Worcestershire Acute Hospitals NHS Trust

Maternity and Neonatal Services Escalation Policy

Countywide Maternity and Neonatal Services Contingency Plan to Manage Bed / Cot Pressures

Key Document code:	WAHT-TP- 094	
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Approved by:	Maternity Governance Meeting	
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Key Amendments

Date	Amendments	Approved by

Introduction

This escalation policy is specific to the maternity and neonatal units and community services within Worcestershire Acute Hospital NHS Trust.

The purpose and intention of this policy is to provide all levels of staff within the multidisciplinary team with instruction on how to manage beds/ cots and staffing levels to ensure business continuity is maintained during times of high activity or staffing shortfall.

This policy is incorporated within the Trust escalation policy but it is vital to remember that due to the nature of maternity and neonatal services constant fluctuations in activity mean that bed / cot management has its own entity.

Every effort should be made to care for women booked within Worcestershire for maternity and neonatal care within the Worcestershire Acute Hospitals NHS Trust maternity and neonatal unit.

At times of high activity, the maternity unit coordinator role will ensure the regular, proactive local management and communication of activity, capacity and staffing within and between the maternity and neonatal unit coordinators. This will support the timely identification and escalation of pressures upon the maternity / neonatal services which may impact on continued provision of services (See Appendix A for role outline and associated documentation).

Alert Declaration Summary

Green: ***Routine bed / cot management procedures***.
Operating levels normal within maternity and neonatal unit.

Amber: ***Crisis bed / cot management procedures***.
To be implemented whenever there is a need to create additional capacity quickly. This may be to admit new patients on behalf of regional units, or to respond to capacity issues locally.

Red: **Restriction of Hospital Admission to Maternity/ neonatal Unit**

Decision to restrict hospital admissions to obstetric or neonatal clients. This situation only occurs when the consultant unit has capacity and/or activity pressures. On occasions the neonatal unit cot capacity may also restrict maternity activity.

Green: ***Routine Maternity and neonatal Bed / cot Management***

Clinical directorates will have sufficient designated beds/ cots to fulfil contracted elective and emergency activity.

Day to day management of beds/ cots is the responsibility of Maternity Unit Coordinator, Band 7 labour ward co-ordinators/ NNU Shift coordinator, Ward Managers and Matrons. Implementation of maximum efficiency in bed usage should be ensured. Close involvement by multi-disciplinary team/ Senior Clinicians are key to the efficient discharge planning and practice and ensures effective business continuity planning.

Maternity Department must not accept any outlying patients from the acute side. The only exception will be early pregnancy admissions following consultation with the senior maternity team.

Neonatal Units are expected to contain their activity within cot availability, therefore if cots are closed for reasons of staff shortage etc. activity should be adjusted accordingly. If difficulties in accommodating babies are apparent during the day, early involvement of the Consultant on call and Matron is advised.

Early escalation is vital in daytime hours when capacity activity issues are first identified. If difficulties in accommodating patients are apparent during the day early involvement of the consultant on call and Matrons is advised.

Amber: ***Crisis Bed / Cot Management***

Triggers: The level of bed / cot occupancy has reached crisis point within the unit, i.e. level of activity actual and anticipated is beyond the bed/ cot capacity available.

For MATERNITY: The Unit Coordinator on 12 hr. day shift via bleep 223 or Band 7 labour-ward coordinator out of hours to instigate the following:

- Alert on-call consultant; ensure they undertake additional ward rounds in all areas to review the status of all inpatients, review antenatal patients and any postnatal inpatients with medical complications.
- On-call consultant will expedite clients' discharge and ascertain reasons why discharge is not feasible.
- Review elective work, including inductions of labour, and consider re-arranging or cancellation of any non-urgent activities after liaison between senior medical and midwifery staff.
- Alert senior midwife / Matron, or on call midwifery manager if out of hours.
- Inform the hospital capacity hub.
- If closure of the unit is being considered, the Clinical Director and a member of the Divisional Management Team should be informed (in hours) or the 401 bleep holder and the general manager on call (out of hours).
- Medical staff to alert and liaise with paediatricians, including consultant, and neonatal matron/senior sister to review cot capacity and expedite any neonatal transfers or discharges.
- Encourage early discharge home following delivery for appropriate women and babies.
- Alert and liaise with the on call consultant anaesthetist.

- Designate staff to help with discharge procedures.
- Ensure clients are kept fully informed during bed crisis situations.
- Documentation should reflect any discussions with the women during a crisis.
- Consider transfer of patients with early pregnancy complications or pregnant with medical condition as main reason for admission to other female wards or the dedicated antenatal beds for gynaecology patients.
- Inform Ambulance Control

This should be a standard procedure regardless of clinical area, when the bed/ cot situation is approaching crisis, i.e. no further discharges available, ward beds/ cots full and labour ward beds/ cots anticipated cot use rapidly reaching capacity.

Diversion of women should be carried out on an individual woman by woman basis. It is paramount that this is done sensitively following consultant and/or senior midwife involvement and without increasing the clinical risk for the woman.

When a woman rings maternity triage, the midwife should take her details as is normal procedure. Where possible the woman should be invited to the unit for assessment in accordance with the triage guideline (WAHT-OBS -115).

Communication between all clinical areas is paramount; this communication should involve the Senior Midwives (DS coordinator and maternity manager on call), neonatal nurse (coordinator) senior medical staff including paediatricians and anaesthetists. Ambulance Control should also be alerted of the internal crisis.

Community midwives may also be able to help with home assessment and accepting early postnatal discharges and countywide outpatient maternity staff should also be informed to enable them to appropriately refer women should the need arise.

Additional maternity inpatient bed capacity may be accommodated within maternity triage, located at the entrance to the Antenatal ward. This would provide an additional 3 inpatient beds leaving 1 triage clinical assessment room without en-suite facilities.

Duty Operations Manager and Bed Manager within the Trust capacity Hub should be informed.

The Communications department should be made aware if women are diverted to another unit.

The on-call maternity manager will record a summary of escalation calls via the on-call summary sheet.

For NEONATAL UNIT: The Senior nurse, shift coordinator and/or Band 7 senior nurses will be aware and will instigate the following:

- Alert on-call Consultant, ensure they undertake additional ward rounds in all areas to review the status of all inpatients
- On Call consultant will expedite discharge where possible and ascertain reasons why discharge is not feasible.
- Designate staff to help with discharge procedures.
- Ensure parents are kept fully informed during cot crisis situations
- Documentation should reflect any discussions with the parents during a crisis
- Consider transfer of babies requiring low level care to Transitional Care
- Consider the use of the Ben Bennett Suite

- Consider transfer of care to neonatal outreach service if appropriate

Communication between neonatal and maternity staff is paramount; this communication should involve Senior Nurses, Senior Medical Staff including Paediatricians and Obstetricians, Senior Midwives.

The 401 bleep holder should be informed of the situation and requested to inform the senior nurse bleep holder where additional support can be provided.

Neonatal Outreach Nurses may also be able to help with accepting early discharges.

If staffing allows, extra cot capacity may be accommodated within the neonatal unit. This will dependant on space and equipment availability.

Duty Operations Manager and Bed Manager within the Trust Hub should be informed.

The Communications department should be made aware if mothers and/or babies are diverted to another unit, especially if outside the County.

The Neonatal Intensive Care Unit (NICU) shift coordinator will record a summary of escalation calls via the on-call summary sheet.

Red: *Restriction of Hospital Admission to Maternity/ Neonatal Unit*

Triggers: Following instigation of actions within amber alert **all** available beds within ward areas and the Meadow Birth Centre are full and delivery suite have only 2 rooms available, which can be used for assessment of patients or imminent delivery OR **all** available cot spaces/equipment within the unit are full except for one emergency cot space.

Maternity Red: Restricting admission to Worcestershire Acute Hospitals maternity unit for maternity patients is a **last resort** and the ultimate decision to do so can only be taken by an **Executive Director.** This decision would be made following consultation with the relevant senior clinical and management staff as identified in the Maternity and Neonatal Escalation Algorithm in Appendix G.

When the maternity unit is on red alert women who are considered clinically safe, following telephone triage and discussion with medical staff, may on an individual basis be asked to attend an alternative maternity unit without undergoing assessment. If the clinicians have any concerns the woman should be invited to attend and an assessment should be carried out. See contingency plans for facilitating divert or transfer of women to alternative maternity unit.

Neonatal Red: Review all admissions to maternity services of high risk women: high risk will include any women likely to require delivery under 37 weeks and/or complication of pregnancy likely to result in their baby requiring neonatal care

Closure of the Neonatal Unit will impact on to Maternity Services. Restricting admission to hospital for maternity patients is a **last resort** and the ultimate decision to do so can only be taken by an **Executive Director.** This decision would be made following consultation with the relevant senior clinical and management staff as identified in the Maternity and Neonatal Escalation Algorithm in Appendix G.

SEE CONTINGENCY PLANS FOR CLOSURE OF MATERNITY / NEONATAL UNIT

Staff shortage can occur at times of unusually high workload or high dependency, at times of increased staff sickness levels, when there are unfilled vacancies or during adverse weather events.

It is imperative that all duty rotas are completed with the correct analysis of staff utilisation. No more than 20% of total establishment should be off at any one time for annual leave; sickness and study (please refer to Safe Staffing levels Maternity / Neonatal Unit

Short Term Staff Shortage

Midwifery / Nursing / Support Staff

The Matron, Labour Ward Coordinator/ NICU Shift coordinator and or Ward Manager will:

ACTIONS: -

- Review all clinical areas and judge workload and dependency.
- Review of duty rotas for all midwives / Nurses across the three sites and consider utilising staff centrally in area of greatest need.
- Redeploy non-clinical midwives/ Nurses and support staff to work in clinical areas.
- Review planned study leave / annual leave and reschedule
- Review women/ babies to identify and expedite discharges.
- Review elective work – inductions, caesareans with Consultant on call
- Review ward areas to expedite discharges; involve NIPE trained midwives from community to assist patient flow.
- Liaise with Consultant on call and consider cancellation of any non-urgent activities
- Utilise community staff. On call midwives to be asked to assist in extreme situations.
- Assess overall skill mix of midwifery, nursing and support staff and utilise appropriately.

The allocated ward manager / labour ward or shift co-ordinator should contact: -

- Antenatal clinics and community midwifery teams to ascertain if any staff are available to cover on a short term basis
- Part time staff who have indicated they would be willing to work additional hours.
- Staff on annual leave to ascertain if they are willing to work
- Staff already on duty who are willing to working additional hours
- Follow HR advice during exceptional times, full time staff may be requested to work overtime hours (including those on Annual Leave)
- Review usage of NHSP
- The maternity department does not use Agency midwives.

To ensure patient safety and safe staffing levels staff must be prepared to move to another area when requested to do so.

NB Delivery Suite and the Neonatal Unit, as central points must maintain an up to date staff contacts list for reference.

Medical Staffing

In the event of short term medical staffing shortage, the on call Consultant will take responsibility for assessing and managing the shortage to minimise risk and impact on care.

Depending on the nature of the staffing shortage this may include:

Review of the weekly duty rota and re-allocating duties amongst the doctors available (NB – copy found on delivery suite or in Directorate office at WRH site – in O & G Secretaries offices)
Link to rota available to band 7's kept on Delivery Suite
https://worcsacuteobs.medirota.com

Username and password available from maternity coordinator.

- Contact other medical staff to seek help in covering the shortfall.
- Contact other consultants to seek help in covering shortfall.
- Review countywide medical staffing levels to identify any additional staff that may be transferred to provide cover.
- Undertake additional ward rounds to expedite discharges
- Contact locum agencies to provide cover.
- Cancellation of some or all elective activity to free up other staff members
- Consultant may need to reside in the unit to cover junior doctor shortfall and minimise risk and impact on care.
- In hours: Escalation to Clinical Director or Directorate Manager where another solution has not been identified. Out of hours: escalate to on call Consultants to review and inform hospital manager for further support and escalation.
- NB – Contact numbers for all current members of directorate medical staff are kept in a red 'Emergency Contacts' folder on each site. In WRH this is located in the Directorate office – in O & G secretaries' offices.
- Review of planned study leave / annual leave and reschedule as required.

Where the above is not practical or possible, the on call Consultant will contact the designated medical staffing coordinator (Out of hours contact on call general manager) who will:

- Review of planned study leave / annual leave and reschedule

already in above

Should the staffing issue pose a medium to long-term risk the appropriate escalation process will be followed, with reference to Medical Safe Staffing Obstetric Levels (WAHT-CCG-498) and 'Obstetric Directorate Escalation Process Algorithm' (Appendix H).

Medium term staff shortages

When the above measures have not resolved the crisis and the situation is considered clinically unsafe, the following staff are made aware of the crisis situation (see Appendix B for contact details).

Matron / Senior Midwife/shift coordinator for the area
Divisional Director of Nursing & Midwifery
Clinical Director

Directorate Manager
Divisional Operations Manager
Divisional Medical Officer

Midwifery / Nursing / Medical and Support Staffing

Allocate a member of the team to:-

- Review all clinical areas and judge workload and dependency.
- Contact part time staff who have indicated they would be willing to work additional hours.
- Roster non-clinical midwives/nurses and support staff to work in clinical areas.
- Contact specialist and senior midwives/nurses to work clinically.
- Contact staff who are on annual leave to ascertain if they are willing to work.
- Contact full time staff to work additional hours (including those on annual leave)
- Review use of NHSP.
- Consider contacting retired or flexi retired midwives.

ACTIONS

- Review of planned study leave / annual leave and reschedule.
- Review of elective work – e.g. Caesareans and inductions of labour with Consultant on call.
- Cancellation of any non-urgent activities.

At times of long term staff shortages

When the above measures have not resolved the situation it is imperative that the relevant senior team (i.e. Matrons/Senior Midwives/Nurse on call, Clinical Directors, Directorate Manager, and Divisional Management Team) are made aware of the situation and that a risk assessment and business case be developed. This will be recorded on the directorate risk register and escalated via the divisional leads.

If Maternity or Neonatal Services business continuity is threatened due to either staff shortages and/ or excessive activity refer to:

Contingency Plans for Closure of the Maternity/ Neonatal Unit and Suspension of countywide inpatient services

The closure of a maternity unit would have major implications for all women booked for care, neighbouring hospitals and neonatal services. The recommendation to close would be made to the Executive Director on call by the Divisional Management Team (in hours) or by the on call manager (out of hours) after consultation with the senior clinical team. Out of hours, this recommendation would be made by the on call hospital manager. The Executive Director on call would then make the ultimate decision regarding closure of the unit.

Closure would only be considered when all other potential solutions are exhausted. In the rare event of the closure of the maternity unit, it is paramount that we have clear safe alternative arrangements for the care of mothers and babies.

The most senior person available should be responsible for co-ordinating the procedure for closure.

Possible Reasons

1. Lack of essential resources – e.g. power
2. No available beds/ cots or neonatal unit cots (all contingency plans must be exhausted)
3. Lack of manpower – midwives or doctors (all contingency plans must be exhausted).
4. Infection in the clinical areas – advised by microbiologist
5. Pandemic

Procedure

- The senior midwife and consultant obstetrician on call, following an in depth discussion and review of all contingency plans, make the decision of the need to close the maternity unit.
- The most senior midwife/matron on duty will coordinate the suspension of maternity services (complete Appendix D – 'Maternity Unit Dependency Record at time of closure').
- The Head of Midwifery/Directorate Manager and Clinical Director need to be fully informed to ensure all factors have been discussed and support the decision to close (see Appendix E for contact details).
- The Directorate Manager (in hours) or on-call hospital manager (out of hours) needs to be informed as referenced in the Maternity and Neonatal Escalation Algorithm in Appendix G.

The following steps will depend on reasons for closure and therefore need to be instigated appropriately-:

1. Liaison with neighbouring units will be paramount regarding how much they can assist and the procedure to refer must be strictly adhered to (Complete Appendix C– 'Workforce and capacity status record').

2. In the first instance, consider if the unit can offer triage facilities to assess women. Only women who require clinical need and are safe to be transferred to be re-directed. (Transferred women should be given or sent letter of explanation – Appendix F).

3. If women who are inpatients are to be transferred to another hospital, the senior midwife in consultation with medical staff must make the decision taking into account the distance to the receiving hospital and presenting clinical picture holistically.

4. Maternity unit to ensure that women in labour are appropriately diverted and transported to another hospital

5. Inform women who telephone maternity triage in anticipation of possible admission in labour that the unit is closed to admissions and that they may be diverted to another hospital following assessment within the unit (if this can be accommodated) , or at home by a community midwife depending on assessment of risk.

6. If women have not contacted the maternity unit prior to their arrival in labour, clinical assessment needs to be made re: safety of transfer or to stay and deliver.

7. It is essential to access women's notes and liaise with the maternity units who have agreed to accept women for care to share specific issues or concerns e.g. Safeguarding Children. If required, a **copy** of the notes may need to be forwarded to the accepting unit. Clerical support should be obtained to assist with arrangements.

8. A record of women diverted to other units should be maintained using Appendix D (Maternity Unit closure).

9. All staff on duty will be informed of the suspension of services and unit closure via the senior midwife/Band 7 or consultant on call.

10. The decision to suspend maternity services, close the maternity unit and ongoing closure must be assessed two hourly with the full management team to ensure all factors have been fully considered and appropriate actions taken. The multi-disciplinary team on duty should be kept informed after each of the review sessions and updated regarding ongoing service status.

11. When it is safe to re-open the maternity unit this will be agreed by the management team and communicated to the multi-disciplinary team on duty and the Ambulance service, via Silver control.

12. The Communications department will be kept informed, especially if closure is likely to last several days as the closure will generate media interest.

13. The CCG's will be kept informed by the executive team with status updates throughout the suspension of maternity services.

14. A DatixWeb incident form should be completed as soon as is practical.

15. A summary report will be written to reflect the activity and capacity issues that led to the closure.

If the decision to restrict admissions has been taken, the Senior Midwife / Nurse or Delivery Suite /NICU co-ordinator should notify the following: -

- On-call consultant obstetrician
- On call consultant anaesthetist
- On-call consultant paediatrician
- Senior nurse in NICU/SCBU
- A&E shift coordinator
- Bed manager on duty for the Hospital

Other Trusts should be contacted to ascertain which maternity units are able to accept admissions as part of the contingency planning.

See contact details below Appendix C Workforce and Capacity Status Record

Appendix A: Maternity Unit Coordinator Role

Maternity Unit Coordinator Role (MC) 07:30 – 20:00

The role of maternity unit coordinator (MC) requires a working knowledge of the whole unit in terms of staffing and flow and combines clinical skills, knowledge and management, coordinating the maternity unit and balancing competing priorities to make best use of resources.

Role Outline:
Being allocated MC does not detract from the responsibility of the ward sister or Band 7 labour ward coordinator duties to review, anticipate and address future staffing issues or first line management of sickness absence. The role is being implemented to enhance hour by hour, day to day management and coordination of the maternity unit and relies upon the rostering of a supernumerary Band 7 each day as outlined below.

The MC will undertake a physical walkabout review of all areas at regular intervals following the 08:00 SBAR meeting on DS This will then be communicated to the Band 7 shift coordinator

If activity, capacity or staffing challenges arise during the shift, the MC should be the first point of contact (by bleep). The MC will then determine necessary actions or if escalation is required (i.e. to matron or Consultant). The escalation policy should be referred to at this point (i.e. re-deployment of staff to area of need; re-deployment of non-clinical midwives to work clinically; etc.)

The areas for review include:

- Maternity Triage
- Antenatal ward
- Postnatal ward and Transitional Care Unit
- Delivery Suite
- Meadow Birth Centre
- Transitional Care Unit
- Neonatal Unit

Appendix B: Key Contact Numbers (Neonatal/ maternity Services)

Contacts:

Unit	Telephone Number	Named Contact:	Comments
Worcestershire Royal Hospital	01905 763333		

	Telephone Number	Date & Time informed of need to close	Date & Time informed of reopening
Maternity Manager on call	Bleep 433/ 441 or Via switchboard		
Hospital band 7 on call	Bleep 501		
Hospital General Matron On call	Via Switchboard		
Obstetric Consultant on call	Bleep 217 or Via switchboard		
Paediatric Consultant on call	Via switchboard		
Directorate Manager (in hours) On call hospital manager (out of hours)	Via switchboard Via switchboard		
Supervisor of Midwives	Via switchboard *(Unless other instructions have been given)*		
Ambulance Control	01886 834244		
Executive Director on call	Via switchboard		

Appendix C: Regional Workforce and Capacity Status Record

Please complete table below to record bed / staff status at regional maternity units.
Regional Hospital Contact Numbers
Table 1 Workforce and capacity status

Maternity Unit	Contact	Bed Capacity	Staff levels	Able to accept clients
Universities Hospitals Coventry	02476964000			
Birmingham Heartlands	#6122 0121 424 2000			
Good Hope	#6147 0121 4242000			
City Hospital (Dudley Road)	#6115 0121 554 801			
Birmingham Womens Hospital	#6106 0121 472 1377			
New Cross Wolverhampton	#6139 01902 307999			
Russells Hall Dudley	#6138 01384 456111			
Manor Hospital	#6135 01922 721172			
Gloucester	#6104 01452 528555			
Cheltenham	#6104 01242 222222			
Hereford	#6110 01432 355444			

Appendix D: Record of Maternity Unit Closure and Dependencies at time of closure

1. **Summary**

Date and time unit closed	
Date time unit re-opened	
Total length of time unit closed	
Reasons for closure	
Name of senior manager/bleep holder coordinating closure	
Total number of women referred elsewhere	
Ambulance Control & Community Midwives informed	

2. **Women referred to other Units**

Name	Hospital No.	/40	Details of Referral	Para	Unit referred to	Outcome delivered Discharged	Letter sent by

Incident form completed: ……

Signed …… Maternity Bleep Holder

Date & Time ……

Maternity Unit Dependency Record at time closure

	/40	Parity	Clinical Condition / Stage of labour	Details of risk level	Health professional Caring or woman
1					
2					
3					
4					
5					
6					
7					
8					
9					
Pool Room					
A					
B					
C					
Faye Turner Suite / Bereavement flat					
Obstetric theatre					
Intervention Room					

Total midwives on delivery suite	
Total Maternity Support Workers (MSW)/Nursery Nurse	
Additional staff in support medical / nursing	

Meadow Birth Centre /Triage/Antenatal/Postnatal Ward / TCU Dependency

Total number of women on birth centre	
Total number of women in maternity triage	
Total number of antenatal women	
Total number of postnatal women	
Total number of babies	
Total number of midwives on ward at time of decision to close	
Total number of MSWs / Nursery Nurses on ward at time of decision to close	

Actions taken to prevent closure:

Appendix E

Record of Neonatal Unit Closure and Dependency record at time of closure

1. Summary

Date and time unit closed	
Date time unit re-opened	
Total length of time unit closed	
Reasons for closure	
Name of clinical manager/bleep holder coordinating closure	
Total number of women/babies referred elsewhere	

Incident form completed……

Signed …… Neonatal Co-ordinator/Matron

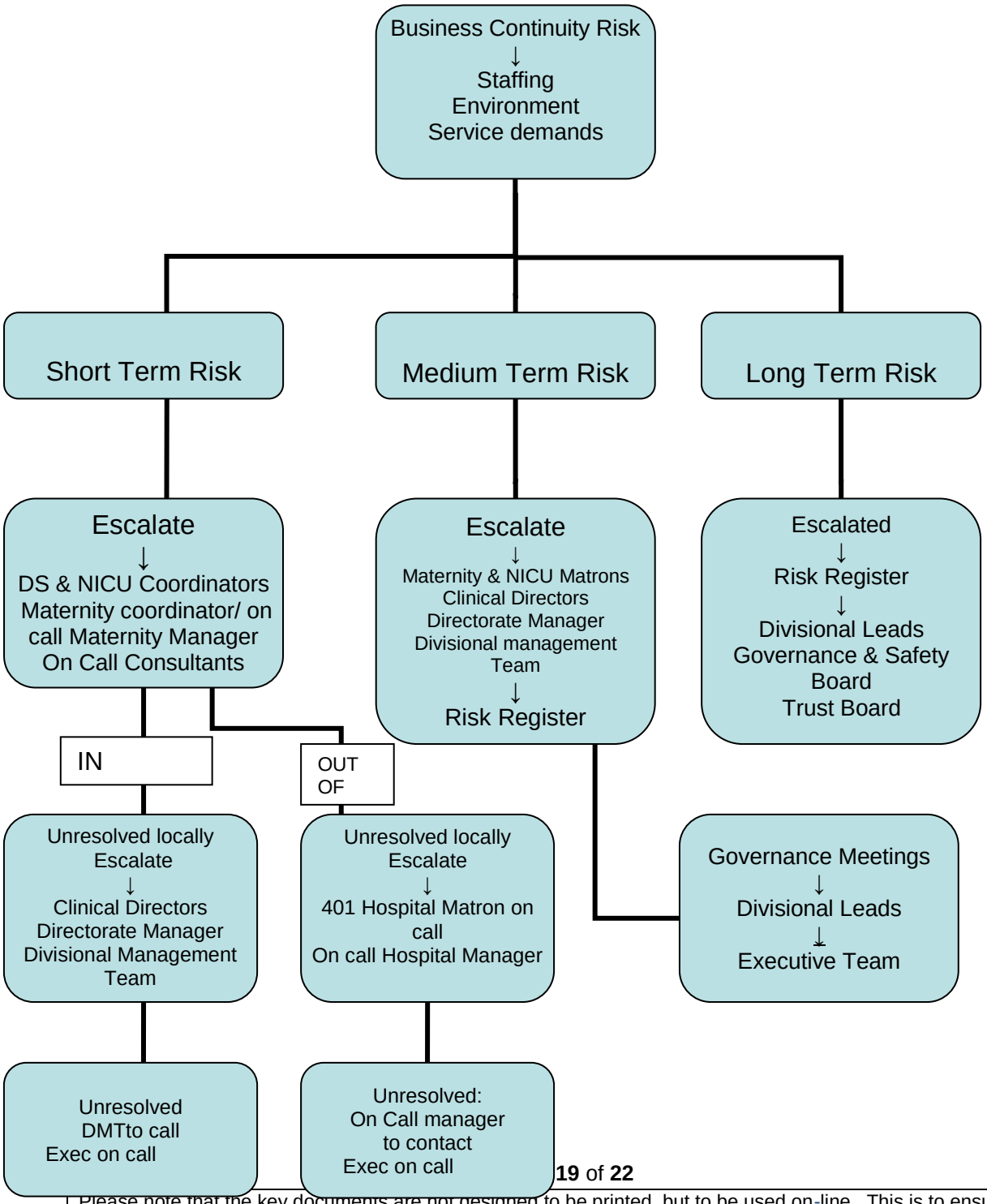
Date & Time ……

Name	**Level of Care**	**Gestation Birth and corrected**	**Clinical Condition Care requirements**	**Equipment in use**	**Health professional Caring for Baby**

Name	**Level of Care**	**Gestation Birth and corrected**	**Clinical Condition Care requirements**	**Equipment in use**	**Health professional Caring for baby**

Total nurses on neonatal unit	
Additional staff in support medical / nursing	

Appendix F - Obstetric and Neonatal Directorate Escalation Process Algorithm



Appendix G

Activity Capacity and Workforce Overview

Worcestershire Acute Hospitals NHS Trust

Chart: Maternity Unit

Level 1 Maternity Units Fully Operational, No major issues	AMBER Level 2 Maternity units operational, However experiencing some pressures	RED Level 3 Maternity services under extreme pressure. Business continuity threatened
Staffing levels normal	Short to Medium term staff shortages, Affecting the units ability to provide specific services	Instigation of contingency plans for yellow alert has failed to avert crisis. (Refer to Maternity Escalation Policy)
Medical staffing levels normal	If staffing issues, consider the option of moving additional staff from within the unit, community, clinic including between sites.	All beds/ cots in maternity unit are full except for 2 rooms on delivery suite available for assessment or delivery
Elective C/S lists proceeding as scheduled. No significant delays	The level of bed occupancy has reached crisis point within the unit.	Severe short, medium, long term staff shortages impacting on safe service
Sufficient capacity to carry out emergency caesareans	Level of activity actual and anticipated is beyond the bed capacity available	Suspension of elective caesarean service
Delivery beds/ cots available	Limited capacity in antenatal and postnatal wards. Additional capacity created in triage	Suspension of induction of labour service
Postnatal ward activity normal levels	Consider suspending home births if staffing issues relating to or escalation impacting on community services	Majax event within maternity services or within the Trust affecting business continuity
Capacity available on antenatal and or postnatal wards	Potential postponement of elective caesarean sections and induction of labour	
	Potential diversion of women maternity units regionally	

Worcestershire Acute Hospitals NHS Trust

Appendix H

Activity Capacity and Workforce Overview Chart: Neonatal Unit

GREEN
Level 1 **neonatal Units** **Fully Operational,** **No major issues**
Staffing levels normal
Medical staffing levels normal

AMBER
Level 2 **Neonatal units operational,** **However experiencing some pressures**
Short to Medium term staff shortages, Affecting the units ability to provide specific services
If staffing issues, consider the option of moving additional staff from within the unit, and community,
The level of cot occupancy has reached crisis point
Level of activity actual and anticipated is beyond the cot capacity available
Limited capacity in TCU
Potential diversion of clients to maternity units regionally

RED
Level 3 **Neonatal services under extreme pressure.** **Business continuity threatened**
Instigation of contingency plans for amber alert has failed to avert crisis.
All cots in the neonatal units are full
Severe short, medium, long term staff shortages impacting on safe service
Majax event within maternity services or within the Trust affecting business continuity