Tomorrow’s Specialist

To describe how tomorrow’s specialists will work in teams delivering high quality women’s health care, and to propose innovative and rewarding ways of working for tomorrow’s specialists, embracing training, lifelong learning and professional challenge.
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Working Party report

September 2012
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Chair’s introduction

It has been a pleasure to chair this Working Party on the future of the specialty of obstetrics and gynaecology. We have been grateful for the wisdom, diligence and intellectual rigour contributed by the members of the Working Party and the officers and support staff of the Royal College of Obstetricians and Gynaecologists (RCOG). Professor Wendy Reid, in particular, has been unfailing in her determination to reflect the views of the Working Party in the report and we appreciate the immense amount of work she has put into it.

In recent years, the College has taken the view that obstetricians and gynaecologists can no longer be – indeed should no longer be – a largely hospital-based discipline dealing essentially with the treatment of illness in women and the safe delivery of their babies.

Instead, obstetricians and gynaecologists should be involved in all stages of a woman’s life, actively promoting healthy lifestyles and the prevention of illness, while taking advantage of changes in technology that allow more care, screening, diagnosis and advice to be delivered closer to home rather than in the hospital setting.

This is an important and dramatic change. It takes place against the background of what is likely to be a long period of constrained growth in health spending, and thus one in which the affordability of services and the value they deliver – the outcomes achieved for each pound spent – will be ever more critical.

That, in turn, will mean that patients, the public and the NHS itself will require more flexibility in the roles of specialists and their responsibilities, and over where and when care is provided. Support for this change was evident across the spectrum of evidence received by this enquiry from patients, the public, the profession and the NHS. We are in no doubt that, although leadership from the top is essential, the real change will come from those working with patients and the public, members and fellows of the RCOG, and their teams.

This has big implications. Specialists – obstetricians and gynaecologists who have achieved their certificate of completion of training (CCT) and are thus qualified to become NHS consultants – will be appointed to teams of specialists in which their roles and responsibilities will change over a career. It will be a career that will see them working in the community as well as in hospital, with continuing professional development, and over longer working lives. Importantly, they will also be working closely with other healthcare professionals.

The College is adamant that the obstetric delivery suite needs fully qualified specialists available at all times, 24 hours a day, 7 days a week – more than half of all births, after all, take place ‘out of hours’. That requires the employment of more specialists, which raises the issue of affordability. This, in turn, may well mean fewer acute obstetric units, so that for the more specialised obstetric care women may have to travel further as the service applies the logic that care should be ‘localised where possible, centralised where necessary’.

More care delivered by fully trained staff, however, will mean less service being delivered by registrars – qualified doctors who are completing their training in the specialty. With more fully trained specialists, however, more of the time of registrars when on duty can be spent learning rather than simply providing service. And given that, at 7 years, training in obstetrics and gynaecology is already long compared with other European countries, in turn that should lead to either fewer registrars or shorter training, or both. Such changes will help to address the affordability issue, while a much more specialist-delivered service should also lead to lower insurance premiums for clinical negligence and mishap as quality and safety rise. The changes may also improve affordability by reducing the length of stay in hospital. No doubt such changes will need to be introduced in a measured fashion and after further work on modelling the effects of the changes.
It is also crucial that all specialists receive sufficient academic training to allow them to participate in the research out of which service improvement comes. The College recognises that the clinical academics who will lead research in women’s health require tailored training according to their specialist interest so that their research and clinical training can be completed by their early 30s, the time at which they are likely to be most creative.

These changes combined should lead to a better, safer and more preventive service for women across their lifetimes. They should also provide doctors with a more varied and stimulating career in which the opportunity to achieve excellence should arrive earlier but during which they will continue to learn and develop, both in terms of their expertise and in terms of where and how they work. This is an exciting, challenging and rewarding prospectus that needs to be fulfilled.

Baroness Cumberlege CBE DL
Working Party Chair

Professor Sir Cyril Chantler
Working Party Vice Chair

September 2012
RCOG President’s foreword

Tomorrow’s Specialist looks to the future of service delivery and places the needs of women first. Uniquely, this Working Party canvassed the views of many non-medical organisations and public groups. The realisation that there is an apparent disconnect between the aspirations of women and the doctors caring for them is a salutary lesson for the leadership of the profession. Women are clear that they need ready access to specialists in most situations concerning their reproductive health. Doctors are consistent in supporting the evolution of specialist-based care, including, in most settings, 24-hour specialist presence on the delivery suite. The balance in workforce planning between subspecialties and the healthcare needs of most women needs urgent definition and alignment.

A continuum in time ‘from cradle to grave’ offers a novel opportunity to examine the life course of women in a model that shifts the emphasis from intervention with treatment to prevention of illness. Such a change in emphasis and philosophy of health care will require a revision in the way that our healthcare professionals respond to contemporary challenges, both in their approach to women and in the manner in which they provide care. Any changes to professional structures recommended must embrace the current economic constraints and provide evidence of appropriate cost benefits to the service.

The specialists of today in obstetrics and gynaecology were trained to be part of a hospital-based system that was consultant led. The emphasis was on producing individuals who, at the completion of accreditation, were able to deliver care in the majority of emergency and elective situations in a hospital-based setting. The working practices of today are unable to meet the changing demography of illness or to reflect the social fabric of our society and are not meeting the expectations of women. This situation is not sustainable.

Training methodologies are constantly changing to embrace new knowledge, required new skills and the expanding curriculum. Simulation training will become a fundamental way to train new specialists in the technical elements of the discipline, to improve patient safety and to counterbalance the lost exposure to certain procedures that are less commonly performed and hence not experienced in sufficient numbers through a reduction in training time. The need to acquire skills and competencies in working in different environments which meet the needs of women must embrace periods of work in the community and work with other professional groups. The community–hospital interface is the ideal environment in which to experience the strengths of multi-professional teamwork, which will become a central component of future working.

‘Flying solo’ has been the perception of independent consultant practice for years, sometimes to the detriment of patient care, safety and outcomes. The realisation that the care of women can be improved by working in pairs, teams and networks is the driver of today. The value of mentoring and active support for less experienced specialists is a strong component of this work and such relationships are two-way, with learning and benefits flowing in both directions.

Societal changes will mean that many doctors will work in specialist practice for between 30 and 40 years, although some may be in part-time work. Creating flexibility within the workforce is vital to delivering service, as is creating exciting opportunities for professional achievement and satisfaction for specialists throughout their working lives. Career opportunities and progression within the specialist grade, with an evolution or change in responsibilities throughout professional life, should be a profound stimulus. Revalidation is a reality for tomorrow’s specialists and this will result in a greater emphasis on outcomes and quality of care. Having training programmes within the specialist grade may facilitate specialists acquiring the skills needed for changing practice and the changing needs of women.

Acquisition of a certificate of completion of training (CCT) should be a stimulus to lifelong learning with an emphasis on quality improvement in delivery of clinical care and professional development. Such continuing professional development (CPD) should be individually targeted and embrace the
local healthcare needs of the population served. Postgraduate training must improve as new working patterns evolve and there are fewer trainees. Attainment of improvement in quality of training may allow the RCOG, with the regulator, to examine the length of time spent in specialist registrar training.

The RCOG has a principal obligation to provide safe care for women, usually defined by excellence in education, standard setting and evaluation of outcomes. Tomorrow’s Specialist addresses the challenges of today with a view to defining the processes necessary to nurture the next generation of specialists to achieve that laudable aspiration.

Dr Anthony D Falconer FRCOG
RCOG President
Summary of key messages

The need for woman-centred care is universally accepted. There needs to be emphasis on maintenance of good health, prevention of disease and community-based care. The concept of delivering women’s health care through a ‘life course’ model in comprehensive clinical networks demands a different kind of doctor in obstetrics and gynaecology. Patients, the public, the health service and healthcare professionals require more flexibility for those with specialist roles and responsibilities. The specialty must provide the leadership necessary to achieve this.

The Tomorrow’s Specialist Working Party has developed the discussion around, and produced a series of recommendations about, future services for women’s health care and the doctors necessary to provide high quality care. The need for these changes was clearly articulated in the evidence given by women, the profession and the NHS. There is a sense of urgency throughout this report, which reflects the need for rapid change within the service if women and their families are to have good, affordable health care now as well as in the future; the present structure and system of delivering care is unsustainable, as services remain disjointed and the focus of the specialty is on hospital-delivered procedures.

Women need a specialist workforce that is able to work in integrated clinical teams, providing care locally where possible. Services are not focused on quality at present, as care during the day is delivered by fully trained doctors but at night care is provided, largely, by doctors in training. The increasing trend towards specialist-delivered care over the past decade must expand so that more trained doctors (specialists) are employed to provide care for women with complex obstetric needs and gynaecological emergencies 24 hours a day, 7 days a week.

Although the safety and quality arguments are impressive, the issue of affordability needs to be addressed through the consolidation of services into fewer obstetric units supported by a network of maternity providers. Although many specialties support this trend (see, for instance, the Royal College of Paediatrics and Child Health’s recent (2011) publication Facing the Future), a specialist-delivered model does need to resonate with employers in the current challenging fiscal environment. The Royal College of Obstetricians and Gynaecologists (RCOG) must be able to describe models of care to employers as well as to obstetricians and gynaecologists. These models must clearly demonstrate how clinical teams of specialists would function, reflecting the intensity and quantity of work and their value, and being sophisticated enough to reflect variations in need from rural and isolated to complex, inner-city services. As the service reconfigures to ensure high quality care with the likely reduction in the number of units providing obstetric care 24 hours a day, 7 days a week, this, de facto, appears to limit women’s choice. It is important that the specialty provides the leadership to explain and justify such changes to the public on the basis of patient safety and quality of care.

The acquisition of a certificate of completion of training (CCT) means that the holder can be appointed to a specialist team. Tomorrow’s specialists will work differently: in teams with peers, providing on-site care 24 hours a day, 7 days a week, in non-hospital settings, as ‘localised where possible, centralised where necessary’ becomes the norm. Within such a team, the roles and responsibilities will differ and change over an individual’s career and may involve periods working in hospital, in the community or both as a member of the wider multidisciplinary team. Working closely with colleagues from other specialties and other healthcare professions is already an important component of a specialist’s work but will be even more vital as boundaries dissolve and professional and physical silos are eroded.

Specialists will, in part for efficiency and affordability but primarily to provide the highest quality care, drive the configuration of services within a network. The high quality outcomes seen in networks such as cancer care need to be replicated across women’s health. There needs to be local and political support for clinical networks in which services are linked and not replicated and where resources, including specialists, are focused where they can be most effective.
As more care is delivered by trained staff, there will be less service dependency on specialist registrars. In turn, this will mean that they will spend proportionately more time being supervised and learning. Given that the training period in the UK is long compared with other European countries, this change could lead to shorter and more efficient training programmes, with the number of specialist registrars reducing to be proportionate to the number of specialist posts available and a reduced need for doctors in non-training, low-grade service posts. It is vital, however, that the quality of care of women is not undermined by changes in the specialist registrar numbers as transition to a specialist-delivered service is managed.

Some units, particularly rural, isolated hospitals with small numbers of births, will need innovative models of care, as there is unlikely to be sufficient clinical activity for an entirely specialist workforce and they are less likely to have specialist registrars in sufficient numbers for full out-of-hours cover. Only by developing networks that are responsive to geographical and regional variation and that provide the totality of women’s health needs will quality and safety be improved.

Doctors of tomorrow cannot look at present practice and assume their own working lives will be similar, not least because the impact of new scientific developments and technology will be translated into clinical practice with increasing rapidity. Women and their families will access health care in a multitude of ways and have higher expectations of all their healthcare providers. Other healthcare professionals will have expanded roles and other providers will have an impact on traditional working practices.

The need for new skills in doctors delivering obstetrics and gynaecology was emphasised in written evidence and during extensive oral hearings. Building on the RCOG’s *High Quality Women’s Health Care* report, the Working Party has proposed a number of changes needed in the education and training of doctors in this specialty that continues throughout their professional life. The principles of care delivered in networks designed to provide services along the life course model are, as yet, an aspiration but the reality is that services delivered as they are now are unsustainable. If quality of care for women is to improve and not be damaged by traditional thinking, new ways of working are vital.

Academics in women’s health underpin research and innovation. Support for academic training is vital if the specialty is to advance its knowledge. All trainees should receive training in academic principles so that they can assist in the academic elements of practice, including research, which is necessary to improve the service. The current training for clinical academics is extensive but relies on doctors spending many years training in aspects of obstetrics and gynaecology that have little or no relevance to their area of academic activity. To attract high quality doctors into academic posts, training programmes need to be innovative and flexible. Their training needs to be completed within a reasonable time so that they can become leaders in their areas of research activity at a stage in their career when they are most creative.

Tomorrow’s specialists must have many professional attributes and be fully committed to lifelong learning. Integrating undergraduates’ experience in women’s health, public health and primary care with the opportunities in the foundation programmes and recognising these as valuable within training will encourage a philosophy of lifelong learning. Developing flexibility within the training programme and beyond will ensure that senior doctors continue to develop their skills, learn new ones and contribute to all aspects of professional life. Support about career development and options should not be limited to younger doctors deciding on which specialty to enter but should be a thread running throughout a doctor’s career. There are currently only two options for doctors entering specialist training: they can leave part-way through with no formal recognition of what they have to offer employers or they can complete the programme and achieve their CCT. Encouraging the development of stages within the training programme and specialist career, where individuals can ‘step off’ for periods of time, would allow doctors to work and train at their own pace, within limits, and the transfer of skills to be accredited.

Following appointment as a specialist, a doctor needs support to develop clinical and non-clinical professional skills. Much has been said about ‘mentoring’ but definitions are variable and, in the high-pressure environment of obstetrics and gynaecology, clinical support from a senior colleague and formal mentoring is a reasonable requirement of employers.
Professional development should begin during undergraduate training and continue until retirement from the medical profession. There are successful vehicles for clinical skill training in the final 2 years of the training programme and these advanced training skills modules (ATSMs) should be more widely available and extended to cover more areas of professional practice. The introduction of revalidation, building on appraisal, offers a major opportunity for the RCOG to develop formally accredited learning programmes within the continuing professional development (CPD) structures so that doctors with an interest in, for example, medical education or management can formally develop their skills. The considerable investment required to develop these programmes will be reflected in a more adaptable senior workforce able to meet the challenges of leadership, teamwork and management necessary for effective service delivery.

Having the metrics necessary to drive up quality and to allow services to be effective and efficient is a challenge for everyone in health care but the recommendations made with respect to this will allow obstetricians and gynaecologists to examine their own performance, organisations to compare outcomes against standards set by the National Institute for Health and Clinical Excellence (NICE) and the RCOG, and the public to have access to reliable outcome data. Revalidation will increase the pressure on employers to ensure access to quality metrics and increasingly this information will be available to the public.

So what is radical about the Tomorrow’s Specialist report? The methodology used to gather evidence has enabled voices rarely heard to influence the content of the report and its recommendations. Specialists working in teams and delivering comprehensive services without relying on doctors in training is a new way of working in the UK. Providing formal professional development programmes for specialists removes the inherent weakness of self-determined CPD, replacing this with a professionally driven, employer-supported process. Transformational change requires leadership and is most likely to be successful if supported by those who will be most affected by the changes proposed. Gaining the views of women and communicating with members of the specialty openly and honestly about the challenges to be faced will continue the evolution that will lead to sustainable change.

The focus for the specialty will always be on improving the quality of women’s health. To do this effectively within a rapidly changing health system requires highly skilled, flexible, adaptable doctors. These professionals must be able to work in teams, providing leadership in situations ranging from clinical decision making to developing policies that will influence politicians locally and nationally. Respect for other healthcare professionals from those within obstetrics and gynaecology is such that closer multidisciplinary teamwork, across different working environments, based on the principles explored in this report and ensuring meaningful engagement with women as partners in health care, is felt to be the most effective way to make High Quality Women’s Health Care a reality.
# Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AoMRC</td>
<td>Academy of Medical Royal Colleges</td>
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<tr>
<td>AQP</td>
<td>any qualified provider</td>
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<tr>
<td>ATSM</td>
<td>advanced training skills module</td>
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<tr>
<td>BMA</td>
<td>British Medical Association</td>
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<tr>
<td>CCT</td>
<td>certificate of completion of training</td>
</tr>
<tr>
<td>CESR</td>
<td>certificate of eligibility for specialist registration</td>
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<tr>
<td>CiWI</td>
<td>Centre for Workforce Intelligence</td>
</tr>
<tr>
<td>CME</td>
<td>continuing medical education</td>
</tr>
<tr>
<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
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<tr>
<td>CPD</td>
<td>continuing professional development</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>ERPHO</td>
<td>East of England Public Health Observatory</td>
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<tr>
<td>GMC</td>
<td>General Medical Council</td>
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<tr>
<td>GP</td>
<td>general practitioner</td>
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<tr>
<td>HCSA</td>
<td>Hospital Consultants and Specialists Association</td>
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<tr>
<td>HEE</td>
<td>Health Education England</td>
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<tr>
<td>LETBs</td>
<td>local education and training boards</td>
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<tr>
<td>MEE</td>
<td>Medical Education England</td>
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<tr>
<td>NHSLA</td>
<td>NHS Litigation Authority</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
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<tr>
<td>PwC</td>
<td>PricewaterhouseCoopers</td>
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<tr>
<td>RCA</td>
<td>Regional College Adviser</td>
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<tr>
<td>RCGP</td>
<td>Royal College of General Practitioners</td>
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<tr>
<td>RCM</td>
<td>Royal College of Midwives</td>
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<tr>
<td>RCOG</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
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<tr>
<td>RCP</td>
<td>Royal College of Physicians</td>
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<tr>
<td>SASGs</td>
<td>staff, associate specialists and specialty grade doctors</td>
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<tr>
<td>SDMP</td>
<td>sustainable development management plan</td>
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<tr>
<td>SPA</td>
<td>supporting professional activity</td>
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Terminology

i. The Working Party did not want to obfuscate the roles required for high quality health care, hence the use of the term ‘specialist’ to describe a doctor who has completed training in obstetrics and gynaecology and achieved a certificate of completion of training (CCT). At present the most senior clinical roles for doctors in the NHS are as consultants and at no stage was any evidence given to the Working Party that would suggest enthusiasm for the creation of a (lower) ‘sub-consultant’ grade.

ii. The term ‘consultant’, while being an important brand, is not exclusive to doctors, with the increasing importance of the contribution made by nurse and midwife consultants; it is a term defined by the role they fulfil for employers. The public need clarity about the professional skills of the individual caring for them.

iii. It is not the name of the post that is important but the recognised qualifications and experience necessary to achieve specialist status. The name of the post and the description of the responsibilities within that post are the responsibility of employers.

iv. It was agreed by the Working Party that general obstetrics and gynaecology should be provided by specialists with a CCT or equivalent in obstetrics and gynaecology. Although the nomenclature is confusing, these specialists are, in reality, the ‘generalists’ of the profession.

v. Similarly, the nomenclature for junior doctors is unhelpful to the public and demeaning for the doctors themselves. ‘Specialty trainee’, ‘junior’ or any of the widely and randomly used terms such as senior houseman, registrar or house officer belittle the fact that these are highly qualified, motivated and effective members of the healthcare team. The decision to use the term ‘specialist registrar’ was reached in discussion with all members of the Working Party and is accepted in other specialties.

vi. Doctors working as staff, associate specialist and specialty grades (SASGs) in the NHS contribute significantly to women’s health care. Although the terminology is nationally agreed, the range of roles and, in particular, the integration of these doctors into clinical teams is variable.

vii. The term, ‘NHS’, in the context of this report, refers to NHS healthcare providers and employers, commissioners in England and policy makers. Where specific groups, for example employers, are mentioned, this will be stated.

viii. In conclusion, doctors in training will be referred to as specialist registrars, and doctors with a CCT or equivalent as specialists, the equivalent of consultants. The role of SASG doctors as the other medical professional group providing women’s obstetric and gynaecological services is clearly valued and an important component for delivering the present service.
Glossary

Buddying
The support provided to a newly qualified clinician by a more experienced colleague. This is different from mentoring because it is specifically practical, professional advice to be given during clinical activities such as high-risk emergencies or complex surgical cases.

Certificate of completion of training (CCT)
It is a legal requirement that a doctor practising as a substantive, fixed term or honorary specialist in the NHS holds specialist registration. A CCT confirms that a doctor has completed an approved training programme and is eligible for entry onto the specialist register.1

Clinical director
A clinician appointed as manager of a hospital department.

Clinical Negligence Scheme for Trusts (CNST)
CNST handles all clinical negligence claims against member NHS bodies. All NHS trusts, including foundation trusts and primary care trusts, in England currently belong to the scheme. The costs of the scheme are met by membership contributions. The projected claim costs are assessed in advance each year by professional actuaries. Contributions are then calculated to meet the total forecast expenditure for that year. Individual member contribution levels are influenced by a range of factors, including the type of trust, the specialities it provides and the number of full-time-equivalent clinical staff it employs. Discounts are available to those trusts which achieve the relevant NHS Litigation Authority (NHSLA) risk management standards and to those with a good claims history.2

Clinician
A doctor, nurse, midwife or any other health service professional dealing with clinical rather than administrative issues.

Continuing professional development (CPD)
CPD is a continuing process, outside formal undergraduate and postgraduate training, that enables individual doctors to maintain and improve standards of medical practice through the development of knowledge, skills, attitudes and behaviour. In the UK, CPD is mandatory for all those involved in obstetrics and/or gynaecology or its subspecialties in career grade posts, including part-time doctors, those wholly in private practice and those who are not members of the RCOG.

CPD programme
The CPD programme requires clinicians to stay up to date in their current areas of practice and develop in the areas they wish to progress. In the UK, the CPD programme will inform the appraisal/revalidation processes which will culminate in a recommendation being made to the General Medical Council (GMC) through an agreed mechanism for the doctor to be revalidated.3

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1 General Medical Council – Certificates of Completion of Training [www.gmc-uk.org/doctors/aboutcct.asp].
2 NHS Litigation Authority – Clinical Negligence Scheme for Trusts (CNST) [www.nhsla.com/Claims/Schemes/CNST].
**Credentialing**

A process that provides formal accreditation of attainment of competencies (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area in the context of effective clinical governance and supervision as appropriate to the credentialled level of practice.\(^4\)

**Foundation training**

A 2-year training programme that follows graduation from medical school. The programme covers all medical disciplines and gives students the chance to find out more about possible career options and to build a wider appreciation of medicine and surgery before embarking on a chosen specialty.

**Generalist**

A doctor who has completed his or her training and obtained a certificate of completion of training (CCT) or equivalent in a medical specialty.

**Head of school**

The head of school is the director of postgraduate specialty training and is responsible for the overall delivery of the training programmes against the standards laid out by the deanship, the General Medical Council (GMC) and the royal colleges. The head of school is responsible for the delivery of educational resources to the trainer/trainee interface at trust level.

**Integrated care**

Integrated care is an organising principle for care delivery that aims to improve patient care and experience through improved coordination. Integration is the combined set of methods, processes and models that seek to bring this about.\(^5\)

**Lead provider**

In the future, ‘lead providers’ will manage the provision of high quality postgraduate medical education in defined programmes, ensuring continual quality improvement and innovation in delivery. They will work with a network of other local education providers. This role was traditionally part of the deaneries’ remit, which will now be focused on commissioning.\(^6\)

**Life course approach to women’s health**

A life course perspective investigates the long-term effects of biological, behavioural and social exposures during gestation, childhood, adolescence and young adulthood on health and chronic disease in later life and across generations. It recognises that early life has an impact on long-term outcomes through effects on homeostatic and other processes, including lifestyle, by which we respond to environmental challenges. A life course perspective highlights the potential for early intervention to reduce disease risk or severity. It also has intuitive relevance to women’s health needs.\(^7\)

**Mentoring**

The support provided by a skilled helper who guides another individual through a process to help them achieve their potential or reflect on problems to move forward.

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Obstetrics and gynaecology
Obstetrics and gynaecology is the medical specialty concerned with the care of the pregnant woman and her unborn child, and, in general, with the female reproductive organs.

Office gynaecology
The term indicates all aspects of gynaecology that can be dealt with in an outpatient environment (for example, contraception advice and provision, and minor surgical procedures).

Portfolio career
A career consisting of several professional roles rather than one. Common portfolio careers include management, medical education, medico-legal work and/or research, but a growing number of doctors are developing portfolios in less traditional areas such as business, media, humanitarian aid and health policy.8

Primary care
Primary care is the term for the healthcare services provided by health professionals who act as the principal point of consultation for patients (for example, general practitioners and nurse practitioners). Depending on the nature of the health condition, patients may then be referred for secondary or tertiary care.

Regional college adviser (RCA)
The key person responsible for supporting the implementation and monitoring of service, professional and clinical standards in a specific geographical area on behalf of the RCOG. The RCA acts as a specialty-specific resource for a variety of matters concerning the provision of services, specialists’ performance and training provision.9

Revalidation
Revalidation is the process that will ensure that licensed doctors remain up to date and fit to practise. The General Medical Council (GMC) will require documented proof of CPD as an essential component of the information needed for successful appraisal and revalidation.

Run-through training
A training programme where progression to the next level of training is automatic (so long as all the competency requirements are satisfied).

Secondary care
Secondary care is the term for healthcare services provided by medical specialists and other health professionals who generally do not have first contact with patients (for example, cardiologists and urologists). Although most of secondary care services are provided in hospitals, many are provided in community settings (for example, health centres and GP surgeries).

Senior clinician
A clinician appointed to provide clinical leadership to a team of specialists and other healthcare professionals, responsible for the day-to-day running of the service and for the quality of care that the patients under the care of the team receive. This role, not widely present in the UK, deals with the more ‘hands-on’ aspects of a clinical director’s job and would therefore be complementary to it. Senior clinician roles are common in Australia and the USA.

8 BMJ Careers – The rise and rise of the portfolio career [careers.bmj.com/careers/advice/view-article.html?id=20001807#ref1].
Specialist
A clinician who has completed all of his or her specialist training, obtained a certificate of completion of training (CCT), and been placed on the specialist register in their chosen specialty.

Specialist-delivered care
Health care delivered by a specialist, as opposed to care delivered by doctors in training.

Specialist-led care
Health care delivered by a team of clinicians under the supervision of a specialist.

Specialist ‘on call’
A specialist that is the designated contact for out-of-hours emergencies. He or she must be available by telephone and able to return to the hospital if required.

Specialist registrar
A doctor who has completed his or her medical school education and foundation training, and is undertaking postgraduate training in a chosen medical specialty.

Specialist resident cover
The presence of a specialist in a department, 24 hours a day.

Staff, associate specialist and specialty grade doctors (SASGs)
Doctors who are in a variety of posts in hospital medicine where service delivery is the only role, and not training. They are rarely in leadership positions and do not have the same responsibilities as consultants. Doctors entering the grade have specific skills and are knowledgeable in their clinical specialty. However, their experience varies.

Subspecialist
A specialist who has completed additional formal training in a specific area of interest (for example, gynaecological oncology, fetal medicine or urogynaecology).

Supporting professional activities (SPAs)
SPAs are defined in the terms and conditions for consultants in England[^10] as ‘activities that underpin direct clinical care. This may include participation in training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.’

Supra-specialist
A specialist who has trained in rarer areas of clinical practice for which very few doctors are required nationally (for example, exenteration surgery for complex cancer cases or recurrent fistula surgery in urogynaecology).

Tertiary care
Tertiary care is the term used for specialised healthcare services, usually for inpatients and on referral from a primary or secondary healthcare professional, provided in a setting that has personnel and facilities for advanced medical investigation and treatment.

[^10]: Terms and Conditions – Consultants (England) 2003
Training curriculum
The established set of course topics that form an accredited training programme for a medical specialty, designed to provide specialised knowledge and skills.

Value-based health care
‘Value’ in health care is defined as ‘health outcomes achieved per dollar spent’. Value improvement in health and health care is a shared goal from which everyone, including clinicians, can benefit. If value improves, patients, payers, providers and suppliers can all benefit while the economic sustainability of the health care system increases. In a value-based system, revenue and profit come from delivering value, not from merely providing treatment.

Woman-centred care
A philosophy of maternity care that gives priority to the wishes and needs of the user, and emphasises the importance of informed choice, continuity of care, user involvement, clinical effectiveness, responsiveness and accessibility.

Women’s health
Health issues specific to human female anatomy. Women’s health issues include menstruation, contraception, maternal health, childbirth, menopause and breast cancer.

Women’s health network
A system of healthcare provision that brings together a group of providers across different settings working in collaboration in a defined geography within agreed principles, guidelines and standards of care, as described by the RCOG report High Quality Women’s Health Care: A Proposal for Change. A women’s health network will include all aspects of obstetrics and gynaecology (incorporating community sexual and reproductive health) as well as related disciplines (for example, neonatology and haematology) and will facilitate the movement of women through a more dynamic referral system.

1. **Introduction**

The Council of the Royal College of Obstetricians and Gynaecologists (RCOG) approved a Working Party to develop the argument for the type of specialist needed to provide high quality women’s health care in the decades to come. This has led to the current report, *Tomorrow’s Specialist*, which echoes, supports and develops the vision and aspirations of the College for service development that were published in *High Quality Women’s Health Care: A Proposal for Change* in July 2011 (RCOG, 2011a).

**The background to Tomorrow’s Specialist**

2. *High Quality Women’s Health Care* addressed the future, with health services being developed and delivered differently as the needs and demands of the population change. There is widespread recognition that a number of initiatives in healthcare policy, including the proposals within the Health and Social Care Act 2012\(^{15}\) in England and the continuing international debate about funding health care in a time of fiscal restraint, are coalescing to make substantial change necessary.

3. Although the focus of this report is on specialist practice, the affordability of any proposed changes within health care need to be addressed as it will have an impact in all areas of women’s health and the wider NHS (Figure 1).

**Figure 1** Life course view of a health service for women

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\(^{15}\) Health and Social Care Act 2012 c. 7 [www.legislation.gov.uk/ukpga/2012/7/enacted].
4. Hospitals are facing major changes in their relationships with primary care, as the latter takes on more responsibility for the commissioning of services, and in their scope by working with other, non-NHS providers from the private or third sector.

5. Integration of health and social care is not the only aim of an integrated system, which must also encompass a wide range of other drivers and influencing agents, for example environmental issues, innovations such as epigenetics, increasing choice, technological inputs, economic considerations and new treatment modalities arising from scientific advances.

6. If much of secondary care is to move out of hospitals into the community, it is important to develop an understanding of what community services will look like, who will provide care in this setting and how transition from one system to another is best managed.

7. High Quality Women’s Health Care suggested that outcomes for women would improve if their healthcare needs were considered as part of a life course continuum (Figure 2). The framework for delivering care should be within a network that is both geographical and clinically structured.

**Figure 2** Population view of women’s healthcare needs across the life course

![Figure 2: Population view of women's healthcare needs across the life course](image)

**Source:** RCOG, 2011.

8. The provision of ever more sophisticated outcome measures will exert considerable influence on the development of services and on the individual practice of specialists.

9. A public health approach to women’s health care will ensure that opportunities to improve health at each contact with healthcare services are maximised.

10. Tomorrow’s Specialist is primarily concerned with the work and careers of obstetricians and gynaecologists but recognises that specialists in women’s health also include those working in community sexual and reproductive health. All of these specialists will form part of any women’s health network integrating primary and secondary care providers.
11. Obstetricians and gynaecologists know that most contacts with health services for women take place in general practice or community sexual and reproductive healthcare settings. Tomorrow’s Specialist aims to define how to improve and develop relationships among the various healthcare professionals, recognising the need for future specialists to have extensive training and gain experience working within multidisciplinary teams.

The specialist

12. The challenges facing current service provision mean that the status quo cannot continue. The Working Party has understood and articulated these challenges to ensure that the case for change is indisputable and clearly understood.

13. This report proposes new ways of working that will address the challenges identified. It makes a number of recommendations to the RCOG on developing the specialty and driving forward change.

14. The Working Party recognised the fact that high quality women’s health care needs to be delivered by many professionals, not just doctors trained as obstetricians and gynaecologists. Although the focus of this report is inevitably on the direct responsibilities of the RCOG, the importance of multi-professional teams, from first contact in community settings to the multiple professionals involved in tertiary level services, has not been forgotten. This message is summarised as ‘the right person in the right place at the right time’.

15. The Working Party reviewed evidence from many stakeholders and developed a comprehensive set of messages and recommendations. These messages have been consolidated into a proposal on how the obstetric and gynaecological specialist’s role should progress after specialist registration, continually learning and developing while delivering the highest quality service to women.

The current workforce in obstetrics and gynaecology

<table>
<thead>
<tr>
<th>Table 1</th>
<th>The current workforce in obstetrics and gynaecology in the UK (source: as yet unpublished results from the RCOG medical workforce census)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of consultant posts</td>
<td>1985</td>
</tr>
<tr>
<td>Total number of training posts</td>
<td>2157</td>
</tr>
<tr>
<td>Total SASG (non-training) doctors</td>
<td>693*</td>
</tr>
</tbody>
</table>

SASG = staff, associate specialists and specialty grade
*This figure refers to the 2010 census

16. The RCOG conducts a regular census of fellows and members in practice in the UK (RCOG, 2011c). This provides data on the number of consultant appointments made annually in England and Wales as well as the number of doctors on track to achieve their certificate of completion of training (CCT). There is, therefore, a crude ratio of available consultant posts to potential number of eligible applicants (RCOG, 2009a).

Dynamics of the current specialist workforce

17. The current number of doctors in specialist training exceeds the anticipated future consultant career opportunities, although predictions are notoriously inaccurate and rely on the current structure and system of service delivery remaining unchanged.

18. Effective medical workforce planning is likely to reduce specialist training numbers and hence their service commitment. The challenge then is to redesign services and professional roles to accommodate this reduction in contribution.
19. Continuing the significant expansion (Figure 3) of the fully trained medical workforce is required to maintain current service provision (because of the expected reduction in specialist registrars in the future) but this creates a challenge for employers in terms of affordability. The question of value-driven service delivery then becomes important, with the need to balance purely financial costs against quality and patient-reported outcomes.

**Figure 3** The number of full-time-equivalent consultant and specialist registrar posts in the NHS in England for the period 2001–2011

![Graph showing the number of full-time-equivalent consultant and specialist registrar posts in the NHS in England for the period 2001–2011](image)

*Source: NHS staff 2001–2011.*

20. The increasing number of women entering medical school is reflected in obstetrics and gynaecology at training level and, increasingly, at specialist level. The impact of this on productivity is poorly understood but it is a reasonable assumption that many women will take time away from work for family reasons and consider working less than full time for at least part of their career. Several surveys have suggested that men also want the option of working less than full time, which perhaps reflects a generation of doctors entering the workforce who wish to have a healthier work–life balance. This has an effect on workforce planners in that ensuring flexibility for the workforce makes it difficult to plan entry numbers to the specialty accurately. The Centre for Workforce Intelligence (CfWI) has addressed some of these challenges in their publication *Shape of the Medical Workforce: Starting the Debate on the Future Consultant Workforce* (CfWI, 2012a) (Figure 4 and Table 2).

**Figure 4** Headcount of UK medical students by gender from 1960 to 2010

![Graph showing headcount of UK medical students by gender from 1960 to 2010](image)

*Source: CfWI, 2012.*
21. The considerable service contribution by staff, associate specialist and specialty grade doctors (SASGs) needs to be taken into account. One of the difficulties is that SASGs provide a wide range of services, from middle-grade acute services to highly specialised services in specific areas of clinical practice. Many of these doctors have significant roles in management and training locally and their professional contribution needs to be recognised and valued.

22. The majority of hospitals still provide traditionally configured obstetrics and gynaecology services and, as yet, few of them have met the delivery suite requirements of previous College reports (RCOG, 2007) in terms of dedicated specialist presence.

23. There are gaps in service provision, particularly in areas such as emergency gynaecology. The current model of care that relies, in most organisations, on specialist registrars providing the majority of out-of-hours service is not sustainable if the aspiration of driving up the quality of care is to be realised.

24. At present, clinical partnerships delivering care tend to be between different professions or specialties. Specialists still tend to work in hierarchical structures where medical leadership is clearly defined but teamwork less so.

25. Although many specialists offer support to colleagues, this is usually informal, is not recognised contractually and relies on good will. When specialists have professional difficulties, it is often because professional relationships have broken down and support has been lacking.

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**Table 2** Workforce by gender in obstetrics and gynaecology in England and Wales *(source: RCOG, 2011c)*

<table>
<thead>
<tr>
<th>Census year</th>
<th>Consultants</th>
<th>Doctors in training*</th>
<th>Senior house officers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td>79.2%</td>
<td>20.8%</td>
<td>51.5%</td>
</tr>
<tr>
<td>2001</td>
<td>77.4%</td>
<td>22.6%</td>
<td>52.3%</td>
</tr>
<tr>
<td>2002</td>
<td>79.1%</td>
<td>20.9%</td>
<td>45.9%</td>
</tr>
<tr>
<td>2003</td>
<td>71.4%</td>
<td>28.6%</td>
<td>43.8%</td>
</tr>
<tr>
<td>2004</td>
<td>71.3%</td>
<td>28.7%</td>
<td>34.6%</td>
</tr>
<tr>
<td>2005</td>
<td>70.9%</td>
<td>29.1%</td>
<td>31.5%</td>
</tr>
<tr>
<td>2006</td>
<td>71.3%</td>
<td>28.7%</td>
<td>34.6%</td>
</tr>
<tr>
<td>2007</td>
<td>68.4%</td>
<td>31.6%</td>
<td>30.1%</td>
</tr>
<tr>
<td>2008</td>
<td>67.1%</td>
<td>32.9%</td>
<td>33.4%</td>
</tr>
<tr>
<td>2009</td>
<td>71.3%</td>
<td>28.7%</td>
<td>34.6%</td>
</tr>
<tr>
<td>2010</td>
<td>60.0%</td>
<td>40.0%</td>
<td>27.0%</td>
</tr>
<tr>
<td>2011**</td>
<td>53.4%</td>
<td>46.6%</td>
<td>23.6%</td>
</tr>
</tbody>
</table>

*For doctors in training, the figures are for the whole of the UK from 2006 onwards

**The gender is not known for 1% of trainees
Current training in obstetrics and gynaecology

26. Postgraduate training in obstetrics and gynaecology is divided into three phases in a programme designed over an iterative 7 years (Figure 5). Entry to the programme is competitive and dependent on successful achievement of foundation programme competencies or equivalent. The total programme is described as ‘run-through’ as there are no further applications or competition within the programme, provided that doctors progress satisfactorily. The detail of the programme is described in Appendix 1.

High quality women’s health care: the future service

27. *High Quality Women’s Health Care* described a philosophy of care centred on the needs of the woman, rather than those of healthcare organisations or professionals. The proposed service model described women’s health networks, with the majority of maternity, general and acute gynaecological care being delivered ‘closer to home’. This change in emphasis will move many hospital-based services into the community. In addition, the focus must be diverted from ‘illness care’-related models to a more preventive strategy.

28. There are examples of services already functioning effectively within the community, particularly in midwifery and community sexual and reproductive health services. Some innovative models of delivering elements of gynaecological care out of hospitals have been developed but there is considerable potential for moving many women’s health services ‘closer to home’. The limitations around specialist equipment and investigations all have solutions if the principles of networks are applied.

29. Breaking down the silos of clinical practice and service delivery needs leadership, which the RCOG has provided in both *High Quality Women’s Health Care* and through this Working Party.
30. Services will be delivered within networks with specialist care being available in the best setting for the woman and where highly specialised care is needed, and will be provided in fewer, ‘subspecialist’, centres; thereby increasing efficiency and driving up quality.

31. Within a network, a large number of different but complementary cross-specialty clinical skills will be required. In the large hospitals in the network, the required skill mix must provide the totality of secondary care services with a realisation that women requiring tertiary care may be referred elsewhere.

32. Where medical care requires specialist input, this should be provided by doctors who have achieved the CCT or equivalent. The number of doctors training in subspecialty areas must match workforce needs for the community and will need national control.

33. In maternity services with significant and high-risk obstetric activity, there must be provision for senior medical specialist care present 24 hours a day, 7 days a week.

34. With the changing demography and the need for major pelvic surgery, the provision of acute and surgical work may be focused in fewer organisations.

35. Different skill mixes and multidisciplinary working within clinical teams will increasingly replace traditional ways of working constrained by professional boundaries.

36. The collaboration between primary care, community sexual and reproductive health care and obstetrics and gynaecology specialist care must be re-evaluated to reflect these new styles of healthcare provision.

37. The revised curriculum and training pathway must reflect future service needs.

Influencing policy makers and other national leaders

38. This report proposes new patterns of work and an innovative vision of the journey that specialists in obstetrics and gynaecology will need to undertake to ensure the future of high quality women’s health care.

39. Defining roles clearly and evolving career pathways is a challenge and, inevitably, there will be some variations in interpretation and the development of these concepts and proposals following publication of the report. The Working Party considers that the challenges posed in this report will lead the specialty on a journey where change occurs at different rates through evolution once the principles are agreed and accepted. The principles in the report will align the specialty with proposed service changes and good educational practice for lifelong learning.

40. It is intended that this report will influence other organisations, including royal colleges, professional associations, policy makers, Health Education England and all healthcare organisations that are facing similar challenges.
41. The report reflects major shifts taking place in health policy in England but the principles established apply equally to the devolved nations.

**Delivering change that is enticing for RCOG fellows and members**

42. Engagement with, and buy-in from, the RCOG membership will be instrumental in delivering an improved service model and will be essential to deliver changes in training necessary to produce high-calibre specialists.

43. There is a need for all agents to recognise the complexity of specialist work in obstetrics and gynaecology, with teamwork, leadership and innovation being an increasing responsibility for fellows and members.

44. Changes proposed in the report will be challenging but will set a course for the specialty that ensures continuing engagement and leadership from obstetric and gynaecological specialists to raise the quality of care for women.

45. Evolution of the obstetric and gynaecological specialist’s role is not a new concept. In the last decade, significant changes in clinical practice with new technologies and working patterns have been embraced by the specialty. It is vital to ensure wide recognition that continuing expansion of specialist numbers is not realistic without substantial changes to the content and working patterns of senior doctors’ roles.

**Drivers for change**

46. Women’s role in society and their influence have changed significantly in recent decades. Their expectations regarding their health care and attitudes from healthcare professionals are quite different to how they were a generation ago.

47. The Working Party is aware that there are many drivers for change in a complex health system and not all will have an obvious impact on the education and training of specialists. However, the extensive evidence base for this report and, in particular, the message that woman-centred care needs clinicians to be at the forefront of change, as leaders, able to work in partnership with women and as advocates for high quality care, has produced a summary of the major influences or drivers for change.

48. Women in the future will have greater access to data on health services’ performance: this data will relate to clinical outcomes, patient satisfaction and, increasingly, the performance of individual doctors.

49. The commitment to women’s choice needs to be supported by adequate mechanisms to inform women of clinical imperatives as well as alternatives in modes or delivery of appropriate care. The doctors most likely to be involved in these discussions will be GPs and it is vital that specialists in all areas of women’s health care cooperate and collaborate to provide women with the best information available.

50. Decision making in partnership with women and their families will be one of the markers of successful health care. Women need doctors, nurses, midwives and other healthcare professionals with highly developed emotional intelligence and listening skills, who can establish a culture of dialogue and shared decision making (Robert et al., 2011; Houle et al., 2007).

51. Increasing use of technology, which women often access before any contact with healthcare professionals, means the advent of a generation of patients who will welcome shared decision making, and who will value their experience of care holistically as well as in terms of the clinical outcomes.
52. The NHS must become more responsive to its service users, the patients, who will increasingly drive commissioning and the quality ratings of healthcare providers. Lay involvement is a constant feature in current NHS structures and will have increasing influence through the forthcoming Healthwatch and health and wellbeing boards and their equivalents across the UK (DH, 2012a). There are other well-established mechanisms for women to have influence on services, such as maternity service liaison committees, and the strengthening of this type of communication can only be of benefit to commissioners, providers and users alike.

53. Changes arising from new commissioning arrangements in England will have a major impact on the configuration of services for women and it is likely that this will influence other areas of the UK. Hospitals will have to reconsider their function in future health service design as much of current hospital-based care shifts into the community and primary care settings. This will inevitably have an impact on traditional obstetric and gynaecological practice.

54. The impact of the current economic climate is likely to resonate for many years. The NHS will have to continue to adapt, with an increasing emphasis on sustainability, efficiency and value for money being an inevitable consequence. The Working Party has been mindful of the need for leaders in health care to understand the impact of the recession and for them to be able to articulate the financial advantages of any changes proposed.

55. The impact on health of both environmental and social factors has been established in many publications and it was a fundamental concept in the RCOG’s High Quality Women’s Health Care report. Tomorrow’s specialists will need to be aware of these factors in the lives of their patients and they must be able to deliver health care that is directed not just at current issues but also at the future disease risk and public health dimension.

56. Scientific advances drive innovation in medical research, which, increasingly rapidly, is translated into new clinical approaches.

57. Changes to the way in which doctors work, ranging from reduced hours in training following the implementation of the European Working Time Directive (NHS Employers, 2011a) to the role that revalidation will play, mean that current working structures need to evolve constantly.
2. Women, the NHS and doctors: their expectations of tomorrow’s specialists

Section A: Women’s perceptions and expectations

58. Women must have confidence in the overall healthcare system, but the relationship between the doctor and the patient is still vitally important. Asking women what they expect of the service and of individual professionals is still uncommon. If tomorrow’s specialists are to be successful in delivering high quality care, developing a listening, responsive relationship with women as patients and service users is vital.

59. Working on the principle of ‘the right person in the right place at the right time’, the surveys questioned the current models of care, access to healthcare professionals, how doctors view their developing careers, and how women view the service (Figure 6).

Figure 6 Women’s preferences on healthcare services access routes

‘If I thought I had a gynaecological problem I would prefer to …’

Source: RCOG working party survey.

60. Alongside a survey of the Royal College of Obstetricians and Gynaecologists (RCOG) fellows, members and specialist registrars, the Working Party developed a similar questionnaire for women. It was not designed to be a detailed examination of women’s views but many of the questions mirrored those put to doctors working in obstetrics and gynaecology. The main questions revolved around access to healthcare, satisfaction, and preferences regarding the type of clinicians involved in their care.

The right person

61. In the UK, specialist registrars in obstetrics and gynaecology deliver between 50% and 75% of all out-of-hours NHS obstetric and gynaecological care. This reliance on ‘junior doctors’, particularly if senior support is limited, potentially presents issues of patient safety, quality of care and satisfaction for women as well as reducing training opportunities (Temple, 2010).
62. In the survey, 56% of women said that they would prefer to see a nurse or midwife if a specialist were not available and if it were appropriate. Although the focus of the survey was about services provided by doctors, this response is a reminder that any integration of services must reflect women’s choices, and doctors must be aware of the way that other healthcare professionals work and know how to work effectively within a multidisciplinary team.

63. There is considerable evidence on the efficiency and quality of the service if ‘care is provided by the right person’. Midwifery 2020 was commissioned by the UK chief nursing officers with the aim of consolidating the achievements of the profession and identifying the changes needed to provide high quality, cost-effective maternity services for women, babies and families in 2020. The report outlines two clear roles for midwives. It suggests that they should be the ‘lead professional’ for women with no complications in pregnancy; they are able to plan, provide and review a woman’s care, with her input and agreement, from initial antenatal assessment through to the end of the postnatal period (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2010). For low-risk women, midwife-led care reduces admission to hospital and results in significantly less intervention during birth (see also Birthplace in England Collaborative Group, 2011).

64. In addition, midwives have a role as the coordinator of care for all women in pregnancy. The midwife is expert in the normal, but also provides a pivotal role in coordinating the journey through pregnancy for all women, ensuring they are referred to health, voluntary and social services when appropriate and that holistic care is provided to optimise each woman’s birth experience regardless of risk factor. While the lead professional may change during pregnancy, for example to the obstetrician when necessary, the coordinator of care remains the same, providing the continuity that women want (Chief Nursing Officers of England, Northern Ireland, Scotland and Wales, 2010).

65. Nursing and midwifery roles continue to evolve, particularly since the advent of nurse and midwife consultant roles. Two examples of evolving roles are midwife sonographers and nurse colposcopists; both are much more apparent now in the workplace. The survey results suggest that women often choose specialist nursing or midwifery input when accessing services.

66. In the surveys, there was a coherence of views between women and doctors responding in several important areas. For example, women were asked their preference regarding the type of doctor they would like to see when referred to secondary care for a problem with their pregnancy or a gynaecological complaint. Their feedback and the correlated doctors’ responses are explained in Figure 7.

67. Women understand that the NHS cannot ensure that a specialist is always available at every consultation in hospital care but there was limited support, in the absence of a specialist or subspecialist, for seeing a junior doctor (Figure 8).

68. However, when it comes to surgery, the women surveyed expressed very clear views on who should carry it out or at least be present, irrespective of the complexity of the procedure, with a significant percentage wanting a specialist present (Figure 9).

16 Doctors were not asked to differentiate between obstetric and gynaecological care.
Figure 7  Women’s attitudes towards consultations with specialists, and the related doctors’ responses

‘If my GP referred me for a gynaecological problem or a problem related to my pregnancy, I would prefer to…’

Source: RCOG working party survey.

Figure 8  Women’s attitudes to consultations with specialist registrars

Source: RCOG working party survey.

Figure 9  Women’s attitudes towards the doctor performing surgery

Source: RCOG working party survey.
The right place

69. In the survey, women were asked where they would prefer to see the specialist if facilities were the same in all settings. The women surveyed preferred to see a specialist near their home and this was in line with doctors’ support for services to be delivered in the community (Figures 10 and 11).

Figure 10 Women’s preferences regarding place of specialist consultation

If my local surgery/clinic/health centre and the nearest hospital had the same facilities, I would prefer to see a specialist doctor near my home

Source: RCOG working party survey.

The right time

70. The RCOG strongly supports the need for all obstetric units to be staffed by specialists 24 hours a day, 7 days a week. In the survey, women were asked about their expectations regarding specialist doctor and midwifery staffing of obstetric units (Figure 12).

Service quality

71. Although the primary aim of the surveys was not to investigate the quality of women’s health services, the Working Party recognised the RCOG’s aspiration to improve women’s health care and satisfaction. In view of this, the surveys asked doctors what they thought about women’s satisfaction with the care they provided. The majority of doctors who responded were confident that 80% of their patients were satisfied with the care received in their organisation (Figure 13).
In order to challenge and check that the perceptions of doctors were in line with women’s expectations, women were also asked about their satisfaction with obstetric and gynaecological services (Figure 14). The perception of doctors that 80% of women are satisfied with their quality of care was not supported by the survey. This disconnect must drive the specialty to reflect on how quality improvement can occur and on the importance of having women’s input into any proposed service development or change.

Caring for disadvantaged women

There is a risk that some groups of women will be disadvantaged as different health models emerge. This is particularly true for poorly educated women with low socio-economic status. Access to care for women who are older, homeless, have mental health problems, are refugees, have a disability or are otherwise isolated from society needs to be innovative and imaginative.
75. The impact on long-term health for individual women is unfavourable if their needs are not adequately met and these poor health outcomes are likely to continue in their children.

76. Women, their partners and their families are concerned with ‘quality of life’ matters, and healthcare provision that takes into account the overall physical, mental and spiritual needs of women is increasingly important. Knowledge of ‘wellness’ and preventive health are important for individuals as well as being of increasing importance to public health. Many of the underlying factors for poor health and poorer health outcomes (for example, obesity) cannot be managed by purely concentrating on the physical aspects of health.

77. Engaging disadvantaged and ‘seldom heard’ women can be facilitated by moving care into the community, providing that all clinicians are ready to collaborate with other professionals: social services, local authorities, schools, police, voluntary organisations and charities. Accessing intelligence on the local population can provide information on how to make contact with and communicate healthcare messages to all women.

78. Disadvantaged women may be less able to make the best healthcare choices for themselves, owing to difficulties in accessing information, but they can be enabled and empowered with the right approach and the right resources (such as interpreters and visual materials). During pregnancy, women’s motivation to take care of themselves and their family can and should be harnessed to communicate fundamental messages and instil lifestyle changes that can be maintained after the birth of their babies (House of Commons Health Committee, 2009).

79. The specific needs of women with mental health problems are a particularly neglected area of practice for the majority of specialists in obstetrics and gynaecology. The stressful nature of many women’s health problems, particularly during pregnancy, means that developing an integrated service and improving the understanding of the psychiatric, psychological and social issues facing these women is vital if their outcomes are to be improved and their future engagement with health services is to be assured.

**Figure 14**  Women’s satisfaction with the quality of obstetric and gynaecological care received

"In my experience with obstetrics and gynaecology services, I have been very satisfied with..."

*Source: RCOG working party survey.*

"Patients cannot exercise their right to manage their lives unless they are given the instruments to do so."

Elizabeth Manero, Health Link

"If we fail to harness the power of the individual and their motivation to do the best for themselves and their families we lose a big part of the picture."

Elizabeth Manero, Health Link

"But health inequalities are not inevitable and can be significantly reduced: They stem from avoidable inequalities in society: of income, education, employment and neighbourhood circumstances.‘ (Marmot, 2010)

"Fair Society, Healthy Lives‘ (The Marmot Review)
80. Doctors caring for women need to work with other healthcare professionals and social care providers to understand the wider health needs. Doctors with expertise in obstetrics and gynaecology, and women themselves, should be the foremost advocates for women’s health.

Summary

81. The proposed structural changes to the NHS in England and the devolved nations have been widely reported but their impact and the continuing economic realities mean that urgent and radical changes to service delivery are also required.

82. Whatever changes occur, women expect a level of expertise, appropriate decision making and good communication regardless of the experience or background of the professional consulted (Fischer and Ereaut, 2012; AoMRC, 2012).

83. The need to travel for more specialised care is accepted but the definition of these highly specialised services needs to be transparent and referral pathways must be clear.

84. Links and relationships between specialists, community sexual and reproductive healthcare doctors, general practitioners (GPs) and all those providing women’s health care need to be defined for the future. Decisions about what services can be delivered in community settings need to be made with the specialty working in collaboration with these partners.

85. The Working Party acknowledged that designing models of integrated care is challenging, but commissioners need to have coherent advice from professionals working collaboratively to provide the appropriate input to service design.

86. Where an individual doctor is not able to provide continuity for a woman, excellent inter- and intra-team communication is vital. The Working Party heard oral evidence that one of the most frustrating elements for women was telling their story many times to many different people during the course of even a relatively short episode of care.

87. Midwives have long recognised the benefits of continuity of care and carer and have designed different models of midwifery care to improve it. The benefits of women-held records have been known about for decades in maternity care but the challenge of all patients holding their own records or there being universal access to electronic records has yet to be met.

88. Experience from the specialty has proved the necessity of specialist presence at times of high risk for women and their babies during pregnancy, labour and birth. This has been recognised by women themselves and there is now an expectation that the right person with the right skills will always be present at the right time.

89. The Working Party was mindful of the need to ensure that gynaecological services are integrated and supported in the same way as maternity and obstetric services. The skills of specialists providing emergency and elective gynaecological care need to be reflected in the proposed service model. This is particularly important if elements of women’s health care are not to become ‘Cinderella services’ as the focus is on maternity and children strategic clinical networks rather than fully integrated services for women’s health (NHS Commissioning Board, 2012).
90. Women expect a high level of expertise, involvement in decision making and respect (NICE, 2012; Entwistle et al., 2012). The RCOG has responsibility for setting standards of care and providing the education and training necessary for doctors in this specialty to deliver high quality care, regardless of the clinical setting. The more women know about the standards for care produced by the RCOG, the National Institute for Health and Clinical Excellence (NICE) and other organisations, the more the drive for implementing those standards is likely to come from women themselves.

Section B: What does the NHS want from tomorrow’s specialists?

91. The Royal College of Obstetricians and Gynaecologists (RCOG) has members from all over the world but is UK based. NHS healthcare provision in the UK is devolved to the four nations. The Department of Health in England, NHS Scotland, NHS Wales and the Department of Health, Social Services and Public Safety in Northern Ireland all have a different structure and approach to the provision of health care. Only England is affected by the Health and Social Care Act 2012 but UK-based College members and fellows will work and train in any one of the four healthcare systems.

The context

92. Different structures across the UK health services are underpinned by the Government’s developing quality agenda and the need to increase efficiency and productivity despite the varied approaches to achieving these aims.

93. As well as the changes proposed by the Health and Social Care Act 2012 in England, the scale of the NHS’s continuing quality and productivity challenge requires it to make substantial efficiency savings by 2014/15. This means that service configuration and delivery changes are inevitable and likely to increase pressure on commissioners and healthcare providers over the coming years.

94. The NHS in England is also continuing to open up the provision of services to ‘any qualified providers’ (AQP’s), where patients can choose from a range of providers, all of whom meet NHS standards and price.

95. Global warming and climate change also pose significant challenges to the sustainability of the NHS. The NHS Carbon Reduction Strategy asked NHS organisations to have a sustainable development management plan (SDMP) in place by April 2010. At the time of writing this report, over 80% of strategic health authorities (SHAs) had adopted a board-approved SDMP (ERPHO, 2012).

Making High Quality Women’s Health Care a reality through Tomorrow’s Specialist: workforce planning and development

96. The NHS requires a flexible medical workforce with the ability to respond rapidly to change. Specialists need to be able and motivated to provide care at locations and times when women want or need it.

97. The structure of health care will inevitably change as reforms arising from the Health and Social Care Act 2012 are implemented. Workforce changes must be the transformative tool for new ways of delivering high quality care.

98. The Working Party concluded that the medical workforce needs to be structured to provide the NHS with specialists delivering the generality of care for the majority of women’s obstetric and gynaecological health needs, with a smaller number of highly specialised individuals (called subspecialists) able to care for women with very complex clinical needs.

99. The Working Party also recognised the importance of the total workforce and of there being no place for competition between specialists and other healthcare professionals in terms of development or numbers. The interdependence of workforce planning for nurses, midwives, general practitioners (GPs), community sexual and reproductive healthcare doctors, obstetricians and gynaecologists and others needs to be reflected locally and nationally if effective and efficient services are to emerge.
Evidence in support of specialist-delivered care has been discussed in reports by the Academy of Medical Royal Colleges (AoMRC, 2012) and the Royal College of Paediatrics and Child Health (2011). A recent *BMJ* editorial stated that ‘the evidence is largely observational and does not identify what makes the difference’ and challenges that the term ‘consultant’ implies more than ‘fully trained’ (Edwards, 2012). It is important to state that proposing a specialist-delivered service is not simply putting more specialists in at the front line – the whole structure of medical professional support needs to change. Specialists will work in teams, there will be fewer specialist registrars and some areas of the service or units will not have specialist registrars available. It remains to be seen how the service will develop using the skills of fully trained specialists but, as the system evolves, it is vital that the professional skills of senior doctors are not ignored in the interests of short-term service provision. The best use must be made of doctors with a certificate of completion of training (CCT) or equivalent. Senior doctors must work at a level commensurate with their abilities, not just as a substitute for others; redesigning the system of care must go hand-in-hand with workforce redesign. Similarly, the skills of tomorrow’s specialists will need to be those required to deliver the majority of care – as the generalists of the service. Specific skills to enable teams of specialists to work effectively together will also be required. These skills are different to those required now, where a specialist leads a team of specialist registrars and others.

The Centre for Workforce Intelligence (CfWI) is the national authority on workforce planning and development in England, providing advice and information to the health and social care system. CfWI undertook a recent exercise to engage with employers and other stakeholders in England to seek views on the current and future shape of the specialist workforce (CfWI, 2012a).

There has been significant expansion in the number of doctors in training and in specialists in recent years. The CfWI report proposed various models for the future medical workforce. However, the challenge for obstetrics and gynaecology is to continue to make a case for consultant expansion, balancing the salary cost implications for employers with the evidence of increased patient safety, better outcomes for women and babies, decreased costs as efficient clinical decision making is maximised and reduced length of hospital stay.

Employers acknowledged to CfWI that, while current medical training provides a high level of knowledge, clinical skills and specialisation, it does not provide the length of experience seen in past decades where there was no limit to training time (CfWI, 2012b).

All employers should, at the very least, develop an individual’s clinical and professional confidence and ensure that all new members of staff have adequate induction, support from senior colleagues and a strong element of reflective practice (see Section C).

**Evidence of high quality care – good clinical outcomes**

The NHS is becoming less focused on who does what and more focused on achievable outcomes. However, value for money is still important and there will no doubt be efficiency savings required for many years to come. This is likely to lead to increasing pressure on the medical profession to demonstrate how they add value, and to promote the effective use of other healthcare professionals. Making training more efficient as the service is increasingly delivered by specialists will reduce training costs and the specialist service will reduce costs from insurance rates owing to reduced lengths of stay and improved patient outcomes.

Healthcare professionals need to understand the definition of value in terms of ‘outcomes per pound spent’ as well as the concept of value-driven or value-based professionals (Porter and Teisberg, 2007).
107. There is evidence that specialist-delivered secondary care has benefits, particularly with regard to improved quality, safety and productivity. A study by the AoMRC in 2011 considered the evidence on the quality and productivity of care delivered by specialists (AoMRC, 2012). They found more effective use of diagnostics and investigations and a reduction in patientsafety incidents. The review did acknowledge the important role that staff, associate specialists and specialty grade doctors (SASGs) have to play in the delivery of high quality healthcare and recognised that it is essential that specialist registrars provide direct patient care as part of their training. They also highlighted the input of other members of the multidisciplinary team and endorsed the need for a continuing debate about which professional is most appropriate to deliver which elements of care.

108. The Working Party heard that specialist presence on the delivery suite improves clinical outcomes but it is accepted that more qualitative evidence is required to convince all commissioners and providers of the need for further specialist expansion. However, as stated in paragraph 100, the evolution of the medical support for obstetric care from specialist registrar to specialist is a more complex proposal than simply adding another layer of resident doctors into the service. The Working Party heard evidence from units where existing specialists had changed their working practices in order to provide resident nights and weekends and were defining a new role, not simply substituting for the shortage of junior colleagues.

109. The lottery of time of birth for women and their babies should not be accepted as the status quo by commissioners, policy makers, providers or women themselves.

110. The inequality of the service for high-risk women giving birth or having a gynaecological emergency during office hours, where a specialist will often be present, versus during the evening, at night or over weekends, when specialist registrars are providing the service, needs to be addressed openly (Hong et al., 2006; de Graaf et al., 2010; Pasupathy et al., 2010). Approximately 50% of all births happen ‘out of hours’. A review of reported patient safety incidents by 4-hourly time periods where fetal distress was a factor suggested that the greatest number of incidents occurred between midnight and 4 am and between 8 pm and midnight (Figure 15).

111. Evidence demonstrating the value of increased specialist presence in terms of patient safety, experience and economics should be made available to the public. This should be through the collection of outcome, patient safety, patient satisfaction and quality of life data.

112. Feedback from women should be constant and universal, and developed in a way that is meaningful and can have an impact on improving services and women’s experience, including feedback at individual clinician level.
A flexible workforce

113. The ‘Nicholson challenge’, as described by former health secretary Stephen Dorrell, makes increasing productivity more important than ever (DH, 2009). As well as the focus on clinical outcomes, appropriate access for women and minimal waiting times are also important.

114. The Working Party heard from obstetric and gynaecological specialists who are delivering major changes to clinical provision. They suggested that, increasingly, discussions with commissioners are driving the types of post being developed. It is not unreasonable to speculate that, in the future, senior doctors working as specialists, or particularly as subspecialists, may be working for strategic clinical networks rather than individual organisations. This would provide opportunities for significant integration with public health and social care structures, for example through joint appointments.

115. The changes outlined in the Health and Social Care Act 2012 in England, for example the AQP provision, will draw specialists out of traditional hospital settings, particularly for elective work, so that care is ‘localised where possible, centralised where necessary’ (Darzi, 2007). The benefits of this type of network approach to women and their families are tangible but there is a risk, particularly during transition, that there could be an insufficient specialist workforce to ensure the provision of 24-hour emergency care in obstetrics and gynaecology, as this element of care will continue to need a hospital base.

116. The NHS must balance this against the need to train its staff and provide high quality accessible emergency cover.

117. Managing the increase in specialist numbers overall in the NHS and the arguments around measuring productivity are complex with respect to obstetrics and gynaecology as the move towards a specialist-delivered service is relatively recent and driven, in part, by women’s expectations.

118. Responding to financial restrictions in the health service will require more efficient use of staff and innovative ways of working, particularly where investment in an individual, such as an obstetric and gynaecological specialist, is substantial.
119. A real challenge to medical workforce planning in women’s health is its codependency with workforce planning across other professional groups, particularly nurses and midwives (Sandall et al., 2011). Increasing numbers of registered midwives and the evolving roles and responsibilities of midwives with an increase in midwife-led care (NHS Maternity Statistics, 2010–11; NHS Staff 2000–2010 (Non-Medical)) are likely to create complexities in accurately predicting workforce requirements. Similarly, nurse specialist roles are also evolving and many now provide care and undertake procedures previously done by specialist doctors, for example outpatient hysteroscopy, colposcopy and menopause services.

120. The impact of new ways of working within the community sexual and reproductive healthcare specialty and general practice, and different commissioning routes, have to be taken into account in sophisticated workforce modelling.

121. A consensus statement produced by the RCOG, the Royal College of Midwives and the Royal College of General Practitioners in 2011 recognised the value of GP input into maternity care, and defined their role and the skills and competencies required for safe and effective woman-centred care (RCGP, RCM and RCOG, 2011).

122. The RCOG must work with other professional organisations to ensure successful workforce planning for women’s services. Good professional relationships with the Royal College of Midwives and others are vital if innovative service plans are to develop, and the Working Party saw examples of how these relationships, including with women’s organisations such as the National Childbirth Trust (NCT), ensure a positive, proactive response to NHS plans.

123. The Working Party found evidence and examples of a number of innovative solutions that are increasing the productivity of the specialist workforce (see vignettes above and below).

124. The Working Party heard evidence that some organisations were able to develop flexible working schedules within the present consultant contract although there is anxiety about changes in Scotland to the balance between direct patient care activity and other professional activities that do create risks to professional development. Obstetrics is a 24-hour specialty with similar intensity of work at night as during the day, unlike other acute specialties. The perception that the current consultant contract is inflexible is important, as negotiating changes to the way care is delivered in a 24 hours a day, 7 days a week health service requires managers to have confidence that change can happen with the current workforce as well as that there is potential for change in the future.

125. While there are roles that are performed to a high standard by SASG doctors who are not on the specialist register, the expectation is that in the future the minimum requirement for delivering women’s health care in obstetrics and gynaecology will be the CCT or equivalent. With the development of true multi-professional teams delivering a specialist service, the medical input will be specialist based, questioning the need for doctors other than trainees being part of future service configuration.
126. The balance between service provision and training must be maintained: the value of ‘training within the service’ must not be undermined by excessive service workloads for specialist registrars at the expense of their education and training.

127. Increased pressure on NHS finances means that specialists need to be more aware of the impact of their practice on finance and each specialist (not just the clinical director) should have insight into how their own practice can influence the balance sheet.

128. A flexible workforce is vital if the aspirations in *High Quality Women’s Health Care* are to be achieved. Commissioners and employers will look for creative approaches and this will require the specialist medical workforce to be flexible both in terms of location (hospital and community) and roles.

129. Employers want a responsive, flexible workforce that can adapt to changing needs, and they are concerned that the current rather rigid model, where specialists are appointed at the start of their career and may remain in the same post until retirement, reduces the opportunity for individuals to develop and change and it also constrains organisations that need to develop their service profile. More specialists will move to different employers during their career and some will have careers with various strands – portfolio careers.

130. There was considerable discussion in the evidence sessions but general agreement that more doctors would work in different organisations and in different roles over the course of their professional life.

131. Development within specialist roles is expected and, to a certain extent, has been a common feature of specialist careers to date but without formal training or accreditation.

132. A substantial proportion of specialist registrars who responded to the survey expect to move jobs during their senior career (Figure 16).

133. Employers want their medical workforce to retain the flexibility to ensure adequate cover for emergency care. This often means having specialists in gynaecological surgery who have enough obstetric training to take part in the on-call obstetric rota, and specialist obstetricians with enough gynaecological competence to deal with gynaecological emergencies.

134. As the reduction in surgical procedures for the management of benign gynaecological conditions continues, the need to address how surgical skills are developed and maintained is an internationally recognised challenge.

135. The model of care described in *High Quality Women’s Health Care* creates a need for more generalist obstetricians and gynaecologists, working with others, to deal with disease prevention, common conditions, chronic illness and an ageing population, and to have an understanding of the impact and importance of public health and the maintenance of good health.

136. True multidisciplinary working should include collaboration with the voluntary sector, social services and other care organisations as well as all the healthcare professionals referred to in Section A.

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**Figure 16** Specialist registrar’s views on moving during their future career

*Do you expect to move about during your career?*

- Yes: 43.3%
- No: 32.3%
- Undecided: 24.4%

*Source:* RCOG working party survey.
137. The diversification of nursing and midwifery roles with enhanced skills has seen an expansion in the number of non-medical experts in obstetrics and gynaecology and this will continue. Reliance on these experts to assist in the training of doctors is common in many organisations and should become accepted practice in all.

138. Employers, educational leaders and others described to the Working Party innovative ways in which greater flexibility in the medical workforce could be achieved, for example by having periods within the training and the specialist career pathway when individuals would work in posts where they can consolidate their experience while providing a defined level of service.

139. The attraction of such posts for employers is the flexibility of having doctors available with defined, accredited skills, and with clear contractual requirements. However, this model of working is not without substantial risk to the quality of the service and the prospects for those individual doctors. Such a development could produce a ‘sub-consultant’ grade of specialist, by default, consuming large numbers of doctors with little realistic prospect of them returning to training to attain the CCT or equivalent. These doctors would potentially work in a service post or a series of service posts without the functions or developmental opportunities of the current specialist role and with no quality assurance for the standards of the service delivered.

140. The Working Party could not support such a development, given the inherent risks to the quality of care if the integrity of the training programme and its outcome standard, the CCT, is not respected.

Effective teamwork

141. Clinical teams are well established within obstetrics and gynaecology but, in terms of developing networks and delivering high quality women’s health care, the integral role that women themselves should play within teams needs to be considered. There is potential for partnerships with women ranging from board-level organisational involvement to providing patient feedback to individual doctors.

142. Improving patients’ care is the aim of the NHS reforms and of High Quality Women’s Health Care but will only be realised with effective teamwork.

143. Specialists will need to work together as specialist medical teams, as well as within multidisciplinary teams. This way of working will enhance the quality of care, with experienced specialists offering support to less experienced colleagues within the medical team while ensuring that the medical element of the multidisciplinary team is available 24 hours a day, 7 days a week.

144. Teamworking benefits all specialists, as senior doctors learn from their younger colleagues and vice versa.

145. Good teamworking improves patient safety. A study at Aston University highlighted the benefits of teamworking both to those working in teams and to those being cared for by teams. They found a significant correlation between the percentage of staff working in teams and patient death rates in acute hospitals (Figure 17). Dysfunctional teams create such significant risks to patients that no teams at all would be a safer option.

Training in how teams function and how individuals fulfil different roles within teams is already a part of the obstetrics and gynaecology curriculum but must become integral to all aspects of clinical practice.

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'We need to transform “teams of specialists” into “specialist teams”.

Patricia Hamilton, Medical Education England

Newly appointed specialists developing their clinical confidence must look to both medical and non-medical colleagues who have gained experience over the years for support, not least when they are facing complex or high-risk clinical challenges.

Senior consultant obstetrician and gynaecologist

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Professional development at Guy’s and St Thomas’ NHS Foundation Trust

At Guy’s and St Thomas’ NHS Foundation Trust, the trust allocates five supporting professional activities (SPAs) to the clinical director role and expects those in the role to fulfil the responsibilities with the support of a strong general manager and head of nursing or midwifery. Recently, several consultant staff members have completed MBAs supported by the trust.
Effective team leadership is a role expected of most specialists in the future, leading teams in their areas of clinical expertise and also in other aspects of professional life such as senior management or education and training. They will need to work comfortably with peers, nurses, midwives and other healthcare professionals.

As teams expand, with more specialists delivering 24-hour care, it is important to ensure that within this framework individual accountability is maintained. Innovation should be encouraged from individual clinicians and from teams. Increasingly important links to academic activity and research, even for those not directly working in an academic institution, will drive up quality and accelerate the translation of research outcomes into clinical practice.

Improved multidisciplinary teamworking needs to be reflected in continuing education provision (for example, continuing medical education (CME) updates and educational meetings), audit and clinical governance. No longer can we have surgeons, anaesthetists and nurses undertaking all of their continuing education and professional development in isolation from each other. The Working Party heard persuasive evidence that the medical royal colleges and other professional bodies should be working together and leading the way in this respect.

Clinical leadership

Good clinical leadership is essential for role modelling for less experienced colleagues and in supporting other members of the multidisciplinary team to raise standards of care.

The paradox for many doctors is that, as they gain experience, they become more useful as practising clinicians but they are expected to take on more management and leadership roles and do less clinical work. These roles should not be seen as mutually exclusive and the development of teams of specialists will support each element.

Specialist doctors and managers need mutual respect, enabling them to work much more closely together in the future. Effective leadership will require individuals to be adequately trained in non-clinical skills.

Good Medical Practice: Working in teams
- Respect for the skills and contributions of other colleagues
- Effective communication with colleagues within and outside the team
- Clear definitions of roles, responsibilities and accountability towards the patients and within the team
- Participation in regular reviews and audit of the standards and performance of the team, taking steps to remedy any deficiencies
- Willingness to support colleagues who have problems with performance, conduct or health.

General Medical Council (GMC) Guidance On Good Practice (2009)

Figure 17 The relation between teamworking and mortality index

Source: Health Care Team Effectiveness Project, Aston University, Birmingham, England.
152. The Working Party recognised that a range of healthcare professionals (for example, midwives, GPs, nurses and managers) may be leading services in women’s health networks. Specialists need to develop the flexibility to work in teams led by other professionals, recognising that the corollary of leadership training is developing followership skills.

153. As well as training in leadership, teamwork and management, tomorrow’s specialists will need an understanding of how to deliver healthcare in a financially constrained system. They must be able to communicate key messages and bring the other team members with them as services reconfigure, while retaining an advocacy role for women.

154. Time management will also become more critical as specialists are required to keep a number of plates spinning at the same time. These plates include clinical duties, appraisal, revalidation, complaints management, general management, guidelines development, patient information, data management, audit, research, clinical governance, teaching and training, as well as delivering considerably more of the hands-on clinical activity as the numbers of specialist registrars decrease. Effective delegation and time management skills are arguably some of the most valuable non-clinical skills required in the future.

155. With changes to service delivery and to the roles and responsibilities of other members of the multidisciplinary team, specialist registrars will need to develop their skills in management and leadership early in their career.

156. The current generation of doctors in training have limited opportunities to gain management experience or act in leadership roles. However, when trainees are offered responsibility for quality improvement projects and have the chance to act as leaders they become very effective champions of high quality care. The Working Party heard from doctors in the training programme that practical opportunities to use and develop their leadership skills would be welcome and are not universally available.

157. There is a role for the RCOG in providing information about NHS policy and education in aspects of leadership, in collaboration with organisations such as the Faculty of Medical Leadership and Management and the Academy of NHS Leadership, and also in developing leadership opportunities within training programmes.

A motivated workforce that feels valued and respected

158. Although the NHS constitution was written for England, the principle of the workforce being valued is espoused by all: ‘All staff should have rewarding and worthwhile jobs, with the freedom and confidence to act in the interest of patients. To do this, they need to be trusted and actively listened to. They must be treated with respect at work, have the tools, training and support to deliver care, and opportunities to develop and progress’ (DH, 2012b).17

159. The Royal College of Physicians’ report Future Physician: Changing Doctors in Changing Times (RCP, 2010) highlighted the profound effect that the changing composition of the medical workforce is likely to have in future years. The report suggests that the majority of NHS doctors are likely to be women within a decade. The RCOG census supports this. Four in ten female doctors are currently under the age of 35 and are likely to become parents at some point.

160. Organisational, technological, demographic and social change is impacting on the way specialists work. The Working Party heard that, in response to similar changes in the commercial sector, PricewaterhouseCoopers (PwC) had looked into the future in order to plan their workforce (PwC, 2007). PwC considered how their professionals’ view of the corporate environment and their own individual style and preferred way of working could be harnessed to improve the accuracy of workforce planning in the future. In their oral evidence, PwC told the Working Party how they pay monetary bonuses according to individuals’ career choices. They suggested that pay does not change people’s behaviours and that the positive influencing agent was rather the individual development of

long-term careers. What counts is making a difference with clients, working with colleagues they respect and social responsibility. This process is recognisable within the NHS, where motivation is more about making a difference to women and developing the service.

161. The Working Party heard similar oral evidence from the education sector. A school has teachers at various stages in their career working together. Experienced teachers support junior colleagues but also learn from them as they have undergone a different training programme. A newly appointed teacher undergoes a period of consolidation lasting 6 years. Unless specifically fast-tracked, they are unable to progress to the next level before the set time.

162. The John Lewis Partnership has a workforce that is completely integrated into the company’s ethos and management structures, ensuring that motivation comes from within individuals, teams and the organisation itself.

163. The Working Party heard that poor data collection, inadequate attention to the detail of data collected and the inability of organisations to produce personalised data for doctors working within their organisation were an increasing frustration for specialists trying to improve their personal performance and the care for their patients.

164. It is important that managers, as well as clinicians, are able to understand and interpret clinical outcomes data. Improvements to clinical coding and data collection should be driven by clinical and non-clinical staff working together in partnership.

165. In health care, a workforce of specialists at various stages in their career working together makes it easier for senior specialists to support less experienced colleagues without becoming overburdened. In addition, it offers the opportunity for individuals to learn new techniques and translate innovation into practice rapidly as knowledge cascades down the generations.

166. Consideration must also be given to doctors moving towards retirement. If tomorrow’s specialists are to work beyond 65 years of age, it is important that they retain their enthusiasm for sharing their expertise with others and do not suffer physical or mental ‘burnout’. The RCOG published a report on work–life balance and the learning from this needs to be incorporated into advice for doctors at all stages of their career so that careers are sustainable and burnout is minimised (RCOG, 2011d).

167. Individuals should be encouraged to drive their own learning, seeking out information and filling gaps in their knowledge. There should be provision in job plans for this and encouragement to enhance learning and joint working with other healthcare disciplines that impact on the specialty.

Summary

168. The NHS more than ever requires a flexible obstetric and gynaecological workforce with the ability to respond to change. In order to improve patient safety and women’s experience, it needs a workforce of highly effective generalists with a smaller number of highly specialised individuals to care for those women with very complex needs.
Commissioners and healthcare providers will be seeking greater productivity over the coming years. The RCOG and others need to be influencing commissioners and healthcare providers and engaging them in the process through the vision of *High Quality Women’s Health Care*. This proposes a life course approach to women’s health care, delivered through strategic clinical networks with effective high quality leadership. This integrated approach means that there should be no artificial barriers between primary and secondary care or between foundation trusts and non-foundation trusts.

**Section C: What doctors in obstetrics and gynaecology want as tomorrow’s specialists**

170. The Working Party recognised the risks of trying to predict the future in health care, particularly with the impact of new technologies such as genomics that are at the very early stages of clinical relevance. However, members of the medical profession are involved at all levels of decision making for the NHS.

171. The Working Party survey of the Royal College of Obstetricians and Gynaecologists (RCOG) fellows and members combined with the wide-ranging evidence received from across the medical profession and from stakeholders in the NHS, where assumptions were tested, provides an impetus for change.

172. The specialty of obstetrics and gynaecology has changed considerably over the past decade. The recognition that having specialists present on the delivery suite is necessary to improve the safety of women and babies, the change from surgical procedures to medical treatment for many gynaecological conditions and the reduction in junior doctors’ hours with the implementation of European Working Time Directive, have resulted in considerable variations in specialist working profiles (RCOG and RCPCH, 2008; RCOG, 2009b).

173. The development of a 7-year training programme in 2007 (House of Commons Health Select Committee, 2008) was designed to produce doctors ready to work as specialists in general obstetrics and gynaecology. The curriculum consists of core requirements delivered through integrated modules over three distinct phases of training (basic, intermediate and advanced), enhanced with advanced training skills modules (ATSMs) to reinforce specific areas of practice suitable for ‘general’ hospital services and to provide those in training with options to develop areas of clinical interest.

174. Highly specialised and complex clinical work is defined in several clinical areas and separate curricula now allow limited numbers of specialist registrars to become subspecialists.

175. The curricula are living documents with all changes, including those to the assessment tools, being submitted for approval to the General Medical Council (GMC).

176. The certificate of completion of training (CCT) or equivalent is currently the minimum standard for specialist practice in obstetrics and gynaecology at the consultant grade.

177. The CCT as the minimum standard for doctors practising in obstetrics and gynaecology was endorsed strongly to the Working Party by those training in obstetrics and gynaecology, by more senior doctors and by other professionals working closely with obstetricians and gynaecologists. The logical consequence of this is that, as the service and the specialty evolve, teams of doctors with the CCT will work together in different roles to provide a comprehensive service. This, in turn, will reduce the reliance on specialist registrars, which will potentially shorten their time in training.

178. The element of service provided by doctors training in obstetrics and gynaecology is significant and their contribution as highly skilled and motivated professionals needs to be recognised and valued. Similarly, there is no intention that successful training can take place without the programme being embedded in clinical reality; that is, within the day-to-day service.

179. It can be assumed that, without specialist registrars delivering the majority of out-of-hours and emergency care, the service would be unsustainable at present.

180. Where specialist registrars are working within their competencies and are well supported by specialists, the quality of care and training is enhanced.
How doctors will work in the future

181. Evidence from doctors training in obstetrics and gynaecology was sought through a questionnaire and from oral evidence. They recognised that their specialist careers after achieving the CCT or equivalent will be different to those of many of their current role models and will include the provision of a ‘specialist-delivered service’.

182. This recognition included an understanding that the next generation of obstetricians and gynaecologists expect to be resident, working shifts in order to provide continuous specialist-delivered care.

183. While not all consultant-led maternity services require resident specialists 24 hours a day at present, those units with a complex case mix and a high intensity of work will increasingly need specialists resident at all times. As the service reconfigures to be more efficient and effective in terms of value and quality, there are likely to be fewer obstetric units in a maternity network so that 24-hour specialist care is possible and women needing an obstetrician can be assured of high quality care regardless of the time or day of their presentation. The RCOG guidelines on hours of senior presence required on the delivery suite are defined in Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (RCOG, 2007) and further advice needs to be developed urgently to meet new configurations of maternity and obstetric services.

184. The survey of RCOG fellows and members did not support the proposal that only doctors in their first 10 or 15 years as a specialist should do all the emergency daytime or out-of-hours work. This would support that within a team of specialists there will be different experiences and aspirations and good team planning should support all the doctors at each stage of their careers (Figure 18).

185. However, there was a clear message (73% of respondents) that resident obstetric work should be limited by age and that those doctors doing resident night and weekend work should have a different contract to other specialists (72% of respondents) (Figure 19).

186. There was, however, little agreement among those responding to the survey about the appropriate age at which to stop resident work and the Working Party heard of some individuals willing, happy and able to offer resident working right up to retirement age. The Working Party was of the opinion that the RCOG should not define rigid limits but provide advice for fellows and members about different working patterns for units and individuals based on the evidence received by the Working Party (Figure 20).

Figure 18 Specialists’ attitudes towards delegating emergency work

‘Should specialists within their 10/15 years of specialist registration practice be responsible for all out-of-hours on-call service?’

Source: RCOG working party survey.
187. No maternity unit has yet achieved full 24-hour cover that includes time off in lieu and annual and professional leave, and many quite large units are struggling to achieve resident overnight cover from specialists. In many places where some cover has been achieved, it is largely based on the goodwill and enthusiasm of experienced individuals acting as role models for colleagues and on the opportunities afforded by the employment of newly appointed specialists.

188. With the relative reduction in specialist registrars in obstetrics and gynaecology, the specialist expansion and the need for specialists to be resident on the front line of clinical care, different types of medical team will be necessary.

189. The Working Party heard from organisations where consultants worked together providing a part of the service, covering each other for shifts at night, time off in lieu, and annual and professional leave.

Figure 20 Obstetricians’ and gynaecologists’ attitudes towards limiting resident work by age

Source: RCOG working party survey.
However, as service provision changes (see Section B), the way in which doctors work will inevitably change. Already some specialists move several times during their career, particularly in academic medicine. In the oral evidence sessions, the Working Party heard from specialist registrars who positively endorsed a portfolio-style career as their personal choice for future employment.

The term ‘portfolio working’ is difficult to define but the Working Party heard from many doctors who have successful portfolio careers providing a wider range of skills to the NHS. Examples of these include educational and managerial roles, roles in policy development and part-time senior roles within professional organisations such as royal colleges and regulatory bodies. It is usual for these activities to be done while maintaining a core but reduced commitment to clinical obstetrics and/or gynaecology.

The training programme and transition into specialist practice

A positive impact of more specialists present 24 hours a day will be on the quality of training as well as on the quality of care because specialists will be physically present to support and supervise specialist registrars.

The current training programme is competency based and takes place over a 7-year period. However, owing to the constraints of annual rotations and the rigidity of the training programmes regionally, specialist registrars do not progress at individual rates based on the achievement of these competencies. Instead, progress is on the chronology of their yearly reviews and moves between hospitals. There is little flexibility for individuals or encouragement for innovative providers of education and training to construct programmes differently.

There are many changes taking place to the structure, commissioning, management and funding of postgraduate medical education. In England, this is a result of the Health and Social Care Act 2012. In the rest of the UK, it is a result of similar funding challenges and recognition of the workforce issues arising if the number of doctors produced in medical schools either exceeds or is less than what is required. The need for rigorous workforce planning may provide opportunities for training programmes that are more flexible and recognise that individual specialist registrars progress at different rates.
195. The Working Party heard from specialist registrars about the rigidity of training programmes where even approved activities (for example, specific training or academic pursuits) are compromised by the need to return to the training programme within a limited period of time. The ‘single track’ CCT does not reflect individual requirements or the different rates at which individuals gain competence and confidence.

196. The Working Party heard the need for individual flexibility within training and indeed this was promoted in the Modernising Medical Careers Inquiry report (Tooke, 2008). Some individuals may wish to take time away from the ‘conveyor belt’ of the training programme to consolidate their skills, gain further experience or manage a time in their personal life without the pressure of having to progress chronologically. As well as responding to the individual needs of doctors, this would encourage the development of a diverse workforce with the associated benefits for women and the service.

197. Similarly, the Working Party heard evidence that experience gained in other aspects of medicine were not accredited to the doctor unless they were recognised as substituting for part of the approved curriculum. The Working Party recognised the difficulty in approving time spent in other specialties but it was agreed that diversity within the specialty was to be welcomed.

198. The Working Party heard no enthusiasm for moving the CCT to the end of intermediate training and no evidence presented to show that this was an appropriate place in training for employers to have a cohort of people with sufficient skills to run a service. This was perceived, in the majority of evidence, to be an unacceptable reduction in time needed to prepare for specialist practice.

199. Local responsibility for training, in England through the proposed local education and training boards (LETBs), and in the rest of the UK via the postgraduate deanery structures, will also include an element of workforce planning. This responsibility extends to other healthcare professionals as well as doctors and could provide innovative training opportunities if the commissioning lever is used appropriately. For example, regional training providers may be able to deliver the curriculum in less than 7 years. There is currently no incentive to do so. However, with an element of competition, a shorter programme may provide specialist registrars with a range of opportunities in the seventh year of training. These could range from working in a senior role, developing further skills for specialist practice, spending time on academic activities or developing new professional skills such as elements of medical management or public health.

200. It remains to be seen what the impact on the length of training will be when the service has more specialists working 24 hours a day, 7 days a week able to provide more extensive supervision and assessment of those in training.

201. The importance of times of transition, from undergraduate to doctor, from foundation doctor to specialty training doctor and, within the training programme, from basic to intermediate and from intermediate to advanced training, and then into specialist practice, is recognised. The expectations for individuals throughout this journey of early professional development are explicit and an accepted part of everyday life. A similar transition into specialist practice supported by formal structures allowing an individual to embed themselves into the new role and department would lead to enhanced standards of patient care and satisfaction for doctors at this vital stage within the profession. Newly qualified specialists would be able to practise at the highest level while having explicit support around clinical decision making, where needed, and with developing advanced professional non-clinical skills in their practice.

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The Trainee Steering Group (TSG) of the Faculty of Medical Leadership and Management

In 2010, the Royal College of Physicians (RCP) and the Royal College of General Practitioners (RCGP) initiated a meeting of interested parties to consider the principles of creating a Faculty of Medical Leadership and Management (www.fmlm.ac.uk) and to identify the next steps. Those involved include individual medical royal colleges and faculties, the Academy of Medical Royal Colleges (AoMRC), the NHS Institute for Innovation and Improvement, nominated strategic health authority medical directors, NHS Employers and others with experience related to medical leadership and management.

The Trainee Steering Group (TSG) comprises six active work streams, which include:

- Personal and Professional Development
- Think Tank/Thought Leaders
- Medical Student Mentoring (MSM).

The MSM’s mission statement is:

Empowering doctors of tomorrow with leadership and management skills today!
202. The Working Party was made aware of anxieties among senior doctors, employers and others about the potential risks associated with this relative lack of experience, particularly if individuals felt isolated or had difficulties developing positive working relationships in their new clinical environments. Although anecdotal, this perceived risk is important as it can reduce newly qualified specialists’ confidence and may further affect their integration into the team.

203. Models of support and mentoring were presented and widely endorsed as methods of supporting doctors at the time of transition into specialist practice. Mentoring, in particular, was felt to be something that many doctors, regardless of their seniority, could benefit from and would want access to throughout their professional life, possibly provided through the RCOG.

Raising standards within training

204. The GMC Trainees Survey shows satisfaction levels of 77.5% with the current training programme (GMC, 2012). There are concerns about the impact of the European Working Time Directive, particularly where gaps in rotas require colleagues to cover for each other. This can result in fewer training opportunities because the focus is on maintaining the service. Professor Sir John Temple’s report Time for Training (2010) makes a series of recommendations that allow effective training to be delivered within the constraints of the European Working Time Directive. There are some positive developments within obstetrics and gynaecology, such as the use of simulation in training and the expansion in specialist numbers within the obstetric service, that have already had an impact but the continuing reliance on specialist registrars means many hours of training can be lost as service needs dominate.

205. Although there are established routes into an academic career, it was clear to the Working Party that all specialist registrars need and value exposure to academic learning. The promotion of scholarship within the curriculum should be enhanced so that all of tomorrow’s specialists have an understanding of and can contribute where appropriate to the advancement of the specialty academically.

206. As provision of postgraduate medical education through the establishment of ‘lead providers’ within LETBs develops in England and through networks in the devolved administrations, there are opportunities to increase academic activity within the training programmes. Although the competency approach to skills has been a positive step towards ensuring high clinical standards, there is a need to ensure that all doctors have an understanding of and a commitment to academic values, including research and innovation. The Working Party heard that one recently formed lead provider of obstetrics and gynaecology training in a deanery is going to provide all specialist registrars with the opportunity to do an MSc in women’s health as part of their programme requirements.

207. The importance of ensuring that academic activity is translated into clinical practice was raised. The Working Party heard that close integration of academic training and activity within the wider training programmes is vital if academic doctors are to develop an understanding of the wider NHS and their role in quality improvement.

208. There remain, however, training programmes where the emphasis seems to be primarily on the service contribution from specialist registrars. The adjustment of training numbers to a steady state, reflecting future workforce needs, will place organisations that do not value training at risk of losing training places to more innovative organisations that can deliver the curriculum, provide ATSMs and offer extra value.

209. Academic training pathways exist and are recruited to separately from standard training programmes. The Working Party heard from academic and educational leaders that the need for flexibility for these doctors is paramount if research grant-giving bodies are to continue to invest in medical training in the UK. Integrating academic activity into all aspects of the RCOG’s work and ensuring that those doctors training in academic programmes are valued and protected is vital to the health of the specialty.

210. The calibre of doctors in academic training in obstetrics and gynaecology is recognised as being excellent. These doctors will be expected to provide significant leadership in the development of the specialty and it is important that those commissioning education recognise the value of this small but
important group and facilitate their training so that they can enter their academic lives as early as possible, when they are at their most creative.

211. The RCOG policy of pressing for specialist expansion to provide safer care on delivery suites and access to trained specialists for women in high-risk or complex clinical situations remains a core commitment. Larger services delivered by specialists working in multi-professional teams are likely to provide the majority of training in the future, given their clinical activity and the intensity of work. This, of course, means that smaller services may not have specialist registrars at all or not in numbers to be in balance with the specialist workforce requirements needed for traditional ‘middle-grade’ rotas at night and over weekends. The ratio of specialists to specialist registrars will change and the latter group will reduce in numbers. This alone will drive how the service is configured and who delivers care.

212. It is therefore likely that postgraduate education and training commissioners will contract training that takes place where there is sufficient clinical caseload and case mix combined with good supervision from specialists. The service impact of allocating specialist registrars to these organisations, removing both the recognition and funding of training places in organisations where delivery of the curriculum is less likely, will drive new ways of working and possibly the configuration of services.

213. The RCOG must provide leadership throughout this evolution so that women are protected, training standards are maintained and fellows and members are able to develop these new ways of working.

214. The numbers of specialist registrars expected to attain the CCT or equivalent in obstetrics and gynaecology between 2012 and 2017 should provide the NHS with sufficient numbers of doctors to enable the provision of women’s health services to be a truly 24 hours a day, 7 days a week system of care by teams of specialists (Table 3) (RCOG, 2009a).

Stages within training

215. The division of training into basic, intermediate and advanced allows organisations to plan their service effectively. They know what the clinical contribution of specialist registrars will be and the access to training that the organisation will be expected to provide.

216. The element of training currently offering some individualisation is the ATSM programme. However, this only constitutes approximately one day a week over the final 2 years of training. The enthusiasm for this modular approach to gaining competencies is perhaps an indication that widening access to ATSMs for doctors after the CCT and increasing the range of topics offered, embracing non-clinical elements and a greater academic focus, would be welcomed (Figure 21).

Table 3  Future output from training: projected CCT awards in obstetrics and gynaecology

<table>
<thead>
<tr>
<th>Year</th>
<th>CCT awards*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>355</td>
</tr>
<tr>
<td>2013</td>
<td>329</td>
</tr>
<tr>
<td>2014</td>
<td>317</td>
</tr>
<tr>
<td>2015</td>
<td>264</td>
</tr>
<tr>
<td>2016</td>
<td>238</td>
</tr>
<tr>
<td>Total</td>
<td>1760</td>
</tr>
</tbody>
</table>

*Including certificate of eligibility for specialist registration (CESR) numbers (approximately eight per year)
The Working Party heard from leaders in medical education that the credentialing of elements of training was under consideration. There was enthusiasm from specialist registrars and from staff, associate specialists and specialty grade doctors (SASGs) that a more modular approach to training would allow credentials to be ‘cashed in’ and could protect training time from excessive service requirements.

There are elements of professional practice that are tangentially addressed within the curriculum rather than being explicitly required. Although there are examples of good practice in some training programmes, there needs to be a review of the content of the curriculum with respect to professional behaviour and practice, for example communication, teamworking, emotional intelligence, leadership and followership skills, negotiating and influencing skills, managing change, sustainability, etc. All the doctors providing evidence to the Working Party recognised the need to develop these professional attributes along with their clinical skills.

The importance for doctors of developing leadership, management and teamworking skills in order to improve the quality of care for women was emphasised to the Working Party by many sources. The need to integrate aspects of leadership training into the curriculum was recognised but the risk of leadership training being seen as something that could be covered by a course in a ‘tick-box’ approach was also discussed. Leadership training needs to be meaningful and continuous through the transition into specialist practice.

Training programme length

Tomorrow’s Specialist sets out to create the vision for the future education and training of doctors who will deliver high quality obstetric and gynaecological care for women over the next decade. To realise this vision, the current training programmes will need to change and evolve, offering new technologies and ways of working as well as advances that will improve women’s health. The journey currently begins at the start of a 7-year training programme approved by the UK regulator, the GMC.

There is considerable focus on the length of training for postgraduate medical specialties in the UK from Health Education England (HEE), the Centre for Workforce Intelligence (CfWI) and the GMC. The RCOG training programme is one of the longest in Europe, although comparisons are difficult as the role of doctors with a CCT varies from country to country. Changes in service configuration and the increasing presence of senior doctors 24 hours a day will make it necessary to reassess the evidence for the length of the training programme and could lead to its reduction. The RCOG needs to reflect changes in service and create a flexible curriculum, working with the GMC as the evidence emerges for the length of time needed to achieve the competencies for a CCT.

The ‘generalists’ produced now cannot currently opt out of any element of the curriculum as the provision of services is still a mixture of obstetrics and gynaecology. The latest RCOG census shows that 67% of consultants practise both obstetrics and gynaecology (Figure 22). This needs to be regularly reviewed as service reconfiguration and the integration of care within networks will drive different models of specialist careers, which will need to be rapidly built into postgraduate training.
223. Service delivery becoming the responsibility of specialists as discussed above will create increased opportunities for the supervision of training. This expansion of learning opportunities will not only improve the quality of training but, if reflected in more efficient training programmes, could lead to a shortened training programme becoming a real possibility. Similarly, there will be a reduction in the numbers of specialist registrars overall when a ‘steady state’ is reached with respect to numbers. Both these developments would in turn assist with the affordability of a specialist-delivered service.

224. The current iteration of the curriculum was launched in 2007 and the first doctors to have trained against these standards are only now entering their last 2 years of training. However, their understanding of workforce changes, the need for more senior input to direct care at all times and changes in gynaecological care makes them aware that they will need a different skill set to their predecessors. In particular, they will need to develop attributes that allow them to continue learning and developing throughout their medical careers (Figure 23).

Subspeciality training

225. There was coherence across senior medical professionals, postgraduate education leaders, the GMC and employers that training for the recognised subspecialties in women’s health should ideally take place after the completion of the training programme as it is unacceptable to invest in training doctors to this specialised level if the majority are not necessarily able to gain employment delivering that level of subspecialist care once trained. Moving it from its current place in core training would allow more effective regional and national workforce planning.

226. In the survey, a small majority of respondents, who were doctors within the specialty, supported this move (Figure 24). However, in oral evidence, the risks of such a proposal were eloquently explained.

227. The Working Party was mindful of these variances in opinion and discussion with employers, educational leaders, the specialist societies and others confirmed the associated risks of moving subspecialist training to post-CCT at this time. These risks include poor planning, potential loss of funding and the LETBs in England not being in a position to commission at this level. As national commissioning processes are as yet undefined, there should not be a recommendation for post-CCT subspecialty training from the RCOG unless it is a joint recommendation with the GMC, HEE and the devolved administrations.

228. Although subspecialty training programmes deliver highly trained, expert doctors, the Working Party heard that there are small pockets of supra-specialist clinical practice, where very few doctors are required nationally. These are not catered for in any training programme. A good example of this would be the surgery required for exenteration in complex cancer cases, or the surgical skills required for recurrent fistula surgery in urogynaecology. These elements of training are currently acquired in an ad hoc way, usually through an individual spending time as a ‘fellow’ in an organisation getting hands-on experience.

229. Workforce planning, with respect to subspecialist numbers or training opportunities, is currently very limited. The RCOG will work closely with the CfWI and the devolved administrations on subspecialty workforce numbers as the need for succession planning is vital in areas of specific high level clinical practice.
Career advice

230. There is excellent career advice from the RCOG for doctors and undergraduates wishing to enter the specialty. Exposure to all aspects of women’s health during undergraduate training is strongly supported by the RCOG and there will be a need for medical schools to adjust their curricula as the service changes and the emphasis on health promotion and disease prevention develops.

231. Doctors interested and able to pursue academic careers often need specific advice from both their clinical supervisors and their academic advisers. They need flexible and consistent support in order to train efficiently and to maximise their academic contribution to the specialty.

232. The RCOG provides guidance on clinical areas where senior posts are likely to be required (these areas are currently mainly obstetrics related). However, there is little advice about other areas of practice.
where specific skills will be required, for example leadership and management. In response to this, the RCOG is developing an integrated leadership module within the training curriculum and is currently testing a ‘first steps’ leadership course.

233. Options available via the ATSMs, within the final 2 years of training, mean that specialist registrars have to make decisions regarding the skills they expect to be required for their future employment plans. There is career advice that can assist specialist registrars with these decisions but it is still currently perceived as something that only trainees dissatisfied with their chosen specialty access.

234. The Working Party heard that doctors currently working in senior roles had benefited from advice about their own career development. They suggested that the RCOG should provide more information, not only about career opportunities but also technical advice about how to develop and change direction within their professional life (Figure 25).

**Figure 25** Specialist registrars’ expectations regarding their future employment

*In terms of your first post-specialist-registration appointment, do you think you will be working in a...*

![Chart showing the percentage of specialist registrars expecting to work in various roles](chart)

Source: RCOG working party survey.

235. The RCOG should develop its web-based career advice and career support service to provide for all doctors at all stages of their career.

**After the CCT**

236. Once doctors have the CCT or equivalent and have entered employment as specialists, there is a universal desire for support to facilitate this transition.

237. The term ‘independent practice’ no longer adequately describes the complex set of professional relationships necessary for modern clinical teams to function effectively. Doctors and the public are increasingly aware that poor outcomes are often the result of poorly functioning teams.

238. While the training programme must develop the skills needed for effective teamwork, training also needs to be extended into the workplace and involve newly appointed specialists and existing teams.

239. The Working Party was presented with evidence of the need for effective support for newer specialists early on in their career. The term ‘mentoring’ is often used but has many interpretations.
240. Mentoring is quite different from the appraisal process and is a role best taken on by more senior colleagues, ideally not within the same department. It is a useful process for discussing practical, professional and personal issues, and is valued by doctors at all stages of their career.

241. Mentors require training if the relationship and the process is to be truly supportive and developmental. The Working Party heard about examples of mentoring for specific issues and for longer support and developmental needs; both are valid but the training and experience of the mentor is vital whatever the aim of the programme.

242. Given the pressures within the specialty of obstetrics and gynaecology and the overwhelmingly positive feedback from individuals who have been mentored, the Working Party recommends that the RCOG should work with experts in the field to develop such a programme.

243. Support is required during the transition from training programme to a specialist role. This is often practical, professional advice required during clinical activities such as high-risk obstetric emergencies or complex surgical cases. Many hospitals have ad hoc systems in place, with a more senior colleague being unofficially available and willing to discuss cases or come in to the hospital in a supportive and supervisory capacity. This role is rarely remunerated or officially recognised and there is no requirement for newly appointed specialists to avail themselves of such an agreement. This type of support is not mentoring but is a vital mechanism for ensuring that new colleagues integrate into the department, are able to demonstrate their skills and develop confidence in their new role with readily available, non-critical support at hand. In the survey of fellows and members, 84% of respondents thought that newly appointed colleagues should have senior support available when on call (Figure 26). The Working Party has used the term ‘buddying’ to describe this relationship and strongly recommends that this process is formalised and the job plan of the ‘buddy’ adjusted for a period of time to allow for this extra commitment.

Lifelong learning

244. The length of time spent in the specialist role is likely to increase as appointments are made at a younger age and the retirement age rises (CfWI, 2012a).

245. The RCOG operates a system of continuing professional development (CPD) that enables individual specialists to maintain and improve standards of medical practice through the

Mentoring – definitions

The Oxford English Dictionary definition of a mentor is:
- ‘An experienced and trusted adviser’
- ‘An experienced person in an organisation or institution who trains and counsels new employees or students’.

The RCOG report Mentoring for all (RCOG, 2005a) states:
- A mentor is a skilled helper who guides another individual through a process to help them achieve their potential or reflect on problems to move forward.
- The mentoring role is separate from that of:
  - an advocate
  - an adviser
  - a preceptor
  - a tutor
  - an educational adviser.

Every obstetrician and gynaecologist needs a mentor throughout training and career.

Flying Start NHS

Flying Start NHS (www.flyingstart.scot.nhs.uk) is a national development programme that was commissioned by the Scottish Government in 2005 and launched to NHS Scotland in 2006. It is aimed at supporting newly qualified nurses, midwives and allied healthcare professionals during their first year of practice, supporting their learning and building their confidence in the difficult transition between training and autonomous practice. All newly qualified nurses, midwives or allied healthcare professionals who join NHS Scotland can register with Flying Start NHS, through a simple process on the website. Following the success of Flying Start NHS in Scotland, a pilot was rolled out in England, leading to the establishment of Flying Start England (www.flyingstartengland.nhs.uk).

Flying Start contains ten learning programmes, which consist of a variety of interactive work-based learning activities including self-assessment:
- communication
- clinical skills
- teamwork
- safe practice
- research for practice
- equality and diversity
- policy
- reflective practice
- professional development
- career pathways.
continuing development of knowledge, skills, attitudes and behaviours.\textsuperscript{18} Individuals are responsible for assessing their own educational needs and are required to participate in activities in line with their job plan. However, there is currently little structure to the programme apart from a requirement that a minimum number of credits must be achieved across four CPD categories.

246. The suggestion that there should be progression points over the course of a career that are acknowledged by both doctors and their employers was proposed in the survey, with a small majority of doctors recognising the value of such a process. The Working Party heard that many doctors expect such significant changes to occur within their working life and that some formal recognition and clarity with their employers about each party’s expectations would be welcomed.

247. The majority of fellows, members and specialist registrars who responded to the survey want the curriculum to be extended into a formal CPD programme (Figure 27). Throughout the Working Party there was enthusiasm for the RCOG to provide structure to CPD, allowing continuing accredited activities and career development to take place throughout professional life.

248. With the developing requirements of revalidation, it is felt that a more advanced, structured CPD programme would enhance professional practice and allow the GMC revalidation process to reassure the public (Schostak et al., 2010).

\textbf{Figure 26} Specialists’ views on supporting newly qualified colleagues during on-call duty

\begin{center}
\textbf{‘Should newly qualified specialists expect senior support when on call’}\\
\begin{tikzpicture}
\fill[red!20] (0,0) circle (2cm);
\end{tikzpicture}
\end{center}

\begin{center}
\textbf{Source: RCOG working party survey.}
\end{center}

\textbf{Figure 27} Obstetricians’ and gynaecologists’ views on extending the training curriculum into a formal CPD programme

\begin{center}
\textbf{‘Should the curriculum be extended beyond specialist registration into a formal CPD curriculum?’}\\
\begin{tikzpicture}
\fill[blue!20] (0,0) rectangle (2cm,4cm);
\fill[red!20] (2cm,0) rectangle (4cm,4cm);
\end{tikzpicture}
\end{center}

\begin{center}
\textbf{Source: RCOG working party survey.}
\end{center}

\textsuperscript{18} RCOG – CPD [www.rcog.org.uk/our-profession/cpd].
3. Delivering care

249. In 2005, the Royal College of Obstetricians and Gynaecologists published *The Future Role of the Consultant* (RCOG, 2005b). Many of the proposals about differentiating between those practising at senior level depending on their clinical activities were well received but not widely enacted. For example, the concept of the ‘office gynaecologist’ working without major surgical commitments but providing advice across the spectrum of low-risk, routine benign gynaecology, although well understood, has not become a reality.

250. The Hospital Consultants and Specialists Association (HCSA) produced a position paper in 2008 on the future role of the NHS consultant (HCSA, 2008). The paper recognised changing working patterns of specialists, with more out-of-hours work, fewer specialist registrars and the potential for a decrease in training opportunities because of other entrants (independent sector treatment centres at the time, ‘any qualified providers’ (AQPs) today) in the NHS service provision arena. They also highlighted the benefits of a specialist career pathway after the certificate of completion of training (CCT).

251. The RCOG reviews and approves the majority of advertised consultant posts and the structure and content of these posts has not changed over the past decade. Exceptions to this are specific subspecialty posts and the expansion in posts requiring delivery suite and obstetric activity.

252. More than two-thirds of existing specialists practise obstetrics and gynaecology, although the current area for expansion is within obstetric practice. The structure of job plans has traditionally limited direct activity on the delivery suite to a maximum of 2 days per week. The new consultant contract (DH, 2003) has some unintentional consequences for organisations wanting to construct a specialist-delivered service, as costs rise considerably if senior doctors are required to be physically present at night and weekends rather than being available from home.

253. This cost has been mitigated in obstetrics because the positive impact of a senior presence on the delivery suite is reflected in better outcomes for women and their babies, a lower Clinical Negligence Scheme for Trusts (CNST) premium (NHSLA, 2012), improved flow of patients, fewer admissions and reduced length of stay (AoMRC, 2012).

Affordability

254. As tomorrow’s specialists will need to work in teams with different responsibilities, it will be necessary for employers to reflect this contractually. As more specialists enter the workforce, and a greater proportion of care is delivered by this group, the service will need to develop different ways of medical staff working together in order to provide the comprehensive care over 24 hours necessary.

255. This may lead to further negotiations on increasing flexibility within the consultant contract for these different levels and types of work. The majority of doctors who responded to the survey supported the need for a different contract for those working at night, recognising the intensity and inherent difference of night shift working.

256. It is not enough simply to increase the number of specialists without also changing how they work or how the service is delivered. *High Quality Women’s Health Care* described the high-level vision for women’s health service provision, and developing the narrative within this report will help continue the debate.
**Tomorrow’s teams**

257. In some areas, the birth rate is rising with considerable consequences for maternity service resources. Planning healthcare workforce requirements must take into account all professional groups. Local education and training boards (LETBs) in England and the devolved administrations should be developing tools to balance workforce requirements effectively across all professionals groups. While the focus of this report is the medical specialty, the impact on other professions cannot be ignored and the sense of urgency for change to happen must be recognised by the leaders of the NHS.

258. The significant expansion in numbers of doctors at specialist grade and in training over the past 15 years has begun altering the ratio of specialists to specialist registrars. The number of doctors in the training grade increased in order to meet the needs of the out-of-hours service and fulfil legal requirements for rota. Simultaneously, the RCOG focused on the need for specialist expansion to provide safer care and this increase in specialist posts was supported by a number of initiatives, such as *Maternity Matters* (DH, 2007). The effect on women’s health services has been profound, with more specialists working directly on the delivery suite and out of hours as resident, instead of on call from home.

259. Further workforce changes to prevent the ‘overproduction’ of specialists will continue to alter the ratio of specialists to specialist registrars, as the former will outnumber the latter with a supply model based on output and quality rather than the needs of the out-of-hours service.

260. Women’s health care is provided by various professionals working together, and obstetricians and gynaecologists are already experienced at working in clinical teams with midwives and nurse practitioners (Mirnezami et al., 2008). The Working Party also heard evidence describing how some individuals are working together in specialist teams. Although these teams are often loose-knit and focused on shared decision making and planning rather than on directly delivering patient care, they are a real part of many specialists’ practice. The Working Party heard of examples of groups of three or four consultants working together to cover a regular day and night on the delivery suite so that one of the ‘team’ was always available. Other specialties have a ‘hot week’ or ‘doctor of the day’, where specialists are devoted to emergency care with no other commitments, linking with colleagues covering the nights so as to provide seamless care. However, the reality that, even where daytime cover is by fully trained doctors, out-of-hours cover still is delivered by specialist registrars or non-training-grade doctors without the CCT.

261. Tomorrow’s specialists in obstetrics and gynaecology will be required to work in more complex teams with a wider range of other specialists, such as specialists in community sexual and reproductive health care, public health and social care.

262. As the number of specialists in the NHS increases and the proportion of specialist registrars falls, there will be a need for very different working practices. Specialists will have to work together, cross covering each other’s practice so that the service remains supported at all times and continuity of care is maintained. Many of today’s specialist registrars accept this as the future and are prepared to work shifts providing a 24 hours a day, 7 days a week service.

263. Members of specialist teams will have different levels of experience and should provide support for each other’s professional development, with recognition of their different roles by the employer.

264. **These teams of specialists will form the obstetric and gynaecological medical element of multidisciplinary teams** that support all elements of the service.
Team structures

265. Teams of specialists providing continuous specialist care 24 hours a day, 7 days a week will increasingly be the model as the ratio of specialist registrars to specialists changes.

266. The Working Party heard support for a ‘chef du service’/‘chief of service’ model. Although obstetricians and gynaecologists are familiar with working with clinical directors, the latter may not be from the specialty and have much broader roles. While understanding the financial and general management issues is important, they also have a key role in protecting the clinical work that is maternity and gynaecology. They need a strong clinical background and need to be skilled at understanding the various clinical components of the directorate and the challenges within each specialist area.

267. The role of a ‘chief’ or ‘senior clinician’ would complement the clinical director’s role and provide the hands-on clinical leadership for a team of specialists and other healthcare professionals, taking responsibility for the day-to-day service and the quality of care for patients under the care of the team. This style of work has, to some extent, been utilised in oncology services.

268. Even though the number of specialists appointed at a younger age will increase, there will also be an increase in the number of experienced doctors working as the retirement age rises. Many of these doctors would have the skills to be the ‘senior clinician’ of a specialist team and to deal with all the clinically related issues and ensure all clinical activity is covered appropriately. Large units may have several teams of specialists and communication in large departments, particularly when members of staff are working shifts, can be difficult; team leaders – ‘senior clinicians’ – would have a pivotal role in ensuring continuity of care between teams and throughout the multidisciplinary team, and in disseminating information to all team members.

269. The need for newly qualified specialists to work with more experienced colleagues when they have to manage complex cases should be recognised in individual job plans. This is more likely to be successful if it is done at departmental level and seen as standard organisational practice, and is important if newly qualified specialists are to feel valued and able to function as fully fledged specialists.

270. The need for support when gaining experience in the less common and/or more complex but still routine elements of clinical practice is not a sign of inadequate training but should rather be seen as a natural part of lifelong learning and professional development. The proposals for ‘buddying’ and mentoring in Chapter 2, Section C would support this new type of team.

271. Specialist registrars and others in training will benefit from the stability and coherence of the team. There is no intention to make specialist registrars supernumerary and all the evidence that the Working Party heard supported the continuing embedding of training within service provision, but no elements of the service should be reliant entirely on this group.

272. If organisations are providers of postgraduate medical education and training, their specialists must have the skills for teamwork, leadership and management in addition to their accredited clinical skills.

273. Each ‘senior clinician’ or team leader will be expected to ensure that adequate training time is available within individuals’ job plans. Similarly, there are some doctors who do not wish to train others or who do not have the skills but who contribute in other ways professionally. The value of a team of specialists responsible for all areas of professional and clinical practice is such that specialist registrars will get better access to high quality supervision and training within their structured programme. The Working Party heard evidence from individuals who are clinical directors in their units and use departmental job planning to support education and training and other elements of professional life such as audit and clinical governance responsibilities. This approach is commendable as it allows individuals to take on specific areas of responsibility and it ensures the efficient use of time and that all areas of work are covered by the specialist team.
274. The contribution to the service from specialist registrars is defined by their abilities at different stages in their training programme. The training matrix used by deaneries and heads of schools already allows organisations to rapidly assess what individual specialist registrars are competent to provide.

**Network development and the impact on specialists**

275. As the expected changes to commissioning in England and the changes in service delivery in the devolved nations emerge, it is clear that continuing to have only cancer and neonatal networks formally established is to miss the opportunity for linking care along the life course of an individual woman. Strong multi-agency strategic women’s health networks will have a positive impact on disease prevention and public health.

276. The NHS Commissioning Board has recently announced the establishment of four strategic clinical networks, one of which is for maternity and children’s services (NHS Commissioning Board, 2012). In view of this, the need for clinicians to establish local and regional women’s health networks is all the more urgent, as the potential gains for women of a fully integrated system can be realised by building on these strategic clinical networks.

277. A women’s health network would consist of organisations where complex and routine services are provided. These organisations do not have to be large but they do need the workload infrastructure and patient numbers to justify their existence. Subspecialist work would take place in these organisations but the actual clinical care would be delivered in a variety of settings. There would be benefits from subspecialty networks to quality assure performance and to allow for rare and complex cases to be managed and for training to be focused.

278. Networks need to link other services for women’s health together with the obstetric and gynaecological components as the majority of interactions for women take place with their general practitioners (GPs) and in community sexual and reproductive healthcare services as well as with the strategic clinical network for maternity and children. Listening to organisations that have a track record in representing women’s views, such as NCT, is important when planning services.

279. The anomaly seen now is that highly committed professionals have developed subspecialist skills but are not necessarily working in organisations where these skills will bring the maximum benefits to women. This situation existed in gynaecological cancer services before the Calman–Hine report (The Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales, 1995) and many specialists at that time had to justify their clinical outcomes and either desist from provision of all cancer services or move to cancer ‘hubs’.

280. For example, it is unrealistic for a maternity service with fewer than 2500 births per year to employ a feto-maternal subspecialist. If they did, the specialist would undoubtedly provide the highest level of care with great expertise in this field but it is highly unlikely that a small service such as this would be able provide 24-hour resident specialist obstetric care. Hence, a woman having received expert care antenatally enters a lottery where she may, for the lack of subspecialist obstetrics, find herself transferred during labour to a unit where there are specialists 24 hours a day but where she is not known and therefore continuity for her is minimal.
281. Commissioners look for efficiency and quality and are unlikely to commission service provision that is fragmented in this way. Tomorrow’s specialists will have to be flexible and work in the appropriate part(s) of the network commensurate to their clinical skills.

282. Academic units led by the academic health science centres are already located within academic, clinical and quality improvement and innovation networks. The learning from these models could be used to improve the quality of care in other networks. Smaller units, linked geographically, will provide core obstetric and gynaecological services and form networks to offer women choice about their clinical care and their provider. Linking the output from academic centres to ensure that scientific advances are translated into clinical actions rapidly across networks will be supported if clinicians working in the service all take responsibility for academic endeavours.

283. Within geographical networks, a multiplicity of organisations will provide care in community settings, possibly through the AQP route, in smaller hospitals and in larger centres (particularly those elements relating to core obstetrics and gynaecology services). Links with primary care and community sexual and reproductive health care provision must be transparent and such that navigation through the network for women is straightforward.

284. Specialists must actively engage in discussions about commissioning and the provision of care. Each specialist must take responsibility for ensuring that, within the constraints of the funding and the political structures around health care, service models are such that quality of care is maintained.

Professional development and adaptability

285. As specialists will have longer careers, development within the specialist grade is seen as vital. Nearly half of respondents to the specialist registrars’ survey expect to move posts during their career (Figure 16). Clearly, the next generation of specialist is aware that they will have a different type of career than their current supervisors. The RCOG must provide support, through its education, continuing professional development (CPD) programmes and e-learning tools, for the professional development for its fellows and members throughout their career.

286. The CPD programme is currently relatively unstructured, offering an accumulation of credits for professional activities but limited opportunity for individuals to develop or demonstrate new skills or expertise. There must be advice on which elements of CPD are most suitable for an individual, reflecting their career aspirations and the needs of their service.

287. CPD, including using feedback from women themselves, should be the vehicle by which specialists develop their non-clinical professional skills such as management, education, patient advocacy and new or more advanced clinical skills. For example, it could also include the development of specialist skills required for the care of women who traditionally have difficulty in accessing services.

288. Employers would find the use of the appraisal mechanism to support career development more straightforward if accredited programmes were available and quality assured by the RCOG.

289. Revalidation will require all specialists to have up-to-date CPD portfolios, feedback from patients and appropriate quality outcome measures. CPD needs to be meaningful not only to the individual doctor but also to employers and the public.

290. It is important that the process of revalidation promotes development and learning and does not stifle flexibility and innovation.
291. It was clear to the Working Party that current specialists, SASGs and specialist registrars in training recognise the need for a healthy work–life balance and that one of the tools to achieve this is maintaining a sense of purpose and continuing to having options throughout working life.

292. The Working Party considered the evidence for a graduated career structure for the specialist workforce in obstetrics and gynaecology. This would be where a specialist career pathway is formally broken down into a number of phases, each lasting a number of years. These phases would each recognise various levels of experience and knowledge. The roles and responsibilities in each phase would also vary. This concept is supported by some employers as it has a number of potential benefits (CFWI, 2012b). In written evidence, several respondents suggested that there are three distinct phases within the specialist career pathway.

293. The HCSA position paper (HCSA, 2008) described a structured specialist career pathway whereby specialists early on in their career would carry more of the clinical workload. Later on, the emphasis would be on teaching, research and management. During the latter part of their career, specialists would relinquish some of their on-call commitments, focusing on other activities including teaching, training, and involvement in other professional activities outside the employing organisation, for example with the royal colleges.

294. However, the Working Party heard evidence that this type of age-related structure was perhaps too restrictive given that senior doctors often value the opportunity of working in front-line services where their experience and resilience is recognised. Likewise, younger doctors often have managerial, leadership and academic talent needed by the NHS. The Working Party did not support the concept that younger specialists take all the clinical workload and senior specialists provide all the other specialist activities. This was supported by the responses to the survey (Figure 18).

295. The Working Party heard oral evidence and noted the results of the survey of specialist registrars which showed that a significant number have personal commitments as carers (Figure 28). In view of this, a number of them want to take some time out of medicine and approximately one-third are considering working less than full time at some stage during their career.

296. The practice of women’s health care will develop and there will be increasing emphasis on delivering care in community settings outside of traditional hospital models. Doctors will need experience in their training in delivering health care in different settings, as well as greater knowledge of public health strategies and the prevention of disease.

Flexibility within the workforce

297. The Working Party heard oral evidence and noted the results of the survey of specialist registrars which showed that a significant number have personal commitments as carers (Figure 28). In view of this, a number of them want to take some time out of medicine and approximately one-third are considering working less than full time at some stage during their career.

19 The Royal College of Surgeons of Edinburgh, the RCOG Scottish Members and Fellows, and the Faculty of Sexual and Reproductive Healthcare.
Taking time out of the training programme is currently possible for specialist registrars. However, with the exception of maternity leave, it is uncommon for specialists to do so.

If employers want flexibility within the workforce in terms of covering all aspects of clinical care and developing new or different skills, it was clear to the Working Party that professional development and support for career development needs to be embedded into the culture of every NHS organisation.

It is possible that employers will develop new roles for specialists as models of health care change. Certainly, within teams of specialists, each doctor will have varying responsibilities and roles with common core activities (Figure 29).

In other specialties, it is not uncommon for specialists to work across quite large geographical areas in teams designed to support services. Commissioners may utilise ‘lead employer’ type structures where tomorrow’s specialists are contracted to a network delivering care in a number of settings. This is more likely in more specialised areas or gynaecological practice.

Figure 28 Specialist registrars’ caring commitments

Figure 29 Specialist registrars’ views on their future employment

‘At the end of the day, the service is where I am.’
Peter Blakeman FRCOG
4. Education and training for tomorrow’s specialists

302. From the evidence the Working Party has received, the preferred definition of a generalist obstetrician and gynaecologist delivering women’s health services is:

‘a doctor who has achieved a certificate of completion of training (CCT) or equivalent in obstetrics and gynaecology’

303. These doctors will be able to deliver the majority of care in obstetrics and in acute and non-complex gynaecology. They will be a highly trained but varied group of professionals, because the development of the ATSM programmes allows diversity of interest and clinical focus at the level of a skilled generalist with an identified area of clinical interest.

304. The terminology used to describe doctors during training and indeed after training as ‘junior’ or ‘senior’ specialists is both confusing and demeaning. The lack of clarity around moving from one specialist ‘level’ to another is of particular concern as it implies a career progression that does not exist. This potentially puts doctors into categories that define their relationship with colleagues rather than their professional skills. However, as teams of specialists develop, there will be roles, such as ‘senior clinician’, which denote the responsibilities of that individual but do not relate to an individual’s age or time in post.

305. The Government’s Education Outcome Framework publication Liberating the NHS: Developing the Healthcare Workforce – From Design to Delivery (DH, 2012c) explicitly links education and learning to improvements in clinical outcomes. Working with stakeholders, local education and training boards (LETBs) and Health Education England (HEE) will develop a mechanism for demonstrating how education quality outcomes impact on patient experience, care and safety, using five key domains:

- excellent education
- competent and capable staff
- an adaptable and flexible workforce
- NHS values and behaviours
- widening participation.

Producing tomorrow’s specialists

306. Ensuring that undergraduates in medicine consider a career in obstetrics and gynaecology is important for the future of the specialty. The Working Party heard evidence from medical students that they value the potential of working in many different situations, including overseas, while training in women’s health and that, although obstetrics and gynaecology was an intensive career, they wanted a decent work–life balance.

307. The Royal College of Obstetricians and Gynaecologists (RCOG) should ensure that it has links into undergraduate training and is able to influence medical schools to deliver education in women’s health that reflects modern, innovative practice.
308. The Working Party heard evidence from undergraduates that they valued and enjoyed learning practical skills, particularly those related to the care of women during labour and birth, and this was often the impetus for them to consider a career in the specialty.

309. Role models for undergraduate and young graduates deciding on their future specialty are important and the RCOG should ensure that clinical and academic leaders are utilised through the career support system to encourage entry into the specialty.

310. The aim of the current training programme is to produce specialists able to practise safely, effectively and efficiently in the generality of obstetrics and gynaecology.

311. The evidence from the surveys of RCOG members in training and those in specialist and in staff, associate specialists and specialty grade (SASG) practice suggests that all groups accept that changes to the training programme and the content of the curriculum will be needed as the service develops and as the impact of care along a life course trajectory is absorbed into obstetrics and gynaecology professional activities.

312. Evidence from the General Medical Council (GMC), Medical Education England (MEE) and other national organisations suggests that the shape of training at present is not sustainable with the current configuration of the workforce. The issue of affordability needs to be addressed if the service is to benefit from specialists on the front line, balancing the costs of investing in this grade of doctor with the benefits of more efficient training in a shorter and more focused programme.

313. The current training programme is delivered over 7 years, with the majority of time spent in secondary care provision. Doctors are trained within a curriculum that covers all aspects of obstetrics and gynaecology and elements of professional development such as leadership and medical ethics as core requirements. The length of training should not be considered to be fixed, particularly as service configuration and delivery changes will lead to greater supervision as discussed in Chapter 2, Section B.

314. An increase in the number of specialists on the front line, delivering direct patient care, will impact directly on training. As appropriate training requires effective supervision, there will be a significant increase in training opportunities and logically this should lead to earlier achievement of the curriculum aims and a shorter training programme. The Working Party recognised that this is not a simple algorithm but it is an area of change that the specialty needs to monitor and respond to through a flexible curriculum.

315. As networks develop, training must not remain static and fixed on historical annual rotations between hospitals. There are advantages to training taking place within a network and for specialist registrars to have access to specific training opportunities across the network regardless of their individual employer. Indeed, it might well be the case that, in England, specialist registrars are contracted to the network by the commissioners, so that those gaining competencies and experience are embedded within the culture and ethos of the local area.

316. The future role of specialists will inevitably evolve as the service changes with the development of new technologies, innovative treatments and the expansion of women’s choice. The current static training model does not

"I would very much hope to see in the future the role of the obstetrician and gynaecologist extended towards providing more holistic models of care, for example a role in helping to integrate services that address the social determinants of health and mental health problems. The model of an obstetrician with an extended role has worked very well in the case of diabetic care and a number of other medical problems. In keeping with the "life course" model of women's health, obstetricians could take a larger role in promoting service integration, with the pregnant woman as the focus and considering in detail how her psychosocial circumstances affect the current and subsequent pregnancies. This will be especially important if there is a move to "any qualified provider". Increasing competition has been shown in a number of settings to be highly detrimental to the integration of complex services as would be required to address women's health across the life course. Doctor's involvement as practitioners, advocates and researchers would then become even more crucial."

Specialist registrar responding to RCOG survey
permit much variation in the types of education provider, with the majority being secondary care organisations. The Working Party heard from undergraduates and specialist registrars that exposure to different clinical settings was a highly valued experience and many elements of the curriculum could be delivered in a variety of settings by a variety of providers.

317. The role for non-NHS, independent or third sector providers of education and training is currently almost non-existent in obstetrics and gynaecology. The Working Party heard compelling evidence from patient groups that specialists need an understanding of the totality of the care system. It may be that in the future a variety of providers will bid for elements of education and training, either in partnership with lead providers or as specific expert providers in their own right.

318. The Working Party listened to discussions from the British Medical Association (BMA), employers, clinical leaders and doctors at various stages of training about the risks of creating a ‘sub-consultant’ grade, in terms of reducing both the quality of care and the attractiveness of the specialty to tomorrow’s specialists.

319. The valued roles performed by SASG doctors are different and complementary to the current specialist role. Provided there is development within the specialist grade, there is no reason why a new grade between the CCT and the specialist post should be created in the future. The logic of service provision in the future being provided by doctors who have the CCT or equivalent will encourage the development of specialist teams.

320. Evidence from the BMA about the flexibilities within the existing consultant contract allowing both professional development and new ways of working was reflected in the evidence from organisations where specialist presence out of hours has been implemented (NHS Employers and British Medical Association, 2011).

321. However, affordability remains a challenge if employers are not able to see a clear cost–benefit analysis supporting specialist-delivered care (see Chapter 2, Section B).

The curriculum

322. The RCOG curriculum is based on the principles of ‘good medical practice’ (GMC, 2009) and is regularly reviewed and altered with changing practice or additional elements being added, for example leadership. The Working Party heard that the emphasis on clinical knowledge and practice needs to be supplemented with more assessment of the non-clinical and professional attributes required for effective senior practice. This is particularly important as those doctors that experience significant difficulties, resulting in referral to the GMC, often have problems that relate to inter-professional communication and non-clinical professional performance.

323. Changes highlighted in *High Quality Women’s Health Care* will have a significant impact on current gynaecological services. Obstetricians and gynaecologists, with colleagues in community sexual and reproductive health care as women’s health specialists, will be expected to work with general practitioners (GPs) and others in women’s health networks rather than only in secondary care hospital settings. Specialist registrars do not currently have significant access to community-based care and many have spent little time in general practice beyond their undergraduate and foundation programme experience. As the configuration of services changes, it is important that the training programmes for tomorrow’s specialists develop the skills necessary to enable them to work in these different environments.

‘It’s not contracts that limit flexibility. In my unit we have done loads using the flexibility allowed by the contract – just using our existing staff, not employing another person. The current contract has enough flexibility to allow different ways of working, it’s about engaging – there’s a lack of engagement between clinical and managerial staff […] The tools are all there – the will is lacking. People just do not have a common understanding of job planning.’

Paul Flynn MR COG, Deputy Chair, BMA Consultants Committee

‘All postgraduate doctors take part in quality improvement projects, clinical risk management and teaching throughout their training time, as they are core to becoming a senior professional.’

Diana Hamilton-Fairley FRCOG, London Deanery
324. The Temple report Time for Training (2010) emphasises the need to use modern technology to enhance training. The Working Party heard evidence from MEE and others that the use of simulation is strongly supported and is an area that specialists need to exploit further. The RCOG uses simulation as a learning tool throughout the curriculum but the benefits to patient safety, particularly when used for ‘skills and drills’ team training, need to be promoted more widely and become a formal part of every team development.

325. The expectations of doctors in terms of their professional development and their work–life balance are difficult to describe. The Working Party heard evidence from doctors at all stages of their career, including undergraduates, of the importance of maintaining a healthy work–life balance as well as developing and maintaining their professional skills.

326. The importance of developing awareness and insight during training was seen to be an area that requires more emphasis within the curriculum in order to produce doctors that are resilient as well as adaptable and flexible.

327. The area of the training curriculum in obstetrics and gynaecology most praised during evidence sessions was the advanced training related to the advanced training skills modules (ATSMs). These were widely recognised as providing in-depth training in specific areas of clinical activity in secondary care. The development of these modules by linking several together for specific career outcomes (for example, specialists with an interest in fetal–maternal medicine) is seen as a positive step towards more focused career advice for those in their final 2 years of training.

328. Controlling access to linked ATSMs was designed to allow local and regional workforce planning. The Working Party heard from Centre for Workforce Intelligence (CfWI) and Department of Health representatives that there are risks if individual specialist registrars are able to train in any area of practice that they choose. This will undermine local and national workforce planning efforts. There is also a risk for these doctors of not being able to gain employment within the NHS if they are unable to ‘offer’ the skills required. Developing better ‘in-training’ career advice based on local and regional future clinical requirements was seen as a vital aid to specialist registrars and clinical service leaders. Ensuring that the NHS has specialists in the right place with the right skills and at the right time is key to a successful specialty.

329. The enthusiasm from specialists for access to ATSMs was evident and the Working Party recommends that the RCOG develop more topics and consider widening access to this form of training.

330. The Working Party considered suggestions on the structure of the training programme with respect to ‘stepping on and stepping off’ points. Approximately one-third of specialist registrars currently take a period of time out of training for professional career development purposes. However, there are no options for a doctor who wishes to ‘mark time’ in a non-training post to gain recognised experience. They must either leave the training programme and relinquish their training number, or take a relatively short time out of the programme for a specific educational purpose.

‘Time for Training’

Professor Sir John Temple’s report (2010) recommends:

Recognise, develop and reward trainers:

- All consultants when they come into contact with trainees in a clinical situation will have a role in teaching and supervising them
- Consultants formally and directly involved in training should be identified
- They must be trained, accredited and supported:
  - Their training responsibilities must be recognised in their job plans
  - They will need a reduced service load in order to be able to focus more on training
  - Trainees will be more closely aligned with this smaller number of training consultants
- Organisations involved in the standard-setting and regulation of training must coordinate their approach and ensure clarity of these training roles
- Trainer excellence must be appropriately rewarded.

‘That’s part of the problem, why we all want to be consultants, there’s no way to be valued otherwise! I’m a graduate but still training so I’m like an undergraduate. It doesn’t feel like a great career.’

Specialist registrar, RCOG Trainees’ Committee
The Working Party heard from education leaders and non-medical employers that the lack of credentialing for elements of the curriculum risked restricting career development to only the ‘specialist grade or nothing’. If there were flexibility to ‘step off and step on’ a training programme, the ‘conveyor belt’ structure would be replaced with something that would benefit individual doctors and encourage innovative training programmes and service delivery.

Although the term ‘apprenticeship’ was not used by those giving evidence, it seems that some specialist registrars would find a formal period of time spent enhancing competence and gaining confidence useful, provided they could return to the training programme and progress to CCT. This ‘step on, step off’ approach would increase the flexibility of training programmes and, provided a mechanism was developed to monitor the quality of posts and a framework was in place to support both the individuals and the employers, this may be a valued option in the future.

Employers may welcome doctors with the specific competencies for delivering the service, even if not at CCT level, as a specialist-delivered model develops.

Academic training

The curriculum for academic training in obstetrics and gynaecology is recognised as producing excellent doctors. However, the Working Party is aware that there needs to be as much flexibility as possible for individual doctors to maintain the highest level of academic activity while achieving their clinical competencies. Given the ability of these doctors, it should not require twice as long to train them simply because of the academic responsibilities.

The RCOG has responsibilities to deliver high-level training that is appropriate to the future activities of these doctors and reflects their individual talents.

Post-CCT education and training

As patterns of service delivery change, doctors may well be employed by a number of organisations and have a portfolio-type career.

As specialists are appointed at a younger age and are likely to retire later, it is inevitable that many will look for new challenges during their career.

Evidence from PwC and other non-medical employers shows that successful organisations invest in their staff, providing and supporting continuing education and training throughout their career. This exposes the current medical career structure as anomalous because much of the formal support framework is removed once a doctor has a specialist appointment.

The Working Party was impressed with the enthusiasm shown in the specialist registrars’ evidence about their wish to have various themes within the CPD programme that would allow specific non-clinical skills to be enhanced as well as creating opportunities for the development of new clinical...
skills. This generation of doctors are already experts at using electronic learning opportunities and it was clear that this mode of education should be fully exploited by the RCOG.

340. Accredited formal training programmes or pathways within the RCOG CPD vehicle would enable doctors to enhance their clinical skills and knowledge, demonstrate competence in new clinical areas and develop expertise in theme areas such as education, medical management and leadership.

341. The impact of revalidation on both doctors and the public’s perception of continuing competence will be significant and the RCOG has a clear role in providing expert educational processes beyond the CCT.
Recommendations

This section should be read in conjunction with the Summary and the body of the report. The following recommendations have been discussed and accepted by the Council of the Royal College of Obstetricians and Gynaecologists (RCOG) and will be implemented by the RCOG working in partnership with external organisations and stakeholders.

Woman-centred issues

1 All changes to the education and training and working practices of tomorrow’s specialists must improve outcomes for women by:

1.1 Developing specialists who are more flexible and adaptable in their approach and skill set to provide services that are truly focused around the needs of women.

1.2 Ensuring that the views of women and the public are an integral part of all activities of the RCOG and specifically in the advice given to the implementation groups for Tomorrow’s Specialist.

1.3 Working with the NHS to improve quality by developing specific patient-reported outcomes, including patient feedback for all doctors working in women’s health.

1.4 Reviewing the curriculum to ensure that professional attributes are as important as clinical competencies, are integral to all elements of the curriculum and training programme, and are embedded in lifelong learning for every doctor.

1.5 Working with women’s groups to ensure that the curriculum and training programmes train doctors in the specific issues relating to the care of disadvantaged women.

1.6 Ensuring that all technological developments that will improve patient safety are embedded into the curriculum.

Professional support and workforce development

2 Clinical service configuration necessary for safe, effective care of women by specialists should be supported and delivered by the NHS, commissioners or equivalent, the RCOG and other royal colleges working together to:

2.1 Develop descriptions of the roles within teams of specialists working together to provide continuity of care and to reduce the reliance on specialist registrars for service delivery. These should reflect the different responsibilities within the specialist-grade roles and develop the description of leadership within specialist teams as well as within multi-professional clinical teams.

2.2 Monitor the impact of increased specialist-delivered care on access and supervision within the training programme. The RCOG must reassess the length of training programmes and recommend evidence-based adjustments in the length of training to the regulator as workforce changes influence the quality and provision of postgraduate medical education.

2.3 Define with the specialist societies in obstetrics and gynaecology, and other providers of low-volume, supra-specialist services, the requirements for fellowship-type training opportunities in these areas that reflect the national service and workforce needs.
2.4 Develop web-based career advice and information systems appropriate for all doctors working in women’s health throughout their professional lives.

2.5 Define the requirements for mentoring of doctors working in women’s health and develop proposals for training mentors regionally specifically to support doctors in early specialist practice, but with the expectation of expanding this element of professional development to all within the specialty.

2.6 Develop with fellows and members of the RCOG working locally with employers a formal period of support from a senior trained colleague to be available for every newly appointed specialist.

2.7 Develop the role of the regional college adviser (RCA) as the professional able to advise and support individuals planning the development of aspects of their careers, particularly if a significant change of focus is required.

Effective, high quality service delivery

3 There is a need for new models of specialist practice that reflect service need in general obstetrics and gynaecology, and that demonstrate how networks of care will deliver integrated services across primary care, community and hospital settings. These can be achieved by:

3.1 The RCOG continuing to press nationally and locally for specialist-delivered services and developing models of practice for the NHS.

3.2 Working in partnership with the Royal College of Midwives, the Royal College of Nursing and others to develop service configuration advice for organisations moving towards a specialist-delivered service that reflects both the numbers of births, the geography and the complexity and intensity of the obstetric workload and the gynaecological commitments required for the service.

3.3 Producing commissioning advice to include information on standards, quality and the establishment of women’s health networks.

3.4 Ensuring that gynaecological services are delivered by appropriately trained specialists, with networks established to reflect clinical complexity and surgical need.

3.5 Supporting the NHS, local networks and individual hospitals in the development of outcome measures that provide the metrics about individual doctors’ performance. The RCOG must support this and should develop a clinical outcomes observatory to provide evidence of quality of care and develop the process of utilising data to support service development.

Education and training

4 The RCOG should develop the training curriculum working with the General Medical Council (GMC) and the lead educational commissioners across the UK to reflect both the professional and personal development needs of doctors, leading to resilient, flexible and adaptable specialists working to deliver high quality women’s health care, by:

4.1 Ensuring that new training structures resulting from the Health and Social Care Act 2012 in England and the equivalent in the devolved nations have the leadership through the College to deliver innovative training models.

4.2 Working with partners such as the Royal College of General Practitioners (RCGP) to identify elements of the curriculum that would benefit from delivery in non-hospital settings so that specialist registrars gain experience in working in community settings and wherever relevant to future specialist practice.
4.3 Ensuring that within the curriculum there are elements that would support academic activity and that there are specific advanced training skills modules (ATSMs) that will enhance scholarship and academic achievements, separate from the curriculum for training of academic specialists.

4.4 Ensuring that academics have access to innovative training that is flexible, allows appropriate progress and supports their academic activities.

4.5 Considering options for developing the ATSM programme and for widening access to this educational element.

4.6 Developing new ways of training in both obstetric surgery and emergency gynaecological surgery to anticipate future clinical innovations.

4.7 Defining, as part of the curriculum review, the potential for credentialing elements of the curriculum to allow doctors to take ‘time out’ but still be given credit for specific skills suitable for employment.

4.8 Working with the GMC, Health Education England (HEE) and others to develop training programmes that can be individualised to a greater extent and that reflect innovative approaches to education and training.

4.9 Working with commissioners of education to develop networks for education and training as well as for service.

**Lifelong learning**

5 The RCOG should formalise post-CCT development and ensure that all doctors delivering women’s health care maintain their core skills and develop other professional skills, particularly in leadership, teamwork and management, keeping them flexible and adaptable, by:

5.1 Establishing an implementation group to develop an accredited CPD programme that reflects all elements of professional development and to develop post-CCT training programmes that are fit for lifelong learning. This must enhance flexibility and adaptability within the specialist grade for employers and doctors, and provide accredited evidence for revalidation.

5.2 Developing the specialist career pathway, working with national organisations, including the GMC, to define career development within the specialist grade.
Appendix 1: Current training in obstetrics and gynaecology

The current training programme in obstetrics and gynaecology is summarised in Figure 30 and additional details are given below.

- Two years at foundation level follows an undergraduate or postgraduate medical degree.
- Entry to the 7-year training programme is competitive and there is a proposed reduction of entry posts to stabilise at approximately 160 per year to enter year 1 (CfWI, 2011). Entry numbers at all levels of the programme in England and Wales were 225 in 2010/2011 and 241 in 2011/2012.
- The 7-year programme is ‘run-through’; this means that there are no further competitive application points within the programme. The attrition rate is small and the doctors who withdraw usually do so during the first 2 years of the programme either because they realise they have entered a specialty that is not for them in the long term or because the basic competencies and the first part of the academic examination are not completed.
- Satisfactory completion of the programme leads to a certificate of completion of training (CCT) and entry to the General Medical Council (GMC) specialist register.
- The majority of CCT holders currently achieve a consultant post, as very few doctors exiting the training programme enter as staff, associate specialists and specialty grade doctors (SASGs).

CCT = certificate of completion of training;  
CESR = certificate of eligibility for specialist registration;  
NTN = national training number

[Figure 30 The postgraduate training programme in obstetrics and gynaecology]
Many SASGs applied for a certificate of eligibility for specialist registration (CESR)\textsuperscript{20} from 2007 and are on the specialist register through this route, although it is currently not usually a requirement of for these posts.

There are a number of doctors in the training programme who have spent periods of time before entering the UK system in other training posts in obstetrics and gynaecology. These doctors are eligible for entry to the specialist register via the CESR route.

The training programme is divided into three sections: basic, intermediate and advanced. This structure allows both employers and those in charge of education and training to utilise the skills of specialist registrars appropriately. The ‘matrix’ of training allows both specialist registrars and their supervisors to see exactly what areas of competence require more training and what the minimum set of competencies are for each phase of training (RCOG, 2011e).

The core curriculum is modular in structure but the modules are integrated and it is unusual for a specialist registrar to be working on only one module at a time.

The core curriculum covers all aspects of obstetrics and gynaecology but the structure of learning is such that some elements are by necessity only minimally covered, as they are part of more specialised learning and practice.

The curriculum is constructed so that current UK practice is reflected and reinforced by the learning objectives. This is why during the final 2 years of training there are advanced training skills modules (ATSMs) for doctors to enhance their skills in the relevant clinical areas for consultant practice and to allow a small number of trainees to gain skills in areas of clinical practice that, although important, do not require subspecialty training programmes, for example adolescent and paediatric gynaecology. These modules are grouped together to reflect current consultant practice, and specialist registrars need the agreement of training programme directors before commencing this element of training.

There are four subspecialty programmes: gynaec-oncology, reproductive medicine, fetal–maternal medicine and urogynaecology. Specialist registrars are able to enter a subspecialty programme after competitive interview for the final 2 years of training.

There is currently limited understanding of the workforce requirements for subspecialists and current calculations based on the Royal College of Obstetricians and Gynaecologists (RCOG) publication The Future Workforce in Obstetrics and Gynaecology (RCOG, 2009a) will be reviewed by work done by the RCOG and the Centre for Workforce Intelligence (CfWI).

Academic training opportunities exist at all levels of postgraduate medical education, beginning with the academic foundation programme. Significant changes in undergraduate medical schools and the emphasis on research has changed the traditional configuration of each university hospital having a professor of obstetrics and gynaecology with a number of other, substantive academic colleagues working at consultant level. The specialty is aware of the risks of reducing the number of academics in training and has a specific academic curriculum for all stages of the programme.

Many doctors take ‘time out of training’ for a variety of reasons, ranging from personal time for maternity leave to time to do a research degree. These requests are managed regionally and locally.
# Appendix 2: Working Party membership

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<td>Professor Sir Cyril Chantler</td>
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<td>Dr Edward Adams MRCOG</td>
<td>RCOG Trainees’ Committee Chair</td>
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<td>Ms Carmel Bagness</td>
<td>Midwifery and Women’s Health Adviser, Royal College of Nursing</td>
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<td>Ms Mary Eyo</td>
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<td>Dr Candace Imison</td>
<td>Deputy Director of Policy, The King’s Fund</td>
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<td>Ms Marie McDonald</td>
<td>Royal College of Midwives representative</td>
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<td>Dr Jane Mears MRCP</td>
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<td>Professor Wendy Reid FRCOG</td>
<td>RCOG Vice President Education</td>
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<td>Dr David Richmond FRCOG</td>
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<td>Dr Judy Shakespeare</td>
<td>Royal College of General Practitioners representative</td>
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<td>Professor Judith Stephenson</td>
<td>University College London</td>
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<td>Professor Terence Stephenson</td>
<td>President, Royal College of Paediatrics and Child Health</td>
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<td>Mr David Stout</td>
<td>Deputy Chief Executive, NHS Confederation</td>
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<tr>
<td>Mr Richard Warren FRCOG</td>
<td>Immediate past RCOG Honorary Secretary</td>
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<tr>
<td>Dr Chris Wilkinson FFSRH</td>
<td>President, Faculty of Sexual and Reproductive Healthcare</td>
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## RCOG support staff

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Appendix 3: Evidence collection methodology

Evidence was gathered using the following methods:

- surveys
- oral evidence
- written evidence
- literature review
- open web consultation.

Surveys

Parallel surveys were created for doctors (specialists and specialist registrars) and for women, so that their feedback could be compared. The doctors’ surveys included questions on the future of obstetric and gynaecological service provision, career progression and women’s wishes and expectations. The survey aimed at specialist registrars was divided into two sections: ‘the future’ and ‘what women want’. The women’s survey mirrored the questions posed to doctors about wishes and expectations. The questionnaire was disseminated to women through patient groups, charities and social media.

The number of survey responses received was as follows:

- active specialists in obstetrics and gynaecology in the UK – 1168 responses
- specialist registrars in obstetrics and gynaecology in the UK:
  - career aspirations – 1058 responses
  - women’s wishes and expectations – 434 responses
- women in the UK – 442 responses.

The aim of the survey was to test the assumptions of the Working Party.

Oral evidence

Oral evidence was reviewed and used to inform the development of the report, and was gathered from the following individuals:

- Peter Blakeman – Darlington Memorial Hospital
- Karen Bloor – University of York
- Paul Buckley and Vicky Osgood – General Medical Council (GMC)
- Alan Cameron – Scottish Government
- Liz Campbell – Wellbeing of Women
- Harry Cayton – Council for Healthcare Regulatory Excellence
- Shree Datta – British Medical Association (BMA) Junior Doctors Committee
- Rowan Davies – Mumsnet
- Paul Flynn – BMA Consultants Committee
- Jackie Gittins – PricewaterhouseCoopers (PwC)
- Patricia Hamilton – Medical Education England (MEE)
- Helen Hyde – Waitrose
- Moira Livingston – Centre for Workforce Intelligence (CfWI)
In addition to the Working Party, the RCOG Council reviewed the report at key stages of the drafting.

**Written evidence**

A total of 46 written evidence responses were received from a range of organisations. All written responses were analysed and used to inform report writing. The organisations included:

- specialist societies
- royal colleges
- RCOG devolved nations committees
- regulators
- education providers.

**Literature review**

A literature review was conducted throughout the duration of the project, to ensure that all relevant pieces of work were included. Where gaps in the evidence were identified, ad hoc literature searches were conducted. The aims of the literature review were:

- to find examples of good, innovative practice
- to find evidence of the medical workforce’s aspirations
- to find evidence of what women want from healthcare professionals
- find evidence of changing trends in the medical profession.

The following databases were searched:

- medical databases:
  - MEDLINE
  - The King’s Fund library catalogue
  - RCOG Library database (for report literature)

- non-medical databases:
  - Human Resources Abstracts
  - ABI Inform
  - Business Source Complete.

Fifty-two relevant publications were identified. Additional documents were suggested by the Working Party members.

**Open web consultation**

A consultation was open to all interested individuals and organisations on the RCOG website from 19 January to 7 May 2012. Specific questions were developed for medical and non-medical organisations.
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Tomorrow’s Specialist

To describe how tomorrow’s specialists will work in teams delivering high quality women’s health care, and to propose innovative and rewarding ways of working for tomorrow’s specialists, embracing training, lifelong learning and professional challenge.