Consultant Obstetric Anaesthetist and Anaesthetic Assistant Cover UHL Obstetric Guideline	University Hospitals of Leicester NHS NHS Trust Trust reference B51/2011

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 women in pregnancy, labour and the puerperium.

Related UHL documents:

Midwifery and support staffing policy C28/2011
Consultant Obstetrician Cover Arrangements for Labour Ward C112/2008

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). 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 two theatres at the LRI and one theatre at the LGH.

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 Assistants 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 Transfer of Activity and Closure Policy.
The optimum staffing levels would be in line with national and Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth 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.

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 anaesthetists for general maternity and labour ward • 1 additional consultant anaesthetist dedicated for elective CS list in theatre 17 (whenever elective CS is running) Fixed Labour Ward sessions time-tabled in job plan Cover arrangements made with Consultant colleagues when booking annual/study leave Medical staffing level: Minimum of one trainee when there is no elective Caesarean Section list and minimum of two trainees during the time of elective lists (at ST3 level and above).	1 Consultant Obstetric Anaesthetist on site Fixed Labour Ward sessions time-tabled in job plan Cover arrangements made with Consultant colleagues when booking annual/study leave Medical staffing level: Minimum 1 trainee or specialty doctor with minimum of 1 years anaesthetic experience and has passed the initial assessment of competence in obstetric anaesthesia.
Monday to Friday 18:00-08:00	Consultant Obstetric Anaesthetist on call available within 30 minutes. Medical staffing level:	Consultant Obstetric Anaesthetist on call available within 30 minutes. Medical staffing level: 1 specialty doctor with a minimum

	2 trainees of ST3 level or above dedicated to delivery suite until 20:00. 1 trainee of ST3 level or above from 20:00 to 0800 Additionally - 1 trainee of ST5 and above in hospital, shared with ITUand theatres at all times	of 1 years anaesthetic experience who has passed the initial assessment of competence in obstetric anaesthesia 1 second on SpR or specialty doctor (who has passed the initial assessment of competence in obstetric anaesthesia) in hospital, shared with theatres and ITU.
Saturday 08:00 to Monday 08:00	<u>Consultant Anaesthetist on call available within 30 minutes:</u> <u>Medical staffing level:</u> 2 trainees of ST3 level or above dedicated to Labour Ward during the day and one trainee during the night (ST3 level or above). Additionally - 1 trainee of ST5 and above in hospital, shared with ITU and theatres at all times	<u>Consultant Anaesthetist on call available within 30 minutes.</u> <u>Medical staffing level:</u> 1 trainee or specialty doctor with a minimum of 1 year's anaesthetic experience who has passed the initial assessment of competence in obstetric anaesthesia. 1 second on SpR or Specialty Doctor (who has passed the initial assessment of competence in obstetric anaesthesia) in hospital, shared with theatres and ITU.

Definition of Anaesthetic Assistant/ Practitioner/ Operating Department Practitioner (ODP): A registered healthcare professional employed to assist the anaesthetist in delivering perioperative care.

Table 2 Minimum requirements for Anaesthetic Assistants

SITE	LRI	LGH
Monday to Friday 08:00-13:00	3 Anaesthetic Assistants on Labour Ward and theatre 17 (one of them is the bleep holder). At least one of the scrub practitioners should be also trained to provide anaesthetic assistance am and pm.	1 Anaesthetic Assistant on Labour Ward Should extra assistance be required, this is supplied by the Central Operating Dept's Emergency Team
Monday to Friday 13:00-18:00	3 Anaesthetic Assistants on Labour Ward and theatre 17 (one of them is the bleep holder)	
Contingency arrangements	Should extra assistance be required, this is supplied by the Central Operating Depts Floor Control Team	
Monday to Friday 18:00-08:00	1 Anaesthetic Assistant on Labour Ward	1 Anaesthetic Assistant on Labour Ward

Contingency arrangements	Should extra assistance be required, this is supplied by the Central Operating Dept's Emergency Team	Should a second Anaesthetic Assistant be required, this is supplied by the Central Operating Dept's Emergency Team Until 01:00 one other ODP is present in main CD. 01:00 to 08:00 ODP on call from home
Saturday 08:00 to Monday 08:00	1 Anaesthetic Assistant on Labour Ward	1 Anaesthetic Assistant on Labour Ward
Contingency arrangements	Should extra assistance be required, this is supplied by the Central Operating Dept's Emergency Team	Should a second Anaesthetic Assistant be required, this is supplied by the Central Operating Dept's Emergency Team Until 01:00 one other ODP is present in main CD. Main theatres contact Labour Ward to check no expectation of opening second theatre before going home.01:00 to 08:00 ODP on call from home

3. Monitoring:

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 CMG Quality and Safety Board.

It is the responsibility of the Head of Nursing and Midwifery, CMG Lead and Head of Service to 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.

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 ongoing 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.

Contingency plans

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).

Ongoing 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. Ongoing shortfalls in ODP/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 ODP/theatre staff due to sickness etc are reported by the Senior ODP 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.

4. Monitoring Compliance

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 required	Action plans reported to 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. Available at www.rcog.org.uk

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

6. Key Words

Obstetric anaesthetist cover ODP labour ward staffing

CONTACT AND REVIEW DETAILS	
Guideline Lead (Name and Title) A Ling	**Executive Lead** A Furlong
Details of Changes made during review: V3 Insertion of further monitoring arrangements (Monitoring is in built into the CLW (medirota) system). Pathway for reporting problems inserted	

7. Appendix 1: Safer Childbirth 2007

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.