South Yorkshire
Local Maternity and Neonatal System
(LMNS)

South Yorkshire Maternity
Escalation Policy & Operational Pressures Escalation Levels Framework

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1.0 Introduction

The North East & Yorkshire Maternity Escalation Policy & Operational Pressures Escalation Levels Maternity Framework (OPELMF) sets out the procedures for the North East & Yorkshire 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.

Having recently implemented a South Yorkshire & Bassetlaw Escalation and Diversion policy, the Local Maternity & Neonatal System (LMNS) Board has agreed to review and adopt the policy to ensure alignment to the NEY policy. This document describes the NEY policy and will also describe the local plans in place to respond to escalation outlining a minimum set of expectations and actions that are in place for the LMNS using existing cross-organisational partnerships.

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 East & Yorkshire
- 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

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.

The temporary suspension of the neonatal unit does not translate to a temporary diversion or closure of a maternity unit. 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. The North East and Yorkshire & Humber Neonatal Operational Delivery Networks (ODN) have a neonatal surge plan to ensure access to neonatal critical care is maintained and not compromised (see Appendix 3 Neonatal ODNs OPEL Framework & Action Cards).

2.0 Principles and overview of the regional framework

This framework has been developed to enable maternity services 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/Birth suite co-ordinator not supernumerary
- Delays in elective work includes induction and elective caesarean section
- Neonatal service capacity

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 incident or power failure – follow local policy

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.
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.
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 & Neonatal System and increased external support may be required. Regional Teams will be made aware of rising system pressure, providing additional support as deemed appropriate.
OPELMF Four	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. 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.

Local maternity services will operate within normal parameters at OPELMF One. At OPELMF One & Two, we would anticipate operations and escalation to be delegated to the relevant named accountable officer in each organisation. At OPELMF Three (Red) and Four it would be expected that there is executive level involvement across the service, see 3.1.

3.0 Guidance for the use of the South Yorkshire Maternity Operational Pressures Escalation Levels Framework & Escalation Policy

3.1 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 (Amber), Three (Red) 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 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

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
- 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 to staff are in a state of readiness when 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

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/Birth suite coordinator
- Consultant obstetrician on call
- Maternity matrons (in hours)
- Professional midwifery advocate for professional support if required following de-escalation
- Silver on call and gold on call
- Director of midwifery/ head of midwifery in/out of hours depending on local arrangements
- Maternity bleep holder
- Consultant neonatologist on call
- Bed manager
- Neighbouring maternity units, see Appendix 4
- Executive director / director on call (in/out of hours)
- Lead commissioner within ICS or CCG as per contractual arrangements

Once the decision has been made to temporarily divert new admissions or close maternity services the appropriate ambulance service 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 and they will be referred to as the coordinator (this should not be a midwife), please see Appendix 4 for diversion template.

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

3.1.1 Notifying others of the decision to close the service in hours and out of hours

The coordinator will make arrangements for key stakeholders (See Appendix 5 for full notification check list) to be notified in addition to the above section in 3.1.

- East Midlands and/or Yorkshire Ambulance Services (depending on location of services)
- Switchboard as per local arrangements
- Neighbouring maternity units (see Appendix 4)
- 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
- Executive director / director on call (in/out of hours)
- Lead commissioner within ICS or CCG as per contractual arrangements
- Accident & emergency department
- Neonatal unit

3.2 Regional escalation & national escalation

- Regional escalation should be triggered when despite all local system escalation actions being exhausted pressure continues to escalate; an external whole system response for additional support is needed, see Appendix 2/OPELMF Four. The maternity escalation triggers and OPELMF is outlined in Appendix 1.

Organisations are responsible for alerting partners and other supporting organisations as outlined in 3.1 & 3.1.1

The relevant first on call should alert other on call colleagues (second on call, EPRR Tac advisor and communications).

- The local maternity service should contact the first on call and clearly outline:
    1. The issue(s) the maternity service is escalating, and actions taken
    2. Support required from regional on call colleagues

3.3 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 safe services operating at OPELMF Two (Amber), a consultation should take place with the same level of authority and focus as the originating closure/diversion. Use re-opening checklist (Appendix 6)
- As aligned to NHSE/I serious incident (SI) framework all diversions and closures must be reported onto StEIS (Strategic Executive Information System).
- Director / head of midwifery to complete root cause analysis (RCA) and SBAR (situation, background, assessment, recommendation) assessment for whole service closure (Appendix 7)

Appendix 1 – South Yorkshire Maternity OPEL Maternity Framework – Escalation Triggers

OPEL STATUS	A/N & P/N Ward beds	Delivery/Birth suite beds	Triage Breaches	Unable to give 1-1 care in established Labour	Birthrate plus activity and dependency score for Delivery Suite	Delivery/Birth 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/birth 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/postnatal 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/birth 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/Birth 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/Birth 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

Below action and roles and responsibilities to be tailored to individual sites:

Alert	The maternity service should automatically alert the silver command on call of the current status once they reach OPELMF Three, as outlined in Action Cards see Appendix 2
Communicate	The maternity service should proactively communicate with and discuss the current status according to defined lines of communication, as outlined in Action Cards see Appendix 2
Act	The maternity service should act in accordance with the agreed action cards, and 'the NHSEI Standard Operating Procedure and Reporting Process: Requesting Ambulance Diverts'.

Roles & Responsibilities within the Trust:

Role	Responsibilities
Strategic (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.
Tactical (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,

Role	Responsibilities
	telephones and manage effective bed clearance on electronic systems etc. They will liaise with delivery/birth suite coordinator to ensure that they have sufficient support
Director of operations/deputy director of operations (within working hours)	The director of operations of the trust will 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 labour/birth suite or out of hours the on call consultant obstetrician 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 also play a key role in the decision-making processes concerning temporary diversion or closure of the service.
Director & Head of Midwifery	DoM holds overall responsibility and accountability for the maternity services flow and capacity with the clinical director. HoMs are responsible for operational leadership to the service; to ensure plans are in place to support the achievement of safe care within the maternity services.
Clinical director	To hold overall responsibility and accountability for the maternity services flow and capacity with the director of midwifery
Maternity bleep holder	To be informed out of hours of any potential capacity concerns when the maternity service is going from OPELMF Two (Amber) to OPELMF Three (Red). There will provide logistical support if needed to support the Maternity Services 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 suite coordinator and ward managers on a daily basis to ensure the safe and timely flow of patients throughout the maternity services by the resolving of staffing shortages and redeployment of staff within the clinical area. Report to the matrons, HoM and community manager. Attend safety huddle with obstetricians, neonatal team, anaesthetists and delivery/birth suite coordinator. At early signs of pressure the manager

Role	Responsibilities
	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.
Maternity bed manager bleep holder	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 as a whole. 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/Birth suite coordinators & 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. Ensure 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 to ensure all discharge planning actions are carried out in an integrated manner.

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

Appendix 2 – OPELMF STATUS TWO (Amber), THREE (Red) AND FOUR ACTION CARDS

OPELMF TWO STATUS(Amber) – SIGNS OF PRESSURE IN THE SYSTEM

TRIGGERS

- Enough beds for delivery/birth 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/Birth 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/birth 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/birth 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 inductions and LSCS 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/Birth 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/Birth 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 blocking beds either awaiting investigation or interim report, hospital coordinator to assist

FREQUENCY OF REVIEW

Delivery/Birth 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 A/N & P/N 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/Birth suite coordinator temporarily providing direct care to antenatal/postnatal women whilst extra support for delivery/birth 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 (Amber) actions are completed
- Manager of the day update silver on call who will inform the trust executive (Chief Operating Officer in ours or Executive director on call out of hours)
- 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 LMNS to alert organisation to pressure points this must also include board maternity safety champions and non - executive safety champions. Where mutual aid cannot be secured organisation to organisation (**which will include usual partners outside of the SYB LMNS (Mid Yorkshire, Nottinghamshire Chesterfield))** proceed to the next step.
- **Escalation with executive level involvement and coordinated response across the ICS/LMNS. Inform neighboring units and obtain their status to see how they can support, this may include full diversions or support with planned activity.** The LMNS PMO will support this in hours. This will be supported by the Executive on call out of hours. The NHS England 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 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
- Silver 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/birthing 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

- Paediatric critical care surge plans have been developed in every region led by the paediatric critical care operational delivery networks (ODNs)
- 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 EPRR policy regarding communications with local communities
- If all OPELMF Status Two actions (Amber) and all the additional OPELMF Three (Red) 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 for the Tactical (silver) on call and Strategic (gold) on call manager for the trust
- Work collaboratively with ambulance trusts to ensure routine escalation policies are enacted when required. Staffing/capacity issues not resolved commence a divert in accordance to *NHS England/Improvement Standard Operating Procedure and Reporting Process: Requesting Ambulance Diverts:* https://www.england.nhs.uk/publication/operational-pressures-escalation-levels-framework/
- Report any immediate risks to the trust gold command and ICS/LMNS
- Manager of the day, delivery suite coordinator, consultant obstetrician, consultant neonatologist, ward manager, maternity matrons to maintain communication until stand down from OPELMF Three (Red)

OUT OF HOURS:

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

FREQUENCY OF REVIEW

Delivery/Birth 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/birth 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/Birth 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 silver and gold command on call who will inform the trust executive on call that divert and closure is to be implemented
- Staffing/capacity issues not resolved commence a divert in accordance to: *NHS England/Improvement Standard Operating Procedure and Reporting Process: Requesting Ambulance Diverts:* https://www.england.nhs.uk/publication/operational-pressures-escalation-levels-framework/
- Responsible person for ICS to be notified in line with contractual arrangements and actions outlined
- Suspend all admissions to maternity unit
- Suspend all community births
- Close 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 silver command and the neonatal call handling service re cot availability
- A contingency plan must be put in place for women that may unexpectedly attend delivery/birth suite & triage areas without notice to manage care safely
- OPELMF Four report SI on StEIS
- 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 to be contacted and request 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/birth suite coordinator, consultant obstetrician, consultant neonatologist, ward manager, maternity matron, silver and gold on call command to maintain communication until stand down from OPELMF Four status

OUT OF HOURS:

- Delivery/Birth 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 (silver) & Strategic (gold) on call command for support & oversight
- Delivery/Birth suite coordinator, maternity bleep holder, consultant obstetrician on call, consultant neonatologist on call, ward manager, Tactical (silver) and Strategic (gold) on call command to maintain communication until stand down from OPELMF Three status

FREQUENCY OF REVIEW

Delivery/Birth suite coordinator or manager of the day and Tactical (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 East & Yorkshire Neonatal ODNs - Operational Pressure Escalation Levels Neonatal ODN Framework (OPELNF) and Actions Cards

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

Yorkshire and the Humber ODN Framework

<table>
<tr><th rowspan="2">RAG RATING</th><th rowspan="2">Escalation Levels</th><th rowspan="2">Triggers</th><th colspan="2">ACTIONS</th></tr>
<tr><th>In Hours</th><th>Out of Hours</th></tr>
<tr><td>GREEN</td><td>Business as usual</td><td>• Bed capacity is limited but managed within usual planning arrangements</td><td><u>ODN</u>
1. On-going monitoring of capacity.
<u>UNITS</u>
1. Units to provide one to three times daily, Cot Bureau information (to be completed on BadgerNet) and/or daily Cot Notifications via scn-tr.yhneocots@nhs.net.
<u>EMBRACE</u>
1. Inform units of repatriation breach status.
2. Provide Lead Nurse with daily Cot Closure notifications as they occur
3. Provide ODN with weekly Neonatal Repatriation Exception Report.</td><td>1. On-going monitoring of capacity.
2. Embrace to inform units of flow issue across the region.</td></tr>
<tr><td>AMBER</td><td>Level 1 Escalation</td><td>• Limited cots in network and patients waiting for a NICU cot
• Inability or limited ability to repatriate babies and accommodate IUTs
• Regional concerns regarding NICU cots</td><td>Continue with Green actions
ODN/Embrace to agree level of escalation/de-escalation.
<u>ODN</u>
1. Inform the neonatal network units and LMSs of status.
2. Inform the surrounding neonatal networks of level status.
3. ODN/Embrace to initiate a call conference between tertiary units when all NICUs are declared at capacity.
<u>UNITS</u>
1. Discuss any concerns with ODN Lead Nurse and/or Embrace.
2. Ensure Repatriation Protocol is being adhered to.
3. Activate internal escalation policy.
4. Escalation level to be included in handover
5. Staffing levels to be risk assessed and ratios adjusted as appropriate to meet demand (A BAPM Framework for Practice, 2019)
6. Maternity services to consider appropriate action to maximise capacity and avoid ex-utero transfers.
<u>EMBRACE</u>
1. Embrace to inform LNU's and SCBU's of status on ring round and refer them to matrix
2. Maximise repatriation and capacity transfers
3 Co-ordinate clinical advice request e.g. Conference Call activation</td><td>1. Call conference between Embrace and Tertiary units (On Call Consultants) to discuss possible options and agree level of escalation / de-escalation.
2. NICU's to inform their local maternity service
3. Embrace to inform LNU's and SCBU''s of status on ring round and refer them to follow this matrix</td></tr>
<tr><td>RED</td><td>Level 2 Escalation</td><td>• No cots in network National concerns regarding NIC capacity.
• Babies awaiting cot and being transferred out</td><td>Continue with Green and Amber level actions
ODN/Embrace to agree level of escalation / de-escalation.
<u>ODN</u>
1. Escalation to NHSE (NEY)
<u>UNITS</u>
1. Discuss any concerns with ODN Lead Nurse/Embrace
2. LNU's and SCBU's to provide higher level treatment until appropriate cots can be found (This process must be discussed through call conference with Embrace and tertiary consultant)
<u>EMBRACE</u>
1. Activation of ODN Control Group (Tertiary Units on Call consultants, Embrace & ODN Reps).</td><td>1. Relevant participation in regional Call Conference.
2. ODN Lead Nurse to be informed (via email) of agreed actions taken.
3. Embrace to inform all network units of status and advised to continue with actions in Green and Amber status.</td></tr>
</table>

North East ODN Framework

RAG RATING	Escalation Levels	Triggers	ACTIONS	
			In Hours	**Out of Hours**
GREEN	**Business as usual**	• Bed capacity is limited but managed within usual planning arrangements	**ODN** 1. On-going monitoring of capacity at networks leads level (MB/SH/LP). **UNITS** 1. Neonatal units to provide Cot Bureau information (to be completed on BadgerNet) and information on capacity to NNeTS twice a day (via ring-round) **NNeTS (Hotline number for all referrals and contact - 0191 230 3020)** 1. Inform units of repatriation breach status (i.e. when have babies waiting to be moved into units but cannot be accommodated). 2. Provide ODN lead (SH) with daily Cot Closure notifications as per ring-round	1. On-going monitoring of capacity. 2. NNeTS to monitor flow issues across the region.
AMBER	**Level 1 Escalation**	Any of: • Limited cots in network and patients waiting for a NICU cot • Inability or limited ability to repatriate babies **impacting on NICU capacity** • Regional concerns regarding NICU cots • Inability to accommodate in-region IUTs • Repeated delay in planned fetal medicine deliveries (IoL or CS)	**Continue with Green actions** **ODN/NNeTS to agree level of escalation/de-escalation.** **ODN** 1. Inform the neonatal network units and LMS leads of status **UNITS** 1. Report concerns to ODN Lead Nurse/Clinical lead/Network manager and escalate staffing issues to senior hospital management locallyctivate internal escalation policy. 2. Regional escalation level to be included in unit handovers 3. Cots to be utilised for repatriation to agreed establishment as reported to network/NNeTS (i.e. any usually held 'Emergency cots' to be utilised for admission/repatriation) 4. Staffing levels to be risk assessed and ratios adjusted as appropriate to meet increased local demand based on clinical acuity of patients (may justifiably exceed BAPM guidance levels that has been agreed at network level) 5. NICU Consultants to consider repatriation of SCU babies to SCU closer to home even if not base unit 6. NICU Consultants to consider exporting 'their own' local SCU babies to create HD/ITU space 7. Maternity services to consider appropriate action/escalation to maximise capacity, utilise IUT transfer and avoid ex-utero transfer: NICU/SCU consultants to liaise directly with Obstetric/Midwifery team **NNeTS (Hotline number for all referrals and contact - 0191 230 3020)** 1. NNeTS to inform NNUs of regional status on ring round and refer them to this matrix to ensure local actions followed 2. Maximise/expedite repatriation and capacity transfers; consider refusal IUT requests from out of region 3 Contact Embrace/Connect NW/ScotSTAR to ascertain out of region NICU cot status and inform the surrounding neonatal networks of NNN alert level status and cot capacity. 4 NNeTS consultant to consider call conference between consultant on call at JCUH/SRH/RVI **after** morning ward rounds when **all NICUs declare zero ITU/HD cot capacity during morning ring round**	1. NNeTS/RVI consultant to consider call conference with consultant on call at JCUH/SRH **after** evening ward rounds when **all NICUs declare zero ITU/HD cot capacity during evening ring round** to discuss: • possible options for movement (utilising repatriation) • repatriation of SCU babies to 'non-home' SCU (including 'local' babies) to create HD/ITU capacity • Agree level of escalation / de-escalation (this matrix). 2. NICU's to inform their local maternity service 3. NNeTS to inform LNU's and SCBU"s of regional alert status on ring round and refer them to follow actions on this matrix
RED	**Level 2 Escalation**	• No ITU/HD cots in network • National concerns regarding NIC capacity. • Babies awaiting cot and being transferred out	**Continue with Green and Amber level actions** **ODN/NNeTS to agree level of escalation / de-escalation.** **ODN** 1. Escalation to NHSE (NEY) (SH/MB) 2. Inform maternity network **UNITS** 1. Report concerns to ODN Lead Nurse/Clinical lead/Network manager and escalate staffing issues to senior hospital management locally 2. SCU's to provide higher level treatment until appropriate cots can be found (facilitated through advice via call conference with NNeTS consultant) as per NNN guidance (especially around respiratory care) **NNeTS (Hotline number for all referrals and contact - 0191 230 3020)** 1. Activation of ODN Control Group (Tertiary Units on Call consultants, NNeTS & ODN Reps).	1. Relevant participation in regional Call Conference. 2. ODN Lead Nurse/Clinical lead/Network manager to be informed (via email) of agreed actions taken. 3. NNeTS to inform all network units of status and advised to continue with actions in Green and Amber status.

Appendix 4 - Neighbouring trust availability to admit diverted women

Temporary closure of maternity service Neighbouring trust availability to admit diverted women			
Unit Name	Contact Number	Date and time contacted	Availability to take/comments

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...Name of Service	Date & Time Informed	Notifying Person	Contact Name	Response regarding their activity
North Cumbria Integrated Care FT				
Northumbria Healthcare FT				
Newcastle-Upon-Tyne Hospitals NHS FT				
Gateshead Health NHS FT				
South Tyneside & Sunderland FT				
County Durham & Darlington FT				
North Tees & Hartlepool FT				
Hull University Hospitals FT				
Calderdale & Huddersfield NHS FT				
Airedale NHS FT				
Harrogate FT				
Bradford Teaching Hospitals FT				
Leeds Teaching Hospitals FT				
The Mid-Yorkshire Hospitals NHS Trust				
Northern Lincolnshire & Goole NHS FT				
Yorks & Scarborough NHS FT				
Doncaster & Bassetlaw NHS FT				
Rotherham NHS FT				
Barnsley Hospital NHS FT				
Sheffield Teaching Hospitals NHS FT				
South Tees Hospitals NHS FT				

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 - Key stakeholders to be informed of temporary diversion or whole 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			
North East Ambulance, Yorkshire Ambulance Service, North West Ambulance, East Midlands Ambulance	√	√			
Neighboring maternity units	√	√			
Integrated care system/Local maternity neonatal system	√	√			
Manager of theday	√	√			
Delivery/Birth suite coordinator	√	√			
Matrons	√	√			
DoM/HoM	√	√			
Obstetric consultant	√	√			
Duty matron	√	√			
Head of emergency performance	√	√			
Tactical (Silver)on call	√	√			
Strategic (Gold) 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	√	√			
Consultant anaesthetist on-call	√	√			
Accident and emergency department	√	√			
Governance lead to assist with reporting arrangements	√	√			
Safeguarding team to assist with safeguardingalert process	√	√			
Site Manager	√	√			
Switchboard asper local arrangements	√	√			
Security as perlocal arrangements	√	√			
	Job Title:				

Appendix 6 – Re-opening Checklist

Date/time unit closed		
Name of exec on call (Strategic/Silver on call) who authorised divert/closure		
Date and time of re-opening		
Total days / hours closed	Days	Hours
Name of exec decision maker (Strategic/Silver on call)		

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

In Hours - If the closure occurs out of hours please inform relevant stakeholders the next working day	**Date**	**Time**	**Notifying Person**	**Comment**
Delivery/Birth 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				
Director/Head of midwifery				
Executive on call				

In Hours - If the closure 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				

Appendix 7 – SBAR Assessment

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 8- 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 suspend services in our Maternity Unit. We experienced an exceptionally high volume of admissions which resulted in a lack of maternity beds being available at the time. Having liaised with our neighbouring maternity providers and the Ambulance Services we asked for you to be seen at the next 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 via:..

Yours Sincerely

Head of Midwifery Services

Appendix 9 – Ambulance Service Action Card

Notification of Maternity Unit Closure in South Yorkshire and Bassetlaw

1. Regional Operations Centre (ROC) to inform EOC Duty Manager and update divert database

2. EOC Dispatch Team Lead to send MDT "MBB" to crews who are affected i.e. area dispatch bay and surrounding areas

"X Maternity Unit closed until further notice – divert agreed to Y Maternity Unit. Any issues contact X (the diverting) Maternity Unit"

3. It is the responsibility of Y Maternity Unit (receiving unit) to inform X Maternity Unit and Ambulance Service ROC if capacity constraints mean that Y Unit can no longer accept the divert.

4. In that instance, the responsibility to arrange a divert to another unit sits with X Maternity Unit (the diverting unit)

5. Ambulance Crews to follow the instruction of the coordinator at the unit on divert and escalate any issues either direct with the unit coordinator or the YAS Clinical Hub. Any patient safety concerns should be reported on DATIX following handover of the patient.

6. ROC informed regarding the unit re-opening.

7. ROC to inform EOC Duty Manager and update the Divert database.

8. EOC Dispatch Team Leader to send MDT 'MBB' to the crews originally informed of the divert that "X Maternity Unit re-opened" and then remove the "MBB".

Trust Approved Documents (policies, clinical guidelines and procedures)
Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Policy
Document title	South Yorkshire Maternity Escalation Policy & Operational Pressures Escalation Levels Framework
Document author (Job title and team)	SYB LMNS Maternity Transformation Programme Lead – based on the NHS England North East and Yorkshire Regional Policy
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development	LMNS wide
Approval recommended by (meeting and dates):	Head of Midwifery Sara Collier 04.03.23 WB&G/CBU3 governance for information March 2023
Date of next review (maximum 3 years)	01/03/2026
Key words for search criteria on intranet (max 10 words)	OPEL LMNS
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the <u>FINAL</u> version of this document	Name: Jade Carritt Designation: Governance Midwife

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU3 Governance

Date approved: March 2023

Date Clinical Governance Administrator informed of approval: 07/03/2023

Date uploaded to Trust Approved Documents page: 16/03/2023