Royal Cornwall Hospitals
NHS Trust

Transitional Care on Wheal Fortune Standard Operating Procedure

V3.1

June 2025

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1. Introduction

1.1. The Transitional care (TC) ward has 25 beds for mothers and babies requiring inpatient, postnatal midwifery and/ or neonatal care.

1.2. This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

The purpose of this document is to describe the Neonatal Transitional Care pathway.

3. Ownership and Responsibilities

The Transitional Care Working group consists of Neonatal consultants, Neonatal Matron, Postnatal Ward Manager, Clinical Skills Facilitator (CSF; Midwifery and Neonatal), Neonatal and Maternity Service Manager. Further speciality roles include input to the group as required and consist of Advanced Neonatal Nurse Practitioner (ANNP) and Neonatal Ward Sister. This group works collaboratively to ensure safe practice and a cohesive approach to TC care on the postnatal ward.

3.1. The Role of the Director of Midwifery and Head of Nursing for Care Group

Holds the regulatory responsibility for ensuring the ward is compliant with appropriate standards.

3.2. Matron for Neonatal / Transitional Care

The Matron for neonatal/transitional Care will have overall management, education, and safety responsibility of Neonatal Transitional Care.

3.3. The Role of the Transitional Care Ward Manager

Direct line management for the Maternity Support Workers (MSW), midwifery team will fall to the Transitional Care Ward Manager. The ward manager is responsible for the health and safety of the ward, managing ward budgets and working in the collaboration with the Neonatal/ Outreach lead Band 7 to ensure the provision of safe, high-quality care.

3.4. The Role of the Staff

Midwives and Neonatal staff will be responsible for the overseeing of high standards of midwifery and neonatal care and develop, monitor, and update plans of care including the giving of medication, referral and discharge planning.

3.5. The Role of the Medical Neonatal Team

Babies will have a review by the Neonatal Team in line with this guideline. This includes consultants, ANNPs, tier 1 and tier 2 doctors.

3.6. **Clinical Skills Facilitators**

The Clinical Skills Facilitators will support the MSWs, Midwives, Neonatal Nursery Nurses, and Neonatal staff nurses to develop skills and competencies.

3.7. **Role of the Maternity Support Worker**

3.7.1. The Maternity Support Worker (MSW) is a Band 3 with skills to support the mother and non-TC baby whilst admitted to the ward.

3.7.2. The MSW will have the skills to take baby observations, recognise abnormal observations, obtain capillary blood from a heel prick for blood glucose, serum bilirubin level (SBR) and other bloods, give tube feeds and support infant feeding.

3.7.3. For the mother's care the MSW will be able to provide post-operative care, parenting support, take blood and remove catheters and intravenous lines, and support breast feeding.

3.7.4. MSWs will have the opportunity to progress through a planned development progress in their role as described through National agendas and local workforce plans.

3.7.5. This group of staff will be supported to develop skills and competencies with the help of the Clinical Skills Facilitator and by having opportunities to work alongside the neonatal team.

See: support worker competency pack.

3.7.6. A key role of the MSW will be to provide on-going intensive support to new parents. The focus will be on supporting the parents to be the main carer for the baby whilst in hospital and to avoid separating mother and infant.

3.8. **Role of the Nursery Nurse**

- To be experts in transitional care pathways and guidance.
- To advocate avoidance of admissions to NNU (Neonatal Unit) and keep families together where clinically safe.
- To manage a set caseload of TC families promoting continuity and providing specialist family integrated care. (BAPM (British Association of Perinatal Medicine) guidelines).
- To undertake the Neonatal Foundation Program and use knowledge to inform practice.
- To support the ward with non-TC families when required.
- To support delivery suite with TC babies.
- To support NNU with special care baby's when required.

- Teach families and support them on their journey to going home.
- Support TC education to all clinicians and families.
- To recognise the deteriorating neonate, undertake appropriate actions including escalation and supporting NLS (Newborn Life Support).

3.9. **Role of the Neonatal Nurse/ Specialist TC Midwife**

- Experienced TC lead on duty day or night providing a constant link between Medical, Midwifery and Nursing staff on the Neonatal unit, Transitional Care, Delivery Suite, and Neonatal Outreach.
- To be the shift leader for babies requiring TC care and therefore not be reallocated to other areas due to staff shortages.
- To meet with daytime neonatal medical team and attend the ward round in full.
- Allocation of Neonatal Nursery Nurses to TC families.
- To lead, supervise and support members of the nursing/ midwifery team and ensure that all babies receive safe and appropriate care.
- To facilitate the implementation and evaluation of Neonatal care pathways within TC.
- Direct point of contact for all staff to provide a clear escalation pathway to the Neonatal medical team.
- Identifies a deteriorating baby and takes the appropriate action to manage the situation, liaising with the multidisciplinary team as appropriate.
- Assist with Neonatal education opportunities for Transitional Care and Delivery Suite staff as an experienced Neonatal Nurse/ Specialist Midwife working together with Neonatal Clinical Skills Facilitator.
- Assist in supporting Neonatal and Maternity leads to minimise term admissions to the Neonatal unit, helping to identify themes and trends, informing improvement projects.
- Support commencement of Neonatal TC in delivery suite to prevent unnecessary admission to NNU.

3.10. **Role of Neonatal TC/ Neonatal Outreach lead Band 7**

- Takes the operational responsibility for provision of effective, quality care within Transitional care and the Neonatal Outreach Service following a family integrated model of care.
- To work alongside the Matron, the ward managers, and wider teams to determine and deliver on service strategic objectives, encouraging interdisciplinary working.

- Manages a team of Neonatal Nurses and Neonatal Nursery Nurses creating constant communication link between Medical, Midwifery and Nursing staff on the Neonatal unit, Transitional Care, Delivery Suite and the Community Neonatal Outreach Service.

- Participates in Network Neonatal service development.

- Provides senior level contributions to resource management in the provision of neonatal services.

- Engages in Clinical Governance initiatives and leads on risks associated with Neonatal Outreach and Transitional Care.

- Leads the discharge process for infants requiring Neonatal Outreach care.

- Develops effective links with the Trust Quality Improvement team to enable the support of staff undertaking QI Projects.

- Represents Neonatal care at appropriate local, network, and national forums.

- Leads on the implementation and evaluation of care pathways within TC and the Neonatal Outreach Service.

- Promotes a progressive attitude to the continual improvement of care through research, evidence-based practice and a knowledge and understanding of up to date National Neonatal and perinatal drivers.

4. Standards and Practice

4.1. **Postnatal Inpatient Criteria**

Currently mothers who are cared for on the postnatal ward fall into one or more of the following categories:

- Mother / parent with baby requiring Transitional Care (see admission criteria).

- Mother / parent with baby on Neonatal Unit.

- Mother recovering from caesarean section or operative / complicated vaginal delivery.

- Post-partum haemorrhage.

- Infection.

- Abnormal observations.

- Post epidural.

- Trial without catheter.

- Parents requiring additional parenting support.

- Parents with safeguarding plan in place.

- Parents with physical or learning disability.
- Postnatal readmission.
- Parents needing support from infant feeding team.
- Any need for inpatient bed after assessment of needs.

4.2. Transitional Care (TC) Criteria (as per BAPM)

Babies who are admitted for TC care fall into one or more of the following criteria:

4.2.1. Criteria for TC for babies from birth:

- Prematurity: 34+0 to 35+6 weeks.**
- Birth weight >1.8kg and <2kg.**
- Risk factors for infection requiring IV antibiotics, clinically stable.**
- Congenital anomaly likely to require tube feeding.
- At risk of haemolytic disease requiring immediate phototherapy.
- 3-4 hourly observations including those fitting criteria for 24 hours of monitoring.
- Babies who have mild respiratory distress, who have had appropriate neonatal review and / or treatment and are felt to not require neonatal admission.
- Infant of mother with diabetes (insulin or diet controlled) or any other babies requiring blood sugar monitoring.
- Neonatal abstinence syndrome observations.
- Newborn thermoregulation requiring hot cot treatment.

4.2.2. Additional care needs developing on Delivery Suite, Postnatal Ward or at home:

- Inability to maintain temperature following an episode of rewarming and despite skin-to-skin contact and/or adequate clothing.
- Stable baby who has developed (or been identified as having) risk factors for infection, requiring IV antibiotics. **
- Inability to establish full suck feeds; predicted to require 3 hourly nasogastric tube feeds. **
- Significant neonatal abstinence syndrome requiring additional feeding support.

- Hypoglycaemic infants only requiring oral treatment or monitoring.
- Newborn jaundice requiring phototherapy and frequent blood tests for SBR monitoring. *

4.2.3. **Babies readmitted from the community:**

- Excessive weight loss and or poor suck feeding requiring complementary nasogastric tube feeds**
- Newborn jaundice requiring phototherapy and frequent blood tests for SBR monitoring.

4.2.4. **Babies stepping down from NNU:**

- Corrected gestational age ≥34+0 weeks and clinically stable. **
- Current weight more than 1.6kg and maintaining temperature. **
- Monitoring vital signs required no more frequently than 3 hourly.
- Tolerating 3 hourly nasogastric tube feeds and maintaining blood glucose. **
- Stable baby with infection requiring ongoing IV antibiotics. **
- Continuing phototherapy when serum bilirubin has stabilised following IV immunoglobulin or exchange transfusion. *
- Rooming in prior to going home with additional needs such as nasogastric tube feeding. **

4.2.5. All admissions should be discussed with the midwife in charge of the ward and a full and thorough handover of care must be carried out.

4.2.6. **HRG criteria 04 and requires baby to be entered onto the Badger system.

* Requires baby to be entered onto the Badger system.

For other admissions to TC consider whether Maxims discharge summary is necessary for sharing of relevant information.

4.3. **Management of babies** should incur in line with the relevant Neonatal and Newborn Care Clinical Guidelines which can be found on the Documents Library.

4.4. **Levels of transitional care at RCHT**

4.4.1. **Normal Postnatal Care:** Admitted due to maternal reason; no additional input needed.

4.4.2. **Protocol Led Care:** Admitted for additional monitoring, can be discharged without medical review having completed defined period of

monitoring if no concerns are raised. Includes:

- Babies on observations due to meconium-stained liquor.
- Babies on observations due to prolonged rupture of membranes.
- Babies having blood sugar monitoring due to maternal diabetes, maternal medications, or birth weight.
- Babies having neonatal abstinence syndrome (NAS) observations due to maternal opioid medications and babies requiring selective serotonin reuptake inhibitor (SSRI) observations.
- Babies having regular observations due to mode of delivery or other concerns not outlined below.
- Babies with safeguarding concerns, but no acute medical need, awaiting social care input/ placement.

4.4.3. **Criteria Led Care:** Admitted for treatment or high intensity/frequency monitoring. Should have documented Tier 2 doctor/ consultant/ ANNP (Advanced Neonatal Nurse Practitioner) review within 24 hours of admission. Subsequent reviews can be completed by the Transitional Care (TC) Tier 1 doctor. This includes:

- Babies having NAS observations due to maternal substance misuse.
- Babies having jaundice monitoring due to maternal antibodies or risk of haemolysis.
- Babies receiving phototherapy.
- Babies having blood monitoring of jaundice levels due to high levels or previous treatment.
- Readmissions with weight loss >12%. 2.1.3.7. Babies discharged from NNU to establish feeding.
- Babies 35-36 weeks gestation at birth.

4.4.4. **Medical Led Care:** Admitted due to prematurity/ birth weight/ feeding support which requires thermoregulatory or nasogastric feeding. Should have daily Neonatal Consultant/ Registrar/ Advanced Neonatal Nurse Practitioner (ANNP) review.

- All babies 34-35 weeks.
- All babies in a hot cot.
- All babies with a nasogastric tube.
- Babies on IV antibiotics for suspected or confirmed infection.

4.4.5. Transitional care on NNU or TC (following discussion with support from

TC and Neonatal Teams).

- Babies 1.6-1.8kg (these babies may have initial management on NNU but can be considered for TC once 3 hourly feeding with a stable temperature in a hot cot if no other systemic concerns).
- Babies on oral morphine for NAS or as part of weaning following medical opiates.
- Babies on low flow oxygen.

4.5. **Staffing model for Wheal Fortune Ward**

Staff Type	Number on Day	Number on Night
Midwifery Ward Manager B7.	1 (5 days a week).	0.
Midwives.	4.	3.
Maternity Support workers.	2.	2.
Neonatal TC/ Outreach Lead B7.	1 (5 days a week).	0.
Neonatal Nurse/Specialist TC Midwife.	2.	2.
Nursery Nurse.	2.	2.
NIPE Midwife B6.	1.	0.
Infant Feeding Support Midwife / MSW.	1.	0.
Neonatal doctor, neonatal nurse, ANNP.	Daily Ward Round and attendance.	Attendance as required.
Specialist Midwife Team (safeguarding, perinatal mental health, bereavement support, diabetes).	Attendance as required.	
Obstetrician.	Attendance ward rounds and as required.	Attendance as required.
Ward Clerks/ admin support.		

Staff Type	Number on Day	Number on Night
Clinical Skills Facilitator.	Attendance as required to support the skills and development of support workers. 1 NNU (4 days per week).	
Student midwives and nurses.	As allocated.	

4.6. **Additional Plans:**

4.6.1. The criteria for Transitional Care will be reviewed 6 monthly to ensure it is in line with national and local guidance in the Transitional Care Meeting.

4.6.2. The service will ensure full involvement of the Maternity Voices Partnership (MVP), parents and neonatal support groups to develop the service and improve the “Wheal Fortune” environment to meet the needs of parents.

4.6.3. See Neonatal and Maternity escalation policies if staffing, equipment, or acuity falls below agreed criteria (as above). Any patient safety issues will be highlighted, and safe plan made at collaborative huddle which is held at 14:00 and 15:00 every day.

4.6.4. Any baby where there are concerns about respiratory distress should be taken to the resuscitaire for assessment and management. If there is apnoea, shock, significant respiratory distress or any saturations <95% a 2222 Neonatal Emergency call should be requested to the postnatal ward.

4.7. **Metrics to monitored via the Transitional Care Working group. These metrics will be adapted by the TC Group as indicated:**

Metric
Number of TC babies per day.
Breaches of safe staffing numbers.
Number of incidents on Datix broken down by theme.
Number of complaints.
Number of MSWs / Nursery nurses.
Patient feedback.

5. Dissemination and Implementation

This is a new document which will be shared with all the relevant staff and stakeholders.

- **Neonatal Matron:** It is the responsibility of the neonatal Matron to ensure the dissemination and communication of the SOP and place of storage.

- **Postnatal ward manager and Neonatal / TC outreach lead Band 7:** It is the responsibility of these managers to ensure that all TC staff and other staff who this will affect, have read the SOP.

6. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	As per 4.3 Metrics to be monitored via the Transitional care Working group.
Lead	The Neonatal Transitional Care Working Group.
Tool	Excel.
Frequency	Once in the lifetime of the SOP.
Reporting arrangements	The Neonatal Transitional Care unit will be monitored within the Trusts Governance processes which will include monthly exception reports to: • Maternity Governance Committee. • Women, Children and HIV Care Group Board. • By exception to the Women, Children and HIV Care Group Performance Review Meeting. The Neonatal Transitional Care Working Group will oversee the everyday management of the unit and monitor key performance areas. The group will oversee the action plan.
Acting on recommendations and Lead(s)	The Neonatal Transitional Care Working Group will maintain the Action Plan, and exception report to the above committees who will scrutinise the actions, recommendations and compliance.
Change in practice and lessons to be shared	The Neonatal Transitional Care Working Group will oversee national and local drivers to ensure the pathway is best practice, and implement change as required. This will also include any learning from complaints and DATIX.

7. Updating and Review

This Standard Operating Procedure will be reviewed every 3 years or earlier if required, in line with national and local drivers, including any learning from complaints and Datix.

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

8.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Transitional Care on Wheal Fortune Ward Standard Operating Procedure V3.1.
This document replaces (exact title of previous version):	Transitional Care on Wheal Fortune Ward Standard Operating Procedure V3.0.
Date Issued / Approved:	June 2025.
Date Valid From:	June 2025.
Date Valid To:	January 2028.
Author / Owner:	Helen Greenhill; Neonatal Matron and Kathleen Bell; Postnatal Ward Manager.
Contact details:	01872 255979 or 01872 253802.
Brief summary of contents:	The purpose of this document is to describe the Neonatal Transitional Care pathway.
Suggested Keywords:	Transitional care/ postnatal ward.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Neonatal Audit and Guidelines Group. Maternity Guidelines Group.
Manager confirming approval processes:	Caroline Chappell; Care Group General Manager.
Name of Governance Lead confirming consultation and ratification:	Michael Cross.
Links to key external standards:	None required.
Related Documents:	None required.
Training Need Identified:	All staff are trained to meet set criteria for TC care.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet.

Information Category	Detailed Information
Document Library Folder/Sub Folder:	Clinical/ Newborn Care.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
July 2019.	V1.0.	Initial version.	Sarah Coe, Wheal Fortune Lead Midwife, Jane Urben Head of Midwifery, Chris Warren, Neonatal Consultant.
September 2021.	V2.0.	Merging of Transitional Care on the Postnatal Ward Clinical Guideline and Transitional Care on Wheal Fortune Standard Operating Procedure.	Emma Stone; Neonatal Nurse.
May 2023.	V2.1.	Section 4.2 updated regarding corrected gestation age. Audit criteria updated to clarify specific scope of the audit, as per the requirements of CNST.	Charlotte Lea; Neonatal Guidelines Lead.
December 2023.	V2.2.	Aligned with BAPM TC framework and staffing model included.	Ellie Lawes; Consultant Paediatrician.
June 2024.	V2.3	Wording in section 4.4.2 updated.	Ellie Lawes; Consultant Paediatrician.
January 2025.	V3.0	4.2 updated in line with BAPM. Section 4.4.2. updated. Afternoon huddle times amended. Appendix 4. Escalation Tool added to document. Full review and update to formatting.	Rebecca Heaney; Neonatal Nurse Lead for Transitional Care and Neonatal Outreach.
May 2025	V3.1	Section 4.4.5. added to guidance. Section 4.2.4 amended from current weight more than 1.8kg to current weight more than 1.6kg.	Neonatal Audit and Guidelines Group.

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Transitional Care on Wheal Fortune Ward Standard Operating Procedure V3.1.
Department and Service Area:	Neonatal.
Is this a new or existing document?	Existing.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Neonatal Audit and Guidelines Group.
Contact details:	01872 252667.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To ensure wide communication of the neonatal TC care pathway in order to ensure mother and babies are cared for together, minimising separation.
2. Policy Objectives	To ensure that staff are aware of the processes.
3. Policy Intended Outcomes	That staff are aware of the process and ensure mother and babies are cared for together.
4. How will you measure each outcome?	Audit SOP- babies admitted to the neonatal unit who could have been managed on transitional care, including those who were admitted specifically for nasogastric feeding.
5. Who is intended to benefit from the policy?	All women and babies who require TC care.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Neonatal Audit and Guidelines Group. Maternity Guidelines Group.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/ carer/ patient's needs- i.e., available in different languages if required/ access to an interpreter if required.

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/ carer/ patients with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly.
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

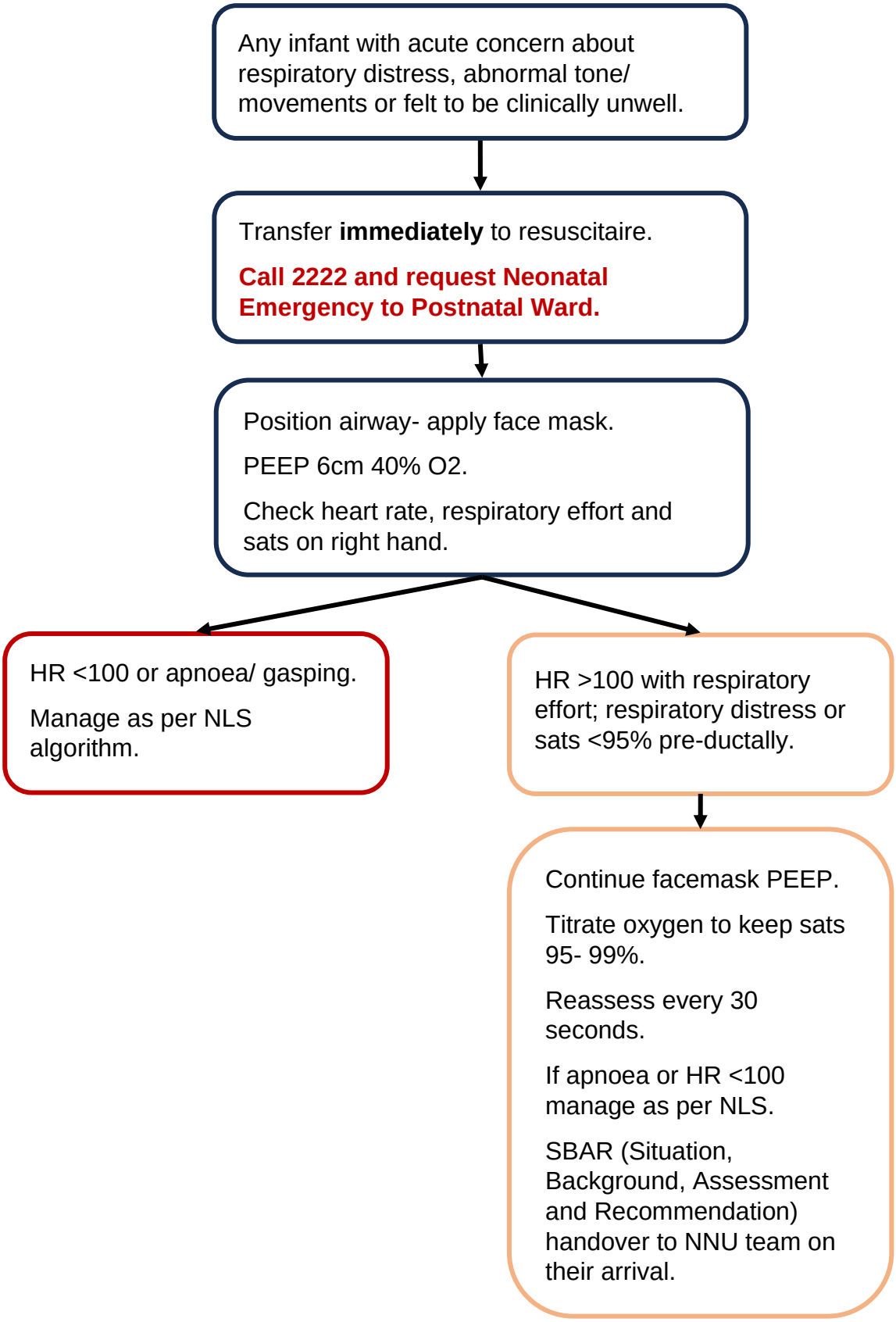
A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Neonatal Audit and Guidelines Group

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Escalation of the Unwell Newborn on TC



Appendix 4. Transitional Care Escalation Tool

	Highest Level of Care Applies:	Number.	
Enhanced Medical.	34-34+6.		
	Requiring NGT (Nasogastric Tube) feeds.		0
Medical Led.	IVAB (Intravenous Antibiotics).		
	Hot cot.		
	35-35+6 first 48 hours.		
	<2kg first 48 hours.		
	Babies with haemolytic disease needing immediate phototherapy.		0
Criteria Led.	Phototherapy.		
	Babies requiring feeding support for weight loss >12%.		
	NAS (Neonatal Abstinence Syndrome) observations (substance misuse).		
	Bilirubin monitoring- previous phototherapy.		
	Babies <36 weeks after initial period of medical led care.		0
Protocol Led.	NAS Observations (medical opiates).		
	SSRI (Selective Serotonin Reuptake Inhibitor) observations.		
	NEWTT (Newborn Early Warning Trigger and Track) observations.		
	Blood sugar monitoring.		
	Bilirubin monitoring- not on phototherapy.		0
Staffing allocation:	**All enhanced medical patients must have care delivered by Nursery Nurse or TC Specialist.**		
Allocate babies in following order:			
1.	Enhanced Medical: allocate 4 per Nursery Nurse.		
2.	TC specialist can take allocation of **maximum** of 1 **enhanced medical** patient and no other allocation (no other patients to be allocated to TC specialist to ensure they have oversight of care to all medical led and criteria led patients).		
3.	If all enhanced medical patients allocated, continue to allocate 1:4 medical led patients to Nursery Nurse.		
4.	If all medical led patients allocated, continue to allocate 1:4 criteria led patients to Nursery Nurse.		
5.	Any unallocated patients allocated to MSW (Maternity Support Worker/ Midwifery as per normal allocation including Medical Led and Criteria Led.		
Staffing.	TC specialist (band 5 or band 6).		0
	TC Nursery Nurse (band 4).		0
Staffing Ratio.	If green- staffing compliant.		0
	If amber- midwifery team to maintain oversight of babies looked after by band 4. Inform neonatal nurse in charge. Complete Datix stating- no TC Specialist.		
	If red escalate as per escalation tool (below).		
	***Neonatal TC staff are not able to provide Maternity Care in any circumstance.**		

Escalation Actions.

	Action.	Desired Outcome
1.	Inform Neonatal Nurse in Charge.	Review of staffing across neonatal service: consider supporting TC staffing from NNU.
2.	Neonatal workload review.	Review suitability of admission of baby + medically fit mum to NNU or Paediatric Ward,
3.	Escalate to TC ward manager (Monday to Friday).	Consider inclusion of ward manager in staffing.
4.	If escalation occurring 6am-9am highlight to Neonatal Consultant **in handover.**	Review of patients- decisions around de-escalation of care (to reduce workload).
5.	If escalation occurring 9am-5pm escalate to Neonatal Consultant.	Review of patients- decisions around de-escalation of care (to reduce workload).
6.	If **no** Nursery Nurse on shift allocate up to 4 enhanced medical patients to TC specialist.	Oversight/ escalation for other babies reverts to midwife in charge with support from NNU.

A copy of the live escalation tool can be found here:

S:\RCH-WCSH\Neonatal\Neonatal shift leaders\Handover\OPEL Tool