1. INTRODUCTION

1.1 This is an Operational Policy for Midwifery Managers, Senior Midwives, Co-ordinating Midwives/Bleep Holders and On–Call Managers, Obstetricians and Paediatricians responsible for the maternity services. The aim of the policy is to ensure safe standards of care are maintained, and wherever possible to prevent women being transferred outside the Trust. A summary of the policy in flow chart format is provided in action card AC1.

2. DEFINITIONS

Escalation relates to the department status currently being red with the expectation that it will progress to black unless immediate action is taken.

<table>
<thead>
<tr>
<th>Word/Term</th>
<th>Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Divert</td>
<td>relates to the transfer of women from one unit within GHNHSFT to another, where appropriate and following discussion, at any point during the escalation process.</td>
</tr>
<tr>
<td>Closure</td>
<td>relates to the transfer of women to an external organisation, following discussion and planning.</td>
</tr>
</tbody>
</table>

Maternity Unit Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
<th>Very high risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>normal working</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amber</td>
<td>Capacity issues – staffing levels normal but temporarily not enough beds for activity – staffing issues – insufficient in any one area for level of activity – temporary deployment of staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Red</td>
<td>Capacity issues – insufficient beds with no discharges planned, staffing issues, staff required to be permanently re-deployed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>More activity than bed/cot capacity or more activity than staffing resources necessity to divert/close</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(to be managed locally)  

(to be managed by senior midwives/manager on call)  

(to be managed by senior midwives/manager on call, with advice from member of tri and/or site manager)  

3. PURPOSE

The establishment of an effective escalation policy within Maternity services will contribute towards:
- Early identification of capacity and staffing problems
- Proactive rather than reactive response
- Concise and clear actions
- Defined responsibilities

The purpose of this document is to highlight concerns at an early stage and ensure bed occupancy and the staffing establishment are used to maximum efficiency and to provide guidance when:

- There are shortages of beds on the maternity ward
- Activity is higher than staffing can manage
- A major event affects service delivery

The escalation policy enables the service to deal effectively with fluctuations in demand and capacity so that it can manage associated clinical risk within acceptable limits. The policy is designed to help mitigate the risk of further escalation and ensure an appropriate response from key staff members to contribute to a reduction in escalation status.

The policy aims to maintain high standards of safety, experience and ensure delivery of high quality care.

### 3.1 COMMUNICATING AND SETTING THE ESCALATION STATUS AND ACTIONS

The following status rating will be used to help communicate the escalation status. This is based on bed capacity, activity and staffing that reflects the level of risk to patient safety and the extent to which patient experience may be compromised. The escalation status refers to the whole of Maternity services provided in Cheltenham, Gloucester, Stroud and the Community Services.

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GREEN Low Risk</td>
<td>Normal Working</td>
</tr>
<tr>
<td>AMBER Moderate Risk</td>
<td>Normal activity but staffing levels below minimum or high activity normal staffing &lt;br&gt; deployment of staff working clinical shifts managed locally, and temporary deployment of non-clinical staff. All staff to commence discharges as soon as possible</td>
</tr>
<tr>
<td>RED High Risk</td>
<td>Increased activity and demand on beds/cots plus staffing concerns &lt;br&gt; Inform manager on call for support,</td>
</tr>
</tbody>
</table>
At any one time, the service has an escalation status ranging Green to Black. The escalation status is continually assessed by the band 7 management lead for delivery suite or out of hours by the bleep holder. Any time the escalation status is at red or black a datix form should be completed and sent to Risk Manager.

3.2 Bed capacity /Staffing Triggers
There are four triggers that help determine the escalation status and appropriate response:

1. bed availability Delivery suite for both Emergency or Elective activity
2. bed availability in the midwifery led birth centres
3. number of patients awaiting assessment in Triage GRH and bed availability on the Maternity ward
4. staff insufficient for level of activity across the service

If the status of the unit is deemed to be red or black a Maternity Services Activity Sheet must be completed. See RD 2

The co-ordinator for delivery suite must use their professional judgement to balance these triggers.

3.3 Intrapartum Acuity
An assessment of Intrapartum Acuity versus staffing activity is made 4 hour-ly between the hours of 0800-2000 on Delivery Suite and 2 hourly overnight on Delivery Suite.

This is entered electronically on to the Birth Rate Plus Acuity Tool on the shared drive.

4. ROLES AND RESPONSIBILITIES

<table>
<thead>
<tr>
<th>Post/Group</th>
<th>Details</th>
<th>Resources</th>
<th>Review/ Monitoring</th>
<th>Implementation</th>
<th>Records</th>
<th>Reporting</th>
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</thead>
<tbody>
<tr>
<td>Person in charge of ward/area</td>
<td>• Escalate any staffing/activity concerns to the Matron (in)</td>
<td>X</td>
<td>X</td>
<td></td>
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<td>X</td>
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<tr>
<td>Role</td>
<td>Responsibilities</td>
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</tr>
</tbody>
</table>
| **Delivery suite Midwife Coordinator** | - Carries the maternity bleep 24 hours a day, 7 days a week  
- Escalate any staffing/activity concerns to the Matron (in hours/Senior Midwife (out of hours)  
- Liaise with medical team to prioritise clinical care and activity.  
- Redeploy staff as necessary (out of hours)  
- Liaise with Matron (in hours/Senior Midwife (out of hours) |
| **Bleep holder Band 7 lead for management bleep holder** | - During office hours the Bleep Holder should ensure the Senior Midwifery Manager (Matron), Divisional Director or Assistant Director of Midwifery is informed of all significant capacity and staffing concerns |
| **Bleep holder, Supervisor of Midwives, Trust “Trust Manager on call” or “Nursing Director on call” or Site Manager** | - Out of Hours the Bleep Holder leads activities to address the problem with the support of the maternity management on call staff, and the Trust “Manager on call” or Trust “Nursing Director on call” or Site Manager if required. (See 4.7 – 4.10 for further details).  
- Redeploy staff as necessary. |
| **Senior Midwifery Manager (Matron), Divisional Director or Assistant Director of Midwifery** | - Debrief staff and patients  
- Lead activities to address problems brought to them by bleep holder during office hours.  
- Review staffing across the service & redeploys as necessary.  
- Inform the Tri and site manager. |
| **Consultant on call** | - Liaise with Matron and/or coordinator (out of hours)  
- Together with the Delivery Suite Midwife Coordinator lead a review and prioritisation of clinical activities.  
- Ensure medically fit are identified, reviewed and discharged where appropriate. |
| **Speciality Director** | - Liaise with Consultant on call  
- Cancel non clinical activity and attend clinical areas where possible.  
- Facilitate additional ward rounds.  
- Redeploy staff as necessary. |
| **Junior Doctors** | - Offer to support clinical areas |
and contact Matron (in hours)/bleep holder (out of hours) and wait instruction to attend area most needed.

- Ensure medically fit patients are identified and reviewed.
- Cancel non clinical activity and attend clinical areas
- Liaise with Registrar and Delivery Suite Midwife Coordinator.

### Practice Development Midwife

- Alert staff attending training of escalation status and cancel training/meetings when required.
- Offer to support clinical areas and contact Matron (in hours)/bleep holder (out of hours) and wait instruction to attend area most needed.

### Specialist Midwives

- Offer to support clinical areas and contact Matron (in hours)/bleep holder (out of hours) and wait instruction to attend area most needed.

### Obstetric Theatre Sister

- Review theatre capacity and facilitate cancellations of non urgent activity when required.
- Liaise with Delivery Suite Midwife Coordinator.

### Divisional Tri

- Ensure awareness of status and liaise with Matron or Coordinator
- Escalate within the Division and Liaise with Speciality Director and Obstetric Consultants
- Escalate outside the Division if required.

5. **ESCALATION ACTIONS**

Key staff members have action cards which provide them with actions that they should undertake at a particular escalation status level. These cards can be found in the action card AC2 policy document.

5.1 **COMMUNICATION**

The escalation status is communicated to staff throughout the service and organisation in a number of different ways. These methods recognise that not all staff will have the opportunity to regularly access emails.

5.1.1 **General Communication**

These forms of communication are designed to provide general information about the escalation status

5.1.2 **Escalation state Email email and text message** to be sent by co-ordinator/2165 bleep holder or Matron for Delivery suite, sent to Tri, (Divisional Director of Nursing and Midwifery, Chief of Service, Divisional Director of Operations) Specialist Midwives, Senior Midwifery Managers, Band 7 Community Team Leaders, when the escalation status is red or black. **Staff who are on call or on duty are expected to respond to the Band 7 Co-Ordinator.** Contact details for text message are on text system

6. **ACTIVITY/STAFFING**

Refer to parent policy GHNHSFT Maternity Staffing Policy and if in RED or BLACK ensure a Maternity Services Activity Status Sheet is completed. See RD 2
If in Red or above

6.2 Shortage of antenatal, postnatal or delivery beds

Review bed allocation of women across TWC and Birth centres in order to increase capacity for the clinical area with most demand.

Triage: This is an area for emergency admission and the workload is unpredictable and high risk. Women waiting to be seen must have a verbal assessment to establish if it is safe for them to wait for full assessment or alternatively they should be transferred to the Delivery Suite so that a timely assessment can be performed.

Birth Centres: Women can be transferred between birth centres for low risk midwifery care, if any of the three areas have reached capacity, but the implications of the options offered should be made explicit if transferring to a stand-alone unit. Only if the Birth Centres continue to be busy and unable to accept women can they be transferred to the Delivery Suite for low risk midwifery care.

TWC: If the Delivery Suite continues to be busy, transfer low risk women to the Birth Unit. If the Birth Unit continues to be busy women can be transferred to the Birth Centres at Stroud and CGH but the implications of the options offered should be made explicit if transferring to a stand alone unit.

In order to INCREASE capacity within the service:

- Identify who is fit for discharge, inform the obstetric staff / paediatric staff on call and ask them to review their patients and discharge ASAP. Consider 6 hour (or earlier) discharge of postnatal mothers and babies or transfer to Stoud Maternity Unit where appropriate. Consider opening up appropriate ward areas for discharges.
- If a NNU mum is fit for discharge and the bed is required, the midwives need to liaise with the neonatal unit, and the unit will agree the best place for mum to be offered accommodation. This may be a room on the neonatal unit overnight accommodation or transitional care or Ronald McDonald rooms located in children’s inpatients.
- Vacate beds and move women due for discharge/transfer to waiting areas such as the mother’s sitting room on the Maternity ward or Waiting area in the Delivery Suite or Birth Unit at GRH.
- Postponement of elective activity/admissions. Ask medical staff to review inductions and elective surgical procedures.
- Avoid admitting babies requiring a higher level of care than normal to the postnatal wards as they may be more appropriately cared for on transitional care/NICU in these circumstances.
- Accommodate non labour antenatal mothers needing admission /assessment utilising space in Maternity Assessment Unit/Gynaecology if possible and appropriate
- Avoid admission of gynaecology patients
- Consider the impact of in-utero transfers (see 6.4.1)

6.3 Staffing problems or high levels of activity (see flow chart)

Where problems can be anticipated in advance, attempts should be made to reduce activity in the unit or specific clinical area and/or increase staffing e.g.

6.3.1 In Hours

The midwife in charge of the clinical area contacts the Modern matron responsible for the area.

- The Modern matron will review the staffing allocation in the area together with the staffing allocation in the whole of the maternity service (The Women’s Centre (TWC) and the Birth Centres (BCs)), including specialist midwives and community midwives.
A decision should be made about whether adequate additional staffing can be arranged by reallocation of staff on duty or rearranging shift patterns for those staff already rostered to work but not presently on duty.

- Establish if additional staff are required and the grade of staff required.
- Identify if staff with non-clinical and specialist roles, need to be reallocated to other duties.
- Speak to staff on duty and offer:
  - additional hours with time off in lieu
  - paid additional hours to part time staff or bank midwives on duty
  - paid additional hours to part time staff or bank midwives not on duty
  - paid additional hours to full time staff (overtime payments)
  - Consider calling in hospital staff before their expected shift time
  - Consider the need for staff to go on call.

If additional staff cannot be found and the unit is covered with less than the accepted minimum numbers (see GHNSHT Maternity Staffing Policy), hospital staff should be asked, where possible, to go on call to provide support during the period of staffing shortage.

Assess the need to call in the on-call community midwife to assist with the provision of care following discussion with senior management.

The Site Manager may be in a position to arrange help from other areas of the hospital particularly where a nursing auxiliary or general nurse would help the situation (consider contacting Theatres, Children’s in Patients (GRH), Battledown (CGH) or NICU (GRH) to see if they can provide help or know any bank staff who could be called in at short notice) or as very last resort the use of Agency staff.

In all cases additional hours should be authorised in advance by the Senior Midwifery Manager (Matron) or Assistant Director of Midwifery.

6.3.2 Maintaining Safety and Professional Accountability

In times of escalating all staff may be required to work in areas that are less familiar to them.

Rule 5 Scope of Practice

All midwives must be capable of meeting the competencies and are within essential cluster set as in Standard 17 of Standards for pre-registration midwifery education that your scope of practice except in an emergency you must not provide any care or undertake any treatment that you have not been trained to give. NMC Midwives rules and standards 2012

Midwives have a professional responsibility to maintain their competences, work within the limits of their competence, but also to clearly articulate any concerns to the bleep holders or managers if they are asked to undertake any duties for which they do not feel competent.

As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.

You must inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards.

You must recognise and work within the limits of your competence.

You must keep your knowledge and skills up to date throughout your working life.

You must take part in appropriate learning and practice activities that maintain and develop your competence and performance. NMC The Code Standards of conduct, performance and ethics for nurses and midwives
6.3.3 Out of Hours

The midwife in charge of the clinical area contacts the 2424 Bleep holder responsible for the unit.

- The bleep holder matron will review the staffing allocation in the area together with the staffing allocation in the whole of the maternity service (The Women’s Centre (TWC) and the Birth Centres (BCs)), including community.
- A decision should be made about whether adequate additional staffing can be arranged by reallocation of staff on duty or rearranging shift patterns for those staff already rostered to work but not presently on duty.
- Establish if additional staff are required and the grade of staff required.
- Speak to staff on duty and offer:
  - additional hours with time off in lieu
  - paid additional hours to part time staff or bank midwives on duty
  - paid additional hours to part time staff or bank midwives not on duty
  - paid additional hours to full time staff (overtime payments)
  - Consider calling in hospital staff before their expected shift time

If additional staff cannot be found and the unit is covered with less than the accepted minimum numbers (see GHNSHFT Maternity Staffing Policy), hospital staff should be asked, where possible, to go on call to provide support during the period of staffing shortage.

Contact the manager on call to assess the need to call in the on-call community midwife to assist with the provision of care.

The Site Manager may be in a position to arrange help from other areas of the hospital particularly where a nursing auxiliary or general nurse would help the situation (consider contacting Theatres, Children’s in Patients (GRH), Battledown (CGH) or NICU (GRH) to see if they can provide help or know any bank staff who could be called in at short notice) or as very last resort the use of Agency staff.

In all cases additional hours including bank should be authorised in advance by the Maternity Unit Bleep holder using the appropriate request form

6.3.4 Medical Staff

Unless there is a major incident declared – there will be no additional back up for the medical team on call. The team will have to prioritise clinical emergencies and manage the cases as best they can within the resources at their disposal.

6.4 Transfer of Women

6.4.1 In-utero Transfers:
The decision not to accept an in-utero transfer should only be made in exceptional circumstances, usually when it is clear that to accept a transfer would force the unit into a red or black status. The NICU coordinator is responsible for communication with requesting units and liaises with the Delivery Unit coordinator. If it is felt that an in-utero transfer cannot be accepted the decision should be escalated to the Consultant Obstetrician on call. The NICU co-ordinator will communicate the final decision to the requesting unit. In such cases to enable monitoring of activity, complete a Refusal of Admission to the Delivery Unit form, See RD 3

6.5 The Site Manager and/or Associate Director of Operations or Trust “Manager on call” are available and
should be contacted for support as appropriate. At weekends there is also a Nursing Director on call.

6.6 Managerial and Support Contacts:

- A senior midwifery manager (Matron) Divisional Director or Assistant Director of Midwifery is available on site Monday – Friday 09.00 – 17.00
- A Site Manager (Bleep 1343 or mobile 07917 553020 CGH, Bleep 2345 or mobile 07813 456571 GRH) is in the hospital 17.00-20.00 Monday-Friday and all day at weekends and a night sister over night.
- The Associate Director of Operations is available via switchboard Monday – Friday 09.00 – 17.00.
- The Trust “Manager on call” is available via switchboard Monday – Friday 17.00 – 09.00 and at weekends and may be contacted
- A manager is available 24/7 for support and advice

6.8 To support the above team an “out of hours” “Executive Director on call” rota is also in place. The purpose of this is to provide advice on strategic issues that require Executive support. All calls must initially be screened by the Trust “Manager on call” or “Nursing Director on call”.

6.9 When staffing levels adversely affect the care that women receive the manager on call should be contacted for support and the incident report via the datix reporting system.

7. DIVERT AND CLOSURE (See RD 1 Divert/Closure check list)

7.1 A Divert may be instigated when the service is in Red or Black status. Women may be transferred between the Trust’s maternity services at Gloucestershire Royal or Cheltenham Birth Centre or Stroud Maternity and should only be considered when other potential solutions are exhausted.

7.1.1 The Gloucester Birth Unit and, as a general principle, the Birth Centres at Cheltenham and Stroud must not be closed. They should be utilised for diverting women to them that can be managed appropriately outside the consultant led unit. In addition the free standing units need to have one midwife and one maternity care assistant on duty at all times to ensure unexpected admissions can be safely managed. The individuals involved in the decision to divert should be notified at an early stage of the risk of potential divert.

7.1.2 Closure may be implemented when the service is in Black status when there is a need to send women to maternity services outside GHNHSFT; in such circumstances the incident is followed up with a full written explanation to the couple by Divisional Nursing and Midwifery Director, see RD 4 sample letter.

7.1.3 A divert/closure is part of the Maternity Services Risk Management Strategy.

7.2 Factors precipitating divert/closure:

- Insufficient midwives or doctors for the level of activity.
- Insufficient delivery and/or antenatal/postnatal beds
- As part of a Contingency Plan to deal with a major event affecting the Service.

7.3 Decision to divert/close

7.3.1 In hours the initial decision to divert women is made by a member of the Divisional Triumvirate (Chief of Service, Divisional Director of Nursing and Midwifery, Divisional Director of Operations) or in their absence a Senior Midwifery Manager (Matron) after consulting with the Co-ordinating Midwife, and On Call Consultant Obstetrician and Senior Midwives.
7.3.2 Out of hours the initial decision to divert women is made by the Midwifery bleep holder after consulting with the On Call Consultant Obstetrician and Senior Midwives.

7.3.3 Both In and Out of Hours the final Decision to close the Maternity Units rests with the Executive Director on call.

They can be accessed via the Site Manager or Assistant Director of Operations (In Hours) or Trust “Manager on call” (Out of hours).

It is recommended that one person is designated to co-ordinate and implement the divert/closure and that this person has no other responsibilities.

7.4 Implementation of divert/closure (See RD 1 Divert/Closure Checklist)

7.4.1 The first option must always be to divert women to another place of birth within the Trust. If closure is necessary, consult with neighbouring maternity units to accept admissions. Collect the names of all units contacted and women transferred together with outcome on the Divert/Closure Checklist provided.

- If the Delivery Suite at TWC is closed to high risk admissions, inform all Birth units immediately, all intrapartum transfers from Trust Midwifery Led Facilities and home births should be prioritised for admission within GHT.

- Women should be directed to their nearest maternity unit provided capacity has been identified to take these women. (See RD 5 for hospital names, telephone numbers and addresses).

- Ensure that the units accepting transfers have the appropriate level of NICU/SCBU cot capacity to take this activity if it is expected that these facilities will be required.

- During divert/closure all requests for both in-Utero and Ex-Utero patients for both Neonatal and Obstetric reasons should be declined. Refusal of Admissions Form should be completed. See RD 3 Refusal of Admissions Form.

7.4.2 Inform women telephoning prior to their admission of the need to present to the designated unit. Explain the reason for this and give them clear instructions on how to get there, if required they will need to be instructed to call an ambulance. (See the resource folders located in the Delivery Suite and Birth Centre offices for maps)

- When women telephone during the divert/closure the midwife receiving the call should telephone the accepting unit and provide the details of each individual woman being re-directed.

7.4.3 Inform Ambulance Control of the divert/closure and arrangements agreed with the receiving unit/units to ensure women are transferred to these centres.

7.4.4 At GRH inform the Consultant Paediatrician and Senior Nurse/Co-ordinator for the NICU to ensure in-utero transfers are not accepted.

7.4.5 Inform all relevant departments of arrangements for divert/closure without Delay as per RD 1 Divert & Closure Checklist provided.

7.4.6 Inform the following departments/individuals in working hours:

- Communications Team
- Information Department
- Inform the Risk Department by completing a Datix Incident Report.
7.4.7 Where women have not contacted the Maternity Unit prior to their arrival in labour, assess their condition and arrange their transfer to the receiving unit if appropriate and safe to do so.

8. **RESUMING NORMAL OPERATIONS AND CEASING THE DIVERT/CLOSURE** (See RD 6 Returning to normal operations checklist)

8.1 The divert/closure should cease at the earliest opportunity and in order to achieve this, the above process is reversed.

8.2 The Divisional Director or Assistant Director of Midwifery will write to all women who have been directed to units outside GHNHSFT to apologise for any inconvenience/distress caused (see RD 4 Sample Letter).

8.3 The manager or Bleep Holder is responsible for a debrief after escalation has ceased. All those involved and all women affected should be offered appropriate and timely opportunities to debrief to ensure lessons are learnt where applicable or explanation given and to ensure staff and women are thanked for their co-operation/contribution to events.

9. **TRAINING**

<table>
<thead>
<tr>
<th>Level of training required</th>
<th>Staff Group / s</th>
<th>Division / Department</th>
<th>Frequency of training / update</th>
<th>Method of training delivery</th>
<th>Lead and department responsible for provision of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Midwifery Managers, Senior Midwives, Co-ordinating Midwives/Bleep Holders and On–Call Managers, Obstetricians and Paediatricians responsible for the maternity services</td>
<td>Women and Children’s</td>
<td>Once</td>
<td>Cascade via newsletter for awareness</td>
<td>PDM Vivien Mortimore Head of Midwifery</td>
</tr>
</tbody>
</table>

*Levels of Training*  
A = Awareness  
(Micro-teach, drop in session, e-learning)  
B = ½ day (2.5 – 3 hours)  
(workshop, training event, e-learning)  
C = Full day (5-6 hours)  
(workshop, training event)  
D = Course  
(more than one day training)

10. **MONITORING OF COMPLIANCE**

10.1 This list is not exhaustive and additional criteria may be included at the Trust discretion

10.2 Audit sizes selected will be dependent on the cohort size. The data collection period will be identified by the Maternity Audit Lead

10.3 Action plans will be developed and reviewed as required by the instigating body

10.4 The audit will be carried out using the standardised audit tool and methodology as agreed by the maternity audit team and in line with the audit process.

10.5 The audit results will be presented to the multidisciplinary Obstetrics and Gynaecology Audit presentation meeting.

10.6 Where deficiencies are identified, an action plan will be developed by the author, following the Multidisciplinary Obstetrics and Gynaecology Audit presentation meeting. These action plans are implemented and monitored by the Associated Forum.

10.7 Audits are undertaken as routine triennially, however if deficiencies are identified or changes implemented, audit will be undertaken sooner.
<table>
<thead>
<tr>
<th>Source</th>
<th>Criteria (Objective to be measured)</th>
<th>Monitoring Methodology</th>
<th>Lead Responsible</th>
<th>Time scales</th>
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</thead>
<tbody>
<tr>
<td>Local i</td>
<td>Incident reporting of implementation of the escalation policy – divert &amp; / or closure</td>
<td>Datix reporting</td>
<td>Risk management midwife</td>
<td>Ongoing</td>
<td>Maternity Clinical Governance</td>
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<td>Datix reporting</td>
<td>Risk management midwife</td>
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</tr>
<tr>
<td>DOCUMENT PROFILE</td>
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<td>Divisional Operations Director</td>
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</tr>
<tr>
<td>AUTHOR</td>
<td>Vivien Mortimore</td>
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<tr>
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<td>Director of Midwifery and Nursing</td>
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<tr>
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<td>June 2017</td>
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<tr>
<td>REVIEW DATE</td>
<td>June 2020</td>
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<tr>
<td>ASSURING GROUP</td>
<td>Women and Children’s Divisional Triumvirate</td>
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<td>APPROVING GROUP</td>
<td>Gloucestershire Obstetric Guideline Group (GOGG)</td>
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<td>APPROVAL DETAILS</td>
<td>23/04/2007 item 4.3 – Women’s Health Team Meeting</td>
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<td></td>
<td>June 2007 – Trust Operational Group</td>
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<td></td>
<td>23/07/2008 item 4.1 – Divisional Board</td>
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<td>18/10/2009 item 5.3 – Women’s Health Team Meeting</td>
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<td>20/11/2009 item 3 – Non-Clinical Policy Group</td>
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<td>20/12/2010 – Divisional Lead Nurses</td>
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<td>01/02/2011 item 4.1.4 – GOGG</td>
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<td>03/02/2015 item 3.3 – GOGG</td>
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<td>June 2017 item 2.23</td>
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<td>DISSEMINATION DETAILS</td>
<td>Upload to Policy Site; cascaded via Women and Children’s Division</td>
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<td>EQUALITY IMPACT ASSESSMENT</td>
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<td>KEYWORDS</td>
<td>Close unit; high activity; divert; closure; escalate; midwifery staffing</td>
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<tr>
<td>OTHER RELEVANT DOCUMENTS</td>
<td>Maternity Staffing Policy</td>
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<td></td>
<td>Maternity Service Contingency plans</td>
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<td>RELATED TRUST DOCUMENTS</td>
<td>AC1 - Escalation flow chart: divert and closure</td>
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<td></td>
<td>AC2 – Roles &amp; Responsibilities cards</td>
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<td>RD 1 – Divert &amp; Closure Checklist</td>
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<td>RD 2 – Maternity Services Activity Status Checklist</td>
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<td>RD 3 – Refusal of admission to delivery suite</td>
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<td>RD 4 – Sample Apology Letter</td>
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<td>RD 5 – Contact details for surrounding units</td>
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<td>RD 6 – Returning to normal operations checklist</td>
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<td>RD 7 – Community On-Call</td>
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# EQUALITY IMPACT ASSESSMENT

## INITIAL SCREENING

<table>
<thead>
<tr>
<th>1. Lead Name:</th>
<th>Hazel Williams</th>
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</thead>
<tbody>
<tr>
<td>Job Title:</td>
<td>Practice Development Midwife</td>
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<thead>
<tr>
<th>2. Is this a new or existing policy, service strategy, procedure or function?</th>
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<tr>
<td>New</td>
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<td>Existing ✓</td>
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<th>3. Who is the policy/service strategy, procedure or function aimed at?</th>
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<td>Patients</td>
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<td>Any other</td>
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<th>4. Are any of the following groups adversely affected by this policy:</th>
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<tr>
<td>If yes is this high, medium or low impact (see attached notes):</td>
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<tr>
<td>Disabled people:</td>
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<tr>
<td>Race, ethnicity &amp; nationality:</td>
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<tr>
<td>Male/Female/transgender:</td>
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<tr>
<td>Age, young or older people:</td>
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<td>Sexual orientation:</td>
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<td>Religion, belief &amp; faith:</td>
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</tbody>
</table>

If the answer is yes to any of these proceed to full assessment.

If the answer is no to all categories, the assessment is now complete.

**Date of assessment:** 08.02.11  
**Completed by:** Hazel Williams  
**Signature:** PDM  
**Director:** Signature:

This EIA will be published on the Trust website. A completed EIA must accompany a new policy or a reviewed policy when it is confirmed by the relevant Trust Committee, Divisional Board, Trust Director or Trust Board. Executive Directors are responsible for ensuring that EIA’s are completed in accordance with this procedure.