Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

Good Practice No. 10
January 2010

LABOUR WARD SOLUTIONS

1. Purpose

This document is aimed mainly at those responsible for implementing the Royal College of Obstetricians and Gynaecologists and Clinical Negligence Scheme for Trusts (CNST) maternity standards. It highlights the many challenges and issues that arise from the process of expanding consultant presence on the labour ward and presents facts, helpful tips and potential pitfalls that may be encountered by those responsible for implementing changes.

2. Background

Safer Childbirth[1] and *Standards in Maternity Care*[2] have clearly stated that one of the main principles for the provision of safe maternity services is that intrapartum care should be provided by appropriately trained individuals. Colleagues working in different parts of the country have used innovative ways of achieving some of the targets for consultant on-site presence in the labour ward. In response to repeated requests for advice, the College held a workshop on 17 March 2009 to examine models developed in different parts of the country to meet these objectives. These individual examples were examined carefully for features that enabled compliance with *Safer Childbirth*[1] and this guidance is based on the information collated for and presented at the workshop. It summarises the key messages of the day, describing what is required for the implementation of 40, 60 and 98 hours of prospective consultant presence on the labour ward.

3. Standards

The number of hours of consultant presence on the labour ward as set out in *Safer Childbirth*[1] and required by the NHS Litigation Authority[3] are in broad terms greater in units that undertake more births (Table 1). The hours of consultant presence should be spread as evenly as possible throughout the working day to ensure that the times of increased consultant presence are used appropriately.

Table 1. Hours of consultant presence on the labour ward

Category	Definition (births/year)	Consultant presence (year of adoption)			Specialist trainees (*n*)
		60-hour	98-hour	168-hour	
A	< 2500	Units to continually review staffing to ensure adequate based on local needs			1
B	2500–4000	2009	–	–	2
C1	4000–5000	2008	2009	–	3
C2	5000–6000	Immediate	2008	2010	
C3	> 6000	Immediate	Immediate if possible	2008	

The RCOG would not recommend a pattern of work where the hours are 'used up' in large blocks of 24-hour resident on-call in units aiming for 60 or 98 hours of presence.

The RCOG believes that we should have a consultant-delivered service irrespective of where it is delivered or whether in a small or large unit. However, in acknowledging that this is not deliverable at present, the RCOG published the above standards as an interim measure. It also published Good Practice No. 8: *Responsibility of a Consultant on-call*.[4]

4. Terminology

To provide clarity, the terms 'births', 'consultant' and 'consultant presence' are defined here:

Births	The number of births a unit is responsible for in a year, including deliveries in co-located/stand-alone midwifery-led birthing units and home deliveries.
Consultant	Those appointed to a consultant post, including those doctors on the specialist register holding a Certificate of Completion of Specialist Training, providing labour ward cover on a sessional basis.
Prospective consultant presence	All consultant presence described in this document should be covered prospectively; that is, if a consultant has a timetabled regular session then there should be robust and demonstrable means to cover this at times of prearranged leave. This can be achieved by pairing consultants in teams who are strictly responsible for covering particular day of the week.

5. Expanding consultant presence: practical aspects

5.1 Roles

Consultant labour ward roles should be considered to be additional to junior doctors at most times. The provision of additional consultant time on the labour ward is to ensure that doctors in training are fully supported to maximise training opportunities. Furthermore, consultants will be involved in patient care directly and in enhancing quality of care.

An expected consequence of the recruitment of consultants to posts with a major commitment to obstetrics may be that they are filled with more newly appointed consultants. It is important that these posts are designed to demonstrate a degree of role progression and a sense of leadership. Other possible roles in addition to labour ward roles include: labour ward management support for risk management liaison with other staff groups education and training.

5.2 Rotas

Key principles:

1. Standard rate programmed activities (PAs) are from 7am to 7pm, approximately 12 hours (4 hours/PA, total 3 PAs).
2. Premium rate PAs are from 7pm to 7am, approximately 12 hours (3 hours/PA, total 4 PAs).
3. Rotas should have times for regular team ward rounds that fit in with the timings of midwifery handovers as per local requirements.
4. Many units use a system of 'hot' weeks (or days) where a consultant is allocated periods in advance that are part of a semi-fixed rota. These provide better continuity for both patients and trainees. Such arrangements require cancellation or alternative cover of commitments. Such interim arrangements are often effective for small to medium-sized units.

5. Some units have divided the departmental consultants into smaller teams (team of the day) who are strictly responsible for covering particular days of the week. This is an effective way of ensuring adequate prospective cover during holiday periods.

6. Some units have rostered resident consultants on-call at night, together with foundation or year 1 or 2 specialist trainees. This releases senior trainees for daytime elective surgical training opportunities.

7. Roles and responsibilities of the covering consultant must be agreed locally and must be clearly available to other healthcare professionals.[4]

8. If compensatory rest is negotiated into contracts then it should be taken immediately after periods of work, if possible, to compensate for tiredness. It would be inappropriate to pool rest into long periods of additional leave without taking most of it after working unsociable hours.

9. To help trust management to appreciate unit workload and numbers of doctors on duty, it may be appropriate to demonstrate the use of staff with a process similar to a British Medical Association junior doctors monitoring exercise or possibly with data from an external agency.

5.3 Calculation of hours

In calculating the required hours, it is important to first calculate the unit's existing labour ward commitment using a diary exercise (Table 2). It is then easier to calculate the additional PAs required to increase the labour

Table 2. Suggested work patterns (for units planning 48–98 hours of cover)

Hours	Mon	Tue	Wed	Thu	Fri	Sat	Sun
40	9am to 5pm	9am to 5pm	9am to 5pm	9am to 5pm	9am to 5pm	On-call after rounds	On-call after rounds
60 (example 1)	8am to 6pm	8am to 6pm	8am to 6pm	8am to 6pm	8am to 6pm	9am to 2pm	9am to 2pm
60 (example 2)	8am to 8pm	8am to 8pm	8am to 8pm	8am to 8pm	8am to 8pm	On-call after rounds	On-call after rounds
98 (example 1)	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm
98 (example 2)	24-hour starts 8am	24-hour starts 8am	8am to 10pm	8am to 10pm	8am to 10pm	9am to 1pm	9am to 1pm

NOTE: In **smaller units** where formal ward rounds at weekends do not routinely take much time, it would be inappropriate to count this time as consultant presence. In **larger units** where such rounds take long periods of time and are often punctuated with urgent labour ward work, it is appropriate to consider this work as consultant presence.

Table 3. Example PA calculations for prospective consultant presence

Consultant presence	Additional PAs required/week
40-hour non-prospective to 40-hour prospective	2.38
40-hour prospective to 60-hour prospective	7.23
40-hour prospective to 98-hour prospective	22.40

Table 4. Total PAs required to achieve 40 hours of prospective on-site consultant presence[a]

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Work time	9am to 5pm	9am to 5pm	9am to 5pm	9am to 5pm	9am to 5pm	0	0
Standard PAs	2	2	2	2	2	0	0

[a] 12.38 PAs/week (calculated using a 42-week year/consultant)

Table 5. Total PAs required to achieve 60 hours of prospective on-site consultant presence[a]

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Work time	8am to 6pm	8am to 6pm	8am to 6pm	8am to 6pm	8am to 6pm	9am to 2pm	9am to 2pm
Standard PAs	2.5	2.5	2.5	2.5	2.5	0	0
Premium PAs	0	0	0	0	0	1.67	1.67

[a] 19.61 PAs/week (calculated using a 42-week year/consultant)

Table 6. Total PAs required to achieve 98 hours of prospective on-site consultant presence[a]

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Work time	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm	8am to 10pm
Standard PAs	2.75	2.75	2.75	2.75	2.75	0	0
Premium PAs	1	1	1	1	1	4.67	4.67

[a] 34.78 PAs/week (calculated using a 42-week year/consultant)

ward presence (Tables 3–6; **Note:** the presented figures in all these examples are hours required and not suggested shift patterns, which will need to be separately designed).

6. The workforce

To plan an increase in consultant numbers, clinical directors will need to:

- ensure that expanding the consultant presence on the delivery suite does not lead to an overall adverse impact on other services, such as the provision of elective gynaecology activity
- demonstrate to the trust management the number of PAs currently provided by consultants (funded establishment) and the number of additional PAs required to increase delivery suite presence to the target level.[1] In these negotiations, the trust will also need to be aware that the new posts will also attract PAs for supporting professional activities
- consider redistribution of workload from incumbent consultants to new posts
- design appropriate jobs that will attract candidates
- be as open and transparent as possible during the process
- involve other appropriate members of the consultant team.

7. Contractual and job planning considerations

7.1 Existing consultants

- Offer changes in working patterns which could improve work–life balance.
- Suggest a more flexible working style.
- Meet regularly, consider the use of an independent facilitator.
- Reinforce that they will be paid for what they do.
- Be aware of the impact of changes on sessions outside the trust setting.
- Make sure that all job plans are up-to-date at the time of business plan.

7.2 New appointments

- Job plans should include flexibility as a backbone of their design.
- Illustrative timetables that include late evening working and the possibility of 24-hour working in the future.
- Avoid 'fixed session' style job plans; consider annualised job plans.
- Describe the number of sessions required per week in each role that the job entails.

7.3 Funding

7.3.1 Business case

The trust management will require a business case to be written, which should highlight the benefits to the trust other than improved labour ward presence; for example:

- improved flexibility
- leave cover
- better coverage of special interest areas
- achieving higher CNST levels
- improved risk management
- as part of solution to address challenges of WTD compliance
- better training and supervision.[4,5]

7.3.2 Potential risks to the trust

- Cost of expansion if funds are not provided by the primary care trust.
- Potential impact on delivery of elective work if the expansion of consultant presence is not accompanied by employment of more consultants.
- Unlikely to achieve appropriate CNST level (if not already in place at the time of CNST inspection; you will need at least a business case with a definitive timeframe for implementation to meet their requirements).

7.3.3 Potential sources of funding

- Changes in intensity payments.
- Existing consultants reducing other commitments with an expansion of consultant numbers may increase PAs.
- Bidding for funding from the primary care trust.

7.4 Recruitment

To aid recruitment:

- job plans should adhere to national terms and conditions and to the RCOG template
- consider more attractive on-call accommodation options
- be more active in encouraging job share and part-time working
- emphasise flexibility in job designs
- be aware of the needs of doctors in training
- demonstrate a supportive environment with mentorship facilities
- show potential for improved work–life balance by using compensatory rest to increase days off
- encourage the development of special interests.

In areas where recruitment is particularly difficult, trusts may have to consider enhanced payments to attract suitable applicants and such payments may also need to be offered to consultants already in post.

7.5 Governance

With major changes in the consultant establishment, it is likely that there will be changes in relationships within units and it is important to observe closely the following:

- adverse impact on the functioning of the unit
- attendance of consultants at labour ward sessions[4]
- the performance of consultants returning to out-of-hours work[5]
- maintenance of practical skills in consultants may also require attention, especially if they return to labour ward practice after some time
- attendance at local obstetric 'drills and skills' sessions or national courses such as PROMPT (PRactical Obstetric MultiProfessional Training) or MOET (Managing Obstetric Emergencies and Trauma).

8. Examples

Many units have made a great deal of progress in increasing their consultant labour ward cover. Examples from some of these can be found in Appendices 1–6. If you wish to share your good ideas with others, please complete the template in Appendix 7 and send it to: Standards Coordinator, Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regent's Park, London NW1 4RG, or email to: swhitear@rcog.org.uk.

Appendix 1: 40-hour consultant presence with prospective cover
Example from: Forth Park Hospital, Kirkcaldy, Fife

Appendix 2: 60-hour consultant presence
Example from: Birmingham Women's Hospital

Appendix 3: Aiming for 98-hour consultant presence
Example from: Liverpool Women's Hospital

Appendix 4: New-style job descriptions for three posts

Appendix 5: Sample job plan for a post incorporating resident on-call

Appendix 6: Options for increasing 60-hour to 98-hour labour ward cover
Example from Chelsea and Westminster Hospital

Appendix 7: Template to be completed by those willing to share their rota experiences for inclusion in this resource

References

1. Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, Royal College of Paediatrics and Child Health. *Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour. Working Party Report*. London: RCOG; 2007 [www.rcog.org.uk/womens-health/clinical-guidance/safer-childbirth-minimum-standards-organisation-and-delivery-care-la].
2. Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, Royal College of Paediatrics and Child Health. *Standards for Maternity Care: Report of a Working Party*. London: RCOG; 2008 [www.rcog.org.uk/womens-health/clinical-guidance/standards-maternity-care].
3. Clinical Negligence Scheme for Trusts. *Clinical Risk Management Standards: Maternity. Version 2*. 2009/10. London: NHS Litigation Authority; 2009 [www.nhsla.com/RiskManagement].
4. Royal College of Obstetricians and Gynaecologists. *Responsibility of Consultant On-call*. Good Practice No. 8. London: RCOG; 2009 [www.rcog.org.uk/responsibility-of-consultant-on-call].
5. Horrocks N, Pounder R. *Working the Night Shift: Preparation, Survival and Recovery. A guide for junior doctors*. Working Group report. London: Royal College of Physicians; 2006 [www.rcplondon.ac.uk/pubs/books/nightshift/nightshiftbooklet.pdf].

This good practice guidance was produced on behalf of the Safety and Quality Committee by Mr Edward Morris FRCOG, Norwich, Dr Tahir Mahmood FRCOG Vice President Standards, and Mrs Charnjit Dhillon, Director Standards, RCOG.

It was peer reviewed by the Safety and Quality Committee and those present at workshop, before being finally approved by the RCOG Standards Board.

Workshop attendees: Ms A Bartholomew, NHSLA Risk Management Director, NHS Litigation Authority; Dr P Fogarty FRCOG, Belfast; Ms F Freedland, RCOG Consumers' Forum; Mr HKS Hinshaw FRCOG, Sunderland; Dr TA Johnston MRCOG, Birmingham; Mr JA Latimer MRCOG, Cambridge; Dr T Mahmood FRCOG, Vice President Standards; Mr G MacNab FRCOG, Sunderland; Ms M McDonald, Clinical Director, Women's Services, St Thomas Hospital, London; Miss H Mellows FRCOG, Department of Health; Mr EP Morris FRCOG, Norwich; Mr NA Myerson MRCOG, Leeds; Mr A Russell FRCOG, Bolton; Dr DH Richmond FRCOG, Liverpool; Ms L Saunders, Risk Management Assessor, Det Norske Veritas; Dr H Scholefield MRCOG, Liverpool; Mr RNJ Smith FRCOG, Sidcup; Professor S Truttero, Midwifery Adviser, CNO Directorate, Department of Health; Dr DR Urquhart FRCOG, Fife; Professor JJ Walker FRCOG, Leeds; Mr JF Watts FRCOG, Worcester; Mr J Woolfson FRCOG, Honorary Treasurer.

The RCOG will maintain a watching brief on the need to review this guidance

APPENDIX 1

40-hour consultant presence with prospective cover: example from Forth Park Hospital, Kirkcaldy, Fife

1. Delivery numbers and design of the unit

The unit delivers 3950 women for a total population of 340,000. There are five outreach clinics a week to provide antenatal care for women at medium-risk of complications. All women classified as high-risk are seen at two clinics based at the obstetric hospital, supported by a fetal medicine team and a dedicated ultrasound scanning department. The obstetric suite has been physically divided into two parts: a consultant-led obstetric unit and a midwife-led unit comprising six delivery rooms and a birthing pool. All women classed as low-risk are offered an opportunity to deliver in the midwifery-led unit. About 1300 women deliver in the midwifery-led unit and there is an intrapartum transfer rate to the obstetric unit of approximately 15%. Our overall caesarean section rate is 21%, with an assisted delivery rate of 7%. We have five elective caesarean section lists a week; caesareans are performed by the on-call team. The cases are prioritised as either performed by the duty consultant or by specialist trainees (depending upon their experience) with direct supervision.

2. Consultant numbers

In 1999, we implemented the 'hot week' concept. At that stage, we had only seven consultants. The 'hot consultant' concept was designed to provide 40-hour consultant presence from Monday to Friday between 9am and 5pm each day and at 5pm the consultant on-call took responsibility for night on-call cover. The weekend was shared by seven consultants and the weekend on-call used to start on Friday 1pm and would end at 9am on Monday morning. Initially, during a 'hot week', all elective operating and gynaecology clinics were cancelled. There were also 14 outreach antenatal clinics which were covered by experienced registrars with consultant advice. Within six months, there was a significant increase in waiting times for elective operating which led to the development of a business case for the appointment of an eighth consultant.

In April 2000, eight consultants met with the clinical director, with the aim of revising their existing job plans. We agreed to be paired into four teams and each team was allocated to be responsible for covering one day a week. This meant that we had to organise our annual leave and study leave in such a way that only one person from each team could go away at a given time. Therefore, even during the summer holidays and half-term breaks, there were always four consultants available in the unit to provide cover from Monday to Thursday. The arrangements for weekend cover continues on a one-in-eight basis over a three-day weekend. A reorganisation of the outreach clinics into more midwifery-led clinics has also occurred.

We have now managed to appoint two more consultants to provide cover for Friday. At the moment, the unit has 48-hour prospective consultant presence. At the weekend, we conduct ward rounds of the labour ward and the obstetrics and gynaecology wards on Saturday and Sunday that start at 9am. Thereafter, telephone ward rounds are conducted at 9pm on Saturday and Sunday. Some of us like to spend more time at the weekend in the hospital, as it allows us to clear our desks and also gives us an opportunity to interact with the on-call team.

3. Funding issues

Currently, we have a Working Time Directive (WTD) compliant middle-grade rota which comprises eight specialist trainees and three staff-grade doctors. This arrangement gives a WTD-compliant rota with an in-built locum cover. While on-call, we have one foundation year 1/2 doctor, together with one specialist trainee. We are currently working on a business case for an eleventh consultant to extend the hours of consultant presence to 60 hours a week.

4. An outline of a typical week

A sample week rota can be found in Example 1.

5. Benefits to the unit

The unit has benefited from the consultants' presence, as we do not have any other commitments when looking after labour ward. We are all in theatre greens on the day of our on-call and assist our specialist trainees at difficult deliveries. We also manage emergency gynaecological cases. We have a very effective early pregnancy clinic and this has significantly reduced our emergency gynaecological admissions after 9pm. Currently, we are managing 80% of ectopic pregnancies laparoscopically.

6. Pitfalls

We had to make a convincing case to management regarding the 'hot week' labour ward concept, a process that took about nine months. During this process, we had difficulty dealing with waiting lists and waiting times which, at that time, was a good strategy to make a case for additional resources.

It did take time to convince team members to move their sessions around to set up the four-team concept. However, it has been functioning very effectively for the past seven years.

7. Top tips

- Work as a team and agree on one basic principle: that the management of labour ward emergencies should take a priority.
- Organise a day out away from the unit, with the help of a facilitator, to discuss the organisation of the job plans.
- Clearly agree that those who wish to undertake private practice do have a choice to do so and that they should agree in return to schedule their private practice work once they have delivered their commitment to the labour ward.
- Do not agree on one PA in a fragmented way. It is better to agree as a team of two for one day with no other commitment. The management, of course, would like to know what you do when you are not on call. That will be your administrative session, together with some elements of supporting professional activities for 42 weeks of the year.
- When calculating your PAs on the labour ward, always remember that there are only 42 working weeks in a year, so your one PA on the labour ward per week essentially becomes 1.3 PAs.
- Be careful when estimating your time commitment when you are consultant on call after 5pm. In our unit, we normally go home once we have sorted out all gynaecological emergencies and quite often this does not happen until 7pm. All this additional time spent while working in the labour ward needs to be factored in when agreeing your PAs for the on-call commitment.

Dr Tahir Mahmood FRCOG
Consultant Obstetrician, Forth Park Maternity Hospital, Kirkcaldy, Scotland

(see Example 1 on following page)

Obstetric and Gynaecological Duty Rota, 9 February – 15 February 2009

Example 1

Day	Consultants											Registrars									SAS Doctors			FY1–2								
BLEEP																																
DRs	DRU	GT	SP	JLM	SCM	JB	CL	TAM	SC	NM	CMcK	HR	PM	HM	ROA	SS	OMS	SH	VP	SR	AH	SD	NP	NT	MP	H	CB	MB	MS	FH	EN	RA
09.02.09 MON	AL	FM	AL	AL	A		GOPD Q	GOPD	OFF	LW	TH	GYN ON CALL	FM	AL	OFF		AL	GOPD Q	TH	OBS ON CALL	GOPD Q	GOPD	Elect C/S	GOPD Q	GOPD	TH		AL	LW	GYN ON CALL	WD	OFF
	AL	ANC Q	AL	AL	COLP		A	TH	OFF	LW		GYN ON CALL	ANCQ	AL	OFF	Night On Call O+G	AL	ANC	FP	OBS ON CALL	TH	US VHK	ANC	ANC Q	TH	ANC	Night On Call O+G	AL	LW	OFF	WD	GYN ON CALL
10.02.09 TUES	AL	FM	AL	AL	A	ANC	LW	A	SPA	SPA	GOPDQ	GYN ON CALL	GOPDQ	AL	OFF		AL	FM	GOPD Q	ANC	OBS ON CALL	Elect C/S	DB	OFF	WD	OPD Q	OFF	AL	Interview	LW	GYN ON CALL	
	AL	PG	AL	AL	PG	PG	LW	ANC PG	PG	PG	TH	GYN ON CALL PG	TH	AL	OFF	Night On Call O+G	AL	US	PG	PG	OBS ON CALL PG	ANC	COM GYN	GYN ON CALL PG	GYN Preass	GYN Preass	OFF	AL	Interview	LW WD	OFF	Night On Call O+G
11.02.09 WED	Diabetic Clinic	ANC	AL	AL	ANCQ	SL	DB	RCOG	LW	SL	A	OFF	ANC	AL	GYN ON CALL		AL	DB	ANC Q	G	OBS ON CALL	SL	SL	DB	Diabetic Clinic	ANC	OFF	OFF	GYN ON CALL	WD	LW	
	DB	TH	AL	AL	COLP	SL	DB	RCOG	LW	SL		OFF	CL DB	AL	GYN ON CALL	Night On Call O+G	AL	TH	GOPD	GOPD	OBS ON CALL	SL	SL	DRU DB	TH	CL DB	OFF	GYN ON CALL	OFF	WD	LW	Night On Call O+G
12.02.09 THUR	A	LW	AL	AL	GOPDQ	Risk Man	TH	RCOG		EPC	GOPD	OFF	TH	AL	GYN ON CALL		AL	OBS ON CALL	GOPD	GOPD Q	Elect C/S	HSG	OPD Q	OFF	GOPD	WD	OFF	AL	TH	LW	GYN ON CALL	
	A	LW	AL	AL	Students	ANCQ	TH	RCOG		GOPDQ		OFF	FP	AL	GYN ON CALL	Night On Call O+G	AL	OBS ON CALL	FP	TH	GOPD Q	ANC Q	COM GYN	GYN ON CALL	COM GYN	WD	OFF	AL	GOPDQ	LW	OFF	Night On Call O+G
13.02.09 FRI	A	AL	AL	AL	Meeting GOPD	TH	URO VHK	LW	GOPD	SCM ANC	URO VHK		URO VHK	AL	GYN ON CALL	OFF	AL	Elect C/S	URO VHK	URO VHK	TH	SCM GOPD	OBS ON CALL	WD	SC GOPD		OFF	LW	GYN ON CALL	OFF	ANC	OFF
	A	AL	AL	AL	DB	A	TH	LW	TH		A	Night On Call O+G	PG	AL	GYN ON CALL	OFF	AL	P G	TH	PG	FP	OBS ON CALL	DB	WD	GYN Preass	Night On Call O+G	OFF	LW	OFF	GYN ON CALL	GYN Preass	OFF
14.02.09 SAT								ON CALL										OBS GYN ON CALL										LW		GYN ON CALL		
								ON CALL				Night On Call O+G						OBS GYN ON CALL								Night On Call O+G		LW		GYN ON CALL		
15.02.09 SUN								ON CALL										OBS GYN ON CALL										LW		GYN ON CALL		
								ON CALL				Night On Call O+G						OBS GYN ON CALL								Night On Call O+G		LW		GYN ON CALL		

Key

A	Available on bleep or mobile (mobile through switchboard)	DM	Division meeting	GYN Preass	Preassessments, Forth Park Hospital	NT	Dr N Talbot	SH	Dr S Hall
ADMIN + AUDIT	Administration and Audit	DRU	Dr DR Urquhart	H	Dr F Henderson	OMS	Oncology Clinic, Victoria Hospital	S/L	Study leave
ANCF	Antenatal Clinic, Forth Park Hospital	EN	Dr E Napier	HM	Dr H Mustafa	ONC	Dr O Milling Smith	SP	Dr S Pinion
ANCQ	Antenatal Clinic, Queen Margaret Hospital	EPC	Early Pregnancy Clinic	HR	Dr H Russell	PG	Postgraduate meeting	SR	Dr S Reddy
AH	Dr A Hasan	FH	Dr F Hutchison	JB	Dr J Boyd	PM	Dr P Mills	SS	Dr S Sinha
A/L	Annual leave	FM	Fetal medicine	JLM	Dr J Macnab	RA	Dr R Adam	TAM	Dr TA Mahmood
CB	Dr C Briscoe	FP	Forth Park Hospital	LW	Labour Ward, Forth Park Hospital	RAC	Rapid Access Clinic, Victoria Hospital	TH	Theatre, Forth Park Hospital
CL	Dr C Lim	FY	Foundation Year	M	Methil Antenatal Clinic	ROA	Dr R Owusu-Ansah	UDM VHK	Urodynamics, Victoria Hospital
CMcK	Dr C McKinley	G	Dovecot Clinic, Glenrothes	MB	Dr M Barber	SAS	Staff and Associate Specialist	UROQ	Urodynamics, Queen Margaret Hospital
COLP	Colposcopy Clinic, Forth Park Hospital	GOPD	Gynae Outpatient Dept, Victoria Hospital	MP	Dr M Paterson	SC	Dr S Coutts	US	Ultrasound
COM GYN	Community Gynae Clinic, Forth Park Hospital	GOPDQ	Gynae Outpatient Dept, Queen Margaret Hospital	MS	Dr M Szewczyk	SCM	Dr SC Monaghan	VP	Dr V Puli
Cupar	Cupar Gynae Outpatient Dept	GT	Dr G Tydeman	NM	Dr N Mary	SD	Dr S Damodaran	W3	Ward 3, Forth Park Hospital
DB	Day Bed Area, Victoria Hospital	GUM	Genitourinary Clinic, Forth Park Hospital	NP	Dr N Parandekar	S/GOPD	St Andrews Gynae Outpatient Dept	WD	Forth Park Wards

APPENDIX 2

60-hour consultant presence: Example from: Birmingham Women's Hospital

1. Delivery numbers and design of the unit

The unit is a tertiary referral teaching hospital and is a stand-alone women's hospital with foundation trust status. We had 7440 births in 2008/09. We provide care for women from our own area and also a significant number of women from outside our area, either because they require tertiary care or because they choose to give birth here. Twelve antenatal clinics are run in the hospital each week, of which five are high risk/subspecialist. There are currently no peripheral consultant-led clinics, although there are plans to develop these with consultant expansion.

The labour ward has 15 rooms (one pool room), including two high-dependency rooms (three beds). There is an alongside midwifery-led unit with five rooms (one pool room) in which 1163 births took place in 2008/09, with a transfer rate to the obstetric unit of approximately 34%. Our overall caesarean section rate is 23.7%, with an assisted delivery rate of 14.4%.

We have five elective caesarean section lists a week, all of which have a designated consultant and junior team. There are two dedicated theatres on labour ward, which allows emergency and elective procedures to be performed simultaneously, and a four bedded recovery area.

2. Consultant numbers

We currently have 15 consultants contributing to the obstetric service, of whom seven are obstetrics-only posts, and we are currently in the process of appointing a further two. At present, those who practice obstetrics and gynaecology cover both as the consultant on call but, with the pending new appointments, we are looking to split the rota entirely to ensure that both an obstetrician and a gynaecologist are on call each night. This would change the frequency of on call from the current 1:14 to approximately 1:10 but we feel it is important from a governance perspective.

To work towards 98 hours, two further posts are in the process of being appointed. Following this, job plans will be redesigned and the evening sessions in four consultant job plans will be removed. The on-call consultant will be present until 22.30 Monday to Friday and then will cover the remainder of the night from home, with the following morning being a non-clinical session.

At the weekends, there will be a further physical evening ward round (1 hour) in addition to the morning 3-hour presence, bringing the total to 78 hours. These changes will be appropriately remunerated. To achieve 98 hours will require further consultant expansion, as weekends will need to be split, and there is concern regarding work–life balance if the weekend frequency increases significantly. Alternatively, consultant expansion will allow us to appoint consultants to posts which contain a fixed resident night shift.

Working towards 168 hours will require significant further expansion following identification of funding, as we will need to split into teams to ensure appropriate daytime coverage to allow services, particularly tertiary services, to continue to run smoothly.

3. Funding issues

We have had major problems in trying to convince (so far unsuccessfully) the primary care trust that funding for consultant expansion does not lie within tariff and that money for consultant expansion has had to come from the trust. Among other reasons, as there are very few trusts in the country whose numbers of deliveries are such that they fall into the recommended 168 hours of consultant presence, it is difficult to see how this could possibly be in tariff. We have been successful in expanding the three junior tiers to ensure that all junior rotas are WTD-compliant for August 2009, again at a cost picked up by the trust for four of six posts, and two extra specialist trainee year 1–2 posts from the deanery. We have been clear that we will not substitute

consultants for junior doctors and that consultant presence on the labour ward must not diminish the junior staffing complement. This level of investment goes some way towards improving consultant presence on the labour ward and the WTD problem with juniors but difficult decisions have been made, as we also need to expand our midwifery numbers.

4. An outline of a typical week's labour ward presence

Our existing 65-hour cover involves daytime cover:

- 08.30 to 20.30 Monday to Friday (evening sessions from 17.00 to 20.30 constitute a PA in four consultant job plans; these consultants then have a half day during the week or are paid for the extra evening PA)
- 08.30 to 19.30 on Friday (on-call person paid to be present till 19.30 as part of predictable on-call)
- 09.00 to 12.00 Saturday and Sunday.

The only element that is not covered prospectively is the four evening shifts, although, if the consultant who takes the evening shift is away, the on-call consultant is paid to be present until 19.30, leaving only 1 hour not covered prospectively.

In the mornings, there are two consultants on for labour ward who cover each other for leave, so one is always present (who can then supervise the senior trainee indirectly for the elective list). To ensure cover for the afternoon if the usual consultant is away, the consultant in the antenatal clinic cuts the clinic and covers the labour ward and is physically present there. This does impact on the running of the antenatal clinics.

- Monday – Friday: prospective 12-hour day, daytime/evening shifts, with 11 of the 12 hours prospectively covered (afternoon sessions at the expense of antenatal clinics).
- Saturday – Sunday: 3 hours of consultant presence prospectively covered.
- Evening and weekend on-call consultant on a 1:14 rota.
- This provides 65 hours a week, 61 of which are prospectively covered.

5. Benefits to the unit

Increased consultant presence will expand our current consultant-based service and will significantly improve supervision and training of junior medical staff, as much of their time on labour ward is now out of hours, which impacts on the amount of direct supervision, training and assessment of skills they receive. Increased consultant presence will lead to improved leadership on the labour ward. We anticipate that the rates of unnecessary intervention will reduce and that appropriate intervention will be more timely, leading to a reduction in clinical incidents.

6. Pitfalls

The biggest hurdle has been funding. The primary care trust is not prepared to consider this as an issue pertinent to them. Without funding, there is nowhere we can go to address this matter and we have ended up funding posts at the expense of other equally important areas within the trust, such as midwifery staffing and service development.

Our current system impacts on the running of the antenatal clinics (not the specialist clinics) to ensure prospective cover for the afternoon sessions, which is not ideal.

There is always a concern regarding the availability of suitably qualified applicants. We are in a situation where we do not particularly need further expansion in the gynaecological workforce but we do need to expand the obstetric workforce. We have concerns about how attractive the new posts would be if they were obstetric only.

Some colleagues can be very resistant to change and this requires careful management and ensuring their full engagement in the process.

The age of the consultant workforce is important, as many obstetricians opt out of on-call after the age of 55

years but continue to work until 60 or 65 years. This means that they come off the rota but there is insufficient money released to appoint a replacement. In our own unit, many of us are of a similar age and may hit this problem around the same time.

7. Top tips

- It would be extremely useful if there was central guidance regarding funding for this that is explicit, so we all know where we stand to avoid the endless arguments.
- Keep your consultant workforce fully engaged with the process.
- Acknowledge their anxieties and explore different options.
- Ensure that the local negotiating committee/medical staff committee is involved at the beginning.
- Ensure that the rest of the unit's activities can continue without major disruption.
- Think laterally about working patterns – we do not all need to be doing the same work.
- Keep the funding issues on the agenda with the primary care trust.

Dr Tracey A Johnston MRCOG
Clinical Director, Birmingham Women's Hospital

APPENDIX 3

Aiming for 98-hour consultant presence: Example from: Liverpool Women's Hospital

1. Delivery numbers and design of the unit

The unit has 8000 births a year for a total population of approximately 708,000. Seventeen consultant antenatal clinics are performed each week, of which six are high risk/subspecialist.

The labour ward has 15 rooms, including four high-dependency rooms. There is an alongside midwifery-led unit with 13 rooms, where 2000 births take place annually, including a birthing pool.

We have seven elective caesarean section lists a week, two of which have a designated consultant. The remainder are covered by specialist trainees with supervision, either direct or indirect from the labour ward duty consultant. There are three dedicated theatres on the labour ward, which allows for emergency and elective procedures to be performed simultaneously.

2. Consultant numbers

Our existing 60-hour prospective cover involves a group of two to three consultants, between them providing a total of four PAs/12-hour weekday.

To achieve 98 hours, and keep contracts at the same number of PAs and maintain WTD compliance, the following solution was calculated:

- Three resident 12-hour nights at 4 PAs and weekend mornings, in addition to the 60 hours of prospective weekday presence would achieve 98 hours.
- This was preferable to the existing consultant body than seven times 14-hour days.
- It was considered that these hours were not feasible at the weekend without splitting shifts and therefore increasing the impact of weekend work on home life.
- WTD requires 11 consecutive hours rest in 24 hours and 14-hour shifts are non-compliant.
- Four daytime direct patient care PAs needed to be taken as time off to compensate for each night.
- Supporting professional activities (SPAs) should not be included in time taken off for nights: it should be like-for-like SPAs.
- We calculated that we needed four additional consultants on the rota to maintain work–life balance and preserve non-labour-ward work.

Working towards 168 hours:

- Adopting the same model, seven to nine more consultants are needed to maintain daytime non-labour-ward service and 24/7 presence on the labour ward.
- This means that we cannot make permanent appointments until funding issues have been dealt with.
- We are considering fixed-term appointments in conjunction with post-Certificate of Completion of Training fellows and trainees on a grace period.

3. Funding issues

We used income from research network, the National Institute for Health Research and other sources and achieved primary care trust funding to expand the consultant body to provide 98 hours on the labour ward and a number of consultant high-risk community antenatal clinics. The junior rotas are all WTD compliant.

4. Outline of a typical week's labour ward presence

- Monday – Friday: prospective 13-hour day daytime/evening shifts to allow personal handover by day consultant to night team, prospectively covered.
- Saturday and Sunday: 3 hours of consultant presence prospectively covered.

- Tuesday – Thursday 12-hour consultant resident night shifts (not prospectively covered) provided by three consultants undertaking a fixed night as part of their job plan. Non-resident cover for their leave provided by other consultants on 1:11 rota.
- Saturday – Monday nights and weekend afternoon and evenings: non-resident on-call consultant on 1:11 rota.

This provides 104 hours per week, 71 of which are prospectively covered:

	Hours of consultant presence on labour ward	
Day of week	**Day**	**Night**
Monday	13	On call
Tuesday	12	12
Wednesday	12	12
Thursday	12	12
Friday	13	On call
Saturday	3	On call
Sunday	3	On call
Total hours	**68**	**36**

5. Benefits to the unit

- Increased consultant presence for training and supervision of junior doctors.
- Consultant-based service.
- Improved handover.
- Maintenance of other aspects of the service.

6. Pitfalls

We advertised twice and had no suitable applicants to make appointment to an obstetric post to reach 60 hours on the labour ward. We then had additional monies from the primary care trust to work towards 98 hours. We then advertised revised job plans, including gynaecology in two positions, and were able to recruit to three posts (job description for the three new posts can be found in Appendices 4–5). Applicants for obstetrics-only jobs were substantially lower than for the combined jobs and it was clear from application forms and interview that the majority still wanted some gynaecology, even if they had applied for an obstetrics-only post.

7. Contractual issues and payment

The obstetric tariff does not include any consultant presence outside 40 hours.

The primary care trust is reluctant to release any more of the £330 million for maternity services following the publication of the Healthcare Commission Survey.

There is little additional funding, as the tariff is based on 2006/07 reference costs that have funding for 40 hours of consultant presence.

The changes to the working patterns were put through our local negotiating committee, which considered that it was not in line with the British Medical Association (BMA) advice on the national consultant contract. The BMA guidance on premium PAs in the consultant contract explicitly states that they are to recognise the work needed to do a consultant's normal job, not resident on-call. It advises that this is not included within the contract. Existing consultants have no obligation to do this. If it is required, there must be local negotiations and 'substantial' additional payments over and above premium rate PAs. We were prepared to do some resident on-call but only by local negotiation of enhanced payments. We were concerned about being unable to recruit a suitable calibre of applicants for consultants if this was not in place.

The trust accepted that our proposals were in line with the national contract. We formalised this through the BMA and by ensuring that the enhanced payments were linked to future pay rises and seniority.

8. Impact on other areas of the maternity service

The cost of the additional payments left insufficient funds to recruit enough additional consultants. There were huge implications on the rest of the service as a result of rest requirements for resident nights.

9. Other issues

The consultant body initially felt strongly that the new appointees should have the same work pattern as existing ones, so as to be equitable. The protracted and difficult negotiations were extremely stressful and unsettling for the consultant body. Relationships between clinicians and managers were strained to the point that a complete rethink was needed. Refocusing on the aims of the service being to provide a high-quality and safe service for our population overcame the difficulties in considering alternative working patterns for individual consultants.

It was accepted that new consultants might actually find alternative working patterns attractive, with appropriate non-financial compensation in terms of a resident fixed night and no prospective cover and choice of developmental career progression sessions.

Our senior consultant requested to change to new-style working, as a lead into retirement. We have advertised two temporary consultant posts pending substantive appointments. This will achieve our aim of 98 hours, 60 of which are prospective.

10. Top tips

Do not underestimate how difficult the process will be.
Be imaginative with the options.
Take into account the specific requirements of your service.
Seek funding from Maternity Matters: £330 million of government investment from your primary care trust.

Dr Helen Scholefield MRCOG
Liverpool Women's Hospital

APPENDIX 4

New-style job descriptions for three consultants in obstetrics and gynaecology

These appointments are new posts to reflect significant increases in obstetric and gynaecological activity.

A candidate who is unable for personal reasons to undertake the duties of a whole-time will receive equal consideration. If such a candidate is appointed, the job content will be modified as appropriate, in consultation with consultant colleagues and local management.

We welcome all applications irrespective of age, disability, gender, sexual orientation, race or religion. Additionally, people with disabilities will be offered an interview, provided that they meet the minimum criteria for the post. The trust operates job share and flexible working.

Duties of the post

The appointment is to the trust, not to specific hospitals.

To recognise changes in consultant working practices within the specialty, the candidate will be expected to provide out-of-hours labour ward presence, with the support of a specialist trainee and a foundation trainee at times. Initially, this is expected to be until 10pm but, if national and local initiatives suggest that further consultant expansion is required, the candidate may be required to work in a rota that provides 24-hour cover with a physical presence on labour ward (resident on-call). At present, in addition to evening working, participation in the consultant on-call rota is expected (approximately one in nine prospective cover, with two mid-grade support staff at weekends and overnight). The three posts will be expected to provide presence for two evenings a week on a prospective-cover basis.

Post 1: Maternal medicine and general obstetrics

This post arises from the increasing numbers of obstetric patients with medical problems in pregnancy who require specialised care. The appointee will contribute to the outpatient and inpatient care of these women and will be encouraged, as a team member, to develop a special interest in managing a patient group. See below for further details of the maternal medicine team. It is considered essential that the appointee has subspecialty training in maternal medicine.

Posts 2 & 3: General obstetrics and gynaecology

These posts arise from a need to expand consultant presence on the labour ward and from an increase in the need for consultant input into outpatient and day case gynaecology. Post 2 is envisaged to have a predominantly obstetric bias, undertaking supporting senior roles in risk management and labour ward leadership. Medical school education, general outpatient diagnostic gynaecology and minor operative gynaecology will also be components of this post. Post 3 will be to take a lead on the provision and development of emergency gynaecology, to support ambulatory management of miscarriage and termination of pregnancy and to provide services in general obstetrics.

Successful candidates will be expected, when appropriate, to participate in the termination of pregnancy service provided by the directorate.

The fixed sessions of these posts will be arranged according to the expertise and wishes of the successful candidate and the needs of the directorate. The posts will have 7.5 fixed programmed activities (PAs) for delivery of clinical service. PAs allocated to labour ward cover will be flexibly allocated to cover for absent colleagues initially until directorate plans for reconfiguration of labour ward cover are complete.

Provisional timetables

The following provide suggested outlines of the expected clinical activity and clinically related activity components of the job plan which occur at regular times in the week. Agreement should be reached between the appointee and their clinical director with regard to the scheduling of all other activities, including supporting professional activities. Upon appointment, the consultant will be given a specific 'work programme' detailing, as a minimum, the direct clinical care (DCC) activities. Given the flexibility of this post, the appointee is required to ensure that PAs worked do not exceed a maximum of 60 over a 6-week period.

Post 1

Per week 1	
1 General antenatal clinic	1 DCC/w 1
1 Maternal medicine clinic	1 DCC/w
Patient admin	1 DCC/w
On-call (1 in 9 non-resident)	1 DCC/w (0.8 predictable)
Protected teaching	1 SPA/w
National research projects	0.5 SPA/w
Teaching and educational supervision	0.5 SPA/w
CME, audit and guideline production	0.5 SPA/w
Alternate weeks	
8am to 5pm labour ward presence	1 DCC/w
Diabetic antenatal clinic	0.5 DCC/w
Special interest antenatal clinic	0.5 DCC/w
Medical school education	0.5 DCC/w
Evening labour ward work	
2 evenings/3 weeks (1.5 DCC/evening)	1 DCC/w
Totals	**7.5 DCC/w**
	2.5 SPA/w

Post 2

Per week	
1 General antenatal clinic	1 DCC/w
1 General gynaecology clinic	1 DCC/w
Patient admin	1 DCC/w
On-call (1 in 9 non-resident)	1 DCC/w (0.8 predictable)
Protected teaching	1 SPA/w
Deputy labour ward/risk management lead	0.5SPA/w
Maintaining operative skills	0.5SPA/w
CME, audit and guideline production	0.5SPA/w
Alternate weeks	
8am to 5pm labour ward presence	1 DCC/w
Day procedure unit	0.5 DCC/w
Special interest gynaecology clinic	0.5 DCC/w
Medical school education	0.5 DCC/w
Evening work	
2 evenings/3 weeks (1.5 DCC/evening)	1 DCC/w
Totals	**7.5 DCC/w**
	2.5 SPA/w

Post 3

Per week	
1 General antenatal clinic	1 DCC/w
1 General gynaecology clinic	1 DCC/w
1 early pregnancy unit session	1 DCC/w
Patient admin	1 DCC/w
On-call (1 in 9 non-resident)	1 DCC/w (0.8 predictable)
Protected teaching	1 SPA/w
Early pregnancy unit lead	0.5 SPA/w
Maintaining operative skills	0.5 SPA/w
CME, audit and guideline production	0.5 SPA/w
Alternate weeks	
8am to 5pm labour ward presence	1 DCC/w
Day procedure unit	0.5 DCC/w
Evening work	
2 evenings/3 weeks (1.5 DCC/evening)	1 DCC/w
Totals	**7.5 DCC/w**
	2.5 SPA/w

DCC = Direct clinical care

PERSON SPECIFICATION

GRADE: Consultant SPECIALTY: O&G

JOB REQUIRMENTS	ESSENTIAL	DESIRABLE
Physical requirements	Good general health	Non-smoker
Qualifications	MRCOG or equivalent accreditation in obstetrics & gynaecology and on specialist register at or within 6 monthsof the AAC. **Subspecialty accreditation in maternal medicine (Post 1).**	Higher degree training and experience in delivering undergraduate education (Posts 1 & 2).
Aptitudes	Good communicator. Capable of working in a multidisciplinary team. Enthusiasm for service development and teaching. A flexible approach to delivery of service in a changing environment	Prepared to work in shared office space. Management skills.
Experience	Extensive experience in obstetrics and gynaecology, including ability and commitment to perform all roles within the job description. Applicants who are nationals from another European country or elsewhere overseas would have to show equivalence to the 5-year training period in the National Health Service required for the specialty.	Experience in research or published papers in area of special interest. Skills in intermediate laparoscopic surgery (posts 2 & 3). Experience in delivering and developing a first class early pregnancy service (Post 2).
Interests	Commitment to develop an appropriate special interest. Training. Audit/research.	
Circumstances	Flexible outlook on working hours. Must live within a 15-mile radius of the base trust or 30 minutes' travelling time. Full driving licence.	
Other	Flexible outlook on working practices. Full registration with GMC. Emotionally well balanced personality.	
Communications and language skills	Ability to communicate effectively with clinical colleagues, colleagues in pathology and support staff. Good knowledge of, and ability to use, spoken and written English. Ability to present effectively to an audience, using a variety of methods, and to respond to questions and queries.	Good presentation skills.

APPENDIX 5

Sample job plan for a post incorporating resident on-call

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning	Hysteroscopy	SPA 1			SPA 1
Afternoon	GOPD	SPA 0.5 ANC (alt weeks)			Operating theatre list (alt weeks)/clinical admin
Night (9pm to 9am)			12-hour resident on-call		

SPA	2.5
Resident on-call	4 PA (DCC)
Clinical admin	0.5 PA (DCC)
OP hysteroscopy	1 PA)
Gynae OP clinic	1 PA) = 3 PA (DCC)
Antenatal clinic	0.5 PA)
Operating theatre	0.5 PA)
Total =	**10 PA**

GOPD = Gynaecology outpatient clinic; OP = outpatient

APPENDIX 6

Options for increasing 60-hour cover to 98-hour labour ward cover

Rationale

For a unit with 4000–5000 births, the Royal College Obstetricians and Gynaecologists guidance specifies that there should be 60 hours of consultant presence on labour wards by December 2008 (achieved) and 98-hour cover by December 2009.

A business case was approved in 2008/09, for an additional 10PAs. It was intended that these would be shared across existing consultants, rather than recruiting to a new post. This was calculated on the basis of the additional hours required, as detailed below:

- Additional (antisocial) hours/week 30 hours
- Additional hours/year 1560 hours
- Additional PAs/year (3hours/PA) 520 PAs
- Additional PAs/week 10 PAs
- **Cost at £10,000/PA** **£100,000**

Increasing consultant presence on labour ward is also a requirement of CNST level 3. As stated above, this will potentially improve quality of care and safety through having more experienced (consultant) medical cover on the labour ward, with less reliance upon junior staff. Weekend cover will be particularly improved, as currently there is only a consultant presence on labour ward for 3 hours each weekend day.

Current model of consultant cover

The consultant cover on the labour ward is currently 68.5 hours/week. This is achieved through fixed labour ward sessions 8am to 8.30pm (Monday to Friday) and 8am to 11am (Saturday and Sunday).

Weekday hours

There are currently 13 consultants contributing to labour ward cover .The team recently moved to a one-in-three labour ward cover model, to staff the five sessions a week required: 8am – 8.30pm (Mon – Fri). Each one-in-three session attracts one PA on a new consultant job plan.

Weekend working and on-call

Weekend on-call cover starts at 8.30pm on a Friday night and runs through to 8am Monday morning and is a different rota to the one-in-three trios. Part of the weekend on-call incorporates a 3-hour ward round on Saturday and Sunday mornings: 8am – 11am (Sat/Sun), Contributing to the on-call rota attracts 1 PA (0.5 PA for recently appointed consultants: this inequity needs to be addressed).

Labour ward trios

Day	Trio	Caesarean section list (am)
Monday	A,B,C	L
Tuesday	D,E,F	TBC
Wednesday	G,H,I	L
Thursday	J,K,L	O
Friday	M,N,O	Clinical fellow 1:2

Permanent staff/sessions contributing to labour ward rota

	Consultant	No. LW sessions/week	No. caesarean section list sessions/week
1	A	1	0
2	B	1	0
3	C	2	0
4	D	1	0
5	E	1	0
6	F	2	1
7	G	1	0
8	H	1	0
9	I	1	0
10	J	1	0
11	K	1	1 (locum: temp)
12	L	1	1+ 0.33
13	M	1	0
	Clinical fellows		0.66 + 0.5
	TOTAL	**15**	**4.5 (3.5 perm)**

The elective caesarean section list runs from 8am to 1pm on the labour ward, with a consultant or senior trainee (C, F) on the rota each day to run the list, separately from the labour ward consultant. There are gaps with the existing cover arrangement on: Tuesday morning and Friday afternoon. Currently, there is no prospective cover for any annual leave or study leave. There is a plan to use senior trainees on these occasions but this is not robust.

Any private sections can be scheduled at either 7am or at 1pm and are undertaken by the private consultant.

Gynaecology on-call service

This will be the subject of separate discussion.

Options for increasing to 98 hours

Increasing labour ward sessions to 12 hours/day for seven days/week

One option to meet the 98-hour cover requirement is to increase the existing labour ward sessions to 12 hours/day: 07:00 to 21:00 or 08:00 to 22:00.

It is recommended that one shift pattern is agreed on and consistently adhered to rather than individual consultants interpreting the times differently, so as to avoid confusion on the unit. This will change the on-call hours, with consultants on call reducing their hours to cover from 21:00 (or 22:00) to 07:00 (or 08:00) as opposed to taking on responsibility from 17:00.

The weekend on-call contribution would consist of providing 12-hour consultant presence on the unit and also retaining on-call responsibility throughout the night.

The length of shift is onerous and four rest periods will need to be factored in: 13:00–14:00, 17:00–18:00 and two half-hour breaks.

Consideration of compliance with EWTD working patterns for consultants may need to be discussed but because the days are one week in three and weekends one in 14, this should be more acceptable.

Labour ward hot-week

An alternative approach to the labour ward trios is to have a 'hot week', during which the consultant is

present for 14 hours each day. The hot week would be on a rolling one in 14 for all consultants and all other work would be cancelled for that week. Many hospitals employ this system outside London but currently not within the city.

Twilight shifts to enable EWTD compliance

The on-call consultant takes over at 17:00 and remains in the hospital until 22:00 before commencing on-call from home. Weekends would be split between two consultants, one providing resident day and one night out of hospital night time cover following a 2-hour ward round. This would overcome EWTD regulations also but would mean one in seven weekends on call.

Remuneration

It is suggested that consultants contribute to the resident rota a total of 1.5 PAs which includes on call. This is on the basis that, while the labour ward days have increased to 14 hours, the other elements of on-call commitments have reduced, with commitments now being one in 14 (previously one in 11). It is intended that this will redress the discrepancy of new consultants only receiving 0.5 PAs for on-call. Individuals who contribute to more than one labour ward session per week or do not have labour ward sessions will negotiate separate arrangements through the job planning process.

Next steps

- Consultants are requested to reach a decision at the awayday on 30 September, regarding how to meet the 98-hour cover requirements.
- Consultants are also requested to consider whether there is a need to staff separate caesarean sections five days per week or whether, in principle, lists could be consolidated into fewer sessions: i.e. three or four days per week.
- Further to agreement at the awayday, the next round of job planning should be planned for October/November in time to implement the changes at the end of the year.
- Colleagues are requested to consider the impact upon other disciplines and form a view about whether there is a need to increase the capacity of other disciplines i.e. anaesthetics.

Keith Duncan & Nicola Sprigens
Chelsea & Westminster Hospital
September 2009

APPENDIX 7

Please use the template below if you wish to share your good practice

Hours of consultant presence: .....

Name of clinical director/consultant: .....

Name of good practice unit: .....

1. Delivery numbers and design of the unit

2. Consultant numbers

3. Funding issues

4. An outline of a typical week (to include rota and on-call rota if available)

5. Benefits to the unit

6. Pitfalls

7. Top tips

