	DIVISIONAL DOCUMENT
Delete as appropriate:	Guideline
DOCUMENT TITLE:	**Escalation and Unit Diversion for Maternity Services**
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LEAD EXECUTIVE DIRECTOR DGM	Divisional General Manager
AUTHOR(S): Note should not include names	CBS Midwifery Lead Matron

TARGET AUDIENCE:	Head of Midwifery, Deputy Head of Midwifery, Matrons, Obstetricians, Band 7 Midwifery Leads, Neonatologists, NICU leads.
DOCUMENT PURPOSE:	The overall aim of this guideline is to support staff during periods of increased operational pressure and to ensure safe staffing levels. This guideline will support: • Safe and effective care for mothers and babies to maintain quality and choice and reduce potential risk during periods of escalation. • Structured implementation of processes to temporarily divert from the unit when the need to do so and risks to safety cannot be mitigated. • Clear expectations and guidance around roles and responsibilities in the processes required for escalation and diversion. • Agreed escalation levels and triggers that are applied and adhered to across Maternity Services with East Lancashire Hospitals NHS Trust.

To be read in conjunction with	ELHT Corporate Guideline C135: Safe Nursing and Midwifery Staffing Escalation Policy ELHT Corporate Guideline C146: Director (DOC) and Senior Manager On-Call (SMOC) Participation Policy ELHT Corporate Guideline C159: Emergency Preparedness, Resilience and Response (EPRR) Policy ELHT Maternity Services Standard Operating Procedure 36: Closing Blackburn Birth Centre Maternity Services Risk Management Strategy ELHT Maternity Services Standard Operating Procedure 37: Central Birth Suite Escalation Triggers ELHT Maternity Services Clinical Guideline 25: Local Management of Maternal Death
SUPPORTING REFERENCES	SITREP (Situational Report) North West Maternity Escalation Policy and Operational Pressures Escalation Levels Framework

CONSULTATION		
	Committee/Group	Date
Consultation	Head of Midwifery, Deputy Head of Midwifery, Matrons, Band 7 Midwifery Leads, Obstetricians, Neonatologists Obs Gline Group	Sept 2022
Approval Committee	Women and Newborn QSB	Oct 2022
Ratification date at WNQSB	October 2022	
NEXT REVIEW DATE:	October 2025	
AMENDMENTS:		

This guideline is local to ELHT, but reference to the North West Maternity Escalation Policy & Operational Pressures Escalation Levels Framework 22.08.1 V2.0 is required for support and guidance with Regional pressures at OPEL LEVEL 4

1.0 Purpose

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 practice options have been exhausted, as the consequence to women and other neighbouring units must be appreciated. When factors which precipitate the temporary formal diversion of maternity services are resolved, the process of diversion should be reversed as soon as is practicable.

The temporary closure of the Neonatal Intensive Care Unit (NICU) does not necessarily result in the closure of a maternity unit. High risk pregnancies that may potentially require neonatal services, such as prematurity or known fetal complications, should be assessed on an individual basis with joint consultation by the consultant obstetrician and consultant neonatologist. These in utero babies may require transfer to a neighbouring obstetric unit with appropriate neonatal facilities.

This guideline will aid the Central Birth Suite coordinator, Consultant Obstetrician, Matrons, Head of Midwifery, Deputy Head of Midwifery and Senior Manager on Call, to source potential solutions to maintain a safe service. When all potential solutions are exhausted, and the delivery of a safe maternity service is compromised the formal diversion of maternity services to other units may occur. The individuals who are likely to be involved in the diversion need to be notified at an early stage to the risk of a potential formal diversion. This guideline has been devised as a local guideline, taking into consideration recommendations and guidance from the North West Maternity Escalation Policy and Operational Framework (OPELMF).

2.0 Scope

This guideline applies to all aspects of maternity services including community and hospital-based services.

3.0 Roles and Responsibilities

Senior Manager

During normal working hours the Matron, Deputy Head of Midwifery and Head of Midwifery should be informed when the unit status is at OPELMF level 3 or purple so that support can be given to the Central Birth Suite coordinator to explore all options to maintain a safe service. Out of hours the Birth Suite Coordinator will contact the Senior Manager on Call to inform them of the unit status. During working hours, the Matron, Deputy Head of Midwifery or Head of Midwifery will need to attend the unit to assist in managing the formal diversion if

required. Out of hours the Senior Manager on Call will contact the Director on Call If it is felt that a formal diversion is required for authorisation.

Clinical Site Manager

The Trusts Clinical Site Manager will work with the Central Birth Suite coordinator to assist with contacting other service providers and other staff and agencies as identified in the diversion checklist and for documenting accordingly.

Head of Midwifery / Deputy Head of Midwifery

The Head of Midwifery, supported by the Deputy Head of Midwifery will ensure that the escalation guideline is appropriate for the service and the guideline is shared with ELHT Senior operational trust management and clinical site manager team.

Quality and Safety Team

The Family Care Quality and Patient Safety Team will ensure there is a robust process is in place for reporting clinical incidents and implementation of the escalation guideline whilst also ensuring formal diversions are reported monthly.

Consultant Obstetrician

The on-call Consultant Obstetrician will work in partnership with the Central Birth Suite coordinator and Matrons to ensure a safe service by appropriate implementation of the guideline as required. **This role is one of the key decision makers in initiating a unit diversion.**

Matrons

The Matrons will ensure that the guideline is implemented into practice and that all midwifery staff are aware of the guideline and their individual roles and responsibilities. During working hours, they will work in partnership with the Central Birth Suite coordinator and on call Consultant Obstetrician to ensure a safe service by appropriate implementation of the guideline as required. **This role is one of the key decision makers in initiating a formal diversion**.

***Central Birth Suite coordinator* / Maternity Band 7 Manager**

- The Central Birth Suite coordinator will ensure that the steps detailed within the guideline are implemented in a timely manner to reduce the need for unnecessary escalation whilst ensuring a safe service is provided. This role is the common point of contact for all staff and embraces responsibility for coordinating all aspects of the service.
- The Central Birth Suite coordinator will be responsible for leading and generating the maternity safety huddle throughout the day and generating the current OPELMF status periodically at 09:30, 14:30, 21:30 and 02:30

- The Central Birth Suite coordinator has responsibility for escalating appropriately to the on-call Consultant Obstetrician and Matrons to ensure a safe service by appropriate implementation of the protocol as required. **This role is one of the key decision makers in initiating a formal diversion**.
- The Central Birth Suite coordinator will work in partnership with the Matrons and the trust Senior Manager on Call to identify appropriate resources available to assist with contacting other maternity units to ascertain their availability to accept women when a formal diversion is necessary.

Antenatal Triage Midwife

- The Antenatal Triage Midwife will communicate with all women phoning the service and risk assess their current care requirements and the most appropriate and safest place for this care to be provided.
- The Antenatal Triage Midwife will communicate with the Central Birth Suite coordinator regarding women who have been risk assessed as needing to be seen within maternity services.

Individual Staff

Staff will ensure they are aware of the protocol and who they should escalate to when concerned about the safety of the service.

4.0 Definitions

ED – Emergency Department
ANC – Antenatal Clinic
ANW – Antenatal Ward
ARM – Artificial Rupture of Membranes
BBC – Blackburn Birth Centre
BGBC – Burnley Birth Centre
BGTH – Burnley General Teaching Hospital
CBS – Central Birth Suite
CLC – Consultant Led Care
COU – Close Observation Unit
ELHT – East Lancashire Hospitals NHS Trust
ECV – External Cephalic Version
HoM – Head of Midwifery
LSCS – Lower Segment Caesarean Section
MLC – Midwifery Led Care
NICU – Neonatal Intensive Care Unit
NWAS – North West Ambulance Service
OPELMF – Maternity Operational Pressures Escalation Levels Maternity Framework
PNW – Postnatal Ward
RBC – Rossendale Birth Centre
SITREP – Situational Report
TC – Transitional Care
UCC – Urgent Care Centre

5.0 Precipitating Factors Requiring Escalation

- Insufficient midwifery or obstetric staff for workload
- Insufficient maternity bed capacity
- Insufficient skill mix for workload
- Major incidents – infection outbreak, fire, maternal death, sudden unexplained neonatal death, power failure, other major incidents
- Adverse weather conditions
- Closure of NICU

7.0 Operational Pressure Escalation Levels Maternity Framework (OPELMF)

The status of the maternity unit will be reviewed by the multidisciplinary team, led by the Central Birth Suite coordinator during the daily safety huddles, which take place at 09:30, 14:30, 21:30 and 02:30 as a minimum.

The Central Birth Suite coordinator will be responsible for monitoring and recording activity and staffing throughout the shift and escalating as required. They are also responsible for informing all clinical areas of unit status.

OPELMF Status	Escalation level
OPELMF One (Green)	The local maternity service capacity is such that the organisation can maintain patient flow and meet anticipated demands with available resources. Additional support is not anticipated.
OPELMF Two (Amber)	The local maternity service is starting to show signs of pressure. The maternity service will be required to take focused actions to mitigate the need for further escalation. Enhanced coordination and communication will alert the whole system to take appropriate & timely actions to reduce the level of pressure in the system.
OPELMF Three (Red)	The local maternity service is experiencing major pressures compromising patient flow and safety and continues to increase. Further urgent actions are now required across the whole Local Maternity System and increased external support may be required, including agreement for deflection of patients within the LMS. Regional Teams will be made aware of rising system pressure, providing additional support as deemed appropriate.
OPELMF Four (Black)	Pressure in the local maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised. Decisive action must be taken locally to recover capacity and ensure patient safety. All available local escalations actions have been taken, external extensive support and intervention is required. Regional teams will be made aware providing additional support and will be actively involved in conversations within the system. National team will be informed by local regional teams through internal reporting mechanisms. When multiple systems in different parts of the country are declared OPELMF Four for sustained periods and there is an impact across local and regional boundaries, national action will be considered.

8.0 OPELMF level one triggers and actions required

OPELMF level 1 – the maternity service can maintain patient flow and meet service demands

Triggers

- All women are receiving 1:1 care in labour.
- All services within maternity are available.
- All areas can maintain safe care based on current activity and acuity.
- Antenatal beds are available.
- Antenatal triage beds are available.
- Induction beds are available with no delays in transfers or admissions.
- BGBC / BBC / RBC are open.
- Home birth service is available.
- Postnatal beds / transitional care beds are available.
- The maternity unit has ideal staffing levels based on activity and acuity.

Actions Required

- Continue to review acuity and staffing levels of the maternity unit periodically and at the safety huddles, as a minimum at 09:30, 14:30, 21:30 and 02:30, with representation from all areas within maternity services, including NICU.
- Be responsible for ensuring staffing levels are checked on a shift-by-shift basis taking action to fill any identified gaps over the next 24-48 hours.
- At end of each shift, to discuss formally with oncoming CBS coordinator current activity and staffing over the next 24 hours, utilising the CBS Band 7 handover log (Appendix 1).

8.1 OPELMF Level 2 triggers and actions required

OPELMF Level 2 – signs of pressure in the system

Triggers

- CBS: Acuity assessment is increased (more than 6 women in labour, COU beds and bereavement suite both occupied).
- Antenatal Ward activity: more than 6 ongoing inductions of labour, more than 6 antenatal ward inpatients, more than 2 patients awaiting admission from home.
- Delay of more than 4 hours for admission from home at the planned time to the induction suite.
- Issues with delays pertaining to NWAS transfers ***(please section 8.4 for specific management).***
- Triage is more than 4 hours waiting time for the next available appointment.

- Divert from either BGBC or BBC to CBS in place to enable delivery of 1:1 care in labour.
- Delay of more than 4 hours for transfer to CBS for augmentation of labour / ARM from induction suite.
- Delay of more than 2 hours when ready for transfer from CBS to postnatal ward due to bed availability.
- Suspension of home births due to home birth already taking place / inadequate midwifery on call cover resulting from sickness / current maternity unit activity and acuity.
- Midwifery / obstetric / anaesthetic staffing / skill gaps identified that cannot be mitigated.
- Staffs breaks unable to be safely facilitated because of current staffing levels throughout the entire maternity service.
- No COU cover.
- NICU is closed.

Actions Required

- Review activity in all areas as to what can be delayed or postponed safely to release staff to areas of increased acuity.
- Collaborate with the senior obstetric and anaesthetic team and utilise support with assessment of the above.
- Escalate to the maternity Matrons / Band Seven Managers / in hours and weekends up to 16:30 or the Clinical Site Manager (out of hours). Matrons to attend CBS and formulate action plan.
- Utilise all managerial staff in clinical areas during working hours.
- Re-deployment of staff within all clinical areas to areas where activity and acuity is deemed highest.
- Utilise unused hours as appropriate and where possible.
- Consider cancelling management time, training, time owing, etc.
- Consider utilising specialist midwives within the clinical area, formulate a rota for specialist midwives during periods of increased staffing pressures.
- Request additional staff members via bank staff on e-roster.
- Two ambers will trigger red and requires urgent escalation to the Matron (within working hours) or Clinical Site Manager (out of hours).

8.2 OPELMF Levels 3 status, triggers and actions required

OPELMF Level 3 – Major Pressure

Triggers

- Unable to provide 1-1 care in labour in any area within maternity services including suspension of home births and closure of BGBC / BBC.
- Maternal death / sudden unexpected neonatal death in hospital (not NICU).

- Two amber escalations.
- Delay of more than 12 hours for admission from home at the planned time to the induction suite.
- Unable to accept urgent admissions for inductions.
- Women labouring on the antenatal ward as no beds available on CBS.
- Postnatal ward / antenatal ward at full capacity and no potential discharges within the next four hours.
- Birth suite coordinator is temporarily providing direct care to antenatal / postnatal women whilst extra support for birth suite is provided.
- Unsafe staffing levels to cover for acuity of the service despite redeployment and closure of the birth centres.

Actions required

- Ensure OPELMF level two actions are complete.
- Temporarily divert services from BBC - midwives to be redeployed to the LWNC and to report to CBS co-ordinator.
- Amalgamate BGBC with CBS – midwives to report to CBS co-ordinator.
- PNW staffing to be minimised to 1 RM and 1 MSW per zone, deliver basic care for an interim period.
- Liaise with clinical site manager to identify whether any nursing staff are available to support postnatal ward during periods of extreme pressure whereby staffing is reduced to 1 midwife and 1 MSW per zone.
- Liaise with NICU co-ordinator to consider re-deployment of NICU nurses to postnatal ward to support with TC babies / neonatal cares.
- Liaise with the Acute Care Team and consider utilising support for women requiring COU care.
- Liaise with Consultant Obstetrician regarding rescheduling of elective LSCS, non-urgent planned inductions of labour and planed admissions to CBS such as ECV's.
- Consultant Obstetrician on call alongside senior registrar to review patients on antenatal and postnatal ward and identify those who can be safely discharged from maternity services.
- Consider redeployment of specialist midwives during working hours.
- Consider redeployment of staff from ANC during working hours.
- Consider calling in community midwives undertaking postnatal home visits to support the unit.
- Amalgamate the ANW and triage.
- Out of hours, if available, if maternity services are about to be fully escalated to purple with the risk of diversion, on call midwives to be contacted and asked to attend the unit. Central Birth Suite co-ordinator to assess where these midwives are to be redeployed to.
- Maternity Matrons to attend central birth suite and formulate plan to mitigate situation.
- If unable to mitigate red, escalate to Head of Midwifery, Deputy Head of Midwifery and Directorate Manager during working hours. Out of hour's the Consultant

Obstetrician on Call, Senior Manager on call and CBS coordinator to formulate an action plan.

- Consultant Obstetrician on call to attend central birth suite and support with formation of action plan whilst ensuring all medical staff are utilised in supporting activity within maternity services.
- Follow trust policy in the event of a maternal death.
- Complete Datix incident form (IR1).
- Log nursing midwifery red flags.
- Continue to monitor situation every two hours, if risk cannot be mitigated and safety cannot be maintained, despite ongoing actions and re-deployment of staff, escalate to purple.

8.3 OPELMF Level 4 status, triggers and actions required

OPELMF Level 4 – Extreme pressure

Triggers

- No beds available within maternity services.
- No patients can be safely transferred home from the service to create maternity beds.
- Cannot give 1-1 care in labour despite escalations.
- Birth suite coordinator not supernumerary.
- Significant midwifery staffing gaps that cannot be mitigated to maintain safety.

Actions required

- Continue to implement actions from OPELMF status level 2 and 3.
- Matrons, Head of Midwifery / Deputy Head of Midwifery in hours, Senior Manager on Call and Director on Call, out of hours, birth suite coordinator to request formal divert to the nearest maternity unit.
- Review hourly and divert for the minimum amount of time to maintain safety – obstetric emergencies attending via ambulance must not be diverted.
- Contact NWAS to inform them of formal diversion request
- Contact ED to inform them of formal diversion.
- Complete Datix incident form (IR1).

8.4 Management of delays pertaining to NWAS transfers

In the event of a major incident being declared by NWAS, this should be communicated via the Director on Call to maternity services. Home births and women in labour at BBC and RBC (standalone birth centres), should be diverted. Women should be informed that a transfer is recommended and preparations for the same should be made. Women who intend to birth at either BBC or RBC should be informed that they should deliver at LWNC due to the risk of significant delays in transfer times, whilst in labour, which could have a significant impact during an emergency.

Any delays with NWAS transfers experienced by midwives whilst attending to women at home or in the standalone birth centres should be escalated to the Central Birth Suite coordinator via the 010 bleep. The Central Birth Suite coordinator will then contact NWAS and advise them of the delay, declaring an obstetric emergency that requires a category 1 response time. Following this, if the delay persists, the Central Birth Suite coordinator should escalate to the Clinical Site Manager, and they will liaise with NWAS.

9.0 Decision to formally divert women from the Maternity Unit

The decision to divert women should be consensual and normally follow discussion by the Matrons, Head of Midwifery, Deputy Head of Midwifery, the Central Birth Suite coordinator, Consultant Obstetrician on call, Senior Manager on call and Director on call.

Executive to executive engagement

The expectation is that all Maternity units will involve executives in the agreement to divert patients away from the unit due to capacity issues etc. It is also the expectation that executives be involved in acceptance of diverted patients. It is however also understood the operational day to day capacity of the unit (both in hours and out of hours) is the remit of the unit managers. Therefore: Any request for a formal divert must have agreement between the diverting trust and receiving trust executives once a dynamic risk assessment has been completed.

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

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

Once the decision has been made internally, in partnership with the receiving units, to temporarily divert new admissions (not including obstetric emergency cases) a request must then be immediately made to the ambulance service to accept or decline a Formal Divert Request dependent on wider regional ambulance capacity and demand and system wide intelligence.

Maternity Services must be aware that a formal divert does NOT include obstetric and neonatal emergency cases and as such all emergencies will be transferred to the nearest unit regardless of a formal divert in place.(North West Maternity Escalation Policy & Operational Pressures Escalation Levels Framework 22.08.1 V2.0)

It is recommended that one person is designated to coordinate the procedure for diverting women. To ensure the Central Birth Suite coordinator can maintain the helicopter view over activity and acuity within maternity services, during working hours, the midwifery Matrons should coordinate the diversion process. Out of hours the Senior Manager on Call should be contacted, and appropriate support sought to assist with this process.
The Clinical Site Manager should assist with contacting other maternity units to ascertain their status and capacity.
If women who are inpatients are to be transferred to another hospital, the Consultant Obstetrician on Call and Central Birth Suite coordinator must make this decision considering the distance to the receiving hospital.
The Central Birth Suite coordinator should complete the Maternity Unit Diversion Checklist (Appendix 5)

10.0 Implementation of a Formal Diversion (Appendix 3 & 4)

The Clinical Site Manager will contact the other maternity units in the area to ascertain if they have the capacity to accept women booked with us in labour. Document each maternity unit's ability to accept women in Appendix 7.

In working hours, Matron to contact the Head of Midwifery or Deputy Head of Midwifery to inform them of the maternity unit status and request a formal diversion. Out of hours the Central Birth Suite coordinator will contact the Senior Manager on Call who will contact the Director on Call to request a formal diversion.

If other units can accept women, complete the unit diversion checklist which documents who has been informed and when (Appendix 5)

1. Contact the Antenatal Triage Midwife to advise them of our need to divert women to other maternity units.
2. Contact ambulance control and inform them of our status and advise them which other maternity units have capacity. (be aware NWAZ can decline any diverts if they have specific pressures themselves)
3. If not already involved in the process, inform the Clinical Site Manager of the implementation of the diversion protocol and the arrangements in place. The clinical site manager will contact the trust on-call Director.

4. Contact the Emergency Department and Urgent Care Centres (UCC) to advise them of the diversion of maternity services and request that they liaise with the Central Birth Suite coordinator if any women attend during this time.
5. Inform the Band 7 coordinator on NICU of the decision to divert women to ensure that in-utero transfers are not accepted. Ask them to inform the Consultant Neonatologist.
6. Inform switchboard.
7. Inform women in labour telephoning prior to their admission, of the possible need to divert to another hospital (please see Appendix 10). Obtain their details and brief history using the Maternity Telephone Assessment Sheet. Review maternity notes and make a risk assessment using the risk assessment tool (Appendix 2) to identify if it is appropriate and safe to divert the woman to another unit. Women in the red category should be discussed with the Consultant Obstetrician on call; women in the amber category will need to be discussed with a Speciality Trainee (ST) Year 5 and above. Women in the green category should have an individual risk assessment based on the current clinical picture. Advise them of the nearest maternity units receiving women and ask which they would prefer. Inform the women that they will receive a phone call back within 30 minutes and advise them that if their situation changes or if they have not heard back within 30 minutes to call again.
8. Contact the receiving unit to check that they are still able to accept the woman and provide the receiving unit with all relevant details. Phone the woman back to inform her that the receiving unit is expecting her and give her the address and contact details of the receiving unit (Appendix 12).
9. If women arrive to the unit un-announced, assess their condition and arrange their transfer to a receiving unit as appropriate.
10. The midwife manning the Antenatal Triage telephone line and staff on Central Birth Suite should maintain a record of all women diverted to other units (Appendix 8) and all women who attend the unit when on divert (Appendix 9).
11. Generate IR1 via Datix
12. If no other maternity unit can accept women from ELHT Maternity Services as they too have capacity, staffing or other issues, document on the Central Birth Suite coordinators log (Appendix 6) and escalate to the Matron or out of hours the Senior Manager on Call. The Senior Manager on Call should inform the Director on Call of the inability of neighbouring units to accept transfers from ELHT Maternity Services.
13. The status of the service should be reviewed at least every two hours and the diversion stood down as soon as it is safe to do so.

11.0 Standing Down Formal Diversion Status

When the factors that precipitated the maternity unit diversion are resolved the above process is reversed.
The Central Birth Suite coordinator should ensure that the maternity unit re-opening checklist (Appendix 11) is completed and sent together with the diversion checklist and details of women who were diverted to other units to the Head of Midwifery within 24 hours. It is good

practice for the Head of Midwifery to write to all women who have been directed to other units to apologise for the inconvenience cause (Appendix 13).

12.0 Dissemination

This guideline will be published on the intranet under Maternity Service Guidelines and will be available for all trust employees.

13.0 Process of Monitoring Compliance and Effectiveness

The capacity of the unit and need to implement the escalation protocol is monitored by the Central Birth Suite coordinator and Matrons. The status of the service is monitored every morning by the multi-disciplinary team and periodically throughout the day via the maternity safety huddle. Contingency plans, if required in the presence of staffing or acuity concerns are made for the next 24-hour period.

Unit diversions will be reported monthly to the Family Care Quality and Patient Safety Team, details of which should be completed by the Central Birth Suite coordinator.

Monitoring on the appropriateness of women being diverted is via the log of women diverted. This is reviewed by the Head of Midwifery or Deputy Head of Midwifery.

Appendix 1 – CBS Coordinator Hanover Sheet

Date – Handover from / shift –

Date – Handover from / shift -

Sickness	
Staffing gaps / added onto roster/ email line manager	
SITREP (R/A/G)	
Admissions to NICU on shift	
Any other incidents requiring a rapid review	

Any other issues – equipment, medicines, other areas affected	
Daily Checklists / Weekly Checklists completed	

Appendix 2 – Patient risk assessment during unit diversion

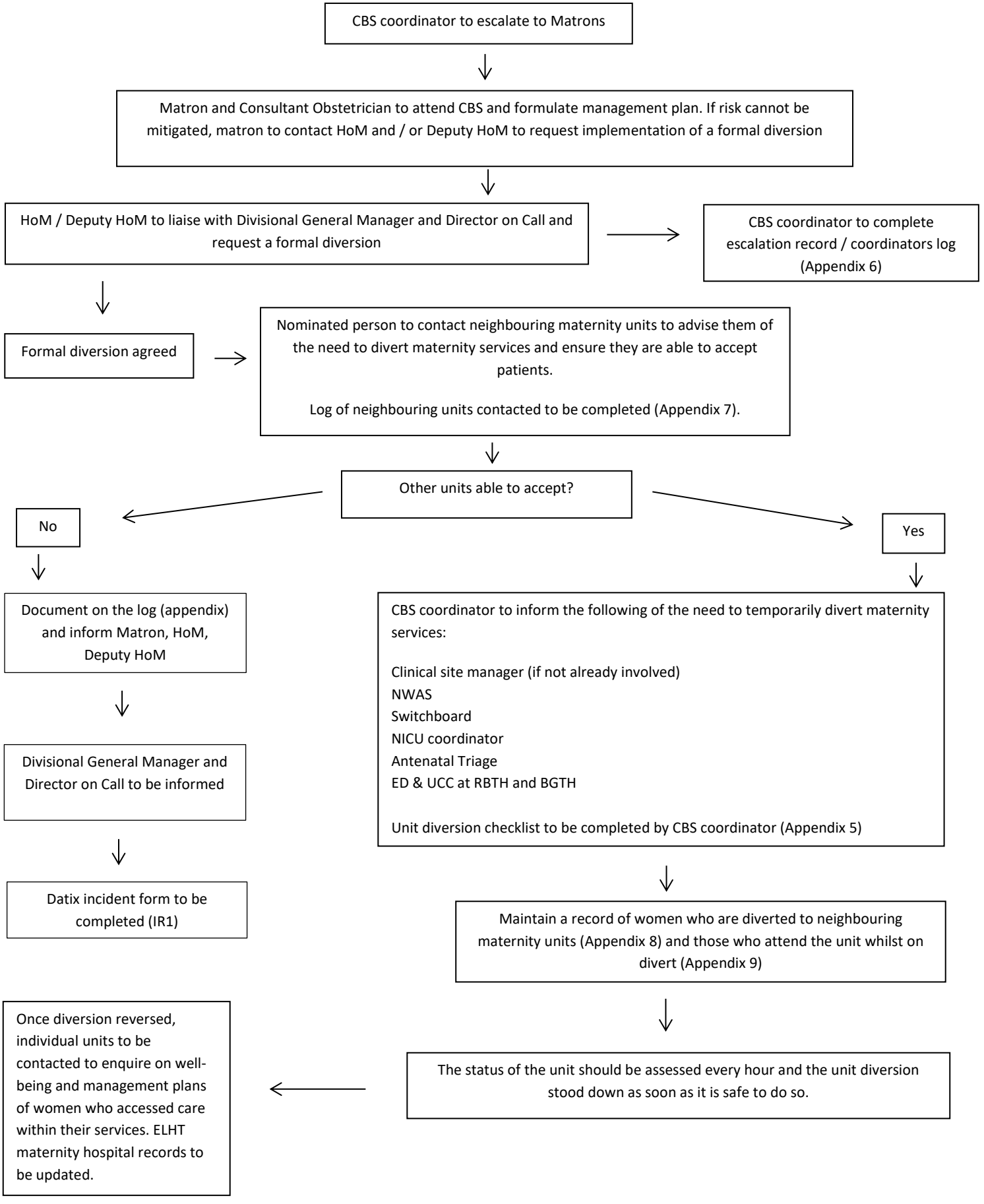
Women in the red category should be discussed with the Consultant Obstetrician on call.

Women in the amber category will need to be discussed with a ST5 or above for guidance and planning.

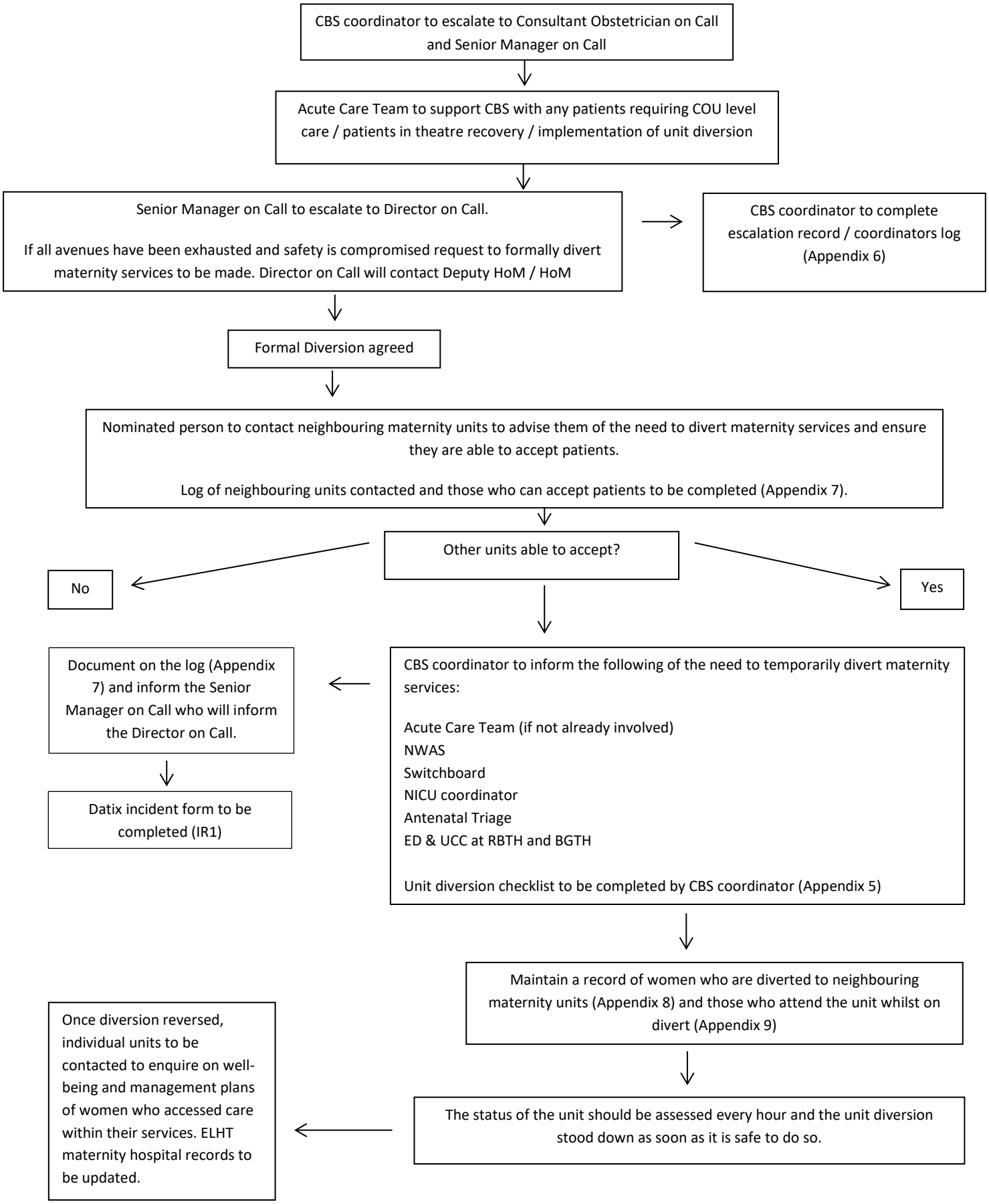
Women in the green category should have an individual risk assessment based on the current clinical picture.

Red
Any event that is considered an obstetric emergency (cord prolapse, APH, PPH, fetal heart rate abnormalities, breech birth, shoulder dystocia). Imminent delivery Serious ongoing medical or obstetric complications, that have required antenatal MDT planning Major fetal anomaly – unless advised to deliver in a unit with surgical facilities – refer to maternity records No fetal movements as per triage RAG rating
Amber
Planned caesarean section in labour Stable medical / obstetric complication i.e., diabetes, known VTE, PIH, PET Reduced fetal movements who need immediate assessment as per RAG rating Spontaneous rupture of membranes with significant meconium-stained liquor
Green
Spontaneous onset of labour Spontaneous Rupture of membranes – clear liquor Reduced fetal movements with no other risk factors that require assessment within 4 hours as per RAG rating

Appendix 3 - in hour's formal diversion process



Appendix 4 - Out of hours unit diversion



Appendix 5 - Maternity unit diversion checklist

Date of protocol implementation		**Time of protocol implementation**	

Reason for protocol implementation	**Additional details**
Insufficient medical / midwifery staff (delete as appropriate)	
Inappropriate skill mix	
No beds	
Infection as directed by microbiologist	
Major incident / power failure	

Personnel notified of diversion	**Name**	**Date**	**Time**
Matron			
Consultant Obstetrician			
Head of Midwifery			
Deputy Head of Midwifery			
Acute Care Team			
Senior Manager on Call			
Director on Call			
NICU coordinator			
Consultant Neonatologist			
NWAS			
Switchboard			
ED at RBTH **UCC at RBTH**			
UCC at BGTH			

Neighbouring units able to provide care
Receiving Units Senior Midwife contacted and informed of ELHT diversion:
Unit & Name:

Form completed by (Name and designation) _____

PLEASE SEND COMPLETED FORM TO HEAD OF MIDWIFERY

Appendix 6 – Escalation Record / Coordinators Log

Please document any issues on shift and escalation steps you have taken

Date: _____ **Time: _____**	**Who / What**	**Outcome / Discussion**
Matron contacted		
HoM / Deputy HoM contacted		
Clinical Site Manager contacted		
Acute Care Team contacted		
CBS Workload / Staffing		
ANW workload / Staffing		
Antenatal Triage Workload / Staffing		
BGBC Workload / Staffing		
BBC Workload / Staffing		
Homebirths / RBC		
PNW Workload / Staffing		
Outstanding Workload (ARM's awaiting transfer, inductions awaiting admission, theatre cases		

Please document any subsequent phone calls / correspondence

Date / Time

Appendix 7 - Record of units contacted to accept women

Date:

	Time:		Time:		Time:		Time:		Time:		Time:	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Airedale General Hospital 17.8 miles												
Calderdale Royal Hospital 20.4 miles												
North Manchester Teaching Hospital 26.6 miles												
Royal Preston Hospital 29.9 miles												
Royal Oldham Hospital 31.6 miles												
Royal Bolton Hospital 37.3 miles												
St Mary's Hospital 60.2 miles												
Blackpool Victoria Hospital 43.8 miles												
Leeds General Infirmary 60.2 miles												
St James, Leeds 61.9 miles												

IF NO UNITS ARE ABLE TO ACCEPT THE CBS COORDINATOR AND THE SENIOR MANAGER ON CALL SHOULD RECORD THIS AS AN ATTEMPTED FORMAL DIVERSION, COMPLETE AN INCIDENT FORM ON DATIX AND ESCALATE TO THE DIRECTOR ON CALL.

COMPLETED FORMS SHOULD BE SENT TO THE HEAD OF MIDWIFERY

Appendix 8 - Record of mothers diverted to another hospital

Date and time formal diversion implemented _____

Date and time formal diversion stood down _____

Date and time of call	Name	RXR number	Reason for phone call	Advice given	Name of unit referred to	Outcome e.g. admitted / delivered

COMPLETED FORMS SHOULD BE SENT TO HEAD OF MIDWIFERY

Appendix 9 Record of mothers who attended ELHT whilst on a formal divert

Date and time formal diversion implemented _____

Date and time formal diversion stood down _____

Date & Time	Name	RXR number	Reason for admission	Reason attended when unit on divert, i.e. risk assessment warranted admission, did not phone prior to presenting, phoned first but decided to come anyway	Outcome of visit 1. Assessed and sent home. 2. Assessed and AN admission 3. Assessed and in labour 4. Assessed and PN readmission	Name of midwife

COMPLETED FORM SHOULD BE SENT TO HEAD OF MIDWIFERY

Appendix 10 - Crib Sheet for formal maternity unit diversion

"Good morning / evening, Antenatal Triage line, (or telephone location) Jane Smith, midwife speaking, how may I help you?"

(Record information given by the woman/her partner on the telephone assessment sheet – Risk assess re suitability to divert - refer to patient risk assessment document and classify woman as RED/AMBER/GREEN)

If **RED** or AMBER – discuss with the on-call Consultant Obstetrician and CBS coordinator.

The woman and her partner should be advised that:

"We are currently working to full capacity and are therefore limiting the number of admissions we accept at this time in order that all women receive safe care. I am going to discuss your case with the doctor and a senior midwife and we will phone you back to advise you where you should attend within the next 30 minutes (give them an expected time), if your situation changes in the meantime please do not hesitate to call us back".

If **GREEN** - the woman and her partner should be advised that:

"We are currently working to full capacity and regret that we are unable to accept any new women at this time in order that all women receive safe care. We are diverting women to other local hospitals that will be able to care for you during this busy period. I am sorry for any anxiety or distress caused by this situation. I will ensure that I will contact the closest maternity unit to you first. We know that a number of maternity units are able to accept women. Please can you give me your address and I will contact the unit nearest to you?" (Record the address on the telephone assessment form).

"I will now call the unit(s) and just double check that they are still able to accept women and pass on your details. I will call you back shortly (give an expected time) to confirm that the unit is expecting you and to give you full directions.

Appendix 11 – Maternity unit re-opening checklist

Date of re-opening		Time of re-opening	
Total days / hours since diversion	Days:	Hours:	

Personnel notified of diversion step down	**Name**	**Date**	**Time**
Head of Midwifery			
Deputy Head of Midwifery			
Matron			
Director On Call			
Senior Manager on Call			
Acute Care Team			
Consultant Obstetrician on call			
NICU coordinator			
Consultant Neonatologist on call			
NWAS			
Switchboard			
ED at RBTH UCC at RBTH			
UCC at BGTH			

Number of women diverted to other units	
Number of women delivered in other units	
Form completed by (name and designation	

COMPLETED FORMS SHOULD BE SENT TO HEAD OF MIDWIFERY

Appendix 12 – Contact details of neighbouring hospitals

Airedale General Hospital
Skipton Road
Steeton
Keighley
West Yorkshire
BD20 6TD

Switchboard - 01535 652511
Labour Ward - 01535292402

http://www.airedale-trust.nhs.uk/

Calderdale Royal Hospital
Salterhebble
Halifax
HX3 0PW

Switchboard - 01422 357171
Labour Ward – 01422 222129

https://www.cht.nhs.uk/home

North Manchester General Hospital
Delaunays Road
Crumpsall
M8 5RB

Switchboard - 01616 240420
Labour Ward – 01616 258008

https://www.pat.nhs.uk/getting-here/public-transport_3.htm

Royal Preston Hospital
Royal Preston Hospital
Sharoe Green Lane
Fulwood
Preston
PR2 9HT

Switchboard - 01772 716565
Delivery Suite – 01772 524495

https://www.lancsteachinghospitals.nhs.uk/directions-to-sharoe-green-unit-and-chorley-birth-centre

Royal Oldham Hospital
Rochdale Road
Oldham
OL1 2JH

Switchboard - 01616 240420
Delivery Suite - 01616278255

https://www.pat.nhs.uk/getting-here/public-transport_4.htm

Royal Bolton Hospital
Minerva Road
Farnworth
Bolton
Lancashire
BL4 0JR

Switchboard - 01204 390390
Delivery Suite – 01204 390579 or 01204390932

http://www.boltonft.nhs.uk

St Marys Hospital
Oxford Road
Manchester
Greater Manchester
M13 9WL

Switchboard - 0161 2761234

https://mft.nhs.uk/saint-marys/

Blackpool Victoria Hospital
Whinney Heys Road
Blackpool
Lancashire
FY3 8NR

Switchboard - 01253 300000
Delivery Suite – 01253 953618
http://www.bfwhospitals.nhs.uk

Leeds General Infirmary

Great George Street
Leeds
LS1 3EX

Switchboard - 01132 433144
Delivery Suite – 01133 927445

https://www.leedsth.nhs.uk/a-z-of-services/leeds-maternity-care/how-to-find-us/

St James's University Hospital

Beckett Street
Leeds
LS9 7TF

Switchboard - 01132 433144
Delivery Suite – 01132069103

https://www.leedsth.nhs.uk/a-z-of-services/leeds-maternity-care/how-to-find-us/

Appendix 13 – Apology letter

East Lancashire Hospitals NHS Trust

Family Care Division
Lancashire Womens and Newborn Centre
Burnley General Hospital
Briercliffe Road
Burnley
Lancashire
BB10 2PQ

(Insert contact telephone number)

(Inset date)

Dear

I would like to apologies that you had to be referred to another Maternity Unit on (insert date) owing to the temporary closure of the Maternity Unit at (insert which hospital). As I believed you were informed at the time, this was due to (insert reason/s here)

Please be assured that the health and safety of both your baby and yourself was our prime concern when the decision to refer you to another hospital was made. A decision to close the Maternity Unit is always made as a last resort, but we understand how stressful this late change must have been for you.

We would like to take his opportunity to offer you further explanation if you feel you should need it. This can be done in a number of ways, i.e. in a meeting or by telephone. If you would like to take up this opportunity, please do not hesitate to contact (insert contact person), on the above telephone number.

Yours sincerely