Trust Policy

Plymouth Hospitals NHS
NHS Trust

Maternity Operational Staffing and Escalation Policy

Date	Version
October 2014	3

Purpose

Maternity Operational Staffing and Escalation policy – to ensure safer Midwifery Staffing Levels at times of high demand.

Who should read this document?

All Midwives
All Medical Staff working in Obstetrics and Gynaecology
Supervisors of Midwives

Key messages

This is an Operational Policy for Midwifery Managers, Supervisors of Midwives and the Unit Coordinator responsible for safe staffing levels for all midwifery and support staff roles throughout the maternity services. The intention of the document is to ensure the safety of mothers and babies by efficient use of bed occupancy and staffing.

The purpose of the document is to provide guidance on what to do when:

- there are shortages of delivery and/or antenatal/postnatal beds
- activity is high and normal staffing levels are insufficient
- staffing levels are below accepted minimum

Accountabilities

Production	Nicola Phillips, Sarah Fitzpatrick
Review and approval	Maternity Clinical Effectiveness Committee
Ratification	Head of Midwifery on behalf of Director of Nursing
Dissemination	Director of Nursing
Compliance	Director of Nursing

Links to other policies and procedures

Policy for Rostering and Electronic rostering of Nursing Staff (PHNT June 2009)
Intrapartum care guideline No 4: Anaesthetics
Maternity Risk Management Framework (CLI/RIS/STR/95/8)
Nursing Safer Staffing Escalation Standard Operating Procedure

Version History

V2	August 2011	Approved at the Maternity Clinical Effectiveness Committee
V3	March 2013	Approved at the Maternity Clinical Effectiveness Committee
V3.1	October 2014	Transferred into new Trust policy template

Last Approval	Due for Review
October 2014	October 2019

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on the Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

1 Introduction

This is an Operational Policy for Midwifery Managers, Supervisors of Midwives and the Unit Coordinator responsible for safe staffing levels for all midwifery and support staff roles throughout the maternity services. The intention of the document is to ensure the safety of mothers and babies by efficient use of bed occupancy and staffing.

The purpose of the document is to provide guidance on what to do when:

- there are shortages of delivery and/or antenatal/postnatal beds
- activity is high and normal staffing levels are insufficient
- staffing levels are below accepted minimum

  (See appendix 1 for accepted minimum)

2 Purpose, including legal or regulatory background

The objectives are to:

- Maintain safe standards of care by rostering appropriate numbers of staff to preserve all maternity services
- Provide safe escalation pathways (see appendix 2) for staff and patients in times of peak capacity / reduction in workforce

3 Definitions

WTE – whole time equivalent

LSA – Local Supervising Authority

PHNT – Plymouth Hospitals NHS Trust

NHSP – NHS Professionals

RCOG – Royal College of Obstetricians and Gynaecologist

4 Duties

Midwifery and Support Staff

Safer Childbirth (RCOG 2007) recommends a midwife to birth ratio of 1 midwife to 28 births in a consultant led maternity services together with 1:1 care in labour, as minimum. It is recognised when planning the staffing and skill mix within Maternity that this needs to reflect the model of care, case mix and needs of the women. The required staffing levels, shown in appendix 1, are designed to reflect the WTE establishment shown below in order to provide an effective and safe Maternity service within all care settings in line with recommendations in Safer Childbirth, 2007.

The current ratio of midwives to births is 1:38. This is monitored on monthly basis via the Maternity Dashboard and on an annual basis through the LSA (Local Supervising Authority) annual report and is submitted to the Midwifery Supervising Officer.

Midwives form the largest staff group with Plymouth Maternity Services and work within both the hospital and Community setting. Within Plymouth Hospitals NHS Trust there is an establishment of 144.67 WTE midwives (including the Head of Midwifery) for an annual birth rate of 4738 (data from 09/10). Posts that do not directly contribute to midwifery care have been removed from this calculation either partly or wholly dependant upon the role. This represents a midwife to delivery ratio of 1:38. The midwifery workforce is supported by 44.19 WTE support staff working both in the hospital and community.

Within the hospital services 83.33 WTE midwives work within the inpatient and delivery ward areas. This includes a Day Assessment area and Transitional Care.

Within the Community setting 48.17 WTE midwives work from Children's Centre's providing antenatal and postnatal care. The Jubilee team provide a caseloading model of care to all women who book for homebirth and those who have suffered a stillbirth or neonatal death in their previous pregnancy and those who are under 17 at the time of delivery.

A senior midwifery team, including 2 Matrons, 2 Practice Educators, Lead Midwife for Governance and Risk, Audit Midwife, Lead Midwife for Safeguarding, Lead Midwife for screening and a specialist drugs/alcohol midwife also contribute to the service.

The workforce is supported by the use of NHS Professionals, a midwifery bank that can be used for planned absence e.g. long term sick and Maternity Leave and occasional Agency Midwife usage.

Within Central Delivery Suite there is a core of experienced midwives supported by rotational midwives who work within the antenatal and postnatal areas and rotate to CDS on a 6 monthly basis. There are also Community midwives who are locality based in teams who provide antenatal and postnatal care in the Community. Day Assessment Unit and Antenatal clinic also have a core of experienced midwives who also perform 12 week dating scans.

Maternity Support Workers, Band 2, support midwives working in the clinical area within the hospital setting. Band 3 Maternity support workers work alongside Community Midwives providing a wide range of support to women in their own homes. Nursery Nurses, Band 4 contribute to the care provided to sick infants on Transitional Care Ward.

In order to achieve the recommended 1:28 ratio PHNT need to employ a further 23.1 WTE midwives. It is recognised however that due to the financial constraints within the NHS this is unlikely to happen; therefore it is vital that contingency plans are in place to ensure the safety of women and their families.

The inquiry into Staffing in Maternity Units found that the effective deployment of the right staff doing the right thing at the right time in the right place is key to the delivery of a safe and effective maternity service. (The Kings Fund 2008, page 48)

3.1 Duty rotas

This policy is to ensure, as far as practically possible that the staff resource is rostered effectively and fairly across the Maternity Unit in line with the agreed establishment with the use of temporary staffing solutions reduced to a minimum. This policy describes the standards required of ward/departmental rosters to ensure a balance between the needs of the service and the needs of individuals' staff members and is essential to the provision of safe and effective care.

Once approved, duty rotas must not be changed without the knowledge and authorization of the workforce co coordinator or Matron.

Where long term shortfalls in staffing occur it is expected that the ward managers will take appropriate action to redress the balance. In the first instance the shift should be covered through the redistribution of remaining staff. All staff should be encouraged to put their availability in the diary on Central Delivery Suite. If after 2 weeks of shifts being advertised there is no cover then the shifts will be covered by NHSP.by the Matron or workforce coordinator. If there are no midwives available on NHSP the shifts will be put out to Agency. Only the Head of Midwifery or Matrons are able to authorise the use of agency staff.

4. Obstetric Staff

4.1 Consultant obstetrician

Safer Childbirth (RCOG 2007) sets out the desired staffing levels for consultant obstetricians on each labour ward. Prospective consultant obstetrician presence on labour ward of 98 hours per week is recommended.

Consultant on duty for obstetrics:

A consultant obstetrician will be on-call 24 hours a day, with a dedicated pager.

Consultant obstetrician presence on labour ward 98 hours per week:

Set out is the timetable of consultant sessions for maternity

AM = 08:00 till 13:00

PM= 13:00 till 18:00

This totals 50 hours per week of consultant cover per week

4.1.1 Current staffing arrangements

A week on service runs from Friday – Thursday from 08:00 to 18:00. There is a Consultant on call for the rest of the time in order to provide cover 24 / 7. The WOS Consultant is free from any other clinical duties to cover obstetric and gynaecological emergencies. They will handover to on-call consultant who will cover the evening and night. This provides 50 hours of consultant cover on labour ward (98 hours recommended by Safer Childbirth).

Consultants can be contacted via the switchboard '0' or by pager (see list on CDS whiteboard)

In an obstetric emergency dial 3333 and state 'obstetric emergency' and location

Consultants are not part of emergency call system. If their presence is required, please ask switchboard to page them.

Minimum requirements for consultant to attend in person:

- Eclampsia
- Maternal collapse (i.e. massive abruption, septic shock)
- Caesarean section for placenta praevia
- Post partum haemorrhage of more than 1500 ml where the haemorrhage is continuing and a massive obstetric haemorrhage protocol has been implemented
- Return to theatre – laparotomy
- When requested

On-call consultants must be able to attend the delivery suite from home within 30 minutes of call out.

Out-of-hours it is expected that the consultant obstetrician is available to perform ward rounds as a minimum once a day (Saturday, Sundays and Bank holidays) (Safer Childbirth recommends twice daily ward rounds with a night ward round). The consultant must sign in and out of the dairy kept on labour ward to demonstrate their presence and that handover has occurred.

In the case of emergencies, anticipated difficult births, including LSCS or whenever the clinical situation gives cause for concern, the consultant obstetrician must be contacted and must attend the Maternity Unit as requested.

4.2 Middle grade medical staff

Central Delivery Suite is covered 24 hours a day by registrars who have no other commitments (see weekly Registrar and SHO rotas).

They are available on a rolling bleep:

Phone 779 0311 followed by extension no.

Await confirmation that call accepted. Replace receiver and wait for call.

4.3 Junior medical staff

Central Delivery Suite is covered 24 hours a day by SHOs who have no other commitments (see weekly Registrar and SHO rotas).

They are available on a rolling bleep:

Phone 779 0464.. followed by extension no.

Await confirmation that call accepted. Replace receiver and wait for call.

4.4 Review of prospective staffing levels

The Care Group Manager, Director of Midwifery and Service Line Director will:

a. Ensure that there is an appropriate level of cover in the short term ie for the next month's rota.

b. Identify and develop contingency plans for any prospective staffing issues in the mid term ie annual leave/ study leave/planned sick leave.

c. Identify and plan for long-term prospective staffing issues to inform business planning.

In the event of a short or long term staffing shortfall, the Directorate Manager, Service Line Manager, Service Line Director, Week-on-Service Consultant and Unit Coordinator must be notified, as appropriate. A contingency plan will be agreed upon and staff notified of actions to resolve issues.

5. Anaesthetic Staff

5.1 Consultant anaesthetist

There is a 24 hour anaesthetic service that covers Maternity with dedicated anaesthetists that have obstetric specialty.

They are available on a rolling bleep:

Phone 779 0399.. followed by extension no.

Await confirmation that call accepted. Replace receiver and wait for call.

Safer Childbirth (RCOG 2007) sets out the desired staffing levels for anaesthetists on each labour ward. The Obstetric Anaesthetist Association and the Association of Anaesthetist of Great Britain & Ireland endorse these guidelines

Anaesthetist on duty solely for obstetrics:

An anaesthetist competent in obstetric anaesthesia will be on-call 24 hours a day, will a dedicated pager, resident in Derriford Hospital

Consultant anaesthetist presence on labour ward 40hours per week:

Set out is the timetable of consultant sessions for maternity

AM = 08:00 till 13:00

PM= 13:00 till 18:00

This totals 50 hours per week of consultant cover per week

Unit should have Lead obstetric anaesthetist

This post will rotate at least every 5 years between consultant obstetric anaesthetists.

Current lead: Dr P Youngs (start 2008)

Unit should have competent duty anaesthetist

Competency will be tested prior to joining obstetric anaesthetic rota in Derriford Hospital. This will involve daytime sessions on labour ward with one of the obstetric anaesthetic consultants. This will be for those with prior obstetric anaesthetic experience elsewhere but new to Derriford Hospital.

Anaesthetists new to obstetric anaesthesia will undergo intensive training as part off the Royal College of Anaesthetists training scheme. Competency assessment will be documented in the training portfolio of the anaesthetist.

On call consultant anaesthetist should be available to help when needed

Immediate out of hours support will be provided by the general consultant on call. This is set out in the Escalation policy for obstetric anaesthetic service.

The escalation policy will cover the weekday and out of hours actions to follow should additional anaesthetists be needed for maternity.

(see intrapartum care guideline No 4: Anaesthetics)

5.1.1 Current staffing arrangements

To cover annual leave of consultants with regular obstetric sessions, those with flexi sessions in their weekly programme will be first in line to cover the vacant session on the morning of a section list.

In the absence of another obstetric anaesthetic consultant to cover leave, one of the SAS doctors with regular obstetric anaesthetic sessions will cover the leave.

In the absence of either a consultant or SAS anaesthetist, a senior trainee will cover the daytime session. This may be a trainee in an obstetric anaesthetic fellowship post. They will have “distant supervision” (Royal College Anaesthetist defined term) by a consultant anaesthetist within Derriford Hospital.

<u>Timetable for obstetric anaesthetic consultants</u>

a) Ten consultant sessions per week for labour ward

It is established practice by the anaesthetic directorate, as set out in the timetables above, with some leave cover built in to job programmes.

b) Separate consultant anaesthetist for each caesarean section list

For the each of the 3 elective C-section lists per week, the consultant will be joined by either an SAS doctor with an interest in obstetric anaesthesia or a trainee anaesthetist who is competent in obstetric anaesthesia.

c) Extra clinical time for HDU care

The obstetric anaesthetic consultants have adequate time to provide HDU care. Backup and support in delivering this care is provided by Critical Care consultants within the hospital

d) Extra clinical time should be made available each week for antenatal referrals, especially when a formal clinic is provided There is extra time given for antenatal referrals, in the form of an obstetric anaesthetic clinic. This is held in the morning, once every 2 weeks, staffed by a Consultant Obstetric Anaesthetist

Rota should allow all levels of training for anaesthetic trainees

5.2 Anaesthetic assistants

There is 24 hour cover in place for anaesthetic assistants / operating department practitioners (ODPs). In the event of rostered staff not being available, an ODP is always transferred from another theatre base to cover maternity.

5.3 Review of prospective staffing levels

The Directorate Manager, Director of Midwifery and Service Line Director will:

- Ensure that there is an appropriate level of cover in the short term ie for the next month's rota.
- Identify and develop contingency plans for any prospective staffing issues in the mid term ie annual leave/ study leave/planned sick leave.
- Identify and plan for long-term prospective staffing issues to inform business planning.

In the event of a short or long term staffing shortfall, the Directorate Manager, Service Line Manager, Service Line Director, Week-on-Service Consultant and Unit Coordinator must be notified, as appropriate. A contingency plan will be agreed upon and staff notified of actions to resolve issues.

6. Unit coordination

During office hours the Maternity Unit Matron is available between 08:00 and 16:30 Monday - Friday. She can be contacted via pager number 89202. The Matron will be responsible for performing a risk assessment with respect to staffing and levels of capacity and log the information on the unit coordination paperwork. A formal risk assessment may also be required using appropriate Trust documentation. The matron will also support patient flow, bed management and manage short term staffing issues on a daily basis.

In order to ensure safe and appropriate care for mothers and infants, during periods of peak activity the Matron will monitor the bed management process a minimum of 4 times a day (08:00, 14:00, 17:00) until capacity has reduced to an acceptable level.

The Matron will ensure the Director of Midwifery and the Week on Service Obstetric consultant are informed. They will assist the unit coordinator in finding solutions to staffing / capacity levels.

Out of hours an experienced band 6/7 midwife will take on the role. A communication book on Central Delivery Suit will be used as a handover from the Matron..) It is expected that the coordinator will visit/ring all clinical areas and record the activity for the night.

The Unit Coordinator will lead activities in finding solutions to staffing / capacity levels with the support of the Supervisor of Midwives (via Maternity reception, tel: 31849), the on-call consultant and the on-call manager (via switch, tel: 0).

See appendix 3.

7. Peaks in capacity

The Matron, Week on Service Consultant and Lead Midwife for Central Delivery Suite should be informed of all capacity issues. These should be escalated to the Head of Midwifery when appropriate.

Where problems can be anticipated in advance, attempts should be made to reduce activities in the unit or specific clinical areas by:

- discharging in-patients as soon as clinically possible
- Discharge of postnatal mothers and infants from Central Delivery Suite.to continue as per policy. Arrangements can be made for examination of newborn to be performed at home by the Community Midwife
- avoiding admission of infants who require a higher level of care than normal to the postnatal wards; they may be more appropriately cared for on NHDU /NICU under these circumstances

- avoiding admission of gynaecology patients to Maternity beds
- considering delay of inductions and non-essential elective activities, ie. elective LSCS lists
- considering closure of unit to level 3 in-utero transfers – liaise with neonatologists, WOSconsultant and Head of Midwifery.

Shortage of antenatal, postnatal or delivery beds

- Avoid unnecessary admissions through the effective use of the Triage service
- Ask medical staff to prioritise discharge reviews in order for patients to be discharged ASAP.

Avoid unnecessary transfer of women from Day Assessment to Argyll ward when discharge is likely – medical staff to review and discharge women home

Beds can be made available on Norfolk ward for antenatal patients only. The decision as to which patients are suitable to be transferred to Norfolk rests with the unit coordinator or WOS consultant.

8. Staffing shortfalls – Contingency planning

Short Term staffing

Short term staffing shortages can occur when there is unexpected sickness, or an unusually high workload or high dependency.

In the presence of staffing shortfalls, escalation should occur as follows:

- Ensure the Head of Midwifery is informed (in office hours)
- The Unit Coordinator will review the staffing allocation throughout the maternity service. A decision should be made to as to whether or not relocation of staff between hospital and community is necessary to safely cover the workload. .
- Overnight the 3rd midwife on Argyll to be relocated to CDS
- Consider re-allocation of other staff already rostered to work within the unit and including s taff with non- clinical and specialist roles
- Consider if additional staff are required and, if so, consider the grade of staff required.
- Consider asking staff to change shifts to cover immediate workload capacity
- Speak to staff on duty or on leave and offer:

  additional hours with time off in lieu

  paid additional hours to part time staff or NHS P staff, if available

  paid additional hours to full time staff (overtime payments)

NB Additional hours should be sanctioned by the Maternity Unit Matron, Coordinator or Head of Midwifery

- Consider calling in hospital staff before their expected shift time
- Specialist midwives and non-clinical midwives to work clinically
- Consider using beds on Norfolk ward as agreed by WOS consultant.

When staffing levels adversely affect the care that women receive the SOM should be contacted and a Clinical Incident Form completed. At this point, if staffing is still in dire crisis, all Midwifery Matrons, Supervisors of Midwives and the Head of Midwifery should be working clinically to coordinate and support the clinical teams.

Long term staffing shortfalls

Long term staffing shortages can occur when there is long term sickness, unfilled vacancies or an unusually high workload or high dependency.

It is essential that rosters are planned in accordance with the Operational staffing policy.

In the presence of long term staffing shortfalls, escalation should occur as follows:

- Ensure the Head of Midwifery is informed (in office hours)
- The Unit Coordinator will review the staffing allocation throughout the maternity service. A decision should be made to as to whether or not relocation of staff between hospital and community is necessary to safely cover the workload.
- Consider re-allocation of staff already rostered to work within the unit and / or community, including staff with non- clinical and specialist roles
- Consider if additional staff are required and, if so, consider the grade of staff required.
- Speak to all staff and offer:

  additional hours with time off in lieu

  paid additional hours to part time staff or NHS P staff, if available

  paid additional hours to full time staff (overtime payments)

NB Additional hours should be sanctioned by the Maternity Unit Coordinator or Head of Midwifery

Explore whether specialist midwives and non- clinical midwives are available to work planned clinical shifts

Consider using beds on Norfolk ward as agreed by WOS consultant.

When staffing levels adversely affect the care that women receive the SOM should be contacted and a Clinical Incident Form completed. At this point if staffing is still in dire crisis then all Midwifery Matrons, Supervisors of Midwives and the Head of Midwifery should be working clinically to coordinate and support the clinical teams.

8.1. Communication

Inform Supervisor of Midwives on call

Inform Head of Midwifery (or nominated Deputy)

Inform On-call Consultant Obstetrician

Inform Consultant Neonatologist / neonatal unit

Inform Director of Nursing or on-call Manager

9. Closure of the Maternity Unit

Whilst it is extremely rare for the unit to have to close, the prime concern is the safety of mothers and infants. The unit will close or restrict admissions as a last resort, when all other potential solutions have been exhausted, after a clinical assessment of the risks within the Maternity Unit / Neonatal Intensive Care Unit has been made. The decision to close ultimately rests with the on-call Consultant Obstetrician and Director of Nursing and Midwifery (or nominated Deputy) in association with the on-call Consultant Neonatologist.

5 Key elements (determined from guidance, templates, exemplars etc)

The purpose of the document is to provide guidance on what to do when:

- there are shortages of delivery and/or antenatal/postnatal beds
- activity is high and normal staffing levels are insufficient
- staffing levels are below accepted minimum ction can contain as many sub sections as needed.

6 Overall Responsibility for the Document

Maternity Clinical Effectiveness Committee

7 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Maternity Clinical Effectiveness Group and ratified by the Chief Nurse or nominated deputy

Non-significant amendments to this document may be made, under delegated authority from the Executive Director, by the nominated author. These must be ratified by the Executive Director and should be reported, retrospectively, to the approving group or committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes

8 Dissemination and Implementation

Following approval and ratification, this policy will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the named Director of Nursing and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

9 Monitoring Compliance and Effectiveness

Midwifery staffing levels are monitored through the Risk Management Maternity Dashboard. The red / amber / green scoring system will provide a measure of staffing and capacity within the Maternity unit. Monthly reviews of the dashboard will take place via the Clinical Effectiveness Group committee. The committee reports to the Trust board via the Risk Assurance & Review Group (see Maternity Risk Management Framework).

Where staffing levels continually fall below the minimum requirements ward managers together with the Head of Midwifery are expected to develop business and contingency

plans to address the shortfall. This will be communicated to the Directorate Manager for escalation to the Trust board where necessary.

10.1.1 Midwifery and support staff

- The Head of Midwifery or nominated deputy will undertake an annual review of midwifery and support staffing numbers
- Any action plans as a result of annual audit and any contingency plans will be monitored by the Clinical Effectiveness Committee, which reports to the Effective Care Group
- The audit findings will also be reported to the Directorate Manager and the Chief Nurse
- The business planning process will be followed as per the Department of Health NHS Operating Framework, annual document.
- The Head of Midwifery will be responsible for contributing to producing the business plan on receipt of the audit report, which will be returned to the Directorate Manager

10.1.2 Obstetric staffing

An audit will be undertaken annually to assess staffing levels for obstetric service. This will include consultant presence on labour ward, attendance for specific cases, e.g. eclampsia, maternal collapse.

Any deficiencies in the level of staffing, when judged against “Safer Childbirth” standards, will be examined.

Cost neutral changes to the provision of consultants on the labour ward will be presented to the Directorate together with future development of Obstetric Service

If increased obstetric consultant presence from the current service is required, a business case will be created for consideration by the Trust

10.1.3 Anaesthetic staffing

An audit will be undertaken annually to assess what grade of anaesthetist covered labour ward on each of the 500 daytime, weekday sessions in a year. An audit of anaesthetic assistants covering labour ward emergency theatre will be undertaken annually.

An audit every 2 years will assess the frequency of calling a second anaesthetist for maternity. This audit may be triggered more frequently if workload is perceived to have increased.

Future development of Obstetric Anaesthetic Service

Any deficiencies in the level of anaesthetic staffing, when judged against “Safer Childbirth” standards, will be examined.

Cost neutral changes to the provision of consultants on the labour ward will be presented to the anaesthetic directorate.

An increased anaesthetic presence from the current service will require additional funding. In such situations, a business case will be created for consideration by the Trust

10 References and Associated Documentation

RCOG, RCM, RCOA, RCPCH (2008) Standards for Maternity Care: Report of a working Party. London:RCOG

RCOG, RCM, RCOA, RCPCH (2007) Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in labour. London: RCOG Press

Royal college of Midwives Guidance Paper Staffing Standards in Midwifery Services Feb 2009

Clinical Negligence Scheme for Trusts NHSLA 2009

Health Care Commission (HCC) (2008) Towards better Births. London: Health Care Commission.

King's Fund (2008) Safe births: Everybody's business. An independent Inquiry into the safety of maternity services in England. London: King's Fund

Core Information	
Document Title	Maternity Operational Staffing Policy
Date Finalised	October 2014
Dissemination Lead	Director of Nursing
Previous Documents	
Previous document in use?	
Action to retrieve old copies.	

Dissemination Plan

Recipient(s)	When	How	Responsibility	Progress update
All staff		Email	Document Control	

Review		
Title	Is the title clear and unambiguous?	
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	
	Does the style & format comply?	
Rationale	Are reasons for development of the document stated?	
Development Process	Is the method described in brief?	
	Are people involved in the development identified?	
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	
	Is there evidence of consultation with stakeholders and users?	
Content	Is the objective of the document clear?	
	Is the target population clear and unambiguous?	
	Are the intended outcomes described?	
	Are the statements clear and unambiguous?	
Evidence Base	Is the type of evidence to support the document identified explicitly?	
	Are key references cited and in full?	
	Are supporting documents referenced?	
Approval	Does the document identify which committee/group will review it?	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	
	Does the document identify which Executive Director will ratify it?	
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	
	Does the plan include the necessary training/support to ensure compliance?	
Document Control	Does the document identify where it will be held?	
	Have archiving arrangements for superseded documents been addressed?	
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	
	Is there a plan to review or audit compliance with the document?	
Review Date	Is the review date identified?	
	Is the frequency of review identified? If so is it acceptable?	
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	

Core Information	
Manager	Nicola Phillips
Directorate	Women & Children's
Date	Jan 2015
Title	Maternity Operational Staffing and Escalation Policy
What are the aims, objectives & projected outcomes?	This is an Operational Policy for Midwifery Managers, Supervisors of Midwives and the Unit Coordinator responsible for safe staffing levels for all midwifery and support staff roles throughout the maternity services. The intention of the document is to ensure the safety of mothers and babies by efficient use of bed occupancy and staffing.
Scope of the assessment	
Collecting data	
Race	Consideration will be made for patients whose first language isn't English and information will be made available in a different language upon request. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Religion	There is no evidence to suggest that there is a disproportionate impact on religion or belief and non-belief regarding this policy. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Disability	Consideration must be made for patients who are unable to read – allowing time for the patient to take in the information and ask questions. Consideration must be made for patients with learning disabilities who will be referred to the learning disability liaison team Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Sex	There is no evidence to suggest that there is a disproportionate impact on sex regarding this policy. However, this is a maternity policy for maternity staffing purposes. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Gender Identity	Data for this protected characteristic is not currently collected. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.

Sexual Orientation	There is no evidence to suggest that there is a disproportionate impact on sexual orientation regarding this policy. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Age	There is no evidence to suggest that there is a disproportionate impact on age regarding this policy. However, this policy is for maternity services and will apply to babies as well as parents. Data collected from Datix incident reporting and complaints will ensure this is monitored.
Socio-Economic	Data for this protected characteristic is not currently collected. Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
Human Rights	Data collected from Internal audit processes, datix incident reporting and complaints will ensure this is monitored.
What are the overall trends/patterns in the above data?	No comparative data has been used to date which means that no trends or patterns have been identified
Specific issues and data gaps that may need to be addressed through consultation or further research	No gaps have been identified at this stage but this will be monitored via Internal audit processes, datix incident reporting and complaints.
Involving and consulting stakeholders	
Internal involvement and consultation	
External involvement and consultation	
Impact Assessment	
Overall assessment and analysis of the evidence	Consideration will be made for patients whose first language isn't English and information will be made available in a different language upon request. Consideration must be made for patients who are unable to read – allowing time for the patient to take in the information and ask questions. Consideration must be made for patients with learning disabilities who will be referred to the learning disability liaison team

Action Plan

Action	Owner	Risks	Completion Date	Progress update
Collect and monitor data collected from Datix on incidents and complaints				