Document Title:	**BUSINESS CONTINUITY MANAGEMENT PLAN - Surge and Escalation in Neonatal Services**
Reference Number:	**STR-ODN-01**
Main Author :	**NWNODN Senior Management Team**
Ratified by:	**SMT**
Date Ratified:	**04.08.21**
Review Date:	**04.08.22**
Version:	**FINAL**

Table of Contents

SECTION 1 - PLAN OVERVIEW

1.1 Purpose

This document provides the Business Continuity Management (BCM) and Escalation arrangements for North West Neonatal Operational Delivery Network (NWNODN) for any event causing a requirement for surge or escalation in neonatal services.

The function of the plan is to mitigate the impact of any pressures on neonatal services across the North West, which will affect the operation of normal business within the NWNDON particularly in terms of prioritising critical functions and in responding to the challenge.

1.2 Objectives

- Provide a strategic framework for the NWNODN's response to and recovery from any surge or escalation events within Neonatal Services.
- Ensure continued equity of access and treatment across the North West
- Identify those who must be notified and kept informed of the changes affecting normal business
- Enable sufficient flexibility to cater for loss of services on a varying scale.
- Identify risks to critical, essential and routine services and define alternative plans to mitigate the impact of these risks
- Identify additional short term resources required for supporting continued operation of neonatal service
- Provide a framework for the timely and orderly recovery of the NWNODN
- Describe a process of escalation to support the NWNODN team and NW neonatal providers in early identification of, and response to, threats to elements of neonatal service provision

1.3 Scope

1.3.1 Within Scope

This plan relates to the business continuity management of the NWNODN. This includes the monitoring and governance of pathways and escalation expectations. This plan will address management of capacity and patient flow.

1.3.2 Out of Scope

This plan will not outline the arrangements for business continuity within specific providers. These arrangements should be detailed within individual provider business continuity plans. Providers should ensure that this document is sighted in any plans.

It is acknowledged that a number of key data sources are heavily reliant on Arden & GEM Clinical Support Unit (CSU). Contractually this organisation is required to ensure arrangements for business continuity are in place. Co-operation will be established to ensure continuity of the service in the event of a significant service interruption.

1.4 Assumptions

A number of assumptions have been made in the creation of this document:

- The plan has the full support of NHS England Specialised Commissioning
- The plan assumes the full cooperation from each provider
- The plan will be reviewed as a minimum monthly throughout any period of disruption
- That all clinical decisions will be underpinned by relevant local and national ethical guidance (e.g. NHS England, General Medical Council, Nursing Midwifery Council and British Association of Perinatal Medicine)

1.5 Definitions

1.5.1 Emergency Preparedness

Emergency preparedness is defined as the extent to which emergency planning enables the effective and efficient prevention, reduction, control, mitigation of, and response to emergencies.

Critical Services: a critical service is defined as a service in which the maximum tolerable period of disruption is less than twenty-four hours.
For North West neonatal services this would include:

- All levels of inpatient neonatal services, including surgery
- The North West neonatal transport service – Connect North West

Essential Services: an essential service is defined as a service in which the maximum tolerable period of disruption is less than forty-eight hours.
For North West neonatal services these are:

- Retinopathy Of Prematurity (ROP) Services
- Access to urgent specialist review services- e.g. cardiology

Routine Services: a routine service is defined as a service in which the maximum tolerable period of disruption is less than two weeks
For North West neonatal services this would include:

- Screening services
    - Newborn Infant Physical Examination
    - Hearing Screening
- Neonatal outpatient services
- Access to routine specialist review services for non-urgent patients

1.6 Triggers for Reporting

Any disruption to service including those listed below should be reported appropriately, using the NWNODN Escalation Guideline.
https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2020/11/GL-ODN-01-Exception-Reporting.pdf

- Any disruption in the provision of neonatal services such as closure beyond 24 hours or loss of services such as ROP, Allied Health Professionals or access to essential services
- Any impacts on capacity to provide normal level of neonatal care such as room closures due to co-horting for any reason. e.g. RSV, CPE
- A positive COVID19 test result on any inpatient within a North West neonatal service. Any impacts on staffing such as high levels of sickness or absence meaning capacity has to be reduced or lack of staffing to provide appropriate isolation and safe support of full capacity
- Paediatric activity taking place in any neonatal unit

1.7 Escalation

Local Provider Responsibility:

For a potential major incident or one that could disrupt service delivery you should ask yourself the following questions:

1. Has the incident triggered or is it likely to trigger negative outcomes?
2. Will these outcomes affect service delivery?
3. Will managing this event at a local level exceed the limit of what can be done with resources available?

If you answer 'yes' to any of these questions then you must report the trigger using the following process:

- Local escalation as per local Business Continuity/Escalation planning.
- Inform Connect North West of changes in capacity or requirement for transfer where urgently required.
- Follow the NWNODN Escalation Process

https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2022/07/GL-ODN-04-Escalation-Guideline.pdf

If escalation is not required, the NWNODN should work alongside the provider to support the management of the trigger/situation at a local level and ensure that actions and decisions are logged appropriately.

1.8 Communicating

1.8.1 NWNODN Units

Continued supportive communication with all providers in the NWNODN is vital to the successful continuation of essential services. When triggers are raised it will require varying periods of time for the relevant plans to be activated and during this time the NWNODN will support providers to ensure safe care is provided until actions are completed.

During initial communication between the NWNODN and providers the following information will be captured and tracked:

- Details of the Trigger/disruption
- What the cause of the Trigger is or may have been
- How long disruption to normal service is likely to last
- How any changes may affect working patterns
- What is expected of them as providers and of the NWNODN
- Confirmation of how ongoing communication should be maintained

1.8.2 Local Maternity System

The NWNODN will ensure that the locality LMS are alerted to any potential or actual service interruptions. Individual units should ensure daily communication with their maternity services.

1.8.3 Managing Communication with Parents

At neonatal providers should ensure that communication to parents is timely and that they are kept informed of any relevant changes to services.

When OPEL 3 level status, as described in this policy, is reached an appropriate communication strategy will be agreed with NHS England Specialist Commissioning, taking into account all system pressures.

All communication and any restrictions to visiting should be based on guidance issued by BAPM and BLISS. This guidance is regularly updated and will be circulated via the NWNODN to ensure all providers have access to this guidance.

1.9 Ethical Decision Making

Ethical challenges are likely to arise during any major interruption. It is possible that demand on health services may outstrip the ability of the NHS to deliver services standards, and decisions about how to meet individual need will give way to decisions about how to maximise overall benefit.

The NWNODN will monitor capacity and acuity across the ODN and will support in making decisions where existing neonatal pathways are deviated from or in situations in which individual units require support in considering ethical decisions.

During the COVID 19 Pandemic BAPM produced guidance for neonatal services. This guidance is pertinent to neonates and has been used to guide this document.
https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf

1.10 Stand Down

It is important that, following the end of any surge or escalation, an appropriate 'stand down' message is communicated to officially end the incident and begin efforts to restore normal service provisions and return to business as usual.

The decision to stand down from a critical incident is made by NHS England. It is essential that all people who were alerted to the incident are notified. The NWNODN will support the dissemination of this stand down across NW neonatal providers and stakeholders.

1.11 Debrief

Debrief arrangements will be put into place to evaluate the response, develop lessons learned and ultimately develop action plans to improve the resilience of the NWNODN.

The NWNODN Senior Team is responsible for ensuring that debrief is carried out from an ODN-wide strategic perspective.

The NWNODN is responsible for ensuring a report is compiled detailing the lessons learned from all providers across the NWNODN.

SECTION 2 TRIGGERS, LEVELS AND ACTIONS

2.0 Escalation & Interventions

In order to ensure that a consistent approach is applied to the delivery of safe care this document is intended to be used by all trusts within the North West region that have dedicated neonatal and maternity services on site. In order to assist with planning for, and responding to, issues it is intended that this guidance should be incorporated within local trust escalation plans and should be viewed as part of the overall response.

This plan will be activated in response to the triggers and levels identified in Appendix 3. Appendix 3 also outlines mitigating actions which should be considered by providers, transport services and the NWNODN at each level.

The levels in this document are based on the NHSE Operational Pressures Escalation Levels Framework (https://www.england.nhs.uk/wp-content/uploads/2019/02/operational-pressures-escalation-levels-framework-v2.pdf)

OPEL 1 - Green - Businesses as Usual – No disruption to services
All unit to provide up to date information regarding capacity and staffing to Cot Bureau on regular ring round

OPEL 2 - Yellow - Greater than normal pressure within a locality
Escalation to OPEL2 will be considered when the following occurs:
One unit closed to all admissions including internal admissions
Two units closed to the network
One NICU closed to the network
One Surgical unit is closed to the Network

Escalation to Yellow, OPEL 2, is a decision of the NWNODN senior management team (SMT).
Please see NWNODN plan (Appendix 3) for details of actions required within this level of escalation.

OPEL 3 - Amber - Impact at Locality Level- A single locality closed
Escalation to OPEL 3 will be considered when the following occurs:

As Opel 2 plus no NICU capacity within one locality and 1 LNU in the same locality closed to the network

Escalation to Amber (OPEL 3) is a decision of the NWNODN senior management team (SMT). This escalation level will result in the activation of the NWNODN Control Group. See Appendix 4 for detail of the membership and actions of this group.
Please see NWNODN Escalation Plan (Appendix 3) for details of actions required within this level of escalation.

OPEL 4 - RED - Impact at ODN Level

Escalation to OPEL4 will be considered when the following occurs:

Two out of the three NW localities are on escalation OPEL 3.

Escalation to Red OPEL4 will be the decision of the NWNODN Control Group.
Please see NWNODN Escalation Plan (Appendix 3) for details of actions required within this level of escalation.

Once the NWNODN Control Group is established at Amber Level 2, it becomes the source of advice to the local providers and NHSE Strategic Command if established.

De-escalation decisions are made by the NWNODN Control Group at higher levels, for example at Amber OPEL3 the NWNODN Control Group would determine de-escalation to Yellow OPEL2. This will be based on an overview

of current activity across the NWNODN and following appraisal of the impact of previous actions to support capacity within the system.

If any organisation or individual requires clarification about implementation of the escalation plan at any stage this should be sought from the NWNODN team at the earliest opportunity to ensure effective dissemination and actions.

2.1 Enabling Measures

In order to maintain surge capacity these enablers will need to be maintained, held on standby or retained as procedures to be reactivated:

- Supporting an increase in the workforce by identification of staff available/accessible to work in a neonatal setting
- Acknowledgement of surge capacity in individual providers with awareness of additional workforce and potential equipment needs
- Understanding of national directives to support escalating to surge capacity specifically around staff movement across services
- Support from NHS England Specialised Commissioning regarding potential resource requirement to support surge capacity

Connect North West will provide a service to include:

- A single point of telephone contact for referring clinicians
- Support the use of conference calling for more than one provider to ensure appropriate conversations undertaken in clinical management
- Access to immediate specialist advice
- Triage to an appropriate level of transport provision and dispatch of transport teams within a clinically appropriate time window
- In collaboration with the NWNODN support the identification of a suitable cot so that the most appropriate care is provided in the most appropriate location
- Maintain a list of all babies in region where neonatal advice is sought with recording of decisions and outcomes

NWNODN Intensive Care Activity:

The NWNODN recognises that due to numerous factors in any incident the capacity within the NICU services to manage all intensive care activity across the region may be impacted.

If this is the case the following enabling measure may be implemented as part of the NWNODN Escalation Plan:

- Upscaling of high dependency transfers to Local Neonatal Units (LNUs) where transport capacity allows
- Support increased IC activity in NICUs with transfer of HD and SC activity to LNUs outside of usual pathways
- Increase in IC activity within the LNU services outside of service specification:
    1. Stable IC activity remains in an LNU for an extended period or if required for the duration of the care episode and is not limited to 48 hours
    2. Enhanced IC activity is undertaken at an LNU where equipment and skills allows
    3. Delivery of infants within new gestation boundaries outside of the service specification but agreed short term with the NWNODN

NB: Points 1, 2 &3 must be undertaken with clear governance support from the NWNODN and with at least 12 hourly clinical discussions between senior medical colleagues from the LNU and an NICU consultant, these conversations should be undertaken using the NWNODN advice guideline. This advice sheet

(appendix 5) should then be scanned and emailed to the NWNODN email address (Nwnodn@alderhey.nhs.uk) following the conversations. This will reduce the requirement for later investigation.

https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2021/06/GL-ODN-14-Advice-Guideline.pdf

Where clear procedure driven IC activity is required within an LNU service, resources maybe made available to that team from CNW or the NWNODN team at the time they are required.

2.2 Surge Capacity

Current cot capacity across the NWNODN is documented below. This capacity is recognised Baseline cots and in no way takes into account staffing. The NWNODN have collected data on possible SURGE capacity which will be considered alongside planning and activity monitoring to maintain safe services. Sufficient neonatal critical care capacity will be required to avoid compromising neonatal clinical outcomes. All providers should ensure their planning takes a system approach and they are able to optimise staffing and capacity. Care may need to be provided outside normal pathways, but any changes should first be discussed with CNW and the NWNODN SMT. All data entered should remain a priority; this should include all Badgernet minimum dataset and information to the Cot Bureau on ring arounds. In order for data collection on a national level the Badgernet Cot Bureau data should also be completed.

Greater Manchester	Unit Level	IC Cots	HD Cots	SC Cots	Total
Manchester Foundation Trust					
• North Manchester	LNU	2	2	15	19
• St Mary's Hospital	NICU/SURGICAL	19	19	31	69
• Wythenshawe Hospital	LNU	2	4	15	21
Royal Bolton Hospital	NICU	9	7	19	35
Royal Oldham Hospital	NICU	9	9	19	37
Stepping Hill Hospital	LNU	2	3	12	17
Tameside General Hospital	LNU	1	3	9	13
Royal Albert Edward Infirmary	LNU	1	3	10	14
Total		45	50	130	225

Cheshire & Merseyside	Unit Level	IC cots	HD cots	SC cots	Total
Arrowe Park Hospital	**NICU**	**6**	**8**	**10**	24
Countess of Chester Hospital	**LNU***	**1**	**2**	**10**	13
(Leighton Hospital	**LNU**	**3**	**4**	**8**	15
Liverpool Women's NHS FT	**NICU**	**12**	**12**	**20**	44
Macclesfield Hospital	**SCU**	**Currently Closed**			
Ormskirk Hospital	**LNU**	**1**	**1**	**8**	10
Warrington & Halton Hospital NHS FT	**LNU**	**3**	**3**	**12**	18
Whiston Hospital	**LNU**	**0**	**2**	**13**	15
Alder Hey Children's Hospital NHS FT	**Surgical**	**0**	**9**	**0**	9
		26	41	81	148

***Countess of Chester currently functioning as a Special Care Unit for routine and escalation purposes**

Lancashire & South Cumbria	Unit Level	IC Cots	HD Cots	SC Cots	Total
Furness General Hospital	**SCU**	**0**	**0**	**4**	4
Royal Lancaster Infirmary	**LNU**	**1**	**2**	**7**	10
Royal Preston Hospital)	**NICU**	**6**	**8**	**14**	**28**
Burnley General Hospital	**NICU**	**6**	**8**	**20**	**34**
Blackpool Victoria Hospital	**LNU**	**2**	**2**	**12**	**16**

		15	20	57	92

2.3 Role of Maternity Services

Maternity services should consider appropriate action to maximise capacity and avoid ex-utero transfers.

Patient transfer during the antenatal, intrapartum and postnatal periods is a high risk time for mother and baby. Excellent standards of communication, patient assessment, care planning and team-working are required to ensure that patient safety is maintained

The clinicians arranging the transfer should follow a robust protocol to ensure the safe transfer of mother and/or baby between care settings, within or outside of the maternity unit and to ensure that effective communication between members of the multidisciplinary team is maintained at all times.

Each unit will follow the clinical network guidelines for maternal and neonatal transfer.

2.4 Paediatric Admissions

In order to support the wider healthcare system neonatal services may be asked to accommodate paediatric patients, which is outside of normal pathways and service specification when surge or escalation occurs in other services. This should be decided as a co-ordinated system approach where possible these infants should be admitted to non-surgical NICUs to protect Surgical Capacity.

Where paediatric cases are admitted they should be reported to the Cot Bureau during the 3 x daily calls. In addition all paediatric patients on a neonatal unit should be admitted onto the Badger system with the place of admission as OTHER then to free type PAEDIATRIC PATIENT
As Paediatric intensive care units (PICUs) may be expected to admit adult intensive care patients their capacity to admit paediatric patients will be compromised, however both PICUs in the NW will continue where possible to admit the majority of paediatric patients requiring intensive care. As NICUs may be required to provide support, the following patients may be required to be admitted to NICUs

2.4.1 Children less than/ equal to 28 days old.

All potential PICU admissions should continue to be discussed with the admitting consultant in PICU or NWTS. If an admission is required for intensive or specialist care, and cannot be accommodated within PICU, then the baby may be considered for admission to an NICU. The referral should be initiated via the NWTS referral line. Following this if a NICU is an appropriate destination, NWTS will contact the Connect NW cot bureau to source the closest appropriate and available cot and to set up a conference call. The most appropriate NICU will depend on location and underlying diagnosis and on completion of the conference call the most appropriate transfer team will be agreed – this may be the local team, connect NW or NWTS depending on the circumstances (see flow chart).

The following patients will be prioritised for admissions to PICU **and it will only be in exceptional circumstances i.e. OPEL 4 , that an admission to a NICU should be considered :**

1. Suspected or confirmed Non- accidental injury
2. COVID-19 positive patients or other transmissible infectious illness eg RSV.
3. Patients requiring Haemodialysis, urgent Cardiac Surgery or ECMO

The following diagnosis could be considered for admission to neonatal services on a case by case basis

(List is not exhaustive)

- Suspected surgical case to be admitted to the closest surgical unit. (MFT or Liverpool Neonatal Partnership (LNP))
- Suspected cardiac pathology should be admitted to LNP
- Possible need for renal replacement therapy should be admitted to MFT
- Suspected oncology should be admitted to MFT
- Possible requirement for exchange blood transfusion – locality NICU
- Sepsis – locality NICU
- Suspected metabolic condition – MFT due to access to specialist paediatricians
- Seizures MFT due to access to specialist paediatricians and cross sectional imaging
- Other diagnosis – following discussion with PICU / NICU consultant to determine most suitable admission location
- **Jaundice needing phototherapy**
- **Haemolytic jaundice needing blood transfusion**
- **Sepsis**
- Excess weight loss >15% birth weight

Local services will be responsible for identifying equipment, co-horting / isolation areas when these patients are admitted to neonatal units.

2.4.2 Children >28days.

These patients are not currently considered for admission to NICUs

2.4.3 Surgical Capacity

Both MFT and Alder Hey Children's Hospital will maintain Neonatal Surgical services and normal pathways will be maintained for babies within the ODN. If either neonatal surgical site reaches capacity, neonatal surgical patients will be prioritised to the open site.

2.5 Staff Indemnity

As any escalation response continues, it is recognised that all groups of clinical staff (medical, nursing and allied health professionals) are likely to be expected to work outside the scope of their usual working practices.

Trust plans and policies should ensure that staff are supported and protected in adopting the flexibility required to deliver the escalation expectations within this framework. Where possible these plans and policies should be consistent across NWNODN organisations.

Changes to working practices in response to an escalation situation should be documented and communicated to affected staff. These changes should be regularly reviewed.

Consideration should also be given to what information is provided to parents outlining the rationale for changes that are been undertaken.

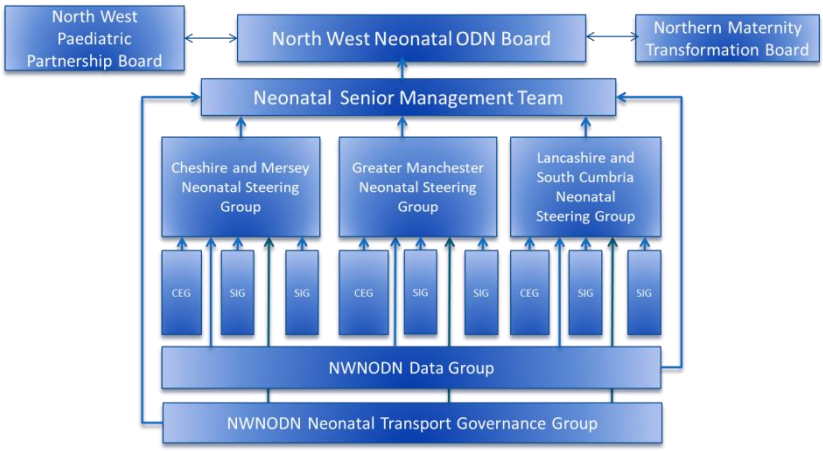
2.6 Connect North West

Connect North West provides the neonatal transport service for the North West as well as operating a Cot Bureau for the management of transport requests. As a critical service, Connect North West have outlined a SOP (see Appendix 6) which sets out how it maintains operational activity in relation to:

- Outpatient transfers
- Repatriations
- Acute uplift transfers
  - Pre transfer
  - Stabilisation and transfer
  - Post transfer

2.7 NWNODN Team

The NWNODN Senior Management Teams sits within the NWNODN governance structure as:



The NWNODN Senior Team comprises:

Throughout stand down and debrief periods, the Senior Team will convene at a midday conference call to discuss activity and capacity within North West Neonatal Units, and to take appropriate mitigating actions as defined within the NWNODN Escalation Plan.

The NWNODN Team, consisting of Network Director, Senior Quality Improvement Lead Nurse and Quality Improvement Lead Nurses. As an essential service the team will maintain their operational activity during the pandemic in accordance with the following protocol:

OPEL 1 - Green - Businesses as Usual – No disruption to services

OPEL 2 - Yellow – Abstraction from Team of 1 x QIL
Reallocation of locality lead responsibility across remaining team members as appropriate to maintain 3 x weekly contact with units

OPEL 3 – Amber – Abstraction from Team of Network Director or Senior Lead Nurse, plus 1 x QIL
Reallocation of mitigating action responsibilities within Escalation Plan
A reduction in exception reporting and monitoring activity across the network monitoring pathways and activity

OPEL 4 – Red – Abstraction from Team of Network Director and Senior Lead Nurse
Escalation to Director of Strategy - Alder Hey Children's NHS Trust (host) and Service Specialist - NHSE Spec Comm North Hub
NHSE Spec Comm membership of NWNDON Control Group to maintain escalation plan decision making

2.8 Lessons Learnt

As soon as possible after de-escalation is in place a review of any exception reports will be undertaken with the appropriate provider and the NWNODN. Dissemination of 'lessons learnt' as part of this process will be circulated via the NWNODN bulletin. Following return to pre-escalation status a full review of the period will be undertaken and reviewed at clinical governance groups.

SECTION 3 – APPENDICES

3.0 Appendix 1 - NWNODN Contact Details

Name	Role	Email
Louise Weaver-Lowe	Network Director	Louise.weaver-lowe@alderhey.nhs.uk
Karen Mainwaring	Senior Lead Nurse (GM Lead)	Karen.mainwaring@alderhey.nhs.uk
Kelly Harvey	QIL (C&M Lead)	Kelly.harvey@alderhey.nhs.uk
Catherine Nash	QIL (LSC Lead)	Catherine.nash@alderhey.nhs.uk
Nim Subhedar	Clinical Lead C&M	Nim.subhedar@lwh.nhs.uk
Ajit Mahaveer	Clinical Lead GM	Ajit.Mahaveer@pat.nhs.uk
Richa Gupta	Clinical Lead LSC	Richa.Gupta@lthtr.nhs.uk
Ian Dady	Clinical Lead CNW	Ian.dady@mft.nhs.uk

Microsoft Teams group "NWNODN + NNUs" has been set up as point of contact for operational and escalation purposes.
https://teams.microsoft.com/l/team/19%3a5da33219a8914fdbb64835d35148ac30%40thread.tacv2/conversations?groupId=716ef75a-adb6-487d-8837-02c1fa0e2537&tenantId=473ccf1b-3957-4eb0-82ba-be8a6aa1f64a

Where any provider feels that an urgent meeting is required they should contact The Network Director or QIL and this will be arranged.

3.1 Appendix 2 - Trigger Report Form

Available at:
https://www.neonatalnetwork.co.uk/nwnodn/wp-content/uploads/2019/11/GL-ODN-04-Escalation-Guideline.pdf

3.2 Appendix 3 - NWNODN Escalation Plan

OPEL1	Area of risk:	Trigger:	Actions to Mitigate: NICU	LNU	Surgical Unit	Connect North West (Appendix 4 For full CNW plan)	ODN	Escalation process
OPEL 1 - Business as usual	**Nil additional to usual risk to services outside of incident**	**Cot capacity is within usual managed planning arrangements.**	**Units to provide 3 x daily updates to Cot Bureau** **Units to follow normal pathways, ensuring patient flows are optimised.**	**Units to provide 3 x daily updates to Cot Bureau** **Units to follow normal pathways, ensuring patient flows are optimised.**	**Units to provide 3 x daily updates to Cot Bureau** **Units to follow normal pathways, ensuring patient flows are optimised.**	**Inform Unit of Repatriation breeches Provide reporting on cot closures**	**Monitor of Capacity in weekly SMT calls to discuss related staffing issues and highlight weekly exceptions**	**Escalation to OPEL 2 - Any unit reaching maximum capacity where they are closed to outside admissions will inform Cot Bureau.** **Any unit reaching maximum capacity and unable to take any admission including their own population/booked women will be escalated via CNW and the NWNODN**

Escalation to OPEL 2 – Consider when a single unit is no longer able to accept admission at any care level, including internal admissions, 2 LNUS within one locality are closed to admissions from the network and /or 1 NICU or surgical unit within a locality is closed to outside admissions. 1 Surgical Unit closed to admissions- Escalation by individual unit to Cot Bureau and the NWNODN

OPEL 2	Area of risk:	Trigger:	Actions to Mitigate: NICU	LNU	Surgical Unit	Connect North West (Appendix 4 For full CNW plan)	ODN	Escalation process
	Unit Capacity	**Closed to new admissions**	**Ensure that internal escalation policies include the ability to staff cots and comply with the agreed repatriation policy.** **Adhere to agreed infection control policies to maintain the patient flows across the network** **Discuss any concerns with Network Locality QIL** **Review outreach services to enable discharge safely as soon as possible.** **Plans to include support for**	**Ensure that internal escalation policies include the ability to staff cots and comply with the agreed repatriation policy.** **Adhere to agreed infection control policies to maintain the patient flows across the network** **Discuss any concerns with Network Locality QIL** **Review outreach services to enable discharge safely as soon as possible.** **Plan to include**	**Ensure that internal escalation policies include the ability to staff cots and comply with the agreed repatriation policy.** **Adhere to agreed infection control policies to maintain the patient flows across the network** **Liaise with Surgical Unit in other locality to understand support available.** **Discuss any concerns with Network Locality QIL**	**Monitor and report any delays in repatriation**	**Move from weekly to daily SMT to Discuss capacity across the NW and impact of local closures on the functioning of the wider network.** **Review requirement for unit to step up to utilise surge capacity if staffing allows.** **Inform the neonatal providers within that locality, and that locality's LMS, of increased escalation status. Maternity services to consider appropriate action to maximise capacity and avoid ex-utero transfers.** **Review capacity**	**Individual providers to notify Cot Bureau.** **Individual providers to inform Lead Nurse or Clinical Lead for locality if able.** **CNW to notify NWNODN at midday SMT meeting.** **Wider locality and**

			LNU/SCU colleagues if pathways altered. **Plan should include support for paediatric services**	**review of equipment and skills to deliver care at a higher level than current service specification.**	**Review outreach services to enable discharge safely as soon as possible.** **Plan to include the projection of surgical capacity.**		**within locality within 24 hours to identify need for further escalation.**	**network capacity reviewed and decision made to remain at OPEL 2 escalation or move to OPEL 3.** **Escalation level and decisions logged.** **Unit to notify NWNODN if unable to mitigate equipment issues through actions within own Trust. (NHSE SPOC / supply chain)**

								Escalate maternity pressures reported to the NWNODN to the LMS.
	Nurse staffing	**Intensity score at High**	**Unit to escalate through Trust escalation processes; ensure agency/ seconded staff skills appropriate** **Staffing levels to be risk assessed and ratios adjusted as appropriate to meet demand relaxing BAPM staffing Ratios.** **Review remote working policy and equipment**	**Unit to escalate through Trust escalation processes; ensure agency/ seconded staff skills appropriate** **Staffing levels to be risk assessed and ratios adjusted as appropriate to meet demand relaxing BAPM staffing Ratios.** **Review remote working policy and equipment**	**Unit to escalate through Trust escalation processes; ensure agency/ seconded staff skills appropriate** **Staffing levels to be risk assessed and ratios adjusted as appropriate to meet demand** relaxing BAPM staffing Ratios. **Review remote working policy and equipment**	**Ensure staffing within Service is monitor and highlight risks**	**Lead nurse to be available to providers to support staffing conversations and talk through potential options to improve staffing levels.** **Highlight to unit managers national measures identified to mitigate staffing inadequacies.** **Increase monitoring of COVID 19 related absences across the NW to daily.** **Offer access (for staff redeployed to support the NNU) to education resources**	**Example triggers see Appendix 7**

							and online teaching available via the NWNODN.	
	Medical	**Unit not achieving locally agreed workforce contingency plan**	**Unit to escalate through Trust escalation processes** **Staffing levels to be risk assessed and rota adjusted as appropriate to meet demand** **To consider stopping non essential activity.** **Review remote working policy and equipment** **All Study Leave cancelled**	**Unit to escalate through Trust escalation processes** **Staffing levels to be risk assessed and rota adjusted as appropriate to meet demand** **To consider stopping non essential activity.** **Review remote working policy and equipment** **All Study Leave cancelled**	**Unit to escalate through Trust escalation processes** **Staffing levels to be risk assessed and rota adjusted as appropriate to meet demand** **To consider stopping non essential activity.** **Review remote working policy and equipment** **All Study Leave cancelled**	**Ensure staffing within service is monitored and risks highlighted**	**Clinical Lead to be available to providers to support medical staffing conversations and talk through potential options to improve staffing levels.** **Increase monitoring consultant/medical absences across the NW to daily.**	
	Equipment (lack of/ supply/ distribution)	**Respiratory support**	**Unit to escalate through trust escalation process. Consider potential to borrow/ obtain from other departments/Trusts**	**Unit to escalate through trust escalation process. Consider potential to borrow/ obtain from other departments/Trusts**	**Unit to escalate through trust escalation process. Consider potential to borrow/ obtain from other departments/Trusts**		**Support conversations across different services regarding the loaning of equipment/resources to cover short term crisis in one service.**	

							Network plan to be drawn up for ROP services.	
		PPE						
		Incubators						
		Other						
	Environment/ facilities	**Isolation facilities – lack of**	**Unit to escalate through Trust escalation process**	**Unit to escalate through Trust escalation process**	**Unit to escalate through Trust escalation process**		**Offer advice regarding isolating of infants in line with national guidance.**	
		Support services e.g. access to X-rays etc.	**Unit to escalate through Trust escalation process**	**Unit to escalate through Trust escalation process**	**Unit to escalate through Trust escalation process**			
		Maternity capacity issues	**Units to highlight with local Maternity units any pressures affecting admissions**	**Units to highlight with local Maternity units any pressures**	**Units to highlight with local Maternity units any pressures**		**Inform Local Maternity System of reported issues.**	

OPEL 3 - Amber - Impact is at Locality Level- a single locality closed to locality network admission with no NICU capacity within the locality or Significant pressure across multiple localities.

OPEL3	Area of risk:	Trigger:	Actions to Mitigate: NICU	LNU	Surgical Unit	Connect North West (Appendix 4 For full CNW plan)	ODN	Escalation process

	Capacity	**As Opel 2 plus 2 x NICUs closed plus 1 x LNU per locality closed for more than 24 hours**	**Review dependency levels of current infants and support early discharge home or transfer to other areas with HD and SC capacity to enable Intensive Care only cots/admissions.**	**To review potential to support higher acuity care outside of service specification with the guidance of named NICU consultant for clinical support.**	**Where one of the two surgical sites are closed there should be documented discussion with the alternate NW neonatal surgical site regarding current capacity and protecting designated**	**Consider ability to increase uplifts using staff outside the team with transport experience.**	**NWNODN to communicate uplift of care and pathways outside of normal to all neonatal providers.** **NWNODN to call each unit and discuss current status and changes to management from usual pathways.** **Changes for specific units to be communicated at daily calls.** **Resources to support LNU's in caring for infants requiring higher acuity to be shared.**	**NWNODN to alert NHSE Spec. Comm. to raised escalation level and provide summary of impact and actions required.** **Escalate specifically the reduction in neonatal surgical capacity in the NW to spec comm.** **Escalate specific staffing concerns to the SMT and Spec comm and describe actions identified.** **Develop**

Consider:
Retaining Stable Intensive Care babies in LNU for unlimited period
Reduce threshold for transfer to NICU from <27 weeks to 26weeks(<27 multiple births).

							Discuss with neighbouring neonatal ODN surgical site regarding reduced capacity within region.	**education packages**
	Nurse staffing	**Intensity score at High**	**Recommend cancelling study leave and annual leave within affected units** **Relaxation of staffing ratios from BAPM throughout the network to facilitate units remaining open where safe.**	**Recommend cancelling study leave and annual leave within affected units** **Relaxation of staffing ratios from BAPM throughout the network to facilitate units remaining open where safe.**	**Recommend cancelling study leave and annual leave within affected units** **Relaxation of staffing ratios from BAPM throughout the network to facilitate units remaining open where safe.**		**NWNODN to complete daily call to units regarding staffing status** **NWNODN team to discuss on midday SMT staffing pressures in specific services and document plans to review/support this.** **Review national HR measures to support movement of staff across services and**	

							see if this is an option here.	
	Medical	**Unit not achieving locally agreed workforce contingency plan**	**Recommend cancelling annual leave** **Relaxation of staffing rota throughout the network to facilitate units remaining open where safe.** **Ensure cancellation of routine medical work including outpatient clinic commitments if medical staffing the cause of unit closure.** **Consider Virtual Ward rounds (use of computerised system)**	**Recommend annual leave within affected units** **Relaxation of staffing rota throughout the network to facilitate units remaining open where safe.** **Ensure cancellation of routine medical work including outpatient clinic commitments if medical staffing the cause of unit closure.** **Consider Virtual Ward rounds**	**Recommend cancelling annual leave** **Relaxation of staffing rota throughout the network to facilitate units remaining open where safe.** **Ensure cancellation of routine medical work including outpatient clinic commitments if medical staffing the cause of unit closure.** **Consider Virtual Ward rounds**		**Support from NWNODN clinical leads to identify potential options available for movement of medical support between units.** **Daily call to units to understand consultant related absences and feedback to SMT midday meeting.** **Support with possible network solution for virtual ward rounds.**	

	Trust/other decisions	**Local decision for neonatal unit to accept paediatric patients as inpatients on the neonatal unit**	**As OPEL 2**	**As OPEL 2**	**As OPEL 2**	**To record number of Paediatric patients on daily ring arounds**	**Disseminate national information available to support this way of working.** **To take details of number of paediatric inpatients cared for on a weekly basis and collate across the NW.** **Monitor NW wide capacity daily and review weekly the impact paediatric patients are having on the neonatal services.**	**Local units should escalate to cot bureau and the NWNODN where paediatric patients are compromising neonatal unit capacity.** **Daily SMT call should take any escalations as above into account and decide if escalation to NHSE is required. Decisions to escalate or not should be documented and logged.**
	Loss of ambulance support to CNW	**Inability to complete any transfers other than time critical neonatal**	**Support LNUs via communications to manage infants requiring transfer.**	**Continue to support infants remaining on LNU when previous**	**Support conference calling with LNUs keeping an infant requiring non-**		**Daily calls to units to ensure infants unable to be transferred are being managed**	**Escalate to Spec. Comm and NWAS clinical director to raise alert.**

		transfers across the NW.	**Maintain capacity for time critical transfers when agreed to avoid additional burden on CNW.**	**pathway meant the infant would have been transferred ensuring at least 12 hourly conversations with nominated NICU consultant. Document clearly all conversations with CNW and NICU regarding management and impact of non-transfer.** **Inform CNW if transfer escalates to time critical immediately.**	**critical surgical support with the NICU consultant and surgical colleagues.**		**in the described way with input from NICU.** **Disseminate information about changes to the ambulance provision in a timely manner to ensure all teams aware of impact and actions.**	**Escalate to CNW host trust.**
	Maternity Closure	**Maternity unit closed for >24 hours.**	**Escalate to the Cot Bureau maternity closure.**	**If short term closure liaise closely with maternity colleagues**	**n/a for stand alone surgical offer at Alder Hey**	**Increased ex-utero transfer capacity**	**Monitor maternity closures and impact on neonatal**	**Escalate closures of maternity services for >24 hours to**

			Ensure staffing and capacity of neonatal cots remains open to ex-utero transfers in to support continued NICU work.	**regarding plans for re-opening.** **Escalate to the Cot Bureau.** **If longer term closure is a threat impacting on continuation of maternity services escalation to NWNODN and Cot Bureau at earliest opportunity.** **Support sharing of parent information.**	**See NICU actions for St Mary's surgical service.**	**likely to be required.**	**pathways via exception reporting process. Weekly exception call with unit managers.** **Highlight impact of closure to LMS.** **If longer term closure disseminate information to other neonatal providers across the NW.** **Support movement of staffing to areas of most need in conjunction with closing units management team.**	**LMS.** **Escalate closures of maternity services impacting on neonatal pathways and capacity to spec comm.**

OPEL 4- RED - Impact at ODN Level - two out of three localities reached level 2 escalation

OPEL 4	Area of risk:	Trigger:	Actions to Mitigate: NICU	LNU	Surgical Unit	Connect North West (Appendix 4 For full CNW plan)	ODN	Escalation process
	Capacity	**2 out of 3 Localities closed to admissions**	**Surge capacity in remaining NICU's to maximum.** **Liaise with community services regarding support for earlier supported discharge home - maintaining safe medical decision making at all times.**	**Surge capacity within LNU services to maximum.** **Liaise with community services regarding support for earlier supported discharge home - maintaining safe medical decision making at all times.**	**Neonatal surgical capacity identified and protected to ensure access to emergency surgery.** **Discuss with PICU services potential support for surgical infants.**		**NWNODN to identify capacity within bordering ODNs and share with SMT and CNW.** **NWNODN to identify capacity within Paediatric services.** **NWNODN team 24/7 support for services and twice daily calls to all managers to discuss changes to capacity.**	**Inform surrounding ODN's regarding capacity and potential need for out of network transfers.** **Escalate to paediatric network leads the lack of capacity for neonatal care and identify area's of support.** **Escalate to spec commif it is identified the closure of one unit may alleviate staffing issues and maintain services in additional units.** **Escalate to deanery and HEE to see if there are any areas**

								to pull medical staffing into neonatal services. **Escalate potential closure of any neonatal unit for >48 hours to the LMS highlighting need to close maternity service.** **Escalate to NWAS and CNW host regarding lack of ambulance provision and impact on neonatal services.**
	Nurse staffing	**Not achieving reduced staffing ratios against local agreement, or insufficient nurse staff available to sustain service**	**Local workforce escalation.** **Access staff outside of the NNU staffing group to support nursing numbers.**	**Local workforce escalation.** **Access staff outside of the NNU staffing group to support nursing numbers.**	**Local workforce escalation.** **Access staff outside of the NNU staffing group to support nursing numbers.**		**Support movement of staff across the network from area's of more adequate staffing.** **Review activity across the network and discuss with SMT and spec comm on daily midday**	

							planning call the need to review the number of units required to support activity levels and if closing one units may liberalise staff to support activity within a larger LNU/NICU. **Daily call to managers to understand any changes to staffing.** **Liaise with LMS regarding potential midwifery staff able to support any neonatal unit across the LMS footprint to maintain services.** **NWNODN team to offer short**	

							term support to unit in crisis if HR support available.	
	Medical Staffing	**Lack of medical team to maintain a neonatal service.**	**Local workforce escalation.** **Access staff outside of the NNU staffing group to support nursing numbers.**	**Local workforce escalation.** **Access staff outside of the NNU staffing group to support nursing numbers.**	**Local workforce escalation.** **Access staff outside of the NNU staffing group to support nursing numbers.**		**Support movement of staff across the network from areas of more adequate staffing.** **Review activity across the network and discuss with SMT and spec comm on daily midday planning call the need to review the number of units required to support activity levels and if closing one units may liberalise staff to support activity within a larger LNU/NICU.**	

							Daily call to managers to understand any changes to staffing.	
	Environment/ facilities	**No ambulance availability to support any neonatal transfers including neonatal time critical.**	**Support LNUs via communications to manage infants requiring transfer.**	**Continue to support infants remaining on LNU when previous pathway mean the infant would have been transferred ensuring at least 12 hourly conversations with nominated NICU consultant.** **Document clearly all conversations with CNW and NICU regarding management and impact of**	**Support conference calling with LNUs keeping an infant requiring non-critical surgical support with the NICU consultant and surgical colleagues.**		**Daily calls to units to ensure infants unable to be transferred are being managed in the described way with input from NICU.** **Disseminate information about changes to the ambulance provision in a timely manner to ensure all teams aware of impact and actions.** **Liaise with neighbouring network transport services to**	

Consider:
Further changes to Pathways
Consolidation of units

				non-transfer. **Inform CNW if transfer escalates to time critical immediately.**			**request support.**	

3.3 Appendix 4 - Terms of Reference and Membership - NWNODN Control Group

Purpose:

To co-ordinate, monitor and direct a region wide response to an increasing demand for Neonatal intensive care cots. This control group would be activated at Amber Level 2, when national concerns are raised regarding NIC capacity.

Membership (or nominated deputies):

- **On Call NICU Consultants and Lead Nurse or shift coordinator from**
  - **Manchester Foundation Trust – St Mary's**
  - **Liverpool Women's Hospital**
  - **Arrowe Park**
  - **Bolton**
  - **Oldham**
  - **Preston**
  - **Burnley**
  - **LNU Consultant from Locality**
  - **Other co-opted members as appropriate**
- **Connect North West**
  - **Clinical Lead**
  - **Lead Nurse**
- **Neonatal Network**
  - **Director**
  - **Senior Lead Nurse**
  - **Lead Nurses**
  - **Clinical Leads**

This group is expected to work in close co-ordination with the North West Paediatric ODN

Operation of the Group

- **Initiation of conference between tertiary units, CNW and ODN (in hours) when all NICUs are declared at capacity (amber or above in escalation plan)**
- **Call conference to be documented by chairperson and emailed to call conference members**
- **Chair to be NWNODN Director or other member of the network team where available. If not available/out of hours, to be chaired by CNW consultant**

Call conference agenda

1. **Discuss current issues with flow**
   - **Review individual cases requiring repatriation from NICUs to create capacity for those requiring uplift in care or potential deliveries**
2. **Clarify that all required actions at the appropriate level of escalation matrix have been taken by the NICUs including communication with labour wards**
3. **Agree any further actions required over the next 24 hours**
4. **Any other issues**
5. **Summary of actions and who is responsible**
6. **Date/time of next call and close**

3.4 Appendix 5 - NICU to LNU Communications Sheet

https://www.neonatalnetwork.co.uk/nwnodn/gl-odn-14-advice-proforma/

3.5 Appendix 6 - Connect North West COVID19 SOP

Connect%20NW%20SOP%20COVID-19%2

TRANSCON%20Matrix.xlsx

3.6 Appendix 7 Example staffing plan

Emergency Staffing Plan for NICU Oct 20.