



Royal College of
Obstetricians &
Gynaecologists

Obstetrics and Gynaecology Workforce Report 2017



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Introduction

The changing demographics and expectations of both the women using obstetrics and gynaecology (O&G) services and those delivering them need to be understood together, in order to respond to workforce needs effectively. This report provides an update for RCOG members and sets out next steps for the College and what is needed from the membership to support this.

The College remains committed to improving women's health, and a strong and sustainable workforce is critical to achieving this

The Royal College of Obstetricians and Gynaecologists (RCOG), together with the profession, needs to continue engaging with workforce planners to define the expectations of the current and future workforce in a way that is inclusive and supportive of a healthy work–life balance, while having an honest discussion about what we

can deliver to women with the workforce available. This will be crucial in not only attracting doctors but also retaining and nurturing them within our profession. This is a critical issue in terms of long-term stability of the workforce and one in which the College will continue to actively engage.

The College remains committed to improving women's health, and a strong and sustainable workforce is critical to achieving this. This report outlines the challenges facing the O&G profession and the commitments the College is making to address them. It also describes opportunities for members of the College to get involved in this work by sharing successful methods they have used to address their own workforce challenges, which can then be communicated to the wider membership.

Key messages

- UK O&G services are being delivered safely but the pressure is rising on all staff involved
- To manage obstetric and gynaecology care, units must address workforce issues in a safe and sustainable way
- 9 out of 10 obstetric units report a gap in their middle-grade rota, which can affect job satisfaction, postgraduate training, quality of care and staff wellbeing (*NMPA 2017*)
- A 30% attrition rate from the O&G training programme is typical, varying from 29% to 37% (*HEE/GMC*)
- 15.4% of trainees think about leaving O&G once a month or more (*Trainee Attrition Survey 2017*)
- Consultant presence in a unit should be based not only on the numbers of births, but also on the complexity of the O&G workload and the case mix of a department
- Providers should explore alternatives to 24/7 consultant presence if they are as effective and more financially sustainable
- Resident consultant working may be needed in many units so there are suitable numbers of doctors with the appropriate competencies
- Consultants who work resident shifts out-of-hours should get parity of responsibility and professional development opportunities
- All on call consultants in a unit should work towards providing a similar on call work pattern taking into account local job plans

This report provides an update for RCOG members and sets out next steps for the College and what is needed from the membership to support this.

RCOG Actions

- Pro-actively work with Health Education England and equivalent agencies in the devolved nations, to model a workforce of the future that has the right number of specialist staff to deliver safe O&G services
- Mitigate against high attrition rates by lobbying workforce planners to:
 - Recruit new trainees so the full time equivalent (FTE) output of Certificate of Completion of Training (CCT) holders in run-through specialty training remains stable and gaps caused by less than full time working can be plugged
 - Consider further rounds of recruitment at later stages of training, i.e. ST3 or beyond
 - Improve flexibility for trainees to step off and then return to the programme
- Develop and support specialty doctors through skill acquisition, continuing professional development (CPD) and a supervision/appraisal structure, improving the retention of these valued staff
- Promote RCOG criteria for approval of new consultant posts. These give newly appointed consultants a job plan that enables them to provide continuity of care, develop professionally and have an appropriate work–life balance. It includes job plans with no more than 3-4 PAs for resident out-of-hours work.
- Set up a working party to take into account the needs of consultants who are considering retirement, including the impact of their activities on more junior consultants

There are opportunities for members of the College to get involved in this work by sharing successful methods they have used to address their own workforce challenges, which can then be communicated to the wider membership.



The changing nature of the O&G workforce.

A message from Mary Ann Lumsden

Over the past few years there have been concerns expressed, by workforce planners, of our specialty training an excess of O&G consultants. However, the RCOG is not aware of any regions in the UK where this seems to be the case; instead, we're witnessing a worrying trend in middle-grade rotas with 88% of units reporting gaps (Source: *National Maternity and Perinatal Audit 2017*).

Rota gaps put an immense pressure not only on teams but also on an individual's ability to deliver safe services, something which our members are doing – but at what cost? Safe services are being delivered at the cost of our doctors' wellbeing, educational opportunities and job satisfaction, which is leading some to leave the profession altogether. High trainee attrition rates together with changes in the visa rules, an increase in less than full time (LTFT) working, maternity and paternity leave, and 'retire and return schemes' are creating rota gaps. Although workforce planners may take account of trainee attrition there is not enough consideration of these other factors in their modelling. Rota gaps cannot be filled with trainees alone and consideration must also be given to other health care professionals of all types who contribute to the delivery of women's health care.

It is essential that we communicate this message to planners and decision makers to ensure we have the workforce required to deliver O&G services going forwards. At the end of 2016 we established a Workforce Task Group to determine a strategy to better support and advocate for the profession. The group's first priority was to confirm the number and type of roles that provide O&G services as well as their working patterns. It was essential to get this right as all future work and modelling would rely on an accurate foundation and database of workforce data.

Where data already existed this was reviewed and sense checked to ensure it was being interpreted in the correct manner. Where data were missing the task group took steps to capture and analyse it, ensuring it was representative of what the profession told us they were experiencing.

Rota gaps put an immense pressure not only on teams but also on an individual's ability to deliver safe services, something which our members are doing – but at what cost?

Many discussions have taken place with workforce planners over the past 12 months to improve their understanding of the O&G workforce and how it operates. The RCOG has also represented the profession on a number of working parties including Health Education England's Maternity Workforce Steering Group, part of the Maternity Transformation Programme. Discussions have led to a greater understanding among planners and a willingness to work together on future modelling.

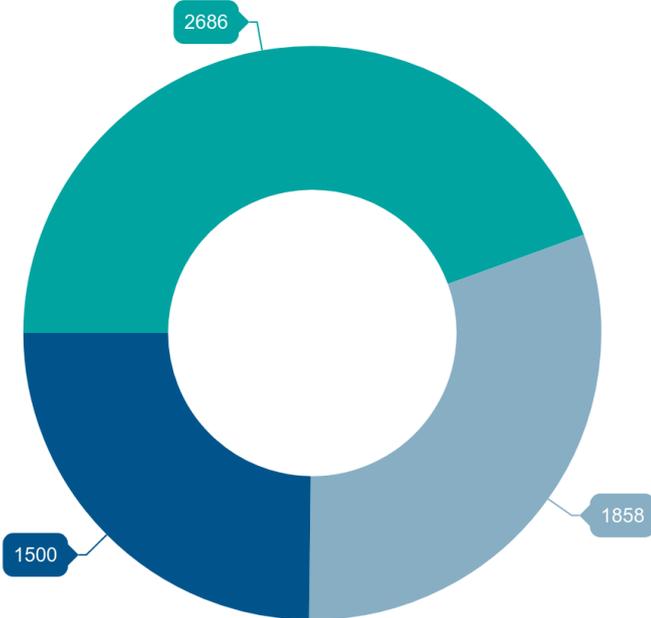
The Workforce Task Force is committed to continue working with planners, decision makers and the profession to address these challenges and to retain our highly valued workforce.

Mary Ann Lumsden
Senior Vice President
Strategic Development
Chair, Workforce Task Group

The O&G profession

NHS O&G workforce

■ Consultants (44.44%) ■ Trainees (30.74%) ■ Specialty doctors (24.82%)



NHS Digital; NI DoH; NHS Scotland; StatsWales; RCOG ePortfolio; NHS Sources



RCOG Members around the UK

England	1550
Northern Ireland	65
Scotland	150
Wales	70

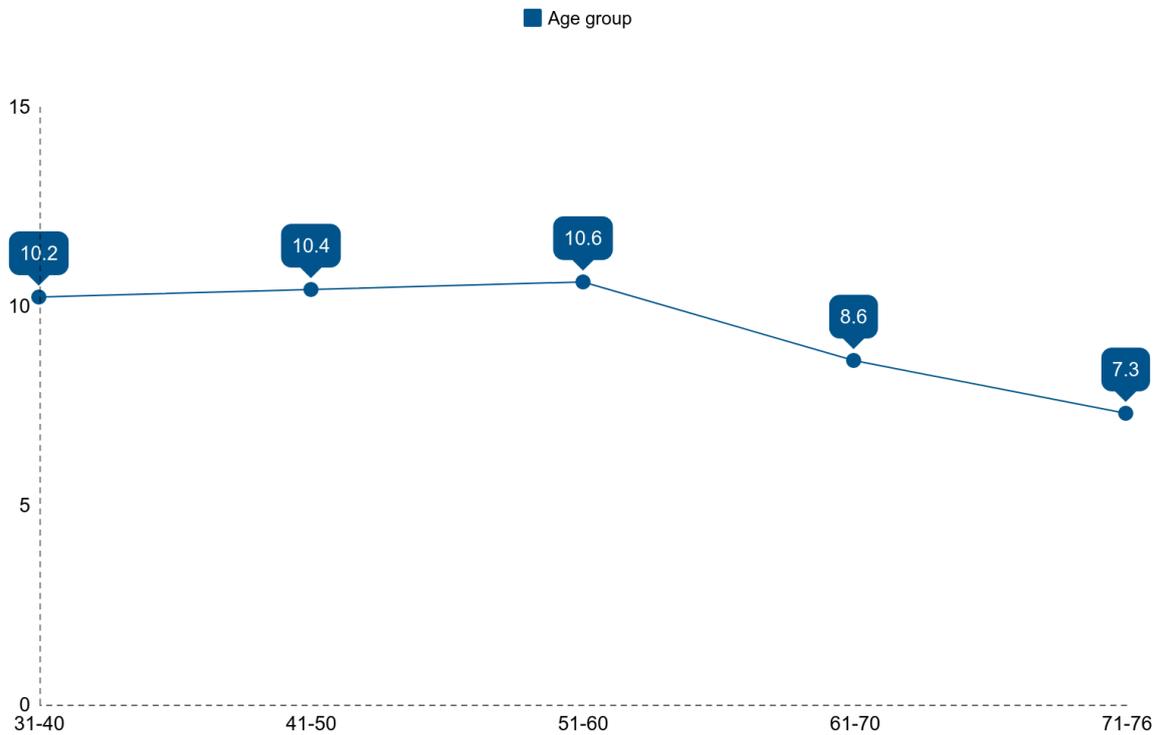
How would you describe your post?

General (12.81%) Special interest (66.97%) Sub-specialty (20.22%)



RCOG Workforce Survey, 2016

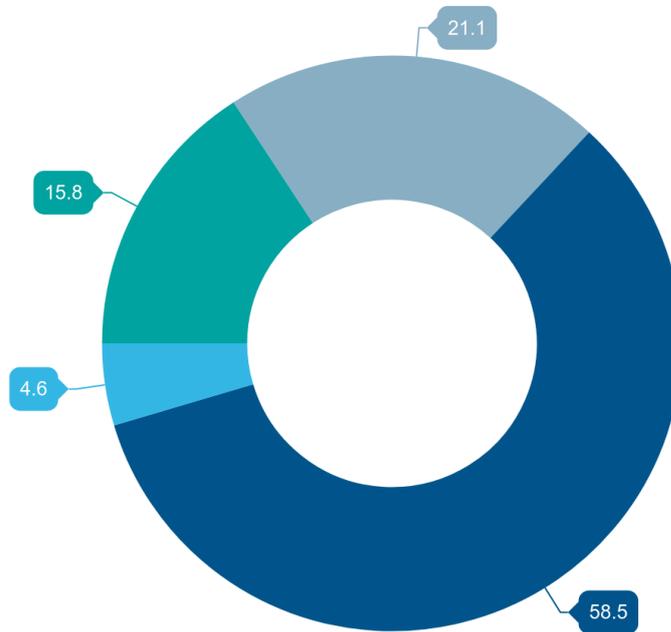
Average number of programmed activities per week by age group



RCOG Workforce Survey, 2016

What is the O&G split of your daytime PAs?

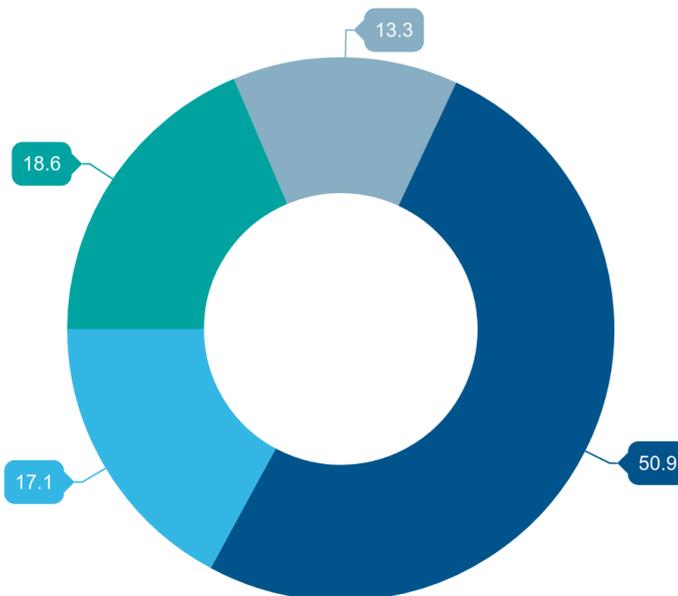
■ Obstetrics only (15.80%) ■ Gynae only (21.10%) ■ Both O&G (58.50%) ■ N/A (4.60%)



RCOG Workforce Survey, 2016

What is the O&G split for your out of hours PAs?

■ Obstetrics only (18.62%) ■ Gynaecology only (13.31%) ■ Mixture of O&G (50.95%) ■ Other (17.12%)



RCOG Workforce Survey, 2016

Workforce challenges - Trainee attrition

GMC data show a significant number of trainees who start the O&G training programme but do not finish. An attrition rate of 30% in any region is not unusual, with rates ranging from 29% to 37% (HEE/GMC).

Recent RCOG trainee surveys show that:

- 75% have considered leaving O&G since the start of specialty training.
- 89% have at some point felt low in mood, depressed or anxious since starting specialty training
- 19% report feeling this way at least monthly
(*Trainee Attrition Survey 2017*)

The factors behind this high trainee attrition rate include:

- Rota gaps
- More out-of-hours working
- Poor work–life balance
- Less supervision
- Fewer training experiences

These are also challenges for the wider workforce that will result in changes to the O&G consultant role of the future. For some it is becoming a less attractive prospect, especially for more junior consultants.

Workforce challenges - Rota gaps

88% of obstetric units reported a gap in their middle-grade rota (*NMPA 2017*).

Locums

83% of units reported requiring locum cover to staff their middle-grade rotas in the previous three months (*NMPA 2017*).

Locums are an important and valued part of the workforce. However, at a time of NHS austerity, relying on locums to cover gaps is an expensive use of budgets. Reliance on locums to deliver services could also lead to inconsistency in service delivery as locums are often unfamiliar with local systems and need time to acclimatise. This impacts on team work and, potentially, patient safety.

A more sustainable and efficient option would be to address the reasons for the gaps being there in the first place.

Number of units in each response category
(excluding units which responded a proportion was
unknown)

Proportion of the middle-grade rota in the last 3 months which was entirely unfilled, filled by a locum or filled by a consultant	entirely unfilled	filled by a locum	filled by a consultant
0%	93 (57%)	28 (17%)	95 (58%)
1 to 5%	25 (15%)	27 (16%)	44 (27%)
6 to 10%	24 (15%)	38 (23%)	10 (6%)
11 to 25%	12 (7%)	54 (33%)	12 (7%)
26 to 50%	5 (3%)	17 (10%)	1 (1%)
More than 50%	4 (2%)	2 (1%)	2 (1%)
Total (excluding unknown)	163 (100%)	166 (100%)	164 (100%)
Overall proportion entirely unfilled, filled by a locum or filled by a consultant (excluding unknown)	70 (43%)	138 (83%)	69 (42%)
Unknown	22	19	21

(NMPA 2017)

Options for addressing workforce challenges

Rota gaps are caused by several factors. The Workforce Task Group quickly realised that there is not a single solution. A work stream was set up to explore and address this complexity. It also aimed to find ways to assess both the extent of the problem and possible solutions.

Below are recommendations that the Workforce Task Group believe will make the biggest impact in terms of addressing rota gaps. Other options considered by the group can be viewed in Appendix I.

Maintain and increase the flexibility of the O&G training programme

Currently, if a trainee leaves the specialty programme, or works part-time, their post cannot be replaced. Recruitment in England is currently only allowed at ST1 level and doctors taking up these posts must have worked in O&G for less than 24 months.

A recalculation of the number of posts required is needed alongside the reality of budget reductions. There are certainly workforce concerns of training an excess of specialists who cannot find consultant posts, but currently recruitment is not taking into account the loss of available staff due to attrition, more maternity and paternity leave and increasing part-time work patterns, as well as the increasing diversity of O&G services.

The RCOG proposes allowing a hybrid model of recruitment, maintaining run-through posts from ST1 but allowing alternatives as well. Options would include recruitment at ST3 or later as well admitting more doctors into ST1 to replace those working LTFT or out of programme, recognising that there is significant attrition in the first two years. The model chosen would depend on the needs of local schemes and the availability of applicants at different stages of training. Recruitment at ST3 or later would replace trainees who had left the scheme and so would not increase the overall number of doctors being trained for future consultant posts.

An increase in flexibility of numbers would allow trainees time out of training for research,

specific skill acquisition, global health work and family commitments, and would improve retention. Training schemes should be able to factor this into their recruitment numbers, with slight expansion, in order to allow out of programme activities more readily.

Increased support for specialty doctors (SAS, Staff grade, Trust, etc.)

There is currently a large workforce of doctors who are not on training schemes or in consultant positions but who provide an invaluable service to O&G departments. It is important to have middle-grade posts that are not dependent on gaining a CCT, but these doctors must be offered appropriate career development with support, appraisal, training and CPD.

Specialty doctors tend to have long-standing experience in O&G, often running clinics and theatre lists alone. However, the turnover of doctors in these posts can be very high depending on the type of post, with around 15% leaving the substantive workforce in any given year. Data from HEE show that a further 10–12% move into either consultant posts or postgraduate training, but there is no further information on where they go.

Active interventions to retain, reskill and upskill these experienced staff would increase workforce supply.

Increased resident consultant working

Faced with growing pressures due to middle-grade rota gaps, many units have introduced resident consultant working out-of-hours. In some units this has been successful, but in others newly appointed consultants have felt undervalued, resentful and disillusioned. In order to maintain a safe service, some resident consultant working will probably be necessary in most units.

The RCOG's 2016 report *Providing Quality Care for Women: Obstetrics and Gynaecology Workforce* set out recommendations to support resident consultant working as part of the solution to rota gaps.

For resident consultant roles to be successful, they must be professionally satisfying with opportunities and support equal to non-resident roles. An RCOG survey of resident

consultants in 2015 highlighted the importance of a predictable work pattern, a defined case-load, opportunities for professional development and the sharing of clinical and managerial consultant responsibilities in the development of a successful resident post. A job plan allowing for improved work life balance was deemed essential. The requirement for all or most consultants to contribute in some way to resident out-of-hours work was also viewed positively; this did not need to be overnight, but could be out-of-hours work in the evenings or during the day at weekends.

In the past, recommendations have been made about the amount of resident consultant presence required for units with various numbers of deliveries. It is now accepted that these figures did not take into account all the necessary evidence. The emphasis should now be placed on providing safe care for women 24/7, and having the appropriate number of doctors with the appropriate skills available. Each individual unit should decide the best way for them to provide this care, based on their knowledge of their workload and case mix. However, in view of the significant rota gap issue it is likely that in many units this will involve some resident consultant working.

Redeployment of retiring consultants

As consultants near the age of retirement, many may consider either reducing their number of sessions or being re-employed on a part-time basis with an adapted job plan ('retire and return'). Many wish to reduce their night-time on-call commitment but have skills which can still be used in the department, particularly conducting clinics, ward rounds, time on labour ward or daytime emergency gynaecology sessions, elective theatre lists and teaching. They could also provide some out-of-hours cover in the evenings or during the daytime at weekends. Without removing training opportunities, they could free up time for other consultant staff to contribute to activities in both O&G.

What next?

The RCOG will continue to work closely with workforce planners and decision makers to address workforce challenges and ensure the profession has the correct number and skill mix to continue to deliver safe O&G services now and in the future.

A number of initiatives are also under way to better support and equip the profession to work within such a challenging environment; to safeguard the welfare of our doctors; to ensure satisfying job plans and career prospects; and, ultimately, to retain more highly skilled doctors within the specialty.

RCOG initiatives

Welfare of the Workforce

The Welfare of the Workforce group, a sub-group of the RCOG's Workforce Task Group, was set up to help the profession in terms of culture, job plans and career development. As well as assessing and confirming the current situation, the group has been developing guidance and recommendations (outlined above) to empower and support doctors to manage workforce challenges more effectively.

Trainee attrition

The group recently surveyed all O&G trainees to find out the proportion considering leaving the training programme and their reasons why. As a follow-up to the survey, the researchers have formed trainee focus groups in all 16 health education authorities in the UK to offer ideas for solutions to the issues that the survey has raised.

New consultants

As well as the recommendations (outlined above) to ensure resident consultant roles are professionally satisfying, the group also recommends that resident working patterns continue to be assessed through data collection and audit and that the RCOG explore novel methods for assessing work intensity and out-of hours staffing levels in both O&G. Model job plans will be held at RCOG for units to look at and inform the creation of their own plans.

The group is also exploring how the College can help new consultants feel better supported, equipped and confident to carry out their roles, particularly the non-clinical aspects of their work. Ideas currently being explored include extending the reach of the RCOG's annual Newly Appointed Consultants meeting by making more content available online. A number of new consultants have already taken the initiative of setting up online and local groups to act as peer-to-peer support networks. The RCOG will be raising awareness of such groups and providing support, in the form of a toolkit, to others also wishing to set up a local group.

Return to work

For those doctors who take time out of practice for maternity/paternity leave or out of

programme experience, returning to the workplace can be a daunting prospect. It is essential that such individuals are up to date on the latest guidance and practices to ensure a seamless and satisfying transition back into work. The Welfare of the Workforce group is therefore exploring an accelerated return to work initiative (courses and web access) that will be available to doctors looking for support and information to get themselves back up to speed.

Future Models of Care

The Future Models of Care group, a sub-group of the RCOG's Workforce Task Group, was set up to assess the workforce needed to deliver O&G services in the next 5-15 years, to propose different workforce models to attempt to mitigate gaps between supply and demand and to highlight the risks posed by identified gaps.

The group is working very closely with HEE to assess and model workforce demand, and is also developing a tool to assess acuity/intensity of O&G workload in a unit with the aim of using this to identify how many tiers of staff are needed.

Supporting Our Doctors

A Supporting Our Doctors Task Group has been established to prevent, minimise and manage workplace stress experienced by doctors. Outputs include a service to support doctors and their employers to manage more workplace conduct and practice challenges locally.

The group is working closely with the GMC to ensure fair, efficient and effective fitness to practice investigations that benefit both doctors and their patients. The group has also collaborated on guidance for doctors who receive notification from the GMC of a complaint against them, advising them of what to do next.

The group will also be providing support and information on how to manage workplace challenges and ensuring doctors are aware of all the support services and resources available to them, either from the College or further afield.

Get involved

The RCOG has been working closely with the membership, through focus groups and surveys, to understand the extent and nature of their workforce challenges and to develop meaningful and sustainable solutions, and is keen that all members have the opportunity to input into this important area of work.

- Do you have an example of how to support a specialty doctor?
- Are you a Clinical Director who has had colleagues who have ‘retired and returned’?
- Do you have examples of how you have filled rota gaps?

If you have ideas or feedback, particularly if you have examples of approaches that are working well in your trust, then we want to hear from you. Please contact workforce@rcog.org.uk to register your interest and we’ll contact you to capture your feedback.

Appendix I.

Additional options considered for addressing middle-grade rota gaps

As well as the recommendations outlined in the report for addressing rota gaps, the Workforce Task Group also considered a number of other options. None of those listed below were considered long-term, sustainable solutions; however, combined with the main recommendations, they may prove useful to some trusts in addressing their rota gaps.

Trust-funded specialty posts

Clinical fellows

Clinical fellow posts are created to attract doctors to spend one to two years gaining a specific skill, and to fill the rota gaps. These posts may attract trainees (who are unable to get sufficient training time in their own posts) to take out of programme experience/training (OOPE/T). However, this may leave further gaps in their own rotas, which the RCOG does not encourage.

Post-CCT fellows

Some trusts have created post-CCT positions with middle-grade on-call responsibilities. Some trainees may initially prefer to take a post which does not have consultant responsibilities and they may suit a CCT holder who is adding further skills to their portfolio. However, these posts may not be easily appointed to as most CCT holders are likely to be looking for a consultant post, unless they are keen to develop new, specialist skills. These jobs may also potentially create an unacceptable sub-consultant tier.

Trust fellows

The trust grade includes a large skill mix of doctors with often creatively designed job descriptions. Some have chosen to leave training, possibly because of failure to pass the MRCOG exam. Others may have been unable to gain a training number or come from a different country with too much O&G experience to apply at STI. Trusts, individually or within a region, could offer training and appraisal on an individualised basis.

Despite there being an increase in numbers of trust grade doctors from 2011 to 2013, there are still significant vacancies in these posts. These doctors may not be sufficiently trained to take up a middle-grade position, and there is no UK training pathway available to them, apart from that offered at a trust level which differs in quality around the country. Current immigration regulations within the UK make recruitment of overseas doctors difficult. For these reasons, this is not a long-term solution.

Research fellows

Teaching trusts are able to ask doctors studying for research doctorates to work on the on-call rota. However, being on-call may also take time away from a research fellow's research.

Middle-grade locums

There is a diminishing number of middle-grade staff available to work as locums. Also, there is risk attached to the use of short-term locums as they are not familiar with departmental working patterns, guidelines and the multidisciplinary team. In addition, locums are a costly resource.

Expanding the number of MTI doctors

This scheme is administered by the RCOG, but determined at a national level by HEE. MTI trainees are employed at ST3 level for two years, but must be supervised, or on the SHO rota, for the first few months to familiarise themselves with UK practice. They are in the UK to gain both training and the MRCOG and must be appropriately supervised and supported. There is a current limit on the number of visas that can be issued to support MTI doctors. As a single initiative, the scheme will be unlikely to be able to expand sufficiently to replace vacancies on the middle-grade rotas. An increase in MTI placements would be a welcome development, particularly as O&G remains popular and is consistently filled each year.

There is also potential to expand this scheme for more senior doctors (above ST3) where more experienced doctors from overseas, who already have MRCOG, could undertake further more specialist training.

Offer training schemes to other countries

UK training in O&G is internationally recognised as being of a high standard, only allocating

CCT once trainees have a wide range of experience. Where deaneries have the capacity to offer additional training schemes, these could be used by trainees from another country on a formalised basis.

HEE is considering letting departments use their trust-funded posts to offer training to overseas doctors who bring their own funding with them. There would be a concern if the RCOG were not able to select and interview these doctors, particularly if they were coming for a period of up to seven years. It would be important for the training to reflect the skills needed to be taken back to the trainees' countries of origin. It would also need to be ensured that trainees recruited from other countries are integrated into an education and appraisal structure.

A potential group of doctors is European CCT holders who gain less practical experience during their shorter training programme, but who may have acquired skills of particular benefit to UK practice e.g. greater familiarity with ultrasound. There is an option to recruit European CCT holders to a level between ST3 and ST7 (depending on their practical experience) and offer them UK structured training but without the need for assessment for CCT, as they already hold it.

Develop other health professionals to provide middle-grade duties

It is unlikely that staff who are not medically trained would be able to take over the duties of an O&G registrar, which are wide ranging and include both specialised surgical skills, acute emergency management and general medical knowledge.

The development of nurse specialists in specific roles such as colposcopy and outpatient hysteroscopy already occurs and should be expanded. This could free up middle-grade time for on-call duties etc. but it must not remove sufficient training opportunities for trainees. The use of physician associates for specific operative roles or specialised clinics will be explored but they would be unable to replace the multiskilled role of O&G middle-grade staff, particularly on-call. Again, access to training opportunities for O&G trainees should not be reduced.

The current crisis and shortfall in nursing and midwifery staff far outweighs the shortfall in

medical staffing and so is not a short- to medium-term solution. The Royal College of Midwives has provided the following statement on this point.

“The RCM accepts that the boundary between midwifery skills and medical skills is not inflexible and that some midwives may develop particular skills in order to sustain continuity of carer, allow more women to benefit from midwifery care at home or in midwifery units or otherwise to improve the care available to women and babies. Good examples of this are perineal repair, cannulation, examination of the new born and undertaking six-week postnatal examination. However this is about adapting the midwife’s role to accommodate women’s requirements, it is not about advancing skills.

The RCM does not however endorse the extension of the midwife’s role into obstetric, nursing or other spheres of practice where this does not demonstrably improve the quality of or access to midwifery expertise. Whilst the RCM accepts that NHS organisations wish to maximise the flexibility of their workforce, it is not acceptable to permanently alter midwifery roles to compensate for staffing shortages or changes in doctors roles. We do not believe this kind of response solves the fundamental problem of medical shortages but merely moves the problem onto another profession.”

Develop GPs with an extended role (GPwER)

There is discussion between RCGP and NHSE about a credentialed programme to develop GPs with an extended role (GPwER) in women’s health. If this is not formalised shortly, trusts could develop their own local schemes, recruiting GPs to provide specific skills such as work in antenatal care or emergency gynaecology, which would free up middle-grade time for on-call duties. Again, it must not remove training opportunities for current trainees nor access to ‘first on-call’ doctors for clinics. However, general practice also has major recruitment and workforce issues, which need to be factored into any plans. That said, these opportunities may be attractive to some GPs and help retain individuals in the workforce.

There are a group of GPs who initially trained in O&G, some leaving after achieving their MRCOG. They would be an ideal group to work with on a sessional basis, with a specific skill and appropriate CPD. The salary scale for this grade of doctor – previously known as clinical assistants – needs to be clarified nationally. It would need to be equivalent to the pay for a GP locum session.

www.rcog.org.uk/workforce2017

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27 Sussex Place
Regent's Park
London NW1 4RG
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