Getting a Life

Work–Life Balance in Obstetrics and Gynaecology
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REPORT OF A WORKING PARTY

April 2011
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### Abbreviations

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<tr>
<td>ARCP</td>
<td>annual review of competence progression</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
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<td>CPD</td>
<td>continuing professional development</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
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<td>HR</td>
<td>human resources</td>
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<td>IT</td>
<td>information technology</td>
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<td>IWL</td>
<td>Improving Working Lives</td>
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<td>LNC</td>
<td>local negotiating committee</td>
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<td>LTFT</td>
<td>less than full-time</td>
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<td>MMC</td>
<td>Modernising Medical Careers</td>
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<td>NCAS</td>
<td>National Clinical Assessment Service</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHSQIS</td>
<td>National Health Service Quality Improvement in Scotland</td>
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<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<td>OPCS</td>
<td>operating procedure code supplement</td>
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<td>PA</td>
<td>programmed activity</td>
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<td>PMETB</td>
<td>Postgraduate Medical Education and Training Board</td>
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<td>RCP</td>
<td>Royal College of Physicians</td>
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<td>SAS doctor</td>
<td>staff and associate specialist doctor</td>
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<td>SHA</td>
<td>strategic health authority</td>
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<td>SIGN</td>
<td>Scottish Intercollegiate Guidelines Network</td>
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<td>SPA</td>
<td>supporting professional activity</td>
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<td>SPCERH</td>
<td>Scottish Programme for Clinical Effectiveness in Reproductive Health</td>
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<td>SpR</td>
<td>specialist registrar</td>
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<td>WTR</td>
<td>Working Time Regulations</td>
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<td>WTE</td>
<td>whole-time equivalent</td>
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Terms of reference, membership of group and contributions to the report

Allan Templeton

Following the publication of *A Career in Obstetrics and Gynaecology,*1 a report that addressed recruitment and retention in the specialty, it became apparent that the issues around work–life balance were of major and particular concern to obstetricians and gynaecologists. In recognition of this, the College Council proposed a further working group to consider the issues in more detail and, as far as possible, to address any concerns. The terms of reference of this group included the following:

- to review the evidence and reasons for those aspects of work–life balance that influence recruitment and retention in the specialty
- to review and consider how rules and regulations can be used to enhance work–life balance and to provide guidance to Fellows and Members
- to advise how, through appraisal and job planning, work–life balance may be improved for obstetricians and gynaecologists.

The initial membership of the group, which met twice, was Dr Richard Birks (Association of Anaesthetists), Dr Maggie Blott FRCOG, Mr John Eddy FRCOG, Mr Keith Edmonds FRCOG, Mrs Sophie Forsyth (Chair, RCOG Consumers’ Forum), Dr Kate Guthrie FRCOG (representing the Faculty of Sexual and Reproductive Healthcare), Mr Mark James MRCOG, Miss Fiona Kew MRCOG (trainee), Dr Tahir Mahmood FRCOG, Miss Helen Moffatt (then Chief Executive, RCOG), Professor Shaughn O’Brien FRCOG (then Vice President, RCOG), Mr David Richmond FRCOG, Mr Alan Russell FRCOG (Chair, Joint Medical Consultative Council; previously Deputy Chair, BMA Consultants Committee), Dr Ewen Walker FRCOG, Mr Richard Warren FRCOG (Honorary Secretary, RCOG) and Miss Melissa Whitten MRCOG (trainee). Mrs Caro Allen acted as Secretary.

This group considered the scope and importance of the issues and, having identified specific concerns, commissioned a number of pieces of work from the individuals whose names are listed against the various chapters that form the basis of this report. Further work on the report was supported by the Standards Department to ensure that the issues and advice contained in the document were fresh and relevant. I am particularly grateful to Maria Finnerty.

Considerable time and debate was given by the RCOG Council and a review and restructuring recommended; further editing and writing was undertaken to incorporate their suggestions. My thanks go to Mr Richard Warren, Honorary Secretary for this work and for his determination to complete this report, which almost certainly impacted on his own work–life balance!

Thus, although the production of this report has been protracted, I believe the recommendations are highly relevant, particularly to all trainees, staff and associate specialist (SAS) doctors and consultants, whether established or about to take up posts and discuss their first
job plan. I am particularly grateful to the colleagues listed in this report but also appreciative of discussions I have had with many colleagues over the years. I do hope that this report will help facilitate the move towards a better and more attractive work–life balance for obstetricians and gynaecologists and enhance the flexibility within job plans to suit individual needs.

Reference

Introduction

David Longdon

It is a privilege to be invited to introduce this important working party report. My perspective is that of an outsider to the RCOG who has worked as a general practitioner (GP) and also as part of a service established in the South West in 1999 to support GPs.

I would urge the reader to take time to go through this report – for the sake of others as well as for themselves. Additional information is available through the National Health Service (NHS) Practitioner Health Programme: Report on the Two Year Prototype Service (www.php.nhs.uk).

Failure to get the right balance between our work and the rest of our lives can contribute to ill health, relationship breakdowns and performance problems. Doctors who suffer stress and/or burn-out are often among the most conscientious and competent members of our profession. In rapidly changing times, whatever the reader’s grade, they have the opportunity to influence something very powerful – the culture in which they and others work. ‘You are not in a queue – you are the queue’ can translate into ‘you are not in a culture – you are the culture’.

Burn-out is one consequence of an imbalance between life and work. In the South West, we know that stress can affect 25% of GPs during their working lives and there is no reason to believe that the rate in hospital colleagues is any lower. Stress is often likened to a car having a flat battery, with no energy available to power even quite simple functions. Unless presentation is early, a significant period of sick leave is required: 2–3 months for a first episode and 6 months or more for a second.

Colleagues who experience burn-out are frightened and confused. Most feel guilty and say ‘if anyone knew how bad I felt, I would never be allowed to work again’. Concentration is poor and sleep disturbance very common, as are symptoms of low mood, anxiety and irritability. Decline in energy levels is not linear but complex, and the expression ‘it pushed him over the edge’ describes in common idiom the potential drop. Many doctors approaching burn-out work harder and harder, perhaps driven by unconscious software from childhood: ‘if you want to be happy, you should work hard’ and ‘I don’t feel happy therefore I must work harder’. Holidays fail to recharge batteries and indeed many feel worse than ever – feelings that resonate with the first few weeks of sick leave.

Over the last 20 years there has been growing interest in physician health and much has been published. A range of psychological difficulties has been described and a great deal of skilled expertise is in place to assess and treat them. Dr Robert Hale published a paper entitled ‘How our patients make us ill’, in which he described the specific anxieties that doctors can have arising from their work as well as fears for their own sanity and health. He describes defences that we put in place. Some, such as drugs and alcohol, can have major consequences. Others, such as ‘throwing ourselves into work’, resonate with themes of future imbalance in energy levels. Witnessing very traumatic situations can produce post-traumatic stress symptoms. ‘Unless you were there you cannot understand how I feel’ can have a major effect in forming barriers at home and threaten relationships.
The assessment and treatment of doctors presenting with burn-out and other mental health problems is variable across the country. For some the process may be relatively simple; taking some time to recharge flat batteries accompanied by a willingness to accept the need to make changes to prevent recurrence. For others, specialist assessment and intervention is required, often over a period of several years. The prognosis for most doctors is very good, even in the presence of secondary factors such as drug and alcohol misuse. Morbidity is reduced by early presentation and assessment.

Individuals can have their own barriers to seeking help early. Feelings of guilt and of letting others down combine with suspicions about confidentiality and stigmatisation. In the South West, it took about 5 years before a critical mass of GPs was seen and assessed. At that point the culture appeared to change; now, after 10 years, many present at a much earlier stage not only in their period of symptoms but also in their careers. This has been possible only because of attitudes fostered at all levels within primary care. Nationally, the Royal College of General Practitioners appointed Professor Ruth Chambers as Stress Fellow in the late 1990s. Primary care trusts have recognised that most concerns about the performance or behaviour of doctors have health-related roots. Early presentation is also linked to awareness of our own needs as well as those of colleagues. Accepting advice and the perspective of others can strengthen rather than reduce individual autonomy.

Models of mentorship and supervision are widely used in other professions. The purist will say that mentorship is usually provided by a more experienced colleague in the same discipline and lasts for the first 5 years of a substantive post. Supervision, on the other hand, can be provided across disciplines and indeed across professions. It is about protected time to explore a wide range of issues, including one’s own reactions to a situation, colleague or patient. Supervision is regarded as good practice in the more psychological branches of medicine but is increasingly used in a preventive way by colleagues in other specialties.

Training programmes offer an opportunity for less individual but equally important learning and represent a time when many of the pitfalls can be made overt. In the current climate, financial expectations can be discussed before unsustainable plans and mortgages are drawn up. For many, this is also the time when balancing work and examination pressures with the demands of a young family at home can provide a relevant context for teaching and learning.

Appraisal as a formative process offers a major opportunity for annual reflection on our own energy levels, work–life balance and how others perceive us. It has taken some time for the paperwork to reflect the fact that work can affect health. There is an opportunity for all of us to use appraisals as a time to take stock and to make a record of how we feel. What are our own early warning signs? Who could we trust either formally or informally if we had a problem? If there are gaps, who should we ask? Have there been any work-related incidents in the past year that have affected our health? Not all of these issues have to be taken to the formal appraisal process. There is an opportunity for trusts to develop and train appraisers so that some increase their knowledge and skills to support colleagues in difficulty by signposting local and other sources of assessment and advice.

GPs and occupational health departments can be very good sources of advice and support. Both represent an important safety net for the doctor who has no other formal or informal support where they are working or when there has been a breakdown of relationships. It is far easier to be objective about someone else’s medication, health and fitness to work than it is about our own. Events such as physical ill health or bereavement are important times to try giving up a little autonomy and allowing someone else to take responsibility for when we return to work. Confidentiality rules are very clear for GPs and building a relationship with your own GP can form a significant part of a doctor’s support network.
In the South West, we used a significant part of our occupational health budget to fund the development of an occupational health psychiatry and psychotherapy network. GPs can refer themselves or be referred at an early stage for a full assessment. About 25% of GPs have used the network in the last 10 years. The vast majority have returned to their normal work. Our psychiatrists work closely with our occupational health consultant. We have learned that making patient safety paramount does not conflict with supporting doctors. While our own service evolved locally, it is easy to argue that achieving a balance in our working lives is good for our patients as well as for ourselves.

References

Executive Summary

Contentment at work should promote contentment at home and vice versa. While improvements in the workplace may be negotiated, individuals can do much themselves to reduce stress and disillusionment. This report concentrates on issues at work but acknowledges the importance of a happy lifestyle outside the profession. Expectations must be managed within the conflicting demands of the NHS and an individual’s financial planning is essential, as a higher income does not always bring happiness. Working in teams and not in isolation brings rewards and flexibility and promotes governance and good practice.

Many obstetricians and gynaecologists find their roles fulfilling, satisfying and very enjoyable; however, work–life balance in the specialty of obstetrics and gynaecology has become a matter of increasing concern. The issue received particular prominence in the RCOG report *A Career in Obstetrics and Gynaecology*,1 which addressed recruitment and retention in the specialty. Obstetrics and gynaecology is perceived as a hard-pressed specialty that should be doing more to address this and related issues. At the same time it is also apparent that many individuals and departments have been developing models of care that take account of the increasing need to combine the demands of professional life with a lifestyle that maintains health, diminishes stress and provides a balance between work and other commitments – a balance, it is hoped, that will be attractive to young doctors and, more immediately perhaps, meet the requirements of the Working Time Regulations (WTR).

It is now clear that the key to a balanced work life is the job plan and the discussion around that. This report offers important advice and guidance in that respect, with practical examples. The strength of the job plan is greater where responsibilities can be discussed and agreed not just on an individual basis but by a team or at departmental level. In this way, the needs of the service can be seen in the light of individual contributions and needs, while at the same time recognising the increasing role of the consultant in leading and developing the service. Whether living in or not, the on-call time should be recognised by appropriate time off for rest and recovery. This is the key to removing the sense of a hard-pressed specialty, although the nature of out-of-hours obstetric responsibilities will always be seen as demanding. These issues will become even more important as the workforce moves increasingly towards flexible working and the demands of the service increase and include targets. In all this, the role of the clinical director is crucial and more training, preparation and support for this responsibility is required than exists in most units.

At the same time, the other responsibilities of the department, including teaching, clinical governance and, particularly, professional development, must be recognised, especially where individuals have lead roles in these areas. Additional responsibilities should be regarded as an essential part of career development, whether at regional or national level. These responsibilities will contribute to job satisfaction and a fulfilled career, which in turn will enhance the quality of care and the clinical service provided. In short, the job planning discussion must aim to provide the flexibility to meet individual needs, compatible with delivery of the service. This is crucial for the future vitality of the specialty and the development of clinical services of increasing quality.

As a specialty, we need to be more frank and open about the sources of stress and discontent. The College has an important role in supporting obstetricians and gynaecologists in ever more effective ways.
Summary of key points

This report was started under a previous government. A subsequent change of government and associated increased challenges of further radical reform in the NHS emphasise the constant importance of tackling pressure at work so that we have confident and content clinicians delivering innovative care of high quality. Never has it been more important to ensure appropriate work–life balance. This report is important reading for clinicians and managers alike.

A fulfilling and enjoyable working life requires direction and planning. Satisfaction at work and at home will lead to a rewarding and pleasing passage through the many years of training, a career in obstetrics and gynaecology and into retirement. The recognition of stress, and avoiding and dealing with it, are important parts of this demanding career. The recommendations of this working party should help to achieve the necessary balance.

Improving working lives

- Individuals should be aware of the causes and signs of stress, with clear, confidential support pathways available through clinical care and occupational health.
- Employers have a responsibility to address issues that are causing stress.
- Good team working offers improved support with better governance and increased flexibility.
- Staffing levels and appropriate use of skill mix should be reviewed to ensure smooth team working.
- The RCOG should review the resources available to those Fellows and Members facing difficulty or stress and consider if additional means of support are required.
- Mentoring and confidential peer support should be available for everyone throughout their career.
- Good administrative and management support is key to quality care and to fulfilling working practice.
- Appropriate time and support is essential for the delivery of education and training and should be reflected in job planning and supporting professional activity (SPA) allocation.
- NHS information technology (IT) infrastructure must be developed to improve clinical care and help with audit, appraisal, continuing professional development (CPD) and job planning.
- Working hours and working patterns should be considered by individuals and teams to match changing work–life responsibilities over a career lifetime.
- Those individuals with caring responsibilities require sympathetic and flexible consideration.
- Plans for career breaks and retirement should be made in advance, with local agreement and professional advice.
Models of care

- The Clinical Negligence Scheme for Trusts (CNST), WTR, RCOG and other guidance should be used to improve standards and to increase the numbers of medical and other health professionals.

- Inappropriate and unsustainable working practices and patterns must be addressed.

- Administrative and managerial support should be improved.

- The RCOG should disseminate examples of good practice and, wherever possible, support Fellows and Members in their working practices.

Job contracts

- The 2003 NHS consultant contract is an opportunity for the recognition and management of workload and working practices.

- Appropriate remuneration, periods of rest, reduced hours or more leave should be reflected in job planning negotiations.

- An appropriate number of SPAs should be negotiated and the RCOG and the Academy of Medical Royal Colleges should give clear guidance and support (Appendix 2).

- Increasing consultant presence on the labour ward (including, with agreement, resident on call) should be planned at a local level, thus improving health care and promoting an individual’s work–life balance.

- The 2003 NHS consultant contract and job planning process should allow career progression and development with changing emphasis of roles over the years.

- The impact of foundation status on the consultant appointment process and working practices must be monitored and, if necessary, challenged.

Job planning

- Job planning, based on a diary of work performed, is an invaluable tool for addressing work–life balance.

- Job planning is an opportunity for improving services and training.

- Job planning should be used to facilitate consultant expansion.

- Annualisation of working time and improved team working offer improved opportunities to work effectively and flexibly.

- Support must be given to newly appointed consultants so that they, too, receive a rewarding job plan and appropriate remuneration.

Getting the support you need at work

- The involvement, understanding and support of clinical management are essential in helping an individual achieve work–life improvements.

- The common benefits of a satisfied workforce are understood and should be supported.

- Suggested changes in practice should be supported within plans for a sustained and developing service.
Be creative with opportunities, work as a team and seek a harmonised solution between colleagues who may have different but synergistic needs.

Maintaining service standards

- Working to high standards in service, training and professional life is the backbone of good, rewarding clinical practice and reduces the risk of complaints and litigation.
- Practising to established guidelines assists the provision and delivery of safe, evidence-based care.
- Guidance issued by the National Institute for Health and Clinical Excellence (NICE), Scottish Programme for Clinical Effectiveness in Reproductive Health (SPCERH), CNST, Welsh Risk Pool and locally agreed guidelines and patterns of care should be used to improve quality and efficiency.
- Good team work aids continuity of care, flexibility of practice and service efficiency.
- Maintaining and developing high personal professional standards and CPD are essential.
- Limiting practice to those areas for which a clinician is trained while maintaining skills and areas of competence is crucial to good, safe and fulfilling practice.

Career development

- Harmonisation of the changing roles and responsibilities at home and at work over the course of a career requires careful consideration and management.
- The increasing needs of, and time commitments to, modern training and assessment must be supported.
- As roles and responsibilities change, appropriate time (and/or remuneration) must be allocated through the negotiation of job planning.
- CPD should be used not only to improve clinical care but also to develop knowledge and skills in other areas of career progression.
- Clinicians with the appropriate aptitudes should be encouraged, trained and supported in taking on increasing roles in management.
- Responsibilities within the wider NHS should be encouraged and supported.

Training and less than full-time working

- There should be departmental commitment to good rota organisation.
- Good support and supervision of trainees increases satisfaction and decreases stress.
- Mentoring should be established for all and should continue from recruitment to retirement.
- Local childcare support facilities are seen as essential and help to balance the calls of family and work.
- Flexibility in training and less than full-time (LTFT) working help to enable the fulfilment of family demands and career development.
Stress

- While the normal response to pressure may be advantageous, prolonged and excessive pressure gives rise to stress.
- Continuing stress is damaging to health and often leads to poor performance, illness and absence.
- The recognition and management of stress is important for the health of the individual and should be beneficial for the employee.
- Simple steps to reduce and manage stress can be very beneficial.
- When necessary, and preferably at an early stage, there are a number of confidential sources of help for the individual.

Reference

1. Improving working lives

Richard Warren

Introduction

The pressures on NHS service life have become progressively more challenging over the years with targets, appraisal, budgets and structured training. The pace of change and demands of the NHS have increased rapidly. The RCOG has sought to influence these developments with the intention of improving the health care of women while at the same time representing the views and concerns of its Fellows and Members.

Many obstetricians and gynaecologists have become aware of a steadily worsening imbalance between their work and home life, which is causing increasing disquiet. The latest rigours of the 2003 NHS consultant contract and job planning, together with a serious deficit in recruitment into obstetrics and gynaecology, has led to a demand for action. A healthy balance between work and life, job fulfilment and the opportunity to work in a supportive environment are crucial to overall job satisfaction. With over 7 years on average in specialty training and 24 years as a consultant, gradual erosion can occur to those aspects of a job that make it enjoyable and rewarding. Growing frustration and burn-out have become more apparent and, perhaps, more prevalent.

In the acute specialties, the hours of work have always been arduous. While the hours of work of those in training have already reduced in line with the WTR, the hours and on-call workload of consultants remain onerous. Those considering a career in obstetrics and gynaecology, together with those in training, have looked at a consultant body that has in some respects become more stressed and disillusioned. Despite continuing commitment and dedication to service delivery, the encouraging role models of the past have become less obvious and less frequent. Trainees have understandably asked themselves why they should train hard in a competitive field if the ultimate consultant role is not enjoyable.

The NHS Plan recognises that improving the working lives of staff contributes directly to better patient care through improved recruitment and retention: ‘A modern NHS must offer staff a better deal in their working lives so that they feel well motivated and fairly rewarded’. Standards to improve working lives were introduced by the Department of Health in September 2000 with a view to achieving implementation and accreditation by April 2003. Despite these recommendations, many of those who work in the NHS feel under greater pressure and less supported than in the past. The time has come to address work–life balance and to see how modifications of the working environment may be used to lead to improvement.
Key points

- Individuals should be aware of the causes and signs of stress. Clear, confidential support pathways should be available through clinical care and occupational health.
- Employers have a responsibility to address issues that are causing stress.
- Good team working offers improved support with better governance and increased flexibility.
- Staffing levels and appropriate use of skill mix should be reviewed to ensure smooth team working.
- The RCOG should, when requested, review the resources available to those Fellows and Members facing difficulty or stress and consider if additional means of support are required.
- Mentoring and confidential peer support should be available to all throughout their career.
- Good administrative and management support is key to quality care and to a fulfilling working practice.
- Appropriate time and support is essential for the delivery of education and training and should be reflected in job planning and SPA allocation.
- IT infrastructure must be developed to improve clinical care and help with audit, appraisal, CPD and job planning.
- Working hours and working patterns should be considered by individuals and teams to match changing work–life responsibilities throughout a lifetime’s career.
- Those individuals with caring responsibilities require sympathetic and flexible consideration.
- Plans for career breaks and retirement should be made in advance, with local agreement and professional advice.

Improving doctors’ working lives

A number of surveys have been undertaken to look at career choice and the factors influencing recruitment into various specialties. These studies have shown the growing importance of flexible training, particularly in association with the increasing number of female graduates and specialist trainees. Many individuals seeking a career in obstetrics and gynaecology are deterred because of the impression of limited training opportunities, arduous hours of work and poor working conditions. These issues have been recognised and the implementation of the recommendations of the RCOG’s working party report A Career in Obstetrics and Gynaecology is beginning to address many of these concerns.

As a result of a pledge by the Government in 2001 to improve the working lives of doctors, a national survey, the first of its kind through all grades of hospital doctors, was undertaken in 2005 to identify what changes would be needed to improve working lives. Importantly, the priorities depended on the stage at which doctors were in their careers. The overwhelming message from consultants was that they require additional support to help them with their roles. Non-clinical support in the form of good administrative and managerial assistance was
a consistent first choice. Clinical support, both medical and non-medical, was also important, followed closely by the need for the provision of good IT.

In light of the changes and reduction in working hours after the introduction of the New Deal, the WTR and shift working, it is not surprising that improved support for education and training is the most important issue for today’s specialist trainees. Improved support for child care was the second choice, with other issues such as non-clinical support, mentoring and improved office accommodation also of high importance.

Stress

Stress is believed to account for 30% of NHS sickness absence, costing the service between £300 and £400 million each year. The Healthcare Commission’s staff survey indicates that more than one in three members of staff report that they have suffered from work pressures in the past year.

People suffer stress when the pressures put on them are greater than their ability to cope. Crucially, however, stress also occurs when the demands made of individuals are not matched by the resources available to meet those demands. Stress will result if workload is too large or time available too short. A boring or repetitive task that does not make good use of individual skills or experience can also lead to stress. The Health and Safety Executive says that there are six factors which influence work-related stress:

- the demands of the job
- one’s control over the work
- the amount of support received from managers and colleagues
- working relationships
- the role within the organisation
- work change and how it is managed.

Over the years, staff surveys enquiring into the recognised causes of stress in the NHS workplace, verified by clinical staff including junior doctors and consultants, have identified factors that many will recognise have become more common within the modern NHS: 6

- erosion of autonomy
- poor work–life balance
- rigidity of the hierarchy
- doing tasks below grade
- lack of the right tools
- increase in patients’ expectations
- increase in administrative duties
- organisational confusion
- isolation from other team members
- colleagues not understanding each other’s roles and competencies
- lack of management support.
Stress may affect individuals in a number of ways. Sleeping may be poor, eating habits may change and some people may start drinking or smoking more. Physical symptoms including tiredness, headaches and palpitations may occur. People tend to become indecisive, find it harder to concentrate and suffer memory loss, as well as experiencing feelings of inadequacy and low self-esteem. Irritability and anger may be expressed and those under stress often become hypersensitive.

The effects of stress can be particularly damaging to the work of the clinician. It is known that stress can lead to mistakes, apathy, poor communication, lack of cooperation, lack of sympathy, obstructive behaviour and lack of commitment. While most individuals suffering from stress are able to cope without overt influence on their work, such symptoms clearly have the potential to significantly affect performance.

Support for the stressed doctor

Within the Department of Health’s strategy for Improving Working Lives (IWL), there is a commitment to provide a better working environment for staff to reduce the causes of workplace stress. The *Improving Working Lives Standard* includes many recommendations aimed at alleviating the recognised causes of stress and offering staff the freedom to manage their own work–life balance and thus have greater control. Employers now have a responsibility to address issues that are causing stress and the human resources (HR) departments of every trust should be fully aware of their responsibilities. Staff should feel enabled and encouraged to explore the factors that are leading to stress and, either through their own actions or with the help of management, to address the problems and put in place measures to reduce the pressures.

It should no longer be considered a failing to admit to being suffering from stress. Recognition of excessive stress and identification of the causes are key to overcoming stress. Help through clinical line management, usually the clinical director or medical director, should be sought at an early stage. Problems should not wait for the clinician’s annual appraisal, although this is certainly an opportunity to discuss these issues and to adopt strategies and changes in working practice and job plans that could lead to improvement. Increased management support, through the HR department or even the chief executive, could be considered to try to resolve problems that cannot be solved through simpler means.

Further help for doctors in difficulty may be found via the National Clinical Assessment Service (NCAS). This organisation promotes patient safety by providing confidential advice and support. Managers, or practitioners themselves, can contact the NCAS for advice, which may lead to a formal assessment of clinical performance or to other forms of help. The performance assessment aims to clarify concerns and make recommendations that will support practitioners and their managers in resolving problems.

While members of the British Medical Association (BMA) may seek advice from their trade union, particularly relating to terms and conditions of employment, and more generally through Doctors for Doctors, the RCOG is also available to help obstetricians and gynaecologists who are in difficulty. Individuals or, with their agreement, their advocates may approach the office of the Vice President (Standards) at the RCOG for a confidential discussion and for assistance.

Mentoring is now recommended for all consultants’ and is no longer considered as a process to oversee doctors in difficulty but rather as an opportunity for all doctors to have confidential peer support throughout a developing career. When problems arise, the support and advice of a colleague who is usually distant from the individual’s working environment can be extremely
valuable and reassuring. It is now recommended that, on appointment, all consultants are
given the opportunity of having a mentor.

The working party report *The Future Role of the Consultant* offers insights into the way in
which NHS obstetric and gynaecological services are likely to be delivered in the future. The
report makes comprehensive recommendations; for instance, the importance of team working
will become more apparent as care networks are developed. Team work offers many
advantages that, while improving women’s health care, also support individuals within the
clinical team.

It is recognised that trainees are becoming less experienced and are not able to offer continuity
of care. The benefits of team working alongside other consultants and other professionals are
recognised. As working patterns evolve, so the benefits and flexibility of a group of clinicians
acting together will be realised. Practice based on clinical guidelines and agreed clinical care
pathways will enable improved practice, despite the absence of the previous style of care
through a single consultant who was responsible day and night. The commitment of the
individual consultant to the patient will be provided as a member of a team, enabling good
clinical care, improved working hours, better governance and enhanced support of the
individual doctor.

Supporting the clinician

Management, secretarial and IT support

The 2005 national survey identified the importance of administrative support as the major
factor that improves the working life of consultants. At a time when financial pressures are
at a height, administrative support may be seen inappropriately as an area where savings can
be made. Cutbacks to secretarial and administrative support should usually be resisted.
Conversely, improved assistance should be considered, as the benefits and savings measured
against consultant time should be cost-effective and lead to improved work–life balance. Line
management and HR departments should realise, and/or be reminded, that adequate support
improves efficiency and reduces the number of complaints.

The IWL recommendations contain auditable standards for trusts. Both the NHS Plan and the
IWL programme ‘aim to make the NHS and employer of choice, a model employer offering a
model career to staff’. While investment in NHS IT is reaching record levels (NHS Connecting for Health: www.connectingforhealth.nhs.uk ), much of this investment is impracticable and there are
significant concerns over its achievability. However, good IT facilities support good clinical
care and the implementation of an IT infrastructure is an important way of improving the day-
to-day working life of all health professionals. Modern equipment with appropriate
speciality-based software and good administrative back-up is of great value. Investment in this
area of IT is cost-effective, aids governance and risk management and supports appraisal, CPD
and job planning. It will also become essential to support the revalidation and recertification
of doctors.

Medical and cross-professional support

There is no doubt that having adequate professional support assists clinical care, helps avoid
stress and improves job satisfaction. However, with the NHS facing increasing financial
pressures and with salaries being the largest area of expenditure, there is great pressure to
resist expansion of the workforce. Indeed, despite greater throughput of clinical work and reduced waiting lists, there has recently been a call for a reduction in the number of staff working across NHS service delivery. Adequate numbers of medical staff and other health professionals are essential to maintain rotas at times of increasing pressure and an overall reduction in working hours. Inadequate staffing levels increase stress and lead to an escalation in absence through sickness.

It is appropriate and cost-effective to use a skill mix across the breadth of health professionals to achieve good clinical care. Some roles performed by highly trained and expensive professional grades are appropriate to be delegated to others who have been fully trained to take over specific areas of responsibility. There is no reason why such team working should harm quality care. Indeed, by releasing the time of other professionals, this practice allows those professionals to concentrate on duties requiring their additional expertise. Overall patient care should be enhanced.

The RCOG working party report The Future Role of the Consultant identifies the workforce and working patterns necessary to deliver the obstetric and gynaecological services of the future. There is a clearly recognised need for significant consultant expansion, even allowing for multiprofessional working and some reconfiguration of service. With the identified need to improve labour ward services combined with further reductions in the working hours of doctors in training, consultant workload is clearly increasing. Consultant expansion in obstetrics and gynaecology is a prerequisite and further and increased investment is essential.

**Working patterns**

Control over working hours and patterns is key to improving working life. There are a number of laws and regulations that support the employee. From October 1998, implementation of the WTR health and safety legislation (Directive of the Council of the European Union [EU] 93/104/EC) allowed consultants and SAS doctors to limit their work to a maximum of 48 hours (average) per week. While in the past many doctors were unaware of the large number of hours they were working, recent job planning and annual recording of time worked over a few weeks has highlighted for many the extent of their dedication to NHS service.

While maintaining the professionalism and continuity of care of which many consultants were proud, WTR legislation and job planning can be used to readdress the issue of work–life balance. With the acceptance of reduced remuneration, a reduction in working hours can release funding that should contribute towards consultant expansion. Many departments have expanded their workforce and improved working patterns across all levels of seniority by adopting this approach. Derogation of WTR legislation delayed the implementation of time limits for doctors in training until 2004. From August 2004, the maximum hours per week for training doctors was set at 58 hours, reducing to 48 hours in 2009.

There are a number of ways in which working patterns can be improved and personalised. The NHS IWL programme encourages increasing cross-professional working, with many examples of good practice. Flexible training and working is now encouraged but not necessarily easy to achieve. Although usually beneficial to staff and sometimes to the organisation, the impact on others and on service at core times must be considered. Staggered hours, time off in lieu and shift swapping are alternative strategies that may lead to successful improvement of working patterns.
Reducing hours of work

Fifty percent of female doctors and 10% of male doctors across the NHS already work less than full time. Owing to demographic changes and the changing perspectives of employment, the proportion of staff wishing to work reduced hours is likely to rise.

There are a number of approaches to reduced hours working, including part-time working, job sharing, school-term working, winter or summer working, annualised hours and voluntary short-term reduced working. These various styles of working can, with local agreement, be adopted to link with home commitments and significantly improve work–life balance. Exploration of these alternative strategies should be made across the professional team. The wishes of one employee may dovetail with another who may be at a different stage in their family life.

The general principle for pay, pensions and other benefits within the NHS is that these apply pro rata to the hours worked. However, the NHS pension scheme is based on final full-time equivalent salary rather than actual earnings, so someone opting to work part-time during the last years of their career will not reduce their pension entitlement other than in terms of length of service.

Agreed actual hours and patterns of work will depend on the needs of service and the circumstances of the employee(s). Again, the acceptance of any change or reduction of working hours must be acceptable to others in the team. However, a pro rata reduction in pay, particularly if the work pattern is adopted by other members of the team, can be used to increase the workforce to cover continuing clinical needs. Alternatively, team-based self-rostering may be considered. Self-rostering means agreeing staffing levels and the skill mix required at any time in the day, then giving staff the ability to schedule their working hours collectively to meet those requirements.

As a healthcare professional’s career advances and with increasing age and seniority, working patterns and commitments may change. The pressures of the delivery of an acute service day and night are significant. The WTR offers the protection of working limits and statutory rights of rest but night work and shift work are less well tolerated with increasing age. With seniority, a natural evolution of both work pattern and work content seems appropriate. Particularly during the lifetime of a consultant, a progression towards more managerial and perhaps training responsibilities is likely, although the experience and attained knowledge that come with seniority should not be lost to clinical work. The out-of-hours acute workload becomes more demanding with age and an increasing shift towards daytime working is appropriate. However, more complex and unusual clinical conditions are arguably better managed by those with experience. Senior clinicians will undoubtedly have to offer clinical back-up to those who are newly trained and have less clinical experience. However, it is recognised that such evolution can come about only if it fits with clinical priorities and with the agreement of other members of the local clinical team. A slow progression, where possible, evenly diluted across an age differential should be possible and acceptable. Realisation that during the earlier years of clinical commitment the workload is directed more towards day and night acute service is balanced by the knowledge of one’s own career advancement. Annual job appraisal and the job planning process are ideal opportunities for initiating the discussion of reducing hours, changing working patterns and improving working life.
Care for the carers

Different times of life bring different family responsibilities. During the early and middle years of working life, many men and women will be responsible for bringing up babies and school-age children. Later in life, particularly those members of the family who are healthcare professionals are often relied upon to care for older and frailer parents or relatives. The needs of carers, therefore, are important issues when considering work–life balance.

Childcare support

The difficulties of raising a family while continuing as a professional within the NHS have long been recognised. It has been realised that if the NHS wants parents to continue as active participants in the workforce, it must support them in combining their domestic and work responsibilities. The government’s National Childcare Strategy should create opportunities for employers to help staff with childcare needs. Almost 50% of NHS trusts already offer some sort of childcare facilities to staff. A number of initiatives are being developed further, including on-site nurseries, out-of-hours schemes, childcare vouchers, childminding networks and a childcare information service. All NHS trusts have been asked to review local needs and to set out a strategy that is in the best interests of everyone in the organisation. Demand on such facilities is likely to be great and eligibility criteria will take into consideration the needs of individuals and the requirements of the trust. Priority will be given to encourage those returning from maternity leave and career breaks. Support should be offered to lone parents and those with low pay as well as those whose parent or child has a disability. The Sex Discrimination Act means that gender or marital status cannot be used as grounds for prioritising allocation of available childcare facilities.

Support for carers

Almost one in seven adults looks after a relative or companion who cannot cope alone because of illness, age or disability. Not all those who are carers seek assistance; some prefer to keep their caring role as a purely private matter. However, others do not know that their caring responsibilities will be recognised and should be supported by the NHS. Those who are caring for others require financial stability and help with the cost of caring. Work provides an external source and focus of life satisfaction, provides the opportunity to build and maintain social contact and helps to improve self-esteem. Failure to help people with caring responsibilities results in disruptive absences disguised as sick leave. Eventually, staff leave work feeling that they are unable to cope with their combined work and caring roles. The NHS as an organisation should recognise the value of carers and should aim to retain valuable staff and thus save on recruitment and the induction of new staff. Long service, motivation and loyalty should be rewarded.

Options should be made available to accommodate the needs of carers. It has been recognised that simple things may make all the difference to enable carers to continue fulfilling their combined responsibilities. An undertaking that work will finish at a specific time each day, an acceptance that a telephone call home may be necessary during working time and an offer of flexibility to increase or decrease hours of work according to caring needs make significant differences to the life of a carer and help to reduce stress. NHS trusts have been asked to assess local needs and explore, through staff attitude surveys, what measures should be taken locally to help.
Career breaks

There are a number of reasons for which an employee may wish to take a career break. Career break schemes were originally devised for parents, usually mothers, to take time out to raise a young family to school age. The employer benefits by staff retention, while there is a reduction in the loss of trained and experienced staff who might otherwise leave and not return.

The scope of a career break has now widened to include people of all ages who have reached a point in their lives when, for whatever reason, they want a period away from work but have the intention of returning to work later. The current NHS scheme allows for up to 5 years away from work. The length of a break, however, may range from 1 to 7 years. The leave is usually unpaid, although paid sabbatical schemes may exist for some professional groups by negotiation where activity during the break has some work-related character, for instance research or other professional development. It is usually accepted that other paid employment will not be undertaken during a career break.

Career breaks should offer the security of a known date for a return to work. In most schemes, employers give a commitment to re-employ participants at the same grade on return to work. However, such terms must be agreed in advance with the employer so that re-entry is assured. The individual does not have to leave employment to achieve their objective. A career break does, however, involve a break in contract that may affect conditions of employment and means that the break will not count in pension calculations based on length of service. It is therefore important to obtain professional advice when considering a career break. For the young parent, a career break offers an opportunity to take time out from work for family commitments with the intention of returning to work and extending a career later. The Parental Leave Directive (96/34/EC) requires employers to offer a minimum of 3 weeks of unpaid leave to parents of children up to the age of 8 years. This is much shorter than a career break. Many clinicians would relish the chance of exploring alternative opportunities as time and life pass by. It is recognised that a career break can help to prevent burn-out and an employee often returns from a career break refreshed and with a richer quality of experience. The NHS and patients benefit as a result. However, absence from clinical work leads to de-skilling and it is now recommended that any absence longer than 6 months should lead to a personalised retraining programme. Retraining is rarely easy to organise. It is strongly recommended that, in advance of taking a career break, agreement is secured with the employing trust as to the content and plan for retraining. The amount and range of retraining will depend on the original post, the time away from work and the nature of the role, if it has changed, on return to work. The RCOG is willing to help and design the content of any retraining programme but, unfortunately, cannot help arrange retraining if it is not available in the original trust.

The College is encouraging all consultants to have a supporting colleague as a mentor and it would be prudent to arrange this before embarking on a career break. Ideally, the clinician would keep in regular contact with the mentor throughout the break and on return.

Flexible retirement

Although many people look towards retirement as a well-earned complete break from working life, others are keen to consider alternatives that enable a reduction in the pace of and commitment to work but still allow them to use their knowledge, skills and experience to the benefit of patients and the health service.

There are now a number of options that allow a change in work style at retirement. There is the opportunity for a doctor to wind down gradually by reducing the number of hours worked.
There is also an opportunity to step down into a less demanding job on a lower pay scale but still making good use of skills and experience. Alternatively, by arrangement with the trust, a doctor can retire and then return to work in a part-time capacity. The Flexible Careers Scheme of the NHS offers a structure for working flexibly at less than half of full-time hours. The scheme can be tailored to individual circumstances and can include a working pattern in which the number of hours worked varies during the course of each year.

While it is stated that the alternatives to conventional retirement, as outlined by the NHS IW L, all have the effect of protecting and some even enhancing pension income, it is essential for anybody considering a flexible retirement option to seek professional advice. The NHS Pensions Agency can provide information but not financial advice. BMA members can discuss their pension options with the BMA Pensions Department or alternatively with an independent financial adviser. There is also a frequently asked questions section relating to NHS pensions within the Department of Health document Reviewing your retirement options – consultants and senior hospital doctors.¹⁰

The future

While the pressures of NHS service delivery are undoubtedly intensifying, there are many opportunities, possibly more than ever, for an individual to reflect on their working practice and manage their work–life balance. The NHS has given an undertaking to improve working lives both in supporting its employees and in recognition of the benefit to patient care. The annual process of job planning and appraisal is a clear opportunity to reassess workload, support in all its forms and the issues that cause stress and concern. A number of goals and objectives can be agreed and progress should be reviewed regularly.

Since the advent of the Postgraduate Medical Education and Training Board (PMETB) and the abolition of hospital visits, the ability of the RCOG to assist local clinicians with improvements to training (and service) has diminished. However, the RCOG will continue to set standards and will drive improvements in women's health care through a variety of avenues. The College recognises that the wellbeing of its Fellows and Members is vital. A workforce that is well trained, fulfilled and satisfied is essential to the delivery of a quality NHS service and the welfare of women.

References

2. Models of care

David Richmond and Mark James

Introduction

The demands of a target-driven NHS striving for efficiency and with cost restrictions have led to a growing feeling of pressure. Too much work, too little time, not enough support and, often, too little recognition of achievements are recognisable factors increasing stress and negatively influencing fulfilment, happiness and work–life balance.

Models of care should be developed to reflect changes in service delivery and the demands on all health professionals.

Key points

- CNST/WTR/RCOG and other standards should be used to improve standards and to increase the numbers of medical and other health professionals.
- Inappropriate and unsustainable working practices and patterns must be addressed.
- Administrative and managerial support should be improved.
- The RCOG should disseminate examples of good practice and, wherever possible, support Fellows and Members in their working practices.

There are almost as many different models of care as there are hospitals. Geographical and demographic variations have forced trusts to develop their own best-fit model using the resources available to them. The range of departmental budgets is also very wide. The distribution of deanery junior staff is variable and often dependent on historical trends as much as service needs.

Future planning must be based on best practice and standards that are achievable and realistic. This applies to consultant medical staffing as well as to nurses and midwives. The RCOG has advised on medical staff complements related to workload. The principle of a recognised equation for midwifery staffing (such as Birthrate Plus) should also be adopted for medical staffing provision according to workload and unit size. This can be achieved through the CNST, which already includes medical staffing levels on the labour ward among its criteria.

Models of care have been developed to address staff shortages, the WTR, Hospital at Night and labour ward consultant presence, among other initiatives. Consultants in obstetrics and gynaecology feel under pressure. Key performance indicators continue to tighten from inpatient waits of 15 months to less than 12 months and now less than 6 months, while the 18-week pathway is now a reality. Cancer targets of 31 and 62 days alongside a rationalisation of service following the Calman–Hine recommendations are just some of the demands increasingly forcing doctors to review their work–life balance. In Scotland, a questionnaire
of 1100 consultants from all specialties produced a response rate of 61% and the following messages:³

- 84% believed some of their work could be delegated
- 79% thought that there were insufficient staff
- 77% felt that their workload had increased with the new contract
- 70% were likely to retire at 60
- 65% felt that the workload was unreasonable and unsustainable (76% in obstetrics and gynaecology)
- 67% felt unable to provide the desired standard of care
- 67% did not take regular meal breaks
- 63% had insufficient time for outside interests (76% in obstetrics and gynaecology)
- 44% felt that their health was adversely affected
- 76% were against shift systems (owing to loss of continuity of care)
- 51% did not take all annual leave – ‘makes work worse on return’ – or used annual leave for college and related activities.

The top five reasons for planning to reduce sessions were:

- more free time
- too much work
- unable to cope
- pay and working conditions
- reduced work coming up to retirement.

The aspects of the job that were least enjoyed were:

- workload (including unreasonable and unachievable deadlines)
- lack of management support
- paperwork
- long hours
- lack of resources
- staff shortages
- frustration with bureaucracy
- lack of recognition for a good job well done.

The aspects of the job that were enjoyed most were:

- patient care and contact
- relationships with colleagues
- variety of work
teaching and research
challenge of job
enjoyment of the specialty.

There is no reason to suspect that the remainder of the UK is any different and this survey probably confirms what most consultants would say if asked. Each of these issues needs addressing. The new contract has offered better remuneration to consultants. Many colleagues now desire greater flexibility in their working lives – this includes both the male and the female workforce. It is fundamental for recruitment that our specialty is seen as stimulating and rewarding but, at the same time, that the intensity of the work and round-the-clock provision of care is recognised. This is surely the time to develop patterns of work that are attractive and yet recognise some of the external demands such as the physical, mental and emotional stimuli needed to fulfil a work–life balance. For example, rest, relaxation and physical exercise need time along with adequate nutrition in an adequate setting. There needs to be appropriate time for study leave and CPD, teaching, research and perhaps even a sabbatical.

Provision of obstetric services

In the 2007 RCOG census there were approximately 660 000 births annually in England and Wales. The average number of deliveries/consultant whole-time equivalent (WTE) was 424, with a range of 311–572. We know, however, that of the 1700 consultants in practice, 6.5% work LTFT, 8.5% are obstetricians only and 13% are gynaecologists only. This equates to a national average of 859 deliveries/WTE consultant obstetrician.

The RCOG publication Safer Childbirth focuses on staffing roles and levels for units of differing size, driving the standard of consultant presence on the labour ward to the recommended minimum of 40 hours proposed in 2000. Of the then 247 maternity units with consultant availability, only 124 (50.2%) had achieved the minimum requirement. Larger units achieved greater compliance (Table 1). For units delivering more than 2500 babies/year, the proposal was to strive for at least a 60-hour presence by 2010 and for 168-hour attendance in units with more than 5000 deliveries/year. This is unachievable with the financial pressures in the NHS at present. The workload within each job plan needs to be established as a minimum standard. Each unit will have different requirements. Models of care in maternity care have been described previously (in 2004) by the Modernisation Agency. Examples of practice around the country are provided in the 2009 RCOG workforce document. All the antenatal and postnatal components of care must be taken into account in conjunction with labour ward responsibility and overall on-call commitment to establish the number of consultants required. Prospective cover must also be included in any assumption of consultant numbers to comply with WTR and statutory leave. It is necessary to identify a reasonable denominator for obstetric care; the total number of programmed activities (PAs) or direct clinical care PAs/clinical unit may be an option for accurate benchmarking.
Table 1 Compliance with 40-hour consultant cover on maternity units

<table>
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<tr>
<th>Completed surveys</th>
<th>All the time (n)</th>
<th>Most weeks (n)</th>
<th>Some weeks (n)</th>
<th>Never (n)</th>
<th>Don’t know or no answer (n)</th>
<th>Compliant (n)</th>
</tr>
</thead>
<tbody>
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<td>96</td>
<td>68</td>
<td>17</td>
<td>2</td>
<td>9</td>
<td>0</td>
<td>71</td>
</tr>
</tbody>
</table>

For example, consultant annual leave is 6–7 weeks and study leave is 2 weeks per year. Professional leave is undoubtedly necessary within the consultant body, and WTR compensatory rest depending on work intensity reaches a further 1–3 weeks/year (a potential total of 12 weeks). The number of consultants required should be calculated on the basis of a 40–42-week working year. All calculations would then be based on, say, 42 weeks rather than 52 weeks. Examples of the calculations for 60-hour, 98-hour and 168-hour cover can be found in the workforce planning document.²

The National Service Framework for Maternity Services has been a considerable step forward and its full implementation is essential.⁷ It is a vision for the provision of maternity care aiming at a continuum of quality, safety, satisfaction and choice. Maternity Matters, in 2007, was a further step in the process.⁸ An agreed set of maternity service standards based on these criteria has now been developed and was published in June 2008.⁹ Reorganisation and even reconfiguration of services will be required. Much will depend on local solutions to local problems. Simply closing smaller units to create a larger single site is unlikely to be the answer that suits all occasions. However, efficiencies might result from stronger networking, even specialty-specific regional or strategic health authority (SHA) collaboration to share best practice and resources.

At present in England and Wales there are approximately 250 units delivering maternity care with a huge range of annual birth numbers, from fewer than 500 to more than 8000. They include:

- 74 units with fewer than 2500 births annually and an average of five consultants
- 76 units with 2500–4000 births annually and an average of eight consultants
- 27 units with 4000–5000 births annually and an average of seven consultants
- 15 units with more than 5000 births annually and an average of 13.5 consultants.

The calculation of workforce numbers now and for the next 10 years was the focus of the College’s Future Workforce in Obstetrics and Gynaecology in England and Wales Working Group.⁶

Safer Childbirth suggests that units that require a 60-hour presence will need six WTE consultants, those that require a 98-hour presence will need at least 12 WTE consultants and those that require a 168-hour presence will need 16–18 WTE consultants.² Those units delivering fewer than 2500 babies/year will need a local solution. Suffice to say, this will result in a minimum of three to four WTE consultants/unit. In all, this would result in the need for 1284 WTE consultant obstetricians for England and Wales.

The calculation is based on the anticipated workload/WTE consultant as well as the minimum recommended standards of labour ward presence. Obviously, this calculation does not take into
account the provision of gynaecological services; based on current figures, this would account for approximately a further 800 consultants. The total needed would then be similar to the number estimated in the *Future Role of the Consultant* document. Whatever the solution, expansion is essential for at least the next 10 years to achieve appropriate standards of care. Inevitably, this will raise issues of resources and funding as well as provoking the reorganisation and reconfiguration of services that is already happening throughout the country.

**Provision of gynaecological services**

**Outpatient clinic** templates should reflect the staff available per session or PA, that is between 3.5 and 4 hours. Earlier College recommendations of 20 minutes for each new patient and on average 10 minutes for each follow-up patient are an acceptable starting point. The template for non-consultant staff will need to be tailored to seniority, ability and whether the session is for teaching, service or both. Other issues that need to be taken into account may include the hospital policy on consenting for surgery, the clinical pathway and the need for additional procedures or investigations within the session, as well as the ‘did not attend’ rate and undergraduate presence. These should be minimum requirements for discussion.

One-stop clinics for the management of menstrual problems, abnormal smear, urinary incontinence or infertility will obviously need further consideration of timing. Appropriate triage of referral letters to reduce ‘in-house’ tertiary referral from one consultant to another with a special interest will become increasingly important with GP-based commissioning and primary care trust scrutiny of activity and remuneration.

For **gynaecology theatres** there is no standard template owing to case mix variation and myriad other variables. However, quality issues, such as start and finish flexibility with annualised work plans based on historical individual throughput, often satisfy other demands. Altering start times to ‘friendly time’ may make an enormous difference and can be season-dependent, such as 7 a.m. to 3 p.m. from May to September or during school holidays. This is much easier to achieve if work planning is team based on annualised activity (for example the agreed amount of work that is appropriate over a 42-week year).

The value of **support staff** cannot be overstated. The single most important support for consultants is their personal assistant or secretary. In a survey of 1603 hospital doctors in the UK, consultants considered that better secretarial and managerial assistance was their number one priority. Education, training and mentoring was the priority for registrars, while childcare provision was the most important for female trainees.

The presence of advanced nurse practitioners needs to be measured using job and work plans similar to those of consultants to achieve maximum effectiveness. Enhancing the role of advanced nurse practitioners to prescribing and obtaining consent improves their satisfaction and eases the consultant burden. Vertical integration within a consultant team is the most satisfying for all, such that clinics are covered, ward rounds are completed and assistance is available in theatre. There is also more time to teach students and postgraduates.

The **WTR requirement for a 48-hour week** has now come into effect for trainees but has applied to career-grade doctors since October 1998. Many trusts and hospitals have already endeavoured to achieve that target to reduce constant change, banding and financial burden. In 2006, the Royal College of Physicians (RCP) published a report on rotas for junior doctors that could equally apply to any group of resident staff. There is increasing evidence that sleep patterns are disrupted with on-call responsibilities. Accident frequency is related to duration of night shift and car-driving ability deteriorates following night work. The Health and Safety Executive tools for assessing fatigue and risk are important considerations, especially in the highly charged atmosphere of a
busy labour ward. The ‘best’ rota is the three times 9-hour model, and the ‘worst’ (the rota carrying greatest risk) is the seven nights in succession model. For example, the last of seven nights worked carries a 41% greater risk than the second night of two in a rota of night, night, day, day, off, off, off; the latter is the common 12-hour industrial pattern of day–night working.

Since August 2009, the following has applied:

- the maximum average number of hours on duty is 48 (over a 26-week period)
- the minimum rest break is 11 hours between shifts
- the maximum continuous spell of duty is 13 hours
- the maximum continuous consecutive duty is for 12 days with a minimum break of 48 hours in a 2-week period
- there must be 35 hours of continuous rest in 7 days or 59 hours rest in 14 days
- there must be one 30-minute break after 4 hours on duty.

The shift pattern rotas are well described in the RCP document and range from the seven nights in succession rota to three 9-hour shift patterns, each with varying degrees of risk and fatigue. Issues pertaining to continuity of care and handover have been documented by the BMA Junior Doctors Committee and by the RCP. Hospital at Night solutions have proved difficult in obstetrics but could be adopted if separate gynaecology on-call rotas exist and other surgical specialties are available. Gynaecology teams could function to 5 p.m., 8 p.m. or 10 p.m. depending on junior availability. This reduces not only the frequency of night work but also the compensatory rest and reduction in elective training exposure. This is an area the Association of Surgeons in Training is actively considering. LTFT working could be accommodated by aligning such trainees to a particular post. The implications of the WTR for children’s and maternity services have now been considered in detail and suggestions for the way forward are included in the working party report published in 2008.¹²

Provision of care in the independent sector is still the source of considerable debate with the impact of alternative providers on services in obstetrics and gynaecology uncertain, although it now appears to be government policy not to encourage the development of further independent centres outside the NHS. Such centres are unlikely to have any bearing on obstetrics, but in gynaecology provision by an independent sector treatment centre could be seen as a threat to NHS provision, particularly in England. The funding will mimic payment by results and tariff. Repayment will be similar for outpatient care but for single operating procedure code supplement (OPCS)-coded surgery. Any bundling or multiple procedure care may prove difficult, requiring re-referral. There are likely to be local solutions, but many problems are still to be overcome. Staffing rules are strict. Medical care may be provided by alternative suppliers, independent practitioners or consultant colleagues. This aspect needs careful consideration and negotiation with both NHS and other providers.

In summary, the work environment is crucial in any model of care. The top five factors that appear to make a difference are:

- a reliable and knowledgeable personal assistant
- consultant lunch break
- consent/information leaflets that are nationally agreed
- appropriate junior doctor support or support from a trained nurse practitioner
- a taxi home if working after 10 p.m.
Some of these may seem unobtainable, but in the private or commercial sector they are seen as important for the recruitment and retention of staff. In addition, there needs to be clarity about the use of the SPA session. This could be outside the hospital environment with appropriate accountability at the annual appraisal. Annualising the work plan may facilitate flexible working during school holidays; seasonal variation in start/finish times may be a beginning. These and other issues will be expanded upon in subsequent chapters.

References

3. Job contracts for consultants

Alan Russell

Introduction

The ‘new’ 2003 time-sensitive consultant contract offers an opportunity to reflect on workload and, through negotiation, to develop clarity of expectation, defined hours of work and appropriate remuneration. The job planning process is an integral step with the potential for common benefits to service delivery and for the individual. The importance of an appropriate allocation of SPAs and the recognition of all duties including training, management and roles in the wider NHS are essential.

Key points

- The new consultant contract is an opportunity for the recognition and management of workload and working practices.
- Appropriate remuneration, periods of rest, reduced hours or more leave should be reflected in job planning negotiations.
- An appropriate number of SPAs should be negotiated and the RCOG and the Academy of Medical Royal Colleges should give clear guidance and support (Appendix 2).
- Increasing consultant presence on the labour ward (including, with agreement, resident on-call) should be planned at local level, thus improving health care and promoting an individual’s work–life balance.
- The new contract and job planning process should allow career progression and development with changing emphasis of roles over the years.
- The impact of foundation status on the consultant appointment process and working practices must be monitored and, if necessary, challenged.

Consultant contract

Renegotiation of the consultant contract took place during 2002 and 2003, this being the first complete renegotiation of the contract since the start of the NHS in 1948. The vote on the first consultation resulted in a small majority in favour in Scotland, where they proceeded to implementation. Much the same happened in Northern Ireland. The vote in the other home nations rejected the proposals. In Wales, the negotiators decided to modify the existing contract and proceeded with further discussions, resulting in an agreement. In England, a new group of negotiators resumed discussions based on the reasons for the rejection of the first proposals. This resulted in a new agreement that was accepted by vote.
The consultant contract is therefore four different contracts, one for each nation. Although there are many similarities among them, there are also significant points of difference. For ease, this document will outline the English contract but should not be seen to disregard the differences in the contracts of the other nations where these occur, many of which are discussed later in the document.

Since October 2003, the ‘new’ contract has been the only permissible contract for new consultant posts, including locums. Consultants in post before this time had the opportunity to move to the new terms and conditions or to remain on their old contract. Over 90% of consultants are now on the new contract. It is probably unlikely that many more pre-October 2003 consultants will now change, but as new consultants are appointed and existing consultants retire, the overall percentage will rise.

The new contract with its associated job planning aspects brings greater clarity to what a consultant is expected to do by agreement and what a consultant is paid for. It also makes clear that duties outside the job plan agreement need further discussion and, logically, further remuneration. The new contract also makes clear the right to perform private practice outside contracted hours. The right to private practice can mean the employer insisting on an extra session being worked for them, but this has rarely if ever been insisted upon.

**Work commitment**

The contract is based on a full-time commitment of ten PAs per week, each being of 4 hours’ duration or 3 hours in premium time (7 p.m. to 7 a.m. Monday to Friday and all weekend in England; Wales and Scotland vary). Any additional work above ten PAs will be by agreement and paid at the full appropriate rate. All consultants have the right to work no more than ten PAs unless they wish to have a private practice, in which case the employer can insist on an eleventh paid PA.

**Job planning**

An annual job plan agreement with a medically qualified colleague, usually the clinical or medical director, is essential. This, by agreement, will detail the work expected and, from that, the remuneration that will apply. Work falls into various categories:

- **Direct clinical care.** This includes emergency duties (including on-call), operating sessions (including pre- and postoperative care), ward rounds, outpatient activities, clinical diagnostic work, other patient treatment, multidisciplinary meetings about direct patient care and administration related directly to the above.

- **SPAs.** These include training, medical education, CPD, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance.

- **Additional NHS responsibilities.** These include medical director, clinical director, clinical lead, audit lead, clinical governance lead, undergraduate or postgraduate dean, clinical tutor or regional educational adviser.

- **External duties.** These include trade union activities, advisory appointment committees, work for the Healthcare Commission, NCAS and GMC and work for Royal Colleges and government departments.
The contract sets out that in a ten-PA job plan there will typically be an average of 7.5 PAs of direct clinical care and 2.5 PAs of SPAs. There is flexibility to agree a difference in balance, but there must be clear justification for fewer than 2.5 SPAs. There is also the freedom to agree to work more than ten PAs either by an increase in direct clinical care or SPA sessions; these will form part of the job plan and be rewarded at the appropriate rate.

**Out-of-hours work**

Out-of-hours and emergency work can be predictable or unpredictable. Predictable work arises from on-call duties such as out-of-hours ward rounds. The average number of hours/week should be calculated and put into the job plan and should include prospective cover for colleagues’ leave. There is no limit to the amount of predictable on-call work that can be allocated to direct clinical care PAs.

Unpredictable work should also be averaged over the week and is best derived from diary evidence. Allocations for unpredictable on-call work should not normally exceed an average of two PAs/week. If this is exceeded, a local agreement should be reached or the job plan and on-call commitment reviewed.

In addition to the above, consultants on an on-call rota are paid an availability supplement, which is determined by the number of people on the rota and the typical nature of the response when called. It is expected that all consultant obstetricians are in a situation where they may be required to return to site immediately and would therefore fall into category A, with higher remuneration.

It is important to note that all the above comments taken from the terms and conditions of service can be modified by local agreement, particularly if this achieves a better scenario, but under all circumstances consultants should resist management-led changes that lead to a worse situation for themselves and their colleagues. Change can occur only by agreement. It is also important to note that there are an increasing number of foundation trusts that do not have to keep to national agreements and can set their own terms and conditions of service. The evidence thus far is that foundation trusts have not sought to stray too far from national agreements, but this could still change. In this situation the importance of local agreement and robust job planning by both employee and employer becomes even more important.

**Consultants 24/7**

There are an increasing number of reasons why it is necessary to consider consultants being resident in obstetric units for 24 hours/day and 7 days/week. Many consultants find that they spend more and more time actually in the hospital when on-call, often owing to trainees being less experienced, and would welcome a more formal approach to the situation. There is some evidence that patient care is in some instances changing because of trainee inexperience; the increase in caesarean section rates is often quoted but there are other examples. It is difficult to explain to a patient why, in a 24-hour service, staffing should be so different in expertise between 3 p.m. and 3 a.m. If patients are asked whether they would prefer to be looked after on-site by a fully qualified obstetrician or by one in training, their responses are predictable.

So much of the money spent on litigation in the NHS comes from obstetrics and it is thought that a consultant on the labour ward 24/7 would reduce this, although the evidence is still incomplete. There will in the future be a relative need for more consultants and fewer juniors. The RCOG has a commitment to working towards a 24/7 presence on the labour ward.
Much of the above will also apply to other acute specialties. Recent informal surveys of Royal College presidents showed that physicians, surgeons, anaesthetists, accident and emergency consultants, paediatricians and radiologists were all considering their position with regard to 24/7 working. Realistically, 24/7 working can be achieved only through a combination of reconfiguration of services and a large increase in consultant numbers, all of which will take time.

24/7 job planning

The terms and conditions in the contract mean that consultants cannot be forced to be resident on-call, although foundation trusts and traditional NHS trusts could change this for new appointees. An approach by management should recognise this and seek to provide an attractive option to persuade consultants to take up the option. It has been said that consultants over a certain age, perhaps 60 or 50, or even 40, should not perform night work. Clearly, the best way forward is to design a system in which the majority of consultants are keen to take part and yet will not experience any risks to their health.

The number of direct clinical care PAs used up by a night on-call or a rota of weekend on-call is enough to give a considerable amount of free time and could well be seen as attractive by many consultants, whatever their age. If it was felt that non-emergency work was being lost during the day, it would be possible to contract to do this extra work for extra money. Examples of possible ways of achieving a satisfactory rota and way of working are given elsewhere in this document.

The BMA is the recognised body for negotiation by doctors with employers. It has been suggested that it should reopen negotiations with employers to reduce premium-time PAs to perhaps 2 hours while consultants work as resident on-call out of hours. It is unlikely that either the BMA or employers would welcome what would be a large-scale renegotiation of the contract at this stage. It would also be considered that the tools are available, particularly with local negotiation, to discuss this with individual employers as necessary.

Points to remember

- There is no obligation to work more than ten PAs (or 11 PAs if private practice is undertaken and the trust insists). There is an absolute right to refuse to do non-emergency work outside 7 a.m. to 7 p.m. (Scotland 8 a.m. to 8 p.m.) Monday to Friday (Scotland after 12 noon on Saturday).

- There is no obligation for a consultant to be resident on-call at night.

- An annual job plan is of extreme importance.

- The job plan can only be reached by agreement and appeals mechanisms are agreed for cases where agreement cannot be reached.

- More thought will have to be given to job planning as foundation trusts could increase their powers for independent negotiation.

- Consultants should be aware of changes that could occur in the contracts of newly appointed colleagues and should review these appropriately as they arise.
4. Job planning in obstetrics and gynaecology

Ewen Walker

Introduction

Job planning is an invaluable process for gauging and managing workload and thereby improving satisfaction and reducing stress. The new contract offers specific guidance for the number and types of PA, thus allowing local negotiation when appropriate to reflect or address an individual’s work.

Key points

- Job planning, based on a diary of work performed, is an invaluable tool for addressing work–life balance.
- Job planning is an opportunity for improving services and training.
- Job planning should be used to facilitate consultant expansion.
- Annualisation of working time and improved teamwork offer improved opportunities to work effectively and flexibly.
- Support must be given to newly appointed consultants so that they, too, receive a rewarding job plan and appropriate remuneration.

Hospital consultants have many diverse needs and concerns associated with the delivery of service in their own particular specialty. The new contract was negotiated by the BMA with all specialties in mind, not specifically for individual specialties such as obstetrics and gynaecology which have significant on-call demands.

For example, paragraph 4.8.5 states that ‘Other than in exceptional circumstances, the number of programmed activities undertaken during the out-of-hours period should not exceed three per week.’ Paragraph 4.9.1 then states ‘Consultants will not, save in exceptional circumstances, undertake resident on-call. However, the employer will agree with the local negotiating committee (LNC) for medical and dental staff the arrangements in respect of resident on-call, including remuneration, paid time off in lieu, accommodation and catering. Where it is agreed between the consultant and employer that he or she will undertake resident on-call duty, these arrangements agreed with the LNC will apply.’ Similarly, paragraph 4.10.4 states: ‘Where consultants’ on-call commitments give rise to work in excess of the equivalent of two programmed activities on average per week, this will be addressed through job planning. In exceptional circumstances, where employers and consultants agree additional work is necessary, employers should make additional arrangements locally to recognise this excess work.’
Although on-call work is not optional (as it is now for GPs), there is the expectation in the new contract that on-call work will not involve more than two PAs/week. For most specialties this is perfectly realistic but for obstetrics, neonatal paediatrics and intensive care this is not the case. For these specialties the ‘exceptional circumstances’ alluded to in the contract apply. There is scope within the new contract to reward resident on-call work, but the current rate of pay is not very encouraging. Three hours of work constitutes an out-of-hours PA, so under the current nationally agreed terms and conditions being resident on-call from, say, 7 p.m. to 7 a.m. (8 a.m. to 8 p.m. in Scotland) would be only four PAs. For a busy unit where this is likely to involve work throughout the night, this may not be perceived as generous and differs from the situation developing in general practice, for example.

The BMA has been reluctant to negotiate specific contracts for different specialties but working for a better deal for resident on-call consultants is not a specialty-specific issue, it applies to many consultants now in acute specialties. Furthermore, with doctors’ hours reducing yet further to 48 with the WTR, more specialties, not just those described above, will have to consider living in on-call.

From the patient perspective it is not unreasonable to expect to be cared for by a fully trained doctor whatever time of day or night. Most of us would be very uneasy flying with an airline that we knew had a policy of encouraging the experienced pilots to stop work at 5 p.m. and let the pilots yet to complete training take over the night flights!

Most hospital obstetric risk management committees are already addressing the issue of appropriate supervision of junior doctors but culture and practice vary considerably across the country. Units are reluctant to be too prescriptive in stating which obstetric activities are considered to require consultant presence. However, rotational forceps, caesarean sections at full dilation and twin deliveries are all examples of activity that 10 years ago would have been considered well within the scope of a third-year registrar. Now, most units, supported by the RCOG, think that they should have a senior trained specialist present supervising and teaching, if not actually performing the delivery. In 10 years’ time, it is likely that most obstetric care will be delivered by trained staff but the immediate challenge is in managing the transitional period.

It is unlikely that there will be a major renegotiation of the new consultant contract for some considerable time, so we will have to work with the concept of the PA, with all its strengths and weaknesses. For doctors performing resident on-call work in acute specialties to achieve a reasonably attractive work–life balance, it is vital that all consultants keep an accurate diary of what they are doing and bring this to their annual job plan review. Most trusts now conduct annual reviews of job plans and, if they do not, the doctor should insist on one. To staff labour wards 24/7 with fully trained specialists/consultants is clearly going to take several years to achieve, with adequate numbers of specialist trainees required over the next 5 years at least. As more and more consultants are appointed and are providing the service, fewer specialist registrars (SpRs) will be required to provide the service but this will impact on other aspects of the job. Most consultants will not have a trainee at any of their clinics or theatres and, if four or five PAs are taken up with on-call work and if an increasingly female workforce chooses to work part time (or even if employers insist on no contracts with no more than ten PAs), practice competencies across the width of the specialty will be threatened.

While the College has been reluctant to consider a split in the specialty into obstetrics and gynaecology, the move towards more and more specialised and tailored job plans within the specialty seems inevitable. There will be fewer specialists training in gynaecological surgery but more specialists involved in obstetric practice or other specialised activity. Drifting out of on-call and obstetric work with advancing years has been common in our specialty but, if the
terms and conditions are attractive and the time off to recover from work is appropriate, there may be less reason not to continue to carry out out-of-hours work until retirement, as occurs in other professions that require out-of-hours work.

The new contract and PAs

While both sides in the negotiation of the new consultant contract were happy with the concept of PAs, it was clear that those on the employers’ side underestimated the amount of work being performed by consultants, both out of hours and unremunerated, before 2003. Certain changes in the new contract continue to cause concern to many. The relationship between employee and employer and the nature of the professional contract have undoubtedly changed. There is no obligation to work more than 40–44 hours/week and an absolute right to refuse non-emergency work outside 7 a.m. to 7 p.m. (8 a.m. to 8 p.m. in Scotland) Monday to Friday or after 12 noon on Saturday (Scotland).

As previously emphasised, the contract was not drawn up with acute specialties such as obstetrics specifically in mind. It is important to remember that non-emergency work after 7 p.m. during the week and at any time at weekends cannot be scheduled without individual agreement, although such work on Saturday mornings or public holidays could be imposed as the result of a job plan appeal.

The job plan and its PAs should be drawn up by agreement. It is explicit in the contract that consultants cannot be required to perform non-emergency work after 7 p.m. Non-emergency work includes regular PAs of specialties with emergency routine cases, including accident and emergency medicine, obstetrics and intensive care. All of these features offer considerable protection and negotiating strength for existing contract holders, but what of future consultants? If future consultants are offered posts (or existing consultants are offered new contracts) where living in while on-call is expected, the number of PAs allocated to on-call work will be significant: most probably about two to four PAs/week depending on the size of the unit, the volume of activity and the frequency of on-call duties.

Currently, a typical job plan of ten PAs might look like this:

<table>
<thead>
<tr>
<th>PAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-call</td>
</tr>
<tr>
<td>SPA activities</td>
</tr>
<tr>
<td>Daytime labour ward cover</td>
</tr>
<tr>
<td>Antenatal clinic</td>
</tr>
<tr>
<td>Gynaecology clinic</td>
</tr>
<tr>
<td>Gynaecology theatre</td>
</tr>
<tr>
<td>Administrative/ward work</td>
</tr>
</tbody>
</table>

There is then the possibility of one or two further PAs for other clinical activity, including special interest work. However, if living in on-call is introduced, this will reduce the opportunities for other clinical activities during the day, perhaps in some cases to the detriment of other aspects of the service, thereby forcing the need for additional consultants.

PAs could be arranged such that this type of contract could be more attractive, especially in the first 10 years of a consultant career. However, this is an age when most consultants will have significant other commitments and time with family will be at a premium. Increasing flexibility will be needed in working practice. For example, annualisation is only very briefly alluded to in the new contract and its potential is not yet widely recognised or exploited.
The new contract (paragraph 4.1.5) states: ‘The number and timetabling of programmed activities to be worked by consultants in each calendar week will normally be defined on an annual basis in the job plan. Alternative approaches may, however, be agreed between the consultant and the employer to allow for flexible timetabling of commitments over a period (e.g. a reduction of hours worked during school holidays). The number of programmed activities worked may therefore vary from week to week provided that the total number worked over the period of each year equates to the number for which the consultant is contracted to work in terms of his/her job plan. In these circumstances, the job plan will be expressed in terms of the average number of programmed activities worked per week, allowing for periods of leave as authorised under section 7.’

Although this kind of language may deter doctors from reading their contracts, it was included to provide the opportunity of working in different ways. In the past, the day job was the main focus and out-of-hours work by consultants was completely ignored. Annualisation was included as it was anticipated that some (possibly younger and female) consultants would like the chance to reduce their daytime fixed sessions during times of year when family demands were most pressing, such as summer holidays. However, the facility to vary the number of fixed sessions/week could be used more often in acute specialties to create job plans that might allow a more attractive balance between home life and work, which would be preferable to young doctors feeling they must choose one thing or the other and end up leaving the specialty altogether. Using the concept of annualisation, night work could be concentrated into a run of nights on-call. The number of nights on-call that might have to be undertaken will vary depending on the size of the unit and the quality and experience of middle grades and individual consultants. Rather than being rewarded financially for out-of-hours work, time off could be a more attractive alternative to many consultants at particular times in their lives.

In our unit in Ayrshire, consultants do not currently live in, although with the reduction in juniors’ hours and experience it is our recently audited experience that consultants will be called in and will work approximately half the nights on-call after 11 p.m. We recently moved to a rota where consultants are rostered for on-call work on Sunday (day and night), Monday, Tuesday, Wednesday and Thursday nights from 8.30 p.m. to 8.30 a.m., with all scheduled activities that week cancelled. The new total loss of activity is not as much as it might first appear, as Monday work after a weekend on-call under the previous rota had always been cancelled anyway; therefore, the new loss of daytime work could be easily made up in the intervening 9 weeks when there are no on-call demands except on a Friday and Saturday.

The current rota involves on-call work with a middle-grade trainee on Sunday for 24 hours from 8.30 a.m. to Monday 8.30 a.m., and then Monday to Thursday 8.30 p.m. to 8.30 a.m. Friday nights and Saturday nights are fitted into the intervening 9 weeks when there are no other on-call commitments except for a second on-call consultant availability 1:10, which is occasionally required if the unit is particularly busy.

Most of the consultants are on ten or 11 PAs. Those on ten PAs have one day/week off in lieu of the two PAs allocated to on-call work on our current rota. Already, even before we start talking about living in on-call, there are problems trying to perform a combined, traditional type of job as an obstetrician and gynaecologist on ten PAs. If there is a need in the future for consultants to live in on-call, the number of PAs that are allocated to on-call duties would roughly double to four PAs/week. A consultant on ten PAs could then in theory be offered 2 days/week off in lieu (if a workable job plan could be created). If the BMA secures a better deal for overnight work, up to six PAs might be allocated to on-call (living in) and it would then start to look unrealistic that 3 days/week off could be included in a feasible job plan, particularly for those with an interest in obstetrics. Obstetric practice needs the status it
deserves, as outlined in the *Future Role of the Consultant*. Trained people in the UK are needed in the labour ward and the job plan must recognise and support this.

Annualisation of hours could be used to allow both obstetrics and gynaecology to be supported if time off is taken after a concentrated run of nights on-call. Even with the current pricing of one PA being equivalent to 3 hours of work, a rota as described above (but living in) would amount to about 40 PAs every 10 weeks. If, say, 1 day a week was taken off every week (a normal contracted week was only 4 days), this still leaves 20 PAs, which approximates to 2 weeks of work. In the rota described above where the consultant only needs to work five runs of nights/year, these PAs could be accumulated: in theory, a consultant could take payment for ten PAs, work a 4-day week normally but in addition accumulate 10 weeks of extra leave entitlement on top of the normal 6 weeks/year. In negotiation with management, this could be taken all at once (which might be attractive to consultants with partners who are teachers, for example) or as scattered weeks throughout the year. Some might choose the money: take a 12-PA contract, forgo the day off a week and pursue a special interest. If the consultant does not have a daytime commitment to labour ward cover, this could free up even more time for other clinical interests. At least in theory, consultants could request this sort of time off in lieu rather than be reimbursed.

Those sceptical about the possibility of a medical director agreeing such a contract should remember that living in on-call jobs will come about only if consultants agree to them. They cannot be imposed. Job plans are always a negotiation and management cannot impose living in on-call without the consultant’s agreement. However, if a job is advertised as resident on-call, the prospective applicant has to decide whether to apply or not. If they are appointed and are aware of their contract, a variation to the contract would need agreement from both sides.

References


5. Implementation: getting the support you need

*Helen Moffatt*

**Introduction**

This chapter offers ways to gain support for improvements in work–life balance in the workplace, with a particular emphasis on how to negotiate successfully with the executive team.

There is a perceived conflict between work–life balance and the increasing need to meet healthcare targets. While regulations, guidance and policies exist to help the individual achieve appropriate working practices, it is essential to obtain the support of clinical management so that expectations are met and changes achieved while not compromising safety and quality.

**Key points**

- The involvement, understanding and support of clinical management are essential in helping an individual achieve work–life improvements.
- The common benefits of a satisfied workforce are understood and should be supported.
- Suggested changes in practice should be supported within plans for a sustained and developing service.
- Be creative with opportunities, work as a team and seek a harmonised solution between colleagues who may have different but synergistic needs.

**Securing understanding and support**

Any change is likely to be more successful if there is support for it. Those involved need to feel comfortable with the overall objectives of the change as well as know what is expected of them. To ensure success, time spent on the productive involvement of both clinical and managerial staff needs to be planned and committed. Work–life balance discussions are already an important aspect of workforce planning in healthcare organisations, as is the management of tensions between the quality of service provision, individual job plans and available resources. However, there is a perceived need to raise the priority of these tensions for the specialty of obstetrics and gynaecology and, by building on local action, to provide an impetus for further positive change.

At an early stage, discussion of this document with members of the executive team to raise awareness of the perspectives of doctors in the specialty will be helpful. At an executive level, the chief executive, medical director, chief nurse, HR director and any director with a change
management, planning or operational responsibility will be helpful contacts. It goes without saying that discussions should also be had with the leadership team for obstetrics and gynaecology services, ensuring that the clinical director/medical director for the speciality, head of midwifery and manager discuss the recommendations together and consider further action. As plans emerge, it is good practice to ensure that HR expertise is obtained throughout the process.

An important factor in gaining support from these various parties is the degree to which they truly understand the tensions and problems of the speciality as a whole as well as in the context of the issues faced by the individual department and the organisation. While there will be much that a department can do with the resources already allocated to it, further help will usually be required. It will be useful for the team to understand the overall position of the organisation, such as its priorities, resource issues and the overall strategic plan for women’s health services and, indeed, services in general. This will be important in deciding what level of support is needed and is possible, and will be important in any successful negotiations.

Appreciating and understanding these perspectives will lead to more realistic and practical solutions being found, while the process of gaining a mutual understanding of departmental and corporate issues will build relationships, providing a firmer footing for future negotiations and subsequent change.

Creativity within the rules

This report suggests a number of ways in which to change working patterns to improve work–life balance. A degree of creativity and team working will be needed to make changes happen. There may, of course, be changes to resources as well. Given the reality of resource constraints, the need to be creative within given perimeters has never been greater. Knowing what these perimeters are is essential. While many will have a comfortable knowledge of the details of the consultant contract, their organisation’s HR policies about areas such as flexible working and basic UK and European Union employment law, some may need an update and some more detailed information. Seeking advice, help and information from the HR department, the BMA and the RCOG at an early stage of planning will be helpful in creating a plan that is sound and feasible but also exploits what is possible to maximum effect.

What does the executive team want to know?

It may be clear to the clinical team what needs to happen and, if needed, what change is desired and what impact the change may have on resources. However, these issues may not be as obvious to those at an organisational level or those who work with obstetrics and gynaecology in supporting services such as IT and finance. The executive team will want to know what needs to change, precisely why the change is needed, what is needed to make the change happen (both departmentally and from the organisational perspective) and what the benefits will be. Assurance will need to be given that as much change as possible is being engineered within the resources available and as far as the supporting terms and conditions, contracts, HR policy and procedures allow. There will also be interest in the appetite for change and what support exists for it departmentally.

It is important to define the benefits of any change clearly – for the patient, for the doctor, for the entire team and for the organisation as a whole. Be prepared to spell out the impact of the change on the efficiency, cohesion and effectiveness of individuals and the team. It is also helpful to consider the impact that any change may have on other specialties and, if needed,
to work on any proposals together. Often, it is helpful to clarify as a team the absolute baseline requirements for change and which changes are desirable rather than essential, giving a sense of what is urgent and important to the delivery of services and to the working lives of doctors. While it may not be possible to put all changes in place at once (they may be too big, too expensive or require considerable consultation), often steps can be made along the way, with much being achieved in this manner.

**Successful negotiation**

If plans can be managed within current resources and are supported by the team, with good planning the implementation of the change can be relatively straightforward. If negotiation is needed for a change in resources or for support in another way, careful preparation for that negotiation can make a significant difference to how successful the outcome is. Successful negotiations tend to be win–win for the parties involved, keep the overall aim in mind and be benefit orientated. The following areas are worth considering prior to the negotiation itself.

**The case for change**

- Why is the practical change needed (precisely and concisely)?
- Is there more than one option? If so, what is the preferred option and why?
- What support is needed: permission, money, IT?
- What are the benefits: for staff, for patients and for the organisation?
- What are the alternatives or implications if there is no change?
- Bring solutions not just problems at this point.
- What is the impact on the workforce, patients, other departments and the organisation?
- What evidence supports your case and what should be provided beforehand?
- Do you have examples from elsewhere that support the change?
- What are the minimum standards that apply: standards of care, consultant contract, use of PAs, WTR?

**Negotiating**

- What is essential to agree at this point?
- What can you offer that are quick wins?
- What do you really want now and what do you want later on?
- Is there anything you can concede?
- Are there any variables that can be traded: ‘if the team does this, what can you give in return?’ Look for words that indicate a shift in position or offer.
- Prepare for questions from a variety of perspectives.
Agreement

- Clarify and summarise as you go, thereby capturing anything that is agreed as you go through the discussion.
- Remember that ‘yes’ is an agreement while ‘no’ means no, not maybe.

There can be no doubt that homework, preparation, political understanding and knowledge of what is possible and feasible are all important factors in a successful negotiation, and that management will be focused on improvements in service quality and provision priority.
6. Maintaining service standards

Tahir Mahmood

Introduction

Good, evidence-based clinical practice is rewarding and fulfilling, avoids complaints and litigation and is key to high-quality care.

Key points

- Working to high standards in service, training and professional life is the backbone of good, rewarding clinical practice and reduces the risk of complaints and litigation.
- Practising to established guidelines assists the provision and delivery of safe, evidence-based care.
- Guidance issued by the NICE/SPCERH/CNST/Welsh Risk Pool and locally agreed guidelines and patterns of care should be used to improve quality and efficiency.
- Good team work aids continuity of care, flexibility of practice and service efficiency.
- Maintaining and developing high personal professional standards and CPD is essential.
- Limiting practice to those areas for which a clinician is trained, while maintaining skills and areas of competence, is crucial to good, safe and fulfilling practice.

Higher standards lead to good-quality care, a better working environment, fulfilment and less stress. There is a misconception among management colleagues who regard clinical guidelines as patient management advice but do not realise their potential in the development of service standards to deliver high-quality care locally. Standards can also be used to benchmark services for regional and national comparisons. Service standards can be used to collect data to support evidence for revalidation, for service planning and to revise job plans to address issues of work–life balance. This chapter will examine differences between clinical guidelines and service standards and how they can be used effectively.

What are clinical guidelines?

Clinical guidelines have been defined as ‘systemically developed statements to assist practitioners and patient decision about appropriate healthcare for specific clinical circumstances’. ¹ Guidelines have also been described as ‘tools for making decisions in healthcare more rational for improving quality of healthcare delivery’.²

Guidelines in our specialty are produced by various authorities in the UK, such as NICE, the Scottish Intercollegiate Guidelines Network (SIGN), the RCOG and the relevant professional societies.
NICE has commissioned guidelines in obstetrics and gynaecology through the National Collaborating Centre for Women’s and Children’s Health, supported by the RCOG. The recommendations made in the NICE guidelines are mandatory for implementation in England and Wales within 3 months of publication but not in Scotland, where NHS Quality Improvement in Scotland (NHS QIS) takes a view and provides guidance to the Scottish government on resource allocation issues. For example, NHS QIS recommended adoption of the NICE guideline on caesarean section but, so far, has not recommended full implementation of the guideline on the management of infertility.

SIGN started publishing its cross-specialty guidelines (such as Antibiotic Prophylaxis in Surgery) in 1994. The obstetric guidelines in Scotland were developed by SPCRERH using SIGN methodology; the most popular guideline is The Management of Postpartum Haemorrhage, published in 2001, which has been used in a large number of obstetric units all over the UK.\(^3\)

The RCOG started publishing evidence-based ‘Green-top’ guidelines in 1995 and, at the time of writing, has published over 50 documents, as well as opinion papers and good practice series, all of which are freely available on the college website (www.rcog.org.uk). The most recently published guidelines also provide a list of auditable standards. Increasingly, guidelines also provide guidance on how doctors in training should be supported.

There is substantial evidence that guidelines of all types can help practitioners succeed in improving quality of care and efficiency. Implementing guidelines can reduce costs and clinical complications. If used properly, they can create a supportive environment among the clinical team. However, guidelines are only a tool: they are a means to an end, not the end in itself.

**What are standards?**

There are three types of standards but fundamentally they all overlap.

**Service standards** help to deliver an equitable and high-quality service in which outcomes can be compared. These are described in detail below.

**Training standards** are crucial. The Modernising Medical Careers (MMC) agenda proposes that service is delivered by trained doctors and not by doctors in training.\(^4\)

The new generation of specialists will be trained in less time and will be ‘fit for purpose’. Therefore, training standards within a framework of service standards need to be developed to fulfil this objective. PMETB wishes to ensure that the needs of persons undertaking postgraduate medical education and training in the UK are met by the standards it establishes. The PMETB publication on generic standards provides further guidance, as follows:\(^5\)

- trainees must be appropriately supervised according to their experience and competence
- those supervising the clinical care provided by trainees must be clearly identified, competent to do so, accessible and approachable both by day and by night and with time for these responsibilities clearly identified within their job plan
- working patterns and intensity of work by day and by night must be appropriate for learning: neither too light nor too heavy
- trainees must be enabled to learn new skills under supervision, for example during theatre sessions, ward rounds and outpatient clinics.
It is important for service planners to acknowledge that service standards are intimately linked with training standards. Clinical services are not delivered according to a textbook description. There are variations in clinical presentation, management and outcomes that should be understood and to which trainees need to be exposed during their formative years. This can be achieved only when the relationship between service and training is clearly understood.

**Professional standards** ensure that clinicians are delivering appropriate care, that they are up to date with their CPD and, in future, that they fulfil the criteria for recertification. Clinicians require dedicated time for CPD activity and this should be clearly recognised in the job plan. It is equally important that colleagues working LTFT are not marginalised when SPA allocation is being agreed at annual job planning reviews.

A high-quality service can be delivered only if all elements of the jigsaw around these three types of standards fit together to allow appropriately trained doctors to deliver a clinical service and to ensure that doctors in training are well supported. It is also imperative that the job planning process adequately reflect these requirements.

**Service standards**

Service standards are the most crucial standards of all and will be the focus of the rest of this chapter. Guidelines provide the evidence base for the development of service standards.

The RCOG has described service standards and includes a training element in its definition: ‘standards of clinical care which the College would expect units and hospitals to adopt in relation to the quality of patient services, training opportunities and participation in national data gathering of relevance to clinical accountability and effectiveness’.\(^6\) However, of late it has been suggested that ‘Service standards should provide a clear description of what a high-quality service looks like so organisations can improve quality and achieve excellence. They should support benchmarking of current performance against evidence-based measures of best practice to identify priorities for improvement’.\(^7\)

The purpose of setting clinical standards is about improving patient care and ensuring it is equitable and safe. Commissioning is crucial to success. There is a plethora of documents published by various organisations that describe various strands of service provision, including *A framework for maternity services in Scotland* (2001)\(^8\) and the *National Service Framework for Children, Young People and Maternity Services in England* (2004).\(^9\) The latter was followed by *Maternity Matters* (2007),\(^10\) with a commitment to offer choice to every parent by the end of 2009.

The Department of Health’s quality initiative, *High Quality Care For All*, sets out an ambitious vision for making quality improvement the organising principle of everything that is done in the NHS.\(^11\) The quality improvement agenda will be underpinned by development of quality metrics and supported by Commissioning for Quality and Innovation. At a regional level, SHAs will measure a small set of metrics to benchmark organisations and to derive quality improvement. It is envisaged that, in due course, professional bodies and NICE will work together to develop these metrics in phase two.

Service standards also help to clearly address issues of risk management. There should be explicit arrangements in place to describe what special skills are required for provision of a certain type of clinical service, such as looking after high-risk obstetric patients in labour.
The National Patient Safety Agency (NPSA) collects information related to risk issues. NPSA data seem to suggest that a higher percentage of severe incidents occur between about 8 p.m. and 4 a.m., probably when consultants are not present, therefore justifying a local policy of risk reduction by supporting doctors in training according to their level of experience. Similarly, a number of reports have explicitly noted that:12–14

- there is a lack of senior input into the care of critically ill women
- there is evidence of substandard care in over 77% of intrapartum deaths among neonates
- direct consultant involvement in the management of near-miss cases makes a significant difference to clinical outcome.

CNST carries out inspections of maternity services by using process-based standards derived from RCOG guidelines to accredit units. Different grades are used to assess their level of risk and liability. CNST follows an incremental approach by regularly reviewing its evidence base for standards of care. For example, until 2008, one of the CNST standards stated: ‘that all maternity units to provide evidence that there was 40 hour consultant presence in the labour ward’; however, the required evidence did not stipulate the arrangements when an individual consultant was on leave. This essentially meant that during periods of annual leave, another consultant could be providing labour ward consultant cover while undertaking another clinical activity such as an operating list or an outpatient clinic. CNST has now revised this standard for inspections taking place during 2010 by clearly stating: ‘evidence to support 40-hour labour ward consultant presence with prospective cover arrangements for annual/study leave’.15 This example clearly demonstrates that the RCOG should proactively influence healthcare regulators to ensure that standards are continuously developing and remain dynamic.16

The Care Quality Commission (previously called the Healthcare Commission) has responsibility for the quality assurance of services. This organisation monitors national standards of services under seven domains, namely safety, care environment and amenities, clinical and cost effectiveness, governance, patient focused, accessible and responsive care and public health.

The Healthcare Commission carried out a detailed inspection of all the maternity units in England in 2006/07 and a comprehensive report was published in January 2008.17 This report for the first time compared units in England against 660 agreed standards and identified deficiencies in the provision of patient-focused care. Such a benchmarking exercise is a welcome initiative and encourages commissioners of services to address solutions to the service gaps identified in the report.

The RCOG has a major role in setting standards. Towards Safer Childbirth (1999) recommended that ‘as a minimum all medium–large sized maternity units should ensure 40 hour consultant presence in the labour ward’.18 This was an important initiative and more than two-thirds of units have so far managed to meet this standard. This document also recommended that ‘units looking after women with complicated pregnancies and those units delivering more than 6000 women per year should move towards a 24 hour consultant based service’. This recommendation has now been reiterated in the 2007 publication Safer Childbirth, with a clearly defined timeline for implementation.19 Some colleagues have viewed such an ambitious statement with scepticism because managers and the public would be expecting senior doctors to work longer hours to meet the standards set by the RCOG. However, it has to be recognised that the nationally agreed consultant contract recognises ‘provision of emergency care as a priority’. It is plausible that this could be a good starting point for negotiation of a new job plan, not only for provision of consultant presence on-site but also to address issues of work–life balance in our specialty.
The RCOG was the first professional organisation to publish its document on standards of care: Clinical Standards: Advice on Planning the Service in Obstetrics and Gynaecology was published in 2002, describing 12 standards for core areas of service. This document was well received by clinicians as they could use it to engage with managers to seek additional resources to develop services to meet the standards. In Scotland in 2003, SPCRHE carried out a national audit of service provision for early pregnancy care in which the performance of 18 units was benchmarked anonymously.

The Council of the RCOG recommended that the Clinical Standards document be developed to take account of evolving evidence. This time the working party’s membership included clinicians as well as representatives from the NHS Confederation, Healthcare Commission and consumers. Two separate working parties were established to critically analyse all new evidence and information. This initiative led to the publication of two documents in 2008: Standards for Gynaecology, which comprises 20 standards, and Standards for Maternity Care, which encompasses 30 standards of care from prepregnancy to postnatal care. The key principles described in these documents should be implemented in the routine clinical practice by using the RCOG solution based publications: Models of Care in Women’s Health (2008) and Models of Care in Maternity Services (2010). These standards provide succinct indicators that can be easily used for local audits and service developments. Furthermore, a clinical governance tool, the Maternity Dashboard, was launched in 2009 to address issues related to risk management in maternity services. The Standards Department of the RCOG has also published good practice advice on Responsibility of the consultant on-call and Gynaecology: emergency services – standards for practice and service organisation.

Service standards should be used in service planning

Service standards should help to identify issues related to workforce recommendations to implement standards published in Safer Childbirth recommending ‘consultant on site presence in labour ward for 60 hours per week in all units delivering > 2500 women by 2010’. To implement this recommendation, each unit needs to identify a minimum of 15 PAs as direct clinical care PAs in the job plans of existing consultants. These calculations should also take account of consultants’ annual/professional leave to ensure that having a labour ward consultant on-site remains a priority. Similar principles apply to larger units where a 98-hour or 168-hour consultant presence will be stipulated in the near future. A key principle is to ensure that the labour ward presence remains a priority in job plans. Once a gap in service provision to sustain elective activity has been identified, a case should be made for additional consultant appointments in the unit.

The management of early pregnancy problems has been revolutionised following the establishment of early pregnancy units all over the UK as most of the care is now delivered on an outpatient basis. The diagnosis and management of ectopic pregnancy is challenging and doctors in training do require senior input. Women need to be counselled about the management options and it would be prudent if all suitable cases of ectopic pregnancy could be managed either laparoscopically or medically. This could only happen if such an activity and time spent by consultants were recognised in job plans.

These service standards should also address issues related to risk management so a senior doctor’s presence and involvement is guaranteed for the management of complex clinical cases as part of direct clinical care, such as direct involvement of a consultant obstetrician in a caesarean section for placenta praevia, especially one with a possibility of a placenta accreta or percreta. The RCOG good practice advice on Responsibility of consultant on-call explicitly lists clinical emergencies where the consultant should always attend, such as eclampsia, maternal collapse, major postpartum haemorrhage and return to theatre for laparotomy.
These standards will also support delivery of the new postgraduate curricula to meet the standards set by PMETB: ‘Sufficient practical experience must be available to support acquisition of competencies as set out in the curriculum’. This can only happen when there is increased senior input with night-time work, especially in larger units where clinical activity continues around the clock with no differential in day- or night-time work. Responsibility of consultant on call clearly recommends that ‘the consultant should have no clinical duties on the following morning/day depending on intensity of the workload’.

Service standards are extremely important for job planning

The working environment of medical professionals is continuously being challenged by the ever-changing demands of service and the short-term objectives of meeting targets. The RCOG must ensure that the strategic direction of changes in the NHS does not impinge on the delivery of a high-quality service by dedicated professionals. Service standards based on sound clinical guidelines must ensure that we safeguard patient safety. Equally important are colleagues’ professional interests and work–life balance so that we can all fulfil our duties and responsibilities without undue stress and pressure.

It seems likely that greater consultant involvement will lead to better organisation and enhanced clinical decision making. From the obstetrician’s point of view, it is far more acceptable if night work commitment is formally recognised as a direct clinical care PA in the job plan.

The new consultant contract also recognises the importance of night-time work but does not yet encourage the on-site presence of a consultant. With the changing nature of the new workforce in training, it is important that seniors are not exposed to the risk of chronic sleep deprivation as they will be expected to continue to provide support for trainees with full clinical commitments on the following day. The principles of the WTR apply equally to seniors as to trainees. The duty rota for seniors should explicitly take account of work–life balance issues.

The RCOG service standards should provide strong ammunition in rationalising acute obstetrics and gynaecology and also provide higher-level expertise in managing high-risk pregnancies to improve outcomes and enhance training opportunities.

Suggestions and implementation strategy

- Service standards should be discussed and implemented in partnership with key stakeholders.
- The impact of implementation needs to be discussed fully within the team to assess the effect on clinical activity, work–life balance and disruption of elective services, which would justify additional resources.
- Change will have to be led by a clinical team leader who will negotiate appropriate resources. This encompasses assessment of all key elements of personnel management – staffing levels, job descriptions, updating training, competence assessment, CPD – as well as making recommendations for future developments.
- Each unit should quantify its own implementation strategy, taking account of its workload, level of middle-grade staffing and the level of consultant input required to implement service standards, as described in the RCOG standards documents.
- To implement service standards, we must ensure that a total quality management approach is developed and that all outcome measures are regularly collected to demonstrate evidence of enhanced quality of care and to ensure a strategy of continuous
improvement is in place. By setting up such a monitoring system, each service unit can contribute towards national benchmarking, recertification and, in due course, service accreditation.

References


Introduction

The demands of training and subsequently the pressures of a career in obstetrics and gynaecology impact on home and work life. Different family commitments and roles outside work have to be matched with new and changing styles of service delivery and evolving working duties. Advancing years of experience are often associated with increasing responsibilities. Such roles often require additional training, support and appraisal. The increasing time commitments and demands of these extra or alternative roles need to be considered and job plans adjusted accordingly.

Key points

- Harmonisation of changing roles and responsibilities at home and at work over a career requires careful consideration and management.
- The increasing need for, and time commitments to, modern training and assessment must be supported.
- As roles and responsibilities change, appropriate time (and/or remuneration) must be allocated through the negotiation of job planning.
- CPD should be used not only to improve clinical care but also to develop knowledge and skills in other areas of career progression.
- Clinicians with the appropriate aptitudes should be encouraged, trained and supported in taking on increasing roles in management.
- Responsibilities within the wider NHS should be encouraged and supported.

Consultants are in post for an average of 30 years and, while moving from post to post at consultant level is becoming more common, most will stay in the same unit for the duration of their time as a consultant. In the early years there is always an emphasis on clinical activity as new specialists refine and develop their clinical skills. Later they will take on other responsibilities, including an increasing number of management and professional roles. However, underpinning all this, from the earliest days all the way through to retirement, will be a commitment to clinical governance, CPD and teaching and training. Although traditionally consultants have worked as individuals providing a service, this is also changing with the move towards flexible working patterns, multidisciplinary team work and clinical networks. It is anticipated that revalidation will encourage the evolution of roles and responsibilities.
Twenty years ago, most consultants in our specialty worked as generalists providing a service in both obstetrics and gynaecology. More recently, it has become clear that the majority are working within a specialist area and most have changed and developed their clinical interests as they have matured into their role. Most new consultant posts will have a job plan consistent with 40 hours of work with six or seven clinical sessions. In addition, time is allocated for on-call and for SPAs, which include teaching, audit and CPD. Within the post the consultant will need to assimilate the following:

- teaching and training
- management responsibilities, including service organisation
- CPD
- clinical governance.

Teaching and training responsibilities

Teaching and training have always been very rewarding parts of the consultant role. In recent years, however, there have been major changes to the training programme and also to the training role of the consultant. MMC and the subsequent development of a run-through training programme have seen the introduction of a training programme centred much more around the needs of the trainee rather than those of the service. Trainees now have dedicated training sessions and follow a structured training programme. The apprenticeship model so familiar to the current cohort of consultants has gone, partly as a result of the reduction in hours and the introduction of shift patterns of working. With the introduction of MMC, trainees enter training in their chosen specialty after 2 years in the foundation training programme. They will then, assuming satisfactory progress through specialty training, emerge 7 years later with a certificate of the completion of training and the prospect, but never the guarantee, of a consultant post. This competency-based training programme relies on the presence of consultants to directly supervise and assess the competency of their trainees in a much more formalised way than previously. As the need to provide direct patient care and the pressure to meet targets increases, it may be that not all consultants will have the time to teach. In the future, it is very possible that not all consultants will have teaching or training responsibilities.

However, the role of consultants within the new obstetrics and gynaecology training programme is crucial. As consultants develop within that role, those with a particular interest in teaching and training may work firstly as an educational and clinical supervisor, then as a College tutor, and then may wish to develop a regional role and then, possibly, a national role. The job descriptions of all of these posts have now been defined and are outlined below.

College tutor

This is a specialist post with responsibility for the day-to-day coordination of high-quality multidisciplinary education in obstetrics and gynaecology. The role of the College tutor is to conduct and oversee RCOG training and education in an individual trust. The responsibility for delivering that training and education lies with the trust, on behalf of and resourced by the postgraduate dean. The College tutor should oversee the provision of the specialist training programme and should also be involved with assisting the deanery in managing the appropriate components of the foundation programmes.
The RCOG recommends that 1.5 PAs be allocated to this role in an average unit with ten senior house officers and ten SpRs. This should be over and above the standard 2.5 PAs for SPAs. Given that this post will rotate, it is very likely that all willing consultants within a department will become a College tutor at some stage in their career.

**Training programme director**

This post carries regional responsibilities and usually lasts for 3 years. It is appointed jointly by the deanery (regional) specialty training committee and the postgraduate dean.

The training programme director is responsible via the head of school (formerly chair of the regional training committee) to the postgraduate dean for coordinating postgraduate training and assessment in the specialty. The training programme director will meet regularly with and advise trainees in obstetrics and gynaecology. Furthermore, it is the role of the training programme director to identify problems in training for discussion by the school board and to take part in the appointment of trainees. The training programme director sits on the deanery school board.

**Head of school – formerly chair of the deanery (regional) specialty training committee**

The deanery training committees have now been replaced by specialty school boards chaired by the head of the school board, who is responsible to the postgraduate dean for coordinating postgraduate training and assessment in the whole deanery (region) and to the RCOG for maintaining national standards of training. The chair is a joint RCOG and postgraduate dean appointment. The chair should meet regularly with and advise trainees in obstetrics and gynaecology and identify problems in training for discussion by the board. The chair is also responsible for the specialist registrar appointments process and for the running of the annual review of competence progression (ARCP) process.

**Regional college advisers**

The regional college adviser is an elected post. The regional college adviser acts within a defined geographical area historically linked to SHAs in England and Wales and equivalent organisations in Scotland and Northern Ireland. Within that area, the regional college adviser supports many areas relating to service, professional and clinical standards, including:

- the implementation and monitoring of standards
- the General Medical Council affiliate and responsible officers at trust level
- a specialty-specific advisory role to trusts and individual doctors where there are perceived problems with the structure and quality of a clinical service or the performance of an individual doctor
- the Centre for Maternal and Child Enquiries
- the development of new posts and approval of job descriptions for consultants and other non-career-grade doctors within their region
- the board of the deanery specialty training school or the specialty training committee as the RCOG representative, depending on the local governance arrangements used by the postgraduate deanery. The regional college adviser should represent the College in ARCP panels.
These responsibilities should be recognised by the provision of appropriate time and funding. Therefore, such work should be included in, and accepted as part of, the annual job planning process. The recommendation is that this work would equate to approximately one PA/week or more.

**Management responsibilities**

The clinical role of the consultant is very closely linked to management responsibilities. On taking up a new post, a consultant will usually assume responsibility for the management of their team in relation to clinics, operating, waiting times, clinical governance and health service targets. In addition, as consultants become more senior they will undertake responsibility for management roles within their directorate. There are now requirements for clearly identified leads for the labour ward, the gynaecology service, clinical governance including risk management, audit and guidelines. Changes to the training programme have been implemented to embrace and train for these responsibilities. There is also a recommendation that trainees undertake formal management training by going on a relevant health service management course. The clinical director leads a directorate and takes responsibility for the management of the service. The importance of management skills in the development of this role is increasingly recognised and supported by the RCOG. While not all management roles will be taken by the more senior doctors, and there is a good argument to strengthen the training of those who wish to work as clinical managers from completion of training, there has been a tendency towards the evolution of a consultant’s role into one that is more management orientated. These roles are often time consuming and stressful and have the potential to adversely affect work–life balance; they should not be considered just as add-ons. Appropriate time and remuneration must accompany these changes and be agreed through the annual job planning processes.

**CPD**

Consultants have a responsibility to maintain and develop their clinical skills and always to work within their level of competence. They will increasingly need to demonstrate that they are maintaining those skills and will in the future undergo a formal assessment of their competence to perform a practical procedure assessed as part of revalidation.

The RCOG has a long tradition of leadership and innovation in setting standards for obstetrics and gynaecology practice and ensuring that they are attained. The College has also refined and promoted the use of core logbooks for trainees, providing them and their trainers not only with guidelines but also with a means to assess both the trainee’s knowledge and whether they have the various practical skills required to become – and remain – a consultant. Participation in the RCOG CPD programme is mandatory: all consultants must complete the 5-year cycle and demonstrate the acquisition of credits confirming participation in local, regional and national meetings. A 2009 working party report, *Recertification in Obstetrics and Gynaecology*, reviewed the essential components for relicensing and recertification and it is almost certain that these will include, in addition to participation in a CPD programme, annual appraisal and multisource feedback.²

Maintaining competencies, CPD and high standards of care helps retain confidence and fulfilment. Increasingly, consultants will be required to demonstrate that they have maintained competence by auditing their personal clinical practice with numbers of procedures undertaken and complication and readmission rates. It will no longer be acceptable to have demonstrated competence in a particular procedure (such as forceps delivery) without needing to regularly
perform the procedure to demonstrate maintenance of skills. All of these issues are now being developed and formalised within the College’s work on revalidation and recertification.²

Conclusion

Career progression is a requirement of the consultant’s role. It is no longer acceptable to sit back once a consultant post is obtained. All posts are dynamic, subject to change and professional development, and consultants will be expected to demonstrate maintenance and development of their clinical skills as well as showing competence in teaching and management responsibilities where these have been allocated. Consultants need time, support and space to ensure their skills are maintained and they are adequately prepared for new responsibilities.

References


8. Issues in training, including less than full-time working

Melissa Whitten

Introduction

If obstetrics and gynaecology is to recruit sufficient trainees of high calibre, it is essential that a career in our speciality is seen to be attractive and fulfilling. Key to this is improving work–life balance throughout training and through work as a specialist.

Surveys have identified key areas that have required, and continue to require, attention to improve lifestyle during training.

Key points

- There should be departmental commitment to good rota organisation.
- Good support and supervision of trainees increases satisfaction and decreases stress.
- Mentoring should be established for all and should continue from recruitment to retirement.
- Local childcare support facilities are seen as essential and help to balance the calls of family and work.
- Flexibility in training and LTFT working help to enable the fulfilment of family demands and career development.

The recruitment and retention of junior doctors in acute specialties such as obstetrics and gynaecology relies on a number of factors, including the opportunity for entry, attractive and varied career prospects, a rewarding working environment and the ability to work in a manner that affords a good work–life balance.1,2 The expectations and aspirations of today’s medical workforce are such that decisions regarding career choice are not just about aptitude and interest in a particular specialty but what working in that specialty will mean at a personal level. The first report of the BMA cohort study of 2006 medical graduates identified ‘hours of work and working conditions’ as an influencing factor in career choice for 72% of all respondents, with one-third of doctors surveyed by this group ranking ‘work–life balance’ as the most important factor influencing their own career choice.3 A cohort of 1995 medical graduates followed by the same group found that 15% of respondents had changed their career pathway 10 years following graduation, with hours of work and working conditions again acting as key influencing factors.4 Considering obstetrics and gynaecology, of over 1500 students and junior doctors surveyed by the RCOG in 2005 regarding their perceptions of the specialty, one-quarter of those who expressed the view that they would be unlikely to pursue a career in obstetrics and gynaecology cited ‘hours of work and working conditions’ as the key
detracting factor. Recognising and addressing these concerns is paramount to any specialty wishing to achieve a productive and fulfilled workforce and is of particular importance when considering recruitment into the specialty, since medical students on attachment will quickly see how their immediate seniors work and train and indeed how their consultants manage their own work–life balance.

Within the medical student community, there is a widely held belief that obstetrics and gynaecology is a ‘busy’ specialty where you are up all night, and that this way of working persists throughout your career. In fact, with the implementation of the WTR, all junior doctors must now work within strict time limits; therefore, regardless of whether it is an acute or non-acute specialty, the actual hours of work for obstetrics and gynaecology are not different from those for any other specialty. However, achieving an optimal work–life balance in terms of the actual rota can be challenging; furthermore, getting the balance right between the number of working hours, the way those hours are grouped together and what a trainee is actually doing during those hours requires some consideration if training opportunities are to be maximised. This requires a motivated and committed rota organiser and senior support. It is of course important that students and junior doctors appreciate that a substantial part of obstetrics and gynaecology clinical care is acute and therefore, like other areas of medicine such as accident and emergency, surgery and anaesthetics, much of the on-call care is unpredictable. For many working within the specialty, it is precisely that unpredictability and variety that provides stimulation and fascination.

The working pattern for most junior doctors in obstetrics and gynaecology at present is a full shift system, containing split night shifts of three or four at a time. However, around 10% of juniors are still working seven nights in a row on-call, which might be described as the worst possible in terms of work–life balance, let alone in terms of patient safety. A preferred option would be to work one night at a time, preferably about once per fortnight, with guaranteed time off after this. So, when considering training within obstetrics and gynaecology, what can be done to ensure a good work–life balance? The Department of Health IWL survey identified among trainees in all specialties, at all levels, that support for education and training was the key factor that would improve the respondent’s working life in the majority of cases. Identifying and accessing training opportunities, especially within the constraints of shift working patterns, requires active support at local and regional (deanery) level. Robust educational supervision and the active engagement of all those charged with delivering training – and assessing performance – is essential if trainees are to progress smoothly through the curriculum for training in obstetrics and gynaecology.

In addition to the provision of education and training support, the IWL group identified that provision of mentoring was included within the top four factors cited by trainees at all levels. Within obstetrics and gynaecology, the RCOG recognised some years ago that changes in working patterns and the models of training within the medical profession as a whole can often result in a feeling of isolation and lack of support, and went on to establish guidelines for mentoring that can be used by and for all doctors working in the specialty. Local or regional initiatives to establish mentoring networks are being encouraged both for trainees and for consultants. Other factors cited commonly by respondents at all levels included the provision of non-clinical support, such as secretarial and managerial support, although this was more predominantly cited by consultant respondents. For SpRs, provision of childcare support was identified as the second most important factor overall and the most important factor for female respondents at this level. This was particularly evident among SpRs working in obstetrics and gynaecology and paediatrics, where there was a high proportion of female respondents (69% and 71%, respectively). At more junior levels of training, effective provision of clinical, non-medical support was ranked as third most important. Within obstetrics and
gynaecology there should be multiple opportunities to facilitate this, both within obstetrics with midwifery colleagues and within gynaecology with nurse practitioner leads, to create a truly multidisciplinary approach to practice.

In addition to all of the factors identified above, the opportunity to have flexibility in terms of career pathway and working pattern is becoming increasingly important too. The variety of clinical areas within the specialty and the opportunity to work across a number of different areas of practice is a key factor attracting medical students to obstetrics and gynaecology as a career choice. It is now a feature within the specialty that all trainees will experience practice across all areas within the core curriculum of training. Aptitude and interest often develop in particular areas of the specialty as training progresses; with appropriate career guidance and recognition of future service needs, trainees have a multitude of areas in which they can attain advanced training, building on the skills gained early on. For many trainees, taking time out from structured training programmes to gain out-of-programme experience, for instance by undertaking research or gaining experience overseas, can be valuable, and such experience is strongly supported by the RCOG. Opportunities to enter clinical academic pathways are equally supported, and initiatives such as the UK Clinical Research Collaboration academic clinical fellowship and lectureship programmes have afforded new opportunities within obstetrics and gynaecology. Later on in training the opportunity also exists for entry into subspecialty training programmes, with training focused towards the endpoint of working as a consultant within a narrower field of practice than that of the generalist obstetrician and gynaecologist.

Flexibility refers not only to the actual content of training but also to the time spent achieving training. Opportunities to train and work flexibly, or LTFT working, are important to increase the number of doctors exiting medical school and those already working in the profession. The BMA first cohort study of 2006 graduates identified that one-third of doctors indicated a desire to train flexibly, with almost half of female respondents expressing a desire to spend at least some time training flexibly. The reasons behind this included family commitments, achieving a satisfactory work–life balance and pursuit of non-medical interests. Similarly, in the IWL cohort study, access to flexible or LTFT opportunities was particularly highlighted by SpRs in obstetrics and gynaecology, paediatrics and medicine, and among anaesthetic consultants. The 1995 BMA cohort study found, by the time of the tenth report, that 75% of the cohort were either already working LTFT or wished to do so in the future, and over the period of 3 years from 2001 to 2004, the proportion who were actually working LTFT had more than doubled, from 13% to 30%. Within obstetrics and gynaecology, the medical workforce statistics for 2008 showed that just under 7% of SpRs were training LTFT (75 of 1138). With the proportion of female trainees within the specialty increasing (currently 64% at SpR level for UK graduates), it is likely that this proportion will increase. A desire to train LTFT is not exclusive to female trainees: both male and female trainees cited a desire to practise LTFT as a consultant in both the IWL surveys and those carried out by the BMA cohort groups and the RCOG. Unfortunately, supply does not always meet demand, and the RCOG, through its LTFT Office, has identified that not all regions currently offer the opportunity to train flexibly. Trainees wishing to work LTFT are strongly encouraged to register their intention with their deanery so that deanery records reflect demand appropriately. The RCOG is committed to improving access to LTFT training opportunities and recognises that this is key to providing many of its current and potential trainees with a framework in which they can progress through training and on into their consultant working lives, while achieving the satisfactory work–life balance that they quite rightly deserve.
References


9. Conclusions and recommendations

Allan Templeton

Recruitment and retention have been major problems in obstetrics and gynaecology, although it is true that the situation has improved in recent years, with complete fill rates and high retention for training posts. Nevertheless, it is recognised that the specialty is hard pressed, with increasing pressures coming from the need for a presence in the labour ward, active involvement in emergency care and out-of-hours obstetric practice. There is evidence that obstetrics and gynaecology has paid less attention to matters of work–life balance than some other specialties, and that this in itself has contributed significantly to perceived recruitment problems. To maintain the renewed interest in the specialty, particular attention must be paid to this issue, which is the purpose of this report.

It is clear that a number of models of care have now evolved and are still evolving that will go some way to addressing conflicting needs, namely the need for an increasingly consultant-led service and consultant presence, while at the same time maintaining an adequate work–life balance. No one model of care suits all and it is clear that the best approach is to adapt and develop models that fit particular needs, depending mainly on factors such as workload and senior and junior staff complement, as well as achieving appropriate standards of care and developing best practice. Possibly the major factor in all of this is the requirements of the WTR. Furthermore, the ability to work in teams and to establish appropriate relationships with colleagues is increasingly paramount. It is clear that working with colleagues is central to the provision of high-quality services, and that this area in the past has been both a source of difficulty and discontent and a major source of satisfaction in professional life, where successful teams have been established.

The reorganisation and reconfiguration of all clinical services in the UK is already under way, not least in obstetrics and gynaecology. Often this will provide an opportunity to improve work–life balance and to develop supportive team structures. Here the value of support staff, particularly personal assistants and secretaries, cannot be overestimated.

Shift patterns are undoubtedly disruptive to team work and training, but nonetheless this pattern of working will feature as a major response to the WTR – not just for trainees and not just in obstetrics. The threat posed by independent treatment centres appears to have receded in the new NHS, so concerns about training opportunities being further diminished do not appear to have been realised. Examples of models of care related to workforce requirements are spelled out in more detail in the 2009 RCOG publication *The Future Workforce in Obstetrics and Gynaecology. England and Wales*.¹

We have now had the new consultant contract for 6 years, but it still seems that any renegotiation to meet specialty-specific needs is unlikely. For the moment we must work within the current contract and make the best of the opportunities available to obstetricians and gynaecologists within the job plan negotiation. In supporting the new contract, the view of the BMA has always been that there is sufficient flexibility within the job plan to address specialty-specific needs, even those of the hard-pressed specialties. Concerns that foundation trusts,
which do not have to keep to national agreements, might set their own terms and conditions again do not seem to have materialised, but it is early days and this needs to be kept under review.

Predictable on-call duties should be covered in the job plan and should include an allocation for prospective cover for colleagues. Allocation for unpredictable on-call work should not normally exceed an average of two PAs/week.

Although negotiation of the job plan is for the individual, this discussion can be strengthened if colleagues can agree as a team to allocate and cover the workload. Increasingly, the job of the consultant is not just to see patients but also to ensure the delivery of the service; appropriate time allocation should be recognised for this in the job plan. Acceptance that we are moving to a consultant-based service and that consultant presence (not just cover) is required will lead inevitably to living in when on-call in the bigger obstetric units. However, whether living in or not, on-call should be recognised with appropriate time off for rest and recovery. The WTR will help to ensure that this happens. If the on-call commitment can be optimised, it should allow for flexibility and remove the sense of a hard-pressed specialty that is so clearly a deterrent to recruitment of otherwise able and interested doctors. Furthermore, there is no obligation to work more than ten PAs if not undertaking private practice, and although there is still no obligation to be resident on-call at night, it is understood that such responsibilities should be appropriately recognised and shared among the team in a way that enhances the work–life balance of all colleagues. Thus, if the terms and conditions are attractive, which we now have the opportunity to ensure, and if the time off to recover is appropriate, there may be less justification not to continue to perform out-of-hours work on-call throughout a career. However, it has to be recognised that the effect on daytime activity is likely to be considerable, and the importance of other approaches such as annualisation needs consideration and discussion within the team. It is already apparent in many units that although consultants are not living in, they are so busy during the night that the issue is irrelevant as they are already in the hospital for much of the time on-call.

Consultants who choose ten PAs will have a day off per week in lieu of on-call activity. This report contains the commendable account of how one sizeable hospital is grappling with the issues and balancing the increasing need for consultant presence on the labour ward for 24 hours per day, as well as meeting the requirements of the WTR, with improving the working conditions and work–life balance of colleagues (chapter 4). It is clear that this needs team work, commitment and an agreed approach to job planning. If the sessions and staff do not add up, the case for additional resource needs to be made, with the arguments and facts laid out clearly.

The role of the clinical director or service lead then becomes crucial and it is clear that in practice they will need more training and support than is now taken up. These individuals have to be creative. They must champion the need for an individual’s work–life balance. At the same time they need to ensure service delivery is not just maintained and meets agreed standards but is at the same time developing. The importance of a continually developing service is increasingly recognised as one of the key factors in maintaining and improving standards of care.

The importance of securing understanding and support for the service, as well as being creative within the rules, is crucial. Successful negotiation with management must justify the need for change, as well as justifying the case for additional resources where needed to meet service agreements and maintain clinical standards. Much of this may not be fully understood by the management team. At the same time others within a department will have particular responsibility for maintaining training and education and ensuring standards are met in this respect,
and all consultants will have responsibility for developing their own professional standards, something that must be supported and accommodated by the department or service as a whole. The complexities of change and the myriad recent initiatives instigated by the health service, the effects of which have not always been well thought through, have been some of the great difficulties of recent times, although it is recognised that many had quality of care and patient safety at their core.

In obstetrics and gynaecology much has been achieved in synthesising a huge amount of work, reports and literature to produce two guiding texts: Standards for Maternity Care\(^2\) and Standards for Gynaecology.\(^3\) These are as relevant as any documents to service provision, planning and development and hence are relevant to job planning, particularly for the increasing number of consultants taking on a clinical service delivery role.

Many consultants, once established in their clinical role, will wish to take on additional responsibilities in teaching, management and clinical governance and it is crucial that such roles are recognised as contributing to the overall work and responsibilities of a department. Again, the job plan should be used to ensure that adequate time is allocated and recognised within the total number of PAs available to any department or team of consultants.

Similarly, it is likely that with an increasingly female workforce, more consultants will wish to work LTFT, perhaps to meet family or other responsibilities. This aspect of achieving a work–life balance must be recognised if able contributors are to be kept in the specialty. Improving Working Lives\(^4\) identified that support for education and training was crucial for trainees, while mentoring has been identified as a key issue for both trainees and consultants. Flexibility in training and in work patterns is crucial for a particular section of the workforce, but less rigidity and the use of the tailored job plan will enhance the lives of all in the workforce.

It is important that the specialty continues to work to support and enhance the lives of obstetricians and gynaecologists. As a specialty we need to be more frank and open about the sources of stress and discontent and to address them either through College initiatives or by directing colleagues to national support systems. There have been a number of excellent initiatives within the College, but we need to think more about how we might develop these and support fellows and members throughout all aspects of their career. Much of this will be about supporting the consultant in the workplace and recommending, for example, adequate secretarial and IT support. However, much work will be about understanding outside commitments, including family commitments, more effectively. These commitments must be recognised in job plan negotiations, even to the point of supporting LTFT working for particular phases of a career as circumstances change and outside responsibilities increase or decrease.

What much of this boils down to is that obstetrics and gynaecology is not just seen as, but actually is, a hard-pressed specialty with considerable on-call and out-of-hours commitments, and that in the past this has been seen as a deterrent to recruitment and in some cases retention of able doctors, most of whom would otherwise be committed to the specialty. Things have to change for this reason if for no other. Work–life balance features as a major issue in all recent surveys of medical students, trainees and young doctors. We must strive to ensure that all young doctors view obstetrics and gynaecology as a specialty that provides professional fulfilment within the context of an attractive work–life balance. This will happen only when potential recruits see their mentors put this into practice themselves.

Appropriate recognition of out-of-hours care with adequate rest and leave following such commitments is one essential component. There are, however, other issues that need proper recognition, the opportunity for which is provided at the annual job planning interview. These issues, including the recognition of non-clinical activities and of other commitments outside the
job, have to be recognised in the job plan negotiation to offer as much flexibility to meet individual needs as is compatible with the delivery of the service and the meeting of clinical commitments. Therefore, it is crucial to have an informed doctor, supported by the team and the department, who is in a position to negotiate a job contract that meets individual needs within the contract and service requirement. However, it is crucial not only to the individual: it is the key to improving the actual and perceived work–life balance and hence the future vitality of the specialty.

References


Appendix 1

The identification and management of stress

Normal levels of adrenaline and cortisol are required to cope with the general pressures of life. When pressures and demands are excessive or prolonged, stress occurs. Stress often develops insidiously and its ill effects may initially go unrecognised. Stress is, however, damaging to health and costly for work.

It is estimated that stress in the workplace costs the UK over £1.24 billion/year. Over 11% of absences amounting to 105 million lost working days per year are attributed to stress.

Doctors are exposed constantly to risks, including stress, alienation, over-involvement, automatic behaviour and burn-out. The medical profession has until now been in the paradoxical position of needing as much support as any other group of professionals (if not more), but generally getting less.

While stress may affect anyone, when it is admitted to it is often perceived as a personal weakness. Stress, however, often affects those with high work principles and those who are very conscientious. The results of stress can accumulate and may cause significant physical, psychological, emotional or behavioural problems.

Pressure itself is not bad. In fact, many thrive on it. However, when pressures exceed a person’s ability to cope, that is when the problems of stress may start. It follows, therefore, that stress can be tackled either by reducing pressures or by increasing coping resources – or by a combination of the two.

The recognition of stress and, where possible, the use of the job planning process to address specific areas are important to maintain a satisfying and achievable working environment. Self-referral to either a general practitioner or an occupational health doctor is an important and frequently discerning step.

The website of the International Stress Management Association (http://www.isma.org.uk/about-stress/questionnaires-and-downloads.html) is a particularly good resource for facts on stress and the identification and management of stress:

- access to a stress questionnaire
- ten top tips for stress-free living
- how to stay calm under pressure.
Appendix 2

Academy of Medical Royal Colleges Advice on Supporting Professional Activities in consultant job planning

Reproduced with permission from the Academy of Medical Royal Colleges. It is a statement and, as such, is subject to review and change. The document reflects the opinion of the Academy of Medical Royal Colleges as at February 2010.
Advice on Supporting Professional Activities in consultant job planning

The Academy of Medical Royal College’s understanding of Supporting Professional Activities (SPAs) is that they reflect time spent undertaking teaching, training, education, CPD (including reading journals), audit, appraisal, research, clinical management, clinical governance, service development etc; activities that are essential to the long-term maintenance of the quality of the service but do not represent direct patient care.

SPAs should not include major additional NHS responsibilities such as those of a Medical Director or Clinical Director, training programme director or Postgraduate Dean. SPAs should not include agreed external duties such as acting as an examiner, peer assessor, College/DH/GMC work etc.

This matter lies partly in the realm of negotiations of terms and conditions of service, which is a responsibility of the British Medical Association (BMA) and the Hospital Consultants and Specialist Associations (HCSA) and is outside the remit of the Medical Royal Colleges; but it also impacts directly on maintaining and improving the quality of the service, which is a direct and legitimate interest of Medical Royal Colleges. Many Royal Colleges have managed this problem simply by referring to the recommendations made in the Consultant Contract as negotiated between the BMA and the Department of Health. This recommends 2.5 SPAs in a 10 Programmed Activity (PA) contract, with a higher proportion of SPAs for those working part time. Some Colleges have taken this as a recommendation that 2.5 SPAs should be a minimum. Others have taken 2.5 SPAs to be an appropriate average across a department, with some consultants having slightly more SPAs and others slightly less. In this context it is important to note (as explained above) that those with heavy managerial workloads should regard their managerial work as ‘additional duties’, not as SPAs.

It is difficult to produce specific guidance on an appropriate number of SPAs on the basis of the area in which the Colleges have a legitimate interest; that is, maintenance of service quality. This is not only because the demands of different jobs differ, but also because of a genuine lack of information on how much time a typical consultant needs to monitor, maintain and improve his or her standards of practice.

The uncertainty is exacerbated by the introduction of medical revalidation. The process of revalidation, and also the work that underlies it (e.g. Continuing Professional Development, audit, multi-source feedback, patient feedback, critical incident review etc.) is all work that has to be accommodated within SPA time. There is consensus that the introduction of revalidation will result in some increase in time spent in such work, but the size of that increase is unknown. One of the purposes of the revalidation pilot schemes (taking place in 2010 – 2011) is to get a better estimate of this requirement; but even these pilots will generate no more than an estimate. Consequently any current recommendation of SPA requirements
A temporary estimate; it will be necessary to review this when the impact of revalidation is better understood.

However, such a review may result in difficult discussions and negotiations, especially in the current financial climate. The Colleges are concerned that they should not be drawn inappropriately into negotiations of terms and conditions of service. Consequently we recommend that despite the current uncertainty any estimate of SPA requirements should include some allowance for the introduction of medical revalidation.

At present, before the introduction of medical revalidation, those Colleges that have estimated the minimum time required solely for a consultant to keep up to date have suggested 1 SPA or 1.5 SPAs. This does not include the agreed annual study leave allowance.

In view of the uncertainty around revalidation, discussed above, the Academy therefore proposes that the minimum number of SPAs allowed for this purpose should be 1.5 per week, not including annual study leave.

However, a contract that includes only 1.5 SPAs and 8.5 Programmed Activities would have no time at all for other SPA work such as teaching, training, research, service development, clinical governance, contribution to management etc. It is unthinkable that a consultant could be employed with absolutely no involvement in management, if only attendance at departmental meetings, reading and responding to messages from management etc. Similarly it is difficult to envisage a post that never involves any teaching or training of any sort; most NHS employers receive funding for undergraduate and postgraduate teaching and should be able to explain how this is used. A post that does not permit any involvement in service development or clinical governance would be contrary to our concept of the consultant role. From this it follows that 1.5 SPAs in total would be inadequate and that the original recommendation in the Consultant Contract of 2.5 SPAs as typical seems reasonable.

We have noticed a trend for newly appointed consultants to be offered a contract with considerably fewer SPAs than this, along with a verbal promise that the number of SPAs will be reviewed annually as part of the job planning process and will be increased if the increase is justified. It is argued that new consultants typically have less involvement in management and teaching than their more experienced colleagues. We regard this as inappropriate for four reasons:

- It places the onus on a new and inexperienced consultant to argue subsequently for a change in the job plan merely to achieve what has been agreed nationally as a reasonable number of SPAs. Reallocating clinical sessions to colleagues is usually difficult.
- This manoeuvre eliminates the previous agreement that there should be input from the relevant Royal College into the design of the new consultant’s job plan, unless the College is also involved in the subsequent review; we are aware of no instances where employers have invited such involvement.
- New consultants should be encouraged to get involved in clinical innovation, management, teaching and training not discouraged.
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- A new consultant is likely to need additional time for orientation and being mentored in the new role, and may need additional CPD to develop any specialist aspects of the post that were not adequately covered by training to CCT level. This would require more SPA time, not less.

On the basis of this analysis we make the following recommendations, which will be subject to review as our experience of medical revalidation accumulates.

1. New consultant posts should continue to be advertised with a job plan which typically includes 2.5 SPAs, with an expectation of annual review.

2. If a consultant is employed with 2 or fewer SPAs, any problems with revalidation should lead to an urgent review of the SPA allocation.

Neil Douglas
Chairman
Academy of Medical Royal Colleges
8 February 2010