

Clinical Guideline: East of England management and escalation of operational pressures in neonatal services

Authors: *Adapted from West Midlands Escalation policy*

For use in: EoE Neonatal Units

Used by: Nurses, Doctors, Management teams,

Key Words: OPEL

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Approved by:

Neonatal Clinical Oversight Group	
Clinical Lead Sajeev Job	S.Job

Ratified by ODN Board:

Date of meeting	
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Audit Standards:

Audit points

- Evidence that the unit's current OPEL status is documented and reviewed at least once per shift.
- Evidence that escalation actions appropriate to the OPEL level (as defined in the network framework) have been implemented and recorded.
- Confirmation that senior neonatal and managerial staff were informed when the OPEL level increased to Level 3 or 4.
- Evidence of communication with PaNDR and/or the ODN during periods of sustained OPEL 3 or 4 pressure.
- Documentation of exception reports submitted to the ODN for episodes where care occurred outside of the agreed pathway due to capacity pressures.
- Review of OPEL activations, escalation actions, and related incidents at unit and network governance meetings.

East of England

Management and escalation of operational pressures in neonatal services

Adapted from West Midlands Escalation policy

1. Introduction

- 1.1. This document outlines the plans for the management and escalation of operational pressures in neonatal services within the East of England Neonatal Operational Delivery Network (ODN). This document will be used in conjunction with local trust neonatal management and escalation of Operational Pressure Escalation Levels (OPEL).
- 1.2. The East of England operational delivery network (EOEODN) spans Norfolk, Suffolk, Cambridge, Hertfordshire, Essex and Bedfordshire. See appendix 1.
- 1.3. The ODNs have clearly defined care pathways that have been agreed by clinicians, the ODN management teams and commissioners (<http://www.eoeneonatalpccsicnetwork.nhs.uk/>). During periods of operational surge in clinical demand for neonatal cots and/or significant EOE region wide staffing levels which impact on operational cot capacity, it may not be possible to follow these pathways.
- 1.4. EOEODN have agreed pathways outside of the region into both London and East Midlands, and pressure within both of these regions will also impact capacity within EOE.
- 1.5. Whilst there is a need to manage capacity and staffing across the whole critical care system, the role of the ODN is to safeguard the care of babies in neonatal services, during periods of operational surge and/or reduced operational cot capacity across the EOE region, in order to minimise the impact on short- and longer-term outcomes for babies.
- 1.6. This document should be used in conjunction with the National Maternity Escalation Policy and OPEL (MF) Maternity Framework, which sets out the procedures for the Maternity Services to manage significant surges in demand and ensures that maternity services can continue to be provided safely and effectively. This policy uses OPELMF to provide a consistent approach in times of pressure, 7 days a week.

2. Purpose

- 2.1. The purpose of this document is to provide a clear and consistent process for the management of patient pathways to:
 - Optimise outcomes for babies, preventing avoidable mortality and morbidity through enabling access to the appropriate level of care whenever possible.
 - Optimise the management of workforce and/or capacity across the ODNs at times of increasing operational pressure.
 - Maximise capacity within the ODNs across geographical boundaries.
- 2.2. For optimal coordination of the service across the ODN, it is vital that all neonatal units within the Network communicate and co-ordinate their activities effectively. This will include effective communications with colocated maternity services.

3. Scope

- 3.1. This document outlines the plans for the management and escalation of Operational Pressure Escalation Levels (OPEL) across all neonatal units within EOE, a list of which can be found in Appendix 1.
- 3.2. There is recognition that the principles outlined in this document may be affected by the OPEL status in interdependent services such as maternity and paediatrics.

4. Key Points

- 4.1. Individual neonatal units will have locally agreed plans for managing when ODN pathways cannot be followed for reasons such as a lack of capacity. These plans will include workforce, resource, and clinical practice issues. Flexibility at local level is necessary but an overarching plan for managing capacity within the EOE Region aims to provide a consistent approach to the escalation of operational pressures.
- 4.2. Neonatal ODN Escalation plans will be shared across the EOE, London and Midlands regions and associated Maternity Services.
- 4.3. Proactive management of workforce and capacity is essential to optimise patient flow within the networks and ensuring that babies are cared for in the most appropriate place, and as close to home as possible.
- 4.4. If capacity across the ODN becomes problematic, it may be necessary for units to care for infants outside their pathway where it has been risk assessed as safe to do so.
- 4.5. There are dedicated transport services available in the ODN to support the transfer of babies between neonatal units.
- 4.6. When a baby is admitted to a neonatal service, parents should be given the transfer information leaflet ([see Neonatal-Units-Leaflet-v01_2024.pdf](#)) which explains the configuration of the Network, the possibility of transfer between different levels of unit within the Network, and the arrangements for repatriation. Parents should be involved in all discussions regarding transfer of their baby and must be kept informed of any changes to agreed plans.
- 4.7. Any decisions to close cots or the neonatal unit should be formally risk assessed. The risk assessment should be shared through Trust escalation processes and accepted at Trust Board level. The decision should be communicated to the relevant ODN, ICB (integrated care board) and Regional Specialised Commissioning Team at the earliest opportunity.
- 4.8. The temporary suspension of the neonatal unit does not translate to an automatic temporary diversion or closure of a maternity unit. The provision of reliable and timely life-saving emergency care overrides any diversion or closure in place thus ensuring that a birthing woman/person and baby go to the nearest hospital for assessment and stabilisation, regardless of gestation or neonatal status. In-utero or ex-utero transfers can be arranged as

required post-stabilisation. A high-risk birthing woman/person whose baby may potentially require neonatal services should have an individual assessment and a personalised risk assessment completed. There should also be joint consultation by the consultant obstetrician and consultant neonatologist.

- 4.9. The decision to close a neonatal unit, alongside a maternity unit closure, must be made in collaboration with the Trust Strategic On Call, Neonatal Operational Delivery Network (ODN) and ICB Strategics. The regional Neonatal ODN Escalation of Operational Pressures and Surge Plan should be followed to ensure access to neonatal critical care is maintained and not compromised.
- 4.10. The East of England Maternity and Neonatal Sitrep indicates where there are pressures on capacity in maternity & neonatal services. It provides daily oversight across the region and locally through the trust operational structures in order to support pressure alleviation by the trusts in collaboration with the Network. It also aims to aid mutual aid discussions where required.
- 4.11. It is the responsibility of each trust to ensure its daily data return is accurate and reflects the real position in terms of pressure at that point in time.
- 4.12. The PaNDR retrieval service manages the daily collection of Neonatal cot availability and manages cot location for transfer, this is a 24/7 service to support capacity across the region.

5. ODN Pathways

- 5.1. The ODNs have clearly defined care pathways, which have been agreed by the Clinicians, the Network Management Team, and the Specialised Commissioning Team.
- 5.2. In-utero transfer to a centre with a NICU is the optimal approach where preterm labour <27/40, < 28 week multiples and anticipated weight < 800gms. All babies <27/40 (whether in - or ex-utero) must be referred for transfer to a hospital with a NICU.
- 5.3. Where possible transfer should be to the cluster NICU to keep families close to home. The receiving hospital should accept the referral, **whenever possible** and there must be consultant (PaNDR) to consultant discussion, which will include the obstetric consultant in the case of an in-utero transfer, to resolve any issues in relation to transfer. In the event of extreme workforce / capacity issues, it is recognised that the availability of ambulance and midwifery staff will have significant impact on the ability to achieve this and cases will have to be decided on a case-by-case basis.
- 5.4. Individual neonatal units will have locally agreed plans for managing when agreed pathways cannot be followed. These plans will include capacity, workforce, resource, and clinical practice issues and should align with the overarching plan for managing escalation within the ODNs, the wider EOE region and nationally.

- 5.5. When ODN demand exceeds capacity, cot capacity will be sought outside of the ODN in line with the current cot locator processes.
- 5.6. If capacity across the ODNs becomes problematic and transfer outside of region is not possible, it may be necessary for units to care for infants outside their pathway where it is safe to do so. This must be risk assessed and agreed through consultant to consultant discussion on a case by case, and risks versus benefits, basis and in conjunction with PaNDR who will support through their decision support service.
- 5.7. All discussions about babies being cared for outside of service specifications should be with the PaNDR decision support team and decisions must be documented in the patient record. The ODN should be informed about any decisions to care for an infant outside of the pathway through an exception report.
- 5.8. Parents must be updated daily with regard to all discussions with the PaNDR decision support, and any plans to transfer or not. Discussions with parents to be documented in the patient record.
- 5.9. In line with current ODN practice, and to ensure that governance processes are maintained, any infant cared for outside of pathway should be reported on the ODN live exception report.

6.0. Regional OPEL Assessment (See Appendix for Local Opel Assessment)

OPEL Level	Description	Actions	Responsibility
OPEL 1 Green Normal	<p>ODN units are open to admissions in line with unit designation.</p> <p>Patient flow can be maintained in line with ODN pathways and services are able to meet anticipated demand with available resources:</p> <ul style="list-style-type: none"> •Nursing and Medical Staff levels meet national standards for number and dependency of babies in units (see section 87 or is manageable with available resources •IC/HD/SC cots available appropriate to designation of unit •Adequate equipment available for acuity and/or capacity • Transport service availability • Planned transfers can be accommodated • Maternity open 	<p>1. Neonatal services will provide care in line with current care pathways and can accept admissions in line with the ODN designated pathways.</p> <p>2. Neonatal Units will assess local OPEL status at least x1 daily</p>	Local unit level

OPEL Level	Description	Actions	Responsibility
OPEL 2 Amber Moderate Pressure	<p>Neonatal services across the ODN are experiencing difficulty in meeting demand / anticipated demand with available resources. One or more unit in the ODN has declared OPEL 3 and / or there is insufficient critical care capacity within the Network necessitating capacity transfers.</p> <p>It is difficult to maintain patient flow in line with ODN pathways due to 1 or more of the following:</p> <ul style="list-style-type: none"> • Nursing and/or Medical Staff levels are reduced below national standards for number and dependency of babies (see section 7) • Limited cot availability appropriate to designation of units • Limited availability of essential equipment (i.e. cot, ventilator, monitor, infusion pumps) to meet increase in dependency or capacity • Reduced transport service availability • Units unable to accept transfers in line with unit designation • Maternity services open 	<ol style="list-style-type: none"> 1. Units will follow locally agreed plans for the management and escalation of OPEL, ensuring appropriate communication and escalation of situation through the Trust managers and processes. 2. OPEL status to be assessed on a shift-by-shift basis or more frequently when activity is high. 3. Proactively manage staffing shortages in line with local escalation policies. See Section 7. 7. Staffing levels to be risk assessed and agreed at local Trust level. 4. Proactively manage capacity in line with local escalation policies. See Section 8. 5. Prioritise parents. See Section 9. 	Local unit level

OPEL Level	Description	Actions	Responsibility
OPEL 3 Red Major Pressure	<p>One or more ODN NICU is at OPEL 4. One or more ODN LNU / SCU is at OPEL 3.</p> <p>Very limited ability to maintain patient flows in line with ODN pathways due to:</p> <ul style="list-style-type: none"> • Nursing and/or Medical Staff levels significantly reduced below national standards for number and acuity of babies in unit (see section 7) • Very limited cot availability appropriate to designation of unit • Very limited availability of essential equipment (i.e., cot, ventilator, monitor, infusion pumps) • Reduced transport service availability • Units unable to accept transfers in line with unit designation • Regional Maternity Services OPEL 3 is experiencing major pressure compromising patient flow & safety 	<p>1. Follow locally agreed plans for the management and escalation of OPEL ensuring appropriate communication of situation through the Trust managers and processes.</p> <p>2. Some units may have to consider caring for infants outside of existing ODN pathways.</p> <p>3. Staffing levels to be risk assessed and agreed at local Trust level.</p> <p>4. Inform the ODN management team (see Section 12) as soon as possible of any decision for partial / full closure of the neonatal unit to internal and/or external admissions</p> <p>5. Unit leads (medical and/or nursing) to attend ODN capacity meetings</p>	Local unit level
		<p>6. ODN to arrange regular meetings with unit leads (medical and nursing) via MS Team</p>	ODN level

OPEL Level	Description	Actions	Responsibility
OPEL 4 Black Critical Pressure	<p>One or more the ODN NICUs is at OPEL 4. Two or more of the ODN LNUs / SCUs are at OPEL 3 or 4.</p> <p>Demand exceeds available resource. Prioritisation on case-by-case basis is required due to:</p> <ul style="list-style-type: none"> • Nursing and/or Medical Staff levels significantly reduced below national standards for number and acuity of babies in unit (see section 7) • Contingency plans (in line with local management and escalation of OPEL) failed • No physical cot space, occupancy 100% or above • All essential equipment is in use • ODN units unable to accept transfers in line with ODN pathways due to any / all the above necessitating transfers out of region. • No transport service availability • Regional Maternity Services OPEL 4 is experiencing extreme 	<ol style="list-style-type: none"> 1. Escalation and contingency plans will have been insufficient to contain or reduce OPEL 3. Neonatal service(s) cannot routinely accept any admissions. 2. It is likely that units will have to care for infants outside their pathway at least for a period of time. 3. Follow locally agreed plans for the management and escalation of OPEL, ensuring appropriate communication of situation through the Trust and ODN processes. See Section 7, Section 8 and Section 9 4. Staffing levels to be risk assessed and agreed at local Trust level. 5. Consider reconfiguration of unit footprint to enable cohorting of all babies according to levels of care in order to optimise use of available staff 6. Inform transport service of decisions to close the neonatal unit. 7. With support from transport service source cot capacity outside of region in line with the current cot locator process used when regional demand exceeds capacity. 8. If there is a lack of transport capacity due to a reduction in staff or ambulances, support from transport services outside of region or where appropriate from paediatric transport services, will be requested. 9. Consider implementation of a divert policy to appropriate designation of neonatal unit with available capacity. This should be led by the relevant transport service. 10. Inform the ODN management team Local unit and service level 11. Ensure appropriate staff available to participate fully in ODN conference calls to discuss management of capacity and /or staffing or equipment issues. 12. Manage local capacity and/or staffing in line with decisions agreed with ODN. 13. Provide updates to ODN management team (see Section 12) until situation is resolved. Timescales for these updates to be agreed with ODN management team. 	Local unit level

pressure and is unable to provide comprehensive care which has the potential for patient safety to be compromised	14. Provide regular updates to parents and families until situation is resolved.	
	15. Inform the ODN Management Team (see Section 12) when decision taken to reopen to admissions.	
	In Hours; Monday to Friday 09.00 to 17.00hrs	ODN level
	1. ODN to arrange conference calls	
	2. ODN to cascade decisions on closure to units within the ODN and neighbouring ODNs.	
	3. ODN to escalate OPEL status to Regional Perinatal team, Specialised Commissioning and/or the National team as necessary and appropriate and where a process for escalation is in place.	
	4. ODN to notify Regional Perinatal Team, Specialised Commissioning and the National team, as applicable, when OPEL status is de-escalated.	
	5. ODN to prepare communication for families explaining situation, apologising, providing reassurance and requesting cooperation.	

6.0. Assessing OPEL

All Trusts will have mechanisms in place for the monitoring and reporting of escalation of operational pressures at local service and Trust level.

- 6.1 Neonatal OPEL status will be dependent on cot availability and/or workforce availability. At times, the availability of equipment may also impact on OPEL status. A neonatal unit may also need to close for reasons other than capacity, for example an infection outbreak or estate issues.
- 6.2 At unit level, there should be a discussion, at least once daily, between the attending consultant and nurse in charge to assess OPEL status. This should be reassessed regularly at times of significant pressure.
- 6.3 There must be evidence that policy and service changes have been risk assessed, notified and agreed through local Trust management and escalation of OPEL processes.

7. Managing Workforce

Both, Medical and Nursing workforce availability must be taken into consideration when assessing and agreeing OPEL status. Units should risk assess cot availability, skill mix and available resources, including transport service availability, on a shift-by-shift basis. All efforts should be made to meet recommended staffing levels in accordance with national standards (BAPM).

7.1. Medical Staffing

Recommendations for medical staffing levels are set out in BAPM workforce standards for SCU/LNU or NICU [BAPM \(2021\)](#); & [BAPM \(2018\)](#).

- 7.1.1 Any gaps in medical staffing rotas should be managed and recorded in line with local trust policies.
- 7.1.2 The principles within this document should be used to guide the development of emergency medical rotas. This strongly recommends including provision for enhanced consultant presence on units where possible.
- 7.1.3 Minimal staffing requirements should be no less than the usual 7-day/ weekend cover with discretion by trusts. This needs to be enhanced for units with high activity, or where there are significant risks due to cross-site working.
- 7.1.4 Neonatal transport services should endeavour to manage their staffing to ensure that a full number of teams is available for each shift to support the network flows. In situations of significant regional pressure, escalation to paediatric transport service or neighbouring network transport services should be considered.

7.2. Nurse Staffing

- 7.2.1. It is recognised that not all units are regularly staffed to BAPM but aspire to this standard. In escalation, units should continue with this aspiration.
- 7.2.2. OPEL status in relation to available nursing workforce, should be calculated by the nurse in charge on a shift-by-shift basis (or more often if necessary) using a workforce calculation tool.
- 7.2.3. Any changes to staff ratios, roles and responsibilities should be risk assessed and agreed by the local Trust. Consider:
 - Movement of staff across sites, where applicable.
 - Staff offered overtime / bank shifts
 - Use of agency staff
 - Redeployment of staff in non-clinical posts to clinical roles
 - Redeployment of community based neonatal nurses to unit-based roles
 - Redeployment of staff from other areas such as paediatric wards and/or maternity wards
 - Cancellation of study leave and management/office days
 - Allocate unregistered nurses to support registered nurses working in ICU/HDU outside of BAPM standards with increased baby: nurse ratio
 - Redeployment of new starters from their supernumerary period in ICU/HDU to work independently in SCU providing the supernumerary hours can be provided

at a later date

- 7.2.4. Where it is not possible to meet national standards for neonatal nursing, a formal risk assessment should be undertaken, and nurse staffing levels agreed at local trusts level.
- 7.2.5. Local arrangements for the management and escalation of nurse staffing shortages will be implemented.

8. Managing Capacity

Many of the regional units are consistently challenged with capacity problems, some working at >100% occupancy for critical care. Proactive management is therefore essential to optimise patient flow.

- 8.1. All neonatal units will have processes and policies in place detailing specific actions required to manage capacity and workforce shortages.
- 8.2. Consideration should be given to whether babies are in the most appropriate cot and consider:
 - 8.2.1. Referral of babies to paediatric services at 40 weeks (rather than waiting until 44 weeks to begin the process)
 - 8.2.2. Early discharge should be facilitated where it is appropriate and safe to do so. Arrangements for support in the community will be required.
 - 8.2.3. Cots available in LNUs and SCUs within the region should be utilised for step down of care to optimise capacity at NICUs as required. Where possible arrangements for step down care should be managed proactively and referred to the relevant transport service at the earliest opportunity.
 - 8.2.4. Transitional care cot usage should be optimised, particularly to support the care of late preterm infants who are otherwise well.
- 8.3. It is anticipated that where staff are available and there is available estate, escalation cots will be opened. The level of care to be provided in these cots and associated equipment required, will have been identified and sourced as part of the local trust surge plans.
- 8.4. Inform the ODN management team (see Section 12) as soon as possible (within office hours) of any decision for closure of cots or the neonatal unit to internal and/or external admissions.
- 8.5. Out of hours any decisions to close must be escalated through Trust Silver and Gold processes.

9. Parents

When considering babies for transfer:

- 9.1. Consider which mothers/birthing parents are fit mentally, physically and financially, for transfer so that separation of mother and baby can be avoided wherever possible.
- 9.2. Parents should be issued with [transfer leaflet](#) when they are admitted to the unit.
- 9.3. Parents should have access to transport to the receiving unit, or this should be provided.
- 9.4. When a baby is to be transferred ex-utero, arrangements should be made for parents to travel in the ambulance with baby whenever possible and clinically appropriate.
- 9.5. Consider whether the receiving unit has available parent accommodation for those parents who are moved away from home.
- 9.6. If there is no available parent accommodation, consider alternatives, such as areas within Trust (on call rooms, staff accommodation, unused wards) where parents can be accommodated.
- 9.7. If there is no suitable accommodation within the hospital then consider the use of charitable funds to support parents with costs of accommodation, such as local hotel / Bed & Breakfast.
- 9.8. Parents should be assisted to access financial assistance, for example the Family Fund. Units should ensure that families impacted by transfers should have access to holistic pastoral and/or psychological support. This should be done through referrals or signposting to services.
- 9.9. Parents should be provided with adequate food and drink throughout their stay.

10. Communications

- 10.1. To facilitate effective and consistent management and escalation of OPEL across the ODN, it is important prompt communication between local, regional and, where necessary, national, partners if measures to contain OPEL 3 are not effective and OPEL 4 is anticipated / reached, and it is necessary to close one or more neonatal unit within the ODN.
- 10.2. Follow locally agreed plans for the management and escalation of OPEL, ensuring adherence to local communication strategies.
- 10.3. Ensure that interdependent services such as, maternity and paediatrics are notified of the Neonatal OPEL status.
- 10.4. Inform the relevant transport service of decision to close the neonatal unit.
- 10.5. Inform the ODN management team (see Section 12) of any partial or full closure of the neonatal unit to internal and/or external admissions.
- 10.6. Out of office hours any closures should be escalated to Silver and Gold Command within individual trusts.
- 10.7. Ensure there is a proactive process for communication with parents. When a baby is admitted to the neonatal service parents should be given the transfer information leaflet ([Neonatal-Units-Leaflet-v01_2024.pdf](#)) see [related documents section](#)) and any pertinent parent letters which explain the

configuration of the Network, the possibility of transfer between different levels of unit within the Network and the arrangements for repatriation or transfer for step down care.

10.8. Inform EOE Regional Specialised Commissioners of any neonatal unit closures via the ODN.

11. Learn from Patient Safety Events (LFPSE) and Patient Safety Incident Response Framework (PSIRF)

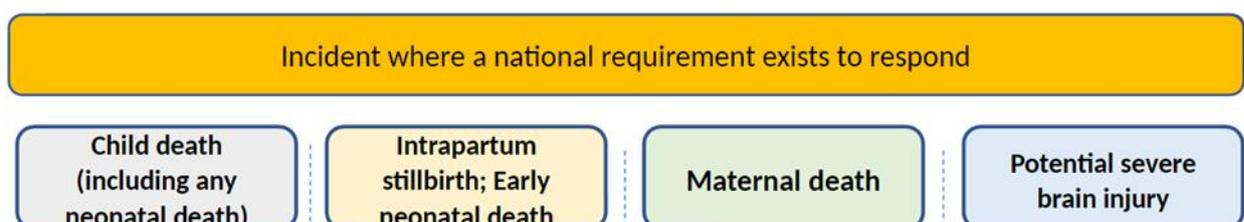
11.1 The **Learn from Patient Safety Events (LFPSE) service** is a national NHS system for the recording and analysis of patient safety events that occur in healthcare using **LFPSE-compliant local risk management systems**. Organisations follow the **Patient Safety Incident Response Framework (PSIRF)** to identify learning from patient safety events. Within PSIRF **SEIPS (systems engineering initiative for patient safety)** is endorsed and all learning responses must follow a system-based approach. PSIRF does not change the expectation to record patient safety events.

11.2 Recorded patient safety events provide vital information to inform the development of Patient Safety Incident Response Plans (PSIRP) and to help support the identification of new learning opportunities. The PSIRP enables organisations to proactively identify and allocate resource to explore safety events and issues that represent the greatest challenges and opportunities to improve patient safety, and to invest resource in delivering improvement where there is sufficient insight about the system changes that are needed. Under PSIRF organisations have the flexibility to decide which type of learning response method to apply to obtain relevant insight to inform improvement and whether a learning response is required, which will be documented in the organisation's PSIRP. The only exception to this is patient safety events which meet a national and regulatory response requirement.

11.3 National and regulatory response requirements

PSIRF does not affect response expectations set out in national policy and regulation. These are described within PSIRF as national response requirements and must be included within an organisation's PSIRP. Within maternity there are several types of patient safety events that require a specific response as follows:

Figure 1: National requirements for patient safety incident response in maternity



11.4 All Neonatal patient safety events that meet the criteria for an organisation's PSIRP or require a national and regulatory response requirement are referred to as Patient Safety Investigation Incidents (PSIIs) and must be recorded on local risk management systems.

11.5 As outlined in the **National Perinatal Surveillance Model (NPSM)** all neonatal PSIIs must be shared with trust boards and the LMNS/ICB. In line with the NPSM, the findings and any subsequent learning identified from the incident reviews should be discussed and shared widely for monitoring and assurance purposes. As a minimum this should include sharing of learning and themes of similar incidents with the trust board, LMNS/ICB board, internal trust directorate and care unit governance teams, maternity safety champions and non-executive director (NED).

11.6 Response requirements for patient safety events not captured by national requirements or PSIRP
For patient safety events not captured within national and regulatory response requirements or the organisation's PSIRP, consideration of the event should include the potential to inform system learning and improvement. The Neonatal Patient Safety Champion is responsible for overseeing that all patient safety events are considered to determine an appropriate learning response. This includes, but is not limited to, the diversion of care from Neonatal services due to a business continuity incident, critical incident or major incident as defined within the NHS Emergency Preparedness Resilience and Response Framework. A PSIRF Incident Response Decision Making Flowchart can be found here **FutureNHS Collaboration Platform**. The PaNDR transport services and any other key stakeholders should be consulted during the patient safety event review to capture any learning around the notification, management, and transfer of patients during the time of the diversion.

11.7 Women or Other Birthing Person's Experience and Feedback

Following a temporary maternity diversion, it is important to engage and involve women/birthing people and families about their experience. A formal apology letter sent to women/birthing people whose care was deflected or diverted due to escalation to another provider from where their care was originally intended is recommended. An example apology letter, developed with regional and national Maternity and Neonatal Voice Partnerships (MNVP), can be found in Appendix 3.

Feedback on their experiences (see example at Appendix 4) is also recommended to be sought. This process should be agreed and led locally at system level in consultation with local MNVP.

12. Contact Details

EoE ODN generic email address: add-tr.eoeneonatalodn@nhs.net

Elizabeth Langham, Director East of England Neonatal, Paediatric Critical Care & Surgery in Children ODN

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PaNDR transport service: 01223274274

Appendix 1. Example of Local Neonatal Unit

Individual neonatal units will have locally agreed plans for managing when ODN pathways cannot be followed for reasons such as a lack of capacity or staffing shortages. These plans will include workforce, resource, and clinical practice issues. Flexibility at local level is necessary but an overarching plan for managing capacity within the East of England Region aims to provide a consistent approach to the escalation of operational pressures. This is an example of an OPEL plan which is aligned with the Neonatal ODN guideline for the Management and Escalation of OPEL and can be used by local units / services as part of their local plans.

NEONATAL UNIT OPEL Level	Description	Actions	Footprint
<p>OPEL 1 – NORMAL</p>	<p>Unit open to all admissions in line with unit designation.</p> <p>Patient flow can be maintained in line with ODN pathways and service is able to meet anticipated demand with available resources</p> <ul style="list-style-type: none"> • Nursing and Medical Staff levels meet national standards for number and dependency of babies in unit (see section 8) or is manageable with available resources • Cots available appropriate to designation of unit IC/HD/SC • Adequate equipment available for increase in dependency or capacity • Transport service availability • Planned transfers can be accommodated • Maternity services open 	<p>Neonatal services will provide care in line with current care pathways and can accept all admissions in line with the ODN designated pathways.</p>	<p>Individual Unit Level</p>

NEONATAL UNIT OPEL Level	Description	Actions	Footprint
<p>OPEL 2 – MODERATE PRESSURE</p>	<p>Unit open to Network admissions in line with unit designation.</p> <p>Patient flow is currently being maintained in line with ODN pathways, but service is expecting difficulty in meeting demand / anticipated demand with available resources due to:</p> <ul style="list-style-type: none"> • Nursing or Medical Staff levels reduced below national standards for number and dependency of babies in unit • Limited cot availability appropriate to designation of unit • Limited availability of essential equipment (i.e., cot, ventilator, monitor, infusion pumps) to meet increase in dependency or capacity • Reduced transport service availability • Unit unable to take transfers • Maternity service open 	<p>Neonatal services will continue to provide care in line with current care pathways, but will prepare for escalation to OPEL 3:</p> <ol style="list-style-type: none"> 1. Units to follow locally agreed plans for the management and escalation of OPEL, ensuring appropriate communication of situation through the Trust managers and processes. 2. Neonatal capacity and unit OPEL status to be agreed through discussion between Senior medical staff on service and nurse in charge daily, on a shift-by-shift basis or more frequently when activity is high. 3. Proactively manage staffing shortages in line with local escalation policies. Consider: <ul style="list-style-type: none"> • Movement of staff across sites, where applicable. • Staff offered overtime / bank shifts • Use of agency staff • Redeployment of staff in non-clinical posts to clinical roles • Cancellation of study leave • Redeployment of staff from other areas, such as paediatric wards 4. Proactively manage capacity in line with local escalation policies. Consider: <ul style="list-style-type: none"> • Transfer of babies to Transitional Care where available and appropriate • Repatriation of babies to referring hospitals • Step down of L2 and L1 babies to LNU or SCU within referral pathways • Liaison with paediatric services once baby reaches 40 weeks (rather than waiting until 44 weeks) • Transfer of babies >44/40 to paediatric ward • Discharge of babies to Neonatal Homecare service where available and appropriate 5. Prioritise parents: <ul style="list-style-type: none"> • Consider most suitable baby and family for transfer taking into account baby’s clinical condition, maternal mental health, ability to drive or access to transport, financial situation, availability of parent accommodation at receiving trust. • Explain and discuss with parents the possible need for transfer, provide them with leaflets and letter about transfer, if not already provided. 	<p>Individual Unit Level</p>

NEONATAL UNIT OPEL Level	Description	Actions	Footprint
OPEL 3 – MAJOR PRESSURE	<p>Unit open to internal admissions (and if a NICU/ Surgical/Neuro Centre open to <27/40 admissions and surgical/Neuro admissions) ONLY. Very limited ability to maintain patient flows in line with ODN pathways due to:</p> <ul style="list-style-type: none"> • Nursing or Medical Staff levels significantly reduced below national standards for number and dependency of babies in unit (see section 8) • Very limited cot availability appropriate to designation of unit • Very limited availability of essential equipment (i.e., cot, ventilator, monitor, infusion pumps) • Reduced transport service availability • Unable to accept transfers • Maternity Services OPEL 3 is experiencing major pressure compromising patient flow & safety 	<p>It is anticipated that a unit will be unable to accept admissions or transfers, in line with ODN pathways due to a lack of cot capacity, workforce, equipment, neonatal transport capability or a combination of any or all of these.</p> <ol style="list-style-type: none"> 1. Follow locally agreed plans for the management and escalation of OPEL, ensuring appropriate communication of situation through the Trust managers and processes. 2. Optimise staffing: <ul style="list-style-type: none"> • See OPEL 2 for managing staffing shortages. • Consider reconfiguration of unit footprint to enable cohorting of all babies according to levels of care in order to optimise use of available staff 3. Optimise capacity in NICUs: <ul style="list-style-type: none"> • See OPEL 2 for managing capacity. • Proactively manage repatriation to LNUs and SCUs. All babies suitable for transfer or repatriation within the network should be identified before morning handover and agreed by the Consultant Neonatologist and Nurse in Charge, in consultation with parents. • The decision to transfer will be made jointly between the NICU, receiving unit and the transport service and in consultation with the parents. 4. Prioritise parents: See OPEL 2 Ensure there is a robust process in place for communication with parents about transfer and any changes to plans. 5. It may be necessary to consider caring for infants outside of existing ODN pathways where it has been risk assessed as safe to do so. 6. Inform the ODN management team using contact details in EoE Region OPEL Guideline Section 10.8 of a decision for any partial or full closure of the neonatal unit to internal and/or external admissions. 	Individual Unit Level

NEONATAL UNIT OPEL Level	Description	Actions	Footprint
<p>OPEL 4 – CRITICAL PRESSURE</p>	<p>Unit Closed. Demand exceeds available resources, requiring prioritisation on a case-by-case basis due to: Demand exceeds available resource. Prioritisation on case-by-case basis required because of one or more of the following:</p> <ul style="list-style-type: none"> • 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. • No transport service availability • Maternity Services OPEL 4 is experiencing extreme pressure and is unable to provide comprehensive care which has the potential for patient safety to be compromised. 	<p>Escalation and contingency plans will have been insufficient to contain or reduce OPEL 3. Neonatal service(s) cannot routinely accept any admissions. There may be more than one unit within the ODN in this position.</p> <p>It is likely that units will have to care for infants outside their pathway at least for a period of time.</p> <ol style="list-style-type: none"> 1. Follow locally agreed escalation and business continuity plans for the management of neonatal staffing and/or capacity shortages ensuring appropriate communication of situation through the Trust processes. 2. Consider reconfiguration of unit footprint to enable cohorting of all babies according to levels of care in order to optimise use of available staff 3. Staffing levels to be risk assessed and agreed at local Trust level. 4. Inform transport service of decision to close the neonatal unit. 5. With support from transport service source cot capacity outside of region in line with the current cot locator process used when regional demand exceeds capacity. 6. If there is a lack of transport capacity due to a reduction in staff or ambulances, support from transport services outside of region or alongside paediatric transport services in region, will be requested. 7. Inform the ODN management team using the contact details in East of England Region OPEL Guideline Section 10.8 of a decision for any partial or full closure of the neonatal unit to internal and/or external admissions. 8. Consider implementation of a divert policy to appropriate designation of neonatal unit with available capacity. This should be led by the relevant transport service. 9. ODN to cascade decisions on closure to units within the ODN and neighbouring ODNs, Regional Perinatal team, Specialised Commissioning and/or the National team as necessary and appropriate 10. Ensure appropriate staff available to participate fully in ODN conference calls to discuss management of capacity. 11. Manage local capacity in line with decisions agreed with ODN. 12. Provide updates to parents and families 13. Provide updates to ODN management team (by email or telephone) until situation is resolved. Timescales for these updates to 	<p>ODN Level</p>

NEONATAL UNIT OPEL Level	Description	Actions	Footprint
		be agreed with ODN management team. 14. Provide regular updates to parents and families until situation is resolved. 15. Inform the ODN Management Team via relevant email address when decision taken to reopen to admissions.	

Appendix 2. EoE Hospitals and Clusters

Cluster Hospital	County	Acute Hospital Trust	Neonatal unit	Unit type
Cambridge cluster	Cambridge and Peterborough	Cambridge University Hospitals NHS Foundation Trust	The Rosie Hospital - Addenbrookes	NICU
		Northwest Anglia NHS Foundation Trust	Peterborough City Hospital	LNU
		Northwest Anglia NHS Foundation Trust	Hinchingbrooke Hospital	SCU
	Essex	Mid Essex Hospital Services NHS Trust	Broomfield Hospital	LNU
		East Suffolk and North Essex Foundation Trust	Colchester Hospital	LNU
		Princess Alexandra Hospital NHS Trust	Princess Alexandra Hospital Harlow	LNU
	Suffolk	West Suffolk Hospitals NHS Trust	West Suffolk Hospital	SCU
	Norwich cluster	Norfolk	Norfolk and Norwich University Hospitals NHS Trust	Norfolk and Norwich Hospital
Queen Elizabeth Hospital Kings Lynn NHS Trust			Queen Elizabeth Hospital	LNU
James Paget University			James Paget Hospital	SCU

		Hospital NHS Foundation Trust		
	Suffolk	East Suffolk and North Essex Foundation Trust	Ipswich Hospital	LNU
Luton Cluster	Bedfordshire	Bedfordshire Hospitals NHS Foundation Trust	Luton and Dunstable Hospital	NICU
		Bedfordshire Hospitals NHS Foundation Trust	Bedford Hospital	SCU
	Hertfordshire	East and North Hertfordshire NHS Trust	Lister Hospital	LNU
		West Hertfordshire Hospitals NHS Trust	Watford Hospital	LNU
Royal London	Essex	Mid Essex Hospital Services NHS Trust	Basildon and Thurrock University Hospitals	LNU
		Mid Essex Hospital Services NHS Trust	Southend Hospital	LNU

Appendix 3: Transfer of Care Apology Letter

Insert Trust Logo

Insert Trust Address & Contact Details

[Insert Date]

[Insert Patient Details]

Dear...

Transfer of care due to closure of Neonatal unit (Insert Trust/Site)

We would like to sincerely apologise to you for any inconvenience or upset caused when we recently had to close our Neonatal unit and were unable to accept your admission for care and treatment.

We experienced an exceptionally high volume of admissions and/or were experiencing staffing pressures, which resulted in the decision to close our neonatal unit to maintain the safety of babies and families currently receiving treatment and/or needing to be admitted for review and care. This decision is only taken once all options to address the high activity have been taken.

Having liaised with our neighbouring Neonatal providers and the local Transport Services, we arranged for you to be seen at the next nearest hospital open to admissions and providing the specialist maternity/neonatal care you and your baby requires.

We would value any feedback about your transfer of care, and would kindly ask you to complete this short form we have created with our Maternity and Neonatal Voices Partnership (MNVP), please complete form via (trust link)

If you wish to discuss the transfer of care further, please do not hesitate to contact our Patient Experience Team who can be contacted via (Insert contact details). If you have any concerns around your ongoing maternity/neonatal care, please contact your local community midwife who will be happy to help you.

You can contact our local Maternity Neonatal Voices Partnership by/at on (Add details).

Yours Sincerely

(Insert Name)

Appendix 4: Transfer of Care Feedback Form

We are sorry to hear that it was necessary to transfer your neonatal/maternity care to another unit or trust. We value all feedback received to help improve the care and our services for women/birthing people, babies, and their families. We kindly ask if you can complete this short feedback form to tell us about your experience. Your midwife, neonatal nurse, support staff or your local Maternity & Neonatal Voice Partnership (MNVP contact details below) will happily help you to complete the form and submit your responses if you require assistance.

Which hospital did you originally book with?
Which hospital where you transferred to?
When and how was the transfer to another unit/trust communicated to you?
Did you understand the reasons why you your care was being transferred?
What, if any, other information would have been helpful in aiding your understanding of the reasons for the transfer of your care?
Were you given the opportunity to ask any questions and discuss the situation?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Somewhat
Would you like to share any further feedback regarding the transfer of your care?

How did you travel to the maternity unit your care transferred to?

- Ambulance
- Booking hospital arranged a taxi.
- I/my birth partner arranged a taxi.
- Own car
- Public transport
- Other

How far away was the maternity/neonatal unit you transferred to?

How was your experience at the unit you transferred to and is there any feedback on your experience you would like to provide?

When discharged home were you aware of the plan for follow up neonatal/maternity care including any required appointments, tests, or treatment?

Was it clear where your follow up care would take place following discharge home?

Yes No Somewhat.

Did you receive contact details in case you needed any help or advise following discharge home?

Yes No



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Were there any delays in seeing a midwife/doctor or receiving any planned follow up care from your original booking hospital following discharge home?

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If you would like to be contacted to discuss the care that you received, please provide your details below:

Name	
NHS Number	
Ethnicity	
DOB	
Religion	
Address & Postcode	
Contact Number	

Please return this completed for to:

(insert contact details here) & MNVP details here

[Add Privacy Statement here in consultation with Trust or System Information Governance Team]

Appendix 5. Example of best practice tool for OPEL scoring created by West



Copy of NNU OPEL
Tool.xlsb

Suffolk Hospital.

Maternity Operational Pressures Escalation Levels - NNU (OPEL rating)							
	Nursing staffing	Medical staffing	NNU Acuity	Expected Admissions	Equipment	Repatiations	Discharges
Black Level 4	Critical shortage or inappropriate skill mix of nursing staff required to deliver appropriate care leading to an unacceptable increase in clinical risk	Insufficient medical skill mix for number of babies leading to an unacceptable increase in clinical risk	Cot occupancy at or above 100% contingency cots are already in use	Closure of NNU. Maternity unit on divert, closed to women whose babies require admission to the neonatal unit	All essential equipment is in use	Unable to accept planned transfers/ repatriations	No discharges expected in the next 24 hours
Red Level 3	Insufficient numbers and/or skill mix of nursing staff required to deliver appropriate care leading to increase in clinical risk	Insufficient medical skill mix for number of babies, leading to an increase in clinical risk	Limited cot availability appropriate to designation of unit IC/HD/SC/ TC - only 1 cot available + emergency cot	Number of expected admissions >1	One set of essential equipment available	Unable to accept planned transfers/ repatriations	No discharges expected in the next 24 hours
Amber Level 2	Insufficient numbers and/or skill mix of nursing staff	Insufficient medical skill mix for number of babies	Unit open to region and own admissions. Limited cot availability appropriate to designation of unit IC/ HD/ SC/ TC- cots available and emergency cot	Number of expected admissions >2	Essential equipment available to accommodate pending activity	Planned repatriations can be accommodated	Expected discharges in the next 24 hours
Green Level 1	Nursing skill mix satisfactory for dependency of babies	Medical skill mix satisfactory for dependency of babies	Unit open to region & own admissions Cots available appropriate of designation of unit	Number of expected admissions ≤2	Essential equipment available to accommodate pending activity	Planned repatriations can be accommodated	Expected discharges in the next 24 hours
Date:		Time:		Overall rating			

BLACK Level 4 Anomaly Closure due to infection control outbreaks

Due to the vulnerable nature of the neonatal population, there are occasions where continued delivery of a service could put patients at risk if they were to be admitted into the area. Infection control outbreaks should be managed in close conjunction with the infection prevention team. On suspicion of an outbreak, a meeting with executive representation must be undertaken to allow discussion and planning of care for all infants on NNU. Reduction of admissions / available cots or closure of the NNU should be immediately reported to the EBS/PaNDR & to the Neonatal ODN and specialist commissioning.

Related Documents

- National Neonatal Critical Care Service Specification 2024.

<https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-e/e08/>

- Implementing the Recommendations of the Neonatal Critical Care Transformation Review 2019

<https://www.england.nhs.uk/publication/implementing-the-recommendations-of-theneonatal-critical-care-transformation-review/>

- EoE Exception Reporting Policy

Need link

- EoE Patient Flow Guideline

[Patient Flow Guideline](#)

- EoE In Utero Transfer Policy

[IUT-policy-EoE-2024.pdf](#)

- EoE Parent Transfer Information Leaflet

[Neonatal-Units-Leaflet-v01_2024.pdf](#)



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Exceptional Circumstances Form

Form to be completed in the **exceptional** circumstances that the Trust is not able to follow ODN approved guidelines.

Details of person completing the form:	
Title:	Organisation:
First name:	Email contact address:
Surname:	Telephone contact number:
Title of document to be excepted from:	
Rationale why Trust is unable to adhere to the document:	
Signature of speciality Clinical Lead:	Signature of Trust Nursing / Medical Director:
Date:	Date:
Hard Copy Received by ODN (date and sign):	Date acknowledgement receipt sent out:

Please email form to: kelly.hart5@nhs.net requesting receipt.

Send hard signed copy to:
Kelly Hart
EOE ODN Office Manager
Box 402
Rosie Hospital
Robinson Way
Cambridge University Hospital
Hills Road
Cambridge CB2 0SW