British Association of Perinatal Medicine

Consultant working patterns

A BAPM Report

November 2023

Leading Excellence in Perinatal Care

Contents

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Introduction

Delivery of safe, effective and continually improving neonatal care to babies and their families relies on a complex interplay of multiple processes, systems, feedback, collaboration and people. The recruitment, retention, well-being and development of neonatal staff is key.

The BAPM 2021-2024 strategy[1] seeks to provide support and advocacy for perinatal professionals. Every member of the perinatal team is equally important, and we recognise that there are challenges in all professional groups; for pragmatic reasons we targeted what we hope will be the first of several workforce surveys at the neonatal consultant group. A UK survey following pilot testing ran in May & June 2022 with results presented at a BAPM webinar in December 2022. Despite current workforce and other pressures within the NHS 81% of survey respondents reported "always" or "often" enjoying their job, and 83% would recommend a career in neonatology.

The content of this report has utilised the data received from the responding consultants with additional stakeholder input to develop 7 key recommendations. While the essence of the report seeks to improve the working lives and increase retention of consultants in neonatology there are inevitable overlaps with other perinatal staff groups as well as existing national reports.

This report supplements the staffing and activity recommendations for the consultant (Tier 3) staff group made in the BAPM frameworks for practice for neonatal intensive care units (NICUs)[2], local neonatal units (LNUs) and special care units (SCUs)[3], and the Service and Quality Standards for Provision of Neonatal Care in the UK[4] document.

Recommendations

1. **Workforce planning** for neonatal services across the UK is urgently required including identification of the number of consultants providing care on neonatal units of all designations and the number of vacancies, to permit planning for training, recruitment and retention and retirement.

2. **Clinical service commitment** during daytime clinical shifts and on calls is paramount. Any other service commitments must not prevent 24/7 immediate availability to the neonatal service including the provision of advice and, where required, in person attendance. In person attendance out of hours should always be within 30 minutes. Immediate availability of consultants will be dependent on the experience of resident Tier 2 staff, particularly in relation to airway skills. This may require resident consultant models in some instances. Local solutions for covering additional areas such as general paediatrics and neonatal transport will need to be robustly job-planned and risk assessed.

3. **Well-being**: all neonatal consultants must have access to appropriate free-of-charge en-suite sleep facilities close to the neonatal unit as well as ability to prepare food and/or access to hot food to support clinical care provision out of hours.

4. **Career progression:** A consultant's pattern of working including on-call will change during their career and those appointed to resident consultant shifts must have the opportunity to choose to change to a hybrid or non-resident rota after a period of time to help avoid exhaustion/burnout and reduce levels of dissatisfaction. Less than full-time working opportunities should be an option for all consultants, regardless of age, gender or family commitments.

5. **Job planning** should be undertaken as a neonatal team to provide a broader understanding of the work required to deliver appropriate neonatal care. This includes ensuring that currently unpaid but regularly delivered additional hours are incorporated into the individual neonatal team members' job-plans, and that consultants can take compensatory rest without destabilising the service.

6. **Rotation of staff:** Neonatal unit consultants of all designations should be supported by their Trust and neonatal network to rotate formally to neonatal units of different designation and have this recognised within their job plan. Rotations should include "hands on" clinical practice opportunities to sustain and build on their experience. This is particularly important for consultant staff in SCUs and LNUs, in keeping with maternity investigation recommendations[5].

7. **Learning from deaths and incidents** is essential for local, regional and national services. Participation in perinatal mortality review (PMR) must be job-planned with time allocated for preparation, attendance, and implementation of actions both within local Trusts and (for some) as external advisor[4].

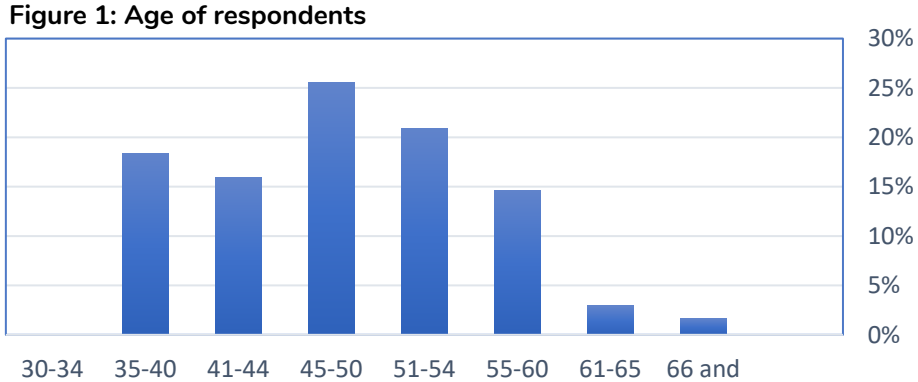
Workforce planning

1. **Workforce planning** for neonatal services across the UK is urgently required including identification of the number of consultants providing care on neonatal units of all designations and the number of vacancies, to permit planning for training, recruitment and retention and retirement.

a. 239 consultants responded to the survey representing every neonatal network in the UK. This response is comparable to data submitted to the Royal College of Paediatrics and Child Health (RCPCH) 2022 census[6]. In the 2019 Getting It Right First Time (GIRFT) survey of neonatal units in England, 1308 consultants were providing tier 3 neonatal cover; data were missing for 5/75 LNUs and 8/38 SCUs[7]. The total number of consultants in the UK contributing to the delivery of neonatal care in all neonatal unit designations cannot therefore be accurately determined.

b. 142 (60%) of survey respondents were aged 50 years or younger. Equivalent numbers of respondents were at or under 40 years (n=44, 18%) or at or over 55 years of age (n=46, 19%), Figure 1.

Figure 1: Age of respondents



c. 65 of the 169 (38%) consultants who provided a response to the question regarding planning a change in their work pattern within the next three years indicated that they were intending to reduce their commitment to the NHS, leave the NHS entirely or retire.

d. Not all neonatal intensive care (NICU) respondents hold GMC specialist registration in Neonatal Medicine: 22 of 65 (34%) medical NICU respondents, and 1 in 10 combined medical-surgical NICU respondents are not speciality registered. 14 of 64 (22%) LNU respondents do hold Neonatal Medicine registration. This is slightly at odds with GIRFT data (England, 2019) which report 18% of medical NICU consultants and 7% of surgical NICU consultants without GMC specialist registration. Somewhat fewer (8%) LNU and 13% SCU consultants in the GIRFT report hold Neonatal Medicine registration.

Figure 2: GMC speciality registration in Neonatal Medicine: NICU medical

Clinical service commitment

2. **Clinical service commitment** during daytime clinical shifts and on calls is paramount. Any other service commitments must not prevent 24/7 immediate availability to the neonatal service including the provision of advice and, where required, in person attendance. In person attendance out of hours should always be within 30 mins. Immediate availability of consultants will be dependent on the experience of resident Tier 2 staff, particularly in relation to airway skills*. This may require resident consultant models in some instances. Local solutions for covering additional areas such as general paediatrics and neonatal transport will need to be robustly job-planned and risk assessed.

*All units should aim to comply with minimum airway capability standards currently being developed by BAPM (The BAPM Airway Standards Framework for Practice currently in development 2023).

a. One-third (65 of 194) of respondents have additional commitments beyond the neonatal unit when on call out of hours.

   I. Areas covered include general paediatrics for LNUs and SCU respondents. Recommendations for staffing in relation to activity for these units including when consultants should cover the neonatal service exclusively are within the BAPM framework for practice[3] supported by the Neonatal Critical Care Review[8].

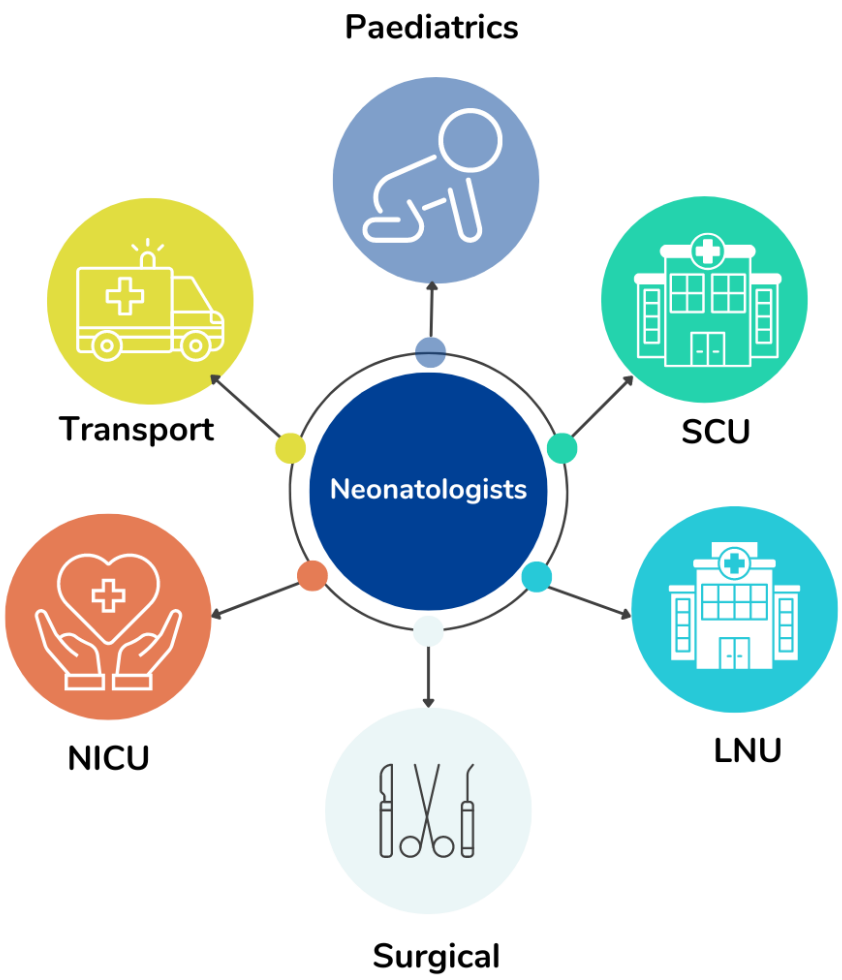
   II. NICU respondents supporting additional services during on-call described covering general paediatric areas, off-site neonatal units (SCUs, NICUs), neonatal transport and other specialist teams, at times covering three separate services. Support included advice only but for some there was an expectation that the respondent would be available to provide emergency care in more than one site during the same on-call period.

b. 47 of the 194 (24%) who responded stated they provide additional cover to areas beyond the neonatal unit in hours when on service, including paediatric services and neonatal transport.

Key message:

Neonatal consultants should not provide a return to base cover for two or more geographically separate sites at any one time; where this is current practice Trusts must urgently review their neonatal service and identify sustainable solutions to improve patient safety.

Figure 3: Areas of additional cover by neonatology consultants



Getting to Good: an example of covering two geographically separate sites

"Running multiple neonatal units with a single medical workforce is against national recommendations. However, some things are hard to change and some of us find ourselves in this tricky position. We have two neonatal units – one cocooned within the Children's Hospital with every specialty on hand and one isolated in an adult teaching hospital with 4500 deliveries a year. The promise is a new unit and maternity service all under one roof, at the Children's Hospital site. This has been delayed multiple times over the years with a current delivery date of 2030. Hence, we continue to manage a split site service. However, both sites are treated as one service, with the same management, governance, teaching and many joint meetings and staff rotation.

Medical training has changed significantly over the last few years, leaving a workforce that is stretched ever more thinly. The plan to fill these gaps with neonatal nurse practitioners is great – but this pulls from an understaffed nursing workforce. That, plus the training time means this has its challenges too. A crystal ball is needed to predict staffing gaps, to future proof rotas that must cover multiple sites.

To reduce clinical risk at the isolated site we had to negotiate with our maternity colleagues to ensure that only relatively low-risk deliveries occur at this site. As a result, our relationship with midwifery and obstetric colleagues has blossomed and that can only help the overall experience, both for patients and staff.

Our Band 6 neonatal coordinators at this site, have completed the Resus Council UK ARNI course to enhance their clinical skills and also give them skills in leadership and communication. We ensure the unit is covered by a minimum of two medical staff 24/7 – an HST or senior ANNP and an LST. There is a consultant neonatologist 8am-5pm every weekday.

National recommendations are that a unit such as this isolated unit should have its own consultant on call 24/7. Our consultant numbers do not allow two separate on call rotas, and we have not been able to gain the investment needed to achieve it. Our current consultant staffing means that there is single consultant on call cover for both sites, Friday 5pm to Monday 8am. For weeknights there is a dedicated consultant for on call at each site. Unfortunately, a serious clinical incident has now ensured the necessary investment has been more forthcoming, meaning an increase in consultant numbers will allow nationally recommended on call rotas within the next couple of years. However, these staffing challenges have meant that over the years the unit has moved from being a level 3 NICU, through a well-staffed period of level 2 to what is now a level 1 unit. Whilst clinical risk has been mitigated with all these changes, the effect on nursing staff morale is significant.

We do rotate many of the staff across both sites, allowing skills to be maintained and some less stressful time in the level 1 unit. The obstetricians also rotate so ensuring the whole perinatal team has a broad oversight of the service. Alongside joint PMRT meetings this has enhanced the perinatal team working further.

So – good practice in running multiple sites would be, primarily, to not do it. If it is inevitable, work closely with maternity to ensure that the level of maternity care matches the level of neonatal care that can safely be offered at each site. Ensure there is safe staffing for this level of care – considering innovative ways of achieving this with nurse practitioners and international medical graduates. Ensure that all staff are adequately trained and confident. Finally, continually review the system and be prepared to adjust the model to mitigate the risks." Anonymous consultant.

Well-being

3. **Well-being**: all neonatal consultants must have access to appropriate free-of-charge en-suite sleep facilities close to the neonatal unit, ability to prepare food and/or access to hot food to support clinical care provision out of hours.

a. 86 of 159 (54%) respondents have access to a bedroom while on call – for 35 of these consultants, a charge is levied for this accommodation.

b. While 144 of 159 respondents had access to food while on call 23 of these respondents (14% of all respondents) had access to a vending machine only without canteen/hospital shop or a kitchen.

c. Despite the high percentage of consultants stating they enjoyed their job in neonatology, 4 in 10 reported being "somewhat" burnt out due to work, with an additional 24% to a "high" or "very high" degree. 7 of 15 consultants participating in exclusively resident rotas who answered this question reported high, or very high, burnout.

d. 39 of 169 (23%) respondents reported being able to take all of their annual leave only "sometimes", "seldom" or "never"; it was not possible to determine if this reflected workload or personal choice.

Key message:
We strongly advocate for free of charge sleep facilities, food preparation area and access to hot food 24 hours a day 365 days a year – in line with BMA Consultants as Clinical Leaders.[9]

Wellbeing: what our respondents said

> Rest facilities for on-call Consultants are grossly unbefitting. Trusts should be tasked with ensuring some decent standards.

> I find it extremely sad that this is not the job it used to be. Neonatology itself is such a rewarding career but there are so many external factors making it a very unhappy place to be.

> Planning to retire at 60 to avoid burnout assuming I can afford to and that I haven't left already by then!

> It makes me sad to reflect on how unhappy I am in my post - I loved neonatology all through training and for the first 10 years of being a consultant - the burden of managerial responsibility with no power or mandate to make meaningful improvements is soul destroying. In the next year I will leave the NHS (something I never thought I would ever consider) and work abroad or in a completely different field."

Career progression

4. **Career progression:** A consultant's pattern of working including on-call will change during their career and those appointed to resident consultant shifts must have the opportunity to choose to change to a hybrid or non-resident rota after a period of time to help avoid exhaustion/burnout and reduce levels of dissatisfaction. Less than full-time working opportunities should be an option for all consultants, regardless of age, gender or family commitments.

a. 162 of 194 (83%) respondents participate in a 1 in 6 or less frequent on-call rota during the weekdays, with 45 respondents increasing frequency at weekends. LNU respondents reported more onerous on-call rotas; 25% (12/48) are on-call 1 in 5 weekdays or more frequently.

b. The majority (67%) of respondents provide a mixture of resident and non-resident cover during weekend shifts. Purely resident rotas (n=16) are uncommon and even less so at weekends (n=11), however these respondents are over-represented in the group reporting high or very high burnout (17% of the group, n=7/41, $p<0.05$). On-call rota type varies between weekdays and weekends. These variations likely arise because of locally delivered solutions to achieve standards of care such as Seven Day Services[10], neonatal unit staffing standards, and delivery of care to all required services.

Figure 4: Make-up of on-call shifts

n=194 respondents	Hybrid on-call (%respondents)	Non-resident (%respondents)	Purely resident (%respondents)	> 1 type of rota*
Weekday on-call	57.2	20	8.3	14.5
Weekend on-call	67	10.8	5.7	16.5

*Due to covering more than one service e.g., another NNU, transport

c. While 24 of 45 responding stated they were currently content to do resident nights, 36 of the 66 respondents participating in resident on-call night shifts either as purely resident or part of a hybrid rota have no scope to lessen this commitment as they progress through their career.

d. Flexibility in on-call rotas is evident from some respondents: 54/167 (32%) respondents have resident on-call shifts different to that of their fellow consultants; 45 of 171 (26%) were aware of possible flexibility in frequency and type of on-call.

e. Less than full time (LTFT) respondents working in <41-year age consultant group (n=7/36) were exclusively female; for consultants aged ≥55-years (n=6/33) LTFT working was reported equally by male and female consultants. 71% of respondents were aware of LTFT colleagues who provided pro-rata or other adapted on-call and 29% worked with LTFT colleagues who provided a full on-call commitment. LNUs were over-represented in the group of consultants who reported no LTFT consultants in their department (n=22/46).

A more flexible approach to out of hours cover for older consultants is addressed within Consultant workforce shortages and solutions*: Now and in the future, BMA 2020*[11]

Job planning

5. **Job planning** should be undertaken as a neonatal team to provide a broader understanding of the work required to deliver appropriate neonatal care. This includes ensuring that currently unpaid but regularly delivered additional hours are incorporated into the individual neonatal team members' job-plans, and that consultants can take compensatory rest without destabilising the service.

a. The majority of neonatal consultants who responded to the survey worked a full-time contract providing between 10-11.5 total programmed activities (PAs), including 1.5-2.5 supporting PAs (SPAs) in their job plan. Variation in direct clinical care (DCC) PAs to the neonatal service was evident among consultants providing care in LNUs (median 4, IQR 2-7).

b. 128 of 194 (66%) of respondents have additional PAs in their job plan. These are many and varied. The 3 most common paid commitments reported were:

   i. Neonatal service lead/director and other senior Trust management roles
   ii. Education roles: undergraduate, foundation, tutor, supervisor, director
   iii. Mortality, quality improvement, and governance or patient safety roles

c. Additional roles were undertaken by 120 of 171 (70%) respondents, 47 of whom participated voluntarily.

d. For non-resident shifts either as part of a hybrid or purely non-resident rota the majority of respondents (n=98/166, 59%) are contacted between the hours of 23:00 and 07:00 on more than 50% of their shifts and 89 either provide telephone advice or are physically present on the NNU for between 1-4 hours during these overnight non-resident shifts. Capacity within teams is required to ensure that job plans reflect the intensity of workload provided overnight and can permit consultants to take compensatory rest following a disturbed on-call shift with insufficient rest.

e. On weekend shifts 07:00-23:00 more than 4 resident hours out with their job plan were provided on average by 42 of 166 (25%) of respondents with a further 91 (55%) contributing between 1-4 additional non-job planned hours. Such regular time commitment must be acknowledged in job plans and renumerated accordingly if consultants are to feel valued.

f. The most challenging aspects of a career in neonatology given were:
   I. Balancing work and family life
   II. Non-clinical administration
   III. Intensity of out of hours work

Key message:
By including in job plans the regularly provided additional hours contributed during out of hours on-call shifts consultants are likely to feel more valued, experience less burnout and stress and remain working for longer.

Rotation of staff

6. **Rotation of staff:** Neonatal unit consultants of all designations should be supported by their Trust and neonatal network to rotate formally to neonatal units of different designation and have this recognised within their job plan. Rotations should include "hands on" clinical practice opportunities to sustain and build on their experience. This is particularly important for consultant staff in SCUs and LNUs, in keeping with maternity investigation recommendations[5].

a. The vast majority of consultants do not rotate between or provide cover for NNUs of different designations; only 7/74 (9%) reported rotating from SCU/LNU to an NICU as recommended.

Figure 5: Formal job planned NNU rotation to another unit designation.

Joint working between units provides opportunity to further develop team relationships and develop a greater understanding of each other's working environments with consequent positive effects on the care of the babies and families. This is likely true for all consultants.

Consultants with neonatal CCT who chose to work within an LNU or SCU may benefit in terms of skill retention by formal rotation to an NICU. This would support the retention of essential skills within neonatology, particularly in regard to resuscitation and stabilisation.

All consultants providing neonatal care need to maintain and develop new skills and knowledge and simulation supports this. Excellent practice includes simulation within own unit environments supported by a linked unit and/or network: such joint training should improve consultants' understanding of colleagues' working environments enhancing the support they can provide when participating in calls for advice and/or cot requests for a preterm or sick newborn.

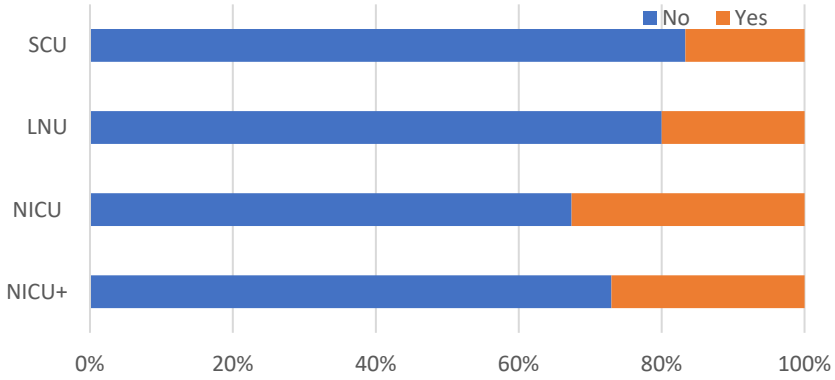
Additional opportunities include supernumerary attendance at another neonatal unit under an Honorary contract for a set number of days and/or service weeks, permitting wider learning and sharing of knowledge, governance and practical skills. Such training needs will vary and should be identified at consultant appraisal and collated by Trusts for the department with subsequent liaison with the linked networks and agreement on how to support.

Learning from deaths and incidents

7. **Learning from deaths and incidents** is essential for local, regional and national services. Participation in perinatal mortality review (PMR) must be job-planned with time allocated for preparation, attendance and implementation of actions both within local Trusts and (for some) as external advisor[4].

a. 3 in 4 (n=126/171) respondents have no allocated job plan time for perinatal mortality review investigations. Where they do this is mostly given as SPA (n=29/45).

Figure 6: Allocated job-planned time for perinatal mortality review



Programmed activity time (PA) for individual deaths must include time for PMR preparation, attendance, documentation and action plan development with 2 independent neonatal consultants attending. The time required to review individual cases varies and individual consultants will have differing contribution to the PMR process. It is recommended that each death is allocated 1PA per reviewing consultant. The direct relevance of the PMR process is consistent with direct clinical care (DCC) activity.

Morbidity and mortality reviews should include identification of areas of excellence in addition to areas for improvement to enable wider learning.

Summary

Despite neonatology being reported as enjoyable by the vast majority of consultants there are concerning levels of burnout and dissatisfaction with a significant proportion of consultants planning to reduce their working hours in the next 3 years or leave the NHS.

The 7 key recommendations made prioritise clinical care provision to babies and families by supporting consultants to achieve a fulfilling career within Trusts that acknowledge the workload and provide sufficient facilities to deliver safe and effective care. A team approach to job-planning is an opportunity to understand colleagues' working practices and identify competing demands on their time which has the potential to improve care provision and empathy within the team and identify areas at risk.

It is noteworthy that as a speciality we do not have the ability to identify the number of consultants who deliver care to the babies and families in our UK neonatal units. This must change if we are to plan our workforce appropriately to ensure safe and effective care.

National reports that stipulate staff rotation[5] and implementation of incident review including mortality[12] must be appropriately funded if these reports are to achieve their vision of reducing harm in neonatal services.

Thank you to the survey respondents and to the consultants attending the webinar. We recognise there are limitations within the survey underpinning this report including under-representation of consultants working in LNUs and SCUs, but we hope that the report and its recommendations can be utilised in job-planning for both newly appointed and existing neonatal consultants and help to improve job satisfaction for all.

It is imperative that we seek properly to understand the entire neonatal consultant workforce to enable future planning for neonatal services.

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Appendix 1: Additional background characteristics of respondents

Figure 7: Gender identity of respondents

Gender Identity, n=239

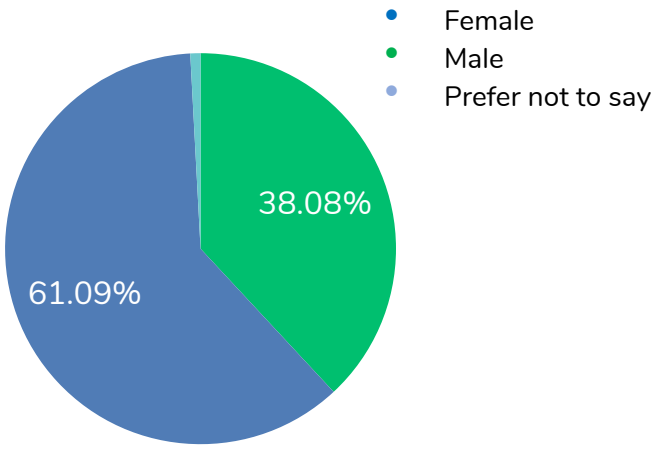
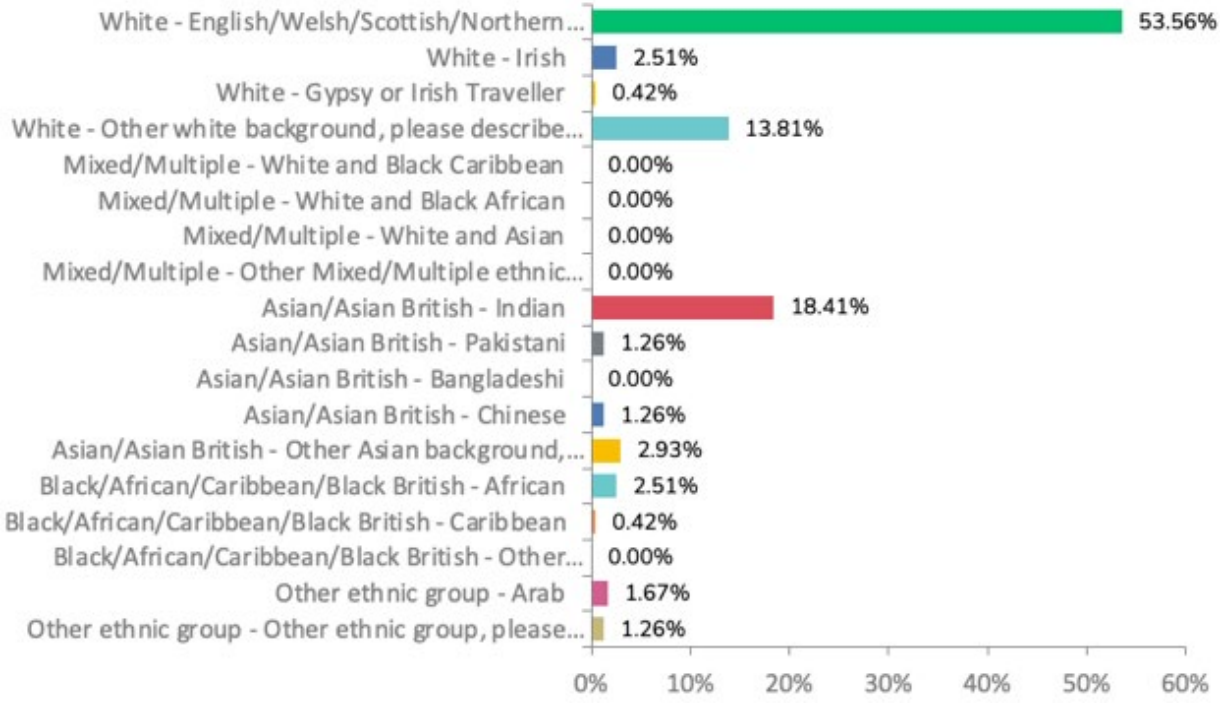


Figure 8: Ethnic group of respondents

Ethnic Group, n=239



BAPM

Leading Excellence in Perinatal Care

This document was produced by the British Association of Perinatal Medicine (BAPM).

BAPM a membership organisation that is here to support all those involved in perinatal care to optimise their skills and knowledge, deliver and share high-quality safe and innovative practice, undertake research, and speak out for babies and their families.

We are a professional association of neonatologists, paediatricians, obstetricians, nurses, midwives, trainees, network managers and other health professionals dedicated to shaping the delivery and improving the standard of perinatal care in the UK.

Our vision is for every baby and their family to receive the highest standard of perinatal care. Join us today.

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