Cot Management and Escalation Policy

Document Code	WAHT-KD-015	
Department / Service:	Neonatal & Transitional Care Unit	
Originator:	Amrat Mahal Lara Greenway	Divisional Director of Nursing Matron for Neonatal Services
Accountable Director:	Dr Wasiullah Shinwari	Clinical Director
Approved by:	Neonatal Guidelines Review Meeting	
Date of Approval:	20th August 2025	
Date of Review: **This is the most current version and should be used until a revised document is in place**	20th August 2028	
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust	
Target Departments	Neonatal & Transitional Care Unit	
Target staff categories	Neonatal and Transitional Care Unit staff	

Policy Overview:
This policy aims to provide clear operational guidance for cot management and escalation and incorporates the escalation status, cot capacity and emergency trigger points and associated actions required in response to operational pressures. This will provide a safe operating framework for staff and reduce the level of risk to babies.

Latest Amendments to this policy:
Appendix E – Amended Neonatal sitrep form Addition of Escalation Plan Minor alteration to Job Title

Contents

1. Introduction

This policy aims to provide clear operational guidance for cot management and escalation and incorporates the escalation status, cot capacity and emergency trigger points and associated actions required in response to operational pressures. This will provide a safe operating framework for staff and reduce the level of risk to babies.

Maintaining flow of babies through the Neonatal Unit (NNU) is the key to maximising cot availability to effectively manage fluctuations in workload. The NNU is commissioned to 18 cots which are made up of 2 intensive care (IC), 4 high dependency (HD) and 12 special care (SC). Transitional Care (TC) is commissioned to 9 maternal beds and up to 12 babies in the event of multiple births. As a key principle the closure of NNU will only be considered when all potential solutions have been exhausted and on the direction of the Directorate/Divisional Management Team (DMT) within working hours or the on-call Operational Manager out of hours.

2. Purpose

The purpose of this policy is to ensure the right care is being delivered to the right baby in the right place at the right time, and that the Neonatal Unit offers the highest standard of neonatal care. The effectiveness of this policy relies on clear and regular communication between maternity and neonatal services. This policy aims to provide clear guidance to those directly involved in cot management and escalation; the establishment of an effective policy and framework which will contribute to the following:

- Clear operational guidance for cot management and escalation within the Neonatal Unit to determine day to day operating levels
- Proactive rather than reactive response
- Defined roles and responsibilities
- Provide a safe operating framework for staff and reduce the levels of risk to babies
- Maintain the flow of babies through NNU and maximise cot availability to effectively manage fluctuations in patient pathways
- To clarify escalation process in the event of cot capacity issues

3. Scope of this document

This policy applies to all staff working within the Neonatal Unit and Transitional Care. The policy recognises that not all staff groups in all disciplines will have direct involvement in cot management and escalation, however all members of staff have a responsibility to support this policy.

4. Definitions

Escalation, for the purpose of this Policy identifies when there are increasing levels of demand in the Neonatal Unit and/or lack of cot capacity and when specific responses are required.

Normal working hours are how the Trust operates on a day-to-day basis (Monday to Friday, 9am - 5pm).

Out of hours is how the Trust operates between the hours of 5pm – 9am on weekdays and 24 hours on weekends and bank holidays.

4.1 Abbreviations

NIC: Nurse in Charge
DDN: Divisional Director of Nursing
CD: Clinical Director
TCU: Transitional Care Unit
NNU: Neonatal Unit
IC: Intensive Care
HU: High Dependency
SC: Special Care
DMT: Directorate Management Team
MDT: Multi-disciplinary team

5. Duties and Responsibility

5.1 Clinical Director

The CD provides strategic leadership and oversight to the Neonatal Unit and Transitional Care Unit, as part of the Directorate Management team (DMT). The clinical director has overall responsibility for ensuring the correct management of neonatal cots. The CD will provide support to the DDN.

5.2 Divisional Director of Nursing

The DDN provides strategic and operational leadership and oversight to the Neonatal Unit and Transitional Care Unit, as part of the Divisional Management team (DMT). The DDN will provide support to the neonatal matron.

5.3 Lead Clinicians in Neonatal

The Lead Clinician for NNU and TCU is the Neonatal Consultant along with the Matron who has the overall responsibility for the neonatal service and flow. The responsibilities of the Lead Clinician are the day-to-day co-ordination of care and discharge on NNU and TCU.

5.4 Matron

The Matron is responsible for the operational management of the Neonatal Unit and Transitional Care Unit. The matron is available to provide support and advice to the team and to support the ward manager and the NIC in the management of effective discharge, transfer and patient flows. The matron is responsible for ensuring there is a supportive, positive environment that encourages learning and development of all staff, as well as ensuring a quality service through evidence-based guidelines, a robust risk management framework, safe and effective resourcing of equipment, and support systems for new and junior nurses and students. The matron will raise concerns regarding capacity and flow to the Divisional Director of Nursing and support the ward manager.

5.5 Ward Manager

The ward manager is responsible for the operational running of the Neonatal Unit and Transitional Care Unit. The ward manager is responsible for supporting the NIC with the day-to-day management of cots and implementation of maximum efficiency in cot usage.

5.6 Nurse in Charge of NNU

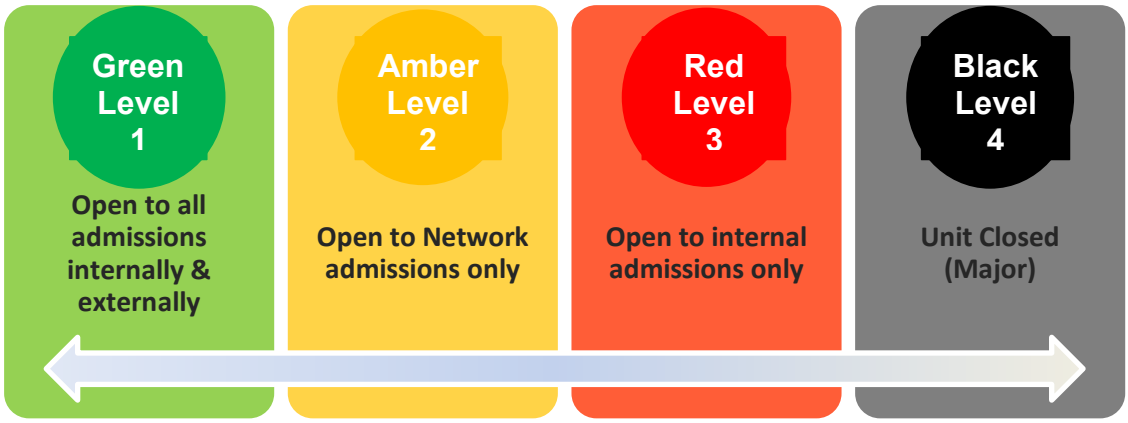
The nurse in charge is responsible for ensuring the smooth running of NNU. The NIC will:

- Have operational responsibility for the management of cots and oversight of all cots across NNU and TCU
- Oversee cot management and patient flow ensuring the right babies are cared for in the right cot at the right unit level

- Ensure neonates are repatriated to their host organisations as per network care pathway
- Delegate or attend the twice daily delivery suite safety huddle at 8am & 8pm to discuss any potential admissions to the NNU or TCU
- Ensure an up-to-date cot status and maintain a record of potential deliveries of babies (elective and non-elective) is maintained.
- Complete the neonatal sitrep (see appendix E) each shift and forward to the ward manager, matron and the Directorate management Team if cot escalation level is red or black.
- Co-ordination of information for presentation at the morning safety huddle to the multi-disciplinary team (MDT) (see appendix A – Safety Huddle)
- Escalation of any potential issues to the ward manager/Matron/DDN and Maternity unit co-ordinator
- Provide relevant cot information to the Cot Locator on the Badgernet system twice daily (Before 11:30 and before 05:30)
- To work proactively with the midwife holding the 223 bleep when requested to take in-utero transfers (see appendix B).
- To work proactively with the consultant lead when requested to take ex-utero transfers. Where these requests are declined to ensure clear and concise records of all refusals is maintained.

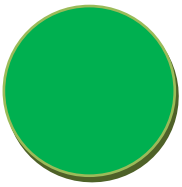
6. Trigger levels and Escalation

There are 4 levels of escalation, an overview of each trigger level with the defining criteria can be found below.

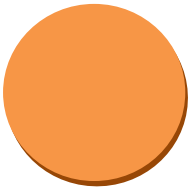


6.1 Escalation Criteria

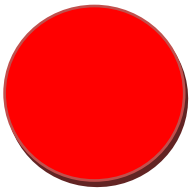
- Adequate staffing levels
- Available cots IC/HD/SC and <80% (14 cots) occupancy
- Available equipment
- Can accept transfers from other units in and out of the Network



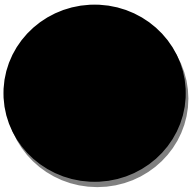
- Staffing levels below national standards for number and dependency of babies on unit
- Limited cot availability at 80-85% (14-16 cots), limited availability of IC/HD
- Limited availability of essential equipment
- Can only accept transfers in from the West Midlands Network



- Staffing levels significantly reduced below national standards for number and dependency of babies in unit.
- Very limited cot availability (85-99% occupancy 16-17 cots), No availability IC/HD cots
- Very limited availability of essential equipment
- Unable to accept transfers from other units



- Staffing levels significantly reduced below national standards for number and dependency of babies in unit.
- Contingency plans (in line with local escalation policy) failed
- No physical cot space, occupancy 100 or above
- All essential equipment in use
- Network units are unable to accept transfers in line with the ODN pathways due to any/all the above necessitating transfers out of region.



7. Escalation Plan & Actions to be taken

Neonatal Operational Pressures Escalation Level (OPEL) Plan					
	Triggers	**Consultant Actions**	**Nurse in Charge (NIC) Actions**	**Ward Manager Actions**	**Directorate Triumvirate Actions**
OPEL level 1 NORMAL Unit open to all admissions internally & externally	• Nursing & Medical staff levels meet national standards for number & dependency of babies on unit • Cots available (<80% 14 cots) • Adequate equipment available for increase in dependency or capacity • Can accept transfers from other units in and out of the West Midlands Network	• Consultant attends safety huddle on NNU prior to commencing the ward round • Undertake ward round as per internal professional standards	• Complete and submit sitrep 07:00, 12:00, 15:00 hrs • Attend the Maternity safety huddle at 8am & 8pm • Lead safety Huddle at 09:00hrs with nursing & medical staff including a representative from TCU. • Complete staffing numbers on Badgernet twice daily • Complete OPEL status on the regional sitrep before 10:00hrs • Support Consultant/parent/nurse led ward round and ensure all actions are followed through by ward team • Appropriate escalation of issues impacting on capacity, acuity & flow	• Oversee sitreps have been submitted timely • Ensure safe staffing is maintained, escalate any gaps in rosters to matron • Attend safety huddle and provide support to ward teams	• Provide support to ward teams to unblock internal and external delays • Maintain awareness of NNU's OPEL level with appropriate escalation of issues impacting on capacity, acuity & flow
OPEL level 2 MODERATE PRESSURE Unit open to Network admissions only	• Nursing or Medical Staff levels reduced below national standards for number and dependency of babies in unit • Limited cot availability (80-85% occupancy 14-16 cots) • Limited availability of essential equipment to meet increase in dependency or capacity • Can only accept transfers in from the West Midlands Network	**As above plus:** • Identify babies who could be transferred to TCU • Identify babies who could be repatriated to their local hospital with the assistance of the nurse in charge	**As above plus:** • Lead a second safety huddle on the ward in the afternoon to ensure ward round actions have occurred. • Support Consultant to identify babies that could go to TCU • Support Consultant to identify babies that could be repatriated to their local hospital • Update the ward manager of situation • Determine if staff on non-clinical duties can be pulled back to work on the unit • Source the possibility of staff support from the Children's Ward	**As above plus:** • Ward manager with NIC to carry out a risk assessment of staff against acuity • Examine the possibility of support from other areas if not already carried out by NIC • Ensure shifts are all out on NHSP/Agency • Escalate to matron as necessary	**As above plus:** • Attend where possible ward safety huddles • Provide increased presence on ward, unblock internal and external delays, escalating where solutions cannot be found. • Liaise with Matron for Paediatrics re supporting staff

OPEL level 3 MAJOR PRESSURE Unit open to internal admissions only	• Nursing or Medical Staff levels significantly reduced below national standards for number and dependency of babies in unit • Very limited cot availability (85-99% occupancy 16-17 cots) • Very limited availability of essential equipment • Unable to accept transfers from other units	**As above plus:** • Initiate and attend a second safety huddle with the maternity team to alert them to the situation and make plans for elective activity and unforeseen emergency activity • Identify babies who could be transferred to TCU unaccompanied temporarily • Assess the suitability of babies that could be transferred to another unit within the Network	**As above plus:** • Escalate capacity and staffing issues to ward manager in hours and Matron/Manager on call (through switchboard) out of hours • Inform Consultant of the week or on call about the situation • Initiate and attend a second safety huddle with the maternity team to alert them to the situation and make plans for elective activity and unforeseen emergency activity • Support the consultant to identify babies who could be transferred to TCU unaccompanied temporarily • Support the consultant to identify babies that could be transferred to another unit within the Network • Contact the cot locator in hours and other hospitals out of hours for available cots	**As above plus:** • Ward Manager visible and present on the ward • Escalate capacity and staffing challenges to matron of Neonatal Services in hours or Matron/Manager on call out of hours • Ward manager in hours with nurse in charge to carry out risk assessment of numbers of staff against acuity & capacity • Identify support from other areas if not already carried out by NIC • Ring unit staff/ put message out via WhatsApp group for staff on days off for extra hours • Put shifts out to NHSP/Agency & escalate to Matron if Programmed Activity shifts are needed • Support NIC with any actions not undertaken	**As above plus:** • Directorate management team to be visible and present in the department to co-ordinate completion of actions from relevant teams and communicate position to Divisional team • Oversee safety huddles are delivered in hours • Escalate to Divisional DMT in hours
OPEL level 4 Unit Closed	• Nursing or Medical Staff levels significantly reduced to or fall below BAPM standards for number and acuity of babies in unit • Contingency plans (in line with local escalation policy) failed • No physical cot space, occupancy 100% or above • All essential equipment is in use • ODN units are unable to	**As above plus:** • Liaise with Obstetric Consultant to discuss plans for in-utero transfers	**All actions as above**	**As above plus:** • Arrange all Quality staff available, including the ward manager to work clinically supporting NIC and staff on unit • Maintain oversight of ward, talk to parents with any concerns raised • Escalate programmed activity shift requests to Matron	**As above plus:** • Early escalation to Divisional team (DMT) • DMT to attend safety huddles and provide support to the clinical team • DMT to escalate ward status at site and incident meetings, notify the execs and on-call manager. • Divisional team to escalate to the ICB for escalation of regional support outlining the safety issues and action taken (refer to Maternity's Escalation & Safe

	accept transfers in line with ODN pathways due to any / all the above necessitating transfers out of region.				Staffing Policy - WAHT-TP-094 for more detailed information) • Once a suspension of services has been agreed a request to local ambulance service should be made to implement service diversion to deflect maternity patients, outlining specifically where the Trust is diverting to and a clear timeframe on how long the divert should last. • A contingency plan should be put in place for women that may unexpectedly attend delivery suite & triage without notice. • Be visible and present in department to co-ordinate completion of actions from relevant teams and communicate to and from site team • De- brief for all staff involved during Black status

8. **Neonatal Closure**

As a key principle the closure of NNU will only be considered when all potential solutions have been exhausted and on the direction of the Directorate Management Team (DMT). If the decision to restrict admissions to the NNU has been taken, the Neonatal Consultant supported by the Matron and Ward Manager in the Matron's absence should notify the following:

- Divisional Director of Nursing (in hours) who will inform the Director of Midwifery and DMT
- Clinical Director (in hours)
- Consultant on call for Delivery Suite (all hours)
- Maternity Bleep (223) holder (in hours)
- Midwife Shift Leader for delivery suite (all hours)
- On-call Operational Manager (out of hours) who will then inform the executive on call.

In these circumstances alternative arrangements will be necessary, for example, transferring babies to other neonatal units. Parents should be kept informed at every step of the baby's journey.
To manage cots and patient flow the following procedure should be followed:

- The nurse in charge and consultant lead, following an in-depth discussion and review of all contingency plans, make the decision of the need to close the neonatal unit.
- The NIC and/or ward manager/matron contact the cot locator to ascertain cots available within the Network ODN
- Liaison with neighbouring units will be paramount regarding how much they can assist and the procedure to refer must be strictly adhered to (see appendix C for neonatal unit names and contact numbers).
- The ongoing closure must be assessed two hourly with the DMT (in hours) & On-call operational Manager (out of hours) to ensure all factors have been fully considered and appropriate action taken.
- Once all factors have resolved, all individuals (internal and external) need to be informed once the NNU is re-opened.
- NIC to complete the Neonatal Unit Closure form (see appendix D).

9. Implementation

This policy will be used as part of the development and training for all shift leaders on the NNU. This policy will be communicated to all NNU shift leaders via email, at the daily safety huddle and team meetings.

10. Monitoring and compliance

This policy will be monitored via the IUT & ExUT outliers' spreadsheet at the weekly quality, risk & safety meetings.

11. **Associated Documents**

Reference to additional policies is recommended:

- Maternity Escalation Policy
- Safe Staffing and Appropriate Utilisation of Human Resource Escalation Policy
- Intra-uterine Transfer Requests Standard Operating Procedure
- Ward based Safety Huddle Standard Operating Procedure

Appendix A

Safety Huddle Discussion

		Issue/Action/Plans in Place	Escalated to Matron
S	**Staffing:** Shortfalls next 24 Hours Welfare Sickness/COVID concerns		Yes/No/NA
A	**Acuity/Alerts:** Any unwell patients or NEWTT escalations that require a priority review Sepsis screening escalations Safeguarding Issues Communication issues Any patients with ACP/End of life care **Medication Acuity:** Antibiotic review Medication incidents (Inc. time critical meds)		Yes/No/NA
F	**Flow:** ADT Whiteboard updated Any discharges/transfers today **Feeding/Fluids** Any babies on TPN **Family:** Concerns/issues Friends and family App completed		Yes/No/NA

E	**Environment:** Cleaning schedules completed Fridge & Room temperature check issues		Yes/No/NA
	Infection Control: Swabs (MRSA/CPE/COVID) Cleaning issues PPE alerts/issues Visitors covid-19 triage & log updated		
	Equipment/Estate Issues Reported:		

T	**Tissue Viability:** Skin assessments completed/issues PVD's/forms completed **Trust News:** **Tasks to complete:**		Yes/No/NA
Y	**Your Local News** Feedback from Audit and recent Incidents, Good practice to share, Items to Celebrate, Thank You' s		Yes/No/NA

Appendix B **Intra-Uterine Transfer Requests SOP**

Appendix C **Regional Hospital Contact Numbers**

Birmingham Women's Hospital	#6106 Tel 0121 627 2686	NICU
Birmingham Heartlands	#6122 Tel 0121 424 3508	NICU
Coventry University Hospital	Tel 0247 696 6673	NICU
Gloucester	Tel 08454 225570	NICU
New Cross Wolverhampton	#6139 Tel 01902 694032	NICU
North Staffs (Stoke)	# 6161 01782 552440	NICU
Gloucester	Tel 08454 225570	NICU
Midland Metropolitan University Hospital	#6115 Tel 0121 507 5106	LNU
Russell's Hall Dudley	#6138 Tel 01384 244364	LNU
Manor Hospital	#6136 Tel 01922 721172	LNU
Princess Royal Telford	Tel 01952 565 923	LNU
Hereford	Tel 01432 364162	SCBU
Sandwell	0121 507 3342	SCBU
Cheltenham	Tel 08454 222349	SCBU
Good Hope	#6147 Tel 0121 424 2000	SCBU
George Elliot	Tel 0247 686 5258	SCBU
Warwick	Tel 01926 495 321 ext. 4560/4750	SCBU

Appendix D

Record of Neonatal Unit Closure

Date and time unit closed	
Date and time unit re-opened	
Total length of time unit closed	
Reason for closure	
Name of manager/on-call manager coordinating closure	
Total number of babies transferred and where	

Datix completed (circle): **Yes** **No**

Neonatal Coordinator/Matron:

Print Name: ……

Signature: ……

Date:

Time:

Appendix E

Neonatal Sitrep **Complete** 0800h for 0830h bed meeting, 1200h for 1230h bed meeting, 1530h for 1600h bed meeting

Date	24/11/22	Time	08;00
No. of cots NNU (actual)		18	
No. of cots TCU (actual)		9 (up to 12 if multiples)	
No. of babies on NNU			
No. of babies on TCU			

Safe Staffing Recommendations (BAPM)	Nurse Staffing Ratios	shift	Total staff required to achieve BAPM safe staffing	Total staff on duty
Nurse in charge	1	**Early** on NNU		
IC	1:1	**Early** on TCU		
HD	1:2	**Late** on NNU		
SC	1:4	**Late** on TCU		
TC	1:4	**Night** on NNU		
		Night on TCU		
Total Staff per shift on NNU & TCU planned v actual				
Staffing BRAG rating based on BAPM figures (place cross)				

Cot Occupancy/Dependency		
Commissioned		**Actual**
Intensive Care (IC)	**2**	
High Dependency (HD)	**4**	
Special Care (SC)	**12**	

Neonatal Unit OPEL (Operational Pressure Escalation Level) Status – add X to all issues that apply

OPEL Levels	Description – Please put an X next to the reason for declaring that Opel status as well as the box declaring what the Opel status is	Issue	Actions taken
OPEL level 1 NORMAL Unit open to all admissions internally & externally	Nursing & Medical staff levels meet national standards for number & dependency of babies on unit		
	Cots available (<80% 14 cots)		
	Adequate equipment available for increase in dependency or capacity		
	Can accept transfers from other units in and out of the West Midlands Network		
OPEL level 2 MODERATE PRESSURE Unit open to Network admissions only	Nursing or Medical Staff levels reduced below national standards for number and dependency of babies in unit		
	Limited cot availability (80-85% occupancy 14-16 cots), limited IC/HD cots		
	Limited availability of essential equipment to meet increase in dependency or capacity		
	Can only accept transfers in from the West Midlands Network		
OPEL level 3 MAJOR PRESSURE Unit open to internal admissions only	Nursing or Medical Staff levels significantly reduced below national standards for number and dependency of babies in unit		
	Very limited cot availability (85-99% occupancy 16-17 cots), No IC/HD cots		
	Very limited availability of essential equipment		
	Unable to accept transfers from other units		
OPEL level 4 Unit Closed	Nursing or Medical Staff levels significantly reduced to or fall below BAPM standards for number and acuity of babies in unit		
	Contingency plans (in line with local escalation policy) failed		
	No physical cot space, occupancy 100% or above		
	All essential equipment is in use		
	ODN units are unable to accept transfers in line with ODN pathways due to any / all the above necessitating transfers out of region.		

Expected Admissions	IC	HD	TC	SC
Numbers				

Communication with Delivery Suite (3 x per day)	
Woman's Name (Initials Only)	**Plan**

Transfers/Discharges			
Planned Transfers to TC	**Planned Discharges**	**Planned Transfers out**	**Planned Transfers in**

Quality and Safety	**Yes**	**No**	**NA**	**If yes, actions taken**
Were there any safety concerns raised at the last safety huddle?				
Has there been any clinical incidents causing harm reported since last sitrep?				
Have these been escalated? (if not, consider escalation to ward manager and/or matron)				

Completed By:	
Name:	**Title**:

Appendix F

Contribution List

This key document has been circulated to the following individuals for consultation;

Designation
Women and Children's Divisional Management Team
Children's Directorate Management Team
Paediatricians
Matrons
Ward Managers

This key document has been circulated to the chair(s) of the following committee's / groups for comments;

Committee
NA

Appendix G – Equality Impact Assessment Form

NHS Worcestershire Acute Hospitals NHS Trust

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Lara Greenway**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Lara Greenway	**Matron for neonatal Services**	**laragreenway@nhs.net**
Date assessment completed	**18.09.2025**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Cot Management & Escalation Policy**
What is the aim, purpose and/or intended outcomes of this Activity?	Equality Impact assessment

Who will be affected by the development & implementation of this activity?	❑ Service User ❑ Patient ❑ Carers ❑ Visitors		❑ Staff ❑ Communities ❑ Other _____	
Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Services required			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Engaged with staff within the department			
Summary of relevant findings	Document approved			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		X		This relates to all babies on NNU and is not dependent on age
Disability		X		This relates to all babies on NNU and is not dependent on disability
Gender Reassignment				NA
Marriage & Civil Partnerships				NA
Pregnancy & Maternity				NA

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Race including Traveling Communities		X		This relates to all babies on NNU and is not dependent on race
Religion & Belief		X		This relates to all babies on NNU and is not dependent on religion & belief
Sex		X		This relates to all babies on NNU and is not dependent on sex
Sexual Orientation		X		This relates to all babies on NNU and is not dependent on sexual orientation
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)			X	Families may have to travel further to see their baby
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		X		This relates to all babies on NNU and is not dependent on health inequalities

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	Families might have to travel further which could be costly	**Assess baby's home address before choosing to transfer so families are not expected to go too far**	**All staff in charge of the unit**	**Ongoing**

How will you monitor these actions?	**Monitor ExUT transfers weekly at Maternity & Safety Meeting**
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**Weekly**

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Lara Greenway
Date signed	18.09.2025
Comments:	
Signature of person the Leader Person for this activity	Lara Greenway
Date signed	18.09.2025
Comments:	

Appendix H – Financial Impact Assessment

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

ID	Financial Impact:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
Other comments:		
[Insert comments here]		