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North West Maternity Escalation Policy & Operational Pressures Escalation Levels Framework

NHS England (North-West)

North West Maternity Escalation Policy & Operational Pressures Escalation Levels Framework

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1.0 Introduction

1.1 The North West Maternity Escalation Policy & Operational Pressures Escalation Levels Maternity Framework (OPELMF) sets out the procedures for the North West region to manage significant surges in demand and ensure that maternity services can continue to be provided safely and effectively. A single policy will reduce variation across the region, improve consistency and will improve communication and multi-disciplinary working relationships, enhancing the experience for mothers and babies and reduce harm.

This policy uses a Maternity Operational Pressures Escalation Levels Maternity Framework (OPELMF) to provide a consistent approach in times of pressure, 7 days a week, specifically by:

- Enabling local systems to maintain quality and patient safety
- Providing a regional and locally consistent set of escalation levels, triggers, and protocols across maternity services in the North West
- Setting clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures at a local level, regional level, and national level
- Setting consistent terminology

1.2 This framework is designed for managers and clinicians involved in managing maternity capacity at a time of excess demand and / or other operational pressures. It is to be circulated to all staff who manage maternity capacity to provide a practical working reference tool for all parties, thereby aiding coordination, communication, and implementation of the appropriate actions in each organisation.

1.3 **It is imperative, however, that each Local Maternity Neonatal System (LMNS) have their own plan in place to respond to escalation outlining a minimum set of expectations and actions, which includes the localisation and initiatives that are in place for the LMNS using existing cross-organisational partnerships.**

1.4 **The temporary suspension of the neonatal unit does not translate to a temporary diversion of a maternity services.** A high-risk birthing woman whose babies may potentially require neonatal services should be assessed on an individual basis with joint consultation by the consultant obstetrician and consultant neonatologist. Consideration should be given to the level of neonatal unit required based on gestation and other known complications (e.g. Surgical condition). The North West Neonatal Operational Delivery Networks (ODN) have a North West wide neonatal surge plan to ensure access to neonatal critical care is maintained and not compromised (see Appendix 4 Neonatal ODNs OPEL Framework & Action Cards).

1.5 This document therefore does not replace individual organisational internal escalation plans or LMNS locally agreed escalation/surge management processes. It is assumed that in the event of a formal divert request this will only be approved when either NWAS, the Maternity Service Provider Trust and the LMNS system have fully implemented all of their agreed internal and local system escalation processes and these have failed to address the system pressure or the specific issue.

Please note that any longer term planned closures requiring adherence to temporary service change process are required to inform/gain support from the ICB and NHSE.

2.0 Principles and overview of the regional framework

2.1 This framework has been developed to enable maternity services and LMNSs to align their escalation protocols to a standardised regional process and escalate regionally when required.

The OPEL Maternity Framework Status is based on eight escalation triggers:

- Ward bed capacity
- Delivery suite bed capacity
- Triage breaches
- Unable to give 1:1 care in established labour
- Birth rate plus activity & dependency score of all intrapartum care on delivery suite
- Delivery suite co-ordinator not supernumerary
- Delays in elective work including induction and elective caesarean section
- Neonatal service capacity (neonatal capacity alone would not trigger OPEL 4)

2.2 There may also be other factors that lead to escalation and diversion, decisions should be considered on a case by case basis this may include:

- Medical staff shortage
- Inappropriate experience skill mix
- Infection Prevention & Control issues – follow local IPC policy
- In the event of a major/critical incident, power failure or business continuity – follow local policy

2.3 **The OPEL Maternity Framework is outlined in Appendix 1, which outlines the escalation triggers. The OPELMF status will be based on three triggers being met at a particular level. If 3 of several colours the highest denominator is the OPELMF rating to be declared.** Please also see Appendix 1 for Trusts roles and responsibilities for patient flow within a maternity service.

Table 1: **Operational Pressure Escalation Levels Maternity Framework**

OPELMF Status	Escalation level
OPELMF One **(Green)**	The local maternity service capacity is such that organisations are able to maintain patient flow and meet anticipated demands within available resources. Additional support is not anticipated**. No interaction with NWAS required, business as usual.**
OPELMF Two **(Amber)**	The local maternity service is starting to show signs of pressure. The maternity service will be required to take focused actions to mitigate the need for further escalation. Enhanced coordination and communication will alert the whole system to take appropriate & timely actions to reduce the level of pressure in the system. **No interaction with NWAS required, refer to internal business escalation processes and procedures.**
OPELMF Three **(Red)**	The local maternity service is experiencing major pressures compromising patient flow and safety and continues to increase. Further urgent actions are now required across the whole Local Maternity System and increased external support may be required, including agreement for deflection of patients within the LMS. Regional

	Teams will be made aware of rising system pressure, providing additional support as deemed appropriate**. No interaction with NWAS required, refer to LMNS escalation processes and procedures.**
OPELMF Four (Black)	Pressure in the local maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised. Decisive action must be taken locally to recover capacity and ensure patient safety. All available local escalations actions have been taken, external extensive support and intervention is required. Regional teams will be made aware providing additional support and will be actively involved in conversations within the system including cot bureau. National team will be informed by local regional teams through internal reporting mechanisms. When multiple systems in different parts of the country are declared OPELMF Four for sustained periods and there is an impact across local and regional boundaries, national action will be considered. **Request NWAS to implement service diversion if operationally possible.**

Local maternity services will operate within normal parameters at OPELMF One. At OPELMF Two, we would anticipate operations and escalation to be delegated to the Manager of the day in each organisation. At OPELMF Three and Four there must be executive level involvement across the service via tactical and strategic command, see 3.1.

3.0 Definition of Terms

3.1 Deflection

Operational decision working with local maternity system to level out operational pressures across a defined system, maximising use of assets while maintaining patient safety, considered during OPELMF three.

3.2 Formal Divert (OPELMF FOUR)

The practical operational application of an agreed ambulance divert in response to significant and overwhelming local and/or wider system operational pressures.

3.3 Emergency Divert

The application of a divert in relation to an emergency e.g. fire, flood where the Emergency Department is non-operational for a period and/or in the Major Incident where the casualty distribution plan is operational i.e. not accepting cardiac arrests, will also include the maternity department to prevent increasing the stress existing in the organisational site further (with the exception of St Mary's Oxford Road).

4.0 Guidance for the use of the North West Maternity Operational Pressures Escalation Levels Framework & Escalation Policy

4.1 Internal Trust Escalation

The temporary diversion 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.

4.2 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 multidisciplinary team (MDT) approach

4.3 Good practice guidance for management of staff

Includes:

- Ensure robust system 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 member working within their skill set. Look at the 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
- Contact Independent or private midwives
- Cancel study leave
- All physical staff in the unit including midwives in specialist roles and those within community will be called upon to assist
- Maternity services should have considered promoting staff rotation across the service, so staff are in a state of readiness when there is increased pressure in the system
- Medical staff shortages should be managed through the manager of the day to ensure appropriate conversations have taken place between obstetricians, anaesthetists and paediatrics and give assurance that all avenues have been explored

4.4 The decision to request a divert

Within a maternity unit this should be discussed with the **executive director on call** for the Trust and will usually be at OPELMF Four status (see Appendix 2 Action Cards) following consultation with:

- Manager of the day or Senior on call manager out of hours
- Delivery suite coordinator
- Maternity bleep holder
- Maternity Bed coordinator (oversight of flow throughout the unit)
- Consultant obstetrician on call
- Maternity matrons (in hours)
- Professional midwifery advocate (for professional support if required)
- Tactical and strategic 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

4.5 Executive to executive engagement

The expectation is that **all** Maternity units will involve executives in the agreement to divert patients away from the unit due to capacity issues etc. It is also the expectation that executives be involved in acceptance of diverted patients. It is however also understood the operational day to day capacity of the unit (both in hours and out of hours) is the remit of the unit managers.

Therefore:

Any request for a formal divert must have agreement between the diverting trust and receiving trust executives once a dynamic risk assessment has been completed.

- **In hours:** executive agreement should be sought for a divert but the acceptance of a divert can be operationally delegated to the receiving unit manager with the executive being informed at the earliest opportunity.
- **Out of hours**: executive agreement should be sought for a divert but the acceptance of a divert can be operationally delegated to the receiving unit manager with the executive being informed at the earliest opportunity.

Once the decision has been made internally, in partnership with the receiving units, to temporarily divert new admissions **(not including obstetric emergency cases)** a **request** must then be

immediately made to the ambulance service to accept or decline a Formal Divert Request dependent on wider regional ambulance capacity and demand and system wide intelligence.

Maternity Services must be aware that a formal divert does NOT include obstetric and neonatal emergency cases and as such all emergencies will be transferred to the nearest unit regardless of a formal divert in place.

4.6 Formal Divert Request

Any formal Divert request to NWAS must only be made when maternity services have implemented their escalation and surge management plans to the full without reducing the system pressures to a safe level as set out in 3.1.

4.7 Formal Divert Process

4.7.1 **Engagement with NWAS ROCC:** The process will involve consultation and agreement with the NWAS ROCC Tactical Commander and the Trusts Senior Operational Manager (or equivalent Manager on call out of hours) on the agreed assumption that the maternity service has enacted all of its internal escalation processes following which they may ask for a Formal Divert for a period of 4 hours without having to go through the previous escalation process.

4.7.2 **Duration of Divert:** A formal maternity service divert **(agreed period but initially 4 hours**) would **not** involve all types of patients – Red/Amber standbys **or any patient requiring resuscitation would be exempt.**

4.7.3 Following the implementation of a Formal Divert, the requesting maternity provider must complete a 72 hour incident review, report the divert onto the national StEIS reporting system in line with the National Perinatal Safety Surveillance Model (NPSM). This process should continue until the National StEIS reporting system is archived in October 2024. The findings and any subsequent learning shared and discussed by both the maternity service and NWAS for monitoring and assurance purposes. The maternity service Trust Board must be made aware via the normal Trust internal incident reporting processes along with the LMNS / ICS / ICB as part of the NPSM as per the immediate and essential action 5 from the Ockenden review.

4.7.4 Once a formal divert has been agreed by both the maternity service and NWAS it is recommended that one person is nominated to coordinate the process and wherever possible should have no other responsibilities during this time, they will be referred to as the 'divert coordinator' (**this should not be an operational midwife)** to ensure all clinicians can support safe service, and preferably would be the divisional general manager or senior manager on call for Obstetrics, Gynaecology & Neonates), please see Appendix 5 for diversion template.

4.8 Notifying others of decision to initiate diversion in hours and out of hours

The divert coordinator will make arrangements for key stakeholders (See **Appendix 6** for full notification check list) to be notified in addition to the above section in 4.4.

- Switchboard as per local arrangements
- Neighbouring maternity units (see Appendix 5)
- Midwifery Led care setting and team leaders
- Safeguarding team to assist with safeguarding alert process
- Consultant anaesthetist on call
- Governance lead to assist with reporting arrangements
- Emergency Department
- Neonatal unit
- Cot Bureau
- Trust coms team

5.0 Regional escalation & national escalation

5.1 When OPELMF 4 is triggered within any maternity service and a formal divert is agreed with NWAS this must be escalated to the regional maternity team who will in turn escalate accordingly to regional processes.

Where a region has extreme pressure, they should work with neighbouring regions to secure mutual aid to escalate through the national structure.

5.2 **The first on call for the Region for NHS England should be contacted via NWAS Regional Operational Coordinating Centre (ROCC):**

Tel: 0345 113 0099 and select the option for the relevant area.

The Trust should clearly outline:

1. The issue(s) the maternity service is escalating, and actions taken
2. Support required from regional on call colleagues

The relevant first on call should alert other on call colleagues (second on call, Emergency Preparedness, Resilience and Response (EPRR) and communications as appropriate).

6.0 De-Escalation of the Maternity Unit

- When the factors that precipitated temporary diversion of maternity services have been resolved and are ready to resume safe services operating at OPELMF Two, a consultation should take place with the same level of authority and focus as the originating diversion. Use de-escalation checklist (Appendix 7)

- It is the responsibility of the divert coordinator within the maternity trust to contact the ROCC to update with the up to date position prior of the 4-hour window expiring. If not updated at 4 hours the ROCC will automatically remove the formal divert status and assume business as usual has been restored.

- Director / Head of Midwifery to ensure all women who were diverted are contacted to apologise (template letter available in Appendix 9).

7.0 References

Midlands Maternity Escalation Policy & Operational Pressures Escalation Levels Framework version 1 2021

North East and Yorkshire Maternity Escalation and Operational Pressures Escalation Levels Framework version 1 202

Appendix 1 – North West Acute Maternity OPEL Maternity Framework – Escalation Triggers

OPEL STATUS	A/N & P/N Ward beds	Delivery suite beds	Triage Breaches	Unable to give 1-1 care in established Labour	Birthrate plus activity and dependency score for Delivery Suite	Delivery suite coordinators not supernumerary	Delays in elective work for non - medical reason	Neonatal Services
Black Four	0 beds	0 beds	0 beds	Unable to give 1-1 care to woman in established labour	Birthrate plus rating RED	Not supernumerary	Unable to transfer to another Trust	Demand exceeds available resource.
Red Three	Not enough beds for delivery suite to transfer or elective activity	Upper limits of bed capacity, no potential bed capacity within 2 hours	Women not seen in red category immediately	Unable to give 1-1 care to woman in established labour	Birthrate plus rating RED	Temporarily providing direct care to antenatal/postnat al women whilst extra support for delivery suite is provided	Delays in elective activity for >24hours	Very limited ability to maintain patient flow in line with ODN pathways
Amber Two	Enough beds for delivery suite to transfer to ward but not elective activity	High activity with high bed occupancy but beds remain available	Women not assessed within 15 minutes in orange category	Moving staff to be able to give 1-1 care	Birthrate plus rating AMBER	Delivery suite coordinators supernumerary	Delays in elective activity for > 4 hours	Neonatal service is experiencing difficulty in meeting anticipated demand with available resources
Green One	No delays in admission or transfers	Bed capacity available for delivery suite activity	All women seen with appropriate timescales in line with unit guidance	1-1 care given to all women	Birthrate plus rating GREEN	Delivery suite coordinators supernumerary	No delays in elective work	ODN unit open to admissions in line with unit designation

Three of any colour equates to that OPELMF rating. If 3 of several colours the highest denominator is the OPELMF rating to be declared. OPELMF Action Cards will be used (see Appendix 2), and actions followed.

Based on Birmingham Symptom – specific Obstetric Triage System (BSOTS), see below:

Triage pathway midwife to see women rag rated red immediately all other women within 15 minutes	Seen for treatment immediately by ST3 registrar or above	Seen for treatment within **15** minutes by ST3 registrar or above	Seen for treatment within **60** minutes by ST3 registrar or above	Seen for treatment within 4 hours by ST3 registrar or above

Appendix 1 has been adapted from East of England OPELMF ratings document

Appendix 2 – OPELMF STATUS TWO, THREE AND FOUR ACTION CARDS

OPELMF TWO STATUS – SIGNS OF PRESSURE IN THE SYSTEM

TRIGGERS

- Enough beds for delivery suite to transfer to wards but not for elective activity
- High activity with high bed occupancy but beds remain available on delivery suite
- Women not assessed within 15 minutes in orange category for triage
- Moving staff to be able to give 1-1 care in established labour
- Birth rate plus activity & dependency score rating AMBER for delivery suite
- Delivery suite co-ordinators supernumerary
- Delays in elective activity for > 4 hours
- Neonatal service is experiencing difficulty in meeting anticipated demand with available resources

Management at this level remains at manager of the day, delivery suite coordinator/ward manager/maternity matron/consultant obstetrician/neonatal co-ordinator

ACTIONS REQUIRED

IN HOURS

- Timely review of ward rounds to ensure flow and discharge of antenatal & postnatal patients.
- Delivery suite coordinator/manager of the day/ward manager to identify women suitable for discharge and expedite medical review where necessary
- Discussion between delivery suite coordinator/manager of the day and consultant obstetrician to consider rescheduling all elective work both women attending for induction of labour and Caesarean sections if clinical conditions permit
- Consider extra cleaning staff to ensure bed and equipment is cleaned and increase through put and flow
- Manager of the day and delivery suite co-ordinator to liaise and redeploy skilled staff according to area of need. Consider deployment of staff, specialist midwives, consider community midwives, consider whether study leave needs to be cancelled and identify if any staff are able to work extra or a longer shift to support safe care delivery. Continuity of care should be maintained wherever possible
- Delivery suite co-ordinator to liaise with neonatal coordinator to identify and plan for any anticipated activity that necessitates neonatal cots, this may require consultant neonatologist and consultant obstetrician to discuss
- Early identification and planning where possible to ensure that women whose babies may not be accommodated on the neonatal unit are transferred to other units in the daytime when staffing levels are optimal
- All staff to be kept briefed of situation and actions agreed

OUT OF HOURS

- Delivery suite coordinator and consultant obstetrician on call assess the situation and create a plan to improve the situation and call maternity bleep holder as required. They will liaise with hospital site manager to provide extra cleaning and maximise available support to manage bed clearance
- Alert neonatologist on call

- If problems encountered with transporting home or to other hospitals or women occupying beds either awaiting investigation or interim report, hospital coordinator to assist

FREQUENCY OF REVIEW

Delivery suite coordinator or manager of the day should:

- **Review OPELMF status which includes staffing, skill mix and bed capacity 4 hourly**
- Take steps to remedy staffing levels acuity if necessary, by redeploying staff around the service in line with activity and identify women suitable for discharge

OPELMF THREE STATUS – MAJOR PRESSURE

TRIGGERS:

- Not enough beds on Antenatal & Postnatal wards for delivery suite to transfer or elective activity
- Upper limits of bed capacity on delivery suite, no potential bed capacity within 2 hours
- Women not seen in red category immediately for triage
- Unable to give 1-1 care to woman in established labour
- Birth rate plus activity & dependency score rating RED for delivery suite
- Delivery suite coordinator temporarily providing direct care to antenatal/postnatal women whilst extra support for delivery suite is provided
- Delays in elective activity for >24hours
- Neonatal services - very limited ability to maintain patient flow in line with ODN pathways

ACTIONS REQUIRED

- Ensure OPELMF Two actions are completed
- Manager of the day update Tactical on call who will inform the Trust executive on call
- Staffing concerns or capacity issues raised and instigate internal escalation. Inform divisional leadership team and active involvement of the head of midwifery
- OPELMF Three communication across the LMS to alert organisation to pressure points this must also include board maternity safety champions and non - executive safety champions
- Escalation with executive level involvement and coordinated response across the ICS/LMS. Inform neighbouring units and obtain their status to see how they can support future diversions this may be outside LMS boundaries. Consider the deflection of elective workload to level out operational pressure across the LMS. The Regional first on call team to be contacted if further support is required
- Request additional bank and agency staff including midwives, maternity support workers and health care support workers
- Liaise with key partners for example gynaecology to see if they can accommodate any antenatal women <20 weeks as per local Trust arrangements
- Consider nursing staff to recover women post caesarean section or following operative procedure
- Consider using prescribing pharmacist or competency nurses to complete drug rounds on wards
- Consider the option of the community midwife undertaking newborn and infant physical examination (NIPE) in the mother's own home to support rapid early discharge of mothers and babies
- Reducing and postponing community midwifery visits. For antenatal visits if a woman requires the need for a physical examination and/or screening these visits should be maintained (A/N visits to postpone for low risk women 16, 25, 31-week appointments). For postnatal visits to consider provision of care by senior student midwives and maternity support workers. Postpone in person visits particularly for healthy term multiparous women and their babies
- Tactical command to consider the potential for additional governance, data and administrative support for maternity services, as all midwives working in those teams will be moved to support front line delivery of clinical services
- Creation, where possible, of extra high-risk labour beds – need to ensure safe staffing and availability of extra medical staff and obstetric theatre teams

- Local services to consider contingency plans to maintain homebirth services
- Utilisation of other staff groups including neonatal and paediatric nurses to care for transitional care babies
- Continue to engage the neonatal ODNs in surge planning to ensure access to neonatal critical care is maintained and not compromised
- Ensure regular and formal contact with Maternity Voice Partnerships (MVP), to ensure consistent communication to service users. MVPs to share and amplify key messages to women, their families and members of the public using established communication routes
- Trust communications department to support comms across the organisation and into the community. Out of hours the Trust should follow its communication policy regarding communications with local communities or seek advice from on call communications staff.
- If all OPELMF Status Two actions and all the additional OPELMF Three actions above have been completed and the unit is still unsafe, initiate a temporary diversion for all admissions, following discussion with the on- call obstetrician, manager of the day, director or head of midwifery with agreement from the tactical on call and strategic on call manager for the Trust
- Report any immediate risks to the Trust gold command and ICS/LMS
- Manager of the day, delivery suite coordinator, consultant obstetrician, consultant neonatologist, ward manager, maternity matrons to maintain communication until stand down from OPELMF Three

OUT OF HOURS:

- Delivery suite coordinator, maternity bleep holder and consultant obstetrician on call assess the situation and implement a plan to improve the situation.
- Delivery suite coordinator to contact tactical command on call for support & oversight
- Delivery suite coordinator, consultant obstetrician on call, consultant neonatologist on call, ward manager and tactical command on call to maintain communication until stand down from OPELMF Three status

FREQUENCY OF REVIEW

Delivery suite coordinator or manager of the day should:

- **Review OPELMF Status staffing, skill mix and bed capacity 2 hourly.**
- Bed capacity hourly review should be managed by the Manager of the day in hours and out of hours by the bed management team
- Take steps to remedy staffing levels acuity if necessary, by redeploying staff around the service in line with activity and identify women suitable for discharge

OPELMF FOUR STATUS – EXTREME PRESSURE

TRIGGERS:

- No beds on wards
- No beds on delivery suite
- No beds for triage
- Not able to give 1-1 care in established labour
- Birth rate plus activity & dependency score rating RED for delivery suite
- Delivery suite coordinators not supernumerary
- Unable to transfer to another Trust for elective activity
- Neonatal services – demand exceeds available resource. Prioritisation on a case by case basis is required

ACTIONS REQUIRED

- Ensure OPELMF Two & OPELMF Three actions are completed
- Manager of the day update tactical and strategic command on call who will inform the Trust executive on call that divert is to be implemented
- If staffing/capacity issues not resolved commence a divert in accordance to: North West Ambulance Service Divert and Deflection Policy https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2022/01/NW-DD-V12-Final-22-10-21-Version-12.4.pdf
- Suspend all admissions to maternity unit
- Suspend all community births
- Consider closure of midwifery led units
- In-utero transfer to a centre with a NICU is the optimal approach where preterm labour <27/40 is anticipated. All babies <27/40 (whether in - or ex-utero) must be referred for transfer to a hospital with a NICU, if clinically appropriate. The receiving hospital should accept the referral, **whenever possible** and there must be consultant to consultant discussion, which will include the obstetric consultant in the case of an in-utero transfer, to resolve any issues in relation to transfer. In the event of extreme workforce / capacity issues, it is recognised that the availability of ambulance and midwifery staff will have significant impact on the ability to achieve this and cases will have to be decided on a case-by-case basis. This should be managed through tactical command and the neonatal call handling service regarding cot availability
- A contingency plan must be put in place for women that may unexpectedly attend delivery suite & triage areas without notice and obstetric emergencies attending via ambulance to manage care safely
- OPELMF Four report SI on StEIS in line with SI Framework for maternity unit diversion of services
- If there are multiple sites requiring OPELMF Four actions and mutual aid is being sought but is not forthcoming due to high and sustained pressures across multiple systems, which means that maternity units cannot decompress, impacting on the safety of mothers and babies, the regional team are to be contacted and request made for out of locality / region assistance to ensure a collaborative coordinated response to escalation including mutual aid where appropriate
- If there are multiple sites requiring OPELMF Four actions and mutual aid is being sought, regional communications teams to communicate the extreme and

widespread operational challenges across the region.

- Manager of the day, delivery suite coordinator, consultant obstetrician, consultant neonatologist, ward manager, maternity matron, tactical and strategic command on call to maintain communication until stand down from OPELMF Four status

OUT OF HOURS:

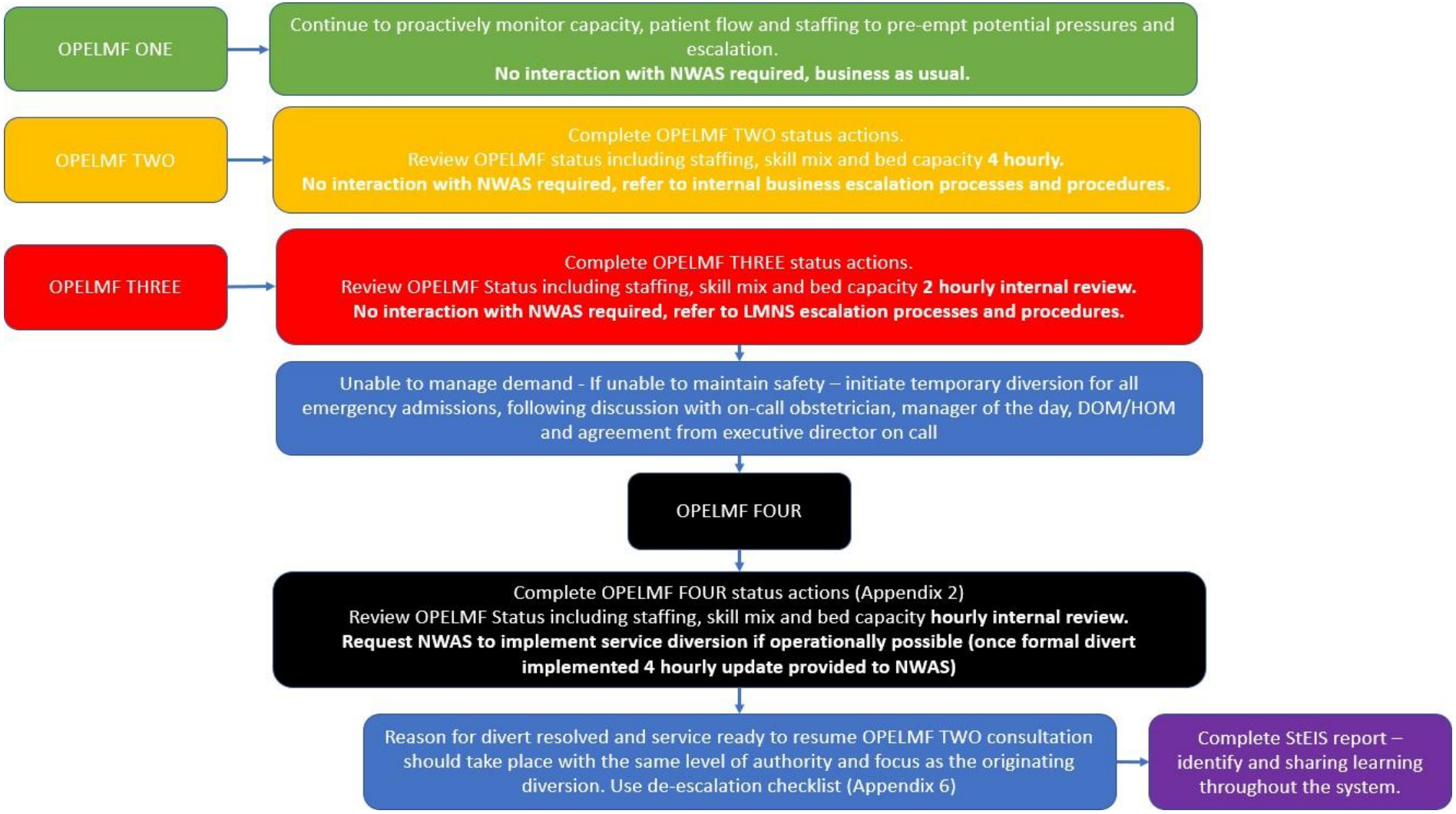
- Delivery suite coordinator, maternity bleep holder and consultant obstetrician on call assess the situation and create a plan to improve the situation
- Maternity bleep holder to contact tactical and strategic command on call for support & oversight
- Delivery suite coordinator, maternity bleep holder, consultant obstetrician on call, consultant neonatologist on call, ward manager, tactical and strategic command on call to maintain communication until stand down from OPELMF Three status

FREQUENCY OF REVIEW

Delivery suite coordinator or manager of the day and silver on call should:

- **Review OPELMF Status staffing, skill mix and bed capacity hourly**
- Bed capacity hourly review should be managed by the manager of the day in hours and out of hours by the bed management team
- Take steps to remedy staffing levels acuity if necessary, by redeploying staff around the service in line with activity and identify women suitable for discharge

Appendix 3 – North West Maternity Escalation Flow Chart



Appendix 4 – North West Neonatal ODNs - Operational Pressure Escalation Levels Neonatal ODN Framework (OPELNF) and Actions Cards

OPELNF status	Description	Actions	Responsibility
OPELNF 1 **GREEN** **NORMAL**	**ODN units are open to admissions in line with unit designation.** Patient flow can be maintained in line with ODN pathways and services are able to meet anticipated demand with available resources: • Nursing and medical staff levels meet national standards for number and dependency of babies in units (see section 8) or is manageable with available resources • IC/HD/SC cots available appropriate to designation of unit • Adequate equipment available for acuity and/or capacity • Transport service availability • Planned transfers can be accommodated	1. Neonatal services will provide care in line with current care pathways and can accept admissions in line with the ODN designated pathways. 2. Neonatal units will assess local OPELNF status at least once daily.	Local unit level

OPELNF status	Description	Actions	Responsibility
OPELNF TWO **AMBER** **MODERATE PRESSURE**	**Neonatal services across the ODN are experiencing difficulty in meeting demand / anticipated demand with available resources. One or more unit in the ODN has declared OPELNF Three and / or there is insufficient critical care capacity within the network necessitating capacity transfers.** It is difficult to maintain patient flow in line with ODN pathways due to one or more of the following: • Nursing and/or medical staff levels are reduced below national standards for number and dependency of babies • Limited cot availability appropriate to designation of units • Limited availability of essential equipment (i.e. cot, ventilator, monitor, infusion pumps) to meet increase in dependency or capacity • Reduced transport service availability • Units unable to accept transfers in line with unit designation	1. Units will follow locally agreed plans for the management and escalation of OPELNF, ensuring appropriate communication and escalation of situation through the Trust managers and processes. 2. OPELNF status to be assessed on a shift-by-shift basis or more frequently when activity is high. 3. Proactively manage staffing shortages in line with local escalation policies. Staffing levels to be risk assessed and agreed at local Trust level. 4. Proactively manage capacity in line with local escalation policies. 5. Prioritise parents.	Local unit level

OPELNF status	Description	Actions	Responsibility
OPELNF THREE **RED** **MAJOR PRESSURE**	**One or more ODN NICU is at OPELMF Four. One or more ODN LNU / SCU is at OPELMF Three.** Very limited ability to maintain patient flows in line with ODN pathways due to: • Nursing and/or medical staff levels significantly reduced below national standards for number and acuity of babies in unit • Very limited cot availability appropriate to designation of unit • Very limited availability of essential equipment (i.e., cot, ventilator, monitor, infusion pumps) • Reduced transport service availability • Units unable to accept transfers in line with unit designation	1. Follow locally agreed plans for the management and escalation of OPELNF ensuring appropriate communication of situation through the Trust managers and processes. 2. Some units may have to consider caring for infants outside of existing ODN pathways. 3. Staffing levels to be risk assessed and agreed at local Trust level. 4. Inform the ODN management team as soon as possible of any decision for partial / full suspension of the neonatal unit to internal and/or external admissions 5. Unit leads (medical and/or nursing) to attend ODN capacity meetings	Local unit level
		6. ODN to arrange regular meetings with unit leads (medical and nursing) via Microsoft Teams	ODN level

OPELNF status	Description	Actions	Responsibility
OPELNF FOUR **BLACK** **CRITICAL PRESSURE**	**One or more the ODN NICUs is at OPELNF Four. Two or more of the ODN LNUs / SCUs are at OPELNF Three or Four.** Demand exceeds available resource. Prioritisation on case-by-case basis is required due to: • Nursing and/or medical staff levels significantly reduced below national standards for number and acuity of babies in unit • Contingency plans (in line with local management and escalation of OPELNF) failed • No physical cot space, occupancy 100% or above • All essential equipment is in use • ODN units unable to accept transfers in line with ODN pathways due to any / all the above necessitating transfers out of region. • No transport service availability	1. Escalation and contingency plans will have been insufficient to contain or reduce OPELNF Three. Neonatal service(s) cannot routinely accept any admissions. 2. It is likely that units will have to care for infants outside their pathway at least for a period of time. 3. Follow locally agreed plans for the management and escalation of OPELNF, ensuring appropriate communication of situation through the Trust and ODN processes. 4. Staffing levels to be risk assessed and agreed at local Trust level. 5. Consider reconfiguration of unit footprint to enable cohorting of all babies according to levels of care in order to optimise use of available staff 6. Inform transport service of decisions to close the neonatal unit. 7. With support from transport service source cot capacity outside of region in line with the current cot locator process used when regional demand exceeds capacity. 8. If there is a lack of transport capacity due to a reduction in staff or ambulances, support from transport services outside of region or where appropriate from paediatric transport services, will be requested. 9. Consider implementation of a divert policy to appropriate designation of neonatal unit with available capacity. This should be led by the relevant transport service. 10. Inform the ODN management team	Local unit and service level

		11. Ensure appropriate staff available to participate fully in ODN conference calls to discuss management of capacity and /or staffing or equipment issues. 12. Manage local capacity and/or staffing in line with decisions agreed with ODN. 13. Provide updates to ODN management team until situation is resolved. Timescales for these updates to be agreed with ODN management team. 14. Provide regular updates to parents and families until situation is resolved. 15. Inform the ODN Management Team when decision taken to reopen to admissions.	
		In Hours; Monday to Friday 09.00 to 17.00hrs 1. ODN to arrange conference calls 2. ODN to cascade decisions on suspension to units within the ODN and neighbouring ODNs. 3. ODN to escalate OPELNF status to regional perinatal team, specialised commissioning and/or the national team as necessary and appropriate and where a process for escalation is in place. 4. ODN to notify regional perinatal team, specialised commissioning and the national team, as applicable, when OPEL status is de-escalated. 5. ODN to prepare communication for families explaining situation, apologising, providing reassurance and requesting cooperation.	ODN level

[redacted]		**Out of Hours; Monday to Friday 17.00 to 09.00 hrs and 24 hrs Saturday and Sunday**	Specialised Commissioning level

Assessing OPELNF

- All Trusts will have mechanisms in place for the monitoring and reporting of escalation of operational pressures at local service and Trust level.

- Neonatal OPELNF status will be dependent on cot availability and/or workforce availability. At times the availability of equipment may also impact on OPELNF status. A neonatal unit may also need to close for reasons other than capacity, for example an infection outbreak or estate issues.

- At unit level there should be a discussion, at least once daily, between the attending consultant and nurse in charge to assess OPELNF status. This should be reassessed regularly at times of significant pressure.

There must be evidence that policy and service changes have been risk assessed and notified and agreed through local Trust management and escalation of OPELNF processes

Appendix 5 - Neighbouring Trust availability to admit diverted women

Diversion of maternity service Neighbouring Trust availability to admit diverted women				
Unit Name	Contact Name and number	Date & time contacted	Availability to take	Comments/Feedback

Accepting Trust notified of decision to transfer take 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 6 - Key stakeholders to be informed of Formal Divert following agreement with NWAS via ROCC

Stakeholder	To be informed Diversion	Date and time contacted	Name of person contacted and method of contact	Date and time informed of re- opening
ICS / LMNS	√			
Neighbouring maternity units	√			
Manager of the day	√			
Delivery suite coordinator	√			
Matrons	√			
DoM/HoM	√			
Obstetric consultant	√			
Duty matron	√			
Head of emergency performance	√			
Tactical command on call	√			
Strategic command on call	√			
Triage midwife in charge	√			
Ward coordinators	√			
Community midwives on call / community & outpatients' matron	√			
Professional midwifery advocate (PMA) for professional support	√			
Bed manager (where applicable)	√			
Neonatal unit/consultant on call	√			
Cot Bureau - 03003309299	√			
Consultant anaesthetist on- call	√			
Accident and emergency department	√			
Governance lead to assist with reporting arrangements	√			
Safeguarding team to assist with safeguarding alert process	√			
Site manager	√			
Switchboard as per local arrangements	√			
Security as per local arrangements	√			
Trust comms team	√			
	Name: **Job Title:**			

Appendix 7 – De-Escalation Checklist

Date/time unit service diversion		
Name of exec on call who authorised divert		
Date and time of re-opening		
Total days / hours diversion	Days	Hours
Name of exec decision maker		

Number of women directed to other units	
Number of women delivered in other units	
SBAR completed	
Reported onto StEIS	
RCA completed / date	

Notify the following people in Hours (if the diversion occurs out of hours please inform relevant stakeholders the next working day)	**Date**	**Time**	**Notifying Person**	**Comment**
Delivery suite coordinator				
Maternity manager of the day				
Maternity bleep holder/ on-call				
Midwifery professional support/advocate				
Consultant obstetrician				
Consultant neonatologist				
Manager on call				
Bed manager				
Head of midwifery				
Executive on call				

Notify the following people in Hours (if the diversion occurs out of hours please inform relevant stakeholders the next working day)	**Date**	**Time**	**Notifying Person**	**Comment**
Ambulance control				
Safeguarding team				
Consultant anaesthetist				
Governance lead				
Executive on call at receiving unit				
ICS/LMNS				
Cot Bureau				

Appendix 8 – SBAR Assessment

SITUATION • Date and time of diversion • Reason for diversion • Other information	
BACKGROUND • Precipitating factors that lead to divert • How many times closed in the last 3 years? • Previous reasons for diversion	
ASSESSMENT • 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 diversion appropriate	
RECOMMENDATION • Appropriate actions taken to try and deescalate situation? • Appropriate decision to temporarily divert maternity services? • Timely review of activity and staffing during diversion and reopening? • How many times has unit diverted in the last 12 months?	
COMPLETED BY	

Appendix 9 – Apology Letter

– Insert your Trust Logo

Dear

Re: **Insert Maternity Provider Details**

As you'll know, we recently had to divert people away from our Maternity Unit. I wanted to say sorry for any issues that this caused you and to explain why we had to take such action.

We know asking patients to attend a different maternity unit is disruptive, so we only do it when we absolutely have to. We do it to ensure that everyone can receive a safe level of care. For a short period of time we weren't able to safely accept any more admissions so we worked with our neighbouring maternity providers and the North West Ambulance Service and came to the conclusion that the safest approach for you was to be seen at the nearest available hospital with maternity care.

If you wish to discuss any of the events further, please do not hesitate to contact our Patient Experience Team who can be contacted by:

Telephone:

Email address: