NHS England

Cheshire & Merseyside Maternity Escalation and Divert Policy

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Contents

1 Background

There is great variation across Cheshire and Merseyside with regard to Maternity Escalation and Diversion Policies. This variation can impact upon effective communication and the safe transfer of pregnant women between maternity service providers. Following a serious incident which was reported onto StEIS [1] it was agreed that the existing individual trusts policies and current practice within the Cheshire and Merseyside region be reviewed with a view to developing a single Maternity Escalation and Diversion Policy for Cheshire and Merseyside.

2 Context

During periods of high activity and an increased demand for bed capacity, or in the event of reduced staffing levels, maternity providers may need to temporarily suspend maternity services.

Currently each provider has their own local Maternity Escalation Policy[2], this can result in variation leading to inefficiencies and to sub optimal care. The development of a single Maternity Escalation and Divert Policy will reduce avoidable harm and inefficiencies in service delivery. A single policy will reduce variation improve consistency across Cheshire and Merseyside and will improve communication and multi-disciplinary working relationships, enhance the experience for mothers and babies and reduce harm.

The Temporary suspension of maternity services should only be considered when all good practise options have been exhausted, as the consequence to other neighbouring units must be appreciated.

The temporary closure of the Neonatal unit does not necessarily result in the closure of a maternity unit. High risk babies who may potentially require neonatal services should be assessed on an individual basis with joint consultation by the Consultant Obstetrician and Consultant Paediatrician. These in utero babies may require transfer to a neighbouring obstetric unit with more suitable neonatal facilities
This policy has been designed to be followed in the event of temporary diversion and closure of a maternity service ensuring a consistent and clear approach.
In line with the NHS Serious Incident Framework[3] all maternity unit closures should be reported onto StEIS with full Root Cause Analysis.

When factors which precipitated the temporary diversion and/or closure of maternity services are resolved, the process of closure should be reversed as soon as is practicable.

3 Aims of the Policy

[1] Strategic Executive Information System
[2] Some providers refer to a Section 6 of the NWAS Divert and Deflection Policy v3
[3] NHS Serious Incident Framework 2015

The overall aim of the policy is to support staff during periods of increased operational pressure and to ensure safe staffing levels.

The aim of this policy is to

- Facilitate safe and effective care for mothers and babies to maintain quality and choice and reduce risk during periods of escalation.
- Enable the individuals who will be involved in the decision to temporarily divert and close the unit to be notified at an early stage when the potential risk of divert and closure has been identified.
- Set clear expectations and guidance around roles and responsibilities.
- Identify a set of escalation levels and triggers to be applied across Cheshire and Merseyside.

4 Benefits of the Policy

- Maximise safety of women, babies and staff.
- Consistent approach to managing risk associated with escalation and diversion within maternity services by standardising triggers, actions and language.
- Robust process to follow during capacity pressures including the ability to provide a universal understanding of a single process for escalation and diversion and reopening of maternity services during times of increased pressure to the system.
- Reduce variation of practice by individual providers of maternity services.
- Staff are clearer about their role and responsibilities. Identification of clear roles and responsibilities.
- Promote transparency and honesty between local maternity providers, and promote equity of services at times of increased pressure.
- Present a more coherent picture of operational pressures when requested.
- Ensures there is a process for all women who have been diverted to be followed up at the earliest opportunity.

5 Media and Press

Local maternity providers will follow their own Policy regarding communications management and media.

6 Factors which can lead to Escalation and Diversion

- No available beds/cots
- Increased pressure in the system
- High levels of activity and dependency
- Shortage of staff

- Medical staff shortage
- Inappropriate experience/skill mix
- Infection Prevention and Control issues
- In the event of major incident or power failure

7 Routine Daily Bed Management

The management of bed capacity, safe staffing levels and skill mix should be monitored by one of the following - Maternity Bleep Holder/Delivery Suite Coordinator/ Deputy Head of Midwifery/Maternity Matron/Manager On-call. The responsible person will undertake a four hourly review of staffing and activity in each department, anticipating as far in advance as is reasonably possible any potential issues, as early identification of these triggers leads to a better outcome.

Indication that there will be no available beds /cots and/or high levels of activity and dependency

Good Practice Guidance – routine actions 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 review of ward rounds. – ensure they are happening.
- Early recognition of potential capacity issues, escalating concern early on so that measures can be put in place.
- Utilisation of all beds appropriately.
- Reschedule elective work both IOL and C/S if clinical condition permits.
- Decline in utero transfers or the repatriation of women back to the unit.
- Request additional bank staff including midwives/MSW[4]/HCA[5] to facilitate safe and effective care.
- Liaise with key partners e.g. local gynaecology or local maternity unit wards to see if they can accommodate any antenatal women <20 weeks as per local arrangements.
- Consider the option of the community midwife undertaking NIPE[6] in the mother's own home.

Women who are ready for discharge and yet awaiting take home medication or documentation can be transferred to a suitable alternative area e.g. discharge lounge. Alternatively women can be discharged home to be with family and a nominated person return for TTO/documentation.

8 Management of Staff

[4] Maternity Support Worker
[5] Health Care Assistant
[6] Newborn and Infant Physical Examination

8.1 Shortage of Staff

Good Practice Guidance - Right staff in the right place at the right time

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 maternity service with sickness and absence updated immediately.

During periods of short term sickness where bed capacity may or may not be an issue, redeployment of staff may be necessary from other clinical areas e.g. community. Maternity services will be expected to deploy local Business Continuity Plan at times of severe staff pressures.

- Where necessary redeploy staff to appropriate area ensuring staff member working within their skill set.
- Consider asking staff to work additional hours.
- Request bank staff.
- Consider asking staff to come in earlier than their shift would normally start.
- Cancel study leave.
- All physical clinical staff in the unit including midwives in specialist roles and those within the community (taking into account homebirth activity) will be called upon to assist, e.g. reschedule/cancel community visits apart from 1st and 5th day.
- Maternity services should have considered promoting staff rotation across the service so staff are in a state of readiness when increased pressure in the system.

8.2 Medical Staff Shortages

Discussion between obstetricians, anaesthetists, paediatricians and the maternity bleep holder will take place to manage medical staff shortages.

8.3 Inappropriate Experience/Skill Mix

During periods of high activity, it is essential that all staff are supported and are working within their skill set, i.e. HDU patients are being cared for by an appropriately trained midwife/nurse. Ensure appropriate redeployment of staff occurs at an early stage and is planned prior to next shift.

9 Infection Prevention and Control

Please follow local IPC Policy.

10 In the Event of a Major Incident

Please follow local Policy.

11 Escalation Criteria – Appendix 2

Level 1 Green

Level 2 Amber

Level 3 Red

12 Decision to Temporarily Divert and Close the Maternity Unit

Prior to any decision to temporarily close a maternity unit staff must explore the Good Practice Guidance identified in section 7 and 8.1. The decision to divert or close a maternity unit is the responsibility of the **Executive Director on-call**, usually following consultation with:

- Delivery Suite Coordinator
- Consultant Obstetrician On-Call
- Maternity Bleep Holder/ Clinical Site Co-Coordinator (where applicable)
- Maternity Matron (In hours)
- Midwifery Support Professional/advocate for professional support if required[7]
- Hospital Manager On-Call
- Head of Midwifery/ Deputy in/out of hours depending on local arrangements
- Consultant Paediatrician On-Call

Once the decision has been made to temporarily divert new admissions or close maternity service then North West Ambulance Service (NWAS) must be contacted immediately.

It is recommended that one person is nominated to coordinate the procedure and wherever possible should have no other responsibilities during this time. This person will be referred to as nominated escalation and diversion co-ordinator to be referred as The Coordinator.

It is recommended that an hourly review of bed capacity and staffing is undertaken so that agreed routine operational working can recommence as quickly as possible.

13 Implementing Divert – Status Red

See Temporary Diversion of Maternity Service Flow Chart Appendix 3.

[7] Statue of Midwifery ceased 31March 2017, some units will include notification to appropriate professional support for individual midwife.

Complete Appendix 4.

13.1 Notifying others of the decision to close the service In Hours and Out of Hours

The Coordinator will make arrangements for the following to be notified in addition the above section 12

- North West Ambulance Service
- Switchboard as per local arrangements
- Neighbouring Maternity units
- Community midwives on call and team leaders
- Security as per local arrangements
- Safeguarding Team to assist with safeguarding alert process
- Consultant Anaesthetist on-call
- Governance Lead to assist with reporting arrangements
- Lead commissioning CCG in line with contractual arrangements
- Accident and Emergency department
- Neonatal Unit

The proforma Referrals and Transfers should be completed with details of all women diverted to other maternity services Appendix 5.

14 Re-opening of the Maternity Unit

- When the factors that precipitated temporary diversion and/or closure of maternity services have been resolved and are ready to resume to safe services operating at level green, a consultation should take place with the same level of authority and focus as the originating escalation to diversion/closure.
- Complete Maternity Unit re-opening checklist Appendix 6 and all the same relevant stakeholders identified in section 13.1 at the earliest opportunity.
- Head of Midwifery /Deputy Head of Midwifery to complete an SBAR[8] Appendix 7, complete RCA. -
- In line with NHSE SI framework[9], all diversions and closures must be reported onto StEIS.

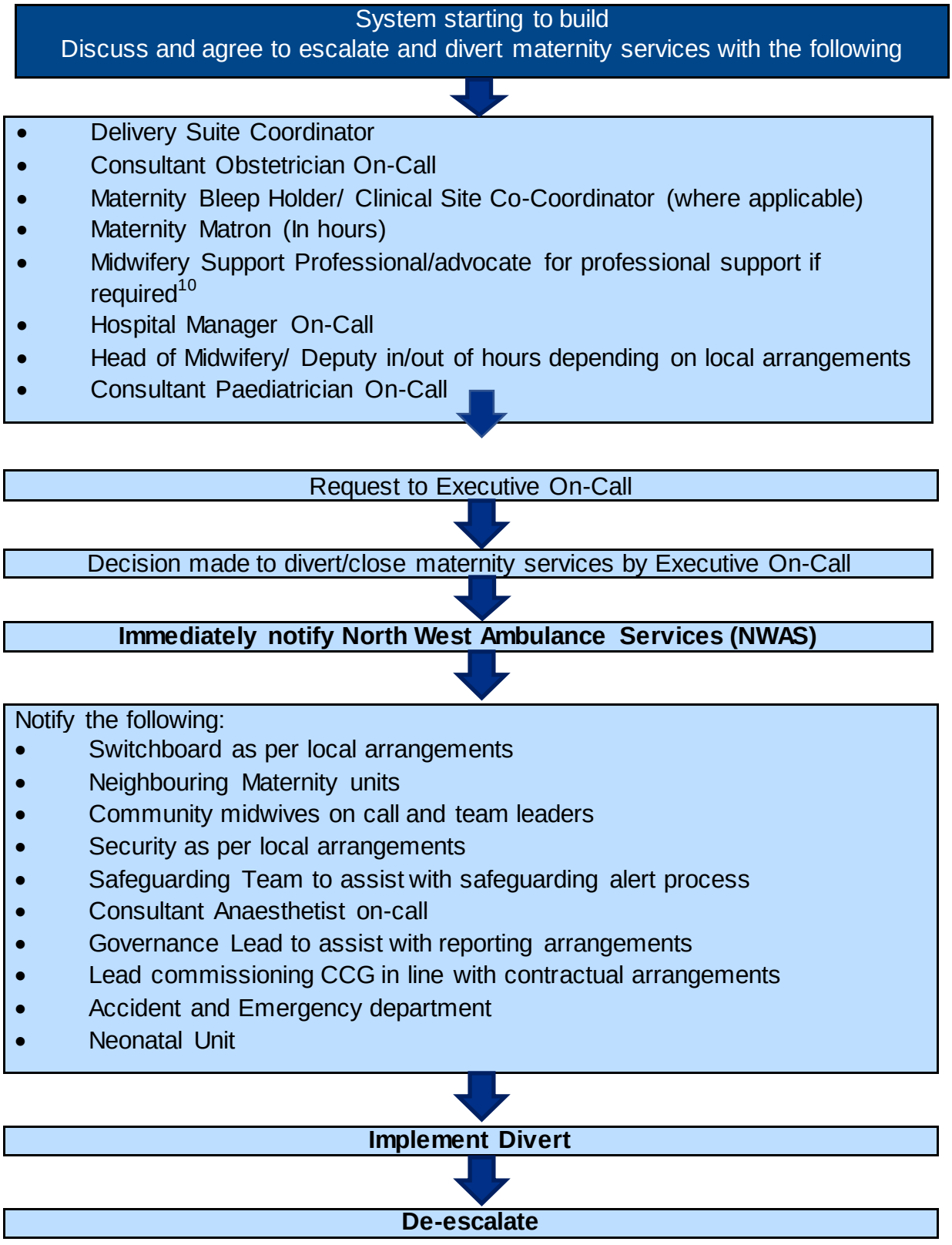
15.0 Sharing Lessons Learnt

All adverse incidents involving any suspension or temporary diversion of services will require an internal investigation review. Any learning identified should be shared across Cheshire and Merseyside.

[8] Situation, Background, Assessment, Recommendation

[9] Revised Serious Incident Framework March 2015

Appendix 1 – Maternity Escalation Chart



[10] Statue of Midwifery ceased 31March 2017, some units will include notification to appropriate professional support for individual midwife.

To be used in conjunction with Appendix 4 & 6 in the Cheshire and Merseyside Maternity Escalation and Divert Policy.

Appendix 2 – Escalation Criteria

LEVEL 1 GREEN - NORMAL OPERATIONAL WORKING
TRIGGERS – NONE • Bed capacity available across maternity service • Appropriate staffing levels • Appropriate skill mix • Management at this level is managed at the established bed management arrangements that are in place

• Normal working whereby midwifery/medical staffing and skill mix is not compromised
• Management at this level is managed by the established bed management arrangements that are in place between the Delivery Suite Coordinator and Maternity Bleep Holder
• Delivery Suite Coordinator or Maternity Bleep Holder should be:
  • reviewing - staffing/skill mix and bed capacity 4 hourly
  • taking steps to remedy staffing levels acuity if necessary by redeploying staff around the service in line with activity and identify women suitable for discharge

ACTIONS REQUIRED	
IN HOURS Aim to manage capacity and patient flow proactively and pre-empt escalation	**OUT OF HOURS**
• Maternity Bleep Holder/Delivery Suite Coordinator to review staffing/bed capacity 4 hourly. • Delivery Suite Coordinator liaises with Neonatal Unit Coordinator twice daily to discuss activity and identify potential admissions. • Maternity Matron Deputy HoM made aware of any irresolvable pressure on the daily bed state for maternity. • Maternity Bleep Holder/Delivery Suite Coordinator to review staffing/skill mix/bed occupancy 4 hourly. • Take steps to remedy staffing levels if necessary by redeploying staff around departments in line with activity. • Maternity Bleep Holder and Ward Manger to identify women suitable for discharge and where appropriate expedite medical review.	• Delivery Suite Coordinator monitors activity and bed status.

LEVEL 2 AMBER – EARLY SIGNS OF PRESSURE
TRIGGERS • Higher patient dependency than staffing ratio and skill mix • High intrapartum activity with high bed occupancy on antenatal/postnatal ward • No significant staffing shortages
• Early signs of pressure requiring additional management support to de-escalate. • Management at this level remains at Maternity Bleep Holder/Delivery Suite Coordinator/Ward Manager/Maternity Matron/Consultant Obstetrician/Neonatal Coordinator.

ACTIONS REQUIRED	
IN HOURS	**OUT OF HOURS**
• Ensure Level 1 status actions are completed. • Maternity Bleep Holder and Delivery Suite Coordinator to liaise and redeploy skilled staff according to area of need. Consider deployment of Community Midwives. • Delivery Suite Coordinator to liaise with Neonatal Coordinator to identify and plan for any anticipated activity that necessitates Neonatal cots. May require Consultant Paediatrician 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. • Maternity Bleep Holder/Delivery Suite Coordinator/Ward Manager to identify women suitable for discharge and expedite medical review where necessary. • If Neonatal Unit is on diversion – plan as early as possible for transfer of women to other units during daytime whilst staffing levels are optimal. Liaise with ambulance service and keep updated re: impact on the service. • If problems encountered with transferring women home or to other hospitals or patients blocking beds either awaiting investigations or reports, Maternity Bleep Holder to assist. • Discussion between Delivery Suite Coordinator/Maternity Bleep Holder and Consultant Obstetrician to consider rescheduling all elective work both IOL/ C/S if clinical condition permits. • All staff to be kept briefed of situation and actions agreed. • Review plan two hourly	• Delivery Suite Coordinator to inform on site Hospital Co-ordinator • Delivery Suite Coordinator to assess the situation and create a plan to improve the situation. • Alert and involve the Consultant Obstetrician & Paediatrician On-Call. • Ensure all key staff are briefed (see Section 7) and aware of all actions agreed. • If problems encountered with transporting women home or to other hospitals or women blocking beds either awaiting investigations or interim report, Hospital Coordinator to assist.

LEVEL 3 RED – EXTREME PRESSURE
TRIGGERS • No potential bed capacity within 2 hours • Labouring women awaiting admission • Telephone referrals still being received from labouring women • Staffing levels insufficient to deal with situation and ensure safe care of labouring women and their babies • Major incident declared / or Maternity Services Business Continuity Plans activated
• Extreme pressure requiring immediate and significant action. • Management at this level to be controlled in hours by the Head of Midwifery or Maternity Matron and out of hours by the Maternity Bleep Holder/Hospital Coordinator and Manager On-Call.

ACTIONS REQUIRED	
IN HOURS	**OUT OF HOURS**
• Ensure Level 2 Amber status actions are completed. • Delivery Suite Co-ordinator update Hospital Manager who will inform the Trust Executive On-Call that the service is requesting that divert be implemented • Suspend all admissions to Maternity Unit. • Suspend all community births as community on call hours may be exhausted if on call midwives have been called into the unit. • Inform neighbouring units and obtain their status. • Complete the Maternity Unit checklist. • Contact NWAS and inform them of the closure and the Hospital/s who have agreed to accept diverted patients • Maternity Bleep Holder, Delivery Suite Coordinator, Consultant Obstetrician, Consultant Paediatrician, Ward Manager, Maternity Matron to maintain communication until stand down from Red to Amber Status. • Once situation has de-escalated to Amber re-open the Unit by reversing the above process.	

Appendix 3 – Maternity Unit Closure Checklist

Maternity Provider diverting/closing the service	
Date and Time of divert/closure	
Name of the Executive On-Call authorising the divert/closure	

It is recommended that one person is nominated to coordinate this procedure who wherever possible should have no other responsibilities during this time.

Nominated Coordinator	
Current Designation	
Contact Details	

Reason for Temporary Diversion	**Tick**
No available beds/high levels of activity and dependency	
Shortage of staff -Midwifery/Medical please specify	
Inappropriate experience/skill mix	
Infection Prevention and Control issue (bays closed)	
Major incident	
Other - Please specify	
Incident Form Completed	

Coordinator to inform the following:

In Hours - If the closure occurs out of hours please inform relevant stakeholders the next working day.	Date	Time	Notifying Person	Comment
Delivery Suite Coordinator				
Maternity Bleep Holder				
Matron On-Call				
MW Professional Support/Advocate				
Consultant Obstetrician				
Consultant Paediatrician				
Trust Manager on call				
Bed Manager (where applicable)				
Head of Midwifery				
Executive on call				
Ambulance Control/NWAS				
Safeguarding Team				
Consultant Anaesthetist				
Governance Lead				
Executive on call at receiving unit				
CCG				

Checklist to be completed following contact with each of the neighbouring units
Receiving unit contact informed to record names of women directed to them Yes/No

Name of Unit	Date and Time Informed	Notifying Person	Contact Name	Response regarding their activity
Arrowe Park 0151 678 5111				
Countess of Chester 01244 365026				
Leighton Hospital 01270 612144				
Liverpool Womens Hospital 0151 708 9988				
Macclesfield Hospital 01625 61140				
Ormskirk Hospital 01695 577111				
Warrington Hospital 01925 635911				
Whiston Hospital 0151 426 1600				
Wigan Hospital 01942 244000				
One to One (North) Ltd 0330 330 9121				

Appendix 4 – Record of Referrals and Transfers

Date and Time of Diversion	

Date and Time of Call	Name	Hospital Number	Safeguarding Issues Identified Yes/No (Ensure all information is shared)	Reason for Call	Advice Given	Name of Unit Transferred To	Delivered Yes/No	Letter Sent Yes/No

Appendix 5 – Maternity Unit Re-opening Checklist (1 of 2 pages)

Date/time unit closed		
Name of Exec on Call who authorised divert/closure		
Date and Time of Re-opening		
Total Days / Hours Closed	**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	

Personnel Notified of Re-Opening of Maternity Unit

In Hours - If the closure occurs out of hours please inform relevant stakeholders the next working day.	**Date**	**Time**	**Notifying Person**	**Comment**
Delivery Suite Coordinator				
Maternity Bleep Holder				
Matron On-Call				
MW Professional Support/Advocate				
Consultant Obstetrician				
Consultant Paediatrician				
Manager on call				
Bed Manager (where applicable)				
Head of Midwifery				
Executive on call				
Ambulance Control				
Safeguarding Team				
Consultant Anaesthetist				
Governance Lead				
Executive on call at receiving unit				
CCG				

Appendix 6 – SBAR

SITUATION • Date and time of closure • Reason for closure • Other information	
BACKGROUND • Precipitating factors that lead to divert and closure • How many times closed in the last 3 years? • Previous reasons for closure	
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 closure appropriate	
RECOMMENDATION • 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?	
COMPLETED BY	

Appendix 7 – Letter of Apology Insert your Trust logo

Dear

Re: **Insert Maternity Provider Details**

We are writing to apologise to you for any inconvenience caused when we recently had to divert/close the services in our Maternity Unit. We experienced an exceptionally high volume of admissions which resulted in a lack of maternity beds being available at this time. Having liaised with our neighbouring maternity providers and the North West Ambulance Service we requested that you to be seen at the nearest hospital providing 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:
xxx

Yours Sincerely

Head of Midwifery Services