Worcestershire Acute Hospitals NHS Trust

# Safe Staffing Levels – Obstetricians and gynaecologists

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

## Introduction

## This guideline is for use by the following staff groups:

Obstetric & Gynaecological Medical Staff

### Lead Clinician(s)

| | |
|---|---|
| Miss Laura Veal | Consultant Obstetrician |
| Miss Alex Blackwell | Consultant Obstetrician and Gynaecologist |
| Approved by *Maternity Governance Meeting* on: | 27th February 2026 |
| Approved by Medicines Safety Committee on: | N/A |
| Review Date:<br>This is the most current document and should be used until a revised version is in place | 27th February 2029 |

### Key amendments to this guideline

| Date | Amendment | Approved by: |
|---|---|---|
| October 23 | Removal of Obstetric service at Alexandra Hospital | Maternity Governance |
| October 23 | Addition of Compensatory rest | Maternity Governance |
| February 26 | Amendments to Consultant attendance – updated to reflect lifesaving emergencies. | Maternity Governance |

To provide safe, consistent and quality patient care the Royal College of Obstetricians and Gynaecologists (RCOG) has set standards for consultant on-call for labour ward based on the clinical activity and number of births per year in the unit. Ideally in the future, there will be 24-hour Consultant presence in the majority of obstetric units as work patterns evolve. Until then, it is recommended that the Consultant must be available in the labour ward when they have a fixed session there and their presence is needed and should be available for telephone advice at all times while on-call.

**Background On The Service / Staff Utilisation**

In Worcestershire Acute Hospitals NHS Trust (WAHT) the Clinical Directors are responsible for planning the on call rota and any alterations that have to be made in collaboration with the rota coordinator. In order to prospectively plan cover, all Consultants should give at least 6weeks notice prior to proceeding with leave. If a Consultant has to be absent at short notice for whatever reason, the rota organiser will arrange for another Consultant to provide Consultant cover. If a short term emergency locum Consultant cover is to be organised the rota coordinator will organise this through a locum agency after the applicant's CV is approved by the Clinical Directors. Short notice arrangements or difficulty with cover should be discussed with the Clinical Directors.

At Worcester there is 1 obstetric theatre located on the delivery suite with an additional intervention suite for emergency work adjacent to it. Emergency Elective obstetric procedures should only proceed once the Consultant Obstetrician and Consultant Anaesthetist have assessed the activity and staff availability on the unit. Due to the location of theatres on the delivery suite the Consultant on call is easily accessible should an emergency arise.
Emergency gynaecology operative work is carried out upstairs in main theatre.

**Required safe staffing level Obstetrics**

Resident Consultant on call cover is currently provided for 75hours/week at Worcester.

There are 3 tiers of obstetric staff on the on-call rota – junior, middle grades and Consultants. The middle grade doctors (Specialist Trainees years 3-7, Specialty doctors or trust doctors) provide the middle tier obstetric cover and work a 1:8 on call rota. This is compliant with the European Working time Directive (EWTD). The junior doctors work a 1:9 on call rota. (Specialist Trainees years 1-2, GP Trainees, Foundation doctors and Physicians Associates). Vacant slots and shifts are filled with short and long-term locum doctors.

All tiers of medical staff cover elective work Cross County with clinical activity running at the Alexandra Hospital, Kidderminster Treatment Centre in addition to the smaller community Hospitals (Evesham, Malvern and Princess of Wales Hospitals).

**Worcestershire Royal Hospital: consultant presence in delivery suite**

There are 14 consultants participating in the obstetric on-call-rota. 8 do purely Obstetrics on a 1:10 rota and 6 work on both the Obstetrics and Gynaecology on call rotas resulting in their Obstetric on call being a 1:20.

The Obstetric consultant on call covers for a 24hour period 08.00am – 08.00am Monday – Friday with 48 hr cover provided at the weekend.

The consultant covering obstetrics will attend the morning handover at 8am and carry out 3 ward rounds during the day – 1 following the morning handover, 1 in the afternoon at approximately 1500hrs and a further one in the evening at approximately 20:00.

These ward rounds should include delivery suite, maternity triage and the antenatal and postnatal wards. Please refer to the SOP 'ward rounds in maternity' for further information.

The Registrar may contact the consultant on call at any time for advice, management decisions or to attend the hospital (see below).

**Consultant's role in labour ward:**

The Consultant on-call for obstetrics must be available in the labour ward when they are on call and their presence is needed and available on the telephone for advice at all times while on-call. Outside the hours of resident duties (9pm – 8am) they will be available to attend within 30minutes for emergency cases or if asked to do so.

Their role encompasses providing a service for those patients who require senior medical assistance while at the same time undertaking routine procedures when there is a need to do so, due to the workload on the unit.

**1) Teaching & training:** The Consultant's role starts by demonstrating leadership and teaching and supporting trainees, midwives and nurses at all times. Obstetrics is an apprenticeship-based specialty and the Consultant must be present to ensure that the trainee is taught and supervised properly. The Consultant must be nearby at all times until the trainee has been assessed as fit for independent practice.

**2) Supporting staff:** In particular, the presence of the Consultant is required when adverse events or poor outcomes occur. Asking the consultant on call to attend during these difficult times will be invaluable support for the mother and her family, as well as the staff.

**3) Respond to call for help**: Doctors at every level have a duty to call for help if they feel that a clinical situation (even outside the list below) requires the direct input of a consultant. Trainees must always feel able to discuss things with the Consultant and should be encouraged to ask the Consultant to attend if needed. A trainee's request for a Consultant to attend should be stated in clear, precise terms, so that there can be no misinterpretation. The request should be documented in the notes.

**4) Jump call**: Senior midwifery staff should contact the Consultant directly if it is considered that ***the clinical situation requires senior medical input*** (known as 'jump call'). Consultants should respond positively to requests for assistance from staff covering the labour ward.

**5) The on call consultant should attend in the following circumstances:**

## ON CALL CONSULTANT OBSTETRICIAN PRESENCE

**Consultant Obstetrician presence mandated* in Delivery Suite / Obstetric theatre**

- Eclampsia
- Maternal collapse (such as massive abruption, septic shock)
- Caesarean section: placental praevia/abnormally invasive placenta
- Caesarean section <28/40
- Caesarean section for BMI >50
- PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
- Return to theatre
- Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
- In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
- Premature twins <30/40
- 4th degree tear
- Unexpected intrapartum stillbirth
- Team debrief requested
- If requested to do so
- If asked to attend due to management disagreements between different clinical staff
- In rare obstetric situations –e.g. Unexplained maternal fits, trial of assisted delivery of a stillbirth, shoulder dystocia where all the routine manoeuvres fail

**Discussion** with Consultant Obstetrician mandated

- Preterm labour < 28weeks (to ensure appropriate management plan & consideration of transfer to tertiary unit
- Consultant involvement in the management and support of IUDs
- Maternal death within the unit
- Difficulty delivering baby

*Clinical judgement should be used as to whether the consultant should attend in a **time critical/lifesaving** situation. If the senior doctor is competent and a discussion with the consultant obstetrician has taken place, it **may** be appropriate to proceed in the absence of the consultant.

**This decision must be clearly documented in the notes.**

## ON CALL CONSULTANT ANAESTHETIST PRESENCE

**Consultant Anaesthetist presence mandated in Obstetric theatre**

- Failed Intubation
- Maternal Cardiac Arrest
- Eclampsia
- Amniotic Fluid Embolism

**Discussion** with Consultant Anaesthetist mandated

- Symptomatic PET with abnormal biochemistry or haematology
- Morbid obesity (BMI over 45)
- Anticipated difficult intubation
- Other rare complex medical problems
- Abnormal Placentation
- Total Spinal Anaesthesia
- Major on-going haemorrhage over 1.5 Litres

**Situations in which the consultant MUST ATTEND unless the most senior doctor present has documented evidence as being signed off as competent.**

If competent the senior doctor and the consultant should decide in advance if the consultant should be INFORMED prior to the senior doctor undertaking the procedure.

- Vaginal Breech Delivery
- Any patient with an EBL >1.5litres and ongoing bleeding
- Review of labour management and delivery of twins/ higher order pregnancy twin delivery
- Trial of instrumental birth
- Caesarean section: full dilation, BMI>40, transverse lie, CS <32/40
- Vaginal twin birth
- 3rd degree tear repair
- To confirm intrauterine fetal demise
- Acute medical / surgical illness in women requiring senior multidisciplinary input

Inform on call consultants of safety huddles to ensure multidisciplinary involvement when unit escalation policy implemented

**6) Handover:** If there are any high risk obstetrics, high dependency care or ITU cases there should be a formal handover (by telephone call or in person) between Consultants following a period of on-call. This is to be clearly documented under the SBAR system.

**Required safe staffing level Gynaecology**

**The Consultant on call for Gynaecology is resident on site at WRH between 8am and 6pm Monday to Friday and between 8am and 11 am on Saturday and Sunday. Outside these hours they are available by phone through switchboard and will attend out of hours as needed.**

**RCOG mandate that consultants should be present in the following instances:**

- Any laparotomy
- Return to theatre
- Debrief requested
- If requested to do so
- High levels of acuity

All emergency admissions will be seen or discussed within 14hours of admission and all emergency admissions will be reviewed by a consultant within 24hrs of admission.

Unless there is a senior post CCT trainee or experienced Associate Specialist/staff grade doctor with adequate skills to conduct an independent gynaecology outpatient clinic (with named telephone support for queries), gynaecology outpatient clinics will be cancelled in the absence of a consultant.

The Directorate have agreed that gynaecology care will provided as follows:

All emergency cases (except straight forward ERPC procedures and Bartholins abscess procedures) must be discussed with and approved by the on call consultant before listing.

1. The consultant must be present or available in the theatre department for all gynaecological surgical procedures performed by trainees at ST3/4/5 level (with the exception of straight forward ERPC procedures and Bartholins abscess procedures)
2. Gynaecological surgical cases can be managed by ST6 / 7 trainees without consultant presence according to the skill level of the trainee but the consultant must be informed by the trainee when the case is going to theatre.
3. The consultant must be present in theatre for ERPC in cases of suspected molar pregnancy, post-natal and post CS ERPC and repeat ERPC.
4. The consultant must be present for all return to theatres following gynaecological surgery.
5. The consultant must be present for any patient with haemodynamic compromise secondary to bleeding with miscarriage or ectopic pregnancy.
6. The consultant must be present for any patient with septic shock.
7. All elective surgical cases must be discussed with and approved by the responsible consultant before listing.
8. All cases of termination of pregnancy must be discussed with a consultant involved in the patients care before the termination is commenced.
9. Breaking bad news or communication in the event of unexpected outcome should done by the responsible consultant or the on-call consultant except where delegation is judged appropriate to a senior trainee following discussion with the consultant.

10. Only staff with certified training are allowed to use the ultrasound scan machine on Lavender Gynae. Trainees must not use this machine without supervision if they have not been signed as competent in ultrasound scanning by a consultant at WAHNHST.
11. The Directorate bleep policy should be followed which states that nursing staff must contact the superior tier of medical staff if a bleep is not answered within 10 minutes or if a patient isn't reviewed within 30 minutes of accepted bleep. Exceptional circumstances would arise if the on call team are busy in theatre.
12. DNR status should be signed by the responsible or on call Gynae consultant when appropriate.
13. All matters and patient care that raise any concern must be referred and discussed with the Consultant gynaecologist on call (or the consultant responsible for the individual patient).

**Compensatory Rest**

There is a greater need and expectation that consultants may be asked to attend in person overnight when they are non-resident on call. Increased acuity, complexity and training and support for juniors have added to this need.

The working Time Directive (WTD) is EU legislation intended to support the health and safety of workers by setting minimum requirements for working hours, rest periods and annual leave. The Directive was enacted into UK law as the Working Time Regulations from 1 October 1998.

The main features are:

- 20 minutes after 6 hours work
- 11 hours rest in any 24 hour period
- 24 hours rest in any 7 day period,
- 48 hours rest in any 14 day period

Employees should normally have a rest period of not less than 11 hours in each 24-hour period. The RCOG suggest that this 11hour period should start after the last interruption to rest and should be for a continuous period of 11hours.

In circumstances where on-call employees are scheduled to work the day following a period of on call activity and their rest has been disturbed so there is a risk to their safety and that of others, the employee must receive compensatory rest and the manager should be informed. Adequate rest may be achieved by delaying the start of the next day's shift or asking a colleague to cover the session. In exceptional circumstances where cover cannot be arranged the clinical activity should be cancelled.

In situations where a consultant has been present and working overnight in the unit, with inadequate rest, managers should ensure that clinical activity is not undertaken by a consultant even if they express a wish to do so.

**Acting Down for Junior Sickness**

Wherever possible sickness within the middle and junior grade tier will be covered internally by a junior of a similar grade. However, there may be times when sickness needs to be covered by a Consultant.

The minimum out of hours resident on call cover is 3 doctors – 1 junior doctor and 2 doctors working at middle grade level with 2 Consultants working non-resident on call.

If there is an absence of **1 Junior grade Dr** (ie. either Obs or Gynae SHO) the remaining SHO will cover both sides but may need extra senior support from middle grades and consultants. This will not be classified as Consultant acting down.

If there is an absence of **2 Junior grade Dr's** (ie. both Obs and Gynae SHO's) one Middle grade doctor will act down to junior level and the Consultant Obstetrician will act down to Registrar 1 (previously Obs Reg). The Consultant Gynaecologist may need to stay resident until 8pm to work as Registrar 2 (previously Gynae Reg). This would be considered as acting down after 6pm for the Gynae consultant.

If there is an absence of **one of the middle grade doctors**, the Obstetric Consultant will become resident on call and act as Registrar 1/2 (depending on whether they cover Obs or Gynae on calls). The remaining middle grade will work as the other Registrar. The Gynae consultant will remain non-resident and an additional Obstetric Consultant will provide non-resident Obstetric cover.

If a Consultant is acting down overnight they will not be able to work the following day and should liaise with the rota co-ordinator and Clinical Directors about a plan for their clinical activities.

If a Consultant is acting down and resident for hours when they would not normally be on site there is an Acting Down policy for additional payment and it is expected that a claim will be made.

Please refer to the Trusts Acting Down Policy for further information.

**Annual Audit Process**

The number of Obstetricians required to provide care in the clinical area is dependant upon workload activity. As set out in the Safer Childbirth: minimum standards for the Organisation and Delivery of Care in Labour (2007), Consultant presence and CNST compliance will be reviewed monthly as a standing agenda item at Obstetric Clinical Governance Meetings and Maternity PRM.

**Business Plan Process**

Where Obstetric staffing shortfalls are identified within the audit or risk management systems a Business case will be developed by the Clinical Directors and Directorate mMnagers in line with the Trust Business case process. Progress will be monitored by the Obstetric and Gynaecology Governance Committee and directorate meetings.

**Contingency Planning Process**

Provision of safe staffing levels is essential to providing women with a safe and positive birth experience. This may be affected short term by an increase in workload activity within the birth setting, staff sickness or long term by inadequate obstetric and midwifery staffing levels.

Contingency plans will be developed as required to address staffing shortfalls by the Clinical Directors and the Directorate Managers. Business plans will be escalated to the Divisional Management Team, the Hospital Assistant Medical Director and Trust Medical Director, and progress monitored by Obstetric Governance Committee and directorate meetings.

**Short term staffing shortage**

For periods of short term staffing shortfalls (e.g. sudden increase in workload, short notice staff sickness) a local resolution should be sought by informing the on call consultant who may also contact the Clinical Directors and the designated medical staffing coordinator responsible for booking locum cover to ensure contingency plans are developed. In circumstances where the Clinical Directors are unavailable to make decisions on short term staffing contingency plans – the on-call Consultant must act in the best interests of good clinical care.

**Medium to Long term staffing shortfalls**

Where ongoing staffing shortfalls are identified through the risk management systems or staffing audit a contingency plan will be developed by the Clinical Governance Team, Directorate managers and Clinical Directors. The plan will be presented at the Obstetric Clinical Governance meeting and added to the Risk register. The contingency plan will be presented to the Divisional Management Team. Where required the Directorate Managers and the Clinical Directors will escalate the issues to the Trust Board via the Divisional Management team.

Please refer to guideline – 'Clinical Supervision of temporary or locum members of junior medical staff policy' for further information regarding recruitment and supervision of locums.

## Monitoring

| Page/ Section of Key Document | Key control: | Checks to be carried out to confirm compliance with the Policy: | How often the check will be carried out: | Responsible for carrying out the check: | Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)* | Frequency of reporting: |
|---|---|---|---|---|---|---|
| | **WHAT?** | **HOW?** | **WHEN?** | **WHO?** | **WHERE?** | **WHEN?** |
| | Compensatory Rest | Audit | Monthly | Clinical Director | Perinatal Safety Report | Quarterly |
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**Contribution List**

This key document has been circulated to the following individuals for consultation;

| Designation |
|---|
| Maternity Governance Meeting |
| Obstetricians |

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

| Committee |
|---|
| Maternity Governance Meeting |