

Maternity Services Staffing Guideline

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1 Description of the Maternity Service

A range of maternity care is offered within our maternity services at the Royal Victoria Infirmary (RVI); from midwifery to specialist led care. Midwifery led care takes place both in the community and within the hospital settings and although home births are offered and are a part of a woman's choice when she books to have her baby here, the majority of intrapartum care and births take place within the hospital. The maternity unit is a tertiary centre for both neonatal and fetal medicine with approximately 45% of births being "out of area" of Newcastle.

Care is organised and delivered by a multi-disciplinary team of midwives, obstetricians, nurses, anaesthetists, geneticists, neonatologists and paediatric surgeons who all work and receive training together in multidisciplinary forums.

The hospital service includes 14 antenatal beds, 48 post natal beds, a Maternity Assessment Unit (MAU) with 2 assessment rooms and 1 ultrasound room, Delivery Suite containing - 14 birthing rooms – 2 of which contain water pools, 1 x 4 bedded induction bay, 2 obstetric theatres, 1 x 3 bedded recovery area and 1 x bereavement suite. Antenatal, Fetal Medicine and Ultrasound services are provided in an adjacent area to the main unit.

Within Newcastle, community midwifery services are provided in 4 bases and midwives work both from GP practices and children's centres providing care in both of these settings and also within women's homes.

The unit provides training for undergraduate and postgraduate medical staff – including higher specialist training in fetal medicine, maternal medicine and reproductive medicine. Training is also provided for midwives and ultrasonographers

2 Purpose of the Document

This guideline has been developed by the Directorate of Women's Services with the intention of outlining the staffing requirements for all care settings within the Maternity Department. The guideline describes:

- The staff groups working in each care setting
- How these staff are utilised within the service
- How the department will monitor staffing levels to establish if they are in line with those requirements
- The actions that will be taken to address any staffing shortfalls both in the short term and on an ongoing basis.

3 Staff Groups within the Maternity Department

3.1 Midwives, Nurses and Support Staff

3.11 Midwives

3.111 HOSPITAL

Within the RVI, midwives work in all areas of the maternity services including the Delivery Suite, MAU, antenatal ward, the two postnatal

wards and Antenatal and Fetal medicine clinics. In each area there is a “core group” of staff with other staff rotating into the various areas – an annual rotation rota is provided in advance and managers meet monthly to balance the changes (such as long term sick and maternity leave) which cannot be predicted when the rotation is first established. In-patient services including the MAU are provided 24 hours per day, seven days per week.

3.112 COMMUNITY

Midwives and maternity support workers provide a full range of maternity care within the community setting. The majority of care is antenatal and postnatal care, but Intrapartum care is also provided when required to women who have requested a home birth. Midwives work in the community between 8.30 and 17.00, outside of these hours an on call service is provided.

3.113 NURSES

Nurses support midwives in providing care to women and their babies. A fully trained theatre nurse team supports the delivery suite on a 24hour basis with the 5 elective lists each week also being covered by the theatre team. Nurses assist midwives in providing a full recovery service for women who have had operative interventions, either under regional or general anaesthetic within the obstetric theatre - this is available 24 hours per day.

3.114 SUPPORT STAFF

The maternity service utilises the resource of maternity care assistants within both the hospital and community care settings. Competency based assessments are required in each area for support staff.

The maternity service also offers clinical placements for student midwives and student nurses.

3.2 Consultant Obstetricians

Consultant Obstetricians ensure that high quality care is delivered to women and babies particularly those with complex needs and they are available for acute and critical obstetric emergencies.

At the RVI, consultant obstetricians have a dedicated, prospective presence on the Delivery Suite between 08.00 and 20.00 Monday to Friday and 08.00 to 14.00 Saturday and Sunday (i.e. for 72 hours per week). Outside of these dedicated hours an on call system is in effect and a consultant obstetrician can be present on the Delivery Suite within 30 minutes

In addition to the required presence of the consultant obstetrician on the labour ward it is also expected that the consultant is present in person in the following clinical situations:

- Eclampsia
- Maternal collapse (such as massive abruption, septic shock)
- caesarean section for major placenta praevia

- postpartum haemorrhage of more than 1.5 litres where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated
- return to theatre – laparotomy
- when requested

Twelve consultants contribute to the maternity service:

Consultant	Other duties / interests	Delivery suite duties
Mr P Ayuk	Lead for the Delivery Suite	✓
Prof Davison	Maternal medicine	
Mr A Loughney	Haematology / neurology / multiple pregnancy	✓
Dr S Macphail	Sub-specialist in Fetal Medicine. Assistant Medical Director.	✓
Miss E Michael	Obstetrician and Gynaecologist	✓
Mr P Moran	Sub-specialist in Fetal Medicine	✓
Prof S Robson	Head of the Academic Department Sub-specialist in Fetal Medicine	✓
Dr M Smith	Senior Lecturer. Maternal medicine	✓
Dr S Sturgiss	Clinical Director. Sub-specialist in Fetal Medicine	✓
Dr S Tweedie	Consultant Obstetrician	✓
Mr J Waugh	Lead clinician for Maternal Medicine	✓
Dr Zachariah	Obstetrician and gynaecologist Obesity in pregnancy (locum)	✓

3.3 Anaesthetists and their Assistants

3.31 Consultant anaesthetists

Overall responsibility for obstetric anaesthesia services at the Royal Victoria Infirmary rests with the duty consultant obstetric anaesthetist. Eight consultants provide resident cover from 0830-2030 five days a week and non-resident on-call cover at all other times.

Elective operating lists on the labour ward are covered by an additional consultant session. This is provided every week day morning from 0830-1300. The consultants who provide this service comprise a close knit team

who work flexibly and cooperatively with one another. Close team working allows for frequent cross-consultation over complex cases.

The following consultants contribute to the service:

Consultant	Obs. sessions in job plan	Additional responsibilities
Dr Val Bythell	3	Lead obstetric anaesthetist
Dr Zoe Eke	3	Teaching session co-ordinator
Dr Will Wight	3	Head of department
Dr Nancy Redfern	2	PG Dean director
Dr Rupert Gauntlett	3	Rota maker
Dr Julia Morch-Siddall	3	College tutor
Dr David Hughes	2	Clinical Director
Dr John Halshaw	3	

3.32 Anaesthetic assistants

28 nurses and ODPs (27 band 5, 1 band 6) provide anaesthetic assistance and recovery care on the delivery suite. Three staff working flexibly between two operating theatres and the recovery unit are assigned from 0800-1400 Monday to Friday and outside of these times one anaesthetic nurse immediately available for duties on delivery suite with a second individual also resident in the hospital 24 hours a day but with additional responsibilities to the emergency operating theatre.

3.4 Others

3.41 Post Natal Liaison Nurse

Within the post natal area several different categories of babies are cared for, hence the development of the above role to enable mothers and their babies to be able to stay together, especially during the initial post natal period for those vulnerable infants. These roles are undertaken by senior experienced neonatal nurses who work collaboratively with both the post natal and neonatal team to ensure high standards and safe care is provided to these babies within post natal. The following are examples of the different types of babies who may be admitted to the post natal ward:

- ◆ Pre term babies of 34 weeks onwards
- ◆ Babies weighing more than 1.8kgs
- ◆ Treatment for Neonatal abstinence syndrome
- ◆ Babies requiring double phototherapy
- ◆ Vulnerable women and babies

- ◆ Mothers with medical conditions e.g. Diabetes/HIV

The role of the post natal liaison nurse is to perform daily reviews of preterm infants, monitor infants with neonatal abstinence syndrome, observation & assessment of feeding and to discuss plans with the mother and the midwife who is caring for her. The post natal liaison nurse also provides education and support to both midwives and junior medical staff.

3.42 Nursery Nurses

Nursery Nurses work within the post natal services and assist midwives in providing care for babies and their mothers with feeding, thermoregulation and general care and education of the mothers needs to assist them in the early days of parenting. The unit also has dedicated nursery nurse resource whose specific role is to facilitate the initiation of breast feeding.

4 Required Staffing Levels

4.1 Midwives, Nurses and Support Staff

Area	Daytime		Night time		Weekends	
Ante Natal	2 MW	1 HCA	1 MW	1 HCA	Same	
MAU	3 MW + 1 MW 10-6 pm 1 HCA		2 MW		Same	
Delivery Suite	10 MW (including D/S co-ordinator) 2 HCA		10 MW 2 HCA		Same	
Theatre	2 Nurses, 1 HCA		1 nurse		Same	
Post Natal 32	3 MW, 3 HCA and 1NN	1 Postnatal Liaison 7am – 4pm	3 MW 1 HCA		3 MW, 3 HCA and 1NN	Postnatal Liaison role covered by Neonatal F2
33	2 MW, 2 HCA		2 MW 1 HCA		2 MW, 2 HCA	
Community	Staffing is variable depending on clinics etc		2 MW on call to cover home births and community emergencies		Designated band 7 coordinator who is aware of staff working and their availability	

DIRECTORATE MANAGEMENT TEAM

	In Post	Budget
<i>Directorate Manager/Head of Midwifery</i>	1.0wte B8c	1.0wte B8c
<i>Consultant Midwife for Normal Births</i>	1.0 wte B8b	1.0 wte B8b
<i>Community/Specialist Midwives Manager/Matron</i>	0.6wte B8a	1.0 wte B8a

<i>Delivery Suite/ward 34/MAU Manager/Matron</i>	1.0wte B8a	1.0wte B8a
<i>Post Natal/Neonatal Unit Manager/Matron</i>	1.0wte B8a	1.0wte B8a
<i>Ante-Natal/Fetal Medicine/Ultrasound Manager/Matron</i>	1.0wte B8a	1.0wte B8a
<i>Gynaecology Manager/Matron</i>	1.0wte B8a	1.0wte B8a
<i>Administration Manager</i>	1.0wte B6	1.0wte B6

4.2 Consultant Obstetricians

Safer Childbirth (RCOG 2007) recommends that units with more than 6,000 births per year should have 168-hour consultant cover. The number of babies born at the RVI has exceeded 6000 / yr since 2009.

At present, NuTH has a dedicated, prospective presence on the Delivery Suite between 08.00 and 20.00 Monday to Friday and 08.00 to 14.00 Saturday and Sunday (i.e. for 72 hours per week).

Outside of these dedicated hours an on call system is in effect and a consultant obstetrician can be present on the Delivery Suite within 30 minutes

A rota is produced each month with the details of consultant assigned to daytime and on-call duties, with agreement that consultants will not be rostered to daytime sessions when they have other clinical commitments

In the event of short-term sickness, cover is arranged by either the rota lead (Dr Moran) or Clinical Director (Dr S Sturgiss)

4.3 Anaesthetists and their assistants

4.31 Consultant anaesthetists

National reports have emphasised the importance of anaesthetists as an integral part of the obstetric team and in the management of mothers who become severely ill. The anaesthetists who work on the labour ward at NuTH are supported by dedicated trained anaesthetic assistants.

Overall responsibility for obstetric anaesthesia services at the Royal Victoria Infirmary rests with the duty consultant obstetric anaesthetist.

The required staffing levels / duties are as follows:

- Eight consultants provide resident cover from 0830-2030 five days a week and non-resident on-call cover at all other times. There are 20 scheduled consultant sessions during the working week and 22 sessions per week appear in job plans. This is compliant with the Safer Childbirth recommendations that (a) all obstetric units should have ten consultant sessions per week, and (b) tertiary referral units – such as the RVI – that are likely to have higher than average proportion of

women needing high dependency care should have more consultant time allocated

- A separate consultant anaesthetist is allocated to each of the 5 formal elective CS lists, as recommended by Safer Childbirth
- Additional clinical time is provided for antenatal referrals
- There is a lead anaesthetist- currently Dr Bythell

4.32 Resident anaesthetists

As recommended by *Safer Childbirth* (2007) there is a duty anaesthetist available 24 hours per day. Resident cover is provided by Specialty trainees in anaesthesia, Trust grade doctors and one staff grade doctor. The exact skill-mix and numbers on this rota changes at least twice a year, as a typical snapshot in June 2009 the resident rota is covered by ten individuals working a full shift system of days 0830-2030 and nights (usually grouped as two consecutive nights during the week and three nights at weekends).

The directorate of Peri-operative and critical care is committed to ensuring that these jobs remain EWTD and New Deal compliant and the Trust undertakes frequent monitoring of hours and intensity of work through an active Junior Doctors Project Team.

Grade	Numbers (6/09)
ST7	1
ST4	4
ST3	2
LAT (ST3 equivalent)	2
Trust grade doctor (ST3 equivalent)	1
Staff grade	1
TOTAL	11

Each trainee is assessed by a consultant before being allowed to go on call for obstetric anaesthesia with distant supervision. This assessment includes a discussion of previous obstetric anaesthetic experience, informed by log book data and an assessment of practical skills in labour analgesia and anaesthesia for operative procedures.

Junior anaesthetists with no previous obstetric experience are supranumary and usually limited to new-starters gaining only brief initial exposure to obstetric anaesthesia. Such trainees are rostered for day time sessions only and work under the close supervision of the resident consultant.

4.33 Anaesthetic assistants

28 nurses and ODPs (27 band 5, 1 band 6) provide anaesthetic assistance and recovery care on the delivery suite. Three staff working flexibly between two

operating theatres and the recovery unit are assigned from 0800-1400 Monday to Friday and outside of these times one anaesthetic nurse immediately available for duties on delivery suite with a second individual also resident in the hospital 24 hours a day but with additional responsibilities to the emergency operating theatre.

All anaesthetic assistant staff who regularly work on the delivery suite have been through a formal induction process which includes detailed guidelines and objectives for the role of the anaesthetic assistant.

4.4 Others

All wards and departments have the support of a ward clerk to assist the staff in the administrative aspects of their role. Within the post natal and antenatal inpatient areas there are ward clerks who work Monday to Friday and this is also replicated in the antenatal and fetal medicine clinic. The delivery suite has ward clerk support 7 days per week 8am – 8pm.

5 Staff Duties

5.1 Labour Ward Coordinator

For each shift on the delivery suite at the RVI there is a designated delivery suite coordinator. This person's role includes:

- day to day management of the team and provision of leadership, advice, supervision and coordination of staff within the integrated team;
- mentor for junior midwives and others;
- supervision of junior midwives and other members of staff;
- provision of specialist advice to midwives and other members of the multi-disciplinary team.

5.2 Consultant obstetricians

A Consultant Obstetrician must be available to provide advice to staff on the Delivery Suite at all times and must be available to attend Delivery Suite in person within 30 minutes of request, 24 hours per day. Responsibility for all obstetric interventions on the Delivery Suite lies with the duty Consultant.

When the Consultant is present on the Delivery Suite, she/he acts as the team leader in the provision of care to women who require medical assistance.

In addition to the required presence of the consultant obstetrician on the labour ward it is also expected that the consultant is present in person in the following clinical situations:

- Eclampsia
- Maternal collapse (such as massive abruption, septic shock)
- Caesarean section for major placenta praevia
- Postpartum haemorrhage of more than 1.5 litres where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been instigated
- Return to theatre – laparotomy
- When requested

5.3 The Specialist Registrar (ST 3-7)

The Specialist Registrar most commonly acts as the first point of medical contact when complications are encountered in labour. He/she must also supervise the care of non-labouring admissions to the Maternity Assessment Unit and is expected to respond to urgent requests for help from the antenatal and postnatal wards. To fulfil this role, the Specialist Registrar is expected to liaise with the G grade midwife on the Delivery Suite and to keep the duty consultant informed of events. Furthermore, he/she must be able to demonstrate an ongoing commitment to the maintenance and development of his/her skills in intrapartum care.

When the Consultant is not present on the Delivery Suite, the SpR acts as the team leader in the provision of care to women who require medical assistance.

5.4 The Senior House Officer (ST 1-2)

The Senior House Officer's role is largely supportive to the Specialist Registrar, the duty consultant and his/her colleagues in midwifery. He/she clerks non-labouring *medical* admissions to the Delivery Suite and organises basic investigations in these patients before liaising with the Specialist Registrar or G Grade midwife. He/she also participates in the management of obstetric complications of labour and obstetric emergencies under the direct supervision of the Specialist Registrar or duty Consultant. He/she must demonstrate an ongoing commitment to the development of skills in intrapartum care.

6 Annual Audit of Staffing Levels

The Directorate will undertake an annual audit of staffing levels for each of the staff groups described above with the exception of junior medical staff. Each audit will be referenced to current staffing levels, as well as determining whether or not the unit is line with the national recommendations in *Safer Childbirth* (2007).

The results of all audits will be presented to CIRG and the Obstetric Group. Any shortfalls in staffing levels as compared with the recommendations in Safer Childbirth will be presented to the Trust executive along with a proposal to address the issues

Details of the individual audit methodology are as follows:

6.1 Midwives and other non-medical staff

This audit will be undertaken / supervised by the Directorate Management Team. There are monthly staff rotas which will be analysed and measured against the required amount of staff which has been designated in the table above in section 4.

6.2 Obstetricians

The Lead Consultant for Obstetrics will undertake this audit. Consultant presence on the delivery suite will be reviewed from the monthly rotas, analysing individual consultant allocation in comparison to the non-delivery suite fixed sessions as described below:

	Morning	Afternoon
Monday	Dr Moran Dr Macphail	Mr Loughney Dr Macphail
Tuesday	Miss Michael	Mr. Loughney
Wednesday	Dr Smith / Mr Waugh Dr Sturgiss	Dr Smith Dr Sturgiss
Thursday	Mr Waugh Dr Moran	Miss Tweedie Dr Moran
Friday		Mr Ayuk

In addition, the Datix database will be reviewed to determine whether or not there were any adverse incidents / events relating to delayed consultant attendance beyond 30 minutes

6.3 Anaesthetists and anaesthetic assistants

All short term staffing crises events should generate a DATIX incident report. They will be reviewed through the risk management framework and referred to the clinical lead for obstetric anaesthesia for review at an obstetric anaesthesia group meeting.

A week long snapshot audit will be conducted in October of each year to establish if staffing levels (anaesthetist and anaesthetic assistants) are adequate and in line with Safer Childbirth (RCOG 2007). In addition to this two exercises are carried out (one out of normal working hours) to review the availability of additional staff to respond to a hypothetical short term staffing crisis. The results of these audits will be presented to an obstetric anaesthesia group meeting and referred on to the delivery suite executive if problems are identified.

Each audit will results reviewed by the team and the Trust Board. The audit of staffing levels will take into account national guidance including Safer Childbirth (RCOG 2007) and the current delivery rate. Where the annual audit show that there are staffing shortfalls against the levels included in this document business and continuity plans will be developed to address these issues.

7 Process for the Development of Business Plans

Due to the continuing rise in the birth rate over the last few years, the Trust executive team have asked for regular updates about staffing levels and possible / potential impacts on quality of care.

The Directorate – for the foreseeable future - have been asked to submit capacity-related business proposals directly to the senior trust management – thereby allowing for almost immediate decisions, with meetings of the executive team held every week.

8 Process for the Development of Longer Term Contingency Plans

Longer term contingency plans for each staff group in the event of an identified long-term staffing shortfall will include:

- Ensure – as far as possible – appropriate staffing levels and competencies for all other grades and levels of the unit workforce
- Monitor quality of outcomes – continually striving to improve all systems of care within the available resource, as well as identifying those occasions when the availability of a consultant (or any other staff) impacts on outcomes – thereby looking to ameliorate the adverse impacts of suboptimal staffing levels by case-based scrutiny for effective counter-measures
- Make optimal use of all opportunities for discussion with and updating the senior Trust team about the current status of the problem, as well as possible solutions. Such opportunities include regular ad hoc meetings with the senior trust management, as well as quarterly performance reviews, at which there is scrutiny of the risk register
- Regular discussion of staffing levels at monthly Directorate meetings – with assessment of overall capacity in relation to workload as a standing item
- Emphasise the willingness of the Consultant team to be contacted at any time by the junior medical staff and midwives
- Reorganisation of staff – wherever possible – to optimise deployment in accordance with levels of activity in each area

9 Process for the Development of Short Term Contingency Plans

The maternity service has a staffing escalation policy which provides staff with guidance when there are increased pressures within the service. It includes the minimum numbers of staff required to provide a safe management of a work area and the preferred numbers of staff to effectively and safely manage the area.

When staffing levels are below those in the staffing standard or the workload is deemed to be excessive the actions contained in the staffing escalation policy should be taken – please see attached.

All short term staffing crises events should generate a DATIX incident report. They will be reviewed through the risk management framework and referred to the appropriate clinical lead for review.

Other actions in response to short-term staffing problems include:

a. Midwives

All rotas are reviewed on a daily basis by a senior member of staff to ensure any shortfalls in staffing caused mainly due to short term sickness absence are rectified.

b. Obstetricians

In the event of short-term consultant sickness, cover is arranged by either the rota lead (Dr Moran) or Clinical Director (Dr S Sturgiss). The response to

unplanned short term absence of junior medical staff is co-ordinated by the College Tutor (Mr J Waugh)

c. Anaesthetists

When there is a shortfall in consultant sessions (with annual and study leave) an additional (senior) trainee is frequently allocated to the labour ward for the morning session to assist with the elective Caesarean section list.

10 Monitoring Compliance with the Document

a. Required staffing levels and staff duties

The required staffing levels and staff duties will be monitored by the Clinical Director through the Obstetric Group and the Directorate Clinical Governance group (Clinical Improvement and Risk Group; CIRG)

The outcomes of audits will be reported to these groups – using the methodology described above, with shortfalls being reported to the Trust executive by the Clinical Director and Head of Midwives / Directorate Manager

The resulting action plans will be monitored through the Directorate's Performance Management Reviews

b. Process for development of business plans

This will be monitored by the Directorate's Clinical Governance lead on a yearly basis, with the Key Performance Indicators (KPIs) being whether or not the Clinical Director and Head of Midwifery / Directorate Manager have submitted business plans directly to the Executive group as a response to any identified staffing shortfalls

c. Process for development of longer term contingency plans

10.31 Appropriate staffing levels for other staff groups

This will be monitored using the methodologies and KPIs as described above for "staffing levels and staff duties"

10.32 Quality of outcomes

The principle quality outcome measurement tool is the maternity dashboard, which is collated on a monthly basis by the Directorate's Information Systems Manager, and reported to the Obstetric Group – with any shortfalls assigned to leads for the relevant clinical areas. The resulting action plan will be monitored by the Obstetric Group

The KPI will be the maternity dashboard, as well as minutes of Obstetric Group meetings

10.33 Updating the senior Trust team

This will be monitored at the Directorate's Quarterly Performance Reviews, as well as the yearly Clinical Governance and Standards review. Significant capacity problems will be entered onto the Risk Register, which is reviewed at the Corporate Governance Committee.

The KPIs will be minutes of the above meetings, as well as the Risk Register

10.34 Regular discussion of staffing levels at monthly Directorate meetings

The Obstetric Group meets monthly, and consists of all Obstetric Consultants, as well as senior Directorate Midwives / Managers – and a consultant anaesthetist

The KPI will be minutes of these meetings at which staffing levels are discussed

d. Process for development of short term contingency plans

The key performance indicator will be the use of the escalation policy – with any use of the policy monitored by the Obstetric Group on a monthly basis under a standing “capacity / staffing” item