NENC Maternity and Neonatal Escalation Policy

Version
3.0

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Prepared by subgroup of the NENC LMNS Board & Maternity Clinical Network

Modified from the Midlands work, with thanks.

Contents

1.0 Introduction

Since April 2022, system co-ordination, oversight and escalation management has become a responsibility of the Integrated Care Boards (ICB). Each ICB leads a collaborative group of providers known as the Integrated Care System (ICS) who in turn provide care and treatment for their local communities (Health and Care Act 2022).

The aim of this escalation policy is to describe the way in which operational pressures will be recognised throughout North East and North Cumbria ICS, as well as set out the high level multi-agency approach that will be taken by the NENC ICS in order that these 'surges' in demand or systems in 'escalation' can be rapidly and seamlessly managed.

The NENC Maternity and Neonatal Escalation Policy sets out the procedures for the NENC to manage significant surges in demand and ensure that maternity services can continue to be provided safely and effectively.

This policy uses NENC Operational 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 locally consistent set of escalation levels, triggers, and protocols across maternity services in the NENC
- 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
- Improving communication and multi-disciplinary working relationships
- Enhancing the experience for mothers and babies and reducing harm

This policy also includes the NENC **Neonatal** Operational Delivery Network (ODN) Escalation Framework which sets out a consistent approach for the Northern Neonatal ODN and the Northern Neonatal Transport Team (NNeTS) in managing escalation, transfer, and repatriation of neonates.

It is essential that maternity and neonatal services and systems work closely together with the NENC System Coordination Centre (SCC) as early as possible (OPELMF Level 2) when they start to experience surges in demand. The aim of having a joint policy is to facilitate this closer working.

2.0 Principles and Overview of the NENC Maternity and Neonatal Escalation Policy

The NENC Maternity and Neonatal Escalation Policy has been developed to enable maternity and neonatal services to align their escalation protocols to a standardised NENC process and escalate when required. This policy is designed for systems, operational teams, managers, and clinicians involved in managing maternity and neonatal capacity at a time of excess demand and / or other operational pressures. It is to be circulated to all staff who manage maternity and neonatal capacity to provide a practical working reference tool for all parties, thereby aiding coordination, communication, and implementation of the appropriate actions in each organisation.

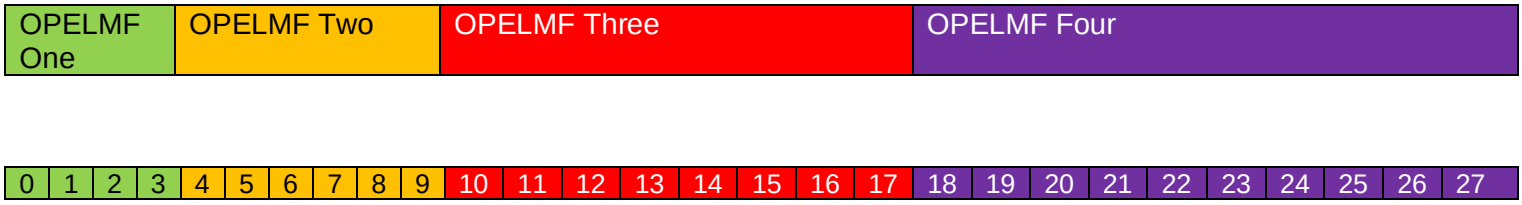
2.1 Operational Pressure Escalation Levels Maternity Framework (OPELMF)

To ensure a consistent approach across the region, there are four OPELMF levels. Definitions for each of the levels are outlined in **Appendix 1.**

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

- Suspension (closures), ambulance diverts and deflections.
- Maternity ward-based bed capacity
- Delivery suite bed capacity
- Obstetric staffing shortfalls impacting on safe care delivery.
- Anaesthetic staffing shortfalls impacting safe care delivery.
- Delivery Suite Birthrate Plus® activity and dependency score
- Labour ward coordinator is not supernumerary (refer NENC definition)
- Delays in IOL
- Neonatal Services OPEL Framework Status Appendix 4c

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



2.2 Maternity escalation process flowchart

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

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

2.3 Action cards

Action cards have been developed to outline individual roles and responsibilities during times of local, ICB and regional escalation. These can be found in **Appendix 4a** for trusts and **Appendix 4b** for ICBs. The action cards outline the communication and operational responsibilities when operating at the varying levels of OPELMF. The action cards should be followed alongside the OPELMF at **Appendix 2**.

3.0 Maternity and Neonatal Sitreps

The NENC Maternity Sitrep indicates where there are pressures and capacity in maternity. It provides daily oversight across the NENC via the NENC System Coordination Centre (SCC) and locally through trust operational structures to support alleviating pressure within trusts and aid mutual aid discussions where required.

It is the responsibility of each trust to ensure its return is accurate and reflects the real position in terms of pressure at that point in time.

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

Trusts who do not report are contacted by the NENC System Coordination Centre.

The NENC Maternity Sitrep dashboard is refreshed daily so that the ICB, systems and local trusts can see the latest reported activity and acuity via RAIDR.

A Neonatal Sitrep is collected via NNeTS who perform a ring round of neonatal units daily, this log is maintained by the NNeTs team, and if required can be shared with the ICB.

Long term information from both Sitreps will be combined to provide a means of all partners and the ICB understanding where there are pressures.

Organisation sensitive information is displayed within the RAIDR dashboard and the information should **not** be reproduced or shared without the explicit permission of the ICB.

4.0 Trust, ICB and NHS England Escalation

It is crucial that North East and North Cumbria Integrated Care System (ICS) develops operational resilience and capacity plans by involving all key local organisations, in order to fulfil both planning requirements and ensure good system working in the future. There is an expectation that the organisations who provide support to the people of NENC ICS will work in partnership to deliver and maintain those services, at all times.

Escalation and incident management structures are in place at all levels of operation across trusts, ICS, and region. NHS Emergency Preparedness, Resilience and Response (EPRR) arrangements are designed to provide a framework for the emergency co-ordination of all NHS organisations and, where appropriate, multi-agency partners, to ensure a collective, whole systems response to an incident and thereby minimise the impact on the health and well-being of the communities. These EPRR processes should form part of local trust and ICB maternity escalation processes.

Gold	Strategic
Silver	Tactical
Bronze	Operational

Each ICS partner organization must have a robust, up-to-date local escalation plan signed off at Board level. These local escalation plans should all heave clearly defined escalation triggers. All partner escalation plans should also be readily available to all relevant managers and clinicians within their own organization, who, importantly, should be familiar with and have a clear understanding of the processes that should be undertaken when necessary.

Trusts and ICBs should follow their local and system escalation policies in the first instance when managing and responding to surges in demand. This NENC Maternity and Neonatal Escalation policy does not replace a trust or system's own escalation processes, but rather builds on this in times when local and system actions to mitigate escalation do not resolve the pressure, or activity continues to increase, and regional mutual aid support is required.

In order to ensure that a whole systems perspective can be taken, each year all key stakeholders must participate in an annual system review of these plans to ensure transparency, inform capacity, and demand planning, as well as understand the trigger levels for escalation for each organization in order that mutual aid can be provided at times of stress.

4.1 Internal Trust Escalation

At OPELMF Two maternity and neonatal services will be required to take internal focused actions to mitigate the need for further escalation. The maternity and neonatal management team structure should be informed of rising escalation and there should be active involvement of the Head/Director of Midwifery. The maternity and/or neonatal service will undertake enhanced co-ordination with the trust operations team and take appropriate and timely actions to reduce the level of pressure in their organisation. The Trust Bronze (Operational) On Call teams should work to source support from other departments. The Trust Silver (Tactical) On Call should be informed that organisational support is required as per the local escalation process. The Trust Operations team will notify the NENC System Coordination Centre (SCC) of the rising pressure and local escalation in place for information only purposes. If actions taken are not addressing the rising pressures, then the SCC may stand up a system call. The Trust should also proactively contact surrounding other Maternity Units to agree a local short-term strategy to manage demand, where appropriate.

At OPELMF Three the maternity service is experiencing major pressure, staffing concerns or capacity issues raised and trust escalation protocols should be instigated. The manager of the day should update the Trust Silver (Tactical) On Call as per the local escalation process. Escalation should also be notified to NENC System Coordination Centre which will trigger ICB escalation protocols (see **section 4.2**).

At OPELMF Four the maternity service is experiencing extreme pressure and all OPELMF Two and OPEL MF Three actions have been completed. The Trust Gold (Strategic) On Call should be contacted and made aware of rising pressure. Any request to temporarily close the maternity service must be agreed by the Trust Gold (Strategic) On Call as per **section 5.1**. The NENC System Coordination Centre must be notified which will trigger ICB to source mutual aid via local ICB escalation, as per **section 4.2**.

There may also be other factors that lead to escalation and decisions should be considered on a case-by-case basis. Such factors may include (but not limited to):

- Inadequate skill mix
- Infection Prevention & Control events – follow local IPC policy.
- A major incident or power failure – follow local major incident policy.

For further information refer to trust Action Card at **Appendix 4a.** A Good Practice Guide of actions to be taken by trusts to reduce pressure within the organisation and system can be found at **Appendix 5**.

Appendix 6 outlines trust roles and responsibilities for patient flow within a maternity service.

Appendix 4c outlines roles and responsibilities within a neonatal service.

4.2 ICB Escalation

The aim of escalating to the ICB through the SCC is to a) provide early warning to the NENC Integrated Care System (ICS) partners of pressures in maternity b) consider as a system how to prevent a suspension of services +/- divert e.g., through mutual aid.

The NENC ICS has a weekly planned call which considers current and predicted capacity and demand pressures, supporting stakeholders with the analytic process of how best to navigate pressures across the NENC ICS geographical footprint.

Process for escalating to the ICB see Appendix 3a and 3b:

When reaching OPELMF Two (amber) communication should be coordinated by the trust operations team/ trust manager on call (tactical/Silver command) to alert the NENC System Coordination Centre (SCC) to rising pressure and local escalation in place (in-hours only). This is for information only initially. Trusts should also proactively contact surrounding Trusts to seek agreement to agree a local short-term strategy to manage demand. If actions do not resolve the rising pressure, then consider with the SCC with system partners how best to manage the pressures in maternity and neonates. If a call is set up NNeTs, who coordinate movement of in-utero transfers (ITU) and babies, should be contacted using their hotline 0191 2303020 (24 hours, seven days a week) Appendix 4c.

At OPELMF Three (red) the SCC should take further urgent actions to source system level support across the whole ICB to mitigate further escalation. Agreements for support with local partners will be organised directly through ICBs, e.g., by standing up a system call with local maternity and neonatal services.

At OPELMF Four (purple) the SCC should take further urgent actions to source system level support across the whole ICB to mitigate further escalation and manage suspension of services. Agreements for support with local partners will be organised directly through ICB. **If support is not forthcoming and pressure continues to escalate,** ICBs should liaise with Regional Coordination Centre (RCC) (in hours only)/NHSE On Call structure (out of hours only) to facilitate regional communications for offers of mutual aid support at OPELMF Four.

For further information refer to ICB Action Card at **Appendix 4b**.

4.3 Regional Escalation

Regional (NEY) escalation should be triggered when pressure in the maternity services across the ICB continue to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised. All available local and ICB escalation actions have been taken and mutual aid support requested and utilised. If an external whole system response for additional support is needed, follow the Maternity Escalation Process Flowchart at **Appendix 3a** (in- hours) and **Appendix 3b** (out of hours) and contact NNeTs and Embrace for Yorkshire and Humber. The Operational Pressure Escalation Levels Maternity Framework Triggers is outlined in **Appendix 2** and the Neonatal ODN Framework in **Appendix 4c.**

When escalating into region in or out of hours the following information should be available to aid the initial discussion:

- The details driving the escalation.
- The specific actions taken to alleviate said pressure.
- The actions taken to ensure patient safety and quality.
- The details of any planned system calls
- Who is the highest senior involved in decisions around mitigating and managing the current escalation.

Escalation should be made via the following routes:

	In-Hours (RCC 8am-8pm) please note ICB In Hours may vary	**Out of hours (NHSE On Call 8pm-8am) please note ICB On Call Out of hours may vary**
Escalation for regional support to be made by:	The System Coordination Centre to complete RCC Escalation template (**Appendix 8**) and forward to the RCC via email & notify NHSE First On Call with verbal update (for OPEL MF 4 only) The ICB SCC to contact the NHSE first on call for OPEL 4 only.	The ICB On Call to contact the NHSE first on call for the region via usual EPRR routes:

If the NENC ICB has extreme pressure or where a major incident is declared, the ICB should work with the RCC and neighbouring regions to secure mutual aid. When further aid is not available or two or more regions are at extreme pressure a national response will be required where all regional maternity teams come together, support as required by the national maternity team.

5.0 Suspensions and Diversions

In times of extreme pressure trusts may decide to:

- Deflect women between sites within their organisation; or
- Suspend maternity care provision for new admissions and divert those women to other trusts either within or external to the NENC region.

5.1 The decision to request a formal maternity divert or suspension

The decision to request to suspend a maternity unit should be agreed by **the Trust Gold (Strategic) On Call.** The **NENC System Coordination Centre (in hours)** and **ICB On Call (out of hours)** should be notified of requests to suspend a service via the in hours (**Appendix 3a**) and out of hours (**Appendix 3b**) escalation process flowchart. NNeTs should be notified during this process by the Trust suspending maternity services.

The decision to deflect women between sites within an organisation is agreed between the **Senior Manager On Call** and **Trust Silver (Tactical) On Call**. This is an internal operational decision and ICBs are not required to be notified, other than through the daily maternity sit rep.

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

5.2 Formal ambulance divert for maternity services

Formal ambulance diverts for maternity services is the operation of an agreed ambulance divert in response to significant and overwhelming local and/or wider system operational pressures.

Any formal ambulance divert request to NEAS, NWAS and YAS must only be made when maternity services and ICBs have implemented their escalation and surge management plans to the full without reducing the system pressures to a safe level and Trust executive agreement has been given (as per above).

Formal ambulance diverts, initiated through this policy, will be for maternity patients only. At times of a formal divert for maternity patients, women who require immediate maternity care will be transferred to the nearest consultant-led maternity unit, which may not necessarily be the booked unit. It will be the ambulance services responsibility to pre-alert receiving units of women who are being diverted who require immediate care. The clinical responsibility of the patient lies with the paramedic on scene unless a midwife is present.

Once a formal divert has been agreed by both the maternity service and the ambulance service it is recommended that one person within the diverting organisation is nominated to coordinate the process and they will be referred to as the ‘divert coordinator’. Wherever possible the ‘divert coordinator’ should have no other responsibilities during this time (and should not be an operational midwife/obstetrician) to ensure all clinicians can support safe service. Preferably the ‘divert coordinator’ would be an operational manager or senior manager on call for obstetrics, gynaecology & neonates.

5.2.1 Category 1 time-critical and life-threatening obstetric emergencies

Ambulance attendances for time-critical and life-threatening obstetric and maternity emergencies will be transferred to the nearest unit regardless of a formal divert in place. These are referred to as Category 1 maternity/neonatal patients and the maternity unit should be pre-alerted to the patient's arrival and agree with the ambulance service the appropriate place of admission e.g., emergency department or maternity unit to ensure appropriate teams are on prepared to receive the patient.

The list below identifies those time-critical and life-threatening obstetric/maternity and neonatal emergencies, but this is by no means exhaustive, and the clinical responsibility remains with the paramedic on scene (unless a midwife also in attendance):

Obstetric Emergencies (Mothers safety is paramount):

- Major obstetric haemorrhage (including antepartum haemorrhage)
- Placental abruption
- Cord prolapses.
- Shoulder dystocia
- Vaginal breech or footling birth
- Eclamptic fit.

- Severe maternal sepsis
- Maternal cardiac arrest or peri-arrest
- Fetal heart rate abnormalities at a homebirth
- Delay in first and second stage at a homebirth
- Unattended birth

Neonatal Emergencies:

- Livebirth of premature baby requiring neonatal care
- Ongoing neonatal resuscitation

5.2.2 Actions required to initiate a formal ambulance divert of maternity services

Formal ambulance divert for maternity services must be agreed as outlined in **section 5.1**. Once agreed, immediate verbal contact with the ambulance service must be made by the 'divert coordinator' to notify of the formal ambulance divert request. The process will involve consultation and agreement with the relevant ambulance service tactical and/or strategic command and the Trust's Senior Operational Manager (or equivalent Manager on call out of hours) on the agreed assumption that the maternity service has enacted all internal escalation processes prior to requesting a formal ambulance divert.

When contacting the ambulance service, the 'divert coordinator' should specifically outline:

1. The details of the Trust Gold (Strategic) On Call who has agreed the suspension and the time that this decision was made.

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

2. Confirm the alternative destination as pre-agreed with the receiving unit.

3. Provide a clear timeframe on how long the divert should last. At OPELMF four a review should be undertaken 3 hourly (in hours) and 4 hourly (out of hours) so that agreed routine operational working can commence as quickly as possible, please see action cards (**Appendix 4a** & **Appendix 4b**).

4. The step down of the formal ambulance divert should be agreed via local escalation processes and verbal notification made by the 'diverting coordinator' to the ambulance service immediately. The details of the Trust Senior Operational Manager (or equivalent Manager on call out of hours) who step down the formal ambulance divert should be confirmed.

5.3 Actions required at time of diversion/suspension.

Agreements for support with local partners will be organised directly through the ICB System Coordination Centre. Once this has been reached the following actions should be taken by the escalating Trust:

1. A risk assessment (escalation paperwork in local escalation policy) must be completed by the 'divert coordinator'.
2. The 'divert coordinator' will inform all key stakeholders as per local escalation policy. See **Appendix 9** for those key stakeholders who, at a minimum, should be notified.
3. Local ambulance services will be communicated with as per above **section 5.2.2**.
4. The diverting trust will communicate directly with the receiving units, and NNeTs, around the deflection of women who do not require emergency transport and are safe to make their own travel arrangements. Women who require emergency ambulance transport should be referred to call 999.
5. The diverting trust has a responsibility to ensure safe arrival of patients at the receiving trust and therefore should have a process in place to monitor this.
6. It is the expectation that Trust executives are involved in decisions around acceptance of diverted patients in consultation with the operational unit managers of receiving units. It is however understood the operational day to day capacity of the unit (both in hours and out of hours) is the remit of the unit managers and Clinical On Call teams.
7. The 'divert coordinator' should report an operational incident via the trust internal incident reporting procedures which should be investigated through trust governance processes.

5.4 Re-opening of the maternity unit

When the factors that precipitated diversion and / or suspension of maternity services have been resolved and safe services resume, a consultation should take place with the same level of authority and focus as the originating closure/diversion. Key stakeholders who were informed of the suspension/diversion should similarly be informed of the re-opening of maternity services.

5.5 Post divert actions

It is recommended that women who were transferred to another trust should be followed up by the diverting/suspended unit to offer a formal apology and to review their ongoing plan of care. An example apology letter can be found in **Appendix 11**.

The Director/Head of Midwifery is responsible for overseeing the completion of a root cause analysis (RCA) and SBAR (situation, background, assessment, recommendation – see **Appendix 9**) assessment for whole service suspension.

The requesting maternity provider must complete a 72-hour incident review for all diversions and suspensions and record this via the trust internal incident management procedures. As outlined in the National Perinatal Surveillance Model (NPSM) all maternity Serious Incidents, (and PSII following the transition to PSIRF) must be shared with trust boards and the LMNS.

The local ambulance service should be consulted during the incident review to capture any learning around the notification, management, and transfer of patients during the time of the diversion/closure.

The findings and any subsequent learning identified from the incident reviews should be discussed and shared widely for monitoring and assurance purposes. As a minimum this should include sharing of learning and themes of similar incidents with the trust board, LMNS board, internal trust directorate and care unit governance teams, maternity safety champions and non-executive director (NED).

5.6 Emergency divert

An emergency divert is the application of a divert in relation to a major incident such as fire or flood which results in the emergency department becoming non-operational for a period; and/or in a major incident where the casualty distribution plan is operational i.e., not accepting cardiac arrests. This would not automatically divert maternity, and this escalation policy should be followed in full.

An emergency divert will involve consultation and agreement with the local ambulance Tactical/Silver Commander and the trust's senior operational manager (or equivalent manager on call out of hours).

5.7 Suspension of neonatal units in region

It is important to note that the suspension of the neonatal unit does not translate to a diversion or suspension of a maternity unit. A high-risk birthing woman whose babies may potentially require neonatal services should be assessed on an individual basis and a personalised risk assessment should be completed. There should also be joint consultation by the consultant obstetrician and consultant neonatologist.

The Northern Neonatal Operational Delivery Networks (ODN) have a NENC wide neonatal surge plan to ensure access to neonatal critical care is maintained and not compromised (Appendix 4c).

5.8 Women's experience and feedback

Women should be involved in the decision-making process as to where they have their baby. A change to their care pathway may occur because of a unit suspension and this discussion should be recorded in their antenatal risk assessment and Personalised Care Support Plan (PCSP) within BadgerNet.

Following a suspension or closure of a maternity service it is important to engage and involve women and families about their experience. A formal apology letter is recommended to be sent to any women whose care has been diverted (see **Appendix 11).**

Appendices

Appendix 1: NENC Maternity OPEL Maternity Framework – Definitions

NENC phase	OPELMF One	OPELMF Two	OPELMF Three	OPELMF Four
Description	The maternity service capacity is such that the organisation can maintain patient flow and meet anticipated demands within available resources. Additional support is not anticipated. No interaction with the local ambulance service needed business as usual.	The maternity service is starting to show signs of pressure. The maternity service will be required to take internal focused actions to mitigate the need for further escalation. The maternity service will undertake enhanced co-ordination with the trust operations team/tactical (silver) command and take timely and appropriate actions to reduce the level of pressure in their organisation. Communication to be coordinated by trust operations team tactical (silver) command to alert the NENC System Coordination Centre to rising pressure and local escalation only (in-hours only) as well as with other Maternity Units to agree a local strategy and short term plan. NENC System Coordination Centre (SCC) will support by liaising with local partners e.g., by standing up a system call if actions do not resolve the rising pressure. Agreements for support with local partners organised directly through SCC. No interaction with local ambulance services needed business as usual.	The maternity service is experiencing major pressures compromising patient flow and safety. Trust operational support having limited impact and organisational pressure continue to increase. Further urgent actions are now required across the whole ICB to source system level support to mitigate further escalation and consider and identify mutual aid support. The SCC should take further urgent actions to source system level support across the whole ICB to mitigate further escalation. Agreements for support with local partners will be organised directly through ICB.	Pressure in the maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised. All available local and ICB escalation actions have been taken and mutual aid support requested and utilised. Regional support and intervention are required. ICBs should liaise with Regional Coordination Centre (RCC) (in hours only)/NHSE On Call structure (out of hours only) to facilitate regional communications for offers of mutual aid support. Request formal divert by local ambulance service when maternity service is suspended.

Appendix 2: Operational Pressure Escalation Levels Maternity Framework (OPELMF) - Escalation Triggers

(NENC LMSN, ODN and SCC to work on updating this framework to align with NENC Neonatal Operational Delivery Network ODN Framework)

Escalation triggers

OPEL MF LEVEL	Suspension (closures), ambulance diverts and deflections	Maternity ward-based bed capacity	Delivery suite bed capacity	Obstetric staffing shortfalls impacting on safe care delivery	Anaesthetic staffing shortfalls impacting safe care delivery	Delivery Suite Birthrate Plus® activity and dependency score	Labour ward coordinator is not supernumerary (refer CNST definition)	Delays in IOL	OPEL Neonatal Framework (OPEL NF) LEVEL
Purple Four	Acute maternity services suspended, **and** ambu-lance divert in place	No ward beds available & no planned discharges	No Delivery Suite beds available & no planned discharges	Staff shortages impacting on patient care and delays in emergency care	Staff shortages impacting on patient care and delays in emergency care	Birthrate Plus® rating RED safety affected – mitigating actions taken, and services stood down	Providing 1:1 direct care and have no oversight of the labour ward	Any delays in **ongoing IOL** e.g., >6hrs from decision for ARM/Syntocinon augmentation to transfer to DS room for 1:1 care or delays admitting prolonged SROM >24 hours **and** delays in planned admissions	OPEL NF FOUR Demand exceeds available resource
Red Three	Women deflected within Trust **and/or** Homebirth services **and/or** MLU suspended due to escalation	Limited ward beds available impacting on inpatient flow	Limited Delivery Suite beds impacting on inpatient flow & admissions	Staff shortages impacting on patient care and elective activity delayed	Staff shortages impacting on patient care and elective activity delayed	Birthrate Plus® rating RED safety maintained – mitigating actions taken and services stood down	Temporarily providing 1:1 care and have limited oversight of the labour ward	Any delays in admissions for IOL from day of planned admission **and** delays of >6hrs from admission to commencement of IOL	OPEL NF THREE Very limited ability to maintain patient flow in line with ODN pathways
Amber Two	Homebirth services and/or MLU suspended due to escalation and no women deflected in Trust/System	Limited ward beds but no impact on inpatient flow	Limited Delivery Suite beds impacting on planned admissions but no impact on inpatient flow	Staff shortages with no impact on patient care or delays	Staff shortages with no impact on patient care or delays	Birthrate Plus ® rating AMBER safety – mitigating actions taken to maintain safe care delivery	Supernumerary and have oversight of labour ward but high acuity	Any delays in admissions for IOL from day of planned admission	OPEL NF TWO Neonatal service is having difficulty in meeting anticipated demand with available resources

Green One	No suspension or diverts across the service and no women deflected in Trust/System	Ward beds available. No delays in admission or transfers	Delivery Suite beds available no delays in admissions, elective activity and inpatient activity	No staffing shortages	No staffing shortages	Birthrate Plus® rating GREEN	Supernumerary and have full oversight of labour ward and able to support other midwives	No delays in admission for IOL from day of planned admission and no delays in ongoing IOL activity	OPEL NF ONE ODN unit open to admissions in line with unit designation

Escalation triggers

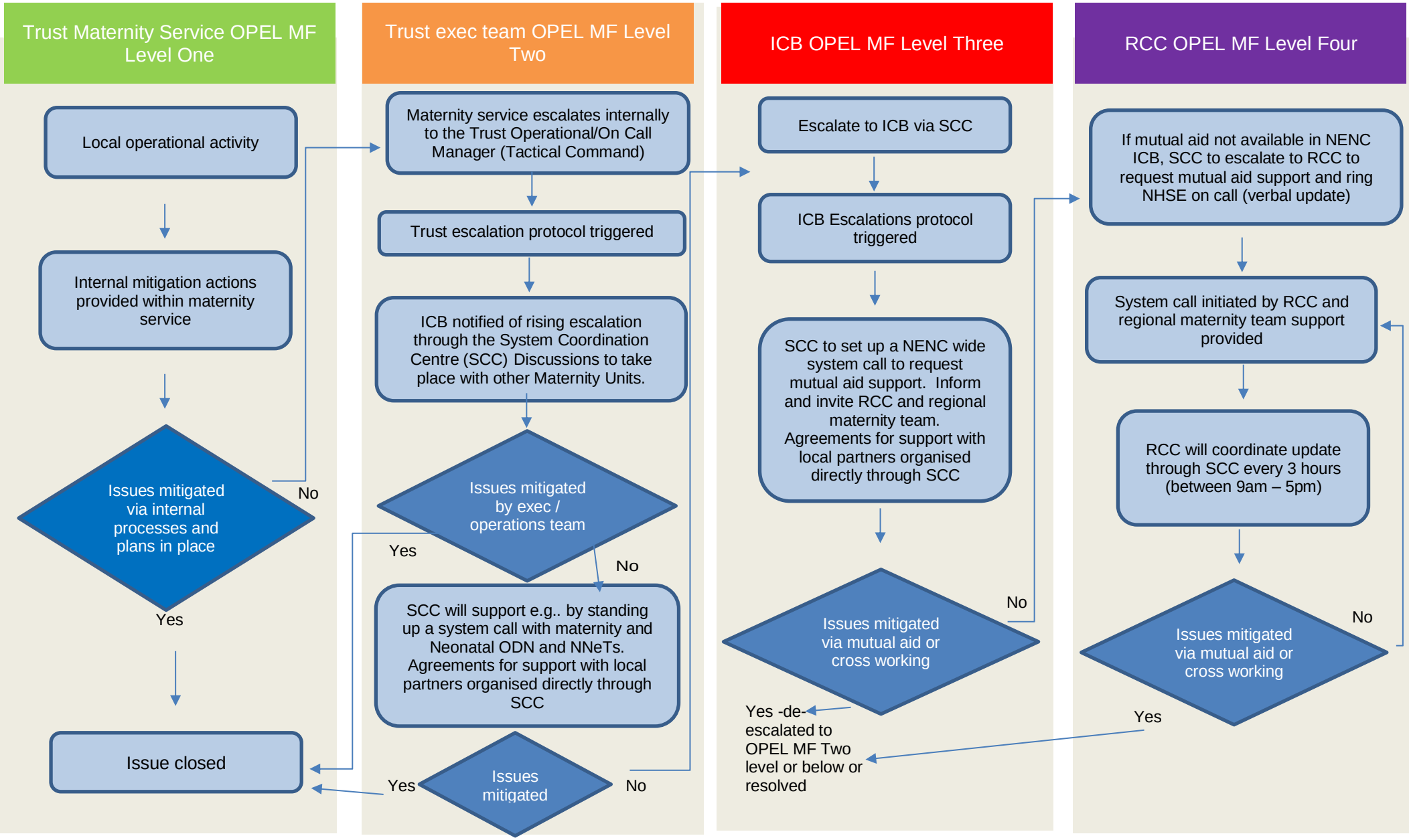
The level of escalation declared is based on the OPELMF status. Each escalation trigger has a corresponding score assigned to it dependent upon the level of escalation (see Table 1 below). The total calculated escalation trigger score defines the final OPELMF rating. Refer to OPELMF Action Cards (see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

Table 1: Escalation Score

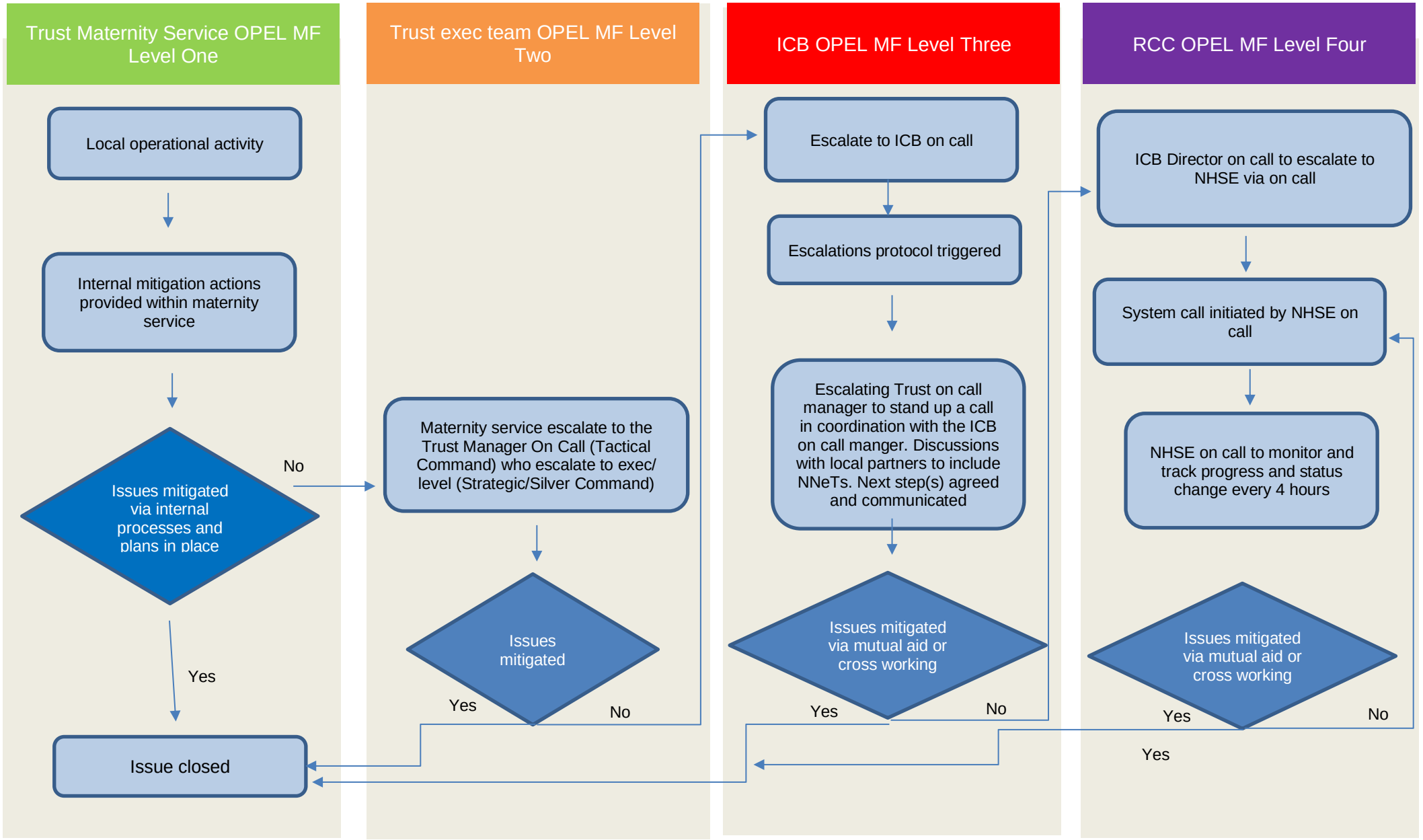
	Suspension and diverts	Maternity ward-based bed capacity	Delivery suite bed capacity	Obstetric staffing shortfalls impacting on safe care delivery	Anaesthetic staffing shortfalls impacting safe care delivery	Delivery Suite Birthrate Plus® activity and dependency score	Labour ward coordinator is not supernumerary (refer CNST definition)	Delays in IOL	OPEL Neonatal Framework (OPEL NF) LEVEL
Purple Four	3	3	3	3	3	3	3	3	3
Red Three	2	2	2	2	2	2	2	2	2
Amber Two	1	1	1	1	1	1	1	1	1
Green One	0	0	0	0	0	0	0	0	0

OPELMF One				OPELMF Two						OPELMF Three								OPELMF Four									
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27

Appendix 3a: IN HOURS Maternity Escalation Process Flowchart NENC System Coordination Centre (SCC) is 8am - 8pm, 7 days a week



Appendix 3b: OUT OF HOURS Maternity Escalation Process Flowchart 8pm – 8am, 7 days a week



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

OPELMF One	OPELMF Two	OPELMF Three	OPELMF Four
DESCRIPTION OF LEVELS			
The maternity service capacity is such that the organisation can maintain patient flow and meet anticipated demands within available resources. Additional support is not anticipated. No interaction with the local ambulance service needed business as usual.	The maternity service is starting to show signs of pressure. The maternity service will be required to take internal focused actions to mitigate the need for further escalation. The maternity service will undertake enhanced co-ordination with the trust operations team/ tactical (silver) command and take timely and appropriate actions to reduce the level of pressure in their organisation. Communication to be coordinated by trust operations team tactical (silver) command to alert the NENC System Coordination Centre (SCC) to rising pressure and local escalation only (in-hours only) and where appropriate with other Maternity Units to develop a strategy to manage demand.. NENC SCC will support by liaising with local partners e.g. by standing up a system call. Agreements for support with local partners organised directly through SCC. No interaction with local ambulance services needed business as usual.	The maternity service is experiencing major pressures compromising patient flow and safety. Trust operational support having limited impact and organisational pressure continue to increase. Further urgent actions are now required across the whole ICB to source system level support to mitigate further escalation and consider and identify mutual aid support. The SCC should take further urgent actions to source system level support across the whole ICB to mitigate further escalation. Agreements for support with local partners will be organised directly through the SCC.	Pressure in the maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised. All available local and ICB escalation actions have been taken and mutual aid support requested and utilised. Regional support and intervention are required. SCC/ICB on call should liaise with Regional Coordination Centre (RCC) (in hours only)/NHSE On Call structure (out of hours only) to facilitate regional communications for offers of mutual aid support. Request formal divert by local ambulance service when maternity service is suspended.
TRUST ACTIONS: In hours only			
OPELMF One	**OPELMF Two**	**OPELMF Three**	**OPELMF Four**
No actions required – business as usual.	Trust in house escalation processes to be followed to source support from within the organisation. The Trust Leadership/Management Team should be informed of rising escalation and there should be active involvement of the Director/Head of Midwifery. The Trust Silver (Tactical) On Call	Ensure all OPELMF Two actions have been completed. Escalate to the SCC. Further urgent actions are now required across the ICB to source system level support from maternity and neonates to mitigate further escalation,.	Ensure all OPELMF Two and Three actions have been completed. The Trust Gold (Strategic) On Call should be contacted to inform them of rising pressures via local escalation processes. Escalate to SCC OPELMF Four status to initiate ICB escalation processes.

	should be informed that organisational support is required as per the local escalation process. The Trust Bronze (Operational) On Call teams should work to source support from other departments. Timely review of ward and delivery suite patients to expediate medical review and ensure flow of patients suitable for discharge. Consider extra domestic staff to increase room availability turn around. Redeploy skilled staff according to the area of need – including deployment of non-clinical teams. Request additional bank and agency staff including midwives, maternity support workers and health care workers. Consider whether study leave and/or meetings need to be cancelled to source additional staff who can work to support safe care delivery. Review neonatal cot capacity for current and anticipated activity. Consider intrauterine transfers required to ensure women whose babies may not be accommodated on the neonatal unit are transferred in the daytime when staffing levels are optimal. Increase communication to staff to ensure everyone is fully briefed of situation and actions agreed. Review OPELMF status which includes staffing, skill mix and bed capacity 4 hourly and update internal On Call Teams. Communication to be co-ordinated by Trust operations team to alert NENC SCC to rising	The decision to divert and deflect women between sites in an organisation to be agreed between the Senior Manager On Call and Silver (Tactical) On Call. This is an internal operational decision and ICB should be notified for information only through the daily sit rep. Consider rescheduling elective work both inductions and LSCS if clinical conditions permit following sign off agreement as per local escalation policy. Consider utilisation of other staff groups including: • Neonatal and paediatric nurses to care for transitional care babies. • Nursing staff to provide post op care. • Prescribing pharmacist or nurse to complete drugs rounds on wards. • Senior student midwives and MSW to compete postnatal visits. For low-risk babies, consider the CMW undertaking NIPE in the mother's home to support rapid early discharge of mothers and babies. Consider postponing non-urgent community midwifery antenatal visits for 16, 25, 31-week low risk women. Liaise with key partners, for example gynaecology, to see if they can accommodate antenatal inpatients <20 weeks gestation as per local Trust arrangements. Silver (Tactical) On Call to consider the potential for additional governance, data and administrative support for maternity services, as all midwives in those teams will be moved	Liaise with ICB to confirm actions taken to resolve the escalation and provide an understanding of the pressures and issue. ICB liaise with RCC to obtain mutual aid support outside of ICB. A Regional Mutual Aid Escalation call will be facilitated by the RCC and supported by the Regional Maternity Team. This call will be arranged within 2 hours of initial notification. Exec and senior representation to attend. Verbal updates to be provided to the ICB every 3 hours (between 08:00-20:00), via the escalation template. The decision to suspend a maternity unit should be agreed by the Trust Gold (Strategic) On Call. The ICB should be informed of requests to close a maternity unit via the in-hours (Appendix 3a) escalation framework process. Request formal divert by local ambulance service when maternity service is suspended. The Trust should specifically outline to the Ambulance Service where the Trust is diverting to and a clear timeframe on how long the divert should last. A contingency plan must be put in place for women that may unexpectedly attend delivery suite and triage without notice to manage care safely. An agreement must be reached between the Trust suspending the maternity service and the Trust(s) accepting the diverted patients regarding the triage of women

	pressure and local escalation in place (in-hours only). NENC SCC will support if needed by liaising with local partners (maternity and neonates) e.g. by standing up a system call. Agreements for support with local partners organised directly through SCC.	to support front line delivery of clinical services. Consider contingency plans to maintain a homebirth service. Engage NNeTs around surge planning to ensure access to neonatal critical care is not compromised, if applicable. Consider facilitating regular safety huddles with all key clinicians and operations team members until OPELMF Two or below reached. Trust communications department to support updates across the organisation and into the community, including with the MVP) to help share and amplify key messages to staff, women, their families, and members of the public.	booked at the suspended service. The expectation is that the suspended service will conduct all telephone triage and liaise with the accepting Trust if a woman requires admission and triage. Report suspensions of a maternity service as an SI. Inform the ICB when the issue raised has been resolved for the purposes of de-escalating and confirm current OPELMF status. Undertake a debrief with the ICB to identify learning. This learning should be captured and evidenced and shared widely.
TRUST ACTIONS: Out of Hours only:			
OPELMF One	**OPELMF Two**	**OPELMF Three**	**OPELMF Four**
No actions required – business as usual.	Trust in house escalation processes to be followed to source support from within the organisation. Delivery Suite co-ordinator and Consultant Obstetrician On Call to undertake a timely review of ward and delivery suite patients to expediate medical review and ensure flow of patients suitable for discharge. Inform the on-site maternity bleep holder of rising escalation. Escalate to the Trust Silver (Tactical) On Call via local escalation processes. ICB On Call teams DO NOT require notification of rising escalation to OPELMF Two out of hours.	Ensure all OPELMF Two actions have been completed. Consider contingency plans to step down homebirth services and On Call Midwives to attend unit to support. Delivery Suite co-ordinator to contact Trust Silver (Tactical) On Call for support and oversight. Escalate to the ICB On Call Team. Further urgent actions are now required across the ICB to source system level support to mitigate further escalation. If a system call is agreed, escalating Trust Silver (Tactical) On Call to stand up the call in liaison with the ICB On Call	Ensure all OPELMF Two and Three actions have been completed. The Trust Gold (Strategic) On Call should be contacted to inform them of rising pressures via local escalation processes. Escalate to ICB On Call OPELMF Four status to initiate ICB escalation processes. Liaise with ICB to confirm actions taken to resolve the escalation and provide an understanding of the pressures and issue. ICB liaise with RCC to obtain mutual aid support outside of ICB.

	Liaise with hospital site manager to provide extra cleaning and maximise available support to manage bed clearance. Bed capacity should be managed by the out of hours bed management team and reviewed every 2 hours. Review neonatal cot capacity for current and anticipated activity with On Call Neonatologist and NNeTs. Review OPELMF status which includes staffing, skill mix and bed capacity 4 hourly and update internal On Call Teams as per out of hours escalation processes.	Manager. Discussions with local partners to include Neonatal units and NNeTs. The decision to divert a service and deflect women between sites in a Trust to be agreed between the Senior Manager On Call and Silver (Tactical) On Call. This is an internal operational decision and the ICBs are not required to be notified, apart from through the daily sit rep. Out of hours the Trust should follow its EPRR policy regarding communications with local communities. Inform ICB On Call when the issue raised has been resolved for the purposes of de-escalating support and confirm current OPELMF status.	A Regional Mutual Aid Escalation call will be facilitated by the NHSE on call and supported by Regional Maternity Team. This call will be arranged within 2 hours of initial notification. Exec and senior representation to attend. Verbal updates to be provided to the ICB every 3 hours (between 08:00-20:00), via the escalation template. The decision to suspend a maternity unit should be agreed by the Trust Gold (Strategic) On Call. The ICB should be informed of requests to close a maternity unit via the in-hours (Appendix 3a) escalation framework process. Request formal divert by local ambulance service when maternity service is suspended. The Trust should specifically outline to the Ambulance Service where the Trust is diverting to and a clear timeframe on how long the divert should last. A contingency plan must be put in place for women that may unexpectedly attend delivery suite and triage without notice to manage care safely. An agreement must be reached between the Trust suspending the maternity service and the Trust(s) accepting the diverted patients regarding the triage of women booked at the suspended service. The expectation is that the suspended service will conduct all telephone triage and liaise with the accepting Trust if a woman requires admission and triage.

			Report suspensions of a maternity service as an SI. Inform the ICB when the issue raised has been resolved for the purposes of de-escalating and confirm current OPELMF status. Undertake a debrief with the ICB to identify learning. This learning should be captured and evidenced and shared widely.

Appendix 4b: Maternity Escalation & OPELMF – Integrated Care Boards (ICBs) Action Card (In and Out of Hours)

DESCRIPTION			
OPELMF One	OPELMF Two	OPELMF Three	OPELMF Four
The maternity service capacity is such that the organisation can maintain patient flow and meet anticipated demands within available resources. Additional support is not anticipated. No interaction with the local ambulance service needed business as usual.	The maternity service is starting to showing signs of pressure. The maternity service will be required to take internal focused actions to mitigate the need for further escalation. The maternity service will undertake enhanced co-ordination with the trust operations / tactical (silver) on call team and take timely and appropriate actions to reduce the level of pressure in their organisation. Communication to be coordinated by trust operations team to alert the NENC System Coordination Centre (SCC) to rising pressure and local escalation only (in-hours only). SCC will support e.g.. by standing up a system call with local partners. Agreements for support with local partners organised directly through the SCC. No interaction with local ambulance services needed business as usual.	The maternity service is experiencing major pressures compromising patient flow and safety. Trust operational support having limited impact and organisational pressure continue to increase. Further urgent actions are now required across the whole ICB to source system level support to mitigate further escalation and consider and identify mutual aid support. The SCC should take further urgent actions to source system level support across the whole ICB to mitigate further escalation. Agreements for support with local partners will be organised directly through the SCC (in hours) or ICB on call (out of hours). RCC to be informed.	Pressure in the maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised. All available local and ICB escalation actions have been taken and mutual aid support requested and utilised. Regional support and intervention are required. ICBs should liaise with Regional Coordination Centre (RCC) (in hours only)/NHSE On Call structure (out of hours only) to facilitate regional communications for offers of mutual aid support. Request formal divert by local ambulance service when maternity service is suspended.
ICB (System Coordination Centre) Actions In hours 08:00 – 20:00			
OPELMF One	OPELMF Two	OPELMF Three	OPELMF Four
No actions required. Managed within maternity trust.	No actions routinely required. Managed within the maternity trust following escalation protocols with support of trust operations team.	ICB and Trust escalation processes to be followed to source support from within the system to mitigate further escalation, consider initiating Surge Call to identify mutual aid support from local partners. Agreements for support with local partners organised directly through the SCC.	Initiate ICB escalation processes, if continued escalation, despite mutual aid, or with several Trusts in escalation liaise with RCC for to obtain mutual aid support outside of ICB. ICB to organise exec and senior leader representation to attend Regional Mutual

		Once agreed the escalating Trust to coordinate directly with mutual aid providers to facilitate transfers. Consider facilitating regular safety huddles with all key clinicians and operations team members until OPELMF Two or below reached. Follow up email sent from SCC to the provider confirming the escalated status. This should include the time and name with whom phone contact was made. A debrief with the escalating provider should be facilitated by the SCC to identify learning. This learning should be captured and evidenced and shared widely.	Aid and Escalation call, facilitated by RCC and supported by Regional Maternity Team. This call will be arranged within 2 hours of initial notification. ICB to contact escalating provider(s) every 3 hours (between 08:00-20:00), using the escalation template. The ICB and escalating Trust to coordinate directly with mutual aid providers to facilitate transfers. ICB responsible for sharing updates with RCC and inform when issue raised has been resolved for the purposes of de-escalating. Follow up email sent from ICB to the provider confirming the escalated status. This should include the time and name with whom phone contact was made. A debrief with the escalating provider should be facilitated by the ICB to identify learning. This learning should be captured and evidenced and shared widely.
ICB (System Coordination Centre) Actions Out of hours 20:00 – 08:00)			
OPELMF One	OPELMF Two	OPELMF Three	OPELMF Four
No actions required. Managed within maternity trust.	No actions routinely required. Managed within the maternity trust following escalation protocols with support of trust operations team.	Where Provider level concerns are reported out of hours these should be made to the ICB On Call. ICB and Trust escalation processes to be followed to source support from within the system to mitigate further escalation, consider initiating Surge Call to identify mutual aid support from local partners.	Where Provider Level concerns are reported out of hours, these should be made to the ICB On Call in the first instance. Initiate ICB escalation processes, if continued escalation, despite mutual aid, or with several Trusts in escalation, liaise

		If a system surge call is agreed, escalating Trust Silver (Tactical) On Call to stand up the call, in liaison with the ICB On Call Manager. Discussions with local partners to include Neonates and NNeTs. The escalating Trust to coordinate directly with mutual aid providers to facilitate transfers. Follow up email sent from ICB to the provider confirming the escalated status. This should include the time and name with whom phone contact was made.	with RCC for to obtain mutual aid support outside of ICB via NHSE On Call. ICB to organise exec and senior leader representation to attend Regional Mutual Aid and Escalation call, facilitated by NHSE On Call Team. This call will be arranged within 2 hours of initial notification. The ICB and escalating Trust to coordinate directly with mutual aid providers to facilitate transfers. ICB On Call to inform RCC when incident closed via NHSE On Call. Follow up email sent from ICB to the provider confirming the escalated status. This should include the time and name with whom phone contact was made. A debrief with the escalating provider should be facilitated by the ICB to identify learning. This learning should be captured and evidenced and shared widely.

Appendix 4c: Neonatal Operational Delivery Network (ODN) Framework (NENC LMSN, ODN and SCC to work on updating this framework to align with OPEL MF)

RAG Rating	Escalation Levels	Triggers	Actions	
			In hours	**Out of hours**
GREEN	**Business as usual**	• Bed capacity is limited but within usual planning arrangements	ODN 1. On-going monitoring of capacity at ODN 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 2303020 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 • NENC system 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 LMNS of status UNITS 1. Report concerns to ODN Lead Nurse/Clinical lead/Network Manager and escalate staffing issues to senior hospital management locally to activate internal escalation polity 2. Regional escalation levels to be included in unit handovers 3. Cots to be utilised for repatriation to agreed establishment as reported to ODN/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 2303020 1. NNeTs to inform NNUs of regional status on ring around 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 monitoring ward rounds when all NICUs declare zero ITU/HD cot capacity during monitoring 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: a. Possible options for movement (utilising repatriation) b. Repatriation of SCU babies to 'non-home' SCU (including 'local' babies) to created HD/ITU capacity c. Agree level of escalation /de-escalation (this matrix) 2. NICUs to inform their local maternity service 3. NNeTS to inform LNUs 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	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. SCUs 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)	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

		Babies awaiting cot and being transferred out	NNeTS (Hotline number for all referrals and contact – 0191 2303020) 1. Activation of ODN Control Group (Tertiary units on call consultants, NNeTS & ODN Reps	with actions in Green and Amber status

Appendix 5: Good Practice Guidance for Escalation Management

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

- Where possible adhere to planned length of stay
- Timely discharge of antenatal/postnatal patients
- Timely neonatal reviews to aid discharge
- Timely review of ward rounds
- Early recognition of potential capacity issues, escalating concerns early on so that measures can be put in place.
- Review elective work through multidisciplinary team (MDT) approach.

Good practice guidance for management of staff includes:

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

Appendix 6: Roles & Responsibilities within the Trust & ICB

Role	Responsibilities
Trust Gold (Strategic) On call	In the event of a whole maternity and neonatal service suspension, the primary role of the Trust Gold (Strategic) On Call is to give strategic direction at an operational level to ensure patient flow is resumed as early as possible. Trust Gold (Strategic) On Call should also handle any communications or media requests out of hours and liaise with the ICB Gold On Call.
Trust Silver (Tactical) On call	The Trust Silver (Tactical) 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 (Tactical) On Call is to support any decision making and to ensure all areas of the maternity and neonatal service are maximised to aid patient flow, safety, and capacity. In the event of any potential full maternity and neonatal service suspension, the Trust Silver (Tactical) On Call should escalate to the Trust Gold (Strategic) On Call.
Trust Bronze (Operational) On call	The Trust Bronze (Operational) On call will coordinate further support for maternity and neonatal services. For example, find extra cleaning team, maximise available support staff to answer doors, telephones and manage effective bed clearance on electronic systems etc. They will liaise with delivery suite coordinator to ensure that they have sufficient support.
Director of operations/deputy 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 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 will work closely with obstetric anaesthetist on call and neonatal consultant on call. They also play a key role in the decision -making processes concerning temporary diversion or closure of the service.
Director & Head of Midwifery	DoM holds overall strategic 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 to OPELMF Three. They 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 (and neonatal) inpatient areas and having oversight of the community service. They support the delivery suite coordinator and ward managers daily to ensure the safe and timely flow of patients throughout the maternity (and neonatal) 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 suite coordinator. At early signs of pressure, the manager of the day will escalate to the matrons and consultant obstetricians and will commence the documentation as required. They will also undertake non-clinical tasks to support discharges and patient flow when required.
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. They are the next stage in the escalation process and will support operational decision making including ensuring safe timely discharges of those able. They will liaise with and support consultant colleagues.

Delivery suite 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 which includes the neonatal unit manager to ensure all discharge planning actions are carried out in an integrated manner.
Integrated Care Board (ICB) On Call	Support local action which includes the localisation and initiatives that are in place for the NENC using existing cross-organisational partnerships and cross border arrangement with neighbouring ICBs. During the escalation process the system on call and the lead commissioner within ICB will be notified as per contractual arrangements via Trust Silver (Tactical) On Call & Trust Gold (Strategic) On Call.

Appendix 7: NEY Regional Coordination Centre (RCC) Maternity and Neonatal Escalation Template

(to be completed by ICB SCC)

Completed by:	
ICB	
Time:	

No	Date Reported	Task Number	Escalation Level (3 / 4)	Provider	Briefly describe the current situation	Confirm actions being taken by the organisation and any support required	Escalation Update (*requires timestamp for update i.e. 20220801: Xxxx*)	Status	Date of change in status
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Appendix 8: Key stakeholders to be informed of temporary diversion or whole service suspension

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	Suspension			
NEAS & NWAS & YAS Ambulance Service	√	√			
Other maternity units	√	√			
NENC System Coordination Centre (In hours) /ICB On Call (Out of hours)		√			
Manager of the day	√	√			
Delivery suite coordinator	√	√			
Matrons	√	√			
DoM/HoM	√	√			
Obstetric consultant	√	√			
Duty matron	√	√			
Head of emergency performance	√	√			
Trust Silver (Tactical) On call	√	√			
Trust Gold (Strategic) On call		√			
Triage midwife in charge	√	√			
Ward coordinators	√	√			
Community midwives on call/community & out-patients matron	√	√			
Professional midwifery advocate (PMA) for professional support	√	√			
Bed manager (where applicable)	√	√			
Neonatal Transport Team (NNeTs via hotline 0191 2303020)					
Neonatal unit/consultant on call	√	√			
Consultant anaesthetist on- call	√	√			
Emergency Department (ED)	√	√			
Governance lead to assist with reporting arrangements	√	√			
Safeguarding team to assist with safeguarding alert process	√	√			
Site manager	√	√			
Switchboard as per local arrangements	√	√			
Security as per local arrangements	√	√			
Trust comms team	√	√			

Appendix 9: 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 10: Transfer Apology Letter

Insert Date]

[Insert Patient Details]

Insert Trust Logo Insert Trust Address & Contact Detai

Dear....

Diversion of care to (Insert Trust/Site)

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

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

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

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

Yours Sincerely

Appendix 11: Glossary of terms

Formal Ambulance Divert	The practical operational application of an agreed ambulance divert in response to significant and overwhelming local and/or wider system operational pressures.
Emergency Divert	An emergency divert is the application of a divert in relation to a major incident such as fire or flood which results in the Emergency Department becoming non-operational for a period; and/or in a major incident where the casualty distribution plan is operational i.e., not accepting cardiac arrests. In the event of an emergency divert, this will automatically include the maternity department to prevent increasing the stress existing in the organisational site further.
EPRR	Emergency Preparedness Resilience and Response
ICB	The Integrated Care Board (ICB) for the North East and North Cumbria is a new statutory NHS organization which formed on 1 July 2022 and took over the responsibilities of the eight clinical commissioning groups (CCGs). The ICB is responsible for meeting health needs of the population, managing the NHS budget and arranging for the provision of health services. The ICB leads the Integrated Care System (ICS) (Health and Care Act 2022).
ICP	The NENC Integrated Care Partnership (ICP) is a statutory committee of the fourteen local authorities and the NHS. It is responsible for setting and developing the strategy for health and care in the North East and North Cumbria. The NENC ICP is made up of four ICPs based around main centres of the population: • North Cumbria • Central (County Durham, Darlington, Sunderland and South Tyneside) • North (Gateshead, Newcastle, North Tyneside, Northumberland) • Tees Valley (Hartlepool, Middlesbrough, Redcar and Cleveland and Stockton-on-Tees)
ICS	The Integrated Care System (ICS) is a new way of working together to combine the collective resources and expertise of the ICP and the ICB, including voluntary and community sector, to combine their collective resources and expertise to plan, deliver and join up health and care.
IPC	Infection Prevention & Control
In hours	Period of time between 08.00hr-20.00hr (SCC and RCC In hours). Please note this may vary across ICBs.
LMNS	A Local Maternity and Neonatal System is a partnership of maternity and neonatal service providers, commissioners, local authorities and maternity voices partnerships, who work together to transform maternity services. They are coterminous with ICBs and report through the ICB structures.
Maternity Suspension	The temporary closure of the maternity service within an organisation, to maintain safety of women and babies, due to extreme operational pressures and/or a major incident.
Maternity Diversion	The diversion of maternity activity from one organisation to another trust, to maintain safety of women and babies, in response to significant and overwhelming local and/or wider system operational pressures.

Maternity Deflection	The operational decision to transfer (deflect) women to level out operational pressures within an organisation, maximising use of assets while maintaining patient safety.
MDT	Multi-Disciplinary Team
NEAS	North East Ambulance Service
NECS	North of England Commissioning Support Unit
NED	Non-Executive Director
NENC	North East and North Cumbria
NEY	North East Yorkshire and Humber
NICU	Neonatal Intensive Care Unit
NNeTS	Northern Neonatal Transport Service (NNeTs). It has a fully staffed tier of dedicated Specialist Transport Nurses and 24-hour access to advice from a Consultant Neonatologist.
NWAS	North West Ambulance Service
Ockenden IEA	Ockenden Immediate & Essential Actions are the recommendations from the Ockenden Review of maternity services at Shrewsbury & Telford NHS Trust.
Operational (Bronze)	The tier of command and control within a single agency (below gold level and silver level) at which the management of 'hands-on' work is undertaken at the incident site(s) or associated areas
Out of hours	Period of time between 20.00hr-08.00hr (ICB and NHSE On Call). Please note this may vary across ICBs.
OPEL MF	Operational Pressures Escalation Level Maternity Framework
Region	Region in this document refers to the North East and Yorkshire (NEY) regional office of NHS England.
RCA	Root Cause Analysis is a systematic process for identifying "root causes" of problems or events and an approach for responding to them.
RCC	Regional Coordination Centres (RCCs) act as a single point of contact (SPOC) to manage all regional operational communications between ICBs and their providers. The RCC is structured to be the regional point of coordination between the National Operations Centre (NOC); be the single point of access for ICBs to escalate issues, report service changes, management of mutual aid; and receive and share communication regarding national policy/guidance change and subject matter expert support from the regional programmes.
SBAR	Situation, background, assessment, recommendation is an approach to articulating information often useful in an emergency.
SCC	System Coordination Centre operate at an Integrated Care Board (ICB) level to lead and facilitate collaboration through senior system-level operational leadership, delivering visibility of operational pressures and risks across providers and system partners; concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges; dynamic responses to emerging challenges and mutual aid; efficient flows of information.
Strategic (Gold)	The level (above tactical level and operational level) at which policy, strategy and the overall response framework are established and managed. (Note – The terms strategic and gold are frequently used

	interchangeably for single agency operations.)
Tactical (Silver)	Level (below strategic level and above operational level) at which the response to an emergency is managed. (Note – The terms tactical and silver are frequently used interchangeably for single agency operations)
YAS	Yorkshire Ambulance Service