File: Gen 11

PORTSMOUTH AND SOUTH EAST HAMPSHIRE HEALTH AUTHORITY

CORPORATE EXECUTIVE BOARD

Notes of the Meeting held on 1 March 2000 at 12.30 p.m. in the Large Conference Room, Finchdean House

---

Present:	Ms P Humphris	Mrs S Clark
	Mr J Henly	Mrs S Robson
	Dr E Jorge	Mr J Kirtley
	Mr B Ward	Dr G Sommerville
	Dr J Barton	Dr J Hughes
	Mr R Weeks for Mr D Pugsley	
In attendance:	Mr S Carr	

No Discussion Action

---

1 Apologies for Absence

Charles Lewis, David Pugsley

2 Minutes from the meeting held on 26 January 2000

These were received and agreed as a correct record

3. Obstetric and Midwifery Workforce Planning

John Bevan, Joy Dillow and David Davies gave a presentation on obstetric and midwifery workforce planning (see attached for OHPs and handout). Following the presentation the following key points were made in discussion:

- The change that medicine, generally, has undergone in terms of becoming more interventionist, the use of technology, the increase in the number of hours worked, the effects of clinical governance and patient expectation as well as the increased incidence of healthcare litigation
- Not just problems in obstetrics, need to also look at other 24 hour services like paediatrics and general medicine, this issue will affect all other specialties in coming years
- Increase in caesarean rates (locally reached a plateaux at 18/19% which is below national average)
- More definition between specialties - less acceptable for obstetric consultant to cover gynaecology emergency and vice versa
- Implications for Isle of Wight
- Need to look at issues in a broader context rather than looking at one aspect of the whole obstetric and midwifery service i.e. peripheral maternity units
- Need to make changes to the service – not just an issue about finance.
- Manpower plan for Trust

- Financial issues around staff grading
- Funding issue needs to be addressed in the wider context of the total Trust position (SAFF process)
- Postgraduate Deans in Region taking different approaches

It was agreed that Penny would write to John Bevan asking him to look at these issues in the wider context of the changes in medical staffing to the range of services provided by the Trust. PH

4. Matters Arising

4.1 Service and Financial Framework

Bob Weeks provided a brief progress report regarding the current position of the Service and Financial Framework. Points covered in discussion included the following:

- Further discussions with the Trusts have taken place regarding delivery of waiting list agenda, elective and emergency admissions.
- No new developments included in SAFF process
- Regionally 00/01 SAFF shows a projected deficit of approximately £110M, locally the projected deficit is £2M
- Alan Meekings has agreed, in the light of the Health Authority having cash to support this, that an I&E deficit is likely but has expressed concern that the sum of £2M is too high

4.2 Creation of new Health Authority

Penny Humphris reported that work was progressing on the creation of a new Health Authority for Portsmouth & South East Hampshire and the Isle of Wight.

The detailed work of developing the new Health Authority will be handled by specific working groups although a project manager, experienced in personnel and human resource management, will be appointed shortly to oversee the detailed HR work relating to the new Health Authority.

Press statements have been issued regarding the creation of the new Health Authority and the South East Regional Office will conduct a consultation, both here and on the Island. This will be launched on 5 April and last for a period of 3 months.

4.3 Future health services for the residents of Gosport and south Fareham

Penny Humphris told the Board that a total of seven meetings had now been held with 3 further meetings still to be held. A four part series was currently being run in The News concerning the changes to the provision of health care services nationally. This was helping to put the local issues regarding RH Haslar into a wider context.

4.4 Progress report on the devolution of commissioning

Sue Robson provided a brief progress report on the devolution of commissioning. An updated paper is currently being prepared which will be presented, in draft form, to the next meeting of the CEB for discussion. SR

4.5 Tackling teenage pregnancy

Elizabeth informed the Board that the Heath Authority was required to prepare a local profile on teenage pregnancy, showing areas of greatest need, before developing a comprehensive strategy by April 2001.

Sarah Wild and Rachel Lennon were leading on this work and were currently preparing an outline bid for funds to support this work

An allocation of £15,000 plus an additional £50,000 (because Portsmouth has a higher than average rate of teenage conceptions) has been made to the HA in order to fund the development of the local strategy.

4.6 PCG to PCT

Sue Robson reported that the first meeting of the East Hampshire Primary Care Trust Development Group had taken place on 25 February. The role of the group was to create and implement the development plan for taking East Hampshire Primary Care Group, Portsmouth HealthCare Trust and associated partner organisations into a Primary Care Trust.

The group will meet every 4 weeks to oversee the work of "task groups", comprising wider representation than the Development Group, whose role is to progress the specific strands of work associated with the transition to Trust status.

A formal application for Trust status will be submitted to the Health Authority by the end of July 2000. This will be followed by a formal, public consultation.

Sue advised the Board that a paper on the progression towards Trusts status would be included in the formal Board meeting of East Hampshire Primary Care Group on 3 March as well as the Health Authority Board papers on 9th March. This would probably result in some press interest.

It was agreed that Sue would contact Sue Galley to discuss how press enquiries regarding this issue should be handled. SR / SG

Boundary Review

John Hughes reported that John Smyth had been asked to conduct the Boundary Review. This should be completed by late April or early May.

5. High Cost Drug and other Contract Exclusions in 2000/2001

The Board received the paper from Dr Nick Hicks highlighting the potential

financial risk of high cost drug and other contract exclusions. In the discussion that followed a number of issues were highlighted. These included:

- Advice comes too late as most SLA's need to be agreed by 10th March
- Ministers are clear that SLA's should be inclusive
- The HA/PCGs need to set aside finances to take account of any contract exclusions and need to be clear about financial risk — PCGs/DP

6. Improving health in the South East

The programme of work for the South East for the next three years, set out by the South East Regional Office, was received by the Board.

It was agreed that this was a useful document that drew together the different strands of work being undertaken in the South East Region. The Regional Office is planning to up-date this document via their website.

7. Any other urgent business

National Bed Enquiry

It was agreed that comments to *Shaping the Future NHS: Long Term Planning for Hospitals and Related Services* should be sent to Simon Carr for collation by the end of April. — ALL / SC

8. Date of Next Meeting

Wednesday 3rd May 2000 at 12.30 p.m. in the Large Conference Room, Finchdean House.

Circulation List:

Ms P Humphris (Chair)
Dr J A Barton
Mrs S Clark
Mr J Henly
Dr J Hughes
Dr E Jorge
Mr J Kirtley
Dr C Lewis
Mr D Pugsley
Mrs S Robson
Dr G Sommerville
Mr B Ward

Mr S Carr
Library

JRB

Information for the Consultants Meeting 12th November 1999

Expanded Roles for Midwives

1. Community Midwifery - 'Making a Difference', the Strategy for Nurses, Midwives and Health Visitors (July 1999) states that 'the role of midwives needs to expand to include wider responsibilities for women's health:
    - Meeting the Public Health strategy in partnership with School Nurses, Health Visitors and G.P's
    - Sexual health
    - Parenting
    - Pre-conception
    - Life styles and life skills
    - Active de-briefing
    - Continuity of post natal care until 6/52, to include the 6/52 post natal check
    - Identification of social problems e.g. domestic violence and in partnership with Social Service appropriately respond
    - Run a service responsive to women's needs

They see the midwives role as from Pre-conception through to the 6/52 check and having a major health improvement role expansion.

2. Units - Core Midwives - 'Making a Difference' as stated above will impact to a lesser degree within the public health, social and psychological agendas but expansion in care and to run a service to women's needs clearly does have an impact.
   The reduction in Junior Medical staff over the next 5 years, is expected to be at least by 50%. There will be an increase in Obstetric Consultants (New style consultant posts). Changes in working practices and conditions of employment will result, i.e. resident on call in units, more direct hands on obstetrics in Labour Suites but smaller personal clinical caseloads.
   N.B. There will be an increase in A/N Clinics due to an increase in Consultants but this should not increase activity.

What can Midwives, in expanding their role, undertake to support the change in medical staffing and at what cost?

Reduction in SHO's - Gap

Service Gap	Can M/W's do?	Training Required
Assessments less than 37 weeks gestation	✓ Senior Midwives	Confidence building In 'judgement' skills
Small proportion of routine suturing	✓ All Midwives	Nil just maintain on going programmes
Initiation of routine laboratory & other investigations (A/N -P/N)	✓ Senior Midwives	Authorisation and some training. Plus some protocols and pathways
Interpretation of lab. results, scans etc and appropriate actions	✓ Senior Midwives	Training required + perimeters and boundaries set
Admission/ANAssessments where primary diagnosis or episode is medical e.g. asthma	X	
Diagnostic investigations triggered by admission assessment (e.g. extended investigation profiles)	✓ All Midwives	Nil
Prescribing	✓ All midwives for e.g. Prostins, Antibiotics, ?I.V.regimes ✓ Senior M/W's needed to support, maintain and manage practice issue	Req. group protocols
Surgical Assistant (LSCS)	✓ All Midwives	Expansion of current training
Consent to Operation	✓ ? Senior Midwife however decision to operate is with Consultant/Registrar so ? need	Nil

Service Gap	Can M/W's do?	Training Required
Clerking of Cold C/S admissions	Not a required task. Anaesthetists always review therefore duplication currently exists	Nil
Cannulation - although M/W's trained they cannot cope when workload busy - M/W's generally only do for Augmentation	✓ All Midwives	Nil
Review of C/S and late P/N discharges following e.g. manual removal high dep. long stay Pre-discharge of the above e.g. checking on investigations. OP Appoints, Home/GP arrangements etc	Comment - M/W's could do but quality issue for women would mean Con/Reg - ✓ All Midwives	

There are probably other tasks and responsibilities undertaken by SHO's but these are our thoughts to date.

Reduction in Registrar's - Gap

Service Gap	Can M/W's do?	Training Required
Extensive perineal suturing	?X - but small nos. by senior midwives could be undertaken if anaesthetists will undertake Spinals for suturing by midwives	Yes but small as already trained in suturing
Decision maker for Operative interventions (above SHO level)	X	

Service Gap	Can M/W's do?	Training Required
Prescriber (above SHO decision level)	X	
Review & plan 'abnormal' management of care A/N, I/P & P/N	✓ Senior Midwife if perimeters set by Con's or clarified by Con's otherwise medical	Some
Fetal blood sampling	Debate issue	
CTG Interpretation	✓ Senior Midwife referral	Currently ongoing expand for Sen. M/W's
Forceps	Mainly Medical but ✓ Senior Midwife if epidural in place and 'lift-out' only. No Fetal Distress etc	Yes
Ventouse	As above for Forceps	Yes
Intra partum Scans for presentation, placental site and presence of FH	✓ Senior Midwives but all eventually	Yes
Performing C/S	X	
Manual Removal of Placenta	X	
Potential Complicated Deliveries i.e. Twins, Breech	✓ All Midwives conduct vaginal delivery with a nearby Con/Reg. presence	Nil (Confidence issue)
Treatment of Prematurity e.g. Tocolytics, Salbutamol, Dexamethazone	✓ Senior Midwives in consultation with Consultants	? Some
1st Response Obstetric Emergencies and Obstetric Crisis (this is jointly with the Anaesthetists)	X and X	
AN Clinic and Decisions	X	

Probably many more tasks and responsibilities but these are all that have been identified to date

Resource requirements

Require 1 x Senior Midwife on duty at all times 24hrs x 365 days
= 5.8 wte Senior Midwives

Require additional Senior Midwife resource Mon - Fri 8 - 5 to support e.g. elective C/S lists etc
=1.4 wte Senior Midwives

Require Clerical/HCSW to obtain and chase results etc from Computer and Lab. Also increase of paper work on wards. Estimate 5 hours per day for the unit x 7 days per week
=1.2 wte Clerical/HCSW support

Total identified resource to date = 7.2 wte Senior Midwife grade
1.2 wte Clerical/HCSW support

Comment

This is only a very rough guide and negotiations with Midwives needs to be undertaken before ANY decisions are agreed and implemented. 'Making a Difference' - the Strategy for Nurses, Midwives and Health Visitors, will mean that Midwives have to increase their roles especially in the Community setting and we already have a National shortage of Midwives. We the midwives will be looking at the current midwives role and what other staff can be enabled to undertake to release midwife time. All of this work needs to be in tandem so that we dovetail the needs of the service, midwifery developments and the obstetric medical staff reduction for the benefit of all concerned and that safety remains paramount as does a woman centered service.

I suggest that work starts very soon with the unit midwives and that protocols are written so that some initiatives can progress rapidly. We also need to establish real costs of the needed increase in Midwives and Clerical staff, and work on revised Job Descriptions etc.

jcdMWexpan

Resource requirements

Require 1 x Senior Midwife on duty at all times 24hrs x 365 days
= **5.8** wte Senior Midwives

Require additional Senior Midwife resource Mon - Fri 8 - 5 to support e.g. elective C/S lists etc
=**1.4** wte Senior Midwives

Require Clerical/HCSW to obtain and chase results etc from Computer and Lab. Also increase of paper work on wards. Estimate 5 hours per day for the unit x 7 days per week
=**1.2** wte Clerical/HCSW support

Total identified resource to date = 7.2 wte Senior Midwife grade
1.2 wte Clerical/HCSW support

Comment

This is only a very rough guide and negotiations with Midwives needs to be undertaken before ANY decisions are agreed and implemented.
'Making a Difference' - the Strategy for Nurses, Midwives and Health Visitors, will mean that Midwives have to increase their roles especially in the Community setting and we already have a National shortage of Midwives. We the midwives will be looking at the current midwives role and what other staff can be enabled to undertake to release midwife time. All of this work needs to be in tandem so that we dovetail the needs of the service, midwifery developments and the obstetric medical staff reduction for the benefit of all concerned and that safety remains paramount as does a woman centered service.

I suggest that work starts very soon with the unit midwives and that protocols are written so that some initiatives can progress rapidly. We also need to establish real costs of the needed increase in Midwives and Clerical staff, and work on revised Job Descriptions etc.

jcdMWexpan

Obstetric Manpower

1997 planned to expand to 2000 consultants over 15yrs = 6%/yr

Profile; 157 CCST per/yr

Consultants 1142 Registrar 1,002 SHOs 1674

Registrar Grade SHO

NTNs = 716 Career = 590
VTNs = 77
FTTAs = 206

Expansion in Consultants not occurred

Reduction NTNs to 420 Career SHOs to 210

Why are there Problems for OBGYN ?

1. SWAG/Calman
2. New Deal on hours
3. European Directive
4. Requirement for Resident Expertise
5. Lack of Midwives
6. Grading Issues for Midwives
7. Will effect Paediatrics / General Medicine/ Orthopaedics

Some simple facts

Non Elective Activity

Consultant Sessions available /yr = 42 x 7 = 294

24hr Labour ward presence = 7 x 365 = 2555

2555/294 = 8. 5 wte

12hr Gynae cover = 4. 2 wte

Fetal Assesment (+ amnio) = 0. 5 wte

Antenatal Clinics = 2. 0wte

Ward Rounds = 1. 0 wte TOTAL = 16. 2

Simple facts continued

Non Elective Work

NPs per yr 5170 8 per session = 600 sessions
Fus 6560 16 " " = 300

Theatre = 1138

Colposcopy = 250

Ward Rounds = 250

Total sessions = 2,550 = 8.0wte

Staffing Profile

Current		Soon	Future ? When	
Consultant	9	15	Specialists	24
Registrar	10	? 6-7	Registrar	4
SHOs	11	7	SHOs	4

Financial Difference +£ 250,000 + £400,000

Excludes need to backfill with midwives

NB. Single Brain Damage Baby Costs £2-3 million ? Cost Peripheral Units

Catch 22

The No. of Specialists we envisage is even greater than RCOG predictions

Portsmouth = 1% England & Wales = 2400 Non training grades

We need to recruit more NTNs reduce FTTNs over next 5yrs

European ratio senior to junior 1: 0.6 U.K = 1:2.3

HELP