Consultant Obstetric Anaesthetist and Anaesthetic Practitioner Cover: UHL Obstetric Guideline

University Hospitals of Leicester NHS
NHS Trust

Trust reference B51/2011

Contents

1. Introduction and who the guideline applies to:

This guideline applies to Consultant Obstetric Anaesthetists and Anaesthetic Assistant staff working within the UHL Maternity Service and is for use by staff providing care for people in pregnancy, labour and the puerperium.

Related UHL documents:

Safe Staffing UHL Nursing and Midwifery Policy.pdf Trust ref: B7/2023

RN's & HCA's supporting RM's in UHL Maternity Trust ref: C63/2022

Consultant Obstetrician Cover Arrangements for Labour Ward Trust ref: C112/2008

Escalation, Transfer of Activity and Closure UHL Obstetric Policy Trust ref: C29/2011

Background:

Assessments of current and future workforce requirements should be made locally to identify the number and experience of staff required to provide appropriate and safe cover on labour ward.

The local requirements should consider those figures identified by RCOG's Safer Childbirth 2007(RCOG are updating current requirements, but have not produced replacement recommendations in the interim. This document continues to be based on the safer childbirth 2007 document and will be reviewed when new recommendations from the RCOG become available).

Recommended Consultant Obstetric Anaesthetist staffing levels are essential for providing a safe service.

There are dedicated Consultant Obstetric Anaesthetist sessions on both UHL Maternity sites, and theatre staffing for theatres at the LRI and theatres at the LGH.

At both sites, emergency obstetric services must always be staffed first. Consideration should be given to cease elective maternity activity to improve the safety of the emergency obstetric service.

2. Guidance:

The prime concern is the safety of mothers and babies. Consultant Obstetric Anaesthetist cover will impact on the service when minimum requirements are not met. The minimum requirements are outlined in Table 1. The minimum requirements of Anaesthetic Practitioners are outlined in Table 2. The service will only close to admissions as a last resort after a clinical assessment of the risks and all options of transfer of activity within the Maternity Service have been explored. The decision to close the Leicestershire Maternity Service rests with the on call Director in line with the Escalation, Transfer of Activity and Closure UHL Obstetric Policy

The optimum staffing levels would be in line with national and Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth 2007 recommendations (see Appendix 1). Where this isn't currently achievable, the minimum levels should be adhered to as a minimum. Annual reviews will allow work force planning to work towards achieving recommended levels in the longer-term.

2.1 Definition of Obstetric Anaesthetist:

'A Consultant Anaesthetist or the Specialist Register who has regular Labour Ward sessions as part of their individual job plans'

- **Lead Obstetric Anaesthetist:**
  There is a designated Obstetric Anaesthetic Lead for each site.

- **Obstetric Anaesthetist Clinics:**
  There are two Consultant Obstetric Anaesthetic clinics each week; these sessions are time tabled into job plans.

Table 1: Minimum requirements for Consultant Obstetric Anaesthetists

SITE	LRI	LGH
Monday to Friday 08:00-18:00	• 2 consultant obstetric anaesthetists for general maternity and labour ward • 1 consultant obstetric anaesthetist dedicated for elective Caesarean Section (CS) list Above sessions time-tabled in job plan. Cover arrangements made with Consultant colleagues when booking annual/study leave	• 1 consultant obstetric anaesthetist for general maternity and labour ward • 1 consultant obstetric anaesthetist dedicated for elective Caesarean Section (CS) list Above sessions time-tabled in job plan Cover arrangements made with Consultant colleagues when booking annual/study leave
Monday to Friday 18:00 – 20:30	One Senior Decision Maker (Consultant or Specialist in Obs. Anaesthesia)	
Monday to Friday 18:00-08:00	Consultant obstetric anaesthetist on call available within 30 minutes.	Consultant obstetric anaesthetist on call available within 30 minutes.
Saturday 08:00 to Monday 08:00	Consultant Anaesthetist on call available within 30 minutes:	Consultant Anaesthetist on call available within 30 minutes.
Saturday and Sunday 08:00 – 20:30	One Senior Decision Maker (Consultant or Specialist in Obs. Anaesthesia)	

2.2 Definition of Anaesthetic Nurse Practitioner:

- The Association of Anaesthetists identify that assistance for the anaesthetist may be provided by Operating Department Practitioners or adequately trained Registered Nurses. Whatever the background, the training for all anaesthesia assistants must comply fully with national standards, such as the College of Operating Department Practitioners (CODP) curriculum, the Perioperative Care Collaborative curriculum or the NHS Education for Scotland core competency framework for anaesthetic assistants.

Table 2: Minimum requirements for Anaesthetic Practitioners

SITE	LRI	LGH
		Monday to Friday 08:00-20:00
Monday to Friday 08:00-18:00	3 Anaesthetic Practitioners on maternity and level 1 Kensington Maternity theatres (one of these holding the epidural/coordination phone).	2 Anaesthetic Practitioners on maternity. An MCA from labour ward is required when opening a second theatre.
Monday, Wednesday & Friday 08:00-14:00	**1 additional** Anaesthetic Practitioner	In the unlikely event extra assistance is required this is supplied by the Main theatre Department until 22.00hrs. They are then on call until -08:00hrs.
Contingency arrangements	Should extra assistance be required, this is supplied by the Central Operating Depts Floor Control Team with MCA from labour ward	
Monday to Friday (out of hours) 18:00-08:00	2 Anaesthetic Practitioners on maternity	**Monday to Friday 20:00-08:00** 2 Anaesthetic Practitioners on maternity An MCA from labour ward is required when opening a second theatre.
Contingency arrangements	Should extra assistance be required, this is supplied by the Central Operating Dept's Emergency Team with MCA from labour ward	In the unlikely event extra assistance is required this is supplied by the Main theatre Department until 22.00hrs. They are then on call until -08:00hrs.
Saturday 08:00 to Monday 08:00 (Weekends & Bank Holidays)	2 Anaesthetic Practitioners on maternity	2 Anaesthetic Practitioners on maternity An MCA from labour ward is required when opening a second theatre.
Contingency arrangements	Should extra assistance be required, this is supplied by the Central Operating Dept's Emergency Team with MCA from labour ward (new)	In the unlikely event extra assistance is required this is supplied by the Main theatre Department until 18.00hrs. They are then on call until 08:00hrs.

2.3 Business Plans

When shortfalls are identified it is the responsibility of the Women's CMG Management Team to liaise with Anaesthesia and Theatres CMG Management Team and devise business plans and contingency plans to address present and future staffing shortfalls based on annual review of staffing figures and any identified shortfalls. The results of the annual review should be referred to and actioned by the

relevant CMG Quality and Safety Board and progressed via the CMG Operational Board and Performance Board depending on the investment cost required to the Executive Strategy Board and the Integrated Finance performance and Investment Committee.
The CMG Quality and Safety Board will monitor the progression of the business plan as an on-going process. Where business plans/funding are not approved, a risk assessment should be performed and the Risk Score entered on the Risk Register as per Maternity Risk Management Strategy.

2.4 Contingency plans

On-going staffing shortfalls in Anaesthetic cover:

These should be addressed and actioned by the Clinical Director of the CMG, Clinical Risk and Safety Manager, CMG Medical Lead, CMG Manager and the Head of Midwifery/Lead Nurse. On-going shortfalls in Anaesthetic Practitioner theatre staff staffing levels should be reported to the Midwifery Matron for Intrapartum and Inpatient services, Quality and Safety Manager, CMG Medical Lead and CMG Manager. Shortfalls should be addressed in conjunction with the Anaesthesia and Theatres CMG management.

Short term staffing shortfalls in Anaesthetic cover:

These include sickness and absence and increased workload. During office hours, short term shortfalls should be reported to Anaesthetic office so that alternative cover can be arranged. This should be escalated to the Lead Obstetric Anaesthetist and Anaesthetics Head of Service if required. Out of office hours and at weekends these should be reported to the consultant anaesthetist on call for General duties and Head of Service so that appropriate cover arrangements can be made. The on call consultant obstetrician and midwife co-ordinator should be notified and an incident form completed.

Short term shortfalls in Anaesthetic Practitioner theatre staff due to sickness etc. are reported by the Practitioner in Charge/Team Leader or Deputy in Maternity to Central Operation Department Floor Control Team to arrange appropriate cover. On call obstetric anaesthetic consultant, consultant obstetrician and midwife co-ordinator should be notified and an incident form completed.

3. Education & training

New and existing staff are educated/orientated to this SOP, its outlining the staffing arrangements so that medical and non-medical staff are sighted to and aware of the provision and escalation arrangements on each site.

4. Monitoring Compliance

Monitoring is in built into the CLW (medirota) system.

Any problems go through the Lead Clinician then the Head of Service for the Leicester Royal Infirmary Critical care, Theatres, Anaesthesia, Pain and Sleep Clinical Management Group (ITAPS).

This is based on a review of incident forms related to staffing by the Quality and Safety Manager in conjunction with the Head of Service and CMG lead. The Anaesthetic office and Anaesthetic Head of Service will be informed of the incident. The review will include trend analysis if considered necessary, and referred to the Perinatal Risk Group where appropriate. Any action points / plans will then be referred to the Maternity Service Governance Group, Clinical Governance Committee and the relevant CMG Quality and Safety Board (Women's/ITAPS or both).

Non-medical safer staffing levels for Maternity theatre specifically, falls under the responsibility of the Head of Nursing for ITAPS.

The Theatre Matron, CMG Operational team and Head of Service should annually review staffing levels to establish whether prospective consultant obstetric anaesthetic presence on labour ward is in line with Safer Childbirth (RCOG 2007). Information can be gathered from incident reporting forms and Medical staffing administration forms. An annual review of staffing levels should take place and the results of which reported to and actioned by the Clinical Governance Committee and the Maternity Service Governance Group.

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Incident forms relating to staffing	All incident forms reviewed	Head of Service and CMG Lead	As occur	Maternity Governance and CMG Quality and Safety Board
Review of staffing levels	Review of incident forms and medical staffing administration forms	Head of Service, CMG Lead and Head of Midwifery	Annually	Maternity Governance Group

5. Supporting References:

Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.* London: RCOG Press.

Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health (2008) *Children's and Maternity Services in 2009: Working Time Solutions*. London: RCOG Press. Available at www.rcog.org.uk.

Royal College of Obstetricians and Gynaecologists, Royal College of Anaesthetist, Royal College of Midwives, Royal College of Paediatrics and Child Health (2008) *Standards for Maternity Care: Report of a Working Party*. London: RCOG Press. Available at www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists (2010) *Labour Ward Solutions. Good Practice No.10.* London. RCOG Press. Available at www.rcog.org.uk

Safe Staffing UHL Nursing and Midwifery Policy Trust ref: B7/2023

Registered Nurses and HCAs Working to Support Midwives Standard Operating Procedure UHL Maternity Guideline Trust ref: C63/2022

Consultant Obstetrician Cover Arrangements for Labour Ward UHL Obstetric Guideline Trust ref: C112/2008

Escalation Transfer of Activity and Closure UHL Obstetric Guideline Trust ref: C29/2011

6. Key Words

Medical staffing, Maternity service, Transfer of activity, Workforce

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

EDI Statement

We are fully committed to being an inclusive employer and oppose all forms of unlawful or unfair discrimination, bullying, harassment and victimisation.

It is our legal and moral duty to provide equity in employment and service delivery to all and to prevent and act upon any forms of discrimination to all people of protected characteristic: Age, Disability (physical, mental and long-term health conditions), Sex, Gender reassignment, Marriage and Civil Partnership, Sexual orientation, Pregnancy and Maternity, Race (including nationality, ethnicity and colour), Religion or Belief, and beyond.

We are also committed to the principles in respect of social deprivation and health inequalities.

Our aim is to create an environment where all staff are able to contribute, develop and progress based on their ability, competence and performance. We recognise that some staff may require specific initiatives and/or assistance to progress and develop within the organisation.

We are also committed to delivering services that ensure our patients are cared for, comfortable and as far as possible meet their individual needs.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) P Ramasamy – Consultant Anaesthetist			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
January 2025	4	P Ramasamy – Consultant Anaesthetist Richard Porter – Consultant AICU & Adult ECMO Jason Loughran - HoN	Added statement re- RCOG are updating current requirements Updated Consultant cover LGH Mon-Fri 08:00-18:00 Updated minimum requirements for anaesthetic practitioners (table 2) Updated definition of Anaesthetic Nurse Practitioner Format throughout updated

Appendix 1: Safer Childbirth 2007

Taken from - Royal College of Anaesthetists, Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, Royal College of Paediatrics and Child Health (2007) *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour.*

4.3 Anaesthetist staffing levels

4.3.1 The roles of the anaesthetist (Section 3.5) recognise their integral part of the team and the need for 24-hour availability. Staffing levels need to recognise that emergencies happen frequently and often with rapidity, with a requirement to respond quickly in order to save mothers' or babies' lives. This means that in all but the smallest units the duty anaesthetist for obstetrics should not, in addition, be responsible for the intensive care unit or other anaesthetic duties. Much of obstetric anaesthetic practice is unplanned but, as well as timely response to emergencies, anaesthetic services also need to respond to elective operating such that it is not normally interrupted by emergencies.

4.3.2 In the same way that limited working hours have reduced the experience of obstetric trainees so it has for anaesthetic trainees. Concomitantly, the expectations of women have increased. The need for greater anaesthetic consultant presence has been recognised for some time such that there is consultant presence on the labour ward for at least 40 hours a week. Achieving this has been hampered by a paucity of suitably trained trainees. The situation in 2007 is such that there are more anaesthetists completing the CCT programme and applying for consultant posts. Failure to have sufficient consultant anaesthetists has been a clinical governance issue and is known to have resulted in higher anaesthetic complications. It is therefore time to implement the following recommendations, which have been in place since May 2005.

4.3.3 The recommendation in *Towards Safer Childbirth*[1] of a minimum of one fixed consultant session per 500 births is no longer adequate because of changes in workload, expectations/role and changes in workforce. The following is now expected:[92]

- For any obstetric unit there should be ten consultant programmed activities or sessions per week, to allow full 'working hours' consultant cover.
- In addition to this, there should be a separate consultant anaesthetist for each formal elective caesarean section list.
- Tertiary referral units that are likely to have a higher than average proportion of women requiring high dependency care should have consultant time allocated for their care.
- Extra clinical time should be made available each week for antenatal referrals, especially when a formal clinic is provided.

4.3.4 Each consultant-led obstetric unit should have a lead obstetric anaesthetist with programmed activities or sessions which reflect both clinical activity and the associated administrative work that this entails. The lead obstetric anaesthetist should be 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 or equivalent multidisciplinary bodies and for training and risk management.

4.3.5 There must be a 'duty anaesthetist' immediately available for the obstetric unit 24 hours a day. This anaesthetist will normally have had more than 1 year of experience in anaesthesia and must have been assessed as being competent to undertake such duties.[75] The duty anaesthetist must have access to prompt advice and assistance from a designated consultant anaesthetist whenever required. Because of the high service demand for obstetric anaesthesia, many units will need to explore other means than solely trainees to provide a 24-hour service.

4.3.6 Life-threatening events can happen suddenly or unpredictably and require anaesthetists skilled in their management. The consultant anaesthetist on-call arrangements must ensure that help will be available when requested. In the absence of a dedicated rota for obstetric anaesthesia this may mean having an additional consultant anaesthetist on-call on a general rota.

4.3.7 In the busier units (more than 5000 births/year, an epidural rate over 35% and a caesarean section rate over 25%, plus tertiary referral centres with a high proportion of high-risk cases) it will be necessary to provide extra anaesthetic cover during periods of heavy workload in addition to the supervising consultant anaesthetist and the duty anaesthetist.

4.3.8 Rostering of anaesthetic trainees must allow for training in all modules including obstetric anaesthesia at basic, intermediate, higher and advanced levels. according to the needs of the trainee.