1. **Introduction and who the guideline applies to:**

This policy applies to all patients that present to the Maternity Service of the University Hospitals of Leicester NHS Trust and is to be followed by all midwifery and medical staff within the Maternity Service and relevant associated Trust staff.

**UHL Maternity Service:**

The UHL Maternity Service provides a wide range of services to women in pregnancy, labour and postnatal period. Hospital based services are offered at the Leicester Royal Infirmary and Leicester General Hospital; these include tertiary level referrals and Category V high risk care as per Birthrate Plus. Low risk intrapartum services are provided in the Orchard Birth Centre at the LRI, and in the Meadow Birth Centre at the LGH. Low risk antenatal, intrapartum and postnatal care is also provided at St Mary’s Birthing Centre, Melton Mowbray, and in the Community.

The Maternity Service provides and supports training for student midwives, student nurses and medical students, alongside postgraduate education.

**Purpose of the document:**

This document has been produced to:

- Provide a description of Midwifery and support staff groups utilised by the UHL Maternity Services
- Provide guidance on minimum acceptable staffing levels for Midwives and Support Staff
- Provide guidance on responsibilities of different staff groups
- Outline the process of short- and long-term contingency planning
- Provide guidance on procedures where there are staff shortage or capacity issues

**Related Documents:**

Home Birth Team Operational Guideline
2. **Guidance:**

**Midwifery and Support Staffing**

**Description of the Staff Utilised within the Maternity Service**

**Midwives**

It is recognised that, regardless of place of birth, midwives will care for women and their babies. At UHL NHS Trust midwives work throughout all areas of the Maternity Service.

**The UHL Maternity Service is provided across 3 sites and in the surrounding community**

- Leicester Royal Infirmary (LRI)
- Leicester General Hospital (LGH)
- St Mary’s Birth Centre within the Melton Hospital
- Community care within Leicester City, Leicestershire and Rutland.

**Midwives work within the following areas:**

- Delivery Suites (LRI & LGH)
- Antenatal and postnatal wards (LRI, LGH and St Marys)
- Birth Centres - the Orchard Birth Centre (LRI), the Meadow Birth Centre (LGH) and St Mary’s Birth Centre
- Maternity Assessment Units (LRI and LGH)

All the above areas provide a 24 hour service

- Antenatal clinics and associated services are provided on a weekday normally between 08.30 and 17.00hrs.(LRI & LGH)

Midwives provide both antenatal and postnatal care within the community setting. For those women who request a home birth there is a Home Birth Team providing 24 hour cover.

See Appendix 1 for further information about community services.

**Nurses / theatre nurses**

Registered Adult Nurses can in some instances support midwives in providing care to women and their babies. RGN's provide a theatre recovery service in daytime hours for women who have had operative interventions either under regional or general anaesthetic, at LGH this is just Monday to Friday. Additionally there is an emergency theatre team to support Obstetric theatres at LRI with 24 hour cover, an elective theatre 8-6pm and one theatre team at LGH 8-6pm weekdays.
**Support Staff**

The Maternity service employs Maternity Support Workers (MSW) and Maternity Care Assistants (MCA’s) Service within the hospital and within the community. MSW’s and MCA’s are available 24 hours a day within the hospital and work within the community between 09:00 and 17.00 hours weekdays. Nursery Nurses are employed on the postnatal wards to support the midwives in the care of the Newborn baby.

The Maternity Service also offers clinical placements for Student Midwives and Student Nurses.

**Other Staff Groups**

Within the hospitals setting there are housekeepers who keep the wards tidy and support in provision of food to the women, they also monitor visiting and control the opening of the secure doors to the wards.

Ward clerks work within the ward environment to ensure the hospitals systems are up to date with admission, transfer and discharge and keep up to date within filing and paperwork and assist the housekeepers with security on the wards.
**Staffing Levels**

Safer Childbirth (2007), Safe Midwifery Staffing for Maternity Settings (NICE 2015) and Birth rate plus (the recognised tool for midwifery staffing) provides recommendations for optimum staffing levels for intrapartum care. The recommended figures are as follows:

| Setting                        | Birthrate Plus case mix category | Definition of category                                                                 | Midwife-to-
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>I &amp; I</td>
<td>Low risk: midwifery care; 35-42 weeks of gestation, normal birth, no intervention, no epidural, good birth weight and Appar</td>
<td>1 WTE midwife to 1 woman</td>
</tr>
<tr>
<td>Birth centre</td>
<td>I &amp; I</td>
<td>Low risk: midwifery care; 37-42 weeks of gestation, normal birth, no intervention, no epidural, good birth weight and Appar</td>
<td>1 WTE midwife to 1 woman</td>
</tr>
<tr>
<td>Obstetric unit based on case mix categories, not dependent on size or setting</td>
<td>I &amp; II</td>
<td>Low risk: midwifery care; 37-42 weeks of gestation, normal birth, no intervention, no epidural, good birth weight and Appar</td>
<td>1 WTE midwife to 1 woman</td>
</tr>
<tr>
<td>III</td>
<td>Moderate degree of intervention: induction, fetal monitoring, instrumental birth, third degree tear, preterm birth</td>
<td>1.2 WTE midwives to 1 woman</td>
<td>1 MCA for 4 midwives each shift to cover diverse duties (non-midwifery)</td>
</tr>
<tr>
<td>IV</td>
<td>Higher risk/higher choice or need; normal birth with epidural for pain relief, elective cesarean sections, post-birth complications</td>
<td>1.3 WTE midwives to 1 woman</td>
<td>1 MCA for 4 midwives each shift to cover diverse duties (non-midwifery)</td>
</tr>
<tr>
<td>V</td>
<td>Highest risk including emergencies; emergency cesarean sections, medical or obstetric complications, multiple births, stillbirths, severe pregnancy-induced hypertension</td>
<td>1.4 WTE midwives to 1 woman</td>
<td>1 MCA for 4 midwives each shift to cover diverse duties (non-midwifery)</td>
</tr>
</tbody>
</table>

MCA = midwifery care assistant; WTE = whole-time equivalent
However the staffing for wards is not as robust and as yet no specific acuity tool for maternity wards has been developed.

Setting the Midwifery Establishment

Birth rate plus is a recognised tool when setting the midwifery staffing establishment.

It is recognised that these figures are currently difficult to achieve. Whilst the service is taking steps to expand staff numbers and address any shortfalls, minimum acceptable staffing figures have been agreed locally by the Head of Midwifery, Ward Managers and Midwifery Matrons. These are as follows:

- **Midwives**
  - **UHL Wards** within the CMG have between 26 and 32 beds. The preferred staffing numbers for each day shift are 22 trained staff at LRI and 16 at LGH, and 18 and 16 trained staff at night respectively; the Ward Managers and Midwifery Matrons however agree that they regard the figures below as the **minimum** acceptable level for trained staff. Off-duty planning should always aim to ensure the staffing numbers below are achieved as a minimum and electronic rostering is in place to facilitate this. It should also take into account that the Midwife Coordinators on the Delivery Suite are supernumery. However, activity and skill mix can be contributing factors to the final decision regarding staffing levels noting that changes in activity need to be taken into account. The Midwife in charge of the Delivery Suite at both the LRI and LGH completes an acuity score to assess the level of activity and clinical need versus the midwifery ratio every 4 hours and this is documented on an acuity spreadsheet on the Intra Partum Toolkit Drive. If numbers fall below the acuity score and/or clinical need dictates, the Coordinator/Maternity Bleep Holder redeploy staff to meet the clinical need. Where staff are redeployed this is documented on the acuity spreadsheet. Should the redeployment of staff not be effective the Coordinator/Maternity Bleep Holder would contact the Manager on call for the CMG and contingency plans would be made. These should be in line with the Escalation, Transfer of Activity and Closure Policy, initiated by the Manager on call for the CMG and coordinated by the Maternity Bleep Holder. The relevant documentation must be completed as per the Escalation, Transfer of Activity and Closure Policy.

<table>
<thead>
<tr>
<th>Shift</th>
<th>LRI</th>
<th>LGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td>Night</td>
<td>15</td>
<td>12</td>
</tr>
</tbody>
</table>

- Combination of 11.5 and 6 hour shifts
- **Community and St Mary’s Birth Centre at Melton Mowbray**
  - The Community Midwifery Teams vary greatly in the staffing establishment, caseload, nature and size of the geographical area covered. The preferred staffing numbers for each Late and Night shift is 3.
The Midwifery Matrons and Head of Midwifery agree that they regard the **minimal acceptable** level for registered staff to be as follows. Off-duty planning should always aim to ensure the minimum staffing numbers are achieved. Activity and skill mix should be contributing factors to the final decision regarding staffing levels whilst noting that changes in activity need to be taken into account.

NB. These standards reflect current service organisation rather than team caseloads or dependency and are therefore subject to alteration following ongoing review.

<table>
<thead>
<tr>
<th>Day</th>
<th>Mon</th>
<th>Tues</th>
<th>Wed</th>
<th>Thur</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
<th>B / H</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late Night</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>St Mary’s Birth Centre</td>
<td>Minimum of 1 Midwife + 1 MCA per shift</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Birth Team</td>
<td>Minimum of two midwives on duty to cover the and provide the home birth service, currently supported with the above late or night shift within the community team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Support Staff

<table>
<thead>
<tr>
<th>Area</th>
<th>Staff Group</th>
<th>Early</th>
<th>Late</th>
<th>Night</th>
<th>Other hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward 30</td>
<td>MCA (M-F)</td>
<td>1-2</td>
<td>2-3</td>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MCA (BH/ Wkend)</td>
<td>1-2</td>
<td>2-3</td>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housekeeper (5days / week)</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursery Nurse (4days / week)</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MCA (BH/ Wkend)</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursery Nurse (M-Sat)</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LGH D/S</td>
<td>MCA (M-F)</td>
<td>2-3</td>
<td>2-3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MCA (BH/ Wkend)</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housekeeper</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursery Nurse (M-Sat)</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward 5</td>
<td>MCA (M-F)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MCA (BH/ Wkend)</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housekeeper</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nursery Nurse</td>
<td>1</td>
<td>1</td>
<td>0-1</td>
<td></td>
</tr>
<tr>
<td>LRI D/S</td>
<td>MCA (M-F)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MCA (BH/ Wkend)</td>
<td>1-2</td>
<td>1-2</td>
<td>1-2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housekeeper</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housekeeper(BH/ Wkend)</td>
<td>0-1</td>
<td>0-1</td>
<td>0</td>
<td></td>
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<tr>
<td></td>
<td>Nursery Nurse</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td></td>
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<tr>
<td></td>
<td>Nursery Nurse(BH/ Wkend)</td>
<td>0-1</td>
<td>0-1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MCA</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Reporting

Real Time staffing is displayed on Hot Boards in place along the main Trust Administration corridor. This information is also available for the general public on each ward. Any shortfalls in staffing will be demonstrated in this way.

Red Flags

A midwifery red flag is a warning sign that there may be a deficit in midwifery staffing. If a midwifery red flag occurs, the midwife coordinator / ward manager in charge of the service should be notified. The Midwife Coordinator / Ward Manager in charge should determine whether midwifery staffing is the cause, and the action that is needed. The red flag capture form below should be completed every 12 hours (NICE 2015)
<table>
<thead>
<tr>
<th>NUMBER</th>
<th>RED FLAG</th>
<th>M Number</th>
<th>Red Flag Due To Staffing Levels Y/N?</th>
<th>Comments</th>
<th>Day/Night Shift? D/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Delayed or cancelled time critical activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Missed or delayed care (for example, 60 minutes or more in washing or suturing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Missed medication during an admission to hospital or midwifery led unit (for example diabetes medication)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Delay in providing pain relief</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Delay between presentation and triage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Full clinical examination not carried out when presenting in labour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Delay between admission for induction and beginning of process</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Any occasion when one midwife is not able to provide continuous one to one care and support to a woman during established labour</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Action when Red Flag occurs**

The Delivery Suite Coordinator / Ward Manager should be informed of any red flag event. She should then assess whether the midwifery staffing establishment adequately meets midwifery care needs of women and babies and take any action accordingly as follows:

- Review last acuity
- Review current staffing
- Consider redeployment of staff to and from other areas
- Use off duty to contact staff who might be able to work extra shifts
- Consider diverting activity and closure as per transfer of activity and closure policy
- Continue to review time critical activity in order to prioritise workload
- Escalate to the midwifery matron in daytime hours and manager on call outside of daytime hours if transfer of activity or closure is anticipated
- Enter information onto the red flags form
- Complete an incident form where the outcome has been poor or there have been any consequences

A red flag form should be completed and sent to the Midwifery Matrons for Intrapartum and In Patient Care Services at the end of every 12 hour shift where they will be reviewed. A report must be completed and reported to Maternity Governance on a quarterly basis.

**Off Duty**

**UHL**

This document outlines standards and guidelines for planning of off-duty and staffing support mechanisms within the Maternity Service across all three sites. The standards and guidelines have been reached after a consultation process including senior representatives from all ward areas.

The standards represent best practice and are perceived as being achievable and are reviewed on a daily basis by the Maternity Bleep Holder

**Standards**

1. **Off-Duty Planning**

   - Off-duty should be completed electronically and available to staff at least 4 weeks in advance. The 4-week lead-time will be seen as a minimum standard.
   - Self rostering should be offered.
   - All individuals on the off-duty roster will have an identified line of off-
duty accordance to the rules of electronic rostering. All staff have the
opportunity to review off duty through employee on line and can make
requests according to the guidance of e-roster.

2. Bleep holding guidance

The purpose of the bleep holding guidance is to ensure that there is a senior member
of midwifery staff available at all times to ensure that issues that arise with short-term
staffing are addressed in a timely and appropriate manner. A senior Manager is also
on call at all times to give support. There are also Duty managers on all three sites
This is in line with the UHL Escalation, Transfer of Activity and Closure Policy for the
short term management of ward / unit staffing.

- On the LRI and LGH sites the Bleep Holder will be held by an
experienced Midwife or Band 7 for the early shift

- At night the responsibility lies with the Delivery Suite Co-ordinator.

Bleep procedure

- The bleep holder will collate staffing numbers for the day and if appropriate
move staff within the CMG to support areas in need of additional staffing.
- The bleep folder will contain the following minimum:
  - Current copies of all ward off duties
  - Unit staffing numbers
  - Staff telephone numbers
  - Bank list
  - Escalation, Transfer of Activity and Closure Policy
  - Miscellaneous information
  - Sickness diary (smart book)
  - Communication book

- If an individual has advanced knowledge that he/she will be unable to meet
his/her bleep holding responsibilities, it is the responsibility of that individual to
make alternative arrangements.

- The bleep should be handed over to the following shift at a time agreed with a
verbal handover as required and the bleep folder.

- Out of hours bank staff are instructed to contact the Bleep Holder.

Any bank shifts need to be authorised and locked down for payment, this should
happen every Monday Morning by 09.30.
3. Skill Mix

- The skill mix across shifts should ensure there is a midwife on duty through a 24 hour period, with skills in caring for women with enhanced needs, at LGH there should be a midwife competent in scrubbing out of hours and ratio’s of support staff to Midwives according to Birth Rate Plus The Band 7 Coordinator for Labour Ward should be supernumery
- A minimum of one band 6 midwife must be accessible as second midwife if required for births occurring in midwifery led areas i.e. alongside, stand alone birth centres and home births

4. Off-Duty Patterns:

A variety of shift patterns are available, in conjunction with Improving Working Lives, staff can request flexible working which will be approved according to the needs of the service

**Traditional pattern**

<table>
<thead>
<tr>
<th>Shift Type</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long day</td>
<td>07:00 – 19:30</td>
</tr>
<tr>
<td>Long night</td>
<td>19.00 – 07.30</td>
</tr>
<tr>
<td>6 hour shifts</td>
<td>07.00 – 13.30, 13.00 – 19.30 and 19.00 – 01.30 01.00-07.30</td>
</tr>
</tbody>
</table>

**Process for reporting and review**

Staffing is a standing agenda item at the Maternity Service Governance meetings which are held monthly and an update is provided by the Midwifery Matrons. The Head of Midwifery meets with the Chief Nurse or Deputy Chief Nurse on a monthly basis where issues relating to staffing are discussed.

There is a review every six months of the staffing establishment for Midwifery and Support staff with reference to current delivery rates and national staffing recommendations. This six monthly review is the responsibility of the Head of Midwifery. The findings of the review and action plans will be reported to the Women’s Quality & Safety Board.

**Development of business plans**

Where the six monthly review of the staffing establishment for Midwifery and Support staff identifies a significant deficit in reference to national recommendations, a business plan could be developed in order to expand staffing numbers in accordance with the acuity review.

The development of the business plan is the responsibility of the Head of Midwifery and the Women’s and Children’s Deputy Head of Operations. It is reviewed by the Women’s Quality and Safety Board.
Where the business plan is not approved, a risk assessment should take place; the risk rating should be entered on the Risk Register and reported to the Maternity Service Governance Group, Women’s Quality Board in line with the Trust’s risk reporting framework.

**Process for the Development of Short Term Contingency Plans**

- In the event of short term staff shortages on a day-to-day basis (e.g. in the event of illness, industrial action, increased activity etc) the Midwifery and Support Staffing levels are monitored by the Bleep Holder and where deficits are identified they are communicated to the Midwifery Matron for Intrapartum and Inpatient Services. Outside working hours the on-call CMG Manager is informed. Short term contingency measures will include:
  - Reallocation of available staff
  - Use of bank staff
  - Overtime
  - Agency staff
  - Transfer of activity
  - Closure of UHL Maternity Service to admissions

**Process for Monitoring Compliance**

The responsibility to monitor progression of the business plans lies with the Women’s CMG Quality Board.

Key performance indicators/standards:

- There is a record when staff have been redeployed or the situation has required escalation to the CMG Manager
- There is a record of all temporary transfers of admissions
- There is a record of all full closures of the Maternity Service
- There is evidence that the correct processes have been followed
- There are records of the numbers of women admitted and referred elsewhere.

**Out of hours support of the acute unit forms, are completed by the CMG Manager on Call where all telephone calls which include concerns about staffing can be recorded. These forms are sent to the Maternity Administrator for the Matrons.**
Appendix 1

Community Midwifery Operational Guidelines

Cover arrangements / Hand over

24 hour service

- **Night** 21.45 - 08.15 with 1 hour break = 9.5 hours,
- **Late** 14.00 - 22.00 with 30 minute break = 7.5 hours,
- **Day** 0900 - 1700 with 30 minute break = 7.5 hours.

Homebirth team have some staff rostered to work
long days 07.00 - 19.30 with 1 hour break = 11.5 hours
Night 19.00 - 07.30 with 1 hour break = 11.5 hours

**Day shift** – one midwife per team every day, 0900 – 1700hrs.
- Must be on duty and working on patch e.g. home visits at commencement of duty time.
- Midwife with ‘A (admin)’ will be responsible for taking work – (new discharges) from the community office.
- Team leads to be contacted to arrange cover for clinics or visits in order for midwives to go immediately to support home birth.

- Home Birth to take precedence over attendance at a clinic, any visits or attending the birth centre.

- **Late shift** Midwives will work in own team on commencement of duty to cover visits, or clinics as required. They will then report to the homebirth team base at Glenfield General Hospital

- **Night shift** Midwives will report to the homebirth team base at GGH) at 21.45 hrs.

If the Late shift requires Night shift staff to relieve at a home birth, they will be contacted by telephone by the homebirth team directly.

**Contact**

Contact will be made initially before the beginning of commencement of duty by the following method.
- Voicemail information. All staff to ensure voicemail is activated on their work mobile phones
- Text information.
Cross Boundary Working

Team geographical boundaries will be maintained, individual plan for women out of area to provide continuity of carer. Any minor deviations from this will be agreed by the Team Leads.

Storage of equipment etc

The central base for the midwives on late and night shifts – the homebirth team office at GGH - will have available equipment required for a home birth (2 in total). During the day duty, storage of equipment will be managed within local teams in conjunction with the team lead.

St Mary’s Cover Out of Hours

If there is a birth in progress at St Mary’s, the midwife identified on the Late / Night off duty will be called to provide support with this.

- On arrival midwives will phone 01664 854854 (St Mary’s phone number) to gain access to the unit.
- If both teams are out at Home Births – St Mary’s will call their on call midwife
- If a home birth requires attendance and one team is at St Mary’s the on call midwife will be called to attend the St Mary’s birth.
- St Mary’s staff to be informed when second team called out to attend a home birth.

Roles/ responsibilities of staff

Day shift
All usual clinical duties i.e. home visits, clinic cover, work associated with management of their caseload. Staff may be required to help other community teams according to service demands.

Late shift from 17.00 hours and Night shift

Clinics or visits as required then report to the homebirth team office at GGH unless required to attend directly to a homebirth or St Mary’s.

- From 17.00hrs midwives are responsible for covering the clinical workload for the city, the county and Rutland. Homebirths and urgent community matters must take priority.

Other duties will include,
- Telephone advice
- Answering patient queries and recording actions from these
- Actioning any messages left by the community office staff
- E-learning and training – including using the opportunity to update or gain competencies in suturing, water birth etc.
- Attending home assessments as appropriate
St Mary’s Birth Centre will contact teams via landline at the central base or on their mobile phones if already out.

Supporting other areas

If Community midwives are not out at a home birth and the acute Delivery Suites are experiencing staffing and/or capacity issues they may be requested to offer support. This support however should be considered in terms of their area of expertise.

- Firstly by supporting low risk women in labour or giving immediate postnatal care within and alongside the birth centre midwives
- Secondly by acting as the second or third midwife on a ward
- Thirdly, and only at times of extremely high acuity and if there is no other alternative, assisting on the main delivery suites.

If one acute unit’s Delivery Suite is much busier than another the transfer of hospital based midwives to support should be considered as they are more skilled in high risk care.

Coordinators must keep in mind that the Community midwives may be required to attend either a home birth or community emergency at any time and they must be freed up in order to do so. It may be appropriate and a learning opportunity for a birth centre midwife to attend alongside a community midwife depending on the activity at the time.

If there is any concern re this being possible this must be discussed urgently with the on call manager If the withdrawal of the home birth service is being considered this must be discussed with and authorised by the Head of Midwifery.

Off-Duty Planning.

- Team off-duty should be completed and approved by the appropriate community team lead prior to submission.
- Team off-duty should follow a the electronic rostering format
- Team off-duty should be submitted and available to staff 4-6 weeks prior to the commencement of the off duty.
- Off-duty should be submitted including student off-duty (clearly identifying named mentor), and clinic cover
- The process for completing off-duty within each team should be adhered to.
- Self rostering is not possible at the moment but will be made available if the staff would prefer this method of rostering

Lead Availability

- There will be at least two Community Midwifery Team Leads on duty each day Monday – Friday, one Team Lead on a Saturday and Sunday to provide advice, guidance, support and for short term staffing management. There are also maternity bleep holders and Duty managers available. This is in line with the UHL Transfer of Activity and Closure policy.
At night the responsibility lies with the CMG Manager on call.

**Annual Leave**

The process for allocation of annual leave has been agreed at individual team level but must ensure parity and safe service provision during peak times. The annual leave allocation at any one time within a clinical area will follow the rules within electronic rostering of 11-17% and this is monitored in weekly reports by the matron and Head of midwifery.

NB. It is the responsibility of staff to book and to take their annual leave in a timely manner. No annual leave can be carried over to the following financial year except under extreme circumstances, and with prior agreement of the Team Lead. Any period of annual leave exceeding two consecutive calendar weeks must receive written approval from the Team Lead prior to being booked.

a) **Off-duty process**

- Obtain previous months off-duties.
Appendix 2

Guidance for responsibility of On Call Manager for Womens areas (W&C CMG)

The Womens on call management rota is produced every three months to cover areas within women’s services out of hours:

Maternity LRI
  o Delivery Suite
  o Orchard Birth Centre
  o Wards 5 & 6
  o Maternity Assessment Unit

Maternity LGH
  o Delivery Suite
  o Meadow Birth Centre
  o Ward 30
  o Maternity Assessment Unit

Community Midwifery Service
  o St Mary’s Birth Centre
  o Community teams
  o Homebirth team

Gynaecology LRI
  o GAU
  o EPAU
  o ACU

Gynaecology LGH
  o Wards 31 & 11

Neonatal units at LRI & LGH and Neonatal transport.

The rota is to provide out of office hours senior management cover for these areas 24/7. Monday to Friday 09.00-17.00 the responsibility lies with the Matron’s, Ward Managers/bleep holders for their own area.

The responsibility of the on call manager is to support the co-ordinators, nurse in charge and clinical staff with any issues they feel unable to deal with.

In all areas the most common reasons for escalation to the manager on call are capacity and staffing.

Maternity service

The midwife in charge of the delivery suite at both the LRI and LGH completes an acuity score to assess the level of activity and clinical need versus the midwifery ratio every 4 hours and this is documented on an acuity spreadsheet on the Intra Partum Toolkit Drive.
If numbers fall below the acuity score and/or clinical need dictates, the coordinator/maternity bleep holder redeploy staff to meet the clinical need. Where staff are redeployed this is documented on the acuity spreadsheet.

Short term contingency measures may include:
- Reallocation of available staff
- Use of bank staff
- Overtime

Should the redeployment of staff not be effective the coordinator/maternity bleep holder would contact the Manager on call in the first instance and contingency plans made. These should be in line with the Escalation, Transfer of Activity and Closure Policy, initiated by the Manager on call for the CMG and coordinated by the Maternity Bleep Holder.

Agreement for there to be a temporary transfer of activity from one site to the other will be a MDT decision made by the Consultant Obstetrician, Midwife Co-ordinator, Senior Midwife or the Manager on Call for CMG.

Neonatal and Gynaecology services

The nurse in charge will escalate to the CMG manager on call out of hours any concerns regarding acuity and workforce or any other issues that they feel they cannot resolve at ward level. Staffing problems are generally sorted out in daytime hours; normally the need to escalate is due to a change in the acuity, staffing levels/mix or issues of outlying requests within Gynaecology.

Outlying to Gynaecology LGH:

Out of hours the Duty Manager may request ward 31 to accept outliers from the surgical unit. With reference to the Trust policy for outlying ‘Criteria for outlying to Gynaecology’ there are a few basic rules to remember:
- The patient must have an up to date negative MRSA screen, no history of CDT or CRO. Gynaecology is classed as a high risk area from an infection prevention perspective.
- The patient must have a treatment plan in place with a discharge date within the next 24 – 48 hours
- Patients with epidurals must be discussed with the gynaecology nurse in charge in the first instance to ensure there are staff rostered with the appropriate skills

Please note that over a weekend gynaecology reduces the number of staff rostered. This is an elective ward and staffing is determined by activity. If patient numbers are to be increased please check that there is adequate staffing on the day and night shifts. There must always be a minimum of 2 trained nurses on a night duty.
Outlying to Gynaecology Assessment Unit LRI:

GAU is classed as an emergency assessment area and therefore is 'ring fenced', i.e. no outliers from other general areas. In the event of a major incident the duty manager (with instructions from the Trust Director on-call) may outlie to GAU. Patients must have an up to date MRSA screen with no history of CDT or CRO. Patients must have a treatment plan in place with a discharge date within the next 24-48 hours.

Lack of Capacity in Gynaecology:

GAU –
- Has the LRI Gynaecology on-call Consultant reviewed all patients and identified discharges?
- Are there outliers’ on the unit, contact the duty manager to assist with transferring these patients back
- Are there available beds on maternity to utilise

If transferring gynaecology patients to ward 31 LGH the patient must first be accepted by the LGH on-call Gynaecology Consultant. The patient must have a treatment plan and does not require emergency surgery.

For further information see “Guideline for managing and increase in demand for emergency patient activity”

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