



The impact of the redeployment of maternity staff during COVID-19

A Royal College of Obstetricians and Gynaecologists (RCOG) report of a snapshot survey to Clinical Directors and UK RCOG trainees, associates, members and fellows on working patterns and staff changes during the pandemic

Foreword

The COVID-19 pandemic has resulted in unprecedented change in the NHS. It has been remarkable to see the scale and pace of this change and the collective effort of staff to support it.

Throughout the pandemic maternity services have continued to provide high quality, safe care to women and their families. The RCOG and RCM have provided guidance to support both service reconfiguration and delivery.

That said, as a College we heard from members, fellows and via our council representatives, that in some units/hospitals there were concerns about the redeployment of staff away from maternity services to support other areas of the hospital and this had knock on effects for remaining staff working to maintain their usual standards of patient care.

This survey was therefore undertaken to gather feedback specifically with regards to medical staffing, to learn from our experiences and to make recommendations for the future should a second wave occur.

We would like to thank those of you who responded so promptly to this request during an immensely busy time.

This information will enable us to support you to make sure your organisations respond in the best way possible for you and your colleagues, and for women and their babies, in the future.

Dr Eddie Morris

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Introduction

In response to concerns raised about the mandatory redeployment of O&G staff outside of maternity services in acute trusts, the Royal College of Obstetricians and Gynaecologists (RCOG) carried out a survey, inviting UK trainees, associates, members and fellows to feedback on their experiences of staffing changes during the COVID-19 pandemic.

The RCOG recognises that some trusts/units have had major challenges in staffing COVID-19 facing and intensive care services. This report aims to identify changes in the deployment of middle grades, juniors, SAS doctors and consultants within hospitals and maternity units as well as other changes to the services.

As part of the study, O&G professionals were encouraged to raise any concerns they had with the planning and implementation of staff changes as well as offer learning opportunities and unexpected positive outcomes as a result of the reorganisation of staff.

The report offers actions and recommendations based on the survey findings to inform future decision making in this area should a second wave occur.

Methodology

An online questionnaire was created using the Dotmailer platform. An email with a link to the survey was shared with UK Clinical Directors, RCOG Trainees Committee representatives and the RCOG SAS and locally employed doctors' task group. These groups were encouraged to cascade the survey to colleagues in their units and trusts.

The survey was live for 11 days and closed on Tuesday 5th of May 2020. The following main questions were proposed and feedback was provided through multiple choice and free type options throughout.

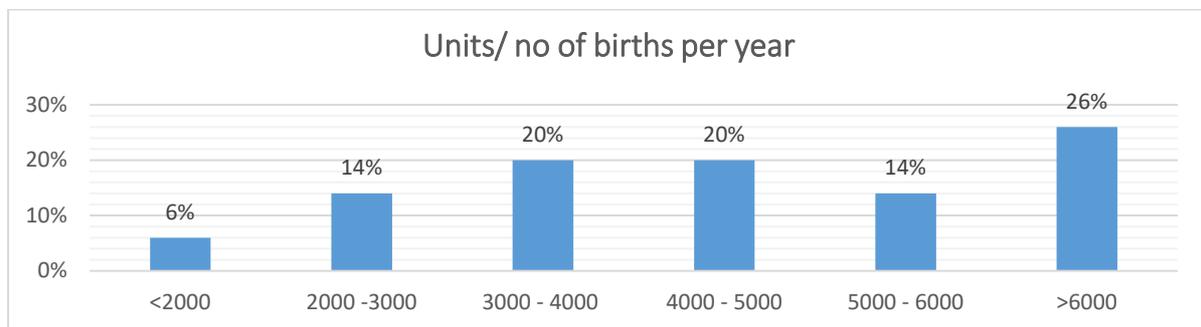
1. Number of births per year?
2. Have your junior grade trainees, including locally employed doctors, been redeployed outside the maternity services?
3. Who is providing junior grade cover?
4. Have any of your middle grade O&G trainees been redeployed outside the maternity services during the Covid-19 pandemic?
5. Have O&G consultants/SAS doctors been redeployed to other specialties?
6. Who is providing remaining O&G cover?
7. Have O&G consultants/SAS doctors been redeployed to improve obstetric cover for obstetric services instead of gynaecology?
8. Have gynaecology only consultants been upskilled to re-join the obstetric service?
9. What proportion of your staff are absent because they are classed as vulnerable and unable to work in patient facing roles?
10. Overall what has been the impact of the changes in staffing you are experiencing?



11. Do you think your trust has planned and implemented medical staffing changes appropriately?
12. Please outline any learning opportunities/positives from the changes in medical staffing.

Response rate

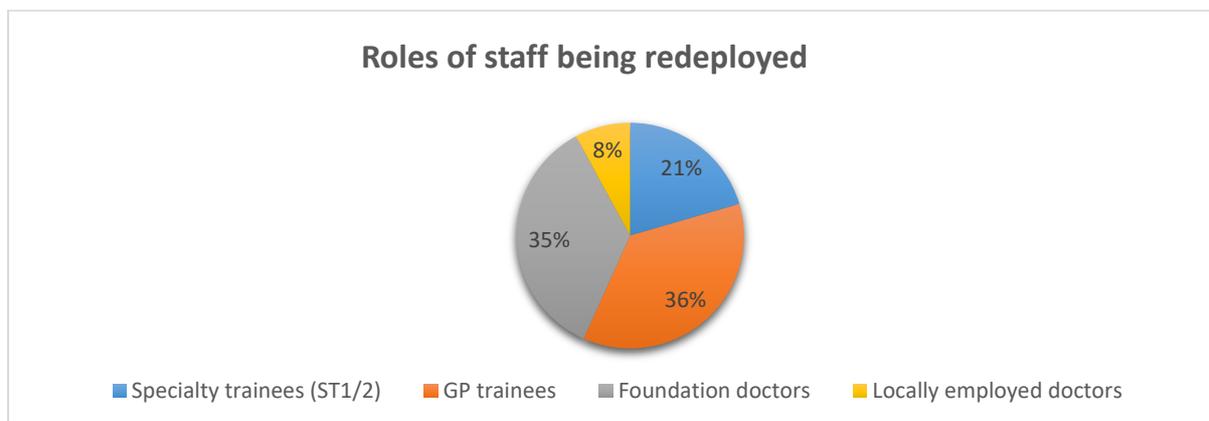
The COVID-19 workforce survey received responses from 91 trusts/units across all regions in the UK. The size of the units varied as is indicated in the below chart on number of births per year.



Findings

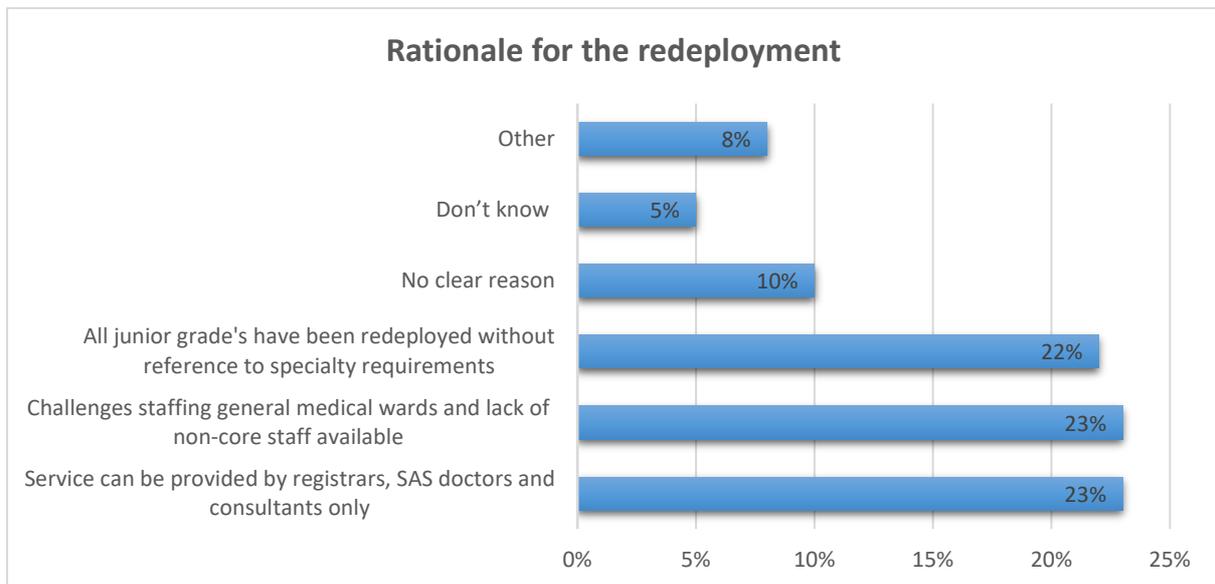
1. Redeployment of O&G staff

During the COVID-19 pandemic there was significant redeployment of medical staff. 53% of our survey respondents reported that junior grade doctors, including locally employed doctors (LED's) were redeployed outside of maternity services without reference to specialty requirements. Although the bulk of the redeployment was felt by GP doctors (36%) and foundation doctors (35%), a considerable proportion of O&G specialty trainees (ST1/2) and locally employed doctors were redeployed away from maternity services.





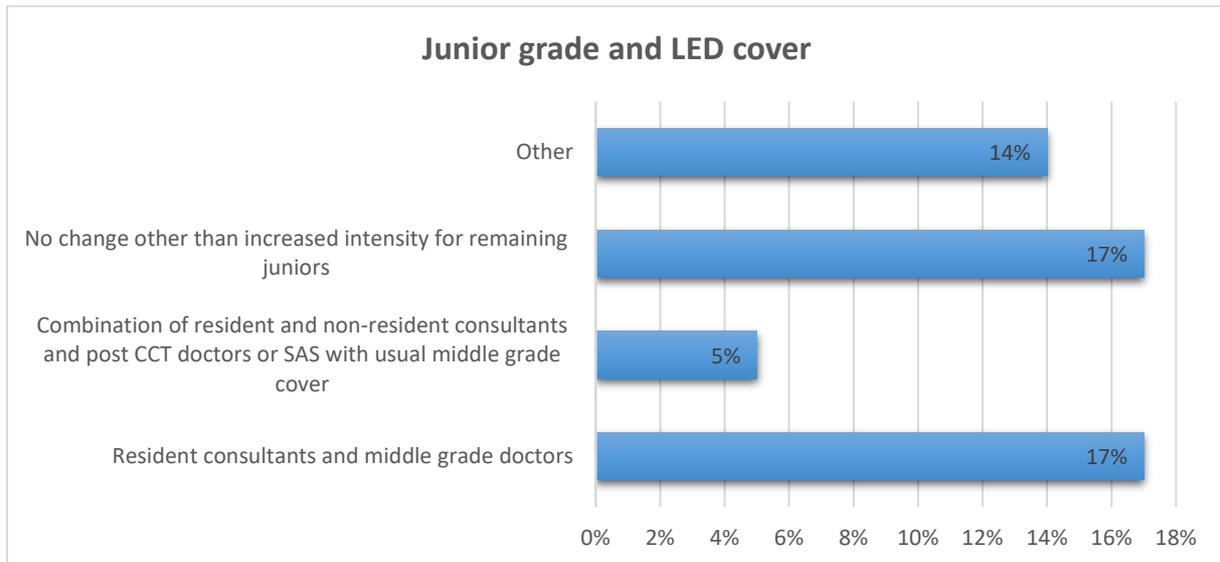
The rationale for the redeployment of junior grade trainees and LED's was mixed, with 23% of trusts/units reporting that the major challenges in staffing general medical wards, as well as the viewpoint that the maternity services could be delivered by registrars, SAS doctors and consultants, were provided as the primary reasons for the redeployment of these groups. Worryingly, 22% of trusts reported that all junior grade doctors had been redeployed without reference to specialty requirements. 10% of all survey respondents didn't feel there was a clear reason for the deployment and an additional 5% didn't understand the rationale for the staffing changes in their trust.



Only 6% of trusts/units confirmed redeployment of middle grade staff (ST3-7) and LED's outside of the maternity services during the crisis. Similarly, consultants and SAS doctors were also far less likely (7%) than junior grades and LED's to be redeployed outside of the maternity services.

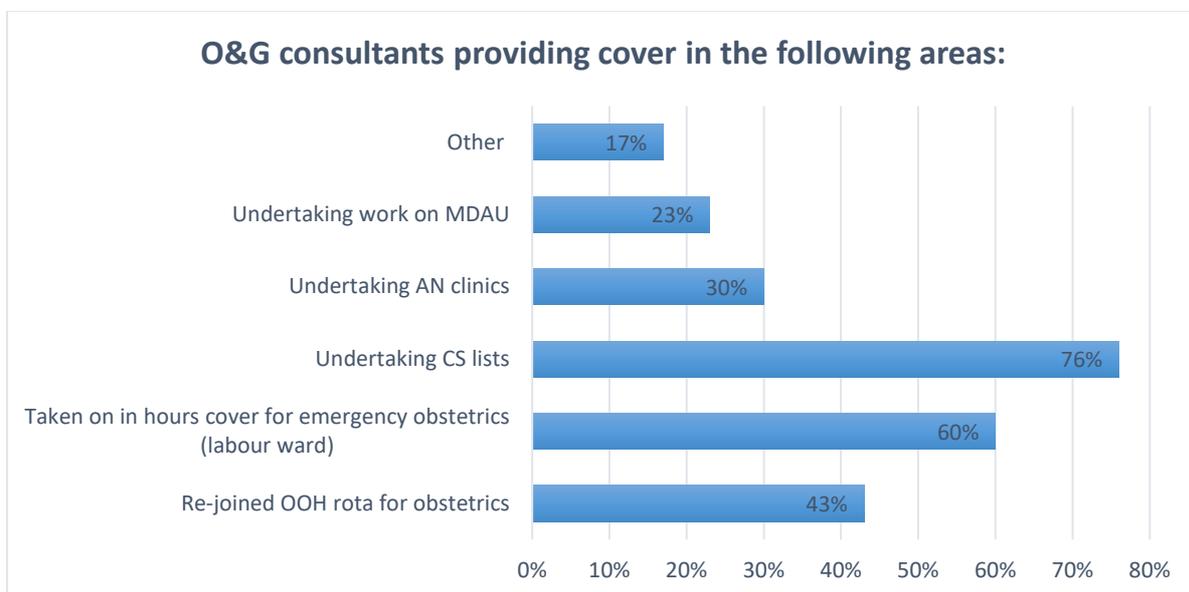
2. Cover for junior grades and LED's

With a considerable proportion of junior grade and locally employed doctors being redeployed, cover was being provided for the most part by resident O&G consultants, SAS and middle grade doctors. 17% of trusts/units reported that there were no changes in cover and remaining junior doctors were working in a more intense way as a result of the redeployment of their colleagues. Only 5% of trusts/units reported that cover was being provided by a combination of resident and non-resident consultants, post CCT and SAS doctors.



3. Redeployment of O&G consultants

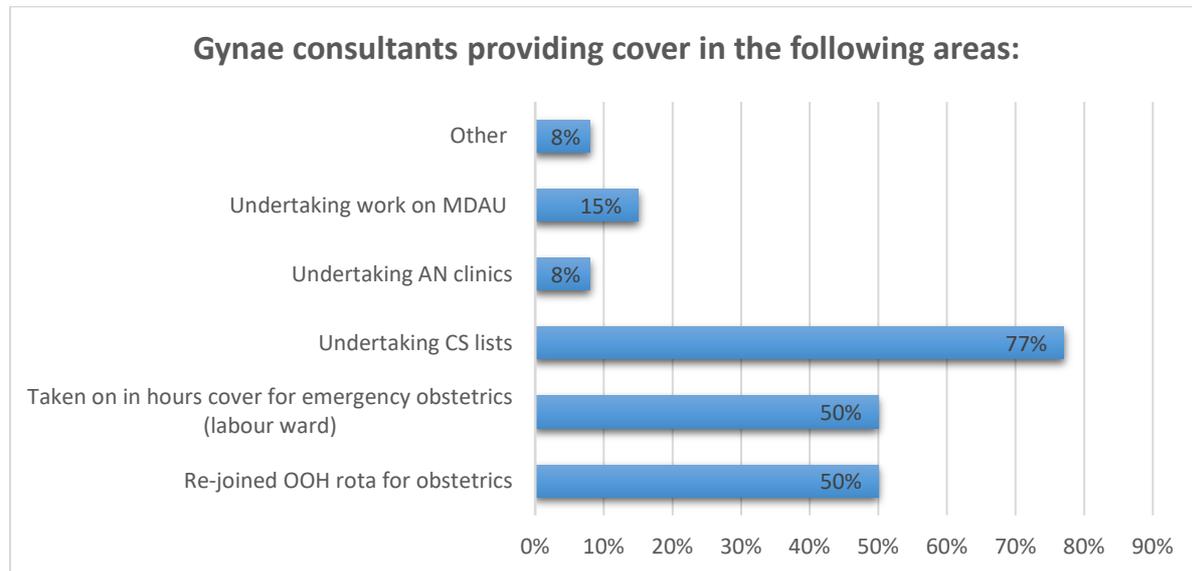
Approximately 53% of trusts/units confirmed that O&G consultants and SAS doctors were redeployed to improve obstetric cover for obstetric services instead of gynaecology. 76% of O&G consultants and SAS doctors took on additional caesarean section lists, 60% covered labour wards, 43% re-joined the out of hours' rota for obstetrics and 30% provided shift cover in antenatal clinics.



There were noticeable differences between the working patterns of gynaecology consultants and obstetric consultants providing cover during this period. One fifth of all gynaecology consultants providing cover underwent upskilling training in order to provide effective and safe cover to obstetric services. The majority of gynaecology consultants were undertaking caesarean section lists, with a much lower proportion (8%) taking on antenatal

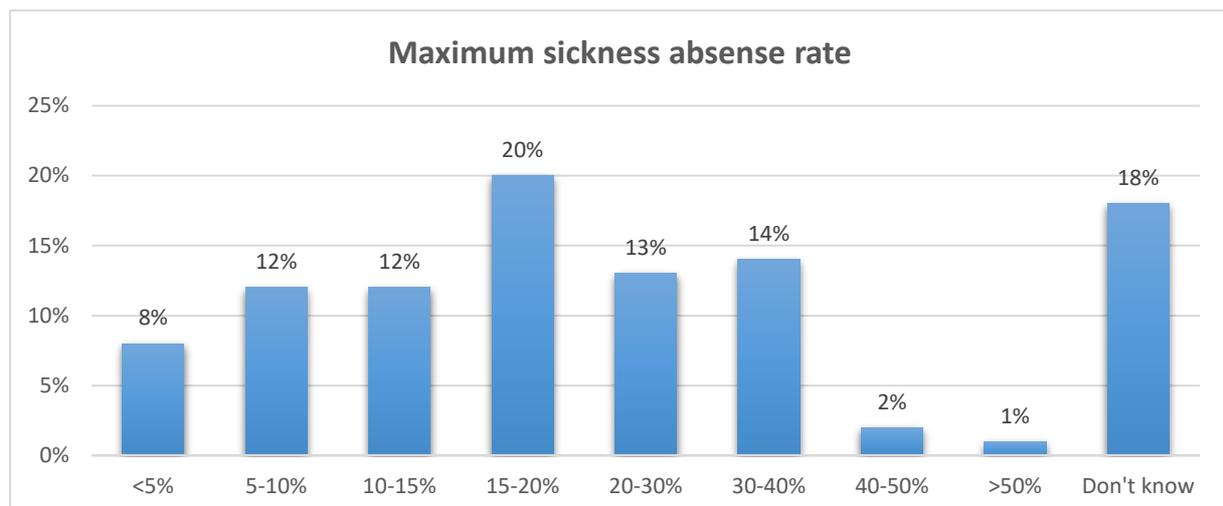


clinics. Approximately 50% of gynaecology consultants provided support in emergency obstetrics and re-joined the out of hours' rota for obstetrics.

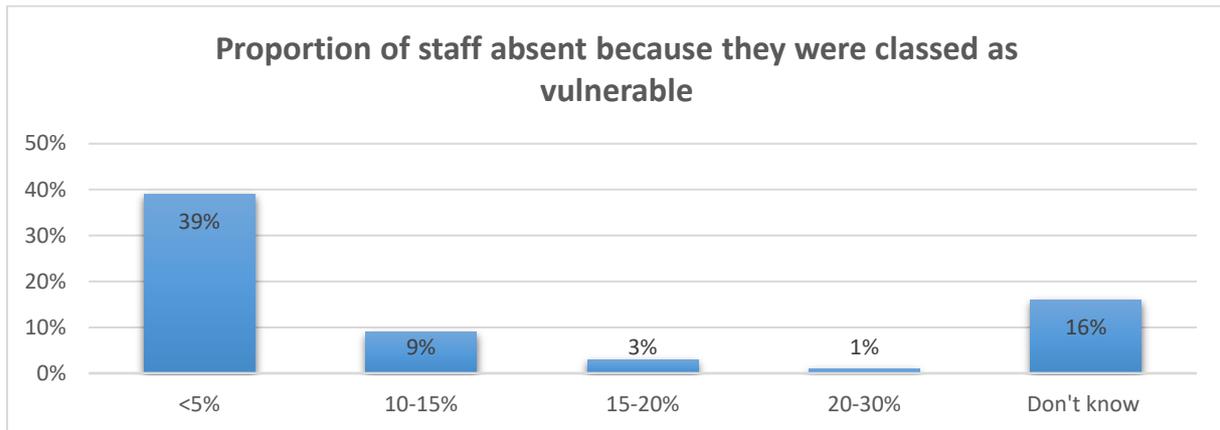


4. Staff absences

Staff absence due to sickness, caring responsibilities and vulnerability also had a considerable impact on maternity services. As part of the study, respondents were asked to provide a maximum sickness absence rate for O&G staff at their trust/unit. 44% reported between a 5-25% maximum staff absence rate, 29% predicted between 20-50% maximum sickness absence with 18% unable to offer an estimate.



Only 12% of respondents felt that the proportion of staff being absent due to vulnerability was between 10-20%. 39% of trusts fed back that fewer than 5% of their O&G staff fell into this category. Many respondents could not provide this data with any certainty so actual rates may be different from those reported.

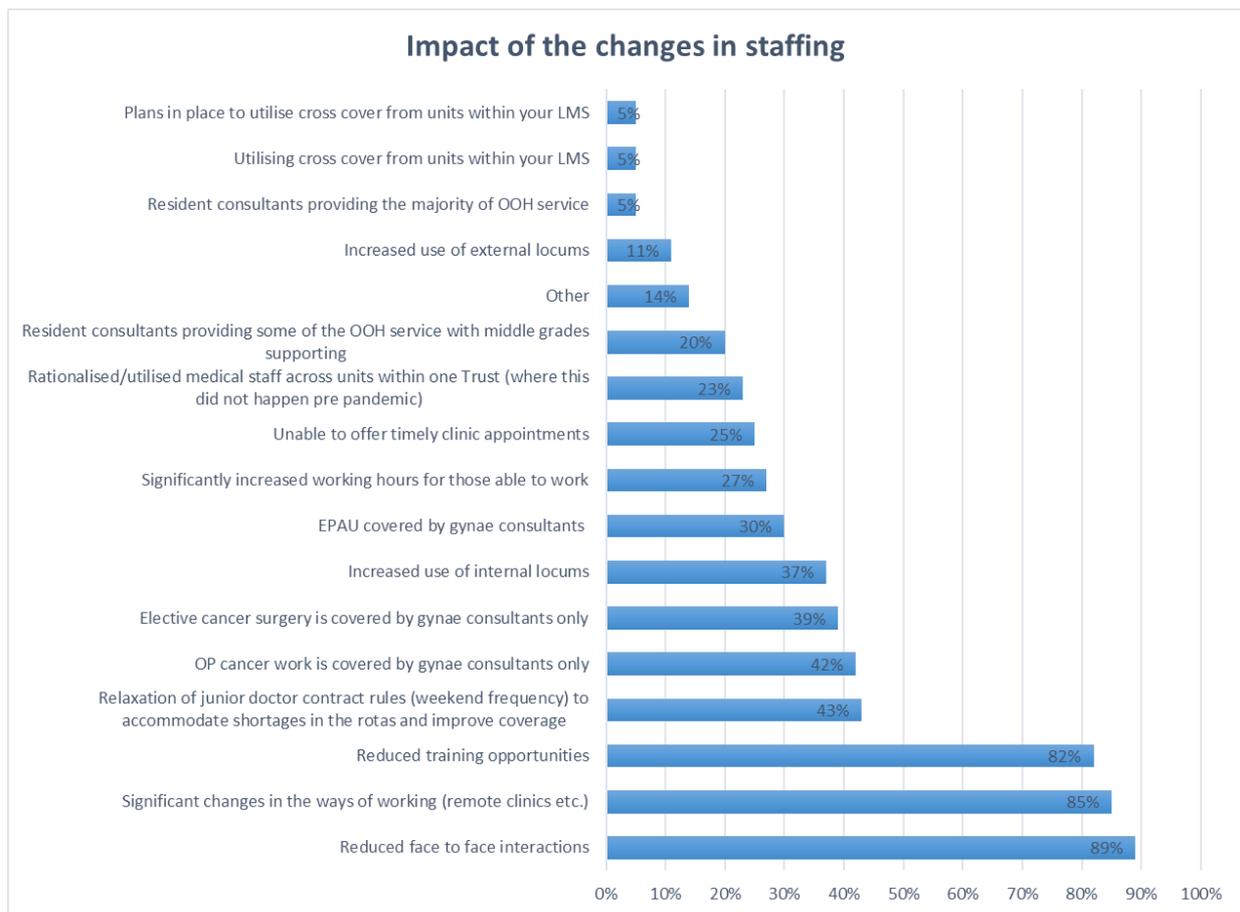


5. Impact of the changes in staffing

There have been several consequences of this redeployment. Overall, 85% of trusts/units reported a significant change in ways of working, with 89% having reduced face-to-face interactions and 82% noting a reduction in training opportunities. Consultants, SAS and middle grade doctors have been placed under increased and unsustainable stress running a core service without a valuable part of the workforce.

A high proportion of trusts experienced a relaxation of junior doctor contract rules in order to accommodate shortages in the rotas and improve coverage. Outpatient cancer and elective cancer surgery was being provided by gynaecology consultants only. There has also been a notable increase in locum use, with a 37% of units who responded reporting an increase in the use of internal locums and 11% reporting an increase in external locum use. This reflects the increased pressure on maternity services.

More than a quarter reported significantly longer hours for those available to work. A similar number stated they were unable to offer timely clinic appointments.



6. Concerns about changes

Over a quarter of survey respondents said they had concerns about the planning and implementation of the medical staff changes at their place of work. Concerns about how the changes were implemented and communicated to staff were by far the most common across all trusts, highlighting the importance of clear and consistent communications when relaying information about staffing changes. Several respondents felt that the redeployment plans lacked efficient planning and transparency and that the changes to their rotas were unnecessary.

The loss of training opportunities was experienced by trusts across the board and in some cases units were not confident that sufficient induction training was provided for staff moving to medical teams. Several respondents were apprehensive about having limited exposure to gynaecology as a direct result of staffing changes and some conveyed that the changes in working patterns resulted in an increased rate of staff sickness at their units.



7. Learning opportunities and positives as a result of the changes

Despite the concerns raised, a large number of survey respondents felt that there were lessons learned and learning opportunities gained through the response to COVID-19. By and large the most collective positive outcome highlighted was the noted increase in staff morale at all levels and sense of comradery amongst teams. Adaptability and flexibility were required to accommodate last minute rota changes due to staff sickness, redeployment, changes in policy and service delivery and several trusts experienced improved team working as a result of these challenges.

In many trusts changes that were in the pipeline, such as telephone triage, outpatient management and MVA provision, were brought forward to meet the service demands. This had a number of positive effects, with some units reporting improved efficiency in their service delivery as senior staff only were doing telephone clinics which resulted in fewer follow-ups. A high proportion of survey respondents also felt that remote clinics have advantages and can be more convenient for some patients with families.

Some trusts reported that there were greater opportunities for reflective practice, leadership, and crisis management, and trainees fed back that their communication skills had improved due to being on the medical rota and having difficult conversations with families during the crisis.

Some consultant gynaecology surgeons felt that they benefited from increased surgical exposure and several junior grade doctors (those who were not redeployed) added that they benefited from increased access to consultants in their work.

Recommendations

1. The maternity workforce should not be redeployed

The RCOG recognises that some trusts have had major challenges in staffing COVID-19 facing and intensive care services. However, maternity services cannot be paused and should be classified as a core service in the context of the current pandemic and any future waves. The RCOG is clear that the maternity workforce should not be redeployed in this, or any future, pandemic unless there are no other viable options to provide medical staffing.

2. The same standards should apply to the maternity workforce as the emergency department workforce

Our survey shows clearly that in some places redeployment has been indiscriminate, without consideration of the needs of different specialties. While this might be appropriate in extreme circumstances, we believe that maternity should be the last option for redeployment, alongside other essential front door services. It makes sense that medical



staff of any grade working in services where elective activity has stopped should be redeployed before those from core services where activity levels have not been reduced. In simplistic terms, if organisations are not removing doctors from the emergency department they should not consider removing doctors providing maternity care until they have exhausted all other options

3. Non specialist doctors working in maternity services should be first to be redeployed if there is no alternative

Should future waves of COVID-19 require movement of staff, we recommend that any decision to move staff out of maternity services must come with a strong rationale, which must be clearly communicated to maternity staff, and a commitment to regularly reviewing staffing with a view to returning maternity staff as soon as possible. We would suggest that only when there is no alternative, GP trainees and foundation doctors are prioritised for redeployment, allowing specialty trainee doctors to remain with their service for as long as possible.

4. Senior and middle grade doctors in maternity should not be redeployed

Lastly, senior and middle grade obstetricians should only be removed from the maternity service as a last resort after all other possibilities have been exhausted.

RCOG activity so far

- Dr Edward Morris, RCOG President, and Dr Jo Mountfield, RCOG Vice President for Workforce and Professionalism, have written to Professor Stephen Powis, National Medical Director for NHS England, highlighting the results of the survey and offering support and recommendations for future decision making should we have another surge of COVID-19.
- The RCOG will shortly be publishing guidance for Consultants and SAS and locally employed doctors on acting up/acting down and guidance on the engagement of locums in maternity care, two areas which were significantly impacted by the changes in staffing across maternity units.
- Findings from the COVID-19 workforce survey helped to shape the [RCOG Restoration and Recovery: Priorities for Obstetrics and Gynaecology](#) framework document.
- The RCOG will be sharing the report findings with all UK trusts, highlighting the impact of changes on maternity services and on the individuals delivering those services.



- A brief follow-up survey to our members is scheduled to find out if staff have been returned to their units and if working patterns have changed as a result of the pandemic.