Neonatal Unit Medical and Nursing Escalation Policy

NHS University Hospitals of Leicester NHS Trust

C26/2009

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1. Introduction and who this document applies to:

This policy applies to all patients that present to the Neonatal Services of the University Hospitals of Leicester NHS Trust and is to be followed by all nursing and medical staff within the Neonatal Services and relevant associated Trust staff.

1.1 Key Points

The policy outlined below sets out appropriate actions to be taken in the event of short-term critical staffing shortages and/or capacity issues.

At University Hospitals of Leicester there is one neonatal service based on two sites at Leicester Royal Infirmary and Leicester General Hospital. The purpose of this policy is to:

a) Provide a safe service
b) Ensure extreme preterm babies receive care in the right place (EMNODN in Utero Transfer Policy, 2020)
c) Take steps proactively to provide wherever possible, capacity for those babies requiring neonatal surgery
d) Prevent closure to admissions
e) Ensure appropriate steps are taken if transfer of activity is unavoidable
f) Ensure appropriate steps are taken if closure is unavoidable
g) Describe further possible contingencies if closure of services is not possible

The Nurse in Charge (NIC) of the affected site will co-ordinate the neonatal escalation policy, liaising with the Matron for Neonatal Service.

2. Policy statement

The prime concern is the safety of babies and to ensure that the service fulfils its role as a tertiary unit and surgical centre for the network. The service will only close to admissions as a last resort after a clinical assessment of the risks and all options for the transfer of activity within the neonatal service have been explored. The decision to close the Neonatal Services rests with the Clinical Lead for Neonatal Service in line with the escalation policy.

Nurse staffing levels are calculated through the use of an acuity assessment tool, using BAPM standards (2011) and through 'SafeCare Live', a trust wide nurse staffing calculator. Both are completed at the start of each shift. This information is then used to complete the East Midlands Neonatal ODN 'OPEL and Surge Plan data tool' which is submitted daily. However, should any significant changes occur, either to activity staffing levels, then a further assessment should be completed contemporaneously, using both tools.

Both medical and nurse staffing levels should be considered across both sites. Nevertheless, it is recognised that there are inherent risks with staff working in unfamiliar areas. Any decision to move staff from one site to another should be done within the context of contemporaneous acuity assessment of both sites to ensure risks are identified and managed according to greatest need. This option should be considered before proposing the movement of the baby or the pregnant mother prior to admission.

2.1 Prevention

It is expected that the Neonatal units will communicate frequently to have an awareness of neonatal activity across Leicester on a shift to shift basis.

The need to either transfer activity or to close the service to admissions usually stems from one main cause:

Insufficient staff:
The principles of the Neonatal Staffing Guidelines (see Appendix 1) and the escalation process (Appendix 2) should be followed.

2.2 Assessment

An assessment of the activity, acuity and staffing will be undertaken at the start of each shift and additionally, in the event of activity peaks and changes to staffing levels. (See appendix 5). The Nurse in Charge (NIC) will attend the Obstetric 'safety huddle' at commencement of each day shift, so that any potential high risk deliveries can be factored into multi-disciplinary planning.

2.3 Information

At all stages it is important to keep the appropriate people informed of the situation. (See appendix 6).

2.4 Transfer of activity

An agreement for a transfer of activity from one site to other, e.g. low dependency babies to LGH will be Multi-Disciplinary Team (MDT) decision made by Consultant Neonatologist and Nurse in Charge. When a baby is admitted to the Neonatal Service, parents will be given information about the configuration of the service and informed proactively of the likelihood that their baby will be transferred to another centre as part of the 'step down' process to create intensive care capacity.

All babies suitable for transfer to Local Neonatal Unit or special care within the network, or repatriation, should be identified before morning handover by the Nurse in Charge and discussed after handover with the consultant neonatologist. Escalation policies should be initiated should repatriation not be possible, which in the first instance, should be to the service Matron.

2.5 Closure of service

If after following the stepwise escalation process, the problems cannot be resolved within Leicester it may be necessary to close Leicester neonatal Units to external admissions. All inborn babies requiring neonatal care will be stabilised. A decision will then be made regarding ongoing clinical care and whether it is appropriate to transfer care to another neonatal unit. This will be a MDT decision made by Consultant Neonatologists and Nurse in Charge and escalated in line with requisite UHL policies. However, it is an aim of the service not to transfer those babies born less than 27 weeks gestation out of Leicester until clinically appropriate.

2.6 Incident reporting

Closure of the neonatal service/or instigation of the escalation policy are both considered as clinical incidents and an incident form must be completed. The number and dependency of the babies, numbers and grade of staff should be recorded on the incident form.

2.7 Audit and monitoring

Records of closure or implementation of escalation plan will be maintained; including details of babies refused admission and referred or transferred. The network exception reporting process should be used to report this as per guidelines.
https://www.emnodn.nhs.uk/media/1472/emdodn-exception-reprting-form-v1-online.pdf

In summary an exception report form should be completed for the following circumstances relating to capacity:

1. Inability to accept an admission for intensive care, or surgical care
2. Inutero transfer refused due to neonatal capacity or staffing
3. Babies>44/40 still on neonatal unit
4. Capacity transfer out of the Leicester Neonatal Service
5. Babies from LGH that require escalation of care that are transferred out of the Leicester Neonatal Service
6. Inability to repatriate due to lack of costs of staff
7. Babies cared for at LGH that are out with the agreed EMNODN care pathway
   http://media.wix.com/ugd/143840 c3c69ea7f72e4cb4a58c1be838fc47d.pdf

The Neonatal Clinical Governance Group will be responsible for monitoring the episodes and reporting through Directorate Governance process.

3. Education & training:

None

4. References

None

5. Keywords:

Acuity assessment tool, East Midlands Neonatal ODN 'OPEL, Surge Plan data tool, Transfer

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) Jo Behrsin – Consultant Alison Nield - Sister			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
Sept 2009	**1**	Original guideline (C Bacon, L Harrison, J Foxon)	
Jun 2016	**2**	Marie Hoy Neonatal Guidelines Meeting	
Sept 2019	**3**	Jo Behrsin, Alison Nield Neonatal Guidelines Meeting	
Feb 2021	**4**	Jo Behrsin, Alison Nield	Guideline update
September 2022	**5**	Guideline and Governance Meeting	Reviewed and Ratified Changes made; Key points added to acknowledge EMNODN policy When closed to external admissions, to stabilise inborn babies. Summary of when exception report should be completed
Jan 2024	**6**	Jo Behrsin, Katherine Millard	Medical Staffing Appendix updated in-line with latest rota templates / and to reflect CenTre move to Castle Donnington

Appendix 1: Neonatal Nurse Staffing Guidelines

Off Duty Planning

- Off duty is completed via E-roster (see attached policy) Staff Rostering Policy and Procedure.pdf
- All off duty requests / annual leave should be made via E-roster and authorised by line manager.
- A variety of shift patterns are offered in conjunction with Improving Working Lives
- Flexible working is available – should be formerly requested and authorised and reviewed yearly.

Staffing

The aim of the off duty is to provide staffing of an appropriate skill mix to meet service needs

Skill Mix

Aim to achieve 70:30% ratio of registered nurses, qualified in specialty: registered nurses not qualified in specialty.

Off duty process

- Document all annual leave
- Maintain Skill Mix
- Check hours rostered are correct for each individual
- All priority shifts should be covered
- An attempt should be made to cover short falls with bank or extras
- Submit the off duty to unit manager for checking

Appendix 2: Combined LRI/LGH nurse staffing escalation process

Assessment of risk

Nurse in charge at both sites:

- Complete acuity assessment tool / safe-care live / surge form at the start of each shift
- Feed results of acuity assessment and any nurse staffing shortfalls into 9am ;medical handover round'
- Acuity assessment / safe care live should also be completed 'in shift' if there are significant changes to activity or nurse staffing levels
- Use acuity assessment tool / safe care live to determine whether safe staffing levels have been breached at any point (use professional judgement to assess whether it is possible to deliver care safely:- baby out for scan / theatre, in conjunction with acuity assessment tool)

Immediate actions:

- Check opposite site to see whether staff can move to provide cover
- Check duty rota to see if staff can be moved from another shift to cover
- Send out text / seek help via appropriate social media groups to see whether staff willing to come in at short notice
- Call paediatric bleep holder (LRI only) to check for available cover
- Assess availability of non-clinically based staff and ANNP team

Intermediate actions:

- Inform consultant on service if cover not available
- In conjunction with Neonatal Consultant, consider whether 'cohorting' care temporarily will alleviate breach of safe staffing levels
- In conjunction with Neonatal Consultant, consider whether cots should be closed to external admissions temporarily
- Escalate via 'requisite' UHL policies (bed coordinator / CMG rep for the tactical command for the day if 'in hours' and via 'on call manager – women's if out of hours). In the first instance, the women's out of hour's on-call manager should be contacted via switchboard.
- Complete Datix incident form detailing occupancy / acuity / gap between required and actual staff
- If costs are closed email network to enable implications

Appendix 3: Medical Staff

Medical rotas can be challenging as posts are sometimes unfilled and in addition there can be unexpected circumstances such as staff sickness that can lead to rota gaps. This escalation process has been put in place to mitigate the risk of unfilled shifts and hence continue to provide safe clinical care for the babies on the neonatal units at both LRI and LGH.

Junior Medical Staff and ANNP's

We have put in place mitigations to minimise the need to follow these immediate actions by separating out the ANNP cover from the medical tier 1 & tier 2. In addition, the JDA team and consultant (tier 1, tier 2) rota co-ordinator work to review the rota and swap shifts around known rota gaps or fill with locums from the locum bank. However, despite this sometimes gaps remain or there may be short-notice absence e.g. due to sickness.

The step wise approach to covering the Neonatal Service would be as follows:

1. JDA to email all current members of staff asking if they can offer additional cover for the gap. Children's JDA to approach all Paediatric trainees as well about Neonatal rota gaps. Trainee WhatsApp group also to be messaged asking if anyone available.
2. ANNP team leader to approach ANNP team to ask if they can provide additional ANNP cover to support the service (via WhatsApp).
3. JDA to escalate through locum bank-text to be sent out and all avenues explored through them.
4. JDA manager to pursue an agency locum. Head of Operations to authorise before booking.
5. If additional cover has been unsuccessful by 72 hours then JDA to contact the consultant on service and consultant covering the non-resident night to enable a skill mix review to be performed. This will enable a decision to made around whether the gap is critical
6. **If the output of this review is that a critical gap remains or there are still concerns about skill-mix then to discuss with HoS, or CMG lead to authorise the next steps and feed into the CMG tactical daily huddle. (Table 1 describes usual staffing and definition of critical gaps).**
7. Consultant on service to review trainee rota and trainees asked to move from daytime cover shifts to OOH. HR have clarified that for known rota gaps we cannot contractually make a trainee cover the service; we can only appeal to their good will. Any additional shifts added would need to meet Junior Doctor Contract Rules.
8. Review jaundice clinic provision to see if the ANNP can be redeployed and follow processes to close clinic
9. To review whether it is possible for a consultant to undertake an "acting down registrar shift", Advertise vacant gaps to consultant body, to be paid at trust approved acting down rates and accept service implications for next 24 hours. This advert should go to all general paediatric and paediatric intensive care consultants in the CMG.
10. Head of Service or Clinical Director to contact the consultant team to see if an additional consultant is available to cover LGH overnight so that the rostered on-call consultant can cover LRI and attend if needed from an acuity perspective. This may have implications for duties the following day. Pay the Neonatal Consultant locum rate of pay for this shift and accept service implications for subsequent 24 hours.

11. Head of service to request cross cover from Paediatric Services. Overnight there are 3 Paediatric Registrars on the LRI (CICU, ED and General Paediatrics). This option may have other implications for the paediatric service.

12. Further escalations

a. If with 4 hours left before the unfilled shift (this should be required in exceptional circumstances only due to mitigations above):
b. Escalate to Gold Command / Director on call
c. Move available staff to provide cover at the LRI site where the sicker babies are locate
d. Close the LGH to deliveries and provide F2/ST1-3 or ANNP cover alone at the LGH site for emergency resuscitation and to care for the level 1 babies at this site
e. Complete Datix incident form.

Table 1:

Shift	Staff type	LRI		LGH	
		Ideal staffing	**Critical Gap**	**Ideal staffing**	**Critical gap**
M-F 9-5	Tier 1	4	Weekend cover only (2 tier 2, 3 tier 1 and 1 ANNP (ANNP may be substitute for tier 2 if appropriately skilled)	2	Less than weekend cover as there is a separate consultant covering LGH
	Tier 2	3		1	
	ANNP	1		0 (ANNPs may be substituted for either tier if appropriately skilled.)	
M-F Evening cover	Tier1	2	<2tier 2 (an ANNP may be considered replacement for tier 2 if appropriate skillset) Or < 3 staff on shift Or If there are 3	1	Critical evening gap at LGH would be a single practitioner particularly if this is at tier 1.
	Tier 2	2		1	
	ANNP	1		0 (ANNPs may be substituted for either tier if appropriately skilled.)	

			staff working consultant to check skill mix is acceptable for current level of acuity		
Weekend or Bank Holiday Long Day	Tier 1	2	<2 tier 2 Or < 4 staff on shift (this enables PNW and NNU cover) Or If there are 4 staff working consultant to check skill mix is acceptable for current level of acuity	1	Critical evening gap at LGH would be a single practitioner particularly if this is at tier 1.
	Tier 2	2		1	
	ANNP	1		0 (ANNPs may be substituted for a tier 1 as they are currently covering 2 LGH slots)	
Night	Tier1	1	<2 tier 2 Or < 3 staff on shift Or If there are 3 staff working consultant to	0	No cover
	Tier 2	2		1	
	ANNP	1		0 (A suitably trained ANNP may replace tier 2 doctor)	

			check skill mix is acceptable for current level of acuity		

Considerations when assessing skill-mix:

- **Current acuity**
- **Expected admissions and anticipated workload**
- **Known skill level of individuals covering**
  This is applied when we are in a situation that an additional ANNP or tier 1 factored into shift cover for numbers on shift

Consultant Rota Gaps

Weekday Service Gaps

- Predictable gaps circulated to the consultant team by email for volunteers and pay at appropriate locum rates
- Unpredictable gaps, head of service or rota co-ordinator use WhatsApp to alert team to gaps and try to request cover
- If nobody is available to cover move to two consultants on service one for each site and request for consultant team to be available onsite at LRI should acuity require this
- HoS to review consultant rota and prioritise SPA activities to allocate a consultant to the appropriate area.

Non-Resident On-call Gaps

- Predictable gaps circulated to the consultant team by email for volunteers and pay at appropriate locum rates
- Unpredictable gaps, head of service or rota co-ordinator use WhatsApp to alert team to gaps and try to request cover
- Review the resident on-call allocation to determine the feasibility of covering non-resident cross-site cover for the night. This may require a different consultant to be resident for the evening depending on resident shift pattern.
- HoS to review consultant activity and allocate to ensure service is covered safely.

Resident Oncall Gaps

- Predictable gaps circulated to the consultant team by email for volunteers and pay at appropriate locum rates
- Unpredictable gaps, head of service or rota co-ordinator use WhatsApp to alert team to gaps and try to request cover
- Consider whether non-resident consultant needs to be resident at LRI and provide cross-site cover overnight
- Advertise for a second consultant to cover Leicester General and provide second on-call to LRI overnight
- Escalate that there will cross-site cover only from the non-resident consultant with no resident tier

Appendix 4: Managing Capacity within the UHL Neonatal Service

The neonatal service is commissioned to provide 12 SCBU cots at LGH, 18 ITU/HDU & 12 SCBU costs at LRI.

Capacity problems can be avoided to some extent by managing flow within the Leicester Neonatal Service and wider East Midlands Neonatal ODN (EMNODN) exploring timely repatriation when a baby is fit for transfer close to home and liaising with the obstetricians around the timing of delivery.

Cots may need to be closed due to inadequate staffing (medical or nursing) or the service may be unable to accept a baby due to too many babies being care for within the neonatal service above these commissioned numbers.

To support decision making with regard to staffing and capacity problems, two planning tools have been agreed; acuity assessment and safe-care live. Nevertheless, due to complex and dynamic circumstances, it may not always be possible to clearly define what constitutes 'closed'. In such circumstances, professional judgement must be deployed to support the decision to close cots. To assist in this process and to mitigate inconsistencies, the service has developed a Capacity Assessment Tool (Appendix 7) which takes account of 4 key areas: capacity, geographical staffing, acuity assessment and staffing rosters. This should be considered by the NIC and service Consultant before taking the decision to close cots.

Professional judgement is of particular relevance when ITU/HDU capacity is above the commissioned maximum (10 ITU and 8 HDU) but when the number of babies admitted to the unit falls short of the maximum capacity of 30.

To ensure that the service is optimally placed to accommodate the sickest and most complex babies, it is vital that plans to utilise other units within the network/repatriation/transitioning to the children's services are done well in advance. Agreement between the NIC and Consultant on Service must be made on a daily basis of those babies who fall into these categories so that contingency plans are in place should the need arise. Ideally this should be agreed during the 09:00hrs 'handover round'. Steps should be taken to ensure any spare capacity at LGH is filled by appropriate babies on a rolling basis. To enable a timely and managed approach to create capacity, it is vital that steps are taken well in advance of the event occurring. To enable this regional capacity for special care and high dependency needs to be utilised proactively and that steps are taken at the earliest opportunity to transfer suitable babies out of Leicester Royal Infirmary. It may also be appropriate to transfer suitable babies out of Leicester Royal Infirmary. It may also be appropriate to move babies out of network if they reside close to other network boundaries e.g. George Elliott Hospital in SWMNODN and Peterborough in EOE.

(Calculating Unit Cot Numbers and Nurse Staffing Establishment and Determining Cot Capacity: 2019)

Stepwise Approach to managing capacity on a daily basis:

1. Identify those SCBU babies suitable for transfer to LGH. This should be agreed between the NIC and Consultant on service directly following the morning ward round.
2. Identify those babies that are fit for repatriation to unit of booking. Plans to repatriate appropriate babies should be initiated at the earliest opportunity.
3. Discussion with children's services about transferring those babies approaching 44 weeks corrected gestational age should be initiated when the baby approaches 40 weeks CGA. These discussions should be ongoing with contingencies agreed in advance should neonatal capacity be required at short notice.
4. Identifying a list of babies for possible capacity transfer out should the need arise.

(Steps 1-4 should be part of the routine day to day working and revisited should the unit be full).

Acute Admission that takes unit over safe capacity

Is inborn baby stable and >27 weeks?

If yes arrange transfer out

If "no", identify those babies that are fit for transfer to another local neonatal unit or special care within network and arrange transfer after discussion with parents and receiving unit.

It is not appropriate to transfer out inborn <27/40 except in extreme circumstances.

Inability to accept a regional baby e.g. due to cooling, extreme prematurity, surgery:

Managing capacity around this group of babies is complex – the following options should be worked through with the service consultant and nurse in charge:

1. Ensure the generic capacity management has been performed (steps 1-4)
2. Are there babies who could be transferred to another centre in the region. Consider
    - Clinical needs
    - Geography
    - Social
3. Is there another tertiary cot that could accommodate the baby in another network that is an acceptable distance?

Discussions between Leicester Neonatal Service and Centre Transport team should be initiated at the earliest opportunity)agree trigger point) when it becomes clear that 'capacity transfer' might be needed to facilitate an acute admission from within south hub of EMNODN.

The CenTre Neonatal transport service can facilitate with cot locating if a baby requires transfer out. When making a referral ensure that CenTre are aware that this is a "capacity" transfer.

Stepwise Approach to managing capacity (network extreme premature baby or surgical admission)

Discussions between Leicester Neonatal Service and Centre Transport team should be initiated at the earliest opportunity (agree trigger point) when it becomes clear that 'capacity transfer' might be needed or to arrange for the transfer of those babies (pre-agreed) requiring high dependency or special care to other suitable units within the network, in the first instance.

The CenTre neonatal transport service can facilitate with cot locating if a baby requires transfer out. When making a referral ensure that CenTre are aware that this is a "capacity" transfer.

Appendix 5: Steps to manage difficulties with repatriation / impact upon ability to accept complex referrals / inborn admissions

1. Service consultant Leicester to discuss with service consultant receiving unit
2. NIC to escalate to service matron
3. Consultant on Service / Nurse in charge to escalate via CMG rep / tactical command in hours or, women's on call manager on call ' out of hours' via switchboard
4. Service consultant to Inform East midlands Neonatal Network by email
5. Complete Datix incident form and exception report

Appendix 6: Criteria for Acuity Assessment Tool

(The Acuity Assessment tool is used across both sites. The format for the tool itself may change, but the criteria remain the same until otherwise indicated by BAPM)

Dependency	Definition	Guideline Criteria (BAPM 2011)

A	**ITU 1:1**	• Any day where a baby receives any form of mechanical respiratory support via a tracheal tube
		• BOTH non-invasive ventilation (e.g. nasal CPAP, SIPAP, BIPAP, Vapotherm) and PN
		• Day of surgery (including laser therapy for ROP)
		• Day of death
		• Any day receiving any of the following
		    ○ Presence of an umbilical arterial line
		    ○ Presence of an umbilical venous line
		    ○ Presence of a peripheral arterial line
		    ○ Insulin infusion
		    ○ Presence of a chest drain
		    ○ Exchange transfusion
		    ○ Therapeutic hypothermia
		    ○ Prostaglandin infusion
		    ○ Presence of replogle tube
		    ○ Presence of epidural catheter
		    ○ Presence of silo for gastroschisis
		    ○ Presence of external ventricular drain
		    ○ Dialysis (any type)

B	**HDU 2:1**	Any day where a baby does not fulfil the criteria for intensive care where any of the following apply:
		• Any day where a baby receives any form of non-invasive respiratory support (e.g. nasal CPAP, SIPAP, BIPAP, HHFNC)
		• Any day receiving any of the following:
		    ○ parenteral nutrition
		    ○ continuous infusion of drugs (except prostaglandin &/or insulin)
		    ○ presence of a central venous or long line (PICC)

		○ presence of a tracheostomy ○ presence of a urethral or suprapubic catheter ○ presence of trans-anastomotic tube following oesophageal atresia repair ○ presence of NP airway/nasal stent ○ observation of seizures / CF monitoring ○ barrier nursing ○ ventricular tap
C	**Special Care 4:1**	Any day where a baby does not fulfil the criteria for intensive or high dependency care and requires any of the following: • oxygen by nasal cannula • feeding by nasogastric, jejunal tube or gastrostomy • continuous physiological monitoring (excluding apnoea monitors only) • care of a stoma o presence of IV cannula • baby receiving phototherapy • special observation of physiological variables at least 4 hourly

NIC daily 'quick' checklist to manage capacity / nurse staffing shortfalls

1. Complete acuity assessment tool / safe care live at the start of each shift
2. Agree any spare capacity at LGH for the proactive transfer of babies from LRI to LGH have this information ready to input into morning Obstetric 'safety huddle'
3. Inform service matron / unit manager of nurse staffing shortfalls / any difficulties encountered in repatriation / referral to other specialities is likely to affect whether service open / closed
4. Tactical command / on call manager will call for information regarding bed status / whether unit open or closed / any nurse staffing shortfalls which may affect whether service is open to external admissions

   NIC should advise whether open or closed to external admissions (using acuity assessment tool and safe acre live); list number of ITU A, HDU B and SCBU D and E category babies; subsequent nursing shortfall

   If nursing shortfall, NIC should provide brief summary of steps taken to manage this

   If the unit is 'closed' to external admissions, NIC should provide brief summary of reasons why – i.e. difficulties in repatriating babies to referring unit, steps taken thus far to manage this.

   Not all senior managers are familiar with the neonatal service. To minimise the risk of confused messages, please consider providing the following information:

- Confirm if current ITU / HDU activity is above commissioned levels (10 ITU 8 HDU maximum total of 18) especially if overall, activity levels are less than the maximum of 30 babies
- Identify the nursing shortfall in relation to ITU / HDU and not just overall nursing requirements for the shift
- Identify if the NIC has a workload / remains supernumerary
- Re-emphasis that the service will continue to provide stabilisation for any inborn baby, irrespective of current cost status
- Identify any pending clinically urgent admissions

5. Attend 09:00 hrs medical 'handover' round on neonatal unit. Advise re results of acuity assessment, pending deliveries and any nurse staffing shortfalls for the coming shift. In conjunction with Consultant on service, identify pending discharges and those babies suitable for relocation to LGH / other level 2 / 1 units in network. NIC and service consultant to agree OPEL status.

   If in the event there is a decision taken to temporarily close cots, ensure local and EMODN escalation policies followed

6. Decide jointly with consultant on service whether remedial action likely to be successful, or whether it is necessary to escalate directly to 'Director on Call / CMG rep for the day Command' if any of the above likely to affect ability to accept referrals / in-born admissions.

Appendix 7: Capacity Assessment Tool

	Red Flags	Amber Flags	Green Flags
Capacity	0 cots and no movement and imminent internal admission/s on delivery suite	1 cot but NO movement Imminent internal admission/s on delivery suite	cot or more + movement No imminent admissions on delivery suite
	Consider each area (ITU/HDU and Special Care)		
Geographical Staffing	staff on shift less than 2 QIS staff to each ITU/HDU occupied room SCBU QIS Coordinator NIC not supernumerary Isolation room open	staff on shift enable 2 QIS staff to each ITU/HDU occupied room SCBU QIS Coordinator BUT NIC NOT supernumerary	if staff on shift enable 2 QIS staff to each ITU/HDU occupied room Supernumerary NIC and SCBU QIS coordinator
Acuity Assessment	Acuity assessment is at red	Acuity assessment is at amber BUT manageable shortfall in staffing	BAPM safe staffing levels met on acuity assessment
Staffing rosters (medical and nursing)	Known sickness / rota gaps but NO cover Known sickness / rota gaps long term and include QIS / senior staff	Known sickness / rota gaps over next 48 hrs with cover pending Sickness / rota gaps short term	No known sickness / rota gaps for next 48 hr period
The consultant and nurse in charge should consider each of the following areas and determine how many red flags there are to assess overall status			
Cot Status	RED	AMBER	GREEN