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| Meeting Title | Board of Directors |             |            |
| Date          | 20.01.22           | Agenda item | Bo.1.22.23 |

## MATERNITY INCENTIVE SCHEME – SAFETY ACTION 4

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|---|--|----------|--|
| Presented by                            | Dr Ray Smith, Chief Medical Officer  |          |  |
| Author                                  | Dr Carolyn Robertson, Clinical Director Women's Clinical Business Unit (CBU)   |          |  |
| Lead Director                           | Dr Ray Smith, Chief Medical Officer  |          |  |
| Purpose of the paper                    | Safety action 4: To demonstrate an effective system of Obstetric medical workforce planning to the required standard |          |  |
| Key control                             | Paper requires acknowledgement and sign off at Trust board   |          |  |
| Action required                         | To note  |          |  |
| Previously discussed at/<br>informed by | Details of any consultation  |          |  |
| Previously approved at:                 | Academy/Group  | Date     |  |
|   | People Academy   | 24.11.21 |  |
|   |  |          |  |

### Key Options, Issues and Risks

The purpose of the paper is to demonstrate an effective system of Consultant Obstetric clinical workforce planning at Bradford Royal Infirmary to meet the required standard for safety action 4 of the Maternity Incentive Scheme Year 4.

The Trust Board is required to sign this document off by acknowledging the Women's CBU engagement with the Royal College of Obstetrician and Gynaecologist (RCOG) document (Appendix 1) along with an action plan (see recommendations) for any non-attendance to the clinical situations listed in the document (Appendix 1, pages 13 and 14 for ease of reference).

### Analysis

An audit of consultant attendance for clinical situations was conducted through October 2021. This was a prospective audit and only the Clinical Director and a senior Obstetric trainee were aware of the audit being undertaken.

Audit data for October 2021 demonstrates (see Appendix 2):

- 50 Obstetric cases were taken to theatre at night.
- 100% of cases were discussed with the consultant on-call prior to theatre.
- 12 cases/24% required a consultant to be present according to the 'MUST' attend list provided in the document Roles and Responsibilities of a Consultant (Appendix 1).
- The Consultant on-call attended in person in 28% cases (14 cases).

Reasons for attendance (See Appendix 2 audit findings):

- Trial of instrumental +/- CAT 1 = 6
- 2nd theatre = 1
- Pathological CTG = 5
- Preterm delivery <28 weeks = 1
- PPH > 2 L = 1

Overall a consultant was present in all clinical situations when a consultant should have been present with the exception of 3 trials of instrumental delivery when the consultant was not present for the case but

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all were conducted by ST7 trainees with the skills and expertise to perform these cases alone and with evidence of competence in their log books.

Other notable good practice points:

- Night-time safety debrief sessions at 2000 were always attended by the on-call night Obstetric consultant along with the midwife coordinators, day and night team registrars +FOC.
- Good communication and discussion with on-call consultant and on-call night registrar with 100% involvement in decision making and discussions regarding case management plans.
- Consultant presence in theatre for all cases when requested by the Night Registrar and/or by the midwife Co-ordinators.

### Recommendation

Overall the audit demonstrates good compliance and adherence to the Roles and Responsibilities of a Consultant document from the RCOG and meets the requirements for compliance with Safety action 4 of the Maternity Incentive Scheme Year 4.

These findings and audit will be shared at a Quality and Safety Governance meeting in Obstetrics and Gynaecology in the near future.

Having documentary evidence of the conversation between the registrar on-call and the consultant on-call regarding capabilities and entrust ability for all levels for procedures. This needs formalising and embedding in practice.

Registrars will be requested to document their conversations with the on-call consultant clearly in the patient notes or procedure notes and reasons for calling them in or not.

Consultants attending in the night are requested to document their presence in the patient notes or Medway/Electronic Patient Record (EPR) that they have attended the call and the reasons for attendance.

When opening a second theatre at night this should be a direct trigger for the on-call Obstetric consultant to make his/her way into the hospital.

### Risk assessment

| Strategic Objective                                       | Appetite (G) |         |          |      |      |        |
|---|--------------|---------|----------|------|------|--------|
|   | Avoid        | Minimal | Cautious | Open | Seek | Mature |
| To provide outstanding care for patients                  |              |         | g        |      |      |        |
| To deliver our financial plan and key performance targets |              |         | g        |      |      |        |
| To be in the top 20% of NHS employers                     |              |         |          |      | g    |        |
| To be a continually learning organisation                 |              |         |          | g    |      |        |
| To collaborate effectively with local and                 |              |         |          |      | g    |        |

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| regional partners  |                 |                 |             |                    |  |
| The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes. | <b>Low</b>      | <b>Moderate</b> | <b>High</b> | <b>Significant</b> |  |
| <b>Explanation of variance from Board of Directors Agreed General risk appetite (G)</b>  | <b>Risk (*)</b> |                 |             |                    |  |

|   |                                     |                                     |                          |
|---|-------------------------------------|-------------------------------------|--------------------------|
| <b>Benchmarking implications (see section 4 for details)</b>  | <b>Yes</b>                          | <b>No</b>                           | <b>N/A</b>               |
| Is there Model Hospital data relevant to the content of this paper?   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Is there any other national benchmarking data relevant to the content of this paper?                            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper? | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

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|---|-------------------------------------|-------------------------------------|
| <b>Risk Implications (see section 5 for details)</b>                | <b>Yes</b>                          | <b>No</b>                           |
| Corporate Risk register and/or Board Assurance Framework Amendments | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Quality implications  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            |
| Resource implications   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Legal/regulatory implications                                       | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Diversity and Inclusion implications                                | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |
| Performance Implications  | <input type="checkbox"/>            | <input checked="" type="checkbox"/> |

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| <b>Regulation, Legislation and Compliance relevance</b>   |
| <b>NHS Improvement: (please tick those that are relevant)</b>   |
| <input type="checkbox"/> Risk Assessment Framework <input checked="" type="checkbox"/> Quality Governance Framework<br><input type="checkbox"/> Code of Governance <input type="checkbox"/> Annual Reporting Manual |
| <b>Care Quality Commission Domain:</b> Choose an item.  |
| <b>Care Quality Commission Fundamental Standard:</b> Choose an item.  |
| <b>NHS Improvement Effective Use of Resources:</b> Choose an item.  |
| <b>Other (please state):</b> Maternity Incentive Scheme Year 4  |

| Relevance to other Board of Director's academies: (please select all that apply) |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|
| People   | Quality                  | Finance & Performance    | Other (please state)     |
| <input checked="" type="checkbox"/>  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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## 1 PURPOSE/ AIM

The purpose of the paper is to demonstrate an effective system of Obstetric clinical workforce planning at Bradford Royal Infirmary to meet the required standard for safety action 4 of the Maternity Incentive Scheme Year 4.

The Trust Board is required to sign off by acknowledging the Women's CBU team's engagement with the RCOG document (Appendix 1) along with an action plan (recommendations) for any non-attendance to the clinical situations listed in the document (Appendix 2 for ease of reference).

## 2 BACKGROUND/CONTEXT

The Obstetrics and Gynaecology consultant workforce in the Women's CBU consists of 20 Consultant Obstetricians and Gynaecologists and two locums. There is one Consultant Obstetrician and three Consultant Gynaecologists.

We provide 98 hours of consultant resident labour ward cover every week.

All consultant shifts are covered and there is never a gap.

Four consultant -led labour ward ward rounds are conducted daily and this is embedded in practise.

From April 2020 the consultant on-call for the night shift will arrive in the unit at 1700 and is resident in the unit until 2200. One individual would cover Obstetrics and Gynaecology conducting a ward round on labour ward at 1700 and 2000 and they would then leave the unit at 2200 if safe to do so. There is a recognised list of clinical scenarios (Appendix 2) where the consultant on-call is required to attend or of course if requested to attend by the junior medical staff or midwifery co-ordinators on shift.

From 1 November 2021 the rota has been split so that one consultant covers Obstetrics out of hours from 1700 (arriving at 1700 with a rest day following the night on-call) and another consultant colleague will cover acute Gynaecology from 1700 (having been present in the unit all day and also working the following day). This measure was put in place to address concerns about patient safety, complexity of patients, split site working with Obstetrics and acute Gynaecology sited in different buildings and clinical scenarios occurring simultaneously in both specialities requiring a consultant presence to support the junior medical staff.

For safety action 4 of the Maternity Incentive Scheme evidence of the provision of consultant cover and presence for certain clinical scenarios as set out in the roles and responsibilities document (Appendix 1), an audit has been conducted during October 2021 with 50 Obstetric theatre cases demonstrating compliance with this (Appendix 2).

## 3 PROPOSAL

This paper needs to be signed off by the Trust Board/ People Academy on 24 November 2021. The deadline to demonstrate that sign off has been achieved is by January 2022.

A rolling monthly audit will be required from January 2022 to demonstrate on-going compliance. Deadline for reporting to NHS Resolution using a Board declaration form by 30 June 2022.

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| <b>4</b> | <b>BENCHMARKING IMPLICATIONS</b> |
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There is no model hospital data.

All Obstetrics and Gynaecology units are expected to demonstrate compliance with the RCOG Roles and Responsibilities of a Consultant document (Appendix 1).

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| <b>5</b> | <b>RISK ASSESSMENT</b> |
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Recognition and sign-off at Trust Board level that we have an appropriate medical Obstetric workforce by January 2022. (Self certification by Trust Board).

Deadline for reporting to NHS Resolution using a Board declaration form by 30 June 2022.

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| <b>6</b> | <b>RECOMMENDATIONS</b> |
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A log of documentary evidence of the conversation between the registrar on-call and the consultant on-call regarding capabilities and entrust ability for all levels for procedures. This needs introducing and embedding more formally.

Registrars will be requested to document their conversations with the on-call consultant clearly on the patient notes or procedure notes and reasons for calling them in or not.

Consultants attending in the night are requested to document their presence in the patient notes or Medway/EPR that they have attended the call and the reasons for attendance.

When opening a second theatre at night this should be a direct trigger for the on-call Obstetric consultant to make his/her way into the hospital.

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| <b>7</b> | <b>Appendices</b> |
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Appendix 1- RCOG Roles and Responsibilities of a Consultant.

Appendix 2 - Audit data and presentation October 2021.