

Royal College of Obstetricians and Gynaecologists  
Setting standards to improve women's health

# The Future Role of the Consultant

A Working Party Report



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# Foreword

Workforce planning has never been easy or indeed very successful. Thus, spelling out a vision for the future is a brave and fraught exercise. That having been said, this document is one of the most important produced by the College in recent years. It outlines the way the service of the future can be provided and indicates the workforce and training that will be required to achieve this. I find the vision reassuring and the future exciting. I think that we will be better equipped to meet the needs of women's health and to provide services of the highest quality here in the UK and also in countries where the delivery of health care follows similar patterns. I have not known a document so thoroughly and earnestly debated at Council, nor one so widely discussed. I am enormously grateful to Maggie Blott and the Working Party and to Ric Warren, who took forward Council's views and input. This document is now **the way forward** and will provide the framework for our work on education, training, clinical standards and recruitment.

Professor Allan Templeton  
*President, RCOG*



# Preface

This report takes into account in full the considerations of the RCOG Working Party and Council, as well as the wide-ranging views of the many Fellows and Members who contributed at consultation.

The future role of the consultant must reflect the increasing challenges of scientific progress and rapid developments in clinical practice, service delivery and working patterns.

Improved recruitment is essential and significant consultant expansion must occur to realise the necessary recommendations of this report. The planning of future services must ensure that women receive a safe service of high quality delivered by fully trained staff. In particular, it is essential that the drive to increase the presence of consultants on labour wards receives priority and is fully resourced. Women have a right to expect that the care they receive is of the highest standard, day or night.

There are presently excellent opportunities for those wishing to train towards a career as a consultant in obstetrics and gynaecology. With the suggested advent of increasingly flexible and diverse training schemes, the specialty offers an unprecedented opportunity for the keen and talented doctor.

Like many specialties, the obstetrics and gynaecological workforce is becoming increasingly female. However, irrespective of gender, lifestyle and work balance are becoming increasingly important. The specialty intends to be at the forefront in planning for the future, matching a rewarding, personalised career with the flexibility and working patterns which allow fulfilment in family life and life outside medicine. Lifestyle, work patterns and remuneration must be given increased consideration if recruitment into the specialty is to improve to the necessary level.

This report offers an opportunity to improve the quality of care as well as to improve recruitment and retention by offering a broad and flexible pathway to Completion of Training Certificate (CCT).

New training schemes will allow those with interest and aptitude the opportunity to shape their careers in the way that suits them and in a way that will produce consultants with excellent core training in obstetrics and gynaecology but each with different special skills to match the developments and service needs of the future.

Although consultants traditionally used to work independently and in relative isolation, the new role of the consultant will be different. Flexible working patterns, multidisciplinary teams and clinical networks are the future of healthcare delivery.

The balance between increasing specialisation, workforce limits and geographical constraints can only be achieved through local and regional networks. Some rationalisation and reconfiguration of services may be required

but this must acknowledge that, where possible and when quality can be assured, women and their families wish for their services to be local to them. Such a plan should endorse the recommendations of the National Service Framework for Children, Young People and Maternity Services.

The recommendations of this report will produce consultants who have strong core training but with diverse roles, reflecting their advanced skills and the needs of service provision. These new roles must achieve high-quality care with job satisfaction and with working patterns that are fulfilling inside and outside of medicine.

**Maggie Blott**  
*Chair of the Working Party*

**Richard Warren**  
*Honorary Secretary, RCOG*

# Membership and acknowledgements

## Membership

Dr Maggie Blott (Chair)	RCOG Workforce Advisor
Miss HJ Mellows	Junior Vice President
Dr A Bigrigg	Faculty of Family Planning and Reproductive Health
Professor Linda Cardozo	Consultant Gynaecologist and Urogynaecologist
Mr MD Read	Consultant Obstetrician and Gynaecologist
Mr AD Falconer	Consultant Obstetrician and Gynaecologist
Miss Maggie Tasker	RCOG Flexible Training Advisor
Professor DJ Murphy	Consultant Obstetrician
Dr A Drakeley	Trainees Committee
Miss M Whitten	Trainees Committee
Mrs V Alasia	Consumer's Forum representative
Dr D Sowden	Lead Dean for Obstetrics and Gynaecology
Ms C Basak	Royal College of Nursing
Dr C Gerada	RCGP South East Council Representative

The Royal College of Midwives representative could not be present but submitted comments.

## Acknowledgements

The Working Party met on five occasions and, in addition to its own deliberations, received written contributions and comments from:

- Royal College of Nursing
- Royal College of Midwives
- Professor Stephen Robson, Consultant in Fetal Medicine and Obstetrics
- Mr R Naik, Consultant Gynaecological Oncologist
- Dr S Puthucode-Easwaran, Specialist Registrar
- Dr M Hamilton, Consultant Gynaecologist/Clinical Senior Lecturer
- Professor JJ Walker, Consultant Obstetrician and RCOG National Patient Safety Agency representative
- Mr R Warren, Consultant Obstetrician and Gynaecologist, Honorary Secretary, RCOG
- Professor Henry Kitchener, Academic Unit of Obstetric and Gynaecology, Manchester
- Individual members of Council

Secretary to the Working Party Mrs C Allen

The final report was reviewed and revised by Dr M Blott and Mr R Warren, following thorough discussions at Council. We are grateful to all those who gave feedback during the period of consultation. This final report has fully taken into consideration these additional wide-ranging and diverse views.

Thanks also go to the staff in the RCOG library; documents requested, often at very short notice, appeared quickly and efficiently.

### Abbreviations used in this report

CCT	Certificate of Completion of Training
CESDI	Confidential Enquiries into Stillbirth and Deaths in Infancy
CNST	Clinical Negligence Scheme for Trusts
CPD	continuing professional development
FFPRHC	Faculty of Family Planning and Reproductive Health Care
GP	general practitioner
GPwSI	GP with special interest
NHS	National Health Service
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
SpR	specialist registrar

## Executive summary

The aim of this report is to improve the quality and safety of health care for women.

This working party report addresses the ways of enhancing service delivery by considering future challenges in workforce and training.

Continuing improvement to the care of women requires a major improvement in recruitment and significant consultant expansion. Whether day or night, future services will increasingly be delivered by fully trained obstetricians and gynaecologists who also have the special skills necessary to match the diversity of the evolving specialty.

While acknowledging the need for maintaining acute services in both obstetrics and gynaecology and the need for more consultants with a variety of medical and diagnostic skills, training will also reflect the need for fewer consultants required to deliver advanced general gynaecological surgery.

The needs of individual NHS trusts and the limitations of restrictions in working hours must be balanced. Workforce planning must urgently reflect future needs in terms of the increased numbers of consultants required and those trained in subspecialty or special skills. Particular attention must also be paid to clinical academic medicine and research.

Team working and clinical networks will now be planned to ensure that all women receive the highest possible standards of care across the full width of the specialty.

The increasing challenges of the new NHS require close collaboration by all health professionals to ensure excellence and value for money.

The future role of the consultant will deliver a high quality service. However, it is essential, at the same time, that consultant job plans reflect the importance of work–life balance and offer a fulfilling, rewarding and evolving career.

# 1 Summary of recommendations

- 1.1 The improvement of women's health care is pivotal.
- 1.2 The RCOG must press for the necessary investment to implement the changes outlined in this report. Failure to resource the changes adequately will render them unachievable and threaten the quality of care.

## Workforce

- 1.3 The recommendations within this report indicate an urgent need to increase the number of consultants and trainees in the specialty.
- 1.4 Recruitment into the specialty must be improved.
- 1.5 It is essential that working patterns ensure safe and improved care for women, as well as a rewarding career allowing fulfilment in life outside of medicine.
- 1.6 Changes to service delivery require the development of a diverse and flexible workforce to ensure that the demands of the service are met.
- 1.7 Recruitment into academic medicine requires specific attention. Training pathways for clinical academics are urgently required.
- 1.8 The implications of this report for national workforce planning, service planning, as well as core and specialist training, should now be considered.

## Training

- 1.9 The trainees' logbook must be reviewed to ensure that, at the completion of core training, the trainee has a secure foundation in both obstetrics and gynaecology, from which to develop areas of special interest.
- 1.10 Not all trainees will wish, or need, to acquire additional surgical skills beyond core training.
- 1.11 The number of trainees undertaking special skills training or subspecialty training must be planned according to service need.
- 1.12 The RCOG must continue to be closely involved in the evolving training of general practitioners.

## Service

- 1.13** There is increasing evidence of the need for the continuous presence of fully trained and experienced obstetricians in high-risk delivery suites. Gradual implementation of a consultant-based service is planned.
- 1.14** The service demands of NHS trusts require that the majority of consultants must be trained in obstetrics and be able to deliver an emergency gynaecological service. However, not all obstetricians and gynaecologists of the future will perform major gynaecological surgery.
- 1.15** Appropriate time should be identified, per week, for consultants' supporting professional activities, including teaching, training, clinical governance and continuing professional development. This, as a responsibility of the employing trust, should be part of the requirement for annual job planning. Approval for new consultant posts should only be given where such provision is ensured.
- 1.16** Work on behalf of the specialty, including national responsibilities, carried out by consultants outside of their trust duties, contributes to the wider NHS. This must be accepted and recognised within job planning.
- 1.17** The RCOG supports the implementation of the National Service Framework for Maternity Services module and will work with the Department of Health, Royal College of Midwives, Royal College of Paediatrics and Child Health and the Royal College of Anaesthetists to this end.
- 1.18** There needs to be continuing close collaboration between the RCOG and Royal College of Midwives in relation to service delivery, workforce planning and clinical governance.
- 1.19** It must be recognised that the requirements of individual NHS trusts will differ considerably according to workload, skill mix and geography.
- 1.20** Any evolution and reconfiguration of maternity services will require further considered planning and careful governance. This work should proceed in the context of the National Service Framework.

## 2 Introduction

The management of women's health is a continuum from the problems that may occur in childhood and adolescence, through pregnancy and childbirth to the care of the postmenopausal woman. The role of the consultant is to ensure the appropriate provision of high-quality care and to provide support, information and advice to women to enable them to attain and maintain optimal health.

The lifetime care of women and the safe delivery of their babies are central to the working life of the consultant obstetrician and gynaecologist. While this may seem obvious, the role of the consultant obstetrician and gynaecologist continues to generate much thought and debate. Two working parties,<sup>1</sup> established to determine the consultant role, have reported in the last few years and, despite these deliberations, there is still great uncertainty and a degree of anxiety as to how the consultant will be working in the 21st century.

The introduction of structured training in 1996 provided the opportunity for improvement in the delivery of training, with the balance between service and training being addressed for the first time.<sup>2</sup> However, despite these changes, there remains a concern that current training may not be producing consultants trained in line with future requirements.

Gynaecological practice is changing; the number of major surgical procedures is decreasing and those that remain are often complex. Trainees complain that they do not gain enough operating experience and consultants say that they do not have sufficient cases to maintain their skills. The therapeutic options for many common gynaecological conditions no longer include major surgery, which is increasingly coming under the auspices of the subspecialist. In order to protect women and to ensure good outcomes, major pelvic surgery should now be considered to be an advanced skill. The working practice of the future gynaecologist must reflect these changes. Diverse consultant roles must be planned and special skills developed to reflect the breadth of practice we envisage in the coming decades.

Despite strong evidence that serious clinical incidents on the labour ward are frequently associated with substandard care,<sup>3</sup> there has been no significant change in the organisation of intrapartum care. The 2000–2002 Confidential Enquiry into Maternal Death<sup>4</sup> once again raised concerns about the high number of avoidable factors and, in particular, the lack of senior input into the care of critically ill women. Women in the UK have a right to expect that, when serious complications occur in childbirth, a fully trained senior obstetrician will be available. Two RCOG reports,<sup>5,6</sup> have recommended increased senior input on the grounds of safety. Nevertheless, many delivery suites in the UK are still run by doctors in training for the majority of the time. Many units are now striving to comply with the 40 hours of

delivery-suite consultant cover recommended by the RCOG document *Towards Safer Childbirth*.<sup>6</sup> There is an expectation that the effective management of emergencies by fully trained staff will improve the outcome for the mother and baby.

Traditionally, the consultant has worked in isolation but the focus of the role now needs to move to team working, with the consultant leading a multidisciplinary approach<sup>7</sup> to ensure that health provision is woman-centred and appropriate.

In order to ensure quality of care for women of all ages, the role of the consultant must evolve. Redefining both the opportunities in training and the consultant role is essential to ensure the fully trained and fulfilled workforce necessary to deliver the care that women deserve.

## 3 The Working Party

### 3.1 Background and remit

Changes within the structure of the NHS, advances in therapeutic options and the changing expectations of women, have all had an impact on the consultant role.

In the last few years, there have been changes as to how the ‘consultant’ works but, rather than a conscious redefinition of the role of the consultant, this has been unplanned and uncoordinated. With little planning for the future, this has resulted in a cohort of consultants with poorly defined job plans, having to contend with:

- the unrealistic expectations of management
- increasing patient expectations
- increasing workloads and targets
- the conflict between quantity and quality
- a perceived loss of clinical professionalism and autonomy in prioritising care
- a reduction in the hours worked by trainees leading to an increased load on the individual consultant.

The combined effects of these pressures and a lack of structure risk leading to a demoralised and poorly motivated workforce, reflected in earlier retirement and a lessening of the sense of belonging to the organisation.

This is of particular concern in academic training and the future role of the academic consultant remains uncertain. Recruitment into academic medicine is extremely poor and arguably rewards have not kept pace with their clinical counterparts. Furthermore, much teaching and educational work is now squeezed into the working day rather than being an integral part of the job plan. Advances in obstetrics and gynaecology require a vibrant academic sector. Recent trends suggest that positive measures are required to prevent a national decline in academic medicine.<sup>8</sup>

### 3.2 Terms of reference

In recognition of the need to address the changing and increasing demands on consultant time and to redefine the clinical service needs of women, Council agreed to the establishment of a working party to look at the future role of the consultant. Its terms of reference were:

- to review the changing reproductive health needs of women
- to suggest changes that may be required in the provision of clinical care

- to evaluate the consequences of these changes upon the roles of consultants, including subspecialists and academics
- to discuss implications for other health professionals
- to highlight implications for training in obstetrics and gynaecology
- to advise the College on the development of relevant change.

The Working Party had a clear understanding that there was a need for change to improve services for women and their babies. The current and future healthcare needs of women are at the centre of the recommended changes to the role of the consultant.

The Working Party did not have a remit to discuss whether or at what point the specialty might divide. Indeed, it became apparent during discussion that the future lies as a combined specialty but with a diversity of special skills across the full range of obstetrics and gynaecology.

The Working Party would not support the introduction of a junior consultant grade. However, recognising the increasing specialisation within obstetrics and gynaecology and also the reducing experience of trainees and consultants across the specialty, the group believes there is a clear need for networks, team working and mentoring at all levels.

## 4 The need for change

Many and various factors within the delivery of health care have evolved over the last 20 years and now collectively demand a change in how consultants practise.

### 4.1 Clinical practice

Twenty years ago most consultant obstetrician and gynaecologists worked as generalists. The majority of their time was spent in gynaecology, with only minimal involvement in the delivery suite, which was very much the domain of registrars and midwives. Competition for training and consultant posts was such that many trainees in obstetrics and gynaecology undertook additional post-graduate qualifications, commonly the surgical fellowship or MD. Any special interest was in addition to a full range of clinical services that the consultants provided; inter-consultant referral was unusual. The first subspecialty-trained consultant was appointed in 1986 to a post in gynaecological oncology.

Previously, consultants were more removed from day-to-day service provision: the true 'consultant role' being one of indirect supervision. Over time, the consultant role has changed. The biggest change has been in the balance between obstetrics and gynaecology in the generalist's timetable.

This change is the result of the need to provide consultant care on the delivery suite on the grounds of safety and quality of core training, as outlined in *Towards Safer Childbirth*.<sup>6</sup> This report recommends that larger units (defined as those delivering more than 4000 babies each year) and those with a high number of complex cases, should have the full 168-hours per week consultant presence. There is, within that report, recognition that the recommendations are the bare minimum required for adequate cover.

### 4.2 The consultant role in teaching, training and research

Training, for many, has always been a rewarding and fulfilling part of the consultant role. However, increasing pressure on beds and theatre time, as well as the impact of the European Working Time Directive, have resulted in conventional activities such as ward rounds and outpatient clinics becoming less useful teaching opportunities.

The apprenticeship model has all but gone with the New Deal<sup>9</sup> and the introduction of the shift pattern of working. There is a perception among trainees that teaching is unstructured and of poor quality, and among consultants that the trainee is clocking on and off and has lost professionalism and commitment. The resulting loss of the firm structure has led to an increasing reliance on the consultant to provide the 'continuity of care'.

Within the last 10 years, with an inadequate expansion in consultant numbers and very little change to the job plan, the consultant has had to absorb:

- the need to provide formal educational supervision and appraisal
- attendance at Record of In-Training Assessments, Specialist Training Committee and other educational meetings
- protected teaching time eroding into service delivery
- increasing reliance on locums (and the additional supervision required)
- the requirements for continuing professional development and appraisal.

As the need to provide direct patient care and the pressure to meet government-defined targets both increase, not all consultants have the time to teach. In the future, some consultants may choose not to be trainers. For those continuing to teach, train and perform assessments of trainees, the time taken to do this must be adequately recognised and written into job plans.

While realising that not all consultants will have the opportunity or aptitude for research, clinical research must remain an integral component within the role of the consultant.

#### ACTION POINTS

- Recognise that not all consultants will provide day-to-day training.
- Ensure that training is undertaken by trained trainers.
- Recognise that the provision of training is a trust's responsibility.
- Ensure that trusts allow adequate time, within the consultant job plans, for all trainers.
- Identify specific clinical training sessions.
- Maximise training opportunities by the rearrangement of timetables and duties to enable regular protected training sessions.

### 4.3 Continuing professional development and maintenance of skills

The concept of continuing professional development (CPD) became formalised in 1994 and the idea of maintaining competencies in the mid-90s. Active involvement in audit, recognised as an important adjunct to good medical practice, was encouraged.<sup>10</sup>

CPD and the maintenance of skills is now demanded of all consultants. Indeed, within the framework of the ‘new consultant contract’, appropriate time has been identified per week for supporting professional activities, which include CPD, audit, appraisal and clinical governance.

#### 4.4 Revalidation

Under the jurisdiction of the General Medical Council,<sup>11</sup> revalidation will soon become mandatory for all doctors. There are continuing discussions as to the exact nature of the revalidation process. It is hoped that, with major developments in information systems, the monitoring and performance management of clinical activity and clinical quality will become a reality. Obstetricians and gynaecologists will be required to confirm that they maintain the requisite skills to continue to provide a clinical service. A competency-based system must be developed so that revalidation becomes a simple process through day-to-day activity, audit and record. Outcome data in both obstetrics and gynaecology will be required. Simply having been competent previously, with no attempt to maintain or develop skills, will no longer be sufficient.

#### ACTION POINTS

To be considered by the Working Party on Bridging the Gap between Appraisal and Assessment:

- Revalidation will be based on a wider form of CPD.
- Assessment of fitness to practise should be a continuous process building on that which is now undertaken by trainees in the UK.
- The future consultant will need time within their job plans to allow for CPD and personal development.
- The RCOG should set the standards and appropriate competencies for revalidation and the means of their assessment.
- Databases, into which consultants can log their workload, outcome data, including success and complication rates, need development. This is a trust and NHS responsibility.

#### 4.5 Complaints and litigation

Dealing with complaints and litigation is an important part of a consultant’s workload. Providing timely responses and navigating cases through the complaints process is time consuming. The process of complaint and litigation is particularly stressful and clinicians may feel isolated and vulnerable.

In view of ever increasing patient expectations, it is unlikely that the number of complaints will fall. Adequate systems of incident reporting and clinical governance should help to reduce the number of serious problems by learning from, and pre-empting, mistakes.<sup>12</sup>

By ensuring that practice follows evidence-based guidelines and that there is robust audit of practice and outcomes, it should be possible to improve the quality of care.

In addition, providing direct senior cover in high-risk areas will ensure that, when the outcome is poor, it was in spite of the best care being given by doctors with sufficient skills and experience, and all that should have been done was done. Medico-legal claims should reduce.

### ACTION POINTS

- Training in the handling and management of complaints and litigation should be included within specialist training.
- Trainees need specific training in risk management and clinical governance.
- Practice, where possible, should follow evidence-based guidelines.
- Trusts must ensure that comprehensive systems of clinical governance, including audit, are followed.
- The RCOG should continue to lead standard setting and to endorse Clinical Negligence Scheme for Trusts (CNST) targets.

## 4.6 Workforce

Workforce planning needs to determine the number of consultants required to provide a safe, service of high quality and to ensure sufficient numbers of doctors are in training. (Appendix 1). The RCOG must be able to provide the necessary data to enable accurate calculation of future consultant numbers to provide for the new style of working and service delivery. Particular attention will be required to balance the number of trainees embarking on the different advanced skills and subspecialty training. It is essential, however, that future working patterns also achieve an improved life–work balance.

### ACTION POINTS

- An accurate workforce database must be developed in cooperation with the Deanery Specialist Training Committees and postgraduate deans.
- The present census and data collection needs complete review; electronic capturing of data should be piloted urgently.

- Workforce calculations need to include appropriate numbers entering training in advanced skills and subspecialties.
- Increasing numbers of consultants and of training numbers must be planned to deliver the developing service requirements and demands.
- The RCOG should consider acceptable patterns of work to ensure a rewarding and fulfilling career with an appropriate life–work balance.

#### 4.7 Flexible working patterns

The RCOG has always had a tradition of supporting flexible training. Currently, 20% of trainees are training flexibly. The 2002 Trainees' Survey indicated that many trainees, (both men and women) were considering working less than full time as consultants.<sup>13</sup> However, the expectation that each consultant will provide a comprehensive service in both obstetrics and gynaecology prevails in many district general hospitals and is reflected in inflexible job descriptions and job plans.

Part-time staff are more expensive and therefore less attractive to employ. The British Medical Association advice on job planning is that 'part-time' doctors need the same supporting professional activities and study leave in their job plans as full time staff. The feeling is that this renders the part-time doctor less productive and therefore less attractive.

#### ACTION POINTS

- In keeping with the aims of Improving Working Lives, the RCOG will continue to support flexible patterns of work and encourage the development of new part-time posts.
- Guidance is required on the appropriate formulation of flexible job plans.

#### 4.8 Recruitment

Recruitment to the specialty is at a worryingly low level, with fewer UK graduates than at any time intending to continue to train in obstetrics and gynaecology.<sup>14</sup> This has come about partly as a reaction to the difficulty recently experienced in obtaining a national training number. A general level of dissatisfaction within the specialty is also being passed down to trainees.

The perceived poor career opportunities and the poorly defined and unstructured present role of consultants are believed to be major factors leading to poor recruitment.

The development of flexible and diverse job plans should enable those of all aptitudes and aspirations to pick an appropriate career pathway.

### ACTION POINTS

To be considered by the Working Party looking at Recruitment:

- The excellent career opportunities in the specialty must be propagated and publicised.
- The recommendations of this Working Party require urgent implementation.

## 4.9 Private practice

There are currently uncertainties about the dynamics of the provision of health care in the NHS and the private sector. However, the implementation of the Government's Choice agenda is expected to drive commissioning of some NHS work into the private sector. It is likely that private practice will continue to play a part in the working life of many, but not all, consultant obstetricians and gynaecologists.

To ensure that all training opportunities are used to the full, consideration should be given as to whether structured training could occur within the confines of private practice. Although precedents have been set, how much, if any, more training could be undertaken in the private sector awaits this further assessment. A large portion of reproductive medicine occurs within the private sector and, within many such NHS centres, patients are self-funded. The impact of independent treatment centres on training and case mix will need to be carefully monitored. As cases managed within independent treatment centres will be typically those suitable for trainees, it is likely that trainees will need to train in these centres in order to achieve certain competencies.

Clinical governance demands the regular audit of every consultant's performance. It is essential that this should be carried out in the private sector as well as within the NHS.

### ACTION POINTS

- Monitor the impact of independent treatment centres on clinical exposure and training.
- Establish equitable standards of governance, appraisal and revalidation, across both the NHS and private sectors.

## 4.10 Management

Consultants have a growing administrative and managerial component to their role. Most are experienced in the operational management of their team in relation to clinics, waiting lists and so on. However, we are now seeing increasing demands for explicit roles, for example to meet CNST requirements. Most trusts have defined clinical management roles for clinical directors. The training for these important roles is generally poor and in many cases the duties are often passed in line from one consultant to the next without due preparation. Effective preparation in training and succession planning must become the norm. There should also be clearly identified leads for:

- delivery suite
- clinical governance and risk management
- audit
- guidelines.

Appraisal, revalidation and mentoring require appropriate training and time.

Trusts need clinical advice when planning and negotiating with healthcare commissioners to understand what is, or is not, achievable and what resources would be required to meet existing and new demands, such as waiting list targets, National Institute for Clinical Excellence and RCOG guideline implementation.

Senior clinical involvement is required for successful strategic development, network planning and, where necessary, rationalisation of services.

### ACTION POINTS

- Consultant involvement in management must be encouraged and developed.
- There must be adequate provision of programmed activities within job plans for managerial roles.
- Advanced skills training and postgraduate qualifications in management should be encouraged.

## 4.11 Professional responsibilities outside the NHS trust

Conflicts may arise between the trusts' need for clinical activity and external demands. For the most part, this has been covered on an informal basis by professional leave.

The majority of consultants will contribute to the management of the service throughout their career. Those consultants who show aptitude should be encouraged in professional management roles within and outside the trust. It would be natural for many with the necessary skills and experience to progress their responsibilities at senior management level in a variety of organisations, to the benefit of the NHS as a whole.

With increasing seniority, it is likely that all management roles will increase and this should be reflected in the annual job planning and appraisal process.

### ACTION POINTS

- There must be formal recognition that appropriate work outside of the NHS trust is for the common good of the NHS. Such duties should be accepted and supported by trusts.
- The annual appraisal and job plan review should be used to reflect the workload outside of trusts.
- The RCOG must give guidance as to the appropriate allowance, within job plans, for specific duties such as Deanery College Advisors and committee membership.

## 5 The need for a change in clinical practice

### 5.1 Introduction

Current and future consultants in obstetrics and gynaecology have a responsibility to ensure that the care that is provided in their unit is up to date, appropriate, evidenced based and safe.

Defining the future reproductive health needs of women will determine the future role of the consultant. The consultant of the future must be responsive and flexible to those needs. Women have a right to care that is delivered by well-trained, motivated clinicians with proven competencies, as outlined in the seven points of good practise in the General Medical Council document.<sup>15</sup> As well as this, the healthcare delivery programme needs to recognise that women have changing expectations. There is an increasing need for information that is both accurate, up to date and appropriately presented, in order to facilitate real choice.

The RCOG must continue to work closely with the specialist societies to ensure the continuing development of high-quality service delivery and training.

As the number of consultants required to deliver a predominantly consultant-based service increases, a team approach to care must be developed. In the future, it is envisaged that consultants will work in pairs or teams to offer continuity of care and mutual support and to ensure governance and ease of appraisal and revalidation.

### 5.2 Obstetric practice

It is recognised that neither the role nor the number of obstetricians have developed to keep pace with the needs of women and the increasing advances and subspecialisation through the whole of pregnancy, delivery and the puerperium. While acknowledging the professional role of the midwife in supporting normal pregnancy, the obstetrician will continue to have a role in supporting normal care and be an option in accordance with 'Choice'. The primary role of the obstetrician will, however, continue to be in the management of abnormality and high-risk pregnancy.

All aspects of prepregnancy, antenatal care, delivery and aftercare must be considered and developed.

#### 5.2.1 Prepregnancy care

The complexity of the case mix in obstetrics is increasing, as women with significant medical problems attempt pregnancy with the expectation of a successful outcome.

The concept of prepregnancy planning, already considered an essential component of the care of women with diabetes and epilepsy, must be extended to other women with pre-existing medical and genetic conditions.<sup>16</sup>

### 5.2.2 Antenatal care

Obstetricians have always provided much of routine antenatal care. As the service develops, there needs to be recognition that normal healthy pregnancy does not require obstetric input. Women at low risk, as far as can be assessed and in line with nationally produced guidelines, should be receiving care from midwives in the community. However, women may choose to see an obstetrician at some stage in their pregnancy. The majority of an obstetrician's time will be spent managing those women who are at higher risk or those who develop a problem during pregnancy. Midwives and obstetricians should work in partnership to provide the totality of care required during and after pregnancy.

The lessons from the Confidential Enquiries into Maternal Deaths must be considered and the recommendations adopted, particularly in relation to reaching vulnerable women and communities.<sup>4</sup>

### 5.2.3 Maternal age

Increasing maternal age and the development of sophisticated screening techniques, in conjunction with the publication of national guidelines, will lead to an increased demand for prenatal screening. Consequent upon this is the need for the service to develop and expand.

### 5.2.4 Intrapartum care

There is growing evidence that increasing the input from consultants on delivery suites will improve outcomes (Appendix 2). Recommendations from the RCOG Working Party Report, *A Blueprint for the Future* (2001)<sup>17</sup> highlighted the need for increased consultant presence on the larger and more complex labour wards and these are still to be implemented. The requirement of obstetric units will differ according to size and geography. However, the principle must be enforced that women must be cared for by clinicians with proven competencies. The development of appropriate networks will aid the management of high-risk pregnancy. Such units will require enhanced and specialised consultant cover. An incremental implementation of a consultant-based service must be planned for all units, with appropriate, on-site, immediate availability of consultants for the larger units (Appendix 1). The consultant must recognise that more senior input is needed to oversee the major change that is occurring on the delivery suite. Failure to do so may result in unnecessary or untimely interventions, increasing risks to mothers and babies, increasing morbidity to women and escalating medico-legal claims (Appendix 2).

#### 5.2.4 Postnatal care

Postnatal care has been poorly resourced and services are inadequate. There is accumulating evidence that some women suffer physical problems or extreme psychological distress as a consequence of having a baby. Present services neither recognise, nor have the systems in place, to offer support to these women. Currently, the consultant has little input into the postnatal care of women,<sup>18</sup> except when the woman is referred back by a general practitioner or midwife.

#### ACTION POINTS

- Workforce planners need to be aware of the need for expansion in the numbers of trainees and consultants to cover the requirements of appropriate levels of obstetric care (Appendix 1).
- Adoption of recommended levels of on site consultant presence must be introduced (Appendix 1).
- Incremental targets for consultant cover should be adopted within specified time frames and monitored by hospital visits (Appendix 1).
- The development of training and service provision in pre-pregnancy and postnatal care must be enhanced.
- There is a specific requirement, in recognition of its critical role, that intrapartum care becomes a recognised advanced skill.
- The establishment of networks, for the management of both high-risk obstetrics and maternal and fetal medicine, must be supported and encouraged. Close liaison with neonatology and their networks is essential.
- Department of Health support and appropriate commissioning must be obtained to ensure that these essential developments occur.
- Team working and mentoring must become standard practice.

### 5.3 Gynaecological practice

Gynaecological practice has changed significantly over recent years. While acknowledging the continuing importance of surgery, particularly in the subspecialties, there has been an appreciable trend towards the medical management of many gynaecological conditions. This is illustrated by the considerable impact that the medical management of menorrhagia has had on the number of women undergoing hysterectomy. Department of Health hospital episode statistics show a 20% reduction in hysterectomy rate from 1996 to 2002 and information from individual units suggests that the fall in the numbers of hysterectomies may be as high as 52%.<sup>19,20</sup>

In order to offer personalised care and choice to women, consultants of the future must be skilled in, or have access to, the full range of an increasing variety of treatment options.

It is clear that not all gynaecologists of the future will continue to train as specialists in major abdominal and pelvic surgery. However, the provision of acute care requires the majority of those training in obstetrics and gynaecology to have competency in emergency surgery. It is envisaged that this will include laparoscopy, the laparoscopic management of ectopic pregnancy and the ability to perform a basic laparotomy. Depending on the size of the unit and on geographical location, more major surgery will be undertaken by a smaller number of consultants who are able to maintain their skills despite the overall reduction in surgical workload.

There is an opportunity to improve the quality of care, as well as recruitment and retention, by offering a broad and flexible pathway to the Certificate of Completion of Training (CCT). Some trainees may prefer to become medical and diagnostic consultants, with basic emergency surgery training. These doctors will substitute training in advanced surgery for their choice from a range of gynaecological medical advanced skills.

There will be an increasing need for gynaecological services within the community. These gynaecologists will not necessarily provide a surgical or obstetric service but will refer women to their appropriate colleagues if further treatment, particularly surgical treatment, is required. Local factors will shape the detailed roles played by individual gynaecologists, and consultants will undertake lifelong learning and training in order to fulfil evolving healthcare needs. The numbers of medical and diagnostic consultants required will be determined by the size of the unit and the population it serves. Within the hospital setting, certain consultants will continue to provide a surgical service, although very major surgery may be undertaken by a smaller number of pelvic surgeons. Many units, depending on size and geography, will work within managed clinical networks, as do many gynaecological oncologists now.

### 5.3.1 Consultants in sexual and reproductive health

Increasingly, as margins between gynaecology, the provision of contraceptive services and genitourinary medicine (excluding HIV medicine) blur, there will be an increasing need for specialists working in a community setting. There are currently over 100 consultants in sexual and reproductive health (previously community gynaecology) working in the community and based within primary care trusts. In addition, there are in excess of 100 lead associate specialists or senior clinical medical officers who are expected to be replaced by consultants when they retire. Sexual and reproductive health consultants or community gynaecologists can therefore be expected to make up 10% of the total obstetricians and gynaecologists. An increased number of

trainees will therefore be required in this field. Training will continue to be overseen by the Joint Committee of the Faculty of Family Planning and Reproductive Health Care (FFPRHC) and the RCOG (Appendix 3). As long as those training for a career in sexual and reproductive health need to attain a CCT in obstetrics and gynaecology, they must continue to follow the requirements for core training.

### ACTION POINTS

- Urgent workforce planning is required to determine the additional numbers of trainees in sexual and reproductive health needed to ensure continued provision of this expanding service.
- The RCOG should support and endorse the joint FFPRHC and British Association of Sexual Health and HIV Advanced Skills Module in Sexual Health, which is currently under development.

## 6 The gynaecologist of the future

As the number of major surgical procedures continues to fall, the role of the general gynaecologist will evolve. Not all consultants will perform major gynaecological pelvic surgery, although many will continue an interest in day surgery and basic minimally invasive techniques. In the district general hospital setting, consultants will work with special interests and the majority will provide both an emergency gynaecological and obstetric service. These consultants will have completed core training and at least one or more, of an increasing number of advanced skills modules as part of advanced training. The opportunity to attain new and further advanced skills will exist for all consultants as part of their continuing CPD.

There may be one or two consultants working within each unit, alongside their subspecialty trained colleagues, to provide the major surgical service.

Although geographical considerations may limit appropriate networking in some areas, many hospitals will work within managed clinical networks to provide the necessary major gynaecological surgical cover. Where possible, a consultant gynaecologist will be on call for a number of units to provide major emergency surgical expertise. Gynaecologists will refer to one another and use organised care pathways. Thus, the vision is that of a diverse and flexible workforce, appropriately trained to cover all aspects of obstetrics and gynaecology.

### 6.1 The medical and diagnostic gynaecologist

There will continue to be a role for the generalist as a gynaecologist. All will have completed core training and most will have undertaken one or two advanced skill modules in gynaecology. They will provide a general medical and acute gynaecology service. The majority of these gynaecologists will perform minor and endoscopic surgery but will seek the assistance of the trained surgical gynaecologist for advanced pelvic or subspecialist surgery.

The service needs of many trusts will require that these medical and diagnostic clinicians provide a general obstetric service.

### 6.2 The community consultant

The community consultant will be trained in medical gynaecology and will possess appropriate advanced skills, including, where relevant, abortion and sterilisation. They may also provide services in areas such as contraception, sexual health, psychosexual medicine and office gynaecology. Subspecialists trained in sexual and reproductive health care will work wholly or predominately within the community setting.

Public health, education, management and clinical governance will occupy a substantial amount of time. They will not provide an obstetric or gynaecological surgical service.

As community services evolve, it is envisaged that hospital-based consultants may also provide community services as medical and diagnostic clinicians offering a variety of special skills.

### 6.3 The surgical gynaecologist

Surgical gynaecologists will spend a substantial proportion of their time in providing a service to women who require major gynaecology surgery. These surgeons will have had both core training and advanced training in surgery. They may have had exposure to further obstetrics during training in SpR years 4 and 5. In addition, they will have received the appropriate advanced surgical skills training. As consultants, they must have sufficient access to beds and operating time to maintain their competencies. Depending on the size and perceived needs of the unit, some of these consultants will need to provide a general obstetric service.

Where possible, the provision of major gynaecological surgery would form part of a managed clinical network, modelled on the service currently provided by gynaecological oncology.

### 6.4 The gynaecology subspecialist

Workforce planning of the gynaecological subspecialties must continue to improve in order to ensure that sufficient numbers of subspecialists in urogynaecology, reproductive medicine and gynaecological oncology are trained to fulfil the service requirements, while not overproducing subspecialists who will be unable to find an appropriate consultant post. Subspecialty training programmes are currently recognised without restriction. As a result, trainees continue to be recruited to programmes with little thought of the available job opportunities. There are, therefore, in some subspecialties, accredited individuals who have been unable to secure an appropriate consultant post while, in others, there are subspecialty appointments for which there have been only 'special interest' applicants.

The gynaecology subspecialist will work within a tertiary referral unit with a regional or subregional referral practice. These doctors will have completed core training and subspecialty training. They will not, generally, provide an obstetric service.

All gynaecologists will expect their role to evolve during their working lifetime. At any one time, some gynaecologists may work across two of the broad categories; for example, an operative gynaecologist, may if local needs require it, undertake some work as a medical gynaecologist and, similarly, a community gynaecologist may do some work in hospitals. All elements of the service will be needed within a defined and, for some aspects, wide geographical area.

### ACTION POINTS

- All trainees will complete core training in both obstetrics and gynaecology.
- Create, beyond core training, wide and varying options for advanced skills and subspecialty training to the completion of CCT (Figure 1).
- Revise the Core Logbook in recognition that not all trainees need to achieve level 4/5 competencies in major gynaecological operating or advanced obstetrics.
- To ensure the appropriate numbers of trainees and consultants, future RCOG workforce planning must include advanced skills training and the subspecialties.

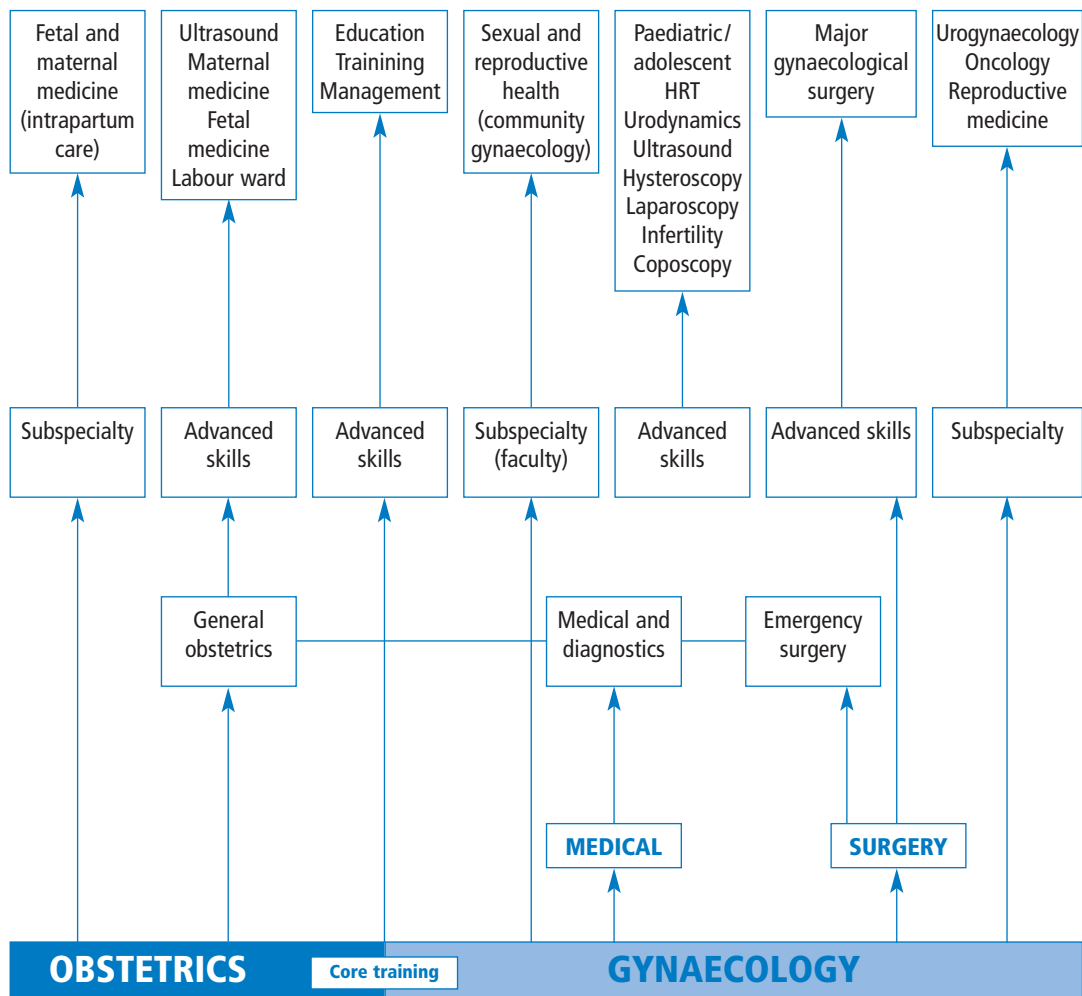


Figure 1. Options for special skills and subspecialty training to completion of CCT

## 7 The obstetrician of the future

The consultant obstetrician will continue to take a lead role in the care of women antenatally and on the delivery suite. This includes women with pre-existing medical disorders, women with a poor obstetric history and women with social circumstances that render them vulnerable to a poor maternal or perinatal outcome. In addition to providing antenatal and intrapartum care to these women, consultants will also provide preconception care to facilitate optimal pregnancy planning for women and their partners.

The potential long-term morbidity, both psychological and physical, associated with childbirth is under-recognised and poorly understood. There is an increasing awareness of the need for consultant involvement in the postnatal period for women with high-risk pregnancies or traumatic delivery experiences.<sup>21</sup> This will allow medical review, debriefing where necessary and optimal planning for future pregnancies or, alternatively, contraceptive advice where appropriate.

The obstetrician will work alongside the midwife to offer choice and to ensure that women are fully prepared for all aspects of childbirth and the unpredictability's of labour. In addition, the consultant obstetrician will work in partnership with the midwife to support 'normality' and to reduce unnecessary interventions.

As maternity services evolve, it is likely that the number of midwifery-led units will increase. The development and improvement in women's obstetric care will place more reliance on local and regional networks. The combination of workforce limits and these developments may impact on the need for the reconfiguration of services. Any such development must be carefully planned, with the necessary governance at the core.

Maternity care provision is an excellent example of where integrated, multiprofessional and multidisciplinary teamwork between primary, secondary and tertiary care is needed to ensure a high-quality, safe and responsive service. The consultant obstetrician must lead the local development of the multidisciplinary service.

### 7.1 Intrapartum care

The safe provision of intrapartum care demands a change to the current and traditional ways of working. There is increasing evidence that the presence on the delivery suite of a fully trained and experienced obstetrician will positively influence outcome (Appendix 2). There must be significant changes in job plans to allow the development of the changing role of the consultant.

Consideration should be given to an advanced skills module in intrapartum care that would include high-dependency care on the labour ward, advanced obstetric care and surgical obstetrics.

Obstetric units providing care to large numbers of women, many of whom have complicated pregnancies, require expertise to ensure that the care of women is of a high standard, regardless of the time of day. It is no longer acceptable for out-of-hours services to be of a lesser quality. In such units, consultants need to be resident in order to anticipate complications and provide a prompt response to intrapartum emergencies. This should not be seen as a substitute for mid-grade cover, which needs to continue, to improve staffing levels and ensure adequate training. This is particularly important as trainees' shift working reduces daytime training opportunities. The implementation of these changes will be gradual and will depend on the number of births and complexity of the case mix. These changes will be reflected in the job plans. Shift patterns will develop and there should be appropriate compensatory rest and remuneration. The realisation that these out-of-hours duties are intrusive and not covered by current contractual arrangements must be reflected in a way, and to a level, that is acceptable to the specialty. Failure to recognise this will result in disagreement, poor implementation of these improved standards and worsening recruitment. The current model of consultants on call must now be structured to reflect this style of service delivery. It is also essential that all clinicians maintain and regularly update their skills. Those clinicians whose working patterns have not enabled them to maintain their skills or confidence must be supported and assisted to regain their competencies.

Whereas there is concern that present styles of night work inhibit retention and recruitment, appropriate job planning linked with improved terms and conditions may be attractive. Recent proposals for a change in the NHS pension provision could, arguably, detract from entry to hospital specialties. However, there is no reason to suggest that obstetrics and gynaecology will be more vulnerable than other specialties.

There is an expectation that CNST will recognise the benefits of a consultant-based service by extending the requirement for 40 hours of consultant presence initially to 60 hours, then to 98 hours, with a 168-hour presence in larger units. Women should benefit from improved care and less intervention. Trusts will benefit from less litigation, fewer complaints and a reduction in the cost of indemnity.

Depending on the size of unit and the availability of immediate compensatory rest, there is a strong argument to recommend an age beyond which it is not expected to deliver resident on-call emergency obstetrics. While realising the difficulties that such a limit may impose on some units, the suggested guidance is that emergency cover should finish at 55 years of age. The present tendency to move from obstetrics to gynaecology with seniority will become more difficult with

increasing specialisation. Alternative clinical commitments or an increasing role in management, governance and training is envisaged. The speed of implementation of this recommendation will, of course, depend on the ages of the consultants within the on-call team. However, the principle stands and enactment should be planned at the earliest opportunity.

## 7.2 The obstetrician

### 7.2.1 The general obstetrician

The general obstetrician will provide emergency cover for the delivery suite and will provide antenatal care. This doctor will have completed core training and will have additional experience in emergency obstetrics obtained during advanced training. In addition, this obstetrician may well provide a general and surgical gynaecology service, aided by the attainment of advanced skills.

### 7.2.2 The obstetrician with a special interest

The obstetrician with a special interest will have a major interest in obstetrics with local leadership in one particular area, such as delivery-suite, maternal medicine or fetal medicine. During training, this doctor will have completed core training and advanced ultrasound training and one or two other advanced skills modules in relevant areas. Many, but not all, will continue a gynaecology interest.

### 7.2.3 The subspecialty obstetrician

The subspecialty obstetrician will have a major obstetric interest with a regional or subregional referral practice and involvement in subspecialist or advanced skills training. This doctor will have completed core training, advanced ultrasound training and subspecialty training in fetal medicine, maternal medicine or, in the future, advanced intrapartum care.

#### ACTION POINTS

- Workforce planning to enable the appropriate increase in consultant numbers.
- Develop advanced training programmes, including advanced skills, towards new consultant roles.
- Increase consultant presence on the delivery suite, without reducing training staff, to reflect the size and complexity of workload (Appendix 1).
- Plan appropriate work patterns, compensatory rest and remuneration.

- Support and assist those clinicians whose working patterns have not enabled them to maintain their skills or confidence to regain their competencies.
- Consider the development of an advanced skills module or subspecialty training in high-dependency and advanced intrapartum care, alongside a review of the individual requirements of subspecialisation in maternal or fetal medicine.
- Out of hours emergency obstetric care should usually finish at 55 years of age.

## 8 The future clinical academic consultant

The clinical role of the academic in obstetrics and gynaecology is similar to the role of the clinical consultant but, in addition, the academic has responsibilities for research, organisation of teaching, especially undergraduate modules. Usually, clinical academics also have some administrative duties within universities. The future role of the clinical academic in obstetrics and gynaecology needs to take account of the increasing challenges of clinical practice, without compromising the ability to meet the increasing challenges of academic medicine, research and education.

The key roles of the clinical academic are:

- to develop and lead on national and internationally recognised research
- to develop and contribute to the provision of high-quality undergraduate and postgraduate education
- to recruit and support future clinicians and academics
- to contribute effectively to a clinical service that is underpinned by excellence in research and teaching
- to develop new treatment modalities and assess effectiveness of novel therapies and diagnostics.

There are some important changes that are likely to be required for the academic obstetrician and gynaecologist of the future.

### ACTION POINTS

- The requirement to maintain clinical competence applies equally to non-academic and academic consultants. While acknowledging that their areas of practice may be narrower, academics must participate in sufficient clinical work to maintain the necessary skills and expertise.
- Obstetric out-of-hours work will need to be balanced with daytime activities and the maintenance of special interest and subspecialty skills.
- It is likely that clinical academics of the future will work in one subspecialty area.
- Some clinical academics will elect to concentrate their academic efforts on research or teaching rather than both.
- Clinical academics should have at least 50% of standard daytime hours dedicated to academic work recognising the needs of both the NHS trust and the university.

## 9 Implications for other health professionals

### 9.1 The role of the nurse

The Royal College of Nursing (RCN) is currently redefining the future role of the nurse, while also recognising a shortfall in the numbers of nurses employed, which is predicted to worsen.

Many nurses will continue to be ‘generalists’ acting as the first point of contact in the community and providing care and support in the acute setting. They will increasingly ‘navigate’ the woman to the appropriate services, making referrals to the community gynaecologist or specialist consultant when appropriate. Other nurses will develop special interests and will work in teams with the specialist consultant and other professionals. Nurse-led services have been developed and they offer many benefits, including better access, shorter waiting times and holistic patient-focused care. Any development of service by extending the role of any health professional must be achieved so as not to impact on training opportunities.

However, the RCN is adamant that changing responsibilities should not be driven by the shortage of trainees brought about by the European Working Time Directive and the New Deal.<sup>9,22</sup>

There cannot be a ‘one size fits all’ approach and nursing work will be varied and innovative to meet local needs.

The consultant in women’s health will work with these ‘advanced’ clinical nurses in close partnerships, sometimes providing leadership to the team as well as supporting and enabling nurse leadership of appropriate services. Nursing and medical staff should be working together, as part of the multiprofessional team, to set standards, develop protocols, procedures and guidelines and ensure safe systems.

#### ACTION POINT

- Encourage the enhanced role of the nurse within gynaecological subspecialties, with particular respect to clinical governance issues.

### 9.2 The role of the midwife

The midwife and the obstetrician must have a mutually supportive relationship. Their roles are separate and distinct but each requires the other to ensure that women and their babies get the best possible care and in order to ensure that women have real choice within a service that is safe. Efforts must be made to prevent polarisation of the service into either normality or abnormality.

The role of the midwife as the primary carer for women with uncomplicated pregnancies and labour has remained essentially unchanged for many years. There have been suggestions that the role of the midwife might be extended to compensate for the reduction in the numbers of available medical staff. This is not acceptable and is not supported by the Royal College of Midwives (RCM).<sup>23</sup> There is already a considerable shortage of midwives and this must be addressed before there can be any consideration of an extended role. Sustaining and developing the core midwifery role should always take priority over assuming new areas of responsibility. It is vital that, as the role of the consultant develops, the RCOG continues to work closely with the RCM to ensure that the service remains safe and acceptable to women.

### 9.3 The role of the general practitioner

General practice has passed through an enormous change in recent years and continues to evolve at pace. The 1999 NHS Act introduced the concept of new roles for GPs (and nurses) with the creation of 1000 GPs with special clinical interest. The term is used to define GPs who, by virtue of having additional training and expertise, are able to act as an intermediate level of support for their peers within the primary care trust and to act as local champions in different areas. While needing to work within a team, usually led by specialists, they are not clinical assistants and are able to assess, plan and provide treatment and discharge without needing to discuss this with more specialised staff. Within the field of obstetrics and gynaecology it is likely that GPs will develop special interests in such areas as infertility management, family planning, sexual health, management of urinary incontinence, menstrual problems and menopause, thus enhancing the existing service. Primary care trusts will be able to purchase the services of a GP with special interest (GPwSI), who would be able to provide a service across a large geographical area. The training requirements for these doctors still need to be developed and the Royal College of General Practitioners is suggesting that it should consist of a mixture of general medicine and special interest.

The new GP contract has redefined the role of the GP and the extent that core or standard services will be provided by them. Core services include the provision of immediate and necessary care. Contraceptive services and maternity services fall within the additional category – implying that in exceptional circumstances GPs can opt out of providing them. The Obstetric List has now been discontinued. All other obstetric and gynaecological services fall into enhanced services and, hence, primary care trusts can commission GPs to provide a range of such services.

There is, however, no evidence that GPwSI are cost effective and the GP may well have competing priorities; women's health is not currently a focus of local or national priority.

By combining the new roles of GPs together with the new flexibilities for primary care trusts to pay them, it could be envisaged that care that was traditionally provided by obstetric and gynaecological specialists could now, in part, be provided by GPwSI – with subsequent disinvestments from specialist services. The RCOG must, however, ensure that the quality of such care is maintained through adequate training and governance.

#### ACTION POINTS

- The RCOG must continue to be involved with the training of GPs.
- The RCOG must work with the Royal College of General Practitioners to ensure the appropriate training of GPwSI in obstetrics and gynaecology.

## 10 Implications for training

### 10.1 Trainees' views

The demography of the trainee workforce is changing. Feminisation of the workforce is occurring rapidly: 44% of the obstetrics and gynaecological workforce is now female.<sup>13</sup> The 2002 Trainees' Survey indicated that only 35% of the trainee workforce is intending to work full time.<sup>13</sup> With breaks for parenting, the current complement of doctors in training is likely to fall well short of the desired extended workforce necessary to provide a consultant-based service.

More trainees currently aspire to subspecialty training than are likely to be required (47% of junior specialist registrars) but there is no rationing or control over the intake (unlike in other countries). Advanced skills modules are proving to be popular with senior specialist registrars, with nearly 60% of trainees preferring obstetric-related topics. The delivery of such training is, however, demanding and more consultant time must be allocated.

Trainees were asked their opinion of the minimum number of years that an obstetrician and gynaecologist should train in the specialist registrar grade: 83% of trainees thought that specialist registrars should be trained for 5 years or longer. The RCOG agrees and there are no plans to shorten training to CCT.

Regarding future perceptions of the specialty, the overall percentage of trainees who stated that they would never be resident on call when a consultant was only 17% in 2002. This had fallen from 30% in 1997 and 24% in 1995. However, there is a split in opinion, with 15% of junior SpRs saying never and 28% of senior SpRs saying never. Of those who were prepared to be resident on call, a large proportion suggested that they would not expect any commitments on the following day (70%). Just under half (47%) thought that they should receive time off in lieu of resident emergency work. Of those who would be prepared to be on call, 64% would expect to receive adequate additional financial compensation.

#### ACTION POINTS

- The numbers of trainees undertaking subspecialty training and advanced skills modules must be monitored and planned to ensure the correct numbers in training to provide the necessary workforce for the future.
- Workforce calculations must continue to take account of lengths of training and numbers in flexible training.

## 10.2 Training for the future

With the introduction of the new specialist training grade, while maintaining the minimum 5 years as SpR, the average overall period of training may shorten. It is vital that training is focused, well-structured but diverse, to ensure that the consultants of the future are adequately trained and experienced to take on the new roles. The impact of the European Working Time Directive and shift working patterns places greater reliance on a competency-based assessment system of training. The time taken to achieve competencies will vary, depending on the training opportunities and the aptitude of the trainee. Slow progress in a particular area should not necessarily be seen as a fault of the individual, who may just require additional experience to ensure the high level of competency now expected.

Prior to entering the specialist training grade, trainees will have completed the foundation years, F1 & F2, and then an initial year (or two) of specialist training, during which knowledge and aptitude will be assessed. During this time, the trainee will be required to attain skills sufficient to allow them to work safely on the delivery suite while being supervised either directly or indirectly by the consultant. Following attainment of a National Training Number, trainees will continue to train in both obstetrics and gynaecology and will complete core training in both areas. After core training, flexibility will increase. Trainees will undertake one or, more likely, more advanced skills modules while most will continue additional, experiential training in both emergency gynaecology and obstetrics. This will produce a cohort of doctors with a sound foundation, capable of undertaking independent practice within their chosen areas. A few trainees will opt for subspecialty training and the majority of these will be in either obstetrics or gynaecology. There will be no requirement to provide a general service outside their area of expertise.

While many of the modules in the Core Logbook require completion to ensure this firm foundation, some will need modification to enhance aspects of training, while reducing the emphasis in other areas. There was consensus within the Working Party that, in all cases, a consultant obstetrician or gynaecologist would be expected to have been trained and deemed competent at performing a range of basic medical, surgical and psychological interventions, even if, by the nature of their later career paths, they no longer use some of these skills. This will be achieved within core training. All must complete competency-based core training (usually years 1–4 SpR). Too-early specialisation would otherwise result in too narrow a range of skills to provide the sound service required in the majority of units.

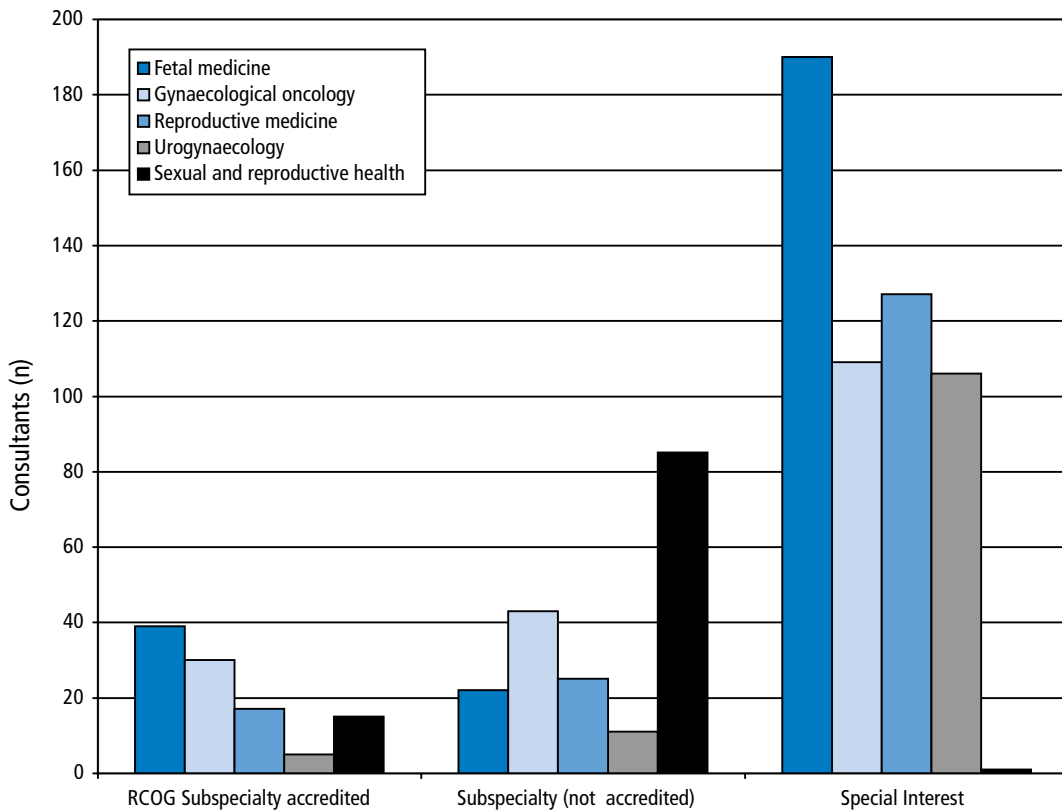
### ACTION POINTS

- Revise the Core Logbook to ensure the required levels of competencies are appropriate.

- We recommend that, during year 4/5 training, one or more advanced skills modules are undertaken and appropriate continuing experience in general obstetrics and gynaecology is obtained.
- Continue to develop:
  - the Core Logbook
  - the entry criteria for the specialist training grade.

# 11 Workforce considerations

There are currently 1466 consultants (1303 whole-time equivalents).<sup>24</sup> Figure 2 shows the number working within a recognised subspecialty having undergone subspecialty training, the number working with a special interest and the number working within a recognised subspecialty but not having undergone specialty training (the ‘grandfathers’ of the specialty). It can be seen that a significant number of the total consultant workforce is already working in a ‘specialist’ area. Currently, the major determinant of how many trainees enter subspecialty or special skills training is the number of available training places. There has been little attempt to match the needs of the population with the numbers in training to ensure the adequate replacement and development of specialists.



**Figure 2.** Consultants working within a recognised subspecialty

There are just over 600 type 1 trainees currently in post. This will allow for an expansion of the consultant body of just over 3%. In 2004, the rate of consultant expansion, recorded from advisory appointment information, was 7.5%. Such workforce statistics once again highlight the difficulties of achieving a balance between training and consultant numbers.

Workforce calculations have been completed to estimate the numbers of consultants required to provide the level of service highlighted in *Towards Safer Childbirth*.<sup>6</sup>

To achieve a service delivered by consultants for 24 hours a day, 7 days a week in units delivering more than 4000 babies in a year or units with a high number of complex cases, we will require between 2000 and 2200 consultants (Appendix 1). The evidence to support such a massive consultant expansion on the grounds of safety is available (Appendix 2) and the argument must be pursued, if the RCOG is to convince the Department of Health and primary care trusts that the expansion is essential. The numbers of doctors in training will need to increase to ensure sufficient numbers to facilitate the necessary consultant expansion. As a steady state is attained, the numbers in training will then need to be reduced.

For the first time, the majority of consultants are, through annual job planning and appraisal, aware of the hours they work, which are often excessive. Major changes within NHS service delivery have added to the challenges and pressures. Increasing workload and enforced targets, hand-in-hand with increasing patient expectations, have led to some consultants, despite their previously unchallenged commitment to the NHS, becoming demoralised and poorly motivated.

The impact of the new contract, pension proposals and age of retirement must continue to be monitored. The job planning process has identified that most consultants are working more than ten programmed activities and many may seek to reduce their hours of work. The new contract pay scales have also skewed retirement intentions and, in combination with the recently proposed changes to pensions, it is increasingly difficult to predict the annual numbers of consultants who will retire.

## 12 Conclusion

This document sets out a vision for the role of the consultant in the 21st century. It is both visionary and ambitious.

The future lies in one combined specialty, with a diversity of advanced skills across the full range of obstetrics and gynaecology. The needs of women and their babies are placed at the forefront of the recommendations.

This document is about improving patient care and safety. There is a recommendation, therefore, that maternity units looking after women with complicated pregnancies must move towards a consultant-based service. The Working Party, recognising the enormous implications, has made recommendations that there be careful workforce planning to implement a large consultant and, therefore, training grade expansion. There is no suggestion that a consultant will be resident without middle grade support and no plan that this should happen without adequate rest and remuneration. The College will, for the first time, address the issues affecting work–life balance.

In order to ensure patient safety, there needs to be enhanced enrolment into a specialty experiencing the worst recruitment cycle in its history. This issue, and the background to it, is being addressed and recommendations have been made. There is a recognition that poor life–work balance, with senior doctors continuing to work long hours as they juggle the needs of their patients and the demands of the service, is turning young doctors to other less demanding but possibly less fulfilling careers. An understanding of this within the Working Party has led to recommendations for realistic job plans with adequate time for clinical governance, teaching and CPD. There is recognition for the first time that consultants cannot in isolation provide a comprehensive clinical service and fulfil all the other traditional roles. Team working at consultant level will increase; consultants must work together to provide a good clinical service, to ensure enhanced patient care with strong clinical governance and mutual support. Mentoring, once reserved for the doctor in difficulty, is now seen to be crucial to future consultants and is to be offered immediately to all new consultants.

The practice of gynaecology is changing, with new techniques and a greater emphasis on medical management. There is no longer the need to train a large number of gynaecologists to perform a wide variety of complex gynaecology cases. There is neither the demand nor the number of cases for the majority of obstetricians and gynaecologists to maintain their surgical competence. There is, therefore, a recommendation that increasing numbers of doctors train in medical and diagnostic gynaecology. Consultants will work both in the community and in the hospital setting and many will continue with an obstetric workload.

The emphasis is on creating a workforce with a range of skills with interesting and rewarding careers that evolve over the professional lifetime. A workforce **setting standards to improve women's health.**

# Appendix 1. Workforce calculations

## Impact of the implementation of 168-hour presence per week

These recommendations increase consultant presence in a step approach.

Recommended plan for the implementation of extended consultant delivery suite service

Births ( <i>n</i> )	Consultant presence			
	40-hour	60-hour	98-hour	168-hour
> 6000	2005	2005–2006	End 2006	End 2008
> 5000	2005	End 2007	End 2008	End 2010
> 4000	2005	End 2008	End 2009	End 2011
2500–4000	2005	End 2009	End 2014	Variable

Prospective cover is essential and implicit.

The 98-hour target will allow 0800 to 2200 hours presence. Depending on subsequent disturbance on call, this may allow sufficient rest time before next day duties.

In recognition of the differing needs of units with less than 4000 deliveries, not all units will require 168-hour presence to ensure the necessary quality and safety standards.

Approximately 80 units deliver fewer than 2500 babies. These hospitals will require individual consideration to ensure that cover is at an appropriately high level, while acknowledging the limitation of numbers, finance and the growing trend towards rationalisation. Special consideration will be required for those units that are in remote and rural areas.

Assuming that, to provide 168-hour service:

- each unit will require at least 12.5 consultant obstetricians in addition to those required to provide the gynaecology service
- there are 43 units delivering more than 4000 babies, with an average of 9.4 consultants in each unit
- consultant expansion in each unit will need to increase by an average of 60–70% and therefore the consultant workforce will need to increase from the current level of 1500 to approximately 2500. While acknowledging the growing impact of flexible working patterns, the anticipated reconfiguration of many services may reduce the necessary expansion to approximately 2000–2200.

In addition, if smaller units are to achieve consultant presence for 60 hours, then 98 hours, a further expansion in numbers of consultants will be needed. Any changes in work patterns should remain within the terms and conditions of service of the present consultant contract and should also be within the 48-hour limit of the EWTD. It is certainly not intended that consultants will work

for 24 hours on the labour ward. The usual requirement of at least 11 hours rest per day will apply. Remuneration for the out-of-hours' work should be at the appropriate rate (3 hours per session).

Other workforce considerations, including the increasing demand for flexible working patterns, must be considered.

Achievement of these recommendations will be difficult and may require a review of consultant work plans. If reconfiguration of services is planned, careful consideration must be given to the impact. The subsequent needs and staffing levels of the evolving units must be fully addressed.

### The impact of different consultant expansion rates

Workforce predictions have, in the past, been notoriously difficult, as NHS trusts, targets and the commissioning process primarily dictate consultant expansion rates. Rates of consultant expansion have fluctuated from less than 1% (1999) to more than 7% (2004). Future rates of consultant expansion remain unpredictable but it is hoped that the recommendations for extending consultant cover will drive the necessary 7% rate. However, how quickly the necessary numbers of consultants can be achieved will depend on the future, largely unpredictable, levels of consultant expansion that are actually achieved.

### Consultant numbers and annual rates of expansion

To achieve the number of consultants for the recommended cover, an expansion rate of 7% will be required. However, the present predicted number of Certificate of Completion of Specialist Training awards over the next 3 years will be fewer than the predicted retirements and will not provide for any expansion. Those clinicians seeking specialist registration through equivalence of training may help in achieving the necessary expansion. However, it is recognised that the recommended plan for the implementation of extended consultant delivery suite presence will be difficult to achieve but must be pursued to improve the safety and care of women.

While acknowledging the present 7 years necessary for training before impact, there is, therefore, a pressing need to increase the numbers of type 1 trainees to provide the necessary consultant expansion. An undertaking must be obtained to ensure funding of the new consultant posts for these additional trainees at the completion of their training. The repetition of the manpower problems of the past, caused by inadequate consultant expansion, must be avoided.

Consultant expansion (%)	Numbers needed by year				
	2004	2005	2006	2007	2008
<b>3</b>	1549	1595	1642	1691	1741
<b>5</b>	1575	1653	1735	1821	1921
<b>7</b>	1605	1717	1837	1965	2102

## Appendix 2. Evidence for a consultant-based delivery suite service

### Obstetric intervention rates

There have been major epidemiological changes in how women give birth:

- more than one-third of women are now experiencing some form of operative delivery<sup>25,26</sup>
- in the last 20 years the caesarean section rate has increased from 10.4% in 1985 to 22% in 2003<sup>24</sup>
- the spontaneous vaginal delivery rate has fallen from 75% to 67%.

These changes have coincided with:

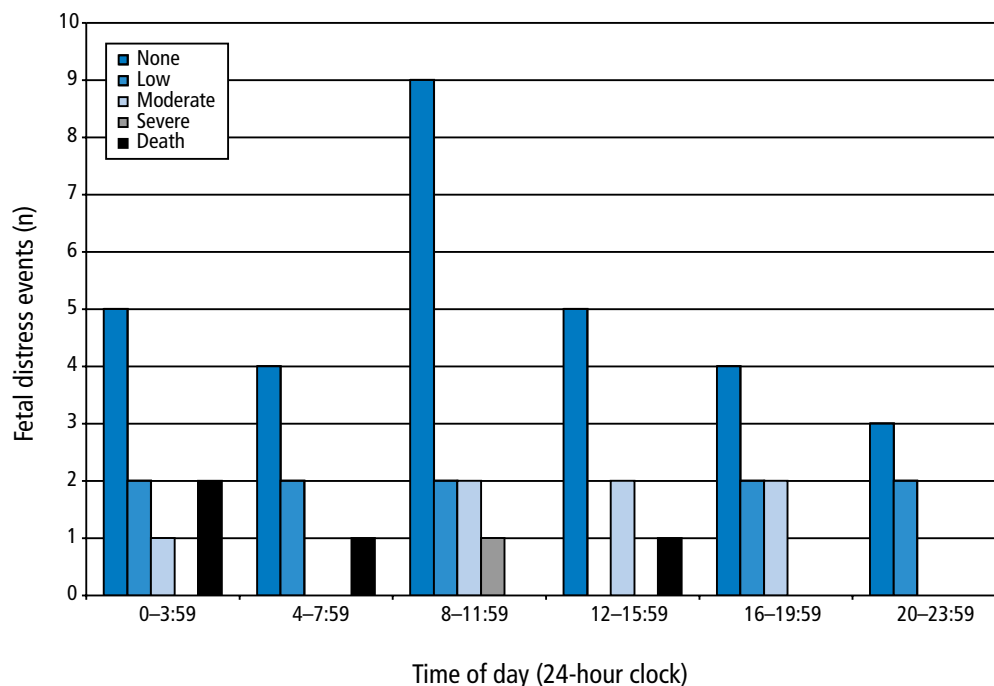
- a reduction in the number of UK career trainees
- only a modest increase in the number of consultants.

The increasing workload has not been recognised.

There is emerging evidence that the increased presence of the consultant on the delivery suite will:

- lead to a fall in the caesarean section rate<sup>27</sup>
- reduce complication rates from vaginal operative deliveries.<sup>21</sup>

### Timings of severe fetal distress events



**Figure 3.** Timing of fetal distress events and outcomes, as reported to the National Patient Safety Agency

New data from the National Patient Safety Agency<sup>28</sup> suggest that severe fetal distress events are more likely to occur after midnight than after 08.00 hours. These data suggest that the proportion of babies that die, or who are severely disabled, is at its highest between 00.00 hours and 04.00 hours and lowest between 08.00 hours and 12.00 hours (Figure 3). We know that the majority of obstetric units have 40 hours of dedicated consultant time and this time coincides with a reduced incidence of death from fetal distress. Combine these data from repeated Confidential Enquiries into Stillbirth and Deaths in Infancy (CESDI) reports and a pattern starts to emerge. Over 77% of the intrapartum deaths reported in the fourth and fifth CESDI reports had substandard care and, in 52% of these cases, alternative management would have made a difference. The critical comments acknowledged that in 95% of cases there were failures in three main areas: failure to recognise the problem, failure to act appropriately and failure of communication.

In a study from Wales, intrapartum complications occurred more commonly at night and during traditional holiday periods, at a time when less experienced staff were available.<sup>29</sup>

### Medico-legal issues

A substantial proportion of the money paid out in clinical litigation settlements by the NHS each year arises from obstetric problems, which result in the birth of babies with brain damage and permanent serious disability. The birth of a baby with brain damage is not always the result of clinical error but a number of consistent factors contribute to those cases, which do involve negligence.

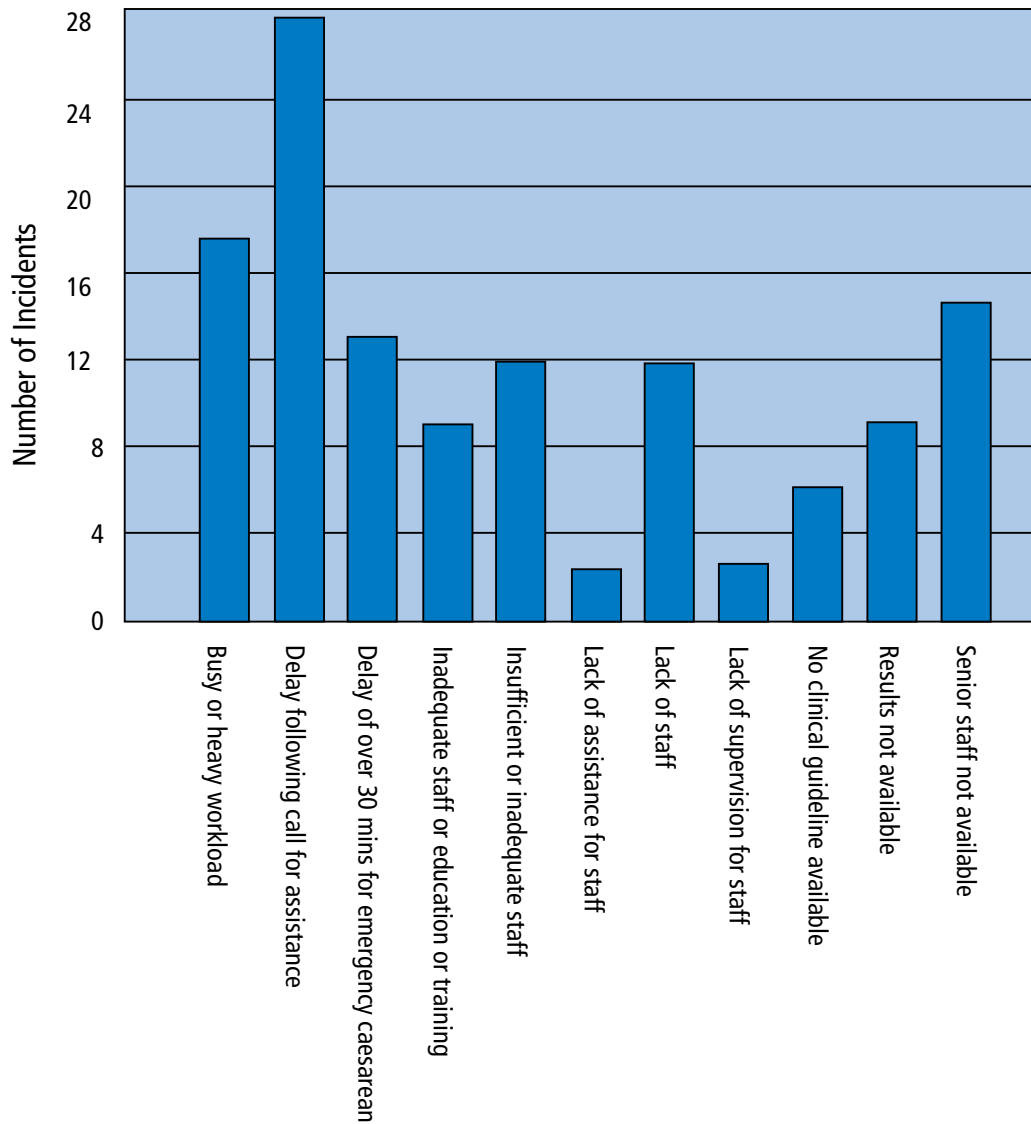
- The average sum awarded is around £1.5 million, with some awards as high as £4 million.
- Claims account for 50% of the NHS litigation bill each year.
- A 10% reduction in the number of adverse events causing brain damage each year would save the NHS an estimated £20 million a year.

Evidence suggests that the following actions would substantially reduce risk in this area:

- improved staff supervision
- proper use of equipment to monitor labour
- better techniques and diagnostic skills at delivery.

In a number of critical serious incidents reported to the National Patient Safety Agency, lack of senior staff presence, lack of supervision and delay in seeking or getting help were important factors in a poor outcome.

There is evidence that the absence of senior staff, lack of supervision of staff and a shortage of staff were significant factors in serious obstetric incidents reported to the Agency.



**Figure 4.** Organisational factors contributing to obstetric incidents (data from National Patient Safety Agency)

### Other supporting evidence for 168-hour consultant cover

The Hospital at Night study<sup>30</sup> has highlighted the importance of making the hospital as safe by night as by day. Hospital at Night has clearly shown that, in obstetrics, paediatrics, intensive care and acute medicine, the level of activity is the same throughout the 24-hour period. Therefore, the cover required should be the same 24 hours a day, 7 days a week. Intensive specialties such as obstetrics will need to address the need for 24-hour-a-day experienced obstetric cover. This report must be used to drive forward the changes that facilitate the highest possible standards of care.

## Appendix 3. Consultants in sexual and reproductive health care

The Faculty of Family Planning and Reproductive Health Care has recommended that there should be one full time consultant in sexual and reproductive health care for every 125 000 population.

Presently, there are 99 consultants in the specialty, with 12 vacancies in 2004 and 19 planned appointments.

There are 97 lead senior clinical medical officers and associate specialists. As these doctors retire, they will be replaced by consultants.

Currently, 19% of services have no medical lead.

There are 22 subspecialty training posts, of which ten are filled.

In order to avert the crisis, the number of training posts will need to increase to approximately 40.

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