Trust Policy

University Hospitals Plymouth NHS Trust

Maternity Operational Staffing and Escalation Policy

Issue Date	Review Date	Version
July 2019	July 2024	5

Purpose

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

Who should read this document?

This is an Operational Policy for Midwifery Managers 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.

Key Messages

The key to effective escalation is to identify that there is a problem, communicate your concerns and make specific recommendations. This document aims to help clinical staff overcome some of the barriers to escalation by providing specific escalation procedures in midwifery, obstetrics and anaesthetics within the maternity department

Core accountabilities	
Owner	Sheralyn Neasham and Charlotte Wilton, Maternity Matrons
Review	Maternity Clinical Effectiveness Committee
Ratification	Director of Midwifery – Sue Wilkins
Dissemination (Raising Awareness)	Maternity clinical staff
Compliance	Director of Midwifery

Links to other policies and procedures
Escalation of concern regarding delivery of acute clinical care in Maternity services Policy V1, January 2018

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
V4	July 2018	Reviewed and approved

V5	July 2019	Reviewed and amended

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business 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 in Document Control. Larger text, Braille and Audio versions can be made available upon request.

Contents

1 Introduction

This is an Operational Policy for Midwifery Managers 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.

2 Purpose

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)

3 Maternity 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.

University Hospital Plymouth Trusts Birth ratio is monitored on monthly basis via the Maternity Dashboard, discussed and circulated at the Clinical Effectiveness Committee meeting.

3.1 Midwifery staff

Midwives form the largest staff group with Plymouth Maternity Services and work within both the hospital and Community setting. The University Hospitals Plymouth NHS Trust monthly establishment of midwives and registered nurses, along with the WTE equivalent of temporary staff is used to calculate the Birth ratio. Posts that do not directly contribute to midwifery care have been removed from this calculation either partly or wholly dependent upon the role. The midwifery workforce is supported by assistant staff working both in the hospital and community.

Within the hospital services midwives work within the inpatient and delivery ward areas. This includes a Day Assessment area and Transitional Care.
Within the Community setting midwives work from Children's Centre's providing antenatal and postnatal care. The senior midwifery team, including 2 Matrons, 2 Practice Educators, Lead Midwife for Governance and Risk, Lead Midwife for Safeguarding, Bereavement Lead Midwife, Lead Midwife for screening and a Public health lead Midwife also contribute to the service.

Off rotation expert (ORE) midwives work in all clinical areas, 3 on Central Delivery Suite, 2 Community, 1 Women's day services and 2 Argyll ward and Transitional care ward.
This is a developmental role for band 6 midwives to gain experience and support each area. 5.5 WTE midwives are Champion staff on Argyll ward.

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 who coordinate each shift and have supernumerary status, defined as having no case load of their own during that shift, they 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 dating scans, anomaly scans and growth 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.

3.1 Obstetric Staff

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.

The Consultant obstetrician is present on labour ward 68 hours per week for the following sessions:

Set out is the timetable of consultant sessions for maternity

AM = 08:00 till 13:00 – 30 hours dedicated session for labour ward and elective Caesarean list

PM= 13:00 till 18:00 – 30 hours provided by Week On Service Obstetrician and Gynaecologist for all Obstetric and Gynaecological emergencies

Saturday and Sunday – 8 hours expected to be on-site for Obstetric and Gynaecological emergency and ward rounds

This totals 68 hours per week of consultant cover per week

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 68 hours of consultant cover on labour ward (98 hours recommended by Safer Childbirth).

In addition to the 68 hours of daytime cover, a further 50% or more of resident night duty is provided at Consultant level (covering the middle grade position), thus providing an average additional 45.5 hours of Consultant cover for Acute Obstetrics.

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

In an obstetric emergency dial 2222 and state 'obstetric emergency' and location.

Consultants are not part of the emergency call system unless they are carrying the 0311 bleep (i.e. there is no Obstetric trainee on duty). There is a consultant bleep included on the Obstetric emergency bleep (0401) however this is not always held by the Consultant and should not be relied on. If the presence of a Consultant is required, please ask switchboard to page them if you know that the Consultant is not carrying the 0311 bleep.

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.

Middle grade medical staff
Central Delivery Suite is covered each day shift day by a Registrar who covers CDS, antenatal, post-natal, Gynaecology ward, theatre and will attend the Emergency department if required for obstetric patients.

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.

Junior medical staff
Central Delivery Suite is covered each day shift day by an SHO who covers CDS, antenatal, post-natal, Gynaecology ward, theatre and will attend the Emergency department if required for obstetric patients.

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.

Review of prospective staffing levels
The Care Group Manager, Service Line Manager and Service Line Director will:

a. Ensure that there is an appropriate level of cover in the short term i.e. for the next month's rota.
b. Identify and develop contingency plans for any prospective staffing issues in the midterm i.e. 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.

3.2 Anaesthetic Staff
Consultant Anaesthetist

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

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 40 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

Unit should have Lead obstetric anaesthetist. This post will rotate at least every 5 years between consultant obstetric anaesthetists

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 hour's actions to follow should additional anaesthetists be needed for maternity.

(See intrapartum care guideline No 4: Anaesthetics)

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.
Timetable for obstetric anaesthetic consultants

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

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.

Review of prospective staffing levels

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

d. Ensure that there is an appropriate level of cover in the short term i.e. for the next month's rota.
e. Identify and develop contingency plans for any prospective staffing issues in the mid-term i.e. annual leave/ study leave/planned sick leave.
f. 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 Care Group 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.

4 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 authorisation 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. If this does not address the staffing situation, then shifts will be released onto the NHSP system and staffing page on social media. If the shift remains uncovered, the shifts may be put out to Agency.

5 Unit Coordination

During office hours the Maternity Unit Matron is available between 08:00 and 16:00 Monday - Friday. She can be contacted via pager number 81630 / 81631. The Matron will be responsible for performing a risk assessment with respect to staffing and levels of capacity that has been recorded on the SafeCare system. 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 the absence of both Matrons, the designated deputy (usually band 7coordinator or ward manager) will be responsible for ensuring the unit workload is assessed.

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 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 and they will assist the unit coordinator in finding solutions to staffing / capacity levels.

Out of hours an experienced midwife will take on the role. It is expected that the coordinator will ring all clinical areas and record the activity for the night and throughout the night shift.

The Unit Coordinator will lead activities in finding solutions to staffing / capacity levels with the support of the on-call manager and the on-call consultant if required (via switchboard).

5.1 Peaks in capacity

The Matron, Week on Service Consultant and Labour Ward coordinator should be informed of all capacity issues. These should be escalated to the Director of Midwifery when appropriate.

Red flags and Acuity assessment

There are twelve specific Maternity Red flags, as recommended by NICE Safe Midwifery Staffing for Maternity (2015).

A Red flag event is activated on Safecare by the band 7 coordinator in charge of the shift and assists in the identification of specific areas of high clinical acuity and the appropriate movement of staff. The adapted Safecare acuity tool supports this assessment and is available for the coordinators of all inpatient areas.

All Red flag events are reviewed by Matron immediately or within a 24 hour period. Data collection and audit identifies themes and trends to demonstrate staffing and activity levels which can be used prospectively to inform planning of staffing and escalation procedures and allocate midwifery staffing appropriately for changing clinical acuity.
Retrospectively this data provides evidence of staffing levels and action taken to escalate a situation.

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 the newborn to be performed at home by a member of the community team

- 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 the Neonatal High Dependency unit / NICU under these circumstances
- Avoiding admission of gynaecology patients to Maternity beds
- Considering delay of inductions and non-essential elective activities, i.e. elective LSCS lists
- considering closure of unit to level 3 in-utero transfers – liaise with neonatologists, WOS consultant 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

6 Staffing shortages – 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 Director 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 registered member of staff on Argyll to be relocated to CDS if activity allows from the ward.
- Call the on-call escalation midwife to work clinically
- Consider re-allocation of other staff already rostered to work within the unit and including staff with non- clinical duties 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 NHSP staff, if available
    - paid additional hours to full time staff (overtime payments)

  NB Additional hours should be sanctioned by the Maternity Unit Matron or Director of Midwifery
- Consider calling in hospital staff before their expected shift time

- Specialist midwives and non-clinical midwives to work clinically

When staffing levels adversely affect the care that women receive the on-call manager should be contacted and a Clinical Incident Form completed.

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 Director 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 NHSP staff, if available
    - paid additional hours to full time staff (overtime payments)

  NB Additional hours should be sanctioned by the Maternity Unit Coordinator or Director of Midwifery
- Explore whether specialist midwives and non- clinical midwives are available to work planned clinical shifts

When staffing levels adversely affect the care that women receive and the escalation midwife is already in the unit, the on-call manager should be contacted and a Clinical Incident Form completed. At this point if staffing is still in dire crisis then both Midwifery Matrons and the Director of Midwifery should be working clinically to coordinate and support the clinical teams.

Communication

Inform Director of Midwifery (or nominated Deputy)
Inform On-call Consultant Obstetrician
Inform Consultant Neonatologist / neonatal unit
Inform Director of Nursing or on-call Manager

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.

7 Monitoring and compliance

Midwifery staffing levels are monitored through the SafeCare acuity system. Where staffing levels continually fall below the minimum requirements, ward managers together with the Director of Midwifery are expected to develop business and contingency plans to address the shortfall. This will be communicated to the Care Group Manager for escalation to the Trust board where necessary.

The Audit and monitoring process of midwifery and Support Staff

- The Director 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.
- The audit findings will also be reported to the Care Group Manager and the Chief Nurse
- The business planning process will be followed as per the Department of Health NHS Operating Framework, annual document.
- The Director of Midwifery will be responsible for contributing to producing the business plan on receipt of the audit report, which will be returned to the Care Group Manager

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

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.
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.

8 Consultation and Ratification

The design and process of review and revision of this policy will comply with The Development and Management of Formal 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 reviewed by the Care Group Manager and ratified by the Director of Midwifery

Non-significant amendments to this document may be made, under delegated authority from the Director of Midwifery, by the nominated owner. These must be ratified by the Director of Midwifery.

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.

9 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 Formal Documents.

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

10 Monitoring Compliance and Effectiveness

Monitoring of the policy and its processes will be undertaken within the Obstetrics Service Line by the Matrons and Line Managers to ensure compliance.

The Safer Staffing acuity tool will be monitored monthly by the matron.

11 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

Appendix 1 – A guide to minimum midwifery staffing levels

Clinical area	**Shift**	**Staffing minimum**
Central Delivery Suite incorporating Maternity Triage and elective theatre lists	E / LD	1 supernumerary band 7 Coordinator 8 midwives (to include a mw for SWAST and a Band 6/7 for Triage) + 2 Maternity Care Assistants (1 working in triage)
	L / LD	1 supernumerary band 7 Coordinator 8 midwives (to include a mw for SWAST and a Band 6/7 for Triage) + 2 Maternity Care Assistants (1 working in triage)
	ND	1 supernumerary band 7 Coordinator 7 Midwives (to include a Band 6/7 for Triage and a midwife for homebirths) + 1 Maternity Care Assistant
Argyll Ward	E / LD	3 midwives + 3 Maternity Care Assistant
	L / LD	3 Midwives + 3 Maternity Care assistant
	ND	3 Midwives + 2 Maternity Care Assistant
Women's Day Services	8-4	1 Midwife, 2 MCA
Midwife sonographer	8-4	4.2WTE to cover scan lists
Antenatal Clinic	8-4	1 Midwife + 1 Maternity Care Assistant
Transitional Care Unit	LD	1 Midwife + 3 support (preferably 2 Nursery Nurses + 1 Maternity Care Assistant
	ND	1 Midwife + 2 support (preferably 2

		nursery nurse and 1 Maternity+ Care Assistant)

Dissemination Plan and Review Checklist | Appendix 1

Dissemination Plan			
Document Title	Maternity Operational Staffing and Escalation Policy		
Date Finalised	July 2018		
Previous Documents			
Action to retrieve old copies			
Dissemination Plan			
Recipient(s)	**When**	**How**	**Responsibility**
All Trust staff		Vital Signs	Information Governance Team

Review Checklist		
Title	Is the title clear and unambiguous?	Y
	Is it clear whether the document is a policy, procedure, protocol, framework, APN or SOP?	Y
	Does the style & format comply?	Y
Rationale	Are reasons for development of the document stated?	Y
Development Process	Is the method described in brief?	Y
	Are people involved in the development identified?	Y
	Has a reasonable attempt has been made to ensure relevant expertise has been used?	Y
	Is there evidence of consultation with stakeholders and users?	Y
Content	Is the objective of the document clear?	Y
	Is the target population clear and unambiguous?	Y
	Are the intended outcomes described?	Y
	Are the statements clear and unambiguous?	Y
Evidence Base	Is the type of evidence to support the document identified explicitly?	Y
	Are key references cited and in full?	Y
	Are supporting documents referenced?	Y

Approval	Does the document identify which committee/group will review it?	Y
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Y
	Does the document identify which Executive Director will ratify it?	Y
Dissemination & Implementation	Is there an outline/plan to identify how this will be done?	Y
	Does the plan include the necessary training/support to ensure compliance?	Y
Document Control	Does the document identify where it will be held?	Y
	Have archiving arrangements for superseded documents been addressed?	Y
Monitoring Compliance & Effectiveness	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y
	Is there a plan to review or audit compliance with the document?	Y
Review Date	Is the review date identified?	Y
	Is the frequency of review identified? If so is it acceptable?	Y
Overall Responsibility	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y

Equalities and Human Rights Impact Assessment | Appendix 2

Core Information	
Date	2.7.18
Title	**Maternity Operational Staffing and Escalation Policy**
What are the aims, objectives & projected outcomes?	
Scope of the assessment	
Collecting data	
Race	There is no evidence to suggest there is a disproportionate impact on race regarding this policy. Data collected from Internal HR processes and workforce data reporting will ensure this is monitored.
Religion	There is no evidence to suggest there is a disproportionate impact on race regarding this policy. Data collected from Internal HR processes and workforce data reporting will ensure this is monitored.
Disability	There is no evidence to suggest there is a disproportionate impact on race regarding this policy. Data collected from Internal HR processes and workforce data reporting will ensure this is monitored.
Sex	There is no evidence to suggest there is a disproportionate impact on race regarding this policy. Data collected from Internal HR processes and workforce data reporting will ensure this is monitored.
Gender Identity	There is no evidence to suggest there is a disproportionate impact on race regarding this policy. Data collected from Internal HR processes and workforce data reporting will ensure this is monitored.
Sexual Orientation	There is no evidence to suggest there is a disproportionate impact on race regarding this policy. Data collected from Internal HR processes and workforce data reporting will ensure this is monitored.
Age	There is no evidence to suggest there is a disproportionate impact on race regarding this policy. Data collected from Internal HR processes and workforce data reporting will ensure this is monitored.
Socio-Economic	There is no evidence to suggest there is a disproportionate impact on race regarding this policy. Data collected from Internal HR processes and workforce data reporting will ensure this is monitored.

Human Rights	There is no evidence to suggest there is a disproportionate impact on race regarding this policy. Data collected from Internal HR processes and workforce data reporting will ensure this is monitored.
What are the overall trends/patterns in the above data?	No gaps have been identified at this stage but this will be monitored via Internal HR processes and workforce data reporting.

Involving and consulting stakeholders				
Internal involvement and consultation				
External involvement and consultation				
Impact Assessment				
Overall assessment and analysis of the evidence				
Action Plan				
Action	**Owner**	**Risks**	**Completion Date**	**Progress update**
Specific issues and data gaps that may need to be addressed through consultation or further research				