Risk Assessment

<table>
<tr><td colspan="4">Risk title: Obstetrics and Gynaecology Medical staffing (3816)</td></tr>
<tr><td>Summarise from the description below:</td><td colspan="3">Obstetrics and Gynaecology Medical staffing is not sufficient to meet the needs of the service.</td></tr>
<tr><td>Risk description:</td><td>CAUSE</td><td>EVENT</td><td>EFFECT</td><td>Risk location:</td></tr>
<tr><td rowspan="2">Include any relevant background information to provide context of why the risk is being assessed:</td><td>IF……..we are unable to release clinical staff for mandatory training due to staffing levels</td><td>THEN……..staff will not receive compulsory training in relation to resuscitation or blood safety</td><td>RESULTING IN……..an increased safety risk to patients</td><td rowspan="2">Womens CSU</td></tr>
<tr><td colspan="3">Due to the sheer workload being delivered by the consultant medical staff within O+G, there is a significant burden of sessions being delivered on top of job planned activity. At times we are struggling to cover acute clinical sessions in Obstetrics and acute Gynaecology.

3 consultant gaps currently contributing to the issues:
• Gynae oncology lead appointed but still not in post
• Funded Obstetric only consultant post not been successful in recruiting to
• Locum consultant within the unit achieved a substantive post due to a colleague leaving- locum remains empty and recent round of recruitment – only x1 applicant who was not suitable for interview</td></tr>
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Assessment:				
Identify the hazards - Think about what may cause harm (these are called hazards).	**Assess the potential for harm -** Who might be harmed and how?	**Existing control measures -** Indicate what is currently in place to control the hazard.	**Gaps in control measures -** Why are the existing control measures inadequate?	**Further controls required -** What further action could you take to control the hazards/ potential cause of harm?
Example: *We are unable to release clinical staff for mandatory training due to staffing levels*	*Patients may be put at risk of harm if staff are not up to date with mandatory training resulting in avoidable harm*	*Managers informed on a weekly basis of non-compliant staff to prioritise their release to complete the training*	*Staff may not be able to be released at the time of the scheduled training sessions*	*Devise alternative ways to deliver the training; for example, by video or in the ward/department by clinical leads*
Identify the hazards	**Assess the potential for harm**	**Existing control measures**	**Gaps in control measures**	**Further controls required**
1. Output of work delivered by the consultant medical staff within the CSU far exceeds the job plans	Staff burn out resulting in increased risk of sickness and absence	Rota consultants having to find cover for on average > 100 clinical sessions/ month	Consultants have used all their flexi in their job plan	• Prioritise Cover for acute service • Do not cover: OP hysto, General Gynae clinics, Urogynae clinics, Repro med clinics, Gynae theatres
2. Gynaecology Oncology Lead consultant not yet in post	Staff burn out resulting in increased risk of sickness and absence Another consultant having to cover this work as well as own job plan which is increased stress for this individual.	Another consultant colleague with Gynaecology oncology experience and surgical skills covering the workload Aspects of her job plan (Obstetrics being covered	Recruited early July 2022 Delays with HR processes confirming start date. Still no start date	Occupational health clearance required DBS check required

		by other colleagues)		CER continues to chase HR regarding a start date
3. Gynaecology OOH on call rota commenced Nov 2021.	Staff burn out resulting in increased risk of sickness and absence Extra burden on consultant medical staff delivering over night and weekend Gynae on call cover additional to their job plans	13 consultants take part in this rota which is additional for those who cover Obstetrics and Gynaecology (11 out of 13 cover both) Take down clinical activity eg clinics when done overnight on call but we also have so many clinics to deliver / year and pressures to improve the WL back log for clinic patients	Occasional night for Gynae not covered OOH	Awaiting value of a Gynae night on call in terms of PAs from HR so this can be written in and included in the consultant job plans Diary exercise submitted to HR around 1 year ago Plan to insert Gynae acute weeks into the rolling rota to share them out and reduce number of acute sessions requiring cover each week- also need PAs for the Gynae acute weeks
4. Significant clinical backlogs in:- Outpatients: **Total waiting list 3294** 200 patients > 40 weeks of which	Staff burn out resulting in increased risk of sickness and absence Further delays in seeing patients on waiting lists	New consultant locum to tackle some of the general Gynae and Urogynae WL in particular new patients OP Hysteroscopy Outsourcing to Westcliffe	Sheer demand on consultant cover Consultant led GOPD OP Hysteroscopy to meet 2WW	Back logs will grow if consultants are not willing to do extra sessions

54> 52 weeks • **General Gynae: 591** awaiting F/up, 237 overdue, News booking at 6 weeks with medinet F2F •**Urogynae 827** awaiting f/up (including nurse f/up), 300 overdue , NEWS currently booking at 10 weeks •**Vulval 262** awaiting f/up,78 overdue NEWS currently booking at 12 weeks •**Reproductive medicine 426** awaiting f/up (212 overdue) News booking at 3 weeks (menopause patients booking at 20 weeks)General GOPD **OP Hysteroscopy** (476 waiting to be booked at Westcliffe and further 58 FUs awaiting slots at BR/ WWP) **In patient Waiting list for theatres** **494** waiting/listed but not treated as yet 1. 28 > 52 weeks		performing procedures at Eccleshill hospital until end of March 2023 Consultants picking up extra lists week and weekend (>17 in October on top of the lists (31) we had already covered Medinet locums doing locum weekend gynaecology clinics seen around 1200 patients to date. 43% discharged from 1st appointment	In patient WL Cover for all acute areas (in Oct 7 sessions not covered without taking elective gynae theatres down) Consultant cover in MAC/ ANDU- only 3.5 PAs of job planned time each week Request for Urogynae clinic and theatre support at AGH A number of consultants have signed the BMA letter relating to not doing extra sessions and work on top of their job plans unless paid at the BMA rate but the trust does not accept these rates and has locally agreed rates Strong feeling amongst the consultant body against using these Medinet locums due to patients being listed under an existing BRI consultant who has never seen them, inappropriate	Discussion with CBU and trust management team about how we manage this or stop the use of Medinet for Gynaecology clinics entirely which will cause greater increases in the WL

			management plans, worries and concern about the quality of the consultation and the poor patient experience which could affect Bradford's reputation of giving good and safe care to women requiring Gynaecology input	

Current/Initial Risk Score

(Current/initial risk score assessed at the time the risk assessment is undertaken)

Consequence		Likelihood		Total score
3	X	5	=	15

It is almost certain that workload will need to be covered by Consultants picking up additional work outside of their job plans. This is having a moderate impact on staff wellbeing and pressure to fill the gaps on the rota to ensure the acute workload is covered as a minimum.

Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Actions Required: add more lines as required

Action – develop actions to address the further controls required.	**Responsible Lead** – who needs to carry out the action	**Expected date for completion**
1. Cover acute service and insert hot Gynae weeks into rolling consultant rota which is currently being delivered as extra to job plans	CER/ASM/CMR	January 2023

2. Include Gynae hot weeks in the job plans and ensure no clinical session affected by OOH on call work and required rest time	CER/ HA	January 2023
3. Confirm a start date with HR for the Gynaecology Oncology Lead	Alyson Coatsworth	October 2022
4. Stop use of Medinet for Gynaecology Clinics due to poor patient experience and concerns regarding clinical safety but this will not improve the waiting list (separate risk assessment required)	CER/ HA/ CT/ CMR	October 2022
5. Advertise for Obstetric only consultant with Maternal Medicine interest	CER/ NS	February 2023
6. Allow Workload to grow for non -urgent Gynaecology waiting lists which will allow the acute to be covered within existing job plans	CER/ HA	
7. Further discussions with the trust regarding local pay rates v BMA rate for extra sessions worked as this will increase the pickup extra work by the existing consultant body.	CER	November 2022

Residual Risk Score (This is the risk score once all mitigation has been actioned and adequate control measures are in place)

Consequence		Likelihood		Total score
3	X	1	=	3

Consequence	Likelihood				
	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
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4 Major	4	8	12	16	20
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Risk Assessment Owners	
Risk Assessment Lead: For example, Ward manager/Matron/CBU lead/Speciality Lead.	Carolyn Robertson – Clinical Director for Women's Services
Risk Assessment created by:	Carolyn Robertson – Clinical Director for Women's Services
Date:	11/10/2022