The Dudley Group
NHS Foundation Trust

Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ

Ref: FOI-062024-000917

Date: 05/06/2024

Address / Email:

Dear

Request Under Freedom of Information Act 2000

Thank you for requesting information under the Freedom of Information Act 2000.

Request

I would like to request the following information:

1. **Do each of your maternity units which offer consultant-led births have two obstetric theatres available 24/7 with a full complement of staff available should the second theatre be needed? How long does it take to mobilise the second theatre and staff if it needed?**
2. **If you don't have a second obstetric theatre, what arrangements are in place should you have two obstetric emergencies requiring theatres at the same time? What hours are covered by these arrangements?**
3. **If you don't have a second obstetric theatre, have you any plans to establish one? Has funding been obtained and how much?**
4. **How long approximately does it take to transfer a woman from the labour ward to 1. Your normal obstetric theatre? 2. Whichever additional theatre would be used in the event of two emergencies at the same time?**
5. **Have you had any serious incidents/Datix (or other reporting system) reports in the last three years involving lack of timely access to fully staffed theatres in maternity emergencies?**
6. **Please attach any policies you have on maternity emergencies/escalation.**

Response

1. **Do each of your maternity units which offer consultant-led births have two obstetric theatres available 24/7 with a full complement of staff available should the second theatre be needed? How long does it take to mobilise the second theatre and staff if it needed?**

   We have 2 dedicated theatres within the maternity unit. One theatre for emergency work which is staffed by an anaesthetist and theatre team 24/7 and one theatre for our Elective caesarean section work and overflow as 2nd emergency theatre as required. During ELCS hours (08:30 - 13:00 Mon-Fri) we would suspend the ELCS service and

utilise the second theatre team for subsequent emergencies. Outside of these hours the on-call emergency theatre team from main theatres cover any emergency work required. If a second theatre team is required, this is summoned by a 2222 emergency call. The team are located in main theatres which is approximately a 2-minute walk away.

2. **If you don't have a second obstetric theatre, what arrangements are in place should you have two obstetric emergencies requiring theatres at the same time? What hours are covered by these arrangements?**

N/A

3. **If you don't have a second obstetric theatre, have you any plans to establish one? Has funding been obtained and how much?**

N/A

4. **How long approximately does it take to transfer a woman from the labour ward to 1. Your normal obstetric theatre? 2. Whichever additional theatre would be used in the event of two emergencies at the same time?**

Both our theatres are located within the maternity department and approximately 30 seconds from delivery suite.

5. **Have you had any serious incidents/Datix (or other reporting system) reports in the last three years involving lack of timely access to fully staffed theatres in maternity emergencies?**

No

6. **Please attach any policies you have on maternity emergencies/escalation.**

Please see attached documents.

If you are dissatisfied with our response, you have the right to appeal in line with guidance from the Information Commissioner. In the first instance you may contact the Information Governance Manager of the Trust.

Information Governance Manager
Trust Headquarters
Russell's Hall Hospital
Dudley
West Midlands
DY1 2HQ
Email: dgft.dpo@nhs.net

Should you disagree with the contents of our response to your appeal, you have the right to appeal to the Information Commissioners Office at.

Information Commissioners Office
Wycliffe House
Water Lane
Wilmslow
Cheshire
SK9 5AF
Tel: 0303 123 1113

www.ico.org.uk

If you require further clarification, please do not hesitate to contact us.

Yours sincerely

Freedom of Information Team
The Dudley Group NHS Foundation Trust

The Dudley Group
NHS Foundation Trust

Emergency Caesarean Section Guideline			
	DOCUMENT TITLE:	**EMERGENCY CAESAREAN SECTION**	
	Name of Originator/Author /Designation & Specialty:	[redacted] Obstetric Consultant and [redacted] Speciality doctor, Obstetrics and Gynaecology	
	Local / Trust wide	Local	
	Statement of Intent:	To assist Midwives, Obstetricians and Anaesthetists in: Categorisation of degree of Urgency of Caesarean section and preparation of women for Caesarean Section	
	Target Audience:	those providing care for women undertaking an emergency caesarean section	
	Version:	6.0	
	Name of Review and Approval Group and Date when Recommended for Ratification	Virtual Policy Group	December 2021
	Name of Division/Group and Date of Final Ratification:	Surgery Women and Children: GAMe	14 February 2022
	Review Date:	February 2025	
	Contributors:	**Designation:**	
	The electronic version of this document is the definitive version		

CHANGE HISTORY

Version	Date	Reason
4.0	September 2012	Adapted and reviewed against CNST standards
5.0	February 2018	Review and Update
6.0	December 2021	Review and Update

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

THE DUDLEY GROUP NHS FOUNDATION TRUST

EMERGENCY CAESAREAN SECTION GUIDELINE

1. GUIDELINE SUMMARY

Caesarean section is an accepted method of delivering babies and is generally considered a safe operation. In well-chosen cases the operation is life saving and prevents serious harm to both mother and fetus. Recommendations from the National Institute of Clinical Excellence (2021) in the classification of caesarean sections have been adopted.
Emergency caesarean section needs to be undertaken in a short enough period to eliminate unacceptable delay. The MBRRACE-UK Confidential Enquiry into Maternal Deaths and Morbidity (2013-15) highlighted the importance of the collection of key data and importance of completing all documentation.

2. GUIDELINE DETAIL

3. CLASSIFICATION OF CAESAREAN SECTION

Category	Urgency	Definition
1-	Maternal or fetal compromise	Immediate threat to the life of the woman or fetus
2-	Maternal or fetal compromise	No immediate threat to the life of the woman or fetus
3-	No maternal or fetal compromise	Requires early delivery
4-	No maternal or fetal compromise	At a time to suit the woman and Maternity Services

Please refer to the Elective Caesarean section guideline for Classification 4 caesarean sections.

3.1 The Timing of Caesarean Section

Standards are set to ensure that each classification is undertaken in an acceptable timescale. The interval between the decision to delivery time sets this standard.

Classification	Standard
1-	The interval between decision to delivery time should not exceed 30 minutes
2-	The interval between decision to delivery time should not exceed 75 minutes in most situations and should be as soon as possible once the decision has been made.

3-	The interval between decision to delivery time should not exceed 48 hours
4-	Undertaken at a time to suit both woman and Obstetric team

Perform category 1 and 2 Caesarean sections as quickly as possible after making the decision, particularly for category 1.
The condition of both the woman and the unborn baby should be taken into account when making decisions about rapid delivery.

3.2 Indication for Caesarean Section

The indication for classification 1, 2, 3 and 4 caesarean sections must be documented within the intrapartum notes by the person who makes the decision. This would normally be the senior obstetrician. The consultant obstetrician must be included in this decision-making process for all sections. In extreme cases with a category 1 section where a delay could be life threatening to the woman or the fetus it would be acceptable to notify the Consultant as soon as possible after or ask a senior midwife to contact the consultant obstetrician on your behalf. The decision time and reasons for caesarean section should be documented in the intrapartum notes prior to transfer to theatre.

3.3 Roles and Responsibilities in deciding the Classification of Emergency Caesarean

- **The Consultant Obstetrician** must be included in the decision-making process for all Emergency Caesarean sections, unless doing so would cause a delay that is life threatening to the woman or the fetus.
- **The Senior Obstetrician** is responsible for documenting any delay in undertaking the operative procedure for any classification of caesarean section and this must be documented within the Intrapartum notes.

4. CARE DURING THE PROCEDURE

4.1 Prophylactic antibiotics

All women are administered, with consent, all the following antibiotics during the caesarean section procedure prior to skin incision:

- Metronidazole 500mg IV
- Clindamycin 600mg IV
- Cefotaxime 1000mg IV

4.2 Prophylactic Thromboprophylaxis

All women who have undergone emergency Caesarean section should be given Low molecular weight heparin (LMWH) unless contraindicated.

- The dose of LMWH should be based on booking weight (refer to Thromboprophylaxis guideline for dosage) The first dose should be given 4 hours after the spinal anaesthesia or removal of the epidural catheter and then daily at 18.00hrs unless the senior obstetrician has requested a review prior to LMWH due to risk of bleeding.
- The duration of the thromboprophylaxis is determined by VTE risk assessment score

- Score of less than 2, LMWH daily until discharge. Review the need to continue if discharge is delayed beyond 48 hours.
- Score 2, LMWH for 10 days
- Score 3 or more, or already on LMWH antenatally, LMWH for 6 weeks

LMWH should not be given for 4 hours after use of spinal anaesthesia or after the epidural catheter has been removed.

All patients who have undergone an emergency caesarean section should be encouraged to mobilise early and keep hydrated to reduce the risk of venous thromboembolism. Women should be encouraged to wear TED stockings whilst in hospital and on discharge until fully mobile.

5. PREPARATION OF A WOMAN FOR CATEGORY 1 CAESAREAN SECTION

- **The Consultant Obstetrician** must be included in the decision making process for all Category 1 caesarean sections, unless doing so would cause a delay that is life threatening to the woman or the foetus.

  It is important to stay calm, work effectively and with speed. The Anaesthetic and theatre staff must be informed prior to transfer to theatre.

  Once a decision is made immediate transfer to theatre is imperative. During transfer to theatre the senior obstetrician should consider methods of intra-uterine resuscitation including IV fluids, left lateral position of the woman and/or tocolysis with Terbutaline 250 microgram s/c.

5.1 Roles and Responsibilities of the Birth Attendants in Organising Class 1 Caesarean Section

5.1.1 Lead Midwife

- Dial 2222. State clearly that there is an **EMERGENCY** and state who is required as per the Maternity Emergency Group call. This should include the anaesthetist, neonatal team and obstetric theatre team (Appendix 1).
- Obstetric Consultant to be informed, lead midwife to contact them by mobile phone if the senior obstetrician is unable.
- If first theatre is in use the lead midwife must contact the second theatre team, stating that it is a crash caesarean section on bleep number 7224.
- Inform team on arrival of CATEGORY 1 Caesarean Section.
- Provide the woman with as much information as possible and ensure that the senior obstetrician obtains consent for the emergency caesarean section. Written consent documenting the reasons for the procedure and the associated risks should be signed by the woman except in cases of extreme emergency where verbal consent is acceptable.
- Ensure woman has had blood taken for full blood count and group and save/cross match. Other bloods may be taken as appropriate to the clinical circumstances. The bloods are hand delivered to the laboratory.
- The indication for emergency caesarean section must be documented in the intrapartum notes.
- If there is any delay the reasons for this must be documented within the intrapartum notes.

5.1.2 Midwife

- Ensure the woman is ready for theatre with a theatre gown and TED stockings. MRSA swabs should be taken. Where possible a Midwifery Support Worker (MSW) will assist with this.
- Complete theatre check list.
- Switch off Oxytocin infusion if running.
- Ensure two name bands in situ (wrist and ankle).
- Provide a handover to the neonatal team on their arrival

5.1.3 Anaesthetist

- Anaesthetist to start pre-assessing the woman (may be continued on journey to theatre and/or in theatre).
- Establish IV access 16G (grey) cannula (if not already established).
- Give antacid treatment, Sodium citrate 30mls orally or 20mg Omeprazole.

5.1.4 Theatre team

In theatre preparing for anaesthetic and setting up for Caesarean section.

5.2 Roles and Responsibilities of the Birth Attendants in Theatre prior to Category 1 Caesarean Section

5.2.1 Theatre team

- Woman in 15 degree left lateral tilt on operating table; oxygen commenced if required.
- Maternal monitoring commenced – Blood pressure (BP); ECG; Oximetry
- WHO theatre checklist to be completed prior to commencing the procedure except in cases of extreme emergency, Cat 1 check list to be completed.
- Regional or General Anaesthesia instituted.
- Pubic hair is trimmed with electric clippers if requested by the Obstetrician.
- Administer, with consent, Prophylactic Antibiotics (point 4.1).

5.2.2 Midwife

- Listen/monitor fetal heart.
- Catheterise with urinary catheter, ensure that instillagel used.
- The infection control sticker must be completed and stuck in the intrapartum notes.
- MRSA swabs to be taken.
- Check Resuscitaire and emergency paediatric trolley.
- Obtain paired cord gases.

5.3 Roles and Responsibilities of the Birth Attendants Following Class 1 Caesarean Section

5.3.1 Obstetric Registrar

Complete documentation of procedure and all relevant parts of pages 16 and 17 of the intrapartum notes. Debrief the woman and partner on the intra-operative events and recovery process.

5.3.2 Anaesthetist/Operating Department Practitioner (OPD)

- Transfer woman to the Recovery room

- Handover to the midwife
- Ensure that appropriate analgesia/ thromboprophylaxis prescribed

5.3.3 Midwife

- To undertake recovery observations if a regional anaesthesia used (if General Anaesthesia used ODP to recover woman)
- To initiate skin to skin and offer encouragement and support to breastfeed
- Complete appropriate documentation

6. CATEGORY 2 CAESAREAN SECTION

The same procedure as for category 1 Caesarean Section, but remembering in most situations the interval between decision to delivery time should not exceed 75 minutes.

In the case of category 2 caesarean section each individual member of the team required in theatre are to be contacted individually. Do not use emergency team call.

7. CATEGORY 3 CAESAREAN SECTION

7.1 Roles and Responsibilities of Birth Attendees Prior to Category 3 Caesarean Section:

7.1.1 Obstetric Registrar

- Explain the decision to the woman and obtain written consent.
- The indication for emergency Caesarean section must be documented in the intrapartum notes.

7.1.2 Anaesthetist

- Pre-assess the woman
- Prescribe appropriate antacid treatment

7.1.3 Lead Midwife

To ensure that a midwife is allocated to caring for the woman if not being cared for already.

7.1.4 Midwife

To ensure that prior to the Caesarean

- CTG monitoring continues
- Complete pre-operative check list
- Assess VTE risk
- Measure and fit for Thromboembolic Deterrent- Ted stockings (TED) stockings
- 2 name bands in situ (wrist and ankle)
- Take bloods for Full Blood Count and Group and Save
- Remove jewellery/piercings
- Ensure Resuscitaire is checked and ready in theatre
- Transfer woman to theatre at appropriate time

Whilst In Theatre to

- Catheterise with urinary catheter, using instillagel
- Vaginal preparation before caesarean birth in women with ruptured membranes to reduce the risk of endometritis (use aqueous iodine) NICE 2021
- MRSA swabs to be taken
- Obtain paired cord gases
- Call for assistance from the Advanced Nurse Practitioner or paediatrician via bleep 6164

7.1.5 Anaesthetists

Whilst in theatre:
Administer, with consent, Prophylactic Antibiotics (Point 4.1).

After Caesarean Section

- To ensure thromboprophylaxis/analgesia prescribed
- Complete Caesarean section audit form

8. DOCUMENTATION

The operative details must be completed on Intrapartum operative notes in Maternity tab

9. IMMEDIATE/24 HOUR POST OPERATIVE CARE

Refer to guidelines:

- Post Anaesthetic Care within the Maternity Unit
- Postnatal care on the maternity unit

10. DEBRIEF

A review and debriefing of the women who have undergone surgery will be undertaken by the Senior Obstetrician on call. This would include discussion about events surrounding delivery, operative findings and its implications for future pregnancies. Discussion about mode of delivery for future pregnancies and Vaginal Birth After Caesarean section (VBAC) if eligible should take place before the woman is discharged home and appropriate follow up should be arranged. This must be clearly documented in the woman's postnatal notes.

11. AUDITABLE STANDARDS

A continuous audit is undertaken of this guideline and is included in the Maternity Audit Programme and is reviewed quarterly within the intrapartum forum. The guideline will be audited as a minimum, against the following standards.

- Classification of all caesarean sections documented in the intrapartum notes
- Classification and timings for all emergency Caesarean sections documented in the intrapartum notes
- Reason for performing Category 1 documented in the intrapartum notes by the person making the decision
- Consultant Obstetricians opinion is sought in the decision making process and this is documented in the intrapartum notes

- If any delay, reason for delay documented
- Prophylactic antibiotics and thromboprophylaxis prescribed and administered
- Appropriate care of the women in the first 24 hours
- Debrief undertaken and documented

When the audit has identified deficiencies, the actions will be monitored through the named meeting/Manager.

12 DEFINITIONS/ABBREVIATIONS (IF APPLICABLE)

Cardiotocography (CTG) is a technical means of recording (-graphy) the fetal heartbeat (cardio-) and the uterine contractions (-toco)
Instillagel- is an anaesthetic gel for use in catheterization
Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections in humans.
Oximetry- is a non-invasive method allowing the monitoring of the oxygenation of a patient's haemoglobin.
Puerperium- is the time immediately after the delivery of a baby.
Thromboprophylaxis- is the prevention of thromboembolic disease.
Venous thrombosis- is a blood clot (thrombus) that forms within a vein.
Venous thrombosis embolism (VTE) - is a disease that includes both deep vein thrombosis (DVT) and pulmonary embolism (PE).

13 REFERENCES

MBRACE-UK Report (2017): Saving Lives, Improving Mothers' Care Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2013–15.

NICE (2011) Caesarean section. Clinical Guideline 132

APPENDIX 1: MATERNITY EMERGENCY GROUP CALL

MATERNITY EMERGENCY GROUP CALL (This is for absolutely critical emergencies only)
Staff will telephone switchboard by using [redacted] and say " EMERGENCY"

- OBSTETRIC TEAM and NEONATAL TEAM.
- Obstetric team only
- Neonatal Team only

And give location by stating
"To go to ……."

OBSTETRIC TEAM consists of:

- Registrar Bleep [redacted]
- SHO Bleep [redacted]
- Anaesthetist Bleep [redacted]

- Lead midwife Bleep [redacted]
- Obstetric consultant [redacted]
- Scrub Nurse Bleep [redacted]
- ODP Bleep [redacted]
- Second Registrar Bleep [redacted]

NEONATAL TEAM consists of:

- Neonatal Registrar Bleep [redacted]
- Neonatal SHO Bleep [redacted]
- ANNP Bleep [redacted]

Switchboard will put out a group call to the relevant bleeps and state the location to which they need to attend.

For example - Obstetric Team to Obstetric theatre
Obstetric and neonatal team to obstetric theatre.
Obstetric Team to [redacted]
Neonatal team to [redacted]

Testing of the emergency group call system will be daily at 11.00 hrs. Switchboard will advise on the extension to ring when message received.

APPENDIX 2: CONSENT FOR CAESAREAN SECTION

- Written consent should be documented by an individual trained to perform the procedure or specifically trained to take consent for the procedure.
- Written consent should be taken for all emergency caesarean sections unless the delay in doing so would cause harm to the life of the mother or fetus in which case verbal consent may be appropriate. The reasons for verbal consent should be documented in the intra-partum notes.
- If a patient has already signed consent for an elective caesarean section and is admitted and needs to undergo an emergency caesarean before this date a new consent form should be signed.
- The consent form should include documentation of the risks of the procedure.
- Maternal risks should include
    - Abdominal pain post-operatively
    - Haemorrhage (5 in 1000 women)
    - Infection (6 in 100 women)
    - Venous Thromboembolism (4-16 in 10,000 women)
    - Injury to other organs (bladder injury 1 in 1000 or ureteric injury 3 in 10,000 women)
    - Increased risk in future pregnancies of uterine rupture, antepartum stillbirth (1-4 in 1000) and placenta praevia/accreta (4-8 in 1000).
- Fetal Risks
    - Fetal lacerations 2%
- Other Procedures which may become necessary during the procedure
    - Emergency hysterectomy (7 in 1000 women)
    - Return to theatre at a later date for further surgery (5 in 1000 women)
    - Blood Transfusion

The Dudley Group
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ESCALATION PROCEDURE FOR OPENING A SECOND EMERGENCY OBSTETRIC THEATRE GUIDELINE			
	DOCUMENT TITLE:	**ESCALATION PROCEDURE FOR OPENING A SECOND EMERGENCY OBSTETRIC THEATRE GUIDELINE**	
	Name of Originator/Author /Designation & Specialty:	[redacted] Consultant Anaesthetist	
	Local / Trust wide	Local	
	Statement of Intent:	To provide guidance on how to escalate when a second emergency obstetric theatre is required	
	Target Audience:	All Anaesthetic, Obstetric and Critical Care Medical staff. All midwifery staff. All anaesthetic ODPs and CEPOD theatre scrub staff. All switchboard operators.	
	Version:	3.0	
	Name of Review and Approval Group and Date when Recommended for Ratification	Virtual Consultation Intrapartum QPDT	November 2022
	Name of Division/Group and Date of Final Ratification:	Surgery Women and Children: GAMe	07/12/2022
	Review Date:	31/12/2025	
	Contributors:	None	
	The electronic version of this document is the definitive version		

CHANGE HISTORY

Version	Date	Reason
1.0	July 2016	*This is a new document*
2.0	July 2019	Updated and Reviewed
3.0	December 2022	Updated and Reviewed

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

ESCALATION PROCEDURE FOR OPENING A SECOND EMERGENCY OBSTETRIC THEATRE GUIDELINE

1. GUIDELINE SUMMARY

Current staffing levels provide sufficient cover for one emergency obstetric theatre, 24 hours a day, 7 days a week. On rare occasions, there may be two simultaneous obstetric emergencies, with both requiring theatre. In these circumstances it may be necessary to open a second emergency obstetric theatre. For such cases, there needs to be an agreed escalation policy for contacting staff in other areas to provide additional help.

2. GUIDELINE DETAIL

2.1 Understanding the Limitations of Second Obstetric Emergency Theatre Provision

It is extremely important that all clinicians involved in the management of labour ward understand the limitations surrounding the provision of a second emergency theatre team. These limitations are most pronounced during, but not limited to, the "out of hours" period, after 1700hrs on a weekday, and during all of Saturday, Sunday and bank holidays.

At no point in the week is there is currently a *dedicated* "second team" to staff an additional emergency obstetric theatre. Should a second theatre team be required, this may involve utilisation of staff from other areas of the hospital and/or calling staff in from home. The inevitable consequence of this is that there may be a time delay from the point at which a team is requested. Such a time delay may be clinically significant in an urgent situation. In addition, the temporary removal of staff from other clinical areas is in itself not without risk, as the team they are leaving becomes depleted.

With this in mind, the safest approach is for labour ward clinicians to manage the maternity patient workload, as though there is **no second team** immediately available. This escalation policy will then only apply should this strategy fail, making the activation of this pathway, **a last resort** to be used only in extremely urgent cases.

2.2 Halting the Elective Caesarean Section List

If there are two simultaneous obstetric emergencies, and there is a fully staffed elective obstetric theatre, then the elective team should undertake the second emergency, temporarily suspending the elective cases. This escalation policy is designed to address those times when there is no elective team – i.e., weekday afternoons, and all out-of-hours periods. **If there is an elective team available to do the second emergency, there is no need activate the pathway described below.**

2.3 How to Activate the Second Obstetric Emergency Theatre Team

The decision to activate the second team pathway should be made by the **on-call consultant obstetrician**. If the most senior obstetrician on site is a registrar or middle grade, they **must telephone their consultant** prior to activating the request for a second team.

Ideally, the discussion between on-site obstetrician and their consultant should happen as soon as it becomes apparent that two emergencies *might* coincide, as this will allow a plan to be formulated to deal with each patient in the safest way possible. Obstetric middle grade doctors are encouraged ask for the physical presence of their consultant if difficulties are expected. In these circumstances, there should also be a discussion with the obstetric anaesthetist so that they can be aware that there *might* be intercurrent emergencies, and they can begin to plan for appropriate anaesthetic cover.

Once the on-call consultant obstetrician has agreed to the activation of the second obstetric theatre team pathway, this should be communicated to the lead midwife on duty. The lead midwife will then call switchboard on 2222 and state "**Second** obstetric theatre team needed", with the emphasis being that the call is for a **second** team, not the main obstetric theatre team.

2.4 Who Will Be Contacted

Switchboard will then speech bleep the following bleep-holders, stating "**Second** obstetric theatre team needed".

Team member	Bleep No.
Theatre Manager, Main Theatres	[redacted]
CEPOD Theatre Scrub Practitioner	[redacted]
CEPOD Theatre ODP	[redacted]
CEPOD Theatre Anaesthetist	[redacted]
CEPOD Theatre Anaesthetic Consultant	[redacted]
Obstetric Anaesthetist	[redacted]
Obstetric ODP	[redacted]
Obstetric Anaesthetic Consultant	[redacted]
Obstetric Consultant	[redacted]
Obstetric Registrar 1	[redacted]
Obstetric Registrar 2	[redacted]
Obstetric SHO	[redacted]
Obstetric Scrub Practitioner	[redacted]
Intensive Care Registrar	[redacted]
Lead Midwife	[redacted]
"Starred" Anaesthetic Consultant	[redacted]

2.5 Individual Actions upon Activation of the Pathway

On receiving this speech bleep, the response of the individuals concerned will depend upon a number of factors, as discussed in detail below. It is recognised that not all of the above bleeps are held "around the clock". This is taken into account when allocating actions to the various bleep holders.

2.6 Theatre Manager – Bleep 5032

In Hours (0800-1600 Monday-Friday)	Out of Hours (all other times)
CEPOD theatre working • Immediately go to CEPOD theatre, theatre 1, and recovery to assess the availability of scrub practitioners and ODPs • Identify any staff who are performing non-clinical duties • From the above, redeploy a scrub practitioner and anaesthetic ODP to obstetric theatres ASAP • If **no team available**, please inform lead midwife straight away on **bleep** [redacted]	
CEPOD theatre not working • Immediately liaise with CEPOD theatre scrub practitioner and ODP at the main theatre reception desk • Liaise with the theatre 1 team • From the above, redeploy a scrub practitioner and anaesthetic ODP to obstetric theatres ASAP • If possible, also identify and redeploy a CSW to obstetric theatres	

2.7 CEPOD theatre Scrub Practitioner / Anaesthetic ODP – Bleeps [redacted] & [redacted]

In Hours (0800-1600 Monday-Friday)	Out of Hours (all other times)
CEPOD theatre working • Continue with case, and await further instructions from theatre manager	**CEPOD theatre working** • One of the team to contact lead midwife on **bleep** [redacted] immediately – inform them that the CEPOD theatre team, including the CEPOD theatre anaesthetist, is **not available**. If possible, give the midwife an idea of when the team will become free • Consider what other lists are currently occurring within the theatre complex. If safe to do so, consider temporarily halting another list in order to redeploy theatre staff and an anaesthetist to obstetric theatres

CEPOD theatre not working
 	
• Attend main theatre reception desk immediately and liaise with theatre manager
• Likely to be either:
  ○ sent to obstetric theatres immediately, or
  ○ redeployed to theatre 1 to allow their staff to attend obstetric theatres
	CEPOD theatre not working
	
	• Attend obstetric theatre ASAP
	• Make a judgement regarding upcoming CEPOD theatre work
	  ○ Do not delay in preparing for a case which is imminent and very urgent (e.g. ruptured AAA). In this case, proceed as if CEPOD theatre were working
	  ○ It is appropriate to stop sending for a less urgent case (e.g. I&D abscess), to enable you to attend obstetric theatres ASAP
	• The emphasis is on attending obstetric theatres if at all possible, providing that it is safe to do so

2.8 CEPOD theatre Anaesthetist – Bleep [redacted]

In Hours (0800-1700 Monday-Friday)	Out of Hours (all other times)
CEPOD theatre working • No immediate action required, other than to be aware of the situation	**CEPOD theatre working** • You, **or** the ODP, **or** the scrub practitioner, to contact lead midwife on **bleep** [redacted] immediately – inform them that the team is **not available**. If possible, give the midwife an idea of when the team will become free

CEPOD theatre not working
 	
• Be aware of the situation
• Call obstetric theatre 1 on Ext [redacted] and ask if you can be of any assistance
	CEPOD theatre not working
	
	• Attend obstetric theatre 1 ASAP
	• Make a judgement regarding upcoming CEPOD theatre work
	  ○ Do not delay in preparing for a case which is imminent and very urgent (e.g., ruptured AAA). In this case, proceed as if CEPOD theatre were working
	  ○ It is appropriate to stop sending for a less urgent case (e.g., I&D abscess), to enable you to attend obstetric theatres ASAP
	• The emphasis is on attending obstetric theatres if at all possible, providing that it is safe to do so, irrespective of whether or not you are an obstetric anaesthetist.
	• **Obstetric anaesthetist?**
	  ○ Liaise with the designated obstetric anaesthetist and help as requested. This may involve taking over case 1, or assessing/anaesthetising case 2. Remember not to anaesthetise a patient until you have an ODP available
	• **Non obstetric anaesthetist?**
	  ○ Liaise with the obstetric anaesthetist and help as able. ***This may include sitting with case 1***. This is acceptable, providing **all** the following are true: baby out / uterine tone good / no on-going bleeding / maternal observations stable / on call consultant anaesthetist on their way in.
	  ○ Contact the obstetric anaesthetist in the next-door theatre if you have any queries whatsoever about the patient's management. Do not administer drugs with which you are unfamiliar, without first taking instruction from the obstetric anaesthetist. The obstetric anaesthetist should not go anywhere else except obstetric theatre 2, whilst a non-obstetric anaesthetist is sitting with a patient in obstetric theatre 1.
	  ○ The consultant anaesthetist will be on their way in, having been contacted by the on-site obstetric anaesthetist

2.9 Obstetric Anaesthetist – Bleep [redacted]

In Hours (0800-1700 Monday-Friday)	Out of Hours (all other times)
• The consultant obstetric anaesthetist on duty will allocate anaesthetic personnel as they see appropriate. • It is likely that you will either continue with the first case, or go and assess the second case ready for theatre.	• You will know that a second obstetric emergency has occurred via a speech bleep. Continue looking after your theatre case. • The lead midwife will attend obstetric theatre 1 with details of the second emergency. They will inform you if the CEPOD theatre team (including the anaesthetist) have declared themselves to be currently unavailable. • Critical care junior 1 should make every effort to attend obstetric theatre 1 if they are free. If necessary, then may need to hand over care of the ITU to critical care junior 2, so long as this is deemed appropriate by the clinicians at the time. • It may be that both the ITU and CEPOD theatre anaesthetists attend. Use your professional judgement to allocate tasks appropriately, and within the skillset of the individuals concerned. • It is **your responsibility** to telephone the on-call consultant anaesthetist and ask them to attend the hospital. • It is acceptable for a non-obstetric anaesthetist (e.g. CT1) to sit with the first case, whilst you start the second case. This is only acceptable in a true emergency, providing **all** of the following are true: Baby out / Uterine tone good / No on-going bleeding / Maternal observations stable / On call consultant on their way in. • If a non-obstetric anaesthetist is left sitting with a case in obstetric theatre 1, then you **must not** go anywhere else except obstetric theatre 2. Offer guidance as required to the anaesthetist in theatre 1. Advise them not to administer any drugs with which they are not familiar without first checking with you. • Remember not to anaesthetise the second case until there is an anaesthetist with the first case, **and** you have an ODP available for each patient • If the call turns out to be a "false alarm", please contact the on-call consultant anaesthetist and let them know they are longer required to attend.

2.10 Critical Care Junior 1 – Bleep [redacted]

In Hours (0800-1700 Monday-Friday)	Out of Hours (all other times)
	• Assess the ICU and decide if it is safe to leave Critical Junior 2 in charge for a short time. • Please make every effort to attend obstetric theatre ASAP. Meet with the obstetric anaesthetist in obs theatre 1, and they will give you details of the second emergency case. You can either sit with case 1, or assess/anaesthetise case 2. The obstetric anaesthetist will allocate tasks as appropriate • If you are able to attend, please do so, **even if you are not an obstetric anaesthetist**. It is acceptable for a non-obstetric anaesthetist to sit with the first case, whilst the obstetric anaesthetist starts the second case. This is acceptable in a true emergency, providing **all** the following are true: Baby out / Uterine tone good / No on-going bleeding / Maternal observations stable / On call consultant anaesthetist on their way in • Do not begin to anaesthetise the second case until you have an ODP and scrub practitioner available • If you are **unable** to attend, please phone obstetric theatre 1 on **ext** [redacted] at the first possible opportunity to state that you cannot attend. If you are so busy that you cannot make this call, please delegate the task of phoning to another member of staff

2.11 Obstetric ODP – Bleep [redacted]

In Hours (0800-1700 Monday-Friday)	Out of Hours (all other times)
• The consultant obstetric anaesthetist on duty will allocate anaesthetic personnel as they see appropriate. • It is likely that you will continue with the first case, and a second ODP will be found to help with the second case	• You will know that a second obstetric emergency has occurred via a speech bleep. Continue looking after your theatre case. • The lead midwife will attend obstetric theatre 1 with details of the second case. They will inform you if the CEPOD theatre team (including the anaesthetist) have declared themselves to be currently unavailable. • If safe to do so, make some preparations for the second case e.g: run through a drip, check the drug cupboards are open, check the spinal trolley. • It is the responsibility of the obstetric anaesthetist to call the on-call consultant anaesthetist and ask them to come in • Other anaesthetists on duty may attend if they are able to do so. • It is acceptable for a non-obstetric anaesthetist (e.g., CT1) to sit with the first case, whilst the obstetric anaesthetist starts the second case. This is acceptable in a true emergency, providing **all** of the following are true: Baby out / Uterine tone good / No on-going bleeding / Maternal observations stable. • If a non-obstetric anaesthetist is sitting with the first case, the obstetric anaesthetist will not go anywhere else apart from obstetric theatre 2. You may need to liaise between the less experienced anaesthetist and their more experienced colleague in the next-door theatre. • Each anaesthetist must have an ODP prior to commencing the anaesthetic. Use your professional judgement to decide which ODP should work with which anaesthetist (e.g., the **more** experienced ODP could decide to stay with the **least** experienced anaesthetist)

2.12 Lead Midwife – Bleep [redacted]

In Hours (0800-1700 Monday-Friday)	Out of Hours (all other times)
• The instruction of the consultant obstetrician triggers the second obstetric theatre team pathway • Once decision confirmed, dial [redacted] - State "**Second** Obstetric Theatre Team needed" • Main theatres will endeavour to send appropriate personnel ASAP, but depending on workload, this cannot be guaranteed – if they are not able to provide cover, they will contact you on the [redacted] bleep • As soon as possible after putting out the [redacted] call, meet with the anaesthetist in obstetric theatre 1. Take a patient sticker with you with details of the second case. • Anaesthetic cover ought not be an issue in normal working hours, and the anaesthetic registrar and consultant anaesthetist will already know via their bleeps • The consultant obstetrician will have been involved in decision-making, so will already know about the case • Complete a Datix form when safe to do so	• The instruction of the consultant obstetrician on call triggers the second obstetric theatre team pathway. The obstetric middle-grade **must** discuss with their consultant on the telephone prior to activation of the pathway. • Once decision confirmed, dial [redacted] – State "**Second** Obstetric Theatre Team needed urgently" • Main theatres will try their best to help, but if CEPOD theatre is working, they will not be able to provide staff. If they are **not** able to provide cover, **they will contact you via the [redacted] bleep**. If this occurs, phone switchboard ask them to begin ringing staff at home to come in urgently • As soon as possible after putting out the [redacted] call, meet with the anaesthetist in obstetric theatre 1. Take a patient sticker with you with details of the second case. If CEPOD theatre have informed you that they are working, relay this information to the anaesthetist, as this confirms to them that the CEPOD theatre anaesthetist is currently unavailable as well • The on-site obstetric anaesthetist will contact the on-call consultant anaesthetist and ask them to come into the hospital. • Complete a Datix form when safe to do so

2.13 Consultant Obstetric Anaesthetist – Bleep 8941

In Hours (0800-1700 Monday-Friday)	Out of Hours (all other times)
• Manage situation and anaesthetic personnel as is deemed appropriate • Main theatres will have been informed by speech bleep and will be organising a second team ASAP. If they cannot provide a team, they will contact lead midwife on bleep [redacted] • Lead midwife will attend obstetric theatre 1 with patient details for the second case • Consultant obstetrician will already be aware of the case, as they will have made the decision to activate the second obstetric theatre team pathway • CEPOD theatre anaesthetic trainee will ○ Know that a second team has been requested ○ Call obstetric theatre 1 on ext [redacted] (if they are free) and enquire if they can be of assistance • CEPOD theatre consultant anaesthetist will ○ Know that a second team has been requested ○ Be contactable on bleep [redacted] if required	

2.14 CEPOD theatre Consultant Anaesthetist – Bleep [redacted] / Phone via switchboard

In Hours (0800-1700 Monday-Friday)	Out of Hours (all other times)
• You will be aware that a second obstetric theatre team has been requested, via a speech bleep • The main theatres manager will have been informed by speech bleep and will be organising a second team ASAP. • After liaising with the theatre manager, consider **temporarily** suspending work in CEPOD theatre (e.g. postpone sending for a minor case) if this is the only way of providing a second obstetric theatre team. Can only be done if feasible (i.e. between cases) • If possible, and safe to do so, consider allowing CEPOD theatre anaesthetic trainee to attend obstetric theatres • You may be contacted by the consultant obstetric anaesthetist if they need urgent assistance	• Upon activation of the second team pathway, the on-site obstetric anaesthetist will phone you and ask that you make your way into the hospital.

2.15 Obstetric Registrars & SHO – Bleeps 7809, 7140 & 7019

In Hours (0800-1700 Monday-Friday)	Out of Hours (all other times)
• Senior obstetricians will know about the case as they will have been involved in the decision-making process • The consultant obstetrician will make the decision to request a second emergency obstetric theatre team • At least some of the obstetricians will be, by definition, in obstetric theatre 1. They will all receive the speech bleep to ensure that all team members are aware what is going on. • Obstetricians in theatre 1 to reallocate personnel as appropriate (e.g. if baby out in theatre 1, might be appropriate to send the assisting SHO to help start the second case)	• Senior obstetricians will know about the case as they will have been involved in the decision-making process • **The consultant obstetrician on call must be telephoned**, and they are responsible for the decision to request a second emergency obstetric theatre team • At least some of the obstetricians will be, by definition, in obstetric theatre 1. They will all receive the speech bleep to ensure that all team members are aware what is going on. • Obstetricians in theatre 1 to reallocate personnel as appropriate (e.g. if baby out in theatre 1, might be appropriate to send the assisting SHO to help start the second case)

2.16 Switchboard Operators

Putting out the emergency speech bleep call
• [redacted] call from lead midwife stating "**Second** obstetric theatre team needed urgently" • Speech bleep out to the group of pre-determined bleeps • Please note this is a different emergency call to the usual "Obstetric theatre team" call, with different personnel being contacted. Midwives making the call will know to emphasise they are asking for a **second** team

3. DEFINITIONS

List and describe the meaning of any terms/abbreviations used in the context of the document.

CD: Clinical Director
CSL: Clinical Service Lead
ODP: Operating Department Practitioner
Obstetric Competent Anaesthetist: Anaesthetic doctor in training, who has successfully completed at least 3 months of training in obstetric anaesthesia

CSW: Clinical Support Worker

4. TRAINING/SUPPORT

All existing staff will receive information about the Escalation policy. New staff will have information provided to them during their departmental induction.

MATERNITY ESCALATION STANDARD OPERATING PROCEDURE			
	DOCUMENT TITLE:	**MATERNITY ESCALATION STANDARD OPERATING PROCEDURE**	
	Name of Originator/Author /Designation & Specialty:	[redacted] – Head of Midwifery [redacted] - Matron	
	Local / Trust-wide	Maternity	
	Statement of Intent:	To provide staff with a clear process for managing the maternity service at times of staffing and/or capacity compromises.	
	Target Audience:	Midwifery, Obstetrics and Neonatal.	
	Version:	15.0	
	Name of Group and Date when Recommended for Ratification	Maternity Governance Group	Date: 09/11/23
	Name of Division and Date of Final Ratification:	Surgery, Women and Children – GAMe	Date: 22/11/2023
	Review Date:	30/11/2026	
	Contributors: ***Individuals involved in developing the document.***	**Designation:** Head of Midwifery Matrons Deputy Matron Lead Midwives	
	The electronic version of this document is the definitive version		

CHANGE HISTORY

Version	Date	Reason
1.0	January 2000	Created New guideline
2.0	April 2003	Adapted and reviewed
3.0	March 2005	Adapted and reviewed
4.0	November 2005	Adapted and reviewed
5.0	August 2006	Adapted and reviewed
6.0	April 2007	Adapted and reviewed
7.0	December 2010	Adapted and reviewed
8.0	November 2011	Adapted and reviewed
9.0	July 2013	Adapted and reviewed
10.0	January 2014	Minor Amendments Agreed at January 31st Policy Group, previous ratification dates apply
11.0	February 2015	Minor amendments
12.0	June 2016	Minor amendments
13.0	October 2016	Full Review – conversion from policy to Standard Operating Procedure
14.0	May 2019	Adapted and reviewed taking into account Senior Midwifery

		on call.
15.0	November 2023	Full review of document.

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

THE DUDLEY GROUP NHS FOUNDATION TRUST

MATERNITY ESCALATION STANDARD OPERATING PROCEDURE

1. STANDARD OPERATING PROCEDURE

1.1. STANDARD OPERATING PROCEDURE SUMMARY

In the event that appropriate staffing levels cannot be achieved, or activity levels become increased various actions are necessary to avoid the compromise of patient safety.

The need for immediate action must be taken by the Lead Midwife in charge of the unit/department in assessment of workload and any potential or 'real' threat to patient safety.

Head of Midwifery, Senior medical staff, Matron, Deputy Matrons, Lead Midwives and ward managers should be involved in agreeing plans to manage escalation to prevent an adverse occurrence.

'Safe staffing' is constituted by the approved number of staff on-duty with the required skill mix to provide effective care for the dependency /complexity of women and babies and those who are expected (booked) to present for care at any given time.

'Safe' staffing numbers for each shift are determined by the acuity tool

'Safe capacity' is represented by having available a suitable environment to be able to provide safe and effective care. This involves the consideration of dignity and privacy for the women and babies and the availability of the appropriate equipment and space.

2. ESCALATION PROCEDURE DETAIL

2.1. Action to Address Midwifery Staffing Compromise

In the event that the Lead Midwife in charge of the unit/department assesses the midwifery staffing levels as **inadequate for the workload** the following action should be taken.

The Ward Manager /Lead Midwife's action:

- Ensure appropriate allocation of staff to each woman determined by her complexity and need

- Liaise with the Lead Midwife (or their deputy) from other maternity areas i.e. the maternity unit, maternity outpatients or community midwifery, to request moving staff to the busy department.
- Stop any unnecessary duties.
- Inform and discuss with Deputy Matron/ Matron or on call Matron/Site co-ordinator (out of hours), and request support to secure additional staff, this may include:
  - Recall staff from study leave, time owing in lieu (TOIL) or non- clinical days
  - Request support from specialist midwives
  - Secure additional staff from staff bank.

2.2. Action to Address Capacity Compromise

In the event that the Lead Midwife in charge of the unit/department assesses the capacity as compromised the following action should be taken.

The Ward Manager /Lead Midwife's action;

- Assess current workload and in liaison with medical colleagues, take steps to safely reduce workload e.g. review and discharge women and babies who are fit, assess transitional care babies for suitability to transfer to NNU or Children's ward
- Review expected/anticipated workload; secure a case-by-case medical review of any elective admission i.e. women awaiting induction of labour or elective Caesarean section

2.3. Action to Maintain Safety

The Ward Manager /Lead Midwife's action*:*

- Reassess and prioritise the clinical workload and staff allocation
- Continue to secure additional staff as required
- Continue to appraise Deputy Matron/ Matron/Head of Midwifery or on-call Maternity Manager
- In conjunction with the on-call Consultant Obstetrician:
  - Continue to review women awaiting induction of labour/elective Caesarean section to ensure intervention is made to high-risk pregnancies only
  - Secure medical approval to safely defer any procedure until the capacity/staffing situation improves
  - Ensure the neonatal team are aware of the circumstances which may preclude accepting Intrapartum and/or neonatal transfers
  - Contact the Paediatric Consultant / Registrar to ensure all babies having transitional care or under paediatric care are reviewed for possible transfer home or to the NNU
  - Alert the obstetric theatre and anaesthetic team
  - Consider transfer to nearby units for appropriate women when necessary

- Ensure that any antenatal women having postponed care e.g. induction of labour is reviewed and referred as required e.g. to the pregnancy day assessment unit for review
- Consider suspension of the services and discuss 'potential' request to divert with the neighbouring units
- Any women who have been prioritised as clinically safe but refuses postponed care should be offered transfer to another unit when this option is available. Agreement to accept the transfer of care must be made by Senior Midwife/Senior Obstetrician to Senior Midwife/Senior Obstetrician in the accepting unit
- Complete DATIX electronic incident system and 'Record of Contingency Plans for Capacity/Staffing Compromise on the Maternity Unit' form **(Appendix 1)**
- Assess the escalation level and inform of any change to the Capacity Team

2.4. Unexpected Medical Staff Absence

When unexpected **Obstetric** medical staff absence occurs the Consultant on call for the Delivery Suite is informed and the medical staff rota is rescheduled to release staff from other clinical duties to provide cover for the Delivery Suite. Out of hours the on-call Consultant will attend to ensure safe medical staffing is maintained.

When unexpected **Anaesthetic** medical staff absence occurs the Consultant on for the Obstetric Anaesthetics is informed and the staff rota is rescheduled to release appropriate staff from other clinical duties to provide cover for the Delivery Suite

In exceptional circumstances medical staff may be asked to work additional hours or locum staff used to provide cover

The Clinical Director must be informed of any unresolved difficulties and a Datix incident form completed

3. ESCALATION LEVELS WITHIN MATERNITY SERVICES

3.1. LEVEL 1 - GREEN

Maternity services are fully operational with normal patient flow and appropriate staffing levels

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3.1.1. The Ward Managers/ Lead Midwife's action:

- Monitor activity
- Monitor staffing levels and skill mix

- Maintain effective and efficient practice to reduce the likelihood of escalation
- The member of the Capacity team or Clinical Site Coordinators (CSC) will contact the Lead Midwife for an escalation update at 8:00 hours,12:00, 16:00 hours and 22:00 hours daily
- At ***any*** other point when a change in escalation level occurs the Lead midwife will inform the Capacity Team or CSC:
    - In hours (08.00 - 22.00) call the capacity team - Ext [redacted]
    - Out of Hours call the CSC - Bleep [redacted]

- The escalation level of the Maternity Unit is displayed on the Trust Hub.
- Daily Regional Maternity Sitrep

3.2. LEVEL 2 - AMBER

Early signs of capacity/staffing compromise requiring additional management support.

3.2.1. The Ward Manager/ Lead Midwife's action:

Ensure all points from 3.1.1 including informing and escalation to senior staff, have been followed for when staffing and capacity has been compromised.

3.2.2. Out of hours inform:

- The CSC (Bleep[redacted] via switchboard), request they:
    - Attend the maternity unit, when required, to provide support to the Lead Midwife e.g. calling other units
    - Update the HUB escalation level
- When any care is delayed the woman and her family are kept informed and updated on the situation at all times and this is documented in the clinical notes on Sunrise
- Continue to assess, appraise and liaise with the multidisciplinary team
- Decline any request from neighbouring units to accept transfer of care

3.2.3. When all possible systems and processes have been undertaken to address the situation, if a capacity/staffing problem continues and there is a strong expectancy that services need to be suspended the Lead Midwife must facilitate:

- Contact neighbouring maternity units to request the 'opportunity' to divert appropriate women on a case-by-case basis, delegating to another senior member of staff or Site Coordinator (out of hours) as needed.
- All units able to 'accept' are documented for future reference and recorded on the 'Record of Contingency Plans for Capacity/Staffing Compromise on the Maternity Unit' form (**Appendix 1**)

Local maternity units - telephone contact numbers:

- **City Hospital**
  Dudley Road Birmingham B18 7QH [redacted] (Labour ward)
- **The Royal Wolverhampton Hospitals NHS Trust**
  Wednesfield Road, Wolverhampton, WV10 0QP [redacted] (Labour ward)
- **Worcester Royal Hospital**
  Charles Hastings Way, Worcester, WR5 1DD [redacted] (Labour ward)
- **Walsall Manor Hospital**
  Moat Road, Walsall WS2 9PS
  (Labour ward)
  [redacted] Ext: [redacted]
- **Birmingham Women's Hospital**
  Metchley Park Road, Birmingham, B15 2TG [redacted] (Labour ward)

3.3. LEVEL 3 – RED (suspended service, CAN divert)

Serious capacity/staffing compromise requiring service suspension with **DIVERT POSSIBLE**

In the event that patient safety cannot be secured, the decision for suspending the service must be considered. This is an extreme measure and should not be undertaken without due consideration of the implications and risk factors for women and only when all other potential solutions have been exhausted.

3.3.1. The Lead Midwife's action:

Follow points in 3.1.1 and in addition:

- **IN HOURS** - Ensure the decision to 'suspend services' has been jointly made with HOM, Matron/deputy Matron and clinical director and / or on call consultant;
- Escalate via the daily Regional Maternity Sit rep for support to divert
- Inform site co-ordinator who will;
  - Inform the Ambulance service - [redacted]
  - Inform Emergency Department (ED) (extension [redacted])
  - Update the HUB escalation level

- **OUT OF HOURS** - Ensure the decision to 'suspend services' has been jointly made with the on-call Consultant and discussed with the on-call maternity manager who informs the on-call Trust on Call Manager, and a joint decision will be made as to whether escalation to Exec on call is required
- Request that the Obstetric Consultants considers the transfer of women with delayed procedures e.g. those awaiting induction of labour; to an accepting unit. Agreement to accept the transfer of care must be made by

Senior Midwife/Senior Obstetrician to Senior Midwife/Senior Obstetrician in the accepting unit

- Continue to liaise with the Lead Community Midwife and discuss potential increase in community triaging for suitable women (**in Hours**) and possible staffing support if required in the unit
- Ensure the Triage Midwife effectively triages women who call and gives appropriate advice with details of care, i.e. advise to stay at home and provide advice, arrange Community Midwife visit at home for Dudley resident women (ensuring lone worker safety), or inform of referral to another unit. In this event the Triage midwife will then:
- Contact the accepting unit with details on a case-by-case basis and confirm transfer
- Call back women with the agreed plan of transfer, ensuring that if more than one unit is able to accept the woman's choice and her home address is considered when diverting to another unit
- Provide details of the address, postcode and contact number of the accepting hospital
- Ensure women are never asked to contact another Maternity Unit themselves
- Continue to complete 'Record of Contingency Plans for Capacity/Staffing Compromise on the Maternity Unit' form (**Appendix 1**)
- Complete DATIX electronic incident system:
- Complete Maternity unit daily escalation report

4. DE-ESCALATION

4.1. Lead Midwife Action: Once de-escalation is declared the unit should be declared as reopened as soon as possible.

- Declare as reopened to Capacity team or Site Coordinator who will:
- Inform West Midlands Ambulance service
- Inform ED
- Update the HUB
- Ensure the incident and 'Record of Contingency Plans for Capacity/Staffing Compromise on the Maternity Unit' form is complete and placed in the folder in Matron's office.

4.2. Matron/ Deputy Matron Action:

- Inform the CCG at the time of declaring service suspension (in hours), or on the next office day (out of hours), by sending an email to [redacted] the email should provide the following detail:
  - The date and time of service suspension
  - The duration in hours
  - The reason
  - The number of women transferred to another unit as a result of the service suspension

This email should be copied to the Directorate Information Officer for transfer to the Dashboard

- Receive all 'Record of Contingency Plans for Capacity/Staffing Compromise on the Maternity Unit' forms
- Checks the clinical outcome for all women who have been diverted to other units
- Undertakes a review and comparison with DATIX incidents updating with outcome information
- Ensures information department are informed for completion of dashboard
- Compiles a report for discussion at the Maternity Risk meeting

5. WHEN THE SITUATION ESCALATES AND OTHER UNITS ARE UNABLE TO ACCEPT TRANSFERS FOLLOW POINT 5.1

5.1. LEVEL 4 - RED (suspended service but CANNOT divert)

Serious capacity/staffing compromise requiring 'suspension of services' but UNABLE TO DIVERT,

If neighbouring units are unable to accept and the situation remains unresolved the following action should be taken to ensure available resources are managed effectively:

5.1.1. The Lead Midwife's action:

Follow point 3.1.1 & 3.3.1 and in addition:

- Ensure all available beds on the Unit are used and implement unit physical changes:
- Reduce Triage beds to Room 2 only
- Secure extra beds from the Trust bed store when required by contacting the Site co-ordinator (Bleep [redacted]). If Trust extra beds are unavailable, Out of Hours only, use beds from Pregnancy Day Assessment Unit as an exception
- Temporarily accommodate two postnatal or antenatal women in one Labour Delivery Recovery Postnatal room, using screens for maintaining privacy and ensuring a call bell can be accessed by both women. These women must be physically mobile and be able to effectively communicate. **Ensure women are assessed and the move is fully informed before room share is implemented**
- When an unexpected emergency admission presents requiring urgent medical attention, the use of the Obstetric theatre complex must be considered when no other alternative is available. This decision must be made in liaison with the Consultant Obstetrician and Anaesthetist.
- Continue to liaise with the Lead Community Midwife and assess the option of suspension of the homebirth service - **this decision should only be made in extreme circumstances and when the suspension would alleviate the problem**

- Continue to complete 'Record of Contingency Plans for Capacity/Staffing Compromise on the Maternity Unit' form (**Appendix 1**)
- Continue to liaise with neighbouring Trusts
- Complete DATIX electronic incident system:
- Record escalation on Maternity Unit Daily escalation report (**Appendix 2**) at start of each shift

5.2. De-escalation

Lead Midwife Action: follow point **4.1**
Matron/deputy Matron Action: follow point **4.2**

TO ADD: CANCELLATION OF HOMEBIRTH SERVICE DUE TO AMBULANCE RESPONSE TIMES- ALSO TO BE INCL. IN HB GUIDELINE/SOP

6. DEFINITIONS/ABBREVIATIONS

6.1. Record of Contingency – a proforma developed to capture the information

.

7. DUTIES (RESPONSIBILITIES)

7.1. Ward Manager/Lead Midwife – it is the Lead Midwives responsibility to ensure that they fully understand and can effectively implement the process outlined in this guideline.

7.2. Obstetrician, Anaesthetist & Paediatrician (in and out of hours) - it is the responsibility of these groups of staff to ensure that they are fully familiar with the process outlined in this guideline and support the effective implementation.

7.3. Deputy Matron/ Matron or on call Matron/Site Co-ordinator/on-call Manager/on-call Director (out of hours) – it is the responsibility of this staff group to ensure they provide support and undertake any action required to achieve effective implementation.

7.4. Head of Midwifery/Clinical Director – it is the responsibilities of these individuals to provide support and undertake any action required to achieve effective implementation. To review the effectiveness of the approved guideline by ensuring the monitoring process is embedded.

8. TRAINING/SUPPORT

There is no formal training for this procedure, all senior staff are expected to be fully familiarised with the contents and ensure they adopt the process when required. If you identify any training needs, please contact the Specialist Midwife – Practice Development.

9. LINKED PROCEDURAL DOCUMENTS

[redacted]

10. PROCESS FOR MONITORING COMPLIANCE

	Lead	Tool	Frequency	Reporting Arrangements	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
Monthly Dashboard Report	Matron/ Clinical director	Dashboard	Monthly	Matron receives and analyses all 'Record of Contingency Plans for Capacity/Staffing Compromise on the Maternity Unit' making comparison with DATIX incidents and informs this data to the Dashboard, discussed at the Maternity Performance meeting, escalating any concerns to the Maternity Quality and governance meeting	Senior Midwife Team/ Clinical Director	Changes and action is disseminated through the Lead midwives and Clinical Director, information provided in staff communication CHATTER/via email/staffing meetings
Midwife staffing 'Red Flags'	Matron	Matron audit of maternity unit daily escalation report	Monthly	Senior Midwife meeting, escalated to Senior nurse team/Chief Nurse	Head of Midwifery	Action documented on the daily escalation report, discussed and monitored at Senior Midwife meeting; action/changes implemented/escalated

APPENDIX 1

RECORD OF CONTINGENCY PLANS FOR CAPACITY/STAFFING COMPROMISE ON THE MATERNITY UNIT

Date: **Time:**

Unit Contacted	Time	Accept: Yes/No	Signature/Comment	Time	Accept: Yes/No	Signature/Comment
City Hospital B18 7QH [redacted]						
Wolverhampton New Cross Hospital WV10 0EN [redacted]						
Worcester Royal Hospital WR5 1DD [redacted]						
Walsall Manor Hospital WS2 9PS [redacted]						
Birmingham Women's Hospital B15 2TG [redacted]						
Other:						

Tick box applicable: ☐ **Level 3 - Staffing** ☐ **Level 3 - Capacity**

☐ **Level 4 - Staffing** ☐ **Level 4 – Capacity**

Iident Form/DATIX Number: .....

Directorate Team	Time Informed	Attendance/Absence (reason)
Clinical Director/Consultant on call		
Head of Midwifery		
Matron/Deputy Matron		
General Manager/Deputy GM		

Date and Time CCG informed by Matron/Deputy Matron	

Date and time of de-escalation	

TRIAGE MIDWIFE
Details of women diverted

Name Unit Number or Address & Date of Birth	Date/ Time	Reason for Divert	Unit Diverted to	Outcome

TRIAGE MIDWIFE: Name/signature:……..

LEAD MIDWIFE: Name/signature:……..

Submit this form to Matron

……

Matron Use ONLY:
Checked with DATIX ☐ ☐

The Dudley Group
NHS Foundation Trust

OBSTETRIC ANAESTHETIC STAFFING GUIDELINE		
	DOCUMENT TITLE:	**OBSTETRIC ANAESTHETIC STAFFING GUIDELINE**
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	Local/Trust Wide	Local
	Statement of intent	To ensure safe obstetric staffing is available particularly during peak annual leave periods
	Target Audience:	Anaesthetic staff and Anaesthetic practitioners
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	Contributors:	Consultant Anaesthetist – [redacted]
	The electronic version of this document is the definitive version.	

CHANGE HISTORY

Version	Date	Reason
1	September 2010	Document created
2	September 2012	Adapted and reviewed against CNST standards
3	September 2015	Full Review
4	December 2015	Amendment to section 2.1.1
5	Januruay 2018	Full Review

A translation service is available for this document. The Interpretation/Translation Policy, Guidance for Staff is located on the intranet under Trust-wide Policies.

THE DUDLEY GROUP NHS FOUNDATION TRUST

OBSTETRIC ANAESTHETIC STAFFING GUIDELINE

1. GUIDELINE

1.1. Guideline Summary

"Anaesthetists are an integral part of the maternity team and a lead obstetric anaesthetist is an essential requirement in the provision of safe services. In addition, an anaesthetics Consultant and Registrar as well as appropriate operating department practitioner (ODP) support, should be on duty in an obstetric unit 24 hours a day.

Pain relief should be made available to women who want it and obstetric units must be able to provide regional anaesthesia on request at all times. There should be timely referral to doctors for women choosing epidural analgesia. The anaesthetic team's response time is crucial during emergencies and appropriate planning is needed to manage the response to elective procedures and to detect postoperative complications." (RCOG, 2013, p.4)

Requirements around staffing levels for professionals involved in the provision of care to women and their babies are detailed in the recommendations of Safer Childbirth (RCOG, 2007, p.27). Where the recommended numbers of staff are not in place, business and contingency plans should be implemented and their effectiveness monitored in order to manage the situation (NHSLA, 2013)

2. REQUIRED STAFFING LEVELS

2.1. Minimum Staffing Levels for Obstetric Anaesthetists

There should be an anaesthetic consultant presence on the Obstetric Unit for at least 40 hours a week. This equates to ten consultant-programmed activities or sessions per week, to allow full 'working hours' consultant cover. (RCOG, 2007, p.35)

There should be 24-hour availability of a duty anaesthetist for obstetrics who should not, in addition, be responsible for the intensive care unit or other anaesthetic duties.The duty anaesthetist must have access to prompt advice and assistance from a designated consultant anaesthetist whenever required.

2.1.1. Obstetric Anaesthetic Cover on the Obstetric Unit

Consultant-level cover during office hours (10 sessions per week) is provided by resident Anaesthetic Consultants with an interest in obstetric anaesthesia. Consultants are present on the Obstetric Unit for 50 hours per week. At other times there is an on call Consultant (non resident). During weekdays, Consultants Changeover times for cover are 08:00 and 18:00hrs. At weekends the changeover time is 08:00hrs.

In addition to consultant cover, resident cover is provided 24 hours per day, 7 days per week, by staff grade doctors or doctors in training who have achieved the required competencies to enable them to undertake the full range of obstetric procedures. They have no other responsibilities other than working on the Obstetric Unit. There is also a resident anaesthetist working in general theatres and on ITU, who may be able to provide support if required.

On weekdays and weekends Trainee / Staff grade changeover times are at 08.00 and 20.00 hrs.

2.1.2. Elective Caesarean Section List

There are elective Caesarean sections daily. The elective Caesarean section cases are covered by a consultant anaesthetist and supervised anaesthetic trainees. On 5 mornings each week there is an independent elective caesarean section list running as well as the emergency theatre, and extra staff are used for this list. These are covered by a dedicated consultant anaesthetist or an anaesthetic trainee with obstetric competencies in the presence of a consultant anaesthetist. There is a dedicated anaesthetic assistant and theatre team. The staff have no other responsibilities except the elective theatre list on these days.

2.1.3. Opening Of The Second Theatre

On occasions, the second obstetric theatre need to be used for an emergency whilst the other obstetric theatre is in use. In office hours, there are always at least two anaesthetists on the Obstetric unit, so this theatre can be covered. Out of hours, the anaesthetist covering ITU or theatres is called for assistance. If they are not available, the consultant anaesthetist is contacted and attends. There are action cards available for all oncall tier team and the instructions to follow are written and this information is reiterated to the team during departmental induction meeting.There is a separate guidelines about opening of a second obstetric theatre escalation procedure.Obstetric second theatre escalation policy SOP

Anaesthetic trainees are placed regularly on the maternity unit for training in obstetric anaesthesia at basic, intermediate, higher and advanced levels.

An antenatal anaesthetic clinic for high risk patients runs on Monday afternoons in the maternity outpatients and this is covered by a separate consultant anaesthetist.

2.2. Minimum Staffing Levels for Anaesthetic Practitioners

Cover is available 24 hours a day by designated staff qualified to provide anaesthetic assistance. Staff are on the 'Theatre ODP' rota designated to cover the Obstetric Unit on a particular shift. There is one anaesthetic practitioner rostered for the Obstetric theatres per shift.

An extra anaesthetic practitioner is rostered for the independent elective lists.

On occasions, the second obstetric theatre needs to be used for an emergency whilst the other obstetric theatre is in use. In office hours, the main theatre department is contacted and the emergency team responds to cover this theatre. If they are not available, an anaesthetic practitioner and theatre staff are released from other duties to attend the obstetric theatre. Out of hours, the main theatre emergency team is called for assistance and for this area are replaced by staff brought in from home.

2.3. Annual Review

The numbers of sessions not covered by a consultant is monitored continuously by the Lead Anaesthetist for Obstetric theatres. An annual audit is conducted at the completion of each financial year using the Anaesthetic medical staffing rotas by the Lead Obstetric Anaesthetist. This is to establish

whether anaesthetic cover is in line with Safer Childbirth recommendations. This is reported at the Directorate Anaesthetic meetings. Staffing levels are reviewed by the Medical Service Head for Anaesthetics to ensure that targets contained in Safer Childbirth (RCOG, 2007) are met. Identified shortfalls are discussed at directorate meetings and business cases are produced as appropriate.

An annual audit will also be conducted to determine if anaesthetic practitioner staffing levels are in line with the maternity services requirement.

Monitoring compliance will be through the Directorate Management Board where the review of the results and implementation and monitoring of business take place. The Medical Service Head of Anaesthetics will take the results to these meetings.

2.4. Business Planning to Address Staffing Shortfalls

When staffing shortfalls have been identified a business case will be written and presented to the Trust Management Executive.

3. CONTINGENCY PLANNING TO ADDRESS SHORT TERM STAFFING SHORTFALLS

3.1. Obstetric Anaesthetists

All absence is reported, monitored and managed as per the Trust's Sickness Absence Policy by the directorate.

3.1.1. Action to be taken in the event of unexpected shortfall during office hours

In case of unexpected shortfall during office hours a Consultant Anaesthetist or staff Grade/Specialist Registrar qualified to cover Obstetrics will be asked to take over obstetric cover.

3.1.2. Action to be taken in the event of unexpected shortfall of anaesthetic staff outside office hours

In case of unexpected shortfalls of anaesthetic staff outside office hours, the Consultant Anaesthetist on-call will be contacted and they will arrange a replacement Consultant and trainee.

3.2. Anaesthetic Practitioner

3.2.1. In Office Hours

In the case of unexpected shortfall in office hours, the theatre duty manager would contact and organise an appropriate member of staff to be reallocated from main theatres to cover the Obstetric Unit.

3.2.2. Out Of Hours

In the case of unexpected shortfall outside office hours the senior member of the theatre on-call team will obtain a substitute either from staff in other areas of the main theatres and then call in staff from home as required.

An incident form must be completed if there are any staffing shortfalls that impact on patient care.

4. CONTINGENCY PLANNING TO ADDRESS ONGOING STAFFING SHORTFALLS

4.1. Obstetric Anaesthetists

Duty rotas are prepared by the anaesthetic department in line with Trust Annual/Study Leave policies Senior Medical Leave Policy/ Study Leave Policy to enable an even distribution of staff at all times. If areas of shortfall are identified in discussion with the lead obstetric anaesthetist, appropriate action is taken, that is locum cover arranged.

Shortages, e.g. through sickness or special leave, may be covered with locum staff if the shift cannot be covered through redistribution of remaining staff.

4.2. Anaesthetic Practitioner

For the anaesthetic practitioners, duty rotas are prepared by the Acting Specialist Manager in line with Trust Senior Medical Leave Policy/ Study Leave Policy to enable an even distribution of staff at all times. If areas of shortfalls are identified, anaesthetic assistants from main theatres are re-deployed to obstetrics. The staff moved from main theatres are replaced by bank staff or agency. Agency staff do not cover obstetrics.

5. AUDITABLE STANDARDS

Annual audit of Obstetric Anaesthetist and Anaesthetic Practitioner staffing levels and associated contingency plans will be undertaken. The audits will be part of the Maternity Audit Programme. The audit will include as a minimum:

- Role of Obstetric Anaesthetists
- Role of Obstetric Anaesthetic Practitioner
- Obstetric anaesthetic staffing for the Obstetric Theatres
- Obstetric anaesthetic practitioner staffing for Obstetric Theatres
- Contingency plans to address ongoing shortfalls
- Contingency plans to address short term staffing shortfalls
- Development of a business case as required

When the audit has identified deficiencies the action plans will be monitored through the named meeting/manager.

6. DEFINITIONS

ODP – Operating Department Practitioners

7. DUTIES (RESPONSIBILITIES)

7.1. Obstetric Anaesthetists

The role of anaesthetists in obstetrics has changed over the years, such that anaesthetists are now involved in some way or another in the care of about 50% of the women who enter the obstetric labour ward. Epidural analgesia during labour has become an expectation of many women and it is now used by almost one quarter of women. Anaesthetists are an integral part of the obstetric team and in the management of women who become seriously ill.

7.1.1. Lead Obstetric Anaesthetist

The lead obstetric anaesthetist takes responsibility for all aspects of the clinical services and is responsible for the organisation and audit of the service, for maintaining and raising standards through provision of evidence based guidelines, for providing anaesthetic input to the labour ward forum and for training and risk management.

7.2. Role of Anaesthetic Practitioner in the Obstetric Unit

There should be a suitably-trained senior member of either nursing or operating department practitioner staff who has overall responsibility for the safe running of obstetric theatres and ensures that current standards in all aspects of theatre work are met. The anaesthetic team's response time should be such that a Caesarean section may be started within a time appropriate to the clinical condition. This requires all the team members to be informed of the case appropriately.

"Trained recovery staff should be in constant attendance for at least 30 minutes after the procedure or until discharge criteria are met". (RCOG, 2007, p.35)

8. TRAINING/SUPPORT

No specific training is required for this guideline.

9. LINKED PROCEDURAL DOCUMENTS

Sickness Absence Policy
Senior Medical Leave Policy
Study Leave Policy
Second Obstetric Theatre Escalation policy

10. REFERENCES

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11. PROCESS FOR MONITORING COMPLIANCE

	Lead	Tool	Frequency	Reporting arrangements and monitoring of action plans	Acting on recommendations and Lead(s)	Change in practice and lessons to be shared
All Anaesthetist, and Theatre Staff to adhere to this guideline	Consultant Obstetric Anaesthetist	Datix Incident reporting system	Continuous	General Managers, Clinical Directors Women and Childrens' Clinical Governance/ Risk Management Team Meetings Anaesthetist Management Team Meeting	Women and Childrens' Clinical Governance/ Risk Management Team Meetings Anaesthetist Management Team Meeting Directorate Anaesthetic Meeting Maternity Theatre Team Meetings	Lessons learnt and any changes in practice will be communicated via • Email • Memos • Posters • Anaesthetic newsletter Training
		Annual Audit	Annually			