Royal College of Obstetricians & Gynaecologists

RCOG position statement

Ensuring safe out of hours support for complex emergency obstetric and gynaecology surgery.

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Background

The skills of the O&G consultant workforce, and the complexities of patient care, are evolving and changing.[1,2] With the increase in specialisation and the reduction in major gynaecological operating, the pool of individuals able to manage both complex gynaecology and obstetric surgical complications is decreasing.

Newly qualified consultants will be able to manage approximately 90% of gynaecology operating cases out of hours, but this leaves a remaining 10% of patients who require more complex care and for whom formal cover from senior doctors must be in place.[3] Adding in the complexities of litigation and rota gaps, and the need for consultants to effectively support colleagues, it is clear that O&G services need to have formal systems in place to provide robust consultant out of hours cover.

Statement Development

This position statement was developed by the RCOG/HEE Working group following extensive investigation of current workload and practice with Members, Fellows, Trainees, SAS & Locally Employed doctors and other key stakeholders, a dedicated afternoon workshop at the RCOG Council, wider feedback from colleagues in the CQC, NHS England, NHS Scotland, Health Education England and approval at RCOG Council.

The RCOG recommends that all units should have a standard operating procedure for the management of complex obstetric and gynaecological operating cases surgery out of hours.*

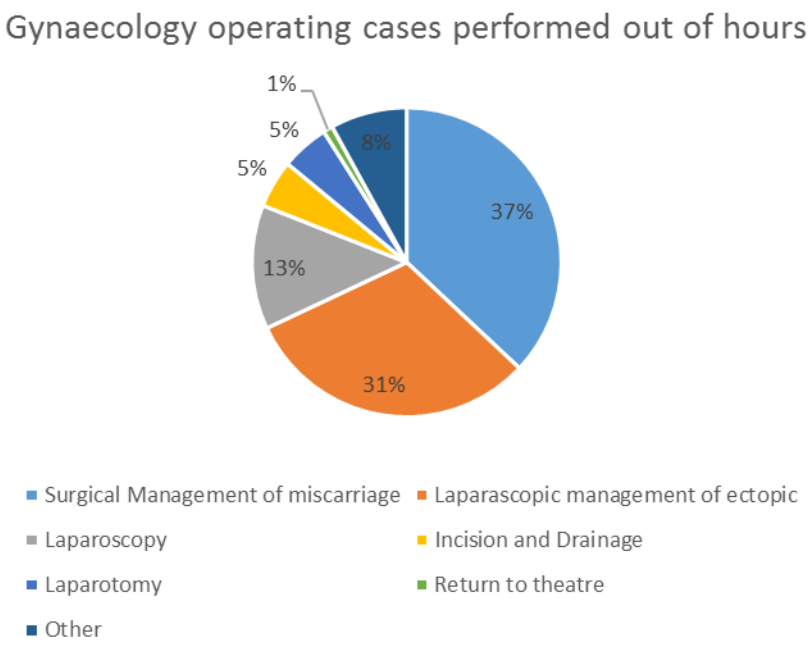
What gynaecological skills do newly qualified consultants have?

The training matrix identifies the core skills newly qualified consultants (those who are on the specialist register) will have in gynaecology. However, how does this translate into the management of gynaecological presentations out of hours?

- A recent national audit of out of hours gynaecology operating showed the skills for 94% of cases would have been covered in the core training curriculum.
- When factoring in more challenging cases such as returns to theatre, laparotomies, and cases where a second consultant was called, this number remained high with 90% of cases being achievable following completion of the core curriculum.
- The assessment of 90% does not take into account Advanced Skills Training Modules (ATSMs) or subspecialty training programmes undertaken by clinicians, so this is the most conservative estimate.

* Defined as between 7pm and 8am weekdays, and between 7pm on Friday to 8am on Monday for weekends.

The following figure shows the proportion of gynaecology operating cases out of hours:



Traditionally, the principles learnt in major gynaecological operating have been used for the management of major obstetric haemorrhage. With an increasing number of doctors practising pure obstetrics, and the ability to perform a hysterectomy no longer being a prerequisite to CCT/CESR/CESR CP, the appropriate level of cover of massive obstetric haemorrhage needs careful consideration.

Incidence of complex obstetric operating out of hours

Reassuringly, caesarean hysterectomies are uncommon events, occurring in 0.037% of births, averaging 317 per year in England. In addition, undiagnosed abnormally invasive placenta is becoming less common as a result of advancing skills in ultrasound scanning and assessment of placental site, meaning most women are treated in-hours by advanced networks of teams specialising in abnormally invasive placentation.

However, management of obstetric haemorrhage, especially in the context of a hysterectomy, requires a second experienced pair of hands.[4]

It is not possible to define all complex out of hours cases due to the breadth of the speciality. A suitably experienced clinician needs to be available to cover these challenging cases as they arise out of hours. How this is achieved will vary significantly dependent on the location, size and skill mix of each individual unit and will evolve over time with the changing shape and skills of the workforce. Appendix 1 suggests ways to facilitate this.

RCOG Recommendation

In the interests of patient safety, peer support and education, the RCOG recommends that all units have a standard operating procedure for the management of complex gynaecological operating and complex obstetric operating cases out of hours.

We recognise that there will always be complex unpredictable cases where further specialist support may be preferable, for example the operating surgeon returning to theatre and thereby assisting colleagues. This recommendation would not wish to discourage this good practice. However, this must not be a substitute for formal arrangements for senior consultant cover in these complex cases, especially out of hours.

We also recognise that no one-size model will fit all. As such, **we recommend that each unit create an individualised, standardised operating procedure considering local nuances, such as number of out of hours cases, geographical location, staffing levels and skill mix. This SOP should be closely audited and recorded.**

Any changes in consultant on-call commitments should be appropriately reflected in job plans.

Appendix 1

Examples of how to provide senior cover

Option 1 – Regional Out of Hour Gynaecology Networks

- Maintain existing first on-call consultant cover in units.
- Create an additional second on-call tier of consultants at a regional/ICS/deanery level (depending on local geography and existing provision of services).
- Careful consideration of which consultants to include on the rota dependent on skill set. There will need to be flexibility as consultants acquire new skills and develop their scope of practice.
- If called, the second on-call consultant would travel to give support to the on-call consultant at the native unit.

Case Study

- Unit 1 - Hull – Tertiary Unit 5500-6000 Births – Existing consultant on-call for O&G.
- Unit 2 - Castle Hill (Elective Surgery Site) – Consultant on-call covers complications for elective surgery and is a flying squad for O&G emergencies at Hull.
- Gynae-oncologists and other experienced gynaecologists are included on the rota.
- The on-call intensity is 1 in 5.
- Consultants do a week on call.
- They are rarely called for gynaecology operating out of hours in Hull, reporting that the majority is carried out in daytime where possible.
- They are very rarely called for a major obstetric haemorrhage.
- They estimate receiving a call or being required to attend in 2-5% of their on-calls.
- If called, their clinical session the following day is cancelled with no resistance from managers.
- Whilst this case study is a system effective in one trust such a model could be expanded to cover a number of trusts.
- Models of regional cover in surgical specialties already exist. Cover in the Wessex region for urology, maxillofacial and vascular surgery have been successfully implemented.
- NHSE/I have commissioned regional centres for the care of women with abnormally invasive placenta which take referrals from their regional units. Such networks where geography permits could be replicated across units/hospitals to provide regional out of hours gynaecology cover.

Option 2 – Separate O&G on-call rotas

- This may be more feasible in large units.
- Appropriately skilled gynaecological consultants provide support for complex obstetric surgery on paired rotas.
- The pairing of consultants would need to be carefully managed – for example, if the obstetric consultant was a pure obstetrician and the gynaecologist specialised in fertility, they may not have the skillset combined to manage the return to theatre of a laparotomy. Consultant pairings would need regular review/SOP by rota coordinators.

Option 3 – Resident and non-resident consultant rotas

- In hospitals with resident and non-resident consultants, this would allow the two to support one another with complex gynaecology and obstetric cases.
- Oversight to ensure appropriate skill mix and seniority should also be undertaken.
- Where units only have resident consultants overnight, they would need to ensure adequate additional support on weekend days.

Option 4 – Creating a formal agreement with the general surgeons

- This may be a good option in a rural or small unit. This model is currently used in a small Scottish hospital.
- Create an agreement with the team of general surgical consultants to provide additional support as required.

Other ways to broaden skills

- Promote and formalise exchange programmes outside the UK, for example to areas with high rates of caesarean hysterectomies for doctors at all grades.
- Post-CCT fellowship roles with education sessions to develop generalist gynaecological skills in rural settings particularly. These fellowships could have placements in both rural and urban settings.
- Fund more posts in rural areas for newly qualified consultants, to allow for succession planning. This would give newly qualified consultants a run-in period to their new unit, working alongside a senior consultant, with educational sessions to expand their skillset.

Other considerations

- Certain units at present may have consultants, all of whom have sufficient skills to manage complex obstetrics and gynaecology. However, this is unlikely to be the case in the future and requires regular review.

References

1. ONS. Population of England and Wales - Ethnicity facts and figures. 2018.

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2. ONS. Childbearing for women born in different years, England and Wales: 2019.

Available from: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/childbearingforwomenbornindifferentyearsenglandandwales/2019

3. Unpublished data, RCOG clinical Audit.

4. Mavrides, E, Allard, S, Chandraharan, E, Collins, P, Green, L, Hunt, BJ, Riris, S, Thomson, AJ on behalf of the Royal College of Obstetricians and Gynaecologists. Prevention and management of postpartum haemorrhage. *BJOG* 2016; 124: e106-e149.