Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

MATERNITY ESCALATION and SUSPENSION OF ACUTE MATERNITY SERVICES POLICY

OPERATIONAL POLICY

Reference	CPG-SP-MAT-ME&SoAMSPol
Approving Body	v8.0, Maternity and Gynaecology CG Meeting v8.1, agreed locally following an incident
Date Approved	v8.0, 27th January 2020 v8.1, September 2023
Issue Date	v8.0, 20th February 2020 v8.1, 14th September 2023
Version	8.1
Summary of Changes from Previous Version	v8.1 • 6.1/ page 6/ Expanding bed space and Appendix A (Plans A, B, C & D): wording amends made to include action required when capacity exceeds the beds required to admit a patient. Amend made in response to an incident. v8.0 • Acute Maternity Capacity Management Plan updated along with telephone number chart for surrounding hospitals
Supersedes	Version 8.0, (CPG-SP-MAT-EOPiMS), Issued 20th February 2020 to Review Date December 2023 (ext4)
Document Category	• Clinical
Consultation Undertaken	• Coordinating Midwives • Senior Midwives • Consultant Obstetricians • Duty Nurse Manager • Bronze and Silver on Call
Date of Completion of Equality Impact Assessment	January 2020
Date of Environmental Impact Assessment (if applicable)	*N/A*
Legal and/or Accreditation Implications	*None*
Target Audience	• Midwives • Obstetricians • Bronze and Silver on Call • Duty Nurse Manager
Review Date	December 2023 (ext4)
Sponsor (Position)	Penny Cole (Acting Divisional Head of Nursing and Midwifery)
Author (Position & Name)	Paula Shore (Interim Matron for Maternity Governance) and Sarah Sarjant (Clinical Risk Midwife)
Lead Division/ Directorate	Women and Children
Lead Specialty/ Service/ Department	Maternity

Position of Person able to provide Further Guidance/Information	Paula Shore

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
1. Suspension of Acute Maternity Services SOP	January 2020

CONTENTS

1.0 INTRODUCTION

During periods of high activity and an increased demand for bed capacity, or in the event of reduced staffing levels, maternity providers may need to temporarily suspend maternity services. The Temporary suspension of maternity services should only be considered when all good practise options have been exhausted, as the consequence to the women, their families and other neighbouring units must be appreciated. When factors which precipitated the temporary diversion and/or suspension of maternity services are resolved, the process of suspension should be reversed as soon as is practicable.

The temporary suspension of the Neonatal unit does not result in the suspension of a maternity unit. High risk babies who may potentially require neonatal services should be assessed on an individual basis with joint consultation by the Consultant Obstetrician and Consultant Neonatologist on call. These in utero babies may require transfer to a neighbouring obstetric unit with more suitable neonatal facilities.

2.0 POLICY STATEMENT

This operational policy is applicable to all clinical professionals and identifies actions to be taken to effectively utilise available staff and resources. This policy has been designed to be followed in the event of temporary diversion and suspension of a maternity service ensuring a consistent and clear approach.

This clinical document applies to:

Staff group(s)

- Midwives
- Obstetricians
- Neonatal Team
- Bronze and Silver on Call
- Duty Nurse Manager

Clinical area(s)

- All Maternity areas
- Neonatal Unit

Patient group(s)

- Maternity patients

Exclusions

- None

3.0 DEFINITIONS/ ABBREVIATIONS

CCOT	Critical Care Outreach Team
DHoNM	Divisional Head of Nursing and Midwifery
DNM	Duty Nurse Manager
IOL	Induction of Labour
IPOC	Immediate post-operative care
ITU	Intensive Therapy Unit
MCOC	Midwifery Continuity of Carer Team
MSW	Maternity support worker
NICU	Neonatal Intensive Care Unit
PDC	Pregnancy Day Care
RM	Registered Midwife
SBU	Sherwood Birthing Unit

4.0 ROLES AND RESPONSIBILITIES

<table>
<tr><td></td><td></td></tr>
<tr><td>Co-ordinating Midwife</td><td>

Green status: the Co-ordinating Midwife is aware at all times of the level of activity and staff available across the acute maternity service, including planned admissions to SBU, PDC and the maternity ward.
Amber status and above: the role of the Co-ordinating Midwife will differ depending upon the hours in which the escalation occurs.

<table>
<tr><th>Working Hours (9-5 Monday to Friday)</th><th>Out of Working Hours</th></tr>
<tr><td>• Co-ordinating Midwife will remain clinically based and will liaise with the Senior Midwifery team</td><td>• Co-ordinating Midwife will liaise directly with the Consultant Obstetrician on call</td></tr>
<tr><td>• Senior Midwife takes responsible for the suspension/</td><td>• Coordinating Midwife to take responsible for the escalation</td></tr>
<tr><td>• Inform Duty Nurse Manager and Silver on Call of the decision to suspend maternity services and all actions leading to this.</td><td>• Inform Duty Nurse Manager and Silver on Call of the decision to suspend maternity services and all actions leading to this.</td></tr>
</table>
</td></tr>
<tr><td>Senior Midwife</td><td>

During working hours a Senior Midwifery team member will co-ordinate any suspension, as per the Acute Maternity Capacity Management Plan and inform Bronze on Call and DNM They will be required to complete the closure report (Appendix B) and attach this with the Birthrate plus reports to the supporting Datix within 5 working days of the suspension.

</td></tr>
</table>

Divisional Head of Nursing and Midwifery	• **During working hours** the Divisional Head of Nursing and Midwifery (DHoNM) will support the Senior Midwifery team by directly liaising with Gold on call. • **Out of working hours** it is important that the Co-ordinating Midwife informs the DHoNM of decision for temporary suspension of service via email.
Obstetric Consultant	• The Obstetric Consultant will work with the Co-ordinating Midwife closely on a regular basis to ensure effective prediction and management of the flow and activity within the whole maternity unit. At times of escalation they need to be involved in any decision making for the suspension of service of the unit.
Bronze on Call	• **During working hours** if the Senior Midwifery team is unavailable then the Bronze on call for the division will help to co-ordinate any suspension , as per the Acute Maternity Capacity Management Plan and they will inform the DNM.
Silver on Call	• **Out of working hours** the Silver on Call will work closely with the Co-ordinating Midwife and Obstetric Consultant to ensure that the Acute Maternity Capacity Management Plan (Appendix A) has been maximised
Duty Nurse Manager	• **Out of working hours**: the Duty Nurse Manager will work closely with the Co-ordinating Midwife and Obstetric Consultant to ensure that the Acute Maternity Capacity Management Plan (Appendix A) has been maximised

NB: the above team members can be contacted through switchboard who will direct the call to the named member of staff for that shift.

5.0 APPROVAL

Following appropriate consultation, this operational policy (v8.0) has been approved by the trust's Maternity and Gynaecology Clinical Governance Group.

6.0. DOCUMENT REQUIREMENTS (NARRATIVE)

6.1. Day to day management of the maternity unit

Reducing admission:

On a day to day basis, management of SBU is coordinated by the Co-ordinating Midwife and supported by Senior Midwives for all clinical areas in conjunction with the Obstetricians, Anaesthetist and Neonatologists. This requires everyone to work as a team and communicate effectively with each other. The Co-ordinating Midwife and the Midwife in charge of the Maternity ward should assess workloads within the unit throughout the day Acuity should be reviewed using Birthrate plus 6 times during a 24 hour period and should be used to standardise this assessment. Regular liaison must occur at least twice a day between SBU and all clinical areas including the Neonatal Unit and Pregnancy Day Care.

Reducing admission is further supported by the SBU triage standards which are taken from a national model. These standards clearly set out parameters for midwifery and obstetric staff to assess the degree of urgency of the individual clinical presentation and refer the woman to the appropriate area. The aim is to standardise care, minimise any delays in treatment, make sure the correct referral processes are followed and reduce unnecessary admissions.

Expanding Bed Space:

The aim where possible, is to maintain enough empty beds throughout the unit at all times, and to effectively manage the flow of activity within the unit. When bed pressures are anticipated staff need to be proactive: review elective work (induction of labour, elective caesarean section) and review postnatal women for suitability of transfer home from the maternity ward or directly from SBU. Ensure appropriate plans are made to aid early transfer home from both SBU and the maternity ward as soon as possible. Following clinical assessment it may be suitable to be admitting women to a differently speciality with an explicit plan for their obstetric review and midwifery input.

During working hours if admission is required to another speciality or if at any point bed capacity exceeds the beds required to admit a patient, an individual assessment of risk is to be undertaken by the midwife and escalation made initially to the SBU coordinator who will discuss with the Senior leadership team/ Bronze on call for the Division to ensure a safe admission can take place. Out of working hours the Coordinating Midwife should liaise directly with the obstetric consultant and DNM.

Promoting Discharge:

During periods of higher acuity the Co-ordinating Midwife and Ward Leader/ Midwife in Charge of the Maternity ward should have regular updates in regards to bed capacity and should promote discharges. Further to this reviews of postnatal women for suitability of transfer home directly from SBU should happen. Within the MDT early escalation should occur as to factors which may delay discharge such as Senior Review's and TTO's so these can be actioned promptly.

6.2. Management of Staffing

It is not feasible to state a definitive number of staff needed in an area; this will vary according to the activity and dependency of women and their babies. However, for the purposes of duty rosters, the agreed minimum midwifery staffing numbers across SBU and the Maternity ward, when the off duty is published, should be 10 midwives on a day shift and 10 midwives on a night shift. In addition it is imperative that all rosters are completed with consideration to appropriate skill mix.

Overall responsibility for monitoring staffing levels to ensure service needs are covered in the Acute Service rests with the Senior Midwife for each area (Coordinating Midwife out of hours). A weekly 'look ahead' exercise should be performed across all grades of midwifery and support staff and where there are shortfalls are identified, rosters need to be amended to ensure an even distribution of staff over the forthcoming shifts, including a review of duty rotas for all midwives and address any potential for shift changes. When gaps are identified the following process should be followed:

- Notify vacant shifts to temporary staffing
- Review planned study leave
- Look at potential shift changes
- Part time staff requested to work additional hours.
- Full time staff requested to work overtime hours (including those on Annual Leave),
- Review availability of specialist midwives
- If the shift remains uncovered, during working hours the shift should be escalated to the Senior Midwifery team who will liaise with Bronze on Call and escalated to Thornbury. A Datix should be completed by either the ward administrator or the ward

Leader. Out of working hours the Coordinating Midwife should inform the DNM that the shift is not able to be covered and complete the Datix so that the shift can be escalated to Thornbury.

There should be a personal handover between Co-ordinating Midwives regarding staffing numbers at each shift change. Staffing and workload and acuity should be assessed and reassessed during the shift as per Birthrate plus. The Co-ordinating Midwife must liaise with the Senior Midwife if staffing problems are anticipated.

In times of high acuity in any area (Pregnancy Day Care, Triage, SBU, and Maternity Ward) then discussion should take place with the Co-ordinating Midwife to consider redeployment of staff and the most appropriate place for women to be assessed.

6.3 Community Midwives

At times of high activity/ acuity or staff shortages within the acute service, the Senior Midwife for Community will liaise with Team leaders during working hours for possible assistance from the community midwifery team. The Team leaders will prioritise team workload e.g. clinic cover, priority visiting. Out of hours, the on call Community Midwives are available to cover the home birth service only and are not to be called to support the Unit when services have been suspended.

6.4. Home Births

The decision whether a home birth can be facilitated should be undertaken by the Co-ordinating Midwife at the time when the woman telephones the unit in labour. Where a woman has planned a home birth and this service is not available due to temporary suspension of services, this will be recorded via Datix by the Co-ordinating Midwife. If a woman is already having a homebirth and SBU needs to suspend services this needs to be communicated to the midwife present at the home birth so they can have clear plans of which hospital to transfer the woman to if this is required.

6.5. Continuity of Care Team

Continuity of Care (MCOC) teams are still part of the generic Community midwifery service and therefore are also not available to support suspension of services. If a midwife from the MCOC team is already on SBU caring for one of their women and services are suspended there is no expectation for her to remain on the Maternity Unit to work when she has completed the care for her woman. However if she chooses to stay to support this is acceptable.

When a member of the MCOC team is contacted by one of their women for a home assessment they are to inform the coordinator on SBU if they are performing a home assessment and should also clarify if the unit has suspended services and the reason why so they can have a clear plan of where to transfer the woman for care if necessary, SBU or a neighbouring Unit that has agreed they are able to support**.**

6.6 Pregnancy Day Care

Pregnancy Day Care is open Monday – Friday 08.00-20.00hrs and Saturdays 09.00-13.00hrs.PDC has a planned list of appointments, which are from 08.30am with the last being at 18.00hrs, each appointment is allocated 45minutes. Monday-Saturday.

PDC also takes ‘emergency’ consultations from a variety of referral routes and these women are seen alongside the women with pre-arranged appointments, Monday-Friday. The Antenatal Suite and Clinic 11 doors are locked at 19.00hrs every weekday evening as part of the security of the department. The department needs to have closed by 20.00hrs and made ready for the following day. The PDC midwife and SBU coordinator should discuss workload at 18.00hrs to maintain flow and communication through both departments.
The PDC team will see women for assessment until 19.15hrs.

Following this the PDC midwife will liaise with the SBU coordinator as to the best place for care to be provided. The acuity of the maternity department and the expected duration of care provision will influence this decision. The PDC midwife will hand over care to the SBU coordinator/triage midwife at 19.55hrs to enable the finish time to be adhered to. In exceptional circumstances this can be negotiated.

6.7 Transitional Care

The Maternity within the 32 bed space will have a 4 bedded allocated bay for transitional care. If there are issues around the capacity of transitional care then transitional care policy should be followed.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

The report and the Datix should be completed within five working days.

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used))**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/ Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)**
Closures	Senior Midwife (in hours) Co-ordinating Midwife (out of hours)	Review of completed incident report and details entered on Datix	As required	Maternity and Gynaecology CG meeting

8.0 TRAINING AND IMPLEMENTATION

The document is to be shared with Senior Midwifery team, Co-ordinating Midwives and with the Silver on Call team.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix D

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- A-Equip- a model of Clinical Midwifery Supervision NHS England 4th April 2017

Related SFHFT Documents:

- Adult Patient Flow and Escalation Policy
- Neonatal Transitional Care (NTC) Guidance

11.0 KEYWORDS

- Suspension, plan, closure,

12.0 APPENDICES

Appendix A – Acute Maternity Capacity Management Plan
Appendix B – Acute Maternity Closure Report
Appendix C – Acute Maternity Escalation Checklist
Appendix D – Equality Impact Assessment form

Appendix A - Acute Maternity Capacity Management Plan

Suspension Declared in Working Hours 9-5 and Surrounding Units have Admitting Capacity

ACUTE MATERNITY CAPACITY MANAGEMENT PLAN A **Suspension Declared in Working Hours 9-5 and Surrounding Units have Admitting Capacity**	
Total Inpatient Beds Available	**48**
Sherwood Birthing Unit	12 birthing rooms (including pool room) 1 bereavement suite 3 beds in triage area
Maternity Ward	28 inpatient beds 4 beds in induction suite
Staffing Day Shift 07:00 to 19:30 A minimum of 10 midwives across the whole unit including at least one Band 7 co-ordinator (max 12 midwives) A minimum of 4 support workers	**10+4**
Other clinical support available from Senior Midwives & Specialist Midwives. Community Midwives and midwives working in Pregnancy Day Care (PDC) may also support **if workload allows**.	
Staffing Night Shift 19:00 to 07:30 A minimum of 10 midwives across the whole unit including at least one Band 7 co-ordinator (max 11 midwives) A minimum of 3 support workers	**10+3**
GREEN *Sufficient bed capacity for requirements with good anticipated flow*	

- ✓ SBU co-ordinator is aware at all times of the level of activity and staff available across the acute maternity service including planned admissions to SBU and the Maternity Ward
- ✓ Beds and staffing update to Flow Room by Divisional Bronze at 07:50,10.50, 13.50 and 16:50. SBU co-ordinator to update the next shift on activity/capacity status

AMBER

Activity is such that bed numbers or staffing numbers are inadequate to meet acuity

As above, plus:

- ☐ Commence 2 hourly Birthrate plus assessments
- ☐ SBU co-ordinator to liaise with Ward Leaders and the multidisciplinary team to expedite discharge planning and execution
- ☐ SBU co-ordinator and Obstetric Consultant to review elective work. Where a procedure is delayed or postponed a full management plan should be made and documented in the notes, and there should be clear verbal communication with the woman and her family regarding the plan. SBU co-ordinators to escalate to Ward Leaders and consider all measures to increase staffing levels, including clinical support from senior and Specialist Midwives and re-deploy from other areas (e.g. community and PDC) **where workload allows.** Ward Leaders to escalate to Senior Midwife.
- ☐ If admission is required to another speciality or if at any point bed capacity exceeds the beds required to admit a patient an individual assessment of risk is to be undertaken by the midwife and escalation made initially to the SBU coordinator who will discuss with the Senior leadership team/ Bronze on call for the Division to ensure a safe admission can take place.
- ☐ Senior Midwife to liaise directly with Duty Nurse Manager/Silver on Call regarding access to temporary staff; support with equipment sourcing; access to other beds in the hospital if appropriate, e.g. Ward 14/Ward 25, redeployment of RN or HCA's from other areas to assist

  Suspend in-utero transfers into the unit after discussion with the neonatal team

RED

Insufficient staff/beds to meet the Unit's requirements after all available staff & resources have been allocated appropriately.

ADD BR+

Mon- Fri 9am – 5pm; As above, plus:

- ☐ SBU co-ordinator to contact Obstetric Consultant to attend
- ☐ Senior Midwife to inform Divisional Head of Nursing and Midwifery and Duty Nurse Manager
- ☐ Continue 2 hrly Birthrate and contact local Trusts to establish who may be able to take diversions

BLACK

Insufficient staff & beds to meet unit requirements; no improvement in foreseeable future; patient safety compromised

Mon-Fri 9am-5pm;If local trust can take, as above, plus:

<u>Execute Maternity Services Suspension SOP</u>

Management Plan B-

*Suspension Declared in Working Hours 9-5 and Surrounding Units have **NO** Admitting Capacity*

ACUTE MATERNITY CAPACITY MANAGEMENT PLAN B **Suspension Declared in Working Hours 9-5 and Surrounding Units have NO Admitting Capacity**	
Total Inpatient Beds Available	**48**
Sherwood Birthing Unit	12 birthing rooms (including pool room) 1 bereavement suite 3 beds in triage area
Maternity Ward	28 inpatient beds 4 beds in induction suite
Staffing Day Shift 07:00 to 19:30 A minimum of 10 midwives across the whole unit including at least one Band 7 co-ordinator (max 12 midwives) A minimum of 4 support workers	**10+4**
Other clinical support available from Senior Midwives & Specialist Midwives. Community Midwives and midwives working in Pregnancy Day Care (PDC) may also support **if workload allows**.	
Staffing Night Shift 19:00 to 07:30 A minimum of 10 midwives across the whole unit including at least one Band 7 co-ordinator (max 11 midwives) A minimum of 3 support workers	**10+3**
GREEN *Sufficient bed capacity for requirements with good anticipated flow*	
✓ SBU co-ordinator is aware at all times of the level of activity and staff available across the acute maternity service including planned admissions to SBU and the Maternity Ward ✓ Beds and staffing update to Flow Room by Divisional Bronze at 07:50,10.50, 13.50 and 16:50. SBU co-ordinator to update the next shift on activity/capacity status	

AMBER

Activity is such that bed numbers or staffing numbers are inadequate to meet acuity

As above, plus:

- ☐ Commence 2 hrly Birthrate plus assessments
- ☐ SBU co-ordinator to liaise with Ward Leaders and the multidisciplinary team to expedite discharge planning and execution
- ☐ SBU co-ordinator and obstetric team to review elective work. Where a procedure is delayed or postponed a full management plan should be made and documented in the notes, and there should be clear verbal communication with the woman and her family regarding the plan. SBU co-ordinators to escalate to Ward Leaders and consider all measures to increase staffing levels, including clinical support from senior and Specialist Midwives and re-deploy from other areas (e.g. community and PDC) **where workload allows.** Ward Leaders to escalate to Senior Midwife
- ☐ If admission is required to another speciality or if at any point bed capacity exceeds the beds required to admit a patient an individual assessment of risk is to be undertaken by the midwife and escalation made initially to the SBU coordinator who will discuss with the Senior leadership team/ Bronze on call for the Division to ensure a safe admission can take place.
- ☐ Senior Midwife (or SBU co-ordinator out of hours) to liaise directly with Duty Nurse Manager/Silver on Call regarding access to temporary staff; support with equipment sourcing; access to other beds in the hospital if appropriate , e.g. Ward 14/Ward 25, redeployment of RN or HCA's from other areas to assist
- ☐ Suspend in-utero transfers into the unit after discussion with the neonatal team

RED

Insufficient staff/beds to meet the Unit's requirements after all available staff & resources have been allocated appropriately.

Mon-Fri 9am-5pm; As above, plus:

- ☐ SBU co-ordinator to contact Obstetric Consultant)
- ☐ SBU co-ordinator to continue liaison Duty Nurse Manager who will escalate to with Silver on Call
- ☐ Continue 2hrly Birthrate plus and contact local Trusts to establish who may be able to take diversions

BLACK

Insufficient staff & beds to meet unit requirements; no improvement in foreseeable future; patient safety compromised

If **NO** local trust can take:

Execute Maternity Service Declared Suspension SOP

Management plan C-

Suspension Declared outside of working hours and Surrounding Units have Admitting Capacity

ACUTE MATERNITY CAPACITY MANAGEMENT PLAN C **Suspension Declared outside of and Surrounding Units have Admitting Capacity**	
Total Inpatient Beds Available	**48**
Sherwood Birthing Unit	12 birthing rooms (including pool room) 1 bereavement suite 3 beds in triage area
Maternity Ward	28 inpatient beds 4 beds in induction suite
Staffing Day Shift 07:00 to 19:30 A minimum of 10 midwives across the whole unit including at least one Band 7 co-ordinator (max 12 midwives) A minimum of 4 support workers	**10+4**
Other clinical support available from Senior Midwives & Specialist Midwives. Community Midwives and midwives working in Pregnancy Day Care (PDC) may also support **if workload allows**.	
Staffing Night Shift 19:00 to 07:30 A minimum of 10 midwives across the whole unit including at least one Band 7 co-ordinator (max 11 midwives) A minimum of 3 support workers	**10+3**
GREEN *Sufficient bed capacity for requirements with good anticipated flow*	

- ✓ SBU co-ordinator is aware at all times of the level of activity and staff available across the acute maternity service including planned admissions to SBU and the Maternity Ward
- ✓ Beds and staffing update to Flow Room by Divisional Bronze at 07:50,10.50, 13.50 and 16:50
- ✓ SBU co-ordinator to update the next shift on activity/capacity status

AMBER *Activity is such that bed numbers or staffing numbers are inadequate to meet acuity*
As above, plus: ☐ Commence 2 hrly Birthrate plus assessments ☐ SBU co-ordinator to liaise with Ward Leaders and the multidisciplinary team to expedite discharge planning and execution ☐ SBU co-ordinator and obstetric team to review elective work. Where a procedure is delayed or postponed a full management plan should be made and documented in the notes, and there should be clear verbal communication with the woman and her family regarding the plan. SBU co-ordinators to escalate to Ward Leaders and consider all measures to increase staffing levels, including clinical support from senior and Specialist Midwives and re-deploy from other areas (e.g. community and PDC) **where workload allows.** Ward Leaders to escalate to Senior Midwife ☐ If admission is required to another speciality or if at any point bed capacity exceeds the beds required to admit a patient an individual assessment of risk is to be undertaken by the midwife and escalation made initially to the SBU coordinator who will liaise directly with the Obstetric consultant and DNM to ensure a safe admission can take place. ☐ SBU co-ordinator to liaise directly with Duty Nurse Manager/Silver on Call regarding access to temporary staff; support with equipment sourcing; access to other beds in the hospital if appropriate , e.g. Ward 14/Ward 25, redeployment of RN or HCA's from other areas to assist ☐ Suspend in-utero transfers into the unit after discussion with the neonatal team
RED *Insufficient staff/beds to meet the Unit's requirements after all available staff & resources have been allocated appropriately.*
Out of Working Hours; As above, plus ☐ SBU co-ordinator to contact Obstetric Consultant for telephone update (provided they can attend within 30 minutes if required) ☐ SBU co-ordinator to inform Duty Nurse Manager and Silver on Call ☐ Continue 2hrly Birthrate plus assessments and contact local Trusts to establish who may be able to take diversions
BLACK *Insufficient staff & beds to meet unit requirements; no improvement in foreseeable future; patient safety compromised*
If local trust can take, as above, plus:
Execute Maternity Services Suspension SOP

Management plan D-

*Suspension Declared outside of working hours and Surrounding Units have **NO** Admitting Capacity*

ACUTE MATERNITY CAPACITY MANAGEMENT PLAN D **Suspension Declared outside of working hours and Surrounding Units have NO Admitting Capacity**	
Total Inpatient Beds Available	**48**
Sherwood Birthing Unit	12 birthing rooms (including pool room) 1 bereavement suite 3 beds in triage area
Maternity Ward	28 inpatient beds 4 beds in induction suite
Staffing Day Shift 07:00 to 19:30 A minimum of 10 midwives across the whole unit including at least one Band 7 co-ordinator (max 12 midwives) A minimum of 4 support workers	**10+4**
Other clinical support available from Senior Midwives & Specialist Midwives. Community Midwives and midwives working in Pregnancy Day Care (PDC) may also support **if workload allows**.	
Staffing Night Shift 19:00 to 07:30 A minimum of 10 midwives across the whole unit including at least one Band 7 co-ordinator (max 11 midwives) A minimum of 3 support workers	**10+3**
GREEN *Sufficient bed capacity for requirements with good anticipated flow*	

- ✓ SBU co-ordinator is aware at all times of the level of activity and staff available across the acute maternity service including planned admissions to SBU and the Maternity Ward
- ✓ Beds and staffing update to Flow Room by Divisional Bronze at 07:50,10.50, 13.50 and 16:50

- ✓ SBU co-ordinator to update the next shift on activity/capacity status

AMBER

Activity is such that bed numbers or staffing numbers are inadequate to meet acuity

As above, plus:

- ☐ Commence 2 hrly Birthrate plus assessments
- ☐ SBU co-ordinator to liaise with Ward Leaders and the multidisciplinary team to expedite discharge planning and execution
- ☐ SBU co-ordinator and obstetric team to review elective work. Where a procedure is delayed or postponed a full management plan should be made and documented in the notes, and there should be clear verbal communication with the woman and her family regarding the plan. SBU co-ordinators to escalate to Ward Leaders and consider all measures to increase staffing levels, including clinical support from senior and Specialist Midwives and re-deploy from other areas (e.g. community and PDC) **where workload allows.** Ward Leaders to escalate to Senior Midwife
- ☐ If admission is required to another speciality or if at any point bed capacity exceeds the beds required to admit a patient an individual assessment of risk is to be undertaken by the midwife and escalation made initially to the SBU coordinator who will liaise directly with the Obstetric consultant and DNM to ensure a safe admission can take place.
- ☐ SBU co-ordinator to liaise directly with Duty Nurse Manager/Silver on Call regarding access to temporary staff; support with equipment sourcing; access to other beds in the hospital if appropriate , e.g. Ward 14/Ward 25, redeployment of RN or HCA's from other areas to assist
- ☐ Suspend in-utero transfers into the unit after discussion with the neonatal team

RED

Insufficient staff/beds to meet the Unit's requirements after all available staff & resources have been allocated appropriately.

Out of Working Hours; As above, plus:

- ☐ SBU co-ordinator to contact Obstetric Consultant for telephone update (provided they can attend within 30 minutes if required)
- ☐ SBU co-ordinator to inform Duty Nurse Manager and Silver on Call
- ☐ Continue 2hrly Birthrate plus assessments and contact local Trusts to establish who may be able to take diversions

BLACK

Insufficient staff & beds to meet unit requirements; no improvement in foreseeable future; patient safety compromised

If NO local trust can take, as above, plus:

Execute Maternity Services Declared Suspension SOP

Appendix B – Acute Maternity Closure Report

Date & Time of Closure	
Co-ordinating Midwife	
Obstetric Consultant on call	
Senior Midwife / Silver on Call (out of hours)	
Datix reference number	
Date & Time of Reopening	

STAFFING NUMBERS AT TIME OF SUSPENSION (*not including Co-ordinating Midwife)*	**RM**	**MSW**
Sherwood Birthing Unit		
Maternity Ward		
Total		

MATERNITY WARD CLINICAL ACTIVITY AT TIME OF SUSPENSION (*not including women still on SBU*)	**Number of Women**
Antenatal Women	
Postnatal Women	
Induction of Labour	
High risk babies	
Empty beds	

Appendix C - Acute Maternity Escalation Checklist

Category	Type of Woman	Examples	Number of Women
I - V	Women in labour and the immediate post-partum period (includes completing records/skin-to-skin, etc., prior to transfer to ward)	Women in established labour (Category dependant on score - see score sheet) IOL that have commenced oxytocin (Category dependant on score) Multiple Pregnancy in labour (Cat V) EL LSCS (Cat IV), EL LSCS + co-morbidities (Cat V) Post-delivery women prior to transfer to ward or directly home once all care and records are complete	
PD1	Continuing care for women post-delivery requiring 1:1 care [1 mw]	PN women who need to remain on DS and still require 1:1 care, i.e. massive PPH, on magnesium protocol, unstable diabetes etc.	
PD2	Post-Delivery women requiring some care [0.5 mw]	PN women who need to remain on DS post-delivery as they require closer observation prior to transfer but not 1 to 1 midwife, i.e. PPH	
PN	Normal Postnatal Women [0.25 mw]	Women transferring directly home from DS Postnatal women fit for ward but awaiting available bed or with a baby on observations	
A1	Antenatal Women requiring monitoring but NOT 1:1 care [0.5 mw]	For example; ECVs; moderate PIH; APH, UTI and women will need frequent monitoring and/or IV Infusion IOL requiring high midwifery input	
A2/R	High Risk Antenatal Women Postnatal Readmission [1 mw]	Threatened Prem Labour needing Nifedipine/Atosiban Significant Pre-Eclampsia SignificantAPH/Placenta Praevia bleeding All Postnatal Readmissions Non-viable pregnancies	
X	Antenatal ‘Triage’ Women [0.25 mw]	SROM, Early Labourers,BP profile CTG, Reduced FM etc.	
Induction of Labour	Prostin or Propess [0.25mw]	Women for IOL, requiring low midwifery input. Move to Category I-V when in established Labour or have an ARM &/or Oxytocin	

ACTIONS TAKEN PRIOR TO SUSPENSION	Comments
Staff moved from other areas	
Elective work delayed/cancelled	
Obstetric consultant called to review	

Comments

APPENDIX D – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Escalation Operational Policy in the Maternity Services			
New or existing service/policy/procedure: Existing			
Date of Assessment: January 2020			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	No issues, needs or barriers	N/A	N/A
Gender	Female only (maternity)	N/A	N/A
Age	No issues, needs or barriers	N/A	N/A
Religion	No issues, needs or barriers	N/A	N/A
Disability	No issues, needs or barriers	N/A	N/A
Sexuality	No issues, needs or barriers	N/A	N/A
Pregnancy and Maternity	No issues, needs or barriers	N/A	N/A
Gender Reassignment	No issues, needs or barriers	N/A	N/A

Marriage and Civil Partnership	No issues, needs or barriers	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	No issues, needs or barriers	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out?

- **None**

What data or information did you use in support of this EqIA?

- **None**

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- **None**

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Paula Shore

Signature: Paula Shore

Date: January 2020