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NHS
Frimley Health
NHS Foundation Trust

Maternity department communication and escalation policy including department closure

Key Points

- All staff are able to escalate to a more senior member of both the obstetric and midwifery team.
- No staff member should be prevented from escalating their concerns by other members of staff.

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Abbreviations

CoS	Chief of Service
CoW	Consultant of the Week
DoM	Director of Midwifery
HoM	Head of Midwifery
MCA / MSW	Maternity Care Assistant / Maternity Support Workers
MDT	Multidisciplinary team
NNU	Neonatal Unit
ODP	Operating Department Practitioner
RAF	Risk Assurance Framework
RN	Registered Nurse
SBAR	Situation, Background, Assessment and Recommendation
TCU	Transitional Care Unit

Contents

1. Introduction

1.1 Intra-professional communication failure and failure to escalate are often highlighted as significant factors in cases with poor outcomes. Professional awareness of different staffing groups working practices helps to foster good multi-disciplinary team working and appropriate care management. Good communication and effective dissemination of information helps to protect the welfare of mother and baby. This can be achieved by the mutual recognition of the respective roles of midwives, doctors and others participating in the care of mother and baby. Communication is important to all aspects of care.

1.2 Escalation may be required for a variety of reasons and may include but is not restricted to, case being outside of an individual's scope of practice, concerns over patient condition, concern of disagreement over care planning (medical or social), activity within the department, bed capacity within the department**.**

All staff members are supported to escalate if they have concerns. No staff member should be prevented from escalating their concerns should the need arise. Midwives and junior doctors can refer directly to a consultant obstetrician or senior midwifery team at any stage of maternity care according to their clinical judgement.

1.3 This document is written to cover information which may support escalation occurring and aid the smooth running of the maternity departments considering roles and responsibilities, communication, staffing and capacity. The guideline will be structured in that order.

1.4 This document is written to outline minimum staffing for Midwives, Nurses, Maternity Support staff, Obstetric staff, Consultants and Anaesthetists and clinical support staff in the maternity services. The organisation of care by staff group is addressed in all care settings, setting minimum safe staffing standards as well and short- and long-term contingency measures, to ensure the best outcome for women and their babies regardless of the birth setting.

1.5 Appropriate staffing levels and skill mix across all professional groups and essential for providing safe maternity services. This paper will set out the process for managing short term and long-term actions in the face of staff shortages.

2. Purpose

2.1 To define the escalation procedure for use when there are concerns about care management, staffing levels and clinical safety of the maternity units. To outline the strategy and thresholds for staffing levels for midwifery, nursing, obstetric and Anaesthetic cover for the maternity service. To outline processes for managing short- and long-term staffing shortages.

2.2 The following staff are on call 24 hours a day, 7 days a week and should be contacted by **any** member of the multi-disciplinary team if there is a concern about safety. Specific examples include capacity concerns, staffing shortages, urgent safeguarding concerns and concerns about clinical decision making:

- **The Midwifery Manager on Call** (contact numbers available via switchboard)
- **Obstetric Consultant on Call** bleep (FPH 5607 or via switchboard) 24/7 weekdays, FPH: 08.30 – 21.00 and WPH: 08.00-20.30 weekends, outside of this the admitting consultant is available via mobile via switchboard FPH: 21.00 – 08.30 and WPH: 20.00- 08.00 Fri/Sat/Sun nights)
- **Clinical Site Manager**

Remember: **when it comes to safety, there is no hierarchy**. Escalate at an early stage if you have concerns, and don't assume that someone is "right" because they are senior to you.

2.2.1 Escalate in all of the following scenarios:

- Midwifery request for obstetric review is not met
- Midwifery request for obstetric review is met but Midwife is concerned about obstetric recommendation.
- Obstetrician request for senior obstetric review is not met (all grades)
- Obstetrician request for senior obstetric review is met but obstetrician remains concerned about senior obstetric recommendation.

3. Scope

3.1 This guideline applies to all Midwifery, Nursing, Paediatric, obstetric and anaesthetic staff working within the obstetric and anaesthetic directorates, trainees and operating department practitioners covering the Labour Ward and obstetric theatres.

4. Roles & responsibilities utilised in all care settings

4.1 MIDWIFERY AND NURSING TEAM

4.1.1 Director of Midwifery for the Directorate (DoM)
The Director of Midwifery provides overall promotion of professional expertise and professional leadership for the service, and acts as an advocate for women. They take the responsibility for quality and clinical governance for the midwifery care provided by the service. The Director of Midwifery is responsible for the strategic direction and implementation of midwifery services. Additionally, they lead the Midwife "Quality Arm" of the midwifery organisation outlined below. This is a cross site role. Responsibility when not on site may be delegated to an appropriate senior and trained delegate.

4.3.1 Associate Director for Women's and Children's services
The Associate Director, the Director of Midwifery and Chief of Service have joint responsibility for overseeing clinical and non-clinical risk management throughout the maternity services. They are accountable for day-to-day management of all types of risks within their area of responsibility which includes ensuring safe staffing levels within the maternity service. They are responsible for the assessment of current and future workforce requirements and, where shortfalls are identified, for producing a business case to address such shortfalls.

4.1.2 Head of Midwifery (HoM)

The Heads of Midwifery and Gynaecology are responsible for the day-to-day operational management of the maternity services; and also supports the DoM with performance management, recruitment, staffing and talent management. This role is site specific.

4.1.3 Consultant Midwives

There is one consultant midwife included within the funded establishment for each site. They are focused on leading the service clinically and work as a direct support to the HoM whilst positively representing the Trust externally. This role has a 50/50 split between office and clinical work.

4.1.4 Midwifery Matrons

A holder of this role will act as overall leader and manager for key areas of the maternity service. Midwifery Matron roles are site specific and cover Community, Intrapartum services, and Inpatient services.

4.1.5 Band 7 Midwifery Sisters

Lead and co-ordinate the clinical, managerial, and educational requirements of Midwives and support staff within a defined area, e.g., Labour Ward, Antenatal/Postnatal Wards, Birth Centre, Community.

The Trust requires that an experienced band 7 Midwife acts as the Labour Ward shift coordinator throughout the twenty-four-hour period. The service is organised to ensure a senior Midwife is on duty 24/7 to coordinate the Labour Ward. This Band 7 coordinator is a senior and experienced Midwife whose role includes overall unit responsibility on shift for safe staffing levels, allocation of cases to appropriate skill mix, patient safety and a vital link with members of the maternity team.
There must be a supernumerary Labour Ward coordinator on duty at the start of every shift. An escalation plan should be available and must include the process for providing a substitute coordinator in situations where there is no coordinator available at the start of a shift. This substitute can be a suitably supported experienced band 6.
It is the shift lead's role to escalate any concerns relating to the women and babies, staffing and potential compromise of maternity's business continuity. The Labour Ward Coordinator is a vital point of contact for the Community Midwifery teams. Communication links, including early warnings of potential transfers in from home birth, enables the shift lead to plan for fluctuations in activity.

At handover, the Labour Ward Coordinator will be informed of any managerial or clinical issues within the unit. This included staffing levels, bed availability and outliers, equipment and stock issues and access to neonatal cots.

- At FPH the Labour Ward Coordinators carry bleep 5059.
- At WPH the Labour Ward Coordinators carry bleep 4576.

They will receive all obstetric and neonatal emergency calls within the hospital.

4.1.6 Band 6 Midwives

Band 6 Midwives provide care and advice to women and their families during pregnancy, labour, and the postnatal period. They act autonomously in the provision of direct client care conducting deliveries autonomously and providing care for the newborn; they support the Band 7 midwives in the management of a defined clinical area or caseload, effectively coordinating and professionally leading the clinical midwifery team.

4.1.7 Band 6 Midwives – newly qualified employed on Annex 21

Provide care and advice to women during pregnancy, labour, and the postnatal period. The newly qualified Midwife acts autonomously in the provision of direct client care but has a named preceptor and clinical competencies to work towards to achieve their full Band 6.

4.1.8 Specialist Midwives

Specialist Midwives have specific roles and responsibilities, e.g., Risk Management, Practice Development, Named Midwife for Safeguarding, Infant Feeding Advisor, Antenatal Screening Midwife, bereavement midwife, diabetes midwife and perinatal mental health midwife. These Midwives provide clinical care which has a significant and positive impact on care delivery. (N.B. these posts are included in funded establishment numbers and a portion of their role are included in the calculations of Midwife to birth ratios).

4.1.9 Student Midwives

Provide care under direct supervision from qualified Midwives in all care settings.

4.1.10 Registered Nurses (Band 5)

RN's work within the postnatal ward of the WPH site only, delivering care for women as directed by the Midwife in Charge. They will also assist with the care and recovery of post-operative women. Designated registered nurses are also employed to undertake the maternity vaccination programme within the ANC and community midwifery setting on both sites.

4.1.11 Maternity Care Assistant/ Maternity Support Workers (Band 3)

Maternity Care Assistants (MCA/MSW) working at a band 3 level work within areas providing postnatal care. This is because the band 3 role makes up 10 percent of the midwifery establishment under postnatal care provisions only. This can include work within the community. They act under the direct supervision of Midwives to deliver individualised plans of care for mothers and babies.

4.1.12 Maternity Care Assistants/ Maternity Support Workers (Band 2)

Maternity Care Assistants (MCA/MSW) act under the direct supervision of Midwives to deliver an individualised plan of care for mothers and babies. Band 2 Maternity Care Assistants work within the hospital setting only.

4.2 MEDICAL STAFF

4.2.1 Medical Staff within Obstetrics

The junior and senior staff of doctors, including consultants, are responsible for the delivery of care according to the guidelines of the maternity service. One consultant holds the role of Consultant Lead for the Labour Ward. Consultants and other

doctors in maternity services are responsible for attending a set of specialist clinics throughout the week, providing Labour Ward cover, performing elective caesarean section lists and conducting ward rounds on the maternity unit.

4.2.2 A key duty of the Obstetric Consultant on call is to attend in person to the following clinical emergencies, the consultant should be informed and attend in person whatever the level of the trainee:

- Eclampsia
- Maternal collapse (such as massive abruption, septic shock)
- Caesarean Section for major placenta praevia
- Postpartum haemorrhage of more than 1.5 litres, where the haemorrhage is continuing, and a massive obstetric haemorrhage protocol has been instigated
- Return to theatre – laparotomy
- Uterine rupture
- Vaginal Breech delivery
- When requested
- In the event of 2 obstetric theatres being opened

4.2.3 In the following situations a Consultant should be informed and either attend or be immediately available if the trainee has not been signed off as competent for the procedure in question:

- any acute deterioration of the maternal condition (antenatal, intrapartum, postpartum), including when patient deterioration requires transfer of the patient to Labour Ward for step up care.
- high acuity on Labour Ward (particularly if all doctors busy in theatre)
- unexpected poor birth outcome
- trial of instrumental delivery in theatre
- twin delivery
- caesarean section at full dilatation
- caesarean section in women with body mass index greater than 40
- caesarean section for transverse lie
- caesarean section at less than 32 weeks of gestation
- repair of 3rd or 4th degree tear
- Antenatal care plan of high-risk woman requests consultant to be informed on arrival on Labour Ward
- Medical staff to consider external escalation to tertiary centres, for maternal medicine advice such as Silver Star in Oxford.

4.2.4 Medical Staff within the Neonatal Team

Consultants and Doctors on the NNU are responsible for the clinical care of babies admitted to the NNU and to the transitional care area on the maternity care unit.

4.3 OBSTETRIC TEAM

4.3.2 Chief of Service

The Chief of Service has a responsibility to manage risks at a local level in their department, and to develop an environment where staff are encouraged to identify

and report risk issues and escalate concerns proactively. They are responsible for developing local quality indicators to include clinical outcomes, patient safety and patient experience issues. They are also responsible for ensuring emergency planning is understood locally and business continuity plans are developed in line with the Trust framework.

The Chief of Service is also responsible for ensuring appropriate allocation of obstetric resources in order to provide safe quality of care at all times. This is a cross site role. Responsibility when not on site may be delegated to their deputies.

4.3.3 Consultant Obstetrician

The Consultant Obstetrician will have overall responsibility for the care of all patients on the Labour Ward, antenatal, postnatal, triage and day assessment unit during their period of duty and provides training, support and supervision for Obstetric medical trainees. They will have responsibility for ensuring a smooth handover to the Consultant on duty. They will liaise closely with the senior Midwife with responsibility for the Labour Ward.

4.3.4 During this time the Consultant specific duties will include:

- Undertake regular ward rounds of the Labour Ward
- Supervision of junior medical staff
- Teaching of junior medical staff and Midwives
- Assisting with the management of both normal and abnormal pregnancy
- Manage critical incident that occur and complete any urgent related follow up
- Ensuring appropriate patient management in line with trust protocols and guidelines

4.3.5 Registrar in Obstetrics (ST3 – ST7)

ST3 to ST5 are middle grade trainees, while ST6 and ST7 are senior trainees in the specialty. They liaise closely with the Consultant Obstetrician and inform the Consultant of any concerns regarding fetal or maternal wellbeing. Escalation can occur to a registrar when a midwife is concerned about an SHO's decision making, or escalate to a consultant.

4.3.6 Junior Medical Staff (O&G ST1 – ST2, GP ST1 – ST2, MTI, FY2) formerly SHO:

Should be supported and supervised in the care of women on the Labour Ward. There are different types junior trainees:

O&G ST1-2's - are junior trainees in obstetrics and gynecology. As ST2's progress, they start to take on more registrar duties, such as covering DAU or doing an elective low risk section with another junior assisting. ST2's are in their last year before progressing to registrar (ST3) level.

MTI - (Medical Training Initiative) trainee on the ST2 rota act as junior trainees (ST1-ST2). Often, they are clinically more experienced, but new to the NHS.

GP ST1-2's - These are GP trainees who only spend 4 months in O&G. Some are from the local deanery and others are military (FPH only).

FY2's - These are the most junior doctors. They are in their 2nd year after finishing medical school and are in our department for 4 months.

There are also several clinical fellows, who, depending on their experience and where they are in their career, will be working on any of the 3 junior doctor rotas such as the registrar rota, the ST2 rota or the GPST/FY2 rota.

4.4 ANAESTHETIC TEAM

4.4.1 Consultant Anaesthetist

The Consultant will have overall anaesthetic responsibility for the care of all patients on the Labour Ward during their period of duty, and will ensure continuity of care through detailed handover of the Labour Ward to the general anaesthetic consultant on call. The consultant anaesthetist assigned to the elective caesarean section list is responsible for all the elective caesarean sections on that list. If the list is undertaken by any other anaesthetist there will be a named anaesthetic consultant responsible for the list.

4.4.2 Consultant Anaesthetist – Lead for Labour Ward

The lead Obstetric Anaesthetist is responsible for the organisation and audit of the service, for maintaining and raising standards through provision of evidence-based guidelines, for providing anaesthetic input to the Labour Ward Forum and for training and risk management activities. They are also responsible for attending the bi-weekly maternal medicine MDT's or ensuring a different consultant obstetric anaesthetist attends instead of them when they are unable to do so.

4.4.3 Duty Anaesthetist

The Duty Anaesthetist provides dedicated cover for Labour Ward through a 24-hour rota. The duty anaesthetist has successfully achieved their initial competencies in obstetric anaesthesia. Supervision is undertaken by a Consultant who is a recognised specialist in obstetric anaesthesia. Assessment includes competence to conduct regional and general anaesthesia for Caesarean section as well as regional techniques for pain relief in labour.

4.4.4 Operating Department Practitioner

The Operating Department Practitioner (ODP) provides dedicated cover for Labour Ward through a 24-hour rota. The ODP offers skilled assistance in perioperative care which includes anesthetic, surgical and recovery skills. They also work alongside Midwives and Theatre Nurses to maintain high standards of care for women before, during and after a theatre procedure. The ODP’s line management is through the Head of Nursing for Theatres.

5. Communication

5.1 The SBAR tool is recommended to healthcare professionals to ensure a consistent approach to handover of care. It is used to frame conversations by discussing the: **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation. It enables the user to clarify what information and how the information should be communicated between members of the team. The SBAR tool helps to develop teamwork, foster a culture of patient safety and ensures staff are sharing concise and focused information. Communication during handovers of care, referral for opinion or referral relating to the care of women must use the SBAR format.

5.2 Labour Ward

5.2.1 A site specific multi-disciplinary ward round should take place morning and evening (Monday to Sunday) to identify and assess any problems in the maternity units. All women identified as high risk should be seen by the obstetric registrar, and, where deemed appropriate, by the obstetric consultant and a plan of care documented in the maternity notes in EPIC. Multidisciplinary working includes twice daily (day and night through the 7-day week) consultant-led (and present) multidisciplinary ward rounds on the Labour Ward.

5.2.2 It is the duty of the Obstetric Registrar to maintain close liaison with the on-call consultant obstetrician, keeping the consultant informed of high-risk women, and obtaining a consultant opinion as the case dictates.

5.2.3 All staff members can contact the obstetric consultant or a member of the senior midwifery team if they feel a second opinion is required on safety concerns or immediate safety of staff members. It is a matter of courtesy and best practice to liaise first with the Labour Ward coordinator and obstetric registrar if problems arise.

5.2.4 Effective communication with the Labour Ward is vital for the professional functioning of the maternity service. The Labour Ward Coordinator must be informed of:

- Impending and actual admissions, discharges and transfers to and from Labour Ward
- All women's progress in labour
- Any women on the Labour Ward with a cause for concern form in their records
- Any problem requiring an opinion, medical assistance, or when more intensive monitoring is required. For example:
    - Significant meconium-stained liquor
    - where there are concerns about a cardiotocograph
    - when an epidural anaesthetic is sited
    - at the onset of the second stage of labour
    - when a physiological third stage of labour is requested
    - when any woman declines advice/treatment
    - impending homebirth

5.3 Handover from the antenatal ward to Labour Ward and from Labour Ward to postnatal ward/TCU should be an in-person midwife to midwife SBAR handover. In

exceptional circumstances an MCA can transfer women from Labour Ward to postnatal, however a telephone handover must occur using SBAR and be documented in the handheld notes.

6. Staffing Requirements

Staffing levels can have a large impact on the need for maternity services to close. To prevent unnecessary closures impacting on women, duty rotas must be prepared in line with annual /study leave guidelines. This is so that there is an even distribution of staff throughout the week. They must be approved by appropriate line managers. The managers will then know in advance where the shortfalls in staffing are and take appropriate actions. Once duty rotas have been approved, they must not be changed without the knowledge and authorisation of the appropriate line manager. Shortages. through sickness or special leave may be covered with bank/ agency staff if the shift cannot be covered through redistribution of remaining staff.

Medical staff rotas are prepared in advance by the rota coordinators with input from the consultants responsible and published. CoS is responsible for ensuring the unit is adequately covered at all times, to ensure provision of safe care. In the event of absence from work due to sickness, injury or accident, Consultants and Registrars should inform the rota coordinators and the Consultant of the Week (CoW) during the day or On-call Consultant, during the night. They should inform them of their absence on the first day of absence or as early as possible, to ensure there is sufficient time to arrange cover for the unit.

6.1 Process for Short-Term Midwifery/Nursing Staffing Shortfalls in all areas prior to “Day of” service delivery.

6.1.1 In all areas, clear ownership for the on-going review of staffing plans are established ensuring on-going bank/agency requests and internal cross cover arrangements are made to reduce the likelihood of avoidable staffing issues arising.

6.1.2 The Directorate is funded for midwifery staffing on a set midwifery birth ratio. The following normal midwifery staffing levels are applicable on both site; differences occur due to the differences in birth rates on each site. Our staffing model requires that Labour Ward has an experienced shift coordinator (Band 7) on duty for each shift.

	Wexham Site		Frimley Site	
Establishment Levels	**Day Shift**	**Night Shift**	**Day Shift**	**Night Shift**
Maternity Assessment Centre (triage/ DAU)				
Midwives	3	2	4	2
MSW/MCA	2	1	0	0
Antenatal Ward				
Midwives	2	2	2	2
MSW/MCA	1	1	0	0
Postnatal Ward				
Midwives	3	2	4	3
MSW/MCA	2	2	3	3
TCU				
Midwives	1	1	1	1
MSW/MCA	1	1	1	1
Labour Ward				
Midwives	6	6	10	10
MSW/MCA	2	2	2	2
Birth Centre				
Midwives	2	2	2	2
MSW/MCA	1	1	0	0
Antenatal Clinic				
Midwives	2	N/A	2	N/A
MSW/MCA	4	N/A	3	N/A
Midwives in the Unit (Total)	**19**	**15**	**25**	**20**
Community on call staff	N/A		N/A	

***** Please note the table above represents core staffing levels, however, there are additional midwives who may be working within these departments covering different roles such as NIPE, Infant feeding etc.

6.1.3 Minimum staffing levels are dependent on patient numbers and activity levels. Areas may need to be merged and run together if staffing numbers and activity require.

6.2.1 Process for Managing Staffing Shortfalls or Sudden Increases in Activity. (see also **Appendix 1**)

6.2.1	**Midwifery/Nursing Short-Term staffing shortfalls**, staffing should be reviewed across the whole of the maternity unit

6.2.2 Review the staffing within the maternity unit and redeploy staff to required areas if able, including consideration of the use of Community Midwives. Contact the **Matron** or nominated deputy for the relevant area during working hours to inform them of the situation and discuss an action plan and assess whether extra staff can be requested through the Frimley Health Temporary staffing bureau. Between the hours of 1700 hrs to 0800 hrs contact the midwifery manager on call for support.

6.2.3 Allocate the available staff to care for women / babies so that the staff from the previous shift can go home when their shift ends.

6.2.4 Inform the Matron, (or Maternity On Call Manager), obstetric team (Registrar / Consultant) of the staffing issues where safety is compromised. If necessary, following consultation with the clinical leads, delay the start time of planned procedures - elective Caesarean section list, induction of labour and external cephalic version.

6.2.5 The Labour Ward Coordinator will inform the staff on the wards / Birth Centre of the staffing issues and the possible need to delay the Caesarean section list and other planned work for that day.

6.2.6 Advise the woman and her partner that the timing of her Caesarean section, induction of labour or augmentation of labour may be delayed. Aim to keep them as informed as possible to prevent them becoming anxious and reduce the number of complaints. The obstetric staff should consider the use of intravenous fluids on any pre-operative woman who may have a prolonged period of ‘nil by mouth’.

6.2.7 Negotiate with the Obstetric and Anaesthetic team when it is feasible to commence the elective list.

6.2.8 If for any reason elective procedures need to be postponed, please ensure that the woman is informed of this as soon as possible. A CTG will need to be performed and a full set of maternal observations need to be undertaken. The woman must then be booked onto the next available list in the week as a priority. The cancellation of the first procedure must be clearly identified alongside the woman’s name, to avoid repetition of a further cancellation.

6.2.9 The re-booking of the procedure should not:

a) Compromise other high-risk women, or
b) Occur at the weekend without prior discussion with the on-call Consultant, Labour Ward manager and theatre team personnel who would be working on that weekend.

6.2.10 Both Neonatal Units are Level 2 Units, and every attempt will be made to accept these babies. The Labour Ward Coordinator will contact the Matron / Maternity On Call Manager if there are concerns regarding the lack of beds in the unit and /or the Labour Ward or in the case of inadequate staffing levels.

6.2.11 The Obstetric and Neonatal teams will make every effort to discharge women if they are able to go home. If Postnatal Ward staff are experiencing problems with the discharge process of babies, then they should contact the on-call Paediatric Consultant. If experiencing problems with the discharge of women who need to be seen by the Obstetrician prior to going home, then the postnatal Midwife should contact the on-call Obstetric Consultant (Consultant of the Week).

6.2.14 If all the above has been explored, the Head of Midwifery, Matron / Maternity On Call Manager will then make the decision to employ extra staff if the situation is unsafe for mothers and babies in the unit. In this case it would be expected that the Matron / Maternity On Call Manager would be in the unit.

6.3 Midwifery/Nursing Ongoing staffing shortfalls

6.3.1 For periods of ongoing staffing shortfalls the following procedure will be followed:

- Following review, the Head of Midwifery will develop a contingency/business case if ongoing shortfalls are identified through review of the workforce and risk management strategy.
- The business plan outlining staff short falls will be recorded on the Maternity Service Risk Assurance Framework.
- Where long term unresolved shortfalls continue the Director of Midwifery, Chief of Service and Associate Director for Women's and children's services will escalate the risk to the Trust Board via the Care Governance Committee or directly to the Trust Board, through the Board safety champion for maternity services.

6.3 Obstetric Short-term Staffing Shortfalls (see also **Appendix 2**)

Rationale: The Royal College of Obstetrics has published guidance (RCOG 2007) regarding prospective Consultant presence on the Labour Ward to provide immediate skilled assistance for the unexpected and unpredictable emergency; to teach, train, supervise and support the junior medical staff; and to work with the coordinating Midwife to provide leadership to the multidisciplinary team. A Consultant cannot take leave when on their 'CoW week' and must swap out, giving at least 6 weeks' notice.

There is currently prospective Consultant or Locum Consultant Obstetrician presence on the Labour Ward as per Standard Operating Procedure for Labour Ward Rounds. In the rare case where the Consultant cover rota for Obstetrics ends with an urgent gap, there is a clear set of escalation steps. The first level of action is to secure a Consultant who is off-duty or in a more flexible, low risk area of the service. The next step, if required, is to secure a locum middle or junior grade for the Labour Ward with a Consultant on call.

Designated Labour Ward sessions are:

FPH: Everyday: 08.30 – 21.00 cover by a consultant with a registrar, Mon - Thurs 20.30 – 09.00 cover by a consultant with a registrar. Fri/Sat/Sun 20.30 – 09.00 cover by 2 registrars with the admitting consultant available within 30 minutes.

WPH: Everyday: 08.00 – 20.30 cover by a consultant with a registrar, Mon - Thurs 20.00 – 08.30 cover by a consultant with a registrar. Fri/Sat/Sun 20.00 – 08.30 cover by 2 registrars with the admitting consultant available within 30 minutes.

	Wexham Park Hospital		Frimley Park Hospital	
Day	Morning Session	Afternoon Session	Morning Session	Afternoon Session
Monday – Friday	08:00 – 17:30	17:00 – 20:30	08:30 – 17:00	17:00 – 21:00
Saturday	08:00 – 20:30		08:30 – 20:30	
Sunday	08:00 – 20:30		08:30 – 20:30	

During designated Labour Ward time Consultants should have no other fixed clinical commitments or managerial responsibilities.

6.4.1 Consultant

The Consultants are expected to provide cover for each other when one is off. If there is unplanned Consultant absence and the alternative Consultant cannot cover, the Chief of Service/ Associate Director should be informed. It is the responsibility of the Consultant designated to do the session to inform Labour Ward and switchboard of the change.

6.4.2 If there is unplanned absence of the on-call Consultant, the Consultant of the Week should be informed and will arrange cover for on-call overnight.

6.4.3 Junior medical staff:

The Trust currently has two tiers of junior medical staff covering Labour Ward, one ST3-ST7 and one ST1-ST2. In the event of short-term absence of junior medical staff, providing Registrar and SHO cover for the Labour Ward carries the highest priority within the service and is usually covered internally to minimise risk. The Consultant on call should be notified of any absence and arrangements should be made for a Registrar or SHO to cover the Labour Ward on call session. Priority of cover should be given in the following order:

1. Labour Ward
2. Emergency Gynaecology
3. Antenatal Clinic/Gynaecology Clinics/Gynaecology Theatres
4. Special Interest Sessions

6.4.4 In the rare event of a Registrar (or SHO) not being available to provide cover, a Consultant may cover following discussion with the Associate Director or the CoS. If a Consultant is providing cover for junior medical staff, they must be resident in the hospital until a locum can be arranged. However, it is preferable to use existing members of staff who are familiar with hospital procedures. All requests for locums

should be via the Manpower Coordinator during office hours or the Associate Director if out of hours and the Consultant on call.

6.4.5 All short-term absences must be recorded in the Labour Ward Logbook to enable monitoring of the process and assist in future planning.

6.5 Obstetric long-term or ongoing Staffing Shortfalls

6.5.1 Consultant

Locum Consultant cover will be arranged for long term sickness absence of more than one week and for maternity leave. Trust policy must be followed in these cases.

6.5.2 Junior medical staff

In the event of long-term Registrar/SHO sickness, an attempt will be made to obtain a Locum Training post initially by the Deanery. If this is unsuccessful, a local locum appointment may be made in liaison with the Deanery. If this is not possible, a Junior Doctor of relevant competence will be used to maintain the Labour Ward and on-call rota at the expense of lower priority sessions (as above). The junior medical staff are European Working Time Directive compliant and the current complement provides some leeway for holiday and sickness.

6.6 Anaesthetic short term staffing shortfalls (see also **Appendix 3**)

In the rare case where the Consultant Anaesthetist is unable to attend the Labour Ward as planned, escalation is made to the main theatre operations team who secure another Consultant Anaesthetist. This is done via phone/bleep communications. In the event that this is not possible, an additional Registrar would be sent to Labour Ward with Consultant Anaesthetic support available in main theatres.

6.6.1 Consultants

Short term absences of Consultants should be notified to the Chief of Service or deputy for Anaesthetics, who will arrange for the session or on-call shift to be covered by another Consultant. In exceptional cases, if it is not possible to cover the session by a Consultant with a specialist interest in Obstetrics, a Staff Grade may provide cover. Providing anaesthetic cover for the Labour Ward carries the highest priority and therefore it may be necessary to cancel elective lists within the Directorate if cover cannot be maintained by any other means.

6.6.2 Duty Anaesthetist

The anaesthetics rota is compiled on a weekly basis and shortfalls are identified before the start of the week to ensure the availability of a Duty Anaesthetist on Labour Ward 24/7. In the event of short-term absence of the Duty Anaesthetist, the Consultant on call should be notified of any absence and arrangements should be made for a Consultant/staff grade or trainee who has had their obstetric competencies signed off to cover the Labour Ward on call session. Providing anaesthetic cover for the Labour Ward carries the highest priority within the service and is usually covered internally to minimise risk. In exceptional cases, it may be necessary to cancel elective lists or suspend the epidural service in order to maintain cover and safety. This decision must be made by the Consultant on call.

6.7 Anaesthetic long-term or ongoing Staffing Shortfalls

6.7.1 Consultant

Locum Consultant cover will be arranged for long term sickness absence of more than one week and for maternity leave. For leave and study the Human Resource Policy TPP 416a Leave (annual, study, professional) for Consultant Medical & Dental Staff must be followed in these cases.

6.7.2 Duty Anaesthetist

In the event of long-term trainee anaesthetist sickness, an attempt will be made to obtain a Locum Training post initially by the Deanery. If this is unsuccessful, a local locum appointment may be made in liaison with the Deanery. If this is not possible, Junior Doctors of relevant competence will be used to maintain the Labour Ward and on-call rota at the expense of lower priority sessions such as special interest sessions. The junior anaesthetic staff are European Working Time Directive compliant and the current complement provides some leeway for holiday and sickness.

7. Assessment of Current and Future Workforce Requirements

7.1 The Chief of Service, Director of Midwifery, Head of Midwifery and Associate Director for Women's and Children's Services should carry out an annual assessment of current and future workforce requirements to ensure that the Trust maternity services are able to provide appropriate midwifery staffing and Obstetric medical cover which is in line with the recommendations of Safer Childbirth. If deficiencies are identified and it is not possible to meet the requirements, the provision of additional medical staff should be included in the Directorate's Strategic Development Plan.

Staffing shortfalls which endanger the Trust's or Directorate strategic, or risk management objectives should be included on the Risk Assurance Framework (RAF) and escalated in the quarterly report to the Clinical Governance Committee. The quarterly report informs the Patient Safety report which is presented by the Medical Director to the Trust Board.

7.1.1 If the risk remains unmitigated, the Chair of the Divisional Clinical Governance Group will ask the Associate Director for Women's and Children's Services, Chief of Service and Director of Midwifery to formulate a business case for presentation to the Corporate Governance committee and onwards to the Trust Board.

7.2 For Anaesthetics, The Associate Director and Chief of Service should carry out an annual review of current and future workforce requirements to establish whether Consultant Anaesthetist and assistant staffing levels are in line with the maternity service's required staffing levels to ensure that the Trust maternity services are able to provide appropriate anaesthetic cover which is in line with the recommendations of Safer Childbirth (RCOG 2007). An annual audit of staffing levels will be carried out by the Consultant Anaesthetist Lead for Labour Ward and this report will form part of the assessment. If deficiencies are identified and it is not possible to meet the requirements, the provision of additional anaesthetic staff should be included in the Division's Strategic Development Plan.

8. Insufficient beds

The nature of maternity care can lead to peaks in activities that exceed capacity. If the problem is a shortage of Labour Ward beds, careful assessment of those women on the Labour Ward should be made to see if any can be safely transferred to the Antenatal or Postnatal Wards.

Consideration should be given to delaying elective induction of labour and caesarean sections. This decision should look at the whole clinical picture and current circumstances to determine if appropriate.

If the problem is lack of beds on the antenatal or postnatal wards careful assessment of existing women should be made to see if any can be safely discharged. Self caring women without clinical need, e.g., those who are inpatients because their baby is in the neonatal unit, should be discharged home or accommodated in the parents' room in neonatal unit.

If all these measures have been taken and the problem is not resolved the escalation /closure policy should be followed.

9. Closure of Neonatal Unit

It is sometimes necessary to restrict admission to the neonatal unit due to reduced cot availability or staffing difficulties. The closure of the neonatal unit impacts on the clients already present on the Labour Ward and pending admissions. When the Neonatal Unit is closed to admissions, all babies in the unit should be reviewed to assess if any are suitable for transfer to the Transitional Care Unit; or Children's Ward. If not, a risk assessment must be undertaken for each woman on the Labour Ward at the time of closure to decide the likelihood of requiring a Neonatal cot. If the baby is at high risk of requiring admission to the Neonatal Unit a multidisciplinary decision must be made as to whether the woman is safe to transfer to another unit or to remain.

In the event of all escalation cots been utilised, and no further capacity in the Neonatal Unit, to accommodate the potential emergency admission from Labour Ward, then the consultant paediatrician, Consultant Obstetrician, Head of Midwifery / Manager on Call should meet to discuss the closure of the Maternity Unit.

10. Closure of the maternity unit

Closure of the maternity or the neonatal unit would have major implications for all women booked for care, neighbouring hospitals and neonatal services. The decision to close would be a final resort and be taken by the Head of Midwifery or their delegate following discussion with the Labour Ward Coordinator, Midwifery Manager on Call and Consultant Obstetrician / Consultant Paediatrician.

In the rare event of the closure of a maternity/neonatal unit, a consistent approach is adopted throughout the region with clear and safe alternative arrangements for the care of mothers and babies. Closure of a maternity/neonatal unit would only be considered when other potential solutions are exhausted. The individuals who are likely to be involved in the decision to close the unit should be notified at an early stage of the risk of potential closure. This course of action must be considered as part of the Trust's risk management strategy.

Factors precipitating closure of a maternity/neonatal unit:

- Insufficient midwives, neonatal nurses or doctors
- Inappropriate experience/skill mix to provide high dependency care
- No available beds/cots or capacity problems are anticipated on current workloads
- Activity is high and capacity problems are anticipated combined with below required staffing levels.
- Infection in clinical areas – advised by microbiologist
- In the event of a major incident or power failure

Escalation of closure of maternity unit (Flow chart 1)

Level One: Green

Matrons/managers/coordinators and consultant for Labour Ward to assess workload within the service, review, realign off duty, redeploy staff. If activity is manageable no further action taken. If one ward is full but there are beds on the other ward, antenatal patients may have to go to the post-natal ward and vice versa.

If workload remains unmanageable progress to level 2 Amber

Level Two: Amber

Matrons/managers/coordinators and consultant for Labour Ward to:

- Further review of off duty/possible shift changes/realignment and redeployment of staff
- Consultant on call/paediatrician and maternity matron to instigate a ward round to assess women who are fit for discharge and action discharges. This will increase availability of beds
- Move staff from non-clinical duties to the clinical areas (i.e. practice development, infant feeding, clinical governance, IT)
- Consider use of bank staff
- Discuss with sisters on gynaecology ward, paediatrics and neonatal unit to see if staff available to help from other areas
- Consider use of on call community staff
- Incident form to be completed
- **Postnatal women waiting for transport home may be asked to vacate their beds and wait in the sitting room**

Level Three Red

- **Decision to close the Maternity Unit**
- The decision to close a maternity unit should be consensual and normally follow discussion by the Head of Midwifery/manager on call, Labour Ward coordinator and consultant obstetrician (out of hours). It is recommended that one person (midwifery manager on call) is designated to coordinate the procedure for closure of the maternity unit; this person should have no other responsibilities during the process. If women who are in-patients are to be transferred to another hospital, the senior midwife, in consultation with medical staff, must make the decision, taking into account the distance to the receiving hospital.

Implementation of closure (Chart 2, 3, 4 & 6)

- **First line divert will be to the opposite maternity unit within the organisation. They should accept unless they are also in escalation, resulting in closure of the unit.**

- Make arrangements with neighbouring maternity units to accept women in labour. This is the responsibility of the manager on call. Alternative named hospitals that have agreed to accept women must be contacted on a case-by-case basis and the women then contacted once a secured referral has been agreed. These referrals must be logged.
- Women requiring assessment antenatally will be seen via the Maternity Assessment Centre/ Maternity triage/DAU during normal working hours. Research no longer supports antenatal admission of many groups of women and suggests they can be equally safely managed on an outpatient basis. Unless there are concerns about their condition overnight, women will be assessed on a daily outpatient basis to keep antenatal admissions to a minimum for those genuinely requiring it. Women will rest / sleep better in their own environment.
- Women in early labour or SROM after 36+6 weeks will be advised to return home providing there are no known contra indications to this. A clear follow up plan should be agreed before discharge.
- The Labour Ward bleep holder will contact the Lead Nurse for the Neonatal Unit (NNU) on a daily basis to assess possible admissions and availability of cots. Every effort should be made to ensure women from East Berkshire are given local priority. The final decision for admission to the NNU is agreed between the Consultant on call for Labour Ward (LW); the LW bleep holder; the Lead Nurse on all for NNU; the on-call midwifery manager and the Consultant on call for NNU.
- Inform the consultant paediatrician and senior nurse/coordinator for the neonatal unit of the decision to close to ensure that **no** in-utero transfers are accepted.
- Inform ambulance control of the closure and arrangements agreed with receiving maternity units to ensure that women in labour are diverted to these centres.
- Inform women telephoning prior to their admission in labour of the need to divert to another hospital. If the woman sounds distressed/or in advanced labour on the phone she should be admitted and transferred if possible. Clear and concise communication regarding the situation must be given to the women making contact with the maternity unit.
- If a woman has not contacted the maternity unit prior to her arrival in labour, assess her condition and arrange transfer to a receiving unit as appropriate.
- Inform switchboard, the hospital site manager and administrator on call.
- Inform the Associate Director, Director of Midwifery and Chief of Service of the unit closure the next working day.
- The next working day, the senior midwife must report the incident to the risk office and liaise with the Trust's communication manager if deemed necessary.
- Maintain a record of women directed to other units.
- If the closure is likely to last for several days, consider writing to women who are near to term to advise them of the situation.
- Inphase Incident form to be completed

Re-opening the Maternity Unit (see Chart 5)

When the factors that precipitated closure of the maternity unit are resolved and the unit re-opens, the above process is reversed.

It is good policy for the Director of Midwifery/ Head of Midwifery/acting head to write to all women who have been directed to other units to apologise for the inconvenience caused. (**Chart 6**)

Appendix 1: Chart 1 -Escalation Flow Chart

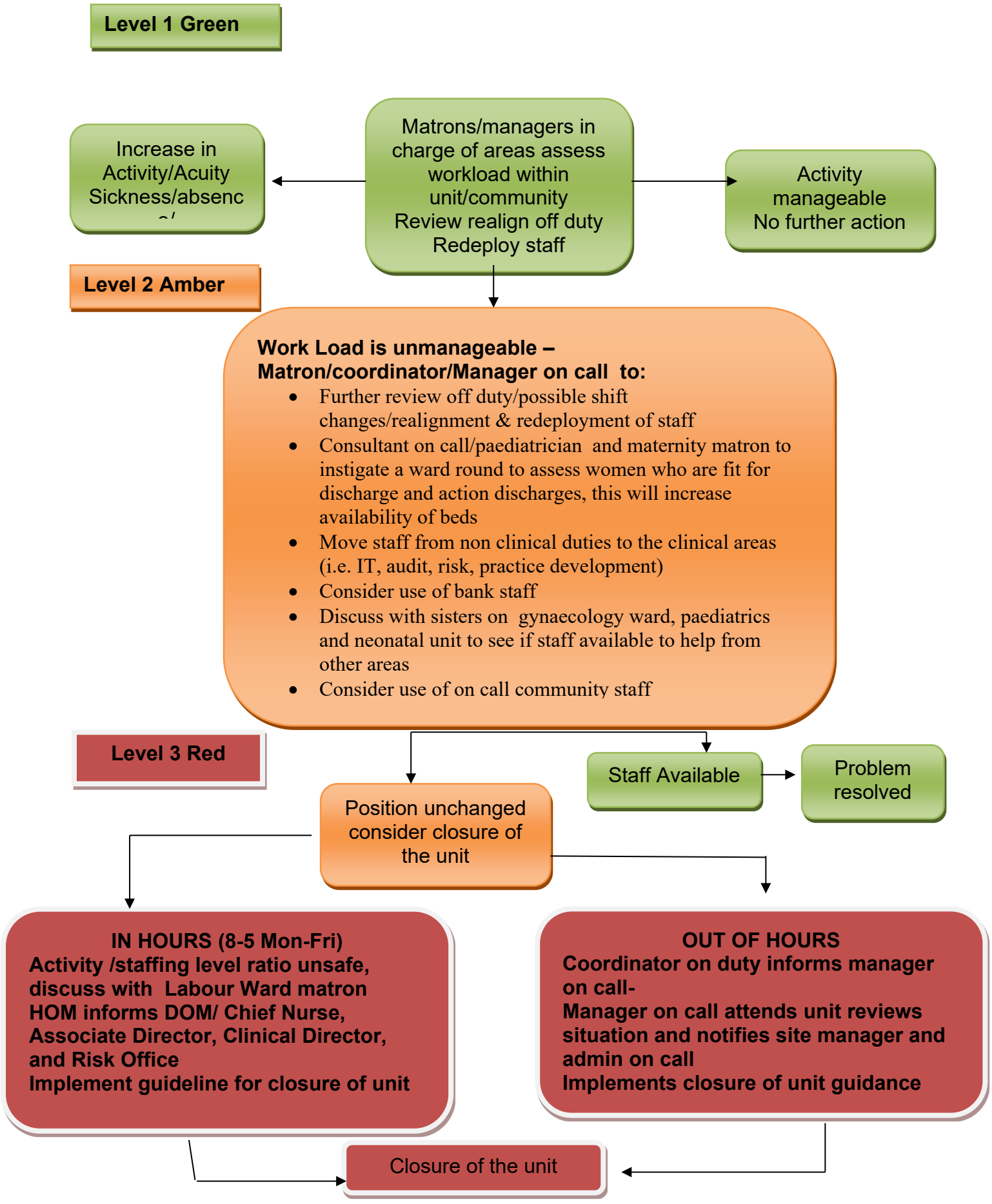


Chart 2: Maternity/Neonatal Unit closure check list

Date of closure……. Time of closure……

Reason for closure (circle as appropriate):

Insufficient medical/midwifery staff
Inappropriate skill mix
Neonatal unit capacity
Infection – as directed by microbiologist
Major incident/power failure
Describe

……
Other
Describe…….....

	Date	Time
Head of Midwifery/Senior Manager		
Consultant Obstetrician		
Consultant Paediatrician		
Chief Operating officer (next working day)		
Ambulance Control		
Administrator on call		

Receiving units asked to record names of women directed to them

Yes ……

List units providing cover:

……..
……..

Form completed by (name and designation):

Unit closed due to: ☐ Maternity unit staffing ☐ Lack of maternity beds ☐ Neonatal unit cot capacity ☐ Other (please state reason) …….. ……..… ……..	Number of midwives on: Labour Ward …… Postnatal……..... Antenatal……... TCU ……...	Number of women on: Labour Ward…… Postnatal…… Antenatal…… Number of babies on: Labour Ward: Postnatal/ TCU……. Neonatal Unit …….

Labour Ward workload including MAC/Triage
(include name, parity, gestation, stage of labour and reason for admission)

Room Name	Name	Gestation / parity	Labour progress/ reason for admission

Birth Centre workload

(include name, parity, gestation, stage of labour and reason for admission)

Room Name	Name	Gestation/ parity	Labour progress/ reason for admission

Chart 3: Record of mothers refused admission when maternity unit closed

Date unit closed: Date unit re-opened:

Time unit closed: Time unit re-opened: …….

Time of call	Name	Maternity number	Reason for phoning	Advice given	Name of unit referred to or community midwife called

Chart 4: Telephone numbers of neighbouring maternity units

Local hospitals

	Switchboard	Labour Ward
St Peter's, Chertsey	01932 872000	01932 722663
Royal Surrey, Guildford	01483 571122	01483 464133
Basingstoke	01256 473202	01256 313600
Royal Berkshire, Reading	0118 3225111	0118 3227215
East Surrey, Redhill	01737 768511	01737 231764
Royal County Hospital, Winchester	01962 863535	01962 824231
Great Western Hospital, Swindon	01793 604020	01793 604575
Southampton General Hospital	02380 777222	02381 206001
Wexham Park Hospital	0300 614 5000	03006154521
Frimley Park Hospital	0300 614 5000	03006134035

Chart 5 : Maternity Unit re-opening check list

Date of re-opening ……

Time of re-opening ……

Total days/hours closed Days ……..…. Hours……..

	Date	Time
Head of Midwifery/Senior Manager		
Consultant Obstetrician		
Consultant Paediatrician		
Chief operating officer (next working day)		
Ambulance Control		
Administrator on call		
Incident form completed		

Number of women directed to other units ……..……

Form completed by: (Name and designation) ……

Chart 6: Head of Midwifery Letter

Head of Midwifery

Direct Line: 03006133899 FPH site
03006154542 WPH site

Date

Dear

I would like to apologise for the fact that you had to be referred to another maternity unit on (insert *date)* owing to the temporary closure of the maternity unit at Frimley Park Hospital/ Wexham Park Hospital (Delete as appropriate) As I believed you were informed at the time, this was due to an exceptionally busy day, resulting in a shortage of beds.

Please be assured that the health and safety of both your baby and yourself was our prime concern when the decision to refer to another hospital was made. A decision to close a maternity unit is always made as the last resort, but we understand how stressful this late change must have been for you.

We would like to take this opportunity to offer you further explanation if you feel you should need it. This can be done in a number of ways, i.e., in a meeting or by telephone. If you would like to take up this opportunity, please do not hesitate to contact my secretary, on the above direct lines.

Yours sincerely

Head of Midwifery

Letter of thanks to Heads of Midwifery at transferred sites

Frimley Health NHS foundation Trust
Portsmouth Rd
Frimley
Camberley
GU16 7UJ
Tel: 0300 614 5000

Directorate of Women & Children's Services
Ref: AP/aw
[Date]

Dear (HOM, add as necessary)

I am writing to thank you for accepting the women we diverted to you during our closure on …….(add in date….).

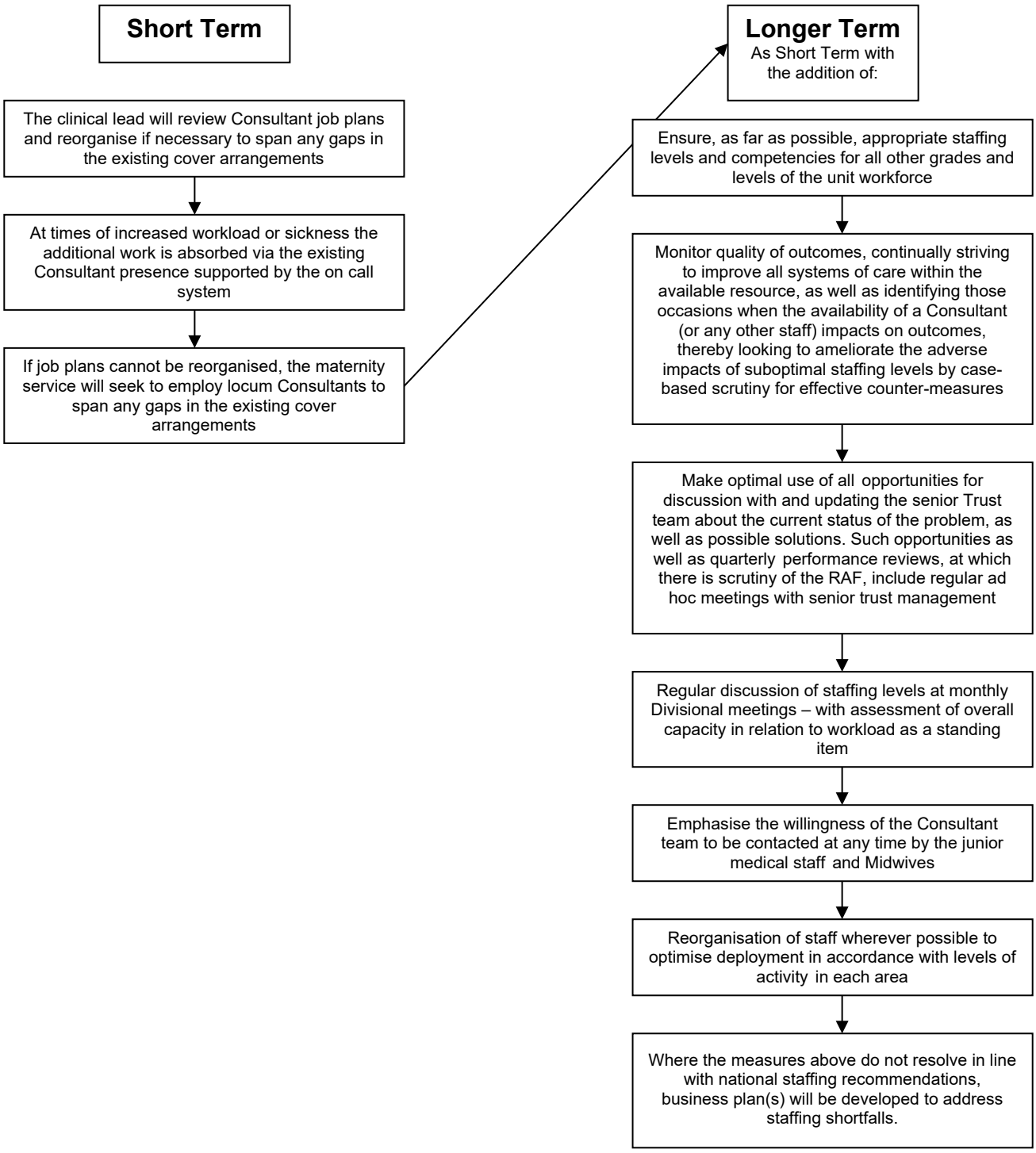
Our aim is to care for all women we have booked and closure of the unit is only activated following a rigorous risk assessment of the whole unit.

Working together ensures the safe care of all mothers and babies. If you ever have any issues related to the process or communication during these peaks in capacity, then please do not hesitate to escalate them to me in order that we can ensure the process for you as the accepting unit and for the women, is as smooth as possible.

Kind regards

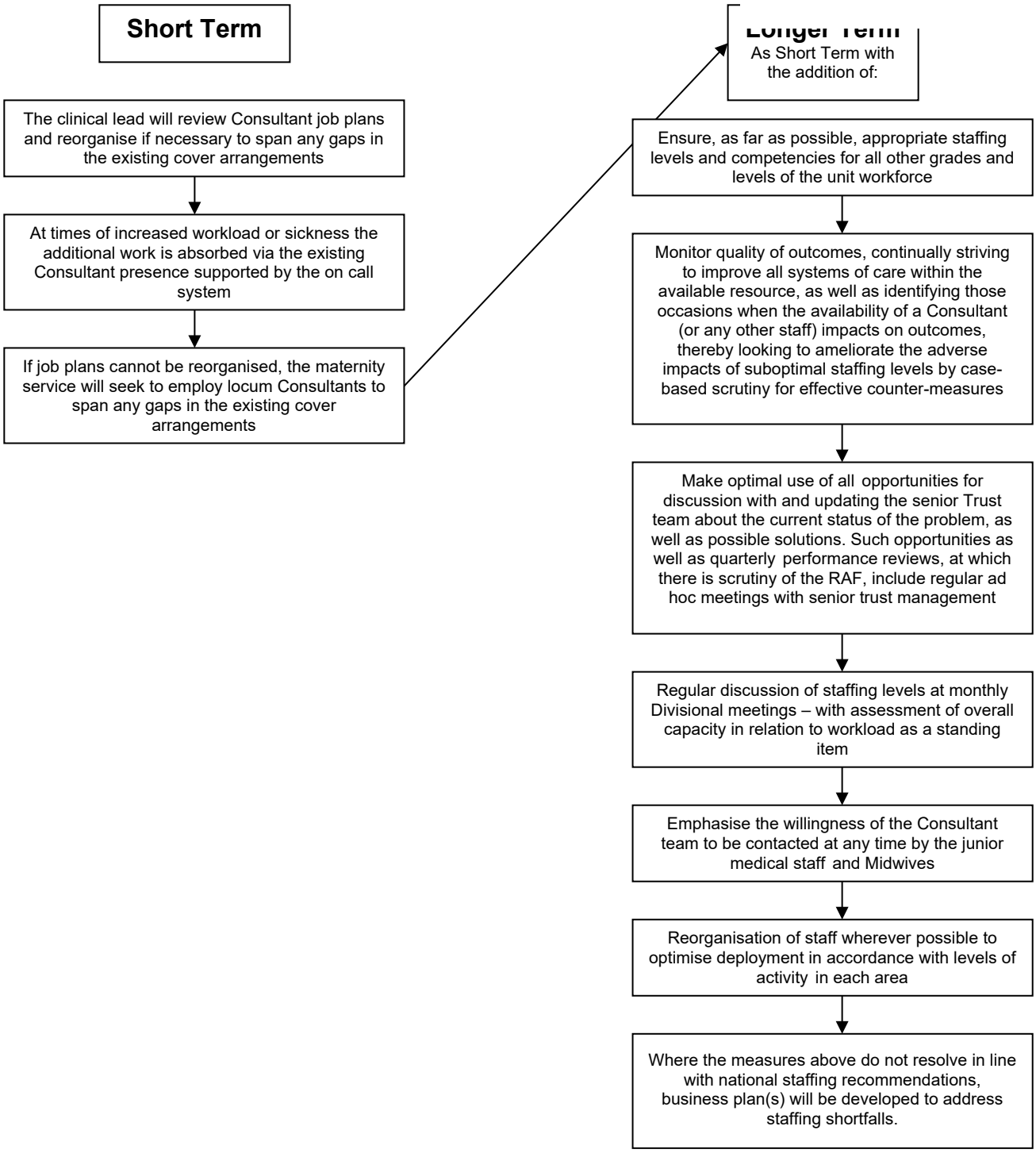
Emma Luhr
Director of Midwifery

Appendix 2: Contingency plans to address short term/long term Consultant Obstetric staffing shortfalls



Appendix 3 Contingency plans to address short term/long term anaesthetic staffing shortfalls

Frimley Health NHS Foundation Trust



Full version control record

Version:	2.0
Guidelines Lead(s):	Andrea Anderson (Head of Midwifery, WPH), Danielle Eghobamien (Head of Midwifery, FPH)
Professional Midwifery Advocate:	Angeliki Karava-Sood
Lead Director / Chief of Service:	Anne Deans
Library check completed:	N/A
Ratified at:	Cross Site Obstetrics Clinical Governance Meeting, 16 December 2024
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Pharmaceutical dosing advice and formulary compliance checked by:	N/A
Key words:	Escalation, staffing, suspension of maternity services, activity

This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1.0	December 2021	Danielle Eghobamien, Andrea Anderson	Final	First cross site version*. Approved at Obstetric Clinical Governance Committee Meeting 21/12/21
2.0	December 2024	Danielle Eghobamien, Andrea Anderson Kirsty wells	Final	Scheduled review. Ratified at Obstetric Clinical Governance Committee Meeting 16/12/24

* The following documents were amalgamated into this new guideline: Wexham Park Hospital Maternity Staffing and Escalation Guideline; Leadership communication and handover of care within the maternity unit; Contingency plan for staff shortages and unexpected increases in clinical activity in the maternity/ neonatal service that may result in unit closure.