consecutively, there must be a minimum 46 hour rest period after.	52.50	RULE: OK
8. Where 8 days are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
9. No doctor shall be rostered for work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 week in 2. Doctors paid at nodal point 2 are exempt from the requirements of the above paragraph for one placement during their foundation year. For these doctors, there is a requirement not to be rostered for shifts starting at any time between 00.01 on a Saturday and 23.59 on a Sunday at a frequency of greater than 1 week in 2.	2.00	RULE: OK Frequency is 1 in 4.5(2 weekend work in 9 weeks)(standard TCS), And 1 in 4.5 (2 Weekends in 9 weeks)(nodal point 2 rule)
10. Where shifts exceeding 10 hours finish after 2300, no more than 4 such shifts can be worked consecutively.	0.00	RULE: OK
11. Where 4 shifts exceeding 10 hours finishing after 23:00 are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
12. There must be no more than 3 on-call duty periods in 7 days, unless it is mutually agreed at a local level	0	RULE: OK
13. The day following an on-call duty period must not be rostered to last longer than 10 hours. Where it is expected that rest requirements will not be met on all occasions, rostered duty must not exceed 5 hours	0.00	RULE: OK
14. Whilst on-call a doctor must get 8 hours rest per 24 hours, of which 5 must be continuous between 2200 and 0700	0.00	RULE: OK
15. Doctors should not be rostered for more than an average of 48 hours of actual work per week, unless they have opted out of WTR in which case they should not exceed an average of 56 hours of actual work per week.	46.90	RULE: OK
16. A maximum of 8 shifts of any length can be rostered or worked on 8 consecutive days. Where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of work on each day, and no more than 3 episodes of work on each day, then such duty is defined as 'low intensity'. In such a 'low intensity' working pattern the 8 day limit will not apply and a maximum of 12 days can be rostered or worked consecutively.	7	RULE: OK
17. Pattern should not contain fixed leave	0	RULE: OK

WORKING TIME REGULATIONS (WTR) COMPLIANCE

Rule	Result	Analysis
1. No doctor to work more than an average of 48 hours per week (unless they have opted out of the WTR).	46.90	RULE: OK
2. Daily rest of 11 consecutive hours in each 24 hour period.	0	RULE: OK
3. Starting each Monday, either: • a 35 hour continuous rest period in 7 days • a 59 hour continuous rest period in 14 days • two 35 hour continuous rest periods in 14 days	0	RULE: OK

Basic details

Site: John Radcliffe Hospital

Specialty: Obstetrics and gyna

Name: Obs & Gynae FY2/CT/ST Doctors V

Grade: SHO

On Call Dr.s: 0

Leave Entitlement: 27

Number of weeks: 14

○ Draft ○ Live ○ Archive

Standard Duties

(Click a time below to edit. You can also use the 'Tab' key to quickly navigate through times)

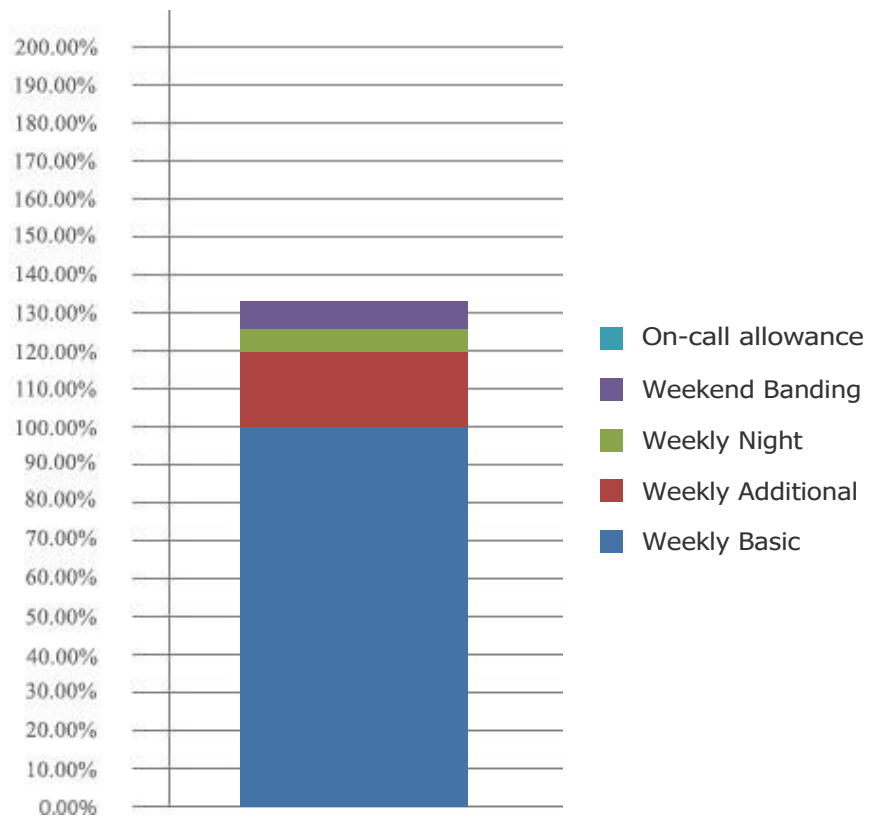
Short Name	Start	End
Mo	08:00	17:00
Tu	08:00	17:00
We	08:00	17:00
Th	08:00	17:00
Fr	08:00	17:00

	Duty Name	Code	Start	End	Intensity	Low Intensity	Day1 12am-7am	Day1 7am-5pm	Day1 5pm-9pm	Day1 9pm-12am	Day2 12am-7am	Day2 7am-5pm	Day2 5pm-9pm	Day2 9pm-12am	Resident	
○	Long Day	A	08:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
○	Nights	B	20:00	08:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
○	weekend Day	C	08:00	17:00	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
○	Zero Hours	0	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	
○	Standard Duty	S	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	

Week No.	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	08:00 - 17:00	00:00 - 00:00	08:00 - 20:30	08:00 17:00	08:00 17:00	00:00 00:00	00:00 00:00
2	08:00 - 20:30	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00	08:00 - 20:30	08:00 - 20:30	08:00 - 20:30
3	08:00 - 17:00	08:00 - 20:30	00:00 - 00:00	08:00 - 20:30	08:00 - 17:00	00:00 00:00	00:00 00:00
4	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
5	08:00 17:00	08:00 17:00	08:00 17:00	08:00 17:00	08:00 17:00	00:00 00:00	00:00 00:00
6	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
7	08:00 17:00	08:00 17:00	08:00 17:00	00:00 - 00:00	08:00 20:30	08:00 20:30	08:00 20:30
8	00:00 - 00:00	08:00 - 20:30	08:00 - 17:00	08:00 - 20:30	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
9	08:00 - 17:00	00:00 - 00:00	08:00 - 20:30	08:00 - 17:00	08:00 20:30	08:00 20:30	08:00 20:30
10	00:00 - 00:00	08:00 - 17:00	08:00 - 17:00	08:00 - 20:30	08:00 - 17:00	00:00 - 00:00	00:00 - 00:00
11	08:00 - 20:30	08:00 17:00	08:00 17:00	08:00 - 17:00	20:00 08:30	20:00 08:30	20:00 08:30
12	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
13	08:00 - 20:30	08:00 17:00	08:00 17:00	08:00 17:00	00:00 00:00	00:00 00:00	00:00 00:00
14	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00	00:00 - 00:00	08:00 - 17:00	08:00 - 17:00	08:00 - 17:00

Pay Breakdown:

	Without adjustment	With leave adjustment/adjustment	With adjustment / rounding
Average Hours	47.64	47.95	48.00
Weekly Additional	7.64	7.95	8.00
Weekly Night	6.25	6.97	7.00
Weekend Banding	7.50%	7.50%	7.50%
Availability Allowance	N/A	N/A	N/A



Indicative salaries for this rota (2017-18)

Note that indicative salaries below are based on the Pay and Conditions Circular (M&D) 1/2017, and do not include any London weighting or Flexible Pay Premia.

FY1	£26,614	£26,614	£5,323	£1,724	£1,997	£0	£35,658
FY2	£30,805	£30,805	£6,161	£1,995	£2,311	£0	£41,272
CT1/CT2	£36,461	£36,461	£7,293	£2,361	£2,735	£0	£48,850
CT3	£46,208	£46,208	£9,242	£2,992	£3,466	£0	£61,908
ST1/SpR1 – ST2/SpR2	£36,461	£36,461	£7,293	£2,361	£2,735	£0	£48,850
ST3/SpR3 – ST8/SpR8	£46,208	£46,208	£9,242	£2,992	£3,466	£0	£61,908

Indicative salaries for this rota (2018-19)

Note that indicative salaries below are based on the This Pay and Conditions Circular (M&D) 3/2018 replaces Pay and Conditions Circular (M&D)1/2017 originally published on 27 March 2017 and updated on 22 March 2018

FY1	£27,146	£27,146	£5,430	£1,758	£2,036	£0	£36,370
FY2	£31,422	£31,422	£6,285	£2,035	£2,357	£0	£42,099
CT1/CT2	£37,191	£37,191	£7,439	£2,409	£2,790	£0	£49,829
CT3	£47,132	£47,132	£9,427	£3,052	£3,535	£0	£63,146
ST1/SpR1 – ST2/SpR2	£37,191	£37,191	£7,439	£2,409	£2,790	£0	£49,829
ST3/SpR3 – ST8/SpR8	£47,132	£47,132	£9,427	£3,052	£3,535	£0	£63,146

2016 CONTRACT COMPLIANCE

Rule	Result	Analysis
1. No more than 72 hours actual work have been undertaken, in any working pattern, in any period of 7 consecutive calendar days. **Please be advised that the Terms & Conditions refer to this as any seven day period, midnight to midnight, and not as 72 hours within any rolling 168 hour period.**	71.50	RULE: OK
2. No shift (other than an on-call duty period) should be rostered to exceed 13 hours in duration.	0	RULE: OK
3. No more than 5 long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) can be worked consecutively.	4	RULE: OK
4. No more than 4 night shifts of any length can be rostered or worked consecutively. A night shift is defined as any shift where a minimum of three hours of rostered work falls into the period between 23:00 and 06:00.	0	RULE: OK
5. On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days, may be agreed locally where both the employer and the doctor agree that it is safe and acceptable to both parties to do so and where such an on-call pattern would not breach any of the other limits on working hours or rest.	0	RULE: OK
6. Where 5 long shifts are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
7. Where either 3 or 4 night shifts are rostered or worked consecutively, there must be a minimum 46 hour rest period after.	167.50	RULE: OK
8. Where 8 days are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
9. No doctor shall be rostered for work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 week in 2. Doctors paid at nodal point 2 are exempt from the requirements of the above paragraph for one placement during their foundation year. For these doctors, there is a requirement not to be rostered for shifts starting at any time between 00.01 on a Saturday and 23.59 on a Sunday at a frequency of greater than 1 week in 2.	5.00	RULE: OK Frequency is 1 in 2.8(5 weekend work in 14 weeks)(standard TCS), And 1 in 2.8 (5 Weekends in 14 weeks)(nodal point 2 rule)
10. Where shifts exceeding 10 hours finish after 2300, no more than 4 such shifts can be worked consecutively.	0.00	RULE: OK
11. Where 4 shifts exceeding 10 hours finishing after 23:00 are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
12. There must be no more than 3 on-call duty periods in 7 days, unless it is mutually agreed at a local level	0	RULE: OK
13. The day following an on-call duty period must not be rostered to last longer than 10 hours. Where it is expected that rest requirements will not be met on all occasions, rostered duty must not exceed 5 hours	0.00	RULE: OK
14. Whilst on-call a doctor must get 8 hours rest per 24 hours, of which 5 must be continuous between 2200 and 0700	0.00	RULE: OK
15. Doctors should not be rostered for more than an average of 48 hours of actual work per week, unless they have opted out of WTR in which case they should not exceed an average of 56 hours of actual work per week.	47.95	RULE: OK
16. A maximum of 8 shifts of any length can be rostered or worked on 8 consecutive days. Where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of work on each day, and no more than 3 episodes of work on each day, then such duty is defined as 'low intensity'. In such a 'low intensity' working pattern the 8 day limit will not apply and a maximum of 12 days can be rostered or worked consecutively.	7	RULE: OK
17. Pattern should not contain fixed leave	0	RULE: OK

WORKING TIME REGULATIONS (WTR) COMPLIANCE

Rule	Result	Analysis
1. No doctor to work more than an average of 48 hours per week (unless they have opted out of the WTR).	47.95	RULE: OK
2. Daily rest of 11 consecutive hours in each 24 hour period.	0	RULE: OK
3. Starting each Monday, either: • a 35 hour continuous rest period in 7 days • a 59 hour continuous rest period in 14 days • two 35 hour continuous rest periods in 14 days	0	RULE: OK

Section 5:

Paper 10: 114 hours consultant presence on labour ward at JR including resident consultants on call. with provision of tertiary level specialist services JR (2016-17 model)

Consultant cover (60 hours 8.00-20.00 Mon-Frid**)**

Per Occurrence	**Non-Premium Time**	**Premium Time**	**Total**
Hours Worked	7.857	4.143	14
PAs Accumulated	1.964	1.381	3.345
Per Week			
Occurrences	3.929	2.417	7
Hours Worked	55	29	84
PAs Accumulated	13.75	9.667	23.417
PAs Accumulated with prospective cover applied	17.024	11.968	28.992

PAs / week 28.992. Premium Time **11.968**

Consultant short day Sat/Sun JR (08.00-14.00**)**

Per Occurrence	**Premium Time**	**Total**
Hours Worked	6	6
PAs Accumulated	2	2
Per Week		
Occurrences	2	2
Hours Worked	12	12
PAs Accumulated	4	4
PAs Accumulated with prospective cover applied	4.95	4.95

PAs / week Premium time **4.952**

42 hours resident cover out of hours to take up cover to 114 hours/week

Per Occurrence	**Premium Time**	**Total**
Hours Worked	5.992	6
PAs Accumulated	1.997	2
Per Week		
Occurrences	7	2
Hours Worked	41.942	42
PAs Accumulated	13.981	13.981
PAs Accumulated with prospective cover applied	17.31	17.31

PAs / week Premium Time **17.31**

Total Premium time PA`s /week= 17.3+4.95+11.968=**34.22 PAs**

In order to preserve the continuity required to provide a specialist service, the out of hours PA`s should not be more than 2.2 PA`s
In a job plan containing 3 PA`s out of hours work the required compensatory rest period before and after a resident night duty would lead to a consultant being unavailable for a specialist clinic 17 weeks out of 52.
By making it 2.2 this increases the availability of specialist consultants.

Total premium time PA`s / week = **34.22**

34.22/2.2= **15.5 consultants**

Summary

The total number of consultants to provide a tertiary level service and 114 hours/week of labour ward presence plus on call at the JR is **15.5**

Section 5:

Paper 11: SARD Summary of PA`s required to provide 24 hour cover for labour ward at HGH by consultants.

Number of PA`s required to cover from 08.00-20.00. 7 days per week with prospective cover.

Per Occurrence	Non-Premium Time	Premium Time	Total
Hours Worked	7.857	4.143	12
PAs Accumulated	1.964	1.381	3.345
Per Week			
Occurrences	4.583	2.417	7
Hours Worked	55	29	84
PAs Accumulated	13.75	9.667	23.417
PAs Accumulated with prospective cover applied	17.024	11.968	28.992

Summary
PAs / week **28.992**

Number of PA`s required to cover from 20.00-08.00 7 days per week with prospective cover

Per Occurrence	Non-Premium Time	Premium Time	Total
Hours Worked	0.712	11.266	11.978
PAs Accumulated	0.178	3.755	3.933
Per Week			
Occurrences	0.416	6.584	7
Hours Worked	4.981	78.865	83.846
PAs Accumulated	1.245	26.288	27.534
PAs Accumulated with prospective cover applied	1.542	32.548	34.089

PAs / week **34.089**

Additional premium time PAs /week if also on call rota

If predictable on call 2 hours each Saturday and Sunday

Unpredictable 6 hours per week after 20.00.with PC

Per Occurrence	**Non-Premium Time**	**Premium Time**	**Total**
Hours Worked			
PAs Accumulated			
Per Week			
Occurrences		1	
Hours Worked		8	
PAs Accumulated			
PAs Accumulated with prospective cover applied		6.60	

Additional **6.6** premium time PA`s

Summary
To provide 24/7 cover (no on call) would require a total of 63 Pas of which 44.46 are out of hours.

The minimum number of consultants to provide this cover 44.46/3 = 14.8 = **15 consultants.**

If specialist services are covered then 2.2 PA`s out of hours required to maintain continuity of care 44.46/2.2 = **20.2 consultants**

If unable to recruit tier 1 doctors or Associate maternity support workers then would require a 1 in 5 consultant on call rota. To support resident consultants on call.
To keep on call cover at weekends to 1 in 5 (1 in 4 with prospective cover).

Would be possible but additional on call out of hours PA`s would be required. If we considered a minimum of 2 hour /day predictable on call out of hours (2 daily ward rounds Mon-Sun) plus 1:4 coming in for unpredictable on call for 3 hours/day.

To provide 24/7 cover (including on call) would require a total of 69.6 Pas of which 51.01 are out of hours.

Number of consultants (no additional on call)
15 generalists with no specialist provision
20 if all had specialist clinical duties.

Number of consultants (with on call included)
17 generalists with no specialist provision
23 if all had specialist clinical duties

Section 5: Paper 12

24 hour consultant delivered service at HGH and 114 hour and tertiary level service at JR using single pool consultants.

Number of PAs required to cover from 08.00-20.00. 7 days per week with prospective cover.at HGH

Per Occurrence	Non-Premium Time	Premium Time	Total
Hours Worked	7.857	4.143	12
PAs Accumulated	1.964	1.381	3.345
Per Week			
Occurrences	4.583	2.417	7
Hours Worked	55	29	84
PAs Accumulated	13.75	9.667	23.417
PAs Accumulated with prospective cover applied	17.024	11.968	28.992

Premium PAs / week **11.968**

Number of PAs required to cover from 20.00-08.00 7 days per week with prospective cover

Per Occurrence	Non-Premium Time	Premium Time	Total
Hours Worked	0.712	11.266	11.978
PAs Accumulated	0.178	3.755	3.933
Per Week			
Occurrences	0.416	6.584	7
Hours Worked	4.981	78.865	83.846
PAs Accumulated	1.245	26.288	27.534
PAs Accumulated with prospective cover applied	1.542	32.548	34.089

Premium PAs / week **32.548**

Total premium PAs/ week **44.5** PAs

114 hours cover at JR using resident consultants on call and tertiary level specialist services JR

Consultant cover (60 hours 8.00-20.00 Mon-Frid)

Per Occurrence	Non-Premium Time	Premium Time	Total
Hours Worked	7.857	4.143	14
PAs Accumulated	1.964	1.381	3.345
Per Week			
Occurrences	3.929	2.417	7
Hours Worked	55	29	84
PAs Accumulated	13.75	9.667	23.417
PAs Accumulated with prospective cover applied	17.024	11.968	28.992

PAs / week 28.992. Premium Time **11.968**

Consultant short day Sat/Sun JR (12 hours weekend)

Per Occurrence	Premium Time	Total
Hours Worked	6	6
PAs Accumulated	2	2
Per Week		
Occurrences	2	2
Hours Worked	12	12
PAs Accumulated	4	4
PAs Accumulated with prospective cover applied	4.95	4.95

PAs / week Premium time **4.952**

42 hours resident cover out of hours to take up cover to 114 hours/week

Per Occurrence	Premium Time	Total
Hours Worked	5.992	6
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Per Week		
Occurrences	7	2
Hours Worked	41.942	42
PAs Accumulated	13.981	13.981
PAs Accumulated with prospective cover applied	17.31	17.31

PAs / week Premium Time **17.31**

Total Premium time PAs /week= 17.3+4.95+11.968=**34.22**

Total number of premium PAs /week to cover both obstetric services

44.5+34.22=**78.72**

15 consultants required to deliver specialist tertiary level service

15x2.2= 33 PAs

78.72-33=45.72 PAs still requiring cover

45.72/3= 15.24 consultants

Total number of consultants =**30.24**

If no tier 1 support at HGH then additional 6.6 premium PAs

78.72+6.6=85.3PAs

85.3-33=52.3PAs

52.3/3=17.4

17.4+15=32.4 Consultants

Summary

30.2 consultants required if Tier 1 support available

32.4 consultants required if no tier 1 support

Section 5: Paper 13:

Horton General Hospital hybrid rota consultants and middle grade doctors.

This consists of running 24 hour cover for delivery suite using a mixture of middle grade doctors and consultants.

When the middle grade doctors are on call there needs to be a consultant on call. Therefore this model would need to have a 2 tier system with a resident doctor and an on-call consultant.

The model would also require a robust tier 1 support to provide onsite medical support for in patients as well as assistance for surgical cases.

It takes 1.6 WTE consultants to replace 1.0 WTE Trust grade doctor.9 (A generalist consultant obstetrician and gynaecologist with 3 PAs premium in 10 PA contract)

This is the model currently adopted by other small units in the UK

At 3 or less middle grade doctors it may be preferable to provide a consultant run service which requires 15 consultants.

The hybrid rota would require.

No Middle trust grades	**No. consultants**	**No.FY2/CT/ST1-2** (including AMSW support)
9	5	4
8	6.6	6
7	8.2	7
6	9.8	8
5	11.4	8
4	13	9
3	14.6	9
2	16.2	9
1	17.8	9
0	20	9

Basic details

Site: John Radcliffe

Specialty: Obstetrics and gyna

Name: OBS HGH/JR Combined ST3 - 7

Grade: StR

On Call Dr.s: 0

Leave Entitlement: 32

Number of weeks: 28

○ Draft ○ Live ○ Archive

Standard Duties

(Click a time below to edit. You can also use the 'Tab' key to quickly navigate through times)

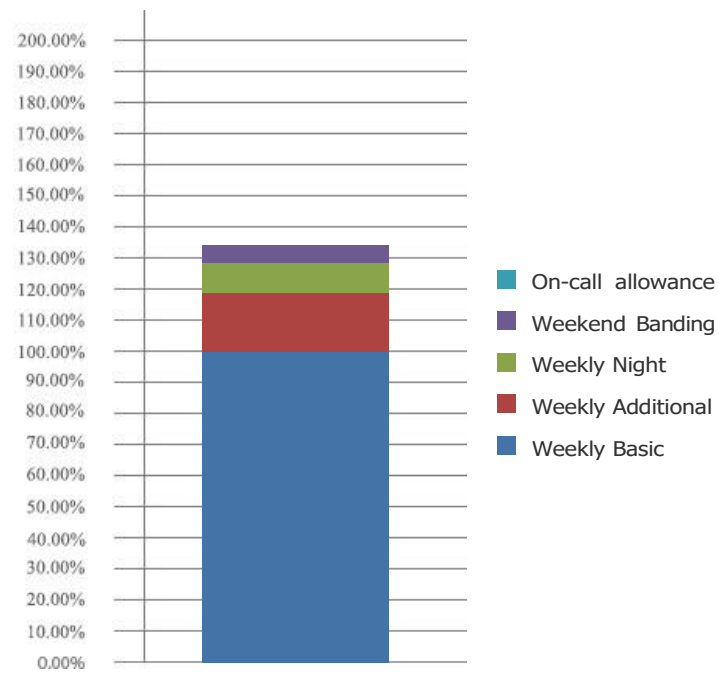
Short Name	Start	End
Mo	08:00	17:30
Tu	08:00	17:30
We	08:00	17:30
Th	08:00	17:30
Fr	08:00	17:30

	Duty Name	Code	Start	End	Intensity	Low Intensity	Day1 12am-7am	Day1 7am-5pm	Day1 5pm-9pm	Day1 9pm-12am	Day2 12am-7am	Day2 7am-5pm	Day2 5pm-9pm	Day2 9pm-12am	Resident	
○	Late Shift JR	A	13:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
	Nights JR	B	20:00	08:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00		
○	standard day	C	09:00	17:00	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00		
	WE day JR	D	08:00	20:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00		
○	Late Shift HGH	E	13:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
	NIghts HGH	F	20:00	08:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00		
○	WE day Horton	G	08:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
	labour ward sessions	H	08:00	17:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑	
○	Zero Hours	0	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	
○	Standard Duty	S	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--	

Week No.	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
2	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
3	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
4	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30
5	00:00 - 00:00	00:00 - 00:00	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
6	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
7	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
8	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	08:00 - 20:30	08:00 - 20:30
9	00:00 - 00:00	00:00 - 00:00	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
10	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
11	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
12	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
13	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
14	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
15	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
16	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	08:00 - 20:30	08:00 - 20:30
17	00:00 - 00:00	00:00 - 00:00	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
18	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30
19	00:00 - 00:00	00:00 - 00:00	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
20	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
21	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	00:00 - 00:00	00:00 - 00:00
22	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
23	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
24	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 20:30	08:00 - 20:30
25	00:00 - 00:00	00:00 - 00:00	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
26	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30
27	00:00 - 00:00	00:00 - 00:00	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
28	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00

Pay Breakdown:

	Without adjustment	With leave /adjustment	With adjustment / rounding
Average Hours	47.63	47.64	47.75
Weekly Additional	7.63	7.64	7.75
Weekly Night	9.38	10.69	10.75
Weekend Banding	6.00%	6.00%	6.00%
Availability Allowance	N/A	N/A	N/A



Indicative salaries for this rota (2017-18)

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Indicative salaries for this rota (2018-19)

Note that indicative salaries below are based on the This Pay and Conditions Circular (M&D) 3/2018 replaces Pay and Conditions Circular (M&D)1/2017 originally published on 27 March 2017 and updated on 22 March 2018

Nodal Point	Basic salary	Basic earned	Additional rostered	Night rate hours	Weekend allowanc	Availability allowan	Total salary
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CT1/CT2	£37,191	£37,191	£7,206	£3,699	£2,232	£0	£50,328
CT3	£47,132	£47,132	£9,132	£4,687	£2,828	£0	£63,779
ST1/SpR1 – ST2/SpR2	£37,191	£37,191	£7,206	£3,699	£2,232	£0	£50,328
ST3/SpR3 – ST8/SpR8	£47,132	£47,132	£9,132	£4,687	£2,828	£0	£63,779

2016 CONTRACT COMPLIANCE

Rule	Result	Analysis
1. No more than 72 hours actual work have been undertaken, in any working pattern, in any period of 7 consecutive calendar days. **Please be advised that the Terms & Conditions refer to this as any seven day period, midnight to midnight, and not as 72 hours within any rolling 168 hour period.**	70.50	RULE: OK
2. No shift (other than an on-call duty period) should be rostered to exceed 13 hours in duration.	0	RULE: OK
3. No more than 5 long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) can be worked consecutively.	4	RULE: OK
4. No more than 4 night shifts of any length can be rostered or worked consecutively. A night shift is defined as any shift where a minimum of three hours of rostered work falls into the period between 23:00 and 06:00.	0	RULE: OK
5. On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days, may be agreed locally where both the employer and the doctor agree that it is safe and acceptable to both parties to do so and where such an on-call pattern would not breach any of the other limits on working hours or rest.	0	RULE: OK
6. Where 5 long shifts are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
7. Where either 3 or 4 night shifts are rostered or worked consecutively, there must be a minimum 46 hour rest period after.	47.50	RULE: OK
8. Where 8 days are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
9. No doctor shall be rostered for work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 week in 2. Doctors paid at nodal point 2 are exempt from the requirements of the above paragraph for one placement during their foundation year. For these doctors, there is a requirement not to be rostered for shifts starting at any time between 00.01 on a Saturday and 23.59 on a Sunday at a frequency of greater than 1 week in 2.	6.00	RULE: OK Frequency is 1 in 4.7(6 weekend work in 28 weeks)(standard TCS), And 1 in 4.7 (6 Weekends in 28 weeks)(nodal point 2 rule)
10. Where shifts exceeding 10 hours finish after 2300, no more than 4 such shifts can be worked consecutively.	0.00	RULE: OK
11. Where 4 shifts exceeding 10 hours finishing after 23:00 are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
12. There must be no more than 3 on-call duty periods in 7 days, unless it is mutually agreed at a local level	0	RULE: OK
13. The day following an on-call duty period must not be rostered to last longer than 10 hours. Where it is expected that rest requirements will not be met on all occasions, rostered duty must not exceed 5 hours	0.00	RULE: OK
14. Whilst on-call a doctor must get 8 hours rest per 24 hours, of which 5 must be continuous between 2200 and 0700	0.00	RULE: OK
15. Doctors should not be rostered for more than an average of 48 hours of actual work per week, unless they have opted out of WTR in which case they should not exceed an average of 56 hours of actual work per week.	47.64	RULE: OK
16. A maximum of 8 shifts of any length can be rostered or worked on 8 consecutive days. Where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of work on each day, and no more than 3 episodes of work on each day, then such duty is defined as 'low intensity'. In such a 'low intensity' working pattern the 8 day limit will not apply and a maximum of 12 days can be rostered or worked consecutively.	7	RULE: OK
17. Pattern should not contain fixed leave	0	RULE: OK

WORKING TIME REGULATIONS (WTR) COMPLIANCE

Rule	Result	Analysis
1. No doctor to work more than an average of 48 hours per week (unless they have opted out of the WTR).	47.64	RULE: OK
2. Daily rest of 11 consecutive hours in each 24 hour period.	0	RULE: OK
3. Starting each Monday, either: • a 35 hour continuous rest period in 7 days • a 59 hour continuous rest period in 14 days • two 35 hour continuous rest periods in 14 days	0	RULE: OK

Section 5: Paper 15:

All OUHFT Hybrid rota. Consultants and middle grades with on call at JR and 114 hours at JR plus mixture of on call and resident at HGH.

15.5 consultants (who work 2.2 PAs in premium time) are required to deliver the specialist service.

From the previous (paper 12) it has been demonstrated that 30 consultants would be required to cover the service. To provide 24/7 hours cover at HGH and 114 hours specialist services at JR. If the consultants had to cover the gaps replaced by the registrars at the JR then an additional 44.5 premium PAs would be required.

44.5/2.2 = 20 additional consultants. Total number of consultants to cover 24 hours for both sites and on call for specialist services is 15+15.5+20 = **50.5** consultants.

In this hybrid model 1 middle grade = 1.8 consultants. When the number drops to below 12 middle grades then the number of consultants required to prop up the rota equals that required for a consultant delivered service

No Middle trust grades	No. consultants
28	20.5
27	22.
26	24
25	26
24	27.7
23	29.5
22	31
21	33
20	36.7*
19	38.5
18	40
17	42
16	44
15	45.7
14	47.5
13	49
12	50.8**
11	52.6
10	54
9	56
8	58
7	59
6	61
5	63
4	65
3	67
2	68.8
1	70.6
0	72.4

* could run as Consultant delivered at HGH
** could run as Consultant delivered service with no reg but need to continue to train for future of specialty

Once there are less than 20 total middle grade doctors on the rota the service could be delivered as consultant only at the HGH leaving the remaining 20 middle grades at the JR.

If all the middle grade doctors and consultants rotate between the JR and HGH then larger numbers are required. This is why the numbers are larger than a consultant delivered service.

This is the minimum doctors required and doesn't take into account the difficulties with providing cross cover to maintain specialist services or addresses the training needs of the middle grades.

Analysis Of Pattern: OBS HGH/JR ST3 - 5 (DRS4 ID:#62020, Analysis Date: 09/04/2019)

Section 5 Paper 16

Basic details

Site: John Radcliffe

Specialty: Obstetrics and gyna

Name: OBS HGH/JR ST3 - 5

Grade: StR

On Call Dr.s: 0

Leave Entitlement: 32

Number of weeks: 20

○ Draft ○ Live ○ Archive

Standard Duties

(Click a time below to edit. You can also use the 'Tab' key to quickly navigate through times)

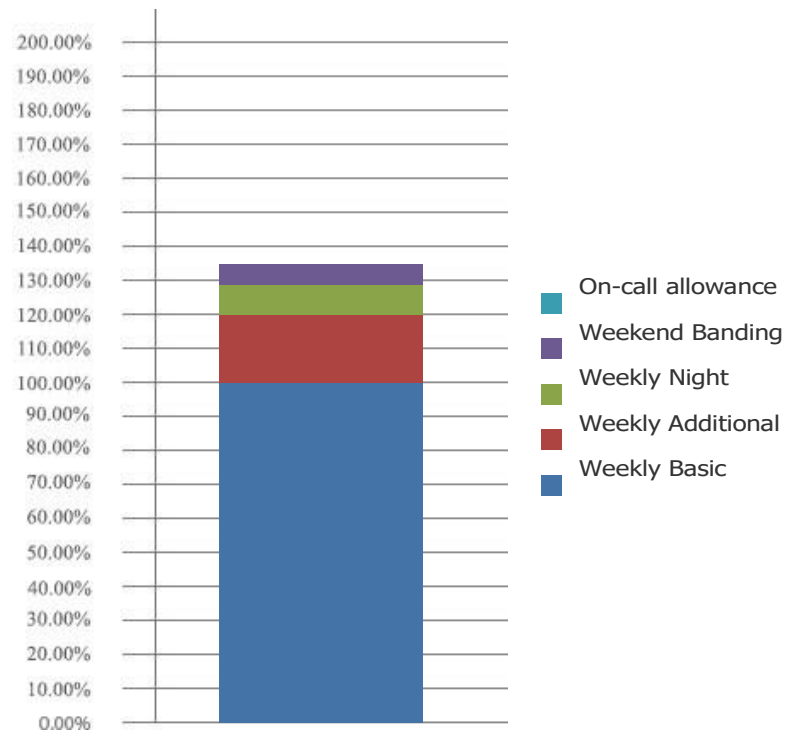
Short Name	Start	End
Mo	08:00	17:30
Tu	08:00	17:30
We	08:00	17:30
Th	08:00	17:30
Fr	08:00	17:30

○	Late Shift JR	A	13:00	20:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	
	Nights JR	B	20:00	08:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	
○	standard day	C	09:00	17:00	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑
	WE day JR	D	08:00	20:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑
	Late Shift HGH	E	13:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑
○	NIghts HGH	F	20:00	08:30	FULL SHIFT		00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	
	WE day Horton	G	08:00	20:30	FULL SHIFT	☐	00:00	00:00	00:00	00:00	00:00	00:00	00:00	00:00	☑
○	Zero Hours	0	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--
○	Standard Duty	S	--:--	--:--	--		--:--	--:--	--:--	--:--	--:--	--:--	--:--	--:--	--

Week No.	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	20:00 08:30	20:00 08:30	20:00 08:30	20:00 08:30	00:00 00:00	00:00 00:00	00:00 00:00
2	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
3	08:00 17:30	08:00 17:30	08:00 17:30	08:00 17:30	08:00 17:30	00:00 00:00	00:00 00:00
4	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30
5	00:00 00:00	00:00 00:00	13:00 - 20:30	08:00 17:30	08:00 17:30	00:00 00:00	00:00 00:00
6	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
7	13:00 - 20:30	08:00 17:30	08:00 17:30	08:00 17:30	08:00 17:30	00:00 00:00	00:00 00:00
8	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	08:00 - 20:30	08:00 - 20:30
9	00:00 00:00	00:00 00:00	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	00:00 00:00	00:00 00:00
10	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00	00:00 - 00:00
11	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 00:00	00:00 00:00
12	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
13	20:00 08:30	20:00 08:30	20:00 08:30	20:00 08:30	00:00 00:00	00:00 00:00	00:00 00:00
14	08:00 - 17:30	13:00 - 20:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00
15	08:00 - 17:30	08:00 17:30	08:00 17:30	08:00 17:30	08:00 17:30	00:00 00:00	00:00 00:00
16	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	13:00 - 20:30	08:00 - 20:30	08:00 - 20:30
17	00:00 00:00	00:00 00:00	08:00 17:30	08:00 17:30	08:00 17:30	00:00 00:00	00:00 00:00
18	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	20:00 - 08:30	20:00 - 08:30	20:00 - 08:30
19	00:00 00:00	00:00 00:00	13:00 - 20:30	08:00 17:30	08:00 17:30	00:00 00:00	00:00 00:00
20	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	08:00 - 17:30	00:00 - 00:00	00:00 - 00:00

Pay Breakdown:

	Without adjustment	With adjustment/adjustment	leave / rounding
Average Hours	47.77	47.81	48.00
Weekly Additional	7.77	7.81	8.00
Weekly Night	8.75	9.98	10.00
Weekend Banding	6.00%	6.00%	6.00%
Availability Allowance	N/A	N/A	N/A



Indicative salaries for this rota (2017-18)

Note that indicative salaries below are based on the Pay and Conditions Circular (M&D) 1/2017, and do not include any London weighting or Flexible Pay Premia.

FY1	£26,614	£26,614	£5,323	£2,462	£1,597	£0	£35,996
FY2	£30,805	£30,805	£6,161	£2,850	£1,849	£0	£41,665
CT1/CT2	£36,461	£36,461	£7,293	£3,373	£2,188	£0	£49,315
CT3	£46,208	£46,208	£9,242	£4,275	£2,773	£0	£62,498
ST1/SpR1 – ST2/SpR2	£36,461	£36,461	£7,293	£3,373	£2,188	£0	£49,315
ST3/SpR3 – ST8/SpR8	£46,208	£46,208	£9,242	£4,275	£2,773	£0	£62,498

Indicative salaries for this rota (2018-19)

Note that indicative salaries below are based on the This Pay and Conditions Circular (M&D) 3/2018 replaces Pay and Conditions Circular (M&D)1/2017 originally published on 27 March 2017 and updated on 22 March 2018

FY1	£27,146	£27,146	£5,430	£2,512	£1,629	£0	£36,717
FY2	£31,422	£31,422	£6,285	£2,907	£1,886	£0	£42,500
CT1/CT2	£37,191	£37,191	£7,439	£3,441	£2,232	£0	£50,303
CT3	£47,132	£47,132	£9,427	£4,360	£2,828	£0	£63,747
ST1/SpR1 – ST2/SpR2	£37,191	£37,191	£7,439	£3,441	£2,232	£0	£50,303
ST3/SpR3 – ST8/SpR8	£47,132	£47,132	£9,427	£4,360	£2,828	£0	£63,747

2016 CONTRACT COMPLIANCE

Rule	Result	Analysis
1. No more than 72 hours actual work have been undertaken, in any working pattern, in any period of 7 consecutive calendar days. **Please be advised that the Terms & Conditions refer to this as any seven day period, midnight to midnight, and not as 72 hours within any rolling 168 hour period.**	70.50	RULE: OK
2. No shift (other than an on-call duty period) should be rostered to exceed 13 hours in duration.	0	RULE: OK
3. No more than 5 long shifts (where a long shift is defined as being a shift rostered to last longer than 10 hours) can be worked consecutively.	4	RULE: OK
4. No more than 4 night shifts of any length can be rostered or worked consecutively. A night shift is defined as any shift where a minimum of three hours of rostered work falls into the period between 23:00 and 06:00.	0	RULE: OK
5. On-call periods cannot be worked consecutively, other than at the weekend when two consecutive on-call periods (beginning on Saturday and Sunday respectively) are permitted. Longer runs of consecutive on-call periods, covering up to a maximum of seven consecutive days, may be agreed locally where both the employer and the doctor agree that it is safe and acceptable to both parties to do so and where such an on-call pattern would not breach any of the other limits on working hours or rest.	0	RULE: OK
6. Where 5 long shifts are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
7. Where either 3 or 4 night shifts are rostered or worked consecutively, there must be a minimum 46 hour rest period after.	52.50	RULE: OK
8. Where 8 days are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
9. No doctor shall be rostered for work at the weekend (defined for this purpose as any shifts or on-call duty periods where any work takes place between 00.01 Saturday and 23.59 Sunday) at a frequency of greater than 1 week in 2. Doctors paid at nodal point 2 are exempt from the requirements of the above paragraph for one placement during their foundation year. For these doctors, there is a requirement not to be rostered for shifts starting at any time between 00.01 on a Saturday and 23.59 on a Sunday at a frequency of greater than 1 week in 2.	4.00	RULE: OK Frequency is 1 in 5.0(4 weekend work in 20 weeks)(standard TCS), And 1 in 5.0 (4 Weekends in 20 weeks)(nodal point 2 rule)
10. Where shifts exceeding 10 hours finish after 2300, no more than 4 such shifts can be worked consecutively.	0.00	RULE: OK
11. Where 4 shifts exceeding 10 hours finishing after 23:00 are worked consecutively, there must be a minimum 48 hour rest period after.	0.00	RULE: OK
12. There must be no more than 3 on-call duty periods in 7 days, unless it is mutually agreed at a local level	0	RULE: OK
13. The day following an on-call duty period must not be rostered to last longer than 10 hours. Where it is expected that rest requirements will not be met on all occasions, rostered duty must not exceed 5 hours	0.00	RULE: OK
14. Whilst on-call a doctor must get 8 hours rest per 24 hours, of which 5 must be continuous between 2200 and 0700	0.00	RULE: OK
15. Doctors should not be rostered for more than an average of 48 hours of actual work per week, unless they have opted out of WTR in which case they should not exceed an average of 56 hours of actual work per week.	47.81	RULE: OK
16. A maximum of 8 shifts of any length can be rostered or worked on 8 consecutive days. Where the work schedule of a doctor rostered for on-call duty on a Saturday and Sunday contains 3 hours or fewer of work on each day, and no more than 3 episodes of work on each day, then such duty is defined as 'low intensity'. In such a 'low intensity' working pattern the 8 day limit will not apply and a maximum of 12 days can be rostered or worked consecutively.	7	RULE: OK
17. Pattern should not contain fixed leave	0	RULE: OK

WORKING TIME REGULATIONS (WTR) COMPLIANCE

Rule	Result	Analysis
1. No doctor to work more than an average of 48 hours per week (unless they have opted out of the WTR).	47.81	RULE: OK
2. Daily rest of 11 consecutive hours in each 24 hour period.	0	RULE: OK
3. Starting each Monday, either: • a 35 hour continuous rest period in 7 days • a 59 hour continuous rest period in 14 days • two 35 hour continuous rest periods in 14 days	0	RULE: OK

Section 6

Section 6:

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

Work Stream 5a Workforce – non-obstetric workforce requirements to open an obstetric unit at the Horton

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

Anaesthetic staff

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

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

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

Midwives

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

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

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

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

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

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

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

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

Recruitment

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

Retention

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

Neonatal nurses

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

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

Recruitment of neonatal nurses is challenging not just in Oxfordshire but nationally. The Trust has a rolling advert but so far this has not recruited any nurses. There is at present a specialist course at Brooks University.

One ward clerk would also be required.

Section 7

Section 7

Recruitment and retention of the obstetric workforce

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

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

- 9 out of 10 obstetric units report a gap in their middle-grade rota, which can affect job satisfaction, postgraduate training, quality of care and staff wellbeing
- A 30% attrition rate from the training programme is typical, further compounded by a loss at transition from training to consultant grade posts
- 54% of those on the O&G Specialist Register are international medical graduates with 14% from the EEA
- O&G services rely on the significant contribution of Specialty and Associate Specialist (SAS) doctors and Trust doctors, however there is a significant turnover among this group with around 12% leaving the NHS workforce in England each year
- Although the majority (63%) of doctors provide both O&G services, 20% provide services in gynaecology only
- Workforce planners predict an increased number of consultants will be required on top of the projected supply by 2021

Consultants

The Trust is not fully staffed at consultant level (in November there were 5 vacancies). Filling these posts will have some difficulty and any of the models that have a large increase in consultant staff will be very difficult to recruit to especially as in these models consultants are required to undertake resident on-call work. Consultants at the Horton General Hospitals would probably largely be consultants in obstetrics and gynaecology (as is the model in other small units) and therefore there also needs to be capacity for the daytime surgical work. It would be important to

focus on the benefits of working in a local unit with a defined catchment that can be forward looking in implementing the community hub model of “Better Births” and working in partnership with the specialist services provided by the same Trust at the John Radcliffe Hospital.

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

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

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

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

Through these methods, we have managed to recruit between 2 and 5 middle grade doctors at any one time, who want to work at the Horton. But we have not come close to sustainably recruiting 9.

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

- Trust Doctors are employed directly by trusts and their contracts aren’t subject to national terms and conditions. This is the type of role that the OUH have been trying to recruit too and on its own has not enabled 9 doctors to be in post.
- Medical training initiative (MTI) doctors from overseas who are qualified and competent at ST3 and come to train and get their RCOG specialist accreditation. For the first year these doctors would not be able to provide the resident on-call service at the Horton so a 2-3 year on-going programme would be required with one year solely at the John Radcliffe and then 1-2 years supporting the Horton rota. This programme is in very early

development so we would be piloting a new approach and we do not therefore have evidence on how successful it would be.

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

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

There are also ongoing recruitment challenges for midwives and neo-natal nurses, which will need dedicated attention to address if the Unit is to be reopened. However, the obstetric workforce has been identified as the critical issue.

May 2019

Section 8

Section 8: Finance

To follow

Section 9

Section 9

Oxfordshire
Clinical Commissioning Group

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

Work Stream 5c Travel and access

1. Introduction

The purpose of this work stream is to understand the range of travel times for services and the impact (in terms of increased travel time) on these of the temporary closure of the obstetric services from the Horton General Hospital. This will differentiate between travel times (defined as the time taken for women and their families to travel to services) and transfer times (defined as the time taken for an ambulance transfer from a Midwife led Unit (MLU) to an obstetric service)

- Travel times; previous analyses to be reviewed and reissued to identify if any further work is required.
- Transfer times
    - Using the information collected over the period of the temporary closure of the obstetric service at the Horton General Hospital a review of transfer times between the Horton MLU and the other three Oxfordshire MLUs and the John Radcliffe will be undertaken. If possible these will be set in the context of national data.
    - An independent clinical view on the acceptability of transfer times will be sought.
    - The processes enacted when there are multiple demands on the dedicated ambulance or severe traffic delays will be summarised.

Completion of this work will be the development of clear information that is used within the option appraisal process.

It is important to note that there have always been some women who would travel to Oxford from the Banbury area and further afield. Women who need the care of specialist services because existing health conditions or other issues that might mean additional specialist support is needed would always need to attend an obstetrics unit in a specialist hospital like the JR. They would be identified early in pregnancy and plans would be made during the pregnancy to ensure they could travel safely. Other women chose to have their baby in Oxford despite having a local obstetric unit in Banbury.

Many of these women would have travelled to Oxford in their own car but others would have needed to travel by ambulance, some will have transferred as an emergency from the Horton to Oxford to ensure they had the specialist care needed.

2. Travel Times

2.1 Sources of information

Work was undertaken during 2017 to analyse and understand the impact on travel and access for women and their families if there was not an obstetric service at the Horton General Hospital (HGH).

This analysis was detailed and included consideration of time of day (peak and off-peak) of the week which impacted on travel time because the traffic conditions vary. The analysis is presented as maps that illustrate how travel time is affected by distance and time of travel.

It was acknowledged that the changes to obstetric services would mean many women and their families would need to travel further for some aspects of their care and the travel times would vary.

This work is still relevant today and is based on standard methodologies for calculating travel times. In addition to the travel times, the impact of parking was also investigated. The congestion on the JR site was highlighted and a survey was conducted by Healthwatch Oxfordshire to gather evidence about availability of parking and delays that could add to travel times.

The work commissioned by Oxfordshire Clinical Commissioning Group resulted in a number of reports that have been published and remain available on OCCG website including:

- Hospital car parking survey conducted by Mott MacDonald
- Healthwatch travel survey
- Integrated Impact Assessment
- Baseline travel analysis
- Travel analysis

These documents can be found here:
http://www.oxonhealthcaretransformation.nhs.uk/what-is-the-vision/consultation-documents

The Integrated Impact Assessment Final Report provided more detailed analysis of the direct impact of changes including the increased travel time (particularly relevant for maternity services are pages 30-32, 39-40 and 69-78; these have been saved as a standalone document and are included at Appendix 1).

In addition

2.2 What this tells us

We know that the changes to obstetric services have meant most people from the Banbury area need to travel further for some of their care. The analysis we have done demonstrates the how the travel time varies and how this impacts on different groups within the community. It is not just the distance to travel, it is also the traffic conditions that affect the time taken for the journey. Rush hour traffic and roadworks all contribute to longer journeys.

The information from the travel confirms that removal of the obstetric service from the HGH results in an increase in journey times. With services at the HGH the majority of the catchment area could access the hospital within 30 minutes and with the HGH this increases to up to 50 minutes (average car journeys). It is understood that one important consideration is the variation in journey times and the CCG is working with the County Council to get an understanding of this variation from the Banbury area to the John Radcliffe Hospital.

It is also clear that the need to have time to find a car parking space adds to the overall experience and journey time.

These factors have an impact on patient experience and this will be considered as part of the appraisal of options where access and experience will be considered alongside the other factors.

Victoria Prentis MP undertook a travel survey #BanburytoJR which highlighted the same issues of increased travel time and time to park.

3. Transfer Times

3.1 *Managing Transfer from an MLU to an obstetric unit*

Some women need to be transferred during labour or soon after birth because of problems that have developed. If these problems are serious or life-threatening, the transfer will be conducted with a blue light ambulance to ensure minimum time to reach the expertise needed.

Being transferred by ambulance from an MLU is not unusual and happens at every MLU. The decision about whether to transfer in these circumstances is taken by the midwife attending the woman and she/he will take into account the distance and time it will take for a transfer.

In Oxfordshire ambulance transfers are classified as ‘time critical’ and ‘non-time critical’. The decision as to whether a transfer is classified as time critical depends on the reason for transfer and the urgency of the clinical problem.

- **Time critical transfers** where the safety of the mother or baby is at risk, these are extremely rare and can be subdivided into those where a blue light transfer is required and those where there is a need for urgent medical review to avoid a poor outcome for either mother or baby.
- **Non-time critical** are when further monitoring or treatment is required for either the mother or baby because there is a potential for risk to occur

3.2 Transfer rates and times from Oxfordshire MLUs 1 October 2016 – 30 September 2018

The transfer data from 1 October 2016 to 30 September 2018 for all the Oxfordshire MLUs has been analysed to look at transfer numbers, rates and time taken for transfer.

3.2.1 Reason for transfer and transfer rates

Women are transferred from MLUs for a variety of factors - for example, the identification of new onset risk factors during birth such as slow progress, meconium stained liquor or suspicion of fetal distress; or maternal choice on pain relief; or, post-birth complications or if the baby requires further assessment or additional monitoring. A safety first culture is operated and if there are concerns, midwives will explain these to the patient and arrange a transfer. Midwives will be in close contact with the obstetricians at the John Radcliffe at all times to discuss options and ensure they are making the best decision for the mother and baby concerned.

The Table below shows the timing of the transfer during labour or in the 4 hours following birth for the 358 women who were transferred over the 2 year period.

Table 1 Transfers broken down by unit and stage of transfer October 2016 to September 2018

Stage of transfer	Cotswold Chipping Norton	Horton Banbury	Wallingford	Wantage	TOTAL
First stage	29	79	40	7	155
Second stage	15	14	13	7	49
Third stage	8	25	11	4	48
Post natal	10	23	10	3	46
Newborn	9	27	21	3	60
TOTAL	71	168	95	24	358

Table 2 below shows the transfer rates for each of the MLUs over the two year period.

Table 2 Births and Transfer rates October 2016 to September 2018

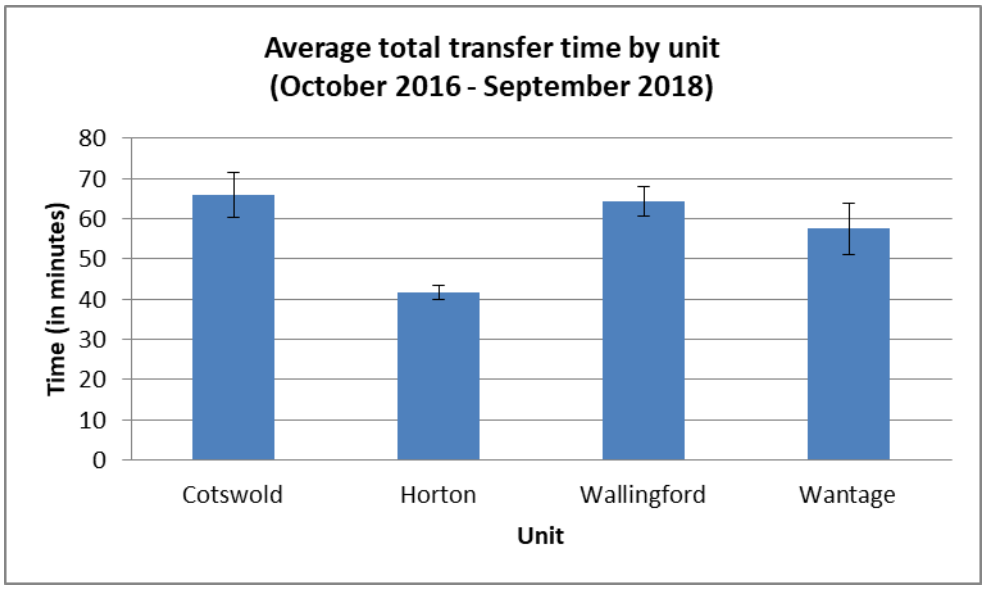
	Cotswold Chipping Norton	Horton Banbury	Wallingford	Wantage	TOTAL
Planned	224	460	393	92	1169
Births	180	370	337	78	965
Transfers	71	168	95	24	358
Transfer rate	32%	37%	24%	26%	31%

3.2.2 Transfer times

The data presented here shows the average total time for transfer (this includes the time waiting for the ambulance to arrive and the journey time). Table 3 contains the mean, median and interquartile range and the mean transfer times are then shown in the graph below.

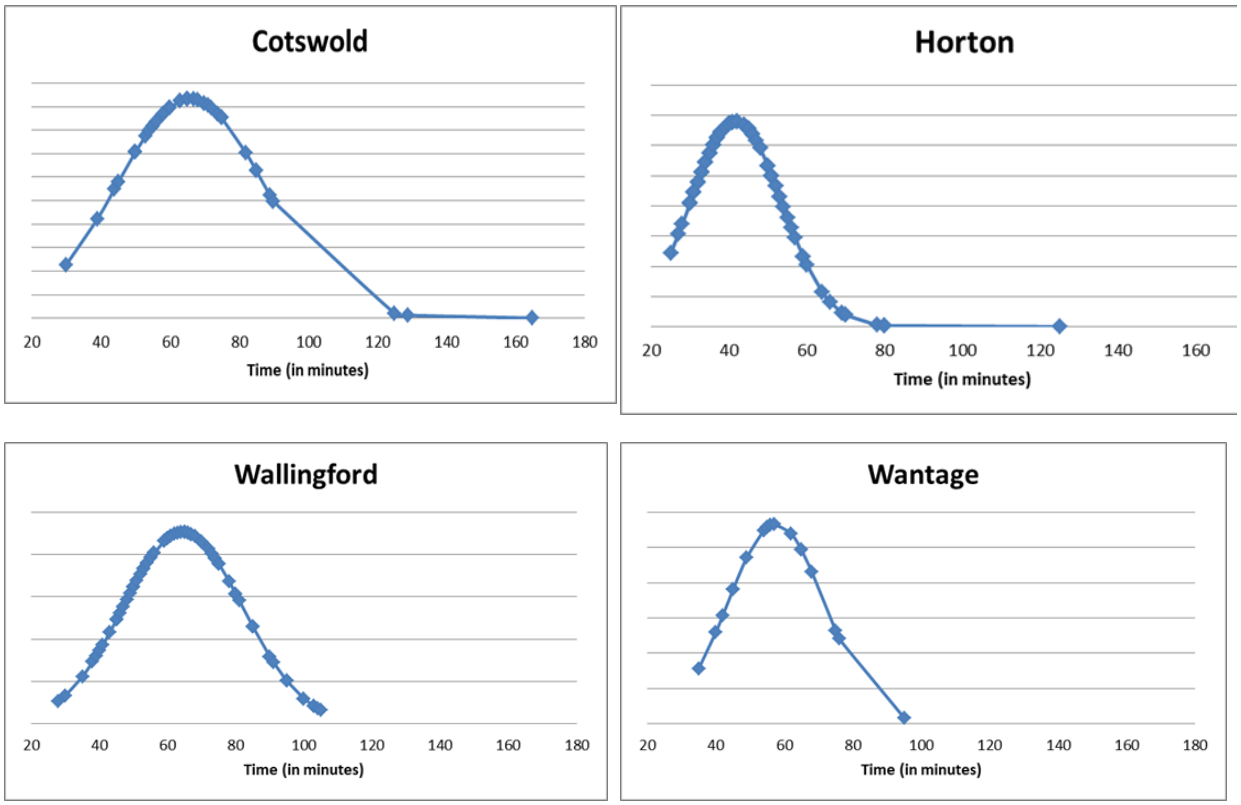
Table 3 – Transfer times from MLUs to John Radcliffe Hospital from October 2016 to September 2018

	Cotswold Chipping Norton	Horton Banbury	Wallingford	Wantage
Mean (minutes)	66	42	64	58
Median (minutes)	60	40	62	55
Interquartile range (minutes)	55 - 72	35 - 45	53 - 75	45 - 65



The Cotswold unit has the highest average total transfer time of 66 minutes. The Horton has a lower average total transfer time (42 minutes) given the shorter time women wait for an ambulance

Distribution curves for each unit showing all recorded total transfer times (i.e. where both the call to arrival and travel time in the ambulance were both recorded).



The longest total transfer time across all of Oxfordshire's MLUs was 165 minutes from the Cotswold unit (135 minutes from call to arrival and 30 minutes travel time). This was a non-time critical transfer. Four transfers took longer than 2 hours in total – one from the Horton (this was due to an ambulance breaking down en route and contact between the ambulance crew and the hospital was maintained throughout until the transfer could be resumed) and three from the Cotswold unit.

3.3 Clinical view on acceptability of transfer rates and times

3.3.1 National context

The Birthplace cohort study, conducted in 2011, collected data on over 64,000 'low-risk' births in England, including 28,000 planned 'low-risk' midwifery unit births in both FMLUs and Alongside MLUs (AMLUs)[1].

The key findings from the study [2] were:

- For women in their first pregnancy who planned birth in a FMLU, the transfer rate during labour or immediately following delivery was 36%.

[1] NPEU Birthplace cohort study (2011).
[2] Extract from 'The Birthplace cohort study: Key findings' found at website

- For women having a second or subsequent baby, the transfer rate was 9%.

There have been a number of practice and guidance changes in the 6 years since the Birthplace cohort study was published. Most notably this includes guideline changes regarding the thresholds for admission and transfer criteria for women in labour and following the birth: for example, recognition and early management of suspected sepsis and an increase in observations required for newborn babies.

It is also worth acknowledging the changing profile of pregnant women due to: a) increased maternal age - around 50% of women having their first baby aged 40 years or over are transferred ; b) the increase in women with a raised body mass index (BMI), and c) the fact that the population is generally less fit/healthy. These factors mean that women are more likely to have pregnancy-related complications, particularly delay in labour and postpartum haemorrhage.

In the Birthplace study, two thirds of the 53 FMLUs studied were between 20-40km from the nearest obstetric hospital with a median transfer time of 60 minutes (interquartile range 45-75 minutes). Most transfers from MLUs to the John Radcliffe Hospital are made via ambulance with the accompanying midwife; however, it is possible for women to be taken by their birthing partner in their own vehicle if the woman and her partner so wish and it is clinically appropriate. Midwives have a guide to review the most suitable mode of transport for transfers depending on clinical presentation.

The distances from each of the MLUs to the John Radcliffe Hospital are as follows:

- Cotswold – 20.2 miles / 32.5km
- Wallingford – 17.5 miles / 28km
- Wantage – 19 miles / 30.5km
- Horton – 23.2 miles / 37km (and 22 miles/35.4km to Warwick Hospital)

From the total transfer time data analysed the median transfer times for all the MLUs in Oxfordshire were in line with those of the Birthplace study.

3.3.2 Local arrangements

The Birthplace study found that

- For planned births in freestanding midwifery units and alongside midwifery there were no significant difference in adverse perinatal outcomes compared with planned birth in an obstetric unit.
- Women who planned birth in a midwifery unit (AMU or FMU) had significantly fewer interventions, including substantially fewer intrapartum caesarean sections, and more 'normal births' than women who planned birth in an obstetric unit.

OUH has provided services from MLUs for many years and midwifes staffing these units are trained to support women in labour including careful monitoring of the progress of labour and the incidence of any complications. There are agreed protocols and thresholds for transfer set to ensure the safety of mother and baby.

The midwives link with the receiving obstetric unit to agree the need and urgency of a transfer and continued communications would also occur between the ambulance crew and receiving unit if the clinical situation changed.

Transfers from the Cotswolds, Wantage and Wallingford midwife led units are provided by South Central Ambulance Service (SCAS). There is a dedicated Ambulance at the Horton MLU which is provided by another provider but dispatched via SCAS. At the Horton HOSC evidence session on 19 December 2018 representatives from SCAS confirmed that all decisions are clinically based and that all factors are taken into account, on an individual patient basis, to balance speed and comfort. When clinically indicated it is safe to transfer the mother and paramedics are trained to support women in labour and would be accompanied by a midwife.

OUH reviews all transfers on a continual basis and any potential concerns or issues would be investigated

4. Conclusions and next steps

From the data we have there is nothing to indicate that the increased travel distance and time (for women and their families to travel to services) and transfer times (the time taken for an ambulance transfer from a Midwife led Unit (MLU) to an obstetric service) is unsafe. Comparison of median transfer times from the Oxfordshire MLUS to the JR obstetric service is in line with the national findings of the Birthplace study. The Public Health Wales Observatory Research Evidence Review (2015) "did not find conclusive evidence to support a causal link between increasing distance, or the time, required to travel from mother's residence to maternity services and adverse birth outcomes"[3].

As stated earlier this analysis of travel and transfer times and the impact on mothers and their families will inform the option appraisal process.

The HOSC is asked to comment on the information requested and identify if there is any further analysis that should be undertaken.

Catherine Mountford
Director of Governance, Oxfordshire CCG
14 February 2019

[3] p.23;Research Evidence Review: Impact of Distance/Travel Time to Maternity Services on Birth Outcomes;1 October 2015; Public Health Wales Observatory

Section 10

Section 10

4 Travel and access impacts

This chapter identifies travel and access impacts, which could potentially be experienced as a consequence of implementing the proposals. The chapter presents impacts for blue light ambulance as the journeys by patients for the services assessed would typically be made by this mode of transport; impacts for private car and public transport are included in appendix F. Impacts have been identified through quantitative journey time analysis, as well as a desk review. Detailed analysis by an equality group is included within the equality chapter (chapter 5). Appendix C provides heat maps for changes in travel times and appendix F provides a further breakdown of the changes in travel times.

Travel and access analysis has been undertaken on the basis of available current patient activity for the phase one services. Activity data, rather than population data, has been used so as to provide as accurate picture as possible about the potential impacts for patient journey times and to understand the potential volume of patients which would require longer trips. Data have been analysed at two levels, defined as:

- Overall patient activity: this refers to the number of patients who have accessed services within Oxfordshire CCG, regardless of whether they are resident in Oxfordshire or have come from outside Oxfordshire to access services.
- Oxfordshire patient activity only: this refers to the number of patients who have accessed services within Oxfordshire CCG and are resident in Oxfordshire.

This report has utilised thresholds of 30 and 60 minutes to report on the travel impacts. This allows for a consistent baseline upon which to record the differences between option configurations. Further details of the travel impact for additional travel time bands can be seen in appendix F.

4.1 Ambulatory care

Travel and access impacts have not been assessed for ambulatory care. This is because patients will continue to receive care at an AAU at their local hospital site, or because ongoing ambulatory care will be delivered in or closer to patients homes.

4.2 Critical care services

Analysis for the change to critical care services has not been assessed for travel and access impacts. This is due to the low volumes of patients receiving level 3 critical care.

4.3 Maternity

The tables below highlight the difference in travel times for maternity patients accessing hospitals for the baseline position and under a future scenario with obstetric-led maternity care removed from HGH. Residents living in the north of the county, namely Banbury and Chipping Norton and the surrounding areas, will need to travel further for their care.

The change to maternity services will not affect all patients. The HGH would move from providing 18 per cent of OUHFT's births to 6 per cent under the proposals in Phase One. The remaining 6 per cent (496) of births would be delivered at HGH at the on-site MLU.

4.3.1.1 Quantitative analysis of journey time impacts: overall patient activity

Based on current maternity patient activity data, 73 per cent of maternity patients can access obstetric-led maternity services by blue light within 30 minutes and 93 per cent within 60 minutes. Should obstetric-led maternity services not be provided at the HGH in future, 52 per cent of patients would be able to able to access obstetric-led maternity services within 30 minutes and 93 per cent within 60 minutes.

Table 5: Blue light ambulance journey time to obstetric-led maternity services: baseline - including services at the HGH (all patients)

	Travel time – blue light (baseline - including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	3,515	2,205	2,692	1,786	543	20	772
Percentage of patients reaching maternity services in journey time range	30%	19%	23%	15%	5%	0%	7%
Cumulative percentage	30%	50%	73%	88%	93%	93%	100%

Source: SUS SEM

Table 6: Blue light ambulance journey time to obstetric-led maternity services: without services at the HGH (all patients)

	Travel time - blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,798	1,540	2,676	3,809	910	19	781
Percentage of patients reaching maternity services in journey time range	16%	13%	23%	33%	8%	0%	7%
Cumulative percentage	16%	29%	52%	85%	93%	93%	100%

Source: SUS SEM

4.3.1.2 Quantitative analysis of journey time impacts: Oxfordshire patient activity only

Based on current maternity patient activity data, 79 per cent of patients resident in Oxfordshire can access obstetric-led maternity services by blue light within 30 minutes and 100 per cent within 60 minutes. Should obstetric-led maternity services not be provided at the HGH in future, 57 per cent of patient's resident in Oxfordshire would be able to access obstetric-led maternity services within 30 minutes and 100 per cent within 60 minutes.

Table 7: Blue light ambulance journey time to obstetric-led maternity services: baseline – including services at the HGH (Oxfordshire resident patients only)

	Travel time – blue light (baseline - including HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patient's resident in Oxfordshire reaching maternity services in journey time range	3,515	2,073	2,636	1,742	469	0	0
Percentage of patient's resident in Oxfordshire reaching maternity services in journey time range	34%	20%	25%	17%	4%	0%	0%
Cumulative percentage	34%	54%	79%	96%	100%	100%	100%

Source: SUS SEM

Table 8: Blue light ambulance journey time to obstetric-led maternity services: without services at the HGH (Oxfordshire resident patients only)

	Travel time - blue light (excluding HGH)						
Journey time (number of minutes)	0-10	11-20	21-30	31-40	41-50	51-60	>60
Number of patients reaching maternity services in journey time range	1,798	1,532	2,641	3,679	785	0	0
Percentage of patients reaching maternity services in journey time range	17%	15%	25%	35%	8%	0%	0%
Cumulative percentage	17%	32%	57%	92%	100%	100%	100%

Source: SUS SEM

4.4 Planned care services

Travel analysis on the impact of the changes to planned care services has not been possible for this IIA. To robustly assess the impacts on planned care services at the HGH, requires a greater level of disaggregation of the patient data than has been available. However, it is likely that travel times will be reduced for patients using these services, given the additional capacity being proposed at the HGH.

4.5 Stroke services

Stroke services for Oxfordshire will be centralised in the JRH. Direct conveyance of all appropriate Oxfordshire patients to the HASU at the JRH will be supported by the roll out of countywide early supported discharge to improve rehabilitation and outcomes. Residents living in the north of the county, namely Banbury and Chipping Norton and the surrounding areas, will have longer journeys to access care.

4.5.1.1 Quantitative analysis of journey time impacts: overall patient activity

Based on current stroke patient activity data, 71 per cent of patients can access stroke services by blue light ambulance within 30 minutes and 98 per cent within 60 minutes. Should stroke services not be provided at the HGH in future, 55 per cent of patients would be able to able to access stroke services within 30 minutes and 98 per cent within 60 minutes.

5.2.2.1 Maternity

The tables below highlight the travel times to obstetric-led maternity services for maternity patients within one of the scoped-in equality groups; baseline journey times are compared with the future proposal.

Table 14: Percentages able to reach obstetric-led maternity services in 30 minutes or less by blue light ambulance

Group	Baseline percentage able to reach obstetric-led maternity services by blue light ambulance in 30 minutes or less (including services at HGH)	Future percentage able to reach obstetric-led maternity services by blue light ambulance in 30 minutes or less (without services at HGH)	Difference
Overall – all patient activity	**73%**	**52%**	**-20pp change**
Oxfordshire patients only	**79%**	**57%**	**-22pp change**
Women aged 15-44 (all patients)	74%	52%	-22pp change
Women aged 15-44 (Oxfordshire patients only)	79%	57%	-22pp change
BAME (all patients)	86%	64%	-22pp change
BAME (Oxfordshire patients only)	92%	68%	-24pp change
Most deprived quintile (all patients)	99%	59%	-40pp change
Most deprived quintile (Oxfordshire patients only)	100%	59%	-41pp change

Source: SUS SEM

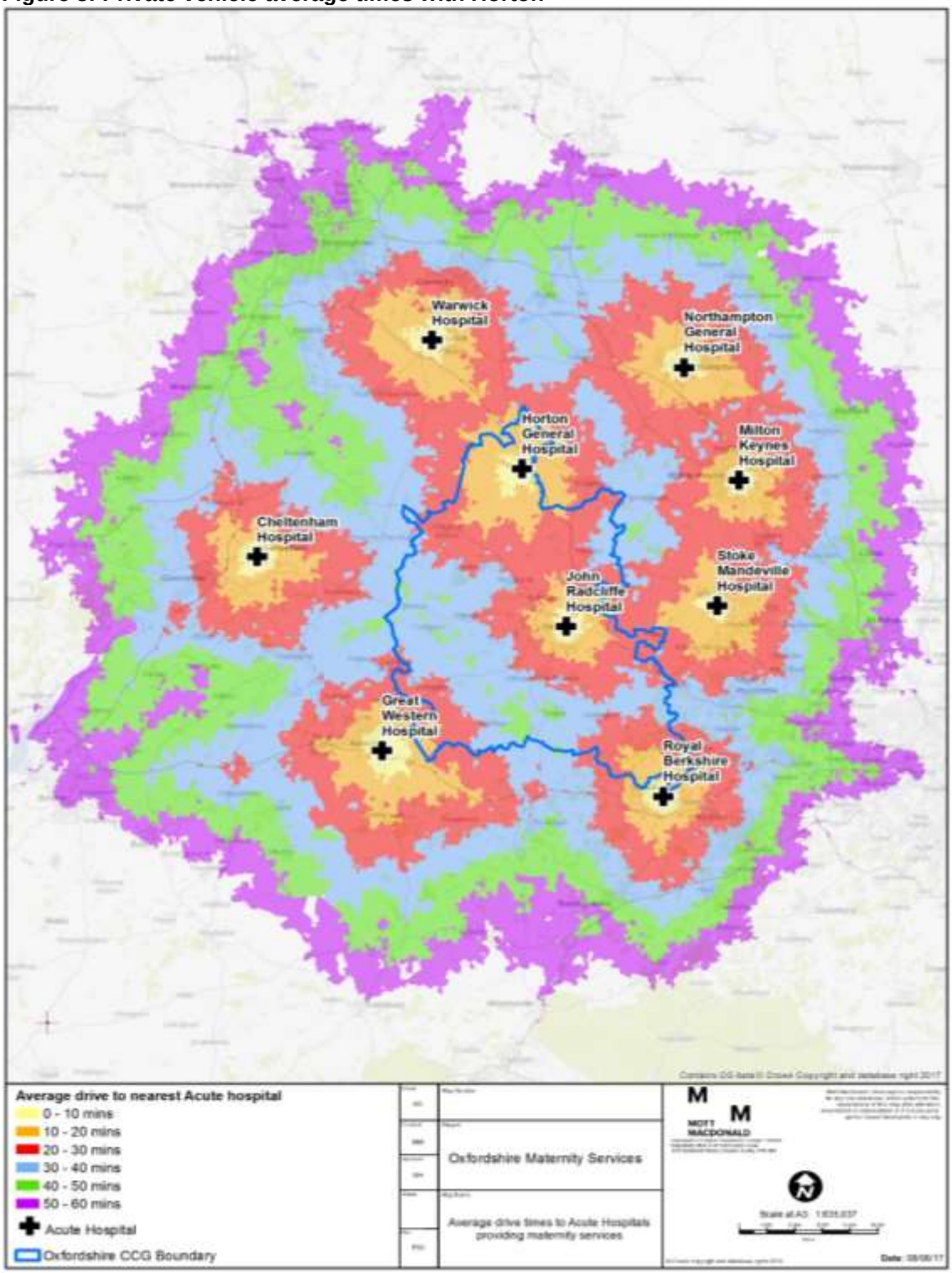
Table 15: Percentage able to reach obstetric-led maternity services in 60 minutes or less with by blue light ambulance

Group	Baseline percentage able to reach obstetric-led maternity services by blue light ambulance in 60 minutes or less (including services at HGH)	Future percentage able to reach obstetric-led maternity services by blue light ambulance in 60 minutes or less (without services at HGH)	Difference
Overall – all patient activity	**93%**	**93%**	**No change**
Oxfordshire patients only	**100%**	**100%**	**No change**
Women aged 15-44 (all patients)	93%	93%	No change
Women aged 15-44 (Oxfordshire patients only)	100%	100%	No change
BAME (all patients)	94%	94%	No change
BAME (Oxfordshire patients only)	100%	100%	No change
Most deprived quintile (all patients)	99%	99%	No change
Most deprived quintile (Oxfordshire patients only)	100%	100%	No change

Source: SUS SEM

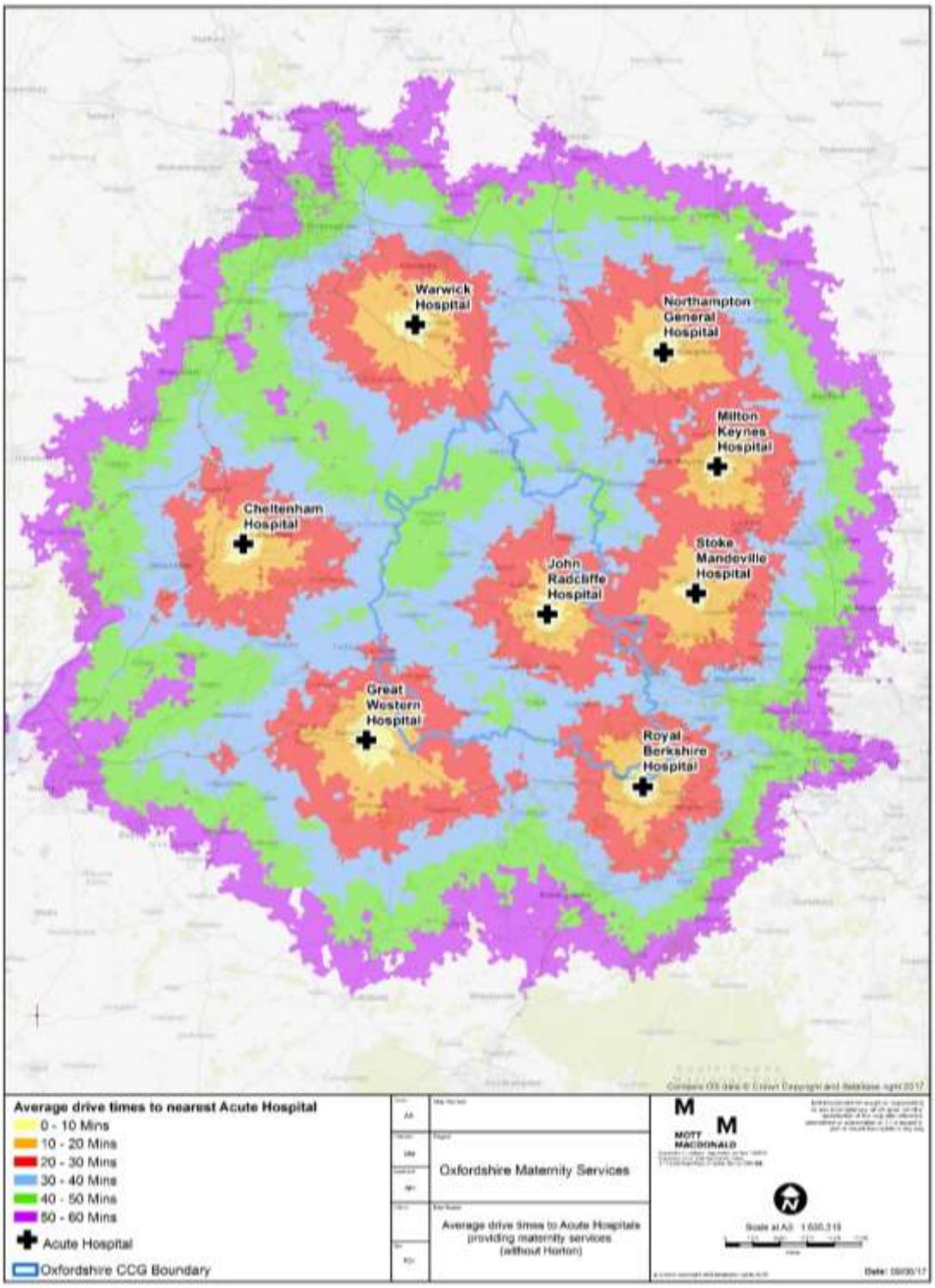
- There is a 40 percentage point reduction in patients from deprived communities being able to reach these services within 30 minutes (by blue light ambulance), compared to a 20 percentage point reduction for the population overall. The change is due to the removal of the HGH as an option, the higher concentration of deprived communities (compared to other protected characteristic groups) in the Banbury area and the longer distances that could be involved in transporting a patient to the JRH.
- Women aged 15-44 will have the lowest percentage of patients who can access maternity services within 30 minutes by blue light (52 per cent - using activity data from all patients); these percentages are in line with access for the overall population.

Figure 8: Private vehicle average times with Horton



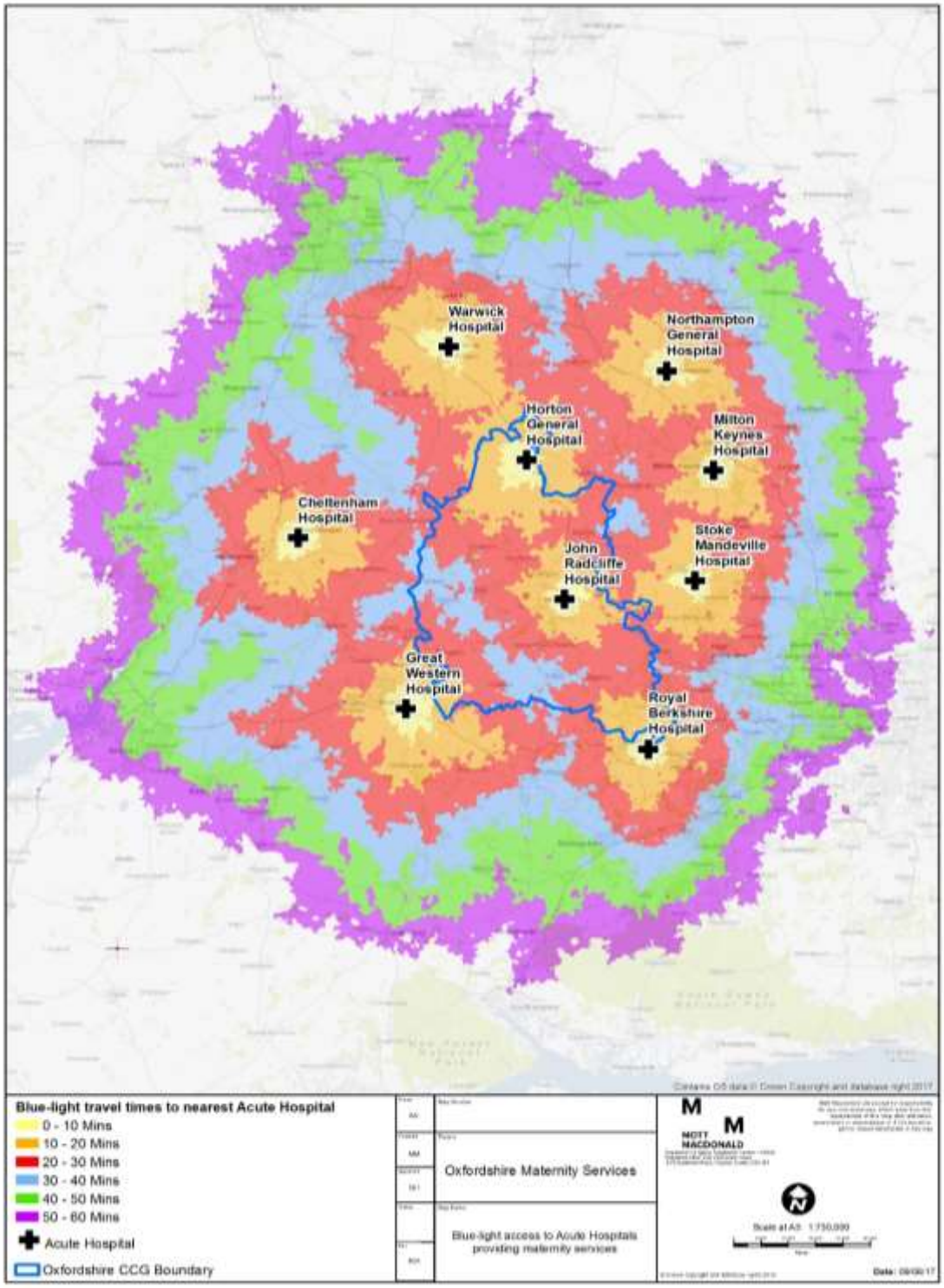
Source: Data provided by the CSU

Figure 9: Private vehicle average times without Horton



Source: Data provided by the CSU

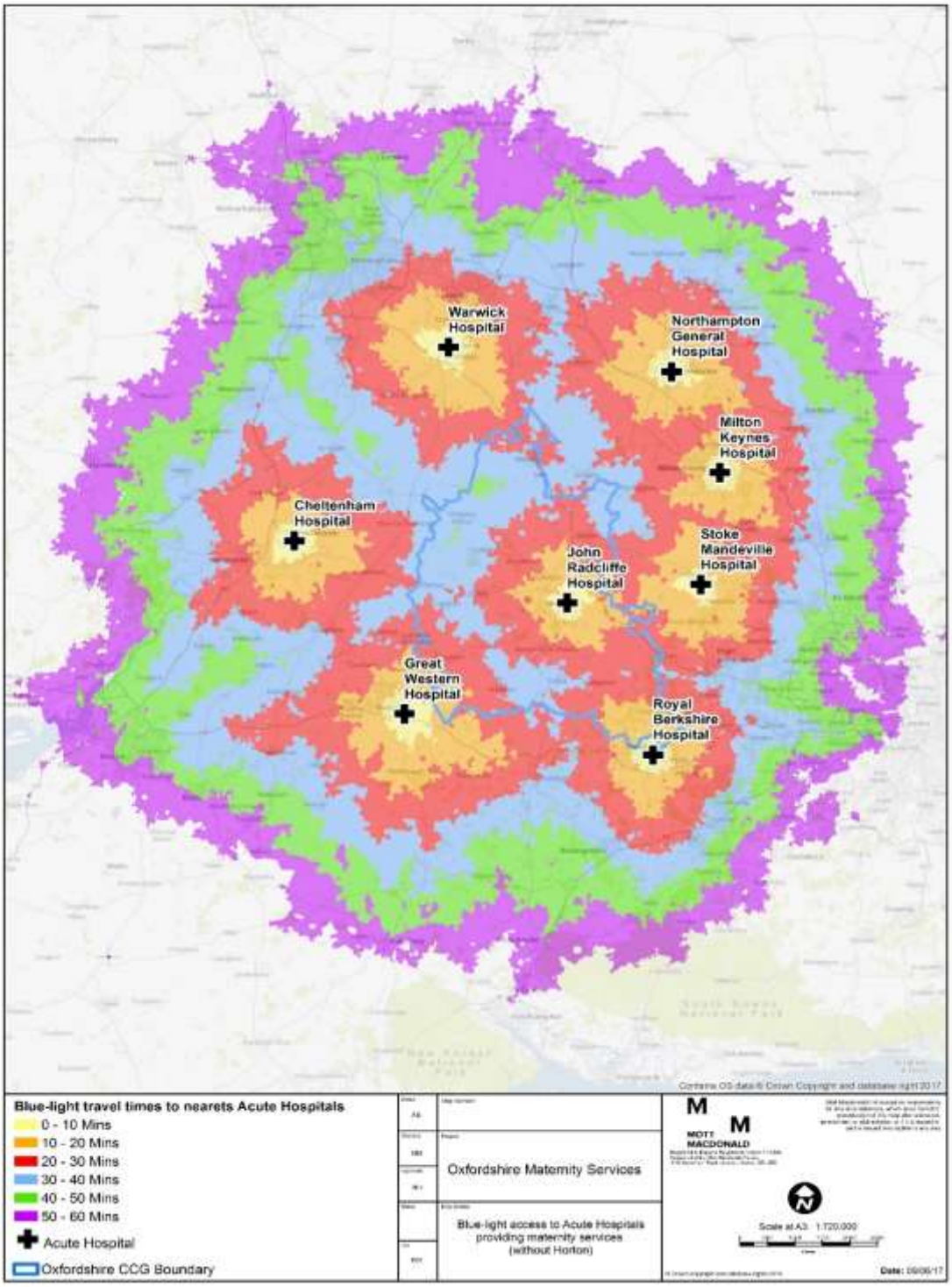
Figure 10: Blue light access with Horton[66]



Source: Data provided by the CSU

[66] Modelling has been done on the basis of pick up to destination both at non peak and peak times.

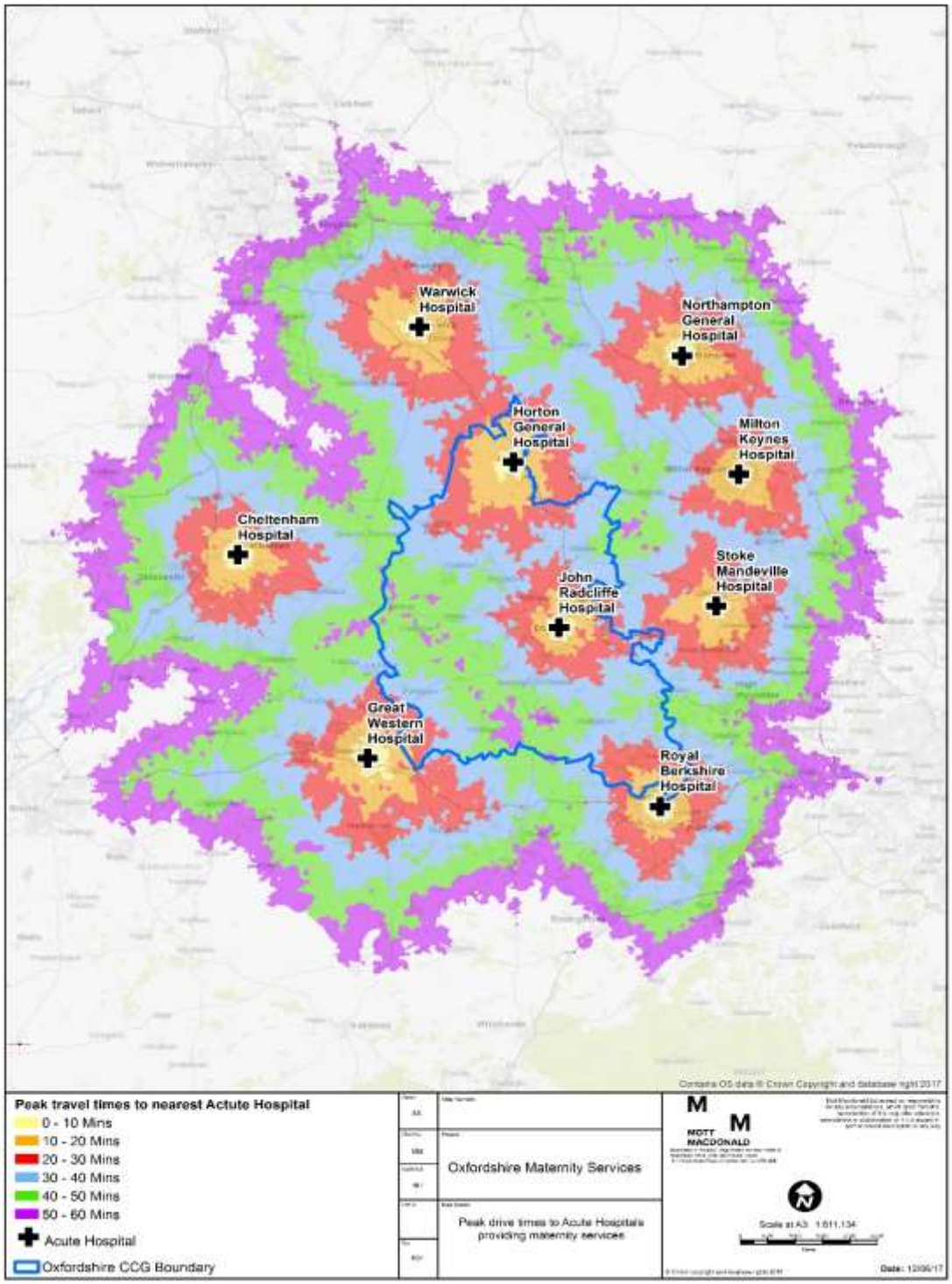
Figure 11: Blue light access without Horton[67]



Source: Data provided by the CSU

[67] Modelling has been done on the basis of pick up to destination both at non peak and peak times.

Figure 14: Private vehicle peak times with Horton



Source: <Insert Notes or Source>

Figure 18: Private vehicle peak times without Horton

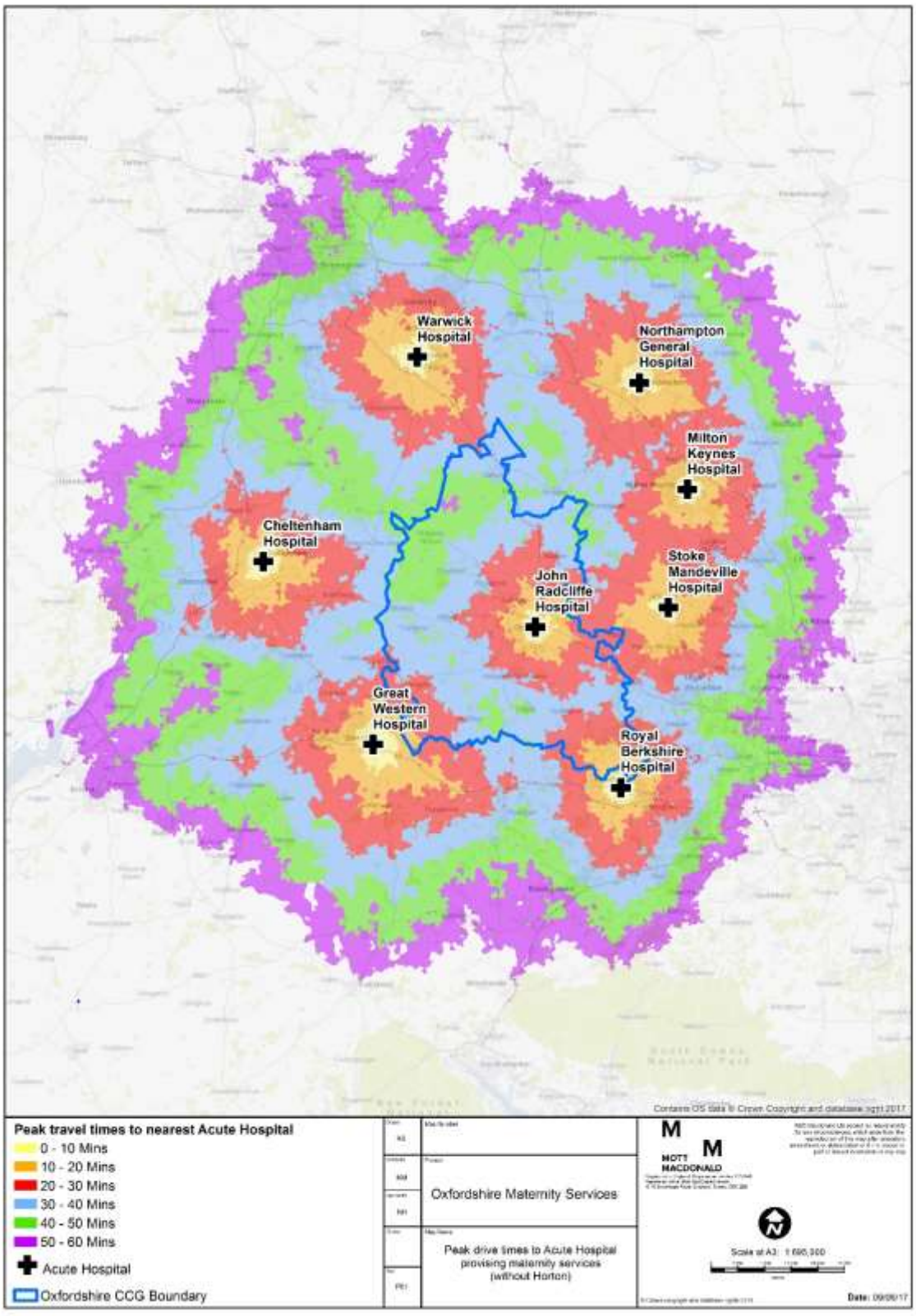
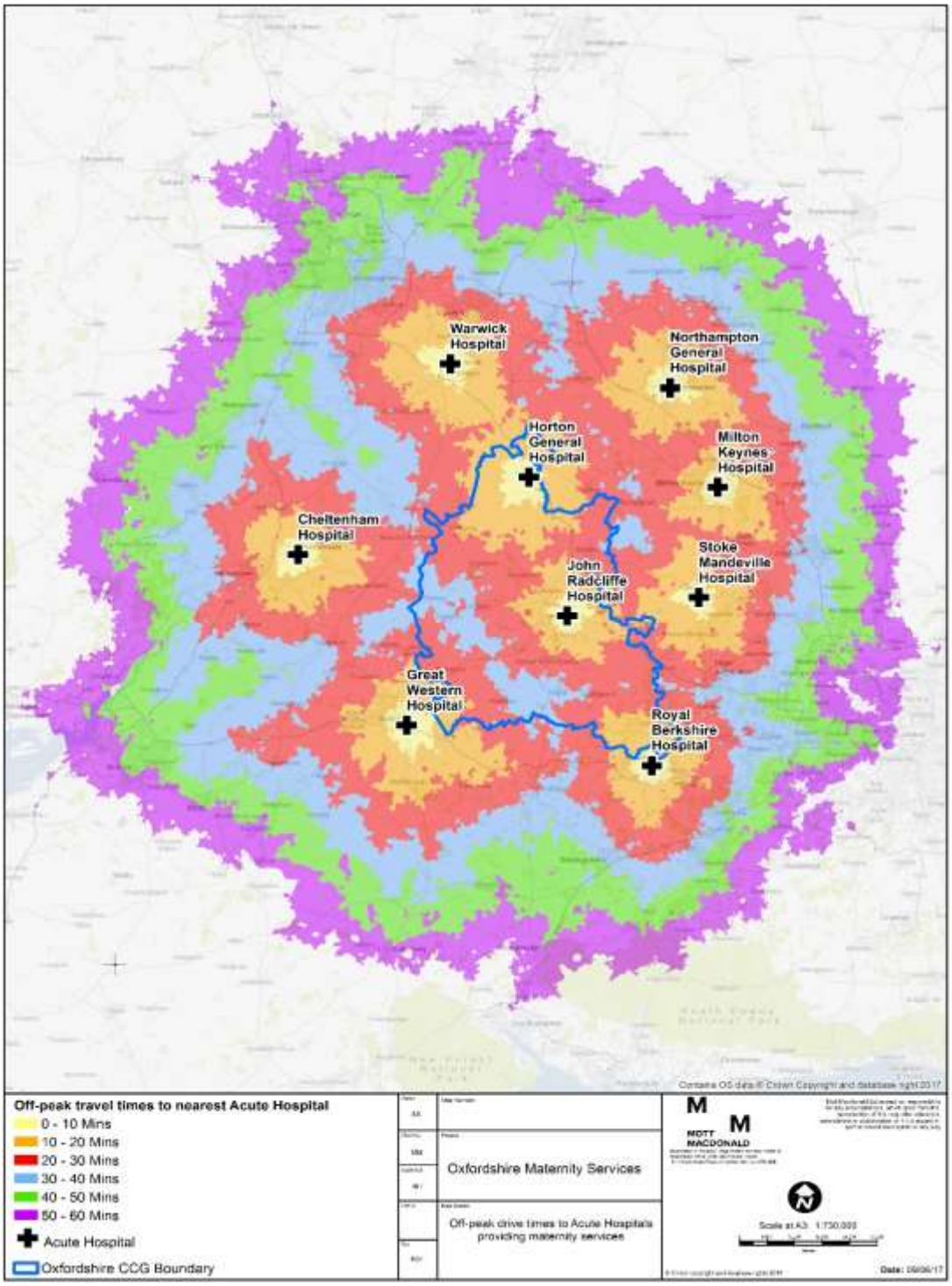


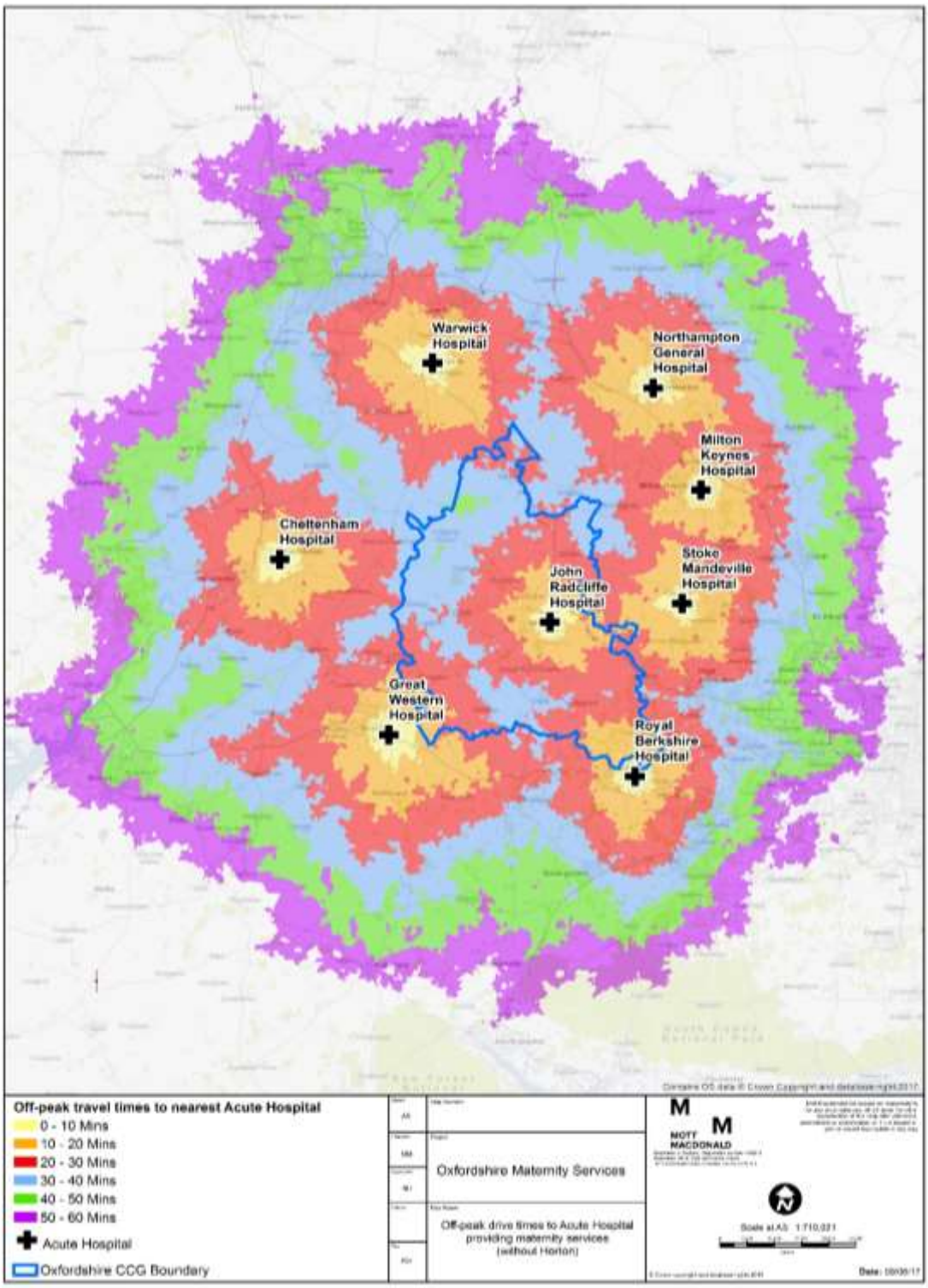
Figure 15: Private vehicle off-peak times with Horton



Source: Data provided by the CSU

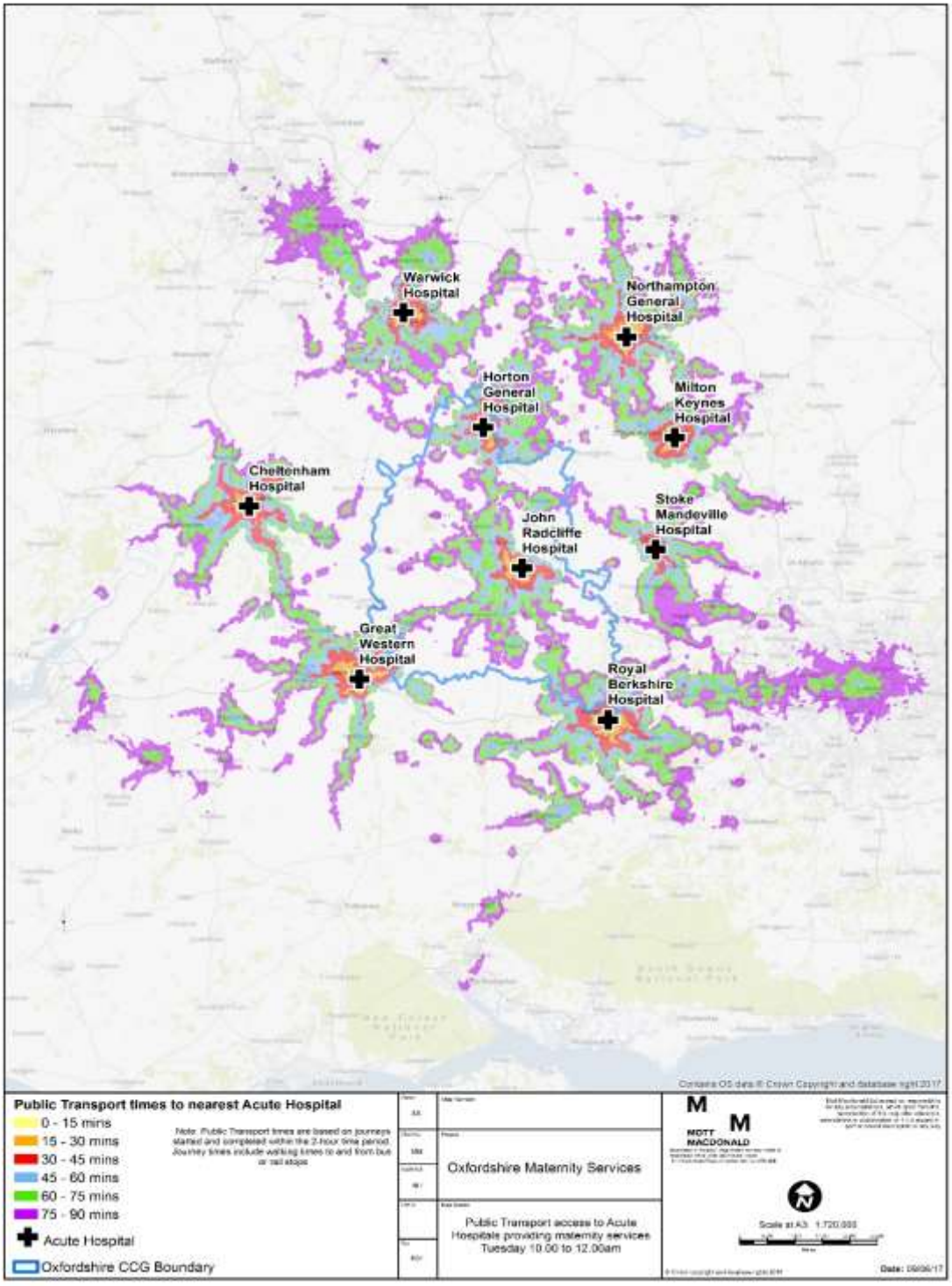
Source: Data provided by the CSU

Figure 19: Private vehicle off-peak times without Horton



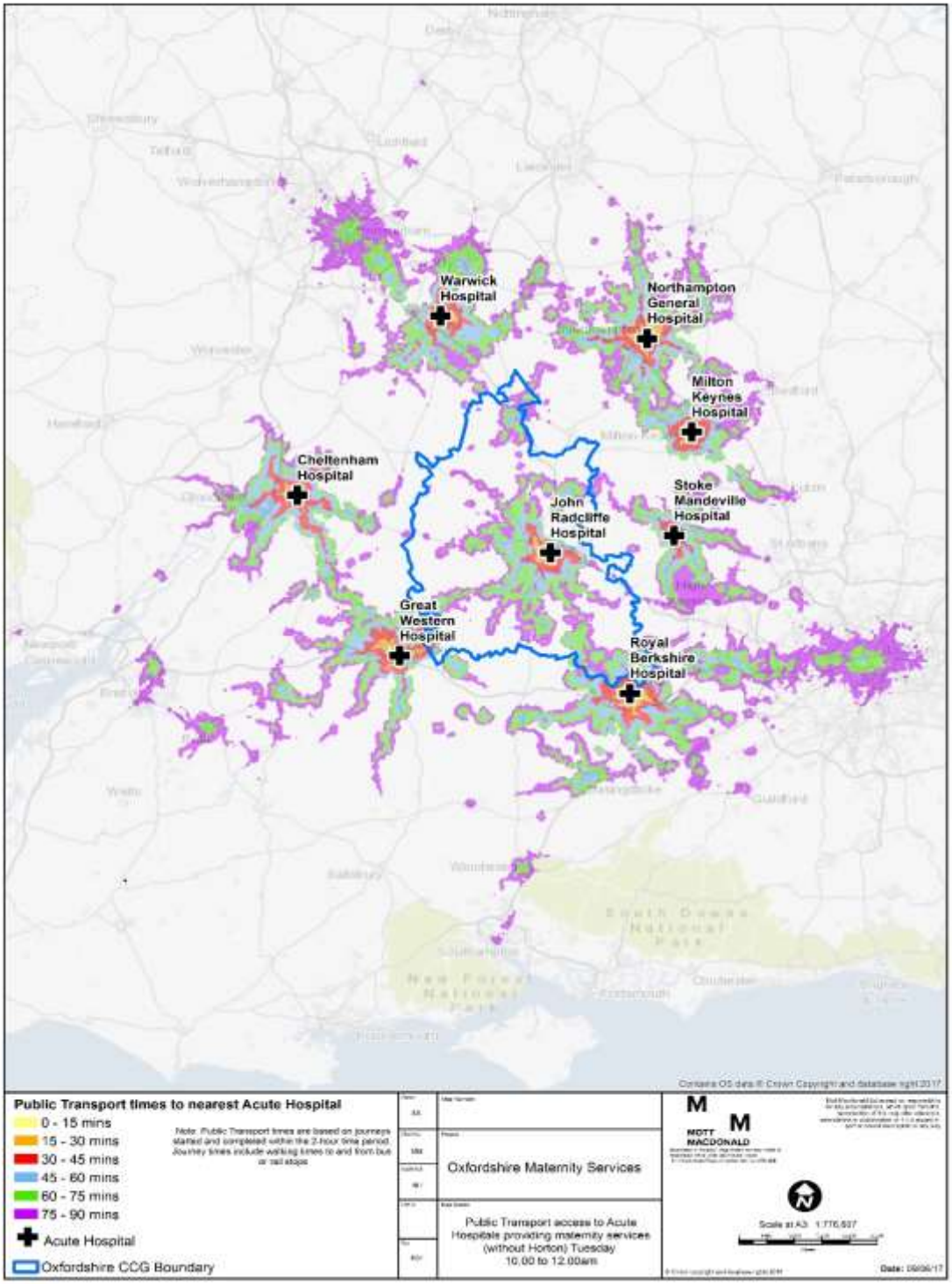
Source: Data provided by the CSU

Figure 12: Public transport Tuesday 10am-12am with Horton – (e.g. access to antenatal services)



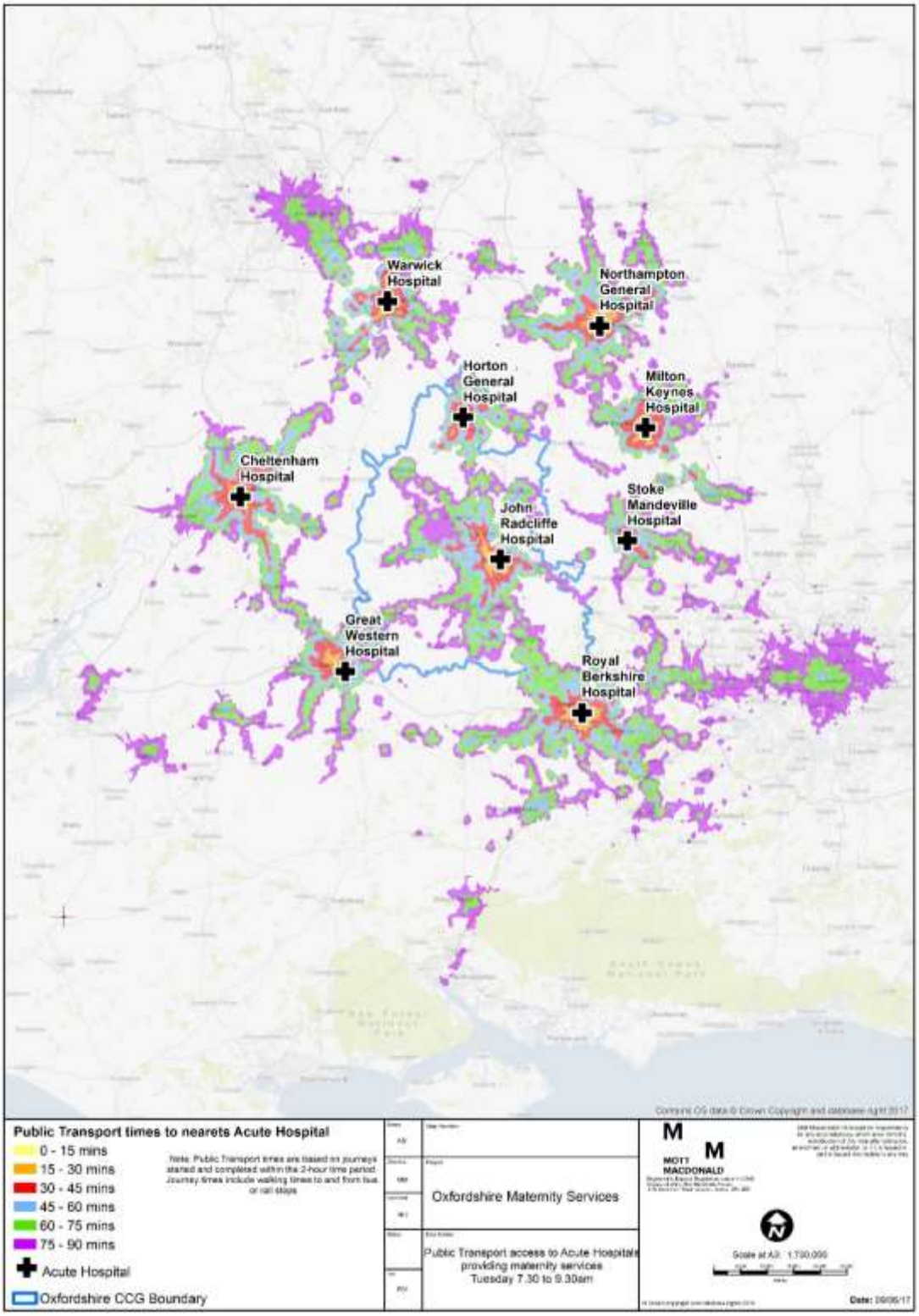
Source: Data provided by the CSU

Figure 13: Public transport Tuesday 10am-12am without Horton – (e.g. access to antenatal services)

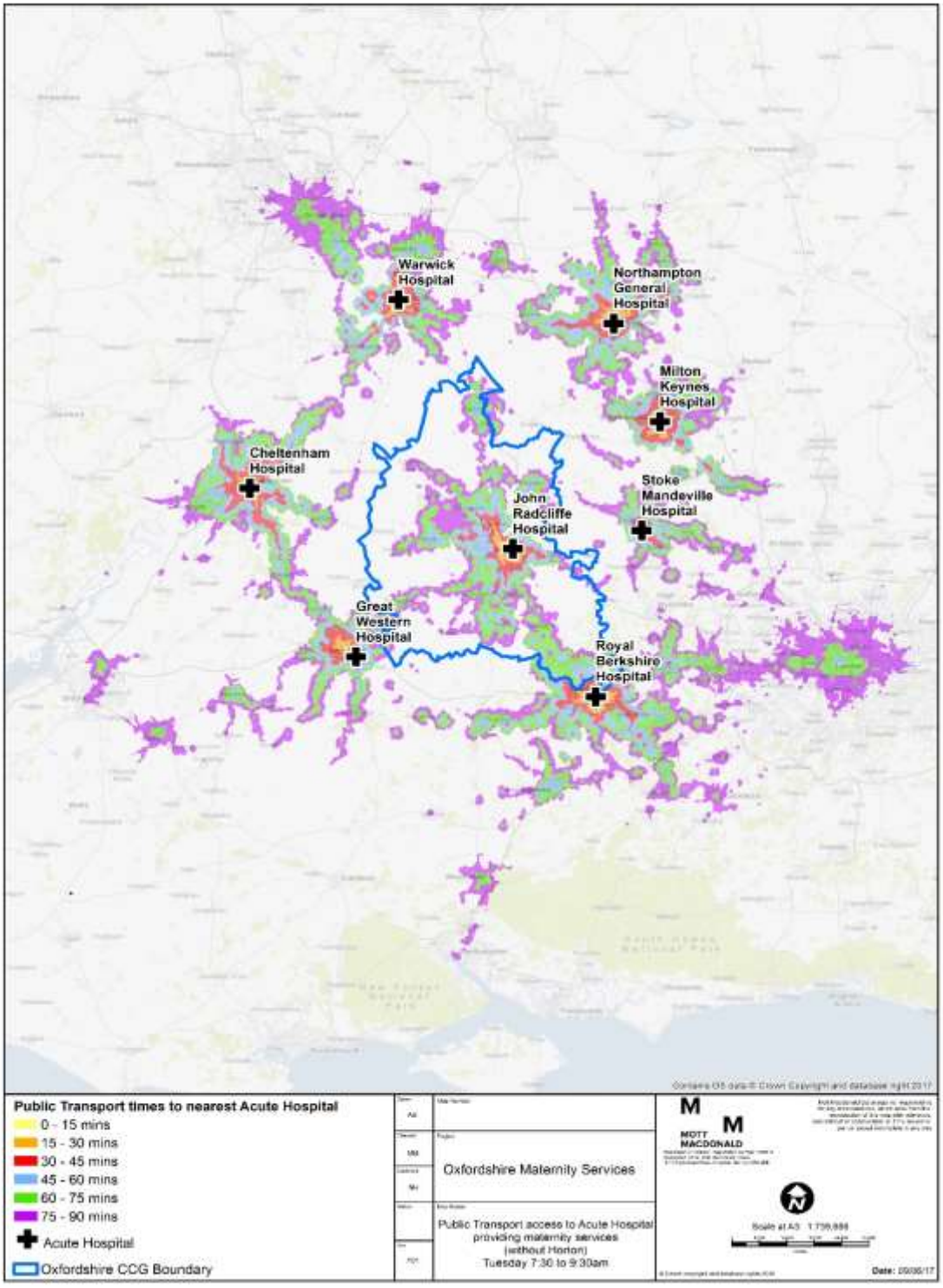


Source: Data provided by the CSU

Figure 17: Public transport Tuesday 7.30-9.30 without Horton
Figure 16: Public transport Tuesday 7.30-9.30 with Horton



Data provided by the CSU


Warwick Hospital
Northampton General Hospital
Milton Keynes Hospital
Cheltenham Hospital
John Radcliffe Hospital
Stoke Mandeville Hospital
Great Western Hospital
Royal Berkshire Hospital
Public Transport times to nearest Acute Hospital
0 - 15 mins
15 - 30 mins
30 - 45 mins
45 - 60 mins
60 - 75 mins
75 - 90 mins
Acute Hospital
Oxfordshire CCG Boundary
Oxfordshire Maternity Services
Public Transport access to Acute Hospital providing maternity services (without Horton)
Tuesday 7:30 to 9:30am
MOTT MACDONALD