Maternity Services Staffing Guideline

CDDFT Guideline

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Approval

Signature of Chairman of Approving body

[Signature]

Name / job title of Chairman of approving Body:  Chair of Quality & Health Care Governance Committee
Signed Master paper copy held at  Library Services Darlington Memorial Hospital
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Table of revisions

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<tr>
<td>17/09/2013</td>
<td></td>
<td>New guideline</td>
<td>Anne Holt</td>
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<tr>
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<td></td>
<td></td>
<td>Lesley Heelbeck</td>
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</table>
1.0 Description of the Maternity Service

A range of maternity care is offered within our maternity services at County Durham and Darlington NHS Foundation Trust, from midwifery to consultant-led care. Midwifery-led care takes place in the community and within the hospital settings including the freestanding midwifery-led unit at Bishop Auckland Hospital. Home births are offered and are part of a woman’s choice regarding the place of delivery.

Care is organised and delivered by a multi-disciplinary team of midwives, obstetricians, anaesthetists, nurses and paediatricians and support workers.

The maternity services within County Durham and Darlington deliver approximately 6000 babies each year and the service is provided over four sites.

Darlington Memorial Hospital (Obstetric and Midwifery led care) (DMH)

- Antenatal beds x 6
- Pregnancy Assessment beds x 3
- Postnatal beds x 17
- Delivery Rooms x 11 (including a Birthing Pool)
- Obstetric Theatre x 1
- Recovery area x 2

The University Hospital of North Durham (Obstetric and Midwifery led care) (UHND)

- Antenatal beds x 6
- Pregnancy Assessment beds x 6
- Postnatal beds x 17
- Delivery Rooms x 10
- Obstetric Theatre x 1
- Recovery area x 1

Bishop Auckland General Hospital (Midwifery led care) (BAH)

- Pregnancy Assessment beds x 2
- Delivery/Postnatal beds x 7 (including a Birthing Pool)

Shotley Bridge Hospital (Outpatient services only) (SBH)

- Pregnancy Assessment beds x 2

Antenatal outpatients and ultrasound services are provided on all four sites and fetal medicine services are offered on DMH and UHND sites only.

Community midwifery services are provided across County Durham and Darlington. There are five community midwifery teams which are each led by a Band 7 Team Leader. Midwives work both from GP practices and Children Centres providing care in both these settings and also within women’s homes.

The maternity service provides training for undergraduate and postgraduate medical staff. Training is also provided for midwives and ultrasonographers.
2.0 Purpose of the Document

This guideline has been developed with the intention of outlining the staffing requirements for all care settings within the maternity services. The guideline describes:

- The staff groups working in each care setting
- How these staff are utilised within the service
- How the service monitors 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

3.0 Staff Groups within the Maternity Department

3.1 Midwives and Support Staff

3.11 Hospital

Midwives within County Durham and Darlington NHS Foundation Trust work in all areas of the maternity service including the Labour Wards, Pregnancy Assessment Units and the Antenatal/Postnatal Wards. In each area there is a core group of staff with other staff rotating into the various areas. Midwives working on DMH and UHND sites provide shifts to the stand alone midwifery-led unit at BAH. An annual rotation is provided in advance and the HOM and Matrons meet monthly to balance the changes across the Trust (such as long term sickness absence and maternity leave) which cannot be predicted when the rotation is first established. Antenatal, Labour and Postnatal Services are provided 24 hours a day, 7 days a week.

3.12 Community Midwifery Services

Midwives and Maternity Support Workers provide a full range of maternity care within the community setting. The majority of care provided is antenatal and postnatal care, but intrapartum care is also provided to women who have requested a home birth. Community midwifery services are provided between 08.30 and 17.00, outside of these hours an on-call service is provided. Community midwives also provide shifts to both Labour Wards and also to the Midwifery-led unit.

3.13 Maternity Care Assistants

The maternity service utilises Maternity Care Assistants (MCA’s) within both the hospital and community care settings. Training programmes addressing the competencies required in each area are provided on an ongoing basis. The key principle in incorporating MCAs within the workforce skill mix is to complement rather than substitute the role of the midwife.

3.14 Team Assistants

Team Assistants are an integral part of the team and act under the supervision of midwives to assist the multidisciplinary team in delivering an individualised plan of care for mothers and babies. They undertake delegated support tasks as specified by midwifery staff.
also provide support for the midwifery and obstetric team in the Operating Theatre.

3.15 Student placements

The maternity service also offers clinical placements for student midwives and return to practice midwives.

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. Labour ward activity forms an identified component of the consultant obstetrician's job plan and consultant obstetricians are present on the labour ward and conduct procedures, labour ward rounds to include reviewing midwifery-led cases on referral and teaching, as appropriate.

Within County Durham and Darlington NHS Foundation Trust consultant obstetricians have a dedicated presence on the Delivery Suite and the provision of this cover varies on each site but as a minimum is in line with Safer Childbirth recommendations (i.e. units in the UK that have between 2500 and 4000 births a year (category B) should reach 60 hours of consultant obstetrician presence by the end of 2009).

The University Hospital of North Durham

The University Hospital of North Durham currently utilises a system of Consultant of the Week to provide consultant presence on the Labour Ward. Between 09.00hrs and 21.00hrs Monday to Friday and 09.00 to 12.00 Saturday and Sunday (i.e. for 66 hours per week) there is consultant presence on the Labour Ward. Outside of these dedicated hours, an on call system is in effect and a consultant obstetrician can be present on the Labour Ward within 30 minutes.

<table>
<thead>
<tr>
<th>Day</th>
<th>Consultant</th>
<th>Registrar</th>
<th>Senior House Officer</th>
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</thead>
<tbody>
<tr>
<td>Monday</td>
<td>09.00 – 21.00</td>
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<td>21.00 – 09.00</td>
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<td>21.00 – 09.00</td>
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<td>21.00 – 09.00</td>
<td>First On Call</td>
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<td>Thursday</td>
<td>09.00 – 21.00</td>
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<td>Friday</td>
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<tr>
<td>Saturday</td>
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<td>21.00 – 09.00</td>
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<td>09.00 – 12.00</td>
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<td>21.00 – 09.00</td>
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</tbody>
</table>
Darlington Memorial Hospital

Darlington Memorial Hospital provides consultant presence on the Labour Ward as follows:

<table>
<thead>
<tr>
<th>Day</th>
<th>Consultant</th>
<th>Registrar</th>
<th>Senior House Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>09.00 – 17.00</td>
<td>09.00 – 21.00</td>
<td>09.00 – 21.00</td>
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<tr>
<td></td>
<td>21.00 – 09.00</td>
<td>21.00 – 09.00</td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td>09.00 – 17.00</td>
<td>09.00 – 21.00</td>
<td>09.00 – 21.00</td>
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<tr>
<td></td>
<td>21.00 – 09.00</td>
<td>21.00 – 09.00</td>
<td>First On-Call</td>
</tr>
<tr>
<td>Wednesday</td>
<td>09.00 – 17.00</td>
<td>09.00 – 21.00</td>
<td>09.00 – 21.00</td>
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<tr>
<td></td>
<td>21.00 – 09.00</td>
<td>21.00 – 09.00</td>
<td></td>
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<tr>
<td>Thursday</td>
<td>09.00 – 17.00</td>
<td>09.00 – 21.00</td>
<td>09.00 – 21.00</td>
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<tr>
<td></td>
<td>21.00 – 09.00</td>
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<tr>
<td>Friday</td>
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<tr>
<td></td>
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<td>21.00 – 09.00</td>
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<tr>
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<td></td>
<td>21.00 – 09.00</td>
<td>21.00 – 09.00</td>
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<tr>
<td>Sunday</td>
<td>09.00 – 13.00</td>
<td>09.00 – 21.00</td>
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<tr>
<td></td>
<td>21.00 – 09.00</td>
<td>21.00 – 09.00</td>
<td></td>
</tr>
</tbody>
</table>

At Darlington Memorial Hospital, between 09.00hrs and 17.00hrs Monday to Friday and 09.00 to 13.00hrs Saturday and Sunday there is consultant presence on the Labour Ward. In addition to this, on a Wednesday and Thursday night there is resident consultant cover supported by a Senior House Officer. In this way, there is consultant presence on the Labour Ward for 72 hours. Outside of these dedicated hours, an on call system is in effect and a consultant obstetrician can be present on the Labour Ward 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

16 consultants contribute to the maternity service across CDDFT:
3.3 Anaesthetists and their Assistants

3.31 Anaesthetists:

Role of anaesthetists on the maternity unit:

The role of anaesthetists in Obstetrics have changed over the years, such that Anaesthetists are now involved in some way or another in the care of 40% of women who enter Labour Ward. Epidural analgesia during labour has become an expectation of many mothers and it is now used by up to a quarter of women. Successive CEMACH/CEMACE reports have emphasised the importance of Anaesthetists as an integral part of the Obstetric team and in the management of mothers who become seriously ill.

3.32 Lead Obstetric Anaesthetist:

There is a nominated Lead Obstetric Anaesthetist on each site with programmed sessions which reflects both clinical activity and the associated administrative work that it entails.

The Lead Obstetric Anaesthetist is responsible for organisation and audit of obstetric anaesthesia service, for maintaining and raising standards through provision of evidence based guidelines, for providing input to the ‘Labour Ward Forum’ and for training and risk management.
Anaesthetic Assistant:

Operating Department Practitioner (ODP)/ Anaesthetic nurse cover is available 24 hours a day by designated staff qualified to provide anaesthetic assistance in labour ward. They are on the theatre ODP/ Anaesthetic nurse rota designated to cover maternity unit on a particular shift. They are supported in their activities in labour ward theatre by Health Care Assistants.

4.0 Required Staffing Levels

4.1 Midwives and Support Staff

<table>
<thead>
<tr>
<th>Area</th>
<th>Day</th>
<th>Night</th>
<th>Weekends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Midwives</td>
<td>Support Staff</td>
<td>Midwives</td>
</tr>
<tr>
<td>Labour Ward</td>
<td>6/7</td>
<td>2</td>
<td>7 (inc 1 MLU)</td>
</tr>
<tr>
<td>Postnatal/Antenatal Ward</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>PAU</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>Staffing is variable depending on clinics etc</td>
<td>2 Midwives are on-call to cover home births and community emergencies</td>
<td>Midwifery staffing levels within each team are agreed in relation weekend workloads</td>
</tr>
<tr>
<td>Antenatal Clinics</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

A Band 7 labour ward coordinator is in charge on every shift. There is no dedicated Obstetric Theatre Team. A midwife is provided from Labour Ward staff to act as the scrub nurse and a second midwife takes the baby. Team Assistants x 2 provide support in theatre.

DMH

<table>
<thead>
<tr>
<th>Area</th>
<th>Day</th>
<th>Night</th>
<th>Weekends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Midwives</td>
<td>Support Staff</td>
<td>Midwives</td>
</tr>
<tr>
<td>Labour Ward</td>
<td>6</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Postnatal/Antenatal Ward</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>PAU</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>Staffing is variable depending on clinics etc</td>
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<td>2</td>
<td></td>
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BAH
### Maternity Services Staffing Guideline

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<thead>
<tr>
<th>Area</th>
<th>Day</th>
<th>Night</th>
<th>Weekends</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Midwives</td>
<td>Support Staff</td>
<td>Midwives</td>
</tr>
<tr>
<td>Midwifery Led Unit</td>
<td>Core</td>
<td>On-Call</td>
<td>PAU (Mon – Thurs)</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Same</td>
<td>Same</td>
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</tr>
</tbody>
</table>

A Band 7 Midwife is responsible for the overall management of the Midwifery-led Unit.

**Supervisor of Midwives**

There is a Supervisor of Midwives on call for support and advice 24 hours a day.

**Obstetric and Gynaecology Management Team**

<table>
<thead>
<tr>
<th>Role</th>
<th>In Post</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head of Midwifery and Gynaecology</td>
<td>1 wte B8B</td>
<td>1 wte B8B</td>
</tr>
<tr>
<td>Matron – Labour Ward/Postnatal Services</td>
<td>1 wte B8A</td>
<td>1 wte B8A</td>
</tr>
<tr>
<td>Matron – Outpatient and Community Services</td>
<td>1 wte B8A</td>
<td>1 wte B8A</td>
</tr>
<tr>
<td>Matron – Gynaecology Services</td>
<td>1 wte B8A</td>
<td>1 wte B8A</td>
</tr>
</tbody>
</table>

#### 4.2 Consultant Obstetricians

Safer Childbirth (RCOG 2007) states that it is essential for all units with between 2500 and 4,000 births a year to move to 60-hour consultant (or equivalent) presence by the end of 2009. Within CDDFT there are approximately 6000 births per annum. The birth rate within each unit over the past three years is as follows:

<table>
<thead>
<tr>
<th>Unit</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
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<tr>
<td>UHND</td>
<td>3044</td>
<td>3261</td>
<td>3212</td>
</tr>
<tr>
<td>DMH</td>
<td>2357</td>
<td>2415</td>
<td>2397</td>
</tr>
<tr>
<td>MLU BAH</td>
<td>369</td>
<td>360</td>
<td>293</td>
</tr>
<tr>
<td>Total</td>
<td>5772</td>
<td>6036</td>
<td>5902</td>
</tr>
</tbody>
</table>

At present, there is at least 60 hours consultant presence on the Labour Ward across both sites within CDDFT.

#### 4.3 Consultant Anaesthetists

Consultant Obstetric Anaesthetic cover meets recommendations in ‘Safer Childbirth, RCOG 2007’. There is a designated Consultant Obstetric Anaesthetist solely covering labour ward between 08:00 to 18:00 hours during week days. This ensures 50 hours of Consultant Anaesthetist cover of labour ward during ‘normal working hours.’
Maternity Services Staffing Guideline

There is a ‘Duty Anaesthetist’ who is ST3 or equivalent immediately available for the Obstetric Unit 24 hours a day. The duty anaesthetist has access to prompt advice and assistance from a designated Consultant Anaesthetist whenever required.

**Anaesthetic presence on the maternity unit:**

Week-day day time cover (08:00 to 18:00) is provided by Anaesthetic Consultants with an interest in Obstetric Anaesthesia. This equates to 10 4.5 hour day time sessions.

In the rare instance of unavailability of Obstetric Anaesthetic Consultant, cover will be provided by other Anaesthetic consultants or rarely Specialty Doctors/ Specialist Registrars who have the required competencies to enable them to undertake the full range of obstetric procedures. In the rare instance, this happen, there would always be a named Consultant Anaesthetist immediately available to help from main theatres/ intensive care unit.

During weekdays between 18:00 and 08:00 and during weekends and bank holidays, an on-call system operates. A resident on-call specialty doctor/ Specialist trainee (ST3+) provides immediate cover to labour ward, with support from two Consultants who are also on-call. The on-call anaesthetist also covers intensive care unit out of hours but their first responsibility is obstetrics. Resident consultant cover is available between 08:00 to 18:00 on all days including weekends and bank holidays.

On-call anaesthetist hand over and change shifts at 08:00 and 20:00 on all days.

**Others**

The care needs of women whilst pregnant can be diverse and demanding. The provision of the appropriate care to these women can only be provided when the staff caring for them have the appropriate skills.

No other groups of staff are employed within the maternity service. The maternity service however utilises the skills of the appropriate professionals when necessary or as described within the clinical guidelines used within the service.

**5.0 Staff Duties**

**5.1 Labour Ward Coordinator**

For each shift on the Labour Wards at DMH and UHND 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 Labour Wards at all times and must be available to attend Labour Ward 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

Following the occurrence of any of the above clinical situations, each individual case is reviewed at the weekly incident review meeting. Part of this review confirms that the consultant was present. If the review ascertained that the consultant was not present this would be reported as an incident and escalated via the maternity services risk management process.

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 Pregnancy 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 Labour Ward Co-ordinator 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 Labour Ward Co-ordinator. 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.

6.0 Annual Review of Staffing Levels

The Maternity Service within County Durham and Darlington NHS Foundation Trust will undertake annual reviews of staffing levels for each of the staff groups described above with the exception of junior medical staff. Each review will be referenced to current staffing levels, as well as determining whether or not the service is line with the national recommendations in *Safer Childbirth* (RCOG 2007).

The annual reviews will:

Establish whether prospective consultant obstetrician presence on labour ward is in line with *Safer Childbirth* (RCOG 2007). This will be undertaken as a prospective review of consultant cover. The Clinical Director for Obstetrics & Gynaecology is responsible for this. The review will be presented in the second quarter of the financial year to the Obstetric and Gynaecology Operational planning meeting in the first instance.

Ensure Midwifery and support staffing levels are appropriate, in relation to the current delivery rate and the recommendations of *Safer Childbirth*. The Head of Midwifery will ensure that an annual review is undertaken. If Birthrate Plus is commissioned during the year then this will be the annual review. On years that Birthrate Plus is not commissioned an audit of all rotas will be undertaken retrospectively following the end of the financial year. This will be undertaken using the MAPS system which stores all rotas for every shift. This review will be presented in the second quarter of the financial year to the Obstetric and Gynaecology Operational Planning meeting in the first instance.

Establish whether obstetric anaesthetist staffing levels are in line with *Safer Childbirth* (RCOG 2007). An audit of all rotas will be undertaken retrospectively following the end of the financial year. This is undertaken as a manual review by the lead obstetric anaesthetist. This review will be presented in the second quarter of the financial year to the Obstetric and Gynaecology Operational Planning meeting in the first instance.

Establish whether anaesthetic assistant staffing levels are in line with the maternity services required staffing levels. An audit of all rotas will be undertaken retrospectively following the end of the financial year. This is undertaken as a manual review by the lead anaesthetic nurse & the obstetric anaesthetic lead. This review will be presented in the first quarter of the financial year to the Labour Ward Forum in the first instance.

An exception report will be presented to Obstetric and Gynaecology Clinical Governance Forum or confirmation that staffing levels are in line with this guideline and the recommendations in *Safer Childbirth*. Any shortfalls in staffing levels as compared with the recommendations in *Safer Childbirth* (RCOG 2007) will be presented to the Quality and Healthcare Governance Committee by the Head of Midwifery (as the designated attendee) along with a proposal to address the issues.

7.0 Process for the Development of Business Plans

Where annual reviews identify that particular staff groups are not in line with national recommendations, a business plan may need to be developed to acquire additional
staff. The business plan will be developed in line with the Trust’s Business Case and Service Development guidance. Once developed, the Business Case will be presented at the Operational Planning Group for consideration. The development of the business case will be the responsibility of the professional lead (i.e. Head of Midwifery, Clinical Director for Obstetrics or Obstetric Anaesthetic Lead).

8.0 Development of longer term contingency plans

8.1 Contingency plans to address long term midwifery and support staff shortfalls

In the case of long term staff absence such as maternity leave, temporary fixed term contracts may be utilised. Staff may be redeployed for a fixed term to other areas of the service.

8.2 Contingency plans to address long term Consultant Obstetrician staffing shortfalls

The clinical lead will review consultant job plans and reorganise if necessary to span any gaps in the existing cover arrangements. If job plans cannot be reorganised, the maternity service will seek to employ locum Consultants to span any gaps in the existing cover arrangements.

8.3 Contingency plans to address long term anaesthetic staffing shortfalls

The clinical lead for anaesthetics will review consultant job plans and reorganise if necessary to span any gaps in the existing cover arrangements. If job plans cannot be reorganised, the anaesthetic service will seek to employ locum Consultants to span any gaps in the existing cover arrangements.

Anaesthetic Assistants

In the case of long term staff absence such as maternity leave, temporary fixed term contracts may be utilised.

In addition to the above the senior medical and midwifery management team will continue to:

- 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
- Discuss staffing levels at bi-monthly Obstetrics and Gynaecology Operational Group – 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
- Reorganise staff – wherever possible – to optimise deployment in accordance with levels of activity in each area
• Make optimal use of all opportunities for discussion with and updating the senior management team about the current status of the problem, as well as possible solutions.

9.0 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 (see appendix 1 and 2).

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.

All short term staffing crises events should generate a Safeguard incident report. These will be reviewed through the maternity risk management framework.

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

A rota is produced each month with the details of the consultant assigned to day time and on-call duties. In the event of short-term sickness, cover is arranged by either the rota lead or Clinical Director.

In the event of short-term consultant sickness, cover is arranged by either the rota lead or Clinical Director. The response to unplanned short term absence of junior medical staff is co-ordinated by the College Tutor(s).

c. Anaesthetists

All short term staffing crises events should generate an incident report. They will be reviewed through the risk management framework and referred to the clinical lead for obstetric anaesthesia for review at the anaesthetic risk management meeting. At times of additional workload or sickness the additional workload is absorbed by the existing anaesthetic on call system.

d. Anaesthetic Assistants

In case of unexpected shortfall out of hours, the senior member of the on-call team would obtain a substitute either from staff covering main theatres or by bringing in a member of staff from home.

10.0 Monitoring Compliance with the Document

10.1 Required staffing levels and staff duties

The required staffing levels and staff duties will be monitored by the Clinical Lead for Obstetrics and the Head of Midwifery and Gynaecology through the Obstetric and
Maternity Services Staffing Guideline

Gynaecology Operational Group and the Quality and Healthcare Governance Committee.

The outcomes of audits will be reported to these groups – using the methodology described above.

10.2 Process for development of business plans

This will be monitored by the Clinical Divisional Manager for Families on a yearly basis, with the Key Performance Indicators (KPIs) being whether or not the Clinical Director and Head of Midwifery and Gynaecology have submitted business plans to Operational Planning Group as a response to any identified staffing shortfalls.

10.3 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 and is the responsibility of the Matron with responsibility for Risk Management and reported to the Obstetric and Gynaecology Operational Group – with any shortfalls assigned to leads for the relevant clinical areas. The resulting action plan will be monitored by the Obstetric and Gynaecology Group.

The KPI will be the maternity dashboard, as well as minutes of the Obstetric and Gynaecology Operational Group meetings.

10.33 Assurance in relation to Maternity staffing levels

This will be monitored at the Quality and Healthcare Governance Committee. Significant capacity problems will be entered onto the Risk Register, which is reviewed at the quarterly Clinical Governance Committee and the Obstetric and Gynaecology Operational Group Meeting. The KPIs will be minutes of the above meetings, as well as the Risk Register.

10.34 Regular discussion of staffing levels at monthly Obstetric and Gynaecology meetings

The Consultants and Senior Staff meeting takes place monthly, and consists of all Obstetric Consultants, as well as senior Midwives / Managers. This meeting also reports to the Obstetrics and Gynaecology Operational Group where staffing levels are also discussed along with the maternity dashboard and the Risk Register.

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

10.35 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 and Gynaecology Operational Group on a monthly basis under a standing “capacity / staffing” item.
### 11.0. Key Performance Indicators (KPI's)

<table>
<thead>
<tr>
<th>Monitoring Criterion</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will perform the monitoring?</td>
<td>Maternity Services Anaesthetic Service</td>
</tr>
<tr>
<td>What are you monitoring?</td>
<td>Required staffing levels and duties of identified staff groups</td>
</tr>
<tr>
<td></td>
<td>Midwives and Support Workers</td>
</tr>
<tr>
<td></td>
<td>Obstetricians</td>
</tr>
<tr>
<td></td>
<td>Anaesthetists and Anaesthetic Nurses</td>
</tr>
<tr>
<td>When will the monitoring be performed</td>
<td>Quarterly via the Maternity Dashboard</td>
</tr>
<tr>
<td></td>
<td>Annual Staffing Audit</td>
</tr>
<tr>
<td>How are you going to monitor?</td>
<td>Annual staffing audit report</td>
</tr>
<tr>
<td></td>
<td>Minutes of meetings</td>
</tr>
<tr>
<td></td>
<td>Maternity Dashboard</td>
</tr>
<tr>
<td></td>
<td>Electronic Staffing Register</td>
</tr>
<tr>
<td></td>
<td>Sickness and Absence Reports</td>
</tr>
<tr>
<td>What will happen if any shortfalls are identified?</td>
<td>Short term and longer term contingency plans will be developed. Business case will be developed to address any identified staffing shortfalls.</td>
</tr>
<tr>
<td>Where will the results of the monitoring be reported?</td>
<td>Obstetric and Gynaecology Operational Group Quality and Healthcare Governance Committee</td>
</tr>
<tr>
<td>How will the resulting action plan be progressed and monitored?</td>
<td>Monitoring of the development and submission of Business Cases to the Operational Planning Group in response to staffing shortfalls.</td>
</tr>
<tr>
<td>How will learning take place?</td>
<td>Regular discussion of staffing levels at monthly Obstetric and Gynaecology meetings.</td>
</tr>
</tbody>
</table>

### 12.0 References


13.0 Associated Documentation

Policy for Policies
Risk Management Operational Policy
Risk Management Strategy - Maternity
Risk Register Procedure
Business Case and Service Development Guidance
### Full Assessment Form v2/2011

<table>
<thead>
<tr>
<th>Division/Department:</th>
<th>Care Closer to Home – Maternity Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of policy, procedure, decision, project, function or service:</td>
<td>Maternity Services Staffing Guideline</td>
</tr>
<tr>
<td>Lead person responsible:</td>
<td>Evidence Base Practice Group - chair</td>
</tr>
<tr>
<td>People involved with completing this:</td>
<td>Anne Holt</td>
</tr>
</tbody>
</table>

**Type of policy, procedure, decision, project, function or service:**

- Existing: □
- New/proposed: ✓
- Changed: □
Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

To ensure women have the safest care that can be given

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Maternity Service

What outcomes do you want to achieve?

No incidents – good outcome – good experience for women and their families

What barriers are there to achieving these outcomes?

Not adhering to guidelines and policies. Not escalating staffing shortages as per policy

How will you put your policy, procedure, project, decision, function or service into practice?

Monitoring incidents and ensuring lessons are learned

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?
Step 2 – Collecting your information

What existing information / data do you have?

Incident data

Who have you consulted with?

Clinical colleagues

What are the gaps and how do you plan to collect what is missing?

N/A

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No

Sex/Gender
No

Age

No

Disability

No

Religion or Belief

No

Sexual Orientation

No

Marriage and Civil Partnership

No

Pregnancy and Maternity


Maternity Services Staffing Guideline

Gender Reassignment

No

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills

No

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?

No

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A
Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Agreed at Obstetrics and Gynaecology Operational Group and approved at the Quality & Healthcare Governance Committee

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

Annual audit of staffing levels in maternity

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be attached to any documentation to which it relates and must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk

Appendix 1

Staffing/workload escalation process
Contact bank staff
↓
Reallocate midwives covering community commitments to unit
↓
Reallocate specialist midwives, Band 7 midwives with managerial time to unit
↓
Cancel planned study days
↓
Contact staff on annual leave/days off
↓
Alert paediatricians & obstetricians to facilitate prompt discharge of suitable patients
↓
Ensure effective discharge management e.g. Early discharge for suitable patients from labour ward, redeployment of staff to discharge duties
↓
Assess planned activity postponement i.e. induction of labour, elective caesarean section
↓
Follow temporary closure of maternity unit guideline if escalation measures exhausted
↓
Complete Safeguard incident form if closure necessary
↓
Co-ordinate likely capacity over next 48 hours due to reallocation of postponed patients
↓
Labour Ward Co-ordinator to document staffing/capacity issues on the shift handover sheet for communication at handover.
NEEP Escalation Framework for: County Durham and Darlington Foundation Trust Maternity Services

Version number: 1
Author: Anne Holt

Explanatory Note:
Our NEEP Framework is split into two parts:
- At Levels 1, 2 and 3, the focus is primarily on internal management of pressures at Site-level, and by sites working together. NEEP level will be determined at both Site and Trust level. Where one Maternity site is at a higher level than the other, the Trust-wide NEEP level will be based on the highest level predicted by the end of the day. For example, if Maternity at UHND is predicting to be at Amber by the end of the day, and DMH Green, the Trust-wide NEEP level for Maternity will be Amber.
- Levels 4 – 6 will always be declared as the Trust-wide position for Maternity and will involve more significant levels of communication with external partners to help us manage demand.

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Level</th>
<th>Action</th>
<th>Communication</th>
<th>Command and control</th>
<th>Impact</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>The trigger for escalation from one level to the next is a judgement by the responsible person. Bed occupancy is not the only trigger factor and should be considered in the context of the whole Trust position and other internal and external factors.</td>
<td>•Name or number for the level. •Description of what is happening in the organisation or service at this level.</td>
<td>•What will be done to mitigate the raised level of pressure as a result of moving to this level? •Who by? When? Where?</td>
<td>•What will be communicated intra and/ or inter organisationally? •Who by? When?</td>
<td>•What command and control arrangements will be in place? •Who has the authority to trigger? •Are these different in hours and out of hours?</td>
<td>•Expected impact of these actions</td>
<td>•Any implications of these actions on other organisations</td>
</tr>
<tr>
<td>Normal operations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Each site has sufficient capacity to deal with its emergency &amp; elective workload in Maternity in the forthcoming 24hr period.</td>
<td>•All services operating</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>NEEP 1</td>
<td>• The emphasis at this level of alert is on timely implementation of standard bed management operational policies and procedures, excellent communications. •Labour Ward Co-ordinators to continually</td>
<td>•Appropriate policies and procedures available on the Obs and Gynae site on the Intranet. •Updates throughout the</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status WHITE</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
### Maternity Services Staffing Guideline

<table>
<thead>
<tr>
<th>Increasing pressure</th>
<th>NEEP 2</th>
<th>Action</th>
<th>Hourly review of activity on Labour Ward</th>
<th>Command and control exercised through hourly reviews of activity.</th>
<th>NEEP level returned to NEEP 1.</th>
<th>Increase awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>normally</td>
<td>(Normal Site Work)</td>
<td>monitor bed availability &amp; expected discharges, ensuring women are admitted to appropriate beds and discharge is timely.</td>
<td>day between Labour Ward Co-ordinators on both sites and the MLU to monitor activity on every site.</td>
<td>Daily updates to matron regarding activity on Labour Ward – more frequently if increased pressure.</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Labour Ward Co-ordinator escalate to the Matron - if increased pressure. (see next level).</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Ward staff should ensure the Labour Ward Co-ordinator has a full &amp; accurate picture of planned discharges.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Obstetric and midwifery teams identify and use Expected date of discharge for all mothers and babies.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Ward staff are responsible for notifying the Labour Ward Co-ordinator of an available bed in a timely fashion and ensuring resulting transfer/admission takes place as quickly as possible.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>- Ward staff should plan discharge to ensure beds are vacated in a timely manner.</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Day between Labour Ward Co-ordinators on both sites and the MLU to monitor activity on every site.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Daily updates to matron regarding activity on Labour Ward – more frequently if increased pressure.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Status GREEN CONCERN</td>
<td>Maternity Services Staffing Guideline</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>There is increased pressure on the site requiring additional action over and above normal working practice.</td>
<td>must agree NEEP 2 status by Labour Ward Co-ordinator and Matron.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Status Green applies:</td>
<td>• Matron co-ordinates all sites through telephone discussions/conferences.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If elective work is delayed due to level of emergency activity</td>
<td>• Escalation Policy in place</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Predicted deliveries/admissions exceed predicted discharges over the remainder of the day</td>
<td>• Matrons can escalate to Amber</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

**Labour Ward Co-ordinator:**
- Ensure all Status Green interventions carried out.
- Ensure high quality information is available to aid decision making.
- Review staffing levels and call in community midwives on call if required.
- Inform Matrons and Head of Midwifery and Gynaecology of increasing pressure.
- Matron and Labour Ward Co-ordinator to undertake review of activity in Labour Ward and Wards and Departments.
- Continuous appraisal of situation by Matron and Labour Ward Co-ordinator.

**Matrons:**
- Should ensure that all ways of accelerating discharge/transfer of mothers and babies have been
considered and have reviewed all patients on the postnatal/antenatal ward to ensure any mother or baby medically fit for discharge has been identified.

- Provide a list of potential discharges to Pharmacy staff to ensure all TTO’s are written up and dispensed expeditiously.
- Accelerate the scheduling of diagnostic procedures/investigations where necessary.

**Clinical Teams:**
- Review immediately any mother and baby awaiting a decision to discharge.
- Identify mothers and babies suitable for transfer to the MLU, BAH if there is capacity.

<table>
<thead>
<tr>
<th>Actual pressure</th>
<th>NEEP 3</th>
<th>Action</th>
<th>Matrons and Head of</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Maternity Service will not have</td>
<td></td>
<td>Matron to advise Head of Service of NEEP status.</td>
<td>Command and control exercised through regular cross site telephone</td>
</tr>
</tbody>
</table>
sufficient capacity to deal with its emergency and elective workload in the forthcoming hours, unless additional measures are implemented to free capacity and avoid admission.

**Status Amber** applies if:

- The number of high risk and complex women in established labour or requiring an increased level of care is equivalent to the number of midwives available.
- The number of women in established labour is in excess of the number of midwives available (level will be judged depending on the complexity of cases)
- Elective activity is cancelled due to emergency

<table>
<thead>
<tr>
<th>Status AMBER (Actual Pressure)</th>
<th>Midwifery and Gynaecology must agree NEEP level 3. (Out of hours inform – Senior Manager on call)</th>
<th>Matron or Head of Midwifery and Gynaecology:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increased frequency of activity reviews and liaison with Patient Flow, as needed.</td>
<td>Liaise with Labour Ward Co-ordinator and Patient Flow Team, evaluate situation and ensure co-ordinated actions.</td>
</tr>
<tr>
<td></td>
<td>Ongoing briefings to staff required</td>
<td>Ensure all Status Amber interventions carried out.</td>
</tr>
<tr>
<td></td>
<td>Engage in internal telephone calls and meetings as required.</td>
<td>Confirm if Status Red has been reached and if necessary escalate/de-escalate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consider/assess capacity to open additional capacity within the maternity unit (e.g. PAU).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assessment of service provision, as frequently as needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participate in cross site telephone calls as required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Determine if one maternity unit can divert internally to the other site.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inform NEAS of the decision to divert.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discussions and decision making.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Head of Midwifery and Gynaecology can escalate to Red</td>
</tr>
</tbody>
</table>

return to NEEP 2.

- Relocation / allocation and resources to areas with high demand
- Some impact on patient satisfaction levels
- Standards of care compromised (clinical care / admission / discharge / patient experience)
- Consultants agree management plans with senior midwifery team.
• Patient safety is compromised

• A neighbouring organisation goes onto external divert for maternity patients

• There is severe weather and consequent travel disruption

**Labour Ward Co-ordinator:**
- Co-ordinate the process of diverting low and high dependency admissions between sites.
- Communicate between sites to ascertain overall position.
- Continuous appraisal of situation supporting the Matrons

**Matrons and Labour Ward Co-ordinator:**
- Redeploy staff as appropriate to ensure staff allocation is based on a risk assessment to ensure patient safety/minimisation of risk.
- Obtain additional staff where indicated by calling in community midwives on call (note: this will lead to temporary suspension of the home birth service).
- Review of all mothers and babies to challenge Estimated Date of Discharge. If plans are not clear or not being assertively managed,
Maternity Services Staffing Guideline

<table>
<thead>
<tr>
<th>Pressure is extreme.</th>
<th>NEEP 4</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status Red applies:</td>
<td>Status RED SEVERE</td>
<td>Head of Service must declare Level 4. Out of hours, the Head of Service must declare Level 4.</td>
</tr>
</tbody>
</table>

**Clinical Teams:**
- Consultants to undertake review of high dependency patients with a review to discharge or transfer to the MLU, BAH.
- Robust management of Estimated Date of Discharge.
- On-call consultants manage consultant to consultant transfers of all diverted patients.
- Consider diverting appropriate patients to pregnancy assessment units on all sites.
- Labour Ward Co-Ordinator to take calls from women and other health care professionals to advise on management of the latent phase of labour and review if necessary in the most appropriate location.

**Pressure is extreme:**
- Status Red applies:
- A surge in emergency admissions that is likely

**Action**
- Head of Service must declare Level 4. Out of hours, the Head of Service must declare Level 4.
- Escalation communicated to the Director of Nursing for information
- Command and control exercised through ongoing review of activity on all sites.
- Head of Midwifery and

**NEEP level will return to**
- Standards of care compromised due to delayed
<table>
<thead>
<tr>
<th>PRESSURE</th>
<th>Midwifery and Gynaecology will inform the Executive Director on call.</th>
</tr>
</thead>
</table>
| Head of Midwifery and Gynaecology: | • Alert ACOO to Red status.  
• Ensure all Status Red interventions carried out, and all actions above have been completed.  
• Give consideration to the use of Pregnancy Assessment Units for additional capacity.  
• Consider the need to divert externally to other maternity units in the region.  
• Inform NEAS on the decision to divert.  
• Determine if the major incident plan or aspects of the major incident plan need to be implemented  
• All elective work postponed. |
| • Escalation communicated to NHS Durham and NHS Darlington as per Trust NEEP | Gynaecology keeps ACOO updated regarding situation.  
• ACOO, in consultation with the Chief Operating Officer escalates to Purple |
• Anticipate a reduction in patient satisfaction, complaints and delays in non-urgent treatment.  
• Non-essential work will be delayed and will need to be planned back into recovery  
• Staff increasingly under pressure and reduced ability to cope  
• Thresholds for women to remain at home by will be higher. |

to mean a prolonged deficit in Labour Ward beds.

- Predicted admissions exceed predicted discharges with no change expected for the forthcoming hours.
- Patients awaiting transfer into a postnatal bed are backing up on the Labour Ward and in other areas of the maternity unit.
Maternity Services Staffing Guideline

<table>
<thead>
<tr>
<th>Situation critical.</th>
<th>NEEP 5</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Ongoing briefings to staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Director of Nursing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Command and control</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• NEEP level will return to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Staff increasingly under pressure</td>
</tr>
</tbody>
</table>

- Continuous appraisal of situation.
- Consider external diverts to other maternity units.

**Clinical Teams**
- Implement higher thresholds for admission, and discharge accordingly.
- Consultants to review all high dependency patients and antenatal patients with a view to discharge.
- Review all elective work for the next day with a view to postponing until a later date.
- Discharge all patients immediately who do not need to be in hospital with follow-up from community midwifery services.
- Labour Ward Coordinator to take calls from women and health professionals to provide advice where necessary and if required, arrange review in alternative settings.
<table>
<thead>
<tr>
<th>Pressure is unsustainable and demand exceeds actual capacity.</th>
<th>Head of Midwifery and Gynaecology in consultation with the ACCO (Director on Call out of hours) must agree NEEP level 5 with PCT Director on Call.</th>
<th>exercised through cross site teleconferences and meetings.</th>
<th>Anticipate an increased number of patient complaints and delays in treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demand for beds has outstripped capacity, and Head of Midwifery and Gynaecology predicts a worsening deficit over the next 12 hours</td>
<td>• Head of Midwifery and Gynaecology to attend site if necessary and co-ordinate actions.</td>
<td>• Executive Director has the authority to trigger all or parts of the major incident plan.</td>
<td>• Non Essential work will cease but will need to be planned back into recovery.</td>
</tr>
<tr>
<td>• All discharges effected and all above contingencies implemented.</td>
<td>• Ensures all Status Purple interventions carried out</td>
<td>• Executive lead to communicate step down from NEEP 5 to the PCT Director on Call.</td>
<td>• Potential service failures impacting on other services.</td>
</tr>
<tr>
<td>• NEEP 5 also applies if there are severe pressures that compromise critical (emergency) service delivery, including:</td>
<td>• Determine if Status Black has been reached</td>
<td></td>
<td>• Prolonged recovery period, likely to be over a period of days.</td>
</tr>
<tr>
<td>- Staff shortages</td>
<td>• Continuous appraisal of situation and redistribution of resources as required</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Maternity Services Staffing Guideline

<table>
<thead>
<tr>
<th>Major incident.</th>
<th>NEEP 6</th>
<th>Action</th>
<th>Refer to major incident plan</th>
<th>Refer to major incident plan</th>
<th>Refer to major incident plan</th>
<th>Refer to major incident plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>An emergency response is required with support from within the Trust and support is needed from external agencies to maintain essential services.</td>
<td>STATUS BLACK (Significant risk of service failure)</td>
<td>Executive Director to launch Major incident plan</td>
<td>Refer to major incident plan</td>
<td>Refer to major incident plan</td>
<td>Refer to major incident plan</td>
<td>Refer to major incident plan</td>
</tr>
</tbody>
</table>