Dear Sir/Madam

Thank you for your Freedom of Information request concerning staff attendance levels and official recommendations.

The Trust can provide the following information:

I seek the following information about staff attendance for the A&E and Maternity units in each of the hospitals within your trust during three specified time periods:

31st March - 17th April
18th April - 21st April
3rd May - 5th May

Specifically, I am looking to receive data about attendance levels of doctors, nurses and consultants in both units during the three separate time periods. I would like to know the numbers of staff present in each role, both those who were physically in attendance and how many were on call. I am enquiring about the numbers of the following specific roles:

Doctors: Junior House Officer (or the equivalent), Senior House Officer (or the equivalent), Registrar and Consultants
Nurses: student nurses, nurses, student midwives and midwives.

Alongside this I am also seeking your official safe staffing recommendations and guidelines for attendance levels of these staff roles in A&E and Maternity, specifying on call or physically in attendance

The request is really quite vague and covers several weeks, so I used 24 hours to calculate the numbers as running from 0800-0800 as this coincidence with on calls and shift changes.

Please see below

Please see the attached maternity staffing document covering midwives, doctors and support staff for the dates requested below - I can confirm that there were no staffing concerns and staffing levels were as expected and as documented in the attached.

If you have any queries about this response please contact the information governance manager at foi@homerton.nhs.uk , in the first instance. If, following that, you still have any concerns, you may contact the Information Commissioner either by letter, FOI/EIR

Complaints resolution, Wycliffe House, Water Lane, Wilmslow, Cheshire SM9 5AF, or by email www.informationcommissioner.gov.uk to take them further.

Yours sincerely

James Cook
Information Governance Administrator

Mike Dunne
Information Governance Manager/Deputy Calidcott Guardian

24 hour period defined as 0800-0800

	FY2 present in 24 hour period	**SHO or equivalent present in 24 hour period**	**Registrar or equivalent present in 24 hour period**	**Consultant present in 24 hour period**	**Consultant on call (from 2200-0800)**
31/03/2014	4	5	4	5	1
01/04/2014	3	6	4	7	1
02/04/2014	5	6	5	11	1
03/04/2014	4	6	2	7	1
04/04/2014	5	4	3	6	1
05/04/2014	5	3	3	1	1
06/04/2014	5	2	3	1	1
07/04/2014	3	5	4	6	1
08/04/2014	4	6	3	6	1
09/04/2014	4	7	4	9	1
10/04/2014	4	8	4	7	1
11/04/2014	4	5	7	6	1
12/04/2014	5	4	5	1	1
13/04/2014	6	3	5	1	1
14/04/2014	4	4	6	7	1
15/04/2014	4	4	5	4	1
16/04/2014	3	5	4 (Study day)	8	1
17/04/2014	1 (Study day)	6	2 (Study Day)	5	1
18/04/2014	5	4	3	1	1
19/04/2014	5	2	3	1	1
20/04/2014	5	2	3	1	1
21/04/2014	5	3	4	1	1
03/05/2014	4	4	2	1	1
04/05/2014	4	4	2	1	1
05/05/2014	5	4	4	1	1

A&E Adult Nursing

31/3 - 17/4	31-Mar	01-Apr	02-Apr	03-Apr	04-Apr	05-Apr	06-Apr	07-Apr	08-Apr	09-Apr	10-Apr	11-Apr	12-Apr	13-Apr	14-Apr	15-Apr	16-Apr	17-Apr
Day Expected 10 Qualfied Staff	10	9	9	10	10	9	9	8	10	10	8	9	10	10	10	9	10	9
Students	1	2		2	1											1		
Night Expected 8 Qualified Staff	8	8	8	8	8	8	7	8	7	9	8	7	8	7	7	7	8	8
Students					1													

18/4 - 21/4	18-Apr	19-Apr	20-Apr	21-Apr
Day Expected 10 Qualfied Staff	9	10	10	10
Students				
Night Expected 8 Qualified Staff	8	8	8	8
Students	1	1		

3/5 - 5/5	03-May	04-May	05-May
Day Expected 10 Qualfied Staff	10	10	10
Students			
Night Expected 8 Qualified Staff	8	7	8
Students			

ENP's

31/3 - 17/4	31-Mar	01-Apr	02-Apr	03-Apr	04-Apr	05-Apr	06-Apr	07-Apr	08-Apr	09-Apr	10-Apr	11-Apr	12-Apr	13-Apr	14-Apr	15-Apr	16-Apr	17-Apr
Nurse Practitioners	2	3	2	3	3	3	3	2	3	3	3	2	3	3	2	2	3	2

18/4 - 21/4	18-Apr	19-Apr	20-Apr	21-Apr
Nurse Practitioners	3	2	3	3

3/5 - 5/5	03-May	04-May	05-May
Nurse Practitioners	3	3	3

CEA

31/3 - 17/4	31-Mar	01-Apr	02-Apr	03-Apr	04-Apr	05-Apr	06-Apr	07-Apr	08-Apr	09-Apr	10-Apr	11-Apr	12-Apr	13-Apr	14-Apr	15-Apr	16-Apr	17-Apr
Day Expected 3 Qualified	3	3	3	3	2	3	3	3	3	3	3	2	2	2	2	3	4	4
Students	1	1	1				1											
Night Expected 2 Qualified	2	2	2	2	1	2	2	2	2	2	1	2	2	2	2	2	2	2
Students			1	1														

18/4 - 21/4	18-Apr	19-Apr	20-Apr	21-Apr
Day Expected 3 Qualified	3	3	3	4
Students				
Night Expected 2 Qualified	2	2	2	2
Students				

3/5 - 5/5	03-May	04-May	05-May
Day Expected 3 Qualified	3	2	3
Students			
Night Expected 2 Qualified	2	2	2
Students			

Homerton University Hospital NHS
NHS Foundation Trust

Maternity services approved staffing levels
Contingency planning
Closure of the unit

Author(s)	Annette Anderson - Maternity Clinical Risk Manager/SoM Joan Douglas - Head of Midwifery/SoM Maryam Parisaei - Consultant Obstetrician Paul Howell Consultant – Anaesthetist Philippa Cox - SoM
Version	Version 3
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Implementation/approval Date	September2013
Review Date	October 2016
Review Body	Maternity Management Team
Policy Reference Number	

Contents: Click on the links

1. Summary

This Homerton Maternity Unit provides maternity care to approximately 6000 maternities annually with capacity to go up to 6200. The maternity service endeavours to place the woman and her family at the centre of care delivery. In line with national recommendations there is provision for choice of place of birth. The options, depending on the woman's clinical history, include birth in the along side birth centre, home birth and consultant led delivery suite. The choice of antenatal care includes home, children centre, GP surgery and hospital antenatal clinic.

There is a team of obstetric consultants, neonatologists and anaesthetists available to provide expert care, advice and training. They work with midwives and support workers predominately on the delivery suite, ward and antenatal clinic; this is replicated in the community setting with GPs working closely with the midwives to provide shared care to obstetrically low risk women. The Trust provides clinical training for student midwives from City University and medical students from Queen Mary University.

The RCOG (2007) have highlighted the impact of safe staffing levels on service delivery. It acknowledged that there can be fluctuations in maternity activity, changes in clinical care and availability of staff with the appropriate skills. It is therefore important that regular reviews of current and future workforce requirements in each discipline take place to confirm that establishment is in line with current activity. Where shortfalls are identified within each discipline contingency plans are made to address both short term and longer term staff shortages.

2. Introduction

This document sets out guidance for recommended staffing levels, contingency planning and action to be taken in the event the maternity unit needs to be closed.

It is devised for use by all professionals working within the maternity service in particular Supervisors of Midwives, Obstetricians and Midwives.

This document outlines the levels of staffing that are provided and assess whether staffing is in line with the recommendations of Safer Childbirth (2007) and the recommendations of the RCM (2009) and NHS England. In addition any contingency plans and subsequent closure of the maternity unit is managed in a consistent manner, with clear, safe and planned alternative arrangements for women and babies.

Closure of the maternity unit should only be considered and indeed carried out when all other potential solutions have been exhausted. If circumstances dictate that it is unsafe for the maternity unit to remain open to admissions, this should be discussed with the on call Supervisor of Midwives, the maternity site coordinator, Midwifery management, the Consultant Obstetrician roistered for Delivery suite along with the Trust Manager on Call. During the working week the Head of Midwifery must also be contacted.

3. Scope

This guideline applies to all staff within the Trust who have responsibility for providing care for women during the intrapartum stages. On commencing work in the Trust staff will be orientated to the guideline. Staff are expected to follow these guidelines unless there has been clear

documentation with the explanation why and an outline of an alternative plan. Failure to follow the requirements of the policy may result in investigation and management action being taken as considered appropriate.

4. Minimum Staffing Levels

4.1 Midwifery Staffing

Staffing requirements for the maternity service as specified by Safer Childbirth (RCOG 2007) and endorsed by the RCM are that staffing levels should be set to facilitate 1:1 care in established labour in 100% of cases. The ratio of staffing to women within the unit should be set with reference to the level of dependency. For example where there is a high level of dependency – category 4 as defined within Birthrate plus (BRP) requires a ratio of 1:28 midwives to women to facilitate a safe level of care but where there is low level of dependency this is set at 1:35. Support staff can be included in the levels and 15% is the accepted level according to NHS England and is referred to as 85/15 split. Within this Trust we are working to developing a model where the additional support workers are predominately based in the postnatal ward and community setting. They have all undertaken additional training to enable them to undertake up to 40% of the midwives' work load.

We monitor on a monthly basis our achievement of 1:1 care in labour, along with our midwife to birth ratio. This ratio has been reported to our maternity risk management review & clinical governance group. It has also been escalated to the executive board, East London Commissioning Authority and NHS England.

It is recognised that, regardless of place of birth, midwives will provide care for women and their babies. All band 6 midwives are employed to work in all areas of maternity where women receive care. The allocated Band 7 midwives on delivery suite, ward, antenatal clinic and community are more permanent; however if they request updating within another area of maternity this is supported.

Student midwives work with an allocated sign off mentor and they are expected to rotate to all areas where women receive care. There is a Clinical Practice Facilitator for the student along with a named Supervisor of Midwives

Midwives work on delivery suite and the ward where services are provided 24 hours a days, seven days of the week.
There are two main shifts:
Day shift 08.00 – 20.30hrs
Night shift 20.00 – 08.30hrs

4.2 Consultant Obstetricians

At present the delivery suite provides 80 hours of prospective consultant cover on the labour ward to comply with the recommendations of Safer Childbirth (RCOG 2007). 60 hours is the national recommendations where the birth rate reaches 4000; in 2012 the birth rate was 5211 and expected to be 6200 in 2013. As our birth rate is predicted to rise a business case will be prepared and submitted for consideration to the trust board for 98 hour consultant cover.

The role of the Consultant Obstetrician on the labour ward is to ensure a high standard of care for women and babies with complex medical or obstetric needs and to be available for the acute, severe and often unpredictable life threatening emergencies.

Greater consultant involvement will improve support and supervision of trainees over 24 hours. In cases of difficult births, including Caesarean Section (C/S) or wherever the clinical situation gives cause for concern, the consultant obstetrician must be contacted and attend the unit as required.
The duty consultant should be informed about any:

- Proposed caesarean section
- Proposed complex operative delivery including trial of instrumental delivery
- Delays in performing a grade 1 or 2 caesarean section
- Severe/significant ante-partum haemorrhage
- Postpartum haemorrhage of more than 1500mls in the ward area and 2000mls in theatre and continuing where the MOH protocol has been instigated.*◊
- Eclamptic fit◊
- Maternal death*◊
- Stillbirth, intrapartum or neonatal death*
- Patients who declines to accept medical advice*
- Any situation the registrar or senior midwifery staff are concerned about* Attend when requested ◊
- Woman who would decline blood products who may require a caesarean section or other intervention*
- Situation where a woman declines medical intervention (e.g. caesarean section), and that decision is deemed detrimental to either the fetus or herself*
- Critically ill pregnant woman admitted to the hospital
- Women in labour with multiple pregnancies
- Maternal collapse ◊
- Caesarean section for Major Placenta Praevia◊
- Return to theatre (laparotomy)◊
- ITU admission*
- Third or fourth degree tear
- Unexpected anaesthetic complication e.g. total spinal block
- Uterine Rupture◊

◊Indicates a consultant obstetrician should attend in person

4.3 Anaesthetic Staffing

OAA/AAGBI Guidelines for Obstetric Anaesthesia Services, Revised Edition, May 2005
Safer Childbirth- Minimum Standards for the Organisation and Delivery of Care in Labour, RCOG, RCM, RCOA, October 2007

Duty Anaesthetist:
A trainee anaesthetist is deemed as one who has been assessed as competent to undertake duties on the delivery suite under a specific degree of supervision. The duty anaesthetist should be immediately available for the obstetric unit 24 hours/day.

The duty anaesthetist should not be primarily responsible for elective obstetric work. In units with 24-hour epidural service, the duty anaesthetist should be resident on site.

Consultant Anaesthetic Cover:

Each obstetric unit should have a nominated consultant in charge of obstetric anaesthesia services with programmed activities (Pas)/sessions allocated for the administrative work that this entails. The nominated consultant should be responsible for the organisation and audit of the service, for maintaining and raising standards through provision of evidence base guidelines, for providing anaesthetic input to the delivery suite labour ward forum and equivalent multidisciplinary bodies, and for risk management.

As a basic minimum for any consultant-led obstetric unit, there should be 10 consultant anaesthetic PAs/sessions per week, to allow full working hours consultant cover.
Extra consultant time should be available to units which are busier than average. When formal elective caesarean section lists are necessary, there should be a separate consultant available.

Tertial referral units which are likely to have a higher than average proportion of sick mothers should have extra consultant time allocated. Extra clinical time should be made available per week for antenatal referrals, especially where a formal clinic is provided.
When there is no consultant available to cover delivery suite during normal working hours, there should be a nominated consultant to cover who must be instantly able to leave a list to attend the delivery suite if necessary.

The names of all consultants covering the Delivery Suite should be prominently displayed and contact numbers readily available.

There should be a named consultant anaesthetist and obstetrician responsible for all HDU patients 24 hours per day.

5. Delivery Suite & the Obstetric Assessment Unit (OAU)

There is an experienced labour ward coordinator utilised for each shift over 24 hours on the labour ward. The coordinator will have overall responsibility for the day to day activities of the birthing unit and will have the responsibility to plan and organise the midwifery and support workforce delegating appropriately to ensure that a safe standard of care can be achieved at all times. In times of high activity or when there is reduced staffing the delivery suite coordinator will liaise with the delivery suite matron and the maternity site coordinator (and other area matrons where appropriate) to discuss staffing and contingency plans; during the working week, outside of these hours the Supervisor of Midwives and if necessary the on call consultant obstetrician must be contacted.

Maternity theatres are staffed with a team of nurses who provide scrub cover for the unit over 24 hours. This is in line with the recommendations of Safer Childbirth (2007) Theatre nurses will also recover the woman in recovery area of main theatres.

The delivery suite has 13 birthing rooms for medium to high dependency care, a
4 bedded birth centre and a 3 bedded obstetric assessment unit (Triage area)

Agreed staffing levels for:

- **Midwives**
- **Maternity Care Assistants**
- **Clerical staff**

These levels are based on the agreed ratios as identified in Table 6 of Safer Childbirth (2007)

Designated area	Day Shift	Night shift
Delivery Suite	9 Midwives	8 Midwives
Labour ward coordinator	1	1
Maternity Care Assistants	1	1
Clerical staff	1	1
OAU	1	1
Triage	1	1

5.1 Homerton Birth Centre

The Homerton Birth centre has 4 low risk delivery rooms.

Agreed staffing levels for:

- **Midwives**
- **Clerical Staff**
- **Maternity care assistants**

Homerton Birth Centre	Day shift	Night shift
Midwives	2	2
Maternity care assistants	1	1

5.2 Templar Ward

Templar Ward has a total bed capacity of 32 beds and capacity for 32 cots.

Agreed staffing levels for:

- **Midwives**
- **Clerical Staff**
- **Maternity care assistants**
- **Nursery Nurses**

Templar ward	Day shift	Night shift
Midwives	5	5
Clerical staff	1	0
Maternity care assistants	2	1
Nursery Nurses	1	0

5.3 Turpin Suite

Turpin suite has a total bed capacity of 9 beds

Agreed staffing levels for:

- **Midwives**
- **Clerical Staff**
- **Maternity care assistants**

Turpin Suite	Day shift	Night shift
Midwives	1	1
Clerical staff	0	0
Maternity care assistants	1	1

5.4 – 2012 ward

2012 ward has a total bed capacity of 7 beds

Agreed staffing levels for:

- **Midwives**
- **Clerical Staff**
- **Maternity care assistants**

2012 ward	Day shift	Night shift
Midwives	1	1
Clerical staff	0	0
Maternity care assistants	1	1

5.5 Antenatal clinic

Agreed staffing levels for:

- **Midwives**
- **Maternity Care Assistants**
- **Clerical Staff**

Antenatal Clinic	Monday to Friday
Midwives	7
MCA	1

5.6 Community Midwifery

Midwives provide antenatal and postnatal care within the community setting. There are also 6 public health midwives who provide ante and post natal support to women with high risk social and medical needs. The community midwives lead the parent education sessions in children centres and in the hospital setting. The community midwives maintain an on call rota 24 hours a day to provide homebirths to women living in City & Hackney. The average community midwife: woman ratio is 1:60-85, allowing capacity within the staffing for a growing birthrate.
Team G has no funding for a public health midwife. The team leader for this area takes on some public health activity.

5.7 Bi Lingual Maternity Support Workers

They are employed to support the midwife by providing basic physical care to women and assist with hygiene needs and help with infant feeding and care. Within the community setting; they also undertake the blood spot screening along with supporting the midwife with their interpreting skills.

Community Midwifery Team Staffing					
Areas	Bi lingual Maternity Support workers	Public health Mw	Band 7	Band 6	Contacts AN/PN
A	2	0.6	1	4	5526
B	2	0.6	1	5.4	7246
C	2	0.6	1	3.4	4410
D	0	0.6	1	4.2	5834
E	1	0.6	1	4	5680
F	1	0.6	1	3.4	4539
G	1	0	1	5.6	
TOTALS	12	3.6	7	30.0	33235

5.8 Homebirth Team

The homebirth team provide care to all women requesting homebirths within City & Hackney and area G. They will have an individual caseload of 1 midwife to 35 women per year. The team is led by 1 band 7 midwives and supported by 4 band 6 midwives and 1 maternity support worker.

5.9 Specialists

There are a number of specialist midwives

- Bereavement midwives 2 midwives (1.0 wte)
- Drug & Alcohol Misuse midwives 2 midwives (2.0 wte)
- Haemoglobinopathy midwife 1 (1.0 wte)
- Antenatal screening midwife 1 (1.0 wte)

- HIV midwife 2 (1.0 wte)
- Stop smoking midwife 1 (0.8wte)
- Mental health midwife 1 (0.8wte)
- Infant feeding coordinator 1 (1.0 wte)
- Consultant midwife PH/ safeguarding 1 (1.0 wte)
- Consultant midwife normality 1 (1.0 wte)
- Clinical Practice Facilitator 1 (1.0 wte)
- Clinical Risk Manager 1 (1.0 wte)
- Clinical Governance midwife 1 (1.0 wte)
- CNST midwife 1 (0.8 wte)
- Audit midwife 1 (0.8 wte)
- Informatics Lead midwife 2 (0.6 wte)
- Volunteer Programme midwife 1 (0.6 wte)
- Research midwives 2 (1 wte)
- Maternity helpline 5 (3 wte)

Each of the specialist midwives will undertake clinical activity within the delivery suite, postnatal ward, antenatal clinic or community setting on a weekly basis.

Newborn examination clinic

One midwife who has undertaken the examination of the newborn course will be rostered to work in the newborn examination clinic every day

6. Consultant Obstetricians

Obstetric Cover (Including consultants) on Delivery suite

Monday to Friday cover (80 hours cover)
Monday to Thursday 08:00 till 10:00 pm. Friday 8:00 till 18:00 and weekend 14 hours on site

5 Day Cover	8-8pm	8pm-8am
CONS	YES	On Call
ST≥3	YES	YES
ST≥3	YES	YES

FY2, ST1-2	YES	YES

Weekend cover

Weekend Cover	**9-1300 pm (Sat) 9-1300 am (Sun)**	**1300pm – 8am (cover) 1300 am – 8am (cover)**
CONS	YES	On Call
ST≥3	YES	YES
ST≥3	YES	YES
FY2, ST1-2	YES	YES

7. Current obstetric anaesthesia services at HUHFT

Requirement	**Service available at Homerton Hospital Yes or No**
Duty anaesthetist with no other responsibilities available 24 hours/day	Yes
Duty anaesthetist assessed as being competent to undertake duties	Yes
Access to prompt advice and assistance from a designated consultant anaesthetist whenever required	Yes
Consultant presence on labour ward for at least 40 hours per week	Yes
Ten consultant programmed activities or sessions per week, to allow full working hours consultant cover	Yes
Separate consultant anaesthetist for each formal elective Caesarean section list	sometimes
Additional anaesthetic cover in periods of heavy workload	Yes
Consultant time specific allocated for high dependency care Consultant allocated for high dependency care	No
Extra clinical time for antenatal referrals, especially if formal clinic is provided	Yes
Consultant allocated for risk management with dedicated clinical sessions	No
Lead obstetric Anaesthetist with programmed activities/sessions for administrative work	Yes
Higher/advanced training for obstetric anaesthesia	Yes

The names of all consultants covering the Delivery Suite should be prominently displayed, and contact numbers readily available	Yes
Anaesthetic assistance available 24 hours/day with no other duties	Yes

8. Staffing and Contingency Planning

8.1 Staff Lists (Rota's)

A staff list is compiled in advance for the inpatient areas in order to ensure that there is the minimum number of staff required. This is achieved by use of bank and agency midwives where appropriate. There is an onsite staff bank which is responsible for requesting locum staff, either hospital bank or agency. A number of the established staff are employed by Homerton Staff Bank (HSB) as well as some regular bank midwives.

When the bank is unable to meet vacancy requests, they contact an agency of our preferred choice, who in turn request staff from the LAP2 approved agencies.

8.2 Management of Midwifery Staff Shortages

Staff rotas:

- These are prepared four weeks in advance for all inpatient and community teams.
- Bank are normally requested a week in advance.
- Staff lists are checked by two members of staff to ensure accuracy.

When sickness occurs, the midwifery matrons will assess where staff should be deployed in order to ensure a safe environment.

8.3 Management of Midwifery Staffing

- Contact the bank and or designated agency – assess if any midwifery staff/support staff are available to work
- In working hours the maternity site coordinator will identify the numbers of staff in each areas. The matron for the relevant clinical area should be contacted and informed. Outside of office hours the bleep holder for the maternity unit (the delivery suite coordinator) on bleep 134 should be made aware of staffing issues and steps taken to resolve the issues
- All clinical areas including community should be reviewed and judgement made about workload and dependency. Any staff requested to move to another area must go to the allocated area as instructed.
- At the twice daily activity review meeting the elective work will be reviewed– inductions, caesareans with the on call consultant obstetrician.
- Check the community on call rota to ensure there are midwives on call to continue to provide a community homebirth service.
- The supervisor of midwives on call should be kept informed of the situation and of any measures taken to alleviate the problem.

- **Obstetric medical staffing issues:**

The 6 months rolling rota for the ST≥3 and the FY2, ST1-2 is received prior to their commencing work with the trust.
The rolling rota is prepared by the college tutor. The weekly rota is sent out by a ST≥3 every Friday for the following week.

Management of Obstetric Junior Doctor Staffing

- Prioritise workload to cover on-calls, clinics, and theatres.
- Discuss with the on-call consultant obstetrician and college tutor.
- Contact the internal staff bank to book internal locum cover.
- Contact the trust's locum recruitment officer to book external locum cover.
- The General Manager should be informed if long term issues arise.

8.4 Management of Obstetric Consultant Staffing

The consultant team work together to ensure that even at weekends or nights prospective cover is maintained. This is completed using the following system:

- The clinical lead for Obstetrics will take responsibility for ensuring that cover is organised immediately by phoning other consultants to ensure that consultant presence is maintained. If the Clinical Lead for Obstetrics is off duty the Clinical Lead for Gynaecology will take this role.

- The rota will be changed on the delivery suite and switch board will be contacted to advise the change.

This agreement can be maintained for a period of up to 4-6 weeks – if further problems were anticipated a Locum Consultant would be employed until the situation had improved.

9. Process for annual audit of staffing levels

It is required that the staffing levels are appropriate to meet the needs of the service. To ensure that the levels are adjusted accordingly, the main staff groups will be audited annually or more frequently if it becomes apparent that the existing staffing levels are not adequate to provide the expected service.

The staffing levels of the groups that require auditing are midwives and support staff, consultant obstetrician, anaesthetists and registered anaesthetic practitioners (ODPs). This will be the responsibility of a nominated lead within the maternity service.

For the purpose of this year's annual audit; data has been collected and covers the months April through to August 2011. These months were chosen to more accurately reflect the existing staffing levels following the remodelling of midwifery staffing across the service due to reduction in funding from the PCT and local authority leading to a reduction in funded midwifery numbers.

The audit report is available to accompany this document.

10. Process for the development of Business Plans

- When it is apparent that there are deficiencies in staffing levels the Head of Midwifery is required to submit a proposal based on the assessment that the information is clinically effective, strategically important and makes a positive financial contribution to the Trust.
- An outline of the proposal is submitted to the General Manager who informs the to performance management group who meet monthly.
- A recommendation is made to the Executive Management Team and then the Trust Board
- Any actions plans (which apply locally) will be monitored at the maternity risk management meeting and or the Labour Ward Forum.

11. Process for the development of short term contingency plans

11.1 Midwives – managing the maternity service

During the week it is the responsibility of the midwifery matrons to manage staffing levels across maternity by the completion of healthroster. Bank or agency staff are requested as required, to ensure a safe service is maintained. It may be appropriate to move staff across the service where the activity is such that additional staff cannot be sourced from the bank. The allocation of staff to address this issue is reflected on healthroster. Shortfalls that are a concern re safety are escalated to the senior management team for discussion and action. Staff should be reviewed at the Activity review meeting which is held at 8.30 and 16.00hrs.

11.2 Obstetricians

It is the responsibility of the clinical director to ensure that a rota system is in place to provide an appropriate level of obstetrician cover for the maternity unit. A system will operate to ensure that annual and study leave is planned and agreed in advance that always leaves sufficient prospective consultant presence on delivery suite to the agreed level e.g. 80 hours. The rota will also be planned to take account of the additional senior obstetric support required at planned times of junior doctors changeovers. Expected short term absences will be notified by each consultant to the clinical director and medical staffing. As with other professionals it is usually preferable to employ staff already familiar with the unit when possible.

Where cover for immediate absences cannot be found at short notice, the clinical director or consultant obstetrician on call will undertake an assessment of priorities which may result in the cancellation of elective work.

11.3 Anaesthetists

It is the responsibility of the clinical director for anaesthetics to ensure that a rota system is in place to provide an appropriate level of anaesthetic cover for the maternity unit. A system operates to ensure that annual and study leave is planned and agreed in advance that always leaves sufficient anaesthetic presence on delivery suite to the agreed level.

Consultant anaesthetists are responsible for ensuring that all their team of junior doctors are on duty as rostered. Expected or immediate short term absence will be notified by each consultant to the clinical director and medical staffing. Where cover for immediate absences cannot be

found at short notice, the clinical director or consultant anaesthetist on call will undertake an assessment of priorities which may result in the cancellation of elective work.

11.4 Anaesthetic Assistants

The manager for theatres is responsible for covering any short term staffing shortfalls of anaesthetic assistants. The first line of action will be to attempt to cover the shortfall by using bank or agency staff via the Trust Bank. Theatres as a last resort may require the cancellation of elective work following consultation with the clinical director for anaesthetics.

12. Closure of the Maternity Unit

Closure of the maternity unit should be seen as a last resort measure. This should only be explored when all alternative measures have been explored e.g. expediting the process for women who can be discharged in cases where there is high activity or utilising specialist midwives / midwifery managers where there is a shortage of staff.
When considering closure of the maternity unit this must be carried out by following the Pan London Maternity Divert Policy. The policy was developed to standardise escalation policies processes across London according to an agreed common threshold. Please click on the link for the document: http://homertonlife/atoz/_qe9yyvm7u.html

12.1 Examples of criteria to close the maternity unit

- Skill mix inadequate to provide high dependency care.
- Inadequate staffing levels due to high sickness/absence.
- Shortage of beds on delivery suite or antenatal postnatal wards.
- Shortage of medical staff due to sickness/absence.
- Outbreak of an infection in the clinical areas and as advised by Infection Control department.
- In the event of major power failure.
- In the event of a major incident in the maternity unit or elsewhere in the Trust.

12.2 The activity review meeting maternity site coordinator

These meetings take place on the Delivery suite everyday at 8.00hrs and 16.00hrs. Key senior members of the maternity team will attend, which will include the following staff

- **Green status:** Matron / Head of Midwifery, Supervisor of Midwives (Mon – Fri) & Consultant Obstetrician on call, maternity bed manager and delivery suite co-ordinator.
- **Amber status:** As above plus Consultant anaesthetist, Neonatologist and theatre coordinator.
- **Red status:** As above plus senior manager on call (who will liaise with the executive manager on call)

Records of the activity and reasons for closure must be maintained to inform investigations that will be required.

It is the responsibility of the labour ward manager (Monday – Friday 8am-1600hrs) or co-ordinating midwife to discuss the situation with the Supervisor of Midwives on-call, providing an outline of activities within the unit. Such activity should also include any concerns regarding the availability of cots on the neonatal unit. The availability of midwives for the next two shifts should be considered and contingency plans enforced.

12.3 Supervisor of Midwives / maternity site coordinator will contact the following when amber or red status.

- The obstetrician on call should already be involved in the decision process.
- Head of Midwifery if not on the unit (or deputy)
- Neonatal consultant if not already aware
- Clinical Director and General Manager for the Division (Monday-Friday 0800-1700hrs)
- Senior Manager on call for the trust
- Site Manager
- (for red status) Commissioners via surge management

An integral part of this procedure is to ensure that maternity units in neighbouring areas are able to take women from the Homerton, before a final decision to close the unit has been made.

The maternity site coordinator and Supervisor of Midwives will confirm with the delivery suite co-ordinator and midwifery matron the decision to close the maternity unit. However, although the Supervisor has a duty of care to ensure the safety of mothers and babies, the decision to close the unit needs to be multi-disciplinary.

Table 1: Neighbouring Hospitals and Telephone Numbers

Hospital	Short Code	Telephone Number
The Royal London	6004	020 7377 7000
Newham General	6027	020 7146 1400
Whipps Cross	6072	020 8539 5522
University College London	6015	020 7380 9721
Whittington	6014	020 8288 5502
North Middlesex	6007	020 8887 2510
Queens	0845 111 4000	0845 111 4000
Chase Farm	0845 111 4000	0845 111 4000
Chelsea & Westminster	6587	020 8746 8000

The Supervisor of Midwives or maternity site coordinator on delivery suite should complete an incident form and inform the Local Supervising Authority Midwifery Officer via the LSA database.

If it is considered necessary to close the unit and not just divert ambulances inform labouring women as they enter the unit of the need for diversion, ensuring that they take their maternity case notes with them.

Table 2: Useful Telephone Numbers

Contact	Telephone/Fax Number
Emergency Bed Service (EBS)	020 7407 7181
Fast dial EBS	6013
Local Supervising Authority Office (Office hours) Jessica Read	O20 7725 2558
Commissioners via surge management	surgemanagement@nelcsu.nhs.uk.

When activities revert to normal within the maternity unit the maternity site coordinator, Head of Midwifery or Supervisor of Midwives will contact the receiving unit (s) and thank them for their help and support. In addition any woman who delivers at another unit should be contacted via telephone or letter.

12.4 Reversing the process

The reverse process becomes applicable as soon as the precipitating factors are resolved and there are adequate facilities and staff within the maternity unit.

The Supervisor of Midwives / maternity site coordinator informs the:

- Consultant Obstetrician
- Midwifery Matron
- The delivery suite co-ordinator
- Head of Midwifery
- Neonatal Consultant
- Senior Manager on call
- Clinical Site Manager
- Ambulance Control
- Receiving unit(s)

12.5 Reflection

When normal activities resume within the unit, time should be identified for all professional involved in the above process to come together. This will enable a period of reflection and to share any lessons learnt form the experience. Closure of the unit is a serious incident and

therefore will be investigated as a serious untoward incident. The investigator is usually the supervisor of midwives who was on call at the time of the closure.

Where appropriate,follow-up reports should be attached onto Datix with the incident form.

13. Training and awareness

This guideline will be available for all to view on the Trust intranet. During their orientation to the Trust staff will be informed where the guideline can be located.

14. Monitoring/Audit

Measurable Policy Objective	**Monitoring/ Audit**	**Frequency of monitoring**	**Responsibility for performing the monitoring**	**Monitoring reported to which groups/committees, inc responsibility for reviewing action plans**
Midwifery and support staff levels are agreed and allocated to cover care in all settings	Audit	Annual staffing audit	Midwifery managers and Head of Midwifery	Maternity Risk Management & Clinical Governance Group Business plans developed where shortfalls are identified Escalation to Trust risk register where there is unresolved risk form staff shortfalls
Experienced coordinator on each shift for the labour ward	Audit in relation to national standards	Annual	Delivery suite Matron	Maternity Risk Management & Clinical Governance Group Labour Ward Forum
Evidence of consultant presence on the delivery suite for 80 hours per week	Audit	Annual	Clinical Director	Maternity Risk Management & Clinical Governance Group Business plans developed where shortfalls are identified Labour Ward Forum Escalation to Trust risk register where there is unresolved risk form staff shortfalls
Evidence that consultant was present in the clinical situations as listed in 3.2 of this document	Review of notes	Continuous	Clinical Director & Maternity clinical risk manager	Maternity Risk Management & Clinical Governance Group Labour Ward Forum Required changes will be disseminated to the obstetric consultant team and actions monitored

Measurable Policy Objective	Monitoring/ Audit	Frequency of monitoring	Responsibility for performing the monitoring	Monitoring reported to which groups/committees, inc responsibility for reviewing action plans
Establishment of consultant obstetricians	Retrospectiv e audit	Annual	Clinical Director	Maternity Risk Management & Clinical Governance Group Labour Ward Forum Business plans developed where shortfalls are identified Escalation to Trust risk register where there is unresolved risk form staff shortfalls
Evidence that anaesthetic service is in line with the service provision as stated in this document	Retrospecti ve audit	Annual	Clinical Director	Maternity Risk Management & Clinical Governance Group Labour Ward Forum Business plans developed where shortfalls are identified Escalation to Trust risk register where there is unresolved risk form staff shortfalls
Anaesthetic assistants available for all operative procedures involving anaesthetists	Retrospectiv e au dit	Annual	Clinical Director	Maternity Risk Management & Clinical Governance Group Labour Ward Forum Business plans developed where shortfalls are identified Escalation to Trust risk register where there is unresolved risk form staff shortfalls
Waiting times for epidurals	Audit	Annual	Lead consultant for anaesthetist for obstetrics	Maternity Risk Management & Clinical Governance Group

15. Sources of Evidence: References/Bibliography

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