Safe staffing Levels – Obstetricians

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Key Amendments

Date	Amendments	Approved by

To provide safe, consistent and quality patient care the Royal College of Obstetricians and Gynaecologists (RCOG) has set standards for consultant on-call for labour ward based on the clinical activity and number of births per year in the unit. Ideally in the future, there will be 24-hour Consultant presence in the majority of obstetric units as work patterns evolve. Until then, it is recommended that the Consultant must be available in the labour ward when they have a fixed session there and their presence is needed and should be available for telephone advice at all times while on-call. Although maternity units around the country are working towards compliance with RCOG standards for Consultant labour ward, at present, the ideal standards for consultant labour ward cannot be achieved by most units in the country. There are no comparable targets for Gynaecology care.

Background On The Service / Staff Utilisation

In Worcestershire Acute Hospitals NHS Trust (WAHT) a Consultant on each site is responsible for planning the rota and any alterations that have to be made. In order to prospectively plan cover, all Consultants should give at least 8 weeks notice prior to proceeding on leave. If a Consultant has to be absent at short notice for whatever reason, the rota organiser will arrange for another Consultant to provide Consultant cover. If a short term emergency locum Consultant cover is to be organised, the secretary to the general manager of the directorate will organise this through a locum agency after the applicants CV is approved by the Clinical Director. Short notice arrangements or difficulty with cover is discussed with the Clinical Director.

On both sites there is 1 obstetric theatre located on the delivery suite with an intervention suite adjacent to the Obstetric theatre on Worcestershire Royal Hospital site, emergency gynaecology operative work is carried out in the main theatres. The obstetric theatres are located on the labour ward. Elective obstetric procedures should only proceed once the Consultant obstetrician and Consultant anaesthetist have assessed the activity and staff availability on the unit. Due to the location of theatres on the delivery suite the Consultant on call is easily accessible should an emergency arise.

Required safe staffing level Obstetrics

In WAHT the Obstetric & Gynaecology directorate is making all the efforts to achieve the standards set by RCOG.

- Delivery suite in Worcestershire Royal Hospital (WRH) with approximately 4000 births per year is a category **B** maternity unit requiring 60 hours Consultant presence.
- Delivery suite in Alexandra Hospital Redditch with approximately 2200 births per year is a category **A** unit requiring continual staffing review to ensure adequate Consultant support for delivery suite matters.

On both sites there are 3 tiers of obstetric cover – lower, middle and Consultant. On each site there are 8 middle grade doctors (Specialist Trainees years 3-7 or Specialty doctors or trust doctors) providing the middle tier obstetric cover in a 1:8 shift system. This is compliant with the European Working time Directive (EWTD). There are also 8 lower grade doctors on each site (Specialist Trainees years 1-2 or

Vocational Trainees) providing the lower tier of Obstetric cover in a 1:8 shift system.
This is compliant with the EWTD. Vacant slots and shifts are filled with short and long-term locum doctors.

Worcestershire Royal Hospital: consultant presence in delivery suite

There are 7 full time and one part time consultants participating in obstetric on-call-rota (1:8). There are 5 obstetric consultants (A-E) who provide daytime labour ward cover as shown in table 1 as part of their job plan. When the day time consultant (A-E) is on leave or absent, the on-call consultant for that day provides the day time labour ward cover, or another arrangement for consultant cover is organised by the rota organiser.

Table1:

MON	TUE	WED	THU	FRI	SAT	SUN
Cons A 0800-1700 On-call cons 1700-2030	Cons B 0800-1700 On-call cons 1700-2030	Cons C 0800-1700 On-call cons 1700-2030	Cons D 0800-1700 On-call cons 1700-2030	Cons E 0800-1300 On-call cons 1300-2030	On-call Cons 0800- 1300 Bank Holiday On-call arrangements will be similar to week end cover	On-call Cons 0800-1300

The consultant covering obstetrics will carry out a labour-ward round in the morning starting between 08:00 and 08:30, in the afternoon at approximately 1300hrs and in the evening at approximately 17:30. The on-call consultant will be present for the evening middle grade handover and may carry out a labour- ward round in the evening at around 20:30. .

The SpR may contact the consultant on call at any time for advice, management decisions or to attend the hospital (see below).

Alexandra Hospital: 40 hour consultant cover in delivery suite

There are 6 full time consultants participating in obstetric out of hours on-call rota.

Each of the current consultants provide between one and two dedicated labour ward sessions a week to ensure 40 hours obstetric consultant cover. The consultant presence is currently provided Monday to Friday between 09:00 and 17:00 hrs. The consultant is present for the Handover ward round at 20.30 hours. Outside of these hours the associate specialist or registrars cover the labour ward and have 24 hour access to the consultant obstetrician on-call. An electronic duty rota will be available in all clinical areas at all times..

The consultant covering obstetrics will carry out a labour-ward round in the morning at 08:30, in the afternoon at approximately 13.00 hrs and in the evening at approximately 17:30. The on-call consultant will carry out a labour- ward round in the evening at around 20:30,

The SpR may contact the consultant on call at any time for advice, management decisions or to attend the hospital (see below).

Consultant's role in labour ward:

The Consultant on-call for obstetrics must be available in the labour ward when they have a fixed session there and their presence is needed and available on the telephone for advice at all times while on-call. Outside the hours of resident duties they will beavailable to attend within 30minutes for cases of emergency.

Their role encompasses providing a service for those patients who require senior medical assistance while at the same time undertaking routine procedures when there is a need to do so, due to the workload on the unit.

- **Teaching & training:** The Consultant's role starts by demonstrating leadership and teaching and supporting trainees, midwives and nurses at all times. Obstetrics is an apprenticeship-based specialty and the Consultant must be present to ensure that the trainee is taught and supervised properly. The Consultant must be nearby at all times until the trainee has been assessed as fit for independent practice.
- **Supporting staff:** In particular, the presence of the Consultant is required when adverse events or poor outcomes occur. Asking the consultant on call to attend during these difficult times will be invaluable support for the mother and her family, as well as the staff.
- **Respond to call for help**: Doctors at every level have a duty to call for help if they feel that a clinical situation (even outside the list below) requires the direct input of a consultant. Trainees must always feel able to discuss things with the Consultant and should be encouraged to ask the Consultant to attend if needed. A trainee's request for a Consultant to attend should be stated in clear, precise terms, so that there can be no misinterpretation. The request should be documented in the notes.
- **Jump call**: Senior midwifery staff should contact the Consultant directly if it is considered that ***the clinical situation requires senior medical input*** (known as 'jump call'). Consultants should respond positively to requests for assistance from staff covering the labour ward.
- **Attend in person:** In the following situations, the Consultant should attend in person, whatever the level of the trainee:
  - Eclampsia
  - Maternal collapse (such as massive abruption, septic shock)
  - Caesarean section for major placenta praevia
  - Caesarean section at <28 weeks of gestation
  - Postpartum haemorrhage of more than 1.5 litres where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated
  - Patient requires return to theatre – laparotomy
  - Uterine rupture
  - Uterine inversion
  - When an unwell antenatal/ intrapartum or postnatal woman requires transfer to another hospital.
  - When requested by staff.
  - In rare Obstetric situations where the medical and midwifery staff are not familiar eg Maternal Fits- Unexplained; Difficult delivery or trial needed for stillbirth; Shoulder dystocia where all the routine manoeuvres fail;

- **Attend in person or immediately available** For the procedures listed below, the consultant should attend in person or should be immediately available if the Middle Grade Obstetrician on duty is a relatively junior Specialist Trainee (ST3/4/5) or has not been assessed and signed-off, (by OSATS where these are available) as competent for the procedure in question:
  - vaginal breech delivery
  - Review of labour management and delivery of twins / higher order pregnancy twin delivery
  - trial of instrumental delivery in theatre
  - caesarean section at full dilatation
  - caesarean section in women with body mass index greater than 40
  - caesarean section for known transverse lie
  - caesarean section at less than 32 weeks of gestation

- confirming intrauterine fetal demise
- when antenatal/ intrapartum or postnatal woman presents with or develop acute medical/ surgical illness requiring senior multidisciplinary input.

Consultant's decision to attend When a senior trainee (ST6/7) is on call it is the Consultant's decision whether to attend when the situations above occur.

Doctors in non-training grades: Doctors in the non-training grades should complete a self assessment competency form and have their capabilities and experience assessed so that a clear decision can be made as to the level at which they should be working. The doctor should then have the same cover as a trainee with equivalent experience.

Handover: If there are any high risk obstetrics, high dependency care or ITU cases there should be a formal handover (by telephone call or in person) between Consultants following a period of on-call. This is to be clearly documented under the SBAR system.

Required safe staffing level Gynaecology

There are no formal guidelines available for the presence of Consultant Gynaecology staff, however, in the interest of providing safe, consistent and quality patient care the Directorate have agreed that all emergency admissions will be seen or discussed within 14hours of admission and all emergency admissions will be reviewed by a consultant by 24hrs after admission.

Unless there is a senior post CCT trainee or experienced Associate Specialist/staff grade doctor with adequate skills to conduct an independent gynaecology outpatient clinic (with named telephone support for queries), gynaecology outpatient clinics will be cancelled in the absence of a consultant.

The Directorate have agreed that gynaecology care will provided as follows:

All emergency cases (except straight forward ERPC procedures and Bartholins abscess procedures) must be discussed with and approved by the on call consultant before listing.

1. The consultant must be present or available in the theatre department for all gynaecological surgical procedures performed by trainees at ST3/4/5 level (with the exception of straight forward ERPC procedures and Bartholins abscess procedures)
2. Gynaecological surgical cases can be managed by ST6 / 7 trainees without consultant presence according the skill level of the trainee but the consultant must be informed by the trainee when the trainee is taking cases to theatre.
3. The consultant must be present in theatre for ERPC in cases of suspected molar pregnancy, post natal and post CS ERPC and repeat ERPC.
4. The consultant must be present for all return to theatres following gynaecological surgery.
5. The consultant must be present for any patient with haemodynamic compromise secondary to bleeding with miscarriage or ectopic pregnancy.
6. The consultant must be present for any patient with septic shock.
7. All elective surgical cases must be discussed with and approved by the responsible consultant before listing.
8. All cases of termination of pregnancy must be discussed with a consultant involved in the patients care before the termination is commenced.
9. Breaking bad news or communication in the event of unexpected outcome should done by the responsible consultant or the on-call consultant except where delegation is judged appropriate to a senior trainee following discussion with the consultant.

10. Only staff with certified training are allowed to use the ultrasound scan machine on Lavender Gynae. Trainees must not use this machine without supervision if they have not been signed as competent in ultrasound scanning by a consultant at WAHNHST.
11. The Directorate bleep policy should be followed which states that nursing staff must contact the superior tier of medical staff if a bleep is not answered within 10 minutes or if a patient isn't reviewed within 30 minutes of accepted bleep. Exceptional circumstances would arise if the on call team are busy in theatre.
12. DNR status should be signed by the responsible or on call Gynae consultant when appropriate.
13. All matters and patient care that raise any concern must be referred and discussed with the Consultant gynaecologist on call (or the consultant responsible for the individual patient).

Annual Audit Process

The number of Obstetricians required to provide care in the clinical area is dependant upon workload activity. As set out in the Safer Childbirth: minimum standards for the Organisation and Delivery of Care in Labour (2007), Consultant presence will be reviewed monthly as a standing agenda item at Obstetric Clinical Governance Meetings.

Business Plan Process

Where Obstetric staffing shortfalls are identified within the audit or risk management systems a Business case will be developed by the clinical director and directorate manager in line with the Trust Business case process. Progress will be monitored by Obstetric Governance Committee and directorate meetings.

Contingency Planning Process

Provision of safe staffing levels is essential to providing women with a safe and positive birth experience. This may be affected short term by an increase in workload activity within the birth setting, staff sickness or long term by inadequate obstetric and midwifery staffing levels. Contingency plans will be developed as required to address staffing shortfalls by the Clinical Director,and the Directorate Manager. Business plans will be escalated to the Divisional Management Team, the Hospital Assistant Medical Director and Trust Medical Director, and progress monitored by Obstetric Governance Committee and directorate meetings.

Short term staffing shortage

For periods of short term staffing shortfalls (e.g. sudden increase in workload, short notice staff sickness) a local resolution should be sought by informing the on call consultant who may also contact the Clinical Director and the designated medical staffing coordinator responsible for booking locum cover to ensure contingency plans are developed. Should the staffing issue pose a medium to long term risk the appropriate escalation process will be followed – See Appendix A Obstetric Escalation Process. In circumstances where the Clinical Director is unavailable to make decisions on short term staffing contingency plans – the on-call Consultants across both sites must act in the best interests of good clinical care.

Medium to Long term staffing shortfalls

Where ongoing staffing shortfalls are identified through the risk management systems or staffing audit a contingency plan will be developed by the Obstetric Clinical Governance lead and Clinical Director. The plan will be presented at the Obstetric Clinical Governance meeting and monitored by this group six monthly. The short fall will also be added to the Obstetric Risk register. The contingency plan will be presented to the Divisional Management Team, . Where required the DirectorateManager and the Clinical Director will escalate the issues to the Trust Board via the Divisional Management team. See Obstetric Escalation Process Chart.