BSCOS Workforce & Service Survey – Autumn 2022

In order to inform future work of the Board, members of the British Society for Children's Orthopaedic Surgery were asked to answer a set of questions concerning the shape of current paediatric orthopaedic services across the United Kingdom.

Questions were posed to departments or services rather than individual clinicians, since functionally the provision of care to patients is generally delivered on this basis and typically involves multiple centres in a given region.

The survey did not require data gathering by individual services, it sought headline information which should have been readily available in all centres.

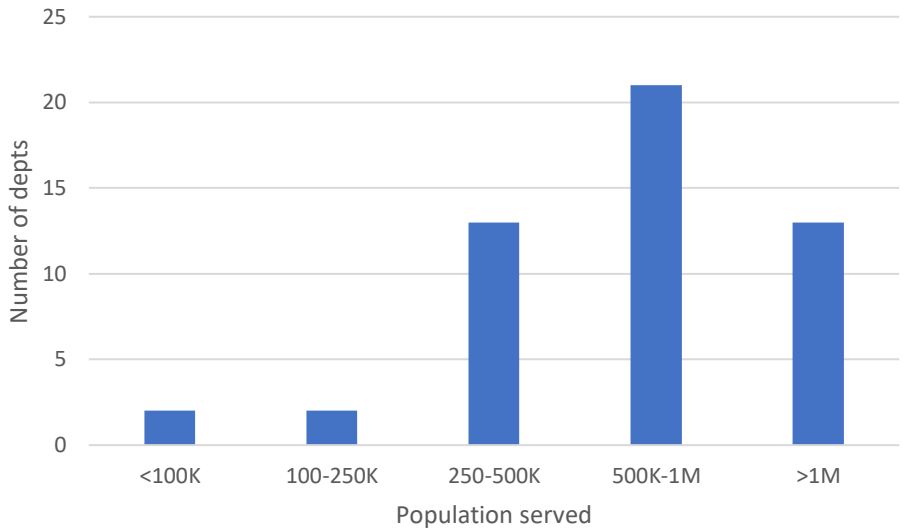
1.0 Response geography

- Responses were received from 51 centres across the UK, including England, Wales, Scotland and Northern Ireland. This gives a broad and therefore likely representative geographical spread of responses from our membership. The list of hospitals/organisations represented (see appendix) supports this contention.

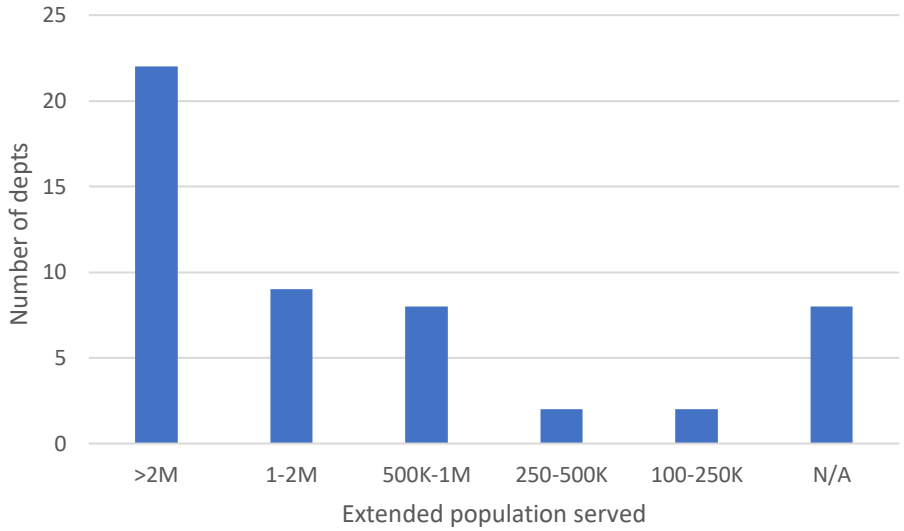
Scotland	6
Wales	3
Northern Ireland	1
NW England	4
NE England	7
Midlands	7
East England	6
SW England	9
SE England	2
London	6

2.0 The shape of services

- We asked about the population directly served by centres (we asked about total population served, not the paediatic population specifically).
- Most are serving populations of over 500,000 with 13 centres exceeding 1 million.
- Whilst the total population served by the respondents falls short of the UK population, it does capture the majority by a considerable margin.



- We also asked about the extent to which services are provided to an extended population on a tertiary referral basis. In only 8 departments that responded is this not the case, indicating a high level of inter-dependency across different centres/services.



- Trauma care is predominantly delivered through major trauma centre settings for most respondents.

MTC - Adult & Paeds	13
MTC - Adult only	5
MTC - Paeds Only	11
Local trauma unit	14
No trauma care	8

- Out of hours provision appears to be fairly evenly split between those services where adult colleagues provide cover out of hours and those where paediatric orthopaedic surgeons are on call.

Dedicated paeds rota	25
Adult covers paeds	21
Mixed paeds/adults	4
No trauma service	1

3.0 Sustainability of services

- We asked **whether the current model for providing services is sustainable**. It is concerning that 7 centres are in or anticipating a 'crisis' in providing service and a further 12 centres do not have plans in place to address concern. 37% of responding centres are therefore in a currently unsustainable situation.

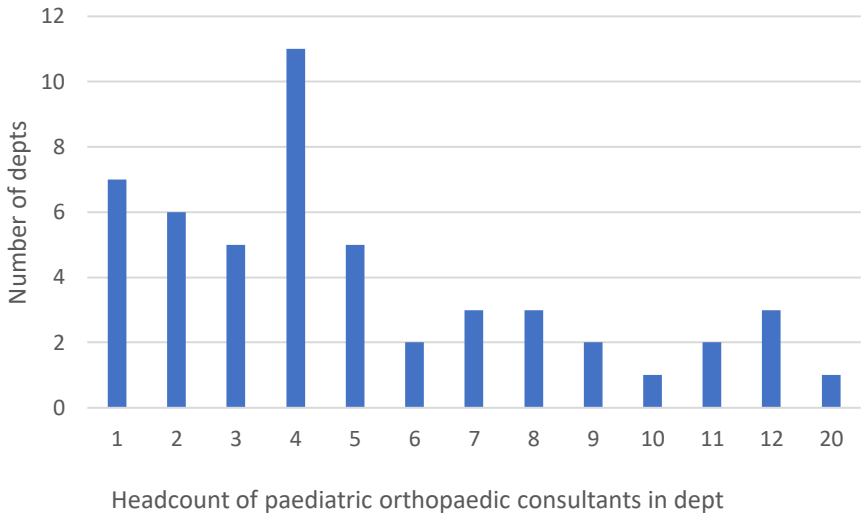
Service in (impending) crisis	7
Significant concern, plans lacking	12
Some concern, plans in place	20
No foreseeable issues	12

- The **recovery of services from the coronavirus pandemic** clearly had significant impact on services. Reported levels of recovery are encouraging with the vast majority returning to normal, though a significant minority (17%) of respondents report ongoing shortcomings with no plan to recover them.

Better than pre-pandemic	3
Restored to pre-pandemic	11
Returning toward 'normal'	28
Very significant shortcomings	9

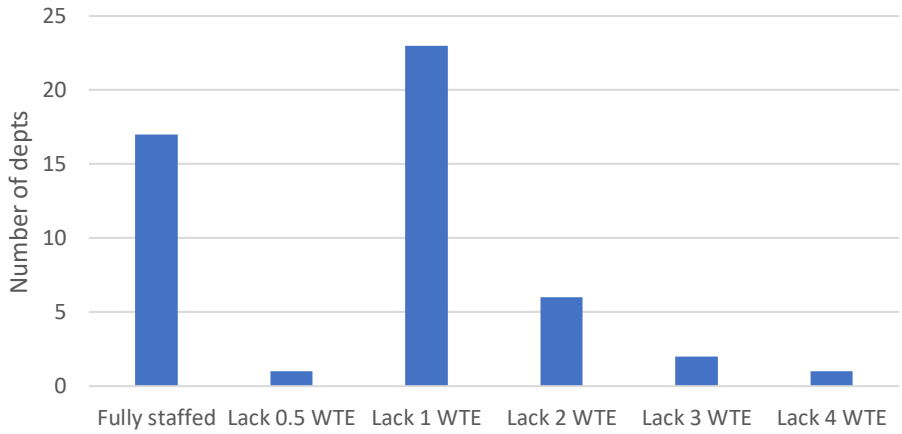
4.0 The shape of our workforce

- There were 266 consultants (by headcount) represented in this survey of 51 centres. The **size of paediatric orthopaedic departments** shows wide variation with seven colleagues working solo through to one department with 20 consultants.
  Most (56%) departments have 4 or less consultants.
  The modal department size of 4 consultants is not adequate to providing a stand alone on-call rota (which requires 5 or more).

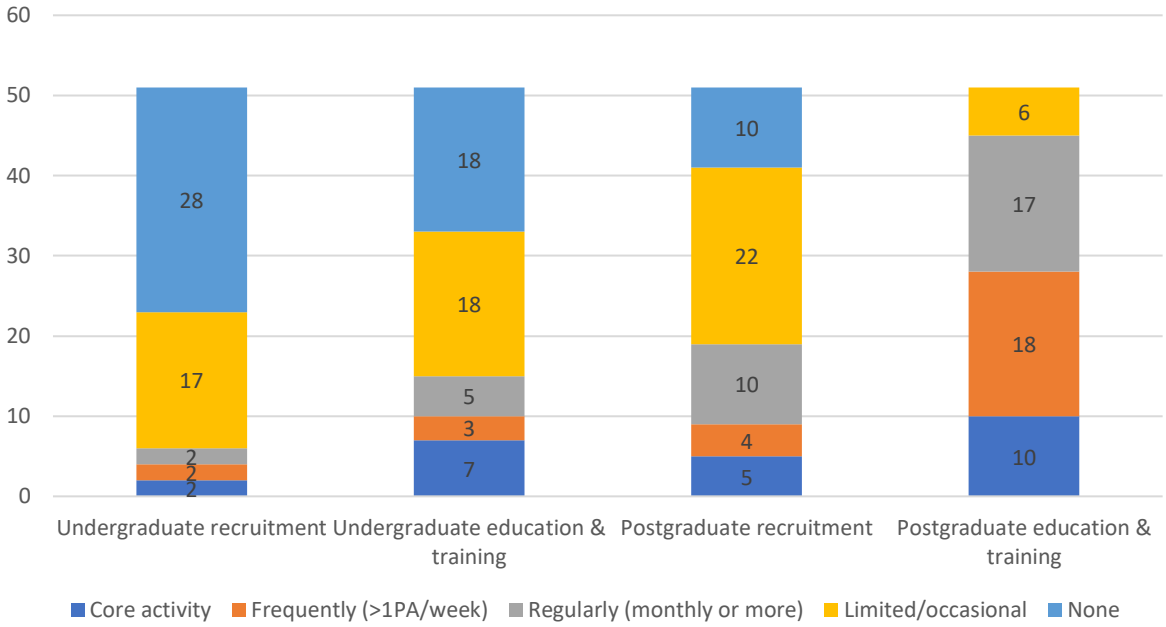


- We asked whether there had been **any recruitment issues** in the department. Almost 2/3 reported no issues. For the other centres:
  - 7 had an impending vacancy
  - 5 had previously advertised but a post was left unfilled
  - 4 reported difficulty securing funding for posts
  - One reported unfilled posts had led to service redesign

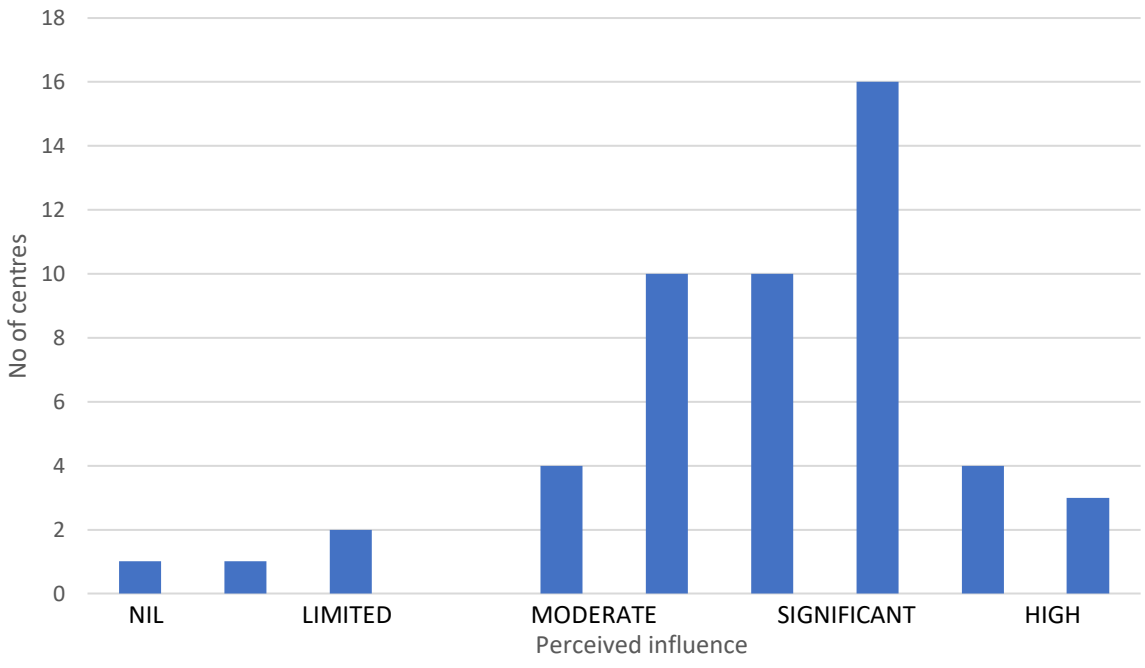
- We asked about the perceived **adequacy of consultant staffing** in the department to meet the demands placed upon them. It is notable that in 2/3 of centres the consultant staff levels were not thought adequate. The deficit amounts to a total of 45 WTE CCT holders with a subspecialist interest in paediatric orthopaedics across the country (for the centres that responded).



- Looking to the future, we asked about involvement in both **undergraduate and postgraduate recruitment and education**.
    - As expected there is greater involvement in postgraduate education and training than undergraduate education and training.
    - Of note a majority of centres reported limited or no involvement in postgraduate recruitment processes.



- We asked about the perceived **capacity to positively influence a career choice** for paediatric orthopaedic surgery. Most centres reported at least moderate levels of perceived influence.



- We sought ideas for delivering better succession planning. The following themes and suggestions emerged:

  Service delivery
  - Consider proleptic appointments x4
  - Improved links between DGHs and Paediatric Hospitals x3
  - Improved theatre access to deliver service (and therefore job satisfaction) x3
  - Proper support from management for the service
  - Improving work life balance (lack of private income noted)
  - Offer attractive job plans (noting we are competing with arthroplasty/adult trauma)
  - Improve pay and conditions
  - Improve private practice opportunities
  - Consider recruitment premia
  - Retirement planning, retire and return to offer ongoing support

  Philosophy of care
  - Acting as good role models x3
  - Aim for more 'blended' posts (supporting DGH adult/paeds combined practice) x3
  - Highlight merits of prolonged doctor-patient relationship (in contrast to vogue for rapid turnaround of care).
  - Advocate for breadth of skill set in paeds orthopaedics
  - Enable better control of practice (and hours) to facilitate work-life integration.
  - Moderate workloads to avoid putting future colleagues off.
  - Proactively raising the profile of our subspecialty.
  - Reduce emphasis on centralisation.
  - Consider the question: Has superspecialisation delivered improved quality and quantity of care?
  - Establish a standard number of paediatric orthopaedic consultants per population
  - Establish standards for plaster room and AP support for paeds ortho services
  - Transparency around resource allocation

  Undergraduate engagement
  - Engage more with our medical schools x4
  - More paediatric orthopaedics in the medical student curriculum x4
  - Taster weeks x2
  - Seek to inspire
  - Smaller groups better for engagement
  - Earlier exposure in the medical student curriculum
  - Offer electives in paeds orthopaedics

  Postgraduate trainee engagement
  - Earlier rotation to paeds ortho in training x3
  - MDTs run across regions to allow local trainees to engage more
  - Engagement with ASIT and BOTA
  - Early identification of candidates
  - Prioritising quality of training offered
  - Offering more post CCT fellowships

- Stream candidates seamlessly into post CCT fellowships
- Engage more in recruitment to orthopaedic training programmes
- Ensure 6 month paeds placement as a minimum
- Offer out of porgramme experiences in paeds orthopaedics
- Actively attract overseas talent
- Offer mentorship towards end of training
- Promote job opportunities through a trainee network
- Taster weeks for FYs and CTs

- We sought feedback on the consequences of workforce issues in respect of **future capacity to deliver services**. Areas in jeopardy in specific centres were highlighted to include:
    - Theatre capacity/access x9
    - Complex Neuromuscular / Cerebral Palsy service x7
    - Trauma x4
    - AHP support
    - Tumour service
    - Scoliosis service
    - Plaster room service

  A clear theme emerged concerning **access to operating theatres, and provision of complex neuromuscular services**.

5.0 GIRFT implementation

- We asked if a department had considered **how the GIRFT report should impact that department** and/or implemented change as a result. The vast majority (89% of responding centres) have or are planning to implement change as a result of GIRFT.

Not yet	6
Not yet - planning to do so	4
Yes - and actively implementing change	28
Yes - planning to implement change	13

- We asked whether each centre had considered how quality assurance could be provided for **low volume /infrequent procedures &/or conditions**. It appears the vast majority of paediatric orthopaedic centres have or are acting to address this issue. The 10% who have not done so is a concern. It is unclear whether they do not believe it necessary or do not consider they have any low volume procedures/conditions in their practice.

No - we have not yet done this but will do so within 6m	7
No - we have not done this and have no plans to do so	5
Yes - we have done this but are struggling to address it	3
Yes - we have done this and have a plan in place	36

- We further explored whether responding to low volume /infrequent procedures &/or conditions had led to a **change in the scope of services provided**. There has clearly been an impact in a majority of centres although in a minority of 15% has this led to transfer of work out (presumably to larger/tertiary centres).

No likely impact on service	22
Impact mitigated by internal changes	21
Impact has let to transfer of patients out	8

- We asked if **problems had been encountered in implementing GIRFT** locally. The following themes emerged:
    - Lack of effective communication with/ recognition by/ prioritisation by management x10
    - Problems with introduction of manipulation of forearms in ED x5
    - Difficulty implementing dual surgeon operating x3
    - Lack of staffing x2
    - Access to theatres x2
    - Difficulty with implementing one stop DDH service x2
    - Dealing with data problems highlighted by GIRFT
    - Too 'overwhelmed with firefighting to address the issues'

  There were 7 centres that reported no issues with GIRFT implementation locally.

Two centres noted that GIRFT was not commissioned by Scottish NHS and therefore lacks traction there.

One centre said it had not looked at GIRFT.

6.0 How can BSCOS help?

- We asked how BSCOS could help members with these issues. Free text suggestions and answers are summarised here in the following themes:

- *Providing expertise*
    - Continue to issue guidelines x3
    - Promote / issue guidance supporting dual operating for low volume & complex cases x3
    - Continue to issue consensus statements x2
    - Issue patient information leaflets x2
    - Develop e-consent facility with agreed lists of common risks per procedure
    - Recommend ratio of consultant per population
    - Recommend minimal trauma cover levels of service
    - Recommend minimum levels of AHP support/service
    - Provide advice on paediatric trauma/emergencies
    - Consider guidance on indicative numbers (for DDH)

- *Direct support*
    - Visit local team management structures
    - Consider developing an ongoing peer-peer support/review process (following on from GIRFT) x3
    - Support those not in 'big centres'

- *Education, Training & Research*
    - Continue to represent and to educate x2
    - Promote clinical trials

- *Advocacy*
    - Mandate GIRFT (as not just guidance)
    - Prioritise childrens' operating theatre access over and above adults
    - Establish regional networks to encourage cooperation over competition, sharing patient load, hub & spoke in both directions
    - Ensure the capacity for ED MUA forearms is present in all centres
    - Promote paediatric orthopaedics as an equal with arthroplasty in policy making circles
    - Promote working with other interface specialties

- *Recruitment*
    - Project paediatric orthopaedics as a diverse, innovative and rewarding specialty
    - 'Make BSCOS free except for substantive consultants'
    - Engage with medical students and FY docs x2
    - Identify future cohort of paediatric orthopaedic consultant colleagues

- *Miscellaneous*
    - Recognise our limitations (because of our size)

7.0 Appendix

Acknowledgements

The BSCOS Board are grateful for the participation of colleagues in the following centres:

Royal Aberdeen Children's Hospital, NHS Grampian
Oxford University Hospitals NHS Trust
University Hospital Coventry & Warwickshire
Sheffield Children's Hospital
Barts
Nottingham University Hospitals
BCUHB
Betsi Cadwaladr University Health Board
The Royal Wolverhampton Hospital NHS Trust
Bristol
Norfolk and Norwich University Hospital
Cambridge University Hospital
OUH
CAVUHB
Portsmouth NHS Trust
Dumfries and Galloway
Royal Cornwall hospital NHS Trust
East Lancashire Hospitals NHS Trust
Alder Hey Children's Hospital
Esneft
United Lincolnshire Hospitals NHS Trust
Great Ormond Street Hospital
Alder Hey
Great Western Hospital
North Cumbria Integrated Care Foundation Trust
HSE South
Nottingham University Hospitals NHS Trust
Hull University Teaching Hospitals Trust
Oxford University Hospital
King's College Hospital
Leeds Teaching Hopsitals
RNOH
Leeds Teaching Hospital Trust
Robert Jones and Agnes Hunt Orthopaedic Hospital
Mid & South Essex Trust (Broomfield Site)
Royal Manchester Children's Hospital
Mid Yorkshire NHS Trust
Sheffield Childrens' NHSFT
South Tees Hospitals NHS Foundation Trust
Southampton Children's Hospital
St Georges
NHS Greater Glasgow and Clyde, Royal Hospital for Children

UHBW
NHS Lothian
University Hospital Bristol & Weston
NHS Tayside
University Hospital Southampton
Norfolk and Norwich University Hospital