University Hospitals of Leicester NHS
NHS Trust

Escalation, Transfer of Activity and Closure UHL Obstetric Policy

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1. Introduction and overview

The policy outlined below sets out appropriate actions to be taken in the event of critical staffing shortages and/or capacity issues within University Hospitals of Leicester NHS Trust (UHL) Maternity Services. It is written in line with the Midlands Maternity Escalation Policy & Operational Pressures Escalation Levels Framework (OPELMF).

UHL Maternity Service is based on three sites, which are the Leicester Royal Infirmary, Leicester General Hospital; St Mary's Hospital, Melton Mowbray and includes Community Midwifery Service.

When activity is high on one site the option to transfer activity to another site should be considered. The Midwifery Birth Centre at St Mary's may also be able to provide extra capacity for low risk maternity care. In the final instance, it may be necessary to consider closure of the Leicestershire Maternity Service to admissions.

This policy uses OPELMF framework definitions (see appendix 1) to provide a consistent approach in times of pressure, 7 days a week, specifically by:

- Enabling the Trust to consistently identify areas of concern and implement internal actions to mitigate where possible the risks.
- Ensure appropriate steps are taken if transfer of activity is unavoidable.
- Ensure appropriate steps are taken if closure is unavoidable.
- Describe further possible contingencies if closure of services is not possible.
- Ensure adequate documentation is completed during this process.
- Alerting the local ICB and wider to ensure they can support us to enable local systems to maintain quality and patient safety.
- Providing a regional and locally consistent set of escalation levels, triggers and protocols across maternity services in the Midlands.
- Setting clear expectations around roles and responsibilities for all those involved in escalation in response to surge pressures.
- Setting consistent terminology.
- Improving communication and multi-disciplinary working relationships.
- Enhancing the experience for mothers and babies and reducing harm.

Neonatal escalation, transfer and repatriation of neonates is managed by the Neonatal Operational Delivery Networks (ODNs). Currently across NHS England (NHSE) each neonatal ODN operates differently and has different geographical boundaries to that of the NHSE regions.

2. Policy Scope

This policy applies to all patients who present to the Maternity Service of the University Hospitals of Leicester NHS Trust and is to be followed by all midwifery and medical staff within the Maternity Service and relevant associated Trust staff. It is to be circulated to all staff who manage maternity capacity to provide a practical working reference tool for all parties, thereby aiding coordination, communication, and implementation of the appropriate actions within the organisation.

3. Policy Development

This policy has been updated to incorporate the Midlands Maternity Escalation Policy & Operational Pressures Escalation Levels Framework procedures to manage significant surges in regional demand for maternity services.
The midwifery, nursing and support staff staffing levels in the Maternity Service will be reviewed by the Director of Midwifery, Head of Midwifery and Midwifery Matrons on a 6 monthly basis to assess establishment requirements and reviewed with a full Birth rate plus assessment Bi-Annually. The workforce report will then be presented to the Executive Quality Board and discussed at Maternity Service Governance Group and the LMNS.

Where staffing levels are not in line with the recommendations from the BirthRate Plus® review, a business plan or contingency plan will be produced to address on-going staffing shortfalls to include comprehensive recruitment campaign as highlighted in the maternity workforce plan in the event of any short-term staffing shortfalls a contingency plan will be produced to address these issues on a day to day basis.

All business and contingency plans will be reported to the Women & Children's CMG Management Team.

4. Definitions and Abbreviations

UHL	University Hospitals Of Leicester NHS Trust	DoM	Director of Midwifery
OPELMF	Operational Pressure Escalation Levels Maternity Framework	HoM	Head of Midwifery
CMG	Clinical Management Group	DHoM	Deputy Head of Midwifery
LMNS	Local Maternity Neonatal System	MDT	Multi-Disciplinary Team
ROC	Regional Operational Centre	ODN	Operational Delivery Network
UEC	Urgent and Emergency Care	EPRR	Emergency Preparedness, Resilience and Response
SBAR	Situation Background Assessment Recommendation	RCA	Root Cause Analysis
JDA	Junior Doctor Administrator	COO	Chief Operating Officer
IPC	Infection Prevention & Control	SCC	System Coordination Centre
RCC	Regional Coordination Centre	HoS	Head of Service
CD	Clinical Director	StEIS	Strategic Executive Information System
EMAS	East Midland Ambulance Service	WMAS	West Midland Ambulance Service
ICB	Integrated Care Board	HOOP	Head of Operations

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 result in the Emergency Department/Delivery Suite/MAU becoming non-operational for a period; and/or in a major incident

Maternity Suspension	The temporary closure of the maternity service within an organisation, which results in either a Deflection or Diversion of patients, to maintain safety of women and babies, due to extreme operational pressures and/or critical or major incident
Maternity Deflection	The operational decision to transfer (deflect) women to different sites within the organisation to level out operational pressures, maximising use of assets while maintain patient safety.
Maternity Diversion	The temporary closure 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.
SBAR	Situation, Background, Assessment, Recommendation is an approach to articulate information often useful in an emergency

5. Roles and Responsibilities within the Trust

Role	Responsibilities
Chief Operating Officer (COO)	Executive responsibility for application of this policy.
Trust Gold (Strategic) On call	In the event of a whole maternity service closure, 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 service are maximised to aid patient flow, safety and capacity. In the event of any potential full maternity service closure, the Trust Silver (Tactical) On Call should escalate to the Trust Gold (Strategic) On Call.
Trust Bronze (Operational) On Call (SMOC)	The Senior Manager on call (SMOC) Duty Manager (DM) will coordinate further support for maternity 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.
CMG Gold (Strategic) Consists of DoM, HOOP, Clinical Director	The CMG Triumvirate have responsibility for ensuring 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 CMG wide response to emergency care/demand/capacity pressures. All processes will be supported by the umbrella of a trust corporate governance process. Hold overall strategic responsibility and accountability for the maternity services flow and capacity
CMG Silver (Tactical) Consists of HoM, Deputy HOOP, Deputy CD	HoMs & Deputy CD and Deputy HOOP 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

Managers/TCM of the day (Maternity Bronze, (operational) Commander) OOH Women's Manager On-Call for Escalation only	Are the central point of information sharing regarding staffing, bed capacity and acuity in all maternity inpatient areas and having oversight of the community service. They support the delivery suite coordinator and ward managers daily to ensure the safe and timely flow of patients throughout the maternity services by the resolving of staffing shortages and redeployment of staff within the clinical area. Report to the matrons, HoM and community manager. 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.
Lead Consultant Obstetrician On call	The consultant on labour suite or out of hours and 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.
Divert Co-ordinator (In-Hours – Maternity Bronze Commander) Out of Hours Trust Silver or SMOC)	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'. 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.
Maternity Flow & Staffing Coordinator (bleep holder)	Attend safety huddle with obstetricians, neonatal team, anaesthetists, and delivery suite coordinator. 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. 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. Receive all staffing shift cancellations and mitigate as necessary in collaboration with ward managers/Midwife in charge. To liaise with senior colleagues as per trust escalation process.
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.
Community Team Leaders	Are responsible for gathering information regarding staffing and acuity in the community service. They are responsible for ensuring the timely and safe allocation of workload, and ensuring all clinics, bookings and home visits are covered. They are responsible for resolving staffing shortages and redeployment of staff within the community area, and escalating to the community midwifery matron where required

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 woman'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
All Staff	All staff to follow the policy and to escalate as soon as possible any deviation.

6. Policy

6.1 Daily oversight and prevention

The Maternity OPEL Level is used internally to determine what level of action is required to either:

- Maintain existing capacity and flow when the Trust is at OPEL 1; or
- Reduce pressures within the system when the Trust is in escalation and at OPEL 2, 3, or 4.

A summary of the actions that will be taken by the Service and/or Trust at OPEL Levels 1, 2, 3, and 4 can be found in Appendix 3 – Maternity OPEL Action Card.

It is expected that the maternity units through the shift coordinator and delivery suite consultants will communicate frequently to have an awareness of activity across Leicester on a shift-by-shift basis. This process is to be done via telephone conversation or text

- Timely completion of staff rotas
- Daily review of staffing numbers
- Good management of annual leave
- Consider potential shift changes
- Request bank/agency staff
- Promote staff rotation so ready when increased pressure
- Medical staff shortages should be managed through the manager of the day Head of service/workforce lead or JDA

Daily cross site and community huddles will be held twice daily via teams at 8.30am and 4.00 (additional huddles will be convened at escalated levels of OPELMF – see action card, appendix 3) to review the current situation within all maternity services. This will be led by the CMG Bronze Commander (TCM Manager of the Day). The purpose of the operational huddle is to ensure safe management of maternity capacity and patient safety. It is expected that there will be representatives from all services within the CMG and each will provide a sitrep of service and escalate key risks mitigate and outstanding risks requiring support. These huddles will be held twice daily but can be reconvened at different points within the day dependent on OPELMF level and where conditions escalate, or concerns arise. This is identified within the Action Card (appendix 3).

The information from this will inform the Trust and Midlands Maternity and Neonatal Sitrep submissions 7 days a week. Trust Sitreps are submitted three times daily (08:30, 12:30,

3:30) and Midlands Sitrep once a day by 10 am (including bank holidays). This is to be submitted using the Maternity Sitrep Data Collection Form - **Midlands Maternity OPEL Sitrep Data Collection Form.**

6.2 Triggers and OPELMF

The need to either transfer activity or to close the service to admissions will be determined by set structured triggers outlined in the OPEL Maternity framework (Appendix 2) aligned to the Midlands Acute Maternity - OPEL Maternity Framework –Appendix 1.

Triggers that determine the OPELMF are:

- Maternity ward-based bed capacity.
- Delivery suite bed capacity.
- Obstetric Staffing
- Anaesthetic Staffing
- Delivery Suite Birth rate plus activity & acuity score of all intrapartum care.
- Delivery suite co-ordinator not supernumerary.
- Neonatal OPEL Framework status.

There may also be other factors that lead to escalation and diversion, and are determined by the below additional internal triggers:

- Triage Breaches within Maternity Assessment Unit (MAU)
- Delays in elective work for non-reason this includes both induction of labour and elective caesarean section
- Infection Prevention & Control issues – follow local IPC policy.
- In the event of a major incident or power failure – follow local policy.

OPEL STATUS	Triage Breaches	Delays in elective work for non -medical reason
Black	≥10 ladies delayed in treatment within category guidelines	Unable to transfer to another Trust
Red	5-9 ladies delayed in treatment within category guidelines	Delays in elective activity for >24hours
Amber	1 or more ladies delayed in treatment within category guidelines	Delays in elective activity for > 2 hours
Green	All women seen with appropriate timescales in line with unit guidance	No delays in elective work

- **Temporary closure of neonatal units in region**

It is important to note that the temporary suspension of the neonatal unit does not translate to a temporary 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 with joint consultation by the consultant obstetrician and consultant neonatologist.

The East Midlands Neonatal Operational Delivery Networks (ODN) have a Midlands wide neonatal surge plan to ensure access to neonatal critical care is maintained and not compromised.

- **Staffing Pressure**

Short-term Contingency plans should be implemented as per Midwifery and Support Staffing Policy and the Consultant Obstetrician Cover Arrangements for Labour Ward– these include:

- Moving staff from one clinical area to another whilst risk assessing which area is in the greatest need from a safety aspect.
- Ensuring the staff have the skills to rotate and allocate work accordingly.
- Ensure all shifts are out to bank or overtime.
- Ensure the situation is clearly described in the Trust and regional sit rep.
- Ensure the out of hours on call manager has the necessary support from a clinician should escalation be required.

It is usual for a maternity service to experience peaks in activity which make an area unable to continue to function as it is. A review of this workload should be undertaken by the bleep holder, shift coordinator and obstetrician. If re-allocation of this workload is not possible actions and escalation should be made in accordance with action card appendix 3.

- **Capacity Pressures**

It is usual for a maternity service to experience peaks in activity which exceed capacity. If the problem is a shortage of Delivery Suite beds:

- Careful assessment of those women on Delivery Suite should be made to see if any can be safely transferred to the postnatal ward, another suitable clinical area, such as St Mary's Birth Centre (if suitable) or home. Co-horting postnatal women in the alongside Birth centre or induction area.
- If the problem is a shortage of postnatal beds, careful assessment of existing women should be made to see if any may be safely discharged home or transferred to another area e.g., St Mary's Birth Centre. Elective activity should also be reviewed and reorganised as appropriate: e.g., Elective Caesarean sections and non-urgent Induction of Labour.

Internal CMG Escalation – the CMG action card appendix 3 identifies the full actions for each OPELMF level the section below summarises the categories. The actions within the Action card must be followed and responses recorded.

OPELMF One
The maternity service capacity is such that the organisation can maintain patient flow and meet anticipated demands within available resources. The need for additional support is not anticipated**.**

OPELMF triggers to be reviewed 6 hourly

OPELMF Two
At OPELMF two the maternity service will be required to take internal focused actions to mitigate the need for further escalation.

The CMG Tactical Triumvirate should be informed of rising escalation and there should be active involvement to mitigate and de-escalate.

The maternity 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 as identified above.

The Trust Bronze (Operational) SMOC should work to source support from other departments as required. OOH 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 ICB System Coordination Centres (SCC) of the rising pressure and local escalation in place for information only purposes in hours only.

OPELMF triggers to be reviewed 4 hourly

OPELMF Three
At OPELMF Three the maternity service is experiencing major pressure, staffing concerns or capacity issues are raised and trust escalation protocols should be instigated.

The CMG Gold Strategic triumvirate will be actively involved to support mitigation and prevention of escalation to OPELMF Four. OOH Strategic Gold should be contacted.

The ICB SCC should be notified which will trigger ICB escalation protocols.

At this point the trust may need to deflect (transfer) activity internally between sites. Agreement for there to be a temporary transfer of activity from one site to the other will be a MDT decision made by the Consultant Obstetrician, Midwife Co-ordinator, Matron or Manager on Call for CMG or SMOC OOH.

It is possible to agree to a partial transfer, when just the MAU closes but labouring women may still be accepted, or a unit may close to labouring women and remain open to triage and assess admissions. It is important this is documented on the Birth rate Plus.

On either site if there are no longer delivery rooms available for higher risk women and a birth centre room is used or a woman is not able to transfer out of the birth centre if her condition becomes more complex, this must also be documented clearly in the Acuity app and the patient record. Oversight of these women must be maintained by the midwife coordinator and obstetrician.

Once the decision has been made for internal transfer there are several services/ organisations who need to be informed – appendix 4 - provides a checklist of those services/organisations should be informed both in hours and out of hours these should be overseen by the divert coordinator who will make arrangements for key stakeholders to be notified.

OPELMF triggers to be reviewed 2 hourly to ensure that deflection is for as short a period as necessary and normal service is restored

OPELMF Four
At OPELMF Four the maternity service is experiencing extreme pressure and all OPELMF Two and OPEL MF Three actions have been completed. The Trust Strategic On Call should be involved and supporting mitigation to de-escalate. Any request to temporarily close the maternity service must be agreed by the Trust Strategic On Call. The ICB SCC must be notified which will trigger ICB to source mutual aid via regional escalation processes

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):

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

Actions outlined in the action card appendix 3 -for trusts declaring OPELMF Four should be undertaken and communicated with partners.

Escalation for mutual aid will made by the ICB SCC; to the RCC. A regional mutual aid and escalation call will be facilitated by the RCC and supported by the regional maternity team will be arranged within 2 hours - Exec and senior leadership attendance should be confirmed.

The Trust will provide verbal updates to the ICB SCC every 3 hours via the escalation template (appendix 9)**.**

Internally the position within UHL maternity services will be reviewed hourly and the information used to inform communication with the ICB SCC.

Confirmation must be made that all relevant areas are aware of the service closure and reasons for this.

There must be a contingency plan in place for women who may unexpectedly arrive at the units without notice to ensure they receive safe and appropriate care.

Unit closure must be recorded on StEIS in line with the SI framework for maternity unit closure.

6.3 ICB Escalation

When reaching OPELMF Two CMG Operational TCM manager of the day should attend the 09:30am system call to alert the ICB's SCC to rising pressure and local escalation in place (in-hours only). This is for information only.

At OPELMF Three the CMG Operational TCM manager should attend 09:30am system call ICB and provide clear escalation of support and the ICB should take urgent actions to source system level support across the whole ICB to mitigate further escalation. In addition, if necessary, the ICB should attempt to identify mutual aid support with neighbouring ICBs. **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 Three. Agreements for support with local partners will be organised directly through ICBs.

At OPELMF Four, escalation for mutual aid support will be made by the ICB SCC (in-hours)/ICB On Call (out of hours) to Regional Coordination Centre (RCC) (in-hours only)/NHSE On Call (in hours and out of hours) structure outlining the safety issues. The ICB SCC/ICB On Call will review the actions undertaken to rapidly resolve the pressures driving the escalation using the ICB escalation process.

6.4 Regional Escalation

Regional escalation should be triggered when pressure in the maternity service continues to escalate leaving UHL 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 Framework (appendix 9)

When escalating to the region the ICB will require the following information:

• 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

Where a region has extreme pressure or where a major incident is declared, the region should work with 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.

Escalation should be made via the following routes:

	In-Hours (RCC 8am-8pm)	**Out of hours (8pm-8am)**
Escalation for regional support to be made by	The ICB SCC to complete RCC Escalation template (**Appendix 6**) and forward to the RCC via email & notify NHSE First On Call with verbal update (for OPEL MF 4 only) (england.midsroc2@nhs.net) The ICB SCC to contact the NHSE first on call for OPEL 4 only East Midlands – Tel: 07623 515942	The ICB On Call to contact the NHSE first on call for the region via usual EPRR routes: East Midlands – Tel: 07623 515942 West Midlands – Tel: 07623 515945

6.5 Deflections and Diversions

At OPEL3 & 4 it may be determined appropriate to either:

- Deflect women between sites at UHL this includes from Community/Home Birth Service as a site; or
- Suspend maternity care provision for new admissions and Divert those women to other trusts within or external to the Midlands region

Tactical On-Call agreement should be sought for an ambulance Deflection, but the acceptance of a deflection can be operationally delegated to the receiving delivery suite coordinator with the tactical being informed at the earliest opportunity.

Strategic On-Call 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.

- Confirm the alternative destination as pre-agreed with the receiving unit.
- The time frame the divert will last for before review (2hrs Deflection/1hr Diversion).

- **Temporary Deflection between sites at UHL**

The decision to deflect women between sites within an organisation is agreed between the **CMG HOOP/HOM/Manager of the Day**, **Senior On Call Manager** and **Trust Tactical On Call**. This is an internal operational decision. In hours ICB will be notified via system call but OOH ICBs are not required to be notified.

- **Formal ambulance Temporary Diversion for maternity services**

A formal ambulance divert 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 EMAS 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 executive agreement has been given.

The decision to request to temporarily suspend a maternity unit should be agreed by **the Trust Gold (Strategic) On Call.** The **ICB SCC (in hours)** and **ICB On Call (out of hours)** should be notified of requests to close a maternity unit via the in hours and out of hours escalation framework process (Appendix 9).

The process will involve consultation and agreement with the EMAS & WMAS ROCC Tactical Commander. Requests for a formal ambulance divert for maternity services must immediately be made to the ambulance service to accept or decline dependent on wider regional ambulance capacity and demand and system wide intelligence.

Any formal ambulance divert request to EMAS must only be made when all OPELMF actions have been completed and failed to de-escalate the pressure to a safe level and executive agreement has been given.

- 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 is the ambulance services responsibility to pre-alert receiving units of women who are being diverted.
- The clinical responsibility of the patient lies with the paramedic on scene.

The divert coordinator is responsible for liaising with EMAS ROCC Tactical Commander to initiate the divert following executive agreement and on an ongoing basis until the divert is stepped down.

The divert coordinator must communicate and document:

- The details of the Trust Gold (Strategic) On Call who has agreed the suspension and the time that this decision was made.
- Confirm the alternative destination as pre-agreed with the receiving unit.
- Agree review periods and method of contact (3hrly in hours and 4hrly out of hours)
- In collaboration with the Consultant Obstetrician on-call ensure contingency plan for Category 1 Ambulance Conveyances, women that may unexpectedly deliver at home, attend delivery suite or MAU without notice to manage care safely

- Complete risk assessment of suspension of maternity services and initiation of formal divert
- Communicate internally to clinical area leads that divert has been initiated and timescales for review and expectation of de-escalation of extreme pressures.
- Communicate directly with receiving units regarding the divert of women who do not require emergency transport and safe to make their own travel arrangements.
- Provide verbal notification of step down of ambulance divert to the ambulance service immediately.
- Report the operational incident on datix

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 standby.
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:

Obstetric Emergencies (Mothers safety is paramount):

- Major obstetric haemorrhage (including antepartum haemorrhage)
- Placental abruption
- Cord prolapses
- Shoulder dystocia
- Vaginal breech
- 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
- Women known to be birthing outside trust guidance
- Unattended birth
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Neonatal Emergencies:

- Livebirth of premature baby requiring neonatal care, an extreme premature baby between 22 weeks, < 27-week (Singleton) & < 28 weeks (Multiples) gestation will require admittance to a unit with a Level 3 NICU
- Ongoing neonatal resuscitation

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. However, the major incident may be directly related to Maternity Services and not the Trust Emergency Department and therefore a Maternal Emergency Divert would be requested.

An emergency divert will involve consultation and agreement with the local ambulance ROCC Tactical Commander and the Trusts Senior Operational Manager (or equivalent Manager On Call out of hours). On the agreed assumption that the maternity service has enacted all internal escalation processes, a Formal Ambulance Divert for maternity services can be initiated for a period of 4 hours without having to go through a separate maternity divert escalation process.

6.6 Re-opening and reporting

- **Re-opening of the maternity unit**

When the factors that precipitated temporary diversion and / or closure 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.

The ICB should be informed for the purposes of de-escalating regional support

- **Post Divert Actions**

It is recommended that women who were transferred to another trust should be followed up by the diverting/closed unit to offer a formal apology and to review their on-going plan of care. An example apology letter can be found in Appendix 7.

As aligned to NHSE 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.

In line with Ockenden Immediate and Essential Action (IEA) 5, actions arising from a serious incident investigation that involve a change in practice must be audited to ensure a change in practice has occurred. Change in practice arising from a serious incident investigation must be seen within 6 months after the incident occurred. As outlined in the National Perinatal Surveillance Model (NPSM) all maternity Serious Incidents (SIs) must be shared with trust boards and the LMNS

IEA5:Ockenden IE5: Incident investigations must be meaningful for families and staff, and lessons must be learned and implemented in practice in a timely manner

- All maternity governance teams must ensure the language used in investigation reports is easy to understand for families – for example, ensuring any medical terms are explained in lay terms.
- Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.
- Actions arising from a serious incident investigation that involve a change in practice must be audited to ensure a change in practice has occurred.
- Change in practice arising from a serious incident investigation must be seen within 6 months after the incident occurred.
- All trusts must ensure that complaints that meet the serious incident threshold must be investigated as such.
- All maternity services must involve service users (ideally via their Maternity Voices Partnership) in developing complaints response processes that are caring and transparent.
- Complaints themes and trends must be monitored by the maternity governance team.

The Head(s) of Midwifery in collaboration with the HOOP and Deputy Clinical Director are responsible for overseeing the completion of a root cause analysis (RCA) and SBAR (situation, background, assessment, recommendation) – see Appendix 8 - assessment for whole service closure.

The requesting maternity provider must complete a 72-hour incident review for all diversions and closures and record this via the Trust internal incident management procedures. The local ambulance service (EMAS and WMAS) 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.

In line with the National Perinatal Surveillance Model, 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).

Appendix 1: Midlands Acute OPEL Framework Definitions

Regional 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 and take appropriate & timely actions to reduce the level of pressure in their organisation. Communication to be coordinated by trust operations team to alert the Integrated Care Boards (ICBs) System Coordination Centres (SCC) to rising pressure and local escalation in place (in-hours only). No interaction with local ambulance service needed business as usual.	The maternity service is experiencing major pressures compromising patient flow and safety. Trust operational support is having limited impact and organisational pressure continues 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 with neighbouring ICBs. Escalation for mutual aid support will be made by the ICB SCC (in-hours)/ICB On Call (out of hours) to Regional Coordination Centre (RCC) (in-hours only)/NHSE On Call structure (out of hours only) outlining the safety issues. The RCC/NHSE On Call will facilitate communications within the region to source mutual aid. Support offers will be received directly by the ICB SCC (in-hours only)/ICB On Call (out of hours only) and managed within the system. Interaction with local ambulance service required if formal divert of ambulances required between sites/organisations.	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. Communication coordinated by trust operations team to alert the ICB SCC (in-hours)/ICB On Call (out of hours) of OPELMF Four via local escalation processes. The ICB SCC/ICB On Call will review the actions undertaken to rapidly resolve the pressures driving the escalation using the ICB escalation process. Escalation for regional support will be made by the ICB SCC (in-hours)/ICB On Call (out of hours) to the RCC (in-hours only)/NHSE On Call (in hours and out of hours) outlining the safety issues and action taken to address. Request local ambulance service to implement service diversion to deflect maternity patients when maternity unit is closed.

Final Version 2, January 2023

Appendix 2 : UHL Operational Pressure Escalation Level Maternity Framework (OPELMF) – Escalation Triggers

OPEL STATUS	Maternity ward-based capacity	Delivery Suite beds	Obstetric staffing shortfalls impacting on safe care delivery	Anaesthetic staffing shortfalls impacting on safe care delivery	Delivery Suite Birthrate Plus activity and dependency score	Delivery Suite coordinators not supernumerary	Neonatal Services Neonatal OPEL Framework Status
Black	No ward beds available & no planned discharges	No Delivery Suite beds available & no planned discharges	NO PLAN to deliver Cat1 C-Section or instrumental deliveries within 30mins	NO PLAN to deliver Cat1 C-Section or instrumental deliveries within 30mins	X2 consecutive Birthrate Plus rating RED safety AFFECTED - mitigating actions taken and services stood down	Providing 1:1 direct care and have no oversight of the delivery suite	OPEL NF FOUR Demand exceeds available resource.
Red	Transfers from labour ward/MAU planned against potential discharges	Patient moves required, expected within 8hrs.	PLAN TO MITIGATE staffing shortages impacting delivery of Cat1 C-Section or instrumental deliveries within 30mins	PLAN TO MITIGATE staffing shortages impacting delivery of Cat1 C-Section or instrumental deliveries within 30mins	Birthrate plus rating RED - safety MAINTAINED - mitigating actions taken and services stood down	Temporarily providing 1:1 care and have limited oversight of the delivery suite	OPEL NF THREE Very limited ability to maintain patient flow in line with ODN pathways
Amber	Transfers from labour ward/MAU planned against definite discharges	Patient moves required, expected within 4hrs.	Staffing shortages with no impact on patient care or delays	Staffing 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 & only able to support complications/emergencies	OPEL NF TWO Neonatal service is experiencing difficulty in meeting anticipated demand with available resources
Green	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 delivery suite and able to support other midwives	OPEL NF ONE ODN unit open to admissions in line with unit designation

	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)	Neonatal Services OPEL Framework Status	MAXIMUM TOTAL
Black Four	3	3	3	3	3	3	3	21
Red Three	2	2	2	2	2	2	2	14
Amber Two	1	1	1	1	1	1	1	7
Green One	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

Appendix 3: Maternity Escalation and OPELMF –Trust Action Cards (In and Out of Hours)

University Hospitals of Leicester CAPACITY FLOW & ESCALATION PLAN	Maternity & Neonates

Standard Daily Operating Processes

The Maternity Services at LRI, LGH & Community together will run a number of daily huddles to manage the emergency flow through the single Maternity front door Maternity Assessment Unit…….

Time	Meeting	Location	Attendees	Led by
07:00	Midwife Shift Handover	Clinical Areas	• Outgoing & incoming shift members	Midwife in Charge
19:45	Midwife area leads huddle	Delivery suite	• Bleep Holder & Midwife in-charge for: Delivery Suite Maternity Assessment Unit (MAU) Antenatal/Postnatal Wards • NICU	Bleep Holder
08:00	Medical Shift Handover (Obstetrics & Anaesthetics)	Delivery suite	• Outgoing & incoming shift members	Lead Registrar
08:15	MDT Clinical Planning Huddle	Delivery Suite	• Obstetrician of the day • Junior doctors • Neonatal Nurse in Charge • Anaesthetist • Bleep holder • Coordinator • ODP	Obstetric consultant
08:30	Women's & Neonates Operational Huddle	MS Teams	• TCM of the Day • Bleep holder both sites • Matrons accordingly to Opel level • Community • Gynae ward managers • Neonatal ward managers	Tactical Command Manager of the Day (TCM)
09:00	Trust Tactical Meeting	MS Teams	• Tactical Command Manager of the Day (TCM)	Senior Manager On-Call
09:30	System Tactical Meeting	MS Teams	• Tactical Command Manager of the Day (TCM) • Trust Senior Manager On-Call	SSC Lead
11:00	Regional Tactical Meeting	MS Teams	• ICB SCC Lead	
13:00	Trust Tactical Meeting	MS Teams	• Tactical Command Manager of the Day (TCM)	Senior Manager On-Call

14:00	MDT Clinical Planning Review Huddle	Delivery suite	• Obstetrician of the day • Junior doctors • Neonatal Nurse in Charge • Anaesthetist • Bleep holder • Coordinator • ODP	Obstetric consultants
16:00	Women's & Neonates Operational Huddle	MS Teams	• TCM of the Day • Bleep holder both sites • Matrons accordingly to Opel level • Community • Gynae ward managers • Neonatal ward managers	Tactical Command Manager of the Day (TCM)
17.00	Dr Handover	Delivery suite	• Outgoing & incoming shift members	Obstetric Consultant
17:00	Trust Tactical Meeting	MS Teams	• Tactical Command Manager of the Day (TCM)	Senior Manager On-Call
19:00	Midwife Shift Handover	Clinical Areas	• Outgoing & incoming shift members	Midwife in Charge
19:45	Midwife area leads huddle	Delivery Suite	• Bleep Holder & Midwife in-charge for: • Delivery Suite • Maternity Assessment Unit (MAU) • Antenatal/Postnatal Wards • NICU	Bleep Holder
20:00	Dr Handover	Delivery Suite	• Outgoing & incoming shift members	Consultant
20:15	MDT Clinical Planning Huddle	Delivery Suite	• Obstetrician of the day • Junior doctors • Neonatal Nurse in Charge • Anaesthetist • Bleep holder • Coordinator • ODP	Obstetric consultant
21:30	Trust Tactical Meeting	MS Teams	• Bleep Holder as required	Senior Manager On-Call
02:00	MDT Clinical Planning Review Huddle	Delivery Suite	• Obstetrician of the day • Junior doctors • Neonatal Nurse in Charge • Anaesthetist • Bleep holder • Coordinator • ODP	Obstetric Consultant

OPEL Level 1 – 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		
OWNER	**ACTION**	**FREQUENCY**
OPERATIONAL OVERSIGHT		
TCM manager of the Day	Review/Completion of OPELMF Triggers Tool for identification of increasing pressure demand	6hrly
Maternity Flow & Staffing Coordinator	Central collation of capacity, staffing and acuity from all clinical areas of CMG to populate sitreps and identify risks/issues in need of escalation.	Ongoing
TCM manager of the day	Completion and circulation of Trust & Regional Sitrep. Including copy of Regional Sitrep sent to ICB inbox llricb-llr.imt@nhs.net	Trust x3 daily (08:30,12:30, 3.30) Regional x1 Daily
CAPACITY		
Consultant On-Call/Bleep Holder	Timely review of ward & delivery suite patients to expedite medical review and ensure flow of patients for discharge Ensuring all women and babies with no reason to reside are discharged safely Nervecentre updated with plans and discharges	Twice a day
Maternity Flow & Staffing Coordinator	Ensure EBeds is updated and women are admitted timely from MAU and Delivery Suite	ongoing
MIDWIFE STAFFING		
Delivery Suite Coordiantor	Birthrate Plus Acuity Tool Completion	4hrly
Ward Managers/Rota Coordinator	Ensure all shift shortages are out to bank or overtime.	Immediately following roster publication & then daily as required
Delivery Suite Coordinator	Ensure the staff have the skills to rotate and allocate work accordingly	Shift Handover and as required throughout day
Bleep Holder	Moving staff from one clinical area to another whilst risk assessing which area is in the greatest need from a safety aspect.	As required
Ward Managers/Rota Coordinator	Ensure leave is managed appropriately and within % compliance standards	Roster completion and ongoing
OBSTETRIC STAFFING		
Consultant	Consultant and junior obstetricians attend planned clinical or SPA sessions	ongoing
Medical Team	Obstetricians assigned to cover labour ward attend handover at 0800, 1700 (if applicable) and 2000 and safety huddle after 0800 handover	Daily
Consultant	Consultant obstetrician identifies escalation (back-up) consultant during safety huddle	8am Daily
Medical Team	Obstetricians attend ward rounds on labour ward at 0800, 1700 and 2000	Daily

Consultant	MAU consultant reports to MAU at 0800 or 1300, collects Nervecentre phone and LRI consultant registers as on call on consultant	Daily
Medical Team	MAU junior obstetricians report to MAU at 0800 or 1300, collects Nervecentre phone and registers as on call doctor	Daily
ELECTIVE ACTIVITY		
Medical Team	Ensure all IOL are clinically appropriate and prioritised based on clinical need and no delays greater than 2hrs from admission/commencement	Twice a day
Medical Team	Ensure all elective caesarean sections are prioritised based on clinical need and admitted timely.	Once a day
NEONATAL SAFETY		
As per Neonatal Escalation Policy		

OPEL Level 2 – 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.

OWNER	ACTION	FREQUENCY
OPERATIONAL OVERSIGHT, ESCALATION & COMMUNICATION		
TCM Manager of the day	Review/Completion of OPELMF Triggers Tool for identification of increasing pressure demand	4hrly
TCM Manager Of the day	Review and ensure all OPELMF ONE Actions are completed	At point of escalation to OPELMF TWO
TCM Manager of the day	The CMG Tactical Triumvirate should be notified of escalation of OPELMF and actively involved in ensuring de-escalation The Trust SMOC should be informed that organisational support is required	At point of escalation to OPELMF TWO
SOM/ Tactical (Silver) commander	Attend ICB System Call informing SCC of status and key issues driving OPEL status, mitigations taken, and outstanding risks and issues being experienced.	09.30 meeting (between 08:00 - 20:00) via escalation template
TCM manager of the day	Increase communications to CMG colleagues to ensure everyone is fully briefed of situation and actions required.	ongoing
CAPACITY		
Delivery Suite Coordinator/Bleep Holder	Careful assessment of those women on Delivery Suite should be made to see if any can be safely transferred to the postnatal ward, another suitable clinical area, such as St Mary's Birth Centre (if suitable) or home. Co-horting postnatal women in the alongside Birth centre or induction area.	As required and ongoing
Bronze Commander TCM Manager of the day SOM	Consider extra domestic support staff to increase room availability turn around	As required and ongoing
MIDWIFE STAFFING		
Bleep Holder	Midwives on management time to support clinically where needed	Ongoing as required
Bleep Holder	Request additional bank and agency staff including midwives, maternity support workers and health care workers	As required

OBSTETRIC STAFFING		
Obstetric Head of Service, junior doctor administrator and/or labour ward consultant	Identify staffing issues and arrange cover from staff available	Ongoing as identified
Consultant Obstetrician	ESCALATION - Staffing issues to be highlighted at handovers and safety huddle	As identified
Consultant Obstetrician	Obstetric consultants informed of staffing concerns via WhatsApp group	As identified
ELECTIVE ACTIVITY		
Consultant obstetrician, anaesthetist, theatre lead and labour ward coordinator	Elective activity should also be reviewed and reorganised as appropriate: e.g. Elective Caesarean sections and non-urgent Induction of Labour.	Morning huddle
Consultant obstetrician, anaesthetist, theatre lead and labour ward coordinator	Consider sharing IOL and elective caesarean workload between LRI & LGH site to reduce delays and ensure care in accordance with National and Local standards	As required and ongoing
NEONATAL SAFETY		
TCM Manager of the day/Neonate Matron	Review neonatal cot capacity for current and anticipated activity	At point of escalation to OPELMF TWO

OPEL Level 3 – The maternity service is experiencing major pressures compromising patient flow and safety. Trust operational support is having limited impact and organisational pressure continues to increase.		
OWNER	**ACTION**	**FREQUENCY**
OPERATIONAL OVERSIGHT, ESCALTION & COMMUNICATION		
TCM Manager of the day	Review/Completion of OPELMF Triggers Tool for identification of increasing pressure demand	2hrly
TCM Manager will coordinate	Ensure OPELMF ONE & TWO actions are completed.	At point of escalation to OPEL THREE
TCM Manager will coordinate	Introduce additional Operational Huddle	12midday or time relevant to point of escalation
TCM Manager of the day/ Womens on call manager OOH	Trust communications department to support updates across the organisation and into the community (including with the Maternity Voice Partnerships) to help share and amplify key messages to staff, women, their families, and members of the public.	
TCM manager of the day/ Matron/ Womens on call manager OOH	The CMG Strategic Triumvirate should be notified of escalation of OPELMF and actively involved in de-escalation The Trust SMOC should be informed that organisational support is required	At point of escalation to OPELMF THREE
TCM manager of the day/ Matron/ Womens on call manager OOH	DCOO (Strategic On-Call OOH) should be contacted and made aware of key issues driving OPEL status, mitigations taken, and outstanding risks and issues being experienced.	At point of escalation to OPELMF THREE

SOM/Silver	Attend ICB System Call informing SCC of status and key issues driving OPEL status, mitigations taken, and outstanding risks and issues being experienced. Make requests for regional comms for mutual aid support if below actions have not resulted in de-escalation. • details driving OPEL • specific actions taken to alleviate pressure • actions taken to ensure patient safety and quality	09.30 meeting then verbal updates every 3hrs (between 08:00 -20:00) via escalation template
Capacity		
Medical staffing	Postnatal beds - careful assessment of existing women should be made to see if any may be safely discharged home with additional community follow up or transferred to another area e.g. St Mary's Birth Centre.	At point of escalation and ongoing
DCOO with Maternity CD/HoM/HOOP Tactical On-Call	Decision to be made to deflect women between sites at UHL. OOH decision to be made between Senior Manager On-Call and Tactical On-Call	At Operational Huddle
Divert coordinator	Request to be made to the local ambulance service to implement a service deflection.	Once deflection agreed between sites
Consultant On-Call/ Divert coordinator	Contingency Plan to be put in place for Category 1 Ambulance Conveyances or attend delivery suite or MAU without notice to manage care safely	Once deflection agreed between sites
Bronze Commander TCM Manager of the day/HoM/Community Matron	Consider contingency plans to maintain homebirth services	Once deflection agreed between sites
Consultant On-Call/ Divert coordinator	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	At point of escalation
Elective Activity		
Consultant On-Call/Bleep Holder/TCM Bronze Commander	Clinical review of all delayed inductions of labour and elective caesareans. Clinical prioritisation plan to be created to maintain mother and baby safety.	
Matrons	Consider the undertaking newborn and infant physical examination (NIPE) in the mother's home to support rapid early discharge of mothers and babies to create capacity on wards for elective or emergency demand.	As required ongoing
MIDWIFE STAFFING		
Bleep Holder	Consider cancelling non-urgent meetings to release office-based Midwives to support safe care delivery.	At point of escalation and for preceding 48hrs
Bronze Commander TCM Manager of the day	Redeploy Risk, Quality and Practice Learning Teams to work clinically	At point of escalation and for preceding 48hrs

Bronze Commander TCM Manager of the day	Request to be made for governance, data, and administrative support to support releasing midwives from administrative tasks enabling them to work clinically	At point of escalation and for preceding 48hrs
OBSTETRIC STAFFING		
Consultant On-Call	Obstetricians asked to support area(s) with staffing concerns. Staff physically present in the hospital will be requested first, in the following order: 1. SPA/admin – not in meetings/teaching etc 2. SPA/admin – those in meetings/teaching etc 3. Antenatal clinic 4. Ultrasound and fetal medicine 5. Elective theatre list 6. Maternity Assessment Unit 7. Staff at home on SPA/rest/day off 8. Staff with external commitments – university, RCOG etc 9. Staff on study leave 10. Staff on annual leave NB Staff may be redeployed in a different order dependent on the clinical area in need of support or their own skillset/occupational health requirements	As identified until mitigated
Consultant On-Call	Obstetricians may be required to cross between sites during this escalation	As identified until mitigated
Consultant obstetricians for labour ward, MAU and elective caesareans	Discuss clinical priority of cases in their area and consider whether any work could be safely postponed.	As identified until mitigated
Neonatal Safety		
Neonate Matron/Head of Service	Engage with the Neonatal ODN around surge planning to ensure access to neonatal critical care is not compromised	At point of escalation to OPELMF THREE

OPEL Level 4 – Pressure in the maternity service continues to escalate leaving UHL 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.

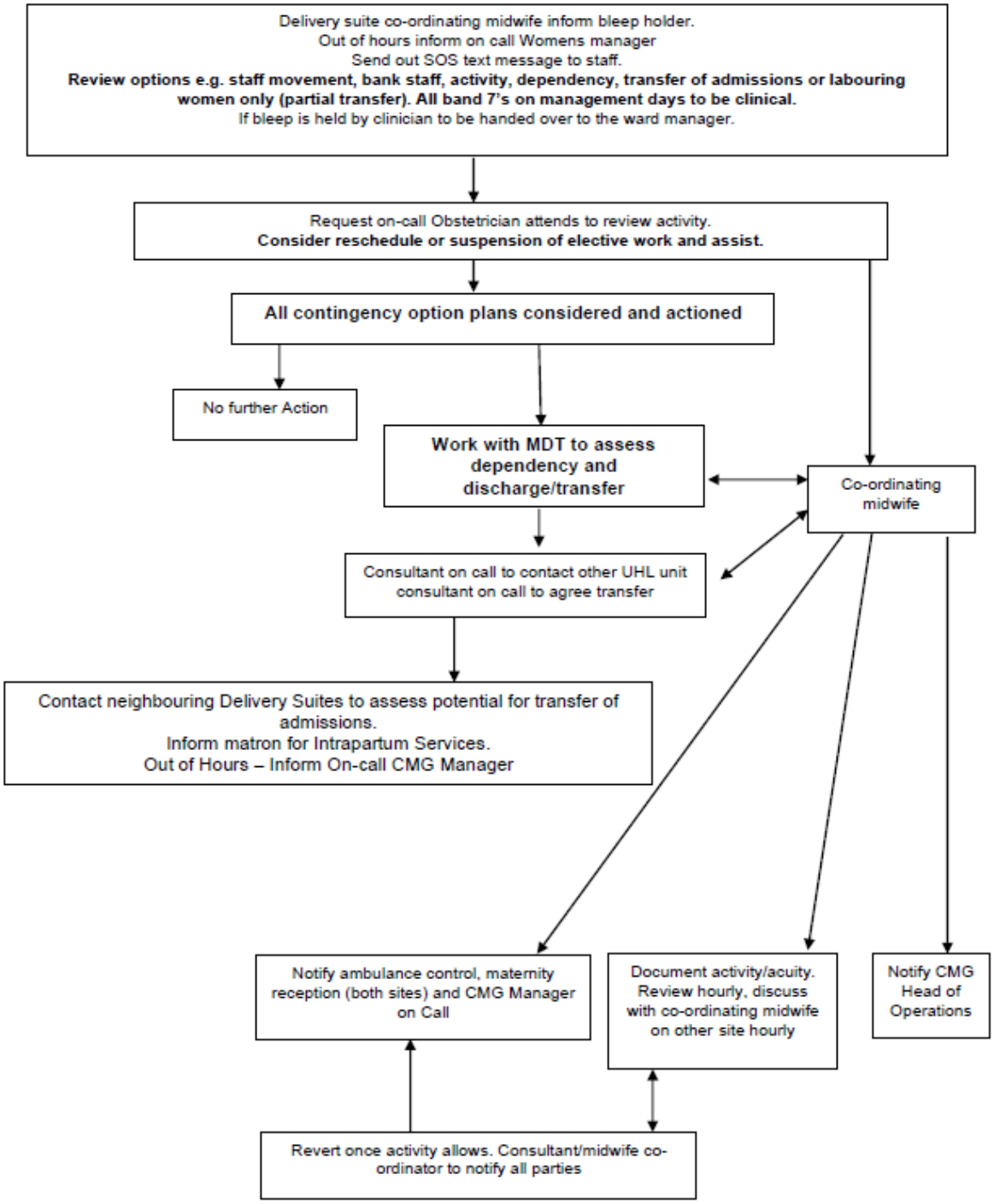
OWNER	ACTION	FREQUENCY
OPERATIONAL OVERSIGHT		
TCM manager of the day? DHooP/ Hoop/HOM	Review/Completion of OPELMF Triggers Tool for identification of increasing pressure demand	1hrly
TCM manager of the day? DHooP/ Hoop/HOM	Ensure OPELMF ONE, TWO & THREE actions have all been completed	
Hoop/ HOM	COO (Strategic On-Call OOH) should be contacted and made aware of key issues driving OPEL status, mitigations taken, and outstanding risks and issues being experienced.	
Hoop/HOM/SMOC	Attend ICB System Call informing SCC of status and key issues driving OPEL status, mitigations taken, and outstanding risks and issues being experienced. Make requests for regional support. OOH contact to be made with ICB Strategic On-Call detailing actions	09.30 meeting then verbal updates every 3hrs (between 08:00 -20:00) via escalation template
ICB SCC ICB Strategic On-Call	Escalation for regional support to the RCC outlining the safety issues and action taken to address. OOH – Escalation to NHSE On-Call	 Verbal updates every 3hrs (between 20:00-8:00)
RCC/Regional maternity Team	A regional Mutual Aid & Escalation Call to be held. Exec and Senior Leader representation to attend the call should be confirmed.	Within 2hrs of initial notification
CAPACITY		
Medical team	All external blockers delaying well women being discharged to be escalated to ICB for immediate support for resolution	At point of escalation and 9.30am system call
COO with Maternity CD/DoM/HOOP Strategic On-Call	Decision to be made to request temporary closure (suspension) of the maternity units at UHL. Request to be made to ICB SCC via escalation framework OOH request to be made to the ICB Strategic on-Call	At point of escalation
SOM	Request to be made to the local ambulance service to implement a service diversion to deflect maternity patients. UHL to arrange and communicate where deflection to be made to and timeframe of how long defection should last. (Agreed by UHL COO to Other Acute COO or UHL Strategic On- Call to Other Acute Strategic On-Call.	Once suspension agreed
Divert coordinator/Consultant On-Call	Contingency Plan to be put in place for Category 1 Ambulance Conveyances, women that may unexpectedly deliver at home, attend delivery suite or MAU without notice to manage care safely.	At point of escalation
Governance team	Report suspension via StEIS in line with SI Framework for maternity unit closure.	Once suspension agreed

SOM/Tactical (silver)	Inform ICB SCC when the issue raised has been resolved for the purposes of de-escalating regional support and confirm OPELMF status OOH – Inform NHSE On-Call when the issue raised has been resolved as above.	When OPELMF Triggers are scoring THREE or clinically safe to step down the divert
Hoop/DCD/HOM	Undertake a debrief with the ICB to identify learning. Ensure learning is captured, evidenced, and shared widely.	Within 24hrs from de-escalation to OPELMF THREE
MIDWIFERY STAFFING		
DoM/HoM	Consider cancelling/rescheduling post-natal activity to release community midwives to work in the acute trust	At point of escalation and plans for preceding 48hrs until de-escalation
DoM/HoM	Consider cancelling all study/training activity for all staff to work clinically	At point of escalation and plans for preceding 48hrs until de-escalation
OBSTETRIC STAFFING		
Head of Service	Antenatal clinics and or ultrasound lists performed by obstetricians should be cancelled	At point of escalation and plans for preceding 48hrs until de-escalation
Head of Service	All available on- site obstetricians should be asked to attend labour ward	At point of escaltion
ELECTIVE ACTIVITY		
Head of Service/ DoM/HOOP	Elective operating should be paused	At point of escalation and plans for preceding 48hrs until de-escalation
Head of Service/ DoM/HOOP	Induction of labour should not be started or continued	At point of escalation and plans for preceding 48hrs until de-escalation
Home Birth Team Service		

Appendix 4: Key stakeholders to be informed of temporary diversion or whole service closure

Stakeholder	To be informed of		Date and time contacted	Name of person contacted and method of contact	Date and time informed of re- opening
	Diversion	Closure			
East & West Midlands Ambulance Service	✓	✓			
Neighbouring maternity units	✓	✓			
Integrated Care Board System Coordination Centre (In hours)/ICB On Call (Out of hours)		✓			
Manager of the day	✓	✓			
Delivery suite coordinator	✓	✓			
Matrons	✓	✓			
DoM/HoM	✓	✓			
HOOP/DHOOP	✓	✓			
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 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	✓	✓			
Security as per local arrangements	✓	✓			
Trust comms team	✓	✓			
Form Completed by		Job title			

Appendix 5: Flow Chart for Diversion of Maternity Services



Appendix 6: Midlands RCC Maternity Escalation Template

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 7: Transfer Apology Letter

Insert Trust Logo

Insert Trust Address & Contact

[Insert Date]

[Insert Patient Details]

Dear....

Diversion of care to (Insert Trust/Site)

We would like to apologise to you for any inconvenience caused when we recently had to close our maternity unit 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 close our maternity unit 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.

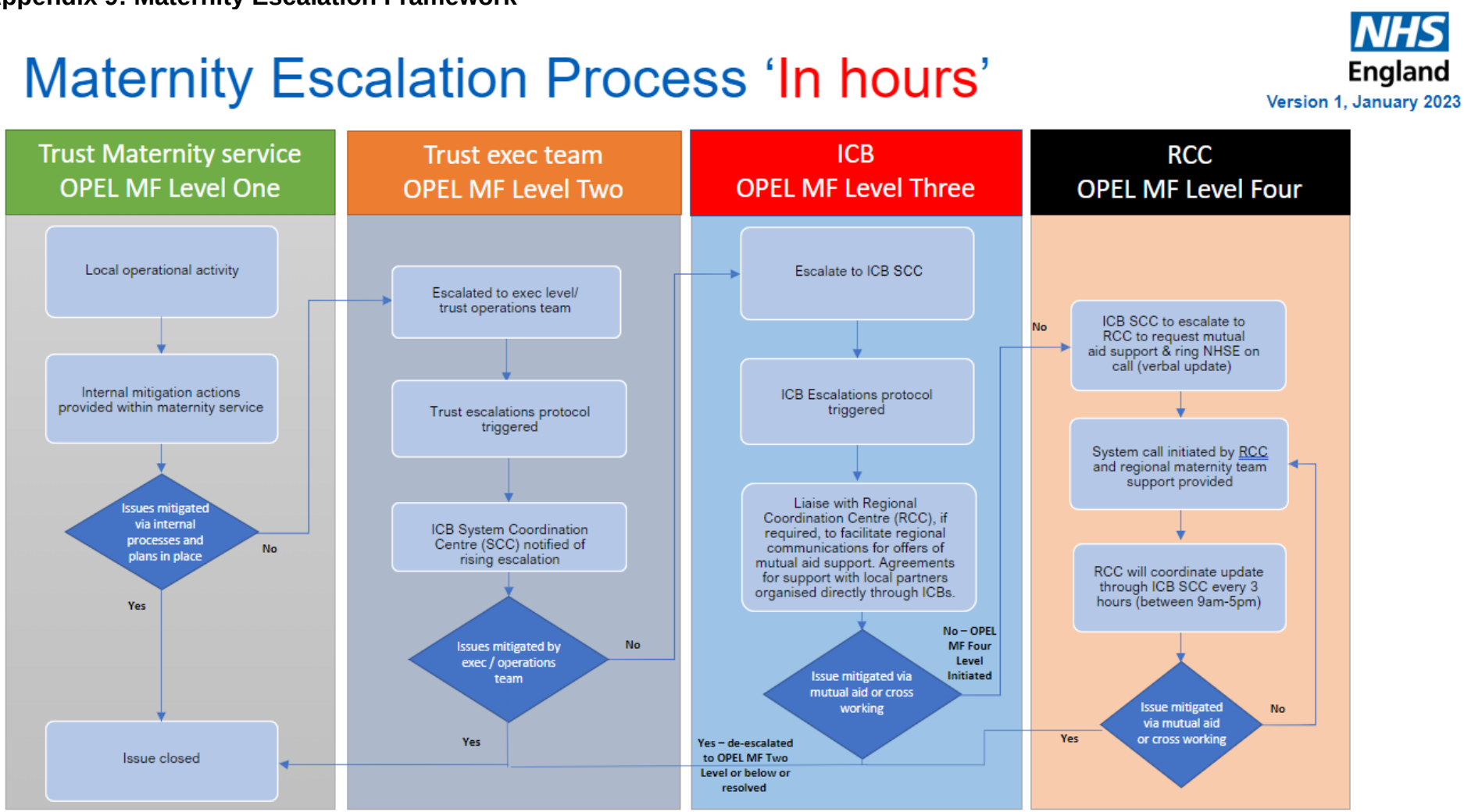
Yours Sincerely

(Insert Name)

Appendix 8: 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	
Designation	
Date	

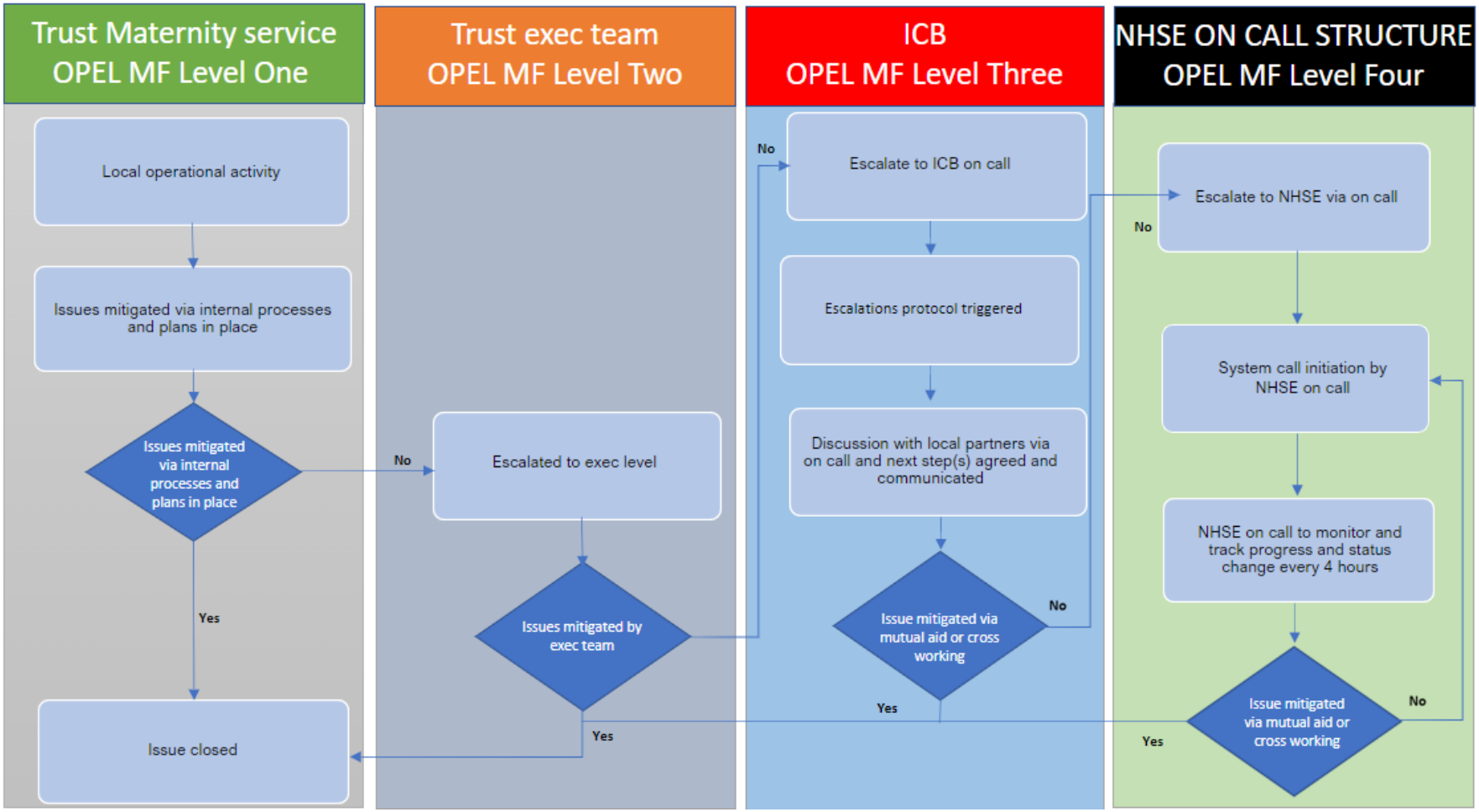
Appendix 9: Maternity Escalation Framework



Maternity Escalation Process 'Out of hours'

NHS England

Version 1, January 2023



Appendix 10: 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

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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
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	0115 9709777	0115 969 1169	Hucknall Road	Nottingham	Nottinghamshire	NG5 1PB
	Queens Medical Centre (QMC)	0115 9709777	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

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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