Royal College of Obstetricians & Gynaecologists

Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology

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Purpose

Successive maternity reports have identified the important role consultants play in being key clinical decision makers, maintaining standards, reducing variations in patient care and role modelling professional behaviour. There is a need for consultants to be visible and effective leaders across both acute obstetrics and gynaecology.

This Paper refines the previous RCOG Good Practice Paper 'Responsibility of Consultant On-Call' published in 2009. It defines the roles and responsibilities of the consultant and examines the organisational support required.

Within this document we use the terms *woman* and *women.* However, it is important to acknowledge that it is not only people who identify as women for whom it is necessary to access women's health and reproductive services in order to maintain their gynaecological health and reproductive wellbeing. Gynaecological and obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

Disclaimer

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Clinicians and other healthcare professionals may consider it appropriate to depart from specific guidance in certain circumstances, such as serious staff shortages, emergencies or unforeseen absences. In such cases, RCOG strongly recommends that any such departure from local clinical protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken, and that the rationale for such departure is recorded elsewhere and reported, as appropriate.

Introduction

This paper refers to the roles and responsibilities of the Obstetrics and Gynaecology Consultant providing acute care. However, it is recognised that some of these roles and responsibilities will also apply to senior Specialty, Associate Specialist and Specialist (SAS) doctors if they are working autonomously, at consultant level, in agreed and designated areas of their work.

The key roles of an O&G consultant encompass clinical skills and decision-making, team leadership, education and supervision, risk management, innovation and patient advocacy. Consultants have a responsibility to role-model personal values consistent with building trust – integrity, reliability, predictability and competence – as well demonstrate respect for colleagues and women. Such values are important in setting the culture of units; a factor repeatedly identified within maternity reports as fundamental to providing safe and compassionate patient care.

O&G consultants work in a wide array of organisational structures. Those in smaller units may have responsibility for both acute obstetrics and gynaecology, working with a single junior tier of highly variable skillset or in some cases, no junior tier at all. Those in larger units may work within multiple consultant teams covering solely obstetrics or gynaecology with a dual junior tier. This paper transcends the spectrum of different unit configurations and activity. Previous discussions have focused on arbitrary levels of consultant presence against an annual number of births. However, the guiding principle should be to ensure that, when required, consultant leadership is present and visible to ensure that there are adequate numbers of staff with appropriate competencies available at all times.

This paper is intended to demonstrate how consultants add value to patient care, promote good practice and uphold standards for acute care in obstetrics and gynaecology. It acknowledges that consultants and their teams are often working to the best of their ability in extremely testing circumstances and under increasing scrutiny. Whilst recognising the general principles of a need for effective leadership, this paper also includes recommended standards to define when consultants need to be involved in discussions about patient care and when they should attend in person. Where individual units or doctors choose to deviate from these standards, there must be a clearly documented justification and rationale for doing so. Guidance is also provided on how ward rounds should be conducted.

Since the publication of the original paper, there is an increased need for organisations to support consultants as they adapt to these growing demands. This includes provision of adequate staffing to reduce rota gaps and ensure workforce sustainability. There is a need to develop fulfilling job plans that can be flexible and adapt to support different career stages and aspirations. At the same time, organisations must ensure that consultants can have adequate compensatory rest following on-calls. All organisations must prioritise staff wellbeing.

The report is presented in two sections: Roles and Responsibilities and Organisational Support. It concludes with a toolkit of resources.

Roles and responsibilities

Many O&G consultants have diverse clinical and non-clinical roles both within and outside of the NHS. However, the core roles and responsibilities of the consultant can be broadly summarised as follows:



Figure 1. Roles and responsibilities of an O&G consultant

Team leader and role model

Establishing cultural norms

Successive maternity reports have graphically illustrated how poor culture negatively impacts upon patient outcomes and experience. Issues such as delay in recognition and escalation of problems, lack of psychological safety of trainees, poor communication and multidisciplinary team working, absence of clinical leadership and stressed service capacity have been recognised to undermine patient safety. Leadership is a key factor in determining organisational culture (West 2014).

At its core, obstetrics and gynaecology training represents an apprenticeship. Consultants can be seen as role models, not just in terms of clinical skills and training but also in the development of professional behaviours. Consultants are always being observed, particularly in stressful clinical situations or on busy ward rounds. The behaviours that consultants role-model can shape organisational culture. A key aspect of maternity safety culture has been defined as the 'constant reinforcing of safe, ethical and respectful behaviours' (Liberati 2020). This requires consistent clinical leadership to demonstrate such values as important and relevant.

Whilst most individuals have a preferred leadership style, the most effective leaders are capable of demonstrating different styles of leadership that can be adapted to different tasks. This ability, known as reflexivity, requires leaders to take a step back, often in difficult situations and consider the best leadership style to link their team to their goals. This, alongside self-awareness, are important antecedents to leaders understanding the effect their leadership has on the team. By understanding the difference between dysfunctional and constructive styles of leadership, consultants can reinforce cultural norms that promote patient safety and trust within teams.

Goleman defined six leadership styles that can be adapted to different roles when providing acute care. No-one excels at all styles, however, learning to flex between styles has been associated with improved team performance. All of these archetypes represent key aspects of largely non-technical skills that today's consultants now require.

Visionary	Inspires and motivates others to work towards a vision through providing clear goals, supporting innovation and recognising team accomplishments Phrase: "Come with me" Example: When developing a new service
Coaching	Develops skills and helps set long-term goals amongst team members. Requires an understanding of the skill mix of the team. Phrase: "Try this" Example: Supporting junior colleagues to acquire new skills, including in stressful situations, without undermining.
Affiliative	Focuses on effective team working Phrase: "Let's do what's best for everyone" Example: Providing support at times of stress or high activity, debriefing after a difficult situation.
Democratic	Values the input of different team members, respecting their diversity of experience and skill sets. Focuses on participation and collaboration rather than clinical hierarchy. Phrase: "Let's decide together" Example: When evaluating a service or planning care for a woman with complex needs.
Pace setting	Expects excellence and quick results from a high performing team. Sets high standards. Phrase: "Do as I do now" Example: During periods of high activity on labour ward or when greater attention to detail is required during complex surgery.
Commanding	Demands immediate compliance. When extremely transactional closed loop communication is required during times of acute crisis. Phrase: "Do what I tell you" Example: management of an acute emergency such as patient collapse, PPH or shoulder dystocia, or during difficult surgery.

Figure 2. Leadership styles applied to Obstetrics and Gynaecology adapted from 'Leadership that gets results' (Goleman 2000).

Valuing diversity and multidisciplinary input

Collaborative, inclusive and compassionate leadership is essential to deliver the highest quality care for women and tackle deep-seated cultural issues in the NHS (West 2017). When multi-professional teams work together, patient satisfaction is higher, healthcare delivery is more effective and staff stress, absenteeism and turnover are lower (West 2011). Consultants have a key role in delivering this by ensuring effective team and inter-team working.

Each day the consultant leads a team, usually in collaboration with the midwifery lead, that is rarely the same as previous days, caring for women with different backgrounds, concerns, and clinical issues: an amalgam of risks and decisions. This high-pressure environment requires a multidisciplinary team adept at responding to concerns, reaching out to women, advocating options for treatment and enacting them. The NHS England White Paper on 'Safety II' recognises that clinicians' ability to adapt and match their work to the conditions is a fundamental aspect of ensuring that things go right in difficult situations (Hollnagel 2015). Conversely, there has been a recurrent theme through maternity reports that the failure to see women as individuals with individual concerns, the breakdown of a collegiate approach within units and the absence of effective clinical leadership underpins poor clinical outcomes. Many of the maternal mortalities within MBRRACE are notable because of the absence of consultant involvement.

However, the consultant's role extends beyond the obstetrics and gynaecology team. Consultants also play a pivotal role in building and maintaining relationships across teams (GMC 2012). Consultants retain influential positions within the hospital and their seniority and familiarity with other clinicians will often remove friction, enable key aspects of care and facilitate requesting and obtaining assistance from other specialities. This is particularly important for women with complex medical problems or for those in whom there is not a clearly established diagnosis.

Having a 'named consultant' promotes good care (Francis 2010) but it needs to be reconciled against modern team structures and flexible working patterns and recognise that women will often be under the care of several consultants during their clinical journey. There is therefore a need for teams of consultants to work cohesively to ensure smooth transitions for women, recognising that the best of management plans developed by the woman and her named consultant may need to change as the clinical picture evolves.

Optimising team performance and commitment

As team lead, the O&G consultant needs to promote positive team working, good information flow and clinical prioritisation. Concern for others and grace under pressure are defined as two key qualities that team members consistently cite in high performing leaders. These qualities are closely aligned to team resilience. 'Civility Saves Lives' defines how uncivil or disrespectful behaviour affects decision making, not just in the recipient but also in those who witness it (Porath 2013). GMC guidance also stresses the importance of understanding how your behaviour affects others (GMC 2014).

O&G consultants need to provide structure for the team and facilitate an authority gradient that promotes good care and enables other team members to speak up when something is wrong (Green 2017). Steep authority gradients between clinical and midwifery leaders have been recognised as unseen influencers when incidents are examined. Poor relationships across the team can delay or prevent escalation. Each Baby Counts reported unbalanced skillsets, unfamiliar team members and inconsistent or incorrect methods of escalation as being factors leading to untoward outcomes (RCOG 2019).

By understanding skillsets, discussing management plans and enabling and accepting respectful challenge, consultants can reduce authority gradients and enable teams to form around the clinical needs of the woman. The consultant, as team lead, is best placed to reinforce respectful behaviour and psychological safety to enhance information sharing across teams and facilitate learning from events. Amy Edmondson coined the phrase 'psychological safety' and defined it as "a belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes." Her original paper and subsequent lectures give further information on how this concept can be applied to medical teamworking and patient safety (Edmondson 1999, 2013, 2014).

Good communication and shared mental models are important to maximise team situational awareness in theatre, clinic and the labour ward (Yoong 2021). Poor communication has been found to contribute to surgical errors (Nagpal 2010). Active listening requires concentration, withholding any assumptions and genuinely listening to gain a deeper understanding of issues and situations (NHSi 2018a).

Positive leadership indicators	**Negative leadership indicators**
Introduction to all team members showing respect	Starts surgical cases without introduction
Good eye contact	No eye contact or social interaction
Responds to trainees and team members' queries fully	Curt, dismissive answers to questions
Suggestions and challenges from trainees acknowledged	Suggestions and challenges from trainees ignored
Use of first name basis (if comfortable)	Doctors and nurses are referred by their formal titles

Figure 3. Creating effective teamwork in the operating theatre by active listening (modified from Sydor, Bould, Naik et al 2012)

The other challenge that consultants face when leading teams within O&G is that teams rarely consist of the same people. Instead, 'action teams' form where individuals must work together to get the job done rather than focus on building relationships (West 2012). In order for teams to work well in these circumstances, consultants need to consistently express shared purpose. By demonstrating humility and a willingness to admit what they don't know and by role-modelling curiosity and a openness to learn from others, they can create psychological safety for the team (Edmondson 2018, 2020). This is not just important for staff morale, but has also been linked to improved patient experience (West 2011). This can be put into practice by encouraging all members of the team to contribute during the ward round and by taking time to have a tea break together to reflect upon cases, get to know one another and build trust.

Lencioni's pyramid of teamworking provides an accessible model outlining how trust, respectful challenge, commitment and accountability are key factors in successful team working.



Figure 4. Lencioni's 5 behaviours of a cohesive team

Trust reduces feelings of vulnerability, stress and anxiety in staff, reduces staff turnover and improves communication, staff morale and commitment (CIPD 2012). Trust is particularly important when dealing with uncertainty, such as that encountered acutely during obstetric emergencies and more chronically as a result of changes in service structure, working patterns and NHS funding. In order to engender trust, leaders must act with ability, benevolence, integrity and predictability (Dietz 2006). There are various ways in which O&G consultants can foster trust and good rapport within teams. Some examples include taking frequent opportunities to relay positive feedback to other members of the team, particularly in front of others, being available to debrief teams after poor outcomes, supporting teams to carry through decisions, maintaining a helicopter view to support teams during heightened activity and being accessible for team members to raise concerns.

Key messages

- The leadership style and behaviours that consultants role-model are fundamental to setting the culture within Obstetrics and Gynaecology units. Consultants should learn to adapt their leadership style according to the situation.
- Consultants have a responsibility to build positive, cohesive relationships with the multi-disciplinary team and with other specialties to ensure seamless, person-centred care.
- Consultants should facilitate shallow authority gradients as these promote psychological safety and are key to staff feeling able to raise concerns and learn from events. This, in turn, improves patient safety and reduces the risk of adverse events.

Clinician

As the most experienced clinician, consultants are now often needed to be physically present, including out-of-hours, to support the care of more complex women or during high levels of activity. It is not unusual for a clinician whose primary role is gynaecology to be the most experienced clinician on labour ward and be required to attend a complex emergency. There is a need for O&G consultants who provide out-of-hours cover for both obstetrics and gynaecology to continue to develop post CCT / CESR and maintain their skillset across both modalities. This particularly applies to less common emergency obstetric scenarios as these are time-critical situations where the confidence, skillset and support of the attending consultant will often define the outcome.

Different units require different thresholds for direct consultant involvement in patient care. Units with a single tier junior rota will experience higher levels of variation in the competence and experience of that tier. Units with dual tier junior rota often experience high levels of complex activity.

This list defines the clinical scenarios and situations when consultants should be informed and when they should attend in person. In situations where the consultant is to be informed, this should include a full discussion regarding the patient's care and any concomitant clinical activity. Where individual units or doctors choose to deviate from these standards, there must be a clearly documented justification and rationale for doing so.

Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
GYNAECOLOGY
Any laparotomy

Figure 5. Situations when the on-call consultant must attend

Situations in which the consultant must ATTEND unless the most senior doctor present has documented evidence as being signed off as competent. In these situations, the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure.
GENERAL
Any patient in obstetrics OR gynaecology with an EBL >1.5litres and ongoing bleeding[#]
OBSTETRICS
Trial of instrumental birth
Vaginal twin birth
Caesarean birth at full dilatation
Caesarean birth for women with a BMI >40
Caesarean birth for transverse lie
Caesarean birth at <32/40
Vaginal breech birth
3rd degree perineal tear repair
GYNAECOLOGY
Diagnostic laparoscopy
Laparoscopic management of ectopic pregnancy

Figure 6. Situations when the on-call consultant must attend unless the most senior doctor present is signed off as competent.

[#] *This includes women in early pregnancy. Consultants should be informed earlier than 1.5 litres if the woman is haemodynamically unstable, has a low body weight, has a low starting haemoglobin, if there is a rapid rate of bleeding or if there are other complexities regarding her care. Should the consultant choose not to attend in person, there should be a full discussion regarding resuscitation of the patient and ongoing management. This should be documented along with the reasons why the consultant has not attended.*

The above lists are not exhaustive and therefore it is recommended that prior to any shift, there should be a discussion between the consultant and the on-call team regarding any scenarios where the consultant would wish to be informed, even if their attendance may not be immediately required. These scenarios may vary according to the level of experience of the most senior doctor present.

Units should consider maintaining a matrix of middle grades' competence level for the above scenarios or develop ways of regularly discussing this information during consultant meetings. This is to ensure patient safety and a supportive training environment while also enabling middle grades to become progressively more independent. While documented evidence of competence is required, it should be remembered that a single competent OSAT may not mean that a doctor is competent in all situations, particularly for less frequently occurring clinical scenarios.

The acute on-call consultant must be available quickly in person, and therefore **should not be engaged in other activities** that could delay attendance*. Duties such as elective surgery, clinics or off-site work should not be undertaken whilst on-call. This avoids a conflict of priorities, ensures availability to the on-call team and maintains ongoing awareness of women who require acute care.

When consultants have to undertake specific clinical tasks, they may no longer be best placed to maintain the helicopter view or situational awareness of the whole environment. This is a particular issue when doing resident second on-call duties, as some consultant posts now entail. It is therefore imperative that when this happens, consultants articulate this so that the responsibility can be shared or transferred to the midwifery co-ordinator or a senior member of the clinical team. Similarly, organisations should appreciate the reciprocal relationship between increased workload intensity and reduced consultant oversight.

Ward rounds and huddles

Ward rounds are an important part of patient care because they are a way for the whole team to share information and gain an oversight of the clinical condition of all women under their care. This enables staff to monitor, anticipate and respond in a timely way to emerging problems (HSIB 2020). They also offer women the chance to ask questions and speak to all those involved in their care. Furthermore, ward rounds are an excellent opportunity for bedside teaching and clinical education. The role of the consultant may be to lead the ward round or to support other team members in doing so. As at all times, consultants should be mindful of the professional behaviours they role model during ward rounds. This includes respectful and courteous communication with women, families and all team members.

The NHS Improvement document 'Implementing handovers and huddles; a framework for practice in maternity units', co-developed with the RCOG, details the need to structure ward rounds with a consistent presentation of information to maintain situational awareness (NHSi 2019). Typically for an obstetric ward round, the midwifery coordinator, obstetric consultant, junior tier and anaesthetic team should be present. However, it is not essential for all those present on the ward round to enter the room of each woman. All team members should be mindful of patient dignity and preferences during labour. This is particularly the case for women in active labour, those separated from their babies immediately after birth and those who have suffered a pregnancy loss. If all team members do not see all women, it remains important that information is shared with all team members and everyone can input into the woman's care. This can be achieved during a board round before the ward round and updated again during the team debrief after the ward round.

Acute obstetric consultants need to conduct twice daily ward rounds as a minimum, one of which should be in the evening (RCOG 2016). The frequency needs to be scaled to the size of the unit, shift change patterns and patterns of activity. Units should consider replacing traditional telephone board rounds and moving towards using web-based technology to undertake board rounds involving the full multidisciplinary team. Further guidance on best practice for conducting ward rounds, based on work from the Royal College of Physicians (RCP 2021) can be found in Appendix 1.

Huddles are a novel but important concept. They are team-based meetings which occur part-way through a shift or task to review activity and care plans and adjust the team response as needed (RCP 2017). As team lead, consultants should see huddles as an opportunity for sharing information, maintaining situational awareness and reducing the risk of patient harm. They should also be considered a means to plan workload, such as inductions or planned caesarean births, outside of the ward round. Handovers are frequently interrupted by emergencies. Huddles are a way of clinicians remaining responsive to concurrent emergencies at handover and reconvening post emergency. Huddles also provide an opportunity for all team members to verify information post ward round.

Obstetric & Neonatal team huddles should occur once both obstetrics and neonatal teams have completed their respective ward rounds. In larger units (>4000 deliveries) these should occur twice per day.

Units should also implement acute gynaecology ward rounds. Large units will benefit from a later ward round, meaning that daytime acute admissions will have a consultant review in the evening. Gynaecology consultants must ensure that they fulfil the standard that all women should be reviewed within 14 hours of admission. This will ensure that clear decisions in relation to diagnostics and theatre are made. This standard also applies to acute antenatal, intrapartum and postnatal admissions within an obstetric pathway.

Safe handovers

Multi-disciplinary handovers improve communication and reduce errors and omissions (RCOG 2019). It is important that information is accurate and succinct so that it is understood and actioned by the incoming team. Good handovers also facilitate clinical decision making and planning of future management to ensure that care is progressive across shifts.

Consultants must ensure that plans are clearly explained and documented for teams providing care out-of-hours or during a weekend. Consultants should support a standardised handover model that promotes information flows across the multidisciplinary team. RCOG Good Practice Paper 12 ‘Improving Patient Handover’, and the NHS Improvement paper ‘Implementing handovers and huddles: a framework for practice in maternity units’ introduce tools that standardise information flow across variable levels of activity (RCOG 2010, NHSi 2019). This will help junior doctors prioritise women across both obstetrics and gynaecology out-of-hours and reduce uncertainty regarding care plans.

Structuring electronic handover aids and boards promotes a consistency that can be followed during each handover to reduce variation across teams. This is particularly important for acute admission of outliers and those who could potentially deteriorate quickly such as postnatal or post-operative re-admissions or women awaiting theatre.

Another key issue is raising consultant awareness of women with more complex presentations. It is notable that communication failures were identified in almost three quarters of pregnancies reviewed by MBRRACE (Draper 2021). Particular attention should be given to women / patients who have prolonged admissions, recurrent attendances or those in whom there is not a clearly established diagnosis. This can make discussion difficult, with such women often overlooked until serious difficulties emerge. Creating psychological safety so that all members of the multi-professional team feel able to escalate concerns and taking a collegiate approach between consultants around unresolved issues will optimise care for a woman with complex needs.

Key messages

- Consultants providing on-call cover in Obstetrics and Gynaecology must ensure that they maintain their skill set post-CCT, particularly for more complex obstetric scenarios.
- When on-call, consultants must not be engaged in other activities such as theatre, clinics or off-site work which could delay attendance*.
- Ward rounds and huddles are important to ensure situational awareness is maintained by the whole multidisciplinary team, appropriate plans and decisions are made regarding patient care and that women have the opportunity to receive information and ask questions.
- Ward rounds should be conducted by consultants twice daily on labour ward, with one of these occurring in the evening.
- Consultant-led gynaecology ward rounds should also take place. Units should ensure that they meet the standard that all patients are reviewed by a consultant within 14 hours of admission.
- Developing a standardised handover model helps improve communication and reduce omissions and errors.
- Consultants must be involved in the care given to women who have prolonged admissions, recurrent attendances or those in whom there is not a clearly established diagnosis

Trainer and supervisor

Effective supervision begins with role modelling collaborative and compassionate clinical leadership. At a time when there is up to a 30% attrition rate of trainees in obstetrics and gynaecology, consultants should be focused on cohesive, inclusive team working, promoting positive feedback and debriefing following difficult situations. The quality of working relationships between consultants and their colleagues is a key enabler of patient safety. By actively supporting their junior medical colleagues, consultants within a unit establish the cultural norms which embed organisational values and underpin a culture which prioritises patient safety.

Traditionally, there has always been a sense of hierarchy in healthcare based on rank, experience and seniority but this culture can prevent junior colleagues, other members of the multidisciplinary team and women from raising concerns when they notice avoidable harm. Consultants should be mindful that sometimes their consultant status alone can make it more difficult for others to speak up (Reitz 2017). Overcoming this requires self-awareness, humility, a genuine belief that all opinions should be heard and an understanding of the relational aspects of team working that enable others to raise concerns, give feedback and share ideas.

Creating a shallow work authority gradient enables trainees and all other more junior members of the wider team to be comfortable with the process of escalation (rather than associating this with weakness or incompetence) and promotes an assertive culture where staff are more willing to speak up and raise concerns. A leader who listens will try to create a work environment where a “shallow” authority gradient is established between the least experienced member and the senior consultant, so that the former is empowered to speak up when he/she notices unsafe conditions (Wachter 2012), while acknowledging that the ultimate responsibility rests with the latter. A “shallow” rather than a “flat” gradient is desired so that there is an understood chain of communication escalation when a response is required.

Technical proficiency of all team members is associated with increased safety in maternity (Liberati 2020). All team members who work together should learn together. This includes multi-disciplinary skills drills and simulation training, as well as informal 1:1 teaching. Different modalities of formal and informal training need to promote not just procedural competence but a broader consciousness of the working environment. Prioritisation of several simultaneous complex situations is a key experiential skill to develop in junior colleagues. The Non-Technical Skills for Surgeons (NOTSS) assessment tool (rcog.org.uk) provides a framework for consultants to undertake this and provide structured, constructive feedback.

Clinical supervision and mentoring of junior colleagues should be one of the most rewarding aspects of the consultant role even in an acute setting. However, the importance of mentorship has often been overlooked in favour of acquiring technical skills and providing service. Enabling technical competence in an emotionally charged, time critical, high-risk, unpredictable situation while promoting team working and leadership requires a unique skill set. Over time, effective supervision, refines autonomy and promotes mastery and purpose for junior doctors in O&G. For trainers, it demonstrates how much their positive influence can establish a legacy of good patient care. Repeated GMC and RCOG Training Evaluation Form (TEF) surveys have highlighted the extent to which trainees feel undermined by consultant feedback and behaviour in acute settings, which demonstrates how difficult this can be to do well. Junior doctors must be able to ask for help

without fearing judgement or criticism. All colleagues must feel able to contact the most senior member of the team without recrimination, bypassing others should they judge it necessary.

Regular positive feedback should be seen as a key goal in delivering good training and building healthy working relationships. Given on a regular basis it promotes psychological safety and active listening on both sides while enabling those situations when constructive or difficult feedback is required.

The junior tier of doctors in O&G usually includes trainees, Locally Employed Doctors (LEDs) including SAS and locum workers. When on-call, a consistent issue is the lack of awareness that consultants have of the level of competence (and confidence) in their junior tier. Within larger units it can take some 3-6 months for all team members to be on-call together and acclimatise. This underlines the need for effective handovers and ward rounds at the changeover of medical shifts.

The Cappuccini test is an audit tool devised to improve patient safety in anaesthetics (RCOA 2018). It is based on the lessons learnt from Frankie Cappuccini's death following a caesarean section and postpartum haemorrhage in which supervision arrangements of a non-consultant grade doctor were found to be undefined and inadequate by the coroner. It is a simple six question audit designed to pick up issues relating to supervision of trainees / LED and non-autonomous SAS grades (NASG). The audit involves two key steps; firstly, asking the trainee / LED / NASG if they know who is supervising them and secondly, how to get hold of them. Using the answer to the second question the auditor attempts to contact the consultant. If contact is made, they ask the consultant if they know who/which lists they are supervising, what specialty list the trainee is covering, if they are aware of any issues and finally would they be able to attend immediately if required. The Each Baby Counts programme identified failing to successfully escalate concerns as a critical contributing factor to adverse outcomes in over a third of cases. The Cappuccini test has been modified for obstetrics and gynaecology in Appendix 2.

For non-permanent roles, the Certificate of Eligibility for Locums provides a standardised competency matrix which will allow roles to be matched against technical proficiency for short-term locums (less than 2 weeks). It will be launched later in 2021. Standards for the support and orientation of long-term locums are also now in place.

The guidance details the key steps for supervision and departmental orientation such as access to electronic ordering systems and patient records. In the same way that they would with any permanent junior colleague, consultants in acute settings, but particularly on-call with non-permanent team members, need to verify that they have both the necessary tools and access required to provide patient care and the skills to provide it. Consultants should ensure junior colleagues have insight into their level of competency, know when to ask for help and that there are no barriers to escalation if they have concerns.

The learning curve between the end of CCT / CESR and year 1 consultant is steep and intimidating. New consultants are expected to deliver the highest standards of clinical care whilst acquiring and refining their leadership skills in new and pressurised environments. Good mentoring at this stage is essential and should be offered to all new consultants to support this transition and allow them to grow in confidence. O&G mentors should offer support to consolidate clinical skills when needed but mentors from other disciplines can be just as effective coaches, helping new consultants navigate their new roles and responsibilities successfully. The same principles should be applied to doctors taking up new Specialist Doctor posts in Obstetrics and Gynaecology.

Key messages

- Inclusive team working, positive feedback and debriefing following difficult situations are key to more junior staff feeling well supported.
- Shallow authority gradients and all members of the multidisciplinary team feeling able to escalate concerns and ask for help are key to patient safety.
- A "shallow" rather than a "flat" gradient is desired so that there is an understood chain of communication escalation when a response is required.
- As well as technical proficiency, there should be an emphasis on teaching leadership and communication skills, particularly during high-pressured situations.
- Juniors should know who is supervising them and how to contact them. Conversely, consultants should be aware of the level of competency of those they are supervising.
- Mentorship, in both clinical and non-clinical skills is important at all career stages, but particularly for new consultants.

Risk manager

O&G consultants, often with other team leads, are well placed to adopt a helicopter view required to maintain situational awareness and anticipate risk to women. Situational awareness can be defined as "…the *perception* of the elements in the environment within a volume of time and space, the *comprehension* of their meaning and the *projection* of their status in the near future…" (Endsley 1995). It is the cognitive state of being vigilant and 'knowing where you are, what is going on around you and therefore, being able to anticipate events.' Factors which positively influence situational awareness include experience, adherence to standard operating procedures (SOPs), communication (briefings, mini-briefings and "sharing mental models"), as well as the ability to manage workload and distractions.

Different sized units will have different system stressors at different times. The consultant is often the fresh pair of eyes to provide balanced decision making and support. Examples include understanding how increased levels of activity or reduced staffing can affect care in labour or in acute gynaecology. Such situational awareness is important both at the level of the individual woman and of general service provision.

Consultants through their influence, experience and ability are often best placed to alleviate potential barriers to care and draw in or provide extra assistance. Complex situations or concerns may go unrecognised particularly at times of high activity due to normalisation bias. A common theme in such situations is that information flows narrow, and more assumptions are made. Consequently, consultants may not be made aware of issues until a situation becomes critical. There is therefore an onus of responsibility on consultants to demonstrate active enquiry to ensure that

they maintain an overview of workload and potential risks in a timely manner. At times of heightened activity in particular, this will require consultants to be physically present.

The modern risk management concept of "Safety II" promotes the view that modern healthcare is a complex and adaptive process that is constantly changing in unpredictable ways. Caregivers who have the ability to take in large amounts of information, reconcile conflicting risk and guidance and make safe decisions based on what is available are key assets in highly functioning healthcare systems (Hollnagel 2015).

DuPont's dozen is summarised in Figure 7. It was developed by Gordon Dupont in 1993 from an analysis of the common human error precursors leading to accidents or incidents in airline maintenance. In broad terms, it establishes levels of activity, competency, leadership and communication as key factors in variation of performance. It has already been applied to CTG interpretation (Nzelu 2018) but could also be extrapolated to other scenarios in acute gynaecology or major obstetric incidents. It adopts a system view of patient safety while recognising key individual concerns that influence care. As such, it clearly defines how consultants can make a difference in acute situations.

Lack of communication	Complacency	Lack of knowledge	Distractions
Lack of teamwork	Fatigue	Lack of resources	Pressure
Lack of assertiveness	Stress	Lack of awareness	Norms

Figure 7. DuPont's Dozen

Key messages

- O&G consultants are well placed to adopt the helicopter view required to maintain situational awareness and anticipate risk to women as well as provide a fresh pair of eyes to help decision-making and provide support.
- Consultants should adopt an approach of active enquiry to ensure they maintain an overview of workload and potential risks in a timely manner. This is important to prevent complex situations or concerns going unrecognised particularly during periods of heightened activity.

Patient advocate

Provision of care in an acute and/or critical situation can test a clinician's ability to engage in shared decision making, explain care plans, offer options and obtain consent from women. However, these concepts remain fundamental to providing safe care, upholding organisational values and respecting patient autonomy. In any situation, consultants must respect the diversity of women, their individual risks and opinions thus promoting personalised care within a standardised framework. This is a fundamental tenet of maternity care.

The consultant's role as patient advocate also involves assisting in the investigation of clinical incidents to ensure that, where necessary, lessons are learnt to continually improve patient outcomes and experience. NHS Improvement's 'Just Culture' guide emphasises the importance of understanding why an incident has occurred and how the system led to sub-optimal behaviours in order to create a learning organisation (NHSi 2018b). Analysing incidents requires a dynamic approach, recognising the infinite variability in safety issues and learning to evaluate and correct these, appropriate to the local setting (Leistikow 2017). This should lead to social and participative learning (Macrae 2008) and eventually system adaptations to minimise future risk. Such responsiveness requires transparency and trust.

It is also well recognised that active patient involvement improves safety (Davis 2008). However, many women are not willing to speak up to doctors, nurses and midwives due to deference and perceived authority gradient; only 25% of patients, for example, would challenge healthcare professionals if they failed to adhere to hand hygiene protocols (Yoong 2019), believing they would cause offence for raising such concerns. O&G consultants must therefore actively listen to the concerns of women and their families and facilitate open dialogue when investigating an incident where harm has occurred.

Key messages

- Consultants must respect the diversity of women, their individual risks and opinions thus promoting personalised care within a standardised framework.
- The consultant's role to investigate clinical incidents should focus on social and participative learning and systems adaptations which aim to continually improve patient experience and outcomes.

Innovator

Traditionally many doctors have focused on clinical effectiveness and safety as measures of care quality, often leaving the broader aspects of efficiency, equity, access and co-ordination to others (Hockey 2009). However, consultants have a responsibility to balance the, sometimes conflicting, demands of treating the individual woman in front of them while also addressing local difficulties and continually striving to improve care systems to benefit whole populations. As previously described, consultants are experienced clinicians, skilled in anticipating and managing risk and listening to and learning from women. By combining these attributes, they hold a unique position in being able to evaluate the care given to women and find new and innovative ways of working to develop services and improve patient care and experience. This is key to managing limited resources and reducing healthcare inequalities.

Furthermore, by engaging junior colleagues and the wider multi-professional team, consultants can help embed improvements by creating direction, alignment and commitment (Kings Fund 2014). Trust, cohesion, belongingness and flexibility have been linked to organisations being able to embrace change (Alharbi 2012, Carlstrom 2012). Consultants should therefore role-model these professional values and behaviours to lead quality improvement effectively.

Contributing to innovation requires consultants to not just appraise the service around them but also reflect on their own practice (GMC 2012). AoMRC defines reflective practice as 'the process whereby an individual thinks analytically about anything relating to their professional practice with the intention of gaining insight and using the lessons learned to maintain good practice or make improvements where possible' (AoMRC 2018). It should focus on both positive and negative events. Consultants also have a responsibility to mentor and support junior colleagues in developing their reflective practice skills. Team reflection, including respectful challenge without attribution of blame, can help individuals to question their previously held beliefs and consider different ways of working.

Key messages

- Consultants are experienced clinicians, skilled in anticipating and managing risk and listening to and learning from women. They hold a unique position in being able to evaluate the care given to women and find new and innovative ways of working to develop services and improve patient care and experience.
- Consultants should engage junior colleagues and the wider multidisciplinary team to initiate and embed improvements.
- Innovation also requires consultants to regularly reflect upon their own practice and to support junior colleagues to develop their reflective practice skills.

Organisational support and structure

Whilst O&G consultants have a responsibility to role-model effective leadership, organisations also have a duty to consistently demonstrate a values framework which underpins how colleagues and women should be treated. A sense of shared purpose, teamwork, valuing and empowering individuals, learning and open communication have been linked to improved patient safety in obstetric units (Milne 2010). Shared mission and employee participation have been found to be the strongest predictors of organisational effectiveness (An 2010). Adopting distributed leadership supports collaborative working, represents the diversity of the workforce and may address burnout amongst consultants (Cordoba 2021).

In obstetrics and gynaecology, there is a clear and present need to improve organisational support for consultants. Fundamentally, organisations must recognise and meet the basic physical and psychological needs of doctors while also ensuring they provide opportunities for self-actualisation. In recent times, Covid-19 has highlighted and augmented what is required. This includes provision of adequate staffing, compensatory rest following on-call duties, ongoing professional development opportunities, simulation training, adequate equipment, mentorship and pastoral care.

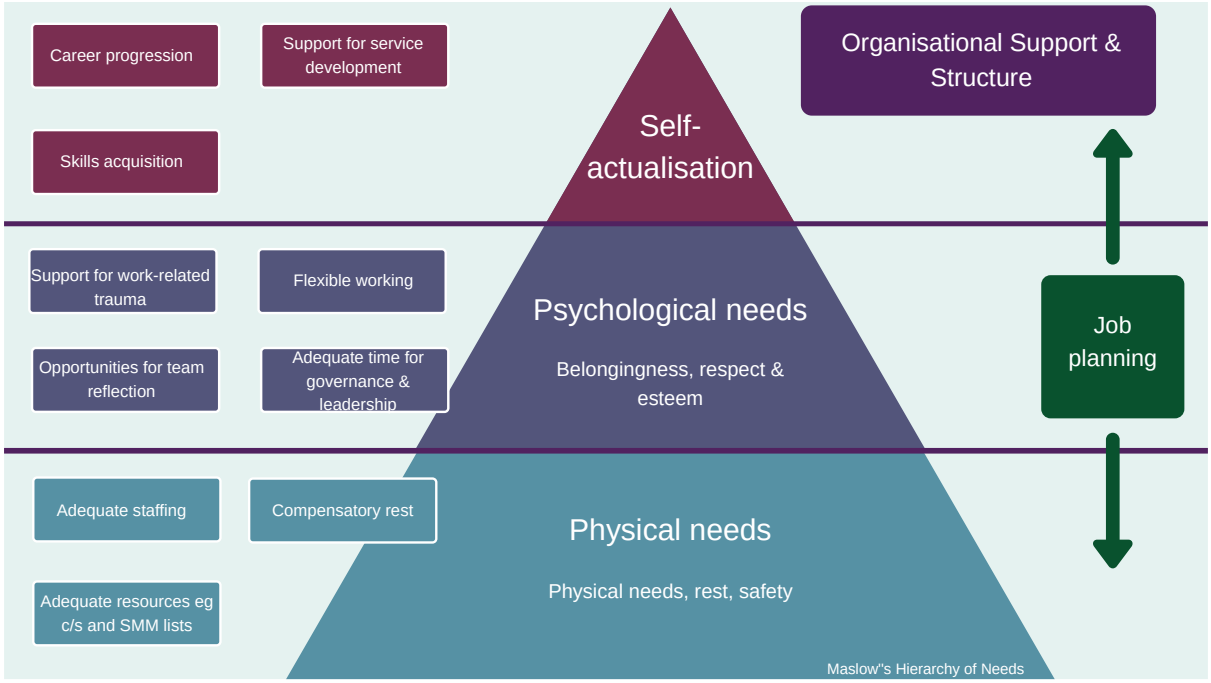


Figure 8. Organisational Support and Structure according to Maslow's Hierarchy of Needs

Adequate staffing

Workforce planning in the 21st century is characterised by a shortage of healthcare workers globally and unprecedented migration of medical professionals away from the NHS. Currently 83% of O&G middle grade rotas have gaps (Blotkamp 2019). Organisations therefore have a responsibility to prioritise recruitment and retention of staff to reduce burnout, safeguard staff morale and wellbeing and deliver safe, person-centred care.

Levels of activity have been recognised as an important determinant of patient safety. While inadequate activity may hamper training opportunities and hence the ability to maintain technical proficiency, excessive levels of activity may increase the likelihood of errors or impair patient experience. There is a strong argument that an acuity score is developed to objectively define the level of unit activity and how well it is being managed. This will enhance awareness of risk across the labour ward and obstetric wards to enable trends in activity levels and complexity to be identified over time and hence enable staffing levels to be matched to patient needs.

Many organisations now require O&G consultants to be resident overnight and during weekends. Resident consultant roles need to be seen as an authentic part of career progression and associated with a genuine sense of leadership. A survey of appointees to these consultant roles found they often felt or were made to feel junior compared to their peers and that equivalent opportunities for career progression were not present (RCOG 2016). In order to deliver resident obstetric cover, organisations must recognise the need to increase staff numbers. This will ensure that such roles deliver a predictable work pattern, acceptable work-life balance and opportunities for individuals to fulfil their career aspirations at the same time as meeting the needs of the service.

From 2013 to 2020, the percentage of O&G trainees training less-than-full-time has increased from 11.3% to 22.8% (HEE training data – unpublished). Many consultants are also now expressing a wish to work fewer than 10 PA job plans. This can be for work-life balance reasons such as caring for children or other relatives, health reasons or to allow time to pursue other non-clinical work or interests. Workforce models therefore need to recognise this and factor it into future predictions for required workforce numbers. Organisations should acknowledge that less-than-full-time working may play an important role in workforce recruitment and retention and that consultants and senior SAS doctors undertaking external non-clinical roles often contribute valuable skills and experience which enhance their clinical work.

Key messages

- Levels of activity have been recognised as an important determinant of patient safety. While inadequate activity may hamper training opportunities and hence the ability to maintain technical proficiency, excessive levels of activity may increase likelihood of errors or impair patient experience.
- If organisations wish to deliver resident obstetric cover, they must recognise the need to increase staff numbers to ensure that such roles enable individuals to fulfil their career aspirations while meeting the needs of the service.
- Workforce models need to recognise that many consultants are now expressing a wish to work fewer than 10 PA job plans and factor this into future predictions for required workforce numbers.

Compensatory rest

As previously discussed, there is an increasing need and expectation for consultants to attend overnight whilst non-resident on-call due to increased patient numbers and the rising complexity of cases. Organisations such as MBRRACE have advocated for greater consultant involvement in patient care. However, burnout has been increasingly reported in the speciality and preventing it requires intervention at a national, organisational and personal level (Bourne et al 2019, Creswell et al 2019).

The decision to attend for an emergency at 2am should not be influenced by the necessity to attend clinical sessions the following day. Therefore, there is a need for appropriate and mandated compensatory rest for consultants following overnight non-resident on-calls.

The British Medical Association's compensatory rest guidance recommends that consultants who are unable to take 11 hours of consecutive rest per day should be entitled to take compensatory rest (BMA 2019). This reflects both in person attendance and telephone calls disrupting sleep. This is to protect patient safety and clinician wellbeing because fatigue and tiredness following a busy night on-call can affect performance and decision making (CAP 737 2016).

Whilst patient safety is paramount, it is recognised that these recommendations may pose challenges, particularly within smaller units. Due to the unpredictability of out-of-hours activity, an astute approach to job planning is required. However a mechanism to facilitate compensatory rest must be in place in all organisations and this should be actively supported by the management team with constructive discussion between the clinician and manager or clinical director, rather than the decision to take rest being left to the individual consultant. There are clear circumstances where a consultant has been present, working in the hospital overnight, where they should not be undertaking clinical activity the following day. Further RCOG guidance on compensatory rest is now in place.

In the event of unfilled middle grade rota gaps, consultants may be required to 'act down' during on-call shifts. If this happens, it is essential that they have compensatory rest the following day and are appropriately remunerated. For more guidance for locum cover and compensatory rest, see https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/safe-staffing

Key messages

- There is a need for compensatory rest for consultants following overnight on-calls. This is to protect women the following day because fatigue and tiredness following a busy night on call can affect performance and decision making. It is therefore not recommended that the decision to take rest is left to the individual consultant.
- If consultants are required to 'act down' during on-call shifts, it is essential that they have compensatory rest the following day and are appropriately remunerated.

Job planning

Due to the rising complexity of clinical cases and in response to safety concerns, organisations have developed rotas that necessitate extended consultant presence both during weekdays as well as weekends and overnight. However there has been little recognition of the changing demands and increased workload intensity during on-calls. There is therefore a growing need to adopt a new approach to consultant job planning which recognises the need for flexible working patterns in order to improve sustainability and workforce recruitment and retention at all career stages.

Health Education England have introduced many types of Out of Programme (OOP) facilities for trainees. This includes OOP Pause which enables trainees to step out of training for up to one year either to have a career break or to undertake other clinical work and acquire new skills. Consideration should be given to organisations facilitating similar sabbaticals for consultants and senior SAS doctors to help address burnout and to support continuing professional development and skills acquisition.

Organisations must recognise the considerable contribution consultants make to managing risk, investigating incidents and engaging with women and their families to ensure a culture focused on patient safety and continual learning and improvement. Reporting adverse outcomes to systems such as PMRT, NHS Resolution and HSIB are processes that require considerable time for all maternity staff. Reports generated by such systems bring transparency, allow comparison of unit performance and together provide an opportunity for safety culture to be assessed and influenced for governance and external review. However, to truly move forward, time and resources must be allocated to the collection, local interpretation and consequent improvement activity.

Similarly, organisations should value and support consultants undertaking leadership and service development roles. Organisations must recognise that the success of such roles hinges upon regular, positive engagement with staff and with women and their families. This is critical to establishing an organisational culture which listens, values a diversity of viewpoints and is

continually responsive and open to learn. By involving staff in the change process, it encourages them to become more patient-centred in their approach to care (Abdelhadi 2011) and to take ownership and responsibility for not only implementing changes but also sustaining them. By involving larger numbers of individuals from different backgrounds, it allows for diversity of opinion and better understanding of what can be perceived as resistance to change. Involvement in decision-making is also the factor most strongly predictive of patient outcomes (West 2013).

Organisations must also recognise the important role that women and their families can play in contributing to service design. Patients' perception of care has been found to be better when there is alignment of objective, communication, information and encouragement, patient incentive (such as ease of access to care) and provider effectiveness (Gill 2013). Patient engagement has also been noted to be of particular importance amongst socially and economically deprived populations and hence plays a key role in addressing health disparities (Poleshuck et al 2015). For consultants to perform leadership roles well and engage with staff and women, organisations must dedicate resources, adequate time within consultant job plans and support from the wider clinical and non-clinical team.

Organisations must also recognise the need for adequate admin time to support clinical activities. The RCOG currently recommend that consultant job plans should dedicate a minimum of 10% of DCC time to clinical administration. Adequate administrative and IT support should also be provided to aid the delivery of patient care

Key messages

- There is a growing need to adopt a new approach to consultant job planning which recognises the need for flexible working patterns in order to improve sustainability and workforce recruitment and retention at all career stages.
- Organisations should consider facilitating sabbaticals for consultants to address burnout and to support professional development and skills acquisition.
- Organisations must allow adequate time and resources to support consultants in investigating adverse incidents and consequent improvement activity.
- Organisations must dedicate adequate time, resources and support for consultants undertaking leadership roles to ensure adequate staff and patient engagement when developing services.
- Organisations must recognise the need for adequate admin time to support clinical activities.

Continuing professional development

There is a need for organisations to ensure that consultants and senior SAS doctors are given the opportunity to maintain and develop their skillsets. When staff are supported to participate in their organisation, it drives innovation and paves the way to creating a 'learning organisation' (Kings Fund 2015). Consequently, this builds competence. Consultants play a key role, not just in terms of what they can offer their organisations through development of their own skills, but also through their ability to further the skillset of their junior colleagues and the wider multidisciplinary team. However, this requires resources and time for simulation training and innovation. Such training has been proven to promote better care, multidisciplinary teamworking and improve patient outcomes and experience (Liberati 2020).

In order to support consultants' professional development, organisations must ensure that adequate SPA time is included in job plans. RCOG guidance recommends that SPA time must be a minimum 15% of the total PAs, including at least 1 SPA for mandatory training, appraisal, audit and CPD. Trusts may wish to allocate further SPA time for education, research or other activities. If a job plan is 7 or more PAs, a minimum of 1.5 SPAs should be allocated. If a job plan has fewer than 7 PAs, a minimum of 1 SPAs should be allocated.

Key messages

- Organisations must ensure adequate SPA time is included in job plans so that consultants can maintain and develop their skillsets.

Conflict with scheduled activities

The provision of acute care within maternity is often characterised by a daily conflict to provide labour ward care including unscheduled operating alongside planned caesarean birth. In only a minority of units does provision of capacity to deliver planned caesarean sections truly match demand. It creates the argument that organisations fail to assign women undergoing planned caesarean birth the same parity of resources as other scheduled procedures. It also often creates an additional daily risk for the labour ward team to manage and resource. It is therefore recommended that maternity units have a separate multi-professional team to provide elective caesarean births rather than relying on those on-call for labour ward to provide this service. The RCOG is working with the Royal College of Midwives, the Obstetric Anaesthetists Association and the Royal College of Anaesthetists to produce a best practice paper to further elucidate these requirements.

In gynaecology, there are often similar issues for women opting to undergo surgical management of miscarriage in non-emergency situations. It is not unusual for women to be placed on a general emergency theatre list with no guarantee of when the procedure will happen. It is therefore recommended that there should be a dedicated theatre list with a named consultant for women

requiring surgical management of miscarriage and other urgent minor gynaecological procedures. The procedure should be offered within 72 hours of diagnosis if this is in keeping with the woman's wishes.

Key messages

- It is recommended that maternity units have a separate multi-professional team to provide elective caesarean births rather than relying on those on-call for labour ward to provide this service*.
- It is recommended that there should be a dedicated theatre list with a named consultant for women requiring surgical management of miscarriage and other urgent minor gynaecological procedures.

Prioritising wellbeing

Doctors tend to be driven by an expert culture which favours outcome over process (Bujak 2003) hence creating a propensity to underappreciate the relational aspects which underpin organisational effectiveness. When staff cannot reflect and explore their emotions and vulnerabilities, they are more likely to act out feelings of anxiety and anger, feel ignored, disrespected and persecuted (Nossal 2015). This in turn results in higher reported rates of bullying and increased staff attrition.

Following the INDIGO study, there has been a growing appreciation of work-related trauma within obstetrics and gynaecology (Slade 2020). Repeated exposure to traumatic experiences and high levels of stress must be recognised by organisations as factors that impair long term performance, retention and ultimately expression of empathy. Organisations therefore need to ensure adequate support and pastoral care are provided to consultants and other doctors. Consideration should be given to the role of clinical psychologists to provide counselling, group reflective sessions and debriefs following adverse incidents. Social spaces where staff can get to know each other and debrief after difficult events are also essential. When these exist, learning and reflection become embedded within routine practice and it facilitates seniors mentoring and role-modelling to juniors. This is associated with improved patient safety. (Liberati 2020).

Schwartz Center Rounds originated in the US in 2001. They are an opportunity for all members of the healthcare multi-disciplinary team to discuss a difficult case. The aim is not to focus on the clinical specifics but rather the feelings individuals experienced whilst caring for the woman. It is an outlet for staff to share their emotions, realise that these feelings are often mirrored in others and dispel the sense of isolation which can often accompany traumatic events (Pepper 2012). There is also evidence that Schwartz Rounds may help overcome organisational hierarchies, promote shared values, improve staff psychological wellbeing and strengthen team-working (Goodrich 2012, Maben 2017, Deppoliti 2015).

Balint Groups originated in the UK in the 1950s. They are a way for teams to discuss complex clinical scenarios or situations where doctors have found patients difficult to engage with. The main aim is to create a safe space amongst colleagues to talk about interpersonal aspects of work. They also aim to help develop doctors' empathy towards patients and enable them to gain a deeper understanding of their own emotions.

Key messages

- Organisations need to recognise the potential for work-related trauma in Obstetrics and Gynaecology and ensure adequate support and pastoral care are provided to consultants and other doctors.
- Social spaces where staff can learn, reflect, get to know their team and debrief after difficult events are essential.
- Schwartz Rounds and Balint Groups are examples of how teams can reflect together to strengthen team working and develop empathy.

Summary

The roles and responsibilities of the obstetrics and gynaecology consultant are diverse and wide-ranging. They extend beyond those of an experienced clinician, competent in both technical skills and complex decision-making. O&G consultants are required to role-model collaborative, inclusive and compassionate leadership thereby establishing positive cultural norms for their teams. They should cultivate a range of leadership styles and skills which they can flex between, allowing them to work across different teams and adapt to the varying challenges of the clinical workload. Adopting shallow authority gradients helps foster trust within teams and is key to developing respectful team relationships and providing safe patient care.

Consultants are also required to provide clinical supervision and mentorship. This helps develop technical proficiency amongst junior colleagues and the wider multi-professional team as well as create a sense of psychological safety. Furthermore, consultants play a key role in ensuring consistency in the quality of care experienced by women. Their situational awareness, prioritisation skills and ability to take a helicopter view are critical to ensuring individual patient safety as well as to developing services to improve patient outcomes and experience. Their role as patient advocate means they have a responsibility to actively participate in incident investigations and contribute towards organisational learning. This requires a willingness and an ability to adopt a reflective approach towards one's own practice and to continually strive towards improving patient care and outcomes.

In order for obstetrics and gynaecology consultants to fulfil these roles and responsibilities, organisations must provide structures and facilities to support them. This includes ensuring that there are adequate levels of staffing of doctors, nurses, midwives and other allied health professionals of all grades. Organisations must recognise the increased intensity of the O&G workload particularly on-call. There should therefore be scope for consultants to work flexibly at different career stages, have career sabbaticals and work fewer than 10 PA jobs. These measures are key to ensure workforce sustainability, improve morale and reduce attrition. Professionals who work together should learn together. Adequate time and resources should be made available to consultants to continue their own professional development, as well as support and teach junior colleagues and the wider multi-disciplinary team to develop new skills. Mentorship is particularly important for those starting their consultant careers in O&G.

Similarly, organisations should acknowledge the acuity of the on-call role by not expecting consultants to carry out other duties simultaneously and by ensuring consultants have compensatory rest periods following on-call duties. This will reduce staff burnout and protect patient safety. There should be dedicated elective caesarean section lists and arrangements for women requiring urgent gynaecological surgery such as surgical management of miscarriage. This will ensure that these women receive the parity of resources as other women undergoing elective and semi-elective surgery and that this workload does not come into conflict with provision of labour ward cover.

Finally, organisations should prioritise the emotional wellbeing of obstetrics and gynaecology consultants. Although the role is immensely rewarding, it also involves long hours, complex decision-making and time-critical emergencies. Initiatives such as Schwartz Rounds and Balint Groups are examples of how the profession can better embrace its diversity, foster empathy between colleagues and build stronger teams, focused on providing person-centred care.

Notes

* These recommendations do not apply to units with fewer than 1500 deliveries per year where it is recognised that the overall workload will usually accommodate this clinical activity in tandem.

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Appendix 1: Ward Round Guidance

Before	During	After
• Decide who is required on the ward round and ensure they are present. Typically it should include the obstetric consultant, junior obstetric staff, the nurse or midwife caring for the patient, the midwife co-ordinator and anaesthetic staff. • Ensure all members of the team know each other • Do a board round so that all members of the team are familiar with the patients • Identify any learning needs or objectives of team members	Environment • Ensure that the midwife or nurse looking after the patient is present • As much as possible, try to minimise interruptions to the ward round or conflicts with other planned work eg elective caesarean sections • Be mindful of the number of team members on the ward round and the need to respect patient dignity. This is particularly the case for women in active labour, those separated from their babies immediately after birth and those who have suffered a pregnancy loss Clinical • As well as addressing individual patient care plans, ensure general safety precautions such as medication reviews and VTE risk assessments are carried out and documented. • Recent observations, blood tests and imaging results should be acknowledged and actioned. Communication • Ensure that the woman is involved in all discussions about her care as much as she wishes to be. • Provide a translator if the woman is unable to communicate easily in English • Ensure there is an opportunity for the woman and her birth partners to ask questions or raise concerns • Team members should speak to one another courteously and with respect. More junior team members should not be reprimanded, undermined or put under pressure • Ensure that clinical findings, plans and discussions with the patient are clearly documented in the patient's notes.	• Debrief with all those present on the ward round to check clarity of clinical care plans, provide an opportunity to ask questions and reflect upon what went well and what could have been better • Allocate tasks amongst the team using closed-loop communication • Take time to discuss cases and complete WBAs to support learning needs of the team.

Appendix 2: The Cappuccini Test (Modified)

For the middle grade tier of the on-call team

1. **Questions to ask the trainee/LED/NASG**

What is your current training grade?	
Who is the consultant supervising you?	
What is their contact number/How can you contact them? (Include exact details to then contact in step 2)	Bleep – Telephone- Other -
Have you had a face to face or verbal handover with the on-call consultant regarding activity?	Yes/No
For any elective or potential theatre cases have you agreed who is doing the procedure and who is covering the remainder of the on-call service?	Yes/No

2. **Questions for the supervisor using the details provided by the trainee/LED/NASG**

Do you know who you are supervising?	Name
Do you know the grade or level of your on-call middle grade?	Yes/No Grade/Level
Are you aware of any specific training concerns or requirements for this middle grade? [O]	Yes/No If yes, please specify:
How long would it take you to be present if called to attend?	Time:
In standard working hours what obstacles might you face (e.g. clinics/gynaecology cover)?	If obstacles, please give details:

[O]This information should subsequently be verified with the College Tutor, the trainee / LED's educational supervisor or via another mechanism to ensure that consultants have accurate oversight of what support is required.

NB. Original tool produced by Dr David Bogod. The Royal College of Anaesthetists have agreed for the modified tool to be used in obstetrics and gynaecology provided the RCOA is acknowledged, Cappuccini is preserved in the tools name and where used the link from the RCOA website is cited: https://rcoa.ac.uk/safety-standards-quality/patient-safety/cappuccini-test