The Shrewsbury and Telford Hospital NHS Trust

Policy for Escalation of Maternity Services

(Mat042)

Additionally refer to: **Policies:**
Midlands Maternity Escalation Policy
Neonatal Escalation Policy

Version 8.1

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V1	June 2010		Final	New
V1.1	3rd October 2011		Final	New structure/ title changes
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V2.1	20th September 2013		Final	Addition of Appendix 2b
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V4.1	29th March 2016	Head of Midwifery	Final	Updated to reflect minimal staffing and one to one care at MLU's
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V4.4	27th July 2017	S Jamieson & M Kennerley	Final	Head of Midwifery extraordinary approval. Additional out of hours guidance for on call managers whilst current suspensions in place
V5.0	1st May 2018	Updated by Anthea Gregory-Page, Jill Whitaker, Jo Banks, Louise Watkins, Andrew Tapp, Ward Managers, Jacqui Bolton	Final	Full version review Addition of Policy on a Page Addition to section 4 responsibility of delivery suite co-ordinator and W&C on call manager Addition of 3.12 Birth Rate Plus® Tool Update to red flags Removal of supervisor of midwives from section 5 and renumbering from section 5 Removed appendix 6 renumbering from appendix 6

				Addition of Obstetric Triage Acuity to appendix 7e. Updated contact numbers appendix 8
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V7.0	June 2022	Rewritten by Annemarie Lawrence Director of Midwifery	Draft	Full version review Circulated to all midwives, obstetricians, and on-call managers for W&C
V8.1	August 2023	Updated by Annemarie Lawrence	Draft	Updated in line with the regional midlands escalation policy

Contents 5

1.0 Introduction

The Trust is committed to providing high quality care to women and babies as standard. This policy for Escalation of Maternity Services sets out the procedures for the service to manage significant surges in demand to ensure that maternity services can continue to be provided safely and effectively. This policy will reduce variation across managers, improve consistency, communication and multi-disciplinary working relationships whilst enhancing the experience for our women and their families.

The policy intends to provide a consistent approach in times of pressure, 7 days a week, specifically by:

- Providing a consistent set of escalation levels, triggers, and protocols
- Set clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressure at local level
- Setting consistent terminology

This Policy should be used in conjunction with the Midland Maternity Escalation Policy & Operational Pressures Escalation Levels Maternity Framework Version 2.

2.0 Principles and Overview

This policy has been developed to enable the maternity service to align their escalation protocols to a standardised process and escalate regionally when required.

The policy is based on seven escalation triggers:

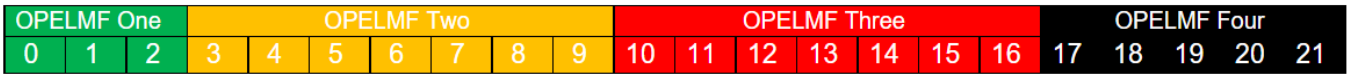
- Maternity ward-based bed capacity
- Delivery suite bed capacity
- Obstetric staffing shortfalls impacting on safe care
- Anaesthetic staffing shortfalls impacting on safe care delivery
- Delivery Suite Birthrate Plus® activity and dependency score
- Labour ward coordinator is not supernumerary (refer CNST definition)
- Neonatal Services OPEL Framework Status

There may be other factors that lead to escalation such as:

- Skill mix of staff on duty
- Shortage of medical staff
- Infection, prevention, and control issues – follow local policy
- In the event of a major incident such as power failure or flood – follow local policy

2.1 To ensure a consistent approach across the region, there are four OPEL Maternity Framework escalation levels, with definitions for each of the triggers outlined in Appendix 1. At OPELMF three and four, it is expected that there is Executive level involvement across the service via silver and gold command.

2.2 The OPELMF Escalation Triggers are outlined in Appendix 2. The level of escalation declared is based on the OPELMF status. Each escalation trigger has a corresponding score assigned to it dependent upon the level of escalation. The total calculated escalation trigger score defines the final OPELMF rating. For example:



2.3 The Maternity Escalation Framework has been developed to enable local systems to align their escalation protocols to a standardised process. The framework has been developed to support decision-making and improve communication channels for 'in hours' (Appendix 3a) and 'out of hours' (Appendix 3b) escalation and support. This will support:

- Local systems to oversee the quality of maternity services provided and patient safety during periods of service pressure
- Provide consistency in response, management and triggers for escalation across the region
- Set clear expectations around roles and responsibilities to support escalations and operational pressures

3.0 Maternity and Neonatal Sitrep dashboard (MNSD)
The Midlands Maternity and Neonatal Sitrep indicates where there are pressures and capacity in maternity services. It provides daily oversight across the region via the Regional Coordination Centre (RCC) and locally through trust operational structures to support alleviating pressure within trusts and aid mutual aid discussions where required.

It is the responsibility of each trust to ensure its return is accurate and reflects the real position in terms of pressure at that point in time. The data is captured via Microsoft Forms online using the following links:

Maternity Sitrep Data Collection Form - **Midlands Maternity OPEL Sitrep Data Collection Form**

East Midlands Neonatal Sitrep Data Collection Form - **EMONDN OPEL and Surge Plan Data Collection Form (office.com)**

West Midlands Neonatal Sitrep Data Collection Form - **WMNODN OPEL and Surge Plan Data Collection Form**

Midlands Maternity and Neonatal Sitrep submissions should be made daily, seven days a week once a day by 10 am (including bank holidays).

3.0 Internal Trust Escalation

The temporary suspension of maternity services should only be considered when all good practice options have been exhausted and action cards for relevant OPELMF status have been implemented.

Action cards should be followed for OPELMF status Two, Three and Four, see Appendix 2 for triggers and actions required.

Good practice guidance – routine actions for bed management if carried out should reduce potential pressures in the system:

- Where possible adhere to planned length of stay

- Timely discharge of antenatal/postnatal patients
- Timely neonatal reviews to aid discharge
- Timely review of ward rounds
- Early recognition of potential capacity issues, escalating concerns early on so that measures can be put in place
- Review elective work through multi-disciplinary team (MDT) approach, ensuring it is appropriate to proceed with the elective CS list; consideration should be given to the redeployment of the elective team if required.

Good Practice guidance for management of staff includes:

- Ensure robust systems in place to ensure timely completion of staff rotas for midwifery, medical and support staff. To view as a total maternity service. Ensure daily review of staffing numbers across the service with sickness and absence updated
- Good management of annual leave across the service
- Where necessary redeploy staff to appropriate area ensuring staff members working within their skill set. Look at whole service to support with escalation. During periods of high activity, it is essential that staff are supported and work within their skill set
- Consider asking staff to work additional hours
- Consider potential shift changes
- Request bank and agency staff
- Cancel study leave (starting with mandatory training and moving to external study as appropriate).
- All physical staff in the unit including midwives in specialist roles and those within community will be called upon to assist
- Maternity service should have considered promoting staff rotation across the service, so staff are in a state of readiness when increased pressure in the system

The decision to divert or close a maternity unit will be discussed with the executive director on call and will usually be at OPELMF Four status (see Appendix 2 Action Cards) following consultation with:

- Manager of the day
- Delivery suite coordinator
- Consultant obstetrician on call
- Maternity matrons (in hours)
- Women and Children's manager on call
- Silver on call and gold on call
- Director of midwifery/head of midwifery in/out of hours depending on local arrangements
- Consultant neonatologist on call
- Bed manager
- Neighbouring maternity units, see Appendix 5
- Responsible person for integrated care system (ICS) & lead commissioner within ICS as per contractual arrangements via silver & gold command

Once the decision has been made to temporarily divert new admissions or close maternity services the ambulance service must be contacted immediately (https://www.england.nhs.uk/publication/operational-pressures-escalation-levels-framework/ and Managing Conveyances Policy v1.3 (002) Rapid handover.pdf

It is recommended that one person is nominated to coordinate the procedure and wherever possible should have no other responsibilities during this time and they will be referred to as the coordinator (this should not be a midwife to ensure all clinicians can support safe service, and preferably would be the manager on call for women's and children's), please see Appendix 5 & Appendix 6 for diversion template & notification checklist.

It is recommended that a 4 hourly review of capacity takes place at OPELMF Two. OPELMF Three capacity review should be 2 hourly & OPELMF Four review is undertaken hourly so that agreed routine operational working can commence as quickly as possible. Please see action cards (Appendix 2).

4.0 Duties, Roles, and Responsibilities

Role	Responsibilities
Gold on call	In the event of a whole maternity service closure, the primary role of the gold on call is to give strategic direction at an operational level to ensure patient flow is resumed as early as possible. Gold on call should also handle any communications or media requests out of hours and liaise with the ICS gold on call
Silver on call	The silver on call provides 24 hour, 7 days out of hours on call operational oversight of the situation. During the escalation process the role of the silver on call is to support any decision making and to ensure all areas of the maternity service are maximised to aid patient flow, safety, and capacity. In the event of any potential full maternity service closure, the silver on call should escalate to the gold on call.
Hospital site manager	The hospital site manager will coordinate further support for maternity services. For example, find extra cleaning team, maximise available support staff to answer doors, telephones and manage effective bed clearance on electronic systems etc. They will liaise with delivery suite coordinator to ensure that they have sufficient support.
Director of Operations/deputy	The director of operations of the Trust will

director of operations (within working hours)	ensure there is a robust and efficient system in place for the recognition and response to emergency care and other demand/capacity pressures. Supports a resilient and robust Trust wide response to emergency care/demand/capacity pressures. All processes will be supported by the umbrella of a Trust cooperate governance process.
Lead Consultant Obstetrician on call	The consultant on delivery suite will work in collaboration with the delivery suite coordinator, to expedite discharges where clinically safe to do so and to consider deferring elective work to improve immediate capacity issues they will work closely with obstetric anaesthetist on call and neonatal consultant on call. They also play a key role in the decision-making processes concerning temporary diversion or closure of the service.
Director of Midwifery or Head of Midwifery	DoM holds overall responsibility and accountability for the maternity services flow and capacity with the clinical director and is responsible for ensuring plans are in place to support the achievement of safe care within the maternity service.
Clinical Director	To hold overall responsibility and accountability for the maternity service flow and capacity with the director of midwifery.
W&C Manager on call	To be informed out of hours of any potential capacity concerns when the maternity service is going from OPELMF Two to OPELMF Three. They will provide logistical support if needed to support the Maternity Service capacity. To attend delivery suite to support with phone calls and to facilitate conversations as required and complete documentation to enable the delivery suite coordinator to continue to coordinate the care of the women, babies, and staff. To liaise with senior colleagues as per Trust escalation process.
Managers of the day	Are responsible for gathering information regarding staffing, bed capacity and acuity in all maternity inpatient areas and having oversight of the community service. They support the delivery coordinator and ward managers daily to ensure the safe and

	timely flow of patients throughout the maternity service by the resolving of staffing shortages and redeployment of staff within the clinical area. Report to the matrons, DoM, and community manager. Attend safety huddle with obstetricians, neonatal team, anaesthetist, and delivery suite coordinator. At early signs of pressure, the manager of the day will escalate to the matrons and consultant obstetricians and will commence the documentation as required. They will also undertake non-clinical tasks to support discharges and patient flow when required. Ensure daily management of admissions and discharges to promote an accurate bed state. Ensure robust data on incoming admissions, and other data that will influence the maternity services ability to manage the fluctuations in demand and capacity. Monitor the quality of bed state reports of wards and provide feedback via handovers and huddles on any themes that may be identified for specific areas. Coordination of information for presentation at Trust bed capacity meetings.
Maternity matrons	Are responsible for coordinating the maternity service. They are the next stage in the escalation process and will support operational decision making including ensuring safe timely discharges of those able. They will liaise with and support consultant colleagues.
Delivery suite coordinator & ward managers	Ensure ward staff has the knowledge and skills in achieving processes for safe and timely discharges within the ward areas. Vacated beds are declared immediately to the bed manager/bleep holder. Ensuring decontamination is carried out promptly and effectively. Escalate any delays in management of a women's care and treatment that could delay a discharge to the senior midwifery management team. Ensure collaborative working which includes the neonatal unit manager to ensure all discharge planning actions are carried out in an integrated manner.

Integrated Care System (ICS) gold on call	Support Local action which includes the localisation and initiatives that are in place for the LMNS using existing cross-organisational partnerships and cross-border arrangement with neighbouring LMNSs. During the escalation process the system on call and the lead commissioner within ICS will be notified as per contractual arrangements via silver & gold command.

5.0 Process

5.1 Staffing model

The current staffing model within the maternity unit is based on birth activity; the following template, which takes into consideration professional judgement, is recommended.

Midwives	**Day**	**Night**
Delivery Suite	11 + 2 Th	12
Triage	3 (includes telephone triage) + 10/6	3
Postnatal Ward	3 + NIPE	3
Antenatal Ward	2+10/6	2
Wrekin MLU	2	2
DAU	1	
Support Staff	**Day**	**Night**
Delivery Suite	2	2
Triage & DAU	2	1
Postnatal Ward	2 + 2 MSW (or 3+1)	2 + 2 MSW (or 3+1)
Antenatal Ward	1	1
Wrekin MLU	1	1

The Maternity Service will undertake a BirthRate Plus® assessment 3 yearly, or in the light of any changing conditions that affect the service i.e., increased activity, or other National recommendations. In addition, the midwifery staffing establishment is reviewed 6 monthly at Board via a report provided by the DoM. The report will include a clear breakdown of BirthRate Plus® calculations (or equivalent) as per the requirements of safety action 5 of the CNST Maternity Incentive Scheme.

5.2 Management of Absence/Sickness

All issues related to staff absence or sickness will be discussed daily at the morning management huddle by the Manager of the Day, including weekends/bank holidays due to the introduction of a 7-day manager of the day service.

Sickness/absence will be managed as per the Trusts Attendance policy.

Where staffing is below template, an incident report should be submitted via Datix by the manager of the day.

Delivery Suite Coordinator
A Band 7 coordinator will be rostered to always manage the Delivery Suite. In times of unexpected absence or sickness of the coordinator, the next most experienced Midwife on duty will assume the role of coordinator. Between the hours of 09:00-17:00, Monday to Friday, the Delivery Suite Matron and/or Delivery Suite Manager and the DoM (or DDoM) will be informed of the absence of the coordinator. Out of hours, the Divisional Manager on-call should be contacted who will contact the off-duty band 7 team to arrange cover using bank/overtime or a change in rota. A Datix will be submitted and reviewed at the next daily huddle, in addition to discussion at the weekly incident review meeting.
All workforce shortages/excess activity or high workload due to acuity of the patients should be reported via Datix and Red Flagged.

Contingency for managing short term sickness/absence
When sickness/absence occurs, the person in charge (Manager of the day in hours, delivery suite coordinator out of hours) will risk assess the need to replace the absent member(s) of staff, taking into consideration the activity and acuity of the patients within the affected area. Not all sickness/absence will require replacement as acuity may be manageable. When it is necessary to replace the absent members of staff, consideration should be given to the reorganisation of immediate shift patterns to allow more time for the rearrangement of staff shifts later in the week.

Where possible, the community teams should provide cover to the MLU during times of decreased staffing due to unplanned absence, however staff may be utilised from other areas within the maternity service.

5.3 HIGH ACTIVITY/ACUITY

Periods of high activity, acuity and staffing shortage can occur within any area in maternity services. Areas of increased risk during these episodes are Delivery Suite, the Midwifery Led Units (where intrapartum, care is being delivered) and the inpatient wards. However, all areas will be considered in this policy.

Delivery Suite
The standard for all maternity services is to provide 1:1 care for women in established labour. In addition, the timely assessment of women presenting to Maternity Triage must be maintained to prevent adverse incidents as a result of delays in care. If there is a concern about either staffing or acuity levels, the Delivery Suite Coordinator will undertake an assessment using the intrapartum acuity tool to support the accurate identification of a staffing/acuity deficit which will inform the need to implement the escalation process. If the tools confirms a deficit, it is essential to identify whether the unit is in amber or red acuity – this is determined not by the numbers of midwives on duty but rather the number of midwives required to safely provide the required midwifery care – this can be above or below the agreed template numbers.

Midwifery numbers (based on acuity tool)	Alert level (BirthRate Plus®)	Action
1 below	AMBER	Consideration to be given to implement the Escalation Policy. Review staffing allocation to ensure effective use of existing on-site staff and provision of 1:1 care as detailed above
2 below	RED	If resolution to staffing is not expected in next 30 minutes or care is being compromised the Escalation Policy MUST be implemented and an incident logged with Datix

Maternity Triage

All women attending triage should be assessed within 15 minutes of their arrival. This will ensure women are then treated in order of priority. In order to do this, it may be necessary for women awaiting medical or other review to move back to the waiting area if appropriate. If the midwife in triage is not able to see a woman or women within 15 minutes for this initial assessment it must be escalated to the Delivery Suite Coordinator who will then review and determine the most appropriate plan of care.

This may include:

- Sending additional midwifery support to triage
- Arranging transfer to another area for review – this may include Delivery Suite or the wards. Moving a woman to another area except for Delivery Suite must be a last option especially if that area would not normally review a woman with the presenting complaint. This decision is made by the Delivery Suite Coordinator following appropriate risk assessment of the overall situation.

Should an alternative not be available this must be escalated to the Director of Midwifery (or Head of Midwifery) in hours and the Divisional Manager on-call out of hours.

An incident form should be submitted for all occasions when a woman is moved anywhere other than Delivery Suite or if a woman is not seen & triaged within 15 minutes.

Any woman not seen within 15 minutes ***due to midwifery staffing*** is to be reported as a red flag

Out of office hours, the Delivery Suite coordinator will be responsible for the initiation of the Escalation Policy. The coordinator will request assistance from the in-patient maternity areas. If the staffing/acuity on the ward areas will be left sub-optimal then the Divisional Manager on-call must be called, and they will review the overall position. They will also assist the ward midwife to risk assess the level of care required on the wards and prioritise the workload. Essential care such as medication, observations etc. will need to be prioritised until the situation on Delivery Suite is resolved. Any redeployment from the wards must be for the shortest time possible and the midwife repatriated back to the ward at the earliest opportunity. Consideration should be given to moving support staff to the ward area which has been depleted of midwifery staffing.

Redeployment of a midwife from the MLU should only be considered in exceptional circumstances and this decision must be made by the Divisional Manager on-call in liaison with the Delivery Suite Coordinator. The midwife (or another midwife e.g., community on-call) must be repatriated to the MLU as soon as a woman is admitted to the MLU in labour.

Antenatal and Postnatal wards
If the area affected is the wards the midwife in charge of the ward area will liaise with the other ward for support. If this is not possible the situation will be escalated to the Delivery Suite Coordinator to identify support from Delivery Suite. Other staff as agreed with the 'Manager of the day' may be utilised during office hours.

Out of hours if Delivery Suite is unable to assist, the Divisional Manager on-call will be contacted who will assist the ward midwife to risk assess the level of care required on the wards and prioritise the workload. Essential care such as medication, observations etc. will need to be prioritised until the situation is resolved. Consideration should be given to the redeployment of support staff to the ward area if it is not possible to redeploy a midwife. Contact site manager or on-call manager for hospital to see if any nursing or support staff can be deployed to assist with general care such as observations or other personal hygiene needs.

Consideration should also be given to requesting support from Neonates should midwives be redeployed to delivery suite. In hours, neonates could support with NIPE etc. if staffing allows.

Community
If the excess workload is in the community the Ward Manager of the day should review the workload of the midwives. Antenatal Clinic cover is the priority followed by essential postnatal visits e.g., primary visit, Day 5 screening visit. Consider the use of a postnatal clinic based at the MLU to facilitate as many reviews as possible by one midwife. Reschedule any other visits following appropriate risk assessment. The appropriate deployment of support workers will support the activity. Antenatal clinics should not be cancelled unless there are no alternative and antenatal assessments should be rescheduled for all women following an individual review of each case taking into account gestation and any risk factors identified. This should only be done in conjunction with the consultant on-call.

Wrekin Midwifery Led Unit (MLU)
The MLU will require additional midwifery staff if 2 women are in labour simultaneously. This can be provided either by Delivery Suite if acuity allows or the community midwifery teams via the on-call system. The midwife in charge of MLU should call the Delivery Suite Coordinator as soon as possible once it is identified that there are 2 women in labour. This may be at the time of the initial phone call from the woman if there is a high index of suspicion that she is in labour. If possible, a midwife will be deployed from Delivery Suite to be the third midwife. If not possible then the on-call community midwife must be called to attend. Inform the Delivery Suite Coordinator to advise that any new admissions will require transfer to Delivery Suite if help cannot be sent to MLU. The home birth service may need to be suspended in these situations

Contact the Divisional manager on-call to advise of situation

The **third midwife** will

- Provide support during the first and second stage of labour
- Offer break relief where required
- Initiate neonatal resuscitation if required
- Assist with other emergency procedures if required
- Remain on MLU if transfer to Delivery Suite (Wrekin MLU Transfer SOP) is required
- Attend to any admissions, planned activity, and offer telephone advice/triage to women who are calling the unit – divert all women in labour to Delivery Suite / triage
- If a third woman arrives in active labour, consider whether it is safe to transfer to Delivery Suite – this will be with the midwife in attendance (Wrekin MLU transfer SOP) – a second on-call community midwife must be asked to attend to take over the duties described above

5.4 Management of Bed Capacity

It is important to ensure that maternity beds are utilised efficiently to avoid unnecessary suspension of maternity services due to capacity issues. Bed monitoring should commence following the morning management huddle at 09:15 throughout the day by all ward managers supported where required by the matrons. An action plan should be formulated prior to the 15:15 hours management huddle by the appropriate Ward manager/matron for each area to keep all staff informed of the situation when the unit is busy

In the event of an anticipated bed shortage the following action should be taken – the Manager of the day/Matron will liaise with the Consultant on duty – **in hours, notify the Clinical Director, DoM, and Divisional Director of the capacity issue if it persists despite these measures being taken**.

- All planned admissions should have an individual risk assessment completed to establish whether admission is required imminently and admission deferred if safe to do so based on multidisciplinary team risk assessment (such as women awaiting IOL). The risk assessment must be documented in the maternal record. Other women who need to be admitted for other reasons may need to be admitted to an alternative unit
- Identify women for early discharge, involving both Obstetric and Neonatal staff
- Women suitable for early transfer to community will be offered an appointment for NIPE in their local MLU if it is not possible to complete whilst in hospital. The examination MUST be completed within 72 hours of birth. The examination may be performed by a community midwife trained in NIPE if available and this information MUST be given to the community teams when advised of the discharge. This will ensure appropriate allocation of a suitably trained midwife where possible for the primary visit.
- At time of significant shortages, help should be sought from the Neonatal team to complete NIPE.
- Any women waiting for induction of labour on the antenatal/postnatal wards should be transferred to Delivery Suite to allow an increase in postnatal beds on the ward. It may be necessary to consider discharging these women home, if

appropriate (based on the outcome of the appropriate risk assessment), to return the next day.

5.5 When Suspension of Services is Required

The temporary suspension of maternity services should only be considered when all good practice options have been exhausted and action cards for the relevant OPELMF status have been implemented.

Action cards should be followed for OPELMF status Two, Three and Four (see Appendix 2 for triggers and actions required).

The decision to divert or close the maternity unit will be the decision of the Executive Director on call and will usually be at OPELMF Four status (see Appendix 2 Action cards). Before making such a decision, the Executive Director must be satisfied that all other procedures in this policy have been followed and that the situation cannot be contained. In addition, **suspension of services can only be implemented if there has been agreement with other maternity units to take any referrals from the Trust during the period of suspension. It cannot be instigated until care provision has been confirmed at a neighbouring Trust.**

In normal working hours, this decision must be agreed with the Director of Midwifery or a designated deputy. In the event that they are not available the decision will be jointly made by the Consultant Obstetrician on call and the Maternity Manager on call and the Divisional Director will be notified at the first available opportunity.

Restricting admissions includes admissions to the unit via Maternity Triage.

Once the decision has been made to temporarily divert new admissions or close maternity services, the ambulance service must be contacted immediately. It is recommended that one person is nominated to coordinate the closure and wherever possible should have no other responsibilities during this time (this should be the on-call manager to ensure all midwifery support is available to support the service).

It is recommended that a four hourly review of capacity should take place at OPELMF Two. OPELMF Three requires capacity to be reviewed 2 hourly and OPELMF Four requires a review hourly to ensure routine operational working can commence as quickly as possible.

In office hours

The Manager of the day must ascertain the number and status of patients on Delivery Suite, the MLU and the ward areas, including the availability of staff across the Trust, including community and specialist services. This information should then be discussed with the:

- Director of Midwifery (or Head of Midwifery)
- Clinical Director (or Deputy)
- Consultant Obstetrician on-call
- Delivery Suite Coordinator

- On-call manager of the day
- Matrons
- Consultant Neonatologist and consultant obstetrician on call
- Divisional Director (or Deputy)

Out of hours including Bank Holidays
The Coordinator on Delivery Suite will contact the W&C Divisional Manager on-call who will ascertain the number and status of patients on Delivery Suite, the MLU and the ward areas, including the availability of staff (on-call) across the Trust. It would be expected that if there was a need to consider restricting admissions the Divisional Manager on-call would attend the hospital. This information would then be discussed with the Consultant on call and the coordinator to determine the position which would then be presented to the Executive Director on Call for final decision.

The Situation Background Assessment Recommendation D tool in appendix 4 and Ward Activity Sheet appendix 5 can be used as a tool for assessing overall staffing and acuity to support risk assessment and decision making.

Out of hours the Divisional manager on call will notify:

- Executive Director / Director on call – for final decision
- Consultant Obstetrician on call
- Consultant on call for Neonatal Unit
- Shift Leaders for Delivery Suite, NICU and wards
- MLU Team leader

Closure of the obstetric unit will lead to closure of the midwifery led unit to any further admissions. Women should be advised when they call that the unit is closed.

Consideration will be given to transferring low risk women to the MLU (even if not booked there). The decision/liaison will be made between the midwives in charge of both areas and must be based on adequate risk assessment of each woman.

Planned home births must be taken into consideration when reviewing acuity across the service. Community Midwives in attendance at a home birth must be informed if there is a possibility that the unit may close, so that discussions can be had with the woman and her family in relation to possible transfer times.

Please note that it may be more appropriate to transfer to a nearby accepting hospital rather than one belonging to the network depending on the woman's personal circumstances and preferences.

The Consultant Neonatologist (9am – 5pm) and Ward Manager/Senior Nurse of the Neonatal unit will be informed to ensure that in-utero transfers are not accepted. Out of hours the senior neonatal nurse will liaise with the Delivery Suite Coordinator and inform the on-call consultant of the situation. The Outpatient Ward Manager should be informed to advise the obstetric medical staff in clinic of the closure and that high-risk

antenatal women should be considered for transfer if it is expected that they will need delivery.

Each woman who contacts Maternity Triage requesting admission must be informed of the suspension of services and redirected to the nearest hospital that is offering assistance.

A record should be kept of all women who have been re-directed and a copy forwarded to the DoM as soon as possible who will contact all women who have been redirected to explain the reason for the suspension of services and to apologies for any inconvenience,

The temporary diversion will be communicated on the Trust website and any applicable social media networks as soon as is practically possible, in addition to alerting the Chair of the local Maternity Voices Partnership.

6.0 Review Process

The Trust will review this policy every 5 years, unless there are significant changes at either national policy level, or locally. In order that this document remains current, any of the appendix to the policy can be amended and approved during the lifetime of the document without the document having to return to the ratifying committee.

7.0 Equality Impact Assessment (EQIA)

This policy has been subject to an Equality Impact Assessment and is not anticipated to have an adverse impact on any specific group.

8.0 Process for Monitoring Compliance

Monitoring Process	Requirements
Who	Director of Midwifery
Standards Monitored	• A review of all staffing related red flags/incidents which reflect deficiencies in staffing levels or skill mix of staff available • Review of the supernumerary status of a Band 7 Coordinator on every shift • A review of bank usage filled by area • Unavailability • Intrapartum acuity • 1:1 care in labour
When	Monthly
How	Staffing report
Presented to	Maternity Governance and Nursing, Midwifery & AHP Workforce Meeting
Monitored by	Director of Midwifery
Completion/Exception reported to	Maternity Governance Women and Children's Divisional Committee Quality and Safety Assurance Committee Trust Board

Appendix 1: Midlands Acute Maternity OPEL Maternity Framework – Definitions

Regional Phase	OPELMF One	OPELMF Two	OPELMF Three	OPELMF Four
Description	The maternity service capacity is such that the organisation can maintain patient flow and meet anticipated demands within available resources. Additional support is not anticipated. No interaction with the local ambulance service needed business as usual.	The maternity service is starting to show signs of pressure. The maternity service will be required to take internal focused actions to mitigate the need for further escalation. The maternity service will undertake enhanced co-ordination with the trust operations team and take appropriate & timely actions to reduce the level of pressure in their organisation. Communication to be coordinated by trust operations team to alert the Integrated Care Boards (ICBs) System Coordination Centres (SCC) to rising pressure and local escalation in place (in-hours only). No interaction with local ambulance service needed business as usual.	The maternity service is experiencing major pressures compromising patient flow and safety. Trust operational support is having limited impact and organisational pressure continues to increase. Further urgent actions are now required across the whole ICB to source system level support to mitigate further escalation and consider and identify mutual aid support with neighbouring ICBs. Escalation for mutual aid support will be made by the ICB SCC (in-hours)/ICB On Call (out of hours) to Regional Coordination Centre (RCC) (in-hours only)/NHSE On Call structure (out of hours only) outlining the safety issues. The RCC/NHSE On Call will facilitate communications within the region to source mutual aid. Support offers will be received directly by the ICB SCC (in-hours only)/ICB On Call (out of hours only) and managed within the system. Interaction with local ambulance service required if formal divert of ambulances required between sites/organisations.	Pressure in the maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised. All available local and ICB escalation actions have been taken and mutual aid support requested and utilised. Regional support and intervention are required. Communication coordinated by trust operations team to alert the ICB SCC (in-hours)/ICB On Call (out of hours) of OPELMF Four via local escalation processes. The ICB SCC/ICB On Call will review the actions undertaken to rapidly resolve the pressures driving the escalation using the ICB escalation process. Escalation for regional support will be made by the ICB SCC (in-hours)/ICB On Call (out of hours) to the RCC (in-hours only)/NHSE On Call (in hours and out of hours) outlining the safety issues and action taken to address. Request local ambulance service to implement service diversion to deflect maternity patients when maternity unit is closed.

Appendix 2 – OPEL Maternity Framework – Escalation Triggers

Escalation Triggers **Final Version 2.0, January 2023**

OPEL STATUS	Maternity ward-based bed capacity	Delivery suite bed capacity	Obstetric staffing shortfalls impacting on safe care delivery	Anaesthetic staffing shortfalls impacting safe care delivery	Delivery Suite Birthrate Plus® activity and dependency score	Labour ward coordinator is not supernumerary (refer CNST definition)	Neonatal Services OPEL Framework Status
Black Four	No ward beds available & no planned discharges	No Delivery Suite beds available & no planned discharges	Staff shortages impacting on patient care and delays in emergency care	Staff shortages impacting on patient care and delays in emergency care	Birthrate Plus® rating RED safety affected – mitigating actions taken and services stood down	Providing 1:1 direct care and have no oversight of the labour ward	OPEL NF FOUR Demand exceeds available resource.
Red Three	Limited ward beds available impacting on inpatient flow	Limited Delivery Suite beds impacting on inpatient flow & admissions	Staff shortages impacting on patient care and elective activity delayed	Staff shortages impacting on patient care and elective activity delayed	Birthrate Plus® rating RED safety maintained – mitigating actions taken and services stood down	Temporarily providing 1:1 care and have limited oversight of the labour ward	OPEL NF THREE Very limited ability to maintain patient flow in line with ODN pathways.
Amber Two	Sufficient ward beds no impact on inpatient flow	Limited Delivery Suite beds impacting on planned admissions but no impact on inpatient flow	Staff shortages with no impact on patient care or delays	Staff shortages with no impact on patient care or delays	Birthrate Plus ® rating AMBER safety – mitigating actions taken to maintain safe care delivery	Supernumerary and have oversight of labour ward but high acuity	OPEL NF TWO Neonatal service is experiencing difficulty in meeting anticipated demand with available resources
Green One	Ward beds available. No delays in admission or transfers	Delivery Suite beds available no delays in admissions, elective activity and inpatient activity	No staffing shortages	No staffing shortages	Birthrate Plus® rating GREEN	Supernumerary and have full oversight of labour ward and able to support other midwives	OPEL NF ONE ODN unit open to admissions in line with unit designation

The level of escalation declared is based on the OPELMF status. Each escalation trigger has a corresponding score assigned to it dependent upon the level of escalation (see Table 1 below). The total calculated escalation trigger score defines the final OPELMF rating. Refer to OPELMF Action Cards (see Appendix 4a and Appendix 4b) for actions to be followed for declared OPELMF rating.

Table 1: Escalation Score

	Maternity ward-based bed capacity	Delivery suite bed capacity	Obstetric staffing shortfalls impacting on safe care delivery	Anaesthetic staffing shortfalls impacting safe care delivery	Delivery Suite Birthrate Plus® activity and dependency score	Labour ward coordinator is not supernumerary (refer CNST definition)	Neonatal Services OPEL Framework Status	MAXIMUM TOTAL
Black Four	3	3	3	3	3	3	3	21
Red Three	2	2	2	2	2	2	2	14
Amber Two	1	1	1	1	1	1	1	7
Green One	0	0	0	0	0	0	0	0

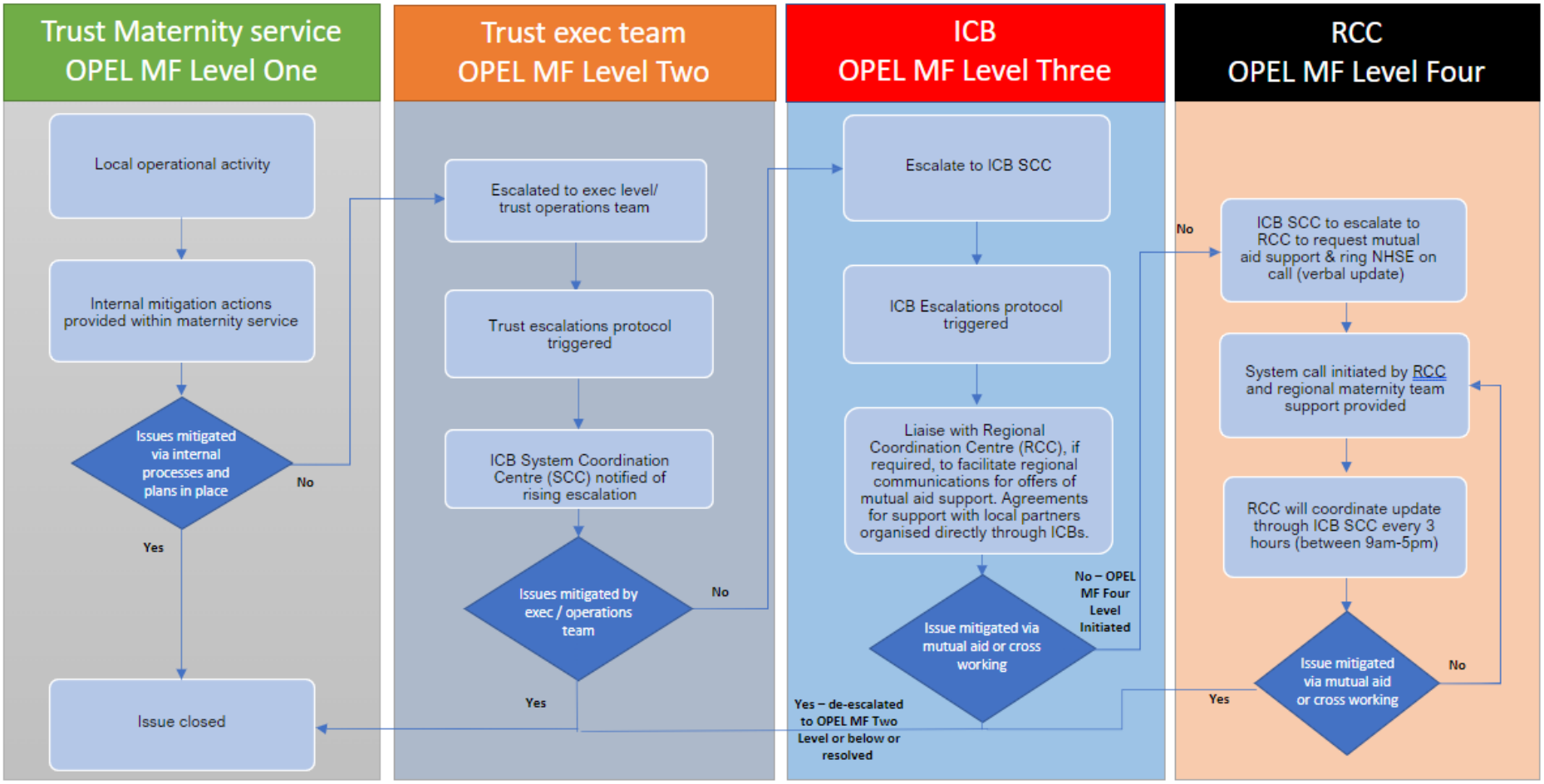
OPELMF One			OPELMF Two							OPELMF Three							OPELMF Four				
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21

Appendix 3a – Maternity escalation framework ‘In hours’

Maternity Escalation Process ‘In hours’

NHS England

Version 1, January 2023

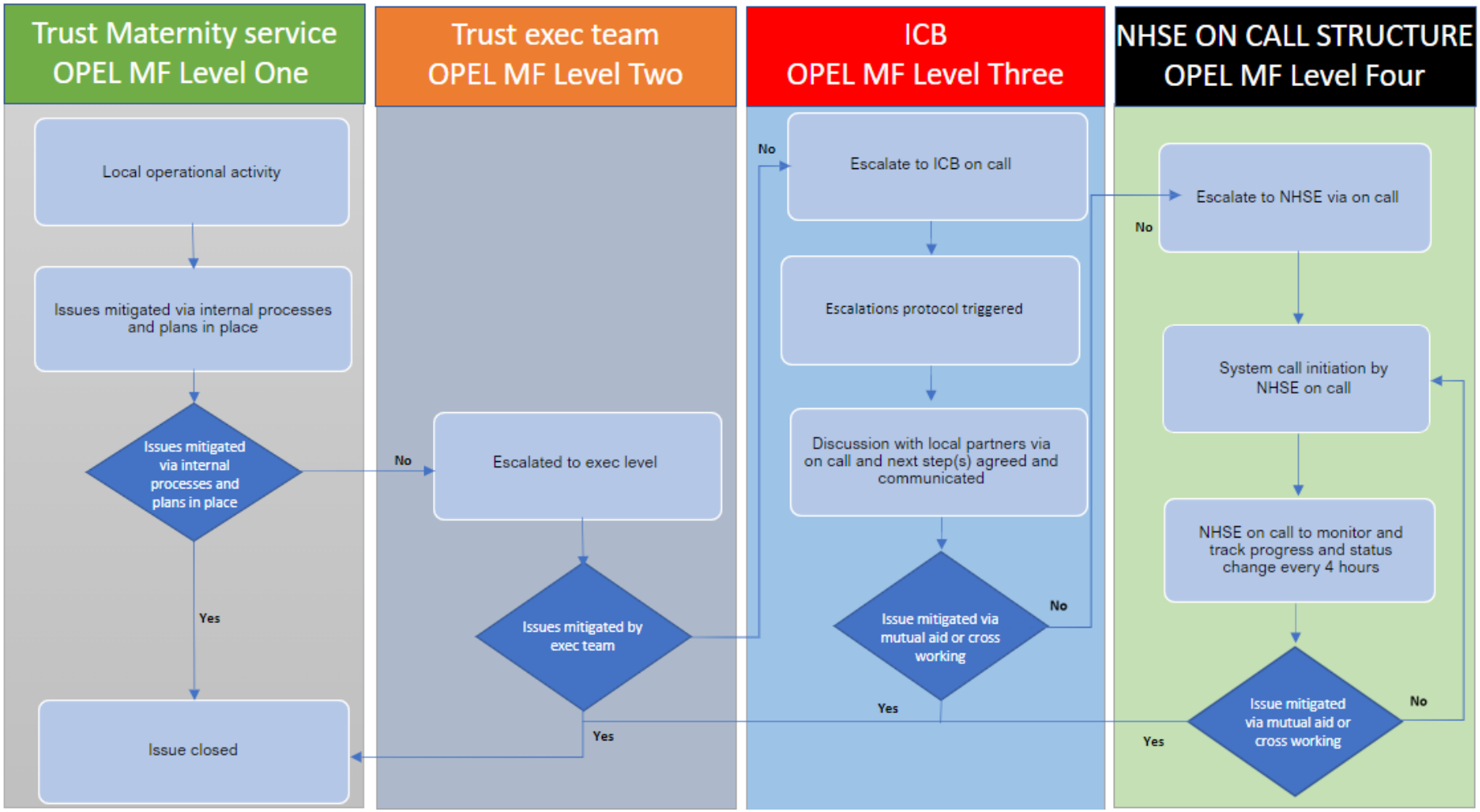


Appendix 3b: Maternity Escalation Framework 'Out of hours'

Maternity Escalation Process 'Out of hours'

NHS England

Version 1, January 2023



Appendix 4: Maternity Escalation & OPELMF – Trust Action Card (In and Out of hours)

Maternity Escalation & Operational Pressures Escalation Levels Maternity Framework (OPELMF) – Action Card for Trusts (In and Out of Hours)

Regional Phase	OPELMF One	OPELMF Two	OPELMF Three	OPELMF Four
Description	The maternity service capacity is such that the organisation can maintain patient flow and meet anticipated demands within available resources. Additional support is not anticipated. No interaction with local ambulance service needed - business as usual.	The maternity service is starting to show signs of pressure. The maternity service will be required to take internal focused actions to mitigate the need for further escalation. The maternity service will undertake enhanced co-ordination with the trust operations team and take appropriate & timely actions to reduce the level of pressure in their organisation. Communication to be coordinated by trust operations team to alert the Integrated Care Boards (ICBs) System Coordination Centres (SCC) to rising pressure and local escalation in place (in-hours only). No interaction with local ambulance service needed - business as usual.	The maternity service is experiencing major pressures compromising patient flow and safety. Trust operational support is having limited impact and organisational pressure continues to increase. Further urgent actions are now required across the whole ICB to source system level support to mitigate further escalation and consider and identify mutual aid support with neighbouring ICBs. Escalation for mutual aid support will be made by the ICB SCC (in-hours)/ICB On Call (out of hours) to Regional Coordination Centre (RCC) (in-hours only)/NHSE On Call structure (out of hours only) outlining the safety issues. The RCC/NHSE On Call will facilitate communications within the region to source mutual aid. Support offers will be received directly by the ICB SCC (in-hours only)/ICB On Call (out of hours only) and managed within the system. Interaction with local ambulance service required if formal divert of	Pressure in the maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised. All available local and ICB escalation actions have been taken and mutual aid support requested and utilised. Regional support and intervention are required. Communication coordinated by trust operations team to alert the ICB SCC (in-hours)/ICB On Call (out of hours) of OPEL MF Four via local escalation processes. The ICB SCC/ICB On Call will review the actions undertaken to rapidly resolve the pressures driving the escalation using the ICB escalation process. Escalation for regional support will be made by the ICB SCC (in-hours)/ICB On Call (out of hours) to the RCC (in-hours only)/NHSE On Call (in hours and out of hours) outlining the safety issues and action taken to address.

			ambulances required between sites/organisations.	Request local ambulance service to implement service diversion to deflect maternity patients when maternity unit is closed.
Trust Actions – In-Hours only:	No actions required – business as usual.	Trust in hours escalation processes to be followed to source support from within the organisation. The Divisional Leadership Team (DLT) should be informed of rising escalation and there should be active involvement of the Head/Director of Midwifery. The Trust Silver (Tactical) On Call should be informed that organisational support is required as per the local escalation process. The Trust Bronze (Operational) On Call teams should work to source support from other departments. Timely review of ward and delivery suite patients to expedite medical review and ensure flow of patients suitable for discharge. Consider extra domestic staff to increase room availability turn around. Redeploy skilled staff according to area of need - including deployment of non-clinical teams.	Ensure all OPELMF Two actions are completed. Escalate to ICB SCC. Further urgent actions are now required across the whole ICB to source system level support to mitigate further escalation and consider and identify mutual aid support with neighbouring ICBs. The decision to divert and deflect women between sites within an organisation to be agreed between the Senior Manager On Call and Silver (Tactical) On Call. This is an internal operational decision and ICBs are not required to be notified. Once divert has been agreed between sites a request should be made to the Ambulance Service to implement service diversion. Consider rescheduling elective work both inductions and LSCS if clinical conditions permit following sign off agreement as per local escalation policy. Consider utilisation of other staff groups including:	Ensure OPELMF Two and OPELMF Three actions are completed. The Trust Gold (Strategic) On Call should be contacted and made aware of rising pressure via local escalation processes. Escalate to ICB SCC OPELMF Four status to initiate ICB escalation processes and request for regional support. Liaise with the ICB to confirm actions taken to resolve the escalation and provide an understanding of the pressures and issue. Escalation for regional support will be made by the ICB SCC to the RCC outlining the safety issues and action taken to address. A Regional Mutual Aid and Escalation call will be facilitated by the RCC and supported by the Regional Maternity Team. This call will be arranged within 2 hours of initial notification. Exec and senior leader representation to attend

		Request additional bank and agency staff including midwives, maternity support workers and health care workers. Consider whether study leave and/or meetings need to be cancelled to source additional staff who can work to support safe care delivery. Review neonatal cot capacity for current and anticipated activity. Consider intrauterine transfers required to ensure women whose babies may not be accommodated on the neonatal unit are transferred in the daytime when staffing levels are optimal. Increase communications to staff to ensure everyone is fully briefed of situation and actions agreed. Review OPELMF status which includes staffing, skill mix and bed capacity 4 hourly and update internal On Call Teams. Communication to be coordinated by trust operations team to alert the Integrated Care Boards (ICBs) System Coordination Centres (SCC) to rising pressure and local escalation in place (in-hours only).	• neonatal and paediatric nurses to care for transitional care babies. • nursing staff to provide post-op care. • prescribing pharmacist or competency nurses to complete drug rounds on wards. • senior student midwives and maternity support workers for community postnatal visits. For low-risk babies, consider the community midwife undertaking newborn and infant physical examination (NIPE) in the mother's home to support rapid early discharge of mothers and babies. Consider postponing non-urgent community midwifery antenatal visits for 16, 25, 31-week low risk women (antenatal care requiring a physical examination and/or screening should be maintained) Liaise with key partners for example gynaecology to see if they can accommodate any antenatal women <20 weeks as per local Trust arrangements. Silver (Tactical) On Call to consider the potential for additional governance, data and administrative support for maternity services, as all midwives working in those teams will	a Regional Mutual Aid and Escalation call should be confirmed. Verbal updates to be provided to the ICB SCC every 3 hours (between 08:00-20:00), via the escalation template. The decision to request to temporarily close (suspend) a maternity unit should be agreed by the Trust Gold (Strategic) On Call. The ICB SCC should be notified of requests to close a maternity unit via the in hours (Appendix 3a) escalation framework process. Once a suspension has been agreed a request should be made to the local ambulance service to implement a service diversion to deflect maternity patients when a maternity unit is closed. The trust should specifically outline to the ambulance service where the trust is diverting to and a clear timeframe on how long the divert should last. A contingency plan must be put in place for women that may unexpectedly attend delivery suite & triage areas without notice to manage care safely.

			be moved to support front line delivery of clinical services. Consider contingency plans to maintain homebirth services. Engage with the neonatal ODNs around surge planning to ensure access to neonatal critical care is not compromised. Consider facilitating regular safety huddles with all key clinicians and operations team members until OPELMF Two or below reached. If trust and system actions taken do not resolve the escalation, the ICB SCC should escalate to RCC to request regional comms for mutual aid support from within the region. Trust communications department to support updates across the organisation and into the community (including with the Maternity Voice Partnerships) to help share and amplify key messages to staff, women, their families and members of the public.	Report suspension via StEIS in line with SI Framework for maternity unit closure. Inform the ICB SCC when the issue raised has been resolved for the purposes of de-escalating regional support and confirm current OPELMF status. Undertake a debrief with the ICB to identify learning. This learning should be captured and evidenced and shared widely.

Trust Actions – Out of Hours only:		Trust out of hour escalation processes to be followed to source support from within the organisation. Delivery Suite Coordinator and Consultant Obstetrician On Call to undertake a timely review of ward and delivery suite patients to expedite medical review and ensure flow of patients suitable for discharge. Inform the on-site maternity bleep holder of rising escalation. Escalate to Trust Silver (Tactical) On Call via local escalation processes. ICB On Call teams DO NOT require notification of rising escalation to OPELMF Two out of hours. Liaise with hospital site manager to provide extra cleaning and maximise available support to manage bed clearance. Bed capacity should be managed by the by the out of hours bed management team and reviewed every 2 hours. Alert Neonatologist On Call and request a review of neonatal cot	Ensure all OPELMF Two actions are completed. Consider contingency plans to step down homebirth services and On Call Midwives to attend unit to support. Delivery suite coordinator to contact Trust Silver (Tactical) On Call for support & oversight. Escalate to ICB On Call to confirm actions taken to resolve the escalation and provide an understanding of the pressures and issue outlining the following: • The details driving the escalation • The specific actions taken to alleviate said pressure • The actions taken to ensure patient safety and quality If the system and local actions taken do not resolve the escalation and operational pressures continue to rise the ICB On Call if required, should escalate to the NHSE On Call requesting mutual aid. Delivery Suite Coordinator, Consultant Obstetrician On Call, Consultant Neonatologist On Call, Trust Silver (Tactical) On Call & ICB On Call to maintain regular communication until OPELMF Two or below reached.	Ensure OPELMF Two & OPELMF Three actions are completed. The Trust Gold (Strategic) On Call should be contacted and made aware of rising pressure via local escalation processes. Escalate to ICB On Call to review the actions undertaken to rapidly resolve the pressures driving the escalation using the ICB escalation process. Escalation for regional support will be made by the ICB On Call to the NHSE On Call outlining the safety issues and action taken to address. A Regional Mutual Aid and Escalation call will be facilitated by the NHSE On Call. This call will be arranged within 2 hours of initial notification. On call senior leader representation to attend a Regional Mutual Aid and Escalation call should be confirmed. Verbal updates to be provided to the NHSE On Call every 3 hours (betwee 20:00-08:00) by phone, or as otherwise agreed. The decision to request to temporarily close (suspend) a maternity unit should be agreed by the Trust Gold (Strategic) On Call. The ICB On Call should be notified of requests to close a maternity unit via the out of hours

		capacity for current and anticipated activity. Review OPELMF status which includes staffing, skill mix and bed capacity 4 hourly and update internal On Call Teams as per out of hours internal escalation processes.	The decision to divert and deflect women between sites within an organisation to be agreed between the Senior Manager On Call and Silver (Tactical) On Call. This is an internal operational decision. Once divert has been agreed between sites a request should be made to the Ambulance Service to implement service diversion. Out of hours the Trust should follow its EPRR policy regarding communications with local communities. Inform the ICB On Call when the issue raised has been resolved for the purposes of de-escalating regional support and confirm current OPELMF status.	(Appendix 3b) escalation framework process. The trust should specifically outline to the ambulance service where the trust is diverting to and a clear timeframe on how long the divert should last. Once a suspension has been agreed a request should be made to the local ambulance service to implement a service diversion to deflect maternity patients when a maternity unit is closed. A contingency plan must be put in place for women that may unexpectedly attend delivery suite & triage areas without notice to manage care safely. Report suspension via StEIS in line with SI Framework for maternity unit closure. Inform the NHSE On Call when the issue raised has been resolved for the purposes of de-escalating regional support and confirm current OPELMF status.

Appendix 5 – Contact details for Trusts in the Midlands with Maternity Units

Trusts with Maternity Units	Hospital Site	Delivery Suite Direct Dial number	Switchboard	Address1	Address2	County	Postcode
Birmingham Women's and Children's NHS FT	Birmingham Women's Hospital	0121 335 8220	0121 472 1377	Mindelsohn Way	Birmingham	West Midlands	B15 2TG
Dudley Group NHS FT	Russell's Hall Hospital	No Direct Dial. Maternity Triage - 01384 456111 Ext 3053 or MLS if low risk on Ext 3064	01384 456111	Pensnett Road	Dudley	West Midlands	DY1 2HQ
George Eliot Hospital NHS Trust	George Eliot Hospital	024 7686 5090	024 7635 1351	College Street	Nuneaton	Warwickshire	CV10 7DJ
Royal Wolverhampton Hospitals NHS Trust	Newcross Hospital	01902 694031 or 01922 694037	01902 307999	Wolverhampton Road	Wolverhampton	West Midlands	WV10 0QP
Sandwell and West Birmingham Hospitals NHS Trust	City Hospital	0121 507 4703 or 0121 507 4184	0121 553 1831	Dudley Road	Birmingham	West Midlands	B18 7QH
South Warwickshire NHS FT	Warwick Hospital	01926 495321 Ext 4552/4553	01926 495 321	Lakin Road	Warwick		CV34 5BW
University Hospitals Birmingham	Heartlands Hospital	0121 424 2710	0121 424 2000	Bordesley Green East	Birmingham	West Midlands	B9 5SS
	Good Hope Hospital	0121 424 7201	0121 424 2000	Rectory Road	Sutton Coldfield	West Midlands	B75 7RR
University Hospitals Coventry & Warwickshire NHS Trust	University Hospital Coventry & Warwickshire	02476 967339 02476 968879 Crm@uhcw.nhs.uk	02476 964000	Clifford Bridge Road	Coventry		CV2 2DX
University Hospitals North Midlands	Royal Stoke Hospital	01782 672333	01782 715444	Newcastle Road	Stoke-on-Trent		ST4 6QG

Trusts with Maternity Units	Hospital Site	Delivery Suite Direct Dial number	Switchboard	Address1	Address2	County	Postcode
Worcestershire Acute Hospitals NHS Trust	Worcestershire Royal Hospital	01905 760571	01905 763333	Charles Hastings Way	Worcester		WR5 1DD
Walsall Healthcare NHS Trust	Manor Hospital	01922 656246	01922 721172	Moat Road	Walsall	West Midlands	WS2 9PS
Wye Valley NHS Trust	County Hospital	01432 364070	01432 344344	Stonebow Road	Hereford		HR1 2BN
Chesterfield Royal Hospital NHS FT	Chesterfield Royal Hospital	01246 200666	01246 277271	Calow	Chesterfield	Derbyshire	S44 5BL
Kettering General Hospital NHS FT	Kettering General Hospital	01536 492879	01536 492000	Rothwell Road	Kettering	Northamptonshire	NN16 8UZ
Northampton General Hospital NHS Trust	Northampton General Hospital	01604 545058	01604 634700	Cliftonville	Northampton	Northamptonshire	NN1 5BD
Nottingham University Hospitals NHS Trust	City Campus	0115 9709777	0115 969 1169	Hucknall Road	Nottingham	Nottinghamshire	NG5 1PB
	Queens Medical Centre (QMC)	0115 9709777	0115 924 9924	Derby Road	Nottingham	Nottinghamshire	NG7 2UH
Sherwood Forest Hospitals NHS FT	King's Mill Hospital	01623 672244	01623 622515	Mansfield Road	Sutton In Ashfield	Nottinghamshire	NG17 4JL
University Hospitals of Derby and Burton NHS FT	Royal Derby Hospital	01332 785141	01332 340131	Uttoxeter Road	Derby	Derbyshire	DE22 3NE
	Queen's Hospital Burton,	Ext 4355 or Ext 4356	01283 511511	Belvedere Road	Burton on Trent	Staffordshire	DE13 0RB
United Lincolnshire Hospitals NHS Trust	Lincoln County Hospital	01522 573140	01522 512512	Greetwell Road	Lincoln	Lincolnshire	LN2 5QY
	Pilgrim Hospital	01205 445424	01205 364801	Sibsey Road	Boston	Lincolnshire	PE21 9QS

Trusts with Maternity Units	Hospital Site	Delivery Suite Direct Dial number	Switchboard	Address1	Address2	County	Postcode
University Hospitals of Leicester NHS Trust	Leicester Royal Infirmary (LRI)	0116 258 6451/6452	0300 303 1573	Infirmary Square	Leicester	Leicestershire	LE1 5WW
	Leicester General Hospital	0116 258 4807	0300 303 1573	Gwendolen Road	Leicester	Leicestershire	LE5 4PW

Appendix 6 - Neighbouring Trust availability to admit diverted women

Temporary closure of maternity service Neighboring Trust availability to admit diverted women				
Unit Name	Contact Number	Date and time contacted	Availability to take	Comments/Feedback

Accepting Trust notified of decision to transfer to them:

Name of Trust ……

Address……

……..

Phone call made by (name) ……

Role …….

Date…… Time …….

Responsibility at accepting Trust taken by (name)……...

Role …….

Phone No: ……. Email…….

Appendix 7 - Key stakeholders to be informed of service closure

Stakeholder	To be informed of		Date and time contacted	Name of person contacted and method of contact	Date and time informed of re-opening
	Diversion	Closure			
East & West Midlands Ambulance Service	√	√			
Neighbouring maternity units + Powys via switch	√	√			
Integrated Care Board System Coordination Centre (In hours)/ICB On Call (Out of hours)		√			
Manager of the day	√	√			
Delivery suite coordinator	√	√			
Matrons	√	√			
DoM/HoM	√	√			
Obstetric consultant	√	√			
Duty matron	√	√			
Head of emergency performance	√	√			
Trust Silver (Tactical) On call	√	√			
Trust Gold (Strategic) On call		√			
Triage midwife in charge	√	√			
Ward coordinators	√	√			
Community midwives on call/community & out-patients matron	√	√			
Professional midwifery advocate (PMA) for professional support	√	√			
Bed manager (where applicable)	√	√			
Neonatal unit/consultant on call	√	√			
Consultant anaesthetist on-call	√	√			
Emergency Department (ED)	√	√			
Governance lead to assist with reporting arrangements	√	√			
Safeguarding team to assist with safeguarding alert process	√	√			
Site manager, W&C on-call manager	√	√			
Switchboard as per local arrangements	√	√			
Security as per local arrangements	√	√			
Trust comms team	√	√			
	Job Title:				

Appendix 8 – SBAR'D Assessment

Situation – describe who and what	Name of caller						
	Role						
	Concern	Staffing		Activity		Other - describe	
Background – what is the current clinical activity and current and anticipated staffing levels	Area	Staffing		Activity / acuity		Concerns	
	Delivery Suite						
	Triage						
	Antenatal Ward						
	Transitional Care						
	Postnatal Ward						
	Wrekin MLU						
	RSH MLU						
	Community including other MLUs						
	ANC						
	Theatre						
	NNU (if required)						

Assessment – which is the actual Problem? Staff deployed according to activity • Addition bank staff requested • Bed management managed appropriately • Relevant people informed in a timely manner • Checklists completed appropriately • Outstanding/pending workload e.g. IOL/CS • Appropriate actions taken at each level to try and deescalate situation • Length of closure appropriate	
Recommendation – what is required? • Appropriate actions taken to try and deescalate situation? • Appropriate decision to temporarily divert maternity services? • Timely review of activity and staffing during closure and reopening? • How many times	

has unit closed in the last 12 months?	
Decision – what is your decision as the on-call manager?	
Additional information	

Appendix 9: Transfer Apology Letter

Insert Trust Logo

Insert Trust Address & Contact Details

[Insert Date]

[Insert Patient Details]

Dear....

Diversion of care to (Insert Trust/Site)

We would like to apologise to you for any inconvenience caused when we recently had to close our maternity unit and were unable to accept your admission for care and treatment.

We experienced an exceptionally high volume of admissions which resulted in the decision to close our maternity unit to maintain the safety of women and families currently receiving treatment and/or needing to be admitted for review and care. This decision is only taken once all options to address the high activity have been taken.

Having liaised with our neighbouring maternity providers and the local Ambulance Services we arranged for you to be seen at the next nearest hospital providing maternity care and open to admissions.

If you wish to discuss any of the events further, please do not hesitate to contact our Patient Experience Team who can be contacted via (Insert contact details). If you have any concerns around your ongoing maternity care, please contact your local community midwife who will be happy to help you.

Yours Sincerely

(Insert Name)

Appendix 10: Glossary of terms

OPEL MF	Operational Pressures Escalation Level Maternity Framework
Formal Ambulance Divert	The practical operational application of an agreed ambulance divert in response to significant and overwhelming local and/or wider system operational pressures.
Emergency Divert	An emergency divert is the application of a divert in relation to a major incident such as fire or flood which results in the Emergency Department becoming non-operational for a period; and/or in a major incident where the casualty distribution plan is operational i.e., not accepting cardiac arrests. In the event of an emergency divert, this will automatically include the maternity department to prevent increasing the stress existing in the organisational site further.
Maternity Suspension	The closure of the maternity service within an organisation, to maintain safety of women and babies, due to extreme operational pressures and/or a major incident.
Maternity Diversion	The diversion of maternity activity from one organisation to another trust, to maintain safety of women and babies, in response to significant and overwhelming local and/or wider system operational pressures.
Deflection	The operational decision to transfer (deflect) women to level out operational pressures within an organisation, maximising use of assets while maintaining patient safety.
RCC	Regional Coordination Centres (RCCs) act as a single point of contact (SPOC) to manage all regional operational communications between ICBs and their providers. The RCC is structured to be the regional point of coordination between the National Operations Centre (NOC); be the single point of access for ICBs to escalate issues, report service changes, management of mutual aid; and receive and share communication regarding national policy/guidance change and subject matter expert support from the regional programmes.
SCC	System Coordination Centres (SCCs) operate at an Integrated Care Board (ICB) level to lead and facilitate collaboration through senior system-level operational leadership, although in some systems SCCs may operate at a sub-ICS level dependent on local patient flows. SCCs deliver visibility of operational pressures and risks across providers and system partners; concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges; dynamic responses to emerging challenges and mutual aid; efficient flows of information.
StEIS	Strategic Executive Information System
RCA	Root Cause Analysis is a systematic process for identifying “root causes” of problems or events and an approach for responding to them.
SBAR	Situation, background, assessment, recommendation is an approach to articulating information often useful in an emergency.
EMAS	East Midlands Ambulance Service

WMAS	West Midlands Ambulance Service
In hours	Period of time between 08.00hr-20.00hr (RCC In hours). Please note this may vary across ICBs.
Out of hours	Period of time between 20.00hr-08.00hr (NHSE On Call). Please note this may vary across ICBs.
ICB	Integrated Care Board
IPC	Infection Prevention & Control
MDT	Multi-Disciplinary Team
NPSM	National Perinatal Surveillance Model is designed to function in the emerging architecture in the NHS, whereby ICS (with full involvement of providers and commissioners) will be responsible for system planning, governance and accountability, management of performance and reducing unwarranted variation in care and outcomes.
LMNS	A Local Maternity and Neonatal System is a partnership of maternity and neonatal service providers, commissioners, local authorities and maternity voices partnerships, who work together to transform maternity services. They are coterminous with ICBs and report through the ICB structures.
NECS	North of England Commissioning Support Unit
EPRR	Emergency Preparedness Resilience and Response
NICU	Neonatal Intensive Care Unit
MNSD	Maternity & Neonatal Sitrep Dashboard
DLT	Divisional Leadership Team
Ockenden IEA	Ockenden Immediate & Essential Actions are the recommendations from the Ockenden Review of maternity services at Shrewsbury & Telford NHS Trust.
NED	Non-Executive Director