Yorkshire & Humber Neonatal Operational Delivery Network

Management of Surge and Escalation in Neonatal Services: Standard Operating Procedure

August 2018

Version 4.3

Prepared by the Y&H Neonatal Operational Delivery Network (ODN)
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Contents

1. Summary

The principles of this Standard Operating Procedure for the Management of Surge and Escalation in Yorkshire and Humber (Y&H) Neonatal Units are:

1.1. An Integrated model across the region.

1.2. A more fluid approach to accommodate capacity in response to demand as outlined in this document.

1.3. Preservation of the 'standard' clinical pathway for neonates for as long as possible.

1.4. Preservation of emergency, general and specialist services for as long as possible.

1.5. Equity of access and treatment across Y&H.

1.6. Management of Y&H Neonatal capacity as a single entity, recognising discrete conurbations and specialist centres but trying to keep families as close to their home as possible.

1.7. At times of escalation there will be a requirement for an increase in the number of patients requiring inter-hospital transfer to access critical care and the distance travelled. This may occur early depending upon the nature of the escalation scenario as the Y&H units strive to maintain the standard of normal clinical pathways.

1.8. De-escalation and return to normal processes as soon as possible in response to demand.

1.9. The Y&H Neonatal ODN will work closely with the Y&H Maternity Network, NHS statutory organisations and the NHS EPRR teams to optimise the use and prediction of a requirement for the use of capacity.

2. Introduction

2.1. The Yorkshire & Humber Neonatal Operational Delivery Network ("the ODN") is committed to ensuring that a consistent approach is applied to the delivery of safe care.

2.2. Recognition that capabilities of maternity units directly impact on the capacity of neonatal units and often result in the inability to transfer in-utero women appropriately.

2.3. To minimise the resulting impact on families and transport services when babies are not able to be placed in an intensive care cot locally and have to transfer long distances to find one.

2.4. This document is intended to be used by all Trusts within the Yorkshire & Humber Region that have dedicated Neonatal and Maternity Services on site to assist with planning for, and responding to, issues that will arise in the management of in-utero or ex-utero transfers requiring neonatal care. It is intended that this guidance should be incorporated within local Trust escalation plans and should be viewed as part of the overall response.

3. Purpose

3.1. This document sets out the background policy and processes for managing surge in demand for Neonatal care in the Yorkshire and Humber region. It describes how the organisations and post holders identified in the standard operating procedure should act.

4. Application

4.1. NHS England's requirements detailed within *Management of surge and escalation in critical care services:* will be met by the adoption of this plan by all Trusts, which form the Y&H Neonatal ODN, alongside the on-going review of internal trust plans for surge capacity within neonatal services.

4.2. Escalation levels have been adapted from the *Operational Pressures Escalation Level (OPEL) Framework* (NHS England, 31 October 2016).

5. Planning assumptions

5.1. That supporting the delivery of neonatal care is a shared responsibility in Yorkshire & Humber and that all Trusts will provide mutual aid to one another, thereby ensuring optimal use of the available Neonatal capacity.

5.2. Optimisation of capacity will be stepped up according to demand.

5.3. De-escalation will occur at the earliest opportunity.

5.4. That Neonatal care will be delivered to national clinical standards until fully staffed capacity is exceeded.

5.5. That agreed surge action plans will be implemented to deliver care to neonates able to benefit and balances increased demand with the minimum possible reduction in standards of care.

5.6. Babies will continue to be admitted to NICUs for as long as possible, utilising regional and national neonatal unit cots available as a resource.

5.7. That all clinical decisions will be underpinned by relevant local and national ethical guidance from (e.g NHS England, General Medical Council, Nursing Midwifery Council and BAPM).

5.8. Difficult clinical decision making and implementation of policies in relation to triage and futility of patient interventions should only be made after consultation with the wider critical care community.

5.9. The levels of Neonatal units are defined within the Specialised Commissioning Neonatal Service Specification – See appendix 6. Approved care pathways applicable to the Yorkshire and Humber ODN are outlined below.

Provided in	Definition
Neonatal Intensive Care Unit (NICU) **Bradford Royal Infirmary** **Hull Royal Infirmary** **Leeds Children's Hospital** **Sheffield Jessop Wing**	The service will provide in addition to services provided by SCUs and LNUs: 1. Neonatal services commensurate with national guidelines and professional standards where births are anticipated after 22+6 weeks gestation (BAPM & Nuffield Council on Bioethics). 2. Intensive care for all the babies born within the network according to ODN approved care pathways including those less 27 weeks gestation singleton, less than 28 week twins or with a birth weight < 800g and any baby requiring more than 48 hours ventilation to be discussed Any baby requiring complex intensive care with symptoms of multi organ failure . ODNs and the Trusts responsible for these units should monitor adherence to the care pathways 3. Neonatal intensive care service for other local neonatal networks or out of area neonatal units when they cannot access a cot in their network NICU because of lack of capacity at that unit 4. Leadership within neonatology for the neonatal ODN units and 24 hour acute clinical telephone consultations as required by the network hospitals. Where more than one NICU is within a neonatal ODN, there will be a sharing of responsibility to provide 24 hour acute clinical consultations. 5. Care for local network babies repatriated from elsewhere requiring on-going care from a NICU.
Local Neonatal Unit (LNU): **Airedale** **Barnsley** **Calderdale** **Chesterfield** **Doncaster** **Grimsby** **Mid Yorks** **Rotherham** **Scunthorpe** **York**	In addition to all the services provided by Special Care Baby Unit's (SCU's) local neonatal units will provide: 1. Neonatal services commensurate with national guidelines and professional standards where; singleton births are anticipated after 26+6 weeks gestational age and multiple births are anticipated after 27+6 weeks gestational age providing the anticipated birth weight is above 800g. 2. ODN care pathways will define antenatal factors or conditions present soon after birth which follow up increase the likelihood that transfer to a NICU for complex or prolonged neonatal intensive care will be required. ODNs and the trusts responsible for these units should monitor adherence to the care pathways. (Please refer to section below which outlines complex and prolonged intensive care). 3. Where possible, women will be transferred in-utero to the Network NICU when gestational age, anticipated birth weight or need for complex or prolonged intensive care is anticipated in accordance with ODN care pathways. 4. Limited intensive care in accordance with approved ODN care pathways (see commissioning exclusions, below) 5. Short periods of intubated ventilator support will be provided, however the clinical condition of any baby requiring this care must be discussed with a consultant in the Network NICU by 48 hours and every 24 hours thereafter if intubated ventilatory support continues. 6. An agreed management plan including decisions regarding transfer criteria will be documented 7. The stabilisation of babies prior to transfer to the Network NICU who require complex High dependency care and special care for their local population. 8. Referrals from other network neonatal units who are unable to undertake this work, due to capacity reasons and/or network guidelines. 9. On-going care for babies who have undergone specialist surgery following repatriation from the network surgical NICU. 10. Care for local babies repatriated from elsewhere in the network who no longer require positive pressure ventilation.

	11. LNUs will not accept out of network referrals without prior discussion with the ODN defined Lead NICU to ensure the integrity of capacity for network babies. 12. LNUs will transfer babies requiring complex care or prolonged care to the approved ODN NICU in accordance with approved care pathways.
Special Care Unit (SCU): **Bassetlaw** **Harrogate** **Scarborough** **St James > 30**	The service will provide: 1. Neonatal services commensurate with national guidelines and professional standards where singleton births are anticipated after 31+6 weeks gestational age provided the anticipated birth weight is above 1,000g. 2. ODN care pathways will define antenatal factors or conditions present soon after birth which increase the likelihood that transfer to a Neonatal Intensive Care Unit (NICU) for complex or prolonged neonatal intensive care **OR** a Local Neonatal Unit for short term neonatal intensive /high dependency care will be required. ODNs and the Trusts responsible for these units should monitor adherence to the care pathways. 3. Stabilisation of babies prior to transfer to an (Local Neonatal Unit (LNU) or NICU predominantly, but not exclusively for intensive care. 4. Care for local babies with high dependency or special care needs following repatriation from LNUs or NICUs within the network or from out of area in accordance with approved ODN care pathways. 5. Referrals for ongoing special care from other network neonatal units who are unable to undertake this work due to capacity reasons. 6. Care for local babies post specialist surgery following repatriation from the network surgical unit or step down from other LNUs in accordance with approved ODN care pathways. 7. Transitional care, working in collaboration with post natal services subject to local service model.

6. Background

6.1. This Yorkshire & Humber Neonatal Standard Operating Procedure (SOP) is informed by the lessons learned regionally and nationally from managing the delivery of Neonatal Care, re-organisation of networks and/or centralisation of services post 2012 NHS re-organisation.

7. Enabling measures

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

- Increasing the workforce by identification of staff available/accessible to work in Neonates.
- Awareness of this SOP, its implications and associated supporting documents.
- The Yorkshire and Humber Infant and Childrens Transport Service 'Embrace' will provide a service according to its '*Main Embrace Standard Operating Procedure' September 2017 version 3* within the context of this Neonatal Surge SOP, taking into account their capacity, to include:

  - A single point of telephone contact for referring clinicians (0845 147 2472).
  - Access to immediate specialist advice.
  - Triage to an appropriate level of transport provision and dispatch of transport teams within a clinically appropriate time window.

- Identification of a suitable cot so that the most appropriate care is provided in the most appropriate location for any baby requiring specialist care in the Yorkshire and Humber region.
- List of all baby's in region where Neonatal advice is sought with recording of decisions and outcomes.
- Terms of reference (Appendix 1) for the Yorkshire and Humber Neonatal ODN Control Group this includes senior representation from NICUs.

8. Current NIC capacity

8.1 Cot distribution as at April 2018

Unit Name	Unit Level	Cot Numbers					
		Total Excluding T/C	Intensive Care	High Dependency	Special Care	Transitional Care	Surgical Cots
Airedale	2	**12**	2	0	10	-	-
Barnsley	2	**14**	2	3	9	-	-
Bassetlaw	1	**8**	0	0	8	-	-
Bradford	3	**31**	7	7	17	9	-
Calderdale	2	**22**	3	3	16	-	-
Chesterfield	2	**12**	1	2	9	-	-
Doncaster	2	**18**	3	3	12	-	-
Grimsby	2	**12**	3	1	8	4	-
Harrogate	1	**7**	0	0	7	-	-
Hull	3	**26**	5	7	14	5	
Jessop Wing, Sheffield	3	**42**	18	6	18	6	-
Leeds (combined)	3	**55**	14	16	25	19	Included in HDU and SCBU numbers
Mid Yorks	2	**22**	3	4	15	5	-
Rotherham	2	**14**	2	2	10	-	-
Scarborough	1	**8**	0	0	8	-	-
Scunthorpe	2	**10**	2	2	6	4	-
Sheffield Children's	3	**-**	-	-	-	-	11
York	2	**15**	2	0	13	3	-
Total		**328**	**68**	**55**	**205**	**55**	**11**

8.2 Usual Care Pathway

NICU	Take admissions from
Bradford	Airedale Calderdale
Leeds	Harrogate Pinderfields
Hull	York Scarborough
Jessop Wing	Barnsley Bassetlaw Chesterfield Doncaster Grimsby Rotherham Scunthorpe
Stand-alone surgical unit	Sheffield Children's Hospital

9. Escalation & interventions

9.1. This plan will be activated in response to the triggers and levels identified in section 10/page 17.

9.2. Escalation to OPEL Two is a joint decision between Embrace and the ODN Lead Nurses.

9.3. Escalation to OPEL Three is as a result of activation of ODN Control Group (Tertiary units on call consultant's, Embrace and ODN reps). Escalation to NHS England (North) via ODN.

9.4. Once the Yorkshire and Humber Neonatal ODN Control Group is established at OPEL Three, it becomes the source of advice to the Area Teams and NHS Strategic Command if established.

9.5. Escalation to OPEL Four will in itself trigger the establishment of NHS strategic command, if this has not already been established in response to the underlying pressures/acute incident.

9.6. Further escalation will be determined by the NHS Strategic Command structures.

9.7. De-escalation decisions are made by the group responsible at the higher level, for example at OPEL Three the Y&H Control Group would determine de-escalation to OPEL Two. This will be based on clinical advice.

10. Triggers, Levels and Actions

10.1. If any organisation or individual requires clarification about implementation at any stage this should be sought at the earliest opportunity to ensure effective, equitable use of limited resources across the health economy.

10.1.2 Assumptions

- All clinical decisions will be based upon appropriate ethical and legal assumptions.
- The OPEL levels are defined in relation to a rapidly progressive increase in demand for or where capacity has been adversely affected at NICUs.
- All trusts will initiate internal escalation policy appropriately.
- All trusts will refer to their own MAJAX policies as required.
- The OPEL actions within this SOP relate to a situation where there is excessive demand for NIC but **not** maternity services or paediatric critical care. Where there is also excessive demand for maternity

services or paediatric critical care, actions will have to be modified. This is likely to cause a more rapid escalation to a higher OPEL level.

- The care of mothers and babies in perinatal services will continue but in some scenarios covered by OPEL, particularly excessive demand for maternity or adult critical care, the provision may come under pressure.

10.1.3 Role of the Yorkshire & Humber Cot Control Group

- There are "Terms of Reference" for the Y&H Control Group which includes senior representation from the NICUs – appendix 1.
- At specified escalation levels (OPEL 3) in relation to NIC across the Network, the Y&H Control Group will (usually by teleconference):
  - Make decisions on escalation in keeping with this plan.
  - Report daily or more frequently as required to address critical care capacity.
  - Make decisions in relation to admission and discharge criteria in keeping with this plan.
  - Support clinicians in making individual case decisions.
  - Monitor cases being managed outside of NIC units.

10.2 OPEL One

Triggers:

- Cot capacity is limited but managed within usual planning arrangements.

Actions: In-hours

- On-going monitoring of capacity.
- Units to provide daily Cot Notifications.
- Embrace to inform units of repatriation breach status.
- Embrace to provide Lead Nurses with Cot Closure notifications as they occur.
- Embrace to provide ODN with weekly Neonatal Repatriation Exception Report.

Actions: Out of Hours

- On-going monitoring capacity.
- Embrace to inform units for any bottlenecks across the region.

Additional Actions for consideration:

- 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

10.3 OPEL Two

Triggers:

- No cots in network and patients waiting for a NIC cots.
- Inability to repatriate babies (48 hours breach).
- Inability to accommodate IUTs from within Y& H Network.
- Regional (ie NHSE North) concerns regarding NIC beds identified through cot notification.

Actions: In-hours

- Discuss any concerns with ODN Lead Nurse(s).
- Ensure Repatriation Protocol is being adhered to (Appendix 3)
- Activate internal unit escalation within units to ensure Neonatal capacity is maximised (as outlined in Appendix 4 & 5).
- Clinical advice via Embrace (conference call activation).
- Maximise repatriation and transfers via Embrace.
- ODN/Embrace to agree level of escalation / de-escalation.
- Escalation to Y&H Specialised Commissioners via ODN.

Actions: Out of Hours

- Ensure Repatriation Protocol is being adhered to (Appendix 3) Call conference between Tertiary units (On Call Consultants) to discuss possible options and agree level of escalation / de-escalation.

Additional Actions for consideration:

- Adhere to local internal escalation policies. See example (Appendix 4)
- Staffing ratios relaxed see example (Appendix 5)

10.4 OPEL Three

Triggers:

- National concerns regarding NIC capacity.

Actions: In-hours

- Discuss any concerns with ODN Lead Nurse(s).
- Activation of ODN Control Group (Tertiary Units On Call Consultants, Embrace & ODN Reps).
- Escalation to NHSE (North) via ODN.

Actions: Out of Hours

- Relevant participation in regional Call Conferences
- ODN Lead Nurse(s) to be informed (via email) of agreed actions taken.

Additional Actions for consideration:

- None registered undertaking registered duties, excluding medication.
- None clinical nursing staff to undertake clinical duties
- Relaxation of service specification unit descriptors. i.e. Relaxation of 48 hour ventilation rule and gestational limits/weight limits
- Potential for non-invasive ventilation in SCBU's
- Cancel study leave and annual leave as situation worsens
- Relaxation of staffing ratios throughout the network to facilitate repatriation to facilitate equity
- All the above with consultant telephone support

10.5 OPEL Four

Triggers:

- Severely limited capacity nationally.
- All previous operational actions have had no impact.

Actions: In-hours

- Discuss any concerns with ODN Lead Nurse(s).
- Activation of ODN Control Group (Tertiary Units On Call Consultants, Embrace & ODN Reps).
- Relevant participation in regional/national Call Conferences.

Actions: Out of Hours

- Relevant participation in regional/national Call Conferences
- ODN Lead Nurse(s) to be informed (via email) of agreed actions taken.

Additional Actions for consideration:

- **Continue as in OPEL 3**

11. Routine Management of Neonatal Capacity

Undertaken to ensure that smooth patient flows are maintained across the network.

11.1 Cot availability

Embrace responsibilities:

- Undertake regular cot ring rounds to ascertain up to date unit capacity data.
- Remind units to complete cot notification form.
- Embrace to complete ring round notification form and send to Y&HNEOCOTS email address
    - If more than 2 level two units are closed/full
    - If 1 Tertiary unit is closed/full.

Units' responsibilities:

- Submit daily cot notification form.
- If significant change in cot status (during subsequent 24 hours) then resend cot notification and inform Embrace via telephone.
- Follow INTERNAL ESCALTION POLICY.

ODN Responsibilities:

- Check weekday notifications.
- Follow appropriate actions.

11.2 Repatriation

Repatriation is a transfer of a baby who is clinically suitable for either admission to a unit to bring them closer to home or for on-going care and includes any surgical baby.

Embrace responsibilities:

- Undertake regular cot ring rounds to ascertain units ability to accept repatriations.
- Embrace to inform ODN of
    - Unit's inability to repatriate at 48 hours.
- Embrace to send a weekly ODN Neonatal Repatriation Exception Report to the ODN.

Units responsibilities:

- Be familiar with the repatriation process and agreed timings – appendix 4.
- Follow internal escalation procedures**.**
- Inform Embrace of any change in baby's condition during the repatriation process**.**

ODN Responsibilities:

- When notified repatriation issues follow appropriate actions.

12. Role of Maternity Services

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.

See **Yorkshire and the Humber In-Utero Transfer Guideline**

13. De-escalation

13.1. There is recognition of the need for organisations to return to normal function as soon as possible to enable everyday Trust activity; however this should not impact negatively on the ability to provide mutual aid across Y&H in the event there are continuing localised pressures. It is important that local identification and discussions on the ability to de- escalate is directed by NHS England and the ODNs in line with the command and control arrangements.

14. Exception Reporting

14.1. As soon after de-escalation as is practical review any Exceptional Reports with appropriate additional provider input and disseminate 'lessons learnt' as part of this process. This would be via the appropriate Clinical Forum.

15. Staff indemnity

15.1. As the 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. Examples of this include:

- Caring for greater numbers of patients than is recognised to be acceptable and safe by medical and nursing professional bodies.
- Non-critical care trained staff working alongside critical care trained colleagues, caring for neonates.
- Working for longer hours than is stipulated by the European Working Time Directive.
- Staff providing a limited/lower standard of critical care than is normally considered acceptable particularly during higher levels of escalation.
- Medical staff having to adjust their decision-making process for admission and treatment withdrawal, in times of extreme capacity limitations.

15.2. 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 Y&H organisations.

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

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

16. Intentions

16.1. Continue to review and amend current policies to ensure robust and effective systems are in place that are 'fit for purpose' and meet the needs of babies and their families for which the service exists,

16.2. Collaborative working with the North of England NHSE representatives, Yorkshire & Humber Adult Maternity and Paediatric CC ODNs to ensure that there is efficient use of all critical care resources within the region.

Operational Escalation Matrix

OPEL LEVEL	Triggers	ACTIONS	
		In Hours	**Out of Hours**
ONE	• Bed capacity is limited but managed within usual planning arrangements	1. On-going monitoring of capacity. 2. Units to provide daily Cot Notifications. 3. Embrace to inform units of repatriation breach status. 4. Embrace to provide Lead Nurses with Cot Closure notifications as they occur 5. Embrace to provide ODN with weekly Neonatal Repatriation Exception Report.	1. On-going monitoring of capacity. 2. Embrace to inform units of any bottlenecks across the region.
TWO	• No beds in network and patients waiting for a NIC bed • Inability to repatriate babies • Inability to accommodate IUTs • Regional concerns regarding NIC beds	1. Discuss any concerns with ODN Lead Nurse(s). 2. Ensure Repatriation Protocol is being adhered to. 3. Activate internal unit escalation within units to ensure Neonatal capacity is maximised, 4. Clinical advice via Embrace (Conference Call activation). 5. Maximise repatriation and transfers by Embrace. 6. ODN/Embrace to agree level of escalation / de-escalation. 7. Escalation to Y&H Specialised Commissioners via ODN.	1. Call conference between Tertiary units (On Call Consultants) to discuss possible options and agree level of escalation / de-escalation.
THREE	• National concerns regarding NIC capacity.	1. Discuss any concerns with ODN Lead Nurse(s). 2. Activation of ODN Control Group (Tertiary Units On Call Consultants, Embrace & ODN Reps). 3. Escalation to NHSE (North) via ODN.	1. Relevant participation in regional Call Conference. 2. ODN Lead Nurse(s) to be informed (via email) of agreed actions taken.
FOUR	• Severely limited capacity nationally. • All previous operational actions have had no impact.	1. Discuss any concerns with ODN Lead Nurse(s). 2. Activation of ODN Control Group (Tertiary Units On Call Consultants, Embrace & ODN Reps). 3. Relevant participation in regional/national Call Conferences.	1. Relevant participation in regional/ national surge calls. 2. ODN Lead Nurse(s) to be informed (via email) of agreed national actions taken.

Glossary

Area team	The local team for NHS England (South Yorkshire and Bassetlaw)
DGH	District General Hospital
EMBRACE	Yorkshire & Humber Specialist Transport Service
EPRR	Emergency Preparedness, Resilience & Response
LNU	Local Neonatal Unit
NICU	Neonatal Intensive Care Unit
OPEL	Operation Pressures Escalation Level
ODN	Operational Delivery Network
SCU	Special Care Unit
SOP	Standard operating procedure
Y&H	Yorkshire and the Humber geographical area

Appendix 1 - Terms of Reference and Membership

Yorkshire & Humber ODN Control Group

Neonatal Services

Purpose:

To co-ordinate, monitor and direct a region wide (Yorkshire and Humber) response to an increasing demand for Neonatal Care. Activated at OPEL 3 when national concerns are raised regarding NIC capacity.

Membership (or nominated deputies):

- On-call NICU Consultants
- Lead Nurses (NICUs)
- On-call Neonatal Clinical Leads Embrace – 0114 2688180
- Neonatal Core Team – members to be determined

This group is expected to work in close co-ordination with the Y&H Paediatric CC ODN – Representation on this group will be Lead Nurse, Y&H PCC ODN.

Operation of the Group

- Escalation to OPEL 3 will be agreed at a Call conference between NICU consultants on call in NICUs and Embrace.
- *Embrace to send out a text message to Y&H Control Group to inform them that the teleconference will take place at 10:30am the next working day. Details of message to include dial in details are 0800 9171950 and Participant Passcode 98693425#*
- *Call conference to be recorded / documented*
- The Chair of the group will report to NHS England

Call conference agenda

1. Chair to introduce group and apologies noted
2. Agreement of escalation level made by group
3. Clarification that all required actions at OPEL 2 have been taken
4. Go through action points for OPEL 3 and agree actions
5. Any other issues
6. Summary of actions and who is responsible
7. Date/time of next call and close

Appendix 2 - Cot Availability – Cot Closure Notification Form

Unit name: -

Date:

Staffing	QIS	Registered non QIS	Clinical Non registered
Day Total			
Night Total			

BAPM 2011	I/C ()	HD ()	S/C ()	T/C ()
Beds Occupied				
Bed available				

Note: - Beds Flex with HDU/ICU Total cots = unable to accept due to:

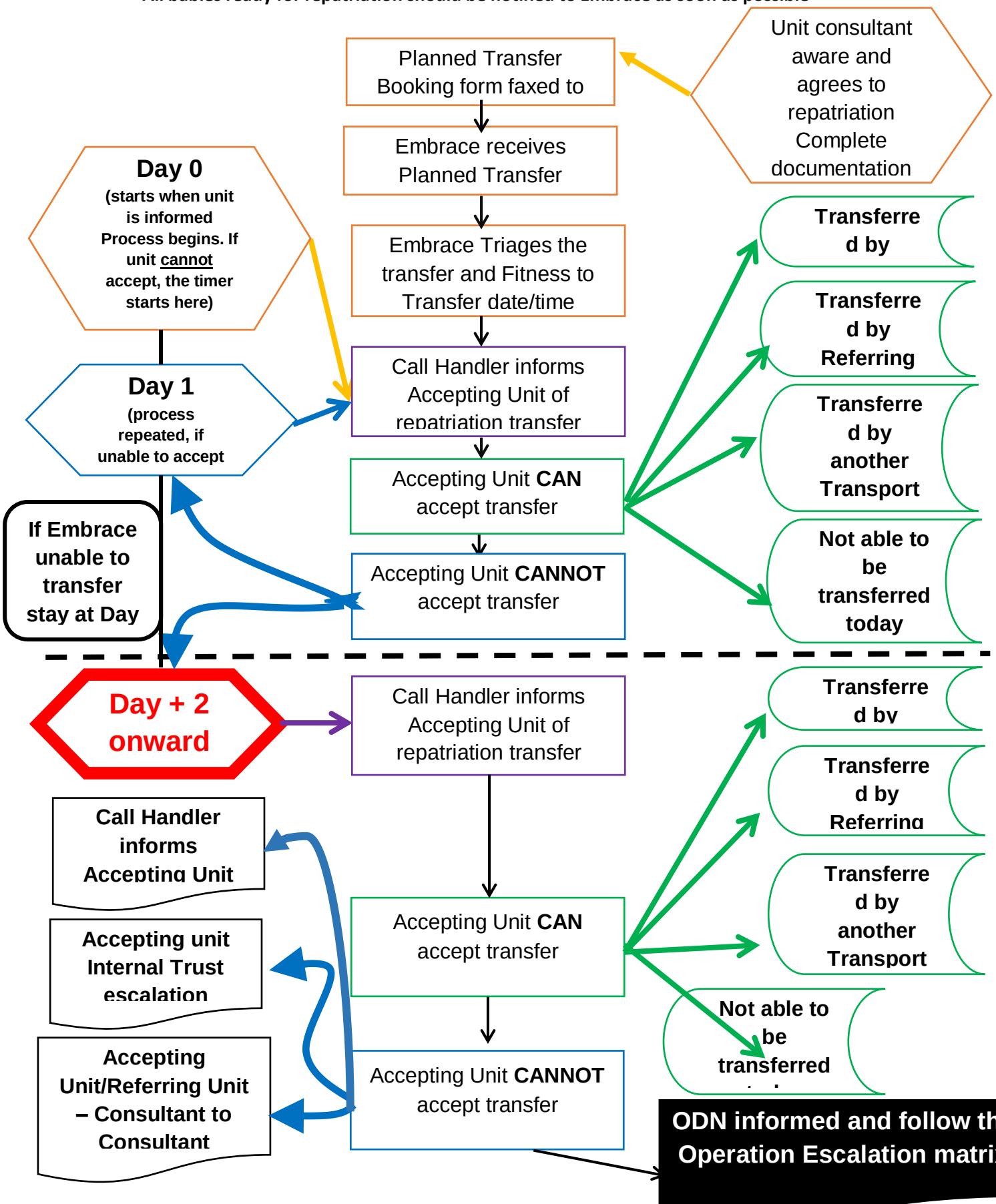
	Y/N	comments
Staffing (nursing)	n	
Medical Staffing	n	
Infra-structure	n	
Anticipated delivery	n	
Babies out of Y & H Network –number/where from	n	
Other		

Patients refused	Gestation	Referral location

Email daily Y&HNEOCOTS@sch.nhs.uk

Appendix 3 – Repatriation Flow Chart

All units deemed to be open unless officially closed (Network informed)
All babies ready for repatriation should be notified to Embrace as soon as possible



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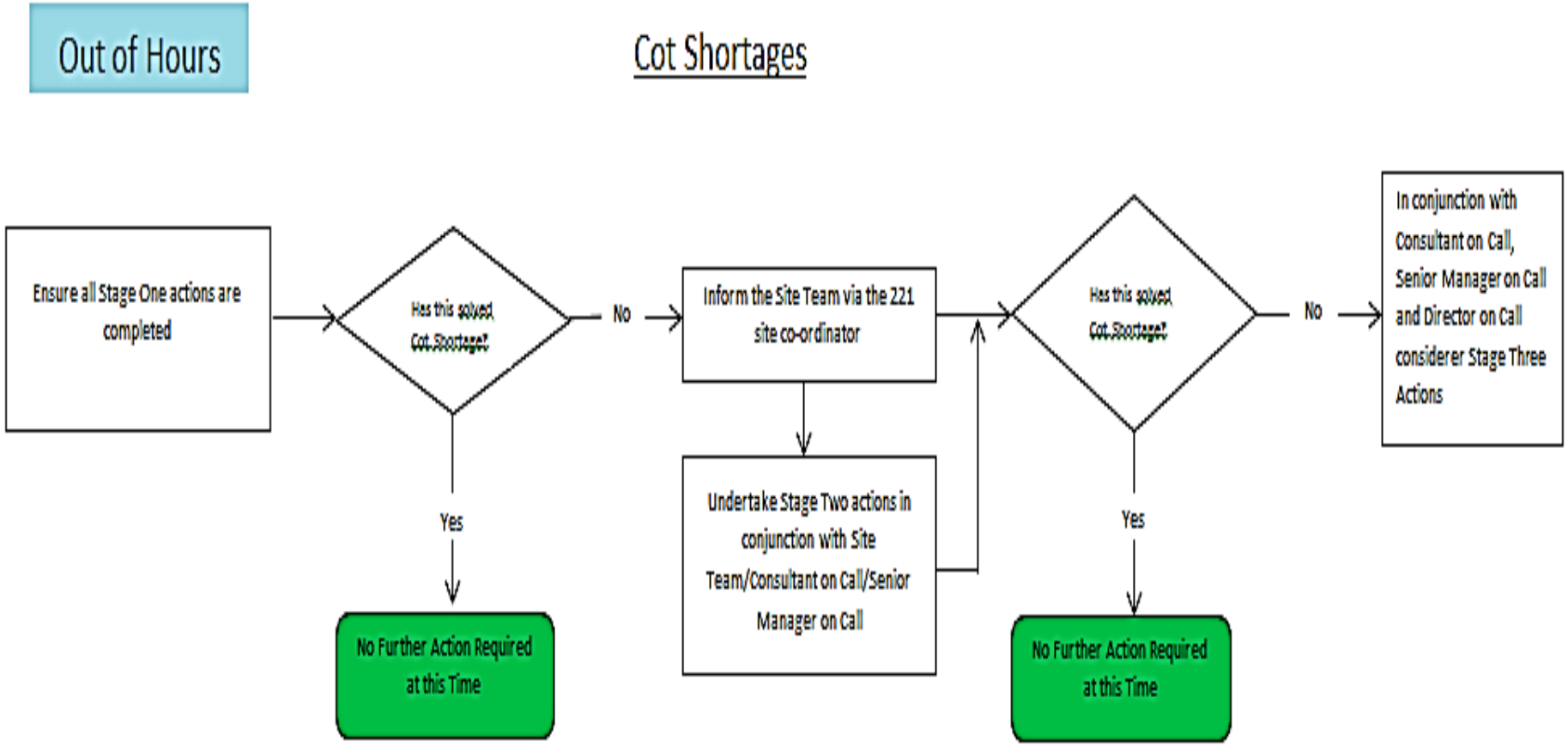
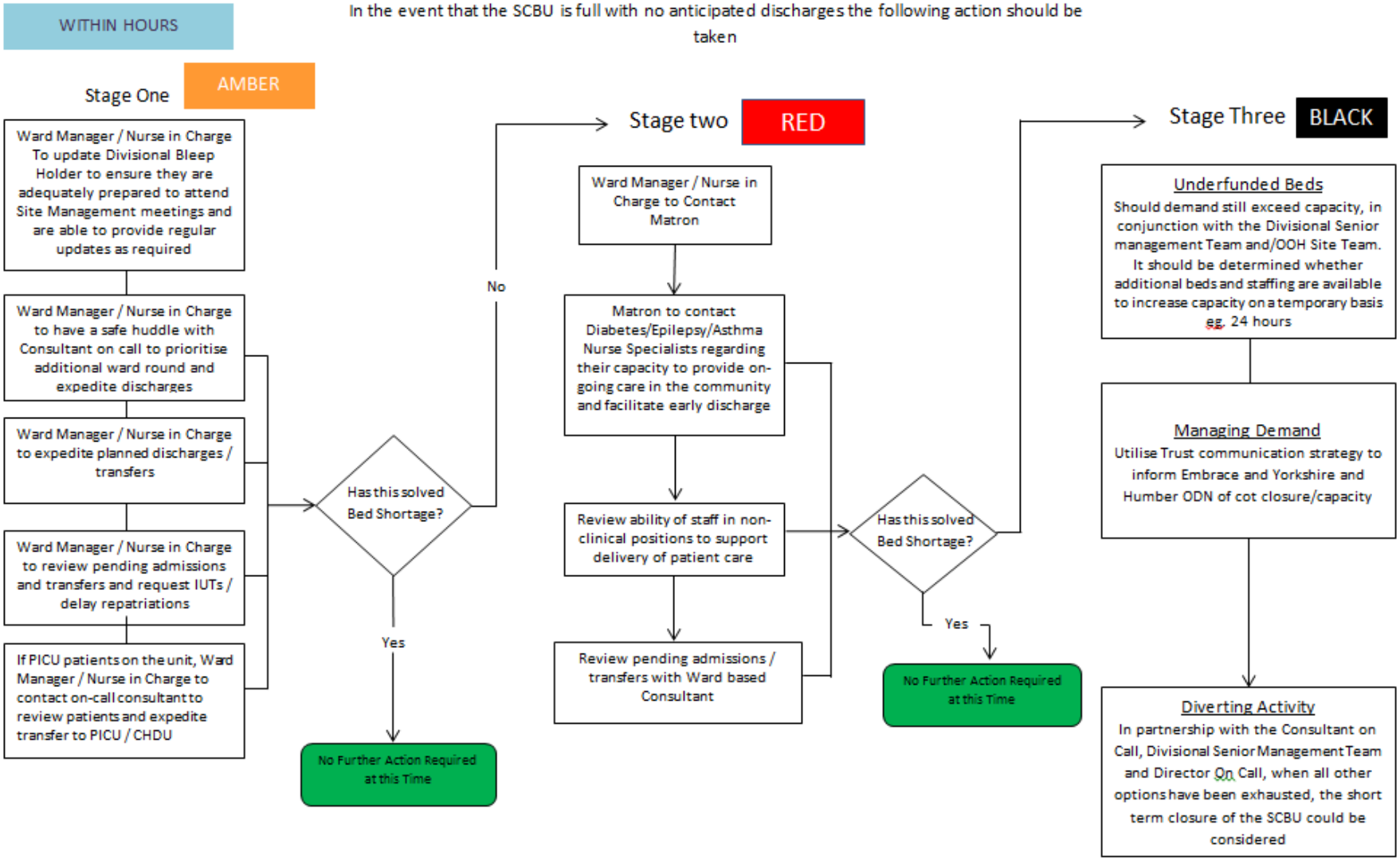
Appendix 4a - Example of Internal Escalation – Cot Shortages



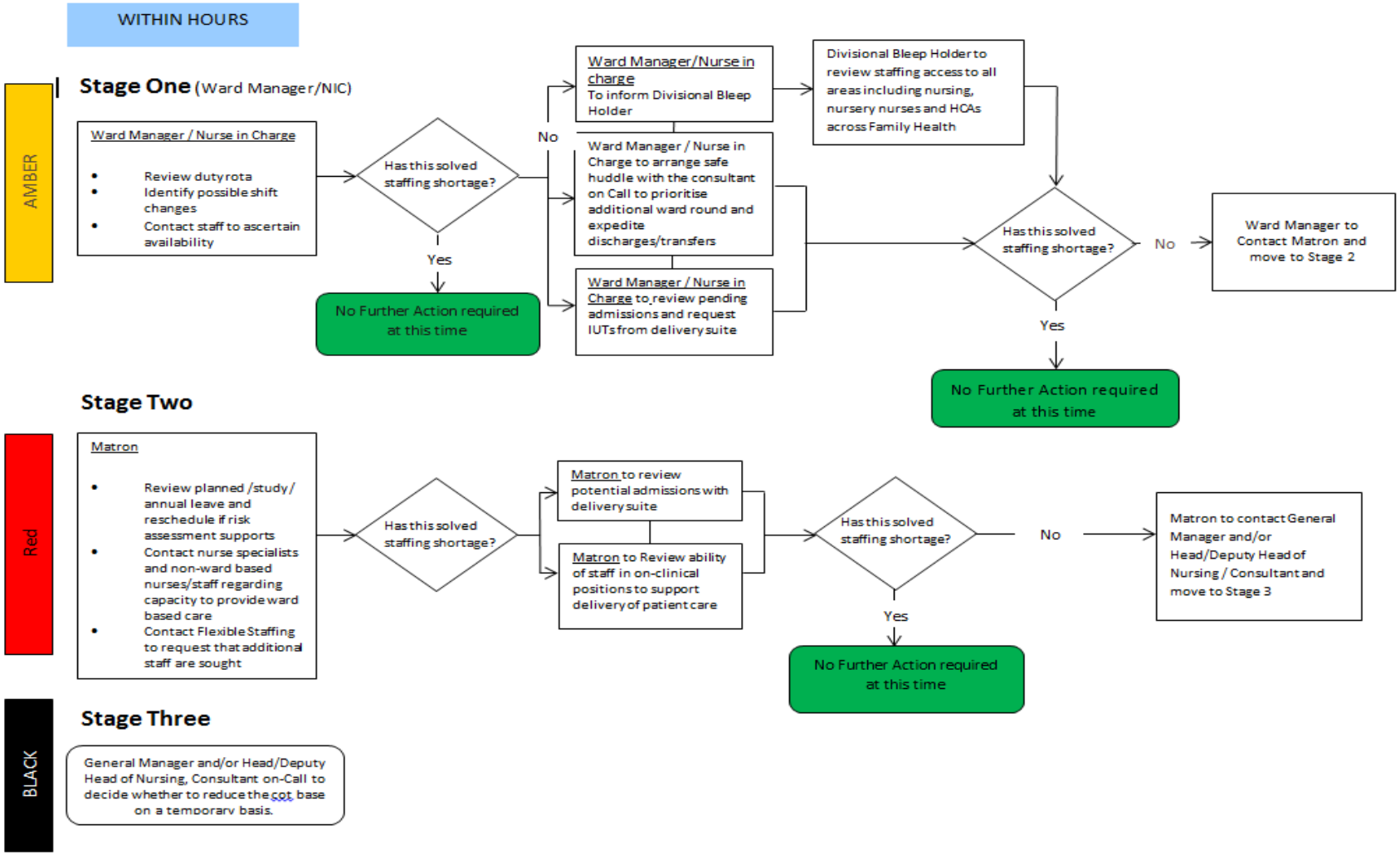
With acknowledgement to Rotherham NHS Foundation Trust Neonatal Unit for providing the above flowchart

Appendix 4b - Example of Internal Escalation – Cot Shortages



With acknowledgement to Rotherham NHS Foundation Trust Neonatal unit for providing the above flowchart

Appendix 4c - Example of Internal Escalation – Staffing Shortages



With acknowledgement to Rotherham NHS Foundation Trust Neonatal unit for providing the above flowchart

Appendix 5 – Staffing Ratios - ICU

RAG rating for HRG 1 (intensive care) staffing ratio's		
HRG XA01Z Staff ratio 1:1		
Prioritise 1:1	**Discuss 1:2**	**1:2**
Any day where a baby receives any form of mechanical respiratory support via a tracheal tube **plus** - Day of admission - Less than 26 weeks - Nitric oxide - Oscillation - Inotropes - <24 hours post-op - Diaphragmatic Hernia - Cooling - Chest Drain -		
Any day where a baby receives any form of mechanical respiratory support via a tracheal tube and does not fit any of the above criteria		
BOTH non-invasive respiratory support(e.g. nasal CPAP, SIPAP, BIPAP, CPAP High Flow ***with > 50% Oxygen***) and Parenteral Nutrition (amino acids +/- lipids)		
BOTH non-invasive respiratory support(e.g. nasal CPAP, SIPAP, BIPAP, CPAP High Flow ***with < 50%)*** and Parenteral Nutrition (amino acids +/- lipids)		
Day of surgery (including laser therapy for ROP, but excluding intraocular injections e.g. Bevacizumab)		
End of life care		
Any day with Umbilical Venous Catheter Present		
Any day with Umbilical Arterial Catheter or Peripheral Arterial Catheter Present		
Any day with a chest drain in situ		
Any day on which Insulin infusion is given		
Any day on which Prostaglandin infusion is given		
Any day on which inotrope or vasodilator (including pulmonary vasodilator) is given		
Day on which exchange transfusion occurs (includes dilutional exchange)		
Any day on which Therapeutic Hypothermia is given (hypothermia treatment given during the initial assessment period should not be counted if ongoing cooling is not required)		
Any day on which a replogle tube is present		
Any day on which an epidural catheter if present		
Presence of External Ventricular drain		
Presence of an Intra Ventricular catheter		
Any day on which an abdominal silo is present (for anterior adominal wall defects)		
Dialysis (any type)		
Cardiac admissions until cardiac review		
Cardiac externally paced		

With Acknowledgement to Leeds Children's Hospital Neonatal unit for providing the above Chart

Appendix 5 – Staffing Ratios – HDU

RAG rating for HRG (high dependency) staffing ratio's		
HRG XA02Z Staff ratio 1:2		
Prioritise 1:2	Discuss 1:3	1:3
Any day where a baby receives any form of non-invasive respiratory support • Nasal CPAP >= 50% • BIPAP • High Flow >=5 litres >=50% **OR** Less than 24 hours post-extubation		
Any day where a baby receives any form of non-invasive respiratory support, with the following parameters: • Nasal CPAP < 50% • High Flow < 5 litres < 50%		
Any day a baby receives Parental Nutrition (amino acids+/ - lipids		
Any day a baby receives an infusion of blood products (red cells, fresh frozen plasma, platelets, cryoprecipitate, intravenous immunoglobulin). It does not include infusion of albumin		
Any day on which a central venous or long line (PICC) is present		
Any day on which a tracheostomy is present		
Any day with a trans-anastomotic (TAT) tube present following oesophageal atresia repair		
Any day with NP airway/nasal stent present		
Confirmed Clinical Seizure (s) today and /or continuous CFM recording		
Ventricular tap (including via reservoir)		

With Acknowledgement to Leeds Children's Hospital Neonatal unit for providing the above Chart

Appendix 6 - National Units Specifications

The levels of Neonatal units are defined within the Specialised Commissioning Neonatal Service Specification and outlined below:

Provided in	Definition
Neonatal Intensive Care Unit (NICU)	The service will provide in addition to services provided by SCUs and LNUs: 6. Neonatal services commensurate with national guidelines and professional standards where births are anticipated after 22+6 weeks gestation (BAPM & Nuffield Council on Bioethics). 7. Intensive care for all the babies born within the network according to ODN approved care pathways including those less 27+6 weeks gestation, or with a birth weight < 800g and any baby requiring complex or prolonged intensive care. ODNs and the Trusts responsible for these units should monitor adherence to the care pathways 8. Neonatal intensive care service for other local neonatal networks or out of area neonatal units when they cannot access a cot in their network NICU because of lack of capacity at that unit 9. Leadership within neonatology for the neonatal ODN units and 24 hour acute clinical telephone consultations as required by the network hospitals and, if required neonatal transport services. Where more than one NICU is within a neonatal ODN, there will be a sharing of responsibility to provide 24 hour acute clinical consultations. 10. Care for local network babies repatriated from elsewhere requiring on going care from a NICU.
Local Neonatal Unit (LNU):	In addition to all the services provided by Special Care Baby Unit's (SCU's) local neonatal units will provide: 13. Neonatal services commensurate with national guidelines and professional standards where; singleton births are anticipated after 26+6 weeks gestational age and multiple births are anticipated after 27+6 weeks gestational age providing the anticipated birth weight is above 800g. 14. ODN care pathways will define antenatal factors or conditions present soon after birth which follow up increase the likelihood that transfer to a NICU for complex or prolonged neonatal intensive care will be required. ODNs and the trusts responsible for these units should monitor adherence to the care pathways. (Please refer to section below which outlines complex and prolonged intensive care). 15. Some ODNs have approved care pathways where all babies born between 27+0 and 27+6 weeks gestational age receive initial care in NICUs rather than LNUs. 16. Where possible, women will be transferred in-utero to the Network NICU when gestational age, anticipated birth weight or need for complex or prolonged intensive care is anticipated in accordance with ODN care pathways. 17. Limited intensive care in accordance with approved ODN care pathways (see commissioning exclusions, below) 18. Short periods of intubated ventilator support will be provided, however the clinical condition of any baby requiring this care must be discussed with a consultant in the Network NICU by 48 hours and every 24 hours thereafter if intubated ventilatory support continues. 19. An agreed management plan including decisions regarding transfer criteria will be documented 20. The stabilisation of babies prior to transfer to the Network NICU who require complex High dependency care and special care for their local population. 21. Referrals from other network neonatal units who are unable to undertake this work, due to capacity reasons and/or network guidelines. 22. On-going care for babies who have undergone specialist surgery following repatriation from the network surgical NICU. 23. Care for local babies repatriated from elsewhere in the network who no longer require positive pressure ventilation. 24. LNUs will not accept out of network referrals without prior discussion with the ODN defined Lead NICU to ensure the integrity of capacity for network babies. 25. LNUs will transfer babies requiring complex care or prolonged care to the approved ODN NICU in accordance with approved care pathways.

Special Care Unit (SCU):	The service will provide: 8. Neonatal services commensurate with national guidelines and professional standards where singleton births are anticipated after 31+6 weeks gestational age provided the anticipated birth weight is above 1,000g. 9. ODN care pathways will define antenatal factors or conditions present soon after birth which increase the likelihood that transfer to a Neonatal Intensive Care Unit (NICU) for complex or prolonged neonatal intensive care **OR** a Local Neonatal Unit for short term neonatal intensive /high dependency care will be required. ODNs and the Trusts responsible for these units should monitor adherence to the care pathways. 10. Some ODNs have approved care pathway where babies born between 30+0 and 31+6 weeks gestational age receive initial care in Special Care Unit (SCU) provided the anticipated birth weight is above 1,000g and intensive care is not required. 11. Stabilisation of babies prior to transfer to an (Local Neonatal Unit (LNU) or NICU predominantly, but not exclusively for intensive care. 12. Care for local babies with high dependency or special care needs following repatriation from LNUs or NICUs within the network or from out of area in accordance with approved ODN care pathways. 13. Referrals for ongoing special care from other network neonatal units who are unable to undertake this work due to capacity reasons. 14. Care for local babies post specialist surgery following repatriation from the network surgical unit or step down from other LNUs in accordance with approved ODN care pathways. 15. Transitional care, working in collaboration with post natal services subject to local service model.