PARENTS IN SURGERY

THE START OF A CONVERSATION

SEPTEMBER 2022

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The vision

For all members of surgical and dental teams to have equitable access and opportunities for employment, training, professional and personal development, regardless of their parental or caring responsibilities or status

The Kennedy recommendation

The Royal College of Surgeons of England (RCS England) has spent the past six months conducting explorative work as part of the Parents in Surgery project that came from the recommendations in the Kennedy report in March 2021.[1] The Kennedy review identified focus on and investment in Parents in Surgery as one of the highest impact areas where RCS England could make a difference to the current professional environment, changing the perception of surgery, and attracting and retaining a diverse workforce.

Kennedy recommendation:

'The experience of parents, who are training to be surgeons or are busy surgeons in practice, is extremely challenging and stressful; it demands urgent attention. A Task Force should be established to work with Deaneries, Trusts and Hospitals to address more supportive structures and career paths. The work of the Task Force should feed into the restructuring planned by government.'

'Invest in a Parents in Surgery study and strategy as a flagship programme. And then strongly advocate outcomes of this work to Deaneries, Trusts, etc. We think that this is the single most important thing that the College can do to indicate support for working parents – particularly of babies and younger children – which will be essential to growing talent in surgery generally and in the College ecosystem. This Parents in Surgery strategy should be prioritised, highly focused and done at pace; delivered with an independent academic partner. It should be inclusive (involving working mothers and fathers) and bold and radical in its definition and outcomes.'

The Kennedy report and recommendations highlighted the need for us to understand more about the issues connected with the experience of parents in surgery. In response to the Kennedy report, we committed to putting together a taskforce to:

1. undertake an immediate review of RCS England policies to ensure that they are suitable for working parents;
2. publish our research and recommendations on the barriers to parent participation in surgery with recommendations for further change in RCS England policy and practice, along with collaborations and advocacy we should undertake to effect changes in policies and behaviours of other organisations.

This report is the response to the commitment we made in September 2021 and details recommendations for further change in policy and practice alongside our next steps to progress this area of work.

Foreword by Fiona Myint

RCS England Vice-President,
Council Lead for Parents in Surgery

Stemming from a strong recommendation in the Kennedy report, Parents in Surgery is our expedition into the world of being a surgeon and how this relates to parenthood. The work we have done so far is the tip of the iceberg. Parenthood touches not just surgeons (and not just parents) but the general population at large. The issues we have looked at and heard about, while focused on our surgical members and fellows, have ramifications throughout society. Although this report relates to parents, we are equally aware of those with other caring responsibilities, including caring for elderly relatives, siblings, adoptive children or other dependants, for whom this report will also have relevance.

Much of this report on parenting in surgery would not have been possible without the honesty and openness of fellows, members and staff, who stepped forwards and shared their joys, sorrows, anxieties and concerns with us. There are some excellent examples of good practice in the workplace and other areas that would benefit from improvement. This is not a report from Lincoln's Inn Fields; it is a report from the broadest reaches of the RCS England membership.

Although many of the issues discussed are also experienced by non-surgeons, there are some that become particularly pronounced as a result of the way we practise as surgeons. During my years as a training programme director and then as a specialty advisory committee liaison representative, I saw first hand the struggles that some young trainees have trying to coordinate family life and the career that they love. Those of us managing programmes have to understand the importance of geography, timetabling and flexibility. We should also remember that those who train or work less than full time are no less passionate about their jobs. They are just actively plate-spinning – and we may only see one of those plates at any one time.

I have been most fortunate to be able to follow my own surgical career and be a parent. My concern was visible as I contemplated balancing the two; my then boss (a father himself) looked me straight in the eye and told me that he knew what I was worried about, that I could do both and that I would know what my priorities were when the time came. While I did not become a parent until a few years after that, I have carried those words with me and have gained great support from them.

This document is a beginning. It is the start of a process to understand the problems in finding equipoise for those surgeons touched by parenthood. It should be extrapolated to those with other home caring roles, and outside surgery. Armed with this understanding, we should then seek solutions to embrace parenthood with a successful surgical career.

Wanting to be, struggling to be and being a parent are part of everyday living. We should seek to accommodate this into our training and working lives and, more importantly, embed it in our mindset.

Foreword by Rebecca Martin

RCS England Head of Learning Innovation, Staff Lead for Parents in Surgery

The Parents in Surgery work has challenged me personally and professionally as the issues brought to the fore in the recommendation from the Kennedy report are much bigger than the surgical profession. It is hard, as a parent, not to be affected emotionally by some of the experiences of colleagues and fellow beings.

The more I have learnt about the issues surrounding the Parents in Surgery recommendation, the bigger this project has become and there are a variety of different directions that this work could take. There is a want (and a need) to do so much. At the end of the first phase of this work, it is the right time to review what we have learnt, consider where we can have the most immediate and long-term impact, and focus our planned activity accordingly.

My career to date has seen me in a number of different organisations ranging from commercial teams through to membership and professional bodies with a non-profit focus. Interestingly, the majority of industries I have worked in are seen as 'male dominated' and, perhaps because of this, I chose to not disclose my parental desires or discuss my children at work. I felt that I would not be seen as dedicated or ambitious or focused and driven, which would in turn negatively affect my career prospects.

This piece of work, however, has forced me to be more transparent, allowing colleagues to see my vulnerabilities, and to actively choose appropriate moments to talk about my children and my parental experiences. As a result, I have found that by being open about the personal challenges I have faced (and continue to face), I am able to support colleagues better and facilitate hard conversations more easily. I am also highly aware that I say all of this as a head of department, in a role that allows flexibility and stability, and so I understand that it might not be as easy for others.

I know that there are elements of this report that not everyone will agree with. Nevertheless, I truly believe that it is the start of an important conversation and a big step forwards to enabling change.

Change will not happen overnight, and if it were easy, then we would already see parity. This is important, vital work, and it will make a difference to the profession and the landscape of the surgical workforce. I am proud of the work we have done collectively so far, and that RCS England is brave enough to front where we need to be leading and doing better.

I have been humbled by the amount of support this recommendation has received by staff and members of RCS England. I really hope that this report does all of your stories and experiences justice, and that it reflects the conversations we have had in an honest and meaningful way.

Executive summary and recommendations

EXECUTIVE SUMMARY

Parents in Surgery has evolved and grown exponentially during the first phase of our work. We embarked on this phase expecting the outcome to be a list of concrete actions that RCS England and others could take to improve the working lives of parents in surgical and dental careers. During numerous stakeholder meetings, exploration of the available data and research, and drafting and redrafting of this report, we have come to understand that the work has two key elements:

1. RCS England as a support and resource for our members
2. RCS England as a leader and a force for change in the profession and the professional environment

This report reflects those two key roles for RCS England. We hope that what we set out in the substance of this report is a thoughtful and thorough consideration of the environment, the challenges and the barriers that parents in surgery face. These challenges, stretching across workforce issues, rotas and planning, the balance between training and delivering the service, and the ability to work or train less than full time are not unique to parents but they are exacerbated by parental, caring and other fixed commitments outside an individual's working life, and they are especially challenging to accommodate in the extended formal postgraduate training route surgeons undertake.

Having explored these areas with a wide range of stakeholders and the available research, we identify some practical recommendations for ourselves and for others to improve the existing environment, as well as areas where further research and work is needed to understand fully both the environment itself and the data and evidence that underpin recommendations to implement future change. There are clear examples of things that are already working well at a team or department level, and at different career stages. We highlight these examples of good practice through the report, and our recommendations pick up on how they can be expanded and adopted to reach a wider group of people.

In some areas, there are clear gaps in the available data, including parental status. There is even less exploration and research into the impact of the particular barriers and challenges that parents and carers face in surgical careers, and although we address some of this and contribute to that pool of knowledge in this report, there is considerably more to find out. In order to rectify this, during the next phase, we will undertake work with the Nuffield Trust as an independent partner to triangulate and corroborate our findings, and to give us some of the insight and data we are missing.

Alongside our exploration of the wider environment, we have considered where we can take action and have the most impact and influence for our members and the wider profession over the short and longer term. Following this first phase of work, the area where we think we can have the most immediate impact is supporting those individuals in the pre-parenthood stage, the time when individuals are planning a family. In our work with stakeholders, discussions about fertility, planning for parenthood, complications and challenges came up constantly as an acute point of pain for people, shrouded in secrecy and silence, where those we spoke to felt that support, transparency and discussion would make a significant difference to our members and the wider profession.

There is a small amount of evidence in the US to suggest that female surgeons 'have first pregnancies later in life, fewer children, and report more issues with infertility. Assisted reproductive technology is implemented more often by female surgeons than the general population.'[2] This needs further investigation and study in the UK but the sentiment resonated in the stakeholder work we undertook. In our work, we heard that increased visibility, understanding of the challenges faced during the planning stages, and the need for flexibility and support within these would help surgeons of all genders. Further to that, the ability to talk openly regardless of gender or circumstance (if not with employers, then with peers) about these challenges and obstacles would have significant benefit for the wellbeing and ultimately retention of parents in the surgical workforce.

It is vital that our work here dovetails with other initiatives; the workforce needs to be considered as a whole and any interventions that resolve a problem for one section of the workforce but potentially create a problem for another are not sustainable over the longer term. If we are to recruit and retain the surgical workforce, meeting service needs, and individual career aspirations and work–life balance, then the full career journey for all (including specialty and associate specialist [SAS] doctors and locally employed doctors, and those in training roles up to retirement) needs to work and be flexible enough for all stages of life.

During my training I had two young children and both myself and my partner were in training. I was lucky to work with an excellent male consultant who understood my conflicting responsibilities and was able to accommodate them with a flexible timetable allowing me to work from home on my non-clinical sessions and also allowing carer flexibility when needed so I can still do the nursery and school drop off and pick up on few days every year while coming to work. We were also lucky to get two jobs in the same regions which is very difficult in dentistry these days as part of national recruitment when there are very few jobs available.

– Sondos Albadri
Professor and Honorary Consultant in Paediatric Dentistry
President of the British Society of Paediatric Dentistry

The Kennedy report focused on cultivating a sense of inclusion and community among our membership and the wider profession, making RCS England feel like a home and a place our members belong.[1]
By opening discussions, providing support and resources, and creating communities and networks of parents and those in the pre-parenthood stage, we aim to take the first steps towards explicitly realising our vision for all members of surgical and dental teams to have the same access to and opportunities for employment, training, and professional and personal development regardless of their parental or caring responsibilities or status.

We would like to thank all the individuals who contributed to the findings of this report; the support and conversations that this work has evoked have been extraordinary. We are grateful and honoured that our fellows, members and colleagues in surgical and other professions felt they could trust us with such personal experiences to try to help make the lives of their colleagues and the future workforce better.

ACTIONS AND RECOMMENDATIONS

Throughout this report, we have identified a series of recommendations to improve the available data and evidence, understand the barriers and challenges that parents in surgery face, and establish how best to address them. Alongside this, we have highlighted some more practical and immediate actions that we and others can take to improve the existing environment or extend best practice beyond local examples. We include all of these recommendations in this section as a quick reference and a practical guide for those seeking to take this work forwards.

The matrix in Table 1 sets out our thinking and methodology for categorising the recommendations and next steps. The Parents in Surgery work is iterative and has the capacity to be all encompassing. We need to start somewhere and keep taking steps towards our vision. Identifying where we can have the most influence and impact is how we have established where to start.

Table 1: *Methodology for categorising our recommendations and next steps*

		IMPACT IT WILL HAVE ON PARENTS IN SURGERY	
		HIGH IMPACT	LOW IMPACT
LEVEL OF INFLUENCE	HIGH INFLUENCE	**HIGH INFLUENCE, HIGH IMPACT:** ACTION FIRST AND RESOURCE DIRECTLY We will develop a network of support and build a community to enable individuals to share their experiences and lean on supportive colleagues and peers. We will develop and signpost resources that support individuals through the stages of planning a family and taking parental leave. We will commission an independent review and impact study of the barriers to becoming a parent in surgery to provide insight and data where these are currently missing, and we will ensure that any advocacy and action is evidence based. **These are the elements we can put in place most easily that will have a high impact on parents in surgery. These actions are therefore the starting point and first priorities. They will have a direct impact on our members, and will foster a sense of belonging and community.**	**HIGH INFLUENCE, LOW IMPACT:** WORK TO INCREASE IMPACT FOR PARENTS We will develop a workforce strategy to understand the challenges faced at different points in the surgical career and by different groups. This will help us use our resources and position to influence change at policy level as well as practically on the ground. The strategy will cover topics raised in this report including gaps in data, less than full-time (LTFT) training and working, job and rota planning, and pathways for SAS and locally employed doctors. We will ensure we promote flexibility generally and LTFT working specifically, and we will lobby for the resources needed to support units where staff choose to reduce their hours of work. We will ensure that the obstacles and challenges raised in this work are included, and that parents in surgery are consulted during the strategy development and implementation. We will work with the NHS in England, Wales and Northern Ireland, the British Medical Association, NHS Employers and other external partners to provide and update meaningful job planning guidance. We will consider personalised and team-based approaches to job planning. We will provide practical examples/templates to support local negotiation and best practice, and to empower surgeons to actually make this happen. **These elements may have less of a direct impact on parents in surgery at the moment but are within our influence. There may be linkages with other RCS England initiatives and groups (Workforce and Training, Women in Surgery) that can strengthen our voice and increase the impact for parents.**
	LOW INFLUENCE	**HIGH IMPACT, LOW INFLUENCE:** WORK WITH THOSE WHO HAVE INFLUENCE We will co-facilitate a workshop with heads of schools of surgery, postgraduate deans, and the NHS in England, Wales and Northern Ireland to raise the issues and barriers that have been brought to light in this report, and to review the current environment and solutions. We will specifically discuss the take-up and culture around LTFT training and working, including innovative solutions for job sharing and rota gaps to allow unhindered LTFT working. We will discuss geographical rotations, transfer between placements, rota and job planning, and return to work after parental or other periods of leave. We will advocate for consistency of approach across trusts, schools of surgery and Health Education England regional offices, and across Wales and Northern Ireland, implemented consistently at a local level. We will seek to clarify the roles and responsibilities for individuals, their managers, supervisors and human resources staff. We will use our influence to advocate for representation in bodies responsible for the design and delivery of surgical training to raise awareness and remove barriers and obstacles for parents and those with caring responsibilities. We will develop champions and supportive networks across the regions, developing clinical managers, and providing and drawing together resources, both for individuals and for their managers and teams. We will develop a toolkit for clinical managers and those overseeing training, and we will signpost resources so they are kept up to date with information they need to support their staff. **These elements have a high impact but are out of our direct influence. We will need to rely on champions, advocates and stakeholders to effect changes through other organisations. Our priorities here will focus on developing our credibility, voice and evidence to nurture those champions, and to provide them with the resources they need to effect change.**	**LOW IMPACT, LOW INFLUENCE:** RECOMMENDATIONS FOR OTHERS A number of areas in this report point to improvements in the information and facilities employers could make available for parents in surgery. We recommend that trusts review their staff facilities and working conditions, including providing private spaces to be used for feeding, expressing and injecting, alongside appropriate space to store milk or medicines. We recommend ensuring that childcare options are clearly signposted and fit for the workforce's service hours, and that there are clear policies and practices that uphold the right to privacy for the workforce needing treatment. Additionally, we recommend that Health Education England and equivalent bodies in Wales and Northern Ireland actively consider implementation of all of these when considering whether a trust or department is fit for purpose as a training unit. **These elements are important but they are out of our direct influence and provide a less immediate impact on parents in surgery. They include things like social norms around parenthood and gender disparity in the wider environment.**

Why does Parents in Surgery matter?

The Parents in Surgery recommendation is our flagship project following the Kennedy review.[1] Fundamentally, it is about the flexibility and sustainability of the workforce, including recruitment, retention and, ultimately, the training and career progression of those who take time out of their career for parental leave. Parents in Surgery is multi-layered and covers themes that span the full surgical career path, extending far beyond the impact on parents alone. As we understand more, we see clear links to other Kennedy recommendations, and the way in which subtle changes to the flexibility and sustainability of the workforce could have a positive impact on other areas of our work.

In our work to date, we have been asked why this is particularly relevant and important for surgeons and dental surgeons, and what makes it different to the challenges and barriers faced in other professions. Surgeons who choose a traditional training route are in postgraduate training for a minimum of ten years,[3] during which individuals are proving themselves constantly, moving around regularly through different rotations, and undertaking interviews and exams at various stages. Where other professions (especially non-medical) may offer stability at an earlier age, in surgery job security and geographical stability is uncertain for much of the period between the ages of 25 and 35, typically when professionals consider starting a family. Individuals we have spoken to described not being perceived as dedicated enough and feared discrimination over job prospects if they discussed their plans or took parental leave during this period, affecting their decisions and sometimes their ability to have a family.

I have found that my attitude towards life, training and work in general took a completely unexpected turn when Seb was born. Being a father has made me a much more compassionate surgeon and colleague.

Our son was born during my research stint and the early years of my specialist training involved significant difficulties in organising childcare, time off to be with him when he was ill and ensuring I left on time (when does that ever happen right!) to collect him from nursery or school.

I felt life was a constant juggling act with a very important person in the middle of all this and dropping a ball was not ever an option. The anxiety related to whether I'm going to finish theatre on time to manage the pick-up, or whenever he needed to be hospitalised for treatment, often came to a head needing both my wife and I to take stock of the situation and re-plan our lives around him.

I am a firm believer that parenting, like surgery, is not a gender-based role. I have huge admiration of couples who are both surgeons who start a family during training – hats off to them!

Would I do it again?….. tough one!

– Andrew Busuttil
Vascular Surgery Registrar

Surgeons who consider planning a family must consider multiple logistical points. The hours are irregular and rotas are difficult to plan around. This can be particularly acute for those on training pathways; training, elective and on-call rotas are available at different times, making it difficult to plan childcare, fertility treatment or pregnancy appointments, and opportunistic training experiences can be missed where individuals are not able to flex their commitments and work outside planned hours. For those who take on caring responsibilities that were not planned into their original career pathways (including becoming a step-parent, or a carer of siblings or elderly relatives), job plans may need to become more flexible and adaptable. Some specialties such as those with fewer on-call obligations like breast surgery[4] and regions with larger workforces may offer more stability than others, and our stakeholder work suggests that perceptions like these can influence career choices.

For those who undergo assisted fertility routes, the geographical challenges and unpredictable hours make it difficult to maintain the continuity of care and treatment required over a sustained period of time. There are additional geographical challenges as people move through rotations. For surgeons who are in relationships or who have children with other surgeons or medical professionals, there are no mechanisms in place to guarantee that this will be given consideration when thinking about rotations and parental responsibilities, and for practical reasons, this often means one person's career takes precedence.

This report aims to set out an honest reflection of the research and evidence we have collected to date. We have made huge steps forwards in our own understanding of the barriers and obstacles surrounding parenthood in surgery. However, we are still at the beginning of our journey, and there is a lot of work and learning for us to do, both as an organisation ourselves and to fulfil our role as a leader of the profession. In the next stage of our work, we will collaborate further across our wide range of stakeholders, working specifically with the Nuffield Trust to test some of the hypotheses we have developed in our work to date, and to underpin further work and recommendations with evidence.

The work we have undertaken to develop our understanding and our future actions has taken in the views, experiences and personal stories of individuals from different paths and backgrounds. This has been essential for us to understand the issues and barriers that our members and the wider profession face when they consider parenthood, undertake any part of the journey planning for parenthood in all its guises, become parents, experience loss or fertility difficulty, or choose not to become a parent.

We have done our best to honour, respect and represent the wide array of experiences, using people's own words directly where they have given us permission to do so. We feel privileged that people have trusted us with their stories and experiences in this way.

Some stories touch on sensitive subjects, some of them are difficult reading and, as we have found undertaking this work, some bring up personal or sensitive subjects for those reading them. At the end of this report, we have listed a wide range of resources, networks and support lines including our confidential support and advice service for members, which readers may find useful.

If you have any comments or feedback after reading this report, we would be very pleased to hear from you. Please email: diversity@rcseng.ac.uk

WHAT DATA DO WE HAVE?

Despite not having any definitive data available to us regarding the parental status of the NHS or surgical workforce, there are some datasets that we have been able to draw on to inform this work. The Office for National Statistics data for January to March 2022 show 12,012,397 working parents in the UK[5] out of a total full-time workforce of 24,517,317.[6] NHS England employs 1,221,380 full-time equivalent hospital and community health service staff (as at April 2022).[7] The NHS is the largest employer in the UK[8] and so if we assume that the proportion of NHS staff who are parents mirrors the UK-wide workforce proportion, then approximately 600,000 (49%) of the NHS workforce would have some form of parental responsibility.

As this report covers in other sections, early studies from the US[9–11] and Canada[12] suggest that the surgical profession demonstrates some differences from the general population in terms of pregnancy and parental trends. The next phase of our work will seek to address the gaps in data and to establish whether surgeons in the UK reflect population norms and those in other medical professions.

In a world of increased waiting lists and staff shortages, exacerbated by the COVID-19 pandemic, we are struggling to ensure that we have the number of individuals we need at the right time and in the right place to cope with the demand on the health service.[13] We know that we have a workforce issue across the profession[14,15] and that additional investment by government is needed to provide adequate training posts to sustain service levels.

Despite service levels rising and waiting list delays demanding further increases, the number of nationally advertised vacancies for core surgical training at CT1 in England has decreased from 642 in 2016 to 607 vacancies in 2021.[16] Alongside additional investment in the workforce numbers required, some medical students continue to see surgery as an unsustainable career path, one that it is not conducive to family life or a work–life balance.[17–19] Conducted by the General Medical Council and Health Education England just before the pandemic, the Completing the Picture Survey looked at why doctors leave the profession, and showed that there is significant burnout and job dissatisfaction.[20] A relatively high percentage of surgeons had left but a relatively high number of surgeons also indicated that they might be persuaded to return if better support and a more balanced work–life culture were in place.

WORKFORCE AND CULTURE

Promoting and putting in place changes to ensure a more flexible and supportive culture in the surgical profession can change the perception that a surgical career is off limits for some people.[21] There are people who do not choose this path despite having an interest in surgery at present but who would nevertheless excel and enjoy a full and successful career given the right environment, support and culture. Working pragmatically and collaboratively across healthcare bodies, we have the opportunity to address some of the barriers and obstacles that the surgical workforce currently faces, and in doing so, we can change the perception that a surgical career is not conducive to family life or work–life balance.

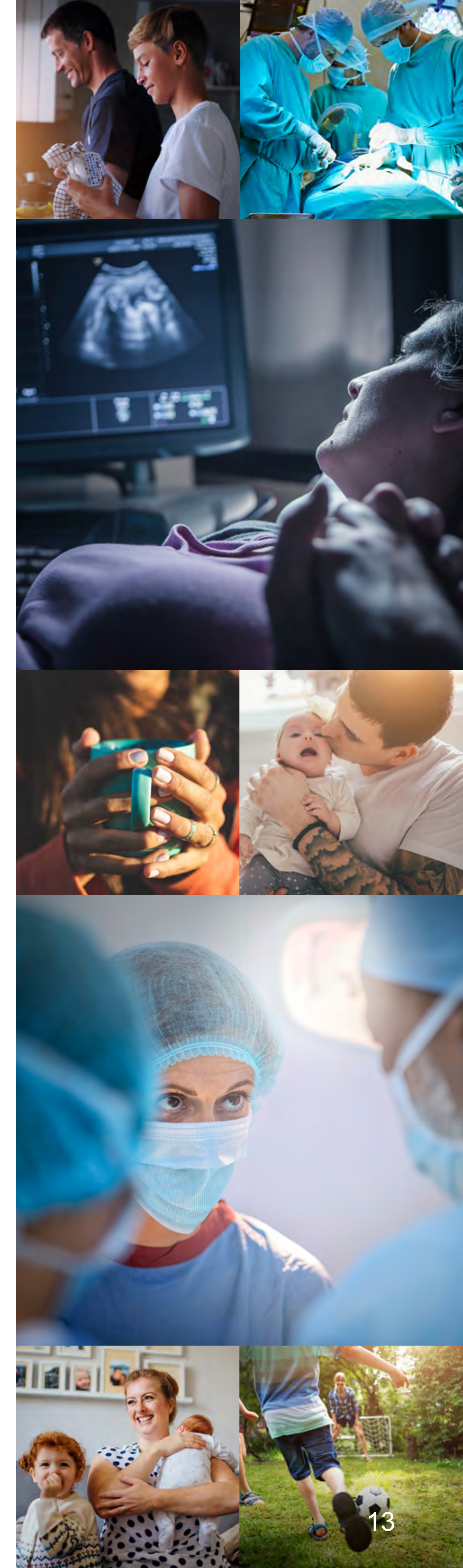
People we have spoken to agonised over their decision to stay or leave the profession. They struggled with the feeling that exiting a profession they love and a career they have worked hard to build is necessary for them if they want a family or home life.

'It's time to put my children first. So I'm sorry to all those who have supported me. I'm sorry to all those juniors who look up to me and to whom I give hope. I'm sorry to the British public for giving up on you. I just can't look into the future and face this anymore.'

– Anonymous (taken from 'I'm sorry, I can't face being a doctor anymore', *The Guardian*)[22]

Those struggling with this dilemma have spoken about feeling alone and unsupported. We can do more across the profession to develop supportive networks that bring people together and more to change the culture on the ground, sharing good practice where we know it happens, and showing what is possible when individuals and teams work in flexible and inclusive cultures.

'The inflexibility of the profession is one of the reasons I left the surgical specialty. The culture just didn't support being a good father and a surgeon, and I wanted both. I miss my old life but it was the right decision for me at the time.'



My partner (a nurse) and I had been together for eight years when I started surgical training. She had already moved region with me four times for my career, involving significant sacrifices. When I received my offers for surgical training jobs all of them required another major move. Both in our mid-thirties, we had wanted to start a family for a couple of years but my career was so uncertain that we kept having to delay. We moved again for my surgical training post, leaving behind our flat, jobs, friends, family and so on. My partner could not find a new job in the nursing area she was trained for. Getting older, we could no longer delay having a child. The birth experience was not straightforward. I took two weeks of paternity leave. I would have been entitled to use some of my partner's unclaimed maternity leave but I had (and still have) the perception that this would have been frowned upon.

In the following months we were unsupported. Compared to the experiences of all other parents we knew, our experience seemed to be at the top end of how difficult a child could be, which was alienating and hard to manage. It felt like I would have to quit surgery to save my family.

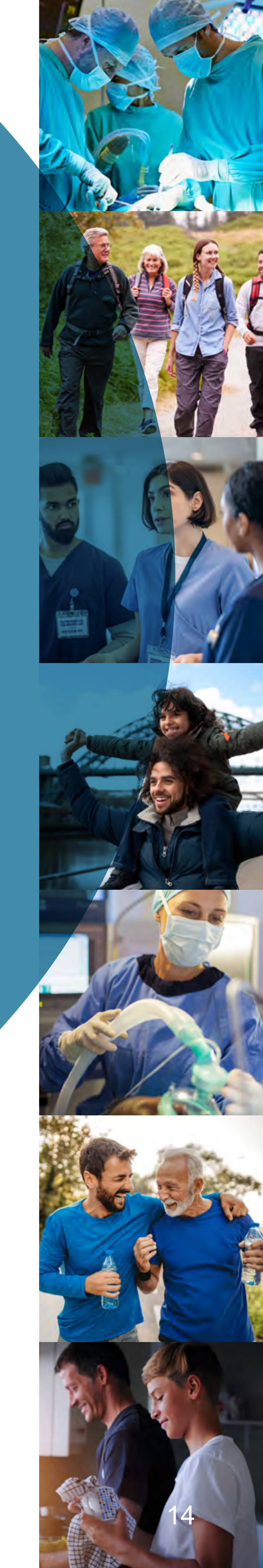
I managed to find a work-around by doing an out of programme experience (still full-time work but more flexible). I dread to think what would have happened if I had not done that.

Trying to be a good surgeon and a good father was not possible: I have the impression that a couple of my seniors at work treated me differently and my workplace became more adversarial. I had to put my family first (e.g. refusing to be summoned back to work by a consultant I was not assigned to once I had already gone home after finishing for the day, refusing to prepare a registrar's presentation for them at 9pm the night before it was due and so on). I had no choice but to do this but it seemed as if this led to negative behaviours from a couple of my colleagues.

The fact I could not just stay around at work and play the game of being seen and I was not able to abandon my family on my days off seemed to count against me.

My overall experience was horrendous. I'm not someone who has ever struggled in my career, I went to medical school specifically to become a surgeon and have an excellent track record. My experience trying to be a father and a surgeon left me ambivalent about whether or not my surgical career even continues at all and I won't be having a second child entirely because of the experience. I'm still in post, but I swore I would lose my career before my family: if something has to go, it will be the career.

– Anonymous



THE VOICE OF THE PROFESSION

During this phase of our work, people have shared their personal stories as parents, and as colleagues and managers of parents. Each account has been different and personal for the people involved. Their background and specific circumstances are varied but clear themes have emerged, pointing to places where change and action can have a positive impact. The people who make up the surgical workforce are central to this work, and within this and later phases of the project, we commit to using our influence and position to make a difference for our members and for the wider profession.

We have also come to understand that small gestures have a big impact on individuals, even in the face of large scale structural challenges. We hope that one of the outcomes of this report is that it empowers and reinforces ways in which the thoughtfulness and kindness of individuals can affect those in their teams and the wider workforce. Local trusts, employers and training bodies may wish to include thoughtfulness and kindness as part of their equality and diversity training.

For those who do not respond to the emotional impact, our work with stakeholders in this project has pointed repeatedly to the fact that inflexibility is having a detrimental effect on retention and recruitment in the profession. Without addressing some of these issues, retention may become a growing problem in the workforce, with more expected of the individuals left. We have the opportunity now to address issues of inflexibility and culture, and to bring the profession up to date, reinvigorate those who would leave and attract those talented, capable doctors who might not currently give surgery a second glance, to ensure that the profession endures and flourishes.

BURNOUT

‘If we want or need to work for longer, then we have to treat ourselves with more kindness.’

Ultimately, this work needs to come back to the people we represent and support. We are currently expecting our workforce to operate in conditions and under circumstances that are not sustainable. The workforce was already showing signs of burnout, and as we have seen an increased demand on the NHS and its staff in the last few years, this is now more of a concern. The Completing the Picture Survey, conducted by the General Medical Council and Health Education England just before the COVID-19 pandemic, looked at why doctors leave the profession. It showed that the reasons for leaving ‘are very varied with a mix of more “neutral” reasons, such as returning to their country of previous residence (32%) and retiring (26.8%), and more negative reasons, such as burnout (27.2%) and dissatisfaction (35.7%)’.[20]

We need to ensure that the wellbeing and mental health of our workforce is supported and taken seriously; without change, we will see a workforce that continues to feel disengaged, tired and burnt out. Under sustained periods of stress, such as this, we risk affecting the quality of care we give our patients and put the reputation of the profession (and the justifiably high standards we hold ourselves to) at risk in the process.[23]

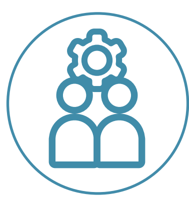
Who is this report for?

RCS England:

We use this report to detail the progress we have made and the journey we see ahead of us, to help us reflect on the learning we have undertaken so far, to communicate our findings, and to hold ourselves to account for our plans and vision for the next steps of this work.

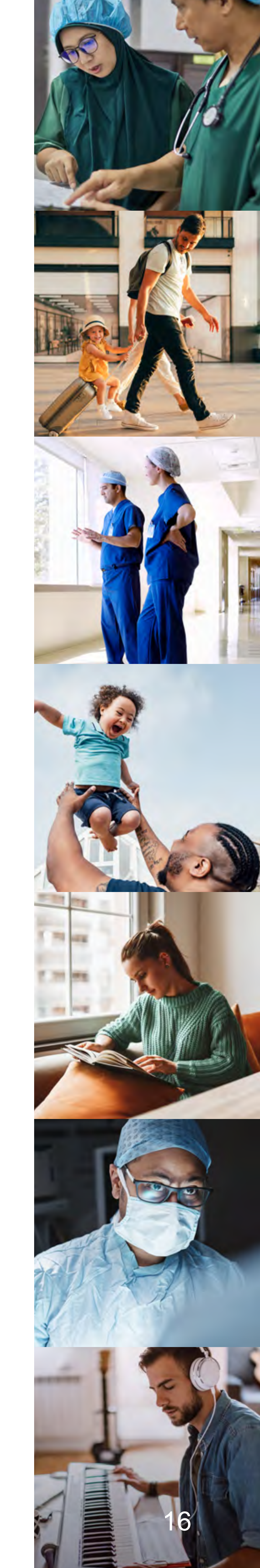
Qualified surgeons, specialty and associate specialist (SAS) and locally employed surgeons, dental surgeons, trainees, aspiring surgical professionals and the wider surgical teams:

This is the start of a conversation to empower and to enable necessary and sometimes difficult discussions in the workplace. This report recognises some of the difficulties that individuals in the dental and surgical professions face, and it represents a step in us working with you to enable effective change.



Trusts, regulators, educational programme bodies, employers, other royal colleges and healthcare bodies, health service organisations and professionals:

This is the start of a discussion to enable progress. This report represents our commitment and desire to work alongside you to deliver effective change for our current and future workforce. We recognise that change does not happen overnight, and we are committed to working together with open communication, transparency and pragmatism to achieve long-term success.



Our methodology and approach

The first stage of our work has been an 'explore phase', giving us the opportunity and time to investigate, at a high level, some of the obstacles and barriers parents in surgery face, and to identify areas where RCS England can have the most influence and impact. This time has enabled us to get to grips with the landscape without prematurely delivering 'solutions' that do not have the impact needed.

During this explore phase, we have spoken purposefully to stakeholders across career stages, geographical locations, specialties and sectors, and with a wide range of career and life experiences. We have spoken to a range of people who are parents and those who do not ever want to be a parent, parents of children with a disability, LGBTQ+ parents, bereaved parents, and individuals who have left a surgical or dental career owing to both the perception and the reality of being a parent in a surgical role. We have spoken to experts in this field, and have sought inspiration from trials and successes of other specialties, professions and organisations.

We have conducted literature searches and reviewed research on the issues surrounding planning a family, becoming a parent and returning to work with respect to healthcare specifically but also to other professions, both in the UK and further afield.

We held 24 one-to-one interviews and 2 focus group sessions, and we had 3 virtual and in-person larger group debates with approximately 240 individuals in total. Over 50 people responded to our initial call for volunteers in autumn 2021 and during the course of this work, others have come forward to request involvement in this work. Alongside the other methods described, we encouraged individuals to send their stories to us electronically. Where permissions have been granted, those narratives have been printed without edit in this report.

We have collaborated with organisations and individuals doing their own research and studies on this subject matter, including those who have gathered data through formal questionnaires and discussions with groups and individuals in surgery. Most notably, the Confederation of British Surgery's parental working group conducted a survey disseminated through trainee organisations including the Association of Surgeons in Training and the British Orthopaedic Trainees Association, which received 78 responses. We have drawn on the findings of this survey and the responses to their work in this report. In addition, we attended seven wider stakeholder meetings covering topics on workforce training, flexibility and less than full-time training; we reference the data and discussions of these conversations throughout this report.

Our work to date has sampled from a range of experiences, backgrounds, career grades, family set-ups and career paths, and we know we have more to do to fill in the data gaps and ensure our action is evidence based. We have commissioned the Nuffield Trust as an independent partner to work with us on the next stage of the Parents in Surgery work, taking forwards our findings, testing the evidence and providing the data to enable us to speak with credibility as we progress with this work.

Our sample size has been small compared with our membership, and we have relied on our networks, stakeholders, volunteers and their networks to undertake this initial piece of exploratory work. Our work centres around belonging, and those we have spoken to told us repeatedly that their experiences of being a parent and a surgeon brought ongoing challenge, negotiation and compromise. While we cannot automatically extrapolate our findings from this sample across the whole surgical and dental workforce, we are committed to respecting and taking seriously the stories and feelings shared with us, and to addressing the obstacles and barriers that those we have spoken to raised with us.

We provide a full list of our stakeholders and collaborators (where they have agreed to be named) as well as references at the end of this document. Some of our volunteers asked to remain anonymous and we have respected their privacy in these cases.

INCLUSIVE LANGUAGE

Words matter. The language we use has the ability to bring people together and make people feel included or to divide and isolate them. This work is based around inclusivity and belonging, and so the language that we have chosen to use aims to reflect this. Language evolves and changes, and we have used terms that aim to respect the current environment at the time of writing this report, recognising that these may change as our collective understanding and education changes, and committing to continually review as we go forwards with this work. Where unsure, we have taken advice from organisations who represent the communities and identities we are talking about and who are directly involved in this work.

The report is aimed at both surgery and dentistry routes and includes all career stages, including specialty and associate specialist (SAS) and locally employed doctor routes. Unless specified, the comments and observations made are applicable across the specialties.

Throughout this report, we have been sensitive about using the phrase 'aspiring parent(s)' as we recognise that some people go through significant planning to become a parent and never become parents.

We have refrained from using the term 'childbearing' so that we remain inclusive to those in surrogacy and adoption routes.

We have tried to refrain from using gendered terms where we are talking about parenting experiences. Similarly, we have tried to differentiate when we are talking about biology (which is important to acknowledge when talking about fertility and pregnancy) and when we are talking about social gender norms of 'typical' parental roles that disproportionately place caring responsibilities on women in our current society. We use the term 'parental leave' instead of the terms 'maternity' and 'paternity' leave unless there is a reason to use either term in the context, in which case we have explained the use in the text.

We use the term 'parent without children' for individuals and families who have lost children either pre or post birth. We use this term as this was how the individuals we spoke to who are living with this wanted to be identified.

WHAT THIS REPORT DOES NOT COVER

There is very little in the way of quantitative data for us to draw on regarding parental status of the workforce. The data available do not support us being able to present key metrics about numbers of the workforce who are parents or planning to be parents, or who have caring responsibilities.

In our research, we have not been able to understand the full breadth of people directly affected by issues surrounding parental responsibilities and status, including any data driven evidence to support the understanding of career level or specialty with regard to when people plan parental leave or begin planning a family. We do not yet understand how socioeconomic diversity and geographical location play a role in these decisions. While we know from studies available that the barriers currently affect women disproportionately (often owing to societal structures and pressures), we are aware that gaps in our work at present include full understanding of intersectional issues faced in the surgical environment (including the roles that race, ethnicity and beliefs play) when planning for a family or undertaking caring responsibilities. Driving forwards the data and evidence is an essential part of this work, and we have engaged with the Nuffield Trust as an independent partner to undertake a piece of research as part of the next phase of the Parents in Surgery work in order to address this better.

In gathering feedback on earlier drafts of this report, areas we have not covered were raised with us, such as the sensitive issue of women having an abortion when they feel that the timing of their pregnancy does not align with their work responsibilities. We were unable to collect data on this and other very sensitive subjects but future work may address such issues. We have concentrated this report on the underpinning themes that emerged during our initial piece of work, recognising that this is not an exhaustive list of the circumstances and barriers individuals face, and that there will be gaps and areas for us to research further.

Socioeconomic diversity

There is a need to undertake additional research into the socioeconomic factors of becoming a parent and how this affects individuals in surgery. Initially, our research started from the widest possible place to understand the themes that span across the whole profession. It is essential that we gain a greater understanding of how these themes then affect specific groups of people in order for us to tailor our work and provide better support as we move forwards. We recognise that different backgrounds and upbringings may have an impact on parenthood.

With SAS/locally employed doctors, who are an ever growing part of the workforce, understanding more about individuals' reasons for choosing alternative career routes is an important part of the picture and an area that is currently underexplored. Anecdotally, during the course of this work, we have heard that some people are choosing to come out of their training route to become a SAS doctor so as to support them better in managing their caring responsibilities. SAS doctors are a group that is rapidly gaining in numbers,[7] and it is important that we understand and address the impact of parenthood on the choices that SAS doctors have and continue to make in a structured way during the next phase of our work, in tandem with the Kennedy work relating to developing a SAS strategy[24] as well as with the existing forums and governance structures.

The child

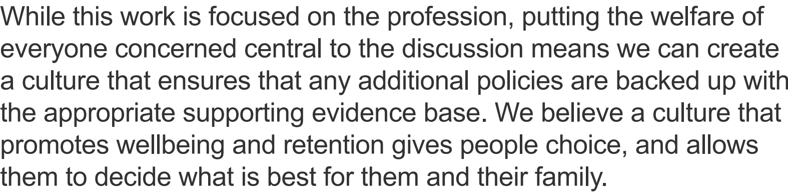
There are very few impact studies on being a parent in the NHS, and the effect that this has on an individual's training and career progression in the UK. There are even fewer that touch on the positive or negative influence that work patterns and rota planning might have on a child with one or two parents working in this environment. Our work centres around the working conditions of those in the surgical environment but we want to note and recognise the wellbeing of all individuals affected directly or indirectly by these topics.

There are a number of parents who face additional challenges especially when their children need medical support, have additional needs, or face ongoing medical issues or disabilities. A benefit of flexibility in the working conditions and culture, which would allow parents and caregivers to be able to plan the appropriate care and support, is the added stability and routine, and this can improve the wellbeing of parents and their children.

Case study

One pertinent conversation that we have had over the past few months was with an individual who spoke about the physical time that she spent away from home. She returned from parental leave when their child was only a few months old and returned to full-time hours straight away.

The commute to and from work was long, as were the shifts. There was a feeling that she wanted to 'prove' that she was back and could do everything that she did before, and so she took on additional shifts and overtime. The individual told us that she felt that by 16 months of age, the child did not know who she was and it was clear that something had to change.



While this work is focused on the profession, putting the welfare of everyone concerned central to the discussion means we can create a culture that ensures that any additional policies are backed up with the appropriate supporting evidence base. We believe a culture that promotes wellbeing and retention gives people choice, and allows them to decide what is best for them and their family.

A women's issue or a workforce issue?

A WOMEN'S ISSUE?

Our work to date suggests that the barriers and obstacles that parents in surgery face are complex and multifactorial, and that they indicate a workforce issue, not simply a 'women's issue'. However, it would be wrong to not acknowledge the physical and social impact that becoming or wanting to become a parent has on women currently in our society and, specifically in this work, on a woman's surgical or dental career.

The Kennedy report noted that the last years of training coincide for many with the start of raising a family.[1] Individuals we spoke to talked about this as a particularly pivotal time as they weigh up their career aspirations, their family desires and financial considerations.

The stress of planning to have a family, fertility treatments, becoming pregnant and returning to work, and the impact on training and on an individual's career is something we have heard a great deal about from the women we spoke to, transcending specialties and career grades. We have heard first hand that the working culture makes women especially feel there is a shame and secrecy that comes with planning for and starting a family, which puts additional pressure on individuals, their colleagues and teams. Although we are starting to see a shift in accepted culture and social norms around who the primary carer of a child can (or should) be,[21] we still live in a society that sees women shoulder disproportionately more responsibility for the upbringing of children and the management of home life.[25]

'It is often the case that mothers are held to a higher standard than others in the workplace and they are penalised if they cannot meet that standard.'

Emily Martin, Vice-President for Education and Workplace Justice, US National Women's Law Center

These are societal and structural expectations and cultures, and we do not propose to try to solve them here. Where they particularly intersect with surgery and our work is the impact that time out of training or work has on the future career and opportunities that are presented to an individual, predominantly women.

Owing to the length of the training pathway for surgery, individuals have often not finished their training when planning for or starting a family. As a comparator, in other non-medical professions, individuals may have already qualified at the time of starting their family and consequently, despite this still being an issue in other industries, the impact may not be as severe. As stated in *Pregnant Then Screwed*: 'We know that a third of employers avoid hiring women of childbearing age, that 40% of employers think that women take advantage of their pregnancy in the workplace and that a third think women are less interested in their career once they get pregnant.'[25] Individuals who have not yet reached a point of stability in their career, such as surgical trainees, may therefore feel additional stress, pressure and vulnerability as they try to negotiate career progression.

Time out of training or work and a societal expectation for women to take on caring responsibilities affects both career progression and a woman's ability to take on additional and voluntary work outside normal working hours. It is often discretionary projects, voluntary roles and additional time that enable individuals to progress faster through pay awards[26] and to be eligible for leadership roles. This element of the Parents in Surgery work intersects with the Emerging Leaders and Women in Surgery Kennedy recommendations,[1] and is borne out by the numbers of women in consultant posts as well as in the most senior leadership roles in the profession (as seen in the original trigger for the Kennedy review).

Despite improvements leading to an increasing number of women surgeons in the UK, gender disparity still persists in the surgical workforce. According to a research paper in *BMJ Open*, achieving gender parity will take some specialties much longer than others, possibly up to 60 years.[27] Based on data submitted annually to NHS Digital by each NHS trust for the period 2011 to 2020, the authors concluded that if nothing changes, neurosurgery would not achieve gender parity of registrars until 2064 while for trauma and orthopaedic surgery and for cardiothoracic surgery, this would not be reached until 2070 and 2082 respectively.

A 2015 US article states that 'the exceptional demands of surgery affected women's careers and family trajectories differently than men's. Twenty-five percent of female surgeons are single, compared to only 6 percent of male surgeons [and] 60 percent of female surgeons have children versus 92 percent of male surgeons. Furthermore, only 25 percent of women choose to have their first child during the rigors of surgical residency, which is half as many as their male colleagues.'[28]

Voluntary and discretionary effort leading to financial and professional reward can disproportionately affect those with caring responsibilities and fixed commitments outside the workplace.[29] These additional barriers make it difficult for people to feel that they belong in leadership positions and can deter them from applying in the first place. Clear and visible support from current leaders and policies that support flexibility in leadership roles reduce some of the barriers for those with caring responsibilities or fixed commitments, including parents, individuals planning for a family and those who require parental leave.

PREGNANCY, ASSISTED FERTILITY AND PREGNANCY LOSS

For those who struggle to conceive and decide to undertake assisted fertility routes to support their journey, a parent who plans to become pregnant is usually the one who needs to undergo any lengthy treatment and is affected in terms of time out of work during this period. In heterosexual cis relationships, this affects women disproportionately. Fertility treatment is also relevant for some LGBTQ+ parents and for those who are transitioning or experiencing treatments that might affect their fertility such as some cancer treatments. Individuals may wish to consider fertility preservation treatments with a view to having a family at a later point in their lives.

Dany Griffiths, the founder and creator of Freedom Fertility Formula,™[30] told us in conversation that around 1 in 7 people struggle to conceive and around 1 in 20 struggle with secondary infertility (the ability to conceive after previously giving birth). There has been some limited research suggesting that surgeons in the US may find it harder to conceive than people in different career paths. A US study revealed: 'Of women surgeons, 32% reported fertility difficulty; 84% of whom underwent infertility workup. Seventy-six percent of these women used ART [assisted reproductive technology] to attempt pregnancy.'[2] The conclusions drawn from this study were that female surgeons have first pregnancies later in life, have fewer children and report more issues with infertility. ART is implemented more often by women surgeons than by the general population. There was supporting evidence to show that differences in fertility also exist between specialties. Anecdotally, our stakeholder discussions reinforced these themes and further work is required to assess the applicability of these findings more widely.

'It was horrendous for many, many reasons but the response by my deanery was awful. I don't know that there are a huge number of surgeons who find themselves in such a position but I am quite sure, sadly, that I am not alone.'

Available fertility treatments (such as egg retrieval, preservation and in vitro fertilisation [IVF]) require an individual to undergo invasive procedures that demand numerous appointments, often at short notice. The treatments are different for everybody, dependent on multiple factors. Typically, there is considerable stress on the body during these treatments. In a normal monthly cycle, a woman may produce one or two eggs naturally. During IVF, a person can produce up to 20 eggs at one time, which can leave an individual exhausted, both mentally and physically. Alongside any specific procedures, it is common to have scans, blood tests and daily injections where timing (including the ability to plan and manage some of these at specific and repeatable times of the day) is critical. Those undergoing treatment such as IVF need to be able to attend appointments in person at short notice over a period of approximately four weeks per treatment cycle. Some may require treatment abroad at short notice, particularly if egg donation or surrogacy are involved, as cycles are individual and timing is crucial.

The inflexibility of surgical rotas often means that those who are undergoing fertility treatments have additional stresses added to an already stressful period as they struggle to find cover for shifts at the last minute.[31] If shifts cannot be covered, appointments can be missed and the health needs of others are put above their own.

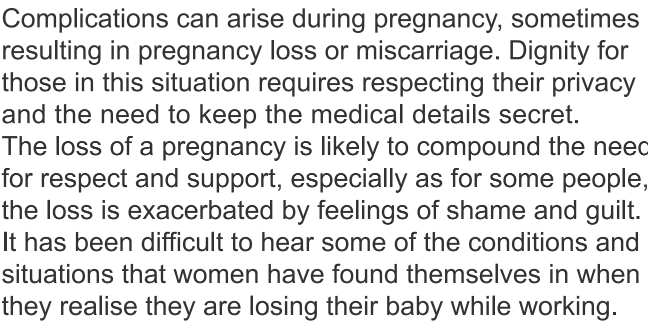
During our discussions and research, people told us that they struggle(d) to talk about undergoing assisted fertility routes, whether through societal pressure to keep silent or more personal feelings of shame and failure. Among those who had undergone treatment, there were few who felt able to confide in colleagues or family to support them at the time. It can be a lonely experience and at a time when an individual may need colleagues to provide rota cover, specific challenges arise if people do not feel they can be honest with colleagues and managers about why they are asking for support or cover.

As a female in surgery I could honesty say I'd never experienced any prejudice due to my sex, that was until I was starting my family. The 2 examples below highlight the more difficult experiences I encountered.

As a pregnant specialty trainee I rotated to a new trust and on my first day I joined the whole team in the morning handover. While commenting on the difficulty caused by a departmental rota gap one of the consultants stated 'and we've got someone new and she's pregnant.' The head of department went on to state he had checked and I wouldn't be allowed in theatre for the duration of the placement. It took some time and several phone calls to convince him that was not the case. I felt immediately judged and made to feel a burden to the department. Because of this, I did want those who are discriminated against often do, I worked harder to prove them wrong. This ultimately meant longer days, finding myself exhausted by the time I made it home and continuing with on-calls for much longer than it was practically safe to do so.

Both my children are IVF babies and for my second it took three rounds to become pregnant. My fertility treatment was something I felt I couldn't discuss with my male trainers. Although, perhaps unfair to the individuals, this was in part based on the prejudice I'd previously experienced. Having just completed a failed treatment I sat through a meeting where I was openly criticised by two senior consultants for rota decisions I had made (at the time, I was responsible for the departmental rota). I left the meeting in tears; at a time when I should have been looking after myself, I had felt obliged to continue in a role that took up considerable amounts of my personal time, caused undue stress and may have played a part in the failed treatment. Looking back at this episode it saddens me that I couldn't discuss my treatment, step back from the stressful role and be honest about the impact of the failed treatment; in my mind it would be perceived as a sign of weakness.

– Anonymous



Complications can arise during pregnancy, sometimes resulting in pregnancy loss or miscarriage. Dignity for those in this situation requires respecting their privacy and the need to keep the medical details secret. The loss of a pregnancy is likely to compound the need for respect and support, especially as for some people, the loss is exacerbated by feelings of shame and guilt. It has been difficult to hear some of the conditions and situations that women have found themselves in when they realise they are losing their baby while working.

We have spoken to women who have been on shift or in theatre when they have started to miscarry, completing the procedure knowing that there was nothing they could do and so 'to carry on was the best action'. We have spoken to women who have paid privately for treatment following a miscarriage so that they do not become a 'name on a hospital board' in the places their colleagues work. In part, those who shared these stories with us told us these decisions were made because they did not want to be 'talked about' but a larger part also worried about the way in which the knowledge that they were planning a family might be 'used against them' and how that might affect their career progression.

Case study

We conducted a one-to-one discussion with an individual who had tried various routes to get pregnant. She had suffered for years through multiple unsuccessful IVF attempts and multiple miscarriages.

It was clear that she was exhausted. She told us that she was exhausted physically but also tired of the secrecy and the daily internal emotional battle of pretending everything was ok.

She said that she and her partner had looked at adoption routes only to be told that the surgical career was deemed ‘unstable’ and ‘not an environment that was suited to a child that would require a great deal of stability and dedicated time in the early settle period’. Her long hours were not supported by flexibility or any regularity. She told us that this put an end to them looking at adoption as a route to becoming a parent; they were heartbroken.

The secrecy, shame and grief attached to assisted fertility treatments, loss of a child, adoption and surrogacy is not restricted to the surgical profession. However, women in surgery face arguably more intense pressures owing to the inflexibility of rotas and schedules, being in a male dominated profession and the possibility that any treatment undertaken may happen in their own place of work.

Parents who have suffered the loss of a child need support, and this requires sensitivity, compassion and care on an individual basis; no two individuals will need the same support in these circumstances. For this reason, we need a flexible approach to supporting staff in these situations.

THE RISE OF THE DUAL-CAREER COUPLE

The existing system of long hours and on-call rotas is built on the unspoken (and historical) assumption either that an individual either has no other responsibilities or that any responsibilities they do have can be managed by somebody else supporting them at home, whether that be a partner, a close family member or a friend. The reality is that most family units today need more than one individual in some form of employment to meet the family's expenses.

'[…] it is important to recognize that being in a dual-career couple relationship is now the norm. In more than 65 percent of couples in North America and Europe, both partners work, a number that grows each year. […] One obvious reason for this trend is economics. In today's expensive and uncertain world, having two salaries helps couples cope with the ever-increasing cost of living and provides a financial safety net […]. But economic necessity is only one part of the picture. Across the globe, couples are becoming more egalitarian. Men and women increasingly define a meaningful life as having a good career and having active roles at home.'

Jennifer Petriglieri
(taken from *Couples That Work*)[32]

Individuals may have to move away from home for work where reliance on extended family members such as grandparents may have been common in the past. Additionally, there is a growing trend to retire later in life.[33] This could mean that extended family members are not able to offer childcare support where this may have been more possible previously.

The rise of the dual-career couple, together with couples not being able to be as reliant on family as they have been in the past, suggests that if both parents have careers in surgery, then the long hours and irregular rota can make it very challenging to find a schedule that works for them. Couples who both work in surgery can struggle to be able to maintain a presence at work, to be flexible and to put in additional hours alongside the responsibilities of looking after their child(ren) together.

'For parents today (especially the one in the traditionally paternal role), it is no longer the case that one parent goes to work and the other does all the childcare. This is a good thing and I for one am grateful to be heavily involved in my daughter's upbringing. But the point is that this is different to how it used to be and there are only so many hours in a day.'

For parents or those planning to be parents in a dual-career couple, negotiation about flexibility is often necessary. This is exacerbated when both parents are surgical, balancing inflexible rotas and unsociable hours. Where this concerns fertility treatment, the person who plans to carry the child is usually the one undergoing more treatment, requiring more flexibility and potentially unexplained time off. Where it concerns childcare, practically, one parent often shoulders more of the caring responsibility, which may mean slowing down their career progression compared with their partner. Consequently, for the dual-career couple who are both surgeons, although both are parents in surgery making the decision together to raise a family, the perception from peers and senior colleagues may be that it is the individual who needs the flexibility who is not as 'committed' to their career.

A MEN'S ISSUE TOO?

The men we spoke to told us about the disproportionate impact that having a child has had on the careers of their partner, wife, daughter, friends and colleagues. They talked about the sacrifices they too have had to make to their careers or their family lives when planning for a family or after becoming a parent.

The men and partners we spoke to said that their priorities changed after having a child but that their experiences were that society did not accommodate the supporting parent spending more time at home. They felt that they were expected to return to work as though nothing has happened although in reality, that was far from the truth.

'I am a male consultant and my partner is pregnant. I would like shared parental leave. There is little information about this and also stigma. It also feels like this is difficult to arrange, with ramifications on service. I feel there needs to be wider discussion about this to normalise it and make planning for shared parental leave easier.'

We have heard from partners that they would like to see increased flexibility to enable them to attend fertility or pregnancy appointments with their partner and play a pivotal role at home without this affecting their career. We have had reports of couples living apart from each other for the majority of the week as both parents try to juggle careers in different geographical locations while looking after a child. This sounds like an extreme example but it was an emerging theme from the men who contributed to our research who had struggled with the fact that their work and family could not exist in the same geographical location. This put added pressure on both career expectation and the family unit.

The period as a trainee or new consultant was particularly acute; a few individuals we spoke to chose to take a clinical research year to try to gain a better work–life balance before re-engaging in the surgical trainee routes, which gave them some short-term resolutions. We do not yet know enough about the factors that influence specialty and associate specialist (SAS) doctors' career decisions but anecdotally, the questions around which routes individuals should choose (and whether they were choosing the SAS route to gain further flexibility) were raised during our work.

'I took paternity leave for our first and shared parental leave for our second child. Talking to female colleagues, the support for maternity leave is much better than for shared parental leave.'

Almost all of the men we spoke to said that they felt a pressure to be 'visible' and an expectation to 'be seen' to get the opportunities that would support their career. This pressure created an internal conflict as those we spoke to said that they want to see more flexibility in the rota planning and in their job plans to allow them to see more of their family and support their children's development. They felt as though the expectation was that women 'almost had an excuse' to leave on time to pick up the children but that this was not as accepted or understood in the same way among colleagues if a man used the same explanation.

There is no doubt of the building pressure on the profession to deal with the impact of the COVID-19 pandemic with expanding waiting lists[34] and lost training opportunities.[35,36] Nevertheless, this must be addressed in a safe manner, and without detriment to the health of our surgical workforce and our patients.

In the 2020 article *Resilience and surgeons: train the individual or change the system?*, Professor Kevin Turner *et al* state:[37]

'Resilience in the context of workplace functioning and wellbeing is of particular importance for doctors, who frequently experience high levels of occupational burnout and poorer mental health outcomes, both of which can negatively affect patient care. Despite a widespread view in the medical profession that doctors should possess an inherent heightened mental robustness to manage the highly stressful nature of their work, findings from several studies indicate that medical professionals commonly report relatively low resilience, which often correlates with adverse outcomes for doctors in terms of burnout and for patients in terms of quality of care.'

The individuals we spoke to want to be present both at work and at home. They want to see more flexibility without impact on opportunity and career development. It is counterproductive to developing a culture that supports work–life balance if being seen, staying late and working double shifts are rewarded with better career opportunities. As a society, we are understanding more about the negative impact that this culture has on an individual's mental health[38] and the ability to be able to perform their roles at optimum level.[23] Rewarding this behaviour and feeding a culture of long working hours may result in more mistakes being made, more 'never events' occurring and more patients being adversely affected.

KEY FINDINGS

Planning a family or becoming parents typically coincides with the last years of training; time away from training and fixed commitments outside work can affect training opportunities and career progression. Individuals who have not yet reached a point of stability in their career when planning a family may feel additional stress, pressure and vulnerability as they try to negotiate career progression and family life.

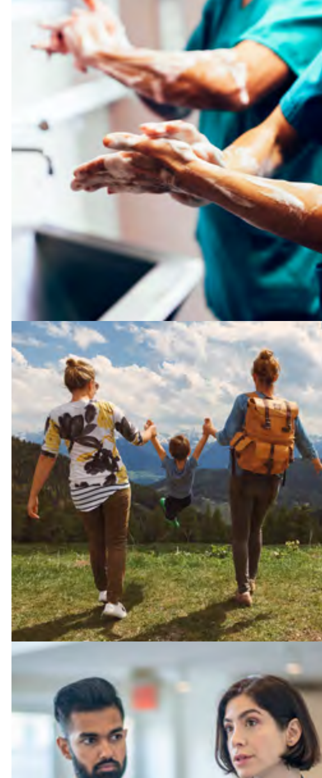
Initial research from the US suggests that female surgeons have first pregnancies later in life, have fewer children and report more issues with infertility.[2] This needs further understanding and exploration in the UK. The nature of fertility treatment and the secrecy that surrounds it can leave women feeling shame and not supported by the systems in which they work.

Increased pressure and reduced workforce numbers are not meeting the service demands and are putting strain on individuals, affecting retention in the profession. This is felt acutely at the point at which individuals consider or start a family.

Most families need two working parents to meet the financial requirements of family life and the infrastructure to support this in the NHS has not kept up with today's working culture. Childcare provisions have an increasingly important role for individuals returning to work and geography plays a large part in families juggling their parental responsibilities with their work.

Women are currently disproportionately affected, typically taking on more caring responsibilities and time out of their careers, which in turn can affect their pay, career progression and ability to access and gain leadership roles. Situations and pressures faced by women in surgery can be exacerbated compared with other professions owing to the pressure and inflexibility of rotas and schedules.

Regardless of gender or caring role, a significant number of surgeons who are parents would like to see more flexibility in their work. It may currently be more culturally acceptable for women to have a more flexible approach to work in surgery but the existing culture also rewards those who are 'visible', stay late and take on additional shifts.



ACTIONS AND RECOMMENDATIONS

What RCS England will do

Working closely with the RCS England Emerging Leaders programme and the Women in Surgery network, we will ensure that leadership roles and leadership development opportunities are accessible for parents and those with caring responsibilities.

We will share examples of best practice and experience to demonstrate ways in which an individual may choose to come out of training and re-enter the training pathway.

We will continue to raise awareness, develop a network of support and build community to enable individuals to share their experiences and lean on supportive colleagues and peers.

We will develop and signpost resources that support individuals through the stages of planning a family and taking parental leave.

We will develop champions and supportive networks across the regions. This will include developing clinical managers, and providing and drawing together resources both for individuals and for their managers and teams.

Wider change required

We will advocate for policies and practices to be developed that reduce barriers for those with caring responsibilities and fixed commitments, for instance by developing a fertility policy that enables flexibility for appointments, and by ensuring that time for ‘voluntary’ opportunities and leadership roles is included in job plans.

Flexible working and training

TIME OFF AND RETURNING TO WORK

As part of this work, we spoke with RCS England members of all genders who have considered delaying planned pregnancy in order to complete their surgical training first. It was concerning to hear that people were given advice by 'well meaning' colleagues to first become a consultant before considering planning a family as it is 'easier to manage' and they will not 'lose as much credibility' with their seniors or peers. We have heard that some people have received advice from peers that they should choose their surgical specialty based on their future family plans or that they were told to consider different routes, such as becoming specialty or associate specialist (SAS) doctors.

Regardless of career stage or profession, it is hard to take time out from any career and return after an extended time away. There are assumptions about degradation or loss of skill during this time (coming both from individuals themselves and the culture more widely) that, anecdotally in our work, appear to extend beyond the perception of those who have had similar lengths of time away from the operating theatre for research or academia, or who were unable to operate or access training during the COVID-19 pandemic. Skills that are essential to the surgical skillset such as building resilience, negotiation, communication skills and prioritisation skills can also be naturally enhanced while on parental leave as new parents negotiate their way through caring for a new individual, and these are under-recognised as contributing to an individual's overall skillset on their return.

'My experience of maternity leave (and subsequent returns to work) has been poor and I felt completely unsupported. The behaviour of my manager during my first return to work caused a lot of stress, which ruined the last few months of my maternity leave, time that I will never get back. This experience has affected my confidence and enjoyment of work, leaving me wondering whether I even want to continue in my job.'

I distinctly remember coming back to theatre after my first maternity leave having left my first precious bundle of joy in the new nursey. It's that time period where they get any and every bug going and spike fevers at random without any warning and the nursery need to get your verbal permission to give Calpol. I was also a two-hour commute away and not able to leave mid surgery! So, I'm down in theatre with no phone signal, like a cat on a hot tin roof, worrying what if the nursery phone me! But equally empowered to be a female in surgery and back in the game! It's a very mixed emotion!

– Anonymous

Legally, an individual can take up to a year off work for parental leave.[39] Including accrued holiday, this can increase to approximately 13 months off work after having a child. Shared parental leave enables that time to be split across both parents where they choose to do so. Despite this, we know that across professions, there are cultural, financial and practical pressures as well as personal reasons that mean people return to work much sooner and shared parental leave is not taken up widely. Individuals we spoke to feel a very real pressure to return to work full time as soon as possible, reporting that taking a full 12 months off is not accepted as 'something you can do in surgery'. The next phase of our work will examine this in more detail.

Research carried out by the Institute for Fiscal Studies (IFS) and funded by the National Institute for Health and Care Research revealed that those working in male dominated specialties are more likely to return to full-time hours after they come back from maternity leave.[40] Cardiothoracic surgery, which has just 18% women across the whole specialty, sees the average hours of those returning after maternity leave at 103% of full-time equivalent (FTE). The authors of the IFS report, which was published in March 2022, contextualise this figure: 'This compares to an average of 72% of FTE among women in public health and 74% among trainees in general practice, which employ more women than men. We see similar patterns in the rates of maternity or the average number of children that women in each specialty have: women in male-dominated specialties have a lower rate of going on maternity leave than women in female-dominated specialties.'[40]

I returned to work full time as a surgical trainee after 9 months of maternity leave with both of my daughters. I was very clear that I didn't want to compromise or delay my surgical training. I still feel that there is a culture of being a slacker if you work less than full time, particularly in the world of surgery, though this is better now our TPD allows 80% working (previously 60% was the only option). Almost all of the female surgical trainees in our deanery with children were working less than full time, and none of the male trainees with children were. This has improved slightly recently but the different impact on training of having children between male and female trainees has always been the biggest factor that bothered me.

When I returned to work my husband then took over with 3 months of parental leave, for both of our children. This gave me the reassurance that I wasn't abandoning my child to anonymous care at a nursery, which helped a lot and allowed me to concentrate on work. Since my husband returned to work we have had the benefit of his parents looking after the children two days a week, which significantly helps with parental guilt, and with costs of childcare.

I was told by a Professor of Surgery on one of my Keeping in Touch days that in order to be a surgeon you need to have a wife. This was rapidly amended by the other consultants in the room to needing to have a 'facilitator'. They meant that you need someone to pick up the slack - someone who can be relied on to get away from work in order to collect the kids from nursery, or who can leave work in the middle of the day to pick up a child who is sick. I am very lucky that my husband, a non-medic, provides this for our family and I would not be able to work as I do without him.

– Melanie Orchard
Post-Certificate of Completion of Training Fellow in Colorectal Surgery

The authors conclude that there are 'many possible causes of this pattern, including – but by no means limited to – differences in training pathways or the availability of part-time contracts across specialties. If we wish to increase the share of women in specialties where they are currently under-represented, the compatibility of work in these specialties with caring responsibilities – and how it could be made more compatible – needs to be a key consideration.'[40]

The individuals we spoke to suggested that 4–6 months off work after having a child was 'standard practice' in surgery. They said that around this time, they were feeling pressure from colleagues to return to work and that if it were any longer, they would feel that their dedication to the profession would be questioned. A lot of individuals also reported internal pressure to return to work, with a building fear of being 'out of practice' and 'letting colleagues down' if they took more time away.

'It felt like I was the first trainee to ever become pregnant. Nobody knew how to advise me. I didn't know about "keeping in touch" days, I didn't know how long I could take off or how to arrange to return feeling safe clinically. I didn't know about what I might have been entitled to by way of a phased return or support in terms of on-call duties as I was still breastfeeding. It was just "leave, have baby, return", as if nothing had happened. My colleagues were very supportive but not in a managerial capacity – they were just nice people.'

An early return to work following childbirth can have an impact on the wellbeing of the individual.[41] Where individuals return to work within these timeframes, facilities and considerations for returning parents need to be understood, made available and clearly signposted. We have heard from multiple contributors that physical facilities and practical considerations are not set up for women returning from maternity leave, particularly with regard to expressing milk. There is little or no time made available to express, and missed opportunities to collect and store milk can result in reduced milk production. Some parents choose to wean their children earlier than they may have wanted to, owing to expressing being 'impractical' and the 'facilities inadequate'.

During this work, we collaborated with the Confederation of British Surgery, which had surveyed its members (with the questionnaire being disseminated through trainee organisations including the Association of Surgeons in Training and the British Orthopaedic Trainees Association). Among the 78 respondents, 88% of women were not given adequate information about their on-call obligations and the facilities available for them to feed or express when they had returned to work.

'I had very little support, particularly when returning from 11 months' maternity leave straight into a 13-hour on-call shift. I had no phased return despite requesting this. I also requested to return initially to "standard" days for a couple of weeks but that was also denied. Despite requesting, there were no facilities I could use to breast pump. It was suggested I use the disabled toilet on a busy surgical assessment unit.'

For women who have had to undergo surgery as part of childbirth, at four months after the birth, their bodies may still need to heal and recover. The pressure to return to work early and deliver the service levels expected prior to them going on leave can be unrealistic. Ensuring flexible and individual support plans are in place for people returning to work must be based on individual needs, in discussion with supportive managers, assigned educational supervisors, training programme directors and human resources staff, and with reference to the facilities and support available.

'Trying to navigate a pregnancy while trying to ensure that my career is not damaged by maternity leave has been a nightmare.'

In 1975, following a year as houseman and a year as SHO in O&G and Paediatrics, I decided to 'do' surgery.

I progressed satisfactorily on a full-time SHO rotation in Nottingham followed by a surgical registrar rotation in Oxford during which I achieved the FRCS.

At that point, I started discussing potential specialist career options which might involve time off for a family. I was encouraged by Dr. Rosemary Rue, who was Medical Director of the Oxford Region and instrumental in encouraging women to return to work following having a family.

In 1979, I was directed towards a full-time SHO job in Plastic Surgery at Wexham Park Hospital where they had the ability to train a senior registrar but did not have the funding!

I started to request part-time training as I had been unwell and was planning a family and was 'sent' to do a part-time registrar post in plastic surgery in Stoke Mandeville. At this time there was a much more 'relaxed' attitude to appointments at the lower levels of training.

My first baby arrived in 1981. I was then formally appointed as a part-time SpR in Plastic Surgery at Wexham Park Hospital following a centralised interview, which effectively identified that I was suitable for training in the specialty of plastic surgery. The Wexham consultants were very understanding and fully supported a flexible attitude to work, so, as the baby weaned off me, I worked a little bit more and was able to attend various activities in the unit as appropriate for my training.

The 2nd baby arrived in 1983 and I was able to do a similar staged return to about 60% flexi time. I was also seconded to other units for extra training in the highly specialised areas of Plastic Surgery, which Wexham did not provide i.e.- Mount Vernon, Oxford and London – all accessible from my home in Buckinghamshire. In 1988, after 9 years in plastic surgery, I gained my CCST and applied for full-time consultant posts in competition with other full-time trainees throughout the UK.

I was offered a consultant post in Birmingham which I started in 1988. After discussion with the Regional Health Authority, I was able to move up to Birmingham 3 months before a start date on continuing commitments allowance so that I could settle my 2 children into school for the summer term. By then I was a single mother….

In 1993, having re-married, I had a 3rd child and once again took about 6 months maternity leave, but because of my very specialist commitments, I started work in some areas earlier and had the baby brought to me, by an employed nanny, so that I could breast feed in theatre sister's office during an operating list!

Although, I did experience episodes of negative attitudes towards being a woman, a mother and a surgeon, my 'handling' of this was to always check back with the senior surgeons I was actually working with, as to their assessments of my professional competencies as a surgeon at whatever level I was working in.

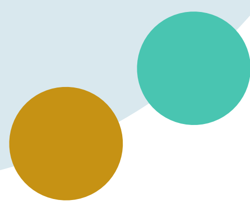
(The main issues around the facilitation of my career as a surgeon and a mother were: Time flexibility, Geographical location, and open competency assessment.)

– Ruth Lester
Retired Consultant Plastic Surgeon

Case study

One individual we spoke to told us about the treatment she experienced when she became pregnant. She compared it with the experience of her colleague, who was based in the same hospital in an office-based role.

She felt as though she and her colleague communicated their pregnancy news to their teams with a very different subtext; she felt apologetic to her team and felt as though she was letting the team down, knowing that rotas and cover would be a concern for her team. The perception was that her colleague was able to celebrate the news with her team without the same sense of concern or guilt.



As mentioned previously, returning to work 4–6 months after having a child is perceived by some as 'standard practice' in surgery. For those who take parental leave, there are also various financial impacts to consider at key points within that period (such as statutory parental pay being reduced, pension contributions and tax).[42,43] Financial considerations are significant across professions and may play a large part in the decision making process for when and how surgical trainees particularly return to work.

The minimum ten-year postgraduate training route in surgery means that geographical stability, job security and financial certainty may all be lacking for surgical trainees during the years when people typically plan for and take time out to have a family. Additional pressure to return sooner may also come from trying to fit in with career staging posts such as rotations, FRCS exam and Certificate of Completion of Training deadlines, and applications for consultant posts. All of this amounts to a significant impact on career progression for those who choose to take any length of time out.

The administrative processes and policies surrounding time off to have or support children are frequently not transparent and differ considerably from one trust to another (and reportedly even from team to team). The level of support that a pregnant individual receives may come down to the relationship they have with their clinical and educational supervisors and training programme director, and the flexibility or compassion of the rota manager. Of the 78 respondents to the Confederation of British Surgery survey, 74% felt that they had not received adequate or clear guidance from their educational programme body and 79% felt they had not received clear guidance from their trainer or supervisor.

Trainers and supervisors we spoke to would like to offer more practical support but can themselves sometimes lack the support and guidance to provide up-to-date advice, and may have variable knowledge of the laws or policies surrounding parental leave. Where policies do exist, they can be out of date, misinterpreted, or misused without reference to the individual or their circumstances; we have spoken to women who have asked to come off the on-call rota at 30+ weeks pregnant and who were refused on the grounds that the policy does not specify at what point someone should stop their operating lists when pregnant.

'The trust refused to let me come off night shifts despite reduced fetal movements and hypotension causing fainting. They just tried to force me to start my maternity leave early at 22 weeks.'

Through our work, we have found that basic information, such as 'keeping in touch' (KIT) days and phased returns to work, is not communicated as standard in the surgical environment and the individuals we have spoken to have often returned to work without knowing about or utilising these tools for support. Only 38% of people in the Confederation of British Surgery survey were made aware of KIT days and knew that this was something they could use as a tool to keep in touch with work and colleagues or to re-engage with work in a phased manner during parental leave.

Our work strongly suggests that there needs to be a clearer process to support managers in disseminating and keeping up to date with policy and legislation, and a smarter way for those planning to take leave to access the information they need. In the Confederation of British Surgery survey, 86% of individuals said they would like to see a standardised information pack including the relevant information and support.

We have come across examples of good practice that could be shared and signposted better. The British Orthopaedic Association has useful guides on maternity, adoption and shared parental leave,[44] and on returning to work.[45] In addition, a Health Education England initiative, Supported Return to Training (SuppoRTT), has been developed to 'enable trainees to have a safe, supported return to work by offering a wide range of learning and support resources, which can be used to create a bespoke package of support which suits their individual needs'.[46] It includes funding, which must be arranged in advance, as well as return-to-work courses and KIT days. We also list a range of resources at the end of this document, and our next stage of work will bring together virtual signposting to these and other resources and initiatives in intuitive and accessible formats.

'My experience of maternity leave was extremely poor. I was not given any information by my trust, the trust policy was unclear and it was difficult to find information about risk assessments. Some colleagues were not supportive, both before and after maternity leave, and I was treated unfairly on my return to work, which continues to affect my work to this day.'

Depending on their length of time off work, a trainee may go on parental leave from one hospital and return to work in another as rotations change. Individuals we have spoken to have told us about their return to work, where they came back to a different hospital, paperwork did not follow them and they were offered no induction or information. They came back to work in an unfamiliar location after a period of leave, not knowing the name of their manager, who to ask for on their first day or where to report.

The continual geographical challenges that trainees particularly face as they move from job to job (along with long hours, inadequate facilities and childcare provision, and juggling on-call and inflexible rota patterns) make being a parent and the desire to continue surgical training difficult to balance. Our work indicates that we are at risk of losing more surgeons from the workforce as they struggle to find balance between having a family and the inflexibility they encounter in their workplaces. We must evolve flexible and feasible working practices to address this, learning from other professions and initiatives, as has started to happen in some areas.

Regardless of the reason for a period of absence, compassion, understanding and support from managers and colleagues is vital to help individuals feel positive about returning to work, how they perform, and how they interact with colleagues and their patients. Flexibility and a different approach to returning to work has the potential to have wider benefit and impact across the workforce.

People need time off work for all sorts of reasons and at different stages in their career, including other caring responsibilities and periods of ill health. Continued support and understanding is required after the return to work is complete, especially for (but not limited to) parents with children with additional needs who may require additional time for hospital appointments and who have no back-up for when their primary childcare fails as it may be very specific to their individual child's needs. A flexible, compassionate and supportive approach to individuals returning to work, putting the individual first and personalising a return plan to meet their specific needs has the potential to benefit the whole workforce and support retention more widely than just those planning or having a family.

'People were generally supportive in spirit but there was no practical support. I was expected to familiarise myself with trust policy regarding maternity leave. It would have been helpful to have someone from the human resources department to clarify and advise.'

LESS THAN FULL-TIME TRAINING

'There is a perceived negative culture in the profession, which may be driven from a lack of understanding about how the system has become less and less flexible to the point of losing the "give" that is needed to do both surgery and parenting.'

A 2021 McKinsey & Company article, *Married to the job no more*, states: 'Working parents are among the record number of employees leaving their jobs or thinking about doing so. To keep this crucial group, organizations must address why they're drawn to other options.'[47] Although this article was not focused specifically on the medical profession, the conversations that have informed our Parents in Surgery report echo their findings.

As part of McKinsey's research, they found that individuals were needing and craving flexibility, and that exhaustion from 'competing pressures' and 'juggling childcare responsibilities' played a big role in revaluating work–life balance and priorities.[47] The report states that parents are 'looking for more flexible work opportunities'.[47] When applying McKinsey's findings and recommendations to the surgical profession, this may mean individuals needing additional time off, wanting to work or train less than full time (LTFT), or considering a portfolio career incorporating a flexible range of responsibilities and roles across a normal working week.

The introduction of LTFT working has been welcomed by some as a flexible way to return to work after having a child. In practice, individuals may still work the same number of hours, over fewer days and for less money, without addressing the work–life balance they are seeking to improve. The 'hidden reality' and unspoken cultural reluctance to accept LTFT working creates a tension between individuals and their team; they may be seen as 'more difficult' to manage and those responsible may find it harder to fill the rota.

When I returned to work after having my first child I remember feeling completely at a loss as to how make work and childcare fit together. I went less than full time but there still seemed to be an expectation by the trust and deanery that I would be available on my non-working days for inductions, teaching, ARCPs and mandatory training. In the grand scheme of things this might seem like a minor issue but at the time was a real challenge. Nursery days are fixed and can't be changed week by week- changing days is usually permanent and requires months of notice. My partner worked full time with frequent foreign travel. I didn't have any local family who could easily step in to help. Each additional day that I had to find childcare for cost me hours of stress and phone calls, calling in of favours and/or significant expense. And yet it was expected that I would do this regularly and without any complaint or else prove that I was another one of those trouble-making trainees who wasn't sufficiently dedicated to their career.

– Rebecca Fish
Consultant Colorectal and Peritoneal Surgeon

Despite a feeling that they are doing the same hours worked over fewer days, we have spoken to surgical parents who have found LTFT working a lifeline that enables them to balance childcare responsibilities more easily across the working week. Access and capacity for LTFT training and working is in the process of being reviewed and piloted. The feedback we received about applying for LTFT roles is that it has been unnecessarily difficult. LTFT training category 1 is available to doctors in training with a disability, ill health or caring responsibility (including caring for children, an ill/disabled partner, a relative or other dependant) while category 2 is for those deemed eligible owing to unique opportunities for their own personal or professional development.[48]

Historically, the fact that LTFT training has not been an option for everyone has created a natural tension between colleagues as there was potential for resentment from those who were not eligible and for reinforcing feelings of exclusion that those in a LTFT role can experience, with implicit undertones that they do not belong in a surgical role. Through our work, we have found that there is a perception that LTFT working is 'more accepted' in some surgical specialties than in others, with one person we spoke to suggesting that 'less than full time is not for surgery at all'.

'I am very supportive of trainees as the training programme director but have heard of and witnessed negative comments several times about trainees taking time for maternity leave or working less than full time at local, regional and national events.'

Guidance from Health Education England for LTFT category 1 applications suggests that trainees should consider 'colleagues' attitudes' and how they 'may act towards you about the decision you make to go LTFT'.[49] Trainees are also asked to consider the impact on teaching and training opportunities, and how they will manage to undertake the necessary opportunities to progress and the subsequent impact on their career. While it may be helpful to make applicants aware of the challenges that LTFT training or working may present, phrasing the guidance in this way implies that the onus is on the individual to find solutions and minimise any inconvenience. This has the potential to create or exacerbate tension between individuals and their managers and teams. Shared ownership for managing agreed and approved flexible working creates a supportive culture and encourages a team approach. For further information on flexible working from the devolved nations, please see the resources section in Appendix 2 of this report.

Health Education England has been working on a LTFT category 3 initiative, which will bring greater flexibility for all trainees.[50] Category 3 allows trainees to request the opportunity to undertake a period of LTFT training out of personal choice. It was piloted initially in emergency medicine in 2017, followed by paediatrics, and obstetrics and gynaecology in 2019, and it has recently become available for all postgraduate specialties on a short-term basis.[48] In August 2022, LTFT category 3 was rolled out fully for all specialties (excluding foundation training).

The work that Health Education England has undertaken around LTFT category 3 suggests that barriers to applying for LTFT training include the application process itself as well as lack of support from senior colleagues, reduction of access to education and training opportunities, and the negative stigma or negative culture attached to being LTFT. Individuals have experienced verbal resistance when they have indicated they may consider a LTFT role; some have been encouraged or felt pressure from their seniors to return to full-time training earlier than they would like.

Data collected by Health Education England through a series of webinars suggest that of those surveyed who are either already in LTFT training or who would consider applying, about 50% would fit within category 1 (ie for childcare and other caring responsibilities or ill heath).[51] Among the remainder, one in three trainees would choose to go LTFT in order to feel like they had a healthier work–life balance (32%) and one in ten for reasons of burnout (11%). During the trial period, emergency medicine saw over 60% of trainees apply for LTFT category 3 roles.

Further rollout of LTFT training will have an obvious impact on rota management but early indications also suggest higher retention of staff during this period.[50] According to a Health Education England update meeting on LTFT category 3, as of October 2021, over 400 trainees across all medical specialties (but mostly from the initial specialties in the pilot [emergency medicine, paediatrics, and obstetrics and gynaecology]) had made use of category 3. The workforce impact of LTFT roles needs to be considered both immediately and as part of predicting trainees' time to achieving their Certificate of Completion of Training (and therefore the filling of future consultant roles). However, the success in retention so far infers strong links between a more flexible working culture and the much needed ability to improve attrition rates in the workforce; similar successes could be seen in other specialties including surgery.

I worked with great colleagues and a clinical line manager who facilitated me working part time when my children were very young. I did not come back to the workplace full time until they were older, the impact was financial in terms of pension, but it was by my choice knowing what the impact would be by working part time. I am pleased to have been part time for so much of my career and been able to return to full time at a time of my choosing to pick up on a clinical management role when I came back to full time work. I was very fortunate to have a good part time clinical career and a good part time clinical management career with the support of a very patient husband over many years – not all women (or men for that matter) have been so fortunate.

– Anonymous

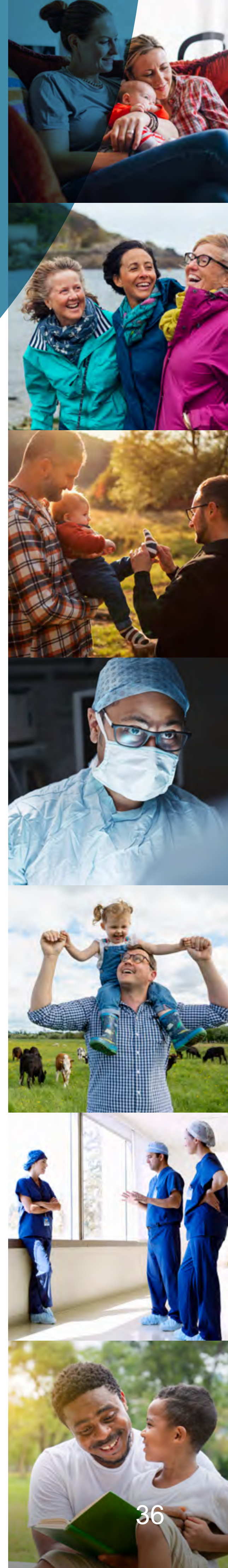
Creating an inclusive culture where working LTFT is seen as normal and for everyone will help to balance the needs of parents and those with caring or fixed commitments outside work, rather than alienating them or building tension with colleagues. Although there may be short-term workforce considerations that need to be addressed with the rollout of LTFT category 3, steps towards more flexibility and acceptance, and support for a better work–life balance in the professional culture can support longer-term workforce retention. There is a need to change the way we communicate about LTFT working, celebrating the direct and indirect positives of this initiative so that the benefits for everyone of LTFT working can be realised.

WORKFORCE AND ROTA PLANNING

Insufficient workforce numbers undermine the stability of rotas[13] and there is potential for this to be compounded by the need for more flexibility across the surgical workforce. During our explore phase, we have heard from a number of contributors about their lack of confidence that current workforce numbers are able to deliver the required service and therefore stress the additional impact that more flexibility (including a LTFT contract) has on the rota.

The flexibility in approach to rotas that is needed to support LTFT training and working has the potential to aggravate tension between LTFT roles and the rest of the team, whose perception can be that they must pick up extra work. Frustration around a lack of ability to change or influence wider workforce issues can end up being directed at individuals who ask to work more flexibly than their colleagues. A reluctance to embrace a more flexible approach to training and working fails to realise the longer-term workforce issues at stake. A continuing lack of flexibility (and an approach and culture in some teams that makes LTFT hard to realise in practice) only exacerbates an existing workforce issue, with fewer individuals choosing a career in surgery and others leaving when flexibility does not meet their work–life balance requirements.

‘The problem as a department is that you are already stretched and then you’re asked to add in a layer of flexibility, which makes a hard job even harder.’



‘Despite all the regulations, a pregnant trainee is looked at negatively. Colleagues feel they have extra work due to pregnancy related leave. This is primarily because the post remains vacant because of recruitment issues.’

Short-term thinking about the impact of LTFT working can cultivate division and animosity, and this can result in some individuals feeling that they do not ‘belong’ in a surgical career. It further creates the perception that a surgical career is unsupportive of family life, and intensifies existing recruitment and retention issues in surgery, favouring those who do not have fixed commitments outside work or those who have the available resource (whether financial or through partners or family members) to support the inflexibility of working patterns. If we are to cultivate a sense of belonging in surgery and create an environment that welcomes diversity, we need to attract a wider group of people into surgery and support our full surgical workforce throughout their careers, enabling individuals to be a successful surgeon, manage their career in the way that best suits them and have a home life (parent or not), without impact on their safety or ability to care for their patients.

‘I was missing my wife and son, who had gone to my in-laws. It was Christmas and I would not be seeing them. This was the final straw. I resigned my training post and now work in a different specialty.’

Beyond the personnel available to staff the rota sufficiently, the instability of rota planning affects parents and those planning for parenthood. The uncertainty of the rota and on-call shifts make arranging childcare difficult and expensive as childcare requirements can change on a weekly basis. The majority of childcare settings (private or in hospital facilities) provide care during the core hours of 8am to 6pm. (Some offer slightly extended hours so this can flex at either end of the day up to one hour and some, especially in rural areas, align to school terms only.) These hours do not correlate with service hours in surgery and childcare can become expensive as additional support needs to be sought. The cumulative impact of increased cost of living, geographical instability and lack of family support that trainees face compared with 20 years ago has been described as ‘overwhelming’, and ‘consuming’ individuals’ thoughts and worries.

Trainees who have caring responsibilities are particularly affected by some of the obstacles and barriers we have identified through our work to date. Access to some training experiences can be opportunistic and last minute, which can mean that they are only available to those able to stay past the end of their shift.

Part of a culture change that would see more diversity and inclusion in the profession (especially in senior leadership in the profession) is around making working practices more flexible, evolving fixed ideas around work and learning from other professions to do this. We will need to accept that some practices and assumptions about what a surgical career looks like and how it works on the ground will need to be worked through over time to improve diverse recruitment and to ensure better retention in the workforce. There are no quick fixes to large scale workforce issues but during our work, we have seen examples of existing good practice that could be expanded and adopted.

Job planning, a feature of the consultant and SAS world, works most effectively through discussion and negotiation.[52] Where it works well, it provides consultants with the weekly structure and support to balance work commitments, take on new leadership roles and challenges, and manage their work–life balance.

The same kinds of principles used in consultant job planning can be expanded effectively to trainees’ discussions with their educational supervisors and training programme directors. Alongside discussion of the curriculum and training opportunities, providing individuals with a supportive space for upfront and unbiased discussion about need for flexibility over longer time periods can give trainees and those responsible for their training the opportunity to create a plan that works for both parties. For the trainee, the upfront knowledge of the next 1–2 years, at a high level, allows individuals to plan their lives better, including making adequate childcare arrangements, and may avoid needing to plan and pivot childcare arrangements on short notice demands.

Availability and timing of childcare facilities has been a real challenge, particularly finding nurseries and schools that open early and close late enough to allow drop-off and then a commute to work to usually arrive by 7am and stay until lists ended, particularly if they overran.

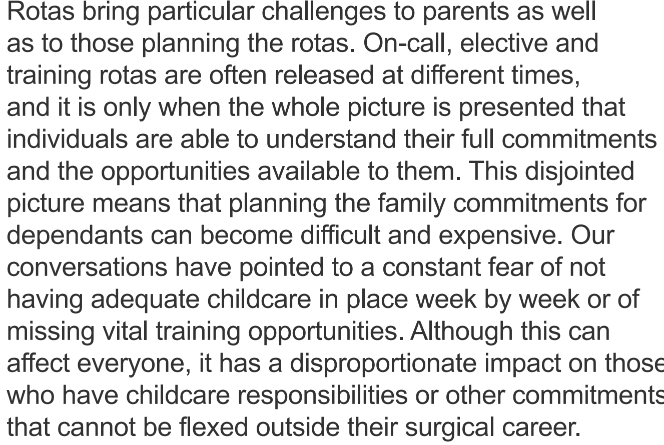
Childcare costs equated to most of my salary and my ability to work full time was predicated upon having a dual income household where my salary wasn’t required for other major expenses.

When I returned to work after my first child was 6 months, my boss told me I initially occasionally had ‘placenta brain’ as I unexpectedly had nominal aphasia and was bewildered when I couldn’t remember simple phrases.

Return to work programmes and support are a great idea to avoid a baptism of fire when returning from maternity leave. I found myself in theatre alone for the first half of a case on my first day back and on-call on the second day.

I returned to work after treatment for cancer while taking care of my young children. I faced lots of uncertainty, compounded by a lack of guidance of my rights and available support, but received overwhelming support from colleagues.

– Anonymous



Rotas bring particular challenges to parents as well as to those planning the rotas. On-call, elective and training rotas are often released at different times, and it is only when the whole picture is presented that individuals are able to understand their full commitments and the opportunities available to them. This disjointed picture means that planning the family commitments for dependants can become difficult and expensive. Our conversations have pointed to a constant fear of not having adequate childcare in place week by week or of missing vital training opportunities. Although this can affect everyone, it has a disproportionate impact on those who have childcare responsibilities or other commitments that cannot be flexed outside their surgical career.

‘Creating a rota with a less than full-time person in the team causes huge headaches as 60% here means you have a 40% hole to fill. How do you cover the Friday night?’

During our research, we spoke to rota managers, past and present, who recounted honestly how difficult it is to plan a fully staffed rota and who described the additional challenges presented when managing the rota with individuals who are working LTFT. Our work has highlighted some departments that have trialled an online rota system in which individuals can self-select their hours. The system allows parameters to be set so that minimum workforce numbers are met each shift and we understand from early conversations that trials have gone well. Further work to explore the specific details of the pilots needs to be conducted and we believe that work looking at how this might translate to a surgical workforce would be very useful.

As well as supporting individuals to make more flexible choices, we should support those who need to balance service and team requirements and make their logistical challenges more straightforward. We also need to support teams who are currently stretched, and continue to lobby for better and more realistic workforce planning; colleagues supporting each other’s flexibility should not have to do so at the expense of their own work–life balance.

Greater flexibility should be in place for the full workforce to support the wellbeing, work–life balance and resilience of the whole team.

KEY FINDINGS

Coming back to work after a period of time off can be challenging. There is evidence to suggest that those in male dominated specialties feel pressure to return to full-time work where other specialties may offer more flexibility.[40] This may, in turn, affect the diversity we see in those specialties.

Although individuals are entitled to a year of parental leave, many choose to return sooner for cultural, financial or practical reasons. It may be that parents in surgery feel pressure to not take their full parental leave entitlement. More work is required to underpin this and compare it with the general population but there may be particular pressures arising from the long postgraduate training route in surgery, and feelings of a lack of geographical stability and job security.

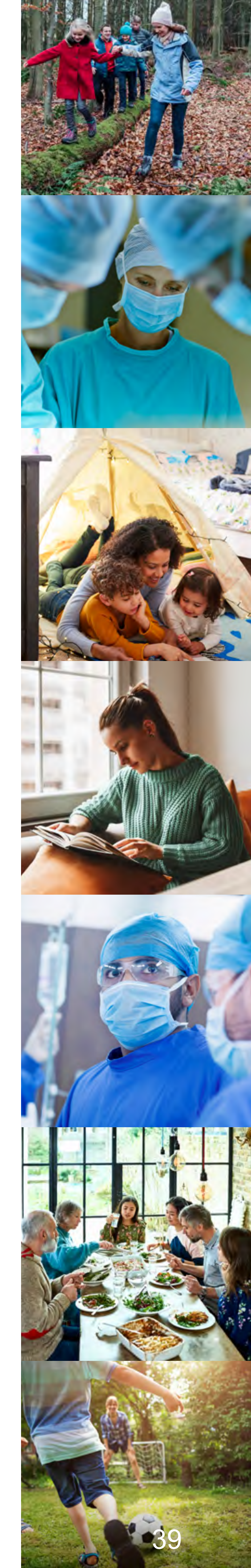
Where individuals do return to surgical training or practice sooner, personalised return plans, practical facilities and professional support are not always in place to make this return feel supported and smooth. Advice and guidance can be difficult to access for individuals as well as for those responsible for their training and work.

For those with competing work and life commitments, LTFT training and working can be a welcome option. In practice, LTFT training is variably supported and can be a source of tension when balancing immediate training and service demands. Health Education England's introduction of the new LTFT category 3 has shown early indications of success, particularly in improving the perception of work–life balance and in retention.

Balancing flexibility with insufficient workforce numbers is an ongoing challenge, especially for rota planning. Managing childcare with short notice rota information is a particular difficultly. There are some trials utilising technology to support rota planning that may be applicable to surgery.

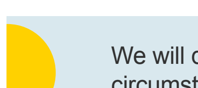
There are no quick fixes to workforce challenges that replace investment in the whole workforce and future planning. Flexibility for some should not come at the expense of colleagues' work–life balance.

Expectations and experiences of inflexibility in the surgical profession lead to a perception that a surgical career it is not a career path that is conducive to family life or a work–life balance.



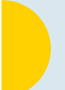
ACTIONS AND RECOMMENDATIONS

What RCS England will do



We will develop and signpost resources to take an individual through what they are entitled to and under what circumstances in order to ensure that all members receive equitable treatment regardless of their trust, specialty or team.

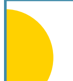
We will develop a toolkit for clinical managers and those overseeing training, and signpost resources so that they are kept up to date with the information they need to support their staff.



We will share examples and best practice to support flexible rota planning, including further research and critical review of self-service rota systems.

We will continue to advocate for better workforce planning, more investment and flexible working across the whole workforce, ensuring that initiatives dovetail and do not have unintended consequences for parents and those with caring responsibilities.

Wider change required



We will advocate for policies to be in place and ensuring that there is a transparent process to support individuals to take leave and return to work regardless of their career grade, gender or specialty.

We will advocate for ensuring that simple parental leave calculators are provided or signposted so as to support individuals in calculating their time off and expected pay, with information relating to the impact on pension contributions and tax. (See www.gov.uk/maternity-paternity-calculator for an example.)

We will advocate for ensuring that localised options for childcare are considered. The opening hours of hospital creches should be reviewed to accommodate an ‘out of hours’ service.

We will advocate for review of staff facilities in hospitals with respect to private spaces for feeding, expressing, injecting and so on, alongside appropriate space to store milk or medicines.

We will advocate for analysis of opportunistic training opportunities and of the potential for disproportionate impact on specific groups. Further use of technology should be considered to support training for those in LTFT positions.

We will advocate for discussing return options clearly with those planning to go on leave prior to their leave so that everyone is clear about options and what may work on their return. Personalised return plans should be in place to meet specific needs, demonstrating flexible, compassionate and supportive approaches to individuals returning to work.

We will advocate for demonstrably encouraging and supporting shared parental leave. This should be discussed with individuals prior to their parental leave, encouraging them to think about what they will need on their return and how they will manage the logistics.

The RCS England environment and leadership

The RCS England environment is multifaceted; while undertaking this work, we have focused on RCS England in three specific roles/environments:

1. **RCS England as a home to the profession**
2. **RCS England as a leader of the profession**
3. **RCS England as an employer**

Organisational change takes time, and RCS England has already begun to take strides in understanding and changing our approach to diversity and inclusion with the initiation and publication of the Kennedy report[1] and our subsequent action plan,[53] of which this work forms a part. Within this work, we have felt it important to give ourselves the same level of internal scrutiny as we direct outwards. This section recognises that significant work and effort has gone into our diversity, equity and inclusion work to date but further steps need to be taken if we are to lead the way for the profession.

As a historical organisation based on a royal charter, the constructs on which structures are built and decisions made can unintentionally favour a look to the past, and ways of working can be complex to unpick and change. This is not an excuse to stand still but it is important to note that initiating change can be challenging and the need for change not universally recognised. Although we know that many people support and encourage the steps we have taken, our diversity, equity and inclusion work has not been met with universal approval.

We have made some recommendations in this report that lie within our direct control as an organisation, as a leader and as an employer, and there are further areas where we have influence to support and promote change. We are committed to working through the recommendations and making an impact in practice. This piece of work is another step in that direction, with further phases of this work expanding and amplifying the impact.

RCS ENGLAND AS A HOME TO THE PROFESSION

RCS England opened the doors to its newly refurbished Lincoln's Inn Fields building on 1 September 2021. The building provides a range of spaces for members and the wider profession, including the Bjorn Saven Centre (where learners can participate in skills and professional development courses), a new assessment suite (enabling exams to return to the building), dedicated conference space, and professional spaces for members and others to study in the Lumley Library and in the Anatomy and Pathology Museum. In 2023, the Hunterian Museum will reopen, bringing members of the public back into the building. The building is a hub for learning and innovation with specific areas designed to bring people together either in formal meeting scenarios or for informal collaboration, and there are facilities to ensure that members can carry out all of their professional activities in a comfortable and welcoming environment.

Our diversity, equity and inclusion work centres around belonging and has explored what it means to be the 'home of the profession', including within its physical spaces. A home should be a place where we feel that we belong and can be ourselves. The building needs to welcome and include our current fellows and members across their careers and lives as well as looking to the membership of tomorrow's generation of surgical professionals, paving the way to provide the facilities, culture and environment in advance of future generations' needs.

Feelings of welcome and belonging are, in part, facilitated by sharing information, ensuring we signpost facilities clearly either on arrival or in advance so that visitors are comfortable that they will have what they need and can feel at ease. Providing this information can alleviate any logistical or practical concerns by knowing exactly where to find facilities and services; for parents, knowing there are facilities available and how to access them can reduce stress and add to a sense of comfort.

During our work, an individual mentioned to us that they did not think that the building had a baby changing facility and had therefore changed their baby on the floor when attending a graduation ceremony. RCS England has a large baby changing facility on the ground floor of the building that is available to both staff and visitors. We are committed to signposting clearly to make staff and visitors aware of the facilities that are in place as well as demonstrably encouraging visitors to provide feedback and ask for further support where needed. When this does happen, it can inspire and create that sense of belonging and support that we have committed to developing across our work.

‘Thank you @royalcollegeofsurgeons for making it so easy to teach today with little Persephone ... The biodegradable nappies, bags and baby wipes are a lovely addition to fantastic baby changing and feeding facilities #royalcollegeofsurgeons #femaleleaders #maternityleave #physicianmum #gastroenterologist #womeninsurgery #womeninmedicine #breastfeeding #breastfeedingmom #breastfeedingmum #teaching’

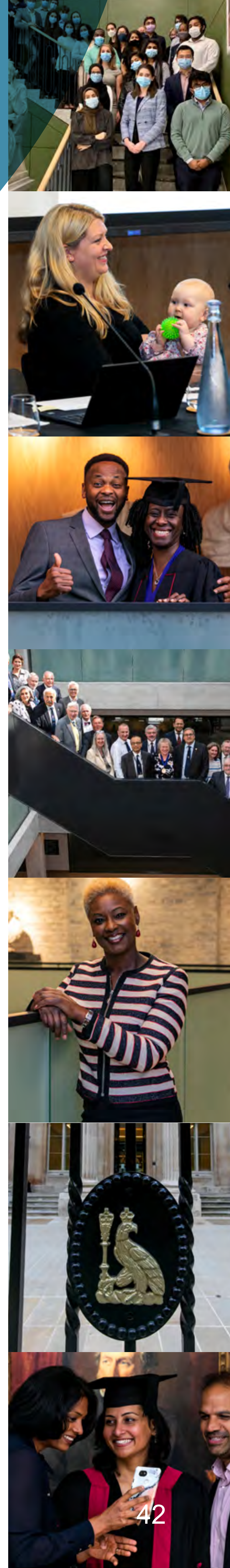
– Shared on Instagram

The building has two gender-neutral quiet spaces for use by staff and visitors to the building. Although the quiet spaces serve multipurpose uses, we are committed to making these rooms accessible to and comfortable for parents for feeding or expressing. Evidence suggests that a safe and comfortable environment facilitates greater production of milk and a longer supply.[54] Some work has already started to ensure that these spaces are fit for purpose. However, more could be done to further encourage a sense of belonging and for individuals to feel that their children (and they as parents) belong.

For our events programme, we have changed the access requirements for diplomates celebration days and made all children’s tickets free. This was piloted in early 2022 with positive responses. During our work, discussions about the times of courses, events and specifically exam preparation study groups or revision opportunities have arisen. Those with parental responsibilities can feel as though they ‘miss out’ on the learning and peer support that those who are able to attend benefit from, especially the social aspects of revision and exam preparation. We have spoken to individuals who have reported having to juggle work and childcare, leaving time for study to late into the night with little or no support. We are committed to reviewing the times of our courses and events so that those with parental and caring responsibilities are able to participate fully.

We heard from one individual who sat her MRCS Part B exam not long after the birth of her child. She was unable to take a suitably long break to feed her child or express, and felt distracted, worried and uncomfortable. Although circuit-based exams involving multiple participants are complicated to accommodate around longer individual rest breaks, across the breadth of the exams that we deliver, we are committed to reviewing our policies, making these transparent and taking a people-centred approach, making reasonable adjustments where we can while maintaining the integrity of the exam.

There may be other aspects of our facilities and services that can be improved to support parents better when attending the building for events, such as spaces for prams and child safety features. We will review this as part of our final phase of work on the building transformation, alongside plans for opening the Hunterian Museum to the public in 2023. There may also be opportunities to explore potential creche facilities in the local vicinity for our members attending events at RCS England.



Case study

We approached a member of our faculty community to teach on a course at RCS England. Having recently been told that she could not attend an event arranged by another organisation because they could not accommodate her and her baby's requirements, she assumed that RCS England would have a similar approach.

The individual spoke of her gratitude when the member of staff she was in contact with went out of their way to understand her needs and requirements, and to ensure that everything was in place for her to carry out her role as faculty (and as a mum) effectively.

'Not so long ago, there would've been no female faculty, let alone a breastfeeding mum to a 12-week-old… Things have changed for the better!'

We are committed to ensuring that the services we provide as a college are accessible. This includes scheduling courses and events at times that suit the requirements of those engaging with those services, and making suitable provisions (where possible) to enable parents in surgery to have the same opportunities for support and training.

RCS ENGLAND AS A LEADER OF THE PROFESSION

As a leader of the profession, we are committed to ensuring that RCS England is representative of all its members and that it provides equitable opportunities to all, closely reflecting and reconsidering any areas in which it might unintentionally put barriers in place. Increasing representation throughout RCS England and all its activities and decision making ensures that it remains diverse in its thinking and progressive in its actions. For this to happen, routes to leadership positions need to be accessible for parents and support should be put in place to ensure that parents can participate fully while in role.

The Kennedy review was initiated following the President and Vice-President elections in 2020.[1] The appointment of White men into all of these senior leadership positions and the resulting make-up of the senior team made us question whether RCS England's existing approaches to diversity, equity and inclusion were sufficient to deliver the progress that our members and the profession (and ultimately, patients) deserve.

The purpose of the review was to analyse in depth the culture at RCS England, in its leadership, its workforce and the wider surgical profession. The results were candid and revealing; 74% of respondents to the survey carried out for the review said that RCS England does not do enough to foster an inclusive environment.[1] The report went far beyond the 'organisation' and talked about leadership in the profession and ways in which RCS England can be the guiding light and set the tone for diversity, equity and inclusion beyond the bounds of our own leadership structures.

The Kennedy report and our subsequent work have indicated that there are barriers in place for women and parents to access and feel as though they are welcome and belong in leadership positions in the profession. In other sections of this report, we have looked at the way in which the voluntary discretion required both to access and partake in leadership roles can create disproportionate obstacles for those who have caring responsibilities and other fixed commitments. Those we spoke to during this work felt that their parental responsibilities had to be 'ignored' if they wanted to progress into leadership roles or felt 'inconvenient' when in role.

It has been widely reported that organisations that encourage diverse thinking, and that have a leadership team from a variety of backgrounds and welcome challenge from its leaders, are organisations that thrive, are most able to adapt to changing environments and are most able to sustain future generations.[55,56] In order to ensure we remain relevant and representative, we need to have people in leadership positions (including Council) who represent the full diversity of the profession, including those who have caring and parental responsibilities. RCS England has an opportunity to lead the way, not only in access to leadership opportunities for parents and those planning for parenthood but also in ensuring that the culture and support is in place for those already in leadership roles who have caring responsibilities, enabling individuals to succeed in their roles and perform them to the best of their ability.

During our stakeholder conversations, we learnt that despite individuals' aspiration, there are perceived and real barriers for those thinking about applying for voluntary leadership roles (including a role on Council) and who have significant caring responsibilities, or who are at a stage in their lives where they are planning or have a young family. These barriers are not unique to Council, and we spoke to individuals who had similar experiences and views about other voluntary leadership roles in their specialties, some of which we reference here. These barriers fell largely into two categories: accessibility and support in role.

The introduction of hybrid meetings during the COVID-19 pandemic has improved accessibility for those who are distanced geographically, or who need to balance meeting times with caring responsibilities or inflexible work commitments. We must continue to invest in hybrid technology so that the benefits and advantages of reducing accessibility barriers can be realised. RCS England will lead the way in raising awareness of these benefits across Council and staff as well as through our networks, by introducing as standard hybrid options for any face-to-face meetings in our own practice, and we will advocate for better accessibility where we have influence in other organisations.

Among those planning to be parents, the lack of clarity and sometimes mixed messages around parental leave while in voluntary roles served as a barrier for those wanting to apply, and an obstacle and disadvantage for those in post. Our aim is to ensure that we build and nurture a diverse leadership team, representing and for the good of the profession. We recognise that parents juggling their careers with caring responsibilities are an important part of our workforce, present and future. We need to reduce perceived and real barriers, improve accessibility of leadership roles for those with caring responsibilities and fixed commitments outside work, and put in place policies and practices to support individuals when they are in role.

Beyond policies and processes, small changes and greater awareness can make leadership roles more accessible for those with caring responsibilities. For those with full working lives and school-aged children, voluntary roles may need to take place on days that combine with childcare responsibilities. Simple logistical changes such as amending the timings of meetings to allow individuals (especially those who volunteer their time) to be able to commit to both of their roles, as a parent and as a leader of the profession, could remove some barriers and encourage more interaction and engagement.

Our influence as a leader of the profession stretches beyond our own organisation and committees, and we will use our learning from this work to advocate for better representation for parents and those with caring responsibilities in decision making bodies so that the needs and challenges of those groups can be fully understood and considered in areas that affect their career progression and working lives. One example raised in our work has been the development and delivery of curricula (particularly flexibility in the timing of examinations) to enable all surgeons to fulfil their career objectives. It may be easier, for instance, for a trainee to focus on an FRCS Section 2 exam while pregnant at an earlier stage of training than with a newborn when returning to work.

The criteria to sit exams could be more mindful of the needs of parents and carers, in conjunction with the holistic oversight of the trainee's development, as determined by their trainers and the training programme director. RCS England works on an intercollegiate basis with the other surgical royal colleges, through the Joint Committee on Surgical Training, the Joint Committee on Intercollegiate Examinations and the Intercollegiate Committee for Basic Surgical Examinations, to develop surgical curricula and set exam standards and criteria on behalf of the General Medical Council. We will use our influence to ensure that the needs of parents and those with caring responsibilities are considered in curriculum development and exam timetabling.

RCS ENGLAND AS AN EMPLOYER

RCS England employs 235 people, working across our Lincoln's Inn Fields and Manchester offices as well as remotely. We attract a diverse range of individuals at varying stages of their career, ensuring a staff base that has the relevant skills and expertise to support a membership of around 27,000 surgical, dental and allied professionals.

In this section, we reflect the issues raised in this report with a particular view to internal RCS England practices. In order to remain credible, the organisation has to practise what it preaches and so, in our work, we have looked at and spoken to RCS England staff and focused on the working practices that support pregnancy, assisted fertility and pregnancy loss; time off and returning to work; and flexible working, mirroring the themes covered in other sections of this report.

Over the past few years, RCS England has had a number of opportunities to reflect internally on its policies, practices and values as an employer. We have listened and learnt from those reflections, and we have come a long way in our approach to supporting staff, progress that can be celebrated. We are committed to continuous improvement, centring inclusion and belonging in our internal organisational culture as well as focusing

Case study

As part of our research, we spoke to PinkNews, the world's largest and most influential LGBTQ+ media brand reaching a global audience of more than 60 million unique users per month across their website and social media. PinkNews was founded in 2005 and currently employs approximately 50 members of staff.

We were interested in speaking with PinkNews specifically as their staff base is mainly a younger demographic, and their policies have had to grow and develop with their staff base. While the policies they have put in place for their team around parenting and miscarriage have been welcomed by staff, they have realised most benefit for staff morale and engagement by developing opportunities for peer-to-peer support. Creating 'communities' where staff are able to support each other through discussion and conversation, with structured feedback mechanisms to the executive teams to ensure issues are accountable and actioned, helps to develop a progressive, forwards looking culture, in tune with its staff.

Senior members of the organisation have shared their own experiences, demonstrated vulnerability and led discussions, acting as role models for the behaviours and attitudes that the senior team wants to promote. This has provided reassurance that it is ok to talk and be vulnerable at work.

externally, and our work here will need to continue for our staff to feel the same belonging and value that we seek for our members and the wider profession. This section draws on an internal look at the cultures and policies that support staff but it also takes a wider look at what some other organisations are doing and how we can learn from the good work happening elsewhere.

Pregnancy, assisted fertility and pregnancy loss

Over the past 18 months, RCS England has driven forwards a review of its policies and benefit structures to support staff. This review has covered a wide range of areas with a particularly positive impact on the policies in place for those planning a family and looking to take parental leave. The maternity and paternity leave policies have been replaced by a parental leave policy, which gives both parents equal enhanced pay and time off. The policy recognises that families can all be different, and is inclusive to families brought together by childbirth, adoption and surrogacy routes or loss of a child.

We have recently introduced a fertility policy that allows those undertaking assisted fertility treatment and their partners protected time off. This reflects a growing movement in other industries and is an important step in normalising conversations around planning a family, dispelling some of the stigma attached to wanting both a family and a career, and opening conversations about fertility that can feel difficult to discuss with an employer. Putting policies in place is an important first step; following these with supportive discussions and visible encouragement is essential in putting policy into practice and changing perceived norms to allow individuals to feel comfortable speaking openly with their managers and peers without the fear of being held back or penalised for wanting or having a family.

Time off and returning to work

Returning to work after a period of leave can be a scary and unnerving prospect in any career. While each return-to-work discussion needs to be individualised and personalised, some structured and centralised support and guidance for individuals and their line managers could be introduced so that individuals feel supported throughout their journey, right from before they go on leave. Beyond policies, some informal and human resources support about practicalities and options would encourage better preparedness for individuals going on leave/returning to work as well as for their managers. Regular (optional) communication from the organisation (beyond their line manager) during periods of leave would support individuals feeling connected. Up-to-date and supportive information such as how to utilise ‘keeping in touch’ days, and when and with whom to discuss returning to work would put some further structure in place.

After returning from a period of extended leave, individuals may feel a little lost and disorientated. They can experience a range of different emotions, all needing to be managed in those first few months after returning. It is common and natural for individuals during this time to cycle through a mixture of feelings, from guilt right through to excitement or from comfort and familiarity to frustration that their world has changed and yet work remains the same.

A lot can change in an organisation in a short period of time (eg the staff in the team or the way IT is utilised, with new technology and systems in place). Not knowing how to do something or who to call on can magnify any emotions already in place about returning to work. Some reorientation sessions (including the relevant facilities and policies) and a structured process to assist in the return to work will allow people the space and support to succeed in resuming employment.

Flexible working

Throughout the COVID-19 pandemic, RCS England supported the NHS and encouraged staff to work from home where possible, in a manner that allowed business activity to continue and kept individuals safe. This also meant that staff could manage any personal health issues and anxieties within their own comfort level.

After the success of a more flexible approach to working for staff, RCS England made the progressive decision to alter its employment terms and conditions following a period of staff consultation. Staff are now able to work where the business needs allow, enabling much more flexibility for staff members whose roles permit this.

This is an important step forwards for those returning to work after a period of absence, and for those with caring responsibilities and fixed commitments outside work, including parents. It allows those who are able to work from home the ability to consider returning to work sooner than they might have otherwise been able to, reducing commuting time and balancing childcare needs with business needs. This approach to flexible working allows for a greater work–life balance and the possibility for both parents to share the parental responsibilities, enabling a more equitable approach to childcare.

For those whose roles need to be performed at the college (or away from home), there is little flexibility in place to support their roles. Better awareness of and encouragement to consider job sharing during recruitment, better utilisation of existing technology and more flexible thinking about the ways in which responsibilities can be split differently could bring more flexibility into those roles currently based in fixed locations.

KEY FINDINGS

Credibility to speak as an authority on parents in surgery must be underpinned by equal scrutiny of internal culture, policies, practices and processes.

RCS England has facilities such as baby changing and breastfeeding spaces in place in its Lincoln's Inn Fields building to support parents. In order to increase feelings of belonging and welcome for parents, these need to be signposted better, and those who work in and visit the building made aware of them.

Some good practice is in place for access to and timings of events and ceremonies. There may be opportunities to explore more supportive initiatives (eg access to local creche facilities). More can be done to consider the timing of events such as revision and exam preparation where those who have parental responsibilities may currently feel disadvantaged.

Provide support, understanding and demonstrate small gestures of kindness – supportive colleagues can make the difference between an individual staying or leaving the profession

At present, there are barriers in place for parents with caring responsibilities to feel that they can access and are welcome in voluntary leadership opportunities, including those at RCS England. We have an opportunity to lead the way in improving access to leadership roles and support for individuals once in role by introducing policies, processes and practices that welcome those with caring responsibilities and that make them feel they belong. Small logistical changes such as meeting times and offering flexible options for hybrid meeting can also improve accessibility.

RCS England employs 235 staffmembers, many of whom are parents or have caring responsibilities.We have recently reviewed our policies and processes, and have introduced an equitable parental leave policy with enhanced benefits as well as a fertility leave policy. Consideration of peer support and more guidance and personalised support for return to work would further enhance RCS England's internal approach to parents and those with caring responsibilities.

ACTIONS AND RECOMMENDATIONS

What RCS England will do

We have augmented our baby changing and feeding facilities in the building, and we will continue to ensure and improve clear signposting to and awareness of facilities and services that support parents in physical RCS England spaces.

We will review standard practices and policies for events and other member services, including timings, format and auxiliary services (eg facilities and childcare options) to support these. We will expand good practice where possible and ensure clear and transparent rationale is communicated where services deviate.

We will lead the way in creating opportunities and reducing barriers to engage in voluntary leadership roles by reviewing policies and processes across all RCS England leadership roles, identifying gaps and setting out a clear action plan to improve accessibility for those with caring responsibilities and to provide better support for individuals once in role.

We will introduce standard hybrid options for meetings and committees, and we will advocate for better accessibility where we have influence in other organisations. We will actively consider the timings of meetings to enable those taking on voluntary roles to balance these with caring responsibilities.

We will advocate for representation in bodies whose decisions affect parents' and carers' career progression, including those responsible for the design and delivery of curricula such as the Joint Committee on Surgical Training and the Joint Committee on Intercollegiate Examinations. Better representation will result in better awareness of the barriers and obstacles that parents and carers face, and this will influence decision making around the curriculum such as the timing of examinations in a training pathway.

We will use our learning from the external environment and the exemplar organisations with which we have spoken to continue to reflect inwards and to improve the information, opportunities and working practices for our staff who have parental and caring responsibilities.

Wider change required

We will advocate for trusts to enable and support colleagues to undertake leadership positions in a voluntary capacity by integrating such roles in job plans.

We will advocate for personalised support and opening the discussion as a role model for a flexible and supportive culture. A dialogue should be started with colleagues and staff about what support they would find helpful, and how they can support one another more. Opening up and visibly supporting topics that people find difficult to discuss facilitates an environment that enables people to share more openly and honestly (if they choose to) as well as a space to share best practice and brainstorm further ideas.

Summary: Reflecting and moving forwards

Our work has pointed to a wide range of areas and themes that are broader than those that affect Parents in Surgery alone: flexibility in training and working, workforce issues and pressure, rota planning and balancing service with training opportunities. There are no ‘quick fix’ solutions that will replace the need to invest in the workforce across a considerable time period but where we have seen scope for good practice to expand and alleviate immediate pressure on those with caring responsibilities, we have identified these in the recommendations. We will ensure our work for Parents in Surgery in these areas dovetails with our workforce, training, and specialty and associate specialist doctors work to improve flexibility across the workforce so that flexibility for some does not affect the work–life balance for others.

There are themes that are distinct for Parents in Surgery, where we can have impact and influence, and where we can immediately improve some of the obstacles and barriers that parents in surgery face. This is where we will focus our immediate energy and resource during the project’s next phase. The most acute point where we feel we can make a difference in the short term is in the pre-parenthood or planning stage. Discussions consistently came up during our work pointing to the secrecy and silence around planning for parenthood. Through creating communities of support and open discussion, RCS England has the power to pilot and develop spaces of safety, solidarity and belonging to legitimise and normalise conversations, and to provide support in those areas where our members struggle to find it elsewhere.

Our approach to our next phase of work is to start to take some steps now, developing and learning as we go. By doing this, we will be gaining insight and building knowledge to ensure that any interventions are evidence based, and that our advocacy is informed by real and diverse experience.

Our next steps will allow us to have a direct impact on some individuals through a programme of work but also an indirect impact on others through the visibility of our work as we gain a voice and start to legitimise the obstacles and barriers we see as well as the way we talk about Parents in Surgery. By legitimising these challenges for people and by building our own credibility in this area, we will make much better advocates for wider change. This wider change lies outside our direct control and with other organisations that have the power to effect that change. A significant part of our work in the next phase will be building our stakeholder engagement, working alongside those organisations and being an advocate for change where it is needed.

Some of what we have seen in Parents in Surgery lies in the power of the individual. Where we have heard about positive change and experiences, it has often come from colleagues and peers choosing to go out of their way to provide support, flexibility and compassion. Culture and organisations come down to the way in which the people within them think, the attitudes and behaviours that are normalised, and the responsibility that people feel towards each other. We have seen that small changes to the ways in which people are treated and supported make a big difference: managers talking to individuals about their specific and personalised return plans, colleagues supporting each other to meet childcare commitments, understanding and compassion from peers during times of tragedy and loss. We hope that by raising awareness and providing support, tools, resources and networks to improve understanding and capacity, individuals will feel empowered to change practice in the workplace for the benefit of the whole profession.

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Appendix 1: Contributors and stakeholders

We are grateful to the many individuals who have contributed to the Parents in Surgery work so far. There have been a number of contributors who wish to remain anonymous and so these people have not been listed below. What follows is therefore an incomplete list of contributors and people to whom we extend our gratitude.

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Appendix 2: Resources, networks and useful links

The resources listed in this section are those that came up during this initial phase of our Parents in Surgery project. During the next phases of our work, we will seek to fill the gaps and make a more holistic set of resources available for the surgical workforce and RCS England staff.

RCS England resources

RCS England confidential support and advice service (CSAS)

RCS England Kennedy report

RCS England diversity, equity and inclusion action plan

Health education and surgical training

These are the links for the four statutory education bodies in the UK:

Health Education England (HEE)

NHS Education for Scotland (NES)

Health Education and Improvement Wales (HEIW)

Northern Ireland Medical and Dental Training Agency (NIMDTA)

The Joint Committee on Surgical Training can provide you with information about the rules and processes that apply to surgical training in particular.

All medical training is based on the Gold Guide, which is regularly updated.

Less than full-time and flexible working

The broad principles of less than full-time (LTFT) training are covered in an information sheet from Health Education England (HEE): LTFT training: a bite size information sheet for trainers

Each HEE region has a LTFT team, and there will be consultant and trainee champions for each specialty. The regional web pages for HEE are very helpful, and local trusts should all have a flexible working champion and may well have other resources available.

HEE | Delivering greater flexibility (LTFT category 3)

HEE | Guidance on LTFT category 3 for August 2022 start

Wales: HEIW | Less than full-time training

Northern Ireland: NIMDTA | LTFT policy

There is good evidence that gradual retirement from work is better for your health so retirement is an ideal time to consider flexible working or a portfolio career. For some general information, visit: NHS Employers | Flexible retirement

NHS | Flexible working: raising the standards

AoMRC | Flexible careers

BMA | Consultant part-time and flexible working

BMA | Flexible training

GOV.UK | Flexible working

Informal advice and support:
Facebook | LTFT Trainees Forum

Planning for a family, pregnancy and fertility support

JCST | Pregnancy: a guide for surgical trainees and trainers

La Leche League GB – Breastfeeding support from pregnancy onwards

NHS | Expressing and storing breast milk

GOV.UK | Having a child through surrogacy

GOV.UK | Child adoption

NHS | Treatment for infertility

Dany Griffiths | Freedom Fertility Formula

Fertility Network UK | Employment issues

Leaders Plus – Supporting working parents to pursue their careers

Time off and returning to work/training

HEE | SuppoRTT: Supported Return To Training

Until recently, Health Education England just covered trainees but the situation was much less certain for non-career grade surgeons. This led to the Career Refresh For Medicine programme: HEE | CaReForMe

The Joint Committee on Surgical Training has a guidance document specific to returning to surgical training

BOA | Parenthood and orthopaedics

Women Returners – Consulting, coaching, networking

Women in the City – Promotes diversity, champions female talent

Here are some general guidelines for arranging and approving out-of-programme (OOP) working, together with the Joint Committee on Surgical Training guidance and flowchart:

HEE | OOP: a bite size information sheet for trainers

JCST | Out of programme

JCST | OOP application process flowchart

Legal frameworks and support

Consultants are employed according to the consultant contract. This is then interpreted by local trusts and their local negotiating committees. The NHS Employers website has links to the legal frameworks as well as to advice about job planning and specimen contracts: Consultant contract (2003)

All jobs are covered by national employment law: Employment Rights Act 1996

CIPD – The professional body for HR and people development

NHS Employers | Doctors and dentists in training terms and conditions (England) 2016

BMA | Junior doctors' handbook on the 2016 contract

Finance

GOV.UK | Check if you can get maternity/paternity leave or pay

GOV.UK | Maternity pay and leave

GOV.UK | Paternity pay and leave

GOV.UK | Maternity, paternity and adoption pay calculator

GOV.UK | Unpaid parental leave

Further reading

Nuffield Trust | Attracting, supporting and retaining a diverse NHS workforce

The New York Times | When the surgeon is a mom

GOV.UK | Our vision for the women's health strategy for England

Dad Matters | Regional and universal resources

Music, Football, Fatherhood – Open conversations around fatherhood

Stonewall | Parenting rights

Gingerbread | LGBTQ+ single parents

Some Families – Podcast dedicated to celebrating LGBTQ+ families

BMA | Who are SAS doctors?

GMC | What do we know about SAS and locally employed doctors?

Working Families | Parents and carers of dependants with a disability

Lullaby Trust | Bereavement support after the death of a baby or child

Journal papers

Al-Hadithy N, Nicholas R, Knight K *et al*. Policy and pregnancy: the impact on working families in the NHS. *Future Healthc J* 2021; **8**: e655–e659.

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Appendix 3: Statements of belief

The following statements were formed in collaboration with a group of surgeons supporting this work to help define our work and focus. It was essential to us that stakeholder input was sought in this exercise to reflect the importance of the words used and the meaning ascribed to those statements. We have therefore presented these beliefs as they were written to ensure their meaning is not diluted.

- Parents in Surgery is not a women's issue – it is a whole workforce issue.
- Parents in Surgery is not just for new parents. It includes (but is not limited to):
    - individuals in planning stages or assisted fertility routes
    - those going through miscarriage or who have experienced loss
    - those undertaking adoption or planning for adoption
    - those who have caring responsibilities
- Parents in Surgery captures all aspects of being a parent (including planning a family, fertility treatments, adoption, surrogacy, parents with older children and parents who have experienced loss).
- Those planning parenthood or at any stage of their family journey should not need to hesitate owing to perceived conflict between their family sphere and their working life.
- Parents in Surgery is inclusive and no group is excluded or discriminated against.
- Parental roles should be afforded equitable rights by the profession. This includes (but is not limited to) paternity rights (eg to childcare, parental leave, flexibility) equitable to those established for maternity.
- Individuals should not be at all disadvantaged in training plans and training opportunities, job role or job security for wanting or having a family.
- Individuals should have children when it is right for them, not when it is right for their role/career.
- Parents in Surgery needs to work for the whole workforce, not just those affected directly by their parental journey.
- Suitable/reasonable provisions should be made for support for individuals with childcare responsibilities to further their own learning and progression in their careers. This includes (but is not limited to) the provision of courses, events and examinations.
- Individuals undergoing treatments or procedures for anything related to Parents in Surgery should expect that their medical privacy is respected.
- The wellbeing of the child(ren) is vital and must remain central to this work.
- No children should be negatively affected by their parent choosing a career in surgery. This may include (but is not limited to) being separated geographically, being removed from established educational frameworks or social groups and parental absence where it has an adverse effect on the child–parent bond.