Maternity & Operational Pressures Escalations Plan – Non-Clinical Guideline

Reference no.: UHDB/Operational/Mat/O12

Contents

1. Abbreviations

AN - Antenatal
ANC - Antenatal clinic
BU - Business Unit
EMAS - East Midlands Ambulance service
NICU - Neonatal intensive care unit
DD - Divisional Director
GM - General Manager
HCA - Health care assistant
IOL - Induction of Labour
MOC - Manager on call
M&G/GUM- Maternity & Gynaecology & Genito Urinary Medicine
MSW- Maternity support worker

NIPE- Newborn Infant Physical Examination
PAU - Pregnancy Assessment Unit
WMAS – West Midlands Ambulance Service

2. Introduction

This policy outlines the arrangements in place and key actions to be taken by members of the maternity team when responding to significant surges in demand in maternity care. The priority for modern maternity services is to provide continuity of care provision along with choice of safe, high quality maternity care for all women and babies. In order to achieve this it is essential that an appropriately skilled maternity workforce has the 'right people in the right place at the right time'.

The local UHDB escalation plan outlined within this policy has been updated to reflect guidance published within the ***Midlands Maternity Escalation Policy & Operational Pressures Escalation Levels Framework*** (OPELMF NHSE/I Dec 2021. The plan is split into four escalation levels which reflect the current status of the service in terms of bed availability, staffing and level of emergency demand. Action cards are included for reference and each level should be reviewed and completed before moving onto the next level.

It is essential that managing increased midwifery staffing and maternity bed capacity is undertaken alongside neonatal unit cot capacity. The temporary suspension of the neonatal unit does not translate to a temporary diversion or closure of the maternity unit. During periods of increased pressure it is essential that robust communication and collaborative management is facilitated by midwifery, obstetric, anaesthetic and neonatal teams.

This policy must be read in conjunction with the Trust Policy for ***Capacity Escalation Plan for Inpatient Wards, CED and NICU – UHDB (Derby & Burton) V2.1 (2021)***

The maternity services escalation plan has overarching actions for key members of the maternity team depending on the level of escalation and links with the ***Trust Full Capacity Plan Final Version 2.0.***

Where OPEL levels 3 or 4 for maternity services are declared, the will need to be on-going communication and escalation / liaison with the Corporate Senior Nursing and Managerial team. The Local Maternity and Neonatal System (LMNS) for Derbyshire and Staffordshire must be informed of any maternity unit closure or suspension of services using the pro-forma as outlined in Appendix 9.

3. UHDB Maternity Services

UHDB provides antenatal, intrapartum and postnatal care for approximately 11,500 women across Derbyshire and Staffordshire. Antenatal and postnatal care is provided across a variety of settings and locations including Health Centre's, GP Practices, Children's' Centre's and at home.

Intrapartum care is provided at Royal Derby Hospital (RDH) and Queens Hospital Burton (QHB). There is an alongside Birth Centre at Royal Derby and Stand-alone Birth Centre at Lichfield. Community Midwives also support women who chose to birth at home.

The Neonatal unit at RDH is a designated Local Neonatal Unit (LNU) and provides care for babies above 27 weeks gestation. The LNU is located in the maternity unit and is adjacent to the labour ward. The neonatal unit at QHB site is a Special Care Unit (SCU) unit and provides care for babies above 32 weeks gestation. The SCU is next to the obstetric theatre on labour ward.

4. Scope

This policy applies to and should be available for all staff groups working within the maternity service at UHDB.
The following areas are incorporated within the escalation plan:

- Royal Derby Hospital inpatient area (Labour ward, Ward 314) and PAU
- Derby Birth Centre

- Queens Hospital, Burton inpatient areas (Labour ward, Wards 11&12/ MAU)
- Stand- alone Midwife led Birth Centre, Samuel Johnson Hospital, Lichfield.
- Community midwifery services Derbyshire and Staffordshire including home birth services
- Midwifery Continuity of Care teams

5. Key Responsibilities and Duties

CD for Obstetrics Maternity Safety champion	Has overall responsibility for the professional leadership, governance, operational and strategic management of the maternity service across all UHDB sites. Works in partnership with the General Manager for the MGG Business unit, Matrons and HOM to provide assurance within the division that appropriate safety standards are met in maternity.
ACD for Obstetrics	Has responsibility for professional leadership, operational and strategic management of the maternity service in the CDs absence working in partnership with the General Manager for the MGG Business unit, Matrons and HOM to provide assurance within the division that appropriate safety standards are met. This is done in collaboration with the ACD of their sister site to ensure safe care across all UHDB sites for maternity.
All Grades of Obstetric and Anaesthetic doctors	Have responsibility for ensuring appropriate professional and clinical safety standards are met by working in partnership as part of the full MDT team. All medical staff have a duty to escalate operational or clinical safety concerns to the appropriate Consultant or senior registrar
Director of Midwifery / Divisional Nurse Director (DOM/DND) Maternity Safety champion	Has overall divisional responsibility for the professional leadership, governance and operational and strategic management of the maternity service, paediatric and neonatal services, gynaecology and GUM. The DOM works in partnership with the Divisional Director (DD) and Medical Director (MD) to ensure all services meet recommended national safety requirements.
Head of Midwifery(HOM)	Has responsibility for midwifery professional leadership, operational and strategic management. The HOM works in partnership with the General Manager for the MGG Business unit, Matrons and Clinical Director (CD) to provide assurance within the division that appropriate safety standards are met.
Deputy HoM (s) (DHoM)	Support the HoM and matrons with operational management of the maternity and gynaecology services. Ensures safety standards are met.
Obstetric registrars	Have a responsibility to ensure they are providing safe maternity care. The (senior) registrars should liaise with the senior midwife manager/ midwife coordinators, escalating concerns to the duty Consultant / Consultant on call.
Midwifery matrons	The Midwifery Matrons work cross site and are responsible for managing their teams, providing operational and clinical leadership for all midwives, specialist midwives and maternity support workers. They will ensure that all areas are safely staffed.
Ward/ Clinical Managers (Senior Midwives)	Ward managers are responsible for the safe delivery of services and operational activities within their clinical areas including workforce, safeguarding, budgetary control and staff support.
Community managers (Senior Midwives)	Community Midwifery managers cover seven Community teams across Derby, Derbyshire and Staffordshire. The teams are located at various bases across the community. The community senior midwives are responsible for the safe delivery of services and operational activities

	within their teams including workforce, safeguarding, budgetary control and staff support.
Senior clinical midwives (Co-ordinators)	The role of the Senior Clinical Midwife / coordinator includes managing patient safety by: • appropriately allocating midwifery and support staff workload (taking into account their experience and skills), • Liaising with coordinator /nurse in charge of Neonatal unit • Liaising with ward coordinators in other maternity inpatient / outpatient areas • Monitoring and managing changing acuity within areas escalating in the first instance to the Senior Midwife / Ward Manager of that area during normal working hours or out of hours to the midwifery manager on call (MoC).
Band 5/6 midwives	All midwives have a responsibility to ensure they provide safe maternity care. Any concerns should be escalated to the ward / area coordinator. All band 5 and 6 rotational midwives are expected to work in all areas across the maternity pathway.
Midwifery Support Workers (MSW's	Support the Midwifery teams in the delegated delivery of care
Midwifery Manager on call	Provide clinical leadership to the teams OOHs, ensuring that all areas are appropriately staffed. Responding to any escalated issues during the period of on call

6. Safe staffing in Maternity

In line with NICE guidance, ***Organisational requirements for safe midwifery staffing for maternity settings*** (March 2021), the maternity workforce model must incorporate the ability for appropriately trained and skilled registered midwives (RM) and non- registered maternity support workers (MSW) to maintain continuity of maternity services and to provide safe care at all times to women and babies in all setting.

Safe midwifery staffing ratios at UHDB are assessed using the recommended Birthrate® Plus maternity staffing and acuity tool. Birthrate Plus® is the most widely used system for classifying women and babies according to their needs and using clinical outcome data to calculate the numbers of midwives required to provide intrapartum, antenatal and postpartum care. The most recent Birthrate® plus review at UHDB was completed in March 2021.

The following staffing templates reflect the numbers of Registered Midwives (RM) and Maternity Support workers (MSW) required to provide safe staffing cover in line with overall Birthrate Plus (2021) baseline staffing establishments.

6.1. Acute Unit – RDH only

Total RM		**RM Labour ward (LW) + Birth Centre (BC)**	**RM 314**		**MSW/ HCA LW**	**MSW/ HCA 314**
			Left side	**Right side**		
Early	**A shift**	11(+1LSCS)+ 3BC	4	5 (includes 1 IOL RM)	2	4
Late		11(+1LSCS)+ 3BC	4	5 (includes 1 IOL RM)	2	4
Night shift	**B**	11+ 3BC	2	4 (includes 1 IOL RM)	2	4

Monday –Friday there is 1 RM,1RN and 1MSW supporting elective caesarean section lists completed in Gynaecology theatres.

- In accordance with National Maternity Safety recommendations, the **labour ward coordinator should remain supernumerary.**
- A band 7 senior clinical midwife /coordinator is allocated on Labour ward every shift.
- Some shifts will be coordinated by band 6 midwives who have successfully completed a core competency package.
- If there are 2 band 7 senior clinical midwives on shift one will be allocated to coordinate, the other will provide additional senior support to all staff.
- Ward 314 also has a designated coordinator on shift, either band 7 or band 6 who has completed a core competency package.
- Ward 314 is a 61 bedded mixed antenatal and postnatal ward with the staffing split into two teams to cover the areas more effectively. The teams are covering two areas as defined below.
    - Left side - Rooms/bays 1-16 which is 27 beds. These beds are primarily for transitional care patients & babies, patients with babies on NNU and postnatal patients.
    - Right side – Rooms/bays A- N (to include the 315 corridor) which is 34 beds. These beds are primarily for IOL patients, antenatal patients and elective section admissions and enhanced recovery postnatal care.
- There is a Consultant on call for Labour Ward with a designated Labour ward Registrar and junior doctor. Cover is provided 24/7 (see Appendix 1 for Consultant presence and ward rounds)

Pregnancy Assessment Unit RDH site only

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
RM - A Day shift	4	4	4	4	4	3	3
RM - B Night Shift	2	2	2	2	2	2	2
HCA Day & Night	1	1	1	1	1	1	1

6.2. **Acute Unit – QHB only**

Total RM LW + 11/12/MAU*		**RM Labour Ward**	**RM Ward 11/12*MAU**	**MSW/HCA LW**	**MSW/HCA** Ward 11/12
Early	**A shift**	6	3+3(+1LSCS)	1	2/1
Late		6	3+3(+1LSCS)	1	2/1
Night shift	**B**	6	2+3	1	1/1

*Ward 12 includes maternity Assessment Unit (MAU)

QHB site

- There is one band 7 senior clinical midwife who coordinates labour ward.

- The band 7 on labour ward liaises with the ward coordinator for wards 11/12 activities during the shift.
- The 310 bleep is used to access the Senior Midwife on duty Monday – Friday 07:00-17:00.
- Senior clinical Midwives hold 578 bleep Monday – Friday 07:00-15:00.
- There is a Consultant on call for Labour Ward with a designated Labour ward Registrar and junior doctor. Cover is provided 24/7 (see Appendix 1 for Consultant presence and ward rounds)

6.3. **Community Midwifery Teams and Antenatal Services**

Community Midwifery Teams and Antenatal Services RDH only

	Mon	Tue	Wed	Thur	Fri	Sat	Sun
Visiting RM	12	12	12	12	12	12	12
COC Gaia	1	1	1	1	1	1	1
COC Juno	1	1	1	1	1	1	1
Nights (Covers HB service)21.45 – 08.00	2	2	2	2	2	2	2
A Shift (Covers HB service) 08:00-16:00	2	2	2	2	2	2	2
B shift (Covers HB service) 16:00-21.45	2	2	2	2	2	2	2
	Mon	**Tues**	**Wed**	**Thur**	**Fri**	**Sat**	**Sun**
Total MSW across teams	7	7	7	7	7	2	2

Community Midwifery Teams and Antenatal Services QHB only

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Total Visiting RM	4	4	4	4	4	4	4
ANC	3	3	3	3	3	3	3

NB Community staffing is calculated above for Community Midwives providing postnatal care as the number required for antenatal clinic each day will vary due to clinics, clinics cancelled due to unavailability's and clinics requiring cover due to unavailability's. It is the role of the Senior Community Midwives to ensure that these are covered.

7. Midlands Operations Pressure Escalation Level – Maternity Framework (OPELMF) and Midwifery Red Flag Events

The Midlands OPEL Maternity framework (Appendix 2) has been developed to enable maternity services to align escalation protocols to a standardised regional process and escalate regionally when required.

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

1. Ward bed capacity
2. Delivery suite bed capacity
3. Triage breaches

4. Unable to give 1:1 care in established labour
5. Birth rate plus activity & dependency score of all intrapartum care on delivery suite
6. Delivery suite co-ordinator not supernumerary
7. Delays in elective work, this includes induction and elective caesarean section
8. Neonatal OPEL Framework status

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 (Appendix 1)
- 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 UHDB OPEL Maternity Framework grid is outlined in section 7.3 and identifies local escalation triggers. The local OPELMF status will be based on three triggers being met at a particular level

7.1. Midwifery Red flag events

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing or bed capacity. If a midwifery red flag event occurs, the senior midwife for the area should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.
Red flag events are captured on the Birth rate Plus acuity tool used on the labour ward at RDH (new App soon to be implemented at both RDH & QHB sites)
Red flag events

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

7.2. Midwifery Staffing Huddle

RDH

- Staffing huddles are competed daily at 08:15 and 15.30 as a minimum Monday to Friday to assess staffing levels, skill mix, and activity.
- Attendance at the staffing huddles includes a Senior Midwife from each area of the acute service and the on -site Midwifery Matron or Deputy HoM.
- The daily safe staffing template must be completed by the senior midwives in clinical areas.
- The Manager on Call will also be present at the 15.30 staffing huddle to receive a full handover of the unit.
- During periods of increased activity or extreme staffing shortages an escalated staffing huddle should take place prior to 15.30 hrs
- Unit status must be escalated to the Trust Flow team (FLO) by the senior midwives following attendance at the staffing huddle twice daily (RDH only Prior to 08.30 & 16.00 hrs)
- When escalating, regarding requesting RN/HCA support to Maternity this must occur before the Trust 1:00pm staffing meeting.

- If staffing or capacity issues are unable to be resolved then the issue must be escalate within the Business unit to the General Manager. Simultaneously, the Trust FLO co-ordinator, HoM, DoM, and CD should be made aware.
- The actions from staffing huddles should be documented on the proforma (Appendix 3) and retained for future reference

QHB

- The LW Senior Midwife Manager, Senior Ward Midwife for Ward 11 and 12 and a Matron are responsible for meeting on LW at 08:30 and 16:00 at a minimum Monday to Friday assessing staffing levels, skill mix and activity.
- Should staffing or capacity issues arise during the shift the staffing huddle should occur prior to 16.00 hours to enable escalation to the Matron in the first instance.
- If unresolved the Matrons will then escalate to FLO, HOM, DOM, CD and business unit General Manager.
- The Manager on call will receive a full unit hand over from the LW coordinator at 17:00 either in person or via telephone if off site

Out of hours Midwifery Manager on Call (MoC)

RDH site only:

A Senior Band 7 Midwife or Band 8 Matron is on call for staffing or bed capacity escalations:

- Mon-Fri -the MoC is on site 16:00 to 20:00 then on call from home 20:00 to 08:00 the following morning.
- Saturday / Sunday the MoC is on site from 08.00 -16.00 then on call from home 16.00-08.00

QHB site only:

A Senior Band 7 Midwife or Band 8 Matron is on call for staffing or bed capacity escalations:

Mon – Fri- the MoC is on call from home from 17:00- 09.00

- Saturday / Sunday the MoC is on call from home from 09.00 -09.00 the following day
- It is the responsibility of the MOC to ring LW at 09:00 on Saturday and Sunday to receive a full handover regarding staffing and activity and to assess if attendance into the unit is required.

It is essential that in times of increased unit activity or where staffing concerns identify gaps in safe staffing templates that communication between the RDH and QHB maternity units are facilitated, allowing for early planning for potential cross site diversion when safe to do so.

Community Midwifery

Daily activity is coordinated by community based team leaders and senior community midwife managers. Community Midwifery teams require senior midwifery operational support during times of increased activity or staffing shortages. Where staffing shortages impact on community clinic cover, essential home visits and homebirth services, escalation should be reported to the Community Midwifery Matron, onsite Midwifery Matron (RDH /QHB) during normal working hours or the Midwifery Manager on call out of hours.

7.3. UHDB OPEL Escalation Triggers

The UHDB OPEL escalation triggers grid (below) has been modified for local use within the acute maternity units at RDH & QHB sites

The UHDB Maternity escalation profroma (appendix 3) is a tool to support senior midwives to assess OPEL status and should be used alongside the local OPEL escalation trigger grid to record status level and document local actions taken.

A guide to the actions which should be considered and involvement of senior managers is outlined within section7.4.

UHDB Operations Pressure Escalation Level – Maternity Framework (OPELMF)

OPEL Status	Labour ward beds	A/N & P/N beds	Triage Status (PAU/MAU/ intrapartum admissions)	Unable to provide 1:1 care in established labour	Birthrate Plus/ Dependency score for Labour ward / Staffing re-deployment	Delivery suite coordinator not supernumerary	Delays in Elective work for non- medical reason	Local Neonatal unit status/ staffing to support in utero transfers
Black Level 4	0 Beds	0 Beds	0 beds	Unable to give 1:1 care in established labour	BR Plus acuity score = Red Mitigations in place do not meet tolerated risk	Cannot remain supernumerary – involved in direct patient care	Unable to transfer to another UHDB site / external Trust	Black / Closed Midwifery staffing unable to support in-utero transfer
Red Level 3	Not enough beds to receive or transfer elective activity	5 or less beds on ward 314 2 beds or less across ward 11/12 QHB	• Women with time critical admission not seen immediately • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour.	Unable to give 1:1 care in established labour for time limited period <2 hours	BR Plus acuity score = Red. Mitigations/staff redeployment in place (meeting tolerated risk) increased safety huddles implemented Diversion of women between sites may be required	Temporarily providing direct patient care	Delays in elective activity for >24 hours (IOL or ELLSCS postponed)	Red / limited Cot space available – Midiwfery staffing unable to support in-utero transfer
Amber Level 2	Beds available but increased levels of activity within the maternity unit	High activity with high bed occupancy but beds available	Within previous hour delays in initial assessment >15 minutes	Redeployment of staff or review of activity will allow 1:1 care	BR Plus acuity = Amber Mitigations in place /staff redeployment in place (meeting tolerated risk)	Labour ward coordinator is supernumerary, although providing clinical support to individual midwives	Some delays to elective activity (IOL delayed >2 hours)	Amber – cots available
Green Level 1	Normal unit activity. No delays	Bed capacity available	All women seen within appropriate timescales in line with unit guidance (within 15 minutes)	1:1 care given to all women in established labour on labour ward	BR Plus acuity =Green	Labour ward coordinator is supernumerary	No delays to elective work	Green – cot availability

Report as highest level if 3 or more boxes triggered in 1 colour

7.4. **local UHDB OPEL Actions**

The following actions should be taken by the maternity team in response to the outlined levels above

Level 1: GREEN
During normal working hours the **Senior Midwife / Ward manager and Coordinators in charge of each area** must maintain on overview of unit and area activity and inform the senior midwives / ward manager when area/ unit activity moves from Green status.
• No action

Level 2: AMBER
When Amber status is triggered the **Senior Midwife / Ward Manager and coordinators in charge of each area must inform the Matron on site** of escalating concerns to enable support to be given. The Co-coordinators, senior midwives and Matron should explore all options to maintain a safe service. This may include re-deployment of staff from one clinical area to another at times of increased activity.
• Escalate as above • Coordinators to inform senior midwives / ward managers and develop a local plan to address areas of increased activity/ shortfall in staffing • Consider additional staffing huddle with matron • Liaise between all areas, including community re staffing / skill mix and redeploy as required (The skill mix and experience of staff being redeployed must be taken into consideration) • Review IOL and ELLCS activity with obstetric team • Ensure inpatient discharge reviews have been completed including NIPE review • Plan ahead for medication requirements to aid early discharge • Consider early PN discharges where suitable • Contact Midwifery Matron on site/ Midwifery manager on call out of hours if actions taken have not resolved situation • **Review situation every 4 hours**. If pressures continue move to next level

Level 3: RED
When Red status is triggered the **Senior Midwives / Ward managers for the area must inform the Matron on site (midwifery manager on call OOH)** and agree actions required to meet acuity. During normal working hours **the HoM and General Manager should be made aware** of mitigations taken to manage staffing or activity and the duty **Obstetric Consultant, senior midwives, matron, neonatal and anaesthetic staff must be involved in planning response.** **Out of hours** - if new pressures arise **Midwifery Manager on call (RDH 07799337679 or QHB bleep via switchboard) and HoM must be contacted.**
• Escalate as above • Review bed capacity across unit and red flag events– ***use proforma in appendix 3 to record assessment and document actions*** • **Review situation every 2 hours** - increase midwifery / MDT staffing huddles e.g. 08.00,10,00,12,00 etc. • Duty Consultant Obstetrician to consider postponement if suitable IOL and patient records must be reviewed and management plan agreed • Duty consultant to review planned ELLSCS • Maternity team to review all postnatal women for suitable transfer home. Consider appropriate early discharges from Labour ward/Birth Centre

- Consider directing women not in labour home. Clear management plans must be documented with any follow up assessments to PAU/MAU/CMW clearly identified and documented.
- Senior obstetric review to agree admissions to ward from PAU / MAU
- Consider using the Induction Unit on Labour Ward or HDU (RDH) for postnatal women if activity allows.
- Contact Patient Flow Coordinator (via switchboard if out of hours) to arrange any possible transfers of patients to the Gynaecology Ward or to request additional RN staff or HCA support
- Where midwifery staffing or activity within the unit is such that this compromises in-utero transfers this must be communicated to the neonatal team
- **Duty consultants across both sites** to discuss any potential transfers of suitable women cross site, taking into consideration patient risk factors, midwifery / obstetric staffing and activity at each site.
- Consider plans for temporary diversion to other internal maternity site (RDH /QHB), suspension of home birth services or temporary diversion to other external maternity site.
- Normal working hours inform MGG General Manager, Deputy HoM / HoM. Out of hours HoM/ DoM and on site flow team/SMOC must be contacted
- **EMAS /WMAS to be informed** of temporary diversion to other ***internal maternity site*** **(RDH /QHB),** ***suspension of home birth services*** **or** ***temporary diversion to other external maternity site*****.**

Level 4: BLACK

Black status will require **a full MDT approach to managing capacity and safe staffing escalations will need to be reported to Business Unit and divisional management team** during normal working hours.
Normal working hours: Duty Obstetric Consultant, senior midwives, matron, HoM, MGG General Manager neonatal and anaesthetic staff must be involved in planning response.

Out of hours will require escalation to the **Midwifery manager on call (07799337679) QHB bleep via switchboard) senior nurse and Trust Senior Manager on call (SMOC) must be contacted. Inform HoM.**

- Escalate as above
- Review bed capacity across unit and red flag events– ***use proforma in appendix 3 to record assessment and document actions .*** Where pressures persist agree plans for temporary diversion/ suspension of maternity services.
- **Review situation every 1-2 hours-** increase midwifery / MDT staffing huddles 08.00,10,00.12,00 etc.
- Out of hours HoM, Senior Nurse, Site Senior Manager on call (SMOC) and Exec on call must be informed.
- **EMAS / WMAS must be informed of any** ***service closure, or external diversion to another maternity unit***
- Derbyshire/ Staffordshire LMNS to be informed (next working day) Appendix

8. Diverting Activity Cross Site (internal UHDB to UHDB site)

When OPEL level 3 or 4 is triggered consideration can be given to diverting planned elective and/or spontaneous admissions to an alternative UHDB maternity unit. Safety of mothers and babies must remain the utmost priority therefore, **diversion between units and temporary suspension of services must only be considered once all other measures have been explored.** Plans to divert or suspend maternity services must be agreed by the Obstetric Consultant, HoM or DoM or senior MDT team on site.

- Any women already in the unit or planned to attend the unit and who is considered suitable for internal cross site transfer must be reviewed and risk assessed by the MDT team on a case by case basis This risk assessment must be clearly documented in the patient record

- Consideration in the first instance should be given to women with low risk pregnancies e.g. women planning to birth in the Birth Centre or low risk planned induction of labour.

- Obstetric Consultant to Consultant communication between sites must occur in all cases.

- The type of care provision the receiving unit can accept should be clearly agreed e.g. support with IOL, low or high risk laboring women, Elective Caesarean section
- The receiving maternity unit Labour ward coordinator must be contacted by the senior midwife / manager / manager on call prior to transfer of care to ensure this remains a safe option.

- Women must be informed of the need for transfer to an alternative maternity unit and be given contact details for the receiving unit and adequate directions.

- The midwife arranging transfer should ensure that the woman is accompanied and has transport

- Women should be advised to take their local maternity hand held record with them to the receiving unit

- The maternity care records should be sent with the women using a red secured transport folder. The notes can be given to the woman to take with her. These notes must be returned following the completed episode of care. It is essential to access the EPR of any woman being diverted cross site to provide the receiving unit of any specific issues, e.g. safeguarding / clinical risks.

- Agreement must be made by the Consultant on duty & senior midwifery manager regarding capacity to invite women in for triage on site. It may be possible to accept those women whose risk of admission to labour ward remains low.

- Once diversion cross site is agreed by the Consultant/ MDT team / Senior managerial team OOH this must be communicated to PAU/MAU who will triage calls.

- PAU/MAU staff along with the registrar / obstetric team will triage all calls identifying if women require admission. If admission is recommended (and the unit is unable to triage

women on site), women will be advised of the need to divert cross site to the agreed receiving unit for care provision.

- Records of any women diverted or transferred cross site must be kept. (spread sheet on Shared drive RDH to be updated by Midwifery Matrons)

- Whilst internal cross site diversion is in place, review of acuity and capacity should be completed every 2-4 hours with the full management team (OOH Midwifery manager on call and Consultant on call) until such time as a step down of escalation is agreed.

9. Temporary disruption to Maternity Services including suspension (external diversion to another Maternity Service outside the Trust)

Temporary suspension of new admission to maternity must only be completed following discussion and agreement with the duty Consultant Obstetrician and Midwifery Manager on call. Co-ordination of the procedure must be undertaken by the most senior **managerial** person on site.
Safety of mothers and babies must remain the utmost priority therefore, **diversion to another maternity service outside of the Trust must only be considered once all other measures have been explored.** Plans to divert or suspend maternity services must be agreed by the Obstetric Consultant, HoM or DoM or senior MDT team on site. Escalation of disruptions to service must be communicated to the Director of Midwifery, Chief Nurse and LMNS (out of hours the Senior Nurse, Site Manager on call (SMOC and on call Exec must be informed).

The following steps will depend on reasons for suspension and therefore need to be instigated appropriately-:

- The labour ward coordinator at neighboring maternity units within the region should be contacted to understand their capacity to accept women (Contact numbers for local units see appendices 4&5).

- The type of care provision the receiving unit can accept should be clearly agreed e.g. support with IOL, spontaneous low or high risk labouring women

- On no account should women be advised to ring alternative units themselves. Women must be informed of the need for transfer to an alternative maternity unit and be given contact details for the receiving unit and adequate directions.

- Agreement must be made by the Consultant on duty & senior midwifery manager regarding capacity to invite women in for triage on site. It may be possible to accept those women whose risk of admission to labour ward remains low.

- Once diversion to the external unit is agreed by the Consultant/ MDT team / Senior managerial team OOH this must be communicated to PAU/MAU who will triage calls.

- PAU/MAU staff along with the registrar / obstetric team will triage all calls identifying if women require admission. If admission is recommended (and the unit is unable to triage women on site), women will be advised of the need to divert to the agreed receiving hospital for care provision.

- Inform East Midlands Ambulance Service /West midlands Ambulance Service of the suspension of maternity services and arrangements agreed with receiving maternity units to ensure that women in labour are diverted to the agreed receiving hospital.

- If women arrive unannounced in labour, clinical assessment needs to be made re-: safety of their transfer to neighboring units or to stay and birth.

- It is essential to access the EPR of any woman being diverted to an external unit to provide the receiving unit of any specific issues, e.g. safeguarding / clinical risks. If required, a copy of the EPR maternity notes may need to be forwarded to the receiving unit. These can be shared electronically observing appropriate Information Governance standards. Clerical support may be required to assist with arrangements.

- If women who are in-patients are to be transferred to another hospital, the Consultant / Consultant on call for obstetrics in consultation with the Senior Midwifery Manager (on call out of hours) must make the decision taking into account the distance to the receiving hospital and clinical picture.

- A record of women directed to other external units will need to be maintained. (spread sheet on Gynae Shared drive RDH to be updated by Midwifery Matrons)

- Whilst suspension of service and external divert is in place, review of acuity and capacity should be completed every 2-4 hours with the full management team (OOH Midwifery manager on call and Consultant on call) until such time as a step down of escalation is agreed.

10. Re-opening of the Maternity Unit

- Once all factors that led to suspension of services are resolved, the managerial team will inform all individuals involved to stand down, and to cascade to relevant areas. Use re-opening checklist (Appendix 6)
- As aligned to NHSE/I serious incident (SI) framework all suspension of services where women have been diverted to **an external trust** must be reported onto StEIS (Strategic Executive Information System) and learning should be shared across the system
- Director / Head of Midwifery to complete root cause analysis (RCA) and SBAR (situation, background, assessment, recommendation) assessment for whole service closure (see Appendix 7)

Actions following suspension / diversion:

- Incident Reporting form (Datix) to be submitted by the labour ward coordinator
- Risk assessment for to be completed and forwarded to the LMNS (appendix 8).
- The Director of Midwifery will ensure that a letter of apology is sent to every woman who is referred to another unit. This letter will provide further explanation.

11. Actions for Maternity during Neonatal Unit Capacity Escalation

During periods of reduced cot availability, communication between maternity and neonates is essential in supporting the safe care of mothers and babies

- The neonatal consultant will inform the Clinical Director for Obstetrics or Clinical Director for O&G, or deputies as applicable.

- A senior member of the obstetric team must review elective activity on labour ward eg IOL / Caesarean Section, and a Consultant ward round to review all women on Ward 314(RDH) Ward 11/12 (QHB)

- Consideration must be given if attempting to transfer babies from NICU for transitional care within the unit – consider mum & baby flat accommodation on NICU / children's ward / ward 314 (RDH) Ward 11 QHB) if mother still an in-patient.

- In the case of in-utero transfers staffing considerations must be taken into account.

- All calls received from women (potentially in labour) following triage assessment and discussion with a senior registrar/consultant obstetrician as to suitability for transfer

- There needs to be senior input to review women admitted to the assessment unit.

- Encourage 6 hour transfer (or earlier if only waiting for a NIPE) of women following normal birth where appropriate with an appointment to return for the baby's' NIPE check.

12. NHSE Covid-19 specific recommendations for managing safe midwifery staffing

The following provides a phased approach to managing maternity staffing escalations affected by COVID -19 transmissions.

Maternity care, especially intrapartum care, is a core non-elective service that needs adequate staffing and access to facilities. The principle must be to maintain the safety and wellbeing of women and their babies. This means preventing avoidable perinatal mortality and morbidity (including issues relating to mental health and wellbeing). At the same time, services should aim to maximise choices for women within the constraints of the available staffing and facilities and should continue to provide a personalised risk assessment for all women and agree with them a package of care.

https://www.nice.org.uk/media/default/about/covid-19/specialty-guides/delivering-midwifery-intrapartum-care-where-local-covid-19-escalation-protocols-are-required-to-be-enact.pdf

In order to ensure that staff are deployed in the best way and women and babies continue to experience safe care the UHDB Maternity teams will maintain services through a phased approach.

Supernumerary labour ward coordinator status and the provision of one-to-one care in active labour must be a priority. As per national guidance, midwives should not be redeployed outside maternity during the COVID-19 pandemic. Redeployment is not an acceptable reason not to provide one-to-one midwifery care in labour. It has undoubtedly been challenging for midwives to adapt to delivering safe care differently during the COVID-19 pandemic.
This document supports them to continue to do so where local COVID-19 protocols are required to be enacted. Maintaining staff wellbeing in these circumstances is very important.

12.1. Key issues to consider when managing Staffing Escalations in Maternity Services

- Plans to protect the health and wellbeing of all staff must be available to all staff groups

- Making changes to midwifery care in other parts of the pathway to increase midwife availability for intrapartum care. Essential antenatal and postnatal care must be delivered. Consideration for service suspensions must be addressed in conjunction with NHSE guideline
https://madeinheene.hee.nhs.uk/Portals/0/Clinical%20guide%20for%20the%20temporary%20reorganisation%20of%20intrapartum%20maternity%20care.pdf

- Sourcing extra staff, such as by using temporary staff/ bank/agency
- Offer additional hours to part time staff
  - Return to clinical practice for midwives in specialist roles, such as digital, educational, diabetes, infant feeding, consultant midwives
  - Recall of midwives on secondment
  - Deployment of third-year students in their final 6 months into clinical placement, in line with guidance
  - Deployment of second-year students and those in the first 6 months of their third year, in line with guidance
  - Engagement with local independent midwives, to support homebirths or intrapartum care
  - Deployment of maternity support workers, healthcare assistants or nurses on the postnatal ward and HDU
  - Review annual leave requests offering alternative arrangements
  - Overtime payment requests must be agreed with Director of Midwifery or Head of Midwifery when all other reasonable actions have been considered.
  - Offer flexible workforce RN shifts to support delivery of care on the ward and in HDU

- **Action in relation to these plans must not cause midwifery red flag events to occur in other areas.**
- **Only consider service cancellations or closures as a last resort.**
- **Actions within the escalation plans related to midwifery staffing should be approved by the Director/Head of Midwifery or Chief Nurse**

12.2. **Maternity Staffing criteria and baseline midwifery staffing levels at UHDB**

Midwives and **maternity support workers** are required to care for pregnant women and their babies and should only be redeployed within maternity care.

• **Obstetricians** should not be redeployed beyond the point where doing so would put the operation of an emergency service at risk, eg inability to maintain the emergency caesarean section and operative vaginal delivery service. Access to clinically indicated elective caesarean section also needs to be maintained to avoid further increases in emergency work.

12.3. **Safe Midwifery staffing levels**

Please refer to agreed midwifery safe staffing templates (section 5)

12.4. **Place of Birth choices in Maternity Services**

Alongside hospital midwifery units, freestanding midwifery units and home birth teams provide a safe option for many women as set out in National Institute for Health and Care Excellence (NICE) guidance. A decision on whether to maintain, limit or withdraw these services should not be taken lightly and will involve careful balancing of a number of considerations:

During the COVID-19 pandemic freestanding units and home births have the advantage of helping to keep women out of hospital, reducing the pressure on hospital services.

Midwifery units and home birth services tend to operate with a smaller pool of midwifery staff. High staff absence in community midwifery services can reduce staffing ratios to an unsustainable level if staff numbers cannot be supported through deployment of student

midwives, maternity support workers, and retired or nonclinical midwives.

A proportion of women need to transfer from home or a freestanding unit to the obstetric unit. This usually requires a response from an ambulance service, which may also be experiencing capacity pressures. This means transfers from home to hospital may not be sufficiently quick to ensure the safety of mother and baby. The service should ensure that any impact to ambulance services is communicated to women choosing to opt for a homebirth.

12.5. **NHSE recommended escalation levels to address staffing shortages and Ambulance services response (Covid-19 specific)**

<table>
<tr><th>Level status</th><th>Midwifery Staffing level</th><th colspan="2">Service activity</th></tr>
<tr><td rowspan="2">Level 1</td><td>Predicted shortage (annual leave, short term absence, Long term absence, maternity leave, restricted duties, training)</td><td>Service restriction consideration</td><td>Local ambulance service impact</td></tr>
<tr><td>Midwifery shortage predicted between 10-20%</td><td>All place of birth available for as long as possible</td><td>Ambulance services running as usual</td></tr>
<tr><td colspan="4">Actions required
Sourcing extra staff, such as by using temporary staff
Offer additional hours to part time staff
Return to clinical practice for midwives in specialist roles, such as digital, educational, diabetes, infant feeding, consultant midwives
Deployment of maternity support workers, healthcare assistants or nurses on the postnatal ward
Review annual leave requests offering alternative arrangements
Overtime payment requests must be agreed with Director of Midwifery or Head of Midwifery when all other reasonable actions have been considered.
Weekly senior team staffing meetings HoM / DoM matron team</td></tr>
<tr><td rowspan="2">Level 2</td><td>Predicted shortage (Annual leave, short term absence, Long term absence, maternity leave, restricted duties, training)</td><td>Service restriction consideration</td><td>Local ambulance service impact</td></tr>
<tr><td>Midwifery shortage predicted between 20-30%</td><td>Restricted home birth service or partial suspension of homebirth service</td><td>Ambulance service experiencing minor delays</td></tr>
</table>

Actions required

- Proactive recruitment measures
- Sourcing extra staff, such as by using temporary staff
- Return to clinical practice for midwives in specialist roles, such as digital, educational, diabetes, infant feeding, consultant midwives
- Managers to work clinically
- Deployment of maternity support workers, healthcare assistants or nurses on the postnatal ward
- Review annual leave requests offering alternative arrangements
- Overtime payment requests must be agreed with Director of Midwifery or Head of Midwifery when all other reasonable actions have been considered.
- Recall of midwives on secondment
- Twice daily staffing safety huddle
- Consider use of independent midwives
- Consider agency midwives
- Consider RNs to support the RMs on HDU and the ward
- Escalate through internal governance processes to Trust safety champion and Chief Nurse

Level 3	**Predicted shortage (leave, short term absence, Long term absence, maternity leave, restricted duties, training)**	**Service restriction consideration**	**Local ambulance service impact**
	Midwifery shortage predicted over 30%	**Centralisation in AMU/obstetric units Discontinuation of homebirth service**	**Ambulance service experiencing severe delays**
Phase three is triggered once the midwifery shortage is over 30% or once the ambulance service is unable to support category 1 emergency calls without severe delays. If the safety of homebirth cannot be assured and midwifery staffing does not allow safe staffing of all places of birth, centralisation is recommended.			

12.6. **Potential groups of staff and students to support intrapartum midwifery care**

Only the following people may attend a woman in childbirth –

- *A Registered Midwife*
- *A Registered Medical practitioner*
- *A student undergoing training with a view to becoming a midwife, as part of an approved course of practical instruction.*

Students: The decision on the level of supervision provided for students should be based on the needs of the individual student. The level of supervision can decrease with the student's increasing proficiency and confidence (NMC Standards for supervision and assessment, 2018). Students must work with appropriate support and supervision within an appropriate delegation framework (Health Education England [HEE] Student support guidance during COVID-19 outbreak, version 1.0 March 2020).
Women have the right to decline student involvement in their care.

NB: In escalation, it is important that the midwifery coordinator in charge of the labour ward has supernumerary status (defined as having no caseload of their own during their shift), to ensure there is an oversight of all birth activity within the service.

To expand the number of staff available to look after women in labour during exceptional staff shortages; those staff groups listed in Categories A and B in Table 1 should be considered.

To free up as many midwives as possible to deliver midwifery care for women in established labour, those staff groups listed in Category C in Table 1 can provide other essential care to women.

It is important that all staff groups listed in Table 1 have training in acute respiratory syndrome.

Category and descriptor	Staff group	Induction/training
Category A1 Can provide care for a woman during established labour. Category A1 staff should be allocated to women who have higher levels of risk.	Registered midwives with recent experience of intrapartum care/labour ward	Category A1 staff should undertake online training in: • coronavirus (COVID-19) infection and pregnancy: information for healthcare professionals • e-learning on COVID-19 • e-Learning for Health COVID-19 programme • updated guidance for personal protective equipment (PPE) during the COVID-19 pandemic.
Category A2 Can provide care for a woman during established labour, if no Category A1 staff are available.	Community midwives (Refer to guidance on changing the configuration of services, community and midwifery staffing: RCM/RCOG's guidance for the provision of midwife-led settings and home births in the evolving coronavirus [COVID-19] pandemic) • Specialist midwives • Independent midwives who have had an individual training needs assessment and undertaken the recommended induction/training	Category A2 staff should undertake training in all the above plus: • orientation to the workplace • fetal monitoring • care of critically ill woman in childbirth, enhanced maternity care • training on the maternity information systems used by the trust (if necessary).
Category B Can provide care for a woman during established labour on the labour ward, if the capacity of Category A1/A2 staff is significantly reduced.	Midwives on the temporary register • Third-year midwifery students (in final 6 months of third-year study) • Students in the final part of the Midwifery shortened programme for nurses • Third-year midwifery students (in first 6 months of third-year study) and second-year midwifery students	Category B staff should undertake training as per Category A plus: • one-to-one discussion between midwife supervisor and individual to understand training need • training in obstetric emergencies • for students, training and support is set out in HEE guidance (see Student deployment below) • For midwives on the temporary register, training and support is set out in

		HEE guidance (Ref: e-LfH Resources for nurses, midwives and AHPs returning to work, being redeployed or upskilled)
Category C In the event of midwifery shortages being such that one-to-one care is not possible, Category C staff can provide essential care to women and families and so support midwives (freeing their time to focus on critical tasks). Examples of this may include: • anaesthetic support • phlebotomy • immediate postpartum care (personal care, support with breastfeeding).	Nurses with skills in high-dependency units (HDUs) and recovery in labour ward (although likely that they will be prioritised in intensive care unit [ICU]) • Nursery nurses (dependent on experience, skills and knowledge) • Medical students in obstetric rotation • Maternity support workers (Support provided by maternity support workers should be within their sphere of competence as set out in the HEE's Maternity support workers, competency, education and career development) • Operating dept assistant (recognising that this group is likely to be fully occupied in acute care)	Category C staff should undertake: • coronavirus (COVID-19) infection and pregnancy: information for healthcare professionals • free e-learning on COVID-19 • e-Learning for Health COVID-19 programme • updated guidance for PPE during the COVID-19 pandemic (PHE) • one-to-one discussion between midwife supervisor and individual to understand training needs

Table 1
Ref: Delivering midwifery intrapartum care where local COVID-19 escalation protocols are required to be enacted - November 2020 NHSE

12.7. **Suspended services due to Covid-19 impacts**

Faced with a shortage of clinical staff, the safest option may be to consolidate care in fewer places by closing specific services temporarily.

Closure of services must be influenced by a risk assessment and only made after considering all alternative staffing options (see above).

A progressive approach must be considered, thereby keeping as many options available for as long as possible – suspending certain options, particularly place of birth, will have a significant impact on some women and should be avoided unless absolutely necessary to ensure a safe service.

All the following conditions must be met before the Trust suspends **intrapartum** care options:

1. The available workforce must be either too small or of insufficient skill mix to ensure the safety of women and their babies with services in their current configuration.
2. Women must still be able to make decisions about the care they receive in line with the principles of informed consent.

3. The withdrawal of services must be temporary and must be clearly communicated to women and their families.
4. The extent of the withdrawal of options must be proportionate and tailored to the specific workforce constraints.
5. The withdrawal of options must be identified in an escalation plan, which has been agreed by the board-level safety champion, cleared through the organisation's internal governance processes and notified to the NHS England and NHS Improvement regional chief midwife and relevant regional director of nursing as appropriate.

Other organisations within the LMNS and maternity clinical network, including the local ambulance service and the local neonatal operational delivery network, must have been consulted on the escalation plan to ensure that the impact on them is manageable and sufficient capacity remains available in the local area to meet demand.

The local Maternity & Neonatal Voices Partnership (MNVP) service user chair, representing local women and families, must have been involved in the decision-making process.

12.8. Supporting staff during redeployment

Staff deployed to maternity intrapartum care areas as part of an escalation plan may be required to work outside their normal practice area. Any changes in working practice will need to be in accordance with the NMC Code and supported to ensure safe care for women, maintenance of staff wellbeing and appropriate supervision and delegation of care.

12.9. Recovery plan

Agreement for de-escalation will depend on level of impact (%) staff absent or redeployed to work in alternate circumstances (non- clinical facing roles).

12.10. Staff Health and Wellbeing

Measures must be in place to protect the health and wellbeing of all staff at all times especially during periods of escalation and staffing redeployment. This pandemic is challenging all staff and they must feel supported and cared for throughout.

Line managers must ensure that all staff are aware of the guidance on wellbeing as per UHDB resource link on the Trust intranet.

12.11. Staff continuing Professional Development

Induction and training needs should be ascertained in a personal development discussion, and based on individual experience and confidence.

Professional midwifery advocates (PMAs) and practice development midwives can provide support and clinical supervision to all maternity staff, tailored to individual need.

13. Monitoring Compliance and Effectiveness

As per agreed business unit audit forward programme

14. References

- Organisational requirements for safe midwifery staffing for maternity settings (NICE March 2021)

- Delivering midwifery intrapartum care where local COVID-19 escalation protocols are required to be enacted - November 2020
- Clinical guide for the temporary reorganisation of intrapartum maternity care during the coronavirus pandemic (9 April 2020 Version 1 NHS)
- Midlands Acute OPEL Maternity Framework (Dec 2021)

Appendix 1
Medical staffing and Consultant presence on Labour ward

The aim is to provide safe, consistent and quality patient care, the Ockenden review of maternity services has set standards for scheduled Multidisciplinary consultant led ward round on labour ward twice daily over 24 hours and 7 days per week

It is recommended that the Consultant must be available in the labour ward when they have a fixed session there and their presence is needed and should be available for telephone advice at all times while on-call.

	RDH	QHB
Monday to Friday	**Consultant Obstetrician available on site (09:00 - 22:00)** Hot week sessions on a rotational basis, prospective cover **Medical staffing level:** ***am*** One Consultant plus one to two middle grade doctors (ST 3 and/or ST 6-7) on site ***pm*** One Consultant plus one to two middle grade doctors (ST 3) and/or ST 6-7) on site (Plus junior tier doctor- foundation, GPTS or ST1-2)	**Consultant Obstetrician available on site (8:30-17:00 ,then 20:00-22:00 pm)** Hot week sessions on a rotational basis, prospective cover **Medical staffing level:** ***am*** one Consultant plus one middle grade doctor on site ***pm*** one Consultant plus one middle grade doctor on site (Plus junior tier doctor- foundation, GPTS or ST1-2)
Monday to Friday on call	**Consultant Obstetrician on call available within 30 minutes from 22:00 to 09:00.** **Medical staffing level:** Two middle grade doctors on site (Two-tier cover, ST3 and ST 6-7) (Plus junior tier doctor- foundation, GPTS or ST1-2)	**Consultant Obstetrician on call available within 30 minutes from 22:00-09:00.** **Medical staffing level:** One middle grade doctor on site (ST 4 or above) (Plus junior tier doctor- foundation, GPTS or ST1-2)
Weekend	**Consultant Obstetrician available on site 08:00-13:00** **Consultant Obstetrician on call available within 30 minutes after 13:00** **Medical staffing level:** Two middle grade doctors on site (Two-tier cover, ST 3 and ST 6-7 plus 2 junior tier doctors	**Consultant Obstetrician available on site Saturdays:08:00-10:00 and 20:00-22:00 Sundays:8:30-10:00 and 20:00-22:00** **Consultant Obstetrician on call available within 30 minutes after 10:00** **Medical staffing level:** One middle grade doctor on site (ST4 or above) and junior tier doctor

Junior Medical Staff Sickness
Monday – Friday 08:30 – 16:30

- Contact the Medical Staffing Administrator/rota co-ordinator on the relevant site to see if spare staff capacity that can be moved.
- If no spare capacity - MSA/Rota co-ordinator asks CD/ACD or Consultant on call to make decision as to who can be moved to support essential areas. (MSA/Operational Manager/DGM/GM may be asked to support by collating information about the whole service activity to support this decision)

OOHS and Bank Holidays

- A list of junior doctors contact numbers (current and regular locum staff) is available on Labour ward at RDH and via Medical Staffing on-call or Switchboard at QHB. Any available member of staff can be asked to telephone round to ask staff to work additional hours to cover the gap at additional rate payment. NB: ensure staff have had the required rest breaks before coming back on duty.

- If no available staff able to assist the Executive on call (EOC) can authorise the use of agency staff. The request should be discussed with the SMOC on the respective site who will escalate to the EOC). The Consultant on call must take responsibility for authorising the CV and induction the agency member of staff to the unit.
- More senior staff can be asked to act down to protect the safety of the unit.

Consultant Sickness
Monday – Friday 08:30 – 16:30

- Contact the Medical Staffing Administrator/rota co-ordinator on the relevant site to see if spare staff capacity that can be asked to move/work additional hours.
- If no spare capacity - MSA/Rota co-ordinator asks CD/ACD to make decision as to who can be moved to support essential areas. (MSA/Operational Manager/DGM/GM may be asked to support by collating information about the whole service activity to support this decision)

OOHS and Bank Holidays

- A list of Consultant contact numbers (current and regular locum staff) is available on Labour ward at RDH and via Medical Staffing on-call or Switchboard at QHB. Any available member of staff can be asked to telephone round to ask staff to work additional hours to cover the gap at additional rate payment.
- In extreme circumstances, where no-one can assist, the Executive on call (EOC) can authorise the use of agency staff. The request should be discussed with the SMOC on the respective site who will escalate to the EOC), however the CD/ACD or a Senior Consultant must be responsible for authorising the CV and arranging the induction of staff on the unit.

In the event of extreme weather or challenging travel conditions:
Extreme weather or other travel difficulties occurs occasionally and this may cause delay in the on call consultant obstetrician arriving within the contractual time of 30 minutes. Once such conditions are anticipated, the on call obstetrician is expected to be resident to support junior medical staff and ensure safe delivery of care, should senior presence be required. The head of service for obstetrics should be notified when this occurs. At Royal Derby Hospital there is a consultant on call room on Level 2 in the Maternity Directorate offices area. At Queens Burton Hospital an on call room is available if required.

Appendix 2 – Midlands Regional OPEL Maternity Framework

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 Neonatal OPEL Framework Status
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	OPEL NF FOUR 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/postnatal women whilst extra support for delivery suite is provided	Delays in elective activity for >24hours	OPEL NF THREE 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 ava ilable	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 > 2 hours	OPEL NF TWO 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	OPEL NF ONE ODN unit open to admissions in line with unit designation

Appendix 3 – Please print pages 27/28 double sided

UHDB ESCALATION PROFORMA Cross Site

Date …… Time …… Co-ordinator …… Site……

Please ensure the following sections are completed **prior** to contacting Manager/ Matron.

1.	**How many available beds on labour ward?**	
2.	**How many available beds on the postnatal/antenatal ward?**	
3.	**Are women in active labour receiving 1:1 care?**	**Yes / No**
4.	**Is the Labour ward coordinator supernumerary?**	**Yes / No**
5.	**How many Elective C sections are planned for today?**	
6.	**How many IOL?** (all areas including outpatient)	
7.	**Has elective activity (e.g. IOL or ELLSCS) been delayed or postponed?** **How many IOL/ ELLSCS are delayed by 2 hours or more**	**Yes / No**
8.	**Are there delays of more than 30 minutes to admissions in any of the following areas:** • **labour ward** • **postnatal ward** • **PAU/MAU**	**Yes / No**
9.	**Are there Registered midwife shortages on the roster?** **How many registered midwives below template** **How many non -registered staff below template**	**Yes / No**
10.	**If staffing at template does this meet the BR plus acuity of women on labour ward / postnatal ward?**	**Yes / No**
11.	**Are there Medical staff shortages?**	**Yes / No**
12.	**Are staff able to take breaks?**	**Yes / No**
13.	**Have clinical staff been redeployed from other areas (Acute / Community)?** **Are specialist midwives / managers working clinically in the unit?**	**Yes / No** **Yes / No**
14.	**What is NICU status**	
15.	**Is Homebirth service available** **Are CMW attending a Homebirth?** **Are Night shift CMW in the unit?**	**Yes / No** **Yes /No** **Yes /No**
16.	**Is there a PMA available to support staff wellbeing**	**Yes / No**
	OPEL Level status	**Green/Amber/Red/Black**

Actions taken by Coordinators/ ward managers

Scoring for OPEL framework:

OPEL Status	Labour ward beds	A/N & P/N beds	Triage Status (PAU/MAU/ intrapartum admissions)	Unable to provide 1:1 care in established labour	Birthrate Plus/ Dependency score for Labour ward / Staffing re-deployment	Delivery suite coordinator not supernumerary	Delays in Elective work for non-medical reason	Local Neonatal unit status/ staffing to support in utero transfers
Black								
Red								
Amber								
Green								

Date & time escalated to midwifery matron on site…… Name ……

Actions / advice

Consultant obstetrician advice & action

Date and time of escalation to General Manager / HoM / DoM / CD……..

Name of Manager ……

Action/ advice

Date and Time of escalation to senior manager on call / senior nurse / exec on

call……Name of senior manager…….

Action/ Advice:

Decision to divert / suspend admissions agreed by:

Name of senior manager(s) / exec …… Date and Time…….

EMAS /WMAS informed of divert/ suspension Date and Time ……

DATIX completed: Date / Time: ……
Reference: ……..……

Appendix 4 – Contact details for Trusts in the Midlands with maternity units

Trusts with Maternity Units	Hospital Site	Delivery Suite Direct Dial number	Switchboard	Address1	Address2	County	Postcode
Birmingham Women's and Children's NHS FT	Birmingham Women's Hospital	0121 335 8220	0121 472 1377	Mindelsohn Way	Birmingham	West Midlands	B15 2TG
Dudley Group NHS FT	Russell's Hall Hospital	No Direct Dial. Maternity Triage - 01384 456111 Ext 3053 or MLS if low risk on Ext 3064	01384 456111	Pensnett Road	Dudley	West Midlands	DY1 2HQ
George Eliot Hospital NHS Trust	George Eliot Hospital	024 7686 5090	024 7635 1351	College Street	Nuneaton	Warwickshire	CV10 7DJ
Royal Wolverhampton Hospitals NHS Trust	Newcross Hospital	01902 694031 or 01922 694037	01902 307999	Wolverhampton Road	Wolverhampton	West Midlands	WV10 0QP
Sandwell and West Birmingham Hospitals NHS Trust	City Hospital	0121 507 4703 or 0121 507 4184	0121 553 1831	Dudley Road	Birmingham	West Midlands	B18 7QH
Shrewsbury and Telford Hospital NHS Trust	Royal Shrewsbury Hospital	01952 565924	01743 261000	Mytton Oak Road	Shrewsbury		SY3 8XQ
South Warwickshire NHS FT	Warwick Hospital	01926 495321 Ext 4552/4553	01926 495 321	Lakin Road	Warwick		CV34 5BW
University Hospitals Birmingham	Heartlands Hospital	0121 424 2710	0121 424 2000	Bordesley Green East	Birmingham	West Midlands	B9 5SS
	Good Hope Hospital	0121 424 7201	0121 424 2000	Rectory Road	Sutton Coldfield	West Midlands	B75 7RR
University Hospitals Coventry & Warwickshire NHS Trust	University Hospital Coventry & Warwickshire	02476 967339 02476 968879 Crm@uhcw.nhs.uk	02476 964000	Clifford Bridge Road	Coventry		CV2 2DX
University Hospitals North Midlands	Royal Stoke Hospital	01782 672333	01782 715444	Newcastle Road	Stoke-on-Trent		ST4 6QG
Worcestershire Acute Hospitals NHS Trust	Worcestershire Royal Hospital	01905 760571	01905 763333	Charles Hastings Way	Worcester		WR5 1DD

Trusts with Maternity Units	Hospital Site	Delivery Suite Direct Dial number	Switchboard	Address1	Address2	County	Postcode
Walsall Healthcare NHS Trust	Manor Hospital	01922 656246	01922 721172	Moat Road	Walsall	West Midlands	WS2 9PS
Wye Valley NHS Trust	County Hospital	01432 364070	01432 344344	Stonebow Road	Hereford		HR1 2BN
Chesterfield Royal Hospital NHS FT	Chesterfield Royal Hospital	01246 200666	01246 277271	Calow	Chesterfield	Derbyshire	S44 5BL
Kettering General Hospital NHS FT	Kettering General Hospital	01536 492879	01536 492000	Rothwell Road	Kettering	Northamptonshire	NN16 8UZ
Northampton General Hospital NHS Trust	Northampton General Hospital	01604 545058	01604 634700	Cliftonville	Northampton	Northamptonshire	NN1 5BD
Nottingham University Hospitals NHS Trust	City Campus	01159 627956	0115 969 1169	Hucknall Road	Nottingham	Nottinghamshire	NG5 1PB
	Queens Medical Centre (QMC)	0115 9709032	0115 924 9924	Derby Road	Nottingham	Nottinghamshire	NG7 2UH
Sherwood Forest Hospitals NHS FT	King's Mill Hospital	01623 672244	01623 622515	Mansfield Road	Sutton In Ashfield	Nottinghamshire	NG17 4JL
University Hospitals of Derby and Burton NHS FT	Royal Derby Hospital	01332 785141	01332 340131	Uttoxeter Road	Derby	Derbyshire	DE22 3NE
	Queen's Hospital Burton,	Ext 4355 or Ext 4356	01283 511511	Belvedere Road	Burton on Trent	Staffordshire	DE13 0RB
United Lincolnshire Hospitals NHS Trust	Lincoln County Hospital	01522 573140	01522 512512	Greetwell Road	Lincoln	Lincolnshire	LN2 5QY
	Pilgrim Hospital	01205 445424	01205 364801	Sibsey Road	Boston	Lincolnshire	PE21 9QS
University Hospitals of Leicester NHS	Leicester Royal Infirmary (LRI)	0116 258 6451/6452	0300 303 1573	Infirmary Square	Leicester	Leicestershire	LE1 5WW

Trusts with Maternity Units	Hospital Site	Delivery Suite Direct Dial number	Switchboard	Address1	Address2	County	Postcode
Trust	Leicester General Hospital	0116 258 4807	0300 303 1573	Gwendolen Road	Leicester	Leicestershire	LE5 4PW

Appendix 5 - 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/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– Maternity unit Re-opening Checklist

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	

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 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				
Ambulance control				
Safeguarding team				
Consultant anaesthetist				
Governance lead				
Executive on call at receiving unit				
ICS/LMNS				

Appendix 7– SBAR Assessment to be completed by Head of Midwifery following diversion / suspension

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

Derbyshire Local Maternity and Neonatal System Reporting Proforma

Service disruption risk assessment proforma

Nature of risk		
Unmitigated risk score (risk matrix overleaf)		
Impact	**Likelihood**	**Score**
Mitigations in place or planned		
Mitigated risk score (risk matrix overleaf)		
Impact	**Likelihood**	**Score**

Date this proforma was completed	Risk review date
Responsible named lead	

	Risk matrix		Likelihood / probability						
Impact			Rare (0-5%)	Unlikely (6-20%)	Possible (21-50%)	Likely (50-80%)	Almost certain (81-100%)	Almost certain (81-100%)	
	SCORES		1	2	3	4	5	6	
	Catastrophic	5	5	10	15	20	25	25	Negligible risk
	Major	4	4	8	12	16	20	20	Low risk
	Moderate	3	3	6	9	12	15	15	Moderate risk
	Minor	2	2	4	6	8	10	10	High risk
	Negligible	1	1	2	3	4	5	5	Extreme risk

Documentation Control

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	Royal Derby prior to merged document:			
Version / Amendment	Version	Date	Author	Reason
	2	04/2014	MDT task and finish group	review
WC/OG/116	**Burton Trust prior to merged document:**			
	1	05/2018	Sue Harrison Sam Collins	
Version control for UHDB merged document:				
	1	02/2022	Lorraine Purcell – Head of Midwifery	
	1.1	04/2023	Joanna Harrison-Engwell	Rewording of on call consultant times
Intended Recipients:				
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors via NHS.net, Published on Intranet, Article in Business unit newsletter;				
To be read in conjunction with: NICU Neonatal Unit Escalation Plan (NIC GI13); Maternal Transfer (T5); Homebirth guideline (H5); Trust Capacity Escalation Plan (CL-CP/2014/041)				
Keywords:				
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Key Contact:	Cindy Meijer			