Royal College of Obstetricians & Gynaecologists

Annual Review 2013/14

Improving women's health care

Better health care for women *everywhere*

'Many halls had standing room only and sometimes people were standing outside to listen to the lectures.'

Dr Jyothi Unni, Jehangir Hospital, India, page 8

'The one thing I'd really like to change is how clinicians taking on more managerial roles are seen as going over to the Dark Side.'

Saahil Mehta, Arulkumaran National Clinical Fellow, page 12

'The best way to tackle undermining is to do something about it yourself. If you see the behaviour, then challenge it.'

Dr Jo Mountfield, Southampton University Hospitals, page 16

'Idi Amin was in charge and it became very dangerous, so I decided to return home.'

Marcus Filshie, Associate Professor (Emeritus), Nottingham University, page 22

'I'm not saying that failure is not an option. What I am saying is that not trying is not an option.'

Prof Zarko Alfirevic, Chair of RCOG Academic Board, page 26

'They realise that we represent the gold standard in women's health care.'

Linda Nash, RCOG Trustee, page 30

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Foreword

David Richmond, President

The past year has been a busy time for our profession, our Fellows and Members, and the College, with some genuine progress made towards better women's health care, both in the UK and abroad.

Since taking the office of President from my outstanding predecessor, Dr Tony Falconer, I have been keen to focus our energies on some specific clinical priorities that will bring measurable benefits to women. In particular, a new RCOG initiative will focus on stillbirths, deaths of newborn babies, and babies born at full term but in poor condition. Eleven babies die in the UK every day and regional improvements have yet to be translated across the country. Over the next five years, we will be auditing the circumstances surrounding infant deaths before adding in research and education to develop lessons and guidance to manage these situations more successfully.

Work has also started in two other areas. The College's clinical audit department is examining the increase in serious tearing of the perineum during labour; we should see progress this year. Meanwhile, the recent sex selection controversy highlighted confusion about the legal parameters surrounding terminations of pregnancies. We have to work within the current act but clearer guidance, particularly on the HSA1 form, will help prevent the situation from recurring in future.

Delivering better health care

This is particularly relevant as we work to realise our vision of integrated health care for women over the whole life course. Last year a conference, *Women's Health Care for the 21st Century*, successfully set the stage. Now begins the larger, lengthier and more complicated task of delivering these reforms in practice.

Modernising our governance

To tackle these projects, the College itself must function effectively. Last year, we split the leadership responsibilities between Council and our new Board of Trustees, which I also chair, and which oversees and scrutinises our business and financial affairs.

With Council now focusing on our professional and clinical leadership, we have instituted some changes to the College's Vice Presidents. The position of Secretary has been renamed Vice President, UK Affairs, to better reflect its practical responsibilities and, with no further need for a Treasurer in Council, I have introduced a new position of Vice President, Strategic Development.

The election in January of Professor Lesley Regan into this role completes the reorganisation. Given her experience advocating for human rights in the UK and abroad, I expect Lesley will play a significant part in our efforts to become a voice for women's health globally.

Besides changing our curricula, this demands a multidisciplinary approach involving primary care physicians, nurses, midwives and public health workers. We need to develop partnerships with a wide range of groups and promote the life-course approach to women and the wider public. Consequently, we have now fully embedded the Women's Network into the College's activities and will soon be broadening the range of women we consult.

A similar impetus towards delivery holds true for our activities outside the UK. Our new global health strategy, the genesis of which came under our previous Senior Vice President, Professor Jimmy Walker, has given this work a fresh focus. We are now prioritising those areas where we can make the greatest difference, and extract greater benefit from our reputation, our global membership, and our natural strengths in clinical standards, training, and education.

Supporting our members

We also need to start communicating with our UK members in ways that matter to them. New pilots will use the changed NHS geography to engage members at a local level and we are examining how Council can better reflect our changing demographics.

This is important for democratic reasons, but also because I believe we can help specialists manage what has become an increasingly challenging workplace environment, with the time made available by the NHS for non-clinical activities under growing pressure. To my mind, this is a very parochial move which ignores the broader needs of the NHS and impedes essential professional development.

Given that *Tomorrow's Specialist* has highlighted the importance of acquiring new skills, such development has never been more important. This work was ably led by our previous Vice President, Education, Professor Wendy Reid, and over the last year, the Specialist Career Development Working Party has been identifying ways in which clinicians can identify and secure training throughout their career.

The working party's report will be published shortly. Although a product of *Tomorrow's Specialist*, it also builds upon the principles and commitments outlined in *Manifesto for Change*, our response to the Francis and Berwick Reports, and embraces recommendations within *The Shape of Training* for more generalist training. It is a comprehensive document which will affect all O&G specialists.

Finally, our 2013 World Congress in Liverpool was an extraordinary success with excellent science, which attracted Fellows, Members and non-members alike from across the world. As such, it set a high bar for this year's Congress, which I am delighted to report Hyderabad met in every conceivable way.

Both Liverpool and Hyderabad displayed the very best of our discipline and reinforced the privilege I feel to be leading this College. We have set ourselves important, ambitious goals and I am grateful to Council and the Trustees, Officers and the Executive Team for working tirelessly on behalf of our members to meet these goals and improve women's health care around the world.

David Richmond
President

Introduction

Ian Wylie, Chief Executive

Following changes to the College's management and functions, 2013 provided some welcome operational stability that allowed our staff and teams to bed down properly. At a governance level, however, the year was one of historic change as we set in place a leadership structure appropriate for the 21st century.

The introduction of a new Board of Trustees marks the first time in our history that non-clinicians have assumed legal responsibility for the College's business and our decision required the approval of the Privy Council. The effort was certainly worthwhile: our rigorous appointment process subsequently produced four new Trustees who have brought considerable rigour to their oversight of our work.

The changes also allow Council to devote more time to the research, education, examination and clinical quality work that underpins our mission to improve women's health care. Beyond these responsibilities, Council's democratic mandate ensures that its voice will always carry great weight.

Consequently, I believe that we are now well-placed to pursue our objectives today and also position ourselves for the years ahead. We are now grappling with the difficult but unavoidable challenge of our pension plan to find a solution that meets our legal and contractual obligations, rewards loyalty and long service, and is fair and equitable for all our staff.

Equally, with the College's strengths derived from our 12,560 Fellows and Members across the world, we must ensure that we accurately reflect our membership's rapidly changing demography. A new Equality and Diversity Committee, with ambitious targets, is working to ensure that our very diverse membership is represented fairly, and guard against any indirect discrimination that may occur.

We have also addressed the impact of digital media by entering into a new partnership with Cambridge University Press. This allows us to draw upon the resources and expertise of an international publishing house and focus the College's own energies on our core activities.

To that end, I am pleased to welcome the staff of NCC-WCH into Sussex Place. Expanding the level of expertise located in one place can only increase our critical mass and benefit everyone. I would also like to thank the College's staff, particularly our recent arrivals, for their professionalism, energy and proactive approach. Finally, I am grateful to the President, Officers, Trustees and Executive Team for their continued support, which has helped us to deliver real improvements to the health and health care of women across the world.

Ian Wylie
Chief Executive

Improving women's health care by…

Supporting our members

Excellent meeting. Clearly a lot of thought and skilful choice of topics. It is no surprise that this was the best attended RCOG meeting ever.

Delegate, RCOG World Congress 2013, Liverpool

Last year's Membership Survey, the first of its kind we have conducted worldwide, drove much of our membership work in 2013. The College scored well on some important issues; for example, most respondents agreed that we provide a first class education and keep in touch with members. Our Green-top Guidelines and *The Obstetrician & Gynaecologist (TOG)*, our journal for continuing professional development (CPD), also scored highly.

More sobering were the responses suggesting that we must become more accessible, representative and responsive. Some membership benefits, including our *Scanner* and *Membership Matters* newsletters, also required improvement.

Engaging clinicians

It is apparent that we need to improve how we communicate with our rapidly diversifying membership, and work harder to make the College an integral part of their professional identity. This will involve helping members extract greater value from the College, and developing a keener ear for what they want and need, and how this changes over time.

Further surveys will enable us to better anticipate the changes taking place in O&G, track perceptions of value and satisfaction and so tailor our service and support more effectively, recognising members' different interests, ages, genders and locations. Indeed, the 2014 survey, completed in March, now suggests that we are heading in the right direction, with small but generally consistent improvements over most measures.

Nevertheless, some changes have happened already. *The Scanner* now summarises where obstetrics and gynaecology or the College have been in the news, while *Membership Matters* will appear in both digital and print formats with a fresh title, *O&G*, and a new focus. Besides more news about our advocacy work, it now covers the College resources that can support members in their daily practice and professional development.

Developing Tomorrow's Specialist

Improving this support is particularly important in light of *Tomorrow's Specialist,* our 2012 report which examined the changes in training and working practices required to provide women with integrated, life-course health care. It concluded that formal learning was needed throughout specialists' careers and highlighted the importance of new skills, such as team working and leadership.

The Specialist Career Development Working Party was set up last year to translate these conclusions into practice. It has been creating a framework which allows specialists, particularly those in their first revalidation cycle, to maintain their professional development while fostering other important skills. It is also examining how CPD can help clinicians identify their learning needs, and how best to create a specialty e-portfolio to support appraisal, CPD and revalidation.

The Working Party's members included patients, trainees and recently qualified specialists, as well as experts in education, training and CPD. Its report is expected to be equally broad, ranging from core clinical skills and patient safety to new areas such as management skills and mentoring. It will also recommend how best to strengthen the appraisal process and make the revalidation process more meaningful.

Finally, the report will include a toolkit to point clinicians towards existing resources, enabling our members to take some initial steps for themselves immediately after publication. Overall, it represents important progress towards more integrated health care for women.

Improving women's health care by…

Supporting our members

Fairer representation

We have also been examining how the College can forge stronger regional connections with our members, using the new NHS map as a template as we work to make the College a starting point for a broader community of mutual support at a local level. We will be piloting a new hub-and-spoke structure in some regions which will move some College business closer to where our members live and work, making it easier for them to engage with College activities, and each other.

However, it's equally important that the significant changes in the NHS are represented within the College. A second strand of activity is examining our electoral processes to ensure that Council properly reflects the new NHS, as well as the changing demographics of our membership.

Improving resources

Much of this work has informed our review into the aims, scope and future development of *TOG*. When published, the review will recommend improving *TOG's* digital presence to include more interactive content, such as video. *TOG* will also start including more content for those people, such as trainees and international members, who don't read the journal for CPD purposes.

Meanwhile, a review of our library services found that they were appropriate for an academic organisation like ours, and valued highly by the relatively few members who use them. We are now placing more of the library online and, once there, making it easier to access.

The Liverpool Congress

For many, a high point of 2013 was our World Congress in Liverpool. It attracted more than 2,000 delegates, speakers and exhibitors from over 68 countries, and a record number of abstract submissions.

For the first time, we worked closely with the specialist societies on the scientific programme. Some of the highlights included the highly entertaining 'Stump the Experts' session and Andrew Browning's inspirational and moving talk about his fistula programme in Ethiopia and Tanzania. With an excellent venue and lucky weather, Liverpool was a tremendous success.

This augured well for our March 2014 World Congress in Hyderabad. More than 3,000 delegates attended this record breaking event and Dr APJ Abdul Kalam, India's former president, delivered the inaugural address. We now look ahead to our 2015 World Congress in Brisbane.

Standing room only

"Organising the Scientific Programme for a Congress involves a lot of planning. In Hyderabad we had around 110 speakers, across 15 streams, in five parallel halls, as well as five plenary lectures and a plenary panel discussion. We wanted the programme to be very clinically oriented, so chose people who had worked in their field for several years. We asked them to stick to clinically relevant issues and case discussions so that people could really relate to it as far as their practice was concerned.

"All of us on the committee work in different parts of the country, so we had just one physical meeting to outline the programme and then had meetings online. It was a great team effort: what was wonderful was that we were able to ensure that we sorted everything out without any acrimony. We had nice, happy discussions every Tuesday; in fact, we thought we'd have withdrawal symptoms so we had another meeting online on the Tuesday after Congress ended, just to catch up.

"Personally, I felt the Congress went very well – beyond our expectations, really. Many halls had standing room only and sometimes people were standing outside to listen to the lectures. For me, the highlight was the last plenary lecture, given by Prof Suresh. Usually at the tail end of a conference very few people are still in the hall but this lecture was such a draw that the plenary hall was absolutely full, and it was a brilliant lecture, extremely well delivered and also very well received.

"We worked very closely with colleagues at the RCOG and they were always open to our ideas and advice. They were very supportive, which was very good of them and I hope we lived up to their expectations. For my part, I'm looking forward to Brisbane next year and meeting all the friends that we've made organising this Congress."

Jyothi Unni specialises in high risk obstetrics at Jehangir Hospital, Pune, is Chair of the All India Coordinating Committee (AICC) West Zone for RCOG and was the Scientific Chair for the 2014 World Congress in Hyderabad.

The Scientific Committee comprised Dr Evita Fernandez, Dr Mala Arora, Dr Uma Ram, Dr Basab Mukherjee and Dr Anuradha Wakankar. The Chair of the Local Organising Committee was Dr P Das Mahapatra.

Improving women's health care by…

Setting standards & assessing quality

Clinicians now have a voice, and our standards and guidelines have a role, in the inspection and regulation of maternity and gynaecological services.

Like an earthquake, the Francis report into Mid Staffordshire NHS Trust reshaped the NHS landscape and the aftershocks continue. Indeed, the number of invited service reviews that the College has been asked to carry out rose by 50% on the previous year and we expect this rise to continue in the years ahead.

Invariably, the organisations asking us to conduct these reviews wish to take steps proactively to improve their patient care, rather than wait for regulators to unearth problems for themselves. Invited reviews enable our assessors, who often include midwives as well as O&G specialists, to provide an independent and objective appraisal of a specific service or individual. They can then deliver a constructive assessment that highlights good practices, suggest solutions to any problems they find, or recommend that unsafe practices are stopped immediately.

We have also established a new partnership with the Care Quality Commission (CQC), which asked for help developing its inspections regime. This means that clinicians now have a voice, and our standards and guidelines have a role, in the inspection and regulation of maternity and gynaecological services. As our dialogue with the CQC continues, we'll be able to promote important issues, such as teamwork in maternity units, and push for a more joined up approach to quality standards in obstetrics and gynaecology. This should produce greater openness and transparency, and improve patient care.

Maternity Indicators Project

Our own work to make maternity services more transparent gathers pace. Last year we published the first report into *Patterns of Maternity Care in English NHS Hospitals*, in partnership with the Royal College of Surgeons and the London School of Hygiene & Tropical Medicine (LSHTM). The report used Hospital Episode Statistics (HES) to present 11 maternity indicators, including emergency caesarean rates and induction of labour. The HES data was processed to remove demographic factors affecting maternity outcomes, such as age and income. By enabling fair comparisons to be made between maternity units serving very different communities, it allowed genuine benchmarks to be set.

The report showed that maternity care was safe. However, although anonymised, the results highlighted large variations around England with certain indicators, such as instrumental delivery, twice as high in some hospitals than in others. Some variation was due to poor quality data and the feedback received since publication suggests that the study has prompted many hospitals to improve their data collection and definition. This should improve the quality of HES maternity data in future years.

Nevertheless, the comparisons appear to have prompted maternity units to reflect on their performance; several Strategic Clinical Networks have since held quality improvement workshops to compare results among nearby hospitals, scrutiny that should deliver better maternity care and improved patient safety.

Towards greater transparency

The report has also been met with considerable interest nationally. The NHS Health and Social Care Information Centre plans to use several of the indicators; the CQC is examining how it can use some of our methodology to improve their Maternity Outliers Surveillance Programme; and the National Audit Office used some of our work in its recent report, *Maternity Services in England*. Following publication, the College has received funding for a new project to validate HES data from 15 selected hospital trusts and the CQC has expressed interest in adopting our indicators as part of its new hospitals inspections process.

Naturally, these endorsements are welcome. However, last year's report was only the first stage of a far larger project. Ultimately, we plan to cover maternity and gynaecological services across the UK and cover a broader range of indicators, including those relating to patient satisfaction.

In the meantime, the second edition is in the planning stages, subject to the release of the relevant data. Feedback from last year's report has prompted us to refine some of the indicators slightly. Thanks to members' suggestions, the next edition will also cover some new indicators, including the normal birth rate.

The results, when published, will be made available to the public and the report will identify individual hospitals, with clinical directors receiving advance notice of their unit's results to allow their comments to be published alongside the data. If a hospital with data quality issues appears to be an outlier, therefore, it can explain how it is addressing the problem.

Given the scale of this project, progress will inevitably take time. Nevertheless, with each edition we expect the data quality to improve further, and maternity services to receive closer scrutiny, improving health care for pregnant women and their babies.

Improving patient safety

Our partnership with the LSHTM also includes a new audit of NHS obstetrician-led maternity units in the UK. We will be examining what steps they are taking to prevent early onset neonatal group B streptococcal disease, a serious infection in mothers and newborn babies. Funded by the UK Screening Committee, and supported by the Royal College of Midwives, the audit will also identify how maternity units should improve their practices, and will assess their adherence to our 2012 Green-top Guideline on this matter.

Work has also started on the new NHS England Women's Health Patient Safety Expert Group. This has been set up to ensure a more consistent and coherent approach to patient safety for women and babies. The RCOG is hosting the group, which includes representatives from the Royal College of Midwives, the Royal College of Nursing and patients' groups. It will enable senior clinicians to inform NHS England about national priorities for patient safety, propose how these

Setting standards & assessing quality

can be implemented, identify how best to communicate essential patient safety information, and provide clinical advice to commissioners. Over time, we hope that the group's wide range of expertise, and its single voice, will drive significant improvements in health care and health outcomes for women and babies.

To this extent, the group complements the College's broader quality and standards work as host of the National Collaborating Centre for Women's and Children's Health (NCC-WCH). The NCC-WCH produces national clinical guidelines for the National Institute of Health and Care Excellence (NICE) on broad issues, such as multiple pregnancies. These are also used to help train NHS staff and inform current research.

Women's health guidelines are produced by our Fellows and Members, supported by specialists from other royal colleges and patients' organisations. Given its close operational ties to the College, the Centre's move into Sussex Place last year should improve our collaboration and, ultimately, women's health.

Listening to patients

All of this work has benefited from the closer involvement of the RCOG Women's Network. In addition, the Network has played a valuable role in producing our patient information leaflets, which summarise specific Green-top Guidelines in more accessible language. Leaflets produced last year covered subjects such as postnatal bleeding and diabetes during pregnancy, and can be downloaded from our website.

The Women's Network has also proved influential in our decision to focus our audit work this year on severe maternal tearing during childbirth. In partnership with the LSHTM, we published research last year which showed a three-fold increase in this problem over the past decade. An expert group recently met to derive a consensus approach on how best to tackle this and progress is expected this year.

Meanwhile, a larger project is also getting under way into the stubbornly high rate of stillbirth, which has remained at some 4,000 babies a year for most of the past 20 years. The project will review the circumstances surrounding infant deaths before, ultimately, developing a package of guidelines and standards to manage these incidents more effectively and improve patient safety and confidence.

The language of leadership

"I'll admit that I was quite sceptical when I was assigned to the RCOG; I'm not an obstetrician or a gynaecologist, so what could I offer? But the Clinical Fellowship is about learning generic skills – it takes clinicians out of training for a year at top level institutions, to immerse them in the leadership and management that the NHS needs.

"I'm really enjoying it and I'm getting to work on things that I would never do usually. I've been leading a project developing clinical dashboards for gynaecological surgery – visual indicators that flag up problems in clinical quality before they become too serious. I've been using the College's expertise to develop the methodology, and I've been really impressed. The people here are passionate about trying to achieve the College's vision of better health care for women, and I've been struck by how hard the College works to really engage with the public on lots of hot topics.

"Before this Fellowship, I never really understood what drives NHS managers. Now I've been taught how to understand their language, so I can engage with them and put across a clinician's perspective. It's like getting a superpower, like x-ray vision – hospitals are full of process and bureaucracy and the Fellowship gives you a kind of x-ray vision to see how you can navigate that structure to get what you need as a clinician, and that's very good for patients.

"When I return to clinical medicine, I hope I'll be able to bring with me this new knowledge of leadership, management and the NHS structure. The one thing I'd really like to change is how clinicians taking on more managerial roles are seen as going over to the Dark Side. It's ridiculous – it should be welcomed. Tomorrow's clinicians not only need superb clinical ability, they need fantastic leadership skills, so that they can make sure that we're efficient, that we have high quality and that we put patient safety above all else. The only way to do that is to understand how to better manage and lead as well."

Saahil Mehta is a Specialist Registrar in Plastic Surgery, an Honorary Research Fellow at Guy's and St. Thomas', and one of 23 National Medical Director's Clinical Fellows, where he is currently seconded to the RCOG.

Improving women's health care by…

Educating, training & examining doctors

We asked members around the country for help… we now have 14 question-writing groups, representing most deaneries in the UK.

Although complicated and frustrating, the changes we made last year to our curricula were also valuable and necessary. Like other royal colleges, we had been operating several curricula in parallel. This was because every incremental improvement to our curriculum – for example, to accommodate new clinical procedures – required approval from the General Medical Council (GMC); in turn, each approval produced a new version of the curriculum.

This didn't affect individual trainees but did mean that each cohort was qualifying with a subtly different skill base. As a result, the situation threatened to undermine the 'gold standard' of our education and, over time, would erode patient safety and confidence. Consequently, the GMC instructed every royal college to move their trainees to the most up-to-date curriculum by December 2015.

Changing our curriculum

We were already working on improvements to the core curriculum, which mostly involved rearranging when certain skills are gained. We therefore decided to combine the two changes well ahead of the deadline – an ambitious plan which was applauded by the GMC. Trainees were closely involved in the project's implementation, which required us to map all previous curricula into one new version, to identify the changes affecting each cohort and to advise trainees and trainers what to do next.

To guarantee that every eligible trainee was working to the same curriculum, we also needed to replace all remaining paper training logs with our ePortfolio platform and work closely with the UK Deaneries and Local Education and Training Boards (LETBs) to ensure that trainees already using this system updated their electronic curriculum.

This process proved extremely frustrating. Nevertheless, the changes have improved the ePortfolio significantly as both trainees and trainers can now track their progress through the curriculum. Furthermore, to give the changes time to bed in properly, no further alterations to the O&G core competencies are planned for the next two years.

Tackling undermining behaviour

Meanwhile, we continue to grapple with the undermining and bullying behaviour that pervades maternity units, affecting performance and threatening patient safety. Last year we were the first college to appoint a Workplace Behaviours Adviser to publicise examples of good practice and work with other organisations to promote a unified approach to this problem.

Given the multidisciplinary nature of maternity teams, we have been working particularly closely with the Royal College of Midwives. Later this year we will release a jointly branded toolkit of standards and resources so that maternity units can take positive, practical steps to stamp it out. And, with the deaneries, we have appointed local champions who can support trainees and push for action where necessary. The GMC also recognises that undermining and bullying behaviour needs to be addressed across the medical profession and will continue to track the issue in its Trainees' Survey.

Modernising our exams

Alongside the curriculum changes, work continues to make the MRCOG exam more flexible, relevant and rigorous. Last year, a working party recommended a series of improvements, including more input from women and the replacement of multiple choice and short answer questions by single best answer (SBA) questions in the Part 2 written exam.

This change required us to build a bank of SBA questions and we asked Fellows and Members around the country to help. Following an enthusiastic response, we now have 14 question-writing groups, representing most deaneries in the UK.

Overall, around 100 specialists are involved, of whom many are in their first five-year CPD cycle and are new to any kind of College activity. After attending a workshop, each volunteer was asked to write four questions. These have now been emailed through and we are hoping for a further four later this year. In the meantime, changes to the Part 1 exam and the Part 2 written exam have been approved by the GMC and will be implemented in 2015, improving their validity and reliability.

We also intend to separate the written and oral elements of the Part 2 exam, enabling candidates to 'bank' a pass in the written exam. The split will also allow us to design the oral exam separately and, in time, to tailor it to local practices abroad, enabling more doctors to achieve this gold standard in women's health care. Other changes include involving lay examiners to ensure that successful candidates meet patients' expectations.

Initial pilots of the new oral element of the Part 2 exam have taken place and will continue this year. We plan to submit our proposals to the GMC in the first half of 2015, and for the new Part 3 exam to go live in 2016, giving trainees plenty of time to prepare themselves.

Expanding eLearning

We have also been improving StratOG, our interactive eLearning platform. Our new SBA online resource has proved particularly helpful to trainees preparing for the Part 1 exam, and the Core Training section has been bolstered by MaternityPearls, which teaches clinicians about second degree tears and episiotomy (a surgical incision to the perineum).

In addition, the recent completion of the College's eLearning strategy is driving several new eLearning resources. We are producing online materials for Advanced Training Skills Modules, the Basic Practical Skills course, and laparoscopy (keyhole surgery). We are also preparing an online training module for external assessors

Improving women's health care by…

Educating, training & examining doctors

and an eLearning tool for workplace-based assessments, and are writing case studies to support specialists' CPD.

StratOG's collection of online lectures continues to expand and recently we tested a powerful video system which can integrate presentations with our AV resources. The system will soon allow us to record and share our events and conference material more effectively, and we are investigating the possibility of live streaming some lectures.

Technological improvements have also been made to our Enhanced Revision Programme (ERP), a 15 week, internet-based course to help candidates outside the UK prepare for the Part 2 MRCOG exam. Our international trainees can now enjoy a virtual classroom experience, including an online learning platform with a shared, interactive whiteboard, internet messaging and two-way voice communication. Last year, we completed the pilots and expanded the programme from India into Pakistan and Sudan, with more countries to follow soon.

Looking ahead

This year, we'll be reviewing our curriculum in light of the *Shape of Training* review of postgraduate education and training. This called for more generalist training and recommended that specialists continue their formal training after qualification, a finding anticipated by our own report, *Tomorrow's Specialist.*

We are also repackaging Advanced Training Skills Modules to help specialists continue learning after they qualify. In the UK, this could form part of CPD, while clinicians abroad could be formally credited for learning new skills, improving women's health care by encouraging further professional development.

In addition, we are modernising our workplace-based assessments to improve the feedback given to trainees. This is currently characterised as box-ticking and criticism, which is easily confused with undermining behaviour. The new workplace-based assessments focus more on constructive feedback and have now been approved by the GMC. They will go into effect later this year, giving us enough time to produce resources that teach trainers how to feed back more constructively.

This work ties in with our plans to develop our teaching faculty. Ahead of the GMC's proposals for official recognition and approval of medical educationalists, we are building a framework to help our trainers identify how they can progress in medical education. Over time, this should provide valuable support to trainers, without whom we will never achieve our vision of high quality health care for women everywhere.

Practical solutions to undermining behaviour

"Undermining is about poor behaviour in the workplace that makes people feel unable to do their job properly. That has implications for them, for their team and for the women we look after.

"For the past year I've been the College's Workplace Behaviour Adviser, a post that the Trainees' Committee pushed hard to create. By having somebody focusing on this at a national level, the College is showing that it treats the issue seriously and wants others to do the same.

"Right now I'm working with the Royal College of Midwives on a toolkit of interventions which will give people some tangible actions they can take. That's important because, if you really want to change behaviour, then individual units have to start owning the culture of their labour ward. We also have representatives now in every single deanery to be regional points of contact for trainees, and we're working to see if there's any correlation between incidents of undermining and poor clinical outcomes. I expect there is, because there's clear data now that says your patient mortality rates go up in units where the team isn't functioning very well.

"The GMC are also taking interest; we had a lot of input into a report they published recently, and later this year I'll be on a GMC visiting team, looking at disseminating good practice but also visiting units where there are issues and telling them that it's not acceptable and has to stop. I've also been travelling around the country, speaking at conferences and holding workshops because now, instead of just worrying about undermining, people around the country have started to do more themselves in terms of workshops and actually challenging people about their behaviour.

"Still, the best way to tackle undermining is to do something about it yourself. If you see the behaviour, then challenge it. If everybody did that, we wouldn't have a problem; we could whack it out in practically no time at all. For me, the essence of tackling undermining is: don't walk by."

Jo Mountfield is Director of Education at Southampton University Hospitals NHS Trust and the RCOG's Workplace Behaviours Adviser.

A year in our life – 2013

January

14/1
New Guidelines App is launched; 456 copies are downloaded on day one, and 6,330 during the year

21/1
Cervical Cancer Prevention Week

24/1
Annual Specialty Report

27/1
Enhanced Revision Programme (ERP) pilot is completed

February

6/2
Francis Enquiry Report and the RCOG's statement are both published; the Keogh Review is commissioned

15/2
New BiliChecker app launched, with 492 downloads to date

15/2
First RCOG Maternity Patient Safety Day

March

4/3
Part 1 MRCOG Examination is taken by 1,440 candidates in 20 centres

5/3
Part 2 MRCOG Examination is taken by 1,129 candidates in 17 centres

8/3
RCOG hosts the International Women's Day 'End Forced Marriage' event and 'Addressing the Challenge of Women's Health in Africa', organised by WHO and Global Library of Women's Medicine

14/3
Catherine Calderwood MRCOG is appointed as the first National Clinical Director, Maternity Services and Women's Health for NHS England

19/3
RCOG welcomes the 57th UN Commission on the Status of Women report

27/3
Founder's Lecture by Sir Kenneth Calman on literature and medicine

27/3
David Richmond is elected as the new President of RCOG, taking up office in September

April

13/4
DRCOG Examination is taken by 649 candidates

11/4
RCOG releases a statement on the death of Sir Robert Edwards, Fellow ad eundem, Nobel laureate and pioneer of IVF

May

2/5
RCOG publishes its 'Patterns of Maternity Care in England' Maternity Outcomes Report

16/5
RCOG Clinical Directors' Forum

20–21/5
Part 2 MRCOG Oral Assessment is taken by 261 candidates in 3 centres

31/5
Members' Admission Ceremony

June

1/6
RCOG Annual General Meeting

3/6
New RCOG Officers are elected, taking up their posts in September

18/6
RCOG publishes Manifesto for Change, its response to the Francis Report

24–26/6
RCOG World Congress 2013 takes place in Liverpool, attended by more than 2,000 delegates; Lord David Steel becomes an Honorary Fellow

29/6
RCOG is visited by Kuwait's Minister of Health

July

4/7
RCOG announces new partnership with Cambridge University Press

CAMBRIDGE UNIVERSITY PRESS

15/7
RCOG publishes its Clinical Commissioning Resources tool

16/7
Publication of the Keogh Review Report

NHS

19/7
First meeting of the new RCOG Board of Trustees

23/7
George Alexander Louis is born to Prince William and the Duchess of Cambridge

August

1/8
Launch of the RCOG Single Curriculum for O&G trainees in the UK

1/8
Sophia Webster MRCOG begins her epic, four month 'Flight for Every Mother' from Newcastle to Cape Town, visiting 24 countries across Africa

4/8
The National Collaborating Centre for Women's and Children's Health (NCC-WCH) returns to Sussex Place

5/8
RCOG Scientific Impact Paper on chemical exposure risks in the environment during pregnancy attracts widespread media attention

6/8
Publication of the Berwick Review into patient safety

November

4/11
Publication of Inter-Collegiate report to tackle FGM

8/11
RCOG responds to the National Audit Office Report on Maternity Services in England

11–12/11
Part 2 MRCOG Oral Assessment is taken by 221 candidates in 2 centres

September

Sep–Oct
RCOG attends all three party political conferences

2/9
Dr Saahil Mehta, first Arulkumaran National Clinical Fellow, begins his secondment at RCOG

2/9
Part 1 MRCOG Examination is taken by 1,495 candidates in 20 centres

3/9
Part 2 MRCOG Examination is taken by 866 candidates in 17 centres

15/9
Enhanced Revision Programme (ERP) goes live in 5 classes at 4 centres in 3 countries

18/9
The National Heavy Menstrual Bleeding (HMB) Audit reports that a majority of women are satisfied with their treatment in secondary care

24/9
Launch of joint RCOG-RCM initiative to address bullying and undermining in the workplace

26/9
Professor Mary Ann Lumsden FRCOG becomes chair of NCC-WCH

27/9
Fellows' Admission Ceremony

27/9
New RCOG President and Officers take up their posts

13/11
RCOG releases its statement on the NHS mandate

15/11
RCOG & BritSPAG publish papers on female genital cosmetic surgery

19–21/11
RCOG Annual Professional Development Conference (APD) sells out weeks in advance, with over 230 senior clinicians attending

22/11
Members' Admission Ceremony

22/11
RCOG Annual Dinner with chief guest and speaker, Professor Lisa Jardine, Chair of HFEA

29/11
HSJ BME 'Pioneers list' features former RCOG President and current FIGO President, Professor Sir Sabaratnam Arulkumaran, and Dr Daghni Rajasingam, RCOG Council Member

December

1/12
World Aids Day

4/12
Ted Adams MRCOG gives the Christmas Lecture for Young People

5–6/12
SpROGs 2013 Nottingham – the Annual National Trainees' Conference is attended by 200 delegates

5/12
GMC publishes its report on undermining

12/12
CQC releases its survey on Maternity Services

12/12
RCOG hosts the first meeting of the Shadow NHS England Women's Health Patient Safety Expert Group

16–17/12
RCOG Annual Academic Meeting

October

2/10
Senior VP Global Health joins ministerial mission to the Gulf, en route to FIGO Africa

2/10
RCOG delegation arrives in Addis Ababa, Ethiopia, for FIGO's Africa Conference

5/10
DRCOG Examination is taken by 671 candidates

17/10
Recruitment starts for the RCOG Gulf Champion

17–18/10
Women's Healthcare for the 21st Century conference, launched by Jane Ellison, MP, Minister for Public Health

24/10
RCOG launches its Global Health Strategy at the House of Lords

24/10
RCOG responds to CMO Annual Report 2012

24/10
RCOG responds to the Shape of Training Report

29/10
Nominations open for new VP Strategic Development post; Prof Lesley Regan is elected on 24th January 2014

Improving women's health care by…

Working globally

All women should have the opportunity to have a child in a safe environment, and hopefully this journey was able to highlight the reasons why this is so difficult for so many.

Dr Sophia Webster, MRCOG

Described as "ambitious but achievable", the College's new global health strategy was launched at the House of Lords last year before an audience of parliamentarians, NGOs and other partners interested in our global health focus and direction over the next five years.

The strategy is ambitious because we intend to develop new initiatives, build on existing work, support more volunteers, increase our partnerships and raise the money needed to make this happen. It's achievable because we will do this by harnessing our existing strengths – our global membership, brand and reputation, and our core competencies in education, training and clinical standards.

With 12,560 Fellows and Members in more than 100 countries, the College has a unique position as a world leader in high quality women's health care. We intend to capitalise on this to push for improvements to women's health care globally, while focusing our own activities where we can achieve greatest impact. To this end, we now assess the needs of different countries and our ability to meet them, pilot the projects that are approved, and refine them if necessary before rolling them out.

A dual approach

Essentially, our global health work operates at both a systemic and a local level. Many of our local activities are in Africa, where we work through our Fellows and Members and other organisations to improve women's health care in specific regions, areas or hospitals.

To promote this work, we travelled to Addis Ababa for FIGO's first Africa Conference, where we held a series of RCOG sessions and ran workshops on clinical guidelines. While there, we visited the Ethiopian offices of VSO, a key partner for placing volunteer clinicians around the world. We assess the placements for clinical suitability and VSO handles the logistics.

We have also been developing relationships with other NGOs which want to use our expertise to underpin the clinical quality of their own operations. For example, we recently teamed up with the Royal College of Surgeons (RCS) to provide O&G training as part of their 'Surgical Training in the Austere Environment' (STAE) course for trauma surgeons working in war or disaster zones. After returning surgeons told the RCS that most of their time was spent delivering babies, we developed a one-day addition to the STAE course which covers essential skills, such as caesarean sections and emergency gynaecology. Last year's pilot was very successful and we plan to run seven more courses over the next three years.

Nascent partnerships

In addition, we are exploring a new partnership with Médecins sans Frontières (MSF) which could involve providing guidance, training and clinical materials before doctors leave for their MSF assignments. We are now in the early stages of working with Merlin (part of Save the Children) and University College London and are exploring a potential partnership with the American Congress of Obstetricians and Gynaecologists (ACOG), whose global health activities largely complement our own.

But there are other ways to make a difference. Last year, Sophia Webster MRCOG, a UK-based obstetrician, piloted a light aircraft to Cape Town in a 'Flight for Every Mother'. En route, she stopped in 24 African countries, visiting medical and midwifery units to donate essential equipment and train local staff. She arrived in South Africa last November and is now back in the UK, having successfully raised awareness of the high levels of maternal morbidity and mortality across the continent.

Furthermore, the generosity of Marcus Filshie FRCOG has allowed us to launch a new volunteering fellowship in Uganda, where women have a 1 in 50 lifetime risk of maternal death, and many others suffer significant disabilities, such as fistula (a hole in the birth canal). The three-year Fellowship will sponsor a trainee to work for six to twelve months at Kitovu Hospital in Masaka Region, which delivers around 2,000 babies every year. It also provides a free service for women with fistula via four camps each year, which are supported by international surgeons, including RCOG Fellows and Members.

Achieving systemic change

The second strand of our global health work takes place at a systemic level, where we help countries that are sufficiently developed to want western standards of women's health care. By providing their clinicians with world-class education, training and exams, and by introducing the highest clinical standards and guidelines, we have the opportunity to transform women's health on a national scale.

Pioneering this approach is our Gulf development project. The College has a strong reputation in this region, thanks in part to our many international Fellows and Members based there. We are now beginning to show how more trainees and senior doctors can become RCOG Members, or accredited faculty members, over the next five to ten years. We are also exploring partnerships with training centres and university hospitals, helped by Hassan Shehata FRCOG, our new Gulf Ambassador.

Meanwhile, our partnerships with UK Trade & Investment (UKTI) and HealthcareUK, its healthcare arm, continue to bear fruit. Last year, we welcomed visits from Kuwait's Minister for Health and the Chief Clinical Officer of SEHA (Abu Dhabi Health Services Company), while our Senior Vice President, Global Health, visited Abu Dhabi and joined an official UKTI ministerial mission to Kuwait.

These developments have significantly expanded our network of decision makers. We have been invited to run a course in Kuwait which outlines the Part 2 MRCOG written exam, and to hold an RCOG day at its O&G Congress later this year. We are also organising an RCOG women's healthcare conference this December in Qatar at the invitation of Sidra Medical and Research Centre.

Working globally

New partners, new products

Currently we are translating our global health strategy into practical action. Part of this involves working more closely with local O&G societies and we are examining how to link our UK-based Liaison Groups and International Representative Committees into the strategy.

Meanwhile, we have begun to collect film, photos and stories that highlight the activities of our members around the world. By using these to illustrate how our members are improving women's health care globally, we can engage with new audiences, specifically potential donors and partners with whom we can extend our reach without diluting our impact.

We are also developing standardised toolkits to communicate our expertise and provide a structured response to the many requests for help that we receive. These toolkits include audit, guideline development and curriculum design, and can be tailored to maximise their benefit in different environments. They will be ready this year.

For now, however, implementation involves scrutinising our activities to ensure that we direct our resources into areas where we have a natural advantage. Elsewhere, we will work with new or existing partners, or help organisations attract support from third parties. This focus lies at the heart of our new global health strategy and will increase our ability to deliver meaningful and sustainable improvements in the health and health care of women around the world.

Serial serendipity

"It all started back in 1969, when I was an SHO at King's. I got involved in some research with Prof Sultan Karim and followed him to Uganda, to be the clinical head of the relevant OBGY research unit at Mulago Hospital. We were doing 22,000 deliveries a year, which gave me a huge amount of clinical experience – when I came back from Uganda nothing frightened me at all!

"My wife and I had a wonderful time in Uganda but Idi Amin was in charge and it became very dangerous, so I decided to return home. By then, I had met Donn Casey, Chairman of the Simon Population Trust, and he asked me to develop a new method of family planning.

"We decided to look at female sterilisation methods that could be done without anaesthetic or electricity. I'd seen an article about a haemo-clip, used to stop bleeding, and had the idea of using a larger version on the fallopian tube. We began selling the clip in 1982 and the number sold is still increasing every year!

"I've had such serial serendipity in my life that I wanted to give something back, so I was obviously delighted to learn that the College wanted to set up a Fellowship in Uganda. It's based at Kitovu Hospital and will provide cover for local clinicians who are training in fistula surgery. This really appeals, because a fistula operation can transform ladies' lives from absolutely the pits to back to normal, and there are so few areas in life where you can make this claim. What's more, I was very keen to fund something sustainable and here we can join up with other groups, expand the work being done and give the College a stronger voice in Uganda.

"I think this is a template for others to follow. Instead of leaving a bequest when you're in a box under the ground, do something while you're alive. If I can support this Fellowship to continue in perpetuum, I'll be the happiest guy ever because I would have achieved something that makes a huge difference to women's lives."

Marcus Filshie FRCOG is Associate Professor (Emeritus) at Nottingham University and co-inventor of the Filshie Clip, of which more than 10 million have been sold to date.

Improving women's health care by…

Collaborating with others

Work is now under way to use our reputation and expertise to raise our national profile so that we ultimately become the authority on women's health and health care.

In 2011, the College published *High Quality Women's Health Care*. This argued for a patient-centred, life-course approach to women's health care in which every clinical contact is used to promote our patients' future health. This year we began developing the partnerships we need to influence the debate and implement practical changes. And although this is just the start of a long process, it is already improving the quality of care that women receive.

A patient-centred approach demands that women receive the right care from the right person when they need it, requiring specialist clinicians to be available 24/7. The move towards 24/7 consultant coverage has been boosted recently by the endorsement of Sir Bruce Keogh, NHS England's National Medical Director. Sir Bruce has said that he wants a full, seven-day service to be operating in urgent and emergency care by 2017. However, change is already happening on the ground in the North West; as part of NHS Manchester's 10 year 'Making it Better' reorganisation, St Mary's Hospital is now implementing 24/7 consultant cover in its labour wards – the first maternity unit in the UK to do so.

In October we further publicised the life-course approach by hosting a conference, *Women's Health Care for the 21st Century*. It was very well-received, with a broad range of speakers including Jane Ellison, MP, Minister for Public Health; Anna Dixon, Director of Strategy, Department of Health; Catherine Calderwood MRCOG, National Clinical Director, Maternity Services and Women's Health for NHS England; and the *Guardian* columnist, Zoe Williams.

Human rights – women's rights

Wherever it is practised, the life-course approach centres on communicating with women honestly and promoting their human rights. Only then can they become sufficiently empowered to exercise genuine control over their health and make properly informed choices about the care available to them.

Using the language of human rights to persuade existing partners and develop new relationships has become the responsibility of the College's new Vice President, Strategic Development. This involves influencing opinion among policy makers, the press and public and work is now under way to use our reputation and expertise to raise our national and international profile so that we ultimately become the authority on women's health and health care.

New relationships, new voices

To ensure that we remain mindful of the opinions of women and the public, we have embedded the Women's Network into every area of our work. We have also harnessed their contacts with other organisations to run focus groups with women in the Bangladeshi and south Asian communities to trial some of our patient information and learn how we can make it more useful.

In addition, we have been working closely with the Faculty of Sexual and Reproductive Healthcare (FSRH).

Together, we have initiated a joint relationship with Public Health England to push local authorities to continue delivering a full range of health services, and to increase the education that women and girls receive about their health choices.

We also produced joint guidelines for commissioners of women's health care in the UK. The interactive resource brings together all the clinical standards for women's health care at both a hospital and community level, and maps out exactly how commissioners can deliver integrated services across the life course.

Providing information, tackling abuse

The need to give women information, choice and control has underpinned other partnerships, too. We published a joint statement with the British Society for Paediatric and Adolescent Gynaecology (BritSPAG) on female genital cosmetic surgery (FGCS) – procedures such as labiaplasty that change the structure and appearance of healthy genitalia. The College's own ethical opinion paper explained that, despite a five-fold increase in such procedures over the past decade, little research into FGCS actually exists. We called for women to be fully informed about this lack of evidence, and for a general moratorium on FGCS for girls under 18.

We have also been addressing female genital mutilation (FGM) as part of a group that includes patients' groups and other royal colleges. Initial meetings with the Crown Prosecution Service and Keir Starmer, then Director of Public Prosecutions, highlighted a gap in how FGM is reported. After consulting charities, NGOs and government, we identified how the police could work with health and social care workers to identify and monitor girls at risk of FGM. Since Tackling FGM in the UK was published last year, the Department of Health has begun collecting statistics on women who present with signs of FGM, and on girls who are at risk – an essential first step towards tackling this abuse.

The Manifesto for Change

Meanwhile, the *Manifesto for Change* was our formal response to the second Francis Inquiry and outlined the governance, infrastructures and ethos required to prevent similar problems from happening in O&G. It builds on the principles outlined in *High Quality Women's Health Care* and *Tomorrow's Specialist*, including the need to treat patients with compassion, dignity and respect, and a duty of candour to prevent substandard care.

The *Manifesto* includes a series of practical commitments, involving mentoring, clinical guidelines and maternity indicators, as well as examinations and post-CCT training. Besides preventing any repeat of the suffering at Mid Staffordshire Trust, they should also increase women's confidence and improve their safety and health outcomes when they are under our care.

We adopted a similar approach to termination of pregnancies. The controversy surrounding gender-selective terminations which played out in the media highlighted confusion over the

Collaborating with others

boundaries of clinicians' responsibilities. College representatives met with NHS England, the Department of Health and parliamentarians to brief them on the challenges in abortion care provision and the impact on women's services, making it clear that these services must be patient-centred. Together with the FSRH, we also launched an email hotline to advise members who were concerned about the investigations.

Chemical exposures

The abortion debate demonstrates the need for academic institutions like the College to advance considered, evidence-led arguments, whatever the possible reaction. Last year, we published a Scientific Impact Paper (SIP) which highlighted the potential risks to pregnant women of unintentional exposure to various chemicals which, in low doses, are often found in cosmetics and household products.

The paper provoked criticism from some commentators, even though its information was consistent with research published by both the European Commission and the US Food and Drug Administration. In addition, similar findings have since been published by ACOG and the University of Illinois, among others. However, we now work more closely with the Women's Network when preparing our communications to ensure that the language used does not cause women unnecessary alarm.

Persuading the public

For now, we are increasing the number of patients' organisations that we work with so that our information can reach even more women. We are also piloting our new Women's Voices Involvement Panel, a virtual network that enables a far wider range of women to tell the College about their own experiences of O&G services.

This matters because persuading politicians, clinicians and journalists will not in itself bring about the improvements we want. We also need to convince the public, because lasting change will only happen when patients accept the responsibilities inherent in a patient-centred, life-course approach and start to demand better health care for themselves.

Integrating research into clinical practice

"The Academic Board is here to give a stronger voice to those of us doing research. Evidence-based medicine is only possible if we base our clinical practice on the best available research, and RCOG-relevant research has to be done by the College's Fellows and Members.

"In particular, we don't want the dichotomy where researchers are sitting in an ivory tower, waiting for clinicians, as a different breed, to integrate research into clinical practice. Instead, we want our practising clinicians to be researchers and our researchers to be practising clinicians. The RCOG is absolutely essential in bringing these together and ensuring that both trainees and clinicians have adequate time and support, not only to do research, but to implement the most up-to-date findings and guidelines into their daily clinical practice.

"Last year the Academic Board launched a GMC-approved academic clinical curriculum for our postgraduate trainees. This is a significant achievement that goes a long way towards integrating the research agenda into everyday clinical practice, because trainees now have clear targets for what they are expected to know and learn when they engage in clinical research.

"We also renewed our 11 clinical study groups. Having a clear mandate to look at national research priorities, and the collaborative research that can deliver them, is a huge achievement. We now have an infrastructure in place to start integrating O&G research into everyday clinical practice.

"This is particularly relevant for our new investigation into safety of intrapartum care (during labour and birth), where ultimately the patient benefit is going to come from high quality, patient-relevant research that is integrated without delay into clinical practice. The Academic Board will ensure that we use all our academic and scientific brainpower to try and make some significant inroads over the next five years, focusing in particular on full-term intrapartum stillbirths and full-term babies with severe brain injury.

"We need everybody to contribute to the RCOG academic agenda because it's our responsibility not just to produce research and guidelines, but also to close the loop and demonstrate the impact on health. It's not going to be easy and I'm not saying that failure is not an option. What I am saying is that not trying is not an option."

Professor Zarko Alfirevic is Professor of Fetal and Maternal Medicine at the Liverpool Women's Hospital and chairs the RCOG's Academic Board.

Improving women's health care by…

Modernising the College

One of the lay trustees has got a very strong track record in equality and diversity and she's made it very clear that she's not here to make us look good just for having an Equality and Diversity Committee.

Ian Wylie, RCOG Chief Executive

Until June 2013, the College had been governed in much the same way for more than 80 years. Then everything changed as we modernised our leadership structure so fundamentally that approval from the Privy Council was required.

The change followed a review, led by Baroness Julia Neuberger, which had considered how best to govern the College in the 21st century. Her solution was to split the leadership responsibilities between Council and a new Board of Trustees.

Chaired by the President, the 10-member Board includes four lay trustees, two of whom must have prior experience of women's health issues. It has responsibility for the College's charity and business operations, including our legal, financial, HR and corporate affairs.

Changes to Council

This leaves Council free to concentrate on professional and clinical issues, ensuring that excellence in women's health remains at the heart of the College's work, and that we stay at the forefront of improvements in women's health care around the world.

We have also made Council more representative. Five Fellows are now elected to be international ambassadors, while the Trainees' Committee and the Chairs of the Academic Board and the Women's Network also attend.

To complete the changes, we have modernised the Officers' titles and responsibilities. With the Board now responsible for our legal and financial affairs, the positions of Hon Secretary and Hon Treasurer became redundant. In their place, the President has created the roles of Vice President, UK Affairs (Ian Currie), and Vice President, Strategic Development (Lesley Regan). These positions now serve alongside the Senior Vice President, Global Health (Paul Fogarty), the Vice President, Education (Clare McKenzie) and the Vice President, Clinical Quality (Alan Cameron), thereby reflecting Council's new remit more accurately.

Cambridge University Press

These developments cap a period of modernisation in which the College has gained a sharper focus and clearer direction. This process has involved outsourcing non-essential activities in order to redirect our energies into our core competencies, such as education, exams, and clinical quality.

To this end, last year Cambridge University Press (CUP) bought our books list and agreed to develop new publications with us under a joint RCOG-Cambridge imprint. The partnership entitles Fellows, Members and Trainees to a 20% discount on all Cambridge Academic titles and will enable us to produce more RCOG-approved publications. CUP has already launched e-book versions of old titles; over time, we expect new textbooks and other professional products to become available in a wider range of formats.

Moreover, CUP's global presence will help us expand our reach, enabling more clinicians to access reliable medical resources. By combining the College's quality assurance with CUP's publishing expertise, this collaboration is good news for our membership and specialty, both in the UK and abroad.

Expanding *BJOG*

We have also been expanding the reach of *BJOG: An International Journal of Obstetrics and Gynaecology*, our monthly journal of peer-reviewed research into women's health. The editorial team has been enhancing the journal's presence in the USA, currently the world's top producer of scientific research, to ensure that we're reporting on the highest quality work in women's health from across the world. This will allow *BJOG* to maintain its reputation and increase revenue.

Last year showed a substantial growth in the number of papers published by US authors and we are confident that we can continue this trend. The journal has also increased the number of open access articles that it publishes. This reflects changes in research funders' mandates, both in the UK and globally, and makes the latest research into women's health more widely available to clinicians and members of the public around the world.

Meanwhile, *BJOG* has been making waves on social media by taking its journal club, which discusses selected articles, onto Twitter (#BlueJC). Summaries of the debates are then published in *BJOG*'s correspondence section.

We've been analysing the impact of *BJOG*'s social media activities via altmetrics, which measure the number of times an article is downloaded, or mentioned on social media. The results show that *BJOG* is leading its competitors in terms of framing the debate on research issues in women's health.

Relaunching our website

Alongside *BJOG*'s increasing use of digital media, last year we launched our Green-top Guidelines app for iPhone and iPad. It sold almost 6,500 copies in 2013 and we have since released an Android app, which is also selling well.

Following a major overhaul, our website is due to be relaunched this summer with a new look, easier navigation, a better search function and a design that adapts to tablets and smartphones. The close involvement of the Women's Network means that it will also have a separate section specifically for patients and the public. Given the difficulty that many lay people have with medical terms, this section has a predictive search function that suggests possible phrases once the first few letters have been entered. We want this section of the site to become an invaluable information resource for patients and the public so that they can access the information they need to make informed choices about their health care.

A fresh pair of eyes

"I've been really impressed by the enthusiasm with which the College has embraced its new governance arrangements. People have spent considerable time getting external advice to help them run the RCOG better, and the Board of Trustees does that. We're here to make sure that the College's business is fit for purpose, so that everything it does is geared towards achieving its strategic objectives in a methodical way.

"For example, I sit on the audit committee, where our job is to ensure that we have the structures in place to look at risks properly and the right controls to manage them. Equally, these need to reflect our strategic parameters: it's about making sure that you know what the risks are and that you've taken steps to minimise them so that they don't threaten the continuing success of the organisation, and the audit committee is shaping up to do that very well.

"The advantage of external Trustees is that each of us has experience of running different types of organisations, so we can stand back and benchmark the College from our different perspectives. We can challenge the College to think outside the box a bit more, to think more commercially, increasing our income streams and sweating our assets.

"For example, right now we're asking how we can make ourselves a globally important college in setting quality standards for women's health worldwide. With our reputation, we have a fantastic opportunity to go to places like China and India which are increasingly interested in working with organisations like the RCOG because they realise that we represent the gold standard in women's health care.

"In helping them it presents a huge business opportunity that would underpin our work here. As we know, the UK faces challenging times and more competing priorities. This is where we rely on the royal colleges and regulators to ensure standards don't fall below a certain line. The RCOG is the champion of women's health and we have to keep beating that door, making sure that people understand about standards of care and the needs of women. That's our core business."

Linda Nash is one of four external trustees sitting on the College's Board of Trustees; she has a broad range of Board experience and was previously Chair of Somerset Partnership NHS Foundation Trust.

2013 at RCOG

Record of Fellows ad eundem and honoris causa

The President had the privilege of admitting the below during the Fellows' admission ceremony on Monday 24 June 2013, held as part of the RCOG World Congress in Liverpool.

Honorary Fellow

Lord Steel of Aikwood

Fellows ad eundem

Professor Chiara Benedetto, Italy

Professor Bernard Clarke, England

Professor Tom Fleming, England

Dr James N Martin Jr, USA

Professor Colin Sibley, England

Fellow honoris causa

Professor Dame Sally Davies, England

The President had the privilege of admitting five **Fellows ad eundem** during the Fellows' admission ceremony on Friday 27 September 2013:

Professor Gudrun Moore, England

Professor Ioannis E Messinis, Greece

Professor Leslie Myatt, USA

Professor Jose Palacios-Jaraquemada, Argentina

Professor Robert Reid, Canada

The President also had the privilege of admitting four **Fellows honoris causa** during the Members' admission ceremony on Friday 22 November 2013:

Dr Jennifer Blake, Canada

Dr Maura Lynch, Uganda

Baroness Julia Neuberger, England

Professor Babatunde Osotimehin, USA

Board of Trustees

President – Anthony Falconer (until 27 September 2013)

President – David Richmond (from 27 September 2013)

Senior Vice President – James Walker (until 27 September 2013)

Senior Vice President/Treasurer – Paul Fogarty (from 27 September 2013)

Honorary Treasurer – Paul Fogarty (until 27 September 2013)

RCOG Fellow – David Farquharson

RCOG Member – Daghni Rajasingam

RCOG Council Representative – Dib Datta

Lay Trustee – Naaz Coker

Lay Trustee – Roy Martin

Lay Trustee – Linda Nash

Lay Trustee – Sir Eric Thomas

Council

Honorary Officers until 27 September 2013

President – Anthony Falconer

Senior Vice President – James Walker

Vice President – David Richmond

Vice President – Wendy Reid

Honorary Treasurer – Paul Fogarty

Honorary Secretary – Ian Currie

2013 at RCOG

Honorary Officers from 27 September 2013

President – David Richmond

Senior Vice President/Treasurer – Paul Fogarty

Vice President – Ian Currie

Vice President – Clare McKenzie

Vice President – Alan Cameron

Vice President – Lesley Regan (January 2014)

Elected Fellows

London – Melanie Davies
Diana Hamilton-Fairley

Eastern – Edward Morris

Northern/Yorkshire – Paul Hilton

South West – Jonathan Frappell

North West – Charles Kingsland

South East – Felicity Ashworth

Trent – Diana Fothergill

West Midlands – Mark Kilby

Wales – Simon Emery

Scotland –
Mary-Ann Lumsden
Phil Owen

Northern Ireland
– Robin Ashe

Republic of Ireland
– John Morrison

International (England) –
Alison Wright
Janice Rymer
Linda Cardozo
Justin Konje

International British Isles – James Dornan

Elected Members

London
– Daghni Rajasingam
– Narendra Pisal

Eastern – Medhat Hassanaien

Northern/Yorkshire – Padma Bharathi Pathi

South West – Jane Mears

North West – Andrew Pickersgill

South East – Dib Datta

Trent – Nicholas Raine-Fenning

West Midlands – Pallavi Latthe

Scotland – Andrew Thomson

Republic of Ireland – Cliona Murphy

Co-opted members

Ted Adams, Chair, Trainees' Committee (to December 2013)

Matthew Prior, Chair, Trainees' Committee (from January 2014)

Andrea Pilkington, Deputy Chair, Trainees' Committee (to March 2014)

Zarko Alfirevic, Chair, Academic Board

Invited members

Cath Broderick, Chair, Women's Network

Angela Hyde, Vice Chair, Women's Network

Christopher Wilkinson, President, Faculty of Sexual & Reproductive Healthcare, RCOG

Unless indicated otherwise, all appointments are as at 31 December 2013.

Council were the legal trustees of RCOG until 3 June 2013.

From 3 June 2013 a Board of Trustees assumed this responsibility.

Senior Management Team

Chief Executive – Ian Wylie

Deputy Chief Executive and Executive Director of Global Education – Michael Murphy

Executive Director of Quality and Knowledge – Sara Johnson

Executive Director of Resources – Fred Emden

Directors of:

Clinical Quality – Anita Dougall

Development – Ann Tate

Education Policy and Quality – Kim Scrivener

Finance – Sandra Tetsola

Global Health – Rachel Cooper

Health Policy and Public Relations – Gerald Chan

Human Resources – Rachel Dell

Information Management and Technology – Ed Horvath

Journals and e-Publishing – Claire Dunn

Marketing – Nigel Moore

Meetings – Lynn Whitley

Membership Relations – Victoria Bytel

National Collaborating Centre, Women's & Children's Health – Moira Mugglestone

Operations – Jan Horsnell

Unrestricted income and expenditure 2013

Unrestricted Income	Unrestricted Funds £
Generated funds	
RCOG Trading Limited	1,358,617
Investment income	175,674
Donations and legacies	37,500
Accommodation and service charges	192,286
Other income	387,358
	2,151,435
Charitable activities	
Conferences and meetings	2,310,552
Examinations	2,356,641
Fellows and Members	3,201,530
Standards and clinical governance	167,659
Education and training initiatives	368,848
BJOG	875,967
International initiatives	0
NCC WCH	1,671,786
	10,952,983
Total incoming resources	**13,104,418**

Unrestricted Expenditure	Unrestricted Funds £
Cost of generating funds	
Investment management costs	
Activities for generating funds	
RCOG Trading Limited	591,755
Accommodation and service charges	211,453
Development	123,747
	926,955
Charitable activities	
Conferences and meetings	1,999,804
Examinations	1,333,758
International initiatives	533,705
Fellows and Members	2,831,627
Standards and clinical governance	1,178,373
Education and training initiatives	1,658,284
BJOG	739,909
NCC WCH	1,603,965
Special funds	81,312
	11,960,737
Governance	74,193
Total resources expended	**12,961,885**

It is essential to establish and maintain a strong financial and business model to support and prioritise the RCOG's strategic objectives and allow the College to build for the future.

Despite the considerable challenges posed by the economic climate, the College ended the year with a positive net movement in funds of £370,989. This surplus was generated through a number of activities, including the Liverpool Congress in June 2013, the sale of the College's book list to Cambridge University Press, and increased turnover from RCOG Trading Limited. These positives have been balanced by a very challenging valuation on the RCOG Pension Scheme.

The unrestricted free reserve allows the College to properly manage risk and remain capable of realising unforeseen opportunities that may arise. On 31 December 2013, this balance stood at £7,945,789, which represents approximately nine months of our budgeted running costs. These funds are invested in short and medium term vehicles and continue to generate a small but steady income which supports the College's ongoing objectives.

Membership services

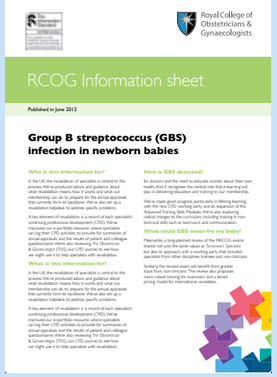
Best practice, support & guidance

Green-top Guidelines – written to help you decide on appropriate treatment for specific conditions (also available as iPhone/iPad and Android apps).

Research and enquiry services – to assist you in your research and clinical practice, including evidence-based literature delivered to you.

Database support – help with essential databases such as MEDLINE and the Cochrane Library.

Patient Information leaflets – helping patients understand their condition and/or treatment.



Professional recognition

Use of MRCOG/FRCOG post-nominals – demonstrating your professional commitment to patients, employers and colleagues.

Annual awards and Fellowships – recognising professional excellence and achievement in O&G, including research grants, travel awards and lectureships.

Awards, Prizes, Lectureships and Scholarships

Something for everyone

Online register of Fellows and Members – a public register to reassure your patients that you are associated with the RCOG and the highest standards of care.

Professional development

Revalidation helpdesk and resources – everything you need to prepare for revalidation and to ensure you meet GMC requirements.

CPD programme and ePortfolio – support to help you plan, undertake and record your CPD.

CPD/Revalidation ePortfolio

StratOG: RCOG's online learning resource – online lectures from RCOG events and courses, and videos demonstrating best practice in specialty training.

StratOG

eFM – free/discounted access to web based learning to improve CTG interpretation.

Comprehensive series of over 70 conferences and courses each year – at special member and trainee rates.

The Obstetrician & Gynaecologist (TOG) quarterly journal – a mixture of high-quality, peer reviewed articles; an ideal CPD resource.

Stay informed

BJOG: An International Journal of Obstetrics and Gynaecology monthly journal and iPad app – read up on the highest quality medical research in women's health worldwide.

Scientific Impact Papers (SIPs) and Safety Alerts – opinion papers on emerging or controversial scientific issues of relevance to O&G, together with the implications for future practice.

Scanner monthly e-newsletter – updates on the latest news, issues and discussions in O&G.

The Scanner

O&G membership magazine – up-to-date information on the work of the RCOG, member case studies, news from around the world, and support resources to aid you with your daily practice and professional development.

LinkedIn group – develop and build a network of professional contacts to share ideas and experiences.

LinkedIn

Additional benefits

20% off all Cambridge Academic titles – including Cambridge RCOG books.

Cambridge University Press

Access to RCOG exxtra – for discounts on travel, home insurance, accommodation and more.

RCOG exxtra

Discounted membership of the Royal Society of Medicine – a reduced rate and no joining fee.

The Royal Society of Medicine

15% off use of College meeting rooms – and support from a dedicated meetings team.

Rooms on Regent's Park – special members rates at our boutique accommodation within RCOG's London premises.

ROOMS ON REGENT'S PARK

www.rcog.org.uk

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27 Sussex Place, Regent's Park
London NW1 4RG

Registered charity no. 213280

Royal College of Obstetricians & Gynaecologists