



Royal College of
Obstetricians &
Gynaecologists

PROVIDING QUALITY CARE FOR WOMEN

OBSTETRICS AND
GYNAECOLOGY WORKFORCE



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OBSTETRICS AND GYNAECOLOGY WORKFORCE

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Providing quality care for women: obstetrics and gynaecology workforce

Executive summary

IN 2015, THE RCOG ESTABLISHED the Safer Women's Health Care working party to consider the different workforce models required to ensure safe obstetrics and gynaecology care. This report addresses the difficulties being experienced in providing sufficient medical workforce in obstetrics and gynaecology to safely staff UK units. Units are reporting difficulties in identifying staffing solutions to address the gaps in middle grade rotas. Guidance is required for service leads, who have responsibility for ensuring safe patient care. This report provides the opportunity to update previous guidance within the *Safer Childbirth* report in light of subsequently published evidence.

It is recognised that there is huge variability of service provision around the country in terms of workload complexity, geography and current middle grade staffing. For this reason there is no single staffing model which is suitable for all UK units. The RCOG presents a summary of the issues and suggests solutions, especially around consultant working out-of-hours. Within obstetrics it is no longer possible to make recommendations about hours of consultant presence on the labour ward based on number of deliveries because of the diversity of consultant contracts and working practices.

KEY MESSAGES

- **Delivery of a high quality and safe service for women at all times is imperative.**
- **All members of the multidisciplinary team must have the appropriate competencies to deliver high quality care.**
- **Appropriate consultant presence should maximise training opportunities, with a balance between direct and indirect supervision.**
- **The expansion of resident consultant working needs to be monitored.**



Executive summary

RECOMMENDATIONS FROM THIS REPORT

RECOMMENDATION 1

All units need to ensure a locally agreed, safe and sustainable solution to address workforce issues to manage care in both obstetrics and gynaecology.

RECOMMENDATION 2

Safe service delivery can only be achieved with safe staffing levels in both maternity and gynaecology units.

RECOMMENDATION 3

All solutions should take into account the national issue of lack of availability of middle grade doctors leading to recurrent rota gaps.

RECOMMENDATION 4

Workforce solutions must optimise training opportunities and accommodate the changing needs of trainees at different stages of their careers.

RECOMMENDATION 5

All solutions should allow for multidisciplinary training, development of quality services and good clinical governance.

RECOMMENDATION 6

All units should have consultant labour ward presence during working hours Monday to Friday, with the intention to extend this to every day of the week.

RECOMMENDATION 7

Resident consultant working within a hybrid rota is recommended to ensure appropriate medical staffing. In most units, this will involve all consultants working in a hybrid rota with some out-of-hours shifts.

RECOMMENDATION 8

Remodelling job plans to include evening and weekend daytime working must be considered in order to maintain equity among the consultant team. Involving only newly recruited consultants in resident working can be divisive.

RECOMMENDATION 9

Culture change within the profession is needed since a contribution to resident working will be required throughout a consultant's career.

RECOMMENDATION 10

Resident consultants must be treated equally to non-resident consultants by all staff.

RECOMMENDATION 11

The RCOG's standards for job descriptions and job plans should be used by all units to help implement the above recommendations.

RECOMMENDATION 12

The RCOG must explore novel methods for assessing work intensity and out-of-hours staffing levels in both obstetrics and gynaecology.

RECOMMENDATION 13

The RCOG should develop a repository of good medical workforce models that are available to all.

RECOMMENDATION 14

Units must ensure that high standards of care are maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time.



Providing quality care for women: obstetrics and gynaecology workforce

I Introduction

THE MANAGEMENT OF PATIENTS

in the specialty of obstetrics and gynaecology is hugely rewarding and the dedicated staff who work within this field provide quality care to women. However, the ability to provide care is increasingly under strain as there are difficulties in providing medical staffing for our services, as well as rising service expectations and financial restrictions. In 2015, RCOG Council established a working party to review the issues, explore options and suggest solutions to address future provision of high quality care in the UK. This work was aligned with reviews of both the maternity and standards for gynaecology care. This report addresses the immediate issues of the medical workforce required to provide safe patient care.

Feedback from Clinical Directors, Heads of Schools and trainees is highlighting identical issues relating to gaps in the middle grade rotas and the difficulty ensuring the balance between service

and training. This situation is not anticipated to change. While ensuring safe maternity services is paramount, it is recognised that gynaecology services, especially emergency gynaecology services, must also be appropriately staffed. As a profession we must ensure that consultants' skills and expertise are valued, and that careers continue to be professionally rewarding.

In planning future care, clinicians and managers must take into account the views of patients around their concerns and choices of care. This requires exploration of women's perspectives on the issues of quality of care, care provider and location of care for both obstetrics and gynaecology.

In undertaking this work, the RCOG has become aware of a number of successful initiatives that are being developed across the breadth of the UK. We will establish a repository that Fellows and Members can access in the future.

In planning future care, clinicians and managers must take into account the views of women around their concerns and choices of care



Providing quality care for women: obstetrics and gynaecology workforce

2 The staffing problem

REDUCTION IN THE NUMBER OF AVAILABLE MIDDLE GRADE DOCTORS

IN A SURVEY of Heads of Schools in 2014 it was estimated that there were gaps in middle grade rotas approximately 30% of the time, and that this was fairly consistent across the country. Trainee rota gaps occur for various reasons, including out of programme time for research or subspecialty training; maternity leave; less than full-time (LTFT) working; and long-term sickness. The specialty remains appealing as a career and 100% of year 1 training posts (ST1) are filled. However, as a specialty with a large proportion of

female trainees, there is a concomitant high rate of maternity leave and LTFT working. This results in a reduced available middle grade workforce.

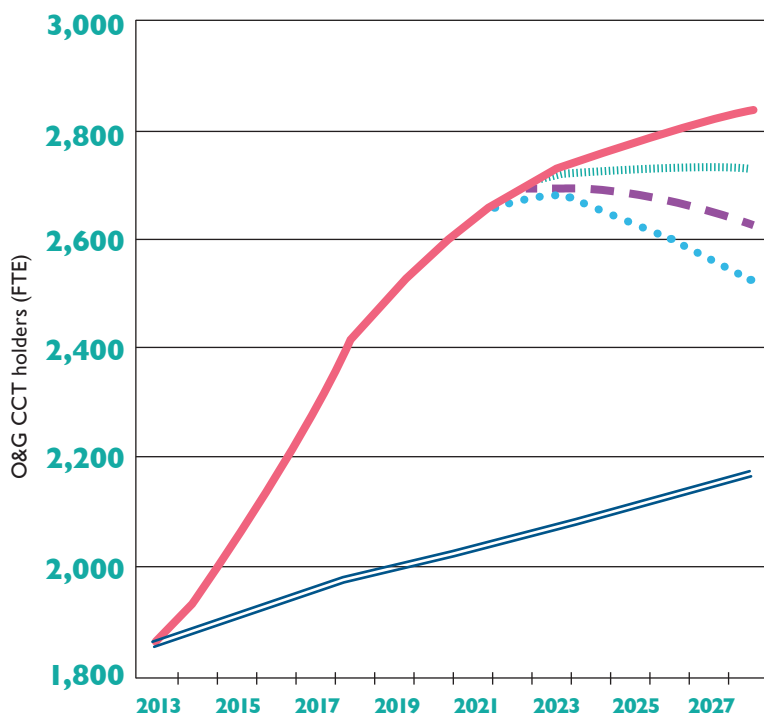
In addition, over the last decade the ability to recruit alternative non-training middle grade staff has been reducing due to specialty training changes, financial drivers and immigration regulations.

The award of a Certificate of Eligibility for Specialist Registration (CESR) to many staff grade doctors, who have demonstrated equivalent training, qualifications and experience to doctors who have completed a General Medical Council (GMC)-approved programme, has resulted in them vacating the middle grade rota to take up substantive consultant posts. Data from the last RCOG censuses¹⁻³ show that there has been a steady decline in the number of staff grade (218 in 2011, 169 in 2013) and associate specialist doctors (177 in 2011, 140 in 2013).

Locum doctor appointments have historically filled gaps in rotas. However, feedback from clinical directors is that the pool of locum staff has diminished considerably, making it extremely difficult to manage a compliant middle grade rota.

Going forward it is anticipated that rota gaps will persist in all units. The need to develop a more sustainable workforce solution is essential and immediate and has been the driving force behind the introduction of many resident consultant posts.

FIGURE 1: PRINCIPAL PROJECTION FOR O&G CCT HOLDERS AND ILLUSTRATIVE OPTIONS FOR REDUCING TRAINING NUMBERS, ENGLAND



Source: CfWI system dynamics model of the O&G CCT holder workforce for England.⁵

CHART KEY

- Demand - principal projection
- Supply - 5% per year (cumulative) reduction from 2015 to 2017
- Supply - 10% per year (cumulative) reduction from 2015 to 2017
- Supply - 15% per year (cumulative) reduction from 2015 to 2018
- Supply - principal projection



2 The staffing problem

EFFECT ON TRAINEE EXPERIENCE

Obstetrics and gynaecology units, which rely extensively on trainees to deliver the acute out-of-hours service at middle grade level, often struggle to sufficiently protect training opportunities when gaps in the rota occur. Trainees may feel pressurised into covering additional shifts and under such circumstances have reported both undermining and a poorer overall training experience.⁴ Increased contribution by trainees to the out-of-hours rota, primarily covering obstetrics, reduces their availability for elective daytime training and ability to gain experience in elective and urgent gynaecology work during the day.

REQUESTS TO INCREASE TRAINEE NUMBERS

Requests to consider increasing the number of specialty obstetric and gynaecology trainees to address the deficient numbers of available

middle grade doctors have been considered. A workforce analysis undertaken by the Centre for Workforce Intelligence (CfWI) highlights that there is likely to be an oversupply of obstetrics and gynaecology trainees gaining their Certificate of Completion of Training (CCT) – i.e. those who have completed the specialist training programme and are eligible to apply for a consultant post – by 2028 (see Figure 1).⁵ In coming to their conclusions, a number of factors were taken into account: 24/7 consultant presence, attrition from the specialty and an increased retirement age. In light of the cost of postgraduate training and the fact that there is no requirement to increase the number of CCT holders, there is no support for increasing training numbers. The CfWI report suggests that a reduction in the number of training posts is required to prevent significant overproduction of CCT holders. However, the RCOG believes that, if this policy were to be adopted, the crisis in the middle grade workforce would intensify.

Obstetrics and gynaecology units rely extensively on trainees to deliver the acute out-of-hours service at middle grade level



Providing quality care for women: obstetrics and gynaecology workforce

3 Potential workforce solutions

IN ATTEMPTING to ensure safe middle grade staffing, various solutions have been suggested which may be an option for some units. However, all of the options have their limitations and none presents a sustainable solution for all UK units. It is important not only to address the need to have a doctor who is a senior decision-maker available to provide the service, but also to ensure a high quality of care is prioritised. The RCOG promotes the principle that standards of care must be maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time.

SUGGESTED WORKFORCE SOLUTIONS

EMPLOY MORE LOCUM DOCTORS

The pool of locum doctors in the UK has diminished considerably due to changes in immigration rules and training programme structures. While locum doctors can provide a workforce solution, there are concerns about the expense. Locum doctors often work short-term contracts with minimal notice periods, which means they may be unfamiliar with the unit, its guidelines and practices. In these situations it is difficult to ascertain an individual's competency level without close direct supervision and difficult to ensure that appropriate emergency skills training is up to

date. Team working suffers as members of staff are unaware of each other's levels of clinical ability, and consequently there is a detrimental effect on patient safety. Locum doctors are therefore not considered a viable, sustainable option for long-term safe patient care.

EMPLOY TRUST GRADE DOCTORS

The number of trust doctor posts has increased considerably from 2011 to 2013 (260 in 2011, 382 in 2013), but the RCOG censuses¹⁻³ show a significant number of vacancies in these posts. Despite the increase in numbers, the gaps in middle grade rotas remain. Recruitment to these posts is difficult as there is no pool of available suitably trained doctors and no UK preparatory training pathway. Generally, recruitment is of overseas doctors and, without a change in UK immigration regulations, it is anticipated that recruitment of trust grade doctors will become even more difficult. Although the UK vote to leave the EU will have implications for immigration regulations, no change will happen in the short term and the nature and timeline of any changes is currently unknown.

INCREASE THE NUMBER OF MEDICAL TRAINING INITIATIVE (MTI) POSTS

The MTI scheme has been developed to allow international medical graduates to train in the NHS for a maximum of two years. As new entrants to UK practice, these doctors require significant supervision and assessment before being able to work independently on middle grade rotas. The RCOG administers this scheme and the number of appointable applicants currently almost matches the number of posts, which has remained stable at approximately 50 per year for the last three years. MTI doctors can only work in the UK for two years and therefore need to be recurrently recruited. There are strict regulations about who is appointable to maximise patient safety. While it may be possible to increase recruitment of MTI applicants and improve the opportunities for overseas doctors, there are limitations. Increasing the number of posts might simply result in unfilled MTI posts. While MTI recruitment may help

THEY SAY

"We had permanent gaps in the registrar rota because the deanery couldn't fill the training posts. It was difficult to get long-term locums and we advertised many times without success. The locum agency costs were extremely large and it was decided to have two posts at York with prospective cover by using the money spent on locums and reducing a trust-funded registrar post. This meant the registrars had to cover Wednesday to Sunday nights and weekend days.

"Resident consultants are still cheaper than a locum spend of £400,000 per year, which was the main reason for us considering and implementing this role."



3 Potential workforce solutions

workforce numbers, it is not felt that this is a sustainable solution for UK services.

APPOINT RESEARCH FELLOWS OR VISITING DOCTORS FROM OVERSEAS

In a minority of units, it may be possible to recruit research fellows or visiting foreign doctors to contribute to the middle grade rota. The units able to do this are likely either to be in London or to be tertiary centres with a strong academic profile. Conversely, if research fellow recruitment to major academic centres is from the UK trainee doctor pool, this compounds the workforce issues in other less academic units – this is already being noticed, creating a two-tier system of units and potentially making units seem ‘unattractive’.

CREATE POST-CCT TRAINING POSTS

Some units are advertising specialised post-CCT training posts with middle grade on-call duties. The current GMC-approved specialty training programme does not require additional post-CCT training, as a CCT holder should have all the necessary competencies to become a consultant. However, some individuals wish to develop more specialised skills in a specific area of practice and will opt to take on these roles for a short period of time. The *Shape of Training* report⁶ proposes post-CCT credentialing; it is possible that components of advanced and subspecialty training could be undertaken after CCT but before taking up a consultant post. If credentialing is approved by the GMC, such post-CCT training post holders could make a contribution to the out-of-hours rota. To date, national terms and conditions have not been developed for these roles; this would be required if post-CCT training were to become a standard part of medical career development.

OTHER HEALTHCARE PROFESSIONALS

While healthcare professionals such as gynaecology specialist nurses, advanced midwife

practitioners or physician associates can and do make a valuable contribution to service delivery, they cannot act in the role of senior decision-maker for emergency care in either obstetrics or gynaecology and hence are not able to fully contribute to the middle grade rota. Additionally, the midwifery and nursing professions have their own workforce issues, and further role development would require expansion of their workforce.

RESIDENT CONSULTANTS

In many units, rotas have been developed where resident consultants cover some slots on a middle grade rota, with other slots covered by middle grade doctors with a non-resident consultant, i.e. a hybrid rota. There are reports of units where this is working well, but also of units where resident consultants are unhappy.

CONCLUSIONS

The options for addressing middle grade rota gaps by employing alternative middle grade doctors are largely short-term solutions, have risks around them and could be costly.

The RCOG believes that, having considered all of the options above, it is evident that resident consultants will be part of any sustainable solution to current workforce difficulties. Therefore, there is a need to determine how best this should be implemented to ensure safe care for women and professional satisfaction for consultants.

The report explores this issue further, with the aim of providing a workforce solution that would ensure sustainable, safe services. The working party captured data on current arrangements for resident consultant working, then analysed this information to determine what is working well and what is a source of discontent. This was then used to develop proposals for resident consultant job descriptions and job plans. Further detail is provided in the following chapters.

Standards of care must be maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time



Providing quality care for women: obstetrics and gynaecology workforce

4 Exploring out-of-hours consultant working

WHEN ADDRESSING STAFFING of obstetrics and gynaecology units, clinical leaders prioritise safe patient care to ensure availability of sufficient staff and appropriate senior decision-makers. The RCOG promotes high standards of patient care and provides guidance to help clinicians to deliver this.

CONSULTANT PRESENCE ON LABOUR WARD

The Hospital at Night study published in 2005⁷ demonstrated that the level of activity in obstetrics is the same throughout the 24-hour period, and recommended that the level of cover should be the same throughout the 24-hour period, seven days a week. The RCOG's *Safer Childbirth* report⁸ included recommendations regarding staffing levels on the labour ward based on the number of deliveries within a unit, with particular emphasis on delivering a consultant-based service. The rationale for these recommendations had its foundation in the drive to improve obstetric outcomes, motivated by the increasing rates of obstetric intervention and increased perinatal mortality at night. In England, these recommendations were incorporated into Clinical Negligence Scheme for Trusts (CNST) standards and thus there was the financial impetus to effect change, albeit slowly. Some units were able to use the recommendations as a lever to increase staffing levels; however, others were criticised for failing to meet the standard. While it is generally agreed that consultant presence is beneficial in terms of improved management and training, there is less agreement on the direct benefit to women in labour and a lack of evidence to support the necessity for a model of 24-hour resident consultant presence on the labour ward in the interest of women's outcomes.⁹

Many units may still wish to increase the amount of consultant presence on their labour ward for a variety of reasons. In light of the current available evidence, fixed levels for consultant labour ward presence for different sizes of units cannot be justified. However, it is strongly recommended that all consultant-led maternity units should have a minimum labour ward consultant presence during working hours Monday to Friday, with the aim of extending this to every day of the week to

provide the same quality of service over seven days, in line with the aims of NHS England's seven-day service standards.¹⁰ This level of consultant presence is felt necessary for service development, multidisciplinary training and clinical governance throughout the working day, seven days a week.

The focus, however, should change from meeting arbitrary levels of consultant presence to ensuring there are appropriate numbers of staff, with the appropriate competencies, available at all times. In many units, the introduction of hybrid consultant rotas as a result of middle grade rota gaps has been necessary to ensure staff with the appropriate competencies are available; as a consequence, the number of hours of consultant presence on the labour ward has also increased.

CONSULTANT PRESENCE FOR EMERGENCY GYNAECOLOGY SERVICES

In considering the availability and level of competency of the appropriate workforce, the seniority of decision-maker required and the frequency of surgical input are relevant. It is important to recognise that, while National Confidential Enquiry into PeriOperative Deaths (NCEPOD)¹¹ data do not recommend undertaking surgical procedures overnight, this is not applicable in obstetrics as there is a need to have an obstetrician available and able to perform a caesarean section at all times. In contrast, the NCEPOD data suggest that most urgent gynaecological surgery should wait until the next working day.

The provision of high quality emergency gynaecological services is very important. These services often suffer lower staffing levels than emergency obstetrics services as obstetrics is prioritised. However, emergency gynaecology

THEY SAY

"We have a hybrid rota with 11 consultants currently providing resident cover two nights per week. The remaining eight consultants cover weekdays. We all share weekends."

The introduction of hybrid rotas ...has been necessary to ensure staff with the appropriate competencies are available



4 Exploring out-of-hours consultant working

The difficulty of staffing medical rota gaps, with the consequent effect of compromising safe service provision, has been growing more profound

patients can require immediate care, resuscitation and surgery. It remains problematic to provide guidance on staffing levels for gynaecology as there is less uniformity of service provision depending upon associated services, e.g. access to emergency theatre, availability of early pregnancy assessment units, provision of anaesthetic staff. It is recognised that emergency gynaecology patients are likely to wait longer as a result of reduced middle grade doctor availability, with decisions on patient care being delayed. This needs to be addressed by clinicians and managers.

In considering how to address safe staffing levels, it is crucial that both obstetrics and gynaecology care is considered. It is inappropriate to develop a solution that only addresses the provision of labour ward cover.

This report is about identifying an acceptable, safe and sustainable solution to a current and ongoing problem of filling the middle grade rota gap. It is not about 24/7 consultant presence nor about meeting a set number of hours of consultant presence.

DEVELOPING SUSTAINABLE SAFE SERVICES

The difficulty of staffing medical rota gaps, with the consequent effect of compromising safe service provision, has been growing more profound, and there are limited alternative non-consultant staff solutions. As set out in Chapter 3, there are possible middle grade staffing options that can be explored to address the shortage of middle grade workforce; however, none is sustainable and most are not suitable for the majority of units within the UK.

THEY SAY

“We have one night which is covered on site by a consultant with a junior doctor (old style SHO level) for 12 hours from 9pm to 9am. On the other nights and weekends we have a traditional on-call system with a registrar and an SHO on site.”

THEY SAY

“Initially we started as four PA residents on-call which was not leaving much time for anything else. We reduced to 2.25 with two consultants sharing one resident and one non-resident post, which is a much nicer option.”

Faced with a persisting staffing crisis, alternative strategies must be considered. Discussion is required to decide whether the current number of maternity units in the UK is sustainable or if there is a need to reconfigure services. This requires greater implementation of the network principles outlined in *High Quality Women's Health Care*.¹² The issues of patient choice, staff requirements, intensity of workload, geography and how services are delivered over the totality of a seven-day week also need to be explored. This work will be taken forward by the RCOG as part of a wider programme of work initiated by the Safer Women's Health Care working party.

The issue of ensuring appropriate obstetrics and gynaecology medical staffing levels in most UK units is immediate. In most hospitals the solution is likely to include resident consultant working, with consultants and the middle grade junior doctors jointly staffing the slots on the out-of-hours rota, i.e. a hybrid rota. In many hospitals hybrid rotas are being developed, with some resident consultants working some nights and a traditional 'consultant on-call from home' on the other nights.

Each unit should determine the workforce required to provide a sustainable, safe, high quality service for both obstetrics and gynaecology. It is clear that no single solution will be applicable to all UK units and, ultimately, local solutions will need to be developed. The service model may need to change over time if the workload or number of middle grade doctors changes.

There are currently insufficient avenues for sharing information about local solutions that work well. The RCOG should develop a repository of good practice examples that can be shared and made available to all.



Providing quality care for women: obstetrics and gynaecology workforce

5 The impact of resident consultant posts

TO DATE, IMPLEMENTATION of resident consultant working has not necessarily occurred in a planned strategic way, but rather as a necessary response to immediate workforce issues. The number of consultant posts with resident working out-of-hours (evenings or nights) is increasing. Resident consultant posts represent a new way of working and it is important for the future of the specialty that such posts are developed appropriately. While these posts are working well in some units, in other units resident consultants are feeling frustrated and disillusioned.

While resident consultant working is inevitable for many units, there are issues which need to be resolved. To identify and explore these in more detail, a survey of resident consultants was undertaken to identify the perceived benefits and the problems faced by individuals in these posts. A survey of trainees was also carried out to assess what their expectations of a future consultant post were. Several units that have established resident consultant posts were also approached and asked to describe their experience and the benefits and disadvantages for their service.

The results are described here, with more detailed accounts provided in the Appendix. Figures 2–4 provide detail from the analysis, and anonymised comments provide some additional context.

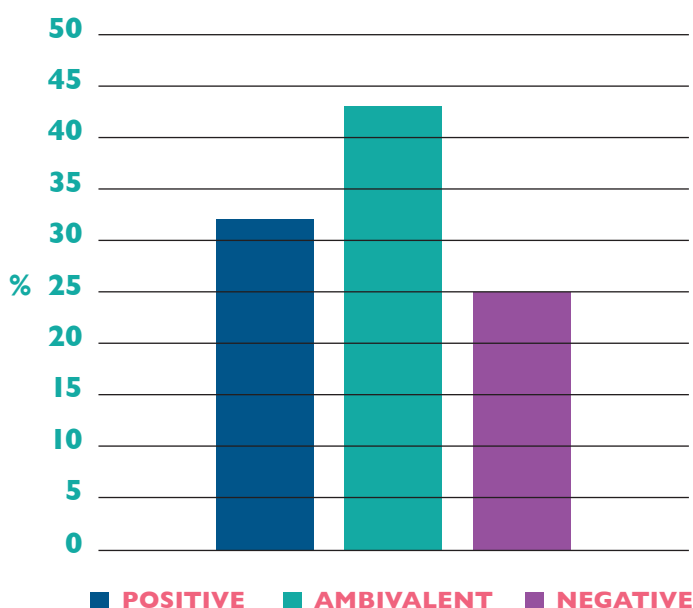
SYNOPSIS OF RESULTS FROM THE SURVEY OF RESIDENT CONSULTANTS

Clinical Directors of approximately 200 units in the UK were contacted by the RCOG in July 2015. Of 85 Clinical Directors who responded, 25 had some consultants contributing to the resident out-of-hours rota. The Clinical Directors were asked to disseminate a survey to all resident consultants working in their unit. The aim of the survey was to identify the perceived benefits and the issues faced by individuals in resident consultant posts.

135 resident consultants responded. The key messages from this survey were:

- Resident consultants were spread across units of all sizes
- An average job plan for a resident consultant had 10.5 PAs, consisting of 5.5 in-hours direct clinical care, 3.0 out-of-hours direct clinical care and 2.0 SPAs
- Almost half the respondents were working on the same tier of the rota as middle grade staff out-of-hours, i.e. 'filling rota gaps'
- Almost half the respondents said colleagues had made them feel 'more junior' and this was associated with a feeling of discontent
- Almost half felt they did not receive the same career development opportunities as non-resident colleagues
- Most felt resident consultant working improved quality of service, patient safety and training (see Figure 3)
- Opinions varied on the impact of resident consultant working on work-life balance
- Concerns about earlier 'burnout' were expressed
- Single fixed nights with a predictable rota were viewed positively
- A system where all consultants make some contribution to the out-of-hours rota was viewed positively

FIGURE 2 – OVERALL ATTITUDES TO RESIDENT CONSULTANT WORKING



5 The impact of resident consultant posts

FIGURE 3 – PERCEPTIONS OF THE IMPACT OF RESIDENT CONSULTANT WORKING



THEY SAY

“I prefer my pattern of resident work as it is not too onerous and gives me more flexibility in terms of my free time. I am never required to be ‘on-call’ from home and weekend work is relatively infrequent. I also prefer to be directly involved in supervising care than doing this from home in such a high-risk unit.”

THEY SAY

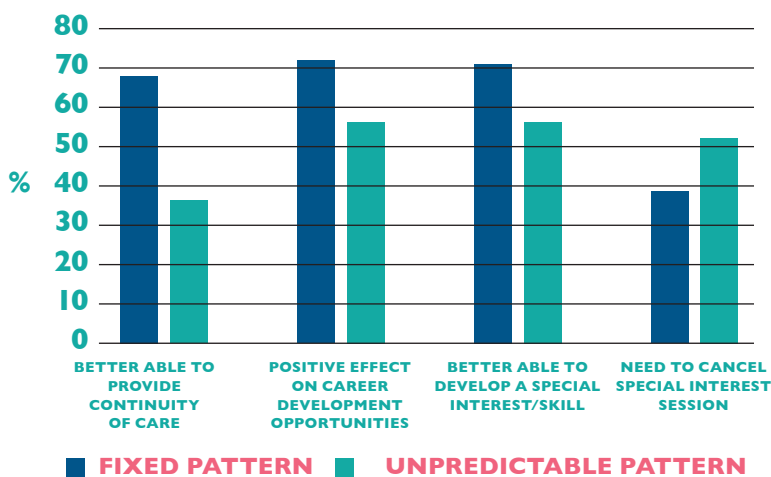
“I don’t mind being resident. In fact, I enjoy being involved directly in teaching, training and supervising trainees. The gynae and delivery suite staff also feel much more supported. The majority of women feel very satisfied being reviewed by a consultant out-of-hours. This also reduces the inpatient admission rate.”

From the feedback received it is evident that single nights, and a predictable pattern, seemed better than blocks of nights for work-life balance, continuity of care and professional development (see Figure 4).

Being made to ‘feel junior’ was more strongly associated with a negative overall view of resident consultant working than any of the other aspects assessed. Consultants who worked with fewer junior staff were much more likely to report that they were made to feel junior to their non-resident colleagues.

If resident consultants are working on the same rota as middle grade doctors, this may affect staff

FIGURE 4 – PERCEIVED EFFECT OF FIXED PATTERN VERSUS UNPREDICTABLE SHIFT PATTERN



THEY SAY

“It’s sometimes difficult to explain that, although I am second on-call, I am a consultant on-call.”

THEY SAY

“As none of the non-resident consultants took up a resident consultant role there is, I feel, some snobbery and divide between the two groups, which I feel is wrong. A case in point is the resident consultant carries a bleep when on-call, but the non-resident while on labour ward, on-call during the day doesn’t, which displays inequity.”



5 The impact of resident consultant posts

perceptions of them, i.e. there may be a tendency for other staff (consciously or unconsciously) to equate them with middle grade doctors. Some units have a second consultant on-call from home, who may be viewed/view themselves as more senior than the resident consultant. To change this perception would require all consultants (including the most senior) to carry out some resident consultant shifts. This would send out a strong message to all staff that level of seniority is not determined by resident or non-resident working.

SYNOPSIS OF RESULTS FROM THE SURVEY OF NORTHERN DEANERY TRAINEES

The RCOG working party also wanted to assess the opinion of future consultants. A questionnaire was emailed to all Health Education England (HEE) Northern Region trainees in June 2015, exploring their views of resident consultant working. 60 trainees responded. 45 (75%) anticipated working resident nights as part of their consultant job, and 36 (60%) were happy with this concept. 26 (43%)

THEY SAY

“I think resident consultant posts can easily cause resentment if it is not expected of the majority of consultants or if it is assumed that only very new consultants will take part. This can lead to more of a sense of a ‘junior/senior’ consultant divide. The resident consultant atmosphere in this hospital is pleasant, mostly because the older, more experienced consultants (even our clinical director!) agreed to take part.”

THEY SAY

“There does not seem to be any divide between a resident consultant and senior registrar in our unit – we do the job of both, which is frustrating and busy at night. There is also an unspoken divide between the resident and non-resident consultants.”

felt that resident consultant working would allow better opportunities for training (19 – 32% – were unsure). 38 (63%) felt that resident consultant working would result in better safety and outcomes for patients.

The responses from both of the surveys described above are similar to those reported in a survey of staff from Heartlands Hospital, where 75% felt that patient safety would be improved and 52% felt that training of junior doctors would be improved by increased consultant presence.

EXPERIENCE OF UNITS WITH ESTABLISHED RESIDENT CONSULTANT POSTS

In several units with established resident consultant posts, individuals also volunteered to describe their experience and the benefits and disadvantages for their service. The RCOG is keen to gather more information that will be useful to those developing new rota models. The submissions provided for this report are available in the Appendix. It is proposed that the RCOG should further explore methods for assessing staffing levels out-of-hours, encompassing both obstetrics and gynaecology. Future work should focus on the number of staff with the appropriate competencies to provide safe patient care.

75% of all Northern Deanery trainees anticipated working resident nights as part of their consultant job



Providing quality care for women: obstetrics and gynaecology workforce

6 Supporting a change of culture

PROVISION OF HIGH-QUALITY

care is critical and requires a sustainable, engaged workforce willing to work together in multidisciplinary teams. Those in senior leadership positions are responsible for ensuring safe medical staffing levels for both elective and emergency work; however, this requires all consultants to contribute to providing solutions to ensure obstetrics and gynaecology patients receive the highest quality of care. Senior clinical leadership can help change the culture within units.

From the analysis of potential middle grade staffing options, it is recognised that providing a safe, high-quality service will require a proportion of out-of-hours care to be delivered by resident consultants sharing slots on the rota with junior doctors (i.e. filling middle grade rota gaps). These rota changes should be developed in a predictable and planned way. It also needs to be acknowledged that, while this is a significant change in the way in which consultant obstetricians and gynaecologists work, consultant status and responsibilities remain the same.

It is important to understand that resident consultant working does not necessarily equate to always working night shifts. Rotas can (and should) be developed whereby some consultants contribute to resident out-of-hours shifts in the evenings or during the day at weekends. This allows **all** consultants to contribute, while recognising that they are not all able to work night shifts.

A number of issues need to be addressed in order to ensure sustainability of resident consultant working, as set out in this chapter.

MAKING RESIDENT CONSULTANT POSTS PROFESSIONALLY SATISFYING

It is important for staff retention and, hence, service provision that individuals find work professionally rewarding. In terms of consultant work, this relates to the clinical and non-clinical work that they provide. Resident consultants should have a job description that clearly reflects the need for service commitment but also includes planned sessions for professional development.

During normal working hours, there must be appropriate professional development

opportunities for consultants to develop clinical services and take on leadership roles, governance responsibilities, medical education and research within units. This is essential for the development of individuals as well as for the future leadership of the NHS. Resident consultants need to ensure that they in turn shoulder their share of clinical and managerial consultant responsibilities (governance, complaints, risk management), which will require the appropriate allocation of time for these activities – known as supporting professional activities (SPA) – in their job plans. There must be equal opportunities for career progression, but a recognition that career progression does not equate to moving to non-resident status.

Resident consultants must have their own caseload of inpatients and outpatients for whom they have responsibility. Patients want continuity of care, and job plans must be organised to ensure this occurs. Job plans with a fixed weeknight duty enable consultants to hold a regular clinic on days when they are not on duty (not necessarily every week) and also ensure the fixed resident shift does not impinge on a clinic or operating list if timetabled appropriately.

If job plans include a set of consecutive nights with blocks of time off, cross-cover arrangements need to be in place to ensure there is regular, consistent consultant cover for both inpatients and outpatients. This can be achieved through a buddying or partnership system, where consultants are paired. Consultants working in pairs facilitate patient management when a consultant is off following resident night shifts as well as reducing the need to cancel elective work during annual leave. For specialist obstetrics or gynaecology services, clearly defined joint working or pairing is particularly important, as both consultants will have the specialist knowledge and skills to continue to provide specialist care for women when their paired consultant is away.

In determining the pattern of resident working, it is important to maximise continuity of patient care. Predictable patterns of work, with single nights rather than blocks of nights, and appropriate time off before and after night shifts were viewed positively in the RCOG survey. Such patterns of working facilitate continuity of patient care, as well as increasing the ability of the consultant to

Senior clinical leadership can help change the culture within units



6 Supporting a change of culture

Preferred patterns of working may vary over the course of a consultant's career, with resident working offering the benefit of predictable time off

undertake specialist sessions or operating lists on a regular basis.

ENSURING CULTURAL COHESIVENESS OF THE UNIT

In units where resident consultant working is successful, senior members of the department have led by example and taken on resident consultant shifts out-of-hours. This leadership dispels the perception that working as a resident consultant equates to being a more junior consultant, and sends out a strong message to other members of the multidisciplinary team.

It is recognised that there may be reluctance among non-resident consultants to move to resident working. However, such consultants may prefer to contribute in a planned and coordinated way to evening or daytime weekend resident shifts, rather than finding themselves repeatedly and unexpectedly on-call overnight with no resident middle grade doctor.

It is also recognised that preferred patterns of working may vary over the course of a consultant's career, with resident working offering the benefit of predictable time off during the day, which may be valued by those with children and those with commitments to daytime external activities (e.g. regional or national roles). In addition, many consultants find it more difficult to undertake resident night work as they grow older.

In some units the frequency of consultant involvement in clinical activity overnight may be so great that it may be safer from a patient perspective, and preferable to the consultant, to be resident with appropriate, timetabled time off the following day, rather than being non-resident and expected to work a normal day after working a busy night on-call. These units may be the larger, busier units, or may be smaller units with a large proportion of locums or inexperienced junior staff.

It is important that there are transparent and clear job planning processes applicable to all consultants. This will ensure that individuals are treated fairly and hence improve cohesion. The process for changing the pattern of out-of-hours working should be agreed within each unit. As an increasing number of units have resident consultant posts, it is important that each unit agrees its own process. Once appointed to a consultant post in a hospital, a consultant should not then need to reapply for another consultant post in the same unit if they wish to change their working pattern. This should be managed through the job planning process. Equally, there should not be a guarantee that a resident consultant will automatically move into a non-resident post at any specified point.

It is inappropriate to fix a particular age at which resident night work should cease. This is firstly because age is a protected characteristic (i.e. it is illegal to discriminate against someone because of their age); secondly because some older consultants may find that working resident nights with time off during the day suits their lifestyle; and thirdly because some units may encounter a situation where a large proportion of the consultant body is of a very similar age and cannot provide the service if a cohort of consultants cease resident shifts at the same time. Changes in a consultant's pattern of work may need to be made to accommodate any relevant health issues.

CONSULTANT SKILLS FOR RESIDENT WORKING

Out-of-hours resident consultants will most often be working in lieu of a middle grade doctor, and will be expected to perform the duties of such a doctor while working on the labour ward or managing gynaecology emergencies. Concern has been expressed that some consultants may have lost basic skills if they have worked for many years in a supervisory capacity rather than being 'hands on'. If these consultants are to begin to work without a middle grade doctor on a resident shift, they will need to deliver basic medical skills as well as emergency obstetrics and gynaecology skills.

Competencies will include, but are not limited to:

- Basic medical skills: ability to site intravenous (IV) access, basic cardiopulmonary resuscitation (CPR), use of IT support (as per local policies), prescribing drugs/IV fluids, requesting and interpreting laboratory and other diagnostic tests
- Obstetric skills: amniotomy, application of fetal scalp electrode, fetal scalp blood sampling, manual removal of placenta, non-rotational forceps and ventouse, familiarity and skills in both managing all acute emergencies (e.g. maternal collapse, major haemorrhage, acute fetal compromise/ intrauterine fetal resuscitation, severe pre-eclampsia and eclampsia, etc.)
- Gynaecological skills: including surgical management of gynaecological emergencies (evacuation of retained products of conception, Bartholin's abscess) and initial assessment and management of critically ill patients



6 Supporting a change of culture

Individual practitioners will need to highlight where they may require training/re-training in certain of the above skills. Senior clinicians may feel they require specific re-training in the basic medical and IT skills required to work as a practitioner involved in hands-on service delivery out-of-hours. Re-skilling, particularly in obstetric skills (including obstetric emergencies), may be facilitated by attendance at an appropriate course such as MOET (Managing Obstetric Emergencies and Trauma). Additionally, unit 'skills and drills' sessions offer opportunities to train as an integral part of the multidisciplinary team.

BENEFITS FOR TRAINING

For the majority of trainees, increased resident consultant presence provides a concomitant increase in the opportunities for training. Resident consultants should demonstrate equal commitment to training out-of-hours as within working hours. The time a trainee spends covering emergency duties in both obstetrics and gynaecology is more likely to be directly supervised by a consultant who is resident. For junior trainees, this is particularly valuable for clinical skills acquisition in the emergency setting, with better opportunities for workplace-based assessments, constructive feedback and delivery of the RCOG training curriculum. For senior trainees, it allows the more technically challenging clinical skills to be learnt in a safe environment. Appropriate consultant presence should maximise training opportunities and the skill of the trainer is to achieve the appropriate balance between direct and indirect supervision.

As trainees approach the end of training, they need to have the opportunity to work in an emergency setting without constant direct supervision, in order to further develop their self-confidence, prioritisation, decision-making and leadership skills. Senior trainees also need the chance to supervise and train those more junior to themselves. In many units, hybrid rotas have been developed where some nights are covered by resident consultants, and others by non-resident consultants. Hybrid rotas have the benefit of providing direct consultant supervision on some nights, while giving trainees the opportunity to work more independently, with indirect supervision, on other nights. Therefore, a hybrid rota should not necessarily be seen as

a compromise, but may actually be a preferred solution to both workforce and training issues. In Peterborough, a model of 'consultant-delivered care' has been introduced, with a measurable improvement in training (see Appendix).

PLANNING SERVICES AND ENSURING APPROPRIATE STAFFING (INCLUDING SECOND ON-CALL)

When planning obstetrics and gynaecology service provision, consideration needs to be given not only to out-of-hours cover but also to how elective work and inpatient cover is provided, and how continuity of care is ensured for both inpatients and outpatients. Units may need to expand the number of consultant posts to implement resident consultant working consequent to the reduced availability of middle grade doctors. An increased number of consultants can reap benefits for other aspects of service provision, with more consultants available to cover inpatient wards, a more consultant-delivered service in outpatients and a larger team of consultants to share educational, managerial and governance roles.

Since the majority of the emergency workload overnight originates in the labour ward, it is possible that resident consultants may not be immediately available for out-of-hours gynaecology emergencies. Depending on the level of activity in a unit, a second non-resident consultant may be needed to provide advice about gynaecology emergencies, and may also be needed as the extra pair of hands in either obstetrics or gynaecology situations. These situations are not uncommon. Therefore, it should be recognised that the number of doctors readily available should not be reduced with the implementation of resident consultant posts.

In planning emergency medical staffing, the skills of individual consultants also need to be taken into account in determining the appropriate number of consultants required to provide emergency cover. The need for a second on-call consultant to support the resident consultant must be considered not only to accommodate times of heavy workload but also to ensure appropriate skills are available for possible complicated surgery (e.g. gynaecology emergencies). This must be a planned and resourced service to ensure patient safety.

Appropriate consultant presence should maximise training opportunities



Providing quality care for women: obstetrics and gynaecology workforce

7 Standards and job descriptions for resident consultant posts

TO ADDRESS the workforce issues discussed in this report, increased numbers of resident consultant posts are required. It is likely that, in the future, almost all consultant posts will include an element of resident working out-of-hours.

Careful job planning for all consultants within the unit and considerate timetabling of all activities is necessary to ensure resident consultants are not disadvantaged compared with their non-resident consultant colleagues. Units that do not provide attractive job plans will struggle to recruit and retain consultants. A high turnover of staff is not only costly, but also demoralising for other colleagues. It results in poor continuity of care for patients and poor continuity in any management roles that the consultant may have accepted.

Job plans for resident consultants must include sufficient time to enable consultants to maintain and develop specialist clinical skills; lead and develop clinical services; and take on academic, managerial and external roles, such as RCOG or NHS responsibilities. There should be an expectation that resident consultants will shoulder these responsibilities, but they need to be supported with resources and time in job plans.

With some systems of working, particularly if sets of consecutive nights are worked, SPA sessions and clinical administration time will be lost. As consultants will be expected to complete their non-clinical or administrative tasks, dedicated time needs to be allocated in another part of the job plan as these essential activities should not be undertaken in a consultant's own time. Careful timetabling and job planning for the whole unit is necessary to ensure appropriate patient care and

professional development opportunities. Rotas can become extremely complex, with little flexibility for taking leave if too many restrictions are in place or the frequency of out-of-hours shifts is too great. The current consultant contracts in England and Scotland place restrictions on the number of out-of-hours PAs.

Adequate cross-cover by other consultants for annual and professional leave should be included when rotas are designed for resident consultants. It is not appropriate to assume that trainees will cover consultant leave, as this will reduce their training opportunities for both daytime and night-time work. It is important to ensure trainees have appropriate levels of supervision for both emergency and elective work.

Consultants who work a mixture of resident and non-resident working would still attract the on-call supplement of between 3% and 8% of the consultant's salary, depending on the frequency of the on-call work. Hybrid rotas are therefore more costly than full-shift rotas; however, they are much cheaper and safer than recurrent payments to locum doctors.

Taking into account the feedback received from the survey of resident consultants, the survey of trainees and communications with Clinical Directors, on the next page are the RCOG's proposed standards for job descriptions and job plans. The aim is to ensure that consultant posts in the future provide appropriate opportunities for continuing professional development, and give post-holders enough time to take on leadership responsibilities. Only posts meeting these standards will be given RCOG approval.

Job plans for resident consultants must include sufficient time to enable consultants to maintain and develop specialist clinical skills



7 Standards and job descriptions for resident consultant posts

The weekly job plan should include a timetable which enables the consultant to maintain continuity of patient care with his/her caseload of patients

RCOG STANDARDS FOR CONSULTANT JOB DESCRIPTIONS

The following should be stated explicitly in the job description:

- That the post provides appropriate opportunities for professional development
- That the post-holder has a defined caseload (potentially shared with another consultant) and takes consultant responsibility for those patients, including their clinical management and for addressing any serious untoward incidents, complaints or claims
- A clear description of what is expected of the resident consultant when they are on duty, i.e. physical presence and involvement in clinical decisions and presence for certain procedures
- A clear description of the junior staff support while working out-of-hours, and whether the consultant will be expected to perform the same tasks as a middle grade doctor in addition to the decision-making, prioritisation and leadership role expected of a consultant
- The amount of time off before and after a night duty, when this should be taken, and whether it is paid or unpaid
- The arrangements for covering the consultant's leave, and also the arrangements for covering leave of the other doctors working on the same rota
- That the way in which the rota is organised for all consultants is fair and transparent
- That the post-holder will also have non-clinical consultant responsibilities, e.g. for teaching, audit, governance, educational supervision, quality improvement and management
- That the entitlement to study leave and professional leave will be the same for all consultants working in the unit
- That there is no expectation that the post would automatically progress to being a non-resident consultant post
- That there is a process in place for consultants to agree changes in their pattern of work
- That the post-holder will have appropriate secretarial support and office facilities

RCOG STANDARDS FOR CONSULTANT JOB PLANS

The weekly job plan should include:

- No more than three PAs worked out-of-hours
- At least one core SPA (mandatory training, appraisal, audit/quality improvement projects and RCOG CPD requirements)
- At least one further SPA for personal development (special interest clinic, leadership role etc.)
- An appropriate amount of specified clinical administration time, commensurate with that of other consultants in the department
- A timetable that enables the consultant to maintain continuity of patient care with his/her caseload of patients
- A regular timetable of work with fixed sessions (clinics and operating lists) and predictable out-of-hours duties with predictable time off
- Time off before and after night shifts that does not impinge on clinical care, clinical administration or professional development sessions
- Recognition of displaced SPA time (i.e. if a SPA session is lost due to time off before or after a night shift, either this should be re-provided in the job plan, or SPAs should be added which can be worked flexibly)
- Subspecialty posts should have at least two PAs for subspecialty activities



Providing quality care for women: obstetrics and gynaecology workforce

8 Managing the transition

WHILE MOST trainees accept that, in the future, they will work resident shifts as a consultant, the profession is currently in a period of transition. Many units have developed hybrid rotas involving a mixture of resident and non-resident consultants, with older consultants who have been in post longer working in non-resident posts and the new appointees working in resident posts. Therefore, at present, this perpetuates the perception of non-resident consultant posts being more senior, and resident consultant posts being more junior. In some hospitals established consultants have chosen to work as resident consultants, and this move has helped shift the culture and perception of this way of working and should be encouraged.

Various models for resident consultant working have been developed and there is no set model that is applicable to all units. Determining the most appropriate model will be influenced by the workload and complexity of the local service provision, the trainee complement of the unit, the age spread of the consultant workforce and individual consultants' characteristics.

Some suggested models involve a gradation of the amount of resident work undertaken during a consultant's career (diminishing in amount with time). While such models appear appealing, they

may be difficult to sustain in practice if several consultants are appointed within a short time frame; if a consultant with health problems (which preclude night time work) is appointed; or if a more experienced consultant is recruited, as it may not be clear where they 'slot' in. Equally, models where all consultants undertake exactly the same amount of resident working are also difficult to sustain in practice, as some consultants may reach a point where they are unable to work overnight due to health reasons.

One solution to these issues is to have patterns of working where all consultants contribute to the resident consultant out-of-hours rota, with some contributing during the evenings or during the daytime at weekends. Hybrid rotas incorporate the facility to change between the different patterns of working at different times in a consultant's career. The need for changes in consultants' patterns of working must be recognised.

During the transition period it is likely that many different models of working will be developed, and the agreements reached with organisations about how to manage changes to working patterns are likely to vary. The standards suggested in this document are designed to help local negotiations and promote consistency between organisations.

During the transition period it is likely that many different models of working will be developed, and agreements reached with organisations about how to manage changes to working patterns are likely to vary

Providing quality care for women: obstetrics and gynaecology workforce

9 Summary and recommendations

THIS REPORT FOCUSES on how to ensure, in a predictable manner, proper levels of clinically appropriate medical staff at all times in an era of reduced working hours and reducing trainee availability. It proposes that the only sustainable solution to address middle grade rota gaps involves some resident consultant working in most units. This requires a permanent change to our way of working and an alteration to historic perspectives of what constitutes a consultant post. Patient safety is paramount within both obstetrics and gynaecology. The need to ensure labour ward cover must not be at the expense of gynaecology service provision.

Resident consultant posts must be developed appropriately, and should have equal responsibilities and engender the same respect as traditional non-resident consultant posts. Resident consultant posts need to be professionally satisfying and sustainable, with clearly defined opportunities for career development and progression. As with any other consultant post, career progression will involve taking on management or leadership roles, but will not necessarily be defined by moving to non-resident on-call.

It is likely that the next decade will be a period of transition from a system where consultants are predominantly non-resident when on-call, to a system where the majority of consultants perform some 'hands-on' resident out-of-hours duties. Resident consultant working does not necessarily mean night shift working: evenings and/or weekend daytime working are alternative options that can be considered as part of a hybrid model, which also has the potential to improve out-of-hours training.

Embracing resident consultant working will allow the profession to move forward in a positive and equitable way for all consultant staff and for the benefit of patients.

RECOMMENDATIONS

1. All units need to ensure a locally agreed, safe and sustainable solution to address workforce issues to manage care in both obstetrics and gynaecology.
2. Safe service delivery can only be achieved with safe staffing levels in both maternity and gynaecology units.
3. All solutions should take into account the national issue of lack of availability of middle grade doctors leading to recurrent rota gaps.

4. Workforce solutions must optimise training opportunities and accommodate the changing needs of trainees at different stages of their careers.
5. All solutions should allow for multidisciplinary training, development of quality services and good clinical governance.
6. All units should have consultant labour ward presence during working hours Monday to Friday, with the intention to extend this to every day of the week.
7. Resident consultant working within a hybrid rota is recommended to ensure appropriate medical staffing. In most units, this will involve all consultants working in a hybrid rota with some out-of-hours shifts.
8. Remodelling job plans to include evening and weekend daytime working must be considered in order to maintain equity among the consultant team. Involving only newly recruited consultants in resident working can be divisive.
9. Culture change within the profession is needed since a contribution to resident working will be required throughout a consultant's career.
10. Resident consultants must be treated equally to non-resident consultants by all staff.
11. The RCOG's standards for job descriptions and job plans should be used by all units to help implement the above recommendations.
12. The RCOG must explore novel methods for assessing work intensity and out-of-hours staffing levels in both obstetrics and gynaecology.
13. The RCOG should develop a repository of good medical workforce models that are available to all.
14. Units must ensure that high standards of care are maintained by having the appropriate workforce, with the necessary competencies, in the right place at the right time.

It is likely that the next decade will be a period of transition to a system where the majority of consultants perform some 'hands on' resident consultant duties



Providing quality care for women: obstetrics and gynaecology workforce

Glossary

ASSOCIATE SPECIALIST DOCTOR

A doctor who is appointed to a permanent position but is not a consultant. The title 'associate specialist doctor' is usually conferred upon staff grade doctors after several years' experience.

ADVANCED MIDWIFE PRACTITIONER

A senior midwife with clinical experience who extends their role beyond the accepted normal sphere of practice.

CCT

Certificate of Completion of Training. This is gained on successfully completing the postgraduate training programme and allows the doctor to submit their name to the General Medical Council (GMC) Specialist Register and be appointed to consultant posts.

CESR

Certificate of Eligibility for Specialist Registration. This allows doctors who have not completed a GMC-approved training programme to be on the GMC Specialist Register.

COMPETENCY

The knowledge, clinical skills and attitudes developed by doctors as they progress through a curriculum. Within the obstetrics and gynaecology curriculum, competencies need to be attained at a defined level to progress to the next year of training.

CREDENTIALING

A process which provides formal recognition of competences (which include knowledge, skills and performance) through an approved training programme in a defined area of practice. This is not a formal GMC-recognised process within medicine at the time of writing this document.

DIRECT SUPERVISION

During training, doctors require supervision by experienced doctors or other trained healthcare staff to develop their skills. Direct supervision

means that the experienced trainer must observe the procedure the junior doctor is performing.

GYNAECOLOGY SPECIALIST NURSE

A nurse with additional specialist skills allowing practice in a defined area of gynaecology.

HYBRID ROTA

A rota that involves both middle grade doctors and consultants, with some out-of-hours shifts undertaken by resident consultants. Consultants may undertake some shifts resident and some non-resident. Different models will be developed in different units depending on geography, acuity, complexity and workload.

INDIRECT SUPERVISION

Indirect supervision means that the experienced trainer does not physically oversee the procedure the junior doctor is performing, but must be easily accessible to support the junior doctor.

MIDDLE GRADE ROTA

A rota staffed by doctors who have attained the required competencies to undertake out-of-hours work (within labour ward and emergency gynaecology settings) but still require support from consultants. Usually, these doctors are in training; however, some will be in non-training posts.

NTN TRAINEES (ST1-7)

Trainees with a national training number (NTN) who are in a GMC-recognised training programme. The obstetrics and gynaecology training programme is 7 years in length, with each year given a number from ST1 to ST7, with ST1 being the most junior.

OUT-OF-HOURS

There are many different definitions of out-of-hours working. In this document, out-of-hours includes evenings, weekend daytimes, bank holiday daytimes and nights.



Glossary

PHYSICIAN ASSOCIATE

A new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision. The role is therefore designed to supplement the medical workforce, thereby improving patient access.

POST-CCT TRAINING POST/FELLOWSHIP

Posts developed by boards and trusts to offer specialised training in a specific area of practice. These doctors will have already completed the obstetrics and gynaecology training programme.

RESEARCH FELLOW

An academic trainee, who can be pre- or post-CCT.

REGISTRAR

A trainee doctor between ST3 and ST7 in the obstetrics and gynaecology training programme.

RESIDENT CONSULTANT

A consultant delivering a service directly to patients out-of-hours and remaining on site for the duration of the shift.

ROTA GAP

Occurs when a member of the medical team involved in the rota to provide patient care is not available. This can be temporary because of sickness or longer term, where the vacancy cannot be filled.

SECOND ON-CALL

The clinician who provides support to the clinician providing immediate first-line clinical cover.

SENIOR DECISION-MAKER

An individual with expertise within the specific clinical field who has the necessary skills and competencies to take responsibility for clinical decision-making.

SENIOR HOUSE OFFICER (SHO)

For the purposes of this document, it is recognised that SHO posts are filled by ST1–2 obstetrics and gynaecology trainees, GP trainees, foundation year doctors and staff grade doctors.

SPA

Supporting professional activities. These are activities that underpin clinical care and include training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.

SUBSPECIALTY

These are subspecialties of main areas of medical practice. Within obstetrics and gynaecology this applies to gynaecological oncology, reproductive medicine, urogynaecology and maternal–fetal medicine.

TRUST DOCTOR OR TRUST GRADE DOCTOR, STAFF GRADE, NON-TRAINING MIDDLE GRADE STAFF

Doctors working in the NHS in non-training posts at an equivalent level to either a registrar or consultant.

WORKING HOURS

In this document, ‘working hours’ denotes weekday daytime working hours. There is wide variation in different units and it would be inappropriate to set an exact timeframe for all to follow.



Providing quality care for women: obstetrics and gynaecology workforce

Appendix

This Appendix provides a number of examples of resident working in practice.

PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST

Mr Stephen Havenga FRCOG, Consultant Obstetrician and Gynaecologist and Associate Clinical Director for Maternity

We are a large district general hospital with 5000 deliveries. We have 12 full-time O&G consultants, one part-time senior consultant who does only obstetrics and no nights, and another part-time senior consultant who does only fertility (no obstetrics) and no nights. We have seven middle grade trainees from the HEE East of England Deanery and seven junior doctors – a mixture of FY2s, STIs and GPSTs.

We have always provided good training but were getting persistently negative feedback from trainees about teaching, supervision and undermining. Also, we weren't able to offer many of the ultrasound modules. Our labour ward resident hours were on average about 60 hours/week. Furthermore, we had a rather critical RCOG review visit, which was prompted by a number of serious untoward incidents. Among the reviewer's recommendations were that we were too busy and needed more juniors and a second middle grade on-call tier, but also that we should consider splitting the daytime consultants' O&G cover. We worked up a radical investment appraisal and business case, funded by our rapidly rising delivery rate, to increase our labour ward cover and improve the training opportunities for our trainees. The aim was to recruit four more consultants, and we were lucky enough to eventually appoint four excellent colleagues at one interview.

Our night/weekend rota is now 1:12, which is not too onerous. We all agreed, as part of the deal, to extend our daytime resident shift to 21:30, seven days per week, which means we now provide 13 hours x 7 days = 91 hours per week of labour ward resident cover per week. The consultant on night call starts their on-call at 17:00, having done their normal day job, stays for the 20:00 handover round with day/night registrar

and juniors, and then remains on site until 21:30 at the earliest, or later if busy. Weekends start at 08:30 and finish in the same way at 21:30 on both days, and the consultant is resident for that entire shift. Consultants are free to swap out and split their weekends if they choose, which many do.

However, the biggest change came in the daytime cover arrangements. Our rota coordinators constructed a rota that uniquely had a lot of the daytime labour ward middle grade cover provided by 'consultant-delivered care'. All four of the new consultants formed part of the team providing this cover and they joined three more senior colleagues (five years in post), and since then another much more senior colleague has begun taking part, making a total of eight out of 12 colleagues providing this service. Most enjoy the role and it is much appreciated by the patients, the midwives and, of course, the trainees, who are freed up to attend the gynaecology outpatient department, theatre and other training sessions, often as supernumerary, so that they can be taught and trained properly. Our trainees get a large component of gynaecology operating. They tend to do most of the 17:00 to 20:00 labour ward registrar cover in return.

Furthermore, the four new appointees now provide the bulk of the gynaecology consultant on-call morning cover, on a sessional basis. This is separate from the obstetric consultants' rota, which is run on a weekly basis as a 'consultant of the week'. Each morning one of them attends the main handover on the labour ward, then they see all the gynaecology patients on the ward and any emergencies, attend the emergency gynaecology ambulatory unit (EGAU)/early pregnancy assessment unit (EPAU), and they also provide a training ultrasound list, run in parallel with the sonographers. They are also available to attend the emergency department with trainees, for teaching purposes. New pathways have been created to allow for more transfer of clinically stable gynaecology emergency patients from the emergency department to the EGAU, so that they can be scanned and assessed 'in-house'.

This single development, i.e. of the scanning component, has allowed us to meet all the requirements to provide the curriculum and practical training/competencies for the



Appendix

intermediate gynaecology/early pregnancy scanning modules. The four new colleagues also provide internal cover for the gynaecology consultant on-call sessions and also cross-cover the abortion service in rotation.

Needless to say, this new arrangement has vastly improved trainee satisfaction and, to our great pride, we came fourth in the country for overall post satisfaction in the last GMC survey. This is a huge improvement for us. We have also made other improvements in the educational domain by creating more teaching sessions on Thursday mornings, run by the trainees, with consultant attendance, perinatal meetings every Tuesday lunchtime, a gynaecology morbidity meeting every month, and we have also set up an educational faculty with attendance by all trainees and clinical and educational supervisors.

Although our new colleagues don't have fixed general gynaecology clinics in the main, they each have a special interest session, e.g. one does a colposcopy clinic, two have an alternate week outpatients hysteroscopy session, and the fourth has a labour ward skills and drills session. They also all do an antenatal clinic. In addition, one is labour ward lead, one is EGAU/EPAU/TOP and gynaecology governance lead, the third is postnatal care lead, and the fourth is medical student lead, so they all have fulfilling SPA sessions and lead roles. They are

all gynaecology scan-trained and they can all do laparoscopic ectopic pregnancies, ovarian cystectomies etc. on the emergency rota.

As senior colleagues we are happy to provide support during daylight hours or at night, and this is often needed. One slight downside is their major operating experience may be slightly reduced, so we encourage them to join us every couple of weeks or so in our elective gynaecology operating theatres to go through a day case list, or abdominal or vaginal hysterectomy, or laparoscopically assisted vaginal hysterectomy or total laparoscopic hysterectomy, for example, to keep up their surgical skills.

I know this arrangement may not work for everyone, but it certainly has for us. Our one ongoing problem is the lack of a second on-call middle grade tier, which at 5000 deliveries we really should have – we have tried many times to recruit staff grades/trust doctors but have had very little success. On the strength of our excellent GMC survey feedback, the East of England Training Programme Director promised us two more registrar posts last year, and this was all costed and funded by the trust. We did put together a plan to provide a consultant resident service 24/7, but we worked out this would have cost the trust eight more consultants and the trust would not fund it, hence the lack of middle grade cover is now sitting as a major risk on the corporate risk register.

This new arrangement has vastly improved trainee satisfaction and, to our great pride, we came fourth in the country for overall post satisfaction in the last GMC survey



We have used this system and have found it works well, with most of us being called less once we have gone home and the labour ward feeling much more organised to the midwifery staff

DERBY TEACHING HOSPITALS NHS FOUNDATION TRUST

**Dr Janet Ashworth FRCOG,
Consultant Obstetrician**

We introduced resident consultant posts at the time I started with the trust in 2003. The posts have metamorphosed and now been entirely altered.

In 2003 we delivered 4500–4800 and had a two-tier registrar rota. All the consultants did joint O&G and covered both on-call. I and three others were appointed to do one night a fortnight, not prospectively covered, from 17:00 to 09:00, with time off in the daytime prior and the day following the night. The rest of the time we worked normal full-time and we took part in the general 1:9 on-call rota with prospective cover. When we were resident, there was no second tier registrar and another consultant colleague was nominally on-call from home to provide support if needed. The aim of the posts was to accommodate a middle-grade rota that was compliant with the European Working Time Directive. As our deliveries steadily increased and increasing numbers of our consultant colleagues became solely obstetrics or gynaecology focused, it became clear that we could no longer sustain only having one trainee at night, especially when the resident was a sole obstetrician and the on-call consultant a gynaecologist, so after one to two years we reinstated two trainees on the night and evening shifts. Over time some of my colleagues moved unit and others ceased doing resident nights, while other new appointees joined the resident team on the same basis as I had.

By 2013, we were delivering around 6300 and only some weekday nights were covered by a resident consultant. We had split the on-call rota into obstetrics and gynaecology a few years before, and the on-call obstetrician was purely nominal, never being called in. I for one had a markedly increased daytime role, which was untenable with missing two days a fortnight.

Those of us who did resident nights were rarely called out of bed (we have a resident consultant on-call room) after 23:00, and on the nights when there was no resident consultant, the on-call consultant was mostly in till at least 21:00. We found that by staying most of the evening, most patients had plans in place and the unit tended to run well.

We wanted to ensure that all weekdays had a minimum of consultant evening cover, restore equality to consultant job plans across the department (some of us were doing much more out-of-hours work, which was also less well rewarded under the new contract) and ensure that there was contracted consultant presence for some time over the weekend. We therefore agreed as a group of obstetricians providing obstetric cover that the person on-call for the night would stay until 22:00 as a minimum, as well as a minimum of eight hours at the weekend (ideally four hours each day). This was felt reasonable. This would mean that all of these sessions were also prospectively covered, as the on-call cover was.

We have used this system since November 2013 and have found it works well, with most of us being called less once we have gone home and the labour ward feeling much more organised to the midwifery staff. We are in the process of appointing to two new obstetric posts. Our trust wanted us to bias the job plan of these posts to include more out-of-hours work, but as a department we have resisted this, as we felt it would be divisive and not conducive to appointing and retaining good colleagues. Hence we have all agreed to increase our out-of-hours resident commitment further to commence at 08:00 (rather than 09:00) on weekdays in our duty week, and to commit to 16 hours minimum resident per weekend. This is in return for a guaranteed day off on Monday after a weekend on-call (now felt essential) and doing slightly less frequent on-call with our new appointments (it will be just under 1:7 on-call).

YORK DISTRICT HOSPITAL

**Mr James Dwyer FRCOG, Clinical Director
and Mr Adrian Evans FRCOG, Consultant
Gynaecologist**

We have 3400 deliveries, and we had permanent gaps in the registrar rota. It was difficult to get long-term locums and we advertised many times without success. The locum agency costs were extremely large and it was decided to have two consultant posts at York with prospective cover by using the money spent on locums and reducing a trust-funded registrar post. This meant the registrars covered Wednesday to Sunday nights and weekend days. Since then, we have had a retirement and used this replacement post to provide further resident consultant cover such that the registrars no longer do Wednesday nights. This increases the amount of time they are present during the day and thus helps their training.

The resident consultant posts are cheaper than the locum spend of £400,000 per year, which was the main reason for us considering and implementing this role. They also allow the non-resident consultants to continue providing sessions the days following their own on-call on Monday, Tuesday and Wednesday night so it keeps the department ticking over from that point of view. It is very likely that sessions will be lost from the non-residents as we are increasingly being called in to help overnight, as I am sure most units are experiencing.

There have been some barriers. One concern is that we may get a different level of person

applying, but we have not found this to be the case. In our recent appointment, we had over 30 applications for two resident posts, of which we shortlisted eight and five accepted interview.

With fewer trainees and less access to long-term locums, the only solution is to increase the amount of resident consultant posts – this means instead of a registrar not as well as in our unit.

Overall, we have worked hard on the job timetable to allow the resident consultants good access to the same opportunities as the non-resident. We could have filled the posts with trust-appointed post-CCT specialists who would not be under the same terms and conditions, but we thought it better to increase the number of consultants.

The more recently appointed consultants may need more support. When on-call, I come in at 22:00 to do a personal ward round with the new resident consultants, as it helps us get to know each other better and for me to provide support. There are many ways this presence is valuable as it is also a chance to discuss a wide variety of topics and give general support.

There are still things we need to evolve but it is a reasonable system. I know there is a degree of frustration that may creep in if no specialist skills are developed and we need to look at this more closely in future.

One of the main problems we have with the current system relates to how our pension is calculated and moving away from the best year out of their last three would be an advantage to this model.

We have worked hard on the job timetable to allow the resident consultants good access to the same opportunities as the non-resident

Resident consultant working was initially introduced to increase from 60 to 98 hours labour ward presence and we identified that we would need three new consultants as otherwise job plans would not be sustainable or attractive

LUTON AND DUNSTABLE UNIVERSITY HOSPITAL

Miss Kathy Waller MRCOG, Consultant Obstetrician and Gynaecologist, and Mr Malcolm Griffiths FRCOG, Consultant Obstetrician and Gynaecologist

We are a unit of 5200 deliveries with a level 3 neonatal intensive care unit. We first proposed a 24/7 consultant rota in 2002 in our department. We saw it as a way of expanding consultant numbers, offering a more consultant-delivered service and providing an opportunity for building up subspecialty teams. We didn't succeed due to a lack of vision and finance. The push later came as a result of RCOG and Clinical Negligence Scheme for Trusts targets and pressure from our primary care trusts and clinical commissioning groups to meet some service targets.

Resident consultant working was initially introduced to increase from 60 to 98 hours labour ward presence and we identified that we would need three new consultants as otherwise job plans would not be sustainable or attractive. The business plan was then accepted by the executive team. We then arranged a consultant away day and circulated seven different potential consultant rotas beforehand for comments.

One suggestion from a very newly appointed colleague was that we should recruit new junior consultants to provide the cover. It was decided that we didn't want to bring about a junior/senior consultant split. We'd expected that at some stage that we'd be working as a resident consultant. We felt that the idea of having experienced on-site consultants would be good for patient safety and training. Once one person pitched in with their 'offer', two colleagues also chose, for personal reasons, to opt in. We then appointed some more new consultants, some of them sharing our rota and some not. At that time we had a full complement of trainees, so medical staffing arrangements were the same as during the daytime.

All existing consultants were given the option to become resident consultants and many chose to do so, working one resident night every four weeks (paid four PAs overnight). Three new consultants were appointed with one also on the same pattern, and two jobs planned for 26 resident

nights per year. We have had no difficulties with recruitment to these posts and have appointed some excellent colleagues. No one has left the resident consultant posts since they commenced in June 2010.

More recently we've had the same problem that other units are facing of too few middle grade doctors. We've now appointed two locum consultants who work resident shifts in place of the senior registrar. We see this (sadly) as inevitable but less positive.

In contrast, a similar system (appointing new consultants to work in place of senior trainees, but without full support) has been happening in parallel for several years with our neonatologists. There it's turned out very differently – the people appointed all ultimately aim to move off resident nights and we have had a steady progression from resident consultants to non-resident (or less resident) as new posts have been created or when there are retirements. We've also had a number who have left (locum and non-locum resident consultants) for substantive posts elsewhere.

I really prefer the resident commitment. I really hate being on-call from home. You will know the feeling when you get called at night about a case, you wonder whether you should go in anyway, you lie awake for a while and then soon after you've gone back to sleep the senior midwife rings to say they did need you after all. When you are resident you are there any way! I love it. I am afraid that they may try to take away my full team and I'll be reduced to acting as a 'senior registrar' – I don't think at my age I could cope with that!

The deanery has always commended us for this particular initiative as the trainees think it so valuable.

In summary, the most important points are: colleagues agree the rota together; the resident consultant did not replace the senior registrar; senior colleagues in the department have led by example; it is excellent for teaching and training and encouraged by the deanery; trainees like it; and there has to be a consultant on-call room.

From a personal point of view, the rota is very family friendly; staying up at all night is becoming more difficult as I get older (now 50+, as are others); and re-scheduling clinics and theatres can be a pain and advance planning is essential.

SAINT MARY'S HOSPITAL MANCHESTER

Dr Sarah Vause FRCOG, Consultant in Fetal and Maternal Medicine and Deputy Clinical Head of Division

In 2010–11, maternity and paediatric services in Greater Manchester were reconfigured, leading to a significant increase in the number of women delivering at Saint Mary's Hospital (currently 9000 women per year). The increased number of deliveries made the 'consultant on-call from home' model unsustainable. There was therefore a desire from the consultant body to change the way of working, but with the proviso that whatever new system was adopted had to deliver benefits for both patients and consultants.

Planning a 24/7 consultant presence obstetric service was a protracted and difficult process, which took over four years to achieve. We developed nine different models before we found one which was acceptable to consultants and affordable for the trust. A number of factors had to be balanced to achieve a sustainable model. This included balancing daytime work for consultants to give them both experience and professional development opportunities, as well as enough time off. It was felt to be important that there should be equity across consultants, with all consultants participating in resident out-of-hours work. It was also felt that there must be equity in status and responsibility with none of the consultants being viewed as more senior than others, and all taking a fair share of management and governance roles. All the consultants contributed to the development of the new system, and although discussions were at times robust, it was an amazing piece of teamwork.

The staffing model arrived at required the appointment of an additional 10 consultants, 26 in total. Consultants are divided into two groups. One group undertakes night shifts. Each

of the 16 consultants on the night rota undertake 13 weeknights per year together with three weekends per year (Friday, Saturday and Sunday nights). This represents a total of 23 resident nights per year and accounts for 2.2 PAs per week. The second group (10 consultants) undertakes weekend daytime and evening out-of-hours labour ward shifts to make up their out-of-hours duties (1.9 PAs per week). It is predominantly (but not exclusively) newer consultants who work night shifts, with the older consultants, who had previously worked a traditional non-resident on-call, now working the resident weekend daytime and weekday evening shifts in the labour ward. The advantage of this model is that consultants can continue to contribute to the resident out-of-hours rota until retirement.

Other benefits have been that the increased number of consultants can now provide more support to the inpatient wards, triage and the antenatal assessment unit. Two consultants are now allocated to each antenatal clinic providing cross-cover for leave, and therefore better continuity of care for women attending specialist clinics.

The new 24/7 consultant presence model of working was introduced on 1 September 2014. Although formal evaluation is not yet possible, initial data suggest that the new system is improving relevant clinical outcomes; that most consultants feel their overall quality of life is either better or different, but not worse; and that training for most junior doctors has improved. There are some concerns about whether the most senior trainees will be able to develop leadership and prioritisation skills, and some concerns that we don't see each other as often as we would like due to numbers and timetabling. We have been working in this way for almost a year now, and overall it feels as though it has definitely been a change for the better.

Each of the 16 consultants on the night rota undertake 13 weeknights per year together with three weekends per year (Friday, Saturday and Sunday nights)

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