WOMEN'S HEALTH AND PAEDIATRICS

MATERNITY UNIT

Medical Staffing Escalation Policy

Amendments			
Version	**Date**	**Comments**	**Approved by**
1	July 2023	New Policy	Maternity Governance Group

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In consultation with: Maternity Governance Group

Ratified by: Perinatal Guidelines Group

Date ratified: **September 2023**

Next review date: **September 2026,** or if legislation, national guidance or lessons learnt indicate an earlier review

Target audience: All health professionals within the maternity services

Comments on this document to: Maternity Governance Group

This SOP should also be used in conjunction with:

Trust Emergency Cover (Acting Down) Policy

Sickness and absence policy

Roles and responsibilities of the Consultant in Obs and Gynae

Maternity Escalation Policy

DAU and triage SOPs – escalation sections

RCOG guidance on compensatory rest 2021

RCOG position statement 2022 ‘Ensuring safe out of hours support for complex emergency obstetric and gynaecology surgery.’

Contents

Medical Staffing Escalation Policy

1.0 Medical Workforce in Obs and Gynae

The levels of medical staffing to provide adequate cover for the Maternity unit and Gynaecology – acute service and in patients, are detailed in the table. All staff are on site with Consultant non-resident on call detailed in the notes below. Consultant cover is further detailed in the 'Roles and Responsibilities' SOP.

Obstetrics and Gynaecology Medical Staffing Acute Care and Inpatients			
Monday to Friday 0900 -1700			
SHO	OBS (LW)	GYN	JBW
Registrar	OBS (LW)	GYN	
Consultant	OBS (LW)	GYN (CoW)	
Monday to Friday 1700-2100			
SHO	OBS (LW)	GYN	
Registrar	OBS + GYN		
Consultant	OBS + GYN[1]		
Saturday and Sunday (and Bank Holidays) 0900 -2100			
SHO	OBS (LW)	GYN (to 7pm)	JBW (to 5pm)
Registrar	OBS + GYN		
Consultant	OBS + GYN[2]		
Monday to Sunday Nights 2100-0900			
SHO	OBS + GYN OBS + GYN OBS + GYN[3]		

Notes:

1. If separate obs and gynae consultant (3 of 12 on rota) the gynae Consultant is non resident on call from 1700

2. Consultant on site to 1800, then non resident on call.

3. Non resident on call, Monday to Friday the Consultant is on site until day to night shift handover and a Consultant led labour ward round are completed.

4. Maternity triage is covered by the LW team with escalation detailed in the Triage SOP

5. DAU is covered by an allocated registrar or by the Gynae Registrar, see weekly rota

6. The workforce model and SOP will be updated in line with any changes to ASPH HR policies, changes in staffing or national terms and conditions

2.0 Escalation in the event of medical workforce shortages

Should staffing levels fall below the establishment detailed above the operational team, service lead and out of hours the Consultant on call and CNSP will attempt to arrange cover. This may involve use of locum / agency staff, adjusting trainee doctors shift patterns, redistributing other daytime activity or cancelling elective activity. The Trust 'acting down' as a Consultant policy may need to be followed.

If levels of cover are felt to be unsafe the escalation protocol should be followed to manage clinical activity and ensure patient safety utilising the agreed OPEL status framework.

OPEL framework specific to medical staffing for maternity:

OPEL 4	No consultant anaesthetist/obstetrician cover for intrapartum care
OPEL 3	Obstetric and anaesthetic rota does not have appropriate cover for maternity unit
OPEL 2	Can mitigate any gaps in obstetric and anaesthetic rota for maternity
OPEL 1	Appropriate obstetric and anaesthetic cover for maternity unit.

3.0 Management of two concurrent emergencies and availability of a second Consultant

In the event of 2 concurrent emergencies the Consultant on call will lead on prioritisation and allocation of staff. The MDT including the midwifery shift leader, anaesthetic team, midwifery manager on call and O+G medical team. In addition support is available via a 2222 'adult priority' call.

3.1 In hours

Mon to Friday 0900 to 1700 – the CoW will be the second consultant and would lead on gynaecological emergencies. Consultant colleagues on site can also be called to support the on call teams. The operational team will support allocation of staff to cover the elective workload should this be required including short notice cancellation of activity.

3.2 Out of hours

The Consultant and Registrar on call will be able to manage 2 concurrent emergencies in most circumstances.

There are an infrequent and limited number of clinical scenarios where a second Consultant is needed. This may include both additional advice and in person clinical support.
The following are the available options for access to this. These are not exhaustive and clinical judgement will apply.

- If separate Obstetric and Gynaecology Consultant (3 in 12 slots on the on call rota) there is availability of a second cons on call to provide assistance within their scope of practice.

- Regional O+G networks – maternal medicine / fetal medicine / placenta accreta (all at SGH) and gynae oncology have on call rotas and can be called for advice and a transfer arranged if required in line with clinical pathways.

- Clinical in person support for haemorrhage, return to theatre or surgically complex and challenging cases – ASPH surgical and urology consultant on call and interventional radiology are available. In addition the Consultant body that are not on call can be contacted and if able to do so can attend to support.

4.0 Managing Compensatory Rest following Consultant Night on Call

The RCOG 2021 advises that:

• Attendance and telephone advice from on-call senior clinicians has increased.

• Compensatory rest for consultants should be actively supported and facilitated by the management team.

• It is recommended that the decision to take rest is not left to the individual consultant but agreed via constructive discussion between the manager/clinical director and clinician.

• Job planning should factor in these recommendations for compensatory rest.

In addition they advise that compensatory rest is fundamental to patient safety and clinician wellbeing with fatigue affecting performance and decision making. Compensatory rest should be taken as soon as practically possible after the sleep disturbance in the interest of protecting the individual's health. Compensatory rest cannot be accumulated and taken as leave.

Where the need for compensatory rest is identified the Consultant and management team will work constructively to support this. The service lead, Cons with responsibility for rota planning and the CoW will support a review of clinical activity and scope for cross cover from a colleague with SPA or clinical admin which can be rescheduled. When arrangements for cover cannot be facilitated clinical activity should be cancelled. The inability to take compensatory rest of the cancellation of clinical activity should trigger a Datix record by the operational team. The need for compensatory rest and any issues will be monitored via the Consultant meeting, feedback from the operational team and Datix as applicable. The consultant should not have to pay back 'missed' clinical sessions or SPA for the purposes of compensatory rest.

Job planning within O+G at ASPH is undertaken annually and includes a review of the workforce model, on call activity and direct clinical care (DCC) sessions. Where possible a dynamic approach has been undertaken to move towards reducing scheduled DCC following a planned on call session and this approach will continue. The RCOG acknowledges that the unpredictability of activity out-of-hours poses challenges when organising compensatory rest; that units will vary in their approach and that moving to a full implementation of the BMA guidance will take time.