Worcestershire Acute Hospitals NHS Trust

Maternity Escalation & Safe Staffing Policy

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

This guideline is for use by the following staff groups: All maternity staff

Lead Clinician(s)

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Approved by Maternity Governance on:	November 2024
Approved by Medicines Safety Committee on:	n/a
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This is the most current document and should be used until revised version is in place

Key amendments to this guideline

Date	Amendment	Approved by:
4th June 2024	Document extended for another 12 months whilst under review	Maternity Governance
15.11.2024	New guideline following development of regional escalation policy	Maternity Governance

Contents

1. Introduction

The aim of this policy is to outline the minimum and optimum staffing levels within the Worcestershire Acute NHS Hospital Trust (WAHT) maternity service and define the roles and working framework for a safe delivery of service.

The policy describes how safe staffing levels are monitored and reported on and sets out to demonstrate the intention of the service to mitigate escalation where possible. It also sets out the process of escalation for when the service becomes compromised by short staffing, increased activity, reduced capacity or is impacted on by internal or external pressures or circumstance.

The principles of the Midlands Maternity Escalation Policy are aligned with Herefordshire & Worcestershire Local Maternity and Neonatal System (LMNS) in terms of the process of escalation whilst maintaining safe staffing and delivery of services.

Herefordshire and Worcestershire LMNS have adopted the Midlands Maternity approach to escalation to ensure that women's safety is prioritised at all times and there is an agreed process for cohesive communication at times of criticality within the LMNS.

The Maternity Operational Escalation Levels (OPEL) Framework used both internally and externally within Herefordshire and Worcestershire supports clear communication and understanding throughout the escalation and de-escalation process

Appropriate staffing levels and skill mix for maternity services are essential in providing a safe maternity service. This policy is intended to outline the approved and optimum staffing levels at Worcestershire Acute Hospitals NHS Trust (WHAT) maternity services.

It also aims to clarify how staffing is monitored and utilised when responding to activity demands of the service. Assessments of current and future workforce requirements are made locally to identify the number and experience of staff required to provide appropriate and safe cover in all care settings.

Contingency for Midwifery staffing shortfall

Contingency management occurs when midwifery staffing falls below minimum staffing levels or staffing resource does not meet the level of activity within the service to provide safe cover for 1:1 care in labour and ensure that the delivery suite shift coordinator remains supernumerary.

2. Scope

This policy describes the safe optimum levels and appropriate skill mix of staffing required in maternity services, as recommended by the NICE Safe Midwifery staffing for Maternity

Setting (2015), Royal College of Midwives (RCM) and Royal College of Obstetricians & Gynaecologists (RCOG) joint response to the Maternity Safety Strategy and Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (RCOG, 2007) which outline principles for safe staffing in place throughout all the maternity care settings.

This policy ensures that there are robust processes in place to manage the peaks of activity and any shortfalls in staffing in a safe way for women accessing the service. Where short term or long-term shortfalls in staffing are identified, the document expresses how they should be addressed.

The policy explains and makes explicit the required methods and regularity of monitoring and auditing, including the requirement for monthly KPI reporting to Board as well as 6 monthly review of minimum staffing requirements.

3. Purpose

The purpose of this policy is to ensure:

• Appropriate staffing levels and skill mix for maternity services are essential for providing a safe maternity service. This policy is intended to outline the approved and optimum staffing levels at WAHT maternity services to ensure that the required staffing resource is implemented, that staffing is responsive and workforce levels monitored.

• Assessments of current and future workforce requirements are made locally to identify the number and experience of staff required to provide appropriate and safe cover in all care settings.

• To define and make explicit the approved safer staffing levels and ratios for the maternity services.

• To describe how staff are utilised within the maternity service.

• To facilitate the monitoring of actual staffing levels and to enable comparison against the approved levels to gauge compliance with the Birthrate plus recommendations and the acuity tool.

• To outline the contingency plans in place to address short term staffing shortfalls or increase in activity.

• To outline the integration of the OPEL framework into the local Sitrep, the internal recording of the scoring matrix and to record actions taken within the three stages of escalation

• To clarify the process of communication and collaboration within the LMNS and the Midlands region

4. Definitions

- Midwife – a person qualified to assist women during pregnancy, birth puerperium, who is registered with the Nursing and Midwifery Council (NMC).

- Professional Midwifery Advocate (PMA) – A midwife with additional training who supports midwives to advocate for women, and supports the practice and professional development of midwives.

- Manager on call – a senior midwife or nurse who is identified as having responsibility for the 'out of hours' operational coordination of the maternity service.

- Unit Coordinator – a band 7 midwife who is supernumerary and allocated daily from 8am – 8pm to manage capcity and flow across the maternity service. To monitor acuity and ensure that staffing is safe in all areas of the maternity service.

- Maternity Support Worker (MSW) – a non-registered person with training in caring for women before, during and after birth in all care settings. And care of babies in the postnatal period.

- Nursery Nurse (NN) – a non-registered person, with specialist training in caring for newborn babies.

- Obstetrician – a qualified medical practitioner who specialises in obstetrics who is registered with the General Medical Council (GMC) and is a member of the Royal College of Obstetricians and Gynaecologists (RCOG).

- Obstetric Anaesthetist – a qualified medical practitioner who specialises in anaesthetics and has been deemed competent to work with pregnant women before, during and after labour, who is registered with the GMC and is a member of the Royal College of Anaesthetists.

- Anaesthetic assistants – are usually Operating Department Practitioners (ODPs) but may also be specifically trained theatre nursing staff.

- Ward Clerk – a clerical officer who deals with administration and reception duties on a hospital ward.

- Community – the wider area outside of the hospital setting in which women are treated and cared for, either in their own homes, GP surgeries or other settings.

- Maternity Triage Services (MTS) MTS aim to provide dedicated telephone triage and support services for women in early labour and also those who have antenatal and postnatal concerns.

5. Abbreviations

DS	Delivery Suite
MW	Midwife
CMW	Community Midwife
CoCMW	Continuity of Carer MW
DoM	Director of Midwifery
DDoM	Deputy Director of Midwifery
WM	Ward Manager
MWIC	Midwife in Charge
MoC	Manager on Call
EoC	Executive on Call
223	Unit Coordinator

6. Safe Staffing within Maternity Services

The maternity service provided by WAHT is commissioned by Herefordshire & Worcestershire ICB and supports approximately 5000 births each year.

Birthplace settings include:

- Delivery suite (located on Worcester site)
- Meadow Birth Centre (alongside midwifery led unit)
- Home

The maternity service spans both hospital and community settings ensuring that women receive care across the continuum of antenatal, intrapartum, and postnatal periods. It is inclusive of the pre–natal diagnostic service comprising of Fetal Medicine(Level 2), Maternal Medicine, Antenatal Screening, and the Ultrasound (USS) Sonography service.

Area	**Capacity**
Delivery Suite	10 en-suite birth rooms (1 pool), 3 Observation Rooms, 2 Theatres and recovery area and 2- bedrooom Bereavement Suite.
Antenatal Ward	14 beds with an additional 6 beds for elective gynaecology patients.
Postnatal Ward	35 beds including 9 beds for Transitional Care.
Meadow	4 ensuite birth rooms (3 pools).
DAU	2 assessment beds.
Triage	4 assessment rooms.
NNU	18 cots- 2 IC, 4HD and 12 Special Care
Transitional Care(TCU)	9 maternal beds and up to 12 babies in the event of multiple births
Antenatal Clinic (located at WRH)	
Maternity Hubs (located at AGH & KTC)	

The maternity service is committed to multi-professional care in all aspects of the service with care being determined by the individual needs of women. The service provides training for all professional groups and support staff involved in the provision of maternity services.

The majority of care in uncomplicated pregnancies is midwifery-led throughout pregnancy and birth, with referral to obstetric services where appropriate. For women accessing the alongside Midwifery Led Birth Centre referral to obstetric care is undertaken in the same way.

Women receiving intrapartum care on Meadow Birth Centre are risk assessed throughout the antenatal period, on admission and throughout labour and will be referred into obstetric care if risk is identified. This multi-professional approach is demonstrated in all aspects of the service with active involvement of all specialties (midwifery, obstetric, neonatal, and anaesthetic) in the organisation of the service, strategic developments, and healthcare governance.

The midwife led birthing environments have a consultant midwife as the professional and clinical lead and women are referred to a consultant obstetrician if the clinical need arises. A consultant midwife is available to provide an expert opinion as required.

7. Description of staff groups who work within the maternity service

This section of the policy describes the staff utilised within the maternity service. Monitoring of staffing status is by a twice daily sit rep form (Appendix 1) and the acuity tool (https://acuity.birthrateplus.co.uk) accessed by user name and password.

7.1 Midwives, Nurses, and Support Staff

It is recognised that, regardless of the place of birth or level of risk, women and their babies will be cared for by midwives. The role of the midwife, her function and scope of practice, is established in statute and cannot be delegated to anyone else.

The maternity service is committed to multi-professional care in all aspects of the service with care being determined by the individual needs of women. The majority of care in uncomplicated pregnancies is midwifery-led throughout pregnancy, birth, and the postnatal period with referral to obstetric services only where appropriate.

Midwives are trained to work throughout all areas of the maternity service and to care for women throughout the continuum of pregnancy, birth, and the postnatal period.
A range of birthplace choices are offered at WAHT inclusive of home birth, an alongside midwifery led Birth centre, and the acute settings of the obstetric led delivery suites at WRH.

Birthplace choice is based on women's informed choice and rigorous risk assessment throughout pregnancy. The key issues relating to risk assessment for place of birth and the lead professional for labour are outlined within the antenatal guideline.

Intrapartum care is prioritised within the service and is responded to as the highest priority of care wherever the setting and in times of annual leave or sickness, cross cover for intrapartum services is found from within the entire midwifery workforce.

The majority of the midwifery workforce is managed as a traditional maternity workforce model with midwives being based within the community setting or the acute hospital setting.

The service has implemented five Continuity of Carer teams in line with the national ambition to transform care to a continuity of carer teams' model. This model ensures that women are followed throughout their pathway by a named or known midwife working within a team of 8 - 10 midwives with an individual caseload of no more than 36 women.

Midwives based within the community setting, deliver antenatal and postnatal care from either GP surgeries, Children's Centres or community hubs as well as providing home visits when required.

Midwives working within the acute hospital setting are based within the Delivery suite, Meadow Birth Centre, Postnatal ward, Antenatal ward,Transitional care unit or outpatients including the maternity Triage, Day Assessment Unit (MDAU) and Antenatal Clinic.

The hours of operating, and shift-patterns used are responsive to the needs of each element of the service and are being reviewed to ensure they meet the needs of the service but currently they are as follows:

- The Maternity Day Assessment Unit (MDAU), runs Monday - Saturday, offering a day unit service to women between 8-8pm.

- Community antenatal and postnatal care is scheduled between 09.00 and 17:00; however home visits may take place outside of these hours as the service continues to make every effort to optimise access.

- Satellite obstetric clinics are available at Bromsgrove & Evesham Community Hospitals.

- There are two maternity hubs (KTC & AGH); both offering antenatal and postnatal care, ultrasonography and Day Assessment Care which operates Monday – Friday 9am- 5pm.

- Maternity Triage services – Triage is located on the WRH site and aims to provide a 24-hour telephone advice/triage service for women in labour and for those with urgent antenatal and postnatal complications. The Birmingham Symptom-specific Obstetric Triage System (BSOTS) was developed to better assess and treat pregnant women who attend hospital with pregnancy related concerns and a BSOTS triage service is utilised at WRH.

- Continuity of Carer (CoC) teams offer women flexibility in terms of provision of care responding to the individual needs of women based in a geographical location. Named or known midwives will follow women throughout the continuum of care. CoC teams will develop their own pattern of working.

- Specialist Midwives are midwives who have developed expertise in specific areas of maternity care and are able to provide enhanced support and knowledge both to midwifery colleagues and women. Within WAHT there are specialist roles for:

- Delivery suite Coordinator
- Safeguarding
- Public Health
- Infant Feeding Leads
- Professional Midwifery Advocate
- Fetal Medicine
- Preterm Prevention
- Diabetes
- Pelvic Health
- Fetal Surveillance
- Bereavement
- Risk and Governance
- Practice Development
- Preceptorship
- Patient Experince
- Guidelines & Audit
- Screening
- Maternal Mental Health
- Compliance & Assurance
- Saving Babies Lives
- Recruitment and Retention

7.2 Consultant Midwives

Consultant midwives are qualified midwives who have received further development through academic and practical clinical experience enhancing their midwifery skills to become experts in midwifery practice and leadership. Within the Safer Childbirth guidance, it is recommended that they are represented in the workforce as 1 WTE for midwifery led units and at a ratio of 1:900 births for obstetric led units. This is re-affirmed within the final Ockenden report (2022).

The consultant midwife is responsible for providing the highest level of clinical midwifery support to midwives and women along the midwifery pathway. They provide expertise for midwives and advocacy for women when navigating clinical pathways for women who present with additional risk factors but who opt for a less interventional pathway.

The consultant midwife works in partnership with the obstetrician, midwife, and women to determine the most appropriate clinical pathway in order to optimise a safe and appropriate birth. They contribute to the governance of the service as leads for audit, guidelines advisers and authors and clinical effectiveness. They offer supervision and support to midwives and play an active role as advisors to the senior management team.

7.3 Professional Midwifery Advocates

Professional Midwifery Advocates (PMAs) covering the maternity service ensure that all midwives working in the service and support:

• Monitoring and evaluating quality assurance.
• Education and development of midwives.
• Clinical supervision and revalidation.
• Streamlining personal actions for quality in midwifery work force.
• Offering hot and cold debriefing sessions.

PMAs leads provide a provision of support for the maternity service between 09:00 -17:00. This service is supported by others who work on a sessional basis.

7.4 Registered Nurses

Within the service, nurses can support midwives in providing care to women and their babies in areas of care that can be overseen by a midwife but do not have to be provided by a midwife as laid out in statute. WAHT maternity service can book bank nurses to support midwives with postnatal care on the postnatal ward following completion of PROMPT. Nurse vaccinators are also employed to deliver the maternal vaccination service.

7.5 Theatres Staffing

The Theatre workforce has a dedicated team of nursing/operating department practitioners (ODPs) and healthcare assistants employed to:

• cover elective and emergency obstetric lists in “scrub” and “anaesthetic assistant” roles.

• Provide a full recovery service for women who have had operative interventions under local, regional, and general anaesthetic.

This support is provided 24 hours a day. Maternity provides a maternity support worker who operates as a support between maternity and theatres.

7.6 Support Staff

The maternity service utilises the invaluable resource of support roles within the hospital and within the community in the following roles:

- Nursery Nurses (Band 4)
- Maternity Support Workers (Bands 3)
- Maternity Care Assistants (Band 2)
- Housekeepers (Band2)

Nursery nurses are non-registered practitioners with specialist training in caring for babies and children. The perinatal service utilises nursery nurses who are rostered to work shifts providing support to midwives within the transitional care units (TCU) in caring for babies with specific needs i.e., requiring observations, receiving phototherapy, problems with feeding.

The maternity service utilises the invaluable resource of trained maternity support workers (MSWs) within the hospital and within the community. Maternity support workers are available 24 hours a day within the maternity service to support the normal postnatal pathway which facilitates midwifery resource to be able to provide 1:1 care in labour for birthing women.

Housekeepers are utilised within the hospital service. Predominantly their role is focussed on environmental cleanliness, restocking and ordering.

The maternity service also offers clinical placements for student midwives, nurses and paramedics however they are supernumerary.

7.7 Consultant Obstetricians

Consultant obstetricians are qualified medical practitioners who have obtained their CCT (certificate of completion of training) or CESR in obstetrics and gynaecology and who are on the Specialist register with the General Medical Council and are members of the Royal College of Obstetricians and Gynaecologists (RCOG).

As described the maternity service is committed to multi-professional care in all aspects of the service; with care being determined by the individual needs of women. The majority of care serves uncomplicated pregnancies and is midwifery-led throughout pregnancy and birth, with referral to obstetric services where appropriate. The role of the Consultant Obstetrician is to lead and develop the maternity services alongside their midwifery colleagues and in particular to influence the organisation of the service, strategic developments, and healthcare governance.

The consultant obstetricians are responsible for ensuring the highest standards of obstetric care is provided as appropriate along all parts of the woman's pathway. In particular, the consultant obstetrician is responsible for ensuring a high standard of care for women and their babies with complex medical or obstetric needs, and to be available for the acute, severe, and often unpredictable life-threatening emergencies. They offer clinical supervision and education to the doctors in training throughout the service and there is always a consultant obstetrician either present or available on call for obstetric emergencies.

There is a consultant present on the delivery suite between 08.00 and 21.00 hours without any other clinical commitments during the day. At the weekend, the consultant will be present between 08.00 – 13.00 hours and again between 20:00 – 21:00 hours for an evening ward round. Outside of these hours the dedicated non-resident consultant obstetrician is available on an on-call basis and is required to be able to be present on the delivery suite within 30 minutes.

WAHT has 14 Consultants providing non-resident consultant cover with all of them having out of hours on call commitment. Those on the Obstetrics only on call rota work on a 1 in 10 basis and those working on both the Obstetric and Gynaecology on call rota work a 1:20 with prospective cover. Three of the Obstetricians have a special interest in fetal medicine and three have a maternal medicine interest.

Obstetrics and gynaecology were the first speciality nationally to implement the new junior doctor contracts in October 2016. The new contract meant less flexibility in deploying the junior doctor workforce across the service which required a need to develop a different work force model with greater reliance on senior substantive medical staff. This is in line with recommendations from the RCOG around expanding the consultant workforce to include more resident consultant cover.

7.8 Obstetric Anaesthetists

Obstetric Anaesthetists are qualified medical practitioners who specialise in anaesthetics and have been deemed competent to work with pregnant women before and during labour, and who are registered with the General Medical Council (GMC) and are members of the Royal College of Anaesthetists (RCoA). National reports have emphasised the importance of anaesthetists as an integral part of the obstetric team and in the management of mothers who become severely ill. The maternity service has a designated obstetric anaesthetic lead with both clinical activity and administration time programmed into his job plan. In the maternity service Consultant Anaesthetists are present as follows:

- Ten programme sessions per week to support Delivery suite and the emergency theatres.
- There is a separate senior anaesthetist for formal elective caesarean section lists. Monday – Thursday 8am –6pm.
- Out of hours *6pm – 8am) There is on call Anaesthetic Consultant support from home (<30 min response time)

In addition there is a dedicated duty anaesthetist rostered for maternity services based on delivery suite and immediately available for direct clinical care (pager 701). There may be a senior registrar available to assist and support the duty Anaesthetist out of hours. This individual has responsibilities in main theatre and ICU as well and so may not be available for immediate assistance.

There are antenatal high-risk anaesthetic assessment clinics each week at Worcester Royal Hospital and every 2 weeks at the Alexandra Hospital. These are staffed by one Anaesthetic Consultant

7.9 Anaesthetic Assistants

The anaesthetists who work in maternity services are supported by dedicated trained anaesthetic assistants who are provided by the theatre staff within a theatre setting. The emergency theatre is always staffed with a dedicated anaesthetic assistant who has that competency assigned on the roster system. Any other theatre used for obstetrics, including the second obstetric theatre out of hours and the elective caesarean section sessions are also staffed with a trained anaesthetic assistant.

7.10 On call Manager

The role of the on call manager is undertaken by a senior midwife/nurse who is identified as having responsibility for the daily/night-time operational coordination of the maternity service. The on call manager is not part of the staffing escalation process. The on call manager is expected to escalate to the Director of Midwifery when the maternity service is identified to be at OPEL level 2 or above. The Director of Midwifery will, when appropriate, inform the Trust Executive on call and the ICB.

The on call manager will contact the maternity and neonatal service at 21.30 each evening and at the weekend an additional call at 09.30. The call is intended to provide support and receive a verbal sitrep from the unit bleepholder. When the unit bleepholder is unavailable the Delivery suite Coordinator (LWC) will be contacted for the required information.

Any staffing escalation plans will, where possible, be pre-empted and a written plan (Appendix 2) provided from the matron of the day to the bleepholder, delivery suite coordinator and the manager on call. If challenges were not anticpated the escalation plan will be verbally agreed with the LWC or bleepholder at the time of the telephone call.

7.10 Others

The care needs of women whilst pregnant can be diverse and demanding. The provision of the appropriate care to these women can only be provided when the staff caring for them have the appropriate skills. The maternity service works with a range of additional staff groups including:

- Administrative staff who are a vital and integrated part of the team.
- The neonatal workforce comprising of doctors, nurses, midwives and supporting roles.
- Specialist Allied Health Professionals including physiotherapists, sonographers, clinical pharmacists, and dieticians.
- Porters, drivers, domestic services, security, and other non-clinical support.

In addition, the service utilises the skills of appropriate professionals when necessary or as described within clinical guidelines used within the service.

8. Required Staffing Levels Across Maternity Services

Maternity services in the NHS have seen significant change and development in the last decade which has required a review of how care is delivered to women and their families. Central to this refocus and reshaping of maternity care provision is the overarching vision for safer and more personalised care, as illustrated within the policy publication 'Better Births' (2016):

"…. for all staff to be supported to deliver care which is women-centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries."

This has been re-enforced by the first and final Ockenden report (2021, 2022), the Single Delivery Plan (2023) and included within the ten safety standards for CNST.

Appropriate staffing levels and skill mix across the multi-professional team are therefore essential in providing a safe and sustainable maternity service, whilst ensuring that women and their families receive joined-up care appropriate to their needs and wishes. This is aligned to the expectation outlined by the National Quality Board (2016) which supports NHS providers to deliver the right staff, with the right skills, in the right place at the right time. Based on national health agenda and recommendations, this section outlines the approved Staffing levels within the maternity services on a local level.

8.1 Midwives, Nurses, and Support Staff

Staffing levels for the maternity services are determined in accordance with Birthrate Plus (NICE 2015 guidance) and Safer Childbirth (RCOG, 2007). The service is particularly responsive to 'Safe, sustainable, and productive staffing: An improvement resource for maternity services (National Quality Board, 2018) & 'NICE guideline NG4 - Safe Midwifery Staffing for Maternity Settings' (NICE 2015).

NICE guidance recommends the use of Birthrate Plus to establish midwifery staffing numbers. Locally the maternity service has been assessed by Birthrate Plus in 2020 which supports the requirement for a higher level of enhanced care which is based on the complexity of health needs for women locally.

Birthrate Plus currently recommends that there are 230 WTE midwives (209WTE & 21WTE leadership, governance & specialist roles) which is based on 5000 births annually (2021/2022) providing a ratio of 1:24.

Meeting these requirements is influenced directly by the number of different care providers required to keep staffing safe and sustainable. WAHT are committed to ensuring an appropriate workforce with the necessary skills providing good quality, compassionate care in the right place at the right time with the right skills in line with Getting it Right First Time (GIRFT).

The service is also committed to ensuring that Band 5 midwives remain supernumerary for the orientation period. If this is not possible action must be taken to ensure that the staff member is supported or works in an area where an orientation has already been completed (Appendix 3).

Whilst we aspire to meet the national recommendation for safe and sustainable staffing levels within the maternity service, we also acknowledge the value of expanding skill mix to ensure efficient use of staff, through Birthrate Plus and Nice guideline NG4 (2015). It is recommended that about 10% of 'midwifery' time can be reallocated to appropriately trained and graded support staff within the postnatal and community services to facilitate the midwifery workforce in providing 1:1 care in labour.

Within this workforce it should be acknowledged that the number of maternity support workers (MSWs) acting within a supportive framework to the midwifery role is crucial in providing a safe service.

8.1.1 Obstetric Delivery suite

In order to ensure safety, there will be a Specialist midwife - Delivery suite Coordinator on every shift who is responsible for oversight and coordination of the Delivery suite. Staffing on Delivery suite will be as follows:

Midwives	**Optimal**			**Minimum**		
	E	**L**	**N**	**E**	**L**	**N**
LWC	1	1	1	1	1	1
Midwives	7	7	7	7	7	7
Theatre MW	1*	1*	-	1*	1*	-
Maternity Support Worker	1	1	1	1	1	1
Maternity Care Assistant	1	1	1	1	1	1

*elective days only

Intrapartum care is prioritised within the service and is responded to as the highest priority of care wherever the setting and in times of annual leave or sickness cross cover for intrapartum services is found from within the whole team.

8.1.2 0ptimal and Minimum Staffing Levels

Midwifery clinical leadership is provided by the Director of Midwifery, Deputy Director of Midwifery, Consultant midwife (0.5WTE) and the following matrons:

Matron for inpatient care - Antenatal and Postnatal inpatient services
Matron for Acute Intrapartum care, Triage & Birth Centre
Matron for Community, Continuity of Carer and Bereavement services

Table 1-3 demonstrate Optimal and Minimum midwifery and support staffing levels within all care settings.

Table 1

Midwives	**Optimal**			**Minimum**		
	E	**L**	**N**	**E**	**L**	**N**
ANW	3	3	3	2	2	2
Triage	2	2	2	2	2	2
Telephone Triage	-	1	-	-	1	-
PNW	4	4	3	3	3	3
TCU	1	1	1	1	1	1
Meadow	2	2	2	1	1	1
Delivery Suite	7	7	7	6	6	6
LWC (supernumerary)	1	1	1	1	1	1
Theatre	1*	1*	-	1*	1*	-
NIPE	1	-	-	1	-	-
Total	22	22	19	17	17	16

*Not required on non-elective days or night duty

Table 2

MSW	**Optimal**			**Minimum**		
	E	**L**	**N**	**E**	**L**	**N**
ANW	0	0	0	0	0	0
Triage	1	1	1	1	1	1
PNW	1**	1**	1**	1**	1**	1**
TCU	0*	0*	0*	0*	0*	0*
Meadow	0	0	0	0	0	0
Delivery Suite	1(runner)	1(runner)	1(runner)	1(runner)	1(runner)	1(runner)
Total	3	3	3	3	3	3

*Nursey Nurse allocated to TCU (provided by NNU)
** Senior Maternity Support Worker (if available)

Table 3

MCA	Optimal			Minimum		
	E	L	N	E	L	N
ANW	1	1	1	1	1	1
Triage	0	0	0	0	0	0
PNW	1	1	1	1	1	1
TCU	0	0	0	0	0	0
Meadow	1	1	1	0 **	0**	0**
Delivery Suite	1	1	1	1	1	1
Total	4	4	4	3	3	3

**Only appropriate if 2 midwives allocated to MBC

8.2 Consultant Obstetricians

The consultant obstetrician presence on the delivery suite is a key element of safe staffing. The guidance included within Safer Childbirth (RCOG 2007) is outlined as follows:

Category	Definition	Consultant Presence		
	Births/year	60 - hour	98 - hour	168 - hour
C1	4000 -5000	2008	2009	-

The indication from this document therefore would be for 98-hour presence of Consultant Obstetricians on the Obstetric Delivery suite at WRH. However due to a change in how the safety of obstetric cover is now assessed this standard has been locally assessed and the service now focuses on the attendance of a Consulatant Obstetrician at the times manadated. This is reported monthly in the safe staffing report that is reviewed at directorate,divison and Board level. At the time of writing this policy the consultant presence is as follows:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total
Consultant Presence	8am – 9pm	8am – 9pm	8am – 9pm	8am – 9pm	8am – 9pm	8am – 1pm and 8pm – 9pm	8am – 1pm and 8pm – 9pm	77hrs
Prospective cover	8am – 9pm	8am – 9pm	8am – 9pm	8am – 9pm	8am – 9pm	8am – 1pm and 8pm – 9pm	8am – 1pm and 8pm – 9pm	77hrs
Non-resident on call cover	9pm – 8am	9pm – 8am	9pm – 8am	9pm – 8am	9pm – 8am	1pm – 8pm and 9pm – 8am	1pm – 8pm and 9pm – 8am	91hrs
Resident on call	8am – 9pm	8am – 9pm	8am – 9pm	8am – 9pm	8am – 9pm	8am – 1pm and 8pm – 9pm	8am – 1pm and 8pm – 9pm	77 hrs
Hours covered	24hrs	24hrs	24hrs	24hrs	24hrs	24hrs	24hrs	168

8.3 Anaesthetists

The role of the anaesthetist is an integral part of the maternity services team, and the staffing levels need to recognise that emergencies happen frequently and often with rapidity, with a requirement to respond quickly in order to save mothers' or babies' lives.
In line with the guidance included within Safer Childbirth (RCOG 2007) the maternity service requires the following minimum standards of anaesthetic cover:

- Ten consultant programmed activities or sessions per week, to allow full consultant cover. There are occasional sessions where an ST5 or above registrar may be asked to cover delivery suite during core hours to cover leave. There is always a consultant anaesthetist available to assist/advise if required.
- A dedicated anaesthetist for each formal elective caesarean section list.
- Additional clinical time for antenatal anaesthetic review.
- A named lead obstetric anaesthetist with programmed activities as required.

	Mon	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**
Consultant or specialty Dr Anaesthetist present (prospectively covered)	**8am – 6pm**	**8am – 6pm**	**8am – 6pm**	**8am – 6pm**	**8am – 6pm**	**8am – 6pm (consultant supervises all areas of hospital excl. ICU)**	**8am – 6pm (consultant supervises all areas of hospital excl. ICU)**
Additional Consultant/Senior for CS list	**8am – 6pm**	**8am – 6pm**	**8am – 6pm**	**8am – 6pm**			
Duty Anaesthetist (specialist trainee)	**8am-6pm**	**8am-6pm**	**8am – 6pm**	**8am – 6pm**	**8am – 6pm**	**8am – 6pm**	**8am – 6pm**
On call Consultant	**6pm - 8am**	**6pm - 8am**	**6pm - 8am**	**6pm - 8am**	**6pm - 8am**	**6pm -8am**	**6pm -8am**

8.3.1 Anaesthetic Assistants

It is essential that trained anaesthetic assistants are available. The follow represents minimum standards for this requirement:

	Mon	Tues	Wed	Thurs	Fri	Sat	Sum
Emergency Theatre	1 per shift	1 per shift	1 per shift	1 per shift	1 per shift	1 per shift	1 per shift
2nd Theatre	- ad hoc from theatre	- ad hoc from theatre	- ad hoc from theatre	- ad hoc from theatre	- ad hoc from theatre	- ad hoc from theatre	- ad hoc from theatre
El CS	1 per shift	1 per shift	1 per shift	1 per shift	-	-	-

8.3.2 Other staff groups

Staffing levels for other staffing groups including administrative staff, the neonatal unit and clinical and non-clinical support are not within the scope of this document.

9. Staff Duties

The responsibilities of some groups of staff working on the delivery suite are clearly defined within national guidance.

9.1 Specialist Midwife - Delivery suite Coordinator

As a minimum standard there is a designated specialist midwife identified as a Delivery suite coordinator who provides clinical leadership on each shift on the delivery suite and should remain supernumerary to coordinate, have oversight and situational awareness of the evolving clinical activity within the obstetric delivery suite. This person is clearly identified via the rostering system to ensure that this role is a consistent presence. The coordinator's name is written on the Delivery suite board on a daily basis to ensure that all staff are aware of who this person is.

The Delivery suite Coordinator role includes:

• Coordination of the multidisciplinary team on shift and provision of leadership, advice, escalation of clinical concern, supervision of midwifery and care staff for labouring women across the service.
• Delivery suite Coordinator shifts are rostered in a way that allows the delivery suite coordinator to have supernumerary status (defined as having no case load of their own during that shift).
• Mentoring, supervision and advice for midwives and others.
• Liaison with and support for the obstetric and neonatal teams.
• Escalation of suboptimal staffing, increased capacity and other significant issues to the unit coordinator (in hours) or the midwifery manager on call (out of hours) who will liaise with the trust-wide site coordinator as appropriate and as indicated by the OPEL framework.

9.2 Consultant Obstetrician

Whilst maternity services provide a number of hours of prospective consultant presence on the delivery suite in line with the recommendations of Safer Childbirth (RCOG 2007). As the most experienced clinician, consultants are now often needed to be physically present, including out of hours, to support the care of more complex women or during high levels of activity. It is also expected that the consultant will attend the delivery suite in person (if they are not already present) when it is deemed necessary.

WAHT have a standard operating process (SoP) for ward rounds Ward Round SOP. and also a medical staffing document that states when consultant attendance is mandated based on the RCOG paper Medical staffing for Obstetricians Guideline.

The on-call Consultant can be contacted via switchboard; this contact can be made by any member of the multidisciplinary team however it is expected that the delivery suite coordinator and the on call register have been contacted first if they are not the ones making the initial contact. The time should be documented in the notes. The situation should be clearly described using the SBAR model.

9.3 Obstetric Anaesthetist

Delivery of anaesthesia and analgesia is the mainstay of obstetric anaesthetic practice, but it can only be done safely if the service is coordinated and organised. This responsibility falls to the clinical director for anaesthetics and theatres and to the OSM for anaesthetics and theatres. For the maternity services there is a designated lead obstetric anaesthetist. This person's role includes:

- Leadership and development of the maternity services alongside other senior obstetric and midwifery colleagues.
- Responsibility for ensuring the rota for obstetric anaesthetic cover includes cover for all programmed consultant sessions.
- Responsibility for ensuring that there is a 'duty anaesthetist' immediately available for the obstetric unit 24 hours a day.
- Ensuring that the duty anaesthetist has access to prompt advice and assistance from a designated consultant anaesthetist whenever required.
- Ensuring that sufficient anaesthetic assistants are available.
- The "duty anaesthetist" is assigned by the anaesthetic department, and the roster is published with the designation for maternity service.

9.4 On call Anaesthatist

The on call anaesthetist is responsible for:

- Ensuring the safe anaesthesia and analgesia of women within the maternity services who are referred by obstetricians and midwives
- Reviewing post-partum and post-operative women to ensure their ongoing safe management.
- Responding to emergencies as they occur throughout the service.
- Escalating the demand for additional anaesthetic input to the anaesthetic coordinator and the On-call Consultant Anaesthetist as required.

10 Multidisciplinary Ward Rounds on Delivery suite

To safeguard safety and appropriate escalation of concerns or issues on the Delivery suite the maternity service ensures that there is a consultant led ward round three times per day (over 24 hours) Monday – Friday and twice a day at the weekend. This ensures that the

Delivery suite staff are working together to provide multidisciplinary team working. Where there is no consultant presence then a Datix should be completed. A review of the incident
should take place and actions implemented to ensure improvement. A monthly audit is undertaken as part of safety standards for CNST.

11 Oversight of Midwifery Staffing Levels

The Director of Midwifery is accountable for overseeing the review of midwifery staffing, and for ensuring actions are taken forward required from the review. The allocated workforce leads draw together data recorded on the live establishment trackers and from supporting information from the maternity service acuity tool to summarise compliance with all standards within this document, both local and national.

Each month the maternity service reviews and reports the midwifery staffing levels within the maternity safer staffing paper at the Trust Board meeting. The safer staffing paper includes a review of all vacancy rates, absence (sickness, study days and annual leave), as well as fill rate for bank and agency shifts. Red flags related to staffing are also reviewed and reported having been cross checked using the Acuity tool.

Every six months a staffing review using the Birthrate Plus table top tool will be presented to Trust Board via the Divisional Governance meeting. The Trust Board will be responsible for determining whether short-term contingency, long-term contingency or business planning is required.

This report is required to comply with part of the clinical negligence scheme for Trusts, **Safety action 5**: *Can you demonstrate an effective system of midwifery workforce planning to the required standard.* The review will consider the current numbers of births, the recommendations of national guidance, i.e., NICE Maternity Staffing 2015 and Safer Childbirth (RCOG 2007) and any local expectations for safe staffing.

The Trusts funded staffing establishment position against the most recent Birthrate Plus assessment will also be evidenced. The review will reflect staffing levels specifically at the point of the review and will make recommendations regarding required actions for identified gaps. It will also indicate the number of red flags raised as a result of compromised staffing.

13.Operational Process for the Review of Midwifery Staffing Levels

Every four hours the acuity tool is completed by the Delivery suite co-ordinator, and this provides a real-time overview of the acuity, capacity and staffing of the Delivery suite. The Unit manager of the day (Bleep 223) coordinates the two times per day sit rep which provides a whole service overview of acuity, capacity, and staffing. The OPEL status is confirmed on the sitrep using the OPEL scoring matix (Appendix 4) and the OPEL definitions (Appendix 5).

Each Matron has oversight of individual clinical areas within their remit and communicates by exception escalation/concerns. The twice daily reports are shared with the Divisional

Team, Capacity Hub and CNO/CEO.

Safety huddles are held between the two Trusts in the Herefordshire & Worcestershire Local Maternity and Neonatal System (LMNS) when OPEL Level 2 is reached and mutual aid is required.

The maternity service track monthly key staffing indicators to ensure safety. The monthly safe staffing report is presented to Directorate & Divisional Governance meetings. Maternity safe staffing indicators are under continuous review and therefore escalation or identification of need may happen at any point during the year and actions that are short, medium, or long-term may be taken at any point when deemed necessary.

It is important to recognise that the production of the monthly and six-monthly staffing review is supplementary to the continuous vigilance regarding staffing and safety which is required. The maternity services monthly safe staffing report has the following functions:

- Assuring the directorate and the division that there is a review into all elements of midwifery staffing.
- Ensuring that short, medium, and long-term actions are considered, and escalation of issues occurs as necessary.
- Assurance to the Board that Midwifery staffing is monitored and reviewed frequently to demonstrate safe staffing.

14. Contingency Planning

A key element of quality assurance is the safety of the maternity services at times of peak pressure. The maternity service plans robustly for peaks in activity and undertakes detailed risk assessments to ensure safety for all mothers and babies. The number of times that the service externally diverts activity due to a peak in activity and capacity is extremely rare. However, staffing is reviewed daily to respond to peaks in activity and to prioritise care of labouring women. This can also mean that women's choice can be limited in terms of place of birth due to capacity and or staffing resource.

14.1 Short Term Contingency

The maternity services prioritise care in the following manner:

- One to one care in labour (in all settings)
- Acute antenatal (incl Triage) and postnatal care
- Day assessment unit
- Routine antenatal and postnatal community care

As a routine, rigorous oversight of staff rosters occurs prior to the rosters being published and there is a daily review to mitigate for when staff sickness occurs. Wherever possible

WAHT midwifery bank staff are employed to cover identified gaps. Midwives can flexibly work across all areas of the midwifery pathway and when required respond to clinical priorities within the service.

There is a robust on call rota providing senior support to the maternity services out of hours. A senior midwife or a matron from within the W&C Division is available to provide operational support when the service is experiencing peaks in activity or extreme pressures.

Following the identification of OPEL Amber or above the following actions are taken:

- In hours a safety huddle will be called and attended by the Bleepholder, Matron, Deputy Director of Midwifery and/or Director of Midwifery and the Consultant On-call. Out of hours the on call manager will coordinate a safety huddle either on site or via TEAMs.

- Action card (Appendix 6) to be followed to manage the existing and emerging risks.

- Deployment of staff throughout the entire maternity service to support the priorities of care, and in particular intrapartum care.

- Specialist midwives and office-based midwifery staff are available to work clinically.

- Both community and continuity midwives are available to support short term contingency plans. Community staff can be requested to support for a 4-hour period overnight as part of the on-call agreement. MCoC staff can only be contacted during escalation following discussion and agreement with the Director of Midwifery or the Deputy in her absence and will provide a minimum of 6 hours support, a request for a longer period may be considered if OPEL status is Red/Black

- Elective work may be delayed and postnatal dischsrges from the hospital will be a priority.

- Consideration of reduction or diversion of activity (LMNS wide discussion) or redirection of women, including curtailactivity in one or more birthplace location, where all other options have been exhausted.

- The Director of Midwifery will discuss with the CNO or executive on call any recommendation for the temporary suspension of any service before that decision is finalised.

- If the suspension of any service is recommended a risk assessment will be completed, the ICB and the MNVP Lead will be informed.

14.2 Longer term contingency plans

14.2.1 Maternity Dashboard

It is nationally recommended that all NHS providers ensure that they have robust systems in place for the monitoring of quality and performance of the maternity services. The Maternity Dashboard is a tool that has been collaboratively developed to support this recommendation. The intention of the dashboard is that there should be a clear, robust mechanism for ensuring quality and performance is monitored monthly with key and agreed indicators for safety and standards.

The following groups review the dashboard:

- Maternity Governance
- Quality Governance Committee
- Divisional performance review meeting
- Maternity safety Champions
- Trust Board
- Hereford & Worcestershire ICB (LMNS)

All these groups are in a position to monitor a range of key quality indicators and have the authority to identify the need for longer-term contingency plans with regards to safe midwifery staffing.

Where plans have been put in place, they will be reported at Directorate Performance Review who may request that the Divisional Management team take further action. Final plans will be escalated to Trust Board for information or approval via escalation through the Quality Governance Committee.

Recommendations for suspension of a service (longer term)

A decision to suspend any service must be discussed with the Divisional Mnaagement Team. Executive Team, the MNVP and the ICB. A risk assessment must be completed, the quality impact assessed and considered ahead of a suspension. This must be regularly revisited with a clear plan to reinstate the service as soon as possible.

15. Long term Staff Planning

As each scenario requiring a longer-term contingency plan may have different characteristics and therefore required solutions, the key themes are presented here.

Recruitment and retention play a vital role in maintaining a safe service. The maternity service has a multifaceted strategy for recruitment:

- Investing in WAHT trained student midwives as newly qualified staff
- A return to practice midwifery programme
- Developing the role of maternity support workers to compliment the midwifery workforce
- Recruitment of international midwives
- A planned over recruitment of midwifery staff to mitigate the acknowledged turn over in due to leavers and maternity leave
- Retention midwife to ensure that the 5 high impact interventions are in place

Retention of staff is imperative and creating a working environment where staff choose to stay is an important feature for safe working practice.

WAHT actively engage in:

- Developing staff
- Creating opportunities for career progression
- Engaging and working with staff to create a positive culture e.g through briefings and drop in sessions
- Annual staff surveys to hear what works well and what WAHT can do better

Where there is an absence in a senior leadership role, timely recruitment is imperative.

In scenarios of reduced numbers of effective workforce in Midwives, Nurses, and Support Staff an assessment will be made by the relevant clinical manager with support from the Director of Midwifery and the Deputy Director of Midwifery along with the Maternity Directorate Manager, as to whether a longer-term contingency plan is required. Such scenarios include restricted practice, long-term sickness, suspension, maternity leave, or other long-term leave. Options for addressing this shortfall include:

- Recruitment of fixed term posts.
- Recruitment to permanent posts (where turnover is such that this can be facilitated without compromising the existing post-holder).

Where approval is required outside of the senior maternity team, for example with recruitment, the Divisional Management Team will request approval via the Performance Reviw Meeting and the Executive team will be asked to approve the contingency plan.

16. Women and Birthing Peoples Experience

If the service is required to transfer care to another service due to a temporay closure of the service an acknowledgement and apology letter should be arranged and an opportunity to provide feedback about their experience.

Monitoring

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
	SitRep	Daily	Daily	Senior MW	MGM/SM	Monthly

References

NICE Safe Midwifery Staffing for Maternity Settings - https://www.nice.org.uk/guidance/ng4

Safe, sustainable, and productive staffing in maternity services
https://improvement.nhs.uk/documents/1353/Safe_Staffing_Maternity_final_2.pdf

Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour
https://www.rcog.org.uk/en/guidelines-research-services/guidelines/safer-childbirthminimum-standards-for-the-organisation-and-delivery-of-care-in-labour/

Appendix 1. WAHT Maternity SitRep

Completed by	Name:	Role:

ALERTS			
Total number of ARMS waiting		Cat 3 CS required	
No. of people waiting >6 hours for transfer to DS following decision for ARM		Number receiving enhanced care on DS	
No. of people prolonged SROM >24 hours and awaiting transfer to DS		No. of cancelled Elective CS	
No. of people waiting >6 hours for IOL process to start following admission		Outliers (ITU, medical wards etc)	
No of people with Propess in situ and not yet for ARM		In utero transfers required	
No. of people undergoing IOL and waiting >6 hours from SROM to transfer to DS for augmentation		No of clinical safety incidents escalated since last sitrep	
No. of people deferred admission for IOL		Neonatal OPEL Status (BRAG)	

Outpatient Staffing	Planned	Actual
ANC/DAU WRH		
ANC/DAU AGH		
ANC/DAU KTC		

Opel Status				

Community Teams on call	Day	Night
Abbey (Redditch and Evesham)		
Avoncroft (Bromsgrove and Droitwich)		
Cathedral (Worcester and Malvern)		
Severn Valley (Kidderminster, Bewdley, Stourport)		

Birtrate Acuity RAG	
Delivery Suite	
Meadow Birth Centre	
Antenatal Ward	
Postnatal Ward	

Continuity Teams availability	Day	Night
Emerald		
Opal		
Pearl		
Ruby		
Sapphire		

Inpatient Staffing		Planned	Min	Actual
Early	RM	21	17	
	MSW	4	3	
	MCA	3	2	
Late	RM	21	17	
	MSW	4	3	
	MCA	3	2	
Night	RM	20	16	
	MSW	4	3	
	MCA	3	2	

Capacity	Triage 4	Antenatal Ward 14	Delivery Suite 10 birth rooms (3+2)	MBC 4	Postnatal Ward 26	Transitional Care 9
Available Beds						
Confirmed Discharges						
Potential Discharges						
Expected Admissions						

Appendix 2 Escalation Plan

Date:	

Time	Name	Team	Contact No

Submitted By:	Matron
Shared to:	Com/CoC Manager of The Day
	Shift CoOrdinator/s
	223 Bleep Holder
	Matron Team
	DoM and Deputy DoM
	MWs to be escalated
	Maternity Manager on Call

Community Midwives will attend for a period **of four hours.**
CoCMWs will attend for a period **of 6 hours** unless agreed otherwise with **the Matron/DoM/DDoM.**

If escalation is no longer required, MWs should be stood down at the earliest opportunity using the contact number provided above.

With regards to CoC availability shifts there are several options that we take as follows:

1. For those who owe hours we can ask them to attend for either 6 or 12 hours depending on hours owing and how many hours they have worked in the previous week. This is not NHSP or PA
2. For some of those on 6 hours escalation they prefer to drop their availability shift and pick one up later in the week or month to ensure their hours are correct – the escalation then becomes either NHSP or PA or gold coin for those not on NHSP.
3. For those not over their hours and for those who cannot move their availability shift elsewhere then they work 6 hours as part of their total hours and this balances over the 16–18-week hours calculation.

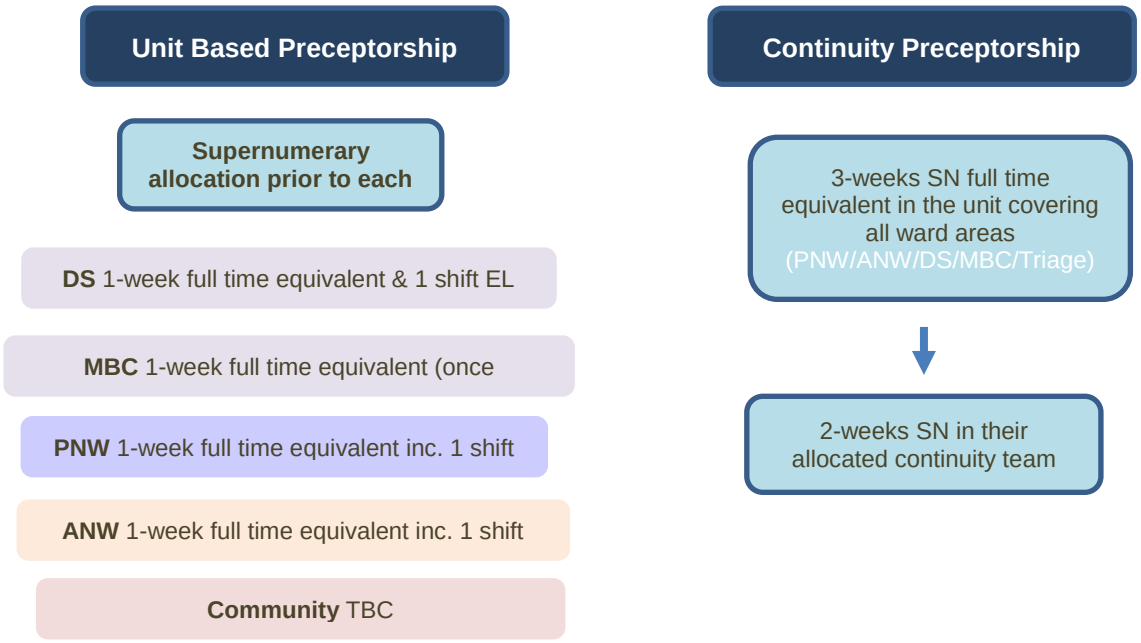
If COC midwives are escalated for 6 hours, they are therefore not available for the woman in their team (Home births as well as women in inpatient area) – obviously from an allocation perspective it would be beneficial for the care to be delivered by the CoC midwife once on site. If they are escalated 02.00-08.00, they will not be available in the earlier part of the evening or vice versa.

Appendix 3 Supernumerary (SN) Plan for Newly Qualified Midwives (NQM):

This element of the policy covers supernumerary time for new starters in particular the orientation of NQM's; therefore, streamlining expectations and enabling an escalation plan to be put in place if the supernumerary period cannot be adhered to. National Frameworks recognise the needs of a supportive comprehensive orientation within preceptorship and therefore recommend protected supernumerary time. The supernumerary time should be in addition to induction requirements, however individual needs should be recognised as required by the NMC.

1.1 Allocation of the supernumerary period

The Preceptorship Lead Midwife allocates the supernumerary period for all Band 5 New Starters and facilitates the rotation of preceptees across all ward areas if unit based. This is the agreed supernumerary period for all NQM within the WAHT. This may need to be individualised if a NQM has not completed their undergraduate level training within the trust.



1.2 Definition of Supernumerary

Within the supernumerary period the NQM is the primary care giver and should be providing all essential care while practicing under their own NMC registration. The NQM is supported by a senior member of staff to provide a comprehensive orientation. The below definitions clarify the supernumerary term for all ward areas.

Inpatient Ward Areas (Antenatal/Postnatal Ward)

"When a staff member works in their clinical area and is in addition to the staffing numbers for that shift, the staff member is indirectly supervised by an allocated core team member or midwife in charge to take a small caseload of women (4 women/babies) to ensure support and orientation but also aids skills surrounding prioritisation and case loading"

" When a staff member works in their clinical area and is in addition to the staffing number for that shift, the staff member is directly supervised by an allocated core team member to ensure appropriate support with labour care and theatre cases. This direct supervision can be tailored to more indirect supervision across the supernumerary period depending on the individual needs of the NQM"

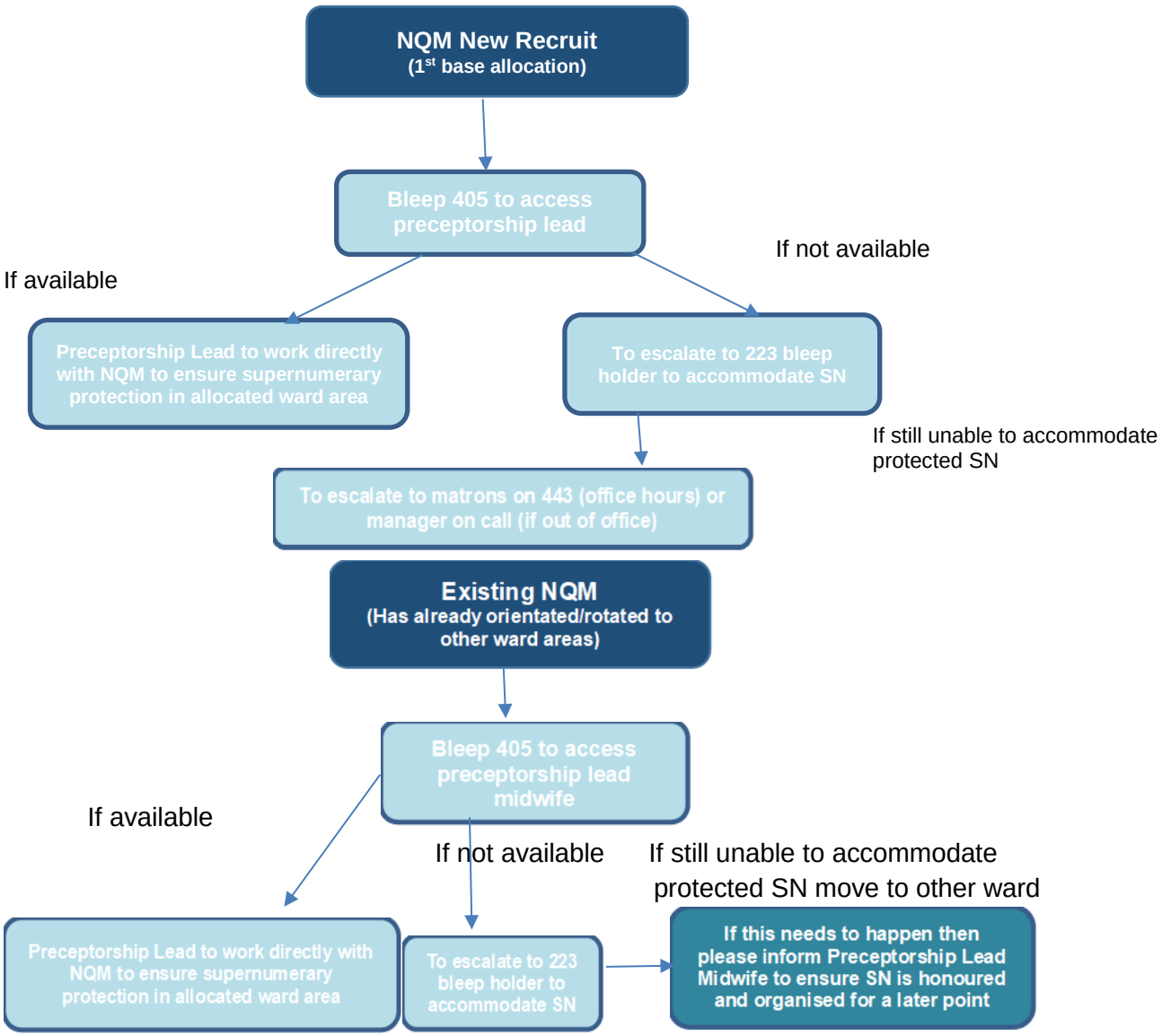
Community

"When a staff member works in their clinical area and is in addition to the staffing numbers for that shift, the staff member is directly supervised by an allocated core team member to ensure appropriate

support with community visits. This direct supervision should be an initial measure and should then be tailored to indirect supervision whereby the support on visits is accessed by a phone call with an allocated buddy.

1.3 Escalation Process

The below flow chart outlines the escalation process if the trust is unable to facilitate protected supernumerary.



Worcestershire Acute Hospitals NHS Trust

Appendix 4 Midlands OPEL Framework & Escalation Triggers

OPEL Score: Green = 0, Amber =1, Red = 2, Black =3

OPELMF 1					OPELMF 2					OPEL MF 3									OPELMF 4											
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

Escalation Triggers Scoring Matrix

FINAL Version 3.0, 19 December 2023

OPEL MF LEVEL	OPEL Neonatal Framework (OPEL NF) LEVEL	Suspension (closures), ambulance diverts and deflections	Maternity ward-based bed capacity	Delivery suite bed capacity	Obstetric staffing shortfalls impacting on safe care delivery	Anaesthetic staffing shortfalls impacting safe care delivery	Delivery Suite Birthrate Plus® activity and dependency score	Maternity staffing shortfalls (ward and assessment areas) impacting safe care delivery	Labour ward coordinator is not supernumerary (refer CNST definition)	Delays in induction of labour (IOL) (see key below for delay criteria)
Black Four	OPEL NF FOUR Demand exceeds available resource	Acute maternity services suspended, and ambulance divert in place	No ward beds available & no planned discharges	No Delivery Suite beds available & no planned discharges	Staff shortages impacting on patient care and delays in emergency care	Staff shortages impacting on patient care and delays in emergency care	Birthrate Plus® rating RED safety affected – mitigating actions taken, and services stood down	Staff shortages impacting on patient care and delays in emergency care	Providing 1:1 direct care and have no oversight of the labour ward	Any delays in ongoing[1] IOL OR delays admitting prolonged SROM >24 hours
Red Three	OPEL NF THREE Very limited ability to maintain patient flow in line with ODN pathways	Women deflected within Trust/ system and/or Homebirth services and/or MLU suspended due to escalation	Limited ward beds available impacting on inpatient flow	Limited Delivery Suite beds impacting on inpatient flow & admissions	Staff shortages impacting on patient care and elective activity delayed	Staff shortages impacting on patient care and elective activity delayed	Birthrate Plus® rating RED safety maintained – mitigating actions taken and services stood down	Staff shortages impacting on patient care and elective activity delayed	Temporarily providing 1:1 care and have limited oversight of the labour ward	Any delays in IOL admissions[3] AND delays in IOL commencement[2]
Amber Two	OPEL NF TWO Neonatal service is having difficulty in meeting anticipated demand with available resources	Homebirth services and/or MLU suspended due to escalation and no women deflected in Trust/System	Limited ward beds but no impact on inpatient flow	Limited Delivery Suite beds impacting on planned admissions but no impact on inpatient flow	Staff shortages with no impact on patient care or delays	Staff shortages with no impact on patient care or delays	Birthrate Plus ® rating AMBER safety – mitigating actions taken to maintain safe care delivery	Staff shortages with no impact on patient care or delays	Supernumerary and have oversight of labour ward but high acuity	Any delays in IOL admissions[3] OR IOL commencements[2]
Green One	OPEL NF ONE ODN unit open to admissions in line with unit designation	No suspension or diverts across the service and no women deflected in Trust/System	Ward beds available. No delays in admission or transfers.	Delivery Suite beds available no delays in admissions, elective activity and inpatient activity	No staffing shortages	No staffing shortages	Birthrate Plus® rating GREEN OR Birthrate Plus DS Acuity Tool not in use	No staffing shortages	Supernumerary and have full oversight of labour ward and able to support other midwives	No delays in IOL admissions[3] AND IOL commencements[2] AND ongoing[1] IOL

Appendix 5 Operational Pressure Escalation Levels Maternity Framework (OPELMF) Definitions

Regional Phase	OPELMF One	OPELMF Two	OPELMF Three	OPELMF Four
Description	At OPELMF 1 the maternity service capacity is such that the organisation can maintain patient flow and meet anticipated demands within available resources. Additional support is not required outside of the service. No interaction with the local ambulance service is needed. This level of the OPEL Maternity Framework is trust owned and led.	At OPELMF 2 the maternity service is starting to show signs of pressure. The maternity service will be required to take internal focused actions to mitigate the need for further escalation. The maternity service will undertake enhanced co-ordination with the trust operations team and take appropriate and timely actions to reduce the level of pressure in their organisation. Additional support is not required outside of the organisation. No interaction with local ambulance service needed business as usual. Integrated Care Boards (ICBs) System Coordination Centres (SCC) should be alerted to rising pressure as per local and ICB escalation policies (in-hours only). This level of the OPEL Maternity Framework is trust owned and led.	At OPELMF 3 the maternity service is experiencing major pressures compromising patient flow and safety. Trust operational support is having limited impact and organisational pressure continues to increase. Further urgent actions are now required to source system level support to mitigate further escalation. Agreements for mutual aid support with local partners (in and out of region) to be sourced directly through ICB SCCs/CNOs (in hours only) and ICB On Call (out of hours). The SCC/ICB On Call will facilitate and coordinate support offers received alongside the trust operations and clinical teams. Interaction with local ambulance service required if formal divert of ambulances required between sites/organisations. This level of the OPEL Maternity Framework is ICB owned and led.	OPELMF 4 is the highest level of escalation, outside of a declared EPRR incident. The declaration of OPELMF 4 is only be made when all actions and tactical options at OPELMF 3 have been exhausted, including local Integrated Care System (ICS) support for mutual aid, with no recognised de-escalation in pressure or clinical risk. This level of escalation would typically see pressure within the maternity service continue to rise leaving organisations having difficulty in delivering comprehensive care, driving the potential for patient safety to be compromised. As with all other levels within the OPEL Maternity Framework, OPELMF Level 4 is ICB owned and led. Escalation to NHS England Region should only be made where all avenues to resolve the pressures leading to OPELMF Level 4 have been exhausted at a local (Provider and ICB) level. Escalation to NHS England Region will be made by the ICB On Call to the NHSE First On Call out of normal working hours (weekends, bank holidays and Monday to Friday 18:00hrs – 08:00hrs).

Final Version 3.0 (Unratified) January 2024

Worcestershire Acute Hospitals NHS Trust

Appendix 6 OPELMF Action Card

Regional Phase	OPELMF One	OPELMF Two	OPELMF Three	OPELMF Four
Description	The maternity service capacity is such that the organisation can maintain patient flow and meet anticipated demands within available resources. Additional support is not anticipated. No interaction with local ambulance service needed - business as usual.	The maternity service is starting to show signs of pressure. The maternity service will be required to take internal focused actions to mitigate the need for further escalation. The maternity service will undertake enhanced co-ordination with the trust operations team and take appropriate & timely actions to reduce the level of pressure in their organisation. Communication to be coordinated by trust operations team to alert the Integrated Care Boards (ICBs) System Coordination Centres (SCC) to rising pressure and local escalation in place (in-hours only). No interaction with local ambulance service needed - business as usual.	The maternity service is experiencing major pressures compromising patient flow and safety. Trust operational support is having limited impact and organisational pressure continues to increase. Further urgent actions are now required across the whole ICB to source system level support to mitigate further escalation and consider and identify mutual aid support with neighbouring ICBs. Escalation for mutual aid support will be made by the ICB SCC (in-hours)/ICB On Call (out of hours) to Regional Coordination Centre (RCC) (in-hours only)/NHSE On Call structure (out of hours only) outlining the safety issues. The RCC/NHSE On Call will facilitate communications within the region to source mutual aid. Support offers will be received directly by the ICB SCC (in-hours only)/ICB On Call (out of hours only) and managed within the system. Interaction with local ambulance service required if formal divert of	Pressure in the maternity service continues to escalate leaving organisations unable to deliver comprehensive care which has the potential for patient safety to be compromised. All available local and ICB escalation actions have been taken and mutual aid support requested and utilised. Regional support and intervention are required. Communication coordinated by trust operations team to alert the ICB SCC (in-hours)/ICB On Call (out of hours) of OPEL MF Four via local escalation processes. The ICB SCC/ICB On Call will review the actions undertaken to rapidly resolve the pressures driving the escalation using the ICB escalation process. Escalation for regional support will be made by the ICB SCC (in-hours)/ICB On Call (out of hours) to the RCC (in-hours only)/NHSE On Call (in hours and out of hours) outlining the safety issues and action taken to address.

			ambulances required between sites/organisations.	Request local ambulance service to implement service diversion to deflect maternity patients when maternity unit is closed.
Trust Actions – In-Hours only:	No actions required – business as usual.	Trust in hours escalation processes to be followed to source support from within the organisation. The Divisional Leadership Team (DLT) should be informed of rising escalation and there should be active involvement of the Head/Director of Midwifery. The Trust Silver (Tactical) On Call should be informed that organisational support is required as per the local escalation process. The Trust Bronze (Operational) On Call teams should work to source support from other departments. Timely review of ward and delivery suite patients to expedite medical review and ensure flow of patients suitable for discharge. Consider extra domestic staff to increase room availability turn around. Redeploy skilled staff according to area of need - including deployment of non-clinical teams.	Ensure all OPELMF Two actions are completed. Escalate to ICB SCC. Further urgent actions are now required across the whole ICB to source system level support to mitigate further escalation and consider and identify mutual aid support with neighbouring ICBs. The decision to divert and deflect women between sites within an organisation to be agreed between the Senior Manager On Call and Silver (Tactical) On Call. This is an internal operational decision and ICBs are not required to be notified. Once divert has been agreed between sites a request should be made to the Ambulance Service to implement service diversion. Consider rescheduling elective work both inductions and LSCS if clinical conditions permit following sign off agreement as per local escalation policy. Consider utilisation of other staff groups including:	Ensure OPELMF Two and OPELMF Three actions are completed. The Trust Gold (Strategic) On Call should be contacted and made aware of rising pressure via local escalation processes. Escalate to ICB SCC OPELMF Four status to initiate ICB escalation processes and request for regional support. Liaise with the ICB to confirm actions taken to resolve the escalation and provide an understanding of the pressures and issue. Escalation for regional support will be made by the ICB SCC to the RCC outlining the safety issues and action taken to address. A Regional Mutual Aid and Escalation call will be facilitated by the RCC and supported by the Regional Maternity Team. This call will be arranged within 2 hours of initial notification. Exec and senior leader representation to attend

		Request additional bank and agency staff including midwives, maternity support workers and health care workers. Consider whether study leave and/or meetings need to be cancelled to source additional staff who can work to support safe care delivery. Review neonatal cot capacity for current and anticipated activity. Consider intrauterine transfers required to ensure women whose babies may not be accommodated on the neonatal unit are transferred in the daytime when staffing levels are optimal. Increase communications to staff to ensure everyone is fully briefed of situation and actions agreed. Review OPELMF status which includes staffing, skill mix and bed capacity 4 hourly and update internal On Call Teams. Communication to be coordinated by trust operations team to alert the Integrated Care Boards (ICBs) System Coordination Centres (SCC) to rising pressure and local escalation in place (in-hours only).	• neonatal and paediatric nurses to care for transitional care babies. • nursing staff to provide post-op care. • prescribing pharmacist or competency nurses to complete drug rounds on wards. • senior student midwives and maternity support workers for community postnatal visits. For low-risk babies, consider the community midwife undertaking newborn and infant physical examination (NIPE) in the mother's home to support rapid early discharge of mothers and babies. Consider postponing non-urgent community midwifery antenatal visits for 16, 25, 31-week low risk women (antenatal care requiring a physical examination and/or screening should be maintained) Liaise with key partners for example gynaecology to see if they can accommodate any antenatal women <20 weeks as per local Trust arrangements. Silver (Tactical) On Call to consider the potential for additional governance, data and administrative support for maternity services, as all midwives working in those teams will	a Regional Mutual Aid and Escalation call should be confirmed. Verbal updates to be provided to the ICB SCC every 3 hours (between 08:00-20:00), via the escalation template. The decision to request to temporarily close (suspend) a maternity unit should be agreed by the Trust Gold (Strategic) On Call. The ICB SCC should be notified of requests to close a maternity unit via the in hours (Appendix 3a) escalation framework process. Once a suspension has been agreed a request should be made to the local ambulance service to implement a service diversion to deflect maternity patients when a maternity unit is closed. The trust should specifically outline to the ambulance service where the trust is diverting to and a clear timeframe on how long the divert should last. A contingency plan must be put in place for women that may unexpectedly attend delivery suite & triage areas without notice to manage care safely.

			be moved to support front line delivery of clinical services. Consider contingency plans to maintain homebirth services. Engage with the neonatal ODNs around surge planning to ensure access to neonatal critical care is not compromised. Consider facilitating regular safety huddles with all key clinicians and operations team members until OPELMF Two or below reached. If trust and system actions taken do not resolve the escalation, the ICB SCC should escalate to RCC to request regional comms for mutual aid support from within the region. Trust communications department to support updates across the organisation and into the community (including with the Maternity Voice Partnerships) to help share and amplify key messages to staff, women, their families and members of the public.	Report suspension via StEIS in line with SI Framework for maternity unit closure. Inform the ICB SCC when the issue raised has been resolved for the purposes of de-escalating regional support and confirm current OPELMF status. Undertake a debrief with the ICB to identify learning. This learning should be captured and evidenced and shared widely.