Royal Devon and Exeter NHS Foundation Trust

Clinical Guideline for; MATERNITY SERVICES STAFFING

Summary

This guideline:

- Describes staffing levels and details how we ensure the maternity service remains safe at all times.
- Covers the arrangements for hospital and integrated midwifery services, community midwifery, obstetric services, paediatric, anaesthetic and recovery services.
- Describes the staffing levels and arrangements in each clinical area, including contingency at times of increased workload or staff absence
- Describes the overall staffing allocation for the maternity service, when the service would be described as *green*.
- Flowcharts are contained in the appendices which describe the actions that should be taken when the complexity and or the capacity of the service is affected, when the service is in an *amber* status.

CONTENTS

1.0 PURPOSE

1.1 This document describes staffing levels and details how we ensure the maternity service remains safe at all times. The document covers the arrangements for hospital and integrated midwifery services, community midwifery, obstetric services, paediatric, anaesthetic and recovery services.

1.2 The document describes the staffing levels and arrangements in each clinical area, including contingency at times of increased workload or staff absence eg flu, including the escalation plan. If activity is increased a workload assessment is made by one of the Midwifery Managers / Associate Director of Midwifery, who provide an on call service 24 / 7 due to the complexity of service delivery. If there is a potential safety issue or advice on clinical care required the Supervisor of Midwives (SOM) will be contacted, they provide 24/7 cover on call to ensure midwives have access at all times*.* In the event of the contingency plan being required the on call midwifery manager should be called to facilitate.

1.3 This document describes the overall staffing allocation for the maternity service, when the service would be described as *green*. Flowcharts are contained in the appendices which describe the actions that should be taken when the complexity and or the capacity of the service is affected, when the service is in an *amber* status. Appendix 3, extreme workload / staffing issues – closure; describes the actions that need to be taken when the service is at capacity and contingency has to be implemented; this is when the service is in *red* status.

1.4 The maternity service is supported by a midwifery bank which is used for planned absence e.g. long term sickness, maternity leave, as required. The overall midwife to delivery ratio is monitored on a monthly basis and included in the clinical dashboard which is reviewed in the Service Line Management Meeting (SLM), Maternity Governance, Directorate Governance Group and by the midwifery managers, enabling scrutiny of midwifery and obstetric staffing levels in relation to activity. This tool is also made available to commissioners via the Maternity Service Liaison Committee (MSLC).

2.0 ORGANISATION OF MIDWIFERY SERVICES

2.1 There is an establishment of 133.5 WTE midwives (this excludes the Head of Midwifery and 2.0 WTE Clinical Midwifery Managers), each of the midwifery managers have a clinical component to their role including safeguarding. For the purposes of calculating the midwife to delivery ratio, two band 7 posts, governance and learning and development are excluded in addition to the midwifery managers. Although key to the service they are not providing direct clinical care. There are approximately 4,200 births per annum representing an overall funded midwife to delivery ratio of 1:31.

2.2 Supporting the maternity service there are a number of more specialist roles which are totally clinical these include, Specialist Midwife for Complex Needs (1WTE), including mental health, substance misuse and vulnerability. Infant Feeding Coordinators (1WTE), who lead on implementation and maintenance of the Baby Friendly Initiative and specifically work on preventing neonatal admissions of baby's with poor weight gain. The Screening Co-ordinators, (1WTE), lead on ensuring that our extensive screening programmes are in line with national recommendations and support women in decision making and treatment.

3.0 ALLOCATION OF MIDWIVES AND SUPPORT STAFF

3.1 Hospital based midwifery services

3.1.1 These services support the whole locality, specifically those women with a high risk pregnancy requiring obstetric input. The Antenatal / Postnatal Ward (APNW) cares for up to 43 mothers and babies with up to 15 discharges per day. Labour Ward includes ten birth, two admission rooms, a bereavement room and an obstetric theatre. There are separate theatre staffing and recovery arrangements see section 3.4.1, however, overnight the labour ward auxiliary assists with theatre 'running'.

3.1.2 The hospital service is managed by 1 WTE Clinical Midwifery Managers with responsibility for:

- Hospital Services including Labour Ward, Antenatal /Postnatal Ward (APNW), the Alongside Birth Centre and Screening

There are 43.5 WTE midwives, 6.8 Band 3, 12.79 Band 2 and 1.0 Housekeeper

3.1.3 At any one time there are 7 WTE staff on annual leave. The majority of staff rotate on a 3 monthly basis to ensure that skills are maintained in all areas. There is a 'core' of experienced staff that remain in each clinical area.

3.1.4 The hospital based services are supported by 12.79 WTE band 2 maternity auxiliary workers; their roles vary from chaperoning to supporting baby care and the cleanliness of the clinical environment. These staff rotate between the ANPN ward and labour ward.

3.1.5 In addition there are 6.8, band 3 maternity support workers based on APNW, their key role is supporting clinical care of women who have had an operative delivery and providing breastfeeding support.

3.2 Labour Ward

3.2.1 There are a core of 6.5 WTE band 7 midwives who provide 24 hour clinical leadership as shift coordinators. They are clinically expert and all have extended clinical competencies providing advice, support and guidance to all staff as well as coordinating the overall clinical activity in the area**.** The coordinator should where possible be supernumerary. If this is not possible then they should have a minimal clinical workload so that they can have an operational overview of labour ward and support / advise and coordinate clinical activity.

Staff allocation per shift (green)

Staff Group	Early 07.30 – 15.30	Late 12.30 – 20.30	Night 20.00 – 08.00
Midwives (including the shift coordinator)	5	4	4
Recovery nurse: Monday- Friday 08.00 – 21.00	1	1	0
Auxiliaries	1	1	1

3.2.2 Labour ward is also covered by the integrated teams, each of whom provides an on call midwife during the day and the night to cover home, birth centre and labour ward cover as activity requires.

3.2.3 **Contingency – (amber)** - If the number of allocated midwives on labour ward is reduced the total staffing for the service needs to be assessed. The contingency is detailed in appendix 1, the Staffing contingency - hospital and integrated services. The flowchart should be followed to ensure that the most appropriate solution is sought. The coordinator should call the midwifery manager for the hospital service or the on call midwifery manager to assist with the coordination of staff, so that the labour ward coordinator is able to coordinate the clinical activity on labour ward.

3.2.4 Labour ward is supported by a recovery nurse from 08.00 hours until 21.00 hours Monday to Friday; this releases midwifery time and provides cover for all of the elective caesarean sections. This post is managed by the critical care division.

3.2.5 The maternity auxiliary will provide theatre auxiliary cover between 21.00 and 08.00 hours.

3.3 Antenatal and Postnatal Ward

3.3.1 There is a small core of staff supported by 1 WTE band 7 matron. The team provides a shift coordinator who has the overview of the clinical area and provides continuity/ overview. The area also has band 3, maternity support workers who have skills which enable them to provide postnatal and breastfeeding support.

3.3.2 The staffing allocation is as follows (green):

Staff Group	Early 07.30 – 15.30	Late 12.30 – 20.30	Night 20.00 – 08.00
Midwives - including coordinator	3	3	3
Maternity Support workers	2	1	
Auxiliaries	1	1	1
Housekeeper	1		
	7	5	4
Midwife designated for examination of the newborn	1		

3.3.3 **Contingency (amber)** - If the number of allocated midwives on APNW is reduced the total staffing for the unit needs to be assessed. The contingency plan is detailed in appendix 1, the Staffing contingency - hospital and integrated services. The flowchart should be followed to ensure that the most appropriate solution is sought. The coordinator should call the midwifery manager for the hospital service or the on call midwifery manager to assist with the coordination of staff.

3.4 Fetal Maternal Assessment Service / Antenatal Clinic – green

3.4.1 **The fetal maternal service** is covered by the Community Clinical Midwifery Manager. The service provides a point of referral for pregnancy related problems requiring surveillance e.g. blood pressure, determination of fetal positioning for women, directly preventing admission and / or assessment on the labour ward. The service operates from 07.30 hours until 20.00 hours Monday to Friday and 7.30 - 15.30 Saturday and Sunday. From 17.00 until 20.00 there is only one midwife to cover the service, as the main work is within the earlier part of the day FMAU also supports those women having an induction of labour.

3.4.2 The area is managed by the 0.8 WTE matron who report to the Clinical Midwifery Manager. Women access this service directly via the community / integrated midwives or by the GP.

3.4.3 **Antenatal Clinics -** provide a service for those women requiring consultant obstetric opinion. This area is supported by midwives based in FMAU but directly staffed with band 2 maternity auxiliary who chaperone, take blood and undertake baseline observations.

3.4.4 Midwifery and support staff are allocated (green):

Area / Staff Group	Monday	Tuesday	Wed	Thurs	Friday	Sat	Sun
ANC							
Midwives	0	1 (Diabetic clinic)	0	0	0	0	0
Support staff	3	3	4 (2 clinics)	No clinic	3	0	0
FMAU							
Midwives	3	3	3	3	3	1	1
First Trimesters screening / Ultrasound	2	2	2	2	2	1 FMAU	1 FMAU

3.4.5 **Contingency (amber)** – in the first instance try and alter off duty for the staff with the competency to work in this area. In the event of excess workload escalate to the Community Clinical Midwifery Manager. If situation continues the safest option is to divert all work to the labour ward and then follow the Staffing contingency - hospital and integrated services, appendix 1.

3.5 **Integrated Midwifery Service -** (green).

3.5.1 The RD&E operates an integrated model of midwifery for the women living in the Exeter locality. There are 3 teams of 9.6WTE (total 28.8 WTE) band 6 midwives caring for approximately 1,550 women, (overall caseload ratio of 1:48**)** in the Exeter locality community based service. As part of each team there is 1 WTE band 7 team leader who works clinically for the majority of shifts and is an experienced community based practitioner who takes a clinical leadership role and provides clinical supervision for safeguarding.

Team	Annual caseload	Midwives	Midwife to Woman ratio
Central	495	10.6	1 : 47
West Exe	550	10.6	1 : 52
Beacon	720	10.6	1: 68
Total	1765	31.8	1 : 55

3.5.2 There are four maternity support workers, supporting midwives by providing additional visits for vulnerable women, support of breastfeeding mothers / babies, undertaking baby weight, surveillance and administrative support. An MSW is allocated to the birth centre on a day shift each day.

3.5.3 The integrated midwifery team provides total care for their caseload of women including taking booking histories, the provision of all community antenatal care, safeguarding responsibility, parent education classes, intrapartum care including a home birth service and postnatal care. The teams take responsibility for covering the service 24 hours a day. Each team provides a member to cover for Intrapartum care.

3.5.4 At night a midwife is allocated from each team to provide intra partum and emergency cover. If less than this, the total number of midwives for the maternity service needs to be assessed, to ensure that services can be provided e.g. homebirth.

3.5.5 **Contingency (amber)** - If the number of allocated midwives for the teams is reduced the total staffing for the teams needs to be assessed. The integrated midwife should call the Community Midwifery Manager or the on call midwifery manager to assist with the coordination of staff. The contingency is detailed in appendix 1 the Staffing contingency - hospital and integrated services. The flowchart should be followed to ensure that the most appropriate solution is sought.

3.5.6 **Exeter Birth Centre**-The centre is staffed by 1 WTE band 7 Matron and 5.5 WTE band 6 midwives. It is staffed at all times by a midwife and in addition between 9am-5pm with a band 3 MSW from the Integrated Team. All low risk women attending this hospital in labour should be triaged within this setting. If a midwife is not available due to sickness etc. women are diverted to the labour ward. If more than 1 woman is in labour the availability of a second integrated midwife is sought to provide 1:1 care in labour. The staff work closely with the APNW staff to cover the actual birth and also the care for post natal mothers and their babies.

3.6 Community Midwifery Services – green

3.6.1 This service transferred in April 2010 from NHS Devon. The service covers a wide geographic patch (excluding Exeter) and supports three birth centres in Honiton, Tiverton and Okehampton. The service is managed by 1.0 Community Clinical Midwifery Manager who also manages the Integrated Service. Each team has a 1 WTE band 7 who also works as part of the clinical team, is an experienced community based practitioner who takes a clinical leadership role and provides clinical supervision for safeguarding.

Area	Annual Caseload	Midwives	MSW	Midwife to women ratio
Honiton	540	9.5	6	1 : 57
Tiverton	650	10.7	6	1 : 61
Okehampton	590	9.5	6	1 : 62
Coastal	510	8	0	1 : 64
Total	2,150	37.7	18	1 : 57

3.6.2 The midwives work in a more traditional model proving caseload continuity for antenatal women, an on call service to support births in the birth centres or at home and selective postnatal visiting. The three birth centres have 6 WTE band 3 maternity support workers who provide cover on a 24 hour basis facilitating support for inpatient postnatal mothers and baby with referral to midwives 24/7 for support and advice. Women choosing an inpatient stay are 'fit' for discharge home but chooses to stay for extra breast feeding support.

3.6.3 **Contingency – (amber)** if the number of allocated midwives required to cover each area is reduced, or there is a problem offering intrapartum cover or inpatient care. Community staffing needs to be assessed. The contingency plan is detailed in appendix 2, the Staffing contingency - homebirths and birth centres. The flowchart should be followed to ensure that the most appropriate solution is sought. The midwife should call the Community Clinical Midwifery Manager or the on call midwifery manager to assist with the coordination of staff.

4.0 CLOSURE OF SERVICE - (red)

In the event that all amber measures have been implemented with one or more of the following:

a. Increased numbers of women
b. complexity of women,
c. availability of clinical staff

A decision is required to ensure that the service and women remain safe; the following needs to be implemented (appendix 3). The Clinical Midwifery Manager, On-Call Midwifery Manager must be called and be on site. A total review of all activity within the maternity services to be undertaken with the Consultant Obstetrician on call for labour ward and the labour ward coordinator.

4.1 Following assessment of the workload make contact with **Torbay- labour ward (01803 654641)** and **Taunton - labour ward (01823 342059).** Using SBAR update them on our situation and confirm that they can take any labouring women. Contact Ambulance control **0845 6020455 (# 6470**) to divert any ambulance calls. Of note Torbay can only accept women with pregnancies at greater than 33 week's gestation.

4.2 Create an area for the triage of women who may present without phoning. If all rooms on labour ward (including the bereavement room) are in use, consider using a birth room on the alongside birth centre or the treatment room on the ANPW.

4.3 Following decision to close and when time allows SoM to update the LSA website

4.4 Re-opening - when possible reverse the closure by contacting ambulance control and other units.

5.0 OBSTETRIC COVER

5.1 The clinical guidelines for labour ward cover the role of the SHO, middle grade and consultant and details the daily provision. The labour ward consultant obstetric provision is as follows:

DAY	MON	TUES	WED	THU	FRI	SAT	SUN
08.00-13.00	MJT / BPJ	JTC / BPJ	RHS / TK	JHW / LAJ	NHL / TK	ON CALL	ON CALL
13.00-18.00	MJT/NHL	BPJ / JTC	RHS / TK	JHW / LAJ	NHL / TK		

5.2 Current provision for labour ward is 60 hours per week. Monday to Friday is covered with 50 hours and the weekend covered with ten hours and consultant on call. This is monitored as part of the clinical dashboard. In the case of consultant absence the Lead Clinician will be responsible for organising cover.

5.3 The rota detailing the consultant on call arrangements is sent out a month in advance to key personnel and a copy is retained on the labour ward.

5.4 Middle grade cover is organised by Mr Ben Peyton–Jones (Consultant) and in the event of absence locum cover is arranged. In the short term if there is no locum cover the consultant will act down.

5.5 SHO cover is organised by Mr Ben Peyton–Jones (Consultant) in the event of absence locum cover is arranged.

5.6 A Consultant will attend 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

6.0 PAEDIATRIC COVER FOR LABOUR WARD / POSTNATAL WARD

- Junior doctor (ST1/2 or F2) available 24 hours a day, trained in neonatal resuscitation, covering the maternity and neonatal service in the Centre for Women's Health.
- Middle grade doctor available 24 hours a day on site, as required.
- Consultant Paediatrician, available but out of hours are on call. Monday to Friday they are based on the neonatal unit.

7.0 OBSTETRIC ANAESTHETIC COVER

7.1 The clinical guidelines for labour ward describe the duties and role of the obstetric anaesthetist. The obstetric anaesthetist will have completed the necessary obstetric anaesthetic module and competencies prior to providing out-of-hours maternity cover.

7.2 The obstetric anaesthetist provides 24 hour cover from 08.00 hrs until 20.00hrs and from 20.00 hrs until 08.00hrs 24 hours a day seven days a week.

7.3 The obstetric anaesthetist is primarily available for the Maternity Unit but also provides cover for minor gynaecology emergencies from 08.00 till 20.00. From midnight until 08.00 they may also be asked to assist in other parts of the hospital but must be available to attend labour ward for any obstetric emergency.

7.4 A consultant obstetric anaesthetist provides direct obstetric anaesthetic care from 08.00 until 18.00 during the working week for 42 weeks of the year. Consultant obstetric anaesthetic cover is provided each week day morning (08.00 until 12.30) 52 weeks of the year. Consultant obstetric anaesthetic cover will be reviewed on a regular basis to ensure compliance with the recommendations of OAA/AAGBI Guidelines for Obstetric Anaesthetic Services.

7.5 Anaesthetic cover is always maintained and if the trainee anaesthetist is absent a consultant anaesthetist will cover.

8.0 ANAESTHETIC ASSISTANT / OPERATING DEPARTMENT PRACTITIONER (ODP)

8.1 Staff are immediately available to assist the obstetric anaesthetist in the Maternity Unit, 24 hours a day, 52 weeks a year. All those employed to cover the service hold recognised qualifications. In the event of absence, the ODP bleep holder arranges cover recognising the Maternity Unit as a priority area.

9.0 CONCLUSION

9.1 This document has described the staffing levels and details of how the maternity service remains safe at all times. The document covers the arrangements for hospital, integrated and community midwifery services, obstetric services, anaesthetic and recovery services.

9.2 To ensure that we comply with the standards, any deficiencies or increase in activity are highlighted through the maternity dashboard, which is reviewed in the maternity governance forum monthly to ensure action plans are developed and escalated to the executives via the regular 1-1 meetings.

10.0 MONITORING COMPLIANCE OF THIS GUIDELINE

In order to monitor compliance with this guideline, the auditable standards will be monitored as follows:

	Minimum Requirements	**Evidenced by:-**	**CNST standard**
a	On an annual basis a review of the staffing establishment for midwifery, obstetric and anaesthetics will take place, including a reassessment of the midwife to delivery	Annual review	1.3, 1.4 & 1.5

	ratio.		
b	If applicable a business case is generated which reflects the results of the annual review to address staffing shortfalls	Business case	1.3, 1.4 & 1.5
c	There is a contingency plan to address ongoing staff shortfalls (if any)	SLM minutes	1.3, 1.4 & 1.5
d	There is a contingency plan to address short term staffing shortfalls	Incident reports	1.3, 1.4 & 1.5
e	A consultant obstetrician was present for the cases outlined in the Clinical guidelines for labour ward	Medical records	1.11
f	There is a experienced midwife as shift coordinator on Labour ward	Off duty	1.11
g	There is an anaesthetist on duty 24/7	Anaesthetic rota	1.11

10.1 Frequency

Annual reviews will be undertaken and a formal report will be written and presented at the Maternity Governance Forum.

10.2 Undertaken by

Multidisciplinary Team

10.3 Dissemination of results

At the Maternity Governance Forum which is held monthly, at the O&G audit session which is held monthly and in the Maternity Governance Newsletter which is produced monthly

10.4 Recommendations/ Action Plans

- Implementation of the recommendations and action plan will be monitored by the Maternity Governance Forum /Service Line Management which meets monthly.
- Any barriers to implementation will be risk assessed and added to local risk register.
- Any changes in practice will be highlighted to maternity unit staff via the monthly maternity risk newsletter, community midwifery & support staff will be informed by their team leaders via email and the medical staff by the labour ward lead consultant obstetrician via email**.**

11.0 REFERENCES

Kings Fund. (2008). Safe Births: Everybody's business – *An independent Inquiry into the Safety of Maternity Services in England,* London: Kings Fund.

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health. (2007). *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour,* London: RCOG Press.

12.0 PUBLICATION DETAILS

Author of Clinical Guideline	**Associate Director of Midwifery and Patient Care**
Directorate/Department responsible for Clinical Guideline	**Child and Women's Health Maternity Unit**
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Appendix 1 Flowchart

STAFFING CONTINGENCY
HOSPITAL AND INTEGRATED SERVICES - Amber

Labour Ward or AN / PN ward

- Contact the hospital clinical midwifery manager or the on call midwifery manager to assist with staffing coordination
- **If there appears to be an issue of Safety call the Supervisor of Midwives on call (via labour ward / switchboard)**

Integration

- Contact the community clinical midwifery manager or the on call midwifery manager to assist with staffing coordination

DAY

Any midwife on pay back to be diverted to where required.
Consider cancelling any non-essential work e.g. postnatal visits

DAY

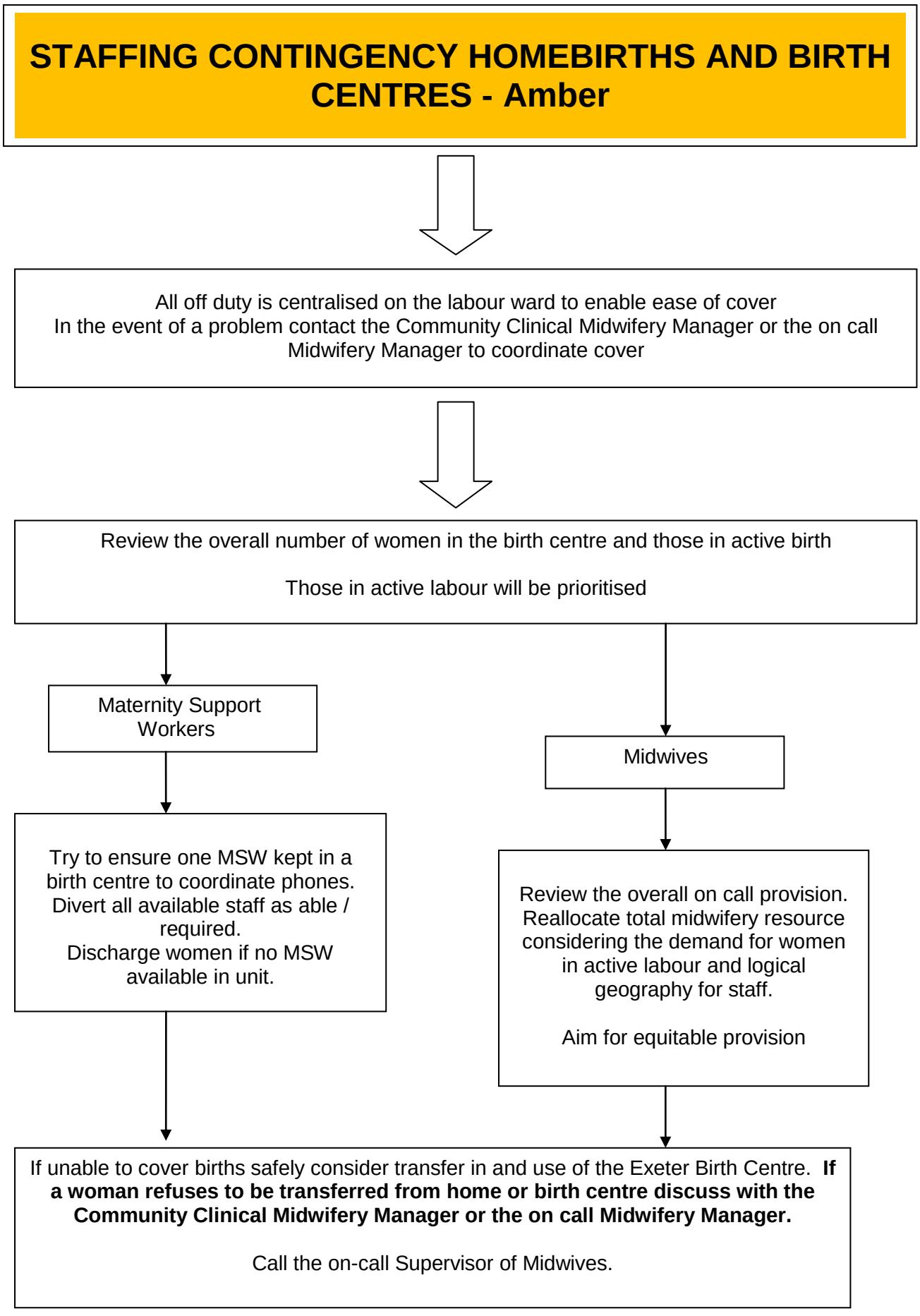
1. Review AN / PN staffing – consider numbers and complexity- reallocate midwives or support staff as able
2. Call in all integrated midwives
3. Divert possible work to FMAU
4. Any midwives on pay back day to be diverted to where required
5. Any non essential community work to stop
6. Consider discharging women to birth centres
7. Follow homebirth / birth centre flowchart, appendix 2

NIGHT

1. Call in rostered on call integrated midwives
2. If problem covering home birth, see - homebirth / birth centre flowchart, appendix 2.
3. Review AN / PN staffing – consider numbers and complexity- reallocate midwives or support staff as able.

Community – if no women labouring in birth centres or home consider deploying all available staff (including MSW's) as required to RD&E site. Ensure community midwife is allocated to low risk labouring women or to work on ANPW.

Appendix 2 Flowchart



Appendix 3 Flowchart

EXTREME WORKLOAD / STAFFING ISSUES CLOSURE

Flowcharts 1 and 2 actions to have been completed. Midwifery Manager on site

Midwifery Manager, Consultant Obstetrician on-call and Director on-call to be involved in the decision to close.
In working hours Divisional Manager and Head of Midwifery to be included in decision making.

Inform Consultant Paediatrician and Neonatal unit – to prevent in- utero transfers into the unit

Contact:

Ambulance Control -	**#6470**
Torbay labour ward -	**01803 654 641**
Taunton labour ward -	**01823 342 059**
Plymouth labour ward -	**01752 763 610**
Barnstaple labour ward -	**01271 322 605**

Use SBAR to update them on the situation and determine their capacity

Women who contact by phone advise them of closure and advise them to contact one of the above units
Women who present must be clinically assessed prior to being transferred. Transfer should be facilitated by Midwifery Manager on call.

Maintain central record of all women who go to other units inform the on-call supervisor of midwives as the SoM needs to update the LSA database.

Reopening
Reverse the process contacting those above particularly ambulance control and the units that have assisted.