ACADEMY OF
MEDICAL ROYAL
COLLEGES

The Academy of Medical Royal Colleges Maternity/Paternity Survey Results

Pregnancy can be a stressful time for prospective parents. We investigated the particular problems experienced by those in the medical and dental professions such as planning maternity and paternity leave; maintaining competencies & returning to work, with appropriate childcare, all of which can present major challenges.

Legislation was introduced in the UK in April 2015 to enable greater access to shared parental leave, and with this in mind we hope the recommendations as a result of these survey findings will enable a more positive experience of returning to work

Produced by
The Academy of Medical Royal Colleges
Flexible Careers Committee

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Executive summary

Introduction
The Flexible Careers Committee of the Academy of Medical Royal Colleges (the Academy) was asked by a representative from one of the constituent Colleges, who had personal sub-optimal experience of returning from maternity leave, to investigate the current barriers experienced by colleagues taking maternity/paternity leave and see if her experience was unique.

Methods
A survey was developed which was piloted to Fellows and Members of the Royal College of Surgeons of Edinburgh under the age of forty. Eighty-eight per cent of the Members and Fellows who opened the pilot email clicked on the link to take the survey. Following evaluation of feedback, the functionality of the survey was amended and extended to include all age groups. The final survey was distributed to all Colleges and Faculties. In total 1,225 responses were received covering all specialties; Deaneries; Local Education Training Boards (LETBs) and regions.

Results
Those responding reported significant non-compliance with many of the NHS terms and conditions relating to pregnancy and maternity leave, particularly in relation to keeping in touch (KIT) days and health assessments on returning to work. Concerns surrounding financial issues and childcare (common to employees in all professions) were identified. There were particular concerns surrounding childcare for those in the craft specialties, such as surgery and anaesthesia, who were unable to guarantee being able to leave the operating theatre in time to collect children from childcare.

Specific concerns for the medical profession were related to the attrition of clinical knowledge and practical skills; expectation of immediately being able to function at a pre-leave level when resuming work; working out of hours without supervision from the outset; worries regarding missed new developments and changes in local and national guidelines; and, in this survey,25% were concerned that their concentration would be impaired in the first few months following return to work.

Conclusions
With increasing numbers of employees in the training grades deciding to take maternity leave and the increasing number of women in the workforce, as well as the changes in legislation that may see a more equal division of parental leave it is essential that steps are taken to improve the experience of those taking parental leave so that returning to the workforce is well supported for the benefit of those returning, their patients and ultimately their employer. This is particularly important in the GP setting; specialties experiencing under recruitment and in craft specialties where women are underrepresented and where men requesting leave may not be considered to be properly committed to their specialty. When returning to work after parental leave is seen as a positive experience, employees are more likely to be loyal their employer thus increasing the stability of the workforce[1].

Many of the solutions are already included in the NHS terms and conditions but there is inconsistency of employing organisations in how they are implemented.

[1] Harvard Business Review Services. (2012). *Commitment to the Future: 10 Years of The Principal 10 Best Companies*. {Accessed 21 January 2016] https://hbr.org/resources/pdfs/tools/17323_HBR_Principal_White%20Paper_webview.pdf

We hope that the dissemination of this Report and its recommendations via all the participating Colleges and Faculties and other organisations will make a significant contribution to raising awareness of the key issues identified and the actions needed to improve the experience of doctors and dentists taking maternity/paternity leave.

Recommended Action Points

- To increase awareness of the Terms and Conditions of Employment in relation to parental leave. To ask NHS Employers to recirculate to Employers their duty and role in discussing voluntary arrangements around KIT days prior to maternity leave and ensure that the employee's returning Trust, if different, is involved in these discussions in order to agree funding support in advance of leave
Suggested action: NHS Employers, Unions

- To remind employing trusts of the requirement under the Terms & Conditions of conducting a risk assessment for pregnancy; breast feeding and all mother's returning from maternity leave
Suggested action: NHS Employers, Unions

- To recirculate the Health and Safety Executive Guidance on breastfeeding to ensure that suitable facilities and working conditions are provided to facilitate continued breast feeding
Suggested action: NHS Employers, Unions

- To recommend to employers that trainees returning from parental leave have a designated consultant who will be available support and advise during the first three months of their return to work
Suggested action: NHS Employers, Unions

- To circulate links to useful information to Colleges; LETB's and Deaneries to promote and support available resources for those seeking to take parental leave
Suggested action: the Academy, Royal Colleges, Unions

- Employers to make available to those taking parental leave information about changes and developments to guidelines, procedures or equipment during their absence
Suggested action: Employers, HR

- Recommend that all employers have an obligation to offer work 'shadowing' to employees returning from leave
Suggested action: Employers, HR

- Recommend LETB's and Deaneries to undertake annual review that appropriate health checks are undertaken prior to trainees recommencing work after a period of leave
Suggested action: LETB, Deanery, Employers' Occupational Health departments

- Recommend the development, provision and expansion of on-site late opening childcare for health care workers with on call commitments or in the craft specialties.

Background

The Academy Flexible Careers Committee (the Committee) comprises representatives from Academy member organisations and other relevant organisations such as the NHS Employers, General Medical Council and the British Medical Association. It exists as a forum to combine input and expertise from all those involved in supporting those in less than full time (LTFT) work and training. The aim of the Committee is to promote a good work-life balance for all doctors and dentists working LTFT at all career stages.

In late 2014 the Committee received a request from a member of one of our constituent Colleges for further investigation into the current barriers experienced when taking Maternity/Paternity leave. In response, the Committee developed an electronic survey to collect clinicians' experiences of taking parental leave (Appendix 1). The aim was to identify issues affecting those who have already taken parental leave so that Colleges and other relevant organisations will be able to provide additional advice and support to members in the future, particularly as changes in law now allow the sharing of parental leave.

Participants were asked about the length of leave taken; the information they received about leave and subsequent working including the sources of information used; their concerns (personal and professional) when returning to work; how they adapted to changes in clinical practice and/or changes in policies and protocols that occurred during their absence, and how they experienced reintroduction to the workplace.

Respondents' responses spanned several decades of experience. Changes in legislation are likely to have had an impact upon those taking leave more recently. The respondents were therefore divided into those taking maternity/paternity leave pre 2010 (cohort) and those taking maternity leave/paternity leave post 2010, i.e. within the last five years. The results show that the barriers experienced remained essentially unchanged over the whole period. However, this report concentrates on the post 2010 cohort making comparisons with the pre 2010 cohort where appropriate.

Male respondents all took only 10-14 days of paternity leave which had no detectable impact on their careers so their data has not been analysed further. The male experience is understandable as the new flexibility to request longer periods of paternal leave has not yet been widely adopted. The data collected will provide a baseline for further studies of male uptake of shared parental leave.

The survey is not exhaustive but had a significant response rate. The findings indicate that increased information and support would improve the experience of those taking leave of absence from the workplace and improve their confidence and effectiveness as clinicians upon their return.

1. Methods

The survey questions were drafted by members of the committee then reviewed and discussed by the entire committee membership. The initial survey was piloted by the Royal College of Surgeons of Edinburgh (RCSEd). The RCSEd circulated the pilot survey to Members and Fellows under the age of forty years. Of the members and fellows contacted who opened the email, 88% took the survey. There was a predominance of male respondents in the pilot group, probably reflecting the lack of women in the surgical workforce. However, of the female who responded the concerns and problems matched those identified in the final survey.

Following a review of the feedback, the survey was revised to improve its reliability and a decision was made to include all age groups. The *‘Flexibility and Equality Parental Leave Survey’* was sent out via an electronic link by all the Royal Colleges to their members in late 2014. Participation closed in February 2015.

2. Results

Section 1 – Classification of respondents

There were a total of 1,225 responses of which 200 (36% women, 64% men) were to the pilot survey. The remaining 1,025 (786 women, 198 men) replied to the final survey. Responses were received from all the Royal Colleges and Faculties. Not all respondents answered every question in the survey. Responses were received across all specialties; Deaneries; LETBs and regions but with very small numbers from a few, e.g. three from Occupational Health (see Table 4 below).

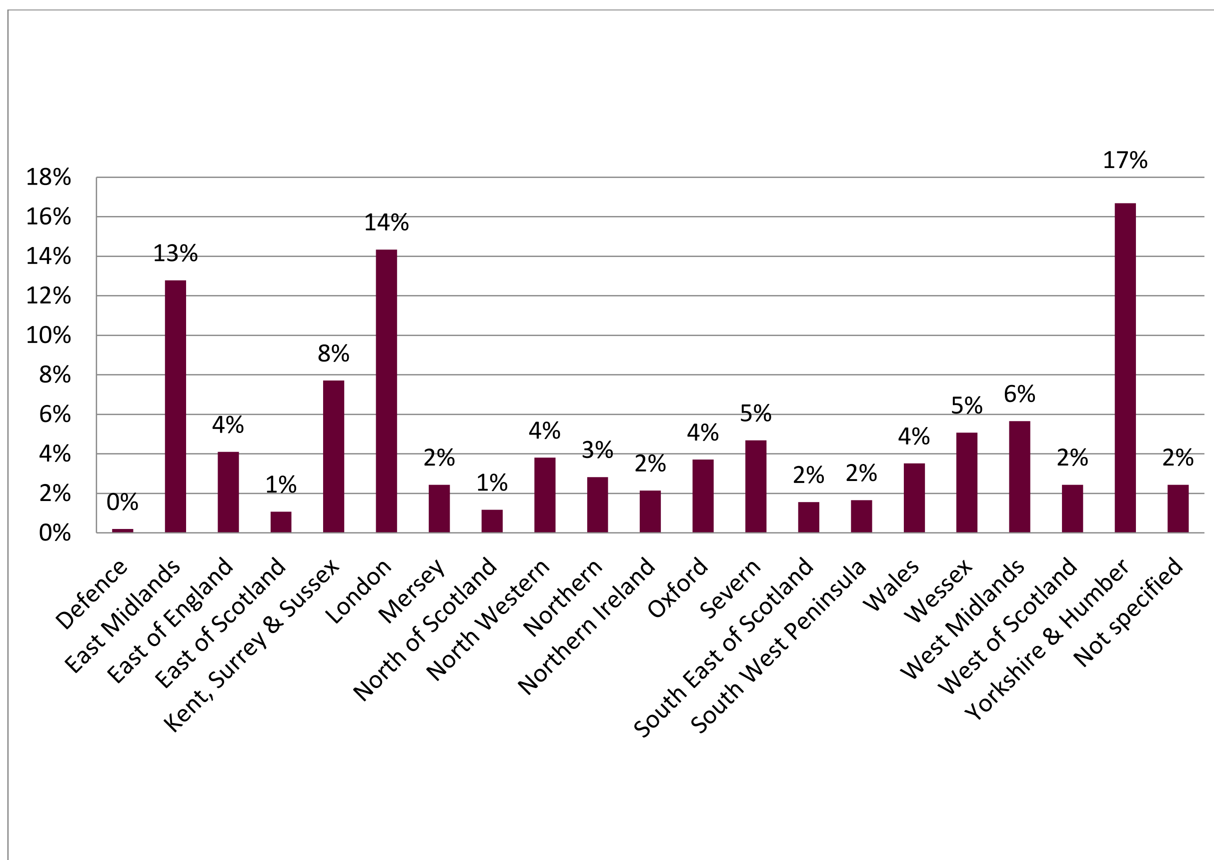
Information has been split into two cohorts :

- Those respondents taking maternity leave before 2010
- Those respondents taking maternity leave from 2010.

5.1 Geographical Origin

Table 1 shows the geographical or other origin of respondents to the final survey. The largest proportion were based in the Yorkshire and Humber region.

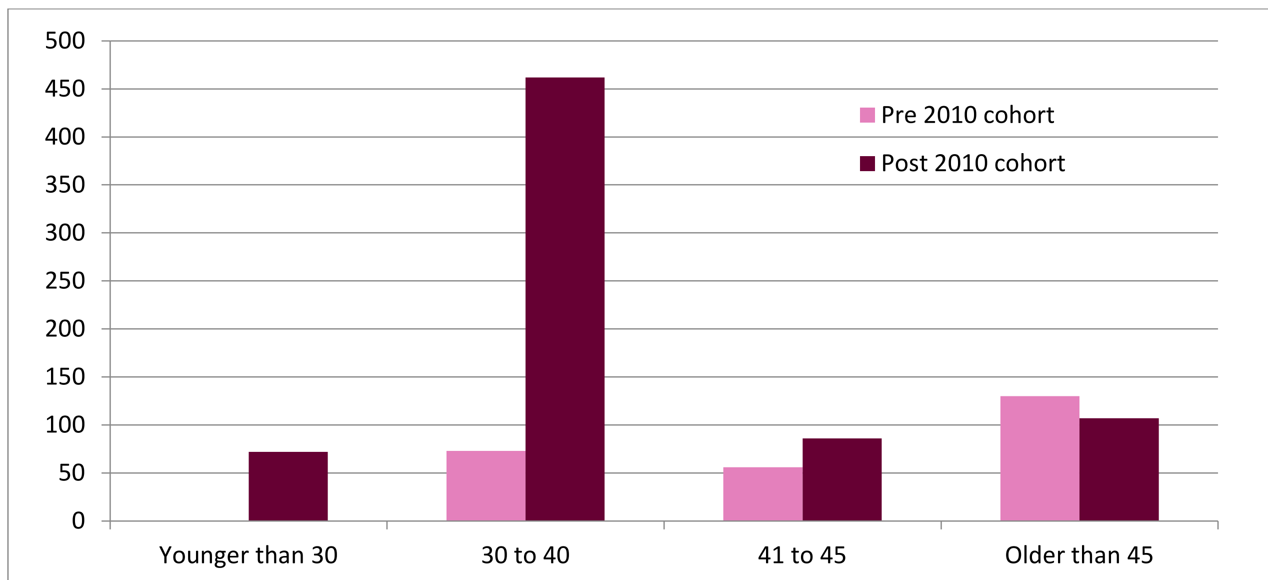
Table 1. Geographical origin



5.2 Age profile

Table 2 shows the ages of the respondents. The majority were aged 31- 46 years though 23.7% (237) were aged over 47 years.

Table 2: Age



The ages in the two cohorts were broadly similar apart from a significant difference in those younger than 30 years taking maternity leave in the post 2010 cohort.
The comparison of the pre and post 2010 cohorts was made in order to see whether changes in employment guidance might have influenced the experiences of those taking parental leave more recently. Recommendations made will relate to recent survey participant experience.

The analysis of the final survey only showed that 274 responses were for leave taken before 2010 compared to 751 post 2010.

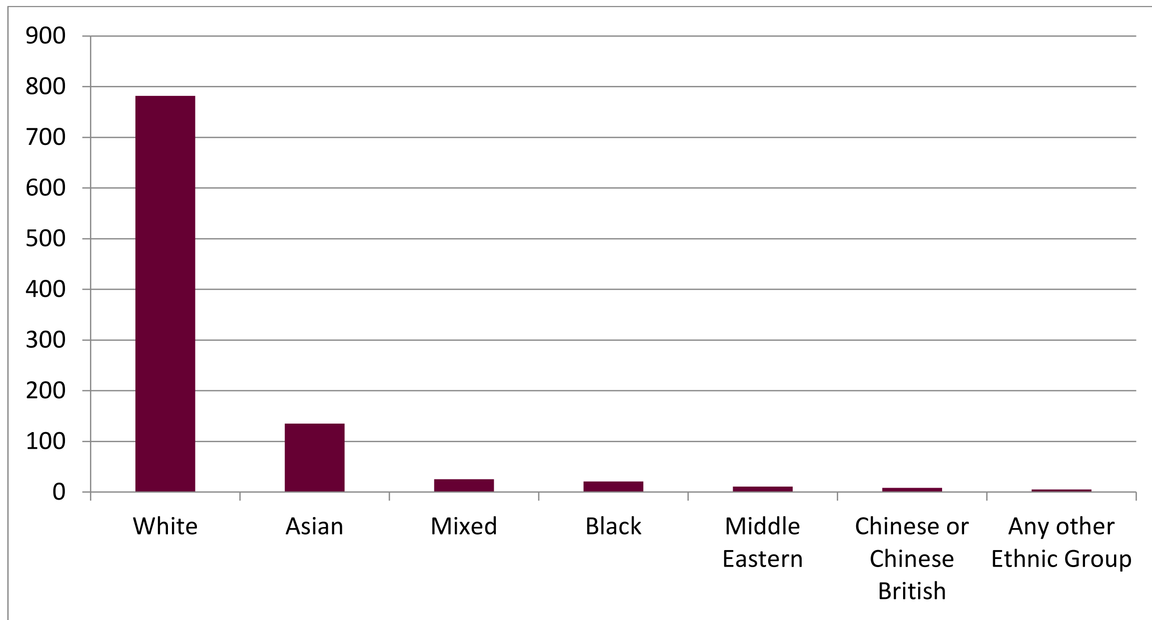
The majority of women in both cohorts reported taking two to four weeks' antenatal leave showing little change over time.

5.3 Ethnic origin

Seventy-nine per cent of respondents identified themselves as of a white ethnic background; 13.6% Asian; 2.5% Mixed; 2.1% Black; 0.9% Middle Eastern; 0.8% Chinese or Chinese British and a small number reported other ethnic backgrounds. Thirty-five respondents declined to answer.

Table 3 shows the reported Ethnic origin of respondents merged into major groups.

Table 3. Ethnic origin



The ethnic origins reported in the two cohorts (pre and post 2010) were broadly similar except for a doubling in post 2010 of those reporting an Indian ethnic (origin from 5% to 10%).

5.4 Specialty of respondents

All responders to the pilot were from the RCSEd and included dentists and paramedics (reflecting the wide constituent base of this College).

Responses to the main survey were received from all LETB's across the country. There were responses from all the Colleges & Faculties represented in the Flexible Careers Group and all but six had 10 or more responders.

Table 4. Royal College/Faculty affiliation (Respondents were allowed to choose multiple responses)

Medical royal college or faculty		
Royal College of Pathologists	31.9%	401
Royal College of Surgeons of Edinburgh (RCSEd) pilot group	15.9%	200
Royal College of Physicians London	13.2%	166
Royal College of GP's	10.0%	126
Royal College of Anaesthetists	4.5%	57
Royal College of Paediatrics and Child Health	4.5%	56
Royal College of Physicians of Edinburgh	3.3%	42
Royal College of Obstetrics and Gynaecologists	2.9%	37
College of Emergency Medicine	1.9%	24
Royal College of Psychiatrists	1.9%	24
Royal College of Surgeons of England	1.9%	24
Faculty of Public Health	1.4%	18
Other	1.4%	18
Royal College of Ophthalmologists	1.3%	16
Royal College of Radiologists	1.1%	14
Faculty of Sexual & Reproductive Healthcare	0.7%	9
Royal college of Surgeons Edinburgh	0.7%	9
Royal College of Physicians & Surgeons of Glasgow	0.6%	7
Faculty of Dental Surgery - London	0.3%	4
Faculty of Dental Surgery - Edinburgh	0.2%	3
Faculty of Occupational Medicine	0.2%	3
Total		**1,258**

The largest number of responders to the final survey came from the Royal College of Pathologists. There were very low response rates from the Faculty of Dental Surgery and the Faculty of Occupational Health (therefore the findings may be less applicable to these specialties).

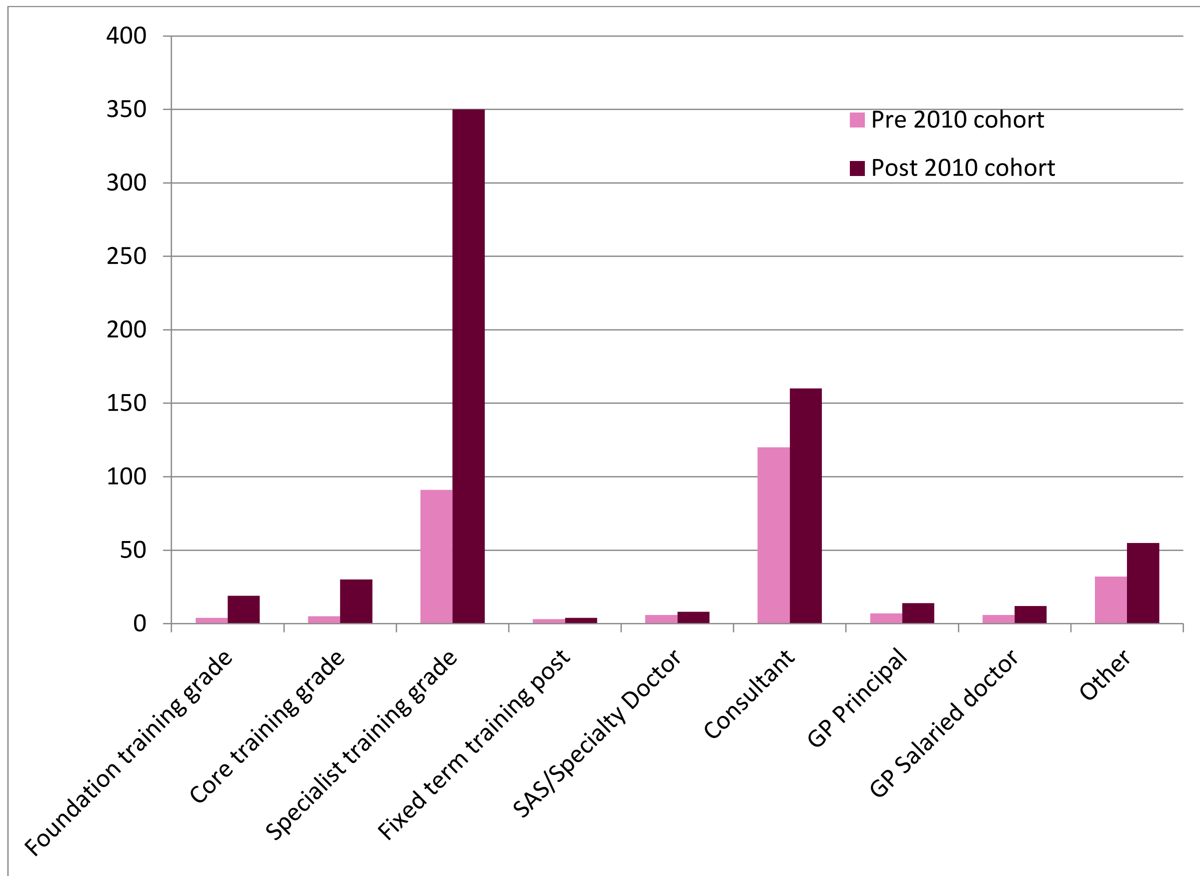
5.5 Grade of respondents

Responses were received from all grades but most had low response rates apart from the specialist trainees and the consultants who, combined, constituted over 70 % of responses.

Table 5. Grades Post 2010 during most recent period of maternity leave

Grade		
Foundation training grade	2.5%	23
Core training grade	3.8%	35
Specialist training grade	47.6%	441
Fixed term training post	0.8%	7
SAS/Specialty Doctor	1.5%	14
Consultant	30.2%	280
GP Principal	2.3%	21
GP Salaried doctor	1.9%	18
Other (e.g. Locum posts, LATs, post CCT, OOPE)	9.4%	87
Not Answered		299
Total		**1,225**

Table 6. Grades Pre 2010 versus Post 2010



Pre 2010, of the respondents who took leave, 33% took it when they were in the specialist training grade and 44% when they were consultants. Post 2010, the position had changed with 54% of the specialist training grades taking maternity/paternity leave compared to only 24.5% when in the consultant grade.

Table 7. Is this your first instance of maternity leave?

Yes	40.3%	366
No	59.7%	542
Not Answered		317
Total		**1,225**

The majority of respondents 59.7% already had other children.

Table 8. Previous episodes of maternity/paternity leave

	0 to 1 year ago	1 to 2 years ago	2 to 3 years ago	3 to 4 years ago	4 to 5 years ago	Longer than 5 years ago	Total
Oldest child	8	49	73	53	71	273	527
2nd child	34	27	28	32	28	175	324
3rd child	5	4	8	10	7	53	87
4th child	2	1	3	3	1	13	23
5th child	0	1	1	0	0	4	6
No reply							**258**
Total	**49**	**82**	**113**	**98**	**107**	**518**	**967**
	5.1%	**8.5%**	**11.7%**	**10.1%**	**11.1%**	**53.6%**	**100.0%**

Section 2 – Analysis of responses

5.6 Family support

The reported incidence of family support was virtually identical in the two cohorts. Thirty-one and 33% of respondents reported having family support but the other 69% and 67% reported no such support. A large percentage (59.7%) of respondents already had other children at the time of taking maternity leave.

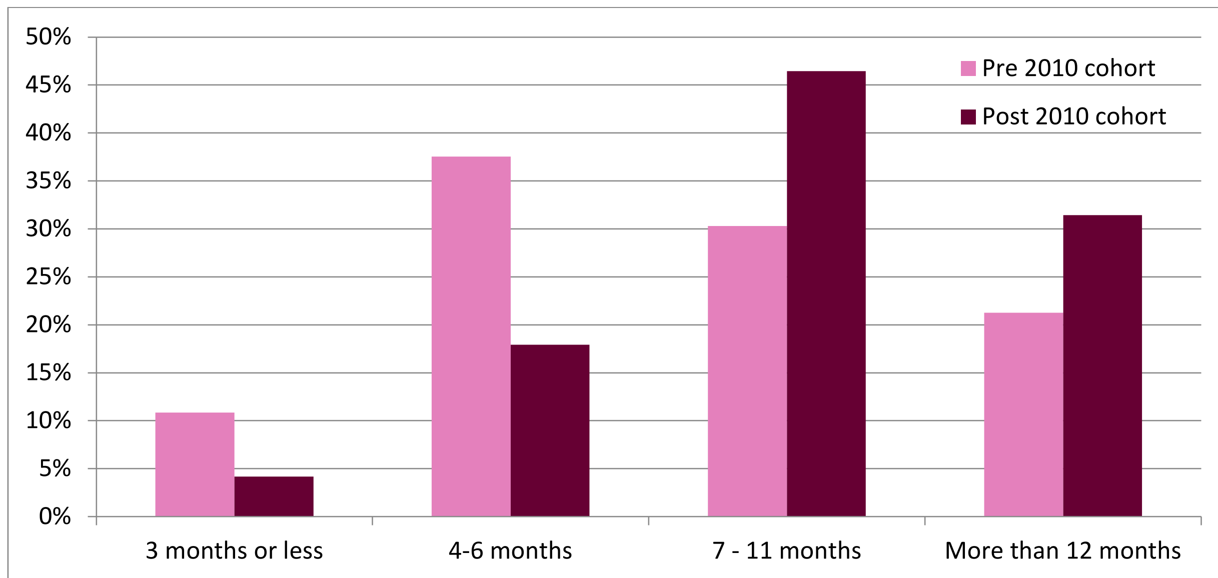
Table 9. Do you have local family (or equivalent) support? - Post 2010 cohort

Yes	32.5%	295
No	67.5%	614
Not Answered		316
Total		**1,225**

5.7 Length of leave

The data suggests that the length of time taken for post-natal leave may be increasing. Of the pre 2010 cohort, 10% took three months or fewer, 33% took four to six months, 33% took seven to 11 months and 24% took 12 months or more (Table 10).

Table 10: Length of Maternity Leave taken

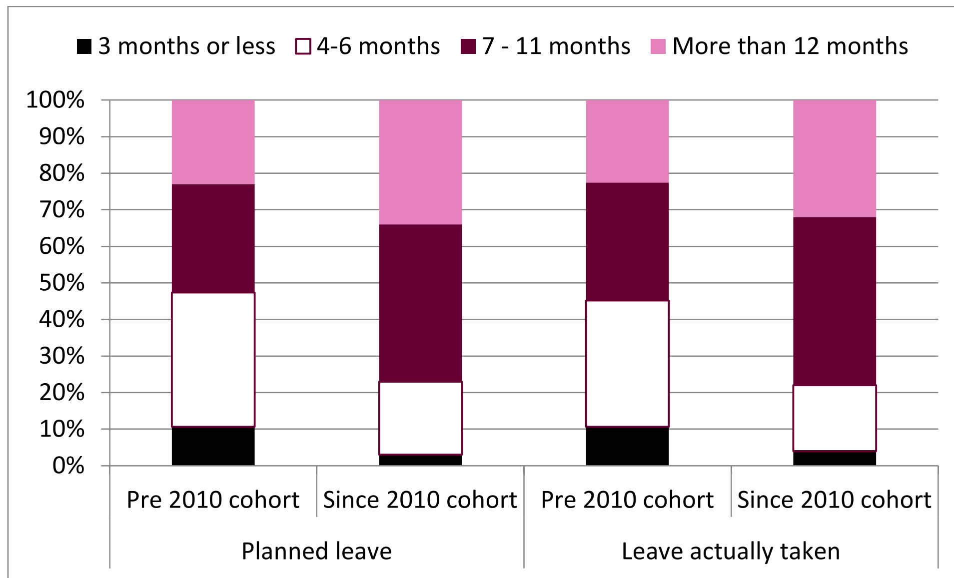


In contrast, in the post 2010 cohort, only 4% took three months or fewer; 18% took four to six months; 46% took seven to 11 months and 30% took 12 months or more.

5.8 Planned leave

Pre 2010 respondents planned and actual periods of maternity leave were identical. However, as shown in Table 11 in the post 2010 cohort there was a statistically significant difference.

Table 11: Planned versus actual leave taken



5.9 Impact of pay decisions

In view of the proposed changes to junior doctors' contracts approximately 20% responded that, if pay progression were paused during maternity leave, it would affect how much maternity leave they took.

Table 12. Would it have changed your decisions about maternity leave if pay progression were paused while you are on maternity leave?

Yes	20.9%	147
No	79.1%	557
Not Answered		521
Total		**1,225**

5.10 Information sources for leave

The most frequently listed information source for planning leave was medical HR departments. Talking to colleagues scored highly – 60% of respondents reported this as a source of information. The BMA website ranked third followed by payroll, government sources and NHS employers.

Table 13. Resources utilised by the post 2010 cohort (Respondents were allowed to choose multiple responses)

Information form HR/medical staffing	77.80%	615
Information from payroll	28.20%	223
Government websites	26.10%	206
NHS employers' website	22.80%	180
Academy of royal colleges' website	1.10%	9
Medical women's federation website	1.80%	14
Specialty / Colleges / Faculties' website	9.00%	71
BMA website	36.70%	290
Other websites	2.80%	22
Talking to colleagues	57.10%	451
Books	2.90%	23
Other resources	3.40%	27
None	6.50%	51
Total		**2,182**

Table 14. Did you take your maternity/paternity leave in the past year?

Yes	34.6%	274
No	65.4%	519
Not Answered		432
Total		**1,225**

5.11 Concerns about leave

High numbers of respondents expressed concerns prior to taking leave about the potential impact of the leave on their professional (Table 15) and home lives (Table 16) and were similar in the two cohorts. Clinical respondents (654) reported anxieties about the effect leave would have in their work including to their continuing professional development clinical competence and working relationships. Non-working concerns included effects on finances and arranging appropriate childcare for their return to work.

Table 15. Pre-leave professional concerns reported
(Respondents were allowed to choose multiple responses)

Clinical Competence	33.3%	460
Working Relationships within your department	27.7%	382
Continuing Professional Development	24.6%	339
Revalidation	9.1%	126
None of the above	5.4%	74
Total		**1,381**

Table 16. Other concerns reported (Respondents were allowed to choose multiple responses)

Arranging childcare	36.1%	477
Finances	34.0%	449
Keeping in touch	18.0%	238
Other please state	8.5%	112
No worries	3.5%	46
Total		**1,322**

Table 17. Have you returned to work?

Yes	85.4%	545
No (still on maternity leave)	14.6%	93
Not Answered		587
Total		**1,225**

5.12 Experience of leave reported

Once on leave, respondents reported concerns and pressures which might make them decide either to shorten or extend their period of leave (see 5.8 above). Just under 47% of respondents felt no pressure to return early as shown in (Table 18).

Table 18. Reasons for early return from maternity leave for post 2010 cohort

No pressure	46.5%	295
Personal finances	22.2%	141
Employer/ Department Pressure	9.8%	62
Other	8.2%	52
Training linked deadlines	7.7%	49
Compliance with return to work training requirements	3.9%	25
Unmissable Childcare opportunity	1.6%	10
No answer		591
Total		**1,225**

Of the pressures, a relatively small percentage arose from the department or workplace but for over 22% of respondents financial pressures affected the duration of leave taken. There is a slight change between the two cohorts in that financial pressures were reported higher by post 2010 compared to pre 2010 (although as the average duration of leave taken is less for the earlier cohort this may have affected the responses). In contrast, pressure from the department or workplace has dropped from 17% to 8%.

Only 25.6% of respondents reported looking forward to their return (Table 19) whereas the remainder had some reservations about returning to work. Of these some 13.5% felt that they were not emotionally ready to return which raises questions about the support they experienced.

Table 19. Emotional Concerns – Post 2010 cohort

Looked forward to returning	25.6%	138
Some reservations	55.3%	298
Not feel emotionally ready to return	13.5%	73
Other	5.6%	30
Not Answered		686
Total		**1,225**

A possible contributory factor to the un-readiness to return from leave reported was sleep deprivation (Table 20). Both cohorts reported a significant lack of sleep with 50% getting less than five hours' continuous sleep.

Table 20. Sleep Deprivation – Post 2010 cohort

0-4 hours	51.8%	280
5-7 hours	42.9%	232
8 + hours	5.4%	29
Not Answered		684
Total		**1,225**

Another important concern similar in both cohorts and reported by 25% of respondents was post-natal problems (Table 21).

Table 21. Did you experience any postnatal problems? – Post 2010 cohort

Yes	23.9%	95
No	76.1%	303
Not Answered		827
Total		**1,225**

5.13 Support for return to work

Over the years a number of supportive schemes have been proposed. These include “keeping in touch” (KIT) days whilst on leave; Occupational Health assessments; private space to help those breast feeding; provision of a mentor/supervisor etc. (see appendix 4).

Keeping in Touch. The Government recommendation is to offer up to 10 ‘keeping in touch’ (KIT) days. However, only 37.3% of those taking leave post 2010 cohort had been informed of this opportunity by their employer.

Table 22. Were you made aware of KIT Days by your employer?

Yes	37.3%	200
No	62.7%	336
Not Answered		689
Total		**1,225**

Only 19.9 % of respondents reported being offered KIT days (Table 23).

Table 23. Were you offered KIT days?

Yes	19.9%	106
No	80.1%	428
Not Answered		691
Total		**1,225**

Of those who said they were offered KIT days, 73% were offered 10 days (Table 24).

Table 25. Number of KIT days offered

0	2.3%	2
1	3.5%	3
2	8.1%	7
5	8.1%	7
8	2.3%	2
10	73.3%	63
Other Responses	2.3%	2
No answer		20
Total		**106**

However, (Table 25) only 22.9% of respondents reported being able to take all the KIT days offered.

Table 25. Advantage taken of KIT days

Yes – all of them	22.9%	25
Yes – part of them	38.5%	42
No	38.5%	42
Not Answered		1,116
Total		**1,225**

Over 70% of respondents (Table 26) understood that remuneration for attending KIT days would not affect their statutory maternity pay.

Table 26. Did you understand that remuneration for attending KIT days would not affect your statutory maternity pay?

Yes	72.7%	78
No	27.8%	30
Not Answered		117
Total		**1,225**

The availability of KIT days (Table 27) for respondents returning to a different Trust after maternity leave was, however, much lower at only 16.1%. This may reflect difficulties in agreeing which employer should be responsible for funding KIT days, particularly if they are undertaken, as would seem appropriate, to support the return to work with a new employer (personal communication LTFT national Forum, Euston 2015)

Table 27. KIT Days offered if returning to different Trust

Yes	16.1%	5
No	80.1%	26
Not Answered		1194
Total		**1,225**

Less than a quarter of respondents (Table 28) reported any opportunity either during of after their leave to refresh or update their clinical skills.

Table 28. Opportunity to refresh clinical skills

During your maternity leave	10.3%	55
On your return	12.3%	66
Neither	77.4%	414
No answer		690
Total		**1,225**

When it came to finding training opportunities to maintain or improve their clinical skills approximately 12% reported any such formal training opportunity. However, some 36% of respondents recognised the issue and arranged their own professional development.

Table 29. Training opportunities for clinical skills

During maternity leave	6.0%	32
On your return	5.8%	31
Arranged own CPD	36.0%	193
Neither	52.2%	280
Not Answered		689
Total		**1,225**

Occupational Health Assessment (OHA) - In both cohorts only 4.9% of respondents reported being offered an occupational health assessment (Table 30).

Table 30. Were you offered an occupational health assessment - post 2010 cohort

Yes	4.9%	
No	95.1%	
Not Answered		
Total		**1,225**

Despite 23.9% of respondents experiencing post-natal problems (see below Table 33), of those reviewed by occupational health, only 1.5% (Table 31) highlighted any issues of concern.

Table 31. OHA highlight any issues

Yes	1.5%	6
No	5.4%	22
Not applicable	93.1%	379
Not Answered		818
Total		**1,225**

Even when concerns had been noted, in only one case (Table 32) did identification of a problem influence discussions with the employer.

Table 32. Influence of occupational health assessment on discussions with Employers

Yes	0.8%	1
No	99.2%	124
Not Answered		1100
Total		**1,225**

Post-natal issues. The lack of occupational health assessment is notable in that post-natal problems were reported by nearly 25% of respondents (Table 33).

Table 33. Actual Post-natal problems

Yes	23.9%	95
No	76.1%	303
Not Answered		827
Total Responses		**1,225**

Breastfeeding support. Whereas some 65% of the pre 2010 cohort were breastfeeding when returning to work, this had dropped significantly to 55.1% in the post 2010 cohort (Table 34). It has not been possible to determine whether this is related to the increasing length of leave being taken or that breast-feeding at work is becoming more difficult. However, a third of respondents reported stopping breast-feeding earlier than they would have liked to because of their work commitments.

Table 34. Breastfeeding when returning to work Post 2010

Yes	55.1%	298
No	44.7%	242
Prefer not to say	0.2%	1
Not Answered		684
Total		**1,225**

On their return to work only 16.4% of individuals returning to work reported that they were given private space and time for breastfeeding (Table 35).

Table 35. Private space for Breastfeeding Post 2010

Yes	16.4%	49
No	60.4%	180
Not Answered		69
Total		**298**

One possible consequence of the difficulties finding time and space was that 32.8% of respondents (Table 36) ceased breast feed earlier than planned.

Table 36. Did you stop breastfeeding early

Yes	32.8%	175
No	67.2%	359
Not Answered		1,041
Total Responses		**1,225**

Many stated they stopped breastfeeding prior to returning to work as they felt breastfeeding was not compatible with working given the nature of shift working and unpredictability of hours (see Appendix 3). Several respondents stated that they had delayed their return to work so that they could complete 9-12 months of breastfeeding. If adequate facilities supporting breastfeeding/expressing had been available these individuals might have returned to the workforce earlier.

The majority of those who reported breastfeeding at their return, had to make adaptations to the baby's feeding regime to accommodate working patterns or discontinued breastfeeding earlier than they had planned. The lack of facilities for expressing breast milk was a recurring theme. Several respondents described harrowing tales of being forced to express in toilet facilities; shower cubicles; other people's offices and in "no locked space" only being provided with a "'do not disturb notice''. Maternity departments either refused to let staff use the facilities provided for patients or demanded staff changed into clean scrubs prior to entering the facility, thereby significantly increasing the time required for the process. Even when facilities were provided they were described as "not particularly attractive/suitable" or "room set aside for breast feeding had been used for storing boxes".

Respondents who were juggling the workload and expressing breast milk were regularly disturbed by being bleeped or by colleagues entering the designated area. Respondents in surgical specialties either ex-

pressed milk in scheduled breaks between operations or stopped breast feeding, citing difficulties with facilities, embarrassment and incompatible and unpredictable work schedules.

Clinical competence. Most respondents reported concerns (Table 37) about whether they would still be clinically competent when they returned to work. Concerns included fear that they had lost knowledge or that there would have been significant developments during their absence. Over 30% feared that colleagues would view them differently. In addition, 45% felt they would struggle to concentrate. It is highly significant that only just under 10% of respondents felt no concern about their professional capabilities on their return to work.

Table 37. Anxieties on Returning to work (respondents were allowed to choose more than one option)

Reduced clinical knowledge and practical skills.	65.7%	352
Possibility of significant developments during absence so not fully prepared when returning to work	48.7%	261
Struggling to concentrate	45.0%	241
Colleagues would view me differently.	34.0%	182
I had other concerns (e.g. supervision, fixed leave etc.) - please state	20.5%	110
No professional or personal concerns	9.5%	51
Total		**1,197**

Induction periods. Only about a fifth were offered any opportunity to refresh/maintain clinical skills either during leave or after the return to work. For only a fifth of the returners, was the first week regarded as an induction period. Two thirds of those who weren't offered this support considered that it would have been helpful. None of the responders were offered the opportunity a clinical attachment to shadow a doctor for one to two weeks prior to returning to work (although this might be considered to be a possible use of KIT time).

Table 38. Offered clinical attachment

Yes	1.0%	5
No	99.0%	510
Not Answered		710
Total		**1,225**

Of the very small number of respondents offered a clinical attachment (Table 39) 80% found it useful.

Table 39. Clinical attachment useful?

Yes	80.0%	4
No	20.0%	1
Total		**5**

Apart from in anesthesia, very few respondents were offered any simulator experience (Table 40) to refresh resuscitation skills or the like. Of those few who did experience simulation, again only around half found it useful (Table 41).

Table 40. Offer of simulation days (all specialties)

Yes	5.3%	27
No	94.7%	485
Not Answered		1683
Total		**1,225**

Table 41. Respondents who found the simulation days useful

Yes (Useful)	53.8%	7
No (Not useful)	46.2%	6
Not Answered		14
Total		**27**

Induction. Only some 22% of respondents reported that their first week back had been treated as a period of induction (Table 42). Of those not offered a period of induction, 70% thought it would have been helpful (Table 43). Interestingly, of the respondents starting at a different trust, 63% received a period of induction (Table 44).

Table 42. Was your first week treated as an induction

Yes	22.3%	119
No	77.7%	415
Not Answered		691
Total		**1,225**

Table 43. If not offered, would induction be thought helpful

Yes	69.9%	290
No	30.1%	125
Total		**415**

Table 44. Induction offered at a different trust

Yes	62.9%	73
No	37.1%	43
Not Answered		35
Total		**151**

Clinical supervisor/mentor. Despite the NHS Employers, GMC and Academy recommendations that doctors returning from prolonged leave should be provided with a clinical supervisor/mentor, only 2.4% of respondents reported formal allocation of a clinical supervisor/mentor to oversee their immediate return to work. Some 8% had some informal arrangement but 68% received no such support (Table 45).

Table 45. Were you allocated a clinical Supervisor/mentor?

Formal arrangement	2.4%	12
Informal arrangement	7.6%	39
No	68.0%	347
Don't know	22.0%	112
Not Answered		715
Total		**1,225**

Some 26% reported being allocated a supervising consultant (Table 46) 75% reported not being informed about new policies or equipment changes which had occurred whilst they were on maternity leave (Table 47).

Table 46. Were you allocated a supervising consultant?

Yes	25.9%	134
No	74.1%	384
Not answered		707
Total		**1,225**

Table 47. Informed of new policies/procedures?

Yes	24.6%	129
No	75.4%	396
Not answered		700
Total		**1,225**

Only 21% were provided with agreed milestones with which to monitor their progress following their return to work (Table 48). Although 26% were informed how their progress would be monitored including information on how this was to monitored (Table 49).

Table 48. Agreed milestones provided to monitor progress?

Yes	20.7%	107
No	79.3%	411
Not answered		707
Total		**1,225**

Table 49. Aware how progress would be assessed?

Yes	26.0%	135
No	74.0%	384
Not answered		706
Total		**1,225**

Resources to aid return to work. Respondents were asked about the resources they were able to access to help them in their return to work. These included both formal and informal arrangements such as support from partners or medical "parents" i.e. other colleagues who had children and experienced returning to work (Table 50). Some 20% or fewer reported support from formal sources such as clinical supervisors, consultants or HR. Informal sources proved a little more helpful The most frequent resource listed by individuals returning to work was their partner.

Table 50. Return to Work Resources (respondents were allowed to choose more than one option)

Your Partner	48.0%	258
Other Medical Parents	27.0%	145
Other	22.7%	122
Other Parents	21.2%	114
Educational or Clinical Supervi-sor	20.1%	108
Other Family Members	16.9%	91
HR/ Medical Staffing	15.5%	83
Your Consultant	13.8%	74
Online forums	8.2%	44
Books	5.0%	27
Total		**1,066**

Childcare. Concern about the provision of childcare on return has been raised in the past and from this survey continues to be a very difficult or impossible problem for 20% of respondents (Table 51). On the other hand, just over 50% found it straightforward or with only minor difficulties.

Table 51. How easy was arranging childcare?

Straightforward	27.0%	146
Minor Difficulty	25.2%	136
Moderate Difficulty	27.2%	147
Very Difficult	15.4%	83
Almost Impossible	5.2%	28
Not Answered		7
Total		**547**

The type of childcare chosen by respondents varied (Table 52) but virtually all used their own resources rather than workplace care.

Table 52. Type of childcare reported (some used a combination) (respondents were allowed to choose more than one option)

Full Time Nanny	26.1%	211
Partner who is house parent/works from home	22.1%	178
Family help	20.2%	163
Nursery placement	17.1%	138
Other	7.8%	63
Childminder	5.1%	41
Au pair	1.6%	13
Total		**807**

A particular concern was the lack of flexibility of some types of childcare especially important for surgeons and those in other craft specialties who may have little control over the finish time of e.g. an afternoon operating list as well as those specialties implementing shift-working patterns in order to provide 24-hour care. The optimal childcare option reported was a fully time nanny although the majority could not afford one.

Full or part time working. Just over 75% of respondents were in full time (FT) work prior to taking maternity leave. Just over 60% (Table 54) were planning to return to LTFT.

Table 53. Were you full time before maternity leave

Yes	75.2%	407
No	24.8%	134
Not Answered		684
Total		**1,225**

Table 54. Planning to return FT or LTFT?

Full time	36.4%	197
Less than full time	62.5%	338
Undecided	1.1%	6
Not Answered		684
Total		**1,225**

Just over a quarter of those returning to LTFT reported difficulties in making suitable flexible training post arrangements (Table 55). Seventy-three per cent were returning to the same post (Table 56).

Table 55. Problems arranging flexible training

Yes	27.5%	103
No	72.5%	272
Not Answered		850
Total		**1,225**

Table 56. Returning to the same post

Yes	73.0%	389
No	27.0%	144
Not Answered		692
Total		**1,225**

Overall experience. Finally, respondents were asked to rate their overall experience of maternity leave (Table 57). Thirteen per cent reported the experience to be better than they had expected. Some 61% found the experience as they had expected but this may reflect the fact that for many respondents it was not their first experience of maternity leave. It could also be interpreted as "as bad/good as expected" rather than it was "satisfactory". Some more insight is gained from some of the comments reported below.

Table 57. Overall experience of maternity leave

As expected	61.4%	444
Worse than expected	16.6%	120
Better than expected	12.9%	93
Yet to return	9.1%	66
Not Answered		502
Total		**1,225**

Respondents were invited to make individual comments about their experience of leave many of which are listed in Appendix 2. (Comments which might identify individual respondents were withheld). A wide range of views was expressed. Some suggested that women expected too much. Others supported parental leave for both parents and some comments were frankly disturbing. Of particular concern were those individuals who expressed anxieties about their future career prospects if they spoke out about the difficulties that had arisen and the treatment they had received following their return from leave.

Considerable frustration was expressed about managing a LTFT return to work, the organisational paperwork required and the multiplicity of forms (Employer paperwork is separate from that required by local education and training boards (LETBs)/Deaneries).

Some comments referred to the lack of guidance for those who had suffered early pre-term stillbirth, or for those who had multiple births.

Other difficulties highlighted included those affecting doctors who move employers including lack of rotas that gave enough notice to plan child care as well as a lack of clarity about working and on-call duties. Individuals found that pay bands were confused and salary was not paid appropriately. Some respondents expressed concern that they returned to the workplace being expected to be at the same level of competence as they had a year before but with little if any support to ensure this.

Another reported challenge which arose was when training requirements are time-based (particularly in relation to legislation that applies to foundation posts). Some employers and trainers were reported to have given the impression that women taking maternity leave were an inconvenience.

Discussion

The survey has collected a great deal of information from the 1,225 respondents much of which can be analysed to gain insights into the effectiveness or otherwise of the systems and support for those taking prolonged leave from work, particularly commenting on individuals' experiences of maternity leave.

The paternity information collected in the survey has not been analysed in any detail as it does not yet reflect the legislated opportunities for men to share parental leave. It may provide to be a useful baseline. Although previous processes for leave appear to have worked satisfactorily for the majority of male responders some, had concerns about having to pre-arrange their paternity leave around the expected date of delivery (EDD) rather than the date of the birth despite NHS Employers guidance.

When planning parental leave, individuals should have easy access to comprehensive information which will include employment and training requirements. From the results of this survey it is clear that more work needs to be done on promoting available resources to those planning parental leave. In particular, there appears to be a very poor awareness of sources of information particularly the Medical Women's Federation documents or indeed the documentation on the Academy website. The majority of respondents relied on the DH website for information. The low score given by respondents in regard to the quality of the information available makes it desirable to prepare a single document which covers all aspects of parental leave and which is widely available on all relevant websites with appropriate signposting.

The NHS Terms and Conditions do provide for parental leave and for support while on leave and on return to work. However, the extent to which the various mechanisms are offered and taken up vary very widely. For example, in addition to the statutory maternity leave the NHS terms and conditions state *"Employees are also entitled to take a further thirteen weeks as unpaid leave to bring the total of leave to fifty-two weeks. However, this may be extended by local agreement in exceptional circumstances, for example, where employees have sick pre-term babies or multiple births"*. Employees who have a miscarriage after twenty weeks or a still birth are entitled to full maternity leave. So there is flexibility built into the system to take account of differing circumstances but it is not clear whether it is recognised as being available and used appropriately.

Forty per cent of respondents who answered the question were experiencing their first period of maternity leave, the rest had other children. Perhaps surprisingly, 68% reported no family support. The majority of the female respondents had no difficulty in organising their maternity pay, although one of the respondents did have to wait an unacceptable length of time for the matter to be resolved. The majority had planned and took two to four weeks off prior to the birth of their child.

The main reported concerns both pre and postnatally are the attrition of clinical knowledge and practical skills. These were expressed in a variety of forms many centering on the expectations employers and colleagues would have of them on their return. Respondents were worried about being expected to resume working immediately at pre-leave level; that they would be expected to work out of hours immediately without supervision and that they may have missed new developments whilst on leave. Twenty-five per cent were also concerned that their concentration would be affected. Another concern was that they would not be given enough warning in regard to timetabling issues to arrange childcare. Obviously financial issues were an ongoing concern especially around childcare arrangements. Consultants respondents had anxieties about continuing professional development and revalidation.

We suggest that such concerns would be significantly reduced by ensuring that the appropriate support mechanisms are in place and are offered to those taking parental leave. In particular KIT days – although recommended by the Government, only 37.3% of respondents were made aware of them. Only 19.9% were actually offered KIT days when returning to the same trust dropping to 16.1% if returning to a different trust. Of respondents who were offered KIT days however, 73.3% were offered ten days. The lack of uptake of offered KIT days must also be addressed as only 22.9% of respondents made full use of their KIT days; 27.8% used part of them and 38.5% used none of them. The reasons stated for not utilising KIT days included lack of childcare support, not enough notice and inconvenient timetabling. Trusts should consider offering onsite childcare facilities both in conjunction with KIT days and to facilitate flexible working and shift-working. Those taking maternity leave must also be reminded that it is their personal responsibility to utilise the KIT days offered. Increasingly technology is offering distance learning opportunities including on-line resources; medical Apps and video conferencing.

All clinicians who have taken extended periods of leave should be made aware of changes to guidelines and equipment that have occurred during their absence. The anxiety associated with returning to work might be allayed by the routine offer of a period of shadowing.

NHS terms and conditions state that *"Where an employee is pregnant, has recently given birth or is breastfeeding, the employer must carry out a risk assessment of her working conditions. If it is found, or a medical practitioner considers, that an employee or her child would be at risk were she to continue with her normal duties, the employer should provide suitable alternative work for which the employee will receive her normal rate of pay. Where it is not reasonably practicable to offer suitable alternative work, the employee should be suspended on full pay".*

"Women who have recently given birth should have paid time off for post-natal care e.g. attendance at health clinics". The majority of respondents stated that health assessments are not taking place. We believe that it should be mandatory for a health assessment to take place and be fully documented in the employee's records.

Interestingly, these provisions also apply to an employee who is breastfeeding if it is found that her normal duties would prevent her from successfully breastfeeding her child. The majority of our respondents were returning to work after six months or more maternity leave so employers may expect that sole breast feeding after this would be unusual. However, if intermittent breast feeding is continuing then facilities for expression of breast milk should be available.

The Health and Safety Executive Guidance recommends that employers provide:

- A clean, healthy and safe environment for women who are breastfeeding
- Suitable access to a private room to express and store milk in an appropriate refrigerator.

It is clear from the comments of many respondents that these recommendations are not universally followed as respondents reported being expected to express breast milk in toilets, showers and spaces in communal use. Some respondents reported being forbidden access to rooms available for breastfeeding parents/patients. The comment section on breastfeeding in our survey indicates that if adequate time and facilities for breastfeeding were provided many mothers would plan an earlier return to work.

The identification and allocation of a supporting/supervising consultant would be considered beneficial but was offered to very few respondents. Even fewer were given agreed milestones and less than 3% were informed about how their progress would be assessed. When considering consultant support or educational supervisors as a resource for returning to work, those offered such support were in the small minority.

The Shared Parental Leave regulations introduced in the UK (relating to births on or after 5th April 2015) provide an opportunity for parents to take advantage of additional flexibility. Employers must have an understanding of their legal obligations and good practice procedures to use in the workplace.

Conclusions

Although the guidance and legislation relating to parental leave have improved significantly, both pre and postnatally people's concerns seem to have changed little over the decade or more covered by this survey. Concerns surrounding financial issues and childcare are common to employees in all professions. In the medical and dental professions there are significant additional concerns relating to perceived attrition of clinical knowledge and practical skills as well as the ability to keep up-to-date with changes occurring within clinical practice during periods of leave and the requirement to function fully as a clinician at the pre-leave level immediately on return. Unfortunately, as this survey shows, for some anxieties are increased when, expectations are that returners should work out of hours without supervision/support immediately on their return. Doctors are naturally concerned about what they might have missed while they were away and whether, for example, their concentration might be impaired.

With the increasing number of employees in the training grades deciding to take maternity leave and the increasing feminisation of the workforce, it is essential that steps are taken to improve the experience of those taking parental leave so that returning to the workforce is seen as easy and attractive. The extent of participation of men in shared leave should be monitored as informal feedback is that men who take extended parental leave may be considered less favourably in their future career. This is particularly important in the GP setting; specialties experiencing under recruitment and in craft specialties. If returning to work after leave is a positive experience then employees are more likely to remain loyal to their employer, increasing the stability of the workforce and reducing the costs associated with staff turn-over. In many ways the tragedy of this report is that many of the recommendations are already in place and are included in the NHS terms and conditions of work and other guidance but seem not to be consistently implemented by employers. Similarly, Deaneries and local education boards (LETB's) could improve trainees support.

We will engage in discussion with NHS Employers to consider how information gathered during this survey may be used to implement improvement. We will also ask NHS Employers to review the mechanism for inter-trust reimbursement for KIT days and if such mechanisms can be agreed to circulate guidance to employers.

The members of the Academy Flexible Training Committee are committed improving the overall experience for all those taking parental leave.

We hope that the dissemination of this Report and its recommendations via all the participating Colleges and Faculties and other organisations will make a significant contribution to raising awareness of the key issues identified and the actions needed to improve the experience of doctors and dentists taking Maternity/Paternity leave and others in LTFT.

Recommended action points

- To increase awareness of the Terms and Conditions of Employment in relation to parental leave. To ask NHS Employers to recirculate to Employers their duty and role in discussing voluntary arrangements around KIT days prior to maternity leave and ensure that the employee's returning Trust, if different, is involved in these discussions in order to agree funding support in advance of leave
  Suggested action: NHS Employers, Unions

- To remind employing trusts of the requirement under the Terms & Conditions of conducting a risk assessment for pregnancy; breast feeding and all mother's returning from maternity leave
  Suggested action: NHS Employers, Unions

- To recirculate the Health and Safety Executive Guidance on breastfeeding to ensure that suitable facilities and working conditions are provided to facilitate continued breast feeding
  Suggested action: NHS Employers, Unions

- To recommend to employers that trainees returning from parental leave have a designated consultant who will be available support and advise during the first three months of their return to work
  Suggested action: NHS Employers, Unions

- To circulate links to useful information to Colleges; LETB's and Deaneries to promote and support available resources for those seeking to take parental leave
  Suggested action: the Academy, Royal Colleges, Unions

- Employers to make available to those taking parental leave information about changes and developments to guidelines, procedures or equipment during their absence
  Suggested action: Employers, HR

- Recommend that all employers have an obligation to offer work 'shadowing' to employees returning from leave
  Suggested action: Employers, HR

- Recommend LETB's and Deaneries to undertake annual review that appropriate health checks are undertaken prior to trainees recommencing work after a period of leave
  Suggested action: LETB, Deanery, Employers' Occupational Health depts

- Recommend the development, provision and expansion of on-site late opening childcare for health care workers with on call commitments or in the craft specialties.

Appendix 1:
Survey questions

Survey questions can be found here:

https://www.rcpworkforce.com/se.ashx?s=253122AC10E6E285

Appendix 2:
Concerns about work

Before you had your leave, what things were you worried about being effected by your time away from work?

Keeping up clinical competencies
I worried about my trainee to the extent that I worked PT during my mat leave with both children (more with first) since we had just secured our 1st SpR & I was single handed cons (colleague left) & dearth of locums.
Took full allowance despite worries as viewed time at home as a priority & work v supportive
Applying for speciality training
Academic progress
The ability to find locum cover for me
Clinical skills
Length of training
Clinical ability
I was doing a distance learning MSc and had concerns about completing that
Getting my next job (in both cases, my maternity leave was at the very end of a post)
Professional development
Clinical competence and perception of being lazy
Career Progression
Completing CMT training on my return in a short space of time
Confidence, competence, time taken to achieve CCT
Having a training job to return to complete my training
The job I would be returning to
CPD,
Reaction of senior colleagues
Making friends trainees when I returned to training

I worried about the effect on my children of being there and then not
Returning to work whilst breastfeeding
The opinion of colleagues about my decision
Getting a new job as my post was ended
Effect on applying for Grid training
Training
Forgetting clinical knowledge; being out of step with my peers
Clinical ability, keeping up to date with medical developments
Organising return to work
Confidence in my clinical skills
Finding another part time job after maternity leave
Maintaining medical knowledge
Microsurgical skills
Break from surgery
The impact on my career
Loss of confidence at work, commitment to work
Losing confidence in clinical skills
The impact on my exam
Effect on applying for consultant jobs
Keeping my CPD up, carrying over and trying to use my Annual leave, HR troubled me about it
My peers moving on and needing to be in a new "year group" on return. Returning part time/arranging job share
Getting a consultant post, CCT date which falls during mat leave, changing trusts during my leave
Keeping up to date with clinical practice
Career progression

Whether the parental leave was adequate enough for when my child got ill, as we have no family nearby to help.
Ability to stay up to date
Procedural competence
Effect of workload on colleagues; effect of my absence on services and governance issues I had worked hard on to improve (governance lead, audit lead, junior doctors lead)
State of my work on return as single handed
Needed to lead a major change in my department
Effects on my capacity to work at the same level as when I left
Success at work
Research - I was writing a PhD at the time
Applying for consultant position whist on mat leave
Professional progression
Concern about convincing colleagues that Ii was committed to career and post
How I would find it at work returning to work. How I would cope with balancing looking after my child with working.
Maintaining the service at work.
Potential changes to my job role on my return
Career progression and perceived level of commitment
Failing marriage
Whether (as in fact happened) any of my work got done at all when I was away, I returned to find a lot of organs in formalin and incomplete reports done by unsupervised juniors
Extending duration of training
How I would manage to get a job on returning to work, as previously locum
Pension entitlement
Post graduate exams on my return to full time work
Cover for the work as there were only 2 consultants
Colleagues opinions of my desire to progress in my career

Finishing research write up
Getting a consultant's job
Parts of my job being taken on and taken over by colleagues, losing my office
Wanting to return part time but consultant said no
Effect on staffing levels of training rotation and impact on colleagues
Colleagues do not view you with the same respect when you are less than full time.
My clinical effectiveness
Threatened by my department to have me thrown off rotation if took maternity leave
Guilt
Completion of training
My desire to continue working as a doctor
Study leave
Husband got a consultant post in another part of the country so had to relocate and change deanery
Perception as a less than committed trainee
I was a single handed consultant and HR said they would interview for a locum but may not appoint! so patient care was my main concern and the strain on my clinical assistant who did not do on call
Next attachment on rotation & arranging accommodation etc.
Leaving colleagues short-staffed.
Keeping up to date with clinical skills and CPD
Effect on next placement and continuing in the same roll
Being seen as less committed by training committee
Having to move area

Appendix 3:
Free text responses regarding breast feeding

Reduced breastfeeding to morning/evening only in order to go back to work.
Concern re shift work and breast feeding
Feeds were already down to 1 a day
There is currently enough time in my day to express, and facilities. It has not been discussed.
I originally planned to continue breast feeding once I had returned to work doing 1 feed a day for as long as the baby wanted it. We only managed it for a month after I returned to work as I came down with recurrent tonsillitis and my milk dried up. I did not have the energy to try to regain my supply as I was completely washed out from being ill and really stressed by full time working. I therefore gave up when my daughter was 8 months old but had I not returned to work then I would definitely have carried on longer. There was no way I could express at work. My job was so busy I barely had time to pee let alone express. I do not know where I would have stored the milk either.
Used work as an excuse to stop breast feeding
Liked the idea of pumping - but not enough hours in the day
I was the first woman consultant in the department to take maternity leave. The men were far too nervous to say anything about me expressing milk. I had one hilarious moment when a new and very ardent young consultant stated to the nurse who was trying to move him away from the screen behind which I was expressing milk that 'Every patient on the ward is mine', and ripped the curtains open to discover me and a breast pump!
I adapted the feeding regime from four feeds a day on days off to twice a day on work days. Amazing how flexible babies and breasts can be. Managed to 1 year both times.
Stopped breast feeding as nowhere to express and too uncomfortable with "exploding" breasts in theatre at end of day, especially with unpredictable finish times.
Fed my third child for as long as I wished long after my return to work but worked part-time. Not quite so true of my other two children
Not practical to continue breastfeeding on return as baby in nursery and my long hours at work
I stopped prior to return to work as I felt the two were not compatible given the nature of shift working and unpredictability.
Only doing night time feed and stopped soon after starting work but probably time to anyway
I was back to on call, which meant I was tired, and I was not able to continue breastfeeding. I was ok with this, as I had fed them successfully for nearly 6 months.
I just got on with breastfeeding and expressing milk. I did not need to involve my employer

Room set aside for breast feeding had been used instead for storing boxes - no space for anything! But the travel and the shifts meant I had to stop anyway.

I was the only female in the entire department so it was not feasible to express milk or discuss anything with colleagues

7.00 am feed. Morning surgery. Home for 11.00am feed. Visits. Home for 14.00 feed. Evening surgery. Was told off for feeding in the surgery.

This became very difficult with work pattern.

I dashed home at lunch time to breast feed....

Gradually reduced breast feeding 2 months prior to the joining date

Starting to transfer over to formula at 6 months before restarting work at 7.5 months. Baby refused to combine feed so had to go to formula completely. This was only because of returning to an on call work schedule, as with nights and long days, I would have struggled to express (particularly in paeds when around crying babies) and would have been embarrassed as I would likely have leaked if not had the opportunity to regularly express. Had I not returned to work at 7.5 months (due to keeping up with training start times), I would have preferred to continue breastfeeding until 9-12 months.

I breast fed all my children. I managed to continue feeding the eldest as I returned to work 70% and used an on-call room to express (personal arrangement with the ward team). I did not think this was feasible for the two younger children as I returned full time and had no suitable facilities apart from a bathroom.

Being out of the house for close to 12 hours a day and with out of hours' commitment meant it hard to continue and I ended up stopping earlier than I had planned to.

I weaned my son in order to attend a national conference where I was speaking

I made sure that I weaning started before return to work so that morning and evening feed only needed, I had a regular 9-5 pattern of work

Despite support at work, on a FT shift, in a busy unit, expressing and breastfeeding was difficult to maintain.

Planned in advance on breast feeding times on return to work

I was on an un-banded job on return to work with regular lunch breaks therefore expressing was easy to do. I had to stop breast feeding when I went back onto out of hours shifts as I was not able to be at home when it was needed. But, this tied in with giving more solid food, so the timing worked out well for me.

I was told I was the first doctor ever to have raised the issue of needing time and space to breast feed. As I was a foundation trainee and therefore moving placements frequently the trust was unable to find me a breast feeding space. I was told to go to the maternity department who needed their rooms for their patients. I was then offered a cancer relatives room but was interrupted mid expressing as it was needed for relatives. I ended up expressing in a toilet. No time was given to do this, I would have to incorporate expressing into 13-hour long on-call days and nights.

With my first pregnancy I returned when my daughter was 6 months and planned to continue breastfeeding. The Trust was inflexible and would not accommodate this. There was little/no understanding of needing to express whilst at work and no facilities provided. Subsequently I stopped feeding my child due to this. This meant that when I had my second child I booked a year maternity leave so I would not have the same issues.

I wanted to stop breastfeeding before working night shifts. I felt it was unfair on my baby and husband for them not to have me there to settle my baby down with a feed. I therefore wanted to have allowed time before my return to work to get my baby used to settling without nursing to sleep
Expressed at work past 1-year-old.
I planned to have weaned her off breast milk in order to return to work.
Previous experience of breastfeeding whilst back at work was very negative, so deliberately avoided doing this again.
Struggled to express as often as I would like and eventually my supply dried up. I wanted to breast feed until 18 months, but only managed about 13-14 months, due to returning to full time work from 9 months
I reduced to twice daily so I could feed pre and post work. However, shifts mean sometimes even this is interrupted and there's no way to express during a busy medical on call!
Would have been unmanageable to express and work so was happy to stop
No, because I took a full year off. I breastfed for 11 months though, so if I had had to return sooner than I wanted to for whatever reason (financial, training considerations etc.) I would have had to stop sooner than I wanted to.
Stopped breast feeding with 1st child at 3 months as I could only take 18 weeks and had already taken 4 weeks pre-birth. She was 2 weeks late so returned when she was very little. Work was 20mins away and had to work 10 hours a day.
Was only once a day by the time of my return. I would have found it very hard work to continue breast feeding as long as I wanted (i.e. 1 year) if I had returned at 6 or 9 months.
Night shifts and long days meant I wouldn't be home to breastfeed- my child wouldn't take a bottle.
I returned to work after my first child but only stayed on for three months and then resigned. One small factor in this was that I was asked to do on-call commitments and would have to have given up breast-feeding in the evenings in order to do this.
Started to introduce formula from 5 months plus in anticipation of returning to work
I knew I had to come back when my son was 6 months old and I did not want to try to combine work and breast feeding so deliberately stopped at 5 months.
I independently decided to contact occupational health to inform them I was still breast feeding. As my son was 11 months it seemed to surprise them that I was breast feeding. They did not provide any assistance as I was only feeding once in the evening, but I would've expected to be asked as it im-pacted on levels of fatigue and comfort with working 12 hour shifts.
Pumped in my own scheduled breaks during surgery. Pumped for a year after returning to work. No locked space but provided with 'do not disturb notice'!
Unable to get home in time for feeds
Had to stop breastfeeding earlier than I would have wanted as I had a long commute daily to work and there was no place to express or store breast milk at work
No time to express during the GP work day so had to suffer painful swollen breasts by end of day
I arranged with the neonatal unit to use their expressing room, and if it was not possible to leave de-

livery suite/during night shifts, our midwives were extremely supportive in finding me a room to express. However, I did sometimes not have time to express during a 12.5-hr shift, and usually would only express once (my daughter was feeding 2 hourly when with me). More of a problem was when I was not on call, as morning and afternoon sessions frequently ran into each other without any break for lunch, and my supervisor was not very accommodating of this. I would find myself expressing sitting on the floor of theatre toilets between theatre cases etc. and having continued worries about discomfort, milk supply, and trying not to disrupt my professional duties.

I had concerns about de-skilling in microsurgery during my maternity leave. There was no support on return to my consultant post to help regain these skills after several months' absence, which would have helped. It would have been easier for me to take the maternity leave during a training post when there would have been senior supervision of my surgery.

I felt it would be impossible to take time out of work to express

After my first maternity there was a private room but only because it was a neonatal unit, but time was sometimes difficult to get. After my second maternity it was quite difficult to get the time and there was no private room designated for expressing, you had to find your own room if any of the cubicles were free.

It was easier than I anticipated to continue with twice daily feeds when I returned to work. I was ready to give up when I did so at 15months. However, my baby would have preferred to continue with morning feeds but this was difficult with shift work.

I am a staff grade anaesthetist, returning to work nearly 13 months, the last 8 weeks of which was annual leave. I carried on working right until 37 weeks. I was very organised and had planned my MAT leave, with involvement of both my clinical director and the HR Mat leave officer, as early as possible i.e. after 21weeks of pregnancy when my midwife signed off the MATb1 certificate. I was the first specialty Dr in my department to ever take maternity leave (the others are older men!). Despite this when I tried to use my annual leave carried over plus accumulated while I was on MaT leave, I was troubled by my HR dept. In the interim my dept had a new Clinical lead and the previous one was not at all helpful. Not being a trainee I had no help/ no one to turn to help at all. This was eventually resolved after a LOT of emails, stress and nearly 6-8 weeks on communication time, all efforts on my behalf alone. Being an immigrant in the UK, I have no family in the UK except my husband who was completing his PhD and I was the sole carer for my 2 children, both of them less than 5 years old. It was hard both physically and financially.

The other thing which bothered me was the GMC revalidation. I was due to revalidate in Oct 2014, less than 8 weeks after joining back. Despite trying to contact the responsible officer at my trust **for 1 year** prior to this date (I have emails to show for both these things) she never responded. I had to physically go to try to meet her many times and **still** have never met her. Eventually 6 weeks before my revalidation was due, the secretary to this lady set me up with a Zircadian account, the online company my trust is using for revalidation. This was done incorrectly so that I could not add any information to it and had to further this secretary to amend it. I wrote to GMC revalidation help desk, they simply referred me back to the responsible officer, who was unreachable and said they could not decide on a deferral. I tried to explain to both of them that as a staff anaesthetist I mainly work alone, most of the time on Intensive care and its difficult to get the required 360-degree feedback from patients, impossible to do in less than 8 weeks I had, this on top of the fact that I had been away for nearly 13 months. Both the responsible officer, **by not responding at all** and the GMC, by sending me regular letters did nothing but add to my stress. I believe I am a good, conscientious doctor and anaesthetist (MD DNB from India and FRCA from the Royal college) but I am also a wife and mother to

2 young children, both at them time less than 5 years of age. Returning to work as a specialty Dr in a busy anaesthetic dept, with a full shift on call rota, covering paediatric emergencies, maternity ward, and ICU in London is both physically and mentally challenging. I enjoy by work enormously and I enjoy being a mother enormously. However, I did not need this extra stress, unnecessarily. This on top of worrying about losing my skills (my specialty is very hands on) and not being able to attend any meeting/courses throughout the year, as I am still breast feeding (most places will **not** take a baby) and was the sole carer for my older child as well. I must say that clinically, going back to work at my friendly department, was fantastic. My new clinical lead was very supportive; trainees, other consultants and specialty Drs, nurses and ODP could not have been more supportive and loved the fact that everyone I met was happy to see me back. This was very touching.
Was only feeding twice a day so wouldn't have needed to express at work
I took the maximum time allowed for mat leave so that I could breast feed for longer. (My baby stopped at 11 months quite easily). My first mat leave I returned sooner -8 months for finances and to fit in with my training scheme posts, I was still breast feeding and found it very awkward to express at work and get home on time for a bed-time feed.
Reduced breast feeding to morning and night for a while. No time or facility to express at work. Expressed during leave and built up frozen supplies.!
Fully supported by colleagues and own department as seen as crucial for my own future work (in maternal and child Health!) that breast feeding went well for me alongside work. It did. I was fine. Both babies were fine and I continued breast feeding each one up to 18 months, and have had high credibility throughout my career when advocating breast feeding as best for a baby.
Due to night shifts etc. I stopped breast feeding to return to work
Stopped feeding during the day with all 3 children on return to work
I didn't need to express during work hours, as I had reduced the breastfeeding to evenings/night time only when I went back to work.
Stopped at 9 months so that this stress was taken away from my return to work, I would have continued for at least the first year of my daughter's life if I wasn't returning to work
Long shifts meant unable to feed
Returned at 10 months so had stopped by then
My new department (which I had already worked in as an SpR) were extremely supportive about my return to work as a new consultant, and were keen to offer extra support e.g. for post-takes etc. as needed.
But it was really hard work - I found myself expressing into sputum pots in the lavatory of the respiratory ward where I worked as there was not time to walk all the way back to the offices to do it properly!
Could not avoid travelling and nights away from home for more than a few months
I returned to work as a flexible trainee and it did not affect my breast feeding as working some half days
In my opinion breast feeding after returning to work is not practical, even if a space is provided for expressing breast milk.

Although facilities were offered, I did not use them as they were not particularly attractive/suitable. Flexed my hours so I could go home to do so
I continued to breast feed for another 9 months after returning. I would NOT have wanted special treatment.
Had to express milk in the lavatory as there was no-where else - maternity refused to let me have access to their areas
Stopped breast feeding during the day due to returning to work and shared leave with father of baby who needed to be able to feed whilst I was away. Continued to feed in evenings/at night.
Although in theory there was somewhere to express there was no cover to be able to get away.
After 48 hours back at work - was no longer able to breast feed - just general business.
A private space was offered, but was someone else's office, and not really ideal as had to ask them to leave if needed to express, was not an ideal environment to express
Had to adjust timings of feeds to fit in with the working day that would not have otherwise done
Just fed at night for a while.
I continue to express milk in the evenings, but I am unable to express enough to meet my child's requirements. There is not enough time during the working day to express at work.
I chose to return to work early as there was potential to further my career. In the long term, this was more beneficial to my children. Getting jobs was very competitive in my day. At the moment, trainees have very little commitment to work or their careers.
Did not have time to express twice per day as planned. Stopped a bit earlier than planned due to having to travel for a meeting away from home for 2 nights.
Managed to keep to early morning/ night time feeds with bottles/food in day
I chose to stop breast feeding before going back to work as I knew it would not be possible to express at work due to time/job commitments so felt it was better to have stopped rather than be stressed about not managing to express.
Too busy to make time. Milk production goes down and then stops when you are running around and not expressing frequently
My department was fantastic about providing me with a private office to express milk in. We have since moved to a more modern department with large floor to ceiling windows into each office - I was quite embarrassed about asking for a more private office (in case I want to get pregnant and breast-feed again in the future).
Difficult in practical terms as still had to carry bleep and make up for missed time during expressing.
With my first child I returned to work after 6 months and tried to continue feeding but could not adequately express during the day so supply became inadequate. For my second I made sure she was well weaned prior to returning so I didn't have the same problems.
By the time I returned to work my daughter was able to manage without a breastfeed
I had to make my own time to express, but I had my own office which made it possible.
Although on a Monday expressing was easy but by Friday much more difficult presumably because of

pressures of work
Only still breast feeding twice a day morning and evening so did not need any facilities to express at work
Had already started weaning as baby 7 months, had never been able to express so continued morning and evening feeding, and finally gave up evening feed at around 20 months. If the baby had been younger, it would have been tricky to express at work and store the milk. My return to work was on my terms re baby/feeding etc. and I would have delayed return if I felt my choices were being constrained
Endured very rapid withdrawal of breast feeding as rapidly realised it was not compatible with hours of working.
My employer was wonderful when it came to supporting me continuing to breast feed on returning to work.
In my first pregnancy I continued to breastfeed after my return to work, but only in the evening. With my second pregnancy, I stopped breast feeding after 3 months purely so I could continue with a weekly course I attended as part of my career progression - I really regret this.
I stopped with my first child at 10 months although it was going well & we both enjoyed it, because I had to do on calls and at that age didn't feel it justified the logistics that would have been involved. With my second son, I was working close to home, and continued at night.
I continue to breastfeed my 2-year-old. The only effect it has is it probably makes me more tired than I otherwise would be. But being a part time trainee and a full time mum couldn't be much more tiring anyway!
I exclusively breast fed until 4 weeks before I was due to return to work. I did not feel it was practically feasible to return to work full time and express at work. If I could have taken longer on maternity leave I would not have stopped breastfeeding. It was quite stressful introducing a bottle - baby refused to drink from a bottle for about 2 weeks. I only managed to fully wean the baby onto a bottle 3 days before I returned to work.
It was so hard. I was just exhausted all the time. It's a bit better now but still hard.
I tried to continue breast feeding only morning and nights as I didn't want the hassle of expressing at work but my milk dried up and my baby also got used to the bottle.
I was asked to go back on the infectious diseases on call rota despite being on research time. I was pressurised to go on but with Ebola as a clinical concern I felt breast feeding and the risks of Ebola were too high. It was difficult to give this as a reason.
I did not inform my employers that I was continuing to breast feed as it did not really impact on my work duties.
Planned my return to work for when I thought I would want to stop breastfeeding anyway. Really don't think it would have been feasible for me to return to work whilst still breastfeeding
Sent on placement away from home for two weeks. When I protested (that I couldn't get childcare at the placement) I was reminded that it would severely affect my career if I didn't go. I left the baby at home and the children in charge of a friend and was forced to stop breastfeeding.
Continued to breast feed before and after work - affected sleep patterns.
As stress levels were higher on return to work I was not relaxed enough to be able to express and continue breastfeeding.

Did have to reduce feeds to twice a day earlier than I'd have ideally liked to as was at work 3 days a week
I had to reduce the frequency of breast feeding because of working hours - which was a problem as my son wouldn't drink more than a few sips of any other fluid all day!
I did not return to work until I finished breast feeding and planned to feed each child (2 lots of maternity leave ran together, unplanned) for 12 months
Line manager happy to accommodate and find out about facilities for expressing milk but I was unable to physically express anything. Perhaps related to the room or time of day or concern about taking time away from work to actually to do it. Line manager had never previously had a request to allow expressing milk.
My specialty was perinatal pathology. Absolutely no consideration was given to how I might feel doing post mortems on babies and foetuses when I had just had my own baby pre-term and a miscarriage. The consultant in charge refused to consider part time so after 3 and a half months I left and then did not work as a doctor for another 8 years. When I returned to pathology, things were made very difficult for me to get CCST which had been introduced in my absence.
Too late back from work to feed baby in evening so naturally had to give up - although fine as showed she didn't need it.
Too tiring breastfeeding and working full time reduced to early morning and night feed initially and then stopped.
I stopped the week before returning to work as did not feel I had the time or the energy to express milk for bottle feeding at nursery.
Not given time to express and under pressure to get through work
Preparing for royal college exams meant I had to leave the baby for several hours, hence gave up breast feeding earlier than I preferred.
I am still breast feeding but my child has cow’s milk when I am at work.
I was overtired and stopped producing breast milk
After my first maternity leave I stopped breastfeeding about a month after returning to work. After my second maternity leave I continued breastfeeding for about 6 months after returning to work, but the only place I could express was a shower room that was often in use. On one occasion I was interrupted mid - expressing as another member of staff wanted to use the shower.
I was breast feeding when I returned to work and wished to express one feed per day. The consultants in my department were fully supportive but the hospital had no designated space for me to do this. It was very difficult to find out where I could go. HR were unhelpful. OH told me there was a designated room on the postnatal ward but when I asked to use it I found the staff had no knowledge of this arrangement and I was told to sit in the staff shower in a changing room. I was forced to use this arrangement until the NNU ward manager allowed me to use the expressing room in the unit - but I was asked to change clothes each time as I was a "dirty" microbiology registrar. This was a difficult few months!
Time and space to breastfeed at work were not offered, but were not required, as my daughter now only breastfeeds at bedtime.
I would've continued breastfeeding up to a year if I didn't have to come back to work.

The hospital had no formal place to express. I had to find an office in a Portakabin. My breast pump could be heard loud and clear by everyone. I stopped using it.
I continued feeding but didn't express at work as it was never really offered and didn't want to make a fuss. Once had to express in the toilet at work at dump it as I was painfully full in later part of 13hr shift.
Impossible given my specialty (emergency medicine) to be able to regularly express milk in a quiet clean environment.
I wanted to stop prior to returning to work as I felt it would not have been possible to continue whilst changing shifts from late, nights etc.
Would have breast fed for 1 year if I had not returned to work at 9 months.
I was mixed feeding, so breast fed the infant when I got home.
My son gave up the effort of feeding!
Reduced frequency of breast feeding prior to return to work
Being a busy Medical Registrar means you work different hours and different times every week – this effects on milk secretion They say it is important that you are constantly thinking or reminded of baby at work to keep secretions going. That was next to impossible - I remembered him only when I went home again
Started to cut down on breast feeding knowing I was going to return to work and it would not be compatible with working hours/ on calls. Had I not had that deadline I may have continued longer and therefore not have to have introduced formula. Difficult to predict as you can only deal with the reality of the world you live in, not returning to work was never an option!
Yes. It was too difficult to express at work as it wasn't easy to leave ward rounds/MET calls/other emergencies to go and express. I was working in A&E and ITU. I was constantly worried about leaking. All of this affected not only my supply, but also my relationship with my baby and at six months old she went on a nursing strike. Our breastfeeding stopped there which is far short of the WHO guidelines and my wishes for the health of me and my baby. I returned to work when both my babies were four months old as we are constantly short of money due to student debt and low levels of pay. I am the full time and main earner in our family. When my baby was eight months old I had my 50% banding removed with one week's notice. I had to locum on all my days off, and failed my exam which then held up my career progression by a year. None of this is acceptable to force on a breastfeeding employee who is the mother and main earner for young children.
I got fed up of having to express in the disabled toilets, plus I often got bleeped whilst I was doing this.
I planned reducing to morning and evening breast feeds when returning to work
It is really difficult to maintain breastfeeding if you are not able to express milk regularly.
It has made on call commitments very difficult as it was important for me to be able to continue breastfeeding. There is very little recognition of that, especially the importance of continuing to breastfeed older children. My children didn't eat very well and still relied heavily on breastmilk when I returned to work even though they were a year old.

Appendix 4: Resources

Return to practice guidance published by Academy of Medical Royal Colleges
http://www.aomrc.org.uk/doc_view/9486-return-to-practice-guidance

British medical association guidance for working parents
http://www.bma.org.uk/support-at-work/working-parents/returning-to-work

Medical Women's Federation guidance about pregnancy and maternity leave
http://www.medicalwomensfederation.org.uk/campaigns/284-pregnancy-and-maternity-leave

NHS Employers guidance about maternity leave
http://www.nhsemployers.org/your-workforce/retain-and-improve/managing-your-workforce/flexible-working/maternity-leave

Department of Health
http://www.nhs.uk/conditions/pregnancy-and-baby/pages/maternity-paternity-leave-benefits.aspx

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