Royal College of Obstetricians & Gynaecologists

RCOG Workforce Report 2022

February 2022

Contents

Please note: Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

Foreword

During my many years working at the RCOG, be it committee member, committee chair, Council member, Vice President and now as President, the issue of our workforce has rightfully been a live and vital issue. Examples of our previous major publications in this area include 'Labour Ward Solutions' (2010), 'Providing Quality Care for Women' (2016) and the two O&G Workforce Reports (2017 & 2018).

This latest report comes at critical juncture for our profession. Our specialty has suffered at least a decade of underfunding and as a consequence the workforce has become spread too thin, waiting lists have grown, and yet we are very much in the spotlight if things go wrong. However, whilst these challenges are real and never more keenly felt, as President elect I felt the narrative needed to change, to one of recognising the strengths we all have, the huge options a career in this amazing specialty offers and that the role of our College is to of course recognise the issues, but importantly, to offer comprehensive yet contemporary solutions.

The pandemic has been a game changer in so many ways. It has crystallised the issues and shown without question just how pressured we all are and that change must happen. There are positive signs that the message is getting though. In the last 12 months we have secured meaningful investment into our workforce from the UK Government and expect to receive more as we continue to produce the compelling case of need.

The team who led this report are obstetricians and gynaecologists and experts in this area. I am grateful to them and all the other contributors to the report. It is a gripping read, carrying an important 'state of the nation' call to arms, whilst offering pragmatic solutions everyone working so hard for this great specialty can adopt.

Dr Eddie Morris PRCOG
President, Royal College of Obstetricians and Gynaecologists

Foreword

Having a motivated, well-trained and adequately staffed workforce underpins all we do in our profession to provide the best quality care we can for women, patients and families.

The challenges our workforce has dealt with in the past two years are unprecedented and whilst the pandemic is easing the challenges will remain as we maintain services and endeavour to recover. Our previous report in 2018 highlighted significant issues around inadequate numbers of staff to deliver the service. This report does not pretend to have all the answers but does look firmly to the future and what we can achieve.

The report has been a year in the making with contributions from women, our patients, doctors, midwives, managers, physicians associates, and many more. We started our working group by exploring what our values are and how they underpin all that we wanted to achieve for our workforce. These are reflected in the golden threads that run throughout the report.

I make no apology for the length of this offering. It is a report to be dipped into, to look to for advice, to emulate the best practice examples it contains.

I want to thank all those people who contributed, who have worked voluntarily in their own time to make this report what I hope you will agree is a very useful resource. Your contributions are hugely appreciated.

The working group was chaired by Jenny Barber and ably supported by Sophie Wienand-Barnett, both workforce fellows at the College (and both trainees on appointment). They also co-authored the report with contributions from their many colleagues. To look forward, we must as a College harness the skills of those people who are the future. I want to thank them for their brilliant work as well as Shona Flannigan (RCOG Workforce Manager) and the workforce team at the RCOG for their unerring support.

Dr Jo Mountfield
Vice President for Workforce and Professionalism

Executive Summary

Since the last RCOG workforce report in 2018, the O&G profession has faced many challenges. Although the birth rate is falling nationally, there are rising levels of clinical complexity, budget cuts and staffing shortages of doctors, midwives, nurses and other allied professionals. Whilst demand for services in some areas is declining, there are increased requirements in other areas due to demographic shifts, an aging population and rising levels of obesity. All of this has been magnified and compounded by the Covid-19 pandemic which has required health professionals to work differently and adapt services to continue to provide care to women.

Such challenging times require the profession more than ever to understand its values and develop a shared vision of how O&G services should be. With this in mind, the RCOG / HEE Workforce Working Group initially started by identifying three key values:

1. Person-centred care

- Prioritising the needs of women in how services are planned, organised and delivered.
- Recognising the holistic needs of women, including how these needs can be met by the whole multi-professional team.
- Actively seeking the views of women and working in partnership with them to develop and improve services.

2. Valuing diversity

- Recognising that O&G services are delivered to a diverse range of people and therefore should be tailored according to demographic, geographic and cultural variables.
- Acknowledging the diversity of roles and individuals within the medical O&G workforce and the need to facilitate flexible working to promote job satisfaction and workforce retention.
- Optimising collaborative working across the much wider multi-professional team within which O&G sits.

3. Promoting learning

- Creating opportunities for mentorship and learning at all career stages and across the multi-professonal team.
- Facilitating organisational learning from all aspects of work, including adverse events.
- Recognising the role that women and families have in contributing to education for healthcare professionals.

These values formed the 'golden threads' of the report and run through all of the chapters. They have formed a focus for our discussions, the cases that have been chosen to highlight best practice and our recommendations.

This report is written collaboratively, between clinicians and women's representatives, for clinicians. It is aimed at all O&G healthcare professionals rather than just workforce planners and those in senior leadership roles. Throughout the report, there are 'best practice' examples from around the UK where units and individuals have put values-based leadership into practice to implement and sustain positive change. It is hoped that these case studies can guide and inspire others within their own units.

The report focuses on five key workforce themes; workforce planning, building learning and supportive cultures in O&G, flexible working, remote and rural working and multi-professional team working.

Workforce Planning

Workforce planning is a complex process of getting the right people with the right skills in the right place at the right time in order to provide person-centred care. Population demographics and requirements differ across the UK and therefore there is regional variation over which services are required to ensure equity of care. For workforce planning to be successful, training opportunities and the skillset of the workforce must be driven by current and predicted patient need. This chapter looks at the impact of advanced and subspecialist training and the current mismatch between the uptake of certain training modules and posts compared to predicted national and regional population requirements.

Whilst there is often focus on consultants and trainees, the pivotal role that specialty, specialist and locally employed doctors play in delivering O&G services is often poorly understood. The chapter explores how the profession can better support this diverse group of doctors. This includes professional development opportunities and career progression, including development of supported paths to Certificate of Eligibility for Specialist Registration (CESR) or enhanced access into specialty training. The benefits and challenges of the Medical Training Initiative (MTI) scheme are also discussed.

Attrition remains a challenge throughout the O&G workforce. The loss of doctors at all career stages has a significant impact on service delivery and the remaining workforce. Although trainee attrition from O&G has almost halved during the last three years, there continue to be significant gaps in rotas due to slowing rates of progression of trainees, less-than-full-time (LTFT) working and out of programme (OOP) experiences. These factors need to be considered and incorporated into workforce planning.

Building supportive and learning cultures in O&G

Creating supportive and learning cultures in O&G requires doctors to feel valued as well as having opportunities for personal and professional development. Meeting the physical and psychological needs of healthcare professionals improves patient safety and experience, fosters compassion, improves staff satisfaction and retention and promotes diversity and inclusion.

Psychological safety is key to patient safety, effective team working and reducing burnout. The chapter explores how psychological safety can be created within O&G units.

Just Culture and Restorative Justice are key concepts in building supportive governance processes and learning organisations. Compassionate leadership and a systems-based, multi-disciplinary approach, which prioritises listening and focuses on strengths, underpin how to best respond to adverse events.

Protected teaching time for O&G doctors at all career stages along with opportunities to access support and reflect together as a team, are recognised as important factors in creating learning organisations and fostering empathy between team members.

Throughout this chapter, the importance of listening to women and their families is acknowledged as being fundamental to providing person-centred care. This includes involving women and their families in all aspects of care from co-production of services, training of the multi-professional team and investigations following adverse events.

Flexible working

Flexible working includes those who work Less Than Full Time (LTFT) but there are a wide range of other ways in which individuals and teams can work flexibly. Opportunities to adopt flexible working are recognised as an important means to reducing burnout and attrition and in turn to protecting diversity amongst the O&G workforce.

The chapter explores various ways in which flexible working can be approached to ensure continuity of person-centred care and to promote team working. Types of flexible working are considered, including compressed hours, buddy systems, job-sharing, job-splitting and flexi-PAs. The chapter looks at the individual, team and organisational benefits and challenges of adopting team job planning, both for consultants as well as trainees, SAS doctors and locally employed doctors. This chapter includes a summary of the LTFT and Out of Programme (OOP) options for trainees and exploration of the differences between career breaks and sabbaticals and options for flexible working approaching retirement.

Remote and Rural Working

Providing O&G services in remote and rural areas brings both advantages and disadvantages to the women receiving care and the workforce. However, remote and rural units face a number of challenges. These include staff shortages, financial constraints and difficulties maintaining a breadth of services, patient choice and providing out-of-hours services. Centralisation of services is not without its pitfalls and is not always in the best interests of women living in either rural or urban areas. In particular, centralisation of services can heighten health inequalities by limiting access to emergency medical care in rural areas, particularly amongst more socially deprived populations.

In order to sustain remote and rural services, a multi-faceted approach is required. This includes engaging with women to listen to their views and work in partnership with them towards finding solutions. Innovative approaches are required to recruit and retain healthcare professionals, to think differently about how the wider multi-professional team works together to deliver services, and to embed regular individual and organisational learning.

The chapter addresses these challenges by sharing best practice examples of how to overcome barriers in providing safe and deliverable person-centred care for women living in remote and rural locations around the UK. Solutions include units promoting the benefits of rural working, providing practical support, flexible working, regular opportunities for all doctors to learn and acquire new skills and creating a friendly, supportive culture.

Multi-professional team working

This chapter looks at how best O&G healthcare professionals can deliver person-centred care through effective team working. It recognises the diversity of the O&G multi-professional team and how awareness of this is key to understanding patient journeys and women's overall experience of care.

The key elements of effective team working, and how complementary skills and experience can be brought together to provide solutions to complex problems and deliver person-centred care, are explored. The importance of compassionate leadership is highlighted along with the need to think beyond traditional professional boundaries and hierarchies to more inclusive ways of working where team members feel listened to and valued. This in turn enables services to be designed and developed around the needs of women rather than being driven by cost savings and professional boundaries. Teams can work collaboratively and think more openly about who is best placed to meet women's needs.

It is acknowledged that for multi-professional teams to work well together there is a need for them to train together, be supported by governance systems which look to improve systems rather than blame individuals, and for there to be continuous methods of feedback. Co-production of services with women is strongly encouraged and should be more widely implemented. Throughout the chapter, there are case studies from units across the UK where multi-professional working has improved care.

Introduction

The RCOG last published a Workforce Report in 2018. During this time, there have been gradual demographic changes to the population which are key in determining what services are needed and where. There are increasing levels of clinical complexity, driven by an aging population and rising levels of obesity. O&G has high rates of litigation and associated costs and there are ever-growing expectations for extended consultant presence on the delivery suite. All of these changes have been magnified and compounded by the Covid-19 pandemic which has affected every aspect of day-to-day life and has resulted in many changes in how healthcare is delivered.

Setting the scene

Demographics: the shifting population served by the O&G workforce

Over the course of the last decade, there have been a number of significant changes in UK demographics that have affected O&G services. Despite steady declines in the number of births per annum across the UK, which may continue for much of the next decade, other anticipated demographic changes in the years to come will likely increase demand upon O&G services

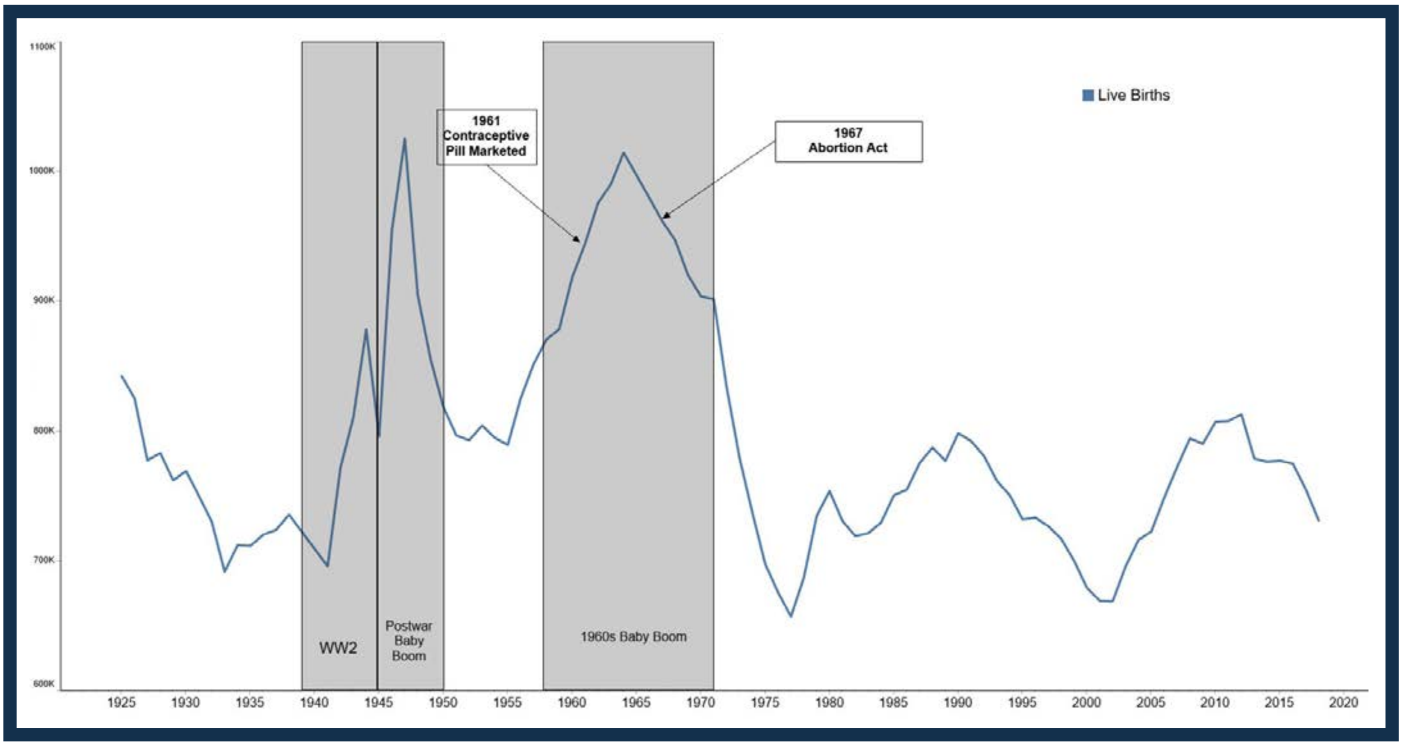
In the last 10 years for which data are available, the number of births per annum has fallen by:

- 109,977 (-15%) in England and Wales[1]
- 11,781 (-20%) in Scotland[2]
- 2,868 (-11%) in Northern Ireland[3]

Trends in UK fertility

In the period following the 1960's 'baby boom', which peaked in 1964 at over one million births per year across the UK[123], there has been a relatively stable and predictable ebb and flow in the number of births per annum, ranging between approximately 650,000 and 800,000 per year. The number of births per annum is informed in part by a 20-25 year cycle caused by the population bulge first initiated by the post-war baby boom (Figure 1); over the course of the next 15 years, the number of births is predicted to first fall and then grow again, as part of this cycle.[4]

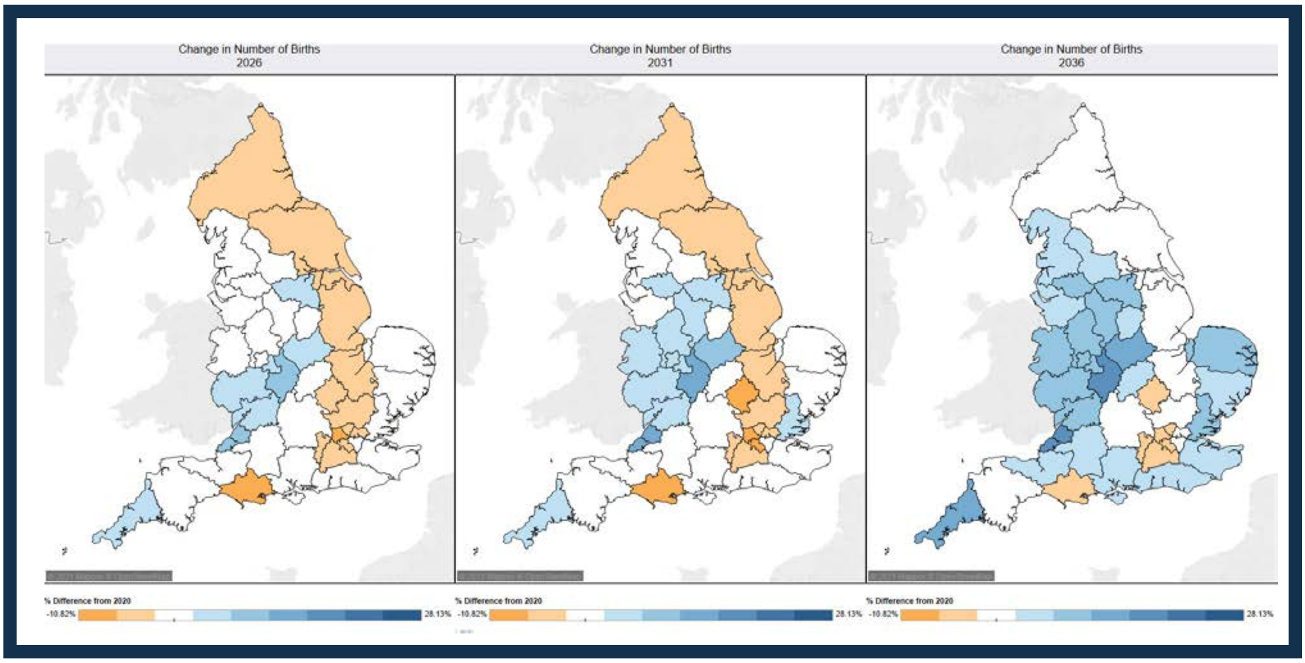
Figure 1. Births in the UK 1925-2019



There are, however, expected to be regional variations in numbers of births in the period to 2036.[4] The available data for England shows:

- There is expected to be steady growth in the number of births across the West Midlands, as well as in Bristol, Leicester and Leicestershire, and Derbyshire;
- The North East, Central and Eastern Yorkshire, Lincolnshire and Cambridgeshire are likely to see an initial decline before numbers recover to present numbers;
- London, Surrey, Bedfordshire and Dorset are likely to decline more rapidly, with numbers not likely to surpass those of the present within 15 years. (Figure 2).

Figure 2. Projected percentage change in number of births by English ICS area, 2026, 2031 and 2036



A changing population of women giving birth

- Women giving birth today in the UK are more ethnically diverse, older, and have a higher average BMI leading to an increased likelihood of pregnancy complications compared to women giving birth in previous generations.[1,5]
- Increasing rates of childhood obesity are likely to lead to increases in obesity among women giving birth.[6,7]
- Women now have a smaller family size, leading to a higher proportion of births being to first-time mothers.[1]
- Women having their first birth, or those who have had a previous caesarean section, have an increased need for obstetric assistance during their labour and birth.[8]
- It is projected that much of the growth in the number of births will be driven by women over the age of 30, with the most rapid growth amongst those over 40, and a steep decline in the number of births to women under 20.[4]

An ageing population

The population of the UK is set to rise from 67.5 million in 2021 to over 71 million by 2036. Much of this growth will be amongst those aged over 65. There is set to be more growth in over 65s (+3.9 million) than there is in the total population (+3.5 million).

Over this time period, it is expected that the number of:

- Children and young people will decline slightly (-3.3%).
- Working-age adults will remain flat (+0.4%).
- People aged over 65 years will rise considerably (+30.6%).

Regional changes in population

Much of the future growth in overall population will be centred in England (+5.9%), with the populations of Northern Ireland, Scotland and Wales to increase more slowly, or slightly decline (+3.8%, +1.9% and -0.5%, respectively). Furthermore, population growth is expected to be unevenly distributed within each country. (Figure 3)

- Growth is predicted in the West Midlands, Southwest, East of England and South East
- Very little growth is expected to be seen in the Northeast, East Yorkshire and Surrey
- Overall population decline is likely to be seen in parts of Wales and Scotland

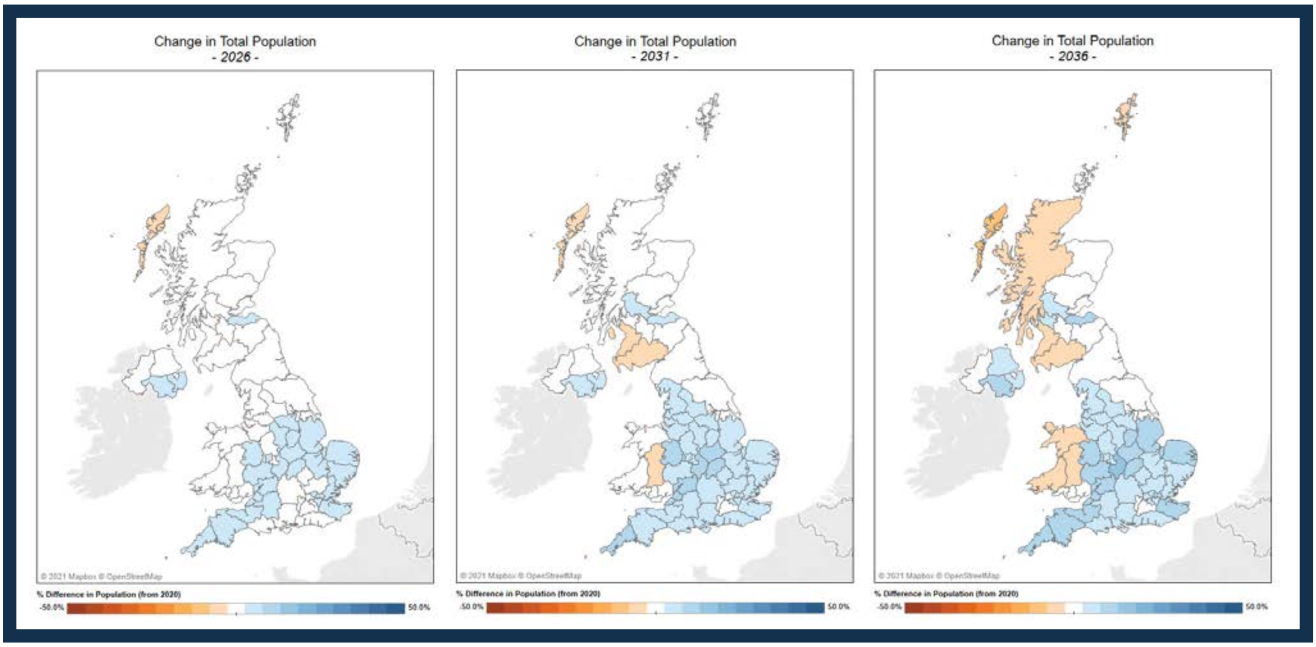


Figure 3. Expected changes in total population in the UK in 2026, 2031, and 2036, by region

Covid-19

The Covid-19 pandemic has led to a global crisis. The pandemic has impacted nearly all facets of daily life and work, including the need to dramatically adjust healthcare systems, patient care and healthcare delivery. At the peaks of the pandemic, priorities changed from teaching and training to survival and damage limitation. The effect on the NHS workforce has been considerable and is still evolving at the point of publication of this report.

Patients

Whilst the NHS has strived to provide the best possible care for patients during the pandemic, access to services has been significantly affected. In O&G, both the short- and long-term impacts on women and their families are colossal and our profession faces a significant challenge in restoring services and reducing waiting times, especially in terms of benign gynaecology and urogynaecology services.

Staff

The impact on individuals and teams has been enormous and hard to give justice to here. Some people continue to face uncertainty about their own health, for example those living with long Covid, while the impact on mental health has been vast whether due to separation from loved ones, working in immensely challenging environments or dealing with bereavement. The extent of the impact is yet unknown but cannot be underestimated in planning for our future workforce needs.

Education and training

The Covid-19 pandemic has proven problematic to training, continuous professional development, and supervision. For trainees with yearly assessments, the impact was time critical and measurable, especially at certain points of training. At present (February 2022) many trusts and health boards have not been able to restore their elective services to pre-pandemic levels, staff sickness and periods of self-isolation are ongoing, and the latest surge of Covid-19 caused by the Omicron variant has made recovery planning difficult.

Health Education England, (HEE) has worked closely with the Department of Health and Social Care (DHSC), the Academy of Medical Royal Colleges (AoMRC), the General Medical Council (GMC) and NHS England to support training recovery as an urgent priority. A dedicated fund from the DHSC has been established to support this work. While the solutions for training recovery vary between units, the overarching
principles are:

- Individualised recovery plans (especially at pivotal training points)
- Meetings with educational supervisors with the specific purpose of the above
- Focus on learning and wellbeing needs

HEE data shows that nationally since the pandemic 5% of trainees are on an outcome 3* or 10.2** which is proportionally similar to outcome 3s in previous years. This is encouraging given that 79% of trainees report that elective work has considerably reduced during the pandemic. However, we know that certain areas such as urogynaecology have been unable to maintain training at the usual pace. It is extremely positive that recruitment has been maintained and no change in attrition has been seen. However, the longer-term impact of Covid-19 on trainees across the UK, from missed and reduced training opportunities, and on O&G workforce numbers is yet to be seen.

(*Outcome 3 is awarded at a trainee's Annual Review of Clinical Progress (ARCP) if they have been unable to meet all learning requirements to progress to the next year in training. Outcome 10.2** is awarded if all learning requirements have not been met as

Where now?
The role of values-based leadership and developing shared vision

During challenging times or periods of rapid change, it is natural to become focused on daily firefighting rather than considering the overarching aims and principles of what the profession stands for and hopes to achieve. However, it is at times like these when it is most critical to have an awareness and understanding of professional values and, more importantly, what it looks like to live them.

It was for this reason that the RCOG/HEE Workforce Working Group initially took time to discuss the core values of the O&G profession when starting this report. From this, the group started to develop a shared vision of current strengths and areas for future development as a profession.

Three key values emerged from the discussions:

Person-centred care

Person-centred care has been described as "building services around people rather than people around services".[9] Person-centred care entails recognising the holistic needs of women, listening to and respecting their individual choices and involving them in all aspects of their care.
Delivering person-centred care is not just about how individual doctors interact with women but about how services are designed and improved. It requires having the right people, with the right skills, in the right place at the right time.

Valuing diversity

The word 'diversity' is often associated with protected characteristics such as gender, age, ethnicity, religion or sexual orientation. However, diversity encompasses the much broader concept of 'difference'. In O&G there is a very diverse workforce. This is partly because O&G has the highest number of female doctors and the highest percentage of overseas graduate doctors of any hospital specialty. However, the workforce is also diverse because it consists of so many different professions and specialties, all of whom contribute to the care provided for women. Acknowledging all of these people as individuals who have different skillsets, career aspirations, personal circumstances and preferences for working patterns is fundamental to improving morale and making the workforce feel valued. This is turn impacts workforce recruitment and retention.

Recognising the diversity and heterogeneity of our patient population is key to being able to provide personalised care to women. Valuing diversity requires ensuring that all voices are heard and respected. This captures the full breadth of opinion and new ideas, drives innovation and promotes inclusivity.

Promoting learning

The importance of lifelong learning for all doctors is recognised. Learning involves embedding and expanding clinical knowledge and skills, but it also extends to improving governance processes, learning from adverse events and involving women in all stages of service development and improvement. Such learning opportunities must be encouraged and accessible for all doctors at all career stages, not just those in training. Furthermore, promoting learning extends to equipping the profession with the skills to lead compassionately, to work cohesively and synergistically within multi-disciplinary teams and with women, and to build supportive cultures based on transparency, integrity and respect.

These values have become the golden threads of the report and are the driving forces behind each of the five chapters:

- Workforce planning
- Building learning and supportive cultures in O&G
- Flexible working
- Remote and rural working
- Multi-professional teams

Chapter 1: Workforce planning: Right people, right skills, right place, right time

Introduction

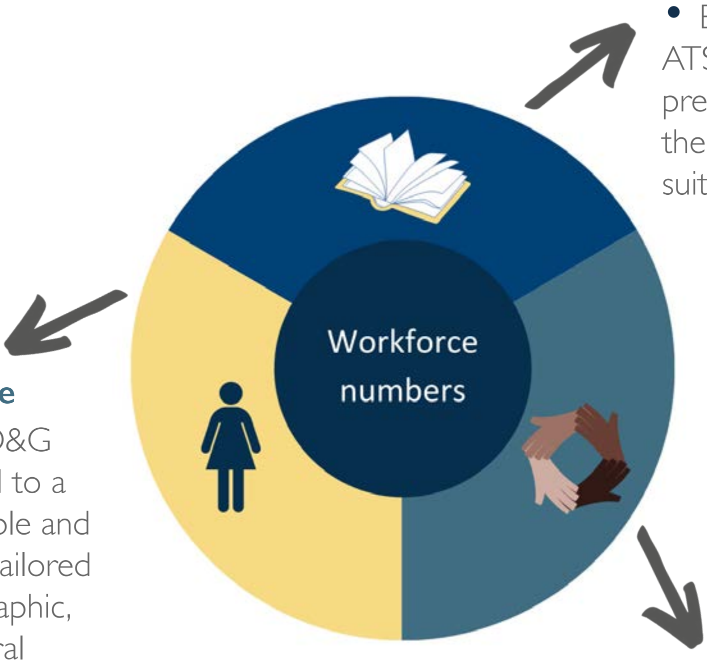
Workforce planning is a complex process of getting the right people with the right skills in the right place at the right time to provide the best possible patient care. The RCOG is currently undertaking a project funded by the Department of Health and Social Care (DHSC) to create a tool to calculate the number of obstetricians required both locally and nationally across England and Wales. Use of this tool will ensure that individual units and national workforce planners are equipped with up-to-date numbers to guide current and future workforce requirements as demographic changes occur.

This chapter explores some of the factors affecting O&G workforce numbers.

How does this chapter relate to our values?

Learning

- Ensuring that the uptake of ATSMs matches the current and predicted skillsets required in the workforce to sustain suitable service delivery.



Person-centred care

- Recognising that O&G services are delivered to a diverse range of people and therefore should be tailored according to demographic, geographic and cultural variables.

Diversity

- Retaining diversity within the workforce by reducing attrition
- Understanding and valuing the role of SAS and LE doctors in O&G

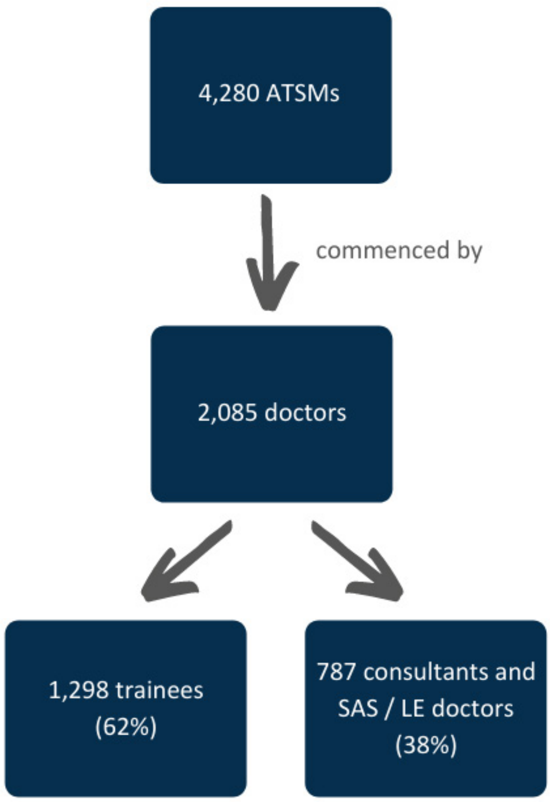
Advanced Training

A key element of providing person-centred care is to ensure that the skills of our workforce match the evolving needs of the population. It is important to consider this nationally but also be aware that regional variations exist.

The RCOG advanced training review committee is currently reconsidering the Advanced Training Skills Modules (ATSMs) content and delivery. This report examines which ATSMs doctors choose, the career guidance trainees receive, and how well matched the uptake of ATSMs is to the population requirements.

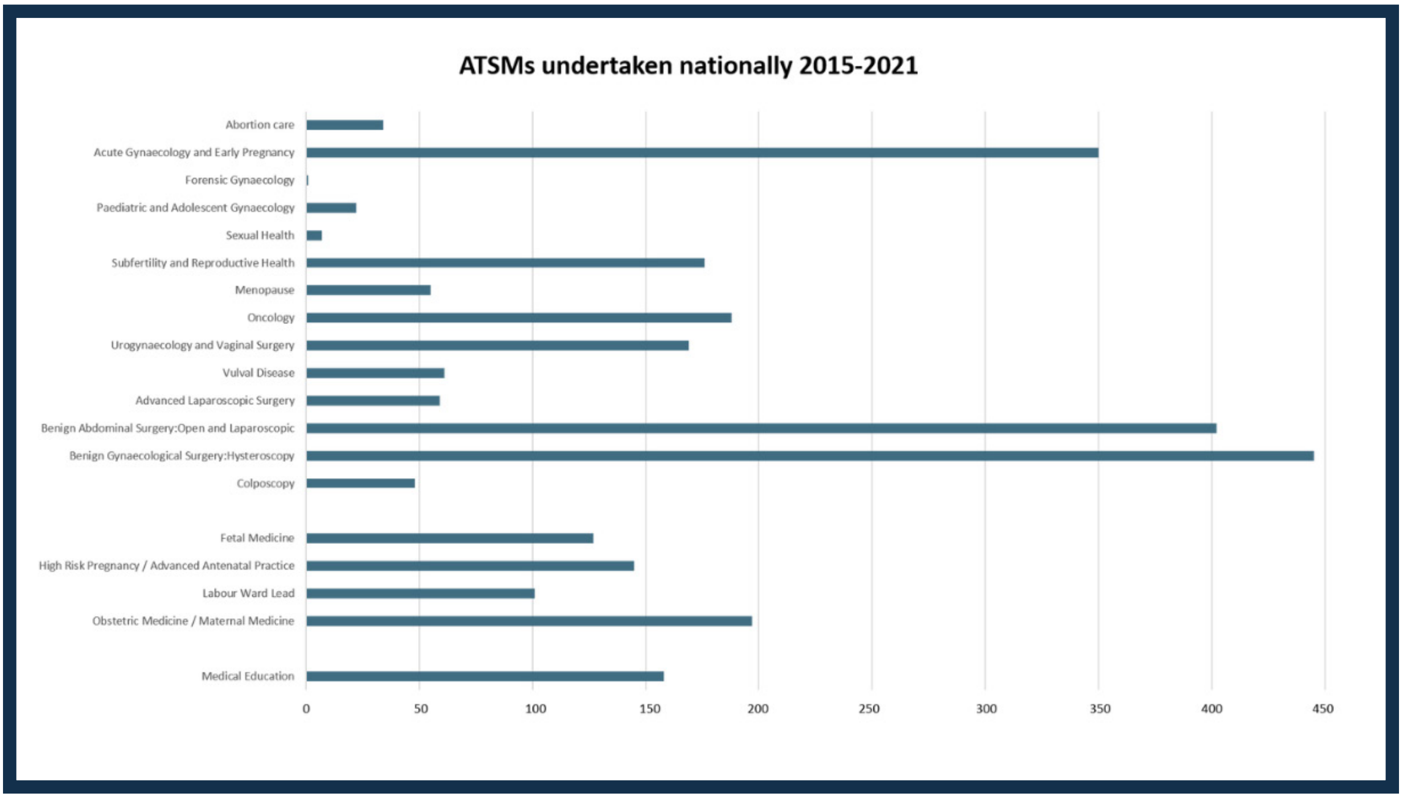
Who is undertaking ATSMs?

RCOG data relating to the uptake of ATSMs between 01/01/2015 and 08/05/2021 showed:



Overall ATSM uptake

The following chart shows the overall ATSM uptake nationally from January 2015 to May 2021. This includes those undertaken by trainees, consultants, SAS and LE doctors. Advanced Labour Ward Practice is the most popular ATSM, accounting for 36% of ATSMs chosen. It was selected by 1,535 doctors and has been excluded from this chart to permit visualisation of the remaining data.



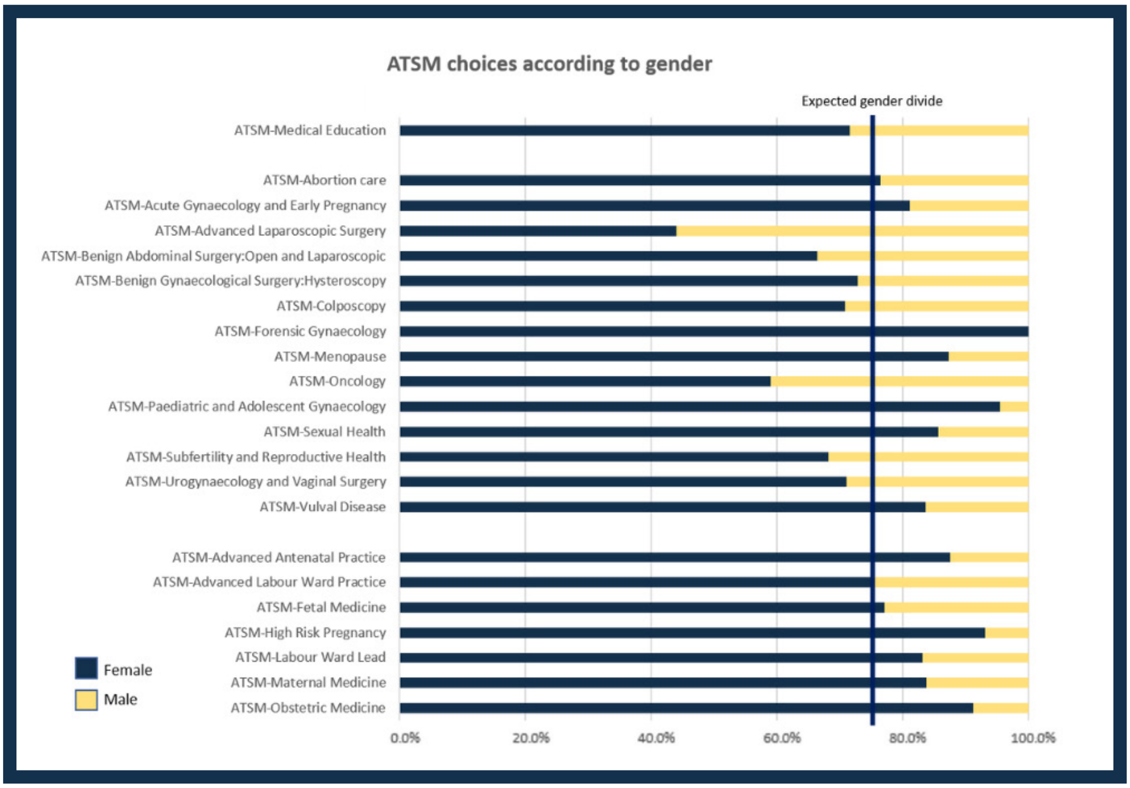
Key findings

- The most popular ATSM is currently advanced labour ward practice.
- The least subscribed ATSMs are forensic gynaecology and sexual health

Gender split in ATSM choices

Three-quarters of O&G trainees are female. However, there are differences between the uptake of different ATSMs according to gender. Recognising this difference is important within our specialty as it forms the first step to understanding why male and female trainees are drawn to different subspecialties and any barriers that may influence decision-making.

The following table shows the gender split for ATSMs since 2015.



Most ATSMs are broadly in line with the 75% female to 25% male gender split that exists within the specialty. However, it is noteworthy that female trainees are less likely to take up some gynaecology ATSMs, particularly advanced laparoscopic surgery (44%) or oncology (59%) compared to their male counterparts. Female trainees are more likely to take up gynaecology ATSMs in menopause (87%), paediatric and adolescent gynaecology (96%) and vulval disease (84%). It is not possible to comment on forensic gynaecology, as this ATSM was only selected by one doctor.

Overall, the uptake of obstetric ATSMs is higher amongst female trainees compared to male trainees. This is most notable for advanced antenatal practice (88%), high risk pregnancy (93%) and obstetric medicine (91%).

Key findings

- **Currently 75% of O&G trainees identify as female.**
- **Female trainees are more likely than male trainees to select obstetric ATSMs but less likely to choose some gynaecology ATSMs including advanced laparoscopic surgery and oncology.**

Is advanced training being planned according to population requirements?

It is important that advanced training not only fulfils the career aspirations of individual doctors but also matches expected population needs. As discussed in the introduction of this report, the demographics of the UK population are changing. There is a decreasing birth rate but with rising complexity of obstetric care. There is also an aging population which is likely to lead to increased demands upon urogynaecology and oncology services. Although both of these trends are true across the UK, there are regional variations. For instance, birth rate is declining and the average age of the population is increasing more rapidly in many rural compared to urban areas (for more information on this see the 'Rural and remote working' chapter of this report).

Figure 4. UK Population 2021

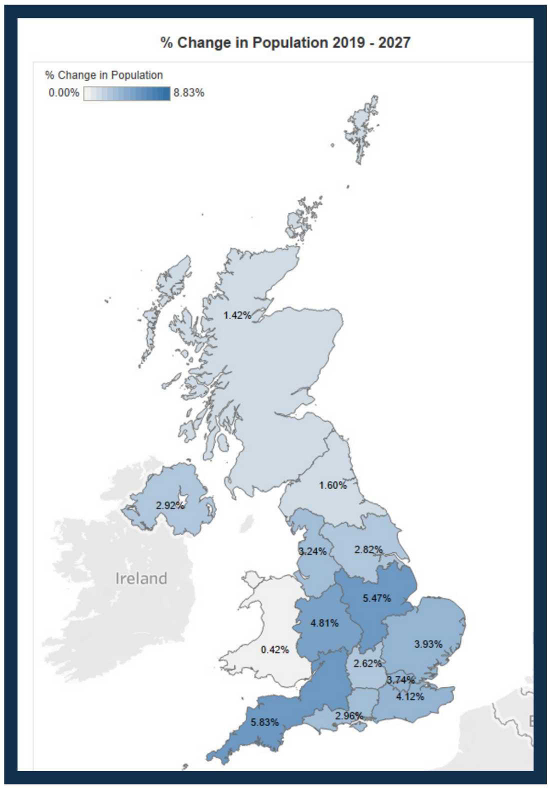


Figure 5. % Change in Population 2019-2027

As expected, the number of births also differs between regions. In some regions, the number of births is expected to increase over the next five years while in other regions it is expected to decline. Predictions for the number of births included here are provided for England only as this data was not published for Wales, Scotland and Northern Ireland.

Figure 6. Births in 2019

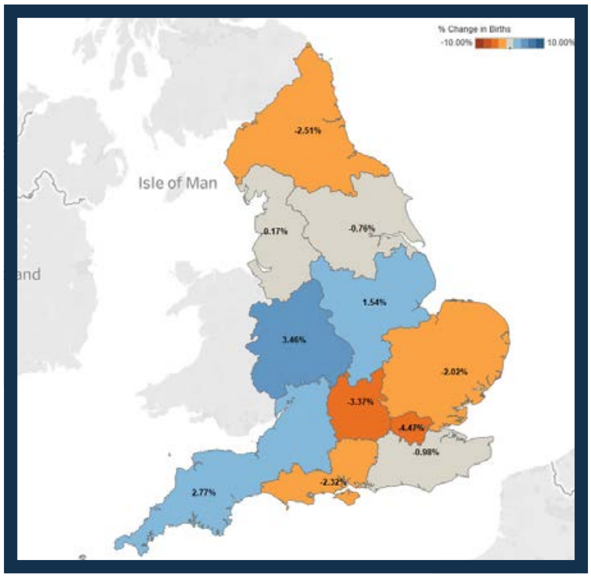


Figure 7. % Change in Births

Similarly, distribution of the population aged over 65 years also varies across the UK. The number of people aged over 65 is expected to increase by around 15% nationally by 2027, but in some areas such as London and Northern Ireland it is expected to be around 20%. By 2036, there is likely to be a 30% increase in the number of people aged 65 and over.

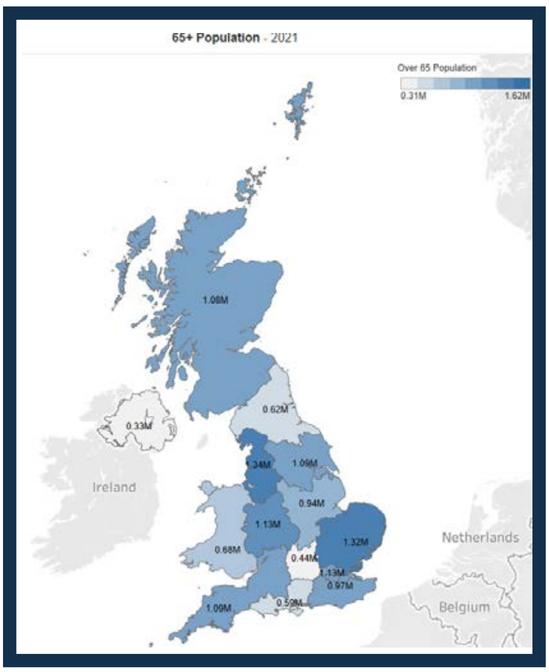


Figure 8. 65+ Population in 2021

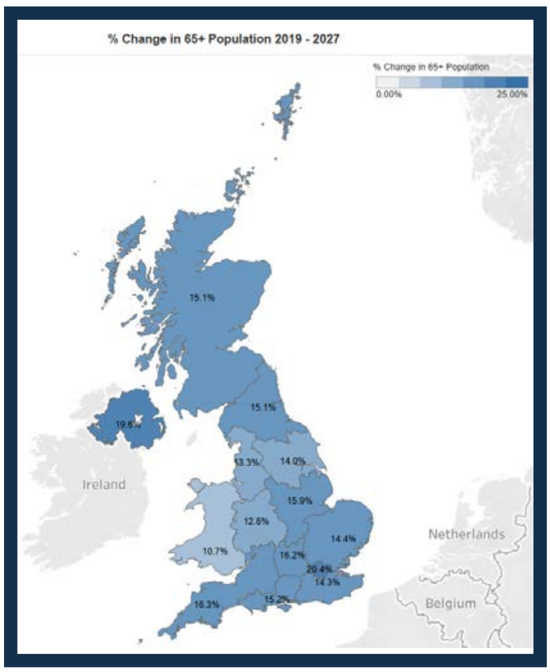


Figure 9. % Change in 65+ Population 2019-2027

In order to deliver person-centred care, it is important that availability and uptake of training opportunities in a region are matched to expected population needs. One method to assess this is to examine ATSM choices.

Individual analyses of each of the ATSMs have been conducted. However, for ease of presentation of the data, ATSMs have been categorised in the following way:

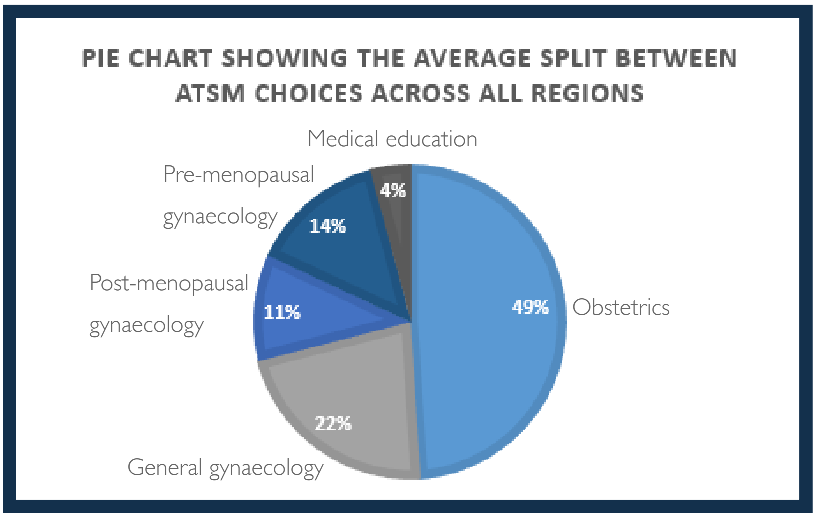
ATSMs pertaining to gynaecology subspecialties mainly caring for pre-menopausal women	This includes abortion care, acute gynaecology and early pregnancy, paediatric and adolescent gynaecology, sexual health, subfertility and reproductive health.
ATSMs pertaining to gynaecology subspecialties mainly caring for post-menopausal women	Menopause, oncology, urogynaecology and vaginal surgery, vulval disease.
ATSMs pertaining to gynaecology subspecialties caring for pre- and post-menopausal women	Advanced laparoscopic surgery, benign abdominal surgery, colposcopy
Obstetric ATSMs	Advanced labour ward practice, fetal medicine, high risk pregnancy (previously advanced antenatal practice), labour ward lead, obstetric medicine (previously maternal medicine).
Medical education ATSMs	Medical education

Uptake of ATSMs according to region (deanery)

The following table shows the number of ATSMs commenced in different regions from January 2015 to May 2021:

East Midlands Deanery	246
East of England Deanery	402
Kent Surrey & Sussex Deanery	210
London Deanery	1,053
North-Western Deanery (Manchester & Mersey)	488
Northern / North-East Deanery	180
Northern Ireland Deanery	98
Thames Valley / Oxford Deanery	161
Scotland East Deanery	37

Scotland North Deanery	53
Scotland South-East Deanery	65
Scotland West Deanery	181
South-West Deanery (Severn)	148
South-West Deanery (Peninsula)	61
Wales Deanery	158
Wessex Deanery	140
West Midlands Deanery	327
Yorkshire & the Humber Deanery	272
Grand Total	**4,280**



Uptake of ATSMs across different regions of the UK are broadly similar. However, there are several points worth noting:

Gynaecology ATSMs

- The uptake of ATSMs pertaining to gynaecology subspecialties mainly caring for pre-menopausal women, was slightly lower than expected in the Wales and Yorkshire and the Humber deaneries (8% and 7% respectively vs 14% nationally).
- The uptake of ATSMs pertaining to gynaecology subspecialties mainly caring for post-menopausal women was slightly higher than expected in Scotland south-east (20%), Northern Ireland (17%) and the East Midlands (17%). In Northern Ireland this is appropriate as the expected rise in the number of people aged over 65 is greater than in other parts of the UK. Conversely in London the uptake of gynaecology subspecialties mainly caring for post-menopausal women was slightly lower than expected (9% vs 11% nationally) despite this being the region of the UK with the greatest expected increase in the number of people aged over 65.
- The uptake of ATSMs pertaining to gynaecology subspecialties caring for pre- and post-menopausal women was higher than expected in Northern Ireland (36%) and SW Peninsula deanery (30%) and lower than expected in the East Midlands (15%) and Scotland east (11%) compared to the national average (22%).

Obstetric ATSMs

- The uptake of obstetric ATSMs was slightly higher than expected (57% vs 49% nationally) in the Northern deanery. This is despite forecasts that the number of births will fall more rapidly in this region compared to other parts of the UK. Similarly in London, uptake of obstetric ATSMs was slightly higher than expected (50%) despite this being the area of the UK with the greatest expected decline in number of births.
- In the Scotland south-east and Northern Ireland deaneries, uptake of obstetric ATSMs is lower than expected (42% and 31% respectively vs 49% nationally). In both these regions, this difference is largely attributable to the very low uptake of the advanced labour ward practice ATSM (26% and 15% of all ATSMs respectively) compared to 36% nationally (range 33-40% across other deaneries).
- The uptake of obstetric ATSMs in the West Midlands is slightly lower (47%) than the national average (49%) despite this being the region with the greatest predicted increase in number of births.

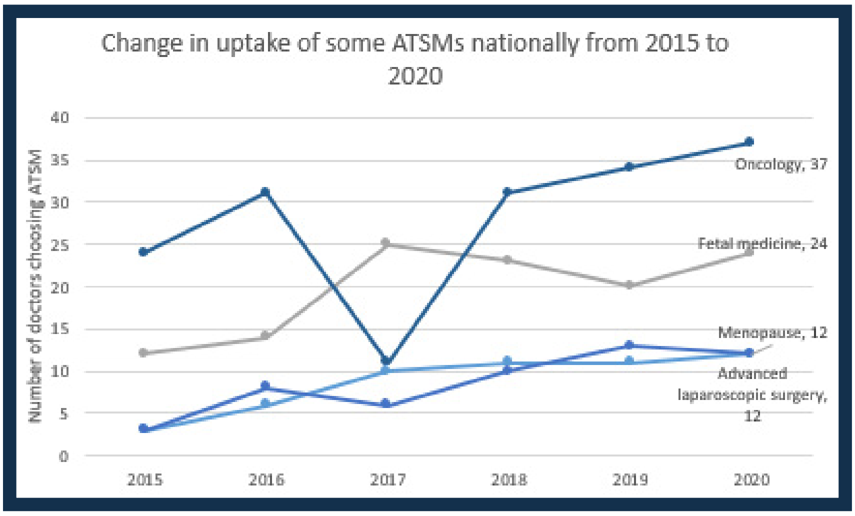
Medical education ATSM

- The uptake of the medical education ATSM is fairly uniform across all regions except in the SW Peninsula deanery where no-one has commenced this ATSM.

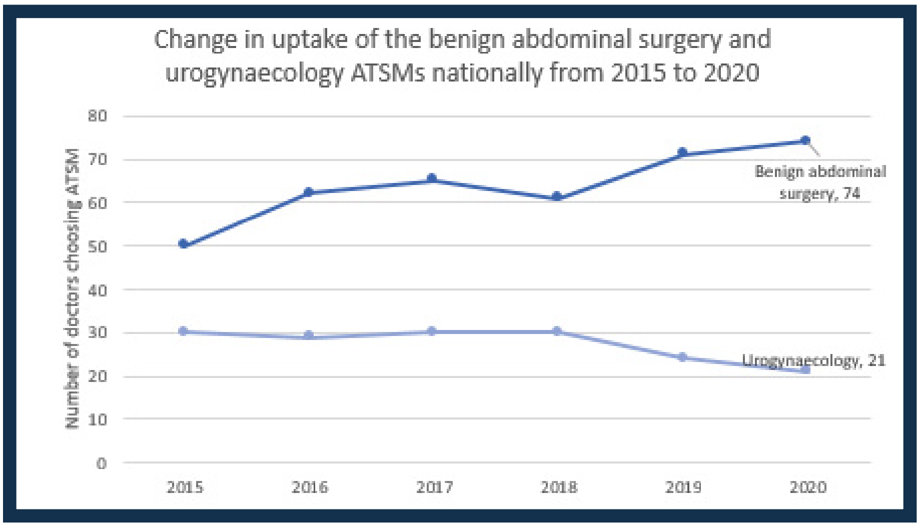
Uptake of ATSMs over time

The following section examines the trends in ATSM choices during the six-year period from 01/01/15 to 31/12/2020. During this period, 4,014 ATSMs were commenced.

- The number of ATSMs commenced was slightly lower in 2015 (598) but has remained relatively static from 2016 to 2020 (range 672-701).
- There have been slow, steady increases in the number of doctors commencing ATSMs in advanced laparoscopic surgery, fetal medicine, menopause and oncology.



• There has been a slight increase in the number of doctors commencing the benign abdominal surgery ATSM in 2019 and 2020.
• There has been a decline in the number of doctors commencing the urogynaecology and vaginal surgery ATSM in 2019 and 2020 compared to previous years. This decline appears to be continuing in the data from January to April 2021 and is mirrored by a reduction in the number of doctors starting subspecialty training in urogynaecology in recent years.



Is the uptake of ATSMs matched to population requirements?

As previously explained, determining exactly which ATSMs are required to meet population needs is very difficult. It not only depends upon population numbers but also age of the local population and how services are arranged in a particular area. As discussed in more detail in the 'Remote and rural working' chapter, small units in more rural settings often require doctors with more generalist skillsets than those working in large urban units.

Despite these ambiguities, there are certain points worth noting:
• The number of people aged over 65 years in the UK is expected to rise by 30% in the next 15 years. We would therefore expect to see a rise in demand for services such as oncology, menopause clinics, urogynaecology and treatment of vulval disease. While there has been a large relative increase in the uptake of the menopause ATSM and a moderate increase in the uptake of the oncology ATSM, the number of doctors starting the vulval disease ATSM has remained static in the last five years and the number of doctors starting the urogynaecology ATSM has fallen.
• The abortion care ATSM has been started by 34 doctors since 2015. Most of these doctors have been in London, the East of England and the East Midlands, with large parts of the UK having no uptake of this ATSM. No doctors have commenced the abortion care ATSM from 01/01/19 to 30/04/21.

• Completion rates of ATSMs were similar across regions and across different sub-specialities. However, of 22 doctors starting the paediatric and adolescent gynaecology ATSM since January 2015, only 7 have completed the ATSM up to May 2021. This is a lower completion rate than for other ATSMs. The reasons for this are uncertain.

• In some smaller regions, there has been no uptake of particular ATSMs since 2015. This raises the question of whether or not training can be provided for these subspecialties in some regions. In particular, this applies to:

- Abortion care
- Paediatric and adolescent gynaecology
- Menopause

• Furthermore, it is estimated that, on average nationally, 80% of trainees remain in the region in which they trained, post-CCT. The Southwest peninsula deanery supports this estimate with 78% of doctors (who have undertaken ATSM's since 2015) commencing consultant posts remaining in the region. For those remaining in or taking up new SAS/LED roles 80% remained in the region. If in some regions, doctors are consistently not selecting certain ATSMs either through choice or due to lack of training opportunities, it may render services unsustainable in the long term.

Current ATSM guidance

A survey was sent to all ATSM directors in April 2021 to gain information about how ATSM guidance is given across the regions. Findings from the 10 regions that responded showed that:

- 100% offer advice via trainees' educational supervisors.
- 90% provide trainees with a meeting with the ATSM director.
- 60% have ATSM discussions at regional teaching events.
- 60% offer advice at ARCP or equivalent deanery panels.
- 50% of regions surveyed have competitive entry ATSMs.
- 40% of ATSM directors felt they offered guidance regarding ATSM choices based on job opportunities available.
- 30% of regions have ATSM/career events.

The Northeast region host an annual event in which they invite the clinical directors from across the region to discuss the strategic direction of the trusts and anticipated workforce requirements for the next five years. The ATSM preceptors present an overview and share their contact details to facilitate further discussion. Newly appointed consultants also attend the event to give advice on what to look for in job applications, how trainees can best market themselves and top tips on pre interview visits and job plans.

Key findings

- Uptake of ATSMs across the UK is broadly similar between regions.
- The uptake of ATSMs pertaining to sub-specialties mainly treating post-menopausal women is not increasing as quickly as the predicted rise in the population of women aged over 65. Uptake of the urogynaecology ATSM is falling. This is suggestive of potential future difficulties in meeting service needs if these trends continue.
- Uptake of obstetric ATSMs across most of the UK are broadly similar but this does not take into account predictions for a rise or fall in total birth numbers in some areas.

Attrition and rota gaps

Attrition is a challenge throughout the O&G workforce affecting trainees, SAS, LE doctors and consultants. The loss of any O&G doctor has a significant impact on service delivery and the remaining workforce.

Gaining data on attrition is challenging given its multifactorial nature. Whilst data about trainee attrition is available it is important not to underestimate the significance of loss amongst LE and SAS doctors and consultants.

Defining attrition amongst trainees is also difficult. This is firstly because it is important to differentiate between trainees who leave the training programme but remain within O&G working as SAS and LE doctors compared to those trainees who leave O&G completely.

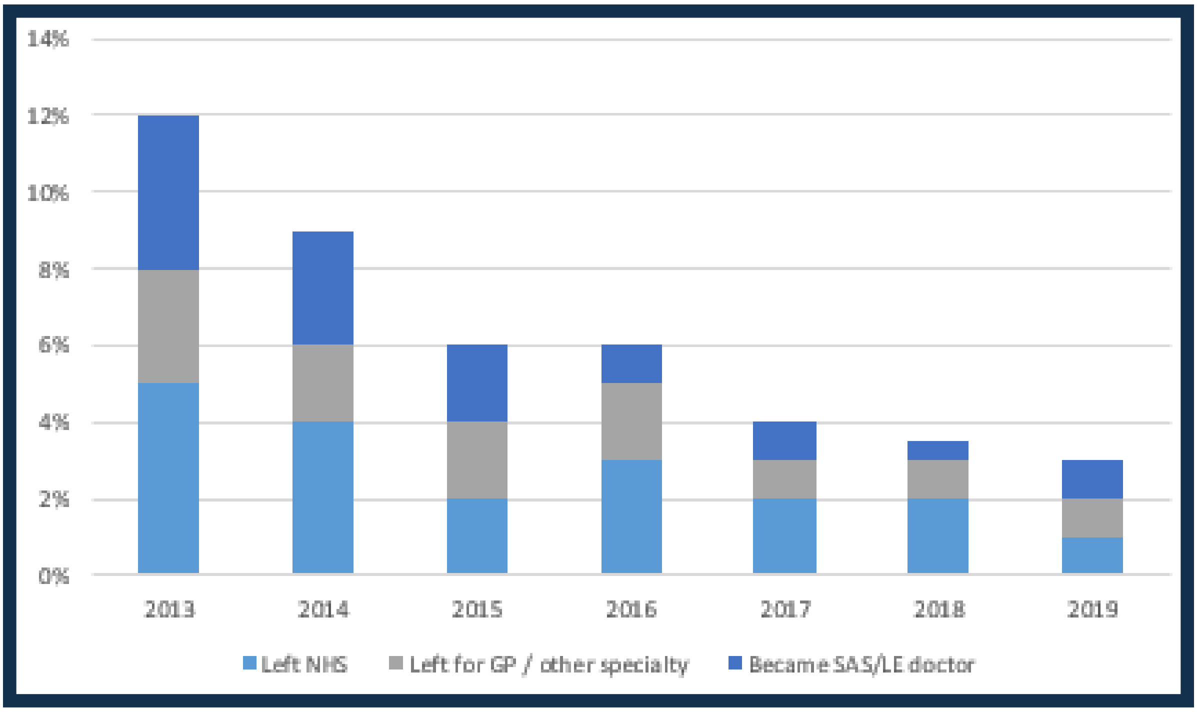
Secondly, it is difficult to follow a full cohort of trainees through the training programme. Although it is a seven-year training programme it is estimated that only 9% of trainees complete O&G training in this time frame.[36] The majority of trainees take longer to complete training due to parental leave, less-than-full-time working, time spent out-of-programme and delayed progression.

The data in the following section provided by Health Education England and relates to O&G trainees in England only. Figures are provided up to 2019.

The number of trainees within the O&G training programme in England has remained static over the last seven years at around 1,840 (range 1,785-1,957). However, from 2013 to 2019, the attrition rate per calendar year for all O&G trainees has steadily declined from 12% to 3%. This includes trainees who have left the training programme for the following reasons:

- Left the NHS
- Left O&G to join another specialty (most commonly GP)
- Left the training programme to become a SAS or LE doctor

The following chart demonstrates this reduction in attrition.



It is worth noting that the number of trainees who have left the O&G training programme to become SAS and LE doctors has declined. The reasons for this are uncertain but it is possible that increased opportunities for flexible working and time out of programme (OOP), alongside other pastoral support such as improved supported return to training following absences of three months or longer have improved workforce retention. For further information on this, see the chapters on 'Flexible working' and 'Building supportive, learning cultures in O&G'.

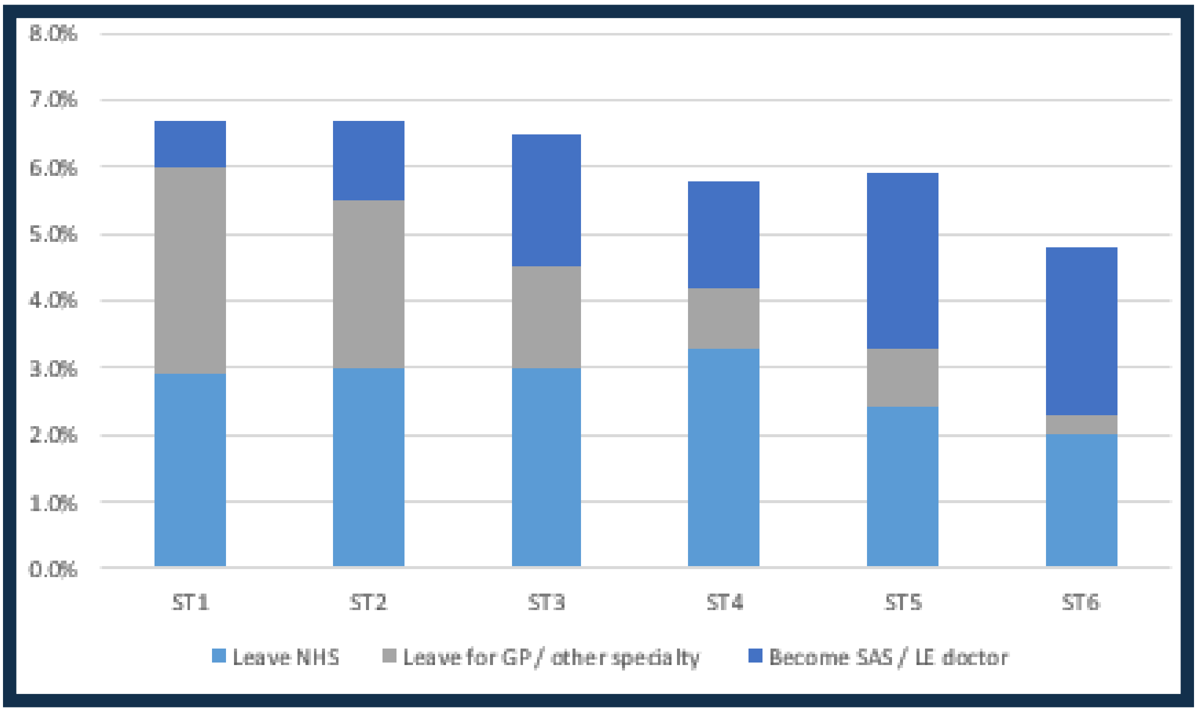
The effects of this are both positive and negative for the workforce. While more trainees staying within the training programme speeds the rate at which individuals are trained to become consultants, SAS and LE doctors provide valuable contributions to staffing non-consultant rotas and therefore reduced availability of these doctors may create rota gaps elsewhere.

Estimates for cohorts of trainees commencing training in 2012-2013 suggest that cumulatively around 30% of trainees have left the training programme at some stage. This is consistent with the figure previously reported by the RCOG in 2018.[10] Further, more accurate data is expected in the next few years but it is anticipated that this rate will decline.

Attrition according to training year

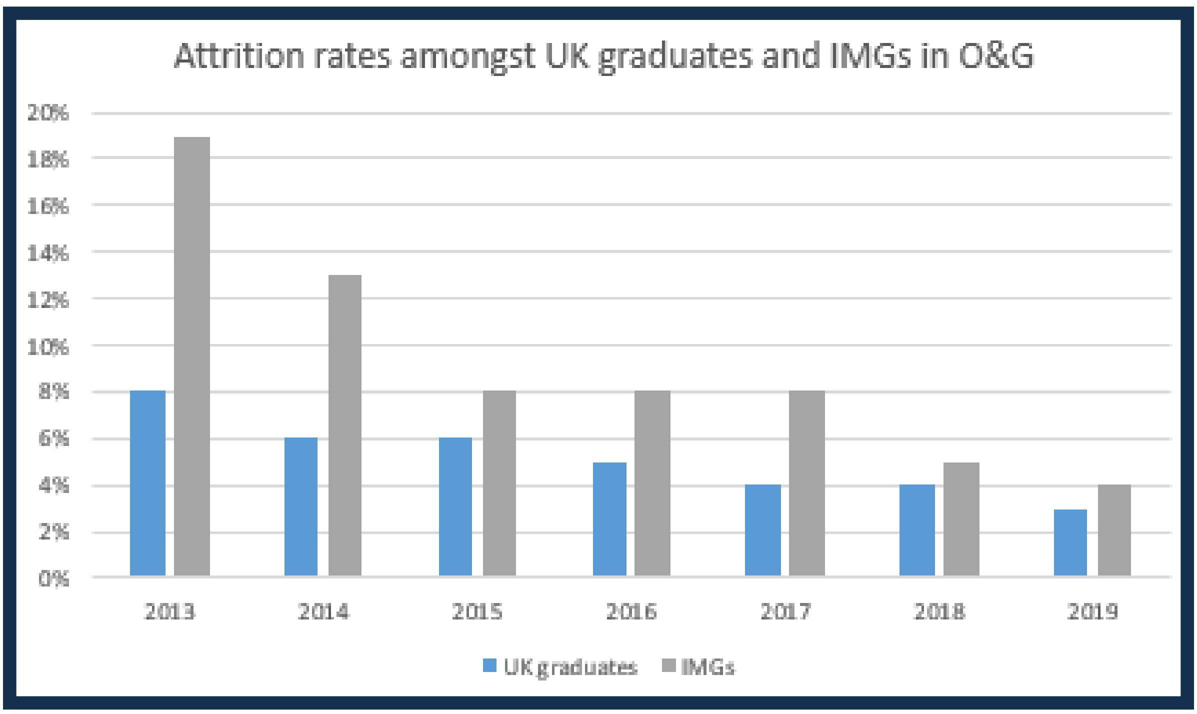
Attrition is highest during the earlier years of training but only declines slightly during later years of training, with trainees still exiting the programme at ST6 (destination of ST7 trainees is considered separately below). While rates of those choosing to leave the NHS remain static at all training years, trainees become progressively less likely to move to GP or another specialty and progressively more likely to become SAS or LE doctors the later they leave through the training programme.

The following chart shows average rates of attrition from 2013-2019 between training years:



Attrition according to gender and country of primary medical qualification (PMQ)

In terms of attrition there is very little difference between male and female trainees. However, there are significant differences between UK graduates and those who have graduated overseas. Rates of UK graduates and international medical graduates (IMGs) leaving to join another specialty are similar, but IMGs are much more likely than UK graduates to leave the NHS or leave to become SAS or LE doctors. However, the gap between UK graduates and IMG has narrowed considerably since 2013.



The reasons for this are uncertain although it is a positive step forward for the profession that more IMGs are choosing to stay in the NHS and continue in the training programme, hence ensuring diversity within the workforce.

Attrition following certificate of completion of training (CCT)

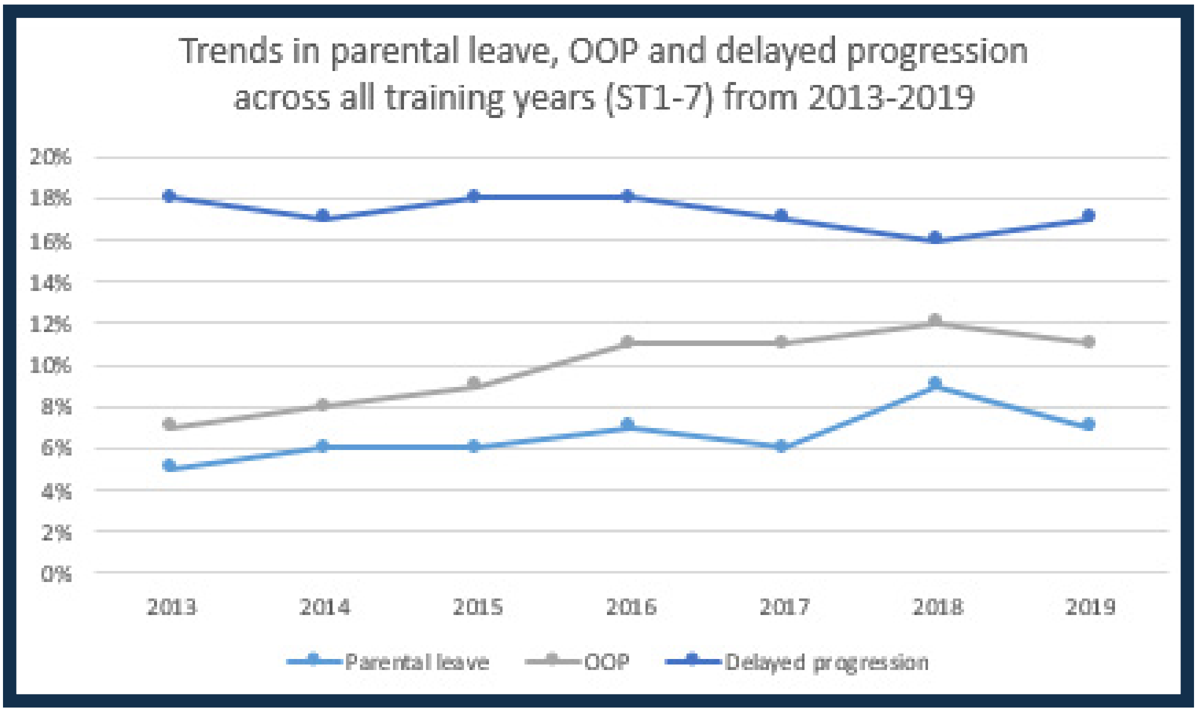
The majority of trainees take up consultant posts, either substantive or locum, within the NHS following CCT. A further 10-20% take up SAS or LE doctor posts. However, it is estimated that 12% of O&G trainees leave the UK within three years of achieving CCT, the highest of any specialty.[11] It is hypothesised that this is because IMGs are much more likely to leave the UK than UK graduates. The workforce within O&G comprises 57% IMGs compared to an average of 35% across all other specialties.[11] There are also a small percentage of O&G trainees who remain in the UK but work exclusively within the private sector or in academic roles following CCT.

Understanding rota gaps

Over the last eight years, there has been a demonstrable reduction in attrition from the O&G training programme. However, rota gaps persist in many units. There are a number of reasons why this may be the case.

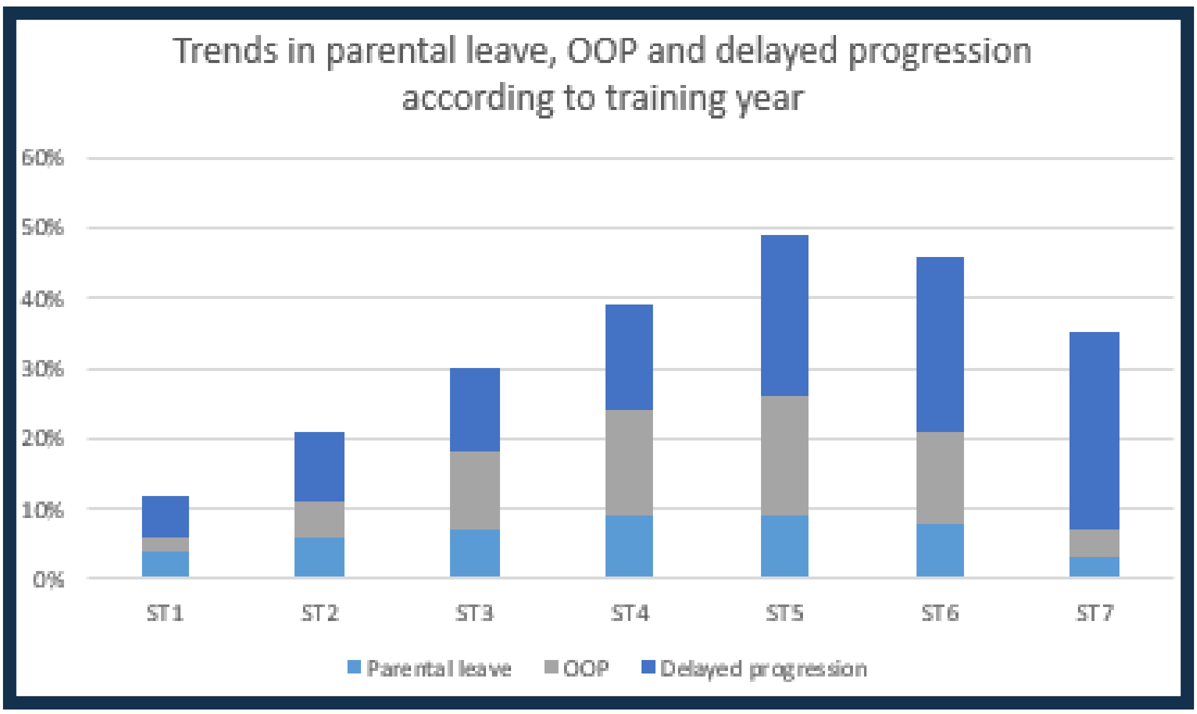
1. There has been an increase in the number of trainees choosing to take time out of programme (OOP). Often these trainees are not working clinically at all or are only working occasional clinical shifts if doing research.
2. More trainees are opting to work LTFT. The figure is higher amongst female trainees, often due to childcare commitments.
3. Fewer trainees who leave the training programme are doing so to become O&G SAS and LE doctors. This means that those who do leave, are lost completely to frontline O&G services.

The following chart shows the trends in parental leave, OOP and delayed progression between training years. It is not possible to separate those trainees who do not progress to the next training year after 12 months due to LTFT working and those who receive unsatisfactory ARCP outcomes.



As trainees progress through training they are progressively more likely to take parental leave, take up OOP opportunities or have delayed progression through training, most commonly due to LTFT working.

This following chart demonstrates why rota shortages are most often noticeable at ST3+ level on rotas.



Key findings

- Attrition from the O&G training programme has fallen significantly between 2013 to 2019.
- Attrition has fallen most dramatically amongst trainees with a non-UK PMQ thereby leading to greater diversity within the O&G workforce.
- While rates of parental leave have remained relatively static since 2013, uptake of OOP opportunities has increased.
- Rates of parental leave, OOP and delayed training progression (mostly due to LTFT working) increase as trainees become more senior.
- Rota gaps persist in many units due to OOP, LTFT working and fewer doctors leaving training to take up SAS and LE doctor posts. This is an important consideration for workforce planners.
- Although attrition has declined, it remains important to better understand further the reasons that influence the decision to leave. An 'exit interview' may allow identification of areas for improvement to prevent further attrition.

Subspecialty Training (SST)

Total Numbers of subspecialists trained:

247
Maternal-Fetal Medicine (MFM)

238
Gynaecology Oncology (GO)

180
Reproductive Medicine (RM)

89
Urogynaecology (UG)

There was a steady increase in the number of doctors completing all four subspecialist training programmes until 2015. However, in the last five years there has been a reduction in the number of trainees completing SST:

MFM decreased by **9%**

RM decreased by **8%**

GO decreased by **32%**

UG decreased by **35%**

Number of subspecialist training centres in the UK with current accreditation offering SST posts recognised by the RCOG:

GO
34 posts in 34 centres

MFM
33 posts in 23 centres

RM
21 posts in 19 centres

UG
13 posts 15 centres*

*the number of centres exceeds the number of posts due to cross-site working

The number of inter-deanery transfers (IDTs) i.e trainees leaving their home deaneries to train elsewhere, is higher in sub-specialty training (GO - 27%, MFM - 24%, RM – 25%, UG 36%) than for core trainees (<1%).

Gender

- In Core O&G training 75% of trainees are currently female
- There is a lower proportion of females undertaking sub-specialty training in the gynaecological sub-specialties (GO, RM, UG 62-64%) than MFM (85%)

Covid-19 Pandemic

As part of the Covid-19 response to enable trainees' progression at Annual Review of Competency Progression (ARCP), two new ARCP outcomes were introduced in April 2020. Outcomes 10.1 and 10.2 recognise that the trainee was achieving progress and developing competencies/capabilities at the expected rate, but that acquisition of some capabilities has been delayed by the impact of Covid-19.[12]

The following table shows the number of trainees receiving a Covid-19 outcome at their ARCP in October 2020 and at March and October in 2021.

	October 2020	March 2021	October 2021
UG	50%	57%	70%
GO	46%	6%	0%
RM	27%	0%	0%
MFM	11%	0%	0%

While Covid-19 has not impacted significantly on the ATSM outcomes for trainees undertaking SST in GO, RM and MFM, it has had a profound effect on those undertaking UG. This can be attributed to ongoing disruption to surgical training due to decreased UG operating lists nationally.

Losses to overseas and the private sector

The following table shows the percentage of trainees moving overseas after SST.

Specialty	% of trainees moving overseas after CCT/SST
Core O&G	9%
MFM	10%
UG	9%
GO	15%
RM	19%

- 7% of RM consultants appear to work solely in the private sector.
- 26% of RM sub-specialists do not work for the NHS after completing their subspecialty training.

Geographical distribution of SST posts

There is uneven geographical distribution of subspecialty consultant jobs and SST posts compared to what is expected for regional demographic requirements in some areas.

The following figure 10 below shows consultant posts in RM. The map on the left shows the current distribution of consultant posts. The map on the right shows the number of consultants expected in a region based on regional demographics.

Figure 10. Consultant post distribution vs guided distribution

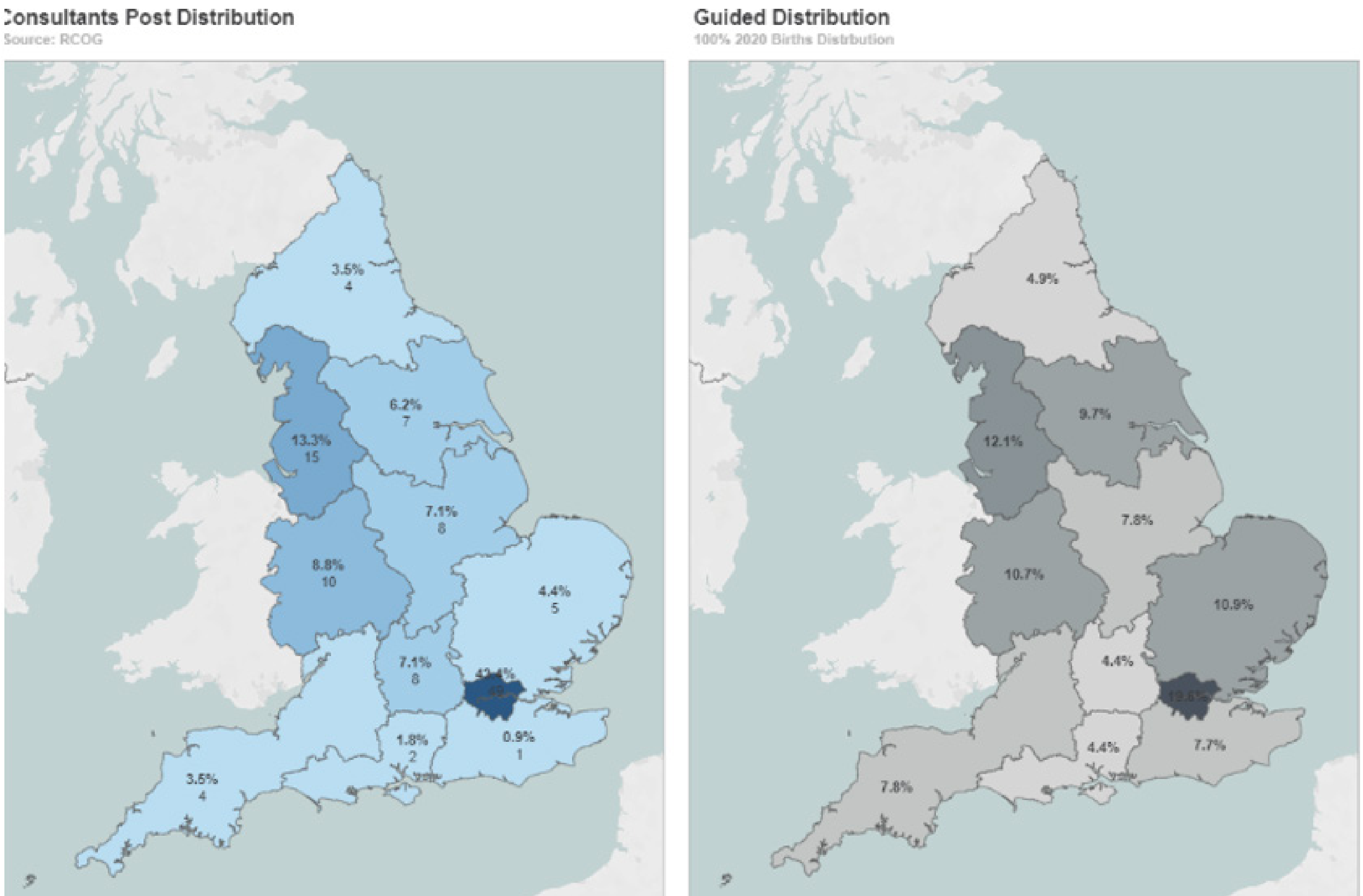
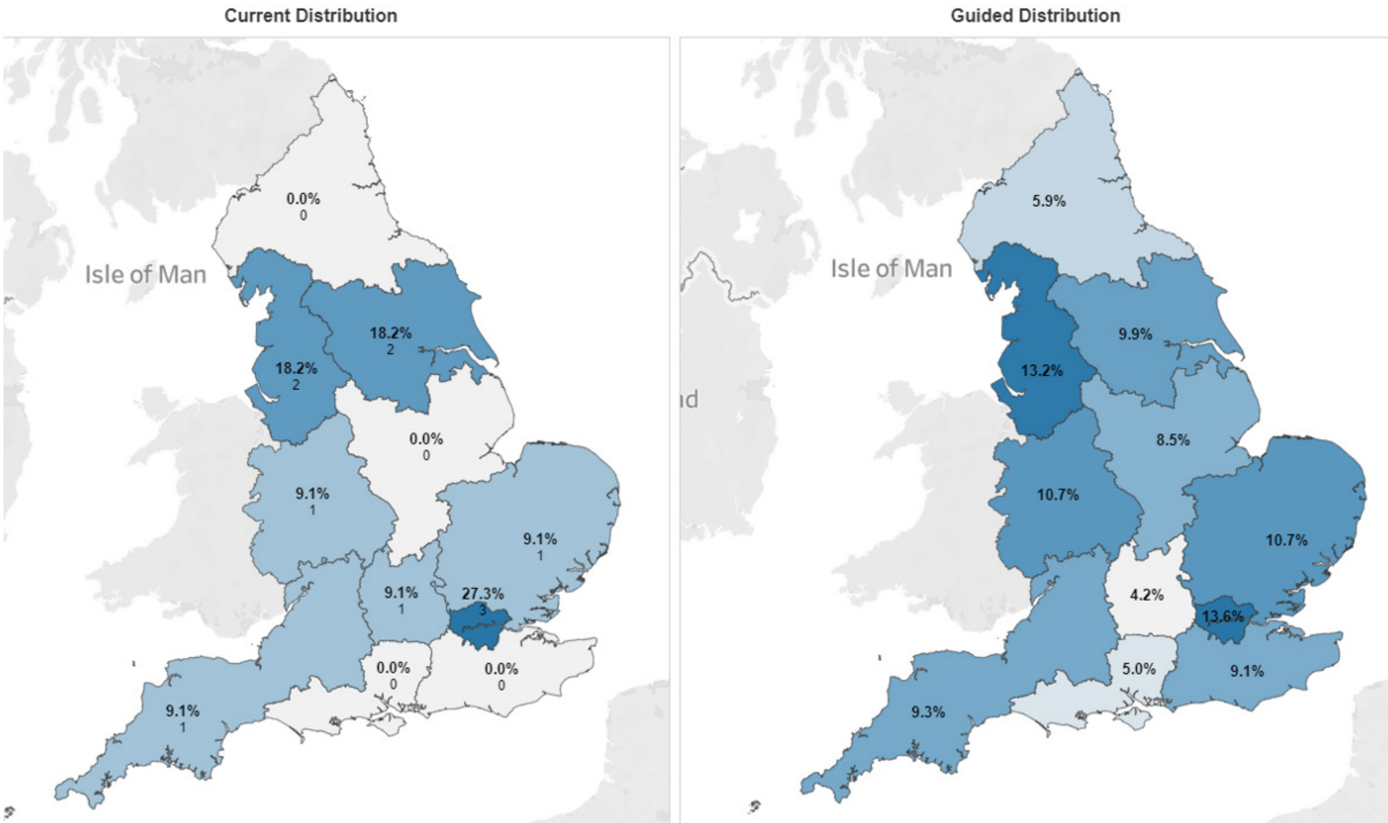


Figure 11 below shows an example of SST posts in UG. The map on the left shows current distribution of SST posts. The map on the right shows the expected number of training posts based on regional demographics.

Figure 11. Subspecialty training in urogynaecology



The maps highlight the uneven spread of consultant and SST posts. They show that in London there are a greater number of RM consultant and SST posts compared to what the modelling suggests are required. There are fewer RM posts than are expected to be required across many other parts of the east and south of England.

In UG, there are more consultant and SST posts compared to what modelling suggests are required in London, the North-West and the North-East. However, there are fewer posts than are expected to be required in the north of England, the East Midlands and the South and South-East of England.

The uneven distribution of SST posts can lead to difficulties in recruiting subspecialty consultants in the regions with fewer posts. This poses problems for long-term supply and sustainability of services to ensure that they continue to meet the requirements of women.

Survey

In 2021 the RCOG surveyed the subspecialist training programme supervisors. The key findings were:

- Over 50% of trainees recruited to SST remain in the same deanery in which they carried out their general O&G training
- Over 50% of subspecialist units are planning expansion of consultant numbers over the next five years
- The planned expansion of subspecialty consultant posts outweighs net losses in retirements in all subspecialties
- Predicted retirement rates over the next five years range from 34-40%
- The current rate of SST expansion will not keep pace with projected workforce needs

Key findings

- **Current ATSM and SST uptake is not matched to predicted population requirements.**
- **There are gender differences between the uptake of various ATSMs and SST, the reasons for which need to be better understood.**
- **Urogynaecology (UG) has the lowest number of subspecialists.**
- **In the last five years the number of trainees completing SST in Gynaecology Oncology (GO) and UG has fallen by over 30%.**
- **The biggest impact of Covid-19 has been in UG SST.**
- **There is uneven geographical distribution of SST posts across the UK.**
- **SST recruitment, particularly in UG is not sufficient to meet predicted demographic needs.**

Recommendations

- An expansion of SST posts is required to keep pace with projected workforce needs.
- Sub-specialist consultant appointments and training posts should be more evenly distributed based on population needs.
- Sub-specialty training centres should be established in regions where currently there is no access to training, to develop a sub-specialist consultant workforce in these areas. Support may be required from other deaneries to train local candidates until a sub-specialty workforce is established.
- Regions should run an annual career planning event to aid trainees in making decisions regarding advanced training choices.

Specialty and Associate Specialist doctors and locally employed doctors

What do SAS and LED mean?

SAS Doctors:

Prior to 2008 there were **Staff Grades** who could be promoted to **Associate Specialist positions.** Both these grades were closed nationally in 2008 and the **Specialty Doctor** contract created.

A **Specialty Doctor** post requires a minimum of four years post-graduate experience, at least two of which must be in the relevant specialty.

These doctors are not on a specialty training scheme but employed on nationally agreed contracts, in permenant posts and have the same appraisal and revalidation requirements as consultants.

In April 2021, a new **Specialty Doctor** contract was introduced in England, Wales and Northern Ireland and a new senior **SAS Doctor** post called **Specialist Doctor** was created.[13,14]

Specialist doctors have at least 12 years post graduate experience, at least six of which must be in the relevant specialty.

Specialist doctor posts are created by employers in response to local service needs, and individual person specifications and job plans are created accordingly. Posts are advertised externally and appointed through open competition. Medical Colleges may be asked to be involved in creating the person specification and to be part of the interview panel but, as with consultant posts, this is entirely at the discretion of the local employer.

LE Doctors

Locally employed (LE) doctors have a variety of titles and are employed on local contracts. Their experience and level of work varies from foundation level through to consultant level.

LE doctors are usually on temporary rather than permanent contracts. Many have 'trainee-like' needs while others are on long-term contracts and are more 'SAS-like'.

The journey to taking up an SAS or LE doctor post within O&G is varied, with this group of doctors having a range of experiences within the UK and overseas. The role that SAS and LE doctors play in delivering O&G services, and their range of skills and competencies, is pivotal but often poorly understood – especially by workforce planners.

This means that SAS and LE doctors often do not receive the professional development opportunities and career support they need, leading to avoidable attrition.

The 2017-18 RCOG Workforce Survey[10] of 257 SAS/LE doctors in O&G showed:

- 87% work full-time
- 74% had more than 15 years' experience working as a doctor
- 67% are female
- 51% work at the equivalent of ST3-7 level
- 23% work at the equivalent of consultant level
- 22% are on the specialist register
- 21% intend to apply for Certificate of Eligibility for Specialist Registration (CESR)
- 12% qualified in the UK
- 10% have previously held a national training number (NTN) post

The reasons cited by respondents for applying for SAS or LE doctor posts were:

Work-life balance

Geographical location

Difficulty obtaining an NTN or consultant post

Stable pay

Regular hours

No on-call commitments (in certain roles) post

Areas of practice of SAS and LE doctors surveyed:

1. 81.3% contributed to both obstetrics and gynaecology
2. 9.7% worked solely in gynaecology
3. 4.3% other
4. 3.9% reproductive medicine
5. 0.8% obstetrics only

Certificate of Eligibility for Specialist Registration (CESR)

CESR is the route to specialist registration for doctors who have not completed a GMC approved training programme but who are able to demonstrate that their specialist training qualifications and experience are equivalent to the requirements for the award of Certificate of Completion of Training (CCT) in the UK.

The following table shows the number of doctors successfully obtaining a CESR over the past five years.[15] On average 40-50% of the applications are rejected, at a significant cost to the doctors, both financially and in time.

Rates of application for CESR in O&G, successful and unsuccessful applications

	2016	2017	2018	2019	2020
Number of successful applications	19	19	22	26	42
Number of unsuccessful applications	13	19	23	16	35
Total applications	32	38	45	42	77
% successful applications	59%	50%	49%	62%	54%

Summary

Understanding the diversity of background, skills and experience amongst SAS and LE doctors is key to ensuring that they feel valued and have opportunities to fulfil their career aspirations. Positive steps have been made with the new 2021 Specialist and Specialty Doctor contracts.[13,14] However, further attention and investment is required to ensure that their roles are optimised. In turn, this offers organisations the chance to capture and grow the skills amongst this professional group to benefit patient care overall.

Recommendations

1. More robust information is required regarding SAS and LE doctors in O&G.
2. Supported paths to CESR and enhanced opportunities for access into specialty training should be developed.
3. CPD opportunities for SAS and LE doctors should be increased and promoted.
4. All consultants and senior specialists should have an appraiser and all other doctors should have an educational supervisor.

The Medical Training Initiative (MTI Scheme)

Key facts

- **The number of applicants to the MTI scheme are significantly increasing.**
- **Approximately 60-70% of doctors remain in the UK after the two-year scheme.**

What is the MTI Scheme?

The Medical Training Initiative (MTI) is a philanthropic 'learn and return' scheme. It is designed to enable a limited number of international medical graduates (IMGs) from developing countries to come to the UK each year to train in the NHS system for up to 24 months, before returning to their home countries to use the skills and knowledge they have gained. The number of IMGs matched each year will vary and depends on spare training capacity.

Detailed information about the MTI scheme can be found on the RCOG website here.

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Total
Applications	33	44	72	74	93	134	174	363	215	215	**1,417**
Placements	20	36	33	46	55	54	58	68	50	17	**437**
Success rate	61%	82%	46%	62%	59%	40%	33%	19%	23%	8%	

What are the benefits of offering an MTI placement post?

- Hospitals benefit from an increased workforce capacity as well as the skills and knowledge that IMGs share with their UK colleagues.
- IMGs provide trusts and health boards with a high-quality, longer-term alternative to using locums to fill rota gaps.
- Recruiting IMGs improves workforce diversity, thereby creating multicultural, inclusive teams which reflect population demographics in the UK.
- MTI doctors are often highly skilled and competent, as well as motivated and hardworking, with a solid knowledge base.
- Opportunities to provide training and contribute to the development of healthcare on a global scale.

- Opportunities to develop and foster partnerships with other countries for research and sharing of good practice.

How many doctors stay in the UK after the 24 months?

It is very difficult to monitor this with accuracy. However, based on the data available, it is estimated that 60-70% of doctors stay in the UK. This is a contentious topic as staying in the UK is not within the philosophy of the scheme.

An audit of 54 doctors starting work in the UK in 2017 under the MTI scheme showed 68% remained practising in the UK. Of these 54 doctors:

- 11 (20.4%) took up ST3 posts with a national training number
- 26 (48.1%) took up trust-funded posts
- 17 (31.5%) were no longer on the GMC register. However, it is impossible to know whether these doctors returned home, went to another country, or remained in the UK but not practising as doctors.

Chapter 2: Building supportive, learning cultures

Introduction

In recent years, there have been significant changes within O&G as a specialty. More pregnancies are higher risk due to rising levels of obesity, women with more complex medical problems becoming pregnant, increasing maternal age and more widespread use of assisted reproductive techniques. Staff working within the specialty not only have to deal with the clinical aspects of complex medical situations but also provide emotional support. Furthermore, there is the weight of public expectation that pregnancy should always entail a healthy outcome for mother and child and that any digression from this is indicative of medical negligence.

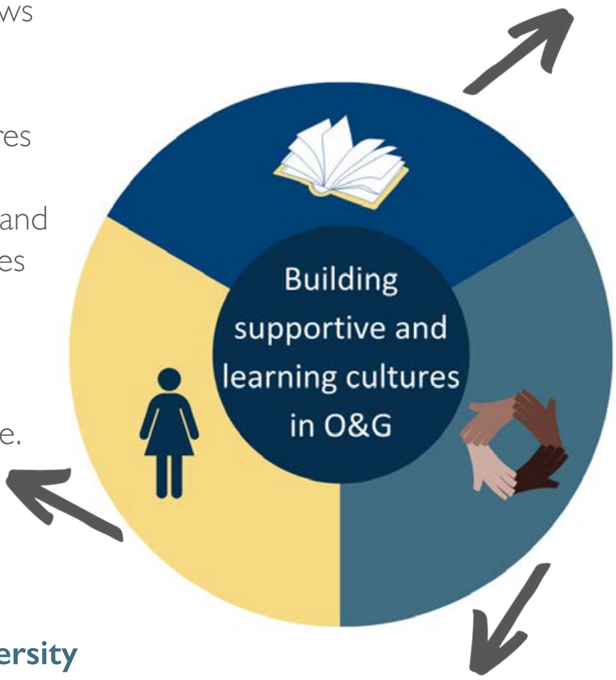
Alongside this, there have been major workforce changes. Many smaller maternity units have merged into larger units with doctors now generally working in larger teams in busier units. The implementation of the European Working Time Directive (EWTD) means that many doctors now work set shift patterns rather than within designated 'firms' with the support and mentorship of one consultant.

All of these factors have led to considerable change and pressure for the O&G workforce. It is therefore important that there is adequate support in place for individuals.

How does this chapter relate to our values?

Person-centred care

- Actively seeking the views of women and working in partnership with them to co-produce services ensures that services are person-centred in their approach and helps unify values, objectives and language.
- Ensuring staff are well supported leads to more compassionate patient care.



Learning

- Facilitating organisational learning from all aspects of work, including adverse events.
- Using routinely gathered data and staff and patient feedback to continually drive improvements.
- Recognising the role that women and families have in contributing to the education of healthcare professionals.
- Acknowledging the role of team reflection in building empathy and supporting positive cultural change.

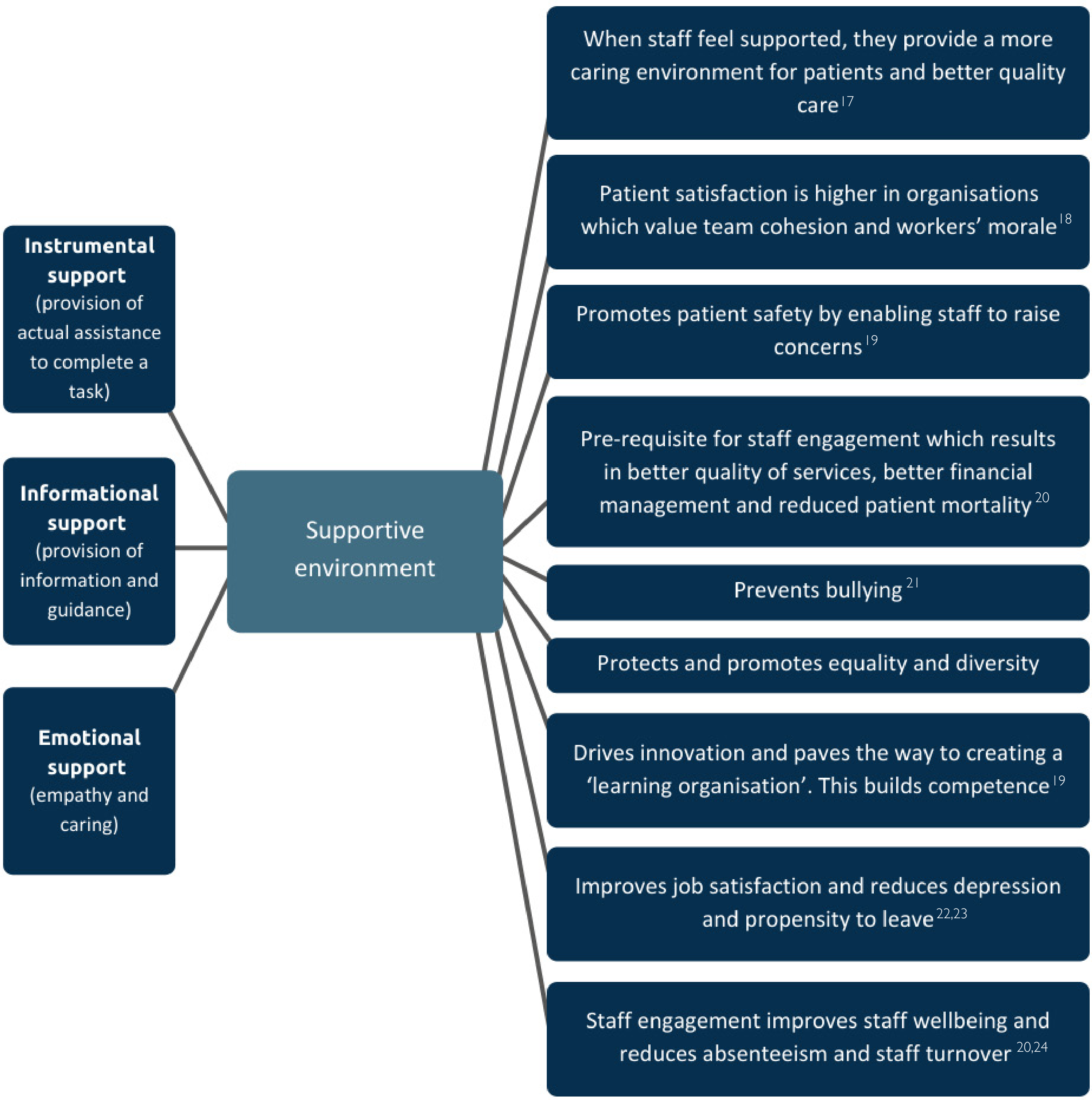
Diversity

- Working with women to co-produce services ensures that a breadth of opinion is heard and helps drive innovation.
- Providing support for staff helps retain diversity within the workforce.
- Adhering to principles of Just Culture so all staff are treated fairly.

What constitutes a supportive environment and why is it important?

Supportive environment:

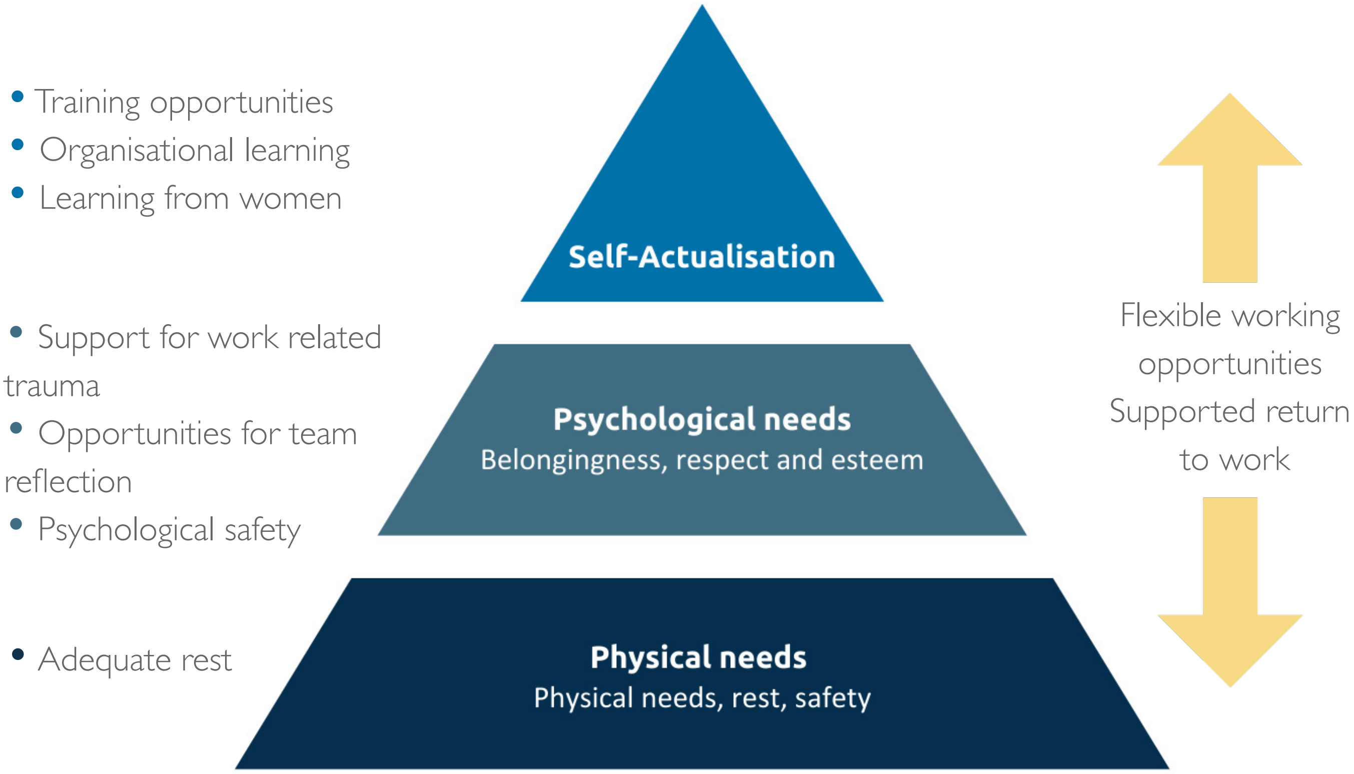
Somewhere which offers protection from factors which can threaten good health, which fosters participation and lets people expand their capabilities and self-reliance.
Ottawa Charter, WHO 1998[16]



What makes a supportive work environment?

A supportive environment meets a person's physical, psychological and self-actualisation needs.

The following diagram summarises how this can be applied to O&G.



A 2018 mixed-methods study involving semi-structured interviews and a survey of 152 O&G doctors[25] found that the factors most conducive to a supportive environment were:

- Feeling valued and being listened to
- Educational supervision / training opportunities
- Provision of instrumental support
- Cohesive team working and shared values

Key barriers to creating a supportive environment were:

- Rota gaps
- The conflict between service provision and education
- A blame culture

The factors which made doctors feel valued were being listened to and colleagues saying 'well done' and 'thank you'.

The following chapter examines what can be done at a local, regional and national level to create supportive environments that help meet the physical needs of the workforce, provide psychological safety and emotional support and create organisations which embed learning from events, staff and women. Further information regarding flexible working opportunities can be found in the flexible working chapter.

Physical needs

Providing adequate rest

- Fatigue and sleep deprivation have short-term and long-term health implications for doctors.
- Unlike other industries such as aviation, recommendations are not consistently embedded.
- The BMA 'Fatigue and Facilities Charter' sets out expectations and encourages trainees to exception report when they do not get their breaks. A comparable system for SAS, LE doctors and consultants should also be in place. This may be the only way to start to demonstrate the true monetary cost, if not the personal cost, of missed breaks.

Effects of sleep deprivation

Short term

- Impaired concentration
- Mood changes
- Slowed reaction time
- Increased risk of accidents
- Memory issues
- Impaired immune system

Long term

- Increased risk of obesity
- Increased risk of developing various medical conditions including high blood pressure, diabetes, stroke, cancer and Alzheimer's disease

Useful resources

Mike Farquhar, Sleep Consultant at Evelina London Children's Hospital, provides a compelling physiological argument for the importance of good sleep habits and rest breaks to be able to continue working effectively in the short and long-term throughout one's career.

- **Sleep: Looking After Your Wellbeing**
- **Sleep, the best medicine**
- **How many hours sleep do you need?**

The Royal College of Anaesthetists have done considerable work looking at the effects of sleep deprivation and how doctors can be better supported at work to ensure they have adequate rest. Some useful resources can be found here:

- **Tips for working night shifts**
- **Standards for rest facilities**
- **Useful tips to aid sleep**

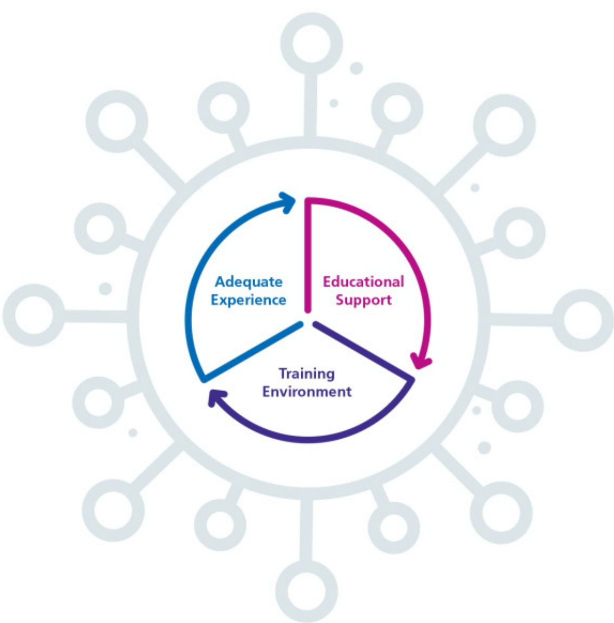
Case Study: The Midlands Charter

What is it?

- The Midlands charter is a region-wide charter comprising three areas:
  - ✓ Providing a supportive training environment including rest and food facilities
  - ✓ Ensuring adequate experience
  - ✓ Providing emotional support.
- Trusts sign up to the charter and aspire to meet the needs.
- This is supported by trainees, the education team and the wellbeing team with sign up from the whole trust.
- It provides practical examples of how to achieve this particularly within scarce resources. Often the human support and acknowledgement of the difficulties go a long way to help resolve them.

Midlands' Charter

NHS



1. Ensuring adequate experience

- [ ] Consult with trainees and schools when making rota changes likely to impact on training.
- [ ] Consult with Health Education England (HEE) at the earliest opportunity when planning service reconfiguration.
- [ ] Ensure that trainees have access to NHS contracted work conducted in the independent sector with training opportunities equal to those provided within the NHS.
- [ ] Facilitate bespoke employment arrangements to allow trainees to catch up on curriculum competencies.

2. Providing educational support

- [ ] Use the consultant job planning process to ensure sufficient time is given for educational and clinical supervision.
- [ ] To continue to provide employer support/counselling services with full access for trainees.
- [ ] Ensure provider IT systems enable access to HEE provided teaching platforms.
- [ ] Ensure medical education and training is represented and discussed at executive board level.

3. Creating a supportive training environment

- [ ] Create quiet, non-clinical areas for trainees to attend virtual teaching.
- [ ] Commit to ensuring trainee representation in leadership, management and employee networks.
- [ ] Provide high quality rest, sleep and changing facilities.
- [ ] Commit to providing 24-hour access to food.
- [ ] Make the necessary changes to educational and common areas to allow them to become COVID-secure.
- [ ] Commit to ensuring adequate time is given to trainees for educational supervision and other supporting activities, such as conducting audits and research.

NHS England and NHS Improvement – Midlands

Key findings

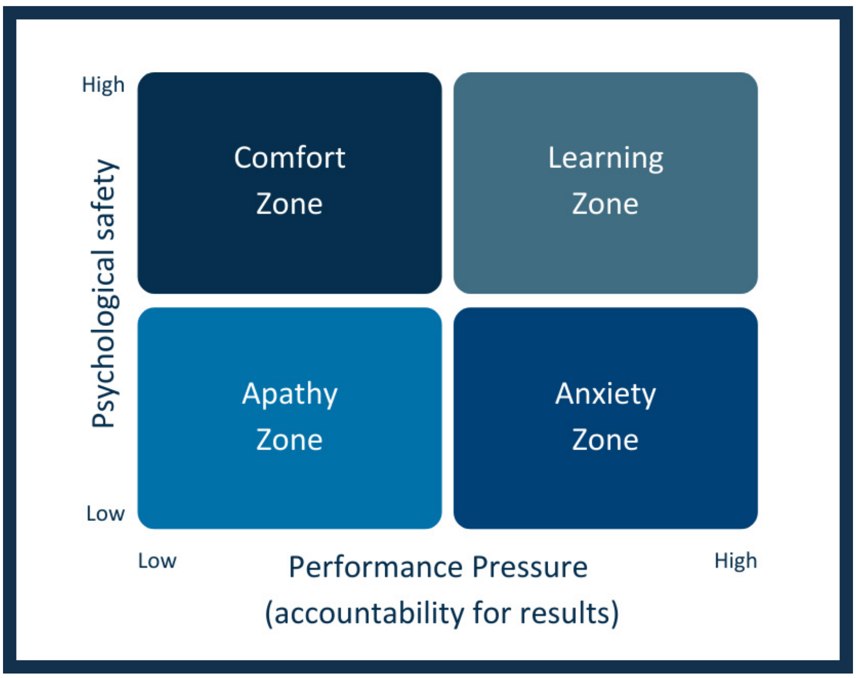
- Creating a supportive environment requires provision of informational, instrumental and emotional support with the aim of meeting an individual's physical, psychological and self-actualisation needs.
- Provision of adequate rest and food facilities help meet doctors' physical needs.

Psychological Safety

What is it?

Psychological safety:
A belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes. Edmonson, A[26]

Figure 12. Four key components of psychological safety



Why is it important?

According to O'Donovan and McAuliffe, "psychological safety allows healthcare professionals to take the interpersonal risks needed to engage in effective teamwork and to maintain patient safety".[27]

Key to the concept of team psychological safety is that it is created at team level, for example on a particular ward or department, or even within a particular 'on-call' team or labour ward team on that particular day, rather than a whole trust or health board. It is therefore something that all staff can impact, especially those in clinical leadership roles (including doctors in training, who often lead obstetric teams out of hours). For more information about other factors which aid effective team working, see the 'Multi-professional team working' chapter.

What can individuals do to improve psychological safety?

1.	**Frame the work as a learning problem, not an execution problem.** • Avoid placing blame ('Why did you do this?') and instead focus on solutions ('How can we work towards making sure this goes more smoothly next time?') • Emphasise the importance of everyone's ideas and contributions to the success of the work
2.	**Acknowledge your own fallibility.** • 'I may miss something, please tell me if you think I have got the wrong diagnosis/plan etc.'
3.	**Model curiosity and ask lots of questions** • Invite opinions from the whole team (from students to senior consultants).
4.	**Make it ok to 'call it out'** • Misunderstandings and poor behaviour, which are managed well and resolved fairly, are part of what makes a supportive and positive department. The **RCOG Workplace behaviour toolkit** provides more support on how to do this.

How can we assess it?

Information is already collected across the NHS which can be used to benchmark current psychological safety.

NHS Staff Survey	Includes questions which can be used to generate a 'Freedom to Speak Up' index (see the national Freedom to Speak up Guardians report) per trust or department.
GMC Survey and RCOG Training Evaluation Form	Include questions pertaining to how comfortable staff feel in raising issues with seniors.

A department could also examine the issue further by looking at any concerns raised via the **Freedom To Speak Up Guardian**.

For departments wishing to undertake deeper work into their culture, a number of safety and organisational culture surveys exist, including the SCORE survey used by the Maternity Transformation Programme in England.

Just Culture and Restorative Justice

How can we create Just Culture?

Just Culture:

"A just and learning culture is the balance of fairness, justice, learning – and taking responsibility for actions. It is not about seeking to blame the individuals involved when care in the NHS goes wrong. It is also not about an absence of responsibility and accountability."
NHS Resolution[28]

Restorative Justice:

Restorative justice aims to repair trust and relationships damaged after an incident using a collaborative approach to include all those who have sustained harm (including staff). **This checklist can aid the process.**

How can we create it?

The NHS Improvement Just Culture guide can be used to support a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

It asks a series of questions that help clarify whether there truly is something specific about an individual that needs support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counter-productive.

It helps reduce the role of unconscious bias when making decisions and will help ensure all individuals are consistently treated equally and fairly irrespective of their staff group, profession or background. This has similarities with the approach being taken by a number of NHS trusts to reduce disproportionate disciplinary action against black and minority ethnic staff.

Top tips

- To change culture, focus more on leadership behaviour and less on procedures
- Support patients and families affected by patient safety incidents to make the experience better for everyone
- Visibly and actively support staff when things become difficult, so they feel safe to be open and honest
- Invest in building good relationships with commissioners and regulators as they have a substantial impact on culture

Did you know?

Just Culture can be assessed in your organisation by looking at NHS Staff Survey results for the statement:

"My organisation treats staff who are involved in an error, near miss or incident fairly".

Responding to adverse events

Learning organisations are recognised as an important part of continually improving patient care. While much of O&G practice results in positive outcomes for patients, adverse events, particularly in obstetrics, can have devastating consequences for women and their families and for the staff involved in caring for them. A key element of creating positive cultures and a supportive working environment within O&G is the response to such incidents.

Whilst the focus of organisational learning is often learning from adverse events, valuable lessons can also be taken from analysing best practice and identifying what has gone well and why. An organisational culture that supports learning from adverse events is important because there is a need to both investigate incidents to protect women whilst also treating staff with compassion and ensuring that any criticism is constructive, proportional and recognises system errors rather than focusing on individual blame. Using routinely collected data to inform practice and identify strengths and areas for improvement strengthens organisational intelligence.

	1. Ensure good leadership Investigations must be led by those trained and experienced in patient safety incident investigation, with the authority to act autonomously and with dedicated time and resource.
	2. Focus on systems Investigations should be systems-focused, not individual-focused. Most incidents are caused by weaknesses in systems which lead to conditions that make it difficult for individuals to do the right thing.
	3. Use analysis techniques Investigations should use analysis techniques that facilitate a systems approach to identification of the interconnected contributory, human and causal factors.
	4. Prioritise listening Investigations should move from over-reliance on documentation and statements to increased use of listening, interviews, discussion and observation.
	5. Identify strengths Investigations should identify system strengths as well as problems (together with their associated mitigating and contributory factors).

	6. Encourage multi-disciplinary input The investigation team should be multi-professional , and where appropriate, include external members.
	7. Apply principles of Just Culture If concerns are raised about an individual's practice, these should be dealt with according to the principles of Just Culture (see Just Culture section).

Further information:

- New Patient Safety Incident Response Framework

Family involvement

Delivery of person-centred care relies on prioritising the needs and preferences of women. This extends to ensuring the involvement of women and their families in investigating adverse events, enabling their views to be heard, valued and respected. It also offers the additional benefits of reinforcing learning opportunities for staff to improve systems and future patient care.

The woman and her family should be empowered to tell their story as part of the investigation. (Healthcare Safety Investigation Branch (HSIB) provide resources and training in **Giving Families A Voice**).

As well as involving families in the fact-finding for the investigation, it is important to offer families a point of contact within the organisation for ongoing support. They should also be signposted to external organisations (e.g. **SANDS**) who can provide additional support.

The PARENTS-2 study

- Looked at parental involvement and engagement in the Perinatal Mortality Review (PNMR) process.
- It found that bereaved parents agreed that engagement in the PNMR process was invaluable and helped them in their grieving.
- It also found that staff felt that parental involvement improved the review process and lessons learnt from the deaths; there were instances where parents could recollect information which was not recorded in the medical notes.
- This is turn helped identify the cause of death or resolve care or system delivery problems thereby improving organisational learning and patient safety.

Support for staff

Involvement in clinical care leading to adverse outcomes can be a significant source of psychological distress for O&G doctors and other healthcare professionals. Psychological support provided by departments can be highly variable and dependent on informal networks of peers and colleagues.

One survey of trainees[29] found that 90% had encountered a clinical event at work that left them feeling anxious, but under 5% had been offered any form of psychological support through their workplace. 77% would be interested in regular sessions of peer support facilitated by a trained psychologist. Another survey of O&G doctors found that less than a third of respondents felt that they regularly had opportunities to reflect with their team.[25]

Departments should consider the inclusion of regular protected time for doctors to discuss the emotional and psychological impact of work, such as Schwartz rounds, sessions with a dedicated psychologist and/or Balint groups, as well as individualised support when required following adverse outcomes.

Schwartz Rounds

- Schwartz Center Rounds originated in the US in 2001.
- They are an opportunity for all members of the healthcare multi-professional team to discuss a difficult case.
- The aim is not to focus on the clinical specifics but rather the feelings individuals experienced whilst caring for the patient.
- It is an outlet for staff to share their emotions, realise that these feelings are often mirrored in others and dispel the sense of isolation which can often accompany traumatic events.[32]
- There is also evidence that Schwartz Rounds may help overcome organisational hierarchies, promote shared values, improve staff psychological wellbeing and strengthen team-working.[33,34,35]
- Trusts wanting to implement Schwartz rounds can access resources to support this **here.**

Balint Groups

- Balint Groups originated in the UK in the 1950s.
- They are a way for teams to discuss complex clinical scenarios or situations where doctors have found it difficult to engage with a patient.
- The main aim is to create a safe space amongst colleagues to talk about interpersonal aspects of work.
- They also aim to help develop doctors' empathy towards patients and enable them to gain a deeper understanding of their own emotions.

The INDIGO and POPPY projects

- Work-related trauma and symptoms of post-traumatic stress disorder (PTSD) are common in midwives and obstetricians due to the frequent potential for time-critical clinical incidents to occur which could threaten the life of the mother, fetus or baby.
- PTSD symptoms have been associated with loss of confidence, increased burnout, less compassionate care and greater levels of absenteeism and attrition from the profession.[30,31]
- The INDIGO study (Investigation into the experience of traumatic work-related events in gynaecologists and obstetricians) was a mixed-methods study involving a survey of 1095 O&G doctors followed by 43 in-depth interviews to assess PTSD-type symptoms amongst O&G doctors. It found that 18% of O&G doctors reported clinically significant PTSD symptoms.[30]
- The INDIGO study[30] concludes by recommending the following:
  - Education for all staff about work-related trauma and self-help
  - Development of a system to routinely provide support to staff after any serious incident
  - Rapid access to trauma-focused psychological intervention
  - Reviews of trust guidelines after serious incidents to ensure staff care is included
- The POPPY project (Programme for the Prevention of PTSD in Midwifery) reported that 33% of midwives report PTSD symptoms. The POPPY intervention comprises an interactive training programme workshop, peer support and referral and access to psychological assessment and input.
- You can read more about this important work in a blog from the project team on the RCOG website **here**.

Supported Return to Clinical Practice

Background

- A break of three months or longer from clinical practice can be associated with a loss of clinical knowledge, skills and confidence.
- The Academy of Medical Royal Colleges recommends that any doctor returning to clinical practice after a break of three months or longer should be supported through this process.
- The type of support should be tailored to the individual's needs and will depend upon factors such as length of absence, reason for absence and career stage.

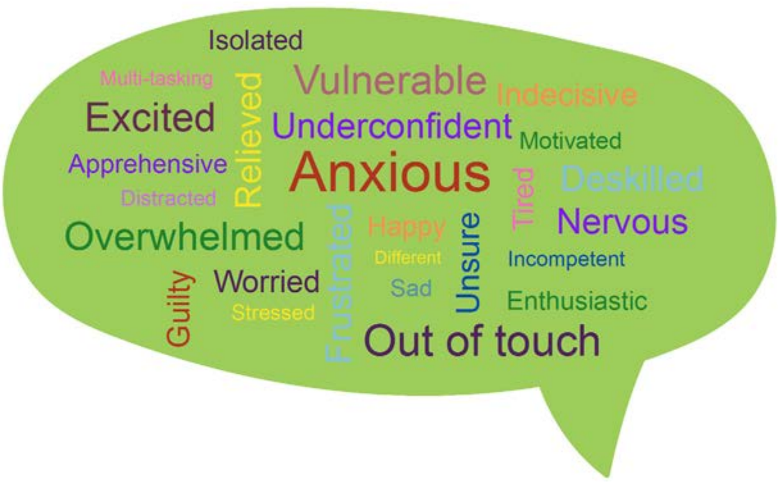
- The **HEE SuppoRTT programme** is a national scheme to provide guidance, resources and signposting to trainees in all specialties returning to clinical practice.
- The HEE **Career Refresh for Medicine (CaReforMe) programme** is aimed at doctors (other than trainees) who have had a break of three months or longer from clinical practice. This includes those new to the NHS, those who have had a career break, SAS and LE doctors and consultants.

What can help a doctor returning to clinical practice?

- Careful planning with their educational supervisor or line manager prior to the absence (if possible) and prior to return.
- Using 'Keeping in Touch' clinical sessions and courses to refresh knowledge and skills.
- A phased return to clinical responsibilities, particularly out-of-hours shifts, until they have regained their skills and confidence. Ideally, time should be spent in a supernumerary capacity.
- Mentorship during the immediate period post-return.
- Support and understanding from all colleagues to help rebuild familiarity and confidence.

Further information:

- **The RCOG Return to Work Toolkit**



Key findings

- Psychological safety is important for building cultures of trust, openness and learning amongst teams.
- Responding to adverse events requires a balance between investigating with due diligence while treating staff with compassion and recognising human fallibility. It is important to take a systems-based approach based on the principles of Just Culture and Restorative Justice rather than apportioning individual blame.
- Involvement of families in adverse incident reviews ensures their voice is heard and improves organisational learning.
- Schwartz Rounds and Balint Groups are both ways in which teams can reflect together, learn and support one another after difficult cases.

Self-actualisation

Creating learning cultures

The final level of Maslow's hierarchy of need outlines the requirement for self-actualisation. In terms of creating a supportive work environment in O&G this includes training opportunities, creating learning organisations and learning from women. It applies to all doctors at all career stages, not just trainees.

Training opportunities are traditionally considered to be those concerned with acquiring and advancing clinical skills and knowledge. While this is certainly true, it also applies to non-technical skills such as communication skills, team working ability and leadership expertise. Indeed, these skills are equally important to delivering person-centred care and creating positive workplace cultures. Identifying training needs should be a balance between an individuals' career interests and aspirations and the current and predicted needs of the service. For further information on this, see the 'Workforce Planning' chapter.

Women play an important role not only in service design and improvement but also in contributing towards the investigation of adverse incidents and the education of all O&G healthcare professionals. Gathering patient feedback is well established but to truly learn from women, their views must be included, listened to and respected throughout all clinical and governance aspects of the specialty. Including this diversity of opinion is key to understanding the needs of all women who receive O&G care, irrespective of age, ethnicity or location in the UK.

10 ways departments can prioritise learning in O&G

	**1. Include everyone** There should be a focus on education, training and career development for all doctors, not just trainees.
	**2. Involve the whole multi-professional team** Training should include all members of the multi-professional team (doctors, nurses, midwives, sonographers and allied health professionals). Doctors should be trained by other healthcare professionals and vice versa. For further information on this see the 'Multi-professional team working' chapter.
	**3. Protect teaching time** Doctors must have protected time for teaching and training. Embed educational needs within the rota. The College Tutor or another consultant with an interest in education and training should oversee the rota. For further information on this see the 'Flexible working' chapter.
	**4. Allocate resources** Education must be prioritised by leaders and managers when allocating resources and budget. There needs to be access to an appropriate physical environment and sufficient resources for learning (e.g. simulation models).
	**5. Dedicate consultant time** Ensure consultants and SAS doctors undertaking educational lead roles have adequate time within their job plans to undertake the role. Encourage use of Supporting Professional Activities (SPA) time for education and promote it as equally important as other lead roles such as risk. Appoint new consultant colleagues and specialist doctors who have a track record in education and are motivated to train.
	**6. Encourage feedback** Have effective mechanisms in place to give and receive feedback between trainers and trainees. Act on feedback. If there are concerns, complaints or compliments involving a trainee, ensure these are always passed through to the educational supervisor or college tutor.
	**7. Pair trainers and trainees** Match educational and clinical supervision with the education and career aims of doctors.
	**8. Create on-call pairs** Match a regular pair of junior and senior trainees whilst on call to maintain their training environment and develop their supportive relationship.
	**9. Support SAS & LEDs** Ensure SAS & LE doctors are supported in their learning, tailored to their career stage, experience and aspirations. Ensure SAS doctors are signposted to the SAS Tutor (or equivalent) in their organisation.
	**10. Allocate SPA time** Allocate SPA time for SAS doctors (minimum 1 SPA/week according to national T&Cs).

Learning from everyday work

Departments should embed processes to learn from all work that occurs, whatever the clinical outcome. This includes learning from what goes well (as the majority of work within O&G does) as well as learning from adverse outcomes.

Triangulate information

A huge amount of information is recorded on a daily basis regarding patient care and outcomes, particularly within maternity. It is, however, important to recognise the value this information holds in its potential to improve patient care. Quality improvement, education and risk departments should work together to share information and determine areas of focus.

Seek and act upon feedback

Qualitative feedback serves as an important 'temperature check' on how services are running. This should be sought on an ongoing basis from both staff and patients and their families. This can be done in formalised ways including the NHS Staff Survey, the GMC survey and the RCOG TEF for staff, and Friends and Family feedback from patients. It can also be gathered informally, just by listening to staff during meetings and patients during consultations and debriefs.

It is important, however, not to just collect this data but also to collate and analyse the findings. Identifying key themes and trends can be extremely useful in helping to inform ongoing training and service development.

Recognise good practice

Departments should have a way to formally recognise and reward good practice, such as the '**Learning from Excellence**' (LfE) programme. This is similar to incident reporting, but rather than report adverse events, staff report when something has gone well so that those involved can be recognised for their contributions and learning from the incident can be disseminated amongst the team. The **LfE how to set up checklist and LfE top 10 tips** have been created for individuals and organisations wanting to implement the programme.

There is evidence that formal, positive feedback can have a beneficial impact on staff behaviours and overall outcomes.

The PRAISe Project (Positive Reporting and Appreciative Inquiry in Sepsis)[36]

- Learning from Excellence methodologies i.e. reporting positive events and appreciative inquiry (focusing on strengths rather than weaknesses) were employed to try to change clinician behaviour regarding antibiotic prescribing.
- Four key process measures were identified, and excellence in these processes was highlighted and reported through LfE, providing formal positive feedback to clinicians.
- Selected reports were followed up with 'appreciative inquiry' interviews.
- Insights gained were shared to generate change across the wider team.
- Following the intervention, use of antibiotics decreased by 6.5% from the equivalent period the previous year. There was also a 31% improvement in broad-spectrum antibiotic use.

Co-production with women

In recent years, there has been increasing recognition of the importance of listening to women in order to improve the care that O&G services provide. This takes many forms. The need to involve women in decision-making around their care, seek and respect their wishes and obtain informed consent are well established. Seeking feedback, both informal and through structured tools such as 'Friends and Family', is now commonplace. However, actually involving women in all aspects of service design and development remains more elusive.

What is co-production with women?

Co-production:
Working in equal partnership with women to make services more effective, efficient and sustainable.

Delivering person-centred care is not only about women being involved at an individual level regarding decisions about their own care. It also encompasses patient involvement at a meso- and macro-organisational level whereby patients are involved in service redesign and appraisal.[37] Unlike feedback, co-production involves working with women through all stages of service improvement and change implementation. It involves recognising women as 'experts by experience' and valuing and respecting their views and contributions. This can be done at a departmental, organisational, regional or national level.

Why is co-production important?

Co-production is important in terms of truly understanding women and what matters to them. It offers a different perspective to that of healthcare professionals alone. This diversity offers many benefits in terms of driving innovation and finding solutions to complex problems as well as offering the opportunity to ensure that views and opinions represent the diversity within the local population. Listening to women is also important in terms of organisational learning and ensuring a culture of continual improvement. The Francis Report highlighted 'no culture of listening to patients' as a failing of Trust Management in Mid-Staffordshire.[38]

Case Study – Service-User Involvement in the North Wales Women's Directorate: Gynae Voices

Who?

- Debbie Schaffer
- Fair Treatment for Women in Wales (FTWW)

Background

- In 2019, the North Wales Betsi Cadwaladr University Health Board (BCUHB) Women's Directorate reached out locally to women's health charity, Fair Treatment for the Women of Wales (FTWW) to establish a 'Gynae Voices' forum where women could regularly feed into the development of gynaecology services in the region.
- The forum is multi-professional, bringing together those who use and those who provide gynaecology services within the Health Board and has wide and varied participation from women across the region with a wide spectrum of gynaecological conditions.
- The forum meets formally on a quarterly basis, with agreed membership and terms of reference. Its aim is to ensure that patients, clinicians and management work together to develop and evaluate women's healthcare in the locality so that it is efficient and effective for all parties, improving outcomes for service users and providers alike. Outside of the formal meetings, emails and ad-hoc meetings enable work to progress in a timely way.

Benefits

- The Gynae Voice forum provides a vital and regular opportunity for women to engage with local service providers as equal partners in the design, delivery, and evaluation of the healthcare services they use.
- Women know their voices are being heard – they have actively participated in the development of new initiatives and services including: a successful business case for a specialist menopause clinic in North Wales; development of outpatient hysteroscopy services; a review of fertility and endometriosis service pathways and provisions; an audit of patient-reported outcome measures in minor gynaecology procedures.
- BCUHB staff can bring questions to patient members, including around content and style of written communications with women, guidance for clinicians and possible new service models.
- Patient members can bring issues of concern to the Health Board.

- Involvement of Gynae Voices provides assurance to other women that gynaecology services are person-centred.
- Co-production helps to ensure efficiency and better outcomes by embedding person-centred care, needs, and preferences right from the start of the design process, rather than consulting on services afterwards.

Challenges

- Establishing meeting times which are conducive for all members to attend.
- Establishing regular clinician attendance at meetings.
- Accessibility when holding meetings in person as members come from a large geographical area
- Digital exclusion when holding meetings online.
- Lack of financial support for women e.g. travel costs for in-person meetings.
- Lack of secretarial support.
- Managing expectations of clinicians, management and women. Women are volunteers and patients so their wide and varying personal circumstances must be considered and accommodated. Similarly, a certain amount of pragmatism is required because not all aspirations can be achieved due to organisational and financial restrictions.

> **Patient engagement is vital to ensure that any service developments are truly inclusive and representative of patient's needs. Service user contributions have been invaluable.**
> Co-Chair, Gynae Voices Forum

Key learning points

- Maintain engagement from all stakeholders. Forums of this nature need strong, motivated and encouraging leadership from women and providers alike.
- The service itself needs to be fully and properly engaged with the process of co-production for it to be successful. It is not just a box to be ticked.
- It may take time and persistence for co-production to be fully embedded into practice and into the culture of the organisation.
- All participants need to be pragmatic about expectations and be prepared to compromise.
- Be realistic with timescales. Co-production takes time, effort and negotiation. The key is to be transparent and maintain regular communication.

- Ensure 'succession planning' is built into the work and do not rely too heavily on one individual clinician or woman to be the flag-bearer for activities.
- Publicise successes and be transparent about challenges and work in progress.

“

Our established way of working in partnership is paramount to real engagement with users in service planning, development, improvement and learning.

Director of Midwifery and Women's Services

Top tips

- Network! Research the existence of patient-led, grassroots communities and organisations and charities in your locality and do not be afraid to reach out to them.
- Do not make assumptions – even the basics, such as where, how often, and in what form to hold conversations need to be discussed and mutually agreed.
- Secure funds to support women's involvement, such as travel expenses, refreshments and administrative support.
- Maintain communications between meetings.
- Be aware that creating a safe, open, productive space takes time. It is important to be aware of historical power imbalances, which may affect relationships in the first instance and be prepared to work at overcoming them.
- Don't hesitate; do it today! It changes the way we work and delivers services for the better.

Case Study – The Perinatal Pelvic Health Services Implementation Reference Group: an example of co-production with women for a national project

Who?

- Emma Crookes
- National Service User Voice Representative

Background

- Better Births identified a need to improve postnatal services for women.
- Around 1 in 3 women experience urinary incontinence postnatally but NICE and a study by the NCT suggest it is under-reported.
- An NHS England Expert Reference Group on Postnatal Care identified regional variation in the services available to women postnatally with pelvic floor problems, referral pathways and quality of information available to women.
- As part of the Long-Term Plan[39], NHS England and Improvement has committed to improving access to postnatal physiotherapy by 2023/24 and ensuring that all women have access to multidisciplinary pelvic health clinics and pathways across England.

What happened?

- As part of the Maternity Transformation Programme, a multidisciplinary group called the 'Perinatal Pelvic Health Services Implementation Reference Group' was established. This included representation from doctors, physiotherapists, midwives and me, as a service user.
- The group listened to my lived experiences, as someone affected by pelvic floor issues and my experience of treatment, including aspects of care that had not been positive.
- I became an integral part of the multi-disciplinary team, working with healthcare professionals to:
  - ✓ Develop systems guidance notes
  - ✓ Provide evidence for a rationale for responsibilities
  - ✓ Appoint 25 early implementer sites
  - ✓ Determine key performance indicators and patient reported outcome measures
  - ✓ Co-create a survey of pregnant and post-partum women regarding their knowledge and experiences of pelvic floor health.

What has been achieved?

- There are currently 14 systems providing Perinatal Pelvic Health Services to local pregnant and postnatal women and people as Early Implementers.
- These systems are engaging with their local populations to create a new pilot service. Each quarter, they report on their progress, key milestones, challenges and service user voice input.
- There are now two National Service User Voice Representatives on the Reference Group, and we are currently co-producing a webinar and online platform for service user voices from each Early Implementer System in partnership with the Project Manager. This will facilitate networking and shared learning and offer support and peer leadership development to each other.

Challenge culture:

If you do what you've always done, you will get what you've always got.

Key findings

- It is important that women are seen and listened to.
- Involve 'experts by experience' from the beginning.
- Women should be cared for by a healthcare professional, not just given a leaflet.
- I learnt that often healthcare professionals and I were talking about the same thing but using different language.
- It has been important to challenge language sometimes e.g. 'normal delivery'.

Case Study – ‘Whose Shoes?’ maternity experience initiative

Where?

Workshops run nationally and internationally across different specialities for various healthcare providers

What is ‘Whose Shoes’?

- ‘Whose Shoes?’ is a series of tools and workshops to help individuals understand various clinical scenarios and topics through different perspectives in the hope of aiding healthcare professionals to become more person-centred in their approach to patient care.
- It encourages participants to ‘walk in other people’s shoes’ to explore the concerns, challenges and opportunities facing the different groups affected by the transformation of health and social care.
- Issues are explored from the perspectives of:
  - ✓ Women and their families
  - ✓ Front-line staff
  - ✓ Managers and leaders, including commissioners
  - ✓ Others who influence people’s experience
- It was originally based on a board game; ‘Whose Shoes? – Putting People First’. This is then used as a catalyst to break down barriers, engage individuals and provide the conditions for people to speak freely.
- The original concept was created by Gill Phillips. The Maternity Experience version has been developed in collaboration with NHS England, the London Strategic Clinical Network and Florence Wilcock, Consultant Obstetrician.

Working together with women

It is not simply about listening to women but about working together with women. Rather than ‘You said, we did’ often quoted in a response to patient feedback, we prefer the saying ‘I said, I did’: **the women are integral to the improvement work.**

Leigh Kendall, a bereaved mother, wrote **this powerful blog** which explains more.

The 'Lithotomy Challenge'

- Florence Wilcock, Consultant Obstetrician, spent an hour in lithotomy position (legs in stirrups as is often used during instrumental birth or stitching).
- She has written a blog describing how she felt physically, how her perception of the delivery room environment differed, how people entering the room interacted with her and how the experience has changed her practice as an obstetrician.
- This work has been highly influential in training other healthcare professionals.
- More info can be found **here**.
- Sarah Winfield, Consultant in Obstetrics & Maternal Medicine in Leeds and now Regional Lead Obstetrician NE and Yorkshire **wrote a blog** with powerful reflections on her experience.

How can you get involved?

- Read our case studies – and support the development of more:
  - ✓ **#MatExp Case Studies - original**
  - ✓ **Case Studies Nobody's Patient**
  - ✓ **Case Studies - #MindNBody**
- Consider running a workshop: - **here's** how it all works.
- Try and attend an event elsewhere before holding your own.
- Check out the **Whose Shoes® Padlet** for more examples and ideas and to see some films of workshops in action – the approach is used in many other specialties too.
- After the event: share the learning with the wider team – use of newsletters, posters, graphic recording; writing an engaging report.
- Tap into people's passions. Dream it, believe it, achieve it.
- Use creativity to share good practice and draw people in – storytelling, videos, poems, music.
- Reward action – it's amazing what people will step up and do for a mini shoe, sticker, sash, or badge. Little incentives work and act as a token to remind people of their pledge.
- Support people to deliver their pledges; help them connect with others.
- Make it inclusive; make it human and make it fun.

Further information:

- Florence Wilcock, Consultant Obstetrician, Lead Obstetrician for perinatal mental health, Kingston Hospital NHS Foundation Trust: Twitter @FWmaternity
- Gill Phillips, Creator of Whose Shoes?® : Twitter @WhoseShoes

Key recommendations

- Regular multi-professional training opportunities in both clinical and non-clinical skills should be available and accessible to all doctors, not just trainees.
- Quality improvement, education and risk departments should work collaboratively to ensure that routinely collected information, including staff and patient feedback is used to drive continual improvement and embed organisational learning.
- Co-production with women entails working with them as equal partners through every part of service design, development and improvement rather than just asking them for feedback. It is key to hearing a diversity of opinions and ensuring that care is person-centred.

Chapter 3: Flexible working

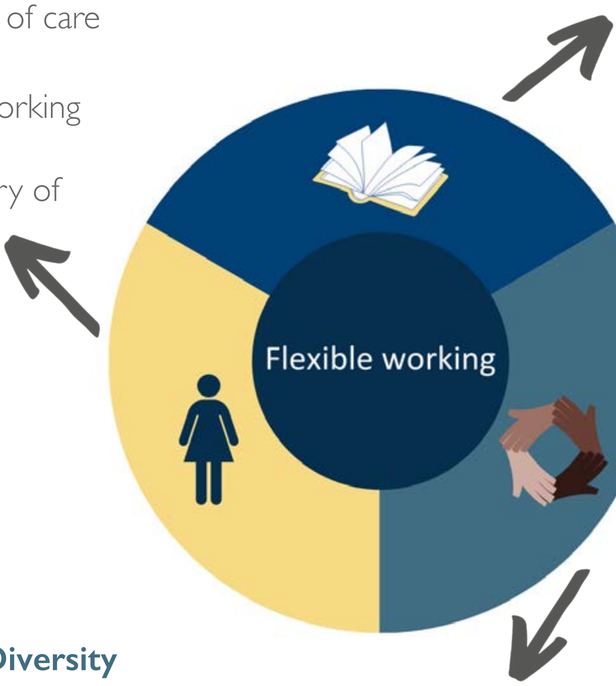
What is flexible working?

Flexible working is a term which has traditionally been synonymous with working less-than-full-time (LTFT). However, while LTFT working constitutes an important part of flexible working, there are many other ways in which individuals can work flexibly. Flexible working is not just about the working arrangements of individuals but is also about creating ways of team working which promote flexibility, resilience and cultures of co-operation within organisations.

How does this chapter relate to our values?

Person-centred care

- Improving continuity of care to women
- Models of flexible working which prioritise not compromise the delivery of person-centred care.



Learning

- Creating opportunities for mentorship and learning at all career stages and across the multi-professional team.
- Improving learning opportunities for trainees, SAS and LE doctors through 'modern-day firm' models of working and team job planning.
- The role of out of programme experiences, career breaks and sabbaticals in promoting learning.

Diversity

- Acknowledging the diversity of roles and individuals within the O&G workforce
- Recognising the need to facilitate flexible wokring to promote job satisfaction and workforce retention at all career stages.

Why is flexible working important?

Adopting flexible working is important for individuals and organisations. Clinical activity, clinical complexity and governance processes are not the same now as several decades ago. There is therefore a need to recognise these changing circumstances and adapt how the profession works to optimise its ability to provide the best care possible for women.

The NHS is facing severe staff shortages and budget constraints, leading to high reported rates of stress and burnout among the workforce.

As discussed in the 'Building learning, supportive cultures in O&G' chapter, different ways of working, which better suit the needs of women and staff, must be urgently identified.

A study of O&G doctors in 2019 showed that just under half of trainees and a third of consultants and SAS doctors reported feeling burnt out.[40] Burnout has been identified as one of the leading causes of attrition rates which, as discussed in more detail in the 'Workforce Planning' chapter, have previously been as high as 30% in the specialty.[10]

Flexible (adj)

1. Capable of bending easily without breaking.
2. Able to be easily modified and adapt to altered circumstances

Flexible working is important for organisations. Reducing feelings of burnout will reduce the human and financial costs of absenteeism and attrition. Retaining staff is important for organisational memory and upskilling the workforce through teaching and mentoring. Giving doctors greater flexibility to attain new skills, either through research, overseas travel or leadership activities, stands to benefit individual and organisational learning in the longer-term. This is important for all units, however smaller hospitals in rural and remote areas may particularly benefit from enabling doctors to work flexibly. For more information, see the 'Remote and Rural Working' chapter.

Flexible working is also fundamental to supporting diversity within the workforce. O&G has the highest percentage of female doctors of any hospital specialty.[11] Statistically, women are more likely to want to adapt their careers to accommodate childcare. Therefore enabling flexible working is key to ensuring that the specialty retains this important part of its workforce. However, it should be acknowledged that increasing numbers of men are now opting to work LTFT due to caring responsibilities. Flexible working can also be an important way of helping those with chronic health problems to pursue or continue a career in O&G.

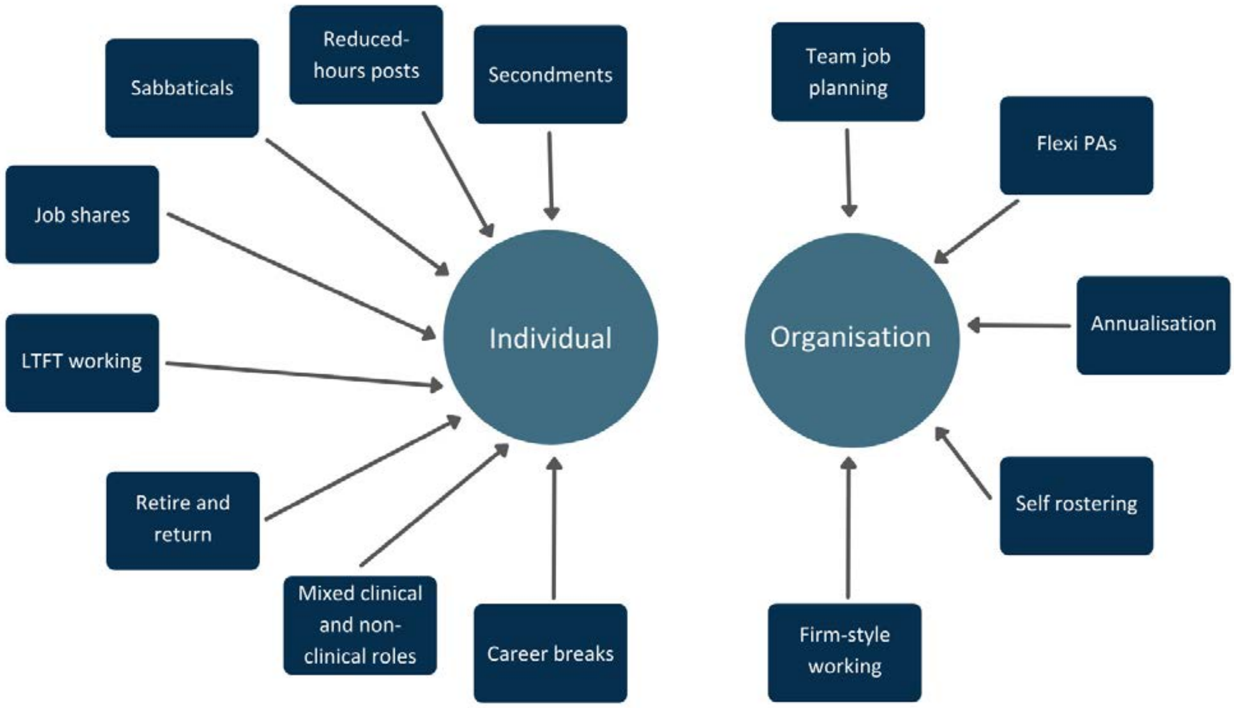
Furthermore, it is recognised that careers are becoming longer. The pension age has increased and many doctors are now working well into their sixties. O&G can be a physically demanding career, with a large proportion of out-of-hours working. Consequently, it is important to find ways to support those later in their career to stay working and ensure the profession can continue to benefit from their skills and experience.

Is flexible working to the detriment of patient care?

Concerns have previously been raised that widespread adoption of flexible working may impact negatively upon continuity of care for patients. This is indeed a challenge and therefore this chapter explores how flexible working is something that the whole department need to recognise and adapt to rather than being something applicable to only a few individuals.

It is important to acknowledge how flexible working may benefit patient care. Studies have shown that when staff feel well-supported, they are more likely to be more compassionate towards patients.[17] Recruiting and retaining a greater breadth of doctors enables the profession to retain skills, provide mentorship for clinical and leadership roles and helps drive creativity and innovation, all of which ultimately benefit women.

Flexible working may facilitate delivery of a greater number of services to women, particularly those living outside of major cities. For more information on this, see the 'Remote and rural working' chapter. Finally, flexible working stands to benefit women when doctors use the time to undertake research or acquire new clinical skills by working abroad. By engaging in a mutual exchange of knowledge and skills, doctors can bring benefits to women and the profession in the UK and also globally.



Flexible working enabled me to have a portfolio career and continue working in O&G following my diagnosis with cancer.

Working less-than-full-time gave me the flexibility to complete my MD and develop my clinical skills.

Flexible working since I retired has allowed me to contribute to obstetrics overseas and return to help my trust during the Covid-19 pandemic.

Flexible working has helped me maintain a good work-life balance with my wife and children and contribute to obstetrics in developing countries both as a trainee and a consultant.

> Flexible working gave me extra time with my children when they were younger and has enabled me to take on other roles in education later in my career.

What are the benefits and challenges of flexible working?

Organisation

Benefits

- Improves staff recruitment and retention. Ensuring that valuable staff are retained in the specialty and attracted from a wider talent pool improves patient care.
- Creates a more inclusive and diverse workforce.
- Reducing attrition reduces the costs of skills loss.
- Improves staff satisfaction which has in turn been linked to more compassionate patient care.
- Reduces the gender pay gap.
- Gives doctors time to acquire new skills in leadership, teaching or research which will benefit trusts and the NHS in the future.

Challenges

- Greater difficulty in delivering continuity of care to patients.
- Costs of mandatory training. Doctors working flexibly still have to complete the same amount of mandatory training per annum and therefore this is proportionally more expensive than full-time equivalents..
- Increased add-on costs (e.g. national insurance and pension).
- Potentially more complicated to fill rosters and manage rotas with more staff.

Team

Benefits

- Reduces burnout and sick leave.
- Having more doctors, some working fewer hours, gives the team more flexibility as there is a larger pool of staff to pull from when short or long-term absence cover is required. This may reduce the reliance on and cost of locum cover.
- Productivity has been proven to increase when people work flexibly.

Challenges

- More appraisals are required when there are more staff. If staff have more than one role (e.g. clinical and academic) then they may require more than one appraisal. This has both time and cost implications.
- Doctors working flexibly can be seen by their colleagues as not fully committed to the specialty and may result in challenging team dynamics. This requires a culture change which has started but is by no means complete.

	**Individual** **Benefits** • Improving doctors' work-life balance results in happier and healthier individuals. • Talented individuals do not have to make all-or-nothing career decisions. They can work flexibly throughout their career, increasing or decreasing their clinical commitments as required. • Taking on other roles may improve job satisfaction. • Doctors have time to gain more experience and expertise, potentially leading to an easier transition into consultant and senior leadership roles. **Challenges** • With a clinical/academic or clinical/management split, the individual reports to two line managers. This can create a conflict in expectations between organisations or line managers. • Doctors working flexibly may have slower career progression compared to full-time peers and in some circumstances this may be demoralising. • Some doctors working flexibly report a negative attitude by senior managers to flexible working. This is a cultural issue that is gradually improving.

Case Study – Flexible working through different life circumstances

Who?

- Susie Crowe
- O&G consultant
- Royal London Hospital
- RCOG Flexible Working Advisor

Flexible working due to children and work-life balance

I've always been interested in a pursuing a portfolio career. One of the reasons I went into obstetrics and gynaecology was due to the variety the specialty offers, and I enjoy the continuous learning and development that comes from working with different people, in different environments. I worked on a sessional basis as a sexual offences examiner for 10 years – both as a full-time, and then less than full-time O&G trainee after my eldest son was born. I am a passionate advocate for flexible working, having represented LTFT trainees regionally for several years. I became a full time Consultant Obstetrician and Gynaecologist in the year after my third son was born and at this point gave up my sexual offences role in order to balance work and life.

Flexible working for career diversity

I always knew I would diversify when the right opportunity came along and this arrived in late 2019 when I was appointed as Clinical Lead to the joint RCOG/RCM project Each Baby Counts Learn and Support (EBCL&S) on two PAs/week. I also continued to represent flexible working as Less than Full Time Advisor for the RCOG. I particularly enjoyed working with my counterparts at the other medical colleges, through the Academy of Medical Royal Colleges flexible working committee, to influence strategy to promote flexible medical careers.

Flexible working due to cancer

I had no idea that the experience I'd gained through the flexible working networks would help me navigate a different course for my own career so soon. The Covid-19 pandemic has taught us all that we have no idea what life really has in store. 2021 brought that home to me personally when I was diagnosed with non-Hodgkin lymphoma following around six months of deteriorating health.

It was clear I could no longer work clinically, but I could still provide some influence, leadership and oversight. My clinical lead role at EBCL&S fitted this perfectly. I'm lucky to have had a compassionate, kind team around me who enabled me to contribute extremely flexibly through this period of illness and treatment. I immediately sought approval from my trust to do part-time, freelance work in this way. It is in accordance with the terms and conditions of the NHS contract, as project work is so different to my clinical role, and was approved by a very supportive HR team.

I remain on immunotherapy and so can't yet return to my clinical role. In part this is because my health is still not back to baseline, but it's also because of my vulnerability to Covid-19. I therefore started looking out for other opportunities and have recently taken on a four PA role at NHSEI that I can deliver from home. I have flexibility across the week and can balance both my mental and physical health with meaningful work.

People often think you want to take a complete pause following a cancer diagnosis, but many doctors want to retain some sort of work – it anchors us and provides a sense of normality through all the turbulence.

Flexible working in my future

There remains a lot of uncertainty about my future. I'm not sure when I'll be able to return to the clinical job that I love so much, but I'm hopeful this will happen thanks to the incredible research that's going into Covid-19 immunity in blood cancer patients. I've also done a lot of work supporting trainees returning to work, unaware that this experience will empower me to advocate my own needs as a consultant.

The clinical role I return to won't be what I'd envisaged back in 2019, but it will be right for me at the time. In the meantime, I will ride the waves whilst navigating the right course for me. I hope that by sharing my personal story I will encourage us all to support our colleagues compassionately and flexibly, whatever life may have thrown at them.

Working patterns which support flexible working

There are a multitude of ways in which doctors can work flexibly. Some doctors may wish to arrange their working week to optimise the amount of time that they can spend at home. Others may wish to do as much of their work as possible during term-time. Equally, organisations find that the demands on the service ebb and flow and that adopting some patterns of flexible working can help meet these changing demands.

There are a variety of working patterns that may be used to support individuals' desire for flexibility as well as build resilience into organisations.

Compressed hours

What are compressed hours?

Doctors working compressed hours work their total contracted hours over fewer working days. For example, a full-time doctor could work 10 Programmed Activities (PAs) over four days rather than five days.

What are the potential advantages?

- Supports better work-life balance

- Supports all day theatre lists, evening clinics and evening meetings
- Improves use of office space especially if combined with home working

What are the prerequisites to success?

While compressed hours can bring benefits, it is important that doctors adopting this way of working retain some flexibility such as being willing to attend important meetings or events on their non-working day with appropriate notice.

Buddying

What is buddying?

A senior consultant or SAS doctor is paired with a less experienced consultant or SAS doctor. They usually have separate job plans but share some sessions together. It may or may not be combined with other types of flexible working e.g. retire and return.

What are the potential advantages?

- Helps less experienced doctors acquire new skills
- Provides mentorship and support to new consultants
- Provides opportunities for more senior doctors to teach

- Helps succession planning and to retain skills within the department
- Doctors may be able to provide some cross-cover for each other during leave

What are the prerequisites to success?

Clear communication at the outset regarding expectations and responsibilities is key. Those paired must both be willing to partake in the arrangement and maintain a positive working relationship.

Less-than-full-time working for consultants and SAS doctors

Types of LTFT working

Job sharing

- Two employees voluntarily share the duties and responsibilities of one full-time post.
- They have a similar remit of clinical skills and interests.
- Typically, they provide cross-cover for one another.
- They share the pay, leave and other benefits accordingly.

Job splitting

- A single post is split into two and two separate job plans are created
- The post-holders may have different remits of clinical interests and therefore do not provide cross-cover for one another.
- Pay, leave and other benefits are calculated according to the number of PAs each doctor works.

What are the benefits and challenges of LTFT working as a consultant or SAS doctor?

	**Organisation** **Benefits** • Better staff retention, reduced burnout, reduced sick leave and reduced staff turnover. • Sustains level of commitment and productivity in the longer term compared to one employee. • Increases productivity – doctors working LTFT often work more than their allotted sessions and together contribute more than one person in post. • LTFT arrangements increase the variety and seniority of work available to those not seeking full-time employment, without reducing the number of full-time jobs in the NHS. **Challenges** • Greater overhead costs initially including contract administration, salaries, office space and equipment, NI contributions for two rather than one post holder.
	**Team** **Benefits** • Complementary skill set and experience. • The arrangement increases flexibility: post holders cover for each other during leave.

	Challenges • In the event of crossover of case-load, explicit arrangement is needed concerning exactly which job-sharing partner has clinical responsibility. • In a job split, leave will affect their specialist clinics as it would with full-time employees.
	**Individual** **Benefits** • Maintains varied career options, such as research/academic interests or teaching and training. • Allows employees to pursue outside interests. • Increases employment opportunities for people with chronic health conditions or caring responsibilities. • Enables existing employees to reduce working hours (e.g. for personal/ domestic reasons or as a pre-retirement option). • Allows employees to broaden their experience and increase job satisfaction by undertaking a wider range of responsibilities at work.

Job sharing

The principle of proportionality should be applied to all entitlements e.g. annual leave, pension etc.

The hours/days/weeks agreed with either job sharer should always be such that should a vacancy occur, the working arrangement advertised will form a sufficiently viable package to attract new applicants.

In the event of the resignation or termination of one job share partner, the vacancy should not be advertised until the remaining sharer has been offered the opportunity to take up the remaining hours. If the individual is unable to take up these hours, the hours should be advertised. If the job share appointment cannot be made within three months of advertising, the job share may not be maintained by the trust.

Good communication is key to successful job sharing and will help overcome the obstacles.

Contract considerations:

- Pay pro-rata processes
- Participation in on-call duties
- Service continuity and pay progression for job-sharers
- Holiday pay calculations for non-standard contracts including annualised or term-time only
- Bank holiday entitlements
- Pension contributions and entitlements
- Flexible retirement arrangements
- Hours should be organised to suit both the service and the employees

Flexi-PAs and annualised job plans

What are annualised hours / flexi-PAs?

Annualised hours contracts require a doctor to work a certain number of PAs over the year rather than a set number of PAs each week.

There may be 'core hours' which the employee regularly works each week, while they work the rest of their hours flexibly, e.g. to facilitate term-time working, or when there is extra demand at work. These flexible hours are used either for certain planned purposes or to deal with other eventualities such as short-term sickness cover, holiday cover, additional clinics or theatre sessions. These can include a number of unrostered hours (banked, spare, committed or flexible).

What are the potential advantages?

- More flexibility to balance work and home life
- Less pressure for trainees, SAS and LE doctors to run clinics and other services during consultant absence

- Less need to cancel or reduce clinical activity in the event of unplanned absences
- Reduces the costs associated with relying on locum cover
- Payroll costs become more stable and easier to control
- Less reliance on locums and trainees, SAS and LE doctors to provide core activity

How can annualised hours / Flexi-PAs be built into job plans?

In order to introduce annualised hours into doctors' contracts, the following is necessary:

- A thorough job plan review of how existing work is carried out.
- A detailed plan of how contracted hours would be managed.
- Agreement about how annualised PAs will be monitored and tracked, e.g. is there a minimum number of sessions that must be delivered per month?
- Job planning software can be used to calculate the number of direct clinical care (DCC) sessions that need to be delivered each year. HR departments and medical staffing will be able to provide assistance.

Annualised contracts of 10 PAs or more are full-time and the doctor will receive a full year of annual leave, study leave entitlement and pension contribution.

Key findings

- There are many working patterns which enable doctors to work flexibly including compressed hours, buddying, job sharing, job splitting and annualised / flexi PAs.
- Compressed hours, buddying and annualised / flexi PAs can be adopted by both those working full-time or less-than-full-time.
- Different arrangements for flexible working bring varying benefits and challenges for organisations, teams and individuals.

Further information:

- British Medical Association

Team Job Planning

National leaders in flexible working are increasingly identifying team job planning as a key component of successful workforce management.

What is team job planning?

Team job planning involves looking holistically at all the clinical sessions and leadership roles which need to be delivered by a department and deciding how these should be shared amongst the consultant body (and any SAS doctors who contribute to the consultant rota). Whilst individual job plans are a contract between an individual consultant or SAS doctor and their employer, a team-based approach encourages the whole department to come together to collectively agree shared principles and a common goal or strategy.

What are the prerequisites to successful team job planning?

Successful team job planning requires engagement from all members of the team in a spirit of openness and co-operation. It requires a shift in mindset from that of being an individual doctor, focused on one's own career and aspirations, to that of a team player who has a broader understanding of the overall needs of the service and an awareness of colleagues' strengths and preferences. It requires compromise and consideration of others.

Why is team job planning important?

Team job planning creates a platform for equity, collaboration, conversation and negotiation, rather than competition. This is particularly important when supporting a flexible workforce. For example, it is possible that a PA one colleague wants to drop may well be desired by another. It supports the concept of consultants working together as a team, which promotes cohesion and a positive workplace culture. Team job planning supports career progression, development, and succession planning as the whole team understands the potential options available to them both now and in the future.

Team job planning also helps everyone better understand the balance between demand and capacity, resource availability and their own role and contributions towards delivering the service as a whole. There is a certain amount of work that has to be delivered by the department, and this can be distributed fairly. It opens up conversations about compromise and promotes transparency and equity across the consultant and SAS workforce.

How to team job plan

Dedicate time

Units that perform successful team job planning set aside at least one session per year. The first time a department undergoes team job planning, several sessions may be required but thereafter it can be achieved with an annual meeting. It requires careful planning, e.g. cancellation of clinical activity and use of locum or senior staff to cover acute services, allowing as many of the consultant / SAS body to attend as possible.

Create a safe space

Consideration should be given to the use of an external facilitator, e.g. a clinical director from another division, and / or representation from HR.

Establish a shared mental model

For the first session, it is often useful to start with some basic principles to create a shared mental model. This can include covering the contractual obligations contained within the NHS consultant contract and BMA guidance on working patterns.

Ensure equity

In order to ensure equity across the department, it is also useful to establish start and finish times for all sessions, e.g. operating lists and clinics, as well as standardised templates for non-specialist clinics. This ensures parity and standardisation.

Map the current workload

The current workload of the whole department can then be mapped onto a spreadsheet – both clinical and non-clinical work. It is particularly important to capture leadership work and remunerate this fairly across the team. This spreadsheet will then demonstrate the number of PAs the department currently needs versus the number of PAs allocated to the service. It therefore potentially creates an opportunity to build a business case for expansion.

Support negotiation and collaboration

At a subsequent meeting, the spreadsheet can be discussed in full. It can be helpful in several ways – for example, if there is clinical work that needs to be picked up, it is visible to everyone and can be distributed fairly. It also means that leadership and non-clinical work can be fairly remunerated through the use of output driven Supporting Professional Activities (SPAs). In addition, it provides an opportunity to map local, regional, and national strategy to the outputs of the department. This is particularly important as new services and roles are introduced.

Sign off individual job plans

Once the team job planning exercise(s) are complete, job planning meetings and sign offs still need to take place between the individual consultant or SAS doctor and their line manager. These are often quicker and easier if team consensus has been reached on key issues.

Benefits of team job planning

	**Organisation** • It supports the delivery of national targets and mandatory roles as consultants' time can be appropriately allocated in a changing landscape. It also encourages agility within the consultant workforce and strategic thinking and planning as a team. • By supporting staff and promoting both flexibility and career progression particularly around retirement age, it prevents attrition and retains experienced, highly valuable clinicians within the service. • Detailed workload mapping may support a potential business case for consultant expansion. • By bringing everyone together it enables the service to see opportunities for growth and plan for the future. This is particularly important when supporting senior trainees who are planning Advanced Training Skills Modules (ATSMs) as it helps to match upcoming jobs with skillsets.
	**Team** • It creates a shared understanding of the workload of the whole department, encouraging consultants to work together as a team with a unified goal rather than working in silos. • It allows the team to reach agreement on time allocated for direct clinical care which ensures parity and standardisation. • It creates a clear understanding of the leadership work of the department. It can be mapped out and appropriate time allocated for key roles, with output driven SPAs. • It provides an opportunity for succession planning, particularly for leadership roles. • It promotes flexible working preferences where the service allows, to adapt to the needs of all involved. • It creates an opportunity for individuals to potentially pick up or drop PAs, normalising a range of job plans from 5 to 12 PAs within a department. It therefore potentially removes the stigma around 'less than full time' when it is understood that there are a wide range of job plans being undertaken. • It creates a shared understanding of departmental policy around SPAs – e.g. expectations for core SPAs, as well as working from home and flexible working policies. This helps ensure equity across the whole team. • It seeks to address potential disparity and inequity within the consultant workforce, addressing workplace culture, burnout, job satisfaction, and creating a platform for mutual support.

	**Individual** • Individual job planning meetings can be easier if a team-based consensus has already been reached. • It supports doctors who may have disabilities or long-term health conditions as contributions of the whole team are seen as being important for the collective goal. • It creates opportunities for career development, including mentorship and buddying in both clinical and non-clinical work. It therefore supports progression and prevents potential attrition.

Challenges of team job planning

- It needs careful moderation – it is often wise to ask for external facilitation from HR or another Clinical Director with experience in job planning. Parameters need to be set about delivery of essential services. Individuals should consider negotiating, swapping or rotating both clinical and non-clinical work.
- Not everyone will be able to have all their preferences met and there will always be a certain number of hours on call that need to be covered. It is important to address this at the outset.

Team job planning…only for consultants?

The introduction of the European Working Time Directive (EWTD) and Modernising Medical Careers (MMC) over 15 years ago led to dramatic changes in how many doctors in training work. Whereas 'firm' structures had previously been the norm, rolling rotas were quickly introduced to ensure that rotas were compliant with new working requirements and contracts.

New legislation and rolling rotas brought many benefits, particularly as doctors were no longer expected to work long runs of night shifts and huge numbers of hours in a single week without adequate rest periods. However, it also resulted in doctors working much less within team structures and losing the apprenticeship style of learning. Arguably in O&G this is particularly relevant as there is a lot of out-of-hours working and it is a craft specialty, where acquisition of surgical and other practical skills are key.

The Modern-Day Firm

The modern-day firm involves job-planning trainees, SAS and LE doctors in a similar way to consultants. It enables teams to work within a 'firm' structure while also ensuring doctors have adequate rest periods and do not work excessive hours. It prioritises training, with service provision as a by-product, rather than vice versa.

The two rotas below demonstrate how doctors can work the same number of hours but with a more predictable pattern of on-call shifts and a regular day off or half days, so they can better organise other activities around their work. It is also more conducive to a trainee, SAS or LE doctor attending a particular theatre list or clinic on a set day to optimise learning opportunities, without interrupting on-call duties.

Typical rolling rota

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week 1	Normal	Normal	Normal	OFF	LONG DAY	LONG DAY	LONG DAY
Week 2	OFF	OFF	Normal	LONG DAY	Half Day		
Week 3	Normal	Normal	LONG DAY	Normal	Normal		
Week 4	Normal	LONG DAY	Normal	Normal	Half Day		
Week 5	LONG DAY	Normal	Normal	Normal	NIGHTS	NIGHTS	NIGHTS
Week 6	OFF	OFF	OFF	Normal	Normal		
Week 7	Normal	Normal	Normal	Normal	Half Day		
Week 8	NIGHTS	NIGHTS	NIGHTS	NIGHTS	OFF		

'Modern day firm' rota

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Week 1	OFF	Normal	LONG DAY	Normal	LONG DAY	LONG DAY	LONG DAY
Week 2	OFF	Normal	Normal	Normal	Normal		
Week 3	OFF	Normal	LONG DAY	Normal	Normal		
Week 4	OFF	Normal	Normal	Normal	Normal		
Week 5	OFF	Normal	LONG DAY	Normal	NIGHTS	NIGHTS	NIGHTS
Week 6	OFF	OFF	Normal	Normal	Normal		
Week 7	OFF	Normal	LONG DAY	Normal	Normal		
Week 8	NIGHTS	NIGHTS	NIGHTS	NIGHTS	OFF		

Benefits of job planning trainees, SAS and LE doctors

	**Organisation** • It improves continuity of care for patients as doctors are mostly in the same clinics rather than rotating round. • It is cost neutral. • There is much less need to use weekly rotas which can be time-consuming to create and administer. • There is greater scope for consultants to be able to mentor and support senior trainees to develop the skills the department will need in the future, thereby helping succession planning. • It enables self-rostering which should reduce absenteeism if doctors choose their own shifts. • It allows units to better identify the ATSMs for which they can and cannot provide training. • It supports senior trainees and SAS doctors undertaking minor procedure lists as there is more predictability about support available in the event of problems.
	**Team** • There is a greater sense of team belonging, support and togetherness. • Everyone has greater awareness of each other's strengths and limitations. This encourages appropriate supervision where those in training are given autonomy to develop their skills without being expected to work beyond their capabilities. • There is improved flexibility to support those wanting to work various LTFT arrangements.
	**Individual** • It better supports training by enabling more regular attendance at particular sessions e.g. operating lists with less interruption from out-of-hours working. • It is more predictable so it is easier for doctors to plan other activities such as childcare. • It improves access to training opportunities for SAS and LE doctors and supports the new Specialty Doctor contract. • It offers the potential for better psychological and pastoral support in what is often a demanding specialty. • It better supports regular SPA time for all trainees, SAS and LE doctors to get involved in non-clinical aspects of the service and to develop leadership skills.

Challenges of job planning trainees, SAS and LE doctors

- It requires additional planning at the outset to ensure that job plans are equitable, support training and cover the full service.
- It may need to be updated or modified every 6-12 months to allow for new trainees with different training needs rotating to the unit.
- It does not prevent rota gaps.

How to job plan trainees, SAS and LE doctors

Map the current workload

Map the current workload of the department onto a spreadsheet. This should highlight the number of sessions available. These should then be categorised according to sub-specialty.

Assess the staffing required

Assess how many doctors are required in each type of session e.g. in clinics. Exclude any sessions which are not suitable for training. Identify sessions which doctors can attend in a supernumerary capacity for training e.g. scan lists.

Identify teams

Identify small groups of consultants (ideally around three although this will depend on the size of the unit) who have a similar remit of work or specialist interests.

Create job plans

Create job plans according to specialist interests and shadowing the team of consultants. Prioritise doctors undertaking ATSMs. For those working at ST3-5 level, either offer jobs with a balanced variety of general O&G or with a specialist interest.

Labour ward cover

Once key training sessions have been identified, factor in a regular on-call day. This should be selected to minimise interruption to special interest sessions.

Flexi-sessions / SPA

Build in flexi-sessions and SPA time. This enables trainees, SAS and LE doctors to become involved in the non-clinical aspects of O&G, thereby better preparing them for becoming consultants. It also can provide prospective cover while other doctors are on nights, zero days or annual leave.

Self-rostering

Doctors can opt to self-roster their blocks of night shifts and weekend day shifts. This gives doctors greater flexibility to avoid clashes with other life events. They may also choose to undertake night shifts when they know certain clinical sessions are cancelled e.g. if a consultant is on leave.

Key findings

- Team job planning can be used at all career stages for consultants, SAS and LE doctors and trainees.
- Team job planning involves a collective departmental approach to evaluating workload and who is best placed to deliver services. It is based upon collaboration not competition. It may offer advantages in terms of fostering positive team culture, ensuring services are more person-centred, delivering education and upskilling the workforce and supporting succession planning both clinically and for leadership roles.
- Team job planning is compatible with the new Specialist doctor contract and facilitating the introduction of these new posts.

Flexible Working Options for Trainees

The opportunities for trainees to work flexibly have increased over the last decade. This includes working less than full time (LTFT), integrated clinical and academic programmes and taking time out of programme.

Did you know?

- There are currently 2,851 O&G trainees in England
- 593 (21%) work LTFT
- Amongst these trainees, the average WTE is 0.73

Working less-than-full-time (LTFT)

There are 3 categories under which trainees can apply to work LTFT:

Category 1

- Ill health
- Caring responsibilities

Category 2

- Unique opportunities
- Religious commitments
- Non-medical professional development

Category 3

- Personal choice/lifestyle

- Trainees applying under Category 1 and Category 2 will be prioritised.
- Trainees can apply to work LTFT at any point in training and should follow their local deanery protocol.
- There are 3 options for how trainees can work LTFT:

Slot share	2 trainees share a full-time slot, often 60% with 50% on-calls
Reduced hours post	1 trainee works fewer hours in a full-time slot, often 80%
Supernumerary	Very flexible but limited number of these posts due to funding

Locums

Locum shifts may be undertaken by trainees who work LTFT but should be approved by their educational supervisor, be infrequent and where possible be for their employing/host organisation. If a trainee wishes to undertake more regular locum shifts then the percentage of LTFT should be reviewed to account for this.

Training time

Generally, training time is proportional to the percentage LTFT
E.g. 1 year of 60% training = 20 months
1 year of 70% training = 17 months
1 year of 80% training = 15 months

However, obstetrics and gynaecology has recently changed from being a time-based specialty to a competency-based specialty. This may mean that some trainees working LTFT are able to progress more quickly than the times outlined above, if they have achieved all their competencies.

Integrated clinical and academic programmes

There are two types of integrated clinical and academic programmes:

Academic Clinical Fellowship

- Generally undertaken from ST1-ST3
- 25% academic component over 3 years
- Allows trainees to work towards a PhD or Fellowship Application

Clinical Lectureship

- Follows a PhD and usually undertaken post membership
- 50% academic component over 4 years
- Enables the trainee to transition to an independent researcher

Academic trainees are given an academic training number and are assessed on both clinical and academic competencies. Academic trainees may choose to delay their training and progress at the rate of their clinical component. This should be discussed with their educational supervisor and may not be applied retrospectively.

Time out of programme (OOP)

Only trainees who have had a satisfactory outcome at their most recent annual review of competency to practice (ARCP) are eligible to apply to take time OOP. There are a number of reasons that a trainee may decide to take time out of training:

OOPT (Training)	• Gives the trainee the opportunity to undertake training that is not part of their training programme • Currently for a maximum of two years • Will not result in a delay to a trainee's completion of core training (CCT) date
OOPE (Experience)	• Gives the trainee the opportunity to gain professional skills e.g. in medical leadership or clinical skills related to but not part of their training e.g. working in a different health environment, to enhance their future career • Usually for a period of a year but may be extended to two years with agreement from the postgraduate dean • The trainee cannot count this time towards their training programme and hence it will prolong the trainee's CCT date
OOPR (Research)	• Allows the trainee to complete an extended period of research such as an MD or PhD • Usually for a period of two or three years but may be extended to four years with prospective approval from the postgraduate dean • This time may count towards the award of CCT where the relevant curriculum allows
OOPC (Career break)	• Gives the trainee time to pursue other interests e.g. for domestic responsibilities or to develop talents in other areas • Normally limited to two years
OOPP (Pause)	• Allows trainees to pause their training to undertake an NHS non-training post, gain further experience, take stock of their training or work in another related specialty. • It differs from OOPE as the time and competencies gained may be considered retrospectively to count towards their training programme • This is for a maximum of a year and may be a way for a trainee to minimise the impact of out of programme time on their CCT date

Career breaks and sabbatical leave

What is the employment break scheme?

• NHS employers should provide all staff with access to an unpaid employment break scheme.
• The scheme should enable people to take a longer period away from work than that provided for by the parental leave scheme and other leave arrangements.
• The scheme should explicitly cover the main reasons for which employment breaks can be used, including but not limited to childcare, eldercare, care for another dependant, training, study leave or work abroad. It should also indicate that other reasons will be considered on their merits.

Career breaks vs sabbaticals

• Both career break leave policies and sabbatical policies are discretionary and locally agreed.
• Career breaks should give opportunities for caring responsibilities and overseas travel.
• Sabbaticals should enable a period of leave to pursue education and development, should be linked to the personal development plan at appraisal and be agreed through the job planning process.

Key findings

• Eligibility: All staff with a minimum of 12 months service.
• Length of break: 3 months to 5 years.
• It should be possible to take breaks either as a single period or as more than one period.
• The length of any break should balance the needs of the applicant with the needs of the service.
• There should be provision for breaks to be extended with appropriate notice, or for early return from breaks.

Employment break agreements

All breaks should be covered by an employment break agreement between the applicant and the employer. These should cover:

- The effect of the break on various entitlements related to length of service.
- A guarantee that, if the applicant returns to work within one year, the same job will be available, as far as is reasonably practicable.
- If the break is longer than one year, the applicant may return to as similar a job as possible.
- Return to work at the equivalent salary level, reflecting increases awarded during the break.
- The notice period required before the return to work should be two months if the break is less than a year and six months if the break is more than a year.
- Arrangements for keeping in touch during the break.
- Requirements for the applicant to keep up to date with their relevant professional registration needs, including attendance at specified training courses and conferences, and any assistance the employer may give in the support of this.
- Training arrangements for re-induction to work.
- NHS pension arrangements during the break.

What are the benefits and challenges of an employment break?

	**Organisation** **Benefits** • Promotes an environment that supports staff to achieve a healthy work-life balance. • Enables employers to attract and retain the experience of staff, consistent with the NHS commitment to the provision of high-quality healthcare. • Improves staff satisfaction and retention, particularly of these with significant experience. • Develops skills and networks that are likely to have value for the employee, the employing organisation, the wider NHS and service users. • May give colleagues opportunities to develop skills and responsibilities by 'back-filling' during the period of absence. **Challenges** • Requirement to backfill the activities of the individual taking the employment break. This may require a short-term appointment which may not be possible dependant on skills required. It may be easier to consider a substantive replacement which then may put the roles and responsibilities 'at risk' for the employee on their return. This may make it impossible to agree a break with a guaranteed return. • May be difficult to implement if the individual holds a leadership role.

	**Individual** **Benefits** • Enables employees to meet personal or domestic commitments whilst maintaining contact with their employer on a long-term basis. • Provides employees with opportunities to pursue education and development such as research, charitable activities, learning of specific techniques/skills or development of wider clinical networks. **Challenges** • Potential impact on income, career progression, employment rights, pension entitlements and job plan on return from long periods of absence. • Need to keep up with training and registration requirements. • Requirement for re-introduction to work/employing organisation will be related to the length of absence and activity during that time. • Management of expectations on return and potential conflict with colleagues if significant change in roles and responsibilities have occurred during the period of absence. Managing this successfully requires clarity about the rationale for an employment break and regular contact during the break. There should be agreement about the timing and arrangements for return and anticipated roles and responsibilities.

Case study: Career break

Who?

- Jane Panikkar
- O&G Consultant
- Shrewsbury and Telford Hospital NHS Trust

Reason

Burnout and to prevent potentially becoming unwell

How did we make it happen?

- Reduced Jane's job plan to one PA for three months to allow continuation of her HEE Training Programme Director role.
- Employed a newly qualified consultant to replace Jane during her absence.

Benefits

Organisation

- The department was able to recruit a newly qualified consultant into Jane's post, on a lower salary. This enabled the department to invest in the future workforce and succession planning and continue to run the service as normal.
- There was no interruption to patient care as we avoided a consultant gap which is likely to have occurred if Jane had taken sick leave.
- Avoided the cost of sick leave (full pay) and the additional cost of locum cover.

Individual

- Jane was not adversely affected by the reduction in pay and it helped balance her pension contributions.

Challenges

- If we had not been able to appoint a new consultant, we would have had to rely on locums which would have been expensive.

- Jane's job plan did not include on-calls. However, if it did and without a replacement, the additional on-calls may have placed a burden on other colleagues.

Post-return

Jane was able to return to work with a new job plan which met her needs, those of the department and those of the organisation. This helped to retain specialist skills and experience within the department.

Did you know?

Career breaks can be paired with other types of flexible working. For example, in a job share one person could take winter off for skiing while the other person takes the summer off for school holidays. Each provides backfill for the other.

Flexible working approaching retirement

In 2020, the RCOG published its '**Later Careers and Retirement**' report.[41] The report highlights that the retirement age amongst doctors is 58.9 years for women and 59.9 years for men, around five years lower than that of the general population. The key reasons cited for retirement are health and wellbeing, workload and burnout. The report recognises the need for flexible working including the option of reducing or stopping out-of-hours working as doctors approach retirement. Similarly, an Academy of Medical Royal College (AoMRC) report, 'Retirement / later careers issues for SAS Doctors and Colleges'[42] discussed the need for SAS doctor job plans to be adjusted in a similar way to consultants.

In 2017, a survey by the AoMRC found that 52% of respondents were planning to retire between the ages of 56 and 60. Their first recommendation was that policy-makers should 'urgently explore ways to offer older doctors greater opportunities for flexible working'.

In 2017, a survey by the Royal College of Physicians (RCP), found that 69% of consultants aged 55-60 would like to retire and return to work on a LTFT basis and subsequently issued a report which again recommended that ways to offer older doctors greater opportunities for flexible working should be explored.

Benefits of flexible working approaching retirement

	**Organisation** • Retain senior, experienced staff within the workforce. • Provide stability and maintain organisational memory.
	**Team** • Transfer knowledge and skills through education or 'surgical buddying' with younger, more recently appointed colleagues. • May take on management roles or mentoring.
	**Individual** • May take on external roles within or outside of the specialty. • Preparation for eventual retirement – 'winding down'. • Continue research or external activities e.g. expert witness, whilst maintaining clinical credibility and the ability to revalidate.

Challenges of flexible working approaching retirement

- Need for consistency between colleagues when agreeing flexible working, and when renewing fixed term contracts following a 'retire and return'.
- Flexible working for older doctors often includes withdrawal from the out-of-hours rota but there may be a desire to continue with major operating. Flexible working as a consultant approaches retirement must not be seen as 'cherry picking'.
- Need for fairness and transparency in job planning.
- Ensuring younger, more recently appointed colleagues who need to gain or maintain surgical experience have the opportunity to undertake major operating. In this situation, 'buddying' of an older consultant approaching retirement with a newly appointed consultant can be a solution.

Further information:

- RCOG Later Career and Retirement Report - Retaining O&G Doctors in the Workforce for Longer March 2020
- Academy of Medical Royal Colleges - Medical careers: a flexible approach in later years. AoMRC 2018.
- Royal College of Physicians - Later careers: Stemming the drain of expertise and skills from the profession RCP 2019
- British Medical Association - Returning to work after retirement. 2021.

Case study: Working post-retirement

Who?

- Rashna Chenoy
- O&G Consultant at Newham University Hospital for 23 years
- Senior Lecturer and Undergraduate Lead for the specialty at Barts and The London School of Medicine and Dentistry

Overseas work – India and the Himalayas

I retired in 2019 after 23 years as Consultant Obstetrician and Gynaecologist at Newham University Hospital and Senior Lecturer and Undergraduate Lead for the specialty at Barts and The London School of Medicine and Dentistry.

The plan post-retirement was to remain professionally active by supporting women's health initiatives in under-resourced areas for a few months each year while indulging my non-medical pursuits in the remaining months. The first assignment was in south India, contributing to the physicians' assistants training programme at a noted leprosy research and treatment centre, which was in the process of expanding its service provision to include maternity and gynaecology care in addition to general medicine and surgery. This not only provided the opportunity to pass on clinical knowledge and practical skills, but also to acquire new ones such as resource-efficient care and managing exotic clinical conditions like snake bite in pregnancy, not commonly encountered in east London.

Returning to the NHS during the COVID-19 pandemic

With the advent of Covid-19, the training programme was interrupted after six interesting and personally fulfilling months, enriched by new experiences, friendships and values. On returning to London, I was pleased to be able to provide basic support at my previous NHS hospital towards managing the pandemic-created backlog in the gynae-oncology service. There were a number of challenges that the Covid-19 situation necessitated and it took some effort to adapt to the new systems and processes in place. With the entirely unfamiliar situation facing everyone, bureaucracy seemed to have increased, or at least it seemed so after the time away. That aside, returning to a familiar set up with former colleagues was very pleasant, besides giving my day structure and purpose.

The future

After a few months with the NHS, I have now taken up another assignment, providing general O&G and primary healthcare at a rural health facility in the Himalayan foothills. It provides a new vista and a different set of conditions, requiring me to keep thinking on my feet and doing the best I can each day to support my colleagues. As the world opens up, I look forward to reverting to being a typical pensioner, unhesitatingly claiming any and all available senior citizen benefits. I hope to balance my work interests with other revived interests, to visit historical and cultural sites and to reconnect with friends around the world.

Key findings

- Career breaks, sabbaticals and flexible working approaching retirement are all valuable ways in which consultants, SAS and LE doctors can pursue other interests and reduce the risk of burnout later in their careers.
- Trusts and health boards should urgently explore how to offer a range of initiatives to enable O&G doctors nearing retirement to stay in the workplace.

Chapter 4: Remote and rural working

Introduction

It is important to distinguish between rural and urban settings when planning O&G services. Each face unique challenges and opportunities due to variations in the demographic, geographical and cultural needs of the population and the differing demands that these place upon healthcare professionals. Traditionally, national guidelines have centred on urban care, often creating significant challenges for rural service providers. Women and their families should be at the centre of decisions about how care is delivered and their varying needs in different geographic locations should be taken into consideration.

Did you know?

In England and Scotland[43,44]

- 17% of people live in rural areas

In Wales

- 33% of people live in rural areas

In Northern Ireland

- 36% of people live in rural areas

Key fact

Approximately 5% of women receiving maternity care in the UK are cared for in units described as small (less than 2,200 deliveries per year).

This is a much lower percentage than in many developed countries. In France, this figure is 55%.[45]

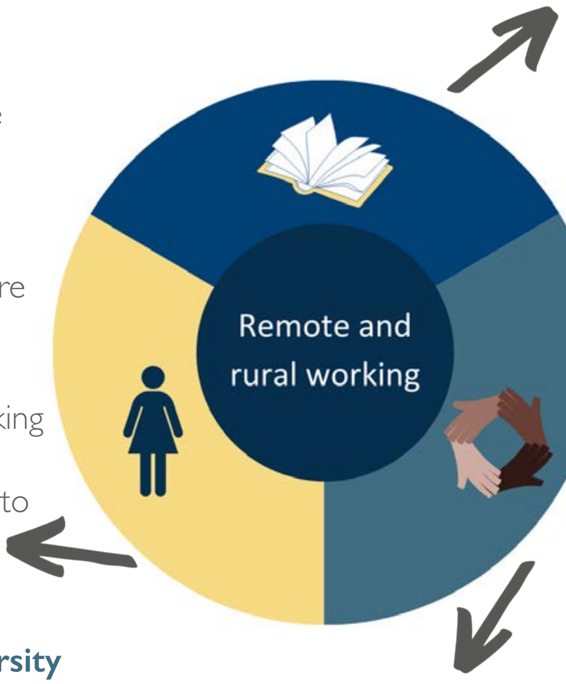
In 2020 the Nuffield Trust, in collaboration with the RCOG and the Royal College of Midwives (RCM) published a working paper titled 'Maternity services in smaller hospitals: a call to action'.[45] The paper provides a comprehensive yet succinct overview of the issues associated with providing maternity care in rural areas in the UK. The report highlighted the following challenges:

- The vulnerability of smaller units to staff shortages
- Financial pressures from economies of scale
- Maintenance of interdependent services such as paediatrics and intensive care
- Closure of maternity units
- Implications of centralising services for patients and staff
- More effective use of networks for service delivery
- Maintenance of patient choice
- Provision of training needs
- Demands of out of hours service provision on a smaller pool of staff

Those working within remote and rural units describe a downward spiral from lack of supporting services, leading to women needing to be transferred to larger units, demoralised staff and resignations to patient numbers dropping below the line at which a unit remains viable. The Covid-19 pandemic has augmented this trend.

This chapter follows on from the findings and recommendations of the Nuffield report but also includes the provision of gynaecology services. It aims to explore women's perspectives of care in rural areas and highlight the benefits and challenges of rural working. It includes examples of best practice from around the UK to provide ideas and inspiration for how it is possible to overcome perceived barriers in providing safe and sustainable O&G services for women in rural locations.

How does this chapter relate to our values?



Person-centred care

- Prioritising the needs of women in how services are planned, organised and delivered.
- The importance of providing safe, accessible care to women irrespective of where in the UK they live.
- Alternative ways of working which enable care to be provided to women locally to where they live.

Learning

- Understanding the role of smaller units in providing learning opportunities for trainees.
- Appreciating the need for mentorship and support, particularly for newly-qualified consultants starting their careers in remote and rural areas.

Diversity

- Recognising that O&G services are delivered to a diverse range of people and thereforce should be tailored according to demographic geographic variables.
- Reducing healthcare inequalities between rural and urban areas.
- Ensuring representation from those working in rural and urban areas on national boards and committees.

Delivering person-centred care in remote and rural areas

There are many definitions of what constitutes person-centred care. The National Voices initiative suggests that person-centred care is about patients being able to work in partnership with their care providers to bring together services to achieve the outcomes important to the patient.[46] Darzi described it as the idea of "organising services around patients, and not people around services".[9] It has also been defined as "treating the patient as a unique individual".[47]

Understanding women's perspectives

In order to improve O&G care in remote and rural locations, it is important to understand the views and perspectives of women living in these areas. This includes recognising the difficulties women face when accessing O&G services, what they value and prioritise when seeking healthcare and what they think could be done to improve the delivery of services in rural areas.

The following section has been written in collaboration with Fair Treatment for the Women of Wales (FTWW), a patient-led charity which advocates for women and girls seeking healthcare. It is dedicated to women's health equality.

Women living in rural areas report the following problems with accessing O&G services:

Limited access to reliable internet connection has made online appointments difficult.

Limited access to regular, affordable public transport makes face-to-face appointments difficult, particularly for those on low incomes.

Undergoing invasive procedures is difficult for those with no family or close support network if they are required to drive.

Those requiring care from district nurses or social workers sometimes find their care is rushed as those providing the care have to drive much further between patients.

Access to specialist services is sparse. This leads to referral pathways which are difficult to navigate, complex funding requests, challenges in ensuring adequate follow up locally and travelling long distances.

Small community clinics are not always financially viable. They then have inadequate numbers of staff so the care is sub-optimal. Women then choose not to use them which in turn results in further closures.

The following are quotes from women regarding their experiences of O&G care in Wales. This highlights issues with distance and access to services, centralisation of services, lack of transport, perceived difficulties getting referred to secondary care and differences in healthcare seeking behaviours.

“

In this part of [mid-Wales], the provision for women's health is terrible...I believe more complex obstetrics / maternity is over in Telford (England), so an incredibly long way for women to travel… especially those at higher risk… who wouldn't be advised to have a home birth or [give birth in] local cottage hospitals...

“

My women's health physio has moved to Shrewsbury (England)...and has referred me to herself there to continue my treatment but I don't know that this is possible for new patients. There was no mention of referring me to a replacement at the local hospital... which would beg the question if there even is a women's health physio in this part of [Wales] now?

“

Even where there are services available, the lack of public transport makes it difficult, expensive or even impossible for non-drivers to access. This adversely affects those who are unable to afford a car/to learn to drive and those who are too ill / in too much pain to drive and if you are single and have no partner to take you... So I think this probably discriminates against more vulnerable women and single mothers too.

“

Those of us who live rurally are probably less likely to access emergency care for things like endometriosis. I lived 10 miles away from my local hospital, and calling for an ambulance would usually be a long wait - I never felt comfortable doing that in the first place (so) I would self-medicate... If you're lucky to have a good GP with an understanding of your condition, primary care will be excellent… I was never referred to Gynae… when I lived rurally… it never seemed to be an option. There seemed to be a culture of GPs trying to solve everything themselves.

“

Rural culture - we would never have had open conversations about menstruation in front of the male members of my family (plus) I am convinced my mum had endo too but, because she was able to have four children very easily, no investigation ever took place. So I was told by her that my symptoms were very normal. Because of these issues, I would say it's less likely that rural females will seek help with their symptoms and less likely they will have a good support network at home.

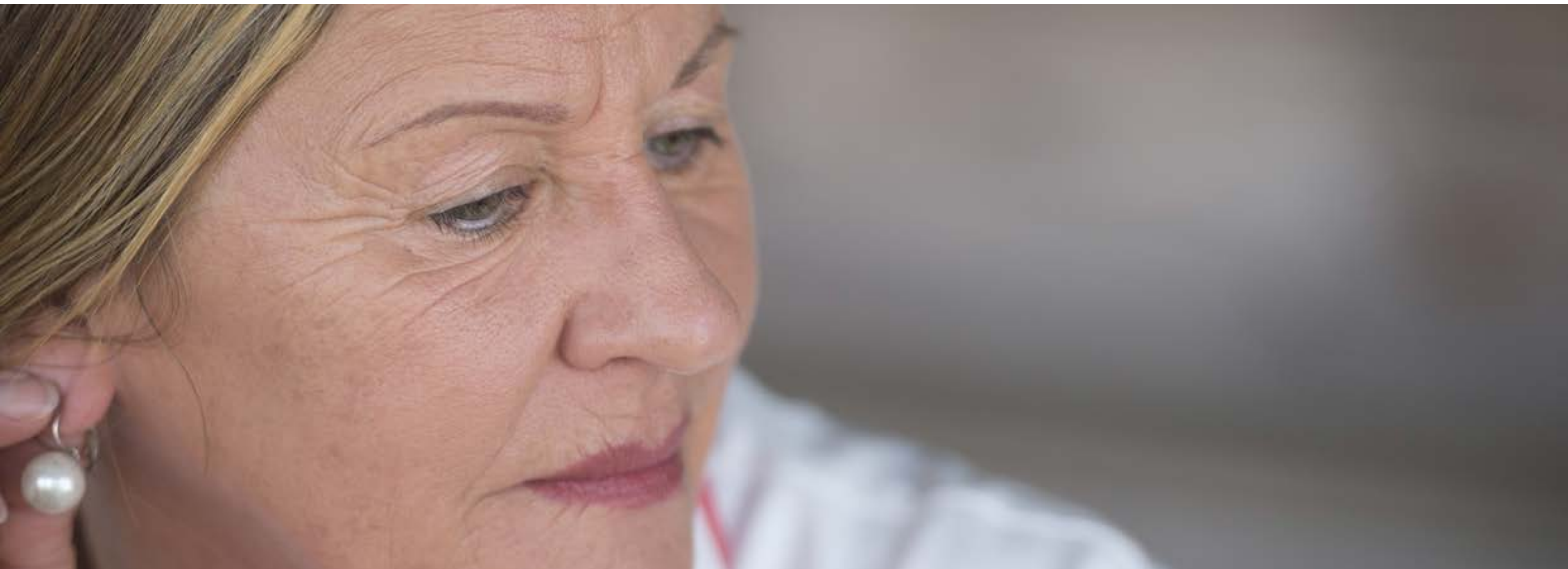
Women have made the following suggestions as to how care could be improved for those living in rural areas:

- ✓ Use of mobile women's health hubs to provide ultrasound scans and minor gynaecology procedures, similar to those used for breast screening and blood donation.
- ✓ Increased use of virtual appointments where good internet connection is available and women do not have communication difficulties.
- ✓ If a woman needs to travel a long distance for an appointment, consider checking her address, providing information about transport links or hospital transport and ask if an appointment later in the day would be more convenient.
- ✓ Hybrid models of care whereby women may need to travel further for more specialised aspects of their care but other parts of their care and follow up is arranged locally. This requires good communication and care co-ordination for those requiring input from multiple teams or specialists.

Maintaining choice for women

Another key aspect of delivering person-centred care is ensuring that women have choices regarding the care that they receive. Although it is not feasible to deliver all sub-specialist services in all localities, reasonable provisions should be made to enable women to access complex care centrally with more generalist care provided locally wherever possible.

In order to do this, it is often necessary to consider different ways of working. Provisions include online and telephone appointments where possible, use of clinical networks and cross-site consultant working. In maternity care, it should be remembered that not all women will require input from obstetricians. A Danish study[48] showed lower rates of intervention and similar perinatal outcomes for appropriately assessed, low-risk primiparous and multiparous women delivering in stand-alone midwife-led units compared to obstetric units. A retrospective study in Scotland reported similar findings.[49]



Ensuring units are safe

Patient safety and outcomes in smaller units is another concern frequently raised by doctors and healthcare regulators. This concern stems from possible deskilling of the workforce due to lower numbers of patients. There is a lack of robust evidence in favour or against this issue, however there are several good practice points which remote and rural units should adhere to:

- Ensure that there are **clear standard operating procedures (SOPs) and escalation policies** in place so that all members of staff are aware of when a woman should be offered care within a remote and rural hospital and when she should be transferred to a larger unit. All members of staff should be aware of when and how transfers should be arranged. At present there are no national standards for this but this merits further research and consideration.
- **Units should use routinely collected data to continually monitor their care and benchmark their outcomes against other units.** This is key to organisational learning and improving care. (For further information on this, please see the 'Building supportive, learning cultures in O&G' chapter). The RCOG is currently developing an online tool to monitor safe staffing levels and maternity outcomes across England and Wales. This is expected to become available to all units in 2022. It aims to enable all units to assess their staffing levels, bed capacity and clinical outcomes against national standards, factoring in local patient demographics.
- **All doctors should have regular opportunities to engage in courses and practical skills workshops.**

Tailoring services to local population needs

As previously discussed, tailoring services to meet the individual needs of women is a key component of delivering person-centred care. Developing and sustaining healthcare services in remote and rural areas is fundamental to reducing healthcare inequalities. Women who are socio-economically deprived, those living with disabilities, older women and those who do not speak English are more likely to experience difficulties accessing care further away and therefore closure of local services and centralisation is likely to widen healthcare inequalities.

Creating and developing services in remote and rural areas requires healthcare professionals and workforce planners to understand the importance of equity of service provision rather than necessarily equality. In other words, it is key that services recognise the different needs and circumstances of rural populations rather than just trying to replicate urban services. For instance, rural populations tend to have a higher percentage of older people than urban populations so this will determine what services are needed.

A more geographical dispersed population may influence how some services should be provided.

Key findings and recommendations

- Seeking and understanding women's views and ideas is key to delivering person-centred care.
- Maintaining choice for women may require services to be delivered in new and innovative ways.
- SOPs, escalation policies, monitoring of routinely gathered data and regular CPD opportunities for all doctors are key to ensuring remote and rural units are safe.
- Consideration should be given to developing national standards for escalation policies for remote and rural regions.
- Healthcare professionals and workforce planners should focus on providing equity than equality of healthcare in rural and urban areas.

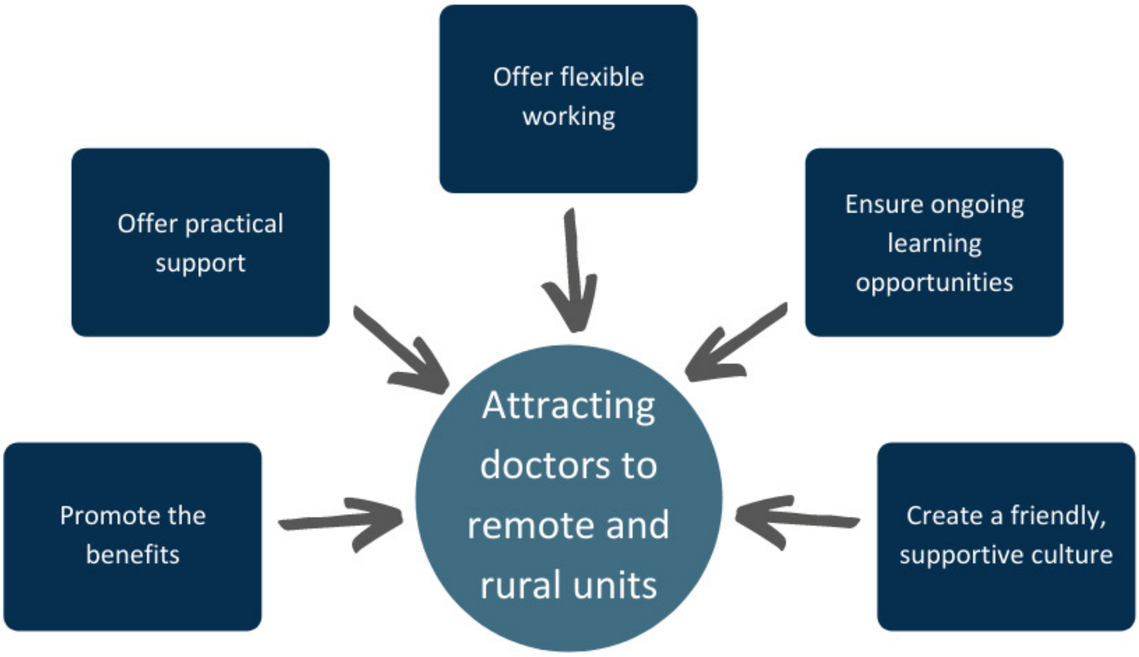
Embracing diversity in remote and rural areas

Embracing diversity in remote and rural areas includes recognising differences in patient demographics and tailoring services to meet women's needs. However, it is also important to recognise the diversity which exists within the O&G workforce nationally and ensure that this is represented within rural and remote areas. This includes the age, gender and ethnicity of staff but also the breadth of roles and ways in which teams work to deliver care.

Positive steps have been taken nationally to reduce geographical disparities through, for example, the location of the new medical schools in more rural parts of England.[50] However, individual units must appreciate the differences that exist between rural and urban hospitals and look at models of care and funding which acknowledge that one size does not fit all. Consideration must be given to optimising the services available to women locally while ensuring that they are logistically and financially sustainable.

Recruitment and retention of O&G doctors

Recruiting and retaining substantive O&G doctors in remote and rural locations can be challenging. Similarly, support services including paediatrics, anaesthetics, midwifery, sonography and laboratory are also affected to varying degrees. The causes are multifactorial but with an ageing workforce and a heavy reliance on overseas doctors and locum cover in these areas, it is essential to showcase the benefits and develop strategies to overcome the less attractive factors. This requires a multi-faceted approach.



Promote the benefits

Working in remote and rural locations offers both personal and professional benefits:

Professional opportunities:

- To cultivate a generalist skillset as part of a small team
- To develop autonomy and responsibility as part of a smaller multi-professional team managing a diverse mix of patients
- To work collaboratively with colleagues in tertiary centres
- To teach and provide mentorship to junior colleagues in smaller teams
- Flexible working

Personal opportunities:

- Rural locations are often considered to be picturesque places with a relaxed pace of life, whilst also being safer, with less crime, pollution, litter, and traffic.
- Families are often drawn to affordable housing and outdoor leisure and recreation opportunities.

Offer practical support

Units should consider offering practical support to healthcare professionals. The following table is based upon suggestions from working groups specific to rural working at Health Education England (HEE), The Nuffield Trust, the RCM and the RCOG; and have been advocated for service planners and providers.

Staff wellbeing	Ensure optimum rest facilities, parking and catering provision.
Accommodation availability	Use of local knowledge to assist incoming staff to find and secure housing.
Childcare availability	Working hours of medical staff are often outside the parameters of childcare hours in rural areas. Trusts can work with local councils to improve accessibility to childcare.
NHS passports	Currently being developed by a joint working group commissioned by NHSE and HEE. This will facilitate the movement of staff between different trusts by removing repetitive HR requirements.
Social and community induction and support	This should be aimed at both staff and their families. Where possible consider spouses employment to help families to relocate.

Offer flexible working

As outlined in the 'Flexible working' chapter there are lots of different ways in which doctors can work flexibly. This includes less-than-full-time working, compressed hours, job sharing and job splitting, annualised contracts and sabbaticals.

Although the facility to work flexibly should be considered good practice in all units, it offers even greater advantages in remote and rural units that may have difficulty recruiting doctors. Flexible working arrangements offer improved work-life balance. This may be particularly of interest to those with young children, those approaching retirement, those with certain medical conditions or doctors wishing to pursue other personal or career interests. It is possible that reduced income is less likely to be of concern given the lower cost of living in rural areas compared to cities.

Flexible working has advantages for units by widening the pool of applicants who may consider working in a unit, thereby ensuring a higher quality, more dedicated, diverse workforce. If doctors use flexible working arrangements to work in other locations, undertake research or leadership roles or develop new skillsets, this also brings benefits to remote and rural units.

Case Study: Part-time, substantive consultant post in a remote location

Where?

- NHS Shetland
- Approx 200 births per year

The problem

Shetland is a remote island with 23,000 residents. It has been challenging to recruit to small remote communities for a number of reasons.

What have we done?

- Created a part-time substantive post made up of 17 weeks worked on island on average per year.
- In addition, there are 13 weeks per year for supporting professional activities, annual leave, study leave, continuous professional development, and time spent developing personal professional interests that benefit NHS Shetland.
- Overall, this results in 30 weeks paid work a year (0.7 WTE), spent as 4 weeks worked on island and 8 weeks off island.

What are the benefits?

- This job plan has allowed provision of care in a previously difficult to recruit to, remote UK setting.
- The post-holder has been able to combine working in the Shetland Islands with working in less developed countries and pursuing a range of other interests.
- The post-holder has been able to spend time working voluntarily in Sierra Leone, allowing maintenance of emergency obstetric and surgical skills in a high intensity, high pathology setting.
- The post-holder has also run emergency obstetric courses and helped develop the O&G part of a training curriculum for emergency clinics. They have mentored health professionals working in the Rohingya refugee clinics in Bangladesh with doctors worldwide.

- When not working in the Shetland Islands, the post-holder works within a bank contract with North Cumbria Integrated Care NHS Trust, allowing maintenance of NHS specific skills.

What are the challenges?

- The vulnerability of a rota due to periods with a single consultant.

Top tip

Encouraging staff to pursue other interests improves staff retention and brings additional talents and skills to the team.

Ensure ongoing learning opportunities

Remote and rural units should reconsider how they can provide training opportunities for trainees and create job plans for SAS and LE doctors and consultants which are fulfilling, include regular learning opportunities and ensure ongoing professional development.

Create a friendly, supportive culture

Many factors determine unit culture. However, staff feeling valued and listened to, collaborative team-working and psychological safety are key determinants.

Further information regarding practical support, providing ongoing learning opportunities and creating positive cultures, can be found in the 'Building supportive, learning cultures in O&G' chapter and the RCOG '**Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology**' guide.

Multi-professional team working

Although traditionally O&G services have been delivered by multi-professional teams, they have often been heavily focused on being doctor-led, with clearly defined roles and hierarchies. As discussed in more detail in the 'Multi-professional team working' chapter, it is important for all O&G teams to reconsider these previous models of care and think about new and innovative approaches to optimise team working and ensure that the needs of women are prioritised.

Examples of how this can be achieved include employing physician associates to review patients in clinics, undertake minor gynaecology outpatient procedures and assist in theatre. Consideration should also be given to extending the roles of midwives and nursing staff. This could include extended roles in the early pregnancy service, obstetric or gynaecology scanning or assisting in theatre. Nursing staff can undergo additional training as advanced nurse practitioners who can develop skills in minor outpatient gynaecology procedures such as hysteroscopy. Some units have provided additional training for midwives to become advanced midwifery practitioners, who can then contribute to the out-of-hours rota in lieu of a first or second on-call doctor.

The role of SAS and LE doctors

SAS and LE doctors make significant contributions towards caring for women in remote and rural units. It is therefore crucial that units consider how best to attract and retain highly skilled individuals.

The new Specialist and Specialty Doctor contracts[13,14] were published in 2021 and are available in England, Wales and Northern Ireland. They offer different terms and conditions to previous SAS and LE doctor contracts which are generally more attractive to individual doctors while offering team stability and enhanced incentives for doctors to develop their skillsets, which in turn benefits remote and rural units.

To apply for a specialist doctor post, doctors must have a minimum of 12 years of post-graduate experience, at least six of which must be at SAS grade in a specialty.

While doctors must be able to demonstrate generic competency and skills required of any senior clinician, they do not require the full breadth of curriculum knowledge required by those applying for consultant posts. Instead, these posts are aimed at developing niche areas of expertise in a particular area of practice, to suit the preferences of the individual and needs of the service. For instance, a specialist doctor could be employed to run the early pregnancy service, colposcopy or the antenatal day unit and triage service. Contribution towards the out-of-hours rota is negotiable with fixed nights being preferable to minimise disruption to delivery of autonomous daytime sessions. Furthermore, specialist doctors can make valuable contributions to teaching, research and leadership roles.

To apply for a specialty doctor post, doctors must have a minimum of four years post-graduate experience, of which two must be in the specialty. The new specialty doctor contract offers a flatter pay scale than previous SAS and LE doctor posts, thereby enabling quicker progression and reducing the gender pay gap. Pay progression is linked to career progression which helps encourage doctors to continue to develop their skillsets and take on further responsibilities with time. The contracts limit the percentage of hours that can be worked out-of-hours making these jobs more attractive and more sustainable in the longer term.

Cross-site working

Another solution to help maintain services and skillsets in remote and rural units is to develop cross-site working arrangements for senior doctors with larger, usually tertiary hospitals. Hospitals jointly appoint a senior doctor who works at both sites. This has the advantages of being able to deliver sub-specialist services, close to the locality where women live. It also improves training opportunities for other doctors and the wider multi-professional team. It reduces pressures on the tertiary unit by dispersing workload by avoiding centralisation of services, thereby improving care for women at both sites.

However, there are also disadvantages of this model of care. While it offers senior doctors a varied job plan, cross-site working can cause issues with travel time, differences between hospital administrative systems and leave doctors feeling isolated from the rest of the clinical team.

Case Study: Cross-site consultant working between a small coastal unit and an urban DGH

Where?

- Royal Devon and Exeter NHS Foundation Trust (approximately 4,000 births per year)
- North Devon Healthcare NHS Trust (approximately 1,400 births per year)

Background

It was challenging to recruit consultants with specialist skills to provide emergency O&G services and specialist fertility outpatient clinics in a remote location.

What have we done?

- Three substantive consultants in O&G were recruited to provide services across both sites.
- One is a consultant with specialist skills in fertility, providing a wider range of fertility services at
- Exeter and a specialist outpatient fertility clinic at North Devon.
- A second consultant provides antenatal clinics and benign gynaecology operating services.
- All three consultants participate in the obstetric out of hours services at both sites.

What are the benefits?

- Specialist services are delivered close to community, hence leading to more personalised care and improved patient experience.
- Maternity staffing at the rural unit was maintained.
- Improved job satisfaction for the recruited consultants due to diverse opportunities with the ability to maintain access to high volume obstetrics.
- More consultants could be recruited by a combination of the career and lifestyle opportunities offered by both sites combined.

What are the challenges?

- Travel time between the units for the clinicians.
- Different policies, guidelines, and passwords for IT systems at different sites can be overwhelming.
- At the start of the jobs, individual consultants might feel like a "part-time" consultant in both the units and may not feel fully integrated.
- If there is no remote access to maternity records or results of the investigations, this may cause delay for patients.

Top tip

Continually seek feedback from staff and reassess job plans to keep developing roles.

Case Study: A collaborative model for providing fetal maternal medicine

Where?

- Evelina London Women & Children's Hospital and St. Thomas' Hospital London (GSTT)
- William Harvey Hospital, a DGH in rural Kent

Problem?

It was challenging to recruit sub-specialist consultants to the rural setting.

What have we done?

- In May 2019 GSTT, London and William Harvey Hospital, Kent jointly appointed a consultant who provides sub-specialist fetal medicine service (3 PAs) in Kent; two sessions on the same day with availability via telephone for clinical and administrative queries in between the clinic during the working week.
- The remainder of their time (7 PAs) is spent at GSTT, London, which includes a subspecialist maternal-fetal medicine (MFM) and a general obstetric service. This includes 3 PAs of medical education at the university hospital attached to GSTT and sessions in the tertiary fetal medicine unit at GSTT/Evelina.
- Antenatal visits for patients to GSTT for fetal medicine scans are kept to the minimum needed, while follow-up scans are facilitated locally through the tertiary-level fetal medicine service provided by GSTT.

What are the challenges?

- Distance travelled by consultant
- Challenges of getting acquainted with two units

What are the benefits?

- **Women and their families:**

a. Tertiary level fetal medicine care closer to home, hence improved patient experience.
b. Minimal disruption from travelling.
c. Continuity of care.
d. Personalised care plans by a collaborative, multi-professional team at both sites in complex maternal-fetal medicine.

- **For the individual consultant working between hospitals:**

a. Job variety with opportunities to manage general fetal medicine cases in the DGH and complex fetal medicine cases in the tertiary unit.

- **For the services:**

a. Alignment of fetal pathways to maternal, neonatal and paediatric pathways.
b. Direct access for obstetricians and neonatologists to the fetal medicine specialist.
c. Consistent cover and minimised variation during leave periods.
d. Greater multi-professional, educational opportunities thereby enhancing staff satisfaction and well-being through better support.
e. Empowerment and support of the DGH to provide safe and high-quality care and retaining specialist services.

Networks

An alternative or complementary way of working is to create clinical networks to provide care to women living in remote and rural areas. These networks can involve any type of sub-specialist obstetric, gynaecological or neonatal aspects of care. They offer the advantages of sharing knowledge between units, standardising models of care and reducing the need for women or doctors to travel long distances between hospitals.

Transfer networks ScotSTAR (Scottish Specialist Transport and Retrieval Service)

- Arranging in utero transfers can be difficult and time consuming for clinicians; a study in London showed clinicians spent a median (interquartile range) of 240 (150–308) minutes contacting seven (6–8) units when trying to arrange transfers themselves. This time can have a potential impact on clinical care and outcomes.
- ScotSTAR (Scottish Specialist Transport and Retrieval Service) is a special branch of the Scottish Ambulance Service. It includes neonatal and paediatric retrieval services as well as co-ordination services.
    - When a referral is made, this team establish details such as gestation, cardiac or surgical risk factors.
    - A conference call is placed by the specialist team between referring and receiving obstetric consultants, with addition of any other required personnel. Details of case discussed and agreed.
    - Coordinating staff then deploy ambulance at agreed timescale.
- Similar models in the UK include Embrace, Yorkshire and Humber, which also include bed locator and conference calling within its neonatal framework.[51]
- The service differs from several other across the UK because the conference call enables all aspects of the transfer to be arranged by the team rather than some elements of it falling to clinicians.

Representation on boards and committees

Traditionally national boards and committees have largely focused on developing protocols, policies and models of care aimed at urban centres. The diversity within types of units and the differing benefits and challenges that this brings to women and healthcare professionals is under-recognised. It is therefore recommended that boards and committees should have representation from those living and working in remote and rural areas.

Adopting flexible working gives greater opportunities for doctors to develop portfolio careers. Participation in national workstreams not only enables individuals to enhance their leadership skillsets but also benefits units through the sharing of ideas and new innovative ways of working.

Key findings and recommendations

- Promoting the benefits of remote and rural working, practical support, flexible working, CPD opportunities and a friendly and supportive culture are key ways in which remote and rural units can recruit and retain O&G doctors.
- Multi-professional teams should consider innovative ways of working that prioritise the needs of women and focus on skillsets rather than adhering to traditional hierarchies and role definitions.
- The new specialist and specialty doctor contracts offer potential benefits to remote and rural units in helping recruit these doctors and develop their skillsets.
- Cross-site working and clinical networks offer alternative ways of delivering care which enable women living in remote and rural areas to access specialised services while minimising travel.

Optimising learning in remote and rural areas

Optimising learning opportunities in O&G in remote and rural units is important for several reasons. Firstly, maintaining the knowledge and skillset of the multi-professional team is critical to providing safe and effective patient care. Secondly, as discussed in further detail in the 'Building supportive, learning cultures in O&G' chapter, meeting self-actualisation needs of the workforce is an important pre-requisite of staff satisfaction, feeling valued and reduced propensity to leave.[22,23] This is perhaps most significant amongst younger generations. A survey of millennials found that 87% say professional development or career growth opportunities are very important to them in a job.[52]

Providing opportunities for trainees in remote and rural areas

Key facts

- Smaller units in rural areas are less likely to be allocated obstetric trainees.
- 80% of trainees will acquire consultant positions in the region in which they train, showing preference to hospitals through which they have rotated.

Small units offer a different training environment for both obstetrics and gynaecology compared to larger tertiary centres. Whilst there may not always be the breadth of subspecialist services, there are often more opportunities for hands-on independent practice. Teams are generally smaller meaning that it can be easier for a trainee to integrate into the wider multi-professional team and to receive mentorship and training from a specific consultant. Smaller patient numbers can better facilitate trainees to personally deliver continuity of care to women.

However, rotations in remote and rural hospitals can present significant challenges to trainees. These include difficulties in accessibility, commuting time, lack of public transport, family constraints, and perceived lack of training opportunities and effective supervision. It is also important that the seniority of trainees and their roles are considered carefully for units particularly out-of-hours. Often small units require senior doctors to work high frequency on-call shifts and therefore those working at ST3+ level must have some ability to autonomously manage frequently occurring emergencies.

Despite the benefits many smaller units have to offer, they are not always afforded the equivalent trainee allocation as larger DGHs and teaching hospitals. This not only means that trainees miss out on the training opportunities these units have to offer but it can also result in longer-term issues for units with consultant recruitment.

HEE has developed a working group specifically to look at the distribution of speciality posts in remote, rural and coastal training locations. Whilst we await the findings of this group, the following factors should be considered:

- ✓ Early discussion with training programme directors to identify a suitable time for a trainee to rotate to a remote/rural/coastal location to satisfy trainee factors and education requirements.
- ✓ When allocating trainees to programmes, smaller units need to be staffed in preference to the larger units (which have the greater potential to attract non-training doctors such as those from overseas).
- ✓ Consider identifying certain years such as ST4 or ST5 (as these are good years for developing broader range O&G skills) so that there is consistency in the skill of the trainees rotating to these places.
- ✓ Review of 'unpopular' locations by Heads of Schools to identify challenges and set up actions to address these.
- ✓ Ensure equity in rotation of trainees to these units – regional and speciality specific standard operating procedures are currently being drafted at HEE.
- ✓ Additional remuneration for relocation above current trainee reimbursement – such as the **Targeted Enhanced Recruitment Scheme** in Cumbria.
- ✓ Remote units could offer a 12 month out of programme experience (OOPE) job for a trainee who wishes to get experience of working in a remote setting (similar to trainees going overseas).

Support for senior doctors in remote settings

Remote and rural units have lower numbers of women under their care. However, complex cases and complications can still arise. Senior doctors are more likely to work alone or in very small teams and therefore it is essential they are provided with adequate support, particularly during their first couple of years in practice. This should ensure that they are able to independently manage time-critical obstetric and gynaecological emergencies as well as be aware of how and when to escalate to others for additional help. Those working in remote and rural units report that the Covid-19 pandemic has further highlighted the need for skills maintenance and refresher opportunities.

In order to support this, it should be mandatory for new consultants and SAS doctors to have an appointed mentor and a 'second on consultant' in place to provide input or assistance if required out-of-hours at the start of their post.

Units should also create flexibility in job plans to enable senior doctors to attend another unit or work with a consultant colleague to acquire new and maintain existing advanced skills. This should include less commonly performed procedures, such as abdominal hysterectomy. It also facilitates consultants engaging in professional support networks.

Succession planning

Succession planning is of particular importance in remote and rural areas where teams are much smaller. The retirement of a senior doctor has the potential to trigger an unsustainable workload crisis or loss of vital skills to a unit. Careful succession planning can help prevent this.

The following are considered good practice points:

- Each service area or department should regularly consider the age demographics and plans of incumbent senior doctors, to minimise the risk of unsustainable workload pressures upon retirement.
- Senior doctors approaching retirement can help their colleagues by giving informal notice of their long-term plans, well in advance of their formal notice period, if possible.
- Employers can help to avoid service pressures by moving quickly to fill any identified vacancies as soon as possible. This may be achieved by appointing to the same post, by service re-design, or by locum cover on an interim basis. A locum appointment should only be made until a substantive appointment is possible.
- Succession planning should be in place when retirement is expected within 2-3 years.
- Consideration should be given to appointing a new senior doctor and provide mentoring and support, 2-3 years in advance of a known retirement. This will ensure they are ready to act independently within the usual on-call arrangements for the unit.

What have other specialties done?

- Most specialties do not have specific training pathways for remote and rural practice. Some regional rotations include district general hospitals that are considered 'remote or rural.'
- General practice in Scotland has a post-CCT fellowship in remote and rural training. This is jointly funded by NHS Education for Scotland and the GP practices taking part in the scheme.

Adequate opportunities for CPD

Opportunities for continuing professional development (CPD) in the context of smaller units is often a concern for doctors, units and external regulators. Although doctors working in remote and rural units typically have lower caseloads than those working in larger DGHs and tertiary units, it is important that they remain up-to-date with mandatory training and management of emergency clinical scenarios. They must also continue to maintain and expand their clinical knowledge and skill-set. It is therefore essential that there are adequate opportunities for 'in house' teaching and training and that all doctors can readily access time and funding for study leave. Remote and rural units should factor in additional time and cost of travel which may be associated with this. Additional consideration should be given to the use of online learning resources.

Organisational learning

Ensuring learning opportunities for individual doctors in remote and rural units is key. However, an emphasis on continual organisational learning is fundamental to patient safety and maintaining standards of care.

Key findings and recommendations

- Remote and rural units offer different training opportunities to larger, urban centres. Placing more trainees in remote and rural units will benefit their learning and is likely to improve recruitment of senior doctors in these areas.
- Senior doctors should be given regular access to opportunities and funding to ensure they can engage in CPD, thereby maintaining and developing their skillsets.
- Succession planning for senior doctors is key to preventing rota gaps, staff shortages and loss of vital skills to a unit.

Conclusion

Small units in remote and rural areas provide essential health services and are key to delivering person-centred care. Centralisation of services creates problems for women living in both rural and urban areas and has the potential to widen healthcare inequalities. This is especially true with regard to emergency medical interventions where time and distance prove immovable barriers to desirable clinical outcomes.

In order to sustain such services, a multi-faceted approach is required. This includes steps to help recruit and retain healthcare professionals, thinking differently about how the wider multi-professional team work together to deliver services and embedding regular individual and organisational learning.

Those planning and providing maternity and gynaecological services should appreciate that 'one size does not fit all'. There is a need to carefully match the needs and expectations of the local populations to models of care which are safe, sustainable and cost effective. National standard setting should similarly reflect variability in service configuration.

Chapter 5: Multi-professional team working

Introduction

Obstetrics and gynaecology holds a unique place in medicine when it comes to multi-professional working due to the close and interdependent relationship with midwives as well as an array of other specialties, nurses, allied health professionals, support staff and non-clinical staff. It is often difficult to fully comprehend the full scale of the multi-professional team to which O&G doctors belong. However, understanding this is key to being able to understand a woman's journey through her care and all the other people with whom she may interact or who influence her experience.

Team map

With this breadth of different professional groups comes great diversity. Multi-professional teams within healthcare enable individuals with complementary skills and experience to work together. They facilitate effective communication which allows real-time problem solving and they provide a social dimension which is beneficial for economic and administrative aspects of work as well as enabling team members to have fun.[53] However, they can also bring challenges due to different opinions, priorities and ways of thinking.

Employees working within well-structured teams have been found to be less stressed at work as the team environment acts to buffer them from problems with organisational conflict and work overload.[54] While this makes for a more pleasant working environment for staff, it also has benefits for patient care. Borrill et al concluded that increased staff participation, support for innovation, co-worker support and reflexivity correlate positively with patient satisfaction.[55]

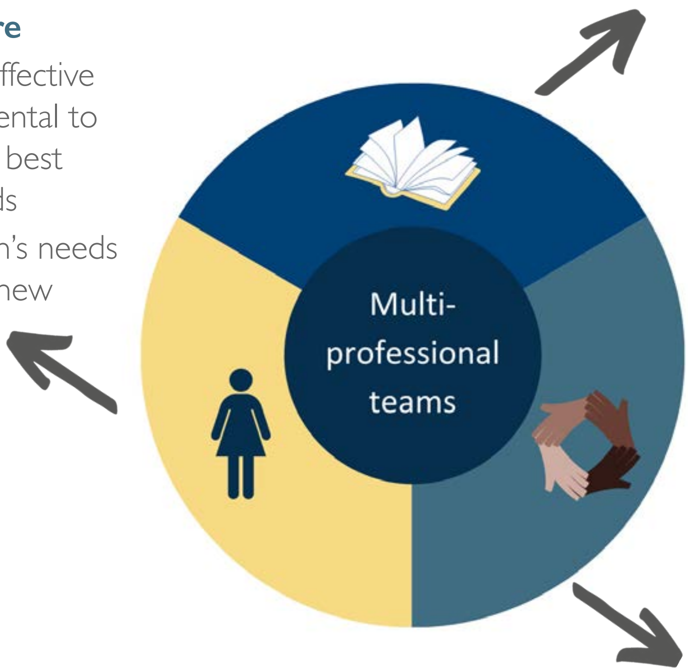
Multi-professional working may include task shifting from one professional group to another. Moreover, it is about embedding flexibility, adaptability and resilience into the whole workforce. It is about learning to work collaboratively in new ways as a cohesive team, putting the needs of women at the centre.

However, teams working within obstetrics and gynaecology have faced many challenges in recent years. There are unprecedented levels of clinical activity and complexity due to demographic factors such as rising obesity levels, advanced maternal age and assisted reproduction techniques. There is a greater focus on the need to ensure patient safety and provide quality of care which has resulted in increased patient expectations and higher litigation rates. At the same time, the NHS is critically short-staffed of doctors, midwives and nurses and managing on overstretched budgets.

How does this chapter relate to our values?

Person-centred care

- Recognising that effective teamwork is fundamental to providing care which best meets women's needs
- Putting the woman's needs first when designing new services



Learning

- Acknowledging that multi-professional teams who work together must also train together
- Appreciating that governance systems should focus on continualy improving systems rather than blaming individuals

Diversity

- Finding ways to optimise collaborative working across the much wider multi-professional team within which O&G sits
- Thinking beyond traditional professional boundaries and hierarchies to more inclusive ways of working

What makes an effective team?

Shared vision

Shared vision is important in developing common goals. Achieving this requires visible leadership, regular communication and a willingness to listen and learn.

Professional identity and role clarity

Within effective teams, it is important that everyone has a sense of individual as well as collective team identity.[57] Team members need to be aware of their own and each other's skills, attributes and experience. There should be clear lines of responsibility and accountability.

Interdependence

Interdependence describes the mutual dependence and synergism between two or more groups with the aim of achieving greater outcomes than either could achieve independently. This requires team members to develop self-awareness and also to acknowledge, respect and value the contributions of others.

Cultures of trust and psychological safety

Amy Edmonson[26] describes the importance of psychological safety for teams and organisations where there is 'a shared belief that the team is safe for interpersonal risk taking and a climate characterised by interpersonal trust and mutual respect in which people are comfortable being themselves'. In order to develop this inclusive culture, it is important that there are strategies to manage and resolve conflict. Further information on this can be found in the 'Building supportive, learning cultures in O&G' chapter.

Team reflexivity

Reflexivity is the ability to change and adapt how one works in response to altered circumstances. This is key for healthcare teams working in rapidly changing environments where resources are limited.

Teamwork:
A distinguishable set of two or more people who interact, dynamically, interdependently, and adaptively toward a common and valued goal/objective/mission, who have each been assigned specific roles or functions to perform (Salas 1992 cited by WHO 2009).[56]

Delivering person-centred care

Traditionally, healthcare focused on a one-to-one doctor-patient relationship. However, in more recent years there has been a shift towards delivery of healthcare by multi-professional teams. This perhaps stems from an increasing recognition that health is composed of psychological and social factors rather than just an absence of physical illness.

Delivering person-centred care in O&G means putting the physical, emotional and social needs of the woman above professional boundaries and working seamlessly together to provide holistic care.

To achieve this, we must move away from cultures of protectionism and recognise that it is no longer about job title but instead looking to who would be best placed to meet all the woman's needs. Continuity of care and streamlining pathways are key elements to this.

Person-centred care:
Organising services around patients, and not people around services. (Darzi, 2008)[9]

The NHS People's Plan, 2020, advocates that multi-professional teams are the foundation of future healthcare and so it is essential that O&G doctors embrace this and develop the skills to enable more collaborative working.[58]

In May 2020, the AoMRC published a report: 'Developing professional identity in multi-professional teams' which provides a clear and well referenced guide to the benefits and requirements for working in multi-professional teams.[57]

Compassionate leadership

Compassionate leadership involves ensuring a climate that encourages team members to listen carefully to each other, understand all perspectives in the team, empathise and help support each other. It requires a shift from hierarchical structures towards collective leadership whereby leaders develop shared vision and purpose and facilitate teams to work towards agreed rather than imposed objectives.[59]

Compassionate leadership also promotes inclusivity thereby creating psychologically safe working environments that embrace diversity and value difference so that multidisciplinary working and collaboration occur with minimal conflict.[60] In order for this to happen, leaders must genuinely value the contributions of staff and service users and accept the validity of their viewpoints.[61]

Leaders must take an approach of seeking first to understand, then be understood[62], then act as facilitators, capable of prioritising objectives and helping teams overcome challenges.[60] This can be achieved through greater use of patient narrative[63], good practice statements[64] and timely feedback.

Further information on patient involvement in O&G and feedback can be found in the 'Building supportive, learning cultures in O&G' chapter.

Changing professional roles within O&G

In order to adapt to the changes the O&G profession faces, it is necessary to look at all the roles within the multi-professional team and consider how we can work differently. This includes looking at what tasks are performed and by whom.

The following section includes case studies of how allied health professionals have adopted extended roles as well as exploring the possibilities for physician associates to contribute to the O&G workforce.

Developing multi-professional teams: Case studies

Case study: Extended role of midwives in maternity triage

Where?

- Leeds General Infirmary and St James' University Teaching Hospital
- Northern England
- District General Hospital and Teaching Hospital
- Approximately 10,000 births per year

Where did we start?

Situation

- Midwives would ask medical staff to review women attending triage.
- Out-of-hours, this would be the on-call team who were also covering delivery suite and all other clinical areas.

Problems

- When labour ward was busy, this would lead to extended delays for the women attending, resulting in poor patient experience, delayed transfers and anxiety for the midwives working in the area.
- Further frustrations for the midwives included the rotation of junior doctors, often with very little experience in obstetrics and limited skills.

What did we do?

- The philosophy of the Leeds Teaching Hospitals NHS Trust (LTHT) Maternity Assessment Centre (MAC) is to provide rapid access to appropriate care for pregnant women with acute (but not emergency) problems during pregnancy. We recognised that by requiring all women to be seen by a doctor, we were not optimising their care.
- Our maternity triage units are staffed by a core set of trained and skilled midwives along with the support of maternity support workers. We therefore decided that the maternity triage service at LTHT should be midwifery-led so that women can be seen, assessed and discharged by the midwife or if indicated, referred to an obstetrician.
- We supported our midwives in developing their clinical skills further so that they became independently able to assess and develop management plans for many of the women attending maternity triage. This includes taking histories and performing speculum examinations to diagnose pre-term rupture of membranes, taking of fibronectins to diagnose pre-term labour, presentation scans and non-medical prescribing.

- Medical staff will only be called where specifically indicated or if the midwife feels it is necessary. In some cases, midwives will consult with a doctor for telephone advice only.
- Supported by the senior midwifery team, midwives were encouraged to take on these extended roles and, where required, additional training was given along with completion of competency documents.

What have been the benefits?

- Midwives are able to provide holistic care to the women who attend their service.
- The medical team can concentrate on women in the acute areas.
- Midwives are empowered and encouraged to take on extended roles and additional training, which leads to improved job satisfaction.
- An improvement in women's experiences as there is a reduction in wait times and they are seen by experienced practitioners.
- Experienced midwives can teach the junior doctors.

What were the challenges?

- Consistency of skills of the midwives working in the maternity assessment unit, as there is not always a core midwife on the unit.
- It is still important for junior doctors to benefit from learning opportunities and for midwives to support them.

> **Our key to success was developing governance processes that looks to improve systems rather than blame individuals.**

Key learning points

- Implementing a midwifery-led triage unit did not require more midwives, it just required our midwives to work in a different way.
- Our maternity triage system recognises the experience of our midwives and supports multi-professional learning.
- Ongoing support from senior midwifery staff, obstetricians and those in leadership roles has been key to developing a 'Just Culture' whereby if an adverse event occurs, the processes around it are investigated and improvements are made. We avoid blaming individuals and progressively restricting practice of staff groups.

Case study: Alternative to a first on-call tier out-of-hours

Where?

- St George's Hospital
- Central London
- Teaching Hospital
- Approximately 4,500 births per year

Situation

- 18 years ago, the trust was not allocated junior tier doctors (ST1/2 trainees and GP trainees), who generally provided the first on-call tier.

What did we do?

- The first on-call tier was removed and tasks were reallocated among the multi-professional team.
- Particular attention was paid to increasing skills and senior support for midwifery staff, robust referral pathways to Early Pregnancy and Acute Gynaecology and employing surgical nurses trained as first assistants within the obstetric theatre team.
- The weekend on-call team includes two registrars covering inpatient gynaecology and obstetrics in addition to a registrar or fellow covering acute gynaecology during the day.
- Early Pregnancy and Acute Gynaecology Unit services are accessible seven days a week. On the night shift, two registrars cover obstetrics and gynaecology; supported by the enhanced multi-professional team.
- In labour ward, triage is staffed by senior band 7 midwives who assess and refer women, including those presenting at pre-term gestations. They will refer to the registrar if required.
- Cannulation and venepuncture training has been prioritised, and the escalation policy where access is difficult involves referral first to the co-ordinating midwife. Similarly, where junior midwives are still developing confidence with perineal repair, support is provided by practice development midwives and the labour ward band 7 midwifery team.
- The obstetric theatre team includes surgical nurses who have completed formal training as surgical assistants and who can work as either scrub nurses or first assistants for caesarean sections. This role was originally planned to be filled by midwifery staff from the labour ward, but it was found to be untenable in removing an intrapartum midwife from the labour ward allocation for unpredictable lengths of time.

What have been the challenges?

- The principal challenges with this model of service provision related not to out-of-hours care but to 'in-hours' routine ward cover.
- Ultimately, junior tier doctors were re-introduced into the department in order to support timely review and discharge planning on the inpatient wards. However, the multi-professional team adaptations described have ensured a robust service out-of-hours that meets the needs of women.

Key learning point

- This model of out-of-hours care provision shows that safe and timely emergency care can be provided with a team structure that does not map directly onto the first, second and third on-call structure. Instead, it draws on the skills of a variety of multi-professional team members to meet women's needs in the acute setting.

Case study: Training Advanced Birth Practitioners (also known as Advanced Midwifery Practitioners)

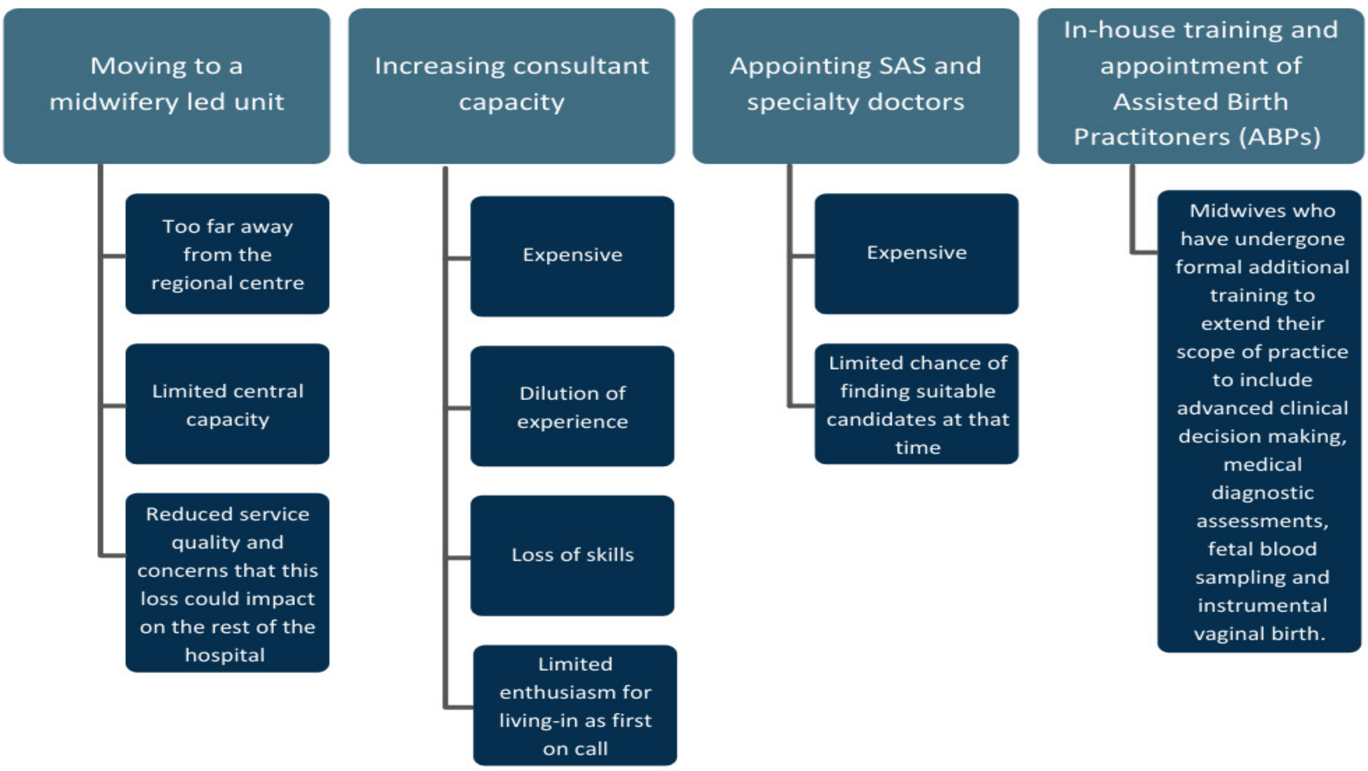
Where?

- Borders General Hospital, Melrose
- South-East Scotland
- Small District General Hospital
- Approximately 1,000 births per year

Where did we start?

- In 2010 we were informed that there would be a reduction in SE Scotland O&G trainee numbers from 44 whole time equivalents (WTEs) to around 30 WTEs to match projected consultant numbers.
- There are four hospitals in the SE Scotland region of which our hospital is the smallest (approximately 1000 births p.a.) and we were concerned that the reduction could fall disproportionately on our service.

Options appraisal



How did we implement change?

- It was felt that training two ABPs was likely to provide the most effective sustainable solution.
- We visited a group in NHS Grampian who had already developed and evaluated this service.[65]
- Although the midwives undertake formal teaching, the key part was their practical labour ward training which was carried out by a combination of trainees and consultants, with the midwives as supernumerary over two years.
- Once trained and deemed competent, they then covered our labour ward 1:5, with the other 4 nights covered by registrars and an Associate Specialist. For the first few months, we ensured that a member of the medical staff stayed in hospital in case help was required at short notice. Thereafter the consultant became non-resident.

Were there any problems implementing the change?

- We took a key decision to allow the ABPs to 'call a category 1 section.' This was seen as controversial, as deciding to do an operation is not always considered within the midwifery scope of practice, and there was some senior midwifery and anaesthetic resistance. We felt it was important to ensure that there was no delay in transferring a woman to theatre and it was understood that the consultant might, on arriving in theatre, decide that a section was not required. Once accepted, this system worked well.

How was the service change evaluated?

We looked at instrumental births in the first year, comparing those carried out by medical staff with those by the two ABPs.[66] We found:

- No difference in maternal and neonatal outcomes
- No difference in the frequency of the need for consultant supervision
- High maternal satisfaction rates for deliveries performed by ABP midwives
- Debriefing rate by the ABPs was almost double that of medical staff

Key finding

The role of the ABPs has worked extremely well for our service and has been invaluable in allowing us to continue providing our service with varying registrar numbers.

Top tip

Succession planning is essential to ensure an ongoing service. A lead-in time of at least 3 years is required from decision to becoming an established practitioner.

Top tips for supporting changing professional roles

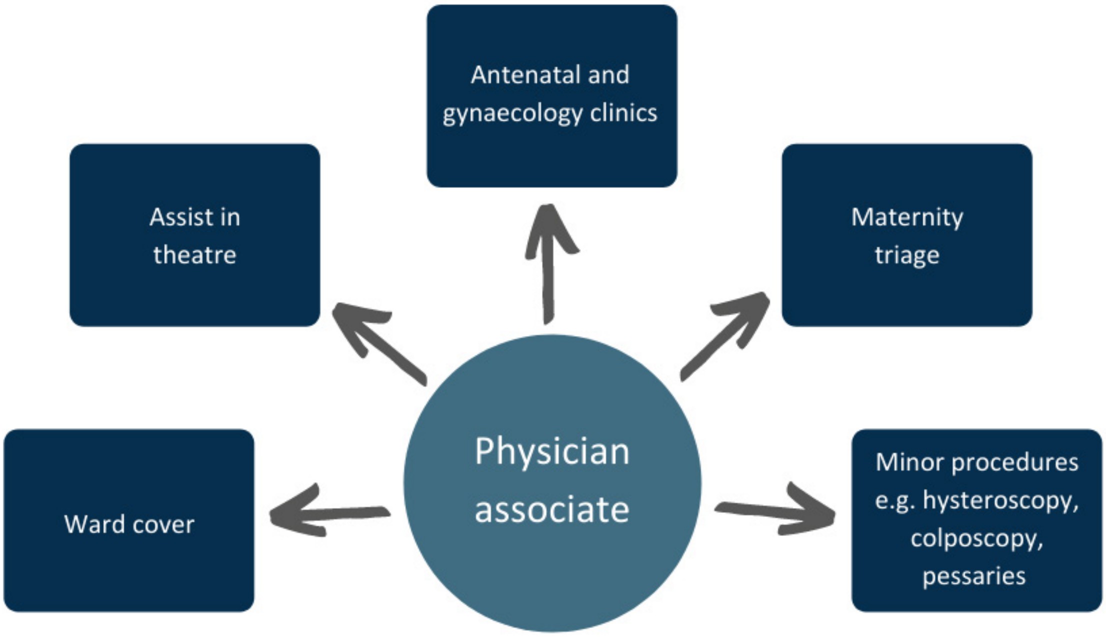
	**1. Keep the woman at the centre** Lots of other factors may play into why change is needed. However, these will often resolve themselves if you keep the focus on improving care for women.
	**2. Share your vision** Share the vision and values of your department so new team members integrate well into the existing team rather than start working in silos.
	**3. Provide role clarity** Provide clarity regarding the role and responsibilities associated with it.
	**4. Ensure adequate supervision** Provide adequate supervision, mentorship and support. This may be from someone within the same staff group or another profession.
	**5. Accountability** Have clear line management structures.
	**6. Prioritise education** Prioritise CPD, learning and training for all healthcare professionals. Create opportunities for multi-professional life-long learning. Involve women and their families in this process. Ensure that staff groups do not feel they need to compete for learning opportunities.
	**7. Allow time** Adapting to change can take time and it is important that all staff feel supported through it. Consider taking a staged approach so that culture is not negatively affected.
	**8. Create supportive governance structures** Governance structures must protect and promote patient safety. They should also foster relationships of trust and psychological safety which look to improve systems rather than apportion individual blame.
	**9. Support flexible working** Support flexible ways of working at all career stages to improve job satisfaction and reduce burnout. For further information see the chapter on flexible working.
	**10. Seek feedback** Continually evaluate the change and seek feedback from women and all staff involved. Use your regularly collected data to review how you are working.

Physician Associates within Obstetrics and Gynaecology

Physician associate (PA) training commenced over 15 years ago in the UK and there are now around 3,000 trained PAs. PAs specialise after qualification, with the majority working within adult hospital medicine. In other specialities, they have taken up roles in outpatient clinics, inpatient wards, theatres and providing specialist minor procedures, often with a similar remit of work to some specialist nurses and junior doctors. However, nationally, only a small number have taken up posts within O&G to date.

	**Training** • To enter PA training, applicants must hold an undergraduate degree in a life science, such as biology or biomedical sciences, or in an allied health profession, such as pharmacy or nursing. • PAs undertake an MSc programme lasting two years which largely focuses on general adult medicine in hospital. • Students will typically spend a 2-3 week attachment in O&G.
	**Registration** • On qualification, a PA is a member of the Faculty of Physician Associates, within the Royal College of Physicians. • It is anticipated that from autumn 2022, PAs will be regulated by the GMC. This will allow them to prescribe.
	**Working hours** • A typical contract is for 37.5 hours.
	**Role** • Taking patient histories, performing examinations, diagnosing and managing conditions, performing some minor procedures. • PAs work under the supervision of a doctor. • Often comparable to a ST1-2 doctor.
	**Pay** • Starting salary is as Band 7 (around £40,000-£45,000 outside London). • Some internships are available as Band 6. • Out of hours payments: - Additional 30% pay from 8pm-6am weekdays and all -day Saturday. - Additional 60% on Sundays and bank holidays.

Potential roles for physician associates in O&G



What benefits could physician associates bring to O&G?

- Team stability compared to junior medical staff who have to rotate every 4-12 months.
- Expertise in gynaecology minor procedures and in turn teach other medical stuff.
- Continuity of care and expertise for patients if they specialise within one area.
- Additional workforce numbers for tasks such as assisting at caesarean section and ward cover, which may enable doctors to attend other sessions which better support their learning.
- Additional workforce for out-of-hours shifts.

What are the pre-requisites to successfully employing a PA?

- Integration into the clinical team and made to feel valued.
- Appropriate supervision and support by a named supervisor.
- Access to CPD and further training opportunities.
- A varied and interesting job plan that benefits the individual, the department and patients.

What are the challenges when employing a PA?

- Physician associates cannot currently prescribe (although this is expected to change in late 2022). This may restrict their role, particularly out of hours.
- They are relatively expensive to employ compared to doctors working at ST1-2 level, whose basic salary is currently around £33,000-£39,500, and particularly for out-of-hours shifts.
- They work fewer hours than most doctors.

Key recommendations for developing multi-professional teams

- Changing how you work does not necessarily require more staff, it may just require staff to work in a different way.
- Focus on developing governance processes which look to improve systems rather than blame individuals.
- Person-centred care can be delivered without always adhering to traditional professional boundaries and hierarchies.
- Succession planning is key when implementing any major change or new way of working.
- Physician associates may have a role in O&G in a variety of ways including performing similar tasks to ST1-2 doctors or developing specialist skills in minor gynaecology procedures.

Developing multi-professional services

Delivering person-centred care as a multi-professional team involves more than just direct patient care. It is also about working collaboratively to change and develop services together.

Shared leadership:

A style of leadership in which all members of the organisation work together to make decisions.

Facilitating shared leadership amongst teams is an important element of making staff feel listened to and valued. It helps foster trust amongst colleagues. When staff feel more engaged at work, they are more likely to be more person-centred in their approach to patient care.[67] Other studies have linked greater staff engagement with improved patient safety and satisfaction.[18] By involving staff in the change process, it encourages them to take ownership and responsibility for not only implementing changes but also sustaining them. By involving larger numbers of individuals from different backgrounds, it allows for diversity of opinion and better understanding of what can be perceived as resistance to the change process.

Greater diversity within a team increases creativity and innovation.[68] However, it can also be a potential source of disagreement and conflict. The following diagram summarises the key elements that are required for multi-professional teams to optimise team performance to build services together:

The following section includes case studies of how multi-professional teams have worked collaboratively to implement, sustain and grow service improvements.

Case Study: Development of a one-stop emergency gynaecology service

Where?

- East Lancashire Hospital Trust
- Burnley, North West England
- Large District General Hospital
- Approximately 6,000 births per year

Where did we start?

Situation

- Our gynaecology inpatient ward and early pregnancy unit (EPAU) /gynae assessment unit are co-located. The EPAU is staffed by nurse sonographers separate from the ward staffing. Morning handover was separate between nursing and medical staff with no senior medical input. The night GP trainee handed over to the daytime GP trainee.
- Ward rounds were done by registrars in the morning before clinics as there was no dedicated consultant time for emergency gynaecology during the day. Consultant ward rounds were ad hoc during the day with the night consultant doing a ward round at 5pm when they took over.

Problems

- The consultant taking over at 5pm was often not on site or was late as their afternoon session was elsewhere.
- Women were admitted overnight for assessment in the morning but often there was no senior review available which resulted in prolonged length of stays.
- We were missing the 14 hour target for consultant review for emergency admissions. Ward nurses liaised with EPAU for scans on an individual basis preventing EPAU planning their workload allocation causing further delays in treatment plans.
- The ward was covered by FY1 doctors and GP trainees with support from the on-call senior registrar who was based largely on the Birth Suite. Therefore, there was limited supervision, delay in women being reviewed and a lack of opportunities for teaching and workplace-based assessments.
- As there was no senior time allocated, we had been unable to develop a manual vacuum aspiration (MVA) service or other outpatient treatments.
- The outpatient hyperemesis pathway was in the initial stages of development but there was no senior input easily available to develop this further.
- There were long delays in getting women to theatre for surgical procedures, resulting in women being kept nil by mouth for longer than necessary.

What did we do?

- The Covid-19 pandemic enabled us to change the service as needed rather than based on a business case. This gave us the freedom to implement change.
- We identified all the key stakeholders in our service: nursing staff (both on the ward and in the early pregnancy unit), trainees, consultants, the gynaecology matron, the clinical director and the AMD for division.
- We developed a shared vision: firstly that we wanted to improve care for our women and secondly to enable better team working amongst staff.
- Nursing and medical staff worked collaboratively to develop the following plan:

1. A consultant dedicated every morning to cover the ward, hot clinic and emergencies.
2. A joint handover at 8:30am which included junior medical staff, nursing staff from the gynaecology ward and nursing staff from EPAU/GAU. We handed over women who had been admitted to the ward including those who needed scans by EPAU teams. We reviewed the admissions for the day e.g. women suffering from hyperemesis, women requiring surgery and women booked in for hot clinic.
3. We created four 'hot clinic' slots where women who needed assessment could have a booked appointment. These included women who had been seen in ED the night before, GP referrals or referrals from within the service e.g. women with post-operative and miscarriage complications who needed review. This also required updating of the triage telephone proformas to manage appropriate timely assessment.
4. We added a slot for minor outpatient procedures including MVA, insertion of Word catheters etc.

What have been the benefits?

1. We identified key stakeholders
2. We developed a shared vision
3. Allocation of consultant time
4. Allocation of a ward nurse to hot clinic who liaised between hot clinic, ward and EPAU
5. Training- for MVA, updating telephone triage sheets
6. Equipment- MVA and beds. We already had scan machines in EPAU
7. Updating of guidelines and SOPs
8. Updating of telephone triage sheets
9. Communication with all partners e.g. ED, GPs and other colleagues.

"

Our key to success was developing a shared vision of wanting to improve care for women. It enabled us to work collaboratively towards a common goal.

What have been the benefits?

1. Reduced length of stay. Women are reviewed by a senior decision-maker so admissions are reduced and we have achieved the 14 hour review target.
2. Reduced waiting for surgical management of miscarriage as our MVA service is now running well. Women now have all options available for management of miscarriage.
3. Other outpatient procedurescan be done without surgery.
4. We have fully implemented a hyperemesis pathway which has significantly reduced admissions.
5. The teamworking between the medical and nursing staff and the ward and EPAU has improved through joint working. The educational opportunities for both junior medical staff and junior nursing staff, who get to work in different areas but with appropriate support, has developed the whole team and improved patient care and safety.

How have women felt about our new service?

"Excellent service."

"The staff have been fantastic making a difficult situation much better."

"My case was difficult and unique which they learn along with treating me and try to make it as safe as possible. The staff were very caring and supportive through this difficult time."

"Excellent level of care and compassion… calm, not over-crowded, no waiting, well planned."

"Friendly approachable staff who… are very empathetic."

"Staff were very compassionate and friendly, made us feel very supported."

"The staff were very professional and caring."

"Excellent service. Well informed and reassured."

Key learning points

- Prioritise women's needs and keep the woman at the centre of any change you make. This will make care more effective in the long term and time and resource efficiencies will flow from this.
- It is important to engage the whole team who will be working together by having a clear vision as to why the change will be good for all.

Top tip

Don't forget, people will choose to get on board with the project at different rates. Try to explore why some people are resistant to implementing change, as it is often an obstacle you have forgotten to sort out.

Case Study: Development and implementation of the Birmingham Symptom-specific Obstetric Triage System (BSOTS)

Where?

- Birmingham Women's Hospital
- Birmingham, England
- Teaching Hospital
- Approximately 8,200 births per year

Where did we start?

Situation

- Like most maternity units in the UK, we identified high numbers of women who attended delivery suite with problems that were pregnancy-related but not labour and that their attendance diverted midwifery staff and clinical care from women in active labour.
- Our maternity triage department had been developed in response to the national recommendation that women who attended with unscheduled pregnancy related problems should be seen in areas away from delivery suite. However, the department had been created in a small repurposed physical space, without standardised clinical processes or pathways or specifically trained staff. As the emergency portal to the maternity service, the clinical workload continued to expand, with attendances increasing to that of double the number of births.
- Women would wait to be seen in the order in which they arrived, without clinical assessment until they were seen, although informal triaging based on any obvious need did sometimes occur.

Problems

- In 2010-11 the delivery suite leadership team identified triage as being problematic, despite the triage area being relocated to a purpose-built space adjacent to delivery suite.
- The whole multi-professional team including the lead obstetrician, departmental manager, clinical midwives and obstetricians felt the department was chaotic and disorganised due to the number of women attending and no standardised approach to prioritisation.
- Local incident reviews repeatedly identified delays and lack of appropriate clinical prioritisation as a contributory factor to clinical incidents.

What did we do?

- The BSOTS was co-produced by clinicians at Birmingham Women's and Children's (BWC) NHS Foundation Trust and researchers at the University of Birmingham. The clinical team included the lead obstetrician for delivery suite, the delivery suite matron, senior midwives and the audit and guideline midwife.
- Between 2011 and 2012 the development group designed and developed BSOTS. The system is based on the established triage system used in emergency medicine (Manchester Triage system). It is a standardised tool to assess women presenting to maternity triage with common pregnancy-related conditions, to determine the clinical urgency with which the women need to be seen.
- The team also developed a bespoke training package for staff and carried out extensive multi-professional training prior to its launch.
- BSOTS was successfully implemented in April 2013 at BWC.
- The midwives from the development group championed and led the use of BSOTS within the clinical area and supported its implementation by working regular shifts in the department after its launch.
- Midwives and medical staff were encouraged to provide feedback about the new system and their training, and this led directly to changes to BSOTS paperwork and its training package.
- More widespread implementation of BSOTS in different maternity units across the UK is a continuing example of multi-professional working. From its inception, and continuing in the sites who implement BSOTS, both obstetricians and midwives work together to improve the safety of mothers and babies when they attend maternity triage.

What have been the benefits?

- Local evaluation demonstrated more women seen within 15 mins (38% to 53% (Relative risk (RR) 1.4 (1.2, 1.7)) and less time to being seen by an obstetrician for those who needed to be.
- The standardised assessment and excellent inter-rater reliability means that there is minimal variation in the clinical urgency assigned by individual midwives, irrespective of midwife band level or triage experience.
- Workload and acuity can be more clearly assessed, and this aids escalation when required, resulting in safer care.
- When obstetricians attend triage there is a clear system to aid the order in which women need to be reviewed.
- An improvement in staff relationships and the working environment.
- BSOTS has resulted in a shared language between healthcare professionals which supports clear communication.

Roll out

- BSOTS has been implemented in 38 maternity units in the UK with a further 20 in the process of implementation, and 25 awaiting training.
- Sunshine Hospital in Victoria, Australia, is the first international maternity unit to implement BSOTS, with interest from others.

Top tip

The multi-professional development, training and implementation of BSOTS enabled the clinical staff to work closely with the BSOTS Development Group to directly impact the system itself and provide timely feedback for improvements.

Further information:

- Birmingham Symptom specific Obstetric Triage System (BSOTS)
- Transforming Triage (RCM, 2018)

Case Study: Development of a midwife-led model of antenatal care for women with a previous caesarean section

Where?

- University Hospital Southampton
- Southampton, SE England
- Teaching Hospital
- Approximately 5,000 births per year

Why did we implement a change?

- We recognised that we had large numbers of women attending consultant-led antenatal clinic appointments. This was compromising care provided to all women due to time constraints.
- We wanted to improve care to women with a previous caesarean section by ensuring they had adequate time to discuss their birth options while not impacting negatively on the care of other women.

What did we do?

- In 2011, UHS Maternity implemented a midwife-led model of antenatal care for women with a single previous caesarean birth.
- The pathway was introduced following collaboration of senior obstetricians and midwives at the trust to reach a consensus on a new guideline.
- All midwives received training on key discussion points prior to implementation of the pathway, and since then, new staff take part in a 'birth after caesarean' workshop during their preceptorship period.
- Women who meet the eligibility criteria have all their antenatal care with a midwife unless other complications arise. Women with a medical condition, uterine or fetal anomalies, previous classical incision, or two or more previous caesarean births are cared for by an obstetrician.
- When the pathway was first introduced, women received specially adapted handheld notes which included a checklist for midwives and relevant information for women to read about their birth options. Now, women's records are electronic and they are signposted to an online information leaflet and 'birth after caesarean' webinar.
- For women planning VBAC, care is managed by their midwife until admission to the Labour Ward where care is overseen by the multi-professional team. Women have the option of telemetry and using the pool following appropriate risk assessment. Women who are unsure about VBAC or want to plan a caesarean are referred to the consultant midwife team to finalise plans for birth.

What have been the benefits of the change?

- A retrospective cohort study published in 2016 showed a reduction in the number of hospital appointments and unscheduled admissions following implementation of the pathway.[69]
- It also led to an increase in the number of women planning VBAC.
- Amongst the women who attempted VBAC, 78.4% had a vaginal birth compared to 68.5% in 2008. No differences in neonatal outcomes were found following implementation of the pathway.

How have women felt about our new service?

"I feel good about my decision and feel it's right for me."
Woman A

"I wanted to say a huge thank you to you and the amount of time you spent speaking to us. She felt that she was listened to and her wishes were respected and valued. It made such a difference to her, and to me, knowing that she had been able to discuss everything in advance with you."
Woman B's partner

"Thank you for the help, now I feel better as I can see the end of the tunnel."
Woman C

Key learning points

- By midwives undertaking a task previously performed by doctors, we reduced the number of hospital appointments which resulted in more streamlined care for women.
- Making the change improved clinical outcomes and was associated with high levels of satisfaction in the women and families we care for.
- Providing training to upskill all of our team has helped sustain and embed the change.

“

Our key to success was working collaboratively with our midwives.

Key recommendations for developing multi-professional services

- Develop a shared vision so that the whole team can work cohesively and collaboratively towards a common goal.
- Prioritise women's needs and keep the woman at the centre of any change you make. This will make care more effective in the long-term and time and resource efficiencies will flow from this.
- Promote multi-professional participation in service transformation to encourage greater diversity of opinions and ways of working which can improve creativity and drive innovation.
- It is important for those who implement change to be directly involved 'on the shop floor' following change so that they can understand how things are working in practice and receive and act upon staff and patient feedback to facilitate ongoing improvement.
- Facilitate multi-professional training to help embed and sustain change.

Where next for multi-professional team working?

Co-production of services with women

While there are many great examples of different healthcare professionals flexing roles and developing multi-professional services to best meet the needs of women, there is still considerable work to be done in recognising women's roles within this. The O&G profession is becoming more proficient in listening to women's personal preferences for their care and seeking women's feedback and views on services. However, much work still needs to be done in terms of true co-production of services between clinicians and women. Often women's views can be an afterthought rather than a priority at the point of implementing change. This must change if the profession is to become truly attuned to those we care for. Further information on this can be found in the 'Building supportive, learning cultures in O&G' chapter.

Relationships with Primary Care

It can be easy for doctors to view a woman's O&G care as what she experiences in the O&G department while interacting with O&G doctors and other health professionals. However, for many women, this journey starts and finishes in the community. If a woman has attended her GP surgery she may have been assessed by a GP, nurse practitioner, practice nurse, physician associate, GP registrar, paramedic or community pharmacist. Alternatively, she may have attended a sexual and reproductive health clinic and been seen by a community sexual and reproductive health or genito-urinary medicine doctor or a nurse.

Secondary care practitioners should be aware of the diversity of the multidisciplinary team in the community and work collaboratively with them. Devising efficient, streamlined referral pathways, preferably one stop and close to the woman's place of residence are key to reducing duplication and unnecessary delays to patient care. Achieving this requires engagement with NHS and local authority commissioners as well as women themselves in order to maximise acceptability to women, appropriate funding and efficient use of resources and staff.

Conclusion

The O&G workforce is facing challenging times. Alongside meeting the background demands of increasingly complex obstetric care, an aging and more ethnically diverse population, greater patient expectations, service restructuring and budget cuts, the Covid-19 pandemic has brought an array of personal difficulties to many and required everyone to work differently.

During such pressured times, it can become easy to lose sight of our overall personal and professional values. The purpose of this report has been to help the profession to re-focus on three key values which unite us; our dedication to delivering person-centred care, our recognition and respect for the diversity which exists within our own workforce and among the women we support, and our continued commitment to embedding both personal and organisational learning in all that we do.

Whilst this report has not been able to cover all O&G workforce issues, it has been written to shine a spotlight on several key topics which are pertinent at the current time.

It has demonstrated the complexities involved in planning and delivering services that will not only meet the needs of women today but also in the future. It has shown the importance of ensuring that advanced and subspecialist training opportunities are tailored both regionally and nationally to predicted population requirements. It has also explained the vital role of SAS, LE and MTI doctors in delivering O&G services and the pressing need to further address attrition and rota gaps.

It has highlighted the importance of meeting the physical, psychological and learning needs of the workforce in order to improve culture within the specialty and ensure learning opportunities for all doctors. Co-production with women and involving families as equal partners are both key to building learning organisations and continually improving care.

It has also identified the huge array of options for flexible working that exist for all doctors at all career stages and the potential benefits that these can bring to individuals, teams and organisations. A particular focus on team job planning showcases how this can positively impact teamworking, training opportunities and creating collaborative cultures.

In addition, it has underlined the differences between the population and service needs when delivering O&G care in rural and remote areas compared to cities. It has presented potential solutions to meeting the needs of women and reducing healthcare inequalities whilst ensuring services are safe and sustainable.

Lastly, it has acknowledged the huge team of professionals who contribute to O&G care. It has recognised that to deliver proper person-centred care, it is necessary to think differently and develop models of care which transcend previously held ideas about hierarchies and role boundaries and instead focus on delivering services which best meet the needs of women.

This report has identified and promoted why professional values are important. However, values only make a difference when they are truly lived by every O&G professional in decision-making, in how we treat our colleagues, in how we lead and most importantly in how we treat women.

Through a multitude of real-life case studies, this report provides inspiration and an ongoing source of reference as to how our values can be implemented and 'lived' in our day-to-day work. The next step now requires everyone to play their part in ensuring that it is these values, rather than external pressures and constraints that drive us. By embracing this shared vision, we have the opportunity to improve ourselves, our teams and our organisations so that we can continue to deliver the highest possible standards of safe, effective and compassionate care to women.

Acknowledgements

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Lead Authors

Jenny Barber
Consultant Obstetrician in Manchester and RCOG Fellow in Workforce and Professionalism. I have had a portfolio career for the last seven years and completed O&G training just under a year ago. I have completed an MSc in Healthcare Leadership through the NHS Leadership Academy. I have previously been an HEE NW leadership fellow and national clinical fellow to the SuppoRTT programme. I am passionate about workforce issues in O&G.

Sophie Wienand-Barnett
ST6 O&G SW Peninsula Deanery. In the RCOG Workforce clinical fellow role I have really enjoyed working with colleagues across the UK to compile this report. I am also working as national clinical fellow at HEE and I have valued working together with both organisations and other professional bodies to influence future workforce planning.

Contributors

Gill Adgie RM
Regional Head, North of England, Royal College of Midwives. Represented midwives as part of the team developing the multi-professional teams working chapter.

Felicity Ashworth
I retired from O&G practice 3 years ago but maintain a keen interest in O&G workforce, particularly how careers should evolve over time, how to encourage new patterns of working which improve retention and how to be more inclusive of other professional groups. I was a member of the team developing the multi-professional teams working chapter.

Danielle Bhanvra
Matron for both Maternity and Women's Service at Harrogate & District Foundation (HDFT). Chair for the West Yorkshire and Harrogate Local Maternity System Workforce steering group. I contributed to the 'Multi-professional working' chapter as I have always had a keen interest in this area; with working together and training together placed high on the agenda at HDFT.

Dr Alastair Campbell
Consultant Obstetrician and Gynaecologist at the Royal Infirmary of Edinburgh, Scotland. I am Associate Postgraduate Dean (Quality) for NES and chair the Specialty Education Advisory Committee at the RCOG. I chaired the team exploring the Multi-professional team chapter.

Miss Rima Chakrabarti
I split my time working as both a Consultant and a Lecturer at UCL Medical School. With a background in Clinical Education, I previously completed research on attrition in senior O&G trainees. My main contribution to this report has been focused on how we can ensure the wellbeing and retention of our future workforce.

Miss F. R. Clarke
Consultant obstetrician and gynaecologist at East Lancashire NHS Trust and lead for the early pregnancy and gynaecology assessment unit. Contributed to the multi-professional working chapter.

Tom Clayton
Deputy Head of Workforce Planning, Health Education England

Miss Susie Crowe
Consultant Obstetrician and Gynaecologist. Flexible Working Champion for the RCOG, Clinical Lead, Each Baby Counts Learn and Support.

Dr Lesley Curry
Consultant Obstetrician and Gynaecologist, NHS Fife. Previous Scottish Clinical Leadership fellow. Contributed to the remote and rural working chapter.

Katharine Edey
Consultant Gynaecological Oncologist in Devon. Contributed to the remote and rural working chapter.

Dr Julie Anne Forbes
Associate Specialist in Gynaecology, Northern Ireland. Representative to the RCOG SAS/LED committee and SAS Lead at Belfast HSC Trust.

Dr Karen Lesley Guerrero (FRCOG)
Sub Specialist Urogynaecologist at NHS Greater Glasgow & Clyde and Chair of the RCOG Sub-Specialty Training Committee.

Dr Andrene Hamilton
I am a rotational part-time consultant in Obstetrics and Gynaecology within NHS Shetland. I contributed to the remote and rural, and the flexible working chapters. This was in view of my role in the most remote hospital in the UK, alongside regular voluntary work in low and middle-income countries and occasional work in Cumbria and the Falkland islands.

Dr Laura Hipple FRCOG
Worked in O&G for over 30 years, Associate Specialist since 2003. Currently working (non-clinically) as a SAS Lead and Tutor in North Cumbria. SAS/LED lead at RCOG since 2018 and vice-chair of the AoMRC SAS Committee. This report helps us to understand and recognise the value of our SAS and LE Doctor workforce and ways of promoting career progression in these posts, alongside traditional trainee/consultant pathways.

Ms Deepa Janga
Consultant in O&G, North Middlesex University Hospital, London. I contributed to the flexible working chapter of the report.

Dr Jennifer Jardine
Specialty Registrar in O&G and a Clinical Fellow at the RCOG. I provided input on sources of routinely collected information about workforce, demographic projections, and data sources for further investigation.

Dr Lorraine Johnston
Consultant Obstetrician and Gynaecologist, Causeway Hospital, Northern Ireland. Contributed to the remote and rural chapter.

Dr Alexandra J Kermack
NIHR Clinical Lecturer in Obstetrics and Gynaecology at the University of Southampton. I have been a trainee since 2010, having had two periods of maternity leave, completed a PhD in reproductive medicine and worked LTFT. I contributed to the flexible working chapter.

Dr Ellen Knox
Consultant Obstetrician (Maternal medicine) and current RCOG workplace behaviours advisor. As part of my workplace behaviours role, I contributed to the chapter on Building learning and supportive cultures in O&G, with an emphasis on embedding learning into the department at every level. I shared learning from the development of the workplace behaviour toolkit and real life examples around the UK.

Judith Kundodyiwa
Consultant obstetrician and gynaecologist and deputy divisional medical director in Bolton FT. I am also the RCOG MTI regional champion for the North West. For the last five years, I have been Specialty Education Lead and College Tutor for Bolton and Salford. I contributed to the 'Building supportive, learning cultures in O&G' chapter.

Miss Stephanie Lamb
I am a consultant in O&G at Plymouth Hospitals NHS Trust. I was part of the workforce planning group, focussing on ATSM regional distribution and guidance.

Dr Ruth-Anna Macqueen (MBBS BSc MRCOG)
Locum Consultant in O&G at Newham University Hospital, East London. I have a passion for improving working environments for staff, and optimising the experiences of those accessing our care. Previous roles include maternity investigator at HSIB and junior doctors' representative to the RCOG and the BMA. Currently completing an MSc in Patient Safety and Clinical Human Factors at the University of Edinburgh.

Dr Neil Maclean
Consultant Obstetrician & Gynaecologist, NHS-Western Isles. Having worked in the North of Scotland for over 30 years, I contributed insight into the service needs of remote and rural inhabitants and the expectations for the professionals who provide such care.

Katie Morris
Advanced Clinical Practitioner (ACP) working in gynaecology for the past thirteen years as a qualified nurse. I completed a Masters in Advanced Clinical Practice two years ago and work with the Benign Gynaecology, Endometriosis and Emergency Gynaecology teams at St. Mary's hospital in Manchester.

Dr Jane Panikkar (FRCOG MMED)
Consultant Obstetrician & Gynaecologist at Shrewsbury & Telford NHS Hospital Trust. Special interest in education, perinatal mental health, colposcopy and global health. Previous RCOG college tutor and HEE WM careers advisor. TPD HEE WM, QA Lead O&G HEE WM, Deputy Head of School HEE WM.

Mr Hiran Samarage
Consultant Obstetrician and Specialist in Fetal Medicine at London North West University HealthCare NHS Trust and RCOG MTI Committee Chair.

Dr Srividhya Sankaran
Consultant in Maternal Fetal Medicine & Obstetrics, Guy's & St Thomas' NHS Foundation Trust, London. I am proud to contribute to this important work. As a contributor to the rural working chapter, I felt privileged to share our experience and am humbled to learn innovative ideas and different models of working across the UK. This report will stimulate new ways of thinking in developing a workforce to deliver a safe, effective and efficient service and enable our specialty to attract, retain and nurture our workforce.

Dr Rakhee Saxena
Locum consultant in O&G in Nottingham. Until recently I worked as a LE doctor in Leicester and was SAS/LED representative for East Midlands. I am a member for the RCOG Race and Equality Taskforce and facilitator for the MTI communication skills workshop. I contributed to the chapter on multi-professional team working.

Dr Ian Scudamore
Clinical Director for Women's and Children's Services at University Hospitals of Leicester NHS Trust, Fellow's Representative on RCOG Council for the East Midlands and Member of the MRCOG Part 3 Sub-Committee. Contributed towards to the Flexible Working chapter.

Dr Farah Siddiqui
I am a Consultant Maternal Fetal Medicine Specialist and Obstetrician. University Hospitals of Leicester NHS Trust. I am also the Training Programme Director for the South East Midlands. I chaired the group of contributors for the workforce planning chapter.

Dr Jyoti Sidhu
O&G senior registrar in North East London, clinical adviser to NHS Resolution's Early Notification Scheme and course organiser for RCOG Risk Management and Medico-Legal Issues in Women's Health Care. Strong interest in learning from adverse outcomes.

Dr Heidi Stelling
As a Specialty Trainee in the North East of England and the Chair of the RCOG's National Trainees' Committee, I recognise the pressures faced in the O&G workforce. As a contributor to the workforce planning chapter, I analysed data held by HEE to deepen our understanding of attrition from Specialty Training in O&G. I am confident this report will motivate change towards improved trainee wellbeing.

Laura I Stirrat MRCOG, PhD

ST6 in Obstetrics & Gynaecology, South-East Scotland Deanery. I am passionate about workforce wellbeing and sustainability which I believe will deliver the highest quality of safe patient care, reduce errors, elicit excellence and reduce attrition in our specialty. Having followed previous RCOG Workforce reports with great interest, I relished the opportunity to learn from the working group and contribute to the rural and remote working chapter.

Rosie Townsend

SCREDS Clinical Lecturer and ST7 in Obstetrics and Gynaecology in Edinburgh. I undertook the majority of my O&G specialist training in London, during which time I completed my MD at St George's University in London. I am currently Chair of the RCOG Global Health Trainees Committee. I contributed to the multi-professional teams chapter of the report.

Ruth Unstead-Joss

I am keen for the diversity of voices of women and people who access obstetrics and gynaecology services to be truly heard in the development of the medical workforce. This will be crucial to the future provision of excellent services and care.

Dr Sarah Vause

Consultant in Fetal and Maternal Medicine and Medical Director of Saint Mary's Hospital, Manchester. As a contributor to the flexible working chapter, I have been incredibly impressed by the individuals we met who have developed and adopted their own models of flexible working. There is a lot to share in the report which will be of benefit to colleagues, departments, the profession and ultimately to the women and families we care for.

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