Maternity Escalation and Closure Guideline

Classification:	Guideline
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Authors Division:	Women and Children's Health
Departments/Group this Document applies to:	Maternity, Obstetricians, Midwives, Nurses, MCA's, Managers

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Guideline to be followed by (target staff): Maternity, Obstetricians, Midwives, Nurses, MCA's, Managers

To be read in conjunction with the following documents:

- Milton Keynes University Hospital NHS Foundation Trust. *Incident Reporting Policy and Procedure (including Serious Incident Procedure).* RM/GL/17. Version 9.1, 2019
- Milton Keynes University Hospital NHS Foundation Trust. *Incident Response Plan.* EMP/GL/2. Version 1.2, Last review 2018
- Milton Keynes University Hospital NHS Foundation Trust. *NNU Escalation Plan.* DOC85. Version 3, 2020
- Milton Keynes University Hospital NHS Foundation Trust. *Risk Management Framework.* RM/GL/11. Version 8, Last review 2018
- Milton Keynes University Hospital NHS Foundation Trust. *Roster Procedure and Policy.* DOC200. Version 1, 2018
- Milton Keynes University Hospital NHS Foundation Trust. *Trust Capacity Escalation Policy.* DOC213. Version 1, 2019

Are there any eCARE implications? No

CQC Fundamental standards:

Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.

The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

Staffing levels and workload in maternity services can change for a wide range of reasons and an urgent response will be required. Staffing levels that are safe and which underpin the delivery of the best possible care is an essential component of a quality health service.

On occasion, the maternity unit may need to temporarily divert its workload and close. This may occur independently or as a result of a major incident. Closure of a maternity unit should only be considered when all other alternatives have been exhausted. In the event of a closure a consistent and clear approach must be adopted to ensure that safe alternative arrangements are made to care for mothers/ Parents and babies. This course of action must be considered as part of the Trust's Risk Management Policy and Bed Management and Escalation Policy**.**

Objectives

The purpose of this guideline is to ensure that Milton Keynes Maternity Services provide safe and effective care to all women/ birthing people being treated within its maternity service.

The Trust must ensure that all women receive safe maternity care from an appropriately skilled workforce, to achieve one to one care in labour. All women will receive care from a registered midwife or nurse appropriate to their clinical needs.

This guideline outlines the process to be followed to manage and monitor the level of risk associated with peaks in demand or interferences to the operational service affecting the ability to provide safe clinical care.

Executive Summary

Staffing levels and workload in maternity services can change for a wide range of reasons and an urgent response will be required. Staffing levels that are safe and which underpin the delivery of the best possible care is an essential component of a quality health service.

The maternity unit may need to temporarily divert its workload and close due to the following:

- Lack of capacity
- Acute staff shortages
- Infection control measures
- Major operational failings e.g. power failure
- Major incident

Closure of a maternity unit should only be considered when all other alternatives have been exhausted. In the event of a closure a consistent and clear approach must be adopted to ensure that safe alternative arrangements are made to care for mothers and babies. The Lead Midwife on call must have oversight of the decision to close the maternity unit.

If the Neonatal Unit (NNU) is unable to admit babies for any reason, it should not normally be necessary to close the maternity unit to all women but consideration must be given to in utero transfers. A risk assessment must be carried out for each woman on admission to identify if a neonatal cot may be required. The NNU Escalation Plan should be read in conjunction with this document.

Factors precipitating closure of maternity unit

- Insufficient maternity bed capacity
- Insufficient midwives and/or doctors
- Inappropriately experienced skill mix
- Infection outbreak in clinical areas as advised by the Infection Prevention and Control Team
- Internal or Major Incident

Definitions

1.0 Roles and Responsibilities:

It is the role and responsibility of all Maternity, Divisional and Trust management teams to be familiar with the Maternity Escalation Guideline.

1.1 The Trust Board and Executives

Have strategic responsibility for providing sufficient capacity and resources for inpatient services.

1.2 The Director of Operations

Has overall responsibility for ensuring that there is sufficient capacity available at any given time.

1.3 The Executive on call (EOC) (Gold)

Assumes overall responsibility for any given situation escalated to them, providing consultation on decisions and responsibility for actions taken in response to developing situations.

1.4 The Trust Manager on Call (MOC) (Silver)

Has the responsibility, alongside the maternity manager on call as required, to advise the **Clinical Site Manager (CSM)** on the implementation of actions to manage the identified areas of concern within maternity services.

1.5 Responsibility of Head of Midwifery

The Head of Midwifery or designated deputy assumes overall responsibility for the provision of safe maternity services and midwifery staffing, with accountability to the Chief Nurse and designated Executive on call.
The Head of Midwifery or designated deputy is contactable for consultation or the provision of support by the Maternity Manager on Call or Executive on Call if the provision of safe midwifery care is not achieved following the implementation of the Maternity Escalation Guideline or Maternity Business Contingency Plan.

In any event that 1:1 care in established labour is not able to be maintained following implementation of the Maternity Escalation Guideline or Maternity Business Contingency Plan, the Head of Midwifery or designated deputy **must** be informed.

1.6 Matrons

Proactive staff management

a. All midwifery and support staff duty rotas are completed as per the Trust Health Roster Guideline to ensure effective utilisation of staff across a 24-hour period where applicable. This must be reviewed and authorised by the Matron for the area and any concerns escalated as soon as possible so that any remedial action can be taken.

b. No more than the agreed number of Whole Time Equivalent (WTE) staff should be on annual leave or study leave at any given time. This needs to be closely monitored by the senior midwifery team so that any remedial action can be taken as soon as possible.

c. All sick leave and absence will be managed in accordance with the Trust sickness and absence policy.

d. Temporary staff should be booked and managed appropriately in response to workload pressures.

1.7 Clinical Site Manager (CSM) (Bleep 1222)

The CSM has the following responsibilities:

- The **CSM** has responsibility for reviewing the initial assessment with Lead Midwife on Call before contacting and informing Manager/Exec on call.

- The **CSM** is informed to support the midwife co-ordinators with the management of staff redeployment including seeking other nursing and nursing auxiliary support in non-statutory midwifery roles and meeting bed management requirements.

- The **CSM** will also provide support in taking action for escalating unit closure and seeking support from the management and executive team on call

1.8 Lead Midwife on Call (LMOC)

The LMOC is the designated contact for all clinical or operational management concerns within maternity services. The LMOC is available by phone 24 hours a day to advise and support the provision of safe maternity services.

The LMOC will advise on and support the implementation of the Maternity Escalation Guideline and Maternity Business Contingency Plan and holds direct responsibility for initiating and advising the Exec of the requirement for closure of the Maternity Unit.

In **any** circumstance that the LMOC recommends the Maternity Service is close or diverted and this is not supported, the Head of Midwifery or designated deputy **must** be informed.

1.9 Maternity Bleep Holder (Bleep 1440)

Has delegated authority to act on the Operational Midwifery staffing levels tool (Appendix 2) and completion and filing of the maternity safety huddle pro forma (Appendix 3) to demonstrate assurance of the decisions made. The maternity bleep holder is also responsible for informing the LMOC, Consultant on Call, Clinical Site manager and the Head of Midwifery or designated deputy in hours of the need to implement the escalation and or closure of the Maternity Unit. They also has the responsibility for completing a RADAR.

This role will be completed by the labour ward coordinator out of hours.

***Continuous evaluation of staffing levels and clinical workload by the Maternity Bleep Holder and Labour ward Coordinator will be undertaken throughout the shift and escalation to the Lead Midwife on Call can take place at any point.**

1.10 All staff

- Have a responsibility to ensure effective communication and handover of care and to support timely discharges and management of elective work
- All staff have a responsibility to ensure that real time bed states are maintained.

1.11 Consultant on call

- When maternity unit is in escalation, to work in collaboration with the lead on call.
- Ther consultant on call will escalate to the clinical director as appropriate.

2.0 Implementation and dissemination of document

This guideline is available on the Trust intranet and has followed the full guideline review process prior to publication.

3.0 Processes and procedures

3.1 Objectives

To provide safe care to women using maternity services in Milton Keynes University Hospital NHS Foundation Trust.

3.1.1 Purpose of the plan

The purpose of this plan is to ensure that women receive the right level of care dependent on their clinical need.

The Birth Rate Plus acuity application will be completed routinely to support management of the changing clinical situation in order to ensure the provision of safe maternity services.

The assessment within the acuity application will support identification of mitigations and workforce movements to enable the provision of midwifery care based on acuity and will be reported at each Maternity Safety Huddle and Site Huddle.

The categorisation of care needs based on the clinical situation will be according to the Birth Rate Plus categorization in appendix

Category	Type of Woman	Examples	
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.	*In the immediate PN period women keep their Intrapartum category*
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.	
Inductions 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	

Antenatal and postnatal women/ birthing people requiring non obstetric based medical care must be escalated to the CSM and bed manager to organise transfer to a medical or surgical ward, as required, following a multi-disciplinary assessment and discussion.

The consultant obstetrician must be made aware of any antenatal or postnatal outliers admitted in non-maternity areas and a plan for obstetric input, as required, must be made and clearly documented in the woman's notes prior to the transfer.

Any outliers are to be documented on the labour ward white board and updated daily by the labour ward co-ordinator.

3.2 Responsibilities during the Escalation Process

3.2.1 Routine CSM responsibilities/ Silver Command:

Maintain regular contact with the maternity bleep holder in hours and Labour ward coordinator out of hours to formally update Operations Team. This will be undertaken through the daily huddle as standard and in times of escalation at the midday and 3pm bed meetings. Information required is as follows:

- Birthrate Plus Acuity Rating
- Number of midwives and support staff on duty
- Number of available beds on Wards 9,10 and Labour ward
- Relevant community activity
- ADAU activity

3.2.2 Responsibilities of the Maternity Bleep Holder (Bleep 1440)

- To work to a set shift of 08.00 – 16.00, Monday – Friday, handing over to the labour ward coordinator out of hours
- Attend the hospital clinical site huddle at 08.30 on MS teams and provide the following information:
    - Labour Ward – Empty Rooms, birth rate plus acuity rating, staffing issues, clinical concerns.
    - Ward 9 – Empty beds, potential discharges throughout the shift, staffing issues, clinical concerns.
    - ADAU – Staffing issues, clinical concerns
    - Please confirm that all areas have check their red adult resuscitation trollies.
    - Please highlight any estates issues that may need urgent attention.
- Lead the maternity safety huddles at 10.00 and 15.30 forecasting and planning for the next 24hrs, this is an opportunity for the areas to come together, agree a status and constructively challenge decisions, discuss concerns, and share ideas.
- Maternity huddle data to be documented and stored on the maternity safety huddle MS teams group.
- Trust site report to be completed and emailed to the site management team after each maternity huddle.

- In hours, the maternity bleep holder is to complete the RADAR when escalation is entered and document this on the huddle form.
- Communicate with the bank office and clinical site team to request and get further staffing support. Ward 9 - can have a registered RN to help with observations, surgical care and drug rounds.
- Escalate concerns to the matron for the area and update the lead on call as required.
- When taking calls to advise of sickness absence please document this in the electronic sickness absence folder, inform the relevant areas and update the erosters.

Order of Staff Redeployment to support safe care

In Hours

1. Second Band 7 on Labour ward to take a clinical caseload during occasions of increased activity
2. Redeploy staff between clinical areas to maintain safe staffing levels in line with clinical activity and acuity
3. Ward Managers to support clinically within their clinical areas
4. Specialist Midwives – the specialist on call roster details two specialist midwives each weekday who are first and second on call to support clinically as required, in times of significant pressure, specialist midwives outside those on call may be asked to support clinically, following discussion with the lead on call.
5. Continuity of Carer Birth Cover midwives, following rolling Continuity of Carer team escalation rota and only after discussion with the lead on call. **NB. The continuity of carer birth cover is currently paused at MKUH**
6. Community midwives.
7. Maternity Bleep holder
8. Maternity Matrons

Out of Hours

1. Second Band 7 on Labour ward to take a clinical caseload during occasions of increased activity
2. Redeploy staff between clinical areas to maintain safe staffing levels in line with clinical activity and acuity
3. Hospital on call
4. Continuity of Carer Teams - In identified order of team via a Rota. A rolling rota will be available identifying the order of which continuity of Carer team will come in to support the

unit first if required out of hours. Agreement to bring in any of the Continuity of Carer teams will be made by the Lead Midwife on call. **NB. The continuity of carer birth cover is currently paused at MKUH**

Homebirth Service

The homebirth service will continue as per their guidance, in the event the service needs to be suspended due to divert/closure, any decision to suspend the homebirth service must be agreed by the LMOC.

Staff Meal Breaks:

Staff meal breaks are to be supported amongst the team members across the inpatient service to maintain resilience as much as possible, especially in periods of high activity.

De – escalation of staff called in to support:

De – escalation should take place at the earliest available opportunity. The labour ward coordinator should ensure that during continuing escalation, team members are relieved as required by escalating to the next step in the escalation policy.

Maternity Escalation Status Consideration:

	Delivery suite beds	Ward beds	Triage Breeches	Unable to give 1-1 care in established Labour	LW coordinators not supernumerary	Operative Deliveries	High Risk Inductions
Black 4	0 beds	0 beds	0 beds	Not able to give 1-1 care	Not supernumerary	No theatres/ no medical staff	Unable to transfer to another Trust
Red 3	1 bed	1 bed	Women not seen in red category immediately	Unable to give 1-1 care to any woman	The last person available to provide 1-1 care	Unable to achieve timeframe for Cat 1 CS or immediate instrumental deliveries.	Unable to continue an induction once the induction has started
Amber 2	2 beds	2 beds	Women not seen within 15 minutes in orange category	Moving staff to be able to give 1-1 care	Providing direct care to antenatal/postnatal women	Unable to achieve timeframe for Cat 2 CS. Delays in urgent instrumental deliveries.	Unable to start an induction process
Green 1	More than 3 beds	More than 3 beds	Women not seen within 60 minutes in yellow and 4 hrs in green category	1-1 care given to all women	LW coordinators supernumerary	No delays	Induction commenced as planned

Three of any colour equates to that Opal rating. If 3 of several colours the highest denominator is the opal rating to be declared.

Maternity Escalation/Divert Action Card will be used, and actions followed.

Triage Pathway:

Triage Pathway MW to see women rag rated red immediately all other women within 15 minutes	Seen for treatment immediately by ST3 registrar or above	Seen for treatment within **15** minutes by ST3 registrar or above	Seen for treatment within **60** minutes by ST3 registrar or above	Seen for treatment within 4 hours by ST3 registrar or above

3.3 Decision to Close the Maternity Unit

In Hours

The decision to close the Maternity Unit should be a multidisciplinary decision and will follow a discussion with the maternity bleep holder, LMOC, Consultation Obstetrician, CSM and the Head of Midwifery. The Head of Midwifery or designated deputy will liaise with the Executive on call.

Out of Hours

The decision to close the Maternity Unit should be a multidisciplinary decision and will follow a discussion with the labour ward coordinator, LMOC, CSM, Consultant Obstetrician, and the Hospital Manager on call who will liaise with the Executive on call.

Out of hours the Lead Midwife on Call will support the labour ward coordinator to close either via phone or in person dependent on activity and reason for closure. If women who are in-patients are to be transferred to another hospital, the Lead Midwife on Call in consultation with medical staff must make the decision considering the distance to the receiving hospital.

3.3.1 Implementation of Closure

- Consideration should be given to inform Ambulance control early should women travelling by ambulance need to be diverted.

- Outbreak of Infection – The IPC will convene outbreak management meetings, laboratory and domestic support where indicated.

3.3.2 Diversion /Redirection of Women

- Women who telephone prior to their admission, should be triaged following a comprehensive telephone assessment.
- On a case-by-case basis explanation should be provided on the need to transfer to an alternative hospital. This should be documented on the telephone triage sheet.
- Where appropriate women should be seen and reviewed either by a community midwife or advised to attend an alternative maternity unit for review.
- Where women are to be redirected, they should be provided with details of the receiving hospital location. Women should be reminded to take their maternity records with them.
- Women who arrive without prior warning during unit closure need a comprehensive assessment and transfer arranged to an alternative unit where appropriate.
- **All women being transferred to another hospital must have their maternity records photocopied prior to transfer**.

3.3.3 Documentation of Closure

Please complete the following documentation in the event of a closure:
Maternity Unit Closure and reopening Check List in Appendix 4
Record of Mothers contacted due to closure in Appendix 5
Neighbouring Hospitals Information Form in Appendix 6

A RADAR should also be completed

4.0 Reopening of the Maternity unit

When the factors that precipitated closure of the Maternity Unit are resolved and the Unit reopens, the above process is reversed.

Following reopening of the maternity unit:

- The maternity bleep holder is to call all receiving units to inform them of the reopening and thank them for their support.

5.0 Closure of Maternity Unit Not Possible

In the event that surrounding Maternity Units are unable to assist with closure of Milton Keynes University Hospital Maternity Services it will become necessary to consider further solutions. The following suggestions are not exhaustive and circumstances at the time of attempted closure will need to be taken into account.

Follow the action chart below:

OPEL 4 **Unit Full - No bed capacity and high acuity**
• There are insufficient beds and an attempt to close the unit has been unsuccessful
Black Status Actions **Undertaken by Lead Midwife on Call with support from the Maternity Bleep Holder and/or LW Coordinator and CSM**
• Inform Matrons, Lead on Call in hours and Lead Midwife on Call out of hours • Notify Head of Midwifery or designated deputy • Notify Associate Director of Operations • Notify Divisional Director • Notify Operational Manager • Notify Clinical Site Manager • Inform the Consultant on Call • Inform Neonatal Consultant on call • Inform Neonatal Nurse Coordinator • If further staff are required telephone staff not on duty for next 24 hours and request whether they could work all or part of a shift. Considerations should be given to adequate staffing over the next 24-48 hours • Group text to all midwifery and support staff "escalation status black" • Contact Bank Office when open. If closed liaise with Manager on Call about possibility of additional agency/bank staff • Obstetric Consultant to review all antenatal inpatients and potential admissions to consider whether management possible via Antenatal Day Assessment Unit • Expedite review and discharges home from Wards 9 and 10
Black Status Bed options
• Convert Labour ward bed in room 10 into 2 postnatal beds • Convert ADAU into postnatal beds and the side room into a labour room • Consider using the MEWS rooms on Neonatal Unit

6.0 The Neonatal Unit

If the Neonatal Unit (NNU) is unable to admit babies for any reason, it should not normally be necessary to close the maternity unit to all women but consideration must be given to in utero transfers. If the NNU is unable to admit babies the following actions should be taken:

- Inform Consultant Obstetrician on call
- Liaise with Consultant Neonatologist and Neonatal Nurse coordinator regularly regarding ongoing activity on NNU
- If NNU is at capacity with 16 babies or unable to admit babies for any reason, then antenatal women who may require an NNU cot must be transferred to another hospital in utero
- A risk assessment must be carried out for each woman on admission to identify if a neonatal cot may be required.
- The NNU Escalation Plan should be read in conjunction with this document

7.0 Other Associated Documents

Milton Keynes University Hospital NHS Foundation Trust. *Incident Reporting Policy and Procedure (including Serious Incident Procedure).* RM/GL/17. Version 9.1, 2019

Milton Keynes University Hospital NHS Foundation Trust. *Incident Response Plan.* EMP/GL/2. Version 1.2, Last review 2018

Milton Keynes University Hospital NHS Foundation Trust. *NNU Escalation Plan.* DOC85. Version 2, 2015

Milton Keynes University Hospital NHS Foundation Trust. *Risk Management Framework.* RM/GL/11. Version 8, Last review 2018

Milton Keynes University Hospital NHS Foundation Trust. *Roster Procedure and Policy.* DOC200. Version 1, 2018

Milton Keynes University Hospital NHS Foundation Trust. *Trust Capacity Escalation Policy.* DOC213. Version 1, 2019

8.0 Statement of evidence/references

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9.0 Governance

9.1 Document review history

Version number	Review date	Reviewed by	Changes made
5	08/2023	Head of Midwifery	Reviewed.
5.2	25/02/2022	Deputy Head of Midwifery	Addition to huddle and Include de-escalation process for CofC Midwives
5.3	30/03/2022	Head of Midwifery and Deputy Head of midwifery	Updated wording within roles & responsibilities. Incorporated BR+ categorisation & acuity tool. Updated appendix to reflect changes to categorisation and include prompts.
5.4	January 2024	Alex Fry	Updated audit criteria
5.5	March 2024	Alex Fry	Addition of consultant on call in 'roles'

9.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Julie Cooper, Head of Midwifery	Midwifery	30.08.17			Yes
Matrons	Midwifery	30.08.17			Yes
Consultant Midwife and Matrons	Midwifery	30.08.17			Yes
Consultants	Obstetrics	30.08.17		No comments received	
Registrars/SHO and Midwives	Obstetrics and Midwifery	30.08.17	30.08.17		
Divisional General Manager	Management	30.08.17	30.08.17		Yes
Labour Ward Band 7 Coordinators	Midwifery	30.08.17	30.10.17	Not all comments endorsed	
Georgena Leroux	Midwifery	30.08.17	6.11.17	Not all comments endorsed	
Lydia Stratton- Fry	Labour Ward Manager	30.8.17	30.08.17	Not all comments endorsed	
Louisa Demetriou	Midwife	30.08.17	30.08.17		Yes
Grainne Ferrari	Labour Ward Coordinator	30.08.17	25.10.17	Not all comments endorsed	
Elaine Patton	Labour Ward Coordinator	30.08.17	6.09.17		Yes
Jan Liddie	Specialist Midwife	30.08.17	6.11.17		Yes
Julie Cooper	Head of Midwifery	15.08.20	15.08.20	Updated guideline	Yes

Janice Styles	Midwifery Matron	17.8.20	17.8.20	Comments endorsed	Yes
Lydia Stratton-Fry	Midwifery Matron	17.8.20	19.8.20	Comments endorsed	Yes
Rebecca Daniels	Consultant Midwife	17.8.20	21.8.20	Comments endorsed	Yes
Suzanna Walsh	Caseload Midwife	3.09.20	3.9.20	Suggestion of rolling rota for on call between teams	Yes
Emma Mitchener	Matron for LW and ADAU				
Deanna Pilcher	Continuity of Carer Midwife	04.07.21	05.07.21	Include de-escalation process for CofC Midwives	Yes
Carrie Tyas	Lead Midwife for Safeguarding	04.07.21	05.07.21	To discuss safeguarding cases at the maternity huddle, huddle sheets reflective of this	Yes
Olivia Albaradura	Team Leader for Continuity of Carer	04.07.21	12.07.21	Include de-escalation process for CofC Midwives	Yes
Katrina Caen	Labour Ward coordinator	04.07.21	18.07.21	The inclusion of the role of the labour ward coordinator in the role and responsibilities section	Yes
Sophie Conneely	Outpatient Matron	04.07.21	02.08.21	Include de-escalation process for CofC Midwives	Yes
Melissa Davis	Head of Midwifery, Gynaecology & Paediatrics	10.03.22	10.03.22	Updated wording within roles & responsibilities. Incorporated BR+ categorisation & acuity tool. Updated appendix to reflect changes to categorisation and include prompts.	Yes
Laura Jewel	Ward 9 Manager	18.03.22	21.03.22	Alteration of wording & clarifications	Partially
Lauren Mitchell	Consultant Midwife	28.03.22	28.03.22	Alteration of wording, clarifications & addition of ADAU	Yes
Natalie Lucas	Practice Development Midwife	30.03.22	30.03.22	Wording alterations	Yes

Lisa Viola	Neonatal Matron	30.03.22	30.03.22	Role clarification	Yes
Women's Health Guideline Review Group	Women's Health	03.01.2024	-	Version 5.4 approved as chairman's action	Yes
Women's Health Guideline Review Group	Women's Health	06.03.2024	-	Version 5.5 approved as chairman's action	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria Tool	**Audit Lead**	**Frequency of Audit**	**Responsible Committee/Board**
Submission of SitRep data to NHSE	Senior Leadership Team	Every 2 weeks	Governance Team
MIS compliance audit	Governance Team	Quarterly	CSU

9.3 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women and Children's	Department	Maternity
Person completing the EqIA	Melissa Davis	Contact No.	87854
Others involved:	None	Date of assessment:	10.3.22
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*All staff working within the maternity department*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to recognise diversity, promote inclusion and fair treatment for patients and staff This escalation procedure does specifically impact on those who are pregnant and will potentially impact the delivery of maternity care specifically to those who are pregnant.
Disability	NO	
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	**YES**	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
Circulation via email for comments, discussed at the guidelines meeting
How are the changes/amendments to the policies/services communicated?
Circulation via email, discussed at the guidelines meeting and WH CIG
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA			

Appendix 1: Maternity Safety Huddle Pro Forma

Maternity Safety Huddle

Labour Ward

	Category 1	Category 2	Category 3	Category 4	Category 5	PD1	PD2	PN	A1	A2/R	X	IOL
Update by												
Number of women												
Available beds												
Transfers to ward												
Discharges												
Elective LSCS												
IOL's / PROM's TCI LW												
Covid 19												
Outliers across hospital												
Clinical concerns: medical/surgical input												

Labour Ward staffing				
Core midwives	Continuity with own women	Specialist for escalation	Continuity for escalation	MCA

Ward 9

Update by									
Empty Beds	Antenatal	Postnatal mothers	Babies	Definite discharges	Potential discharges	Ongoing IOL's	PROM's	Waiting for LW	Neonatal IV's

Clinical concerns	

Ward 9 staffing					
Core midwives	RN	Nursery Nurse	MCA's	Specialist for escalation	Continuity for escalation

Ward 10

Update by									
Empty Beds	Antenatal	Postnatal mothers	Babies	Definite discharges	Potential discharges	Ongoing IOL's	PROM's	Waiting for LW	Neonatal IV's
Clinical concerns									

Ward 10 staffing					
Core midwives	RN	Nursery Nurse	MCA's	Specialist for escalation	Continuity for escalation

ADAU

Update by							
	Appts booked	Women in	Women waiting	Outpatient IOL	Feriniect	ECV	Women for admission
Clinical concerns							

ADAU staffing				Adult and Neonatal Resus trollies checked	
	AM	PM		Labour Ward	
Core midwives				Ward 9	
MCA				ADAU	

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Milton Keynes
University Hospital
NHS Foundation Trust

NNU

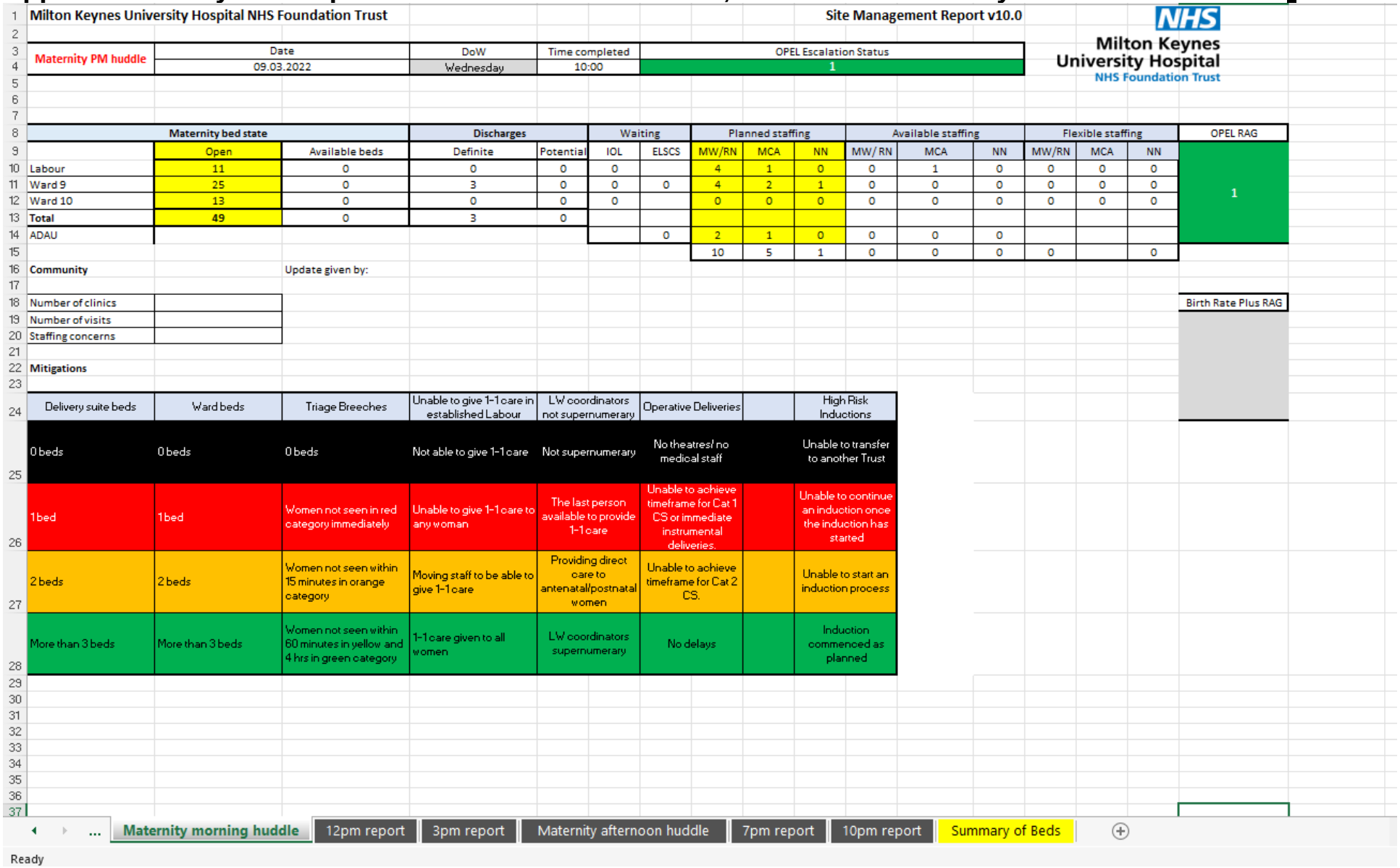
Available cots	Intensive babies	HDU babies	SCBU babies	Transfers out	Repatriations
Staffing/ comments					

Community

Number of clinics	Number of visits

Community staffing			Agreed Plan for unit
Homebirth service available	Staffing concerns		
Day			
Night			

Appendix 2: Daily Site Report to be sent to the site team, available in Maternity Huddle Teams folder:



Milton Keynes University Hospital NHS Foundation Trust — Site Management Report v10.0

Maternity PM huddle	Date	DoW	Time completed	OPEL Escalation Status
	09.03.2022	Wednesday	10:00	1

Maternity bed state			Discharges		Waiting		Planned staffing			Available staffing			Flexible staffing			OPEL RAG
	Open	Available beds	Definite	Potential	IOL	ELSCS	MW/RN	MCA	NN	MW/ RN	MCA	NN	MW/RN	MCA	NN	
Labour	11	0	0	0	0		4	1	0	0	1	0	0	0	0	1
Ward 9	25	0	3	0	0	0	4	2	1	0	0	0	0	0	0	
Ward 10	13	0	0	0	0		0	0	0	0	0	0	0	0	0	
Total	49	0	3	0												
ADAU						0	2	1	0	0	0	0				
							10	5	1	0	0	0	0		0	

Community — Update given by:

Number of clinics	
Number of visits	
Staffing concerns	

Birth Rate Plus RAG

Mitigations

Delivery suite beds	Ward beds	Triage Breeches	Unable to give 1-1 care in established Labour	LW coordinators not supernumerary	Operative Deliveries		High Risk Inductions
0 beds	0 beds	0 beds	Not able to give 1-1 care	Not supernumerary	No theatres/ no medical staff		Unable to transfer to another Trust
1 bed	1 bed	Women not seen in red category immediately	Unable to give 1-1 care to any woman	The last person available to provide 1-1 care	Unable to achieve timeframe for Cat 1 CS or immediate instrumental deliveries.		Unable to continue an induction once the induction has started
2 beds	2 beds	Women not seen within 15 minutes in orange category	Moving staff to be able to give 1-1 care	Providing direct care to antenatal/postnatal women	Unable to achieve timeframe for Cat 2 CS.		Unable to start an induction process
More than 3 beds	More than 3 beds	Women not seen within 60 minutes in yellow and 4 hrs in green category	1-1 care given to all women	LW coordinators supernumerary	No delays		Induction commenced as planned

Maternity morning huddle | 12pm report | 3pm report | Maternity afternoon huddle | 7pm report | 10pm report | Summary of Beds

Ready

Appendix 3 : Maternity Unit Closure and Opening Check Lists

To be completed by Maternity Unit Manager

Date of Closure:
Time of Closure:

Reason for Closure:
(Delete as appropriate)
☐ Insufficient medical/midwifery staff
☐ Inappropriate skill mix
☐ No beds
☐ Neonatal Unit Closure
☐ Infection as directed by Microbiologist
☐ Major incident / power failure / Computer systems failure
☐ Other *(please specify)*

Personnel notified of closure

Name	Contact Details	Personnel called	Time	Signature
Labour Ward Coordinator	Bleep 1440			
Lead on Call	Via Switch			
Clinical Site Manager	Bleep 1222			
Head of Midwifery	Via Switch			
Consultant Obstetrician on call	Via Switch			
Consultant Neonatologist on call	Via Switch			
Divisional Director in hours	Via Switch			
Associate Director of Operations	Via Switch			
Manager on call out of hours	Via Switch			
Chief Executive	Via Clinical Site Manager			
Ambulance Control	0300 123 9822			

Name
Designation
Time

Date of Re-Opening:

Time of Re-Opening:

Total Days/Hours Closed:

Personnel notified of opening

Name	Contact Details	Personnel Called	Time	Signature
Labour Ward coordinator	Bleep 1440			
Lead Midwife on Call	Via Switch			
Clinical Site Manager	Bleep 1222			
Head of Midwifery	Via Switch			
Consultant Obstetrician on call	Via Switch			
Consultant Neonatologist on call	Via Switch			
Associate Director of Operations in hours	Via Switch			
Director of Operations	Via Switch			
Manager on call out of hours	Via Switch			
Chief Executive	Via Clinical Site Manager			
Ambulance Control	0300 123 9822			

Name
Designation
Time

Appendix 4: Maternity Unit Record of Women contacted due to closure

DATE UNIT CLOSED:		**DATE UNIT RE-OPENED:**	
TIME UNIT CLOSED:		**TIME UNIT RE-OPENED:**	

TIME OF CALL	NAME	MRN NUMBER	REASON FOR PHONE CALL	ADVICE GIVEN	NAME OF UNIT REFERRED TO OR COMMUNITY MIDWIFE CALLED	Outcome

Appendix 5: Neighbouring Hospital Information Form

(TVEA to identify units to cover. Midwife to phone with patient details to arrange transfer)

TVEA – 08712374974

HOSPITAL	TEL NUMBER	ABLE TO ACCEPT Y/N	CRITERIA
Bedford NHS Trust Kempston Road Bedford MK42 9DH	01234 355122 Bleep 142		Case by case
Northampton Cliftonville Northampton NN1 5BD	01604 634700 (ask for maternity bleep holder 4100)		Case by case
Stoke Mandeville Mandeville Road Aylesbury Bucks HP21 8AL	01296 315000 (ask for maternity bleep holder 645)		
Luton & Dunstable Lewsey Road Luton LU4 0DZ	01582 491166 (ask for maternity bleep holder 550)		
Kettering Rothwell Road, Kettering Northampton NN16 8UZ	01536 492000 (ask for maternity bleep holder 030)		
Leicester General Hospital & Leicester Royal Infirmary George Hine House Gipsy Lane Leics LE5 0TD	**0300 300 31573 (ask for maternity bleep holder 4001)**		
Nottingham Queens Medical Centre Derby Road Nottingham NE7 2UH	0115 924 9924 (ask for maternity bleep holder – the duty Maternity Bleep holders are on mobiles) 07812268449 for Queens 07812268241 Nottingham City Hospital		

Appendix 6: Template for informing the regional clinical network

Close or divert Template	
Organisation and site	
Date	
Time of closure	
Time of reopening	
Number of hours unit closed	
Reason for closure	
Number of women / babies who needed to be diverted	
Units to where women were diverted	
Any incidents relating to closure or divert.	
Acuity or Red flags at the time of closure	
Decision to close agreed by	
	Please return the completed form to: england.maternitycn@nhs.net

This form is available in the Maternity Safety Huddle Team on MS Teams, to be completed by the bleep holder/LW coordinator in discussion with the LMOC and saved into the teams folder.

The LMOC will review it and email it to the regional clinical network.

Appendix 7: Quick reference guide for Birth Rate Plus categorisation of care

Category	Type of Woman	Examples	
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.	*In the immediate PN period women keep their Intrapartum category*
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.	
Inductions 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	