REF: CTM Obs 113

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

MATERNITY TRANSFER (and communication to ambulance services) Standing operating procedure (SOP) from midwife-led and community home birth ...

Initiated By	Cwm Taf Morgannwg University Health Board Obstetrics and Gynaecology Directorate
Approval Group	Labour ward Forum / guideline group
Distribution	Midwifery, Medical and Neonatal staff within Cwm Taf Morgannwg University Health Board (via email)
Archiving	Directorate secretary will be responsible for archiving all versions
Document Location	Health Board intranet / WISDOM Hard copy in shared drive fileshare-pch guidelines
Freedom of Information	Open

CHANGE HISTORY

Version	Date	Author Job Title	Reasoning
1	April 2023	Bryany Tweedale	New guidance

AUTHORSHIP, RESPONSIBILITY AND REVIEW

Author	Bryany Tweedale	Ratification Date	April 2023
Job Title	Consultant midwife	Review Date	April 2026

Disclaimer

When using this document please ensure that the version is the most up to date by checking the Obstetrics & Gynaecology Guidelines on WISDOM

PRINTED DOCUMENTS MUST NOT BE RELIED ON

GIG CYMRU NHS WALES Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board	**Reference Number:** **Version Number:** **Next Review date: 00/00/00**

MATERNITY TRANSFER (AND COMMUNICATION TO AMBULANCE SERVICES) STANDARD OPERATING PROCEDURE (SOP) FROM MIDWIFE-LED AND COMMUNITY HOME BIRTH SETTINGS

Introduction

Women with a low likelihood of complications during labour will be offered the choice of all 4 birth settings (Home), Freestanding Midwifery-Led Unit (FMU), Alongside Midwifery-led Unit (AMU) and Obstetric Unit, and information about local birth outcomes to support decision making (Maternity Care in Wales, A Five Year Vision for the Future *(2019-2024*).

Within Cwm Taf Morgannwg UHB, there is provision of 24/7 community midwifery cover to support home births across the locality. 2.35% of women gave birth at home during 2022.

A further 8.26% of women gave birth within an Alongside Midwifery-led setting, such as Tair Afon birth centre (PCH), Daffodil suite and Room 3 (POW).

Tirion birth centre, the Freestanding Midwife-led Unit (FMU) is located on the Royal Glamorgan site, where 3.21% of women gave birth during 2022.

There is a clear traditionally accepted model of midwifery-led antenatal, intrapartum and postnatal care in the UK. Consent is a legal requirement for all clinical care, and women may decline or opt out of any aspect/s of traditional maternity care in line with the Human Rights Act (1998), including recommended birth setting. In recognition of the legal framework and rights of all women to choose their birth setting; it is acknowledged that women with complexity may also prefer to plan to give birth in a setting away from an Obstetric Unit.

All women who are suitable to receive midwifery-led care during labour, or those making an informed decision to decline or opt out of obstetric-led care and choose to follow a midwife-led care pathway will have ongoing holistic assessment during labour and birth. Where deviations occur, in line with the All Wales Midwife-led Care Guideline, and the All Wales Clinical Pathway for Normal Labour, women will be advised to transfer to an obstetric unit.

The majority of transfers are for non-urgent clinical indications (Birthplace in England Collaborative Group, 2011; Rowe et al, 2018), and approximately 6% of transfers are considered emergency transfers "Red calls" for life threatening events.

Objectives

- Provision of clear localised guidance for midwives to follow to undertake and manage maternity transfers from midwife-led and out-of-hospital settings
- Support around requesting the appropriate mode of transport for transfers from midwife-led and out-of-hospital settings
- Support robust communication and multidisciplinary working between maternity staff, maternity teams and ambulance services to enable timely transfer from midwife-led and out-of-hospital settings when required
- Support midwifery staff in managing escalation in the case of delay or inappropriate clinical categorisation of cases requiring transfer

Operational Date 00/00/0000	**Expiry Date** **Formal** – three years **Informal** – one year

Scope:

This Standard Operating Procedure applies to the management of all maternity transfers from midwife-led settings and community areas including; Tirion FMU, Tair Afon birth centre (PCH), Daffodil Suite/Bluebell Suite & Room 3 (POW) and home settings across the CTMUHB geographical locality.

Equality Impact Assessment	…
Distribution	All staff via internet and team briefings. To be made available via Wisdom
To be read by	Midwives and maternity staff
Documents to read alongside this Procedure	All Wales Midwife-led Care Guideline All Wales Clinical Pathway for Normal Labour
Approved by	Labour Ward Forum
Accountable Executive / Lead Director	Suzanne Hardacre (Director of Midwifery)
Author / Management Lead	Bryany Tweedale (Consultant Midwife)
Freedom of Information Status	Open

If the review date of this procedure has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Medicines Management Directorate.

To avoid use of out of date procedures please do not print and then store hard copy of this document.

Out of date procedures cannot be relied upon.

Max 2 pages to this point

Amendment Record

If a change has been made to the document, the changes must be noted and circulated to the appropriate colleagues.

Detail of change	Why change made?	Page number	Date of change	Version	Name of Policy Author

The All-Wales Midwife-Led Care Guideline (AWMLCG) 2022, and the All Wales Clinical Pathway for Normal Labour (AWCPNL) outline clinical reasons where transfer in labour or the immediate postnatal period may be warranted, these are varied and the majority are not for life-threatening emergencies.

National data suggests that the chance of peri-partum transfer (transfer in labour or immediately after birth) is between 36-45% for first time mothers from home or Freestanding Midwifery-led Unit (FMU). This rate falls to 9-12% for women in a subsequent birth (NPEU, 2011).

The peri-partum transfer rate for Tirion FMU in 2021/22 was 31.6% for nulliparous women, and 7.5% for multiparous women.

Antenatal discussion, counselling and planning to support birth in midwife-led and home settings:

For decision around place of birth, women should be informed of:

- ✓ Intrapartum transfer rates (updated annually for Tirion FMU)
- ✓ The possibility of a delay in getting an ambulance during times of high ambulance service activity. The Welsh Ambulance Service NHS Trust has confirmed that it will attend maternity calls which will be prioritised accordingly, but there can be a delay.
- ✓ The various modes of transfer that might be utilised should transfer be required.
- ✓ Transfer times to the nearest obstetric unit from their expected place of birth and that transfer is undertaken to the nearest obstetric unit.
- ✓ Of the likely reasons for transfer and how these are managed within midwifery-led settings including the skills and equipment that midwives have access to.

There should be a balanced discussion weighing up the individual risk factors for the pregnant woman or person on the options for place of birth. This should include the benefits of and possible risks with each setting:

- Where home birth is planned, ambulance access to the home address should be assessed by the midwife before 36 weeks of pregnancy.
- Where difficulties are expected in ambulance access, or egress, midwives should liaise with local WAST services, who will undertake a risk assessment in the antenatal period to aid planning for if transfer is required during a homebirth. The risk assessment would normally be completed by the hazardous area response team (HART) leader, a duty operational manager (DOM), or a senior paramedic. Requests should be forwarded to the local WAST operational team for the relevant area.

Reasons to exit midwifery-led intrapartum care

- All women who receive midwifery-led care during labour will have ongoing holistic assessment during labour and birth.

- All deviations from the AWCPNL must be documented accordingly. Appendix A is not exhaustive but identifies common maternal and neonatal concerns where transfer would be indicated. Appendix A should be used in conjunction with the AWCPNL to determine clinical rationale for transfer.

- Where deviations occur, in accordance with the AWMLCG and the AWCPNL, women will be advised to transfer to the nearest obstetric unit, providing the clinical rationale for this recommendation.

- Any deviations requiring transfer should be discussed with the woman and her birth partner/s and documented within the AWCPNL. Ongoing communication with the woman and her birth partner/s is paramount during transfer.

Transfer from a co-located/along-side midwife-led setting to the Obstetric Unit:

- Transfers from settings including Tair Afon AMU (PCH), Bluebell Suite/Daffodil Suite and Room 3 (POW) will usually be completed on foot or via wheelchair.
- Women should be advised this will take a very small amount of time (usually less than 5 minutes to complete).

Transfer from Tirion FMU or home settings within CTMUHB geographical areas to the Obstetric Unit.

- Where transfer is required the flow charts in Appendix B and Appendix C should be reviewed to ascertain the most appropriate transfer method.

****Clinical judgement remains paramount in all situations and this list is not exhaustive****

- Where there are two midwives present for transfer, a conversation should occur around who is most appropriate to lead the transfer.

- Women who require transfer from home or Tirion FMU will be risk assessed, and all available transportation resources should be considered.

- Transfers from Tirion FMU will be undertaken to the Obstetric Unit at Princess of Wales Hospital, Bridgend.

- Transfers from home settings will be undertaken to the geographically closest Obstetric Unit:

  Prince Charles Hospital, Merthyr Tydfil: 01685 728870

  Princess of Wales Hospital, Bridgend: 01656 752383

- Modes of transportation may include paramedic 999 ambulance, Urgent Care Services (UCS), Non-Emergency Patient Transport Service (NEPTS), hospital taxi service or the woman's own car (see Appendix B and C).

- Where indicated and available, the Emergency Medical Retrieval Team (EMRTS) will provide an enhancement of pre-hospital critical care to women and neonates in both home and FMU settings where either are deemed to be in a critical/life threatening condition (see Appendix G). The team can support midwives or lead in providing care to stabilise and safely transfer the woman and/or the neonate. Transfer mode may be by air or by road and will be decided on a case-by-case basis.

- Where it is deemed appropriate to travel by her own car; in accordance with Appendix C, the woman should be provided with her notes. The midwife should ensure the family know where they are going and are clear on how to get there. The midwife must contact the Obstetric Unit to inform them of the attendance of the woman, and later, to ensure the family have arrived.

- Where it is deemed appropriate to transfer by taxi, the necessary company will be contacted, and transfer arranged as in Appendix C.

- The midwife will travel with the woman in the taxi. The birth partner should be advised to travel separately if possible. The midwife should take a kit bag for the transfer.

- If a taxi is not available, the responsible midwife will need to risk assess suitability for the woman to transfer in her own transport **OR** whether to call the ambulance service to arrange transfer.

- From home, if a taxi is not available, the midwife will need to risk assess suitability for the woman to transfer in her own transport with a community midwife following in their own car **OR** whether to call the ambulance service to arrange transfer.

- Where urgent transfer is required the Urgent Care Service (UCS) can be contacted as per Appendix C. A clear, concise summary should be provided. Midwives will need to request a response time during this call. In most cases this would be expected to be within an hour – **should there be indication that a 1-hour time frame will not be achieved for arrival of the UCS then the midwife will need to revert to a 999 call.** This should be clearly documented in the notes and recorded on the Incident report via Datix Incident Reporting system. The midwife must remain with the woman and/or baby for transfer and not follow in their own car.

- Emergency transfers will always be managed via 999 emergency medical service. A 999 WAST service will be contacted and an emergency ambulance requested for transfer. The member of staff making the call will clearly state the situation and that it is a life-threatening emergency and a paramedic crew is required as per Appendix D.

- Midwives present with the woman should coordinate the transfer, where possible, to aid effective communication of current clinical information.

- Midwives will need to request an estimated time of arrival for the ambulance.

- The WAST duty manager details are recorded in Appendix C. Once a time has been agreed for the estimated arrival time for the Ambulance, it will not be possible for the Ambulance service to inform staff if there is a delay and staff should be mindful to contact the Ambulance service again if there is no sign of them close to the expected arrival time. This can be done by ringing Ambulance Control who will provide an update.

- The midwife must remain with the woman and/or baby for transfer in the ambulance.

- Where using the Emergency Care Service (999), call handlers will use predefined scripts/call cards to prioritise all calls. In the event of an emergency transfer, when asked 'what is your emergency?' midwives should confirm where there is an 'immediate threat to life' and state the obstetric/neonatal emergency clearly. Trigger words to ensure an 8-minute targeted response are detailed in Appendix D.

- At the earliest opportunity the midwife in charge and an obstetrician of at least registrar level at the receiving Obstetric Unit must be contacted and an SBAR handover provided including the method of

transport, the urgency of transfer and recommendation, including preparing the receiving team and/or theatre as required.

- In the case of a transfer of a baby, midwives/maternity staff will liaise with the neonatal registrar stating the urgency of transfer and to confirm which area the baby should be admitted to. The neonatal registrar will hold responsibility for informing the on-call consultant neonatologist.

- Risk assessment for mode of transport and flow charts for the process of calling 999 ambulance and UCS are detailed in Appendix B and C.

- In certain situations, and where available the Emergency Medical Retrieval and Transfer Service (EMRTS) may be dispatched. The Midwife should request (EMRTS) attendance where the criteria is met (Appendix G).

- At the end of **all** 999 calls, the midwife should confirm with the call handler the grade of response designated (Appendix B) and provide any advisory information to the call handler, e.g. paramedic to bring tranexamic acid, neonatal harness/warming equipment, entonox.

- Where transfer is in an ambulance, the midwife remains the lead carer. The midwife should advise WAST on their arrival at the birth setting:

    - ✓ The reason for transfer, stating when it is an emergency.
    - ✓ What paramedic intervention, if any, is required to stabilise prior to or during transfer.
    - ✓ Need for ongoing monitoring during transfer including monitoring oxygen saturation.
    - ✓ Likeliness of a change in clinical picture during transfer.
    - ✓ The level of urgency of transfer/if blue lights and sirens are required.
    - ✓ Required destination.

- If EMRTS are at the scene, it may be acceptable for care to be handed over to this team. In all circumstances involving EMRTS a transfer team 'leader' should be identified.

- Where possible, midwifery staff should confirm with the obstetric unit that the ambulance has left and is en-route.

- On arrival at the obstetric/neonatal unit, the midwife should escort the woman to the appropriate area and hand over to the appropriate medical team in SBAR format. A midwife-to-midwife handover is not usually acceptable.

- Generally, partners will accompany in own transport/taxi.

- Where a baby is being transferred, the mother may be able to accompany in the ambulance if her baby does not require resuscitation. A second ambulance may be required to transfer the mother depending on her clinical condition. Where possible, the woman and her baby should not be separated.

- Where both the woman and her baby require transfer for medical reasons, then usually two ambulances will be necessary. This should be communicated with the WAST Call handler.

- All neonatal transfers should be undertaken with appropriate safety restraints/harness in line with WAST protocols. In instances where neonates are transferred via taxi or women's own car, this will be in a British safety approved car seat. No car seats are proven suitable for use in ambulances.

- All WAST 999 vehicles carry neonatal warming equipment, and midwives should request use of this in all emergency neonatal transfers to optimise neonatal thermoregulation and clinical condition.

- All documentation must be completed and accompany the woman in to the receiving OU.

- Timings should be recorded for:

    - ✓ time of decision to transfer and time transport called (if required),
    - ✓ time of arrival of transport at birth setting (if required)
    - ✓ time left birth setting
    - ✓ time of arrival at obstetric unit/neonatal unit
    - ✓ time seen by medical staff

- When a midwife accompanies a woman and/or baby for transfer, arrangements should be made to return the midwife to Tirion FMU or to retrieve their car from a community location. It is not appropriate to use WAST transportation for this means.

- There is currently no accepted standard in relation to reasonable transfer times for maternity cases. It is a recommendation that national transfer standards are devised in conjunction with WAST.

Transfer of babies requiring active resuscitation from Tirion FMU

Approximately 3-5 per 1000 babies born to mothers who are healthy and experiencing a straight forward pregnancy will be born with an adverse outcome (NPEU 2011).

The aim of management in any emergency situation arising in any midwife-led setting is to sufficiently stabilise the condition of the neonate to enable safe transfer to a neonatal unit.

Any baby that is born and:

- ✓ is unresponsive requiring active ongoing resuscitation
- ✓ needs a second set of inflation breaths
- ✓ APGAR score of 5 or below, at 5 minutes (All Wales Midwife-led Guideline 2022).

Will require transfer to the Neonatal Unit Intensive Care (NICU), University Hospital of Wales (UHW), Cardiff. The acceptance of this cohort of babies will be expected at all times.

At times of capacity issues in UHW, the baby will be transferred to the Special Care Baby Unit (SCBU) in the Princess of Wales Hospital (POW) Bridgend, where they can be stabilised by the attending neonatal team. Arrangements can then be made with the Welsh Maternity & Neonatal Network for the baby to be transferred on to an appropriate Level 3 NICU if required.

Operational details:

- A member of the FMU staff will contact Welsh Ambulance Service Trust (WAST) via 999 and request an Emergency Ambulance Crew and a 'Red call' response

- A member of the FMU staff will contact NICU in UHW (receiving hospital) on 02920 742680 / 2684

- If NICU UHW is at full capacity, a call will made to the SCBU POW Bridgend 01656 752376. The baby will be transferred to SCBU in POW where his/her condition can be further stabilised.

- It may be the Health Care Assistant (HCA) trained in emergency drills who will be making the telephone calls to request further assistance

because two midwives will be managing the resuscitation of the baby. The HCA will ask for assistance from:

- ✓ WAST
- ✓ Receiving unit – NICU UHW (or SCBU POW)
- ✓ On-call community midwives (as per on-call rota)
- ✓ Senior midwifery manager on-call (obtained via hospital switchboard)

- The Midwife leading the resuscitation will have support from the second midwife and the Emergency Ambulance crew when they arrive at the FMU.

- The midwife leading the resuscitation will transfer the baby to NICU UHW (or if required to SCBU POW), with support from the Emergency Ambulance Crew.

- In the event of there being a delay with the ambulance, the midwives will continue to stabilise the baby until WAST help arrives.

- Staff would contact the midwife in charge in the Obstetric Unit (OU) UHW on 02920 742684 or POW on 01656 752383 to inform them of the ongoing situation and request that there is a 'postnatal bed' for the mother.

- Uniting the mother and baby (at the unit where the baby has been transferred) will be the next priority. If a bed is not available in the unit where the baby has transferred, the woman will remain in the FMU until such time as a bed becomes available.

- The mother will be transferred via suitable transport; personal car, hospital taxi or if the mother's condition requires; separate ambulance provision.

Escalation at times of known transfer delay or inappropriate categorisation of ambulance response (Appendix E/F)

- In the event of a transfer request not being categorised appropriately by the WAST call handler, the midwife should request a call back from the clinical desk for a clinician-to-clinician discussion.

- This discussion will outline all clinical details and the response the midwife feels is required. Where appropriate, the clinical desk can upgrade the call and/or consider all available resources to get the most appropriate response.

- If the required ambulance response is still not designated, the midwife should escalate concerns to the duty control manager of WAST 01633 294866 and the senior midwifery manager on call (available via hospital switchboard) to obtain support in coordinating a safe transfer.

- In the event that an emergency transfer cannot be accommodated by WAST despite escalation due to activity/acuity, a senior midwifery manager should be informed of the delay to support the team appropriately and consider if further escalation is required. This may include a request to off-load ambulance resource on site.

- Any transfer delays experienced should be escalated and investigated at the earliest opportunity. Any transfers, including delays, should be reported via Datix Incident Reporting system.

- Transfer/midwife-led reflection meetings are held weekly to review all transfers from midwifery-led settings.

Emergency care and Obstetric emergencies in Midwifery-led settings.

- The aim of management of any emergency situation arising in any midwife-led setting is to sufficiently stabilise the condition of the woman/fetus and/or neonate to enable safe transfer to the obstetric or neonatal unit.

- Once the woman or baby is stable, care should then be transferred to the Obstetric Unit/Neonatal Unit at the earliest opportunity.

- All midwives providing home births should carry Community PROMPT Wales and nationally agreed algorithms and proformas, for example Obs Cymru where available to support emergency care provision.

- Community PROMPT Wales and national algorithms and proformas should be used to manage any evolving emergency and for contemporaneous documentation of procedures during an emergency

situation. These documents will accompany the woman/baby to the obstetric unit and be available to the receiving team.

- The equipment available in Tirion FMU and homebirth would only include that required for midwifery stabilisation, with the exception of a maternal arrest at Tirion FMU whereby the cardiac arrest team would attend to provide emergency care via 2222

- It is accepted and expected that both obstetric and neonatal teams may be called to Alongside Midwifery-led settings (Tair Afon Birth Centre, Daffodil Suite/Bluebell Suite and Room 3 POW) in an acute emergency, therefore emergency equipment lists should include anything required by these medical staff groups and medical skill set.

Appendix A - Reasons to exit midwifery-led intrapartum or early postpartum care

Part 2 of All Wales Clinical Pathway for Normal labour (AWCPNL) assessment deems woman unsuitable for midwifery-led intrapartum care.
Slow progress in the first or second stage of labour in line with the AWCPNL
Indication to offer continuous Electronic Fetal Monitoring including inability to effectively monitor via Intelligent Intermittent Auscultation (IIA): • Outside criteria for midwifery-led care due to risk factors for hypoxia • Concerns identified on part 2 (AWCPNL) fetal assessment including concerns around fetal growth and or altered fetal movements in the 24 hour prior to assessment • Raising baseline suspected on IIA • Suspicion of the presence of overshoots, not excluded from increased auscultation • Identification of decelerations heard immediately after a contraction, confirmed with increased auscultation • Prolonged deceleration or bradycardia
Significant meconium stained liquor or change in liquor from clear to meconium stained in the intrapartum period.
Maternal observations indicating that the AWCPNL should be exited and obstetric opinion sort
Offensive vaginal loss or vaginal bleeding
Suspected Mal-presentation
Retained placenta
3rd or 4th degree tear
All obstetric emergencies, including postpartum haemorrhage suspected sepsis and neonatal resuscitation.
Infants at risk of Hypoglycaemia who may be born in a midwifery-led setting: • IUGR or birth weight <2nd birthweight centile/clinically wasted • Temperature <36oC at any time • Suspected sepsis Neonatal concerns where by a medical opinion/review is required and or additional neonatal monitoring including via the hypoglycaemia pathway or All Wales Early Onset Sepsis Calculator follow local addendums for total duration rupture of membranes

Appendix B - WAST Transfer Information

There are various ways in which a midwife may choose to transport a woman or baby into an obstetric/neonatal unit during labour or in the early post-birth period if required.

Transfers should be categorised as **Non-Urgent**, **Urgent** and **Emergency**. Calls to WAST are managed in accordance with the WAST Clinical Response Model.

Calls are divided into four categories:

Red- Emergency
Amber- Urgent
Green- Non urgent
Health Care Professional

Red calls – Immediately life threatening. (Ambition of 8-minute response time). Red calls are those where immediate attendance is required to save life and have a time based response target set by Welsh government. Red calls are the only reportable time based target used by WAST. Target response aim of 8 minutes in 65% of cases

Amber 1 calls – Life-threatening. (Ambition of 20-minute response time but no performance measure target) Amber 1 calls are calls that could be deemed a threat to life but do not pose an immediate threat. Amber 1 calls are responded to as soon as possible using lights and sirens.

Amber 2 calls – Serious but not immediately life-threatening. (Ambition 1-4 hours but no performance measure target) Amber 2 calls are calls that could be deemed serious but not life-threatening Amber 2 calls are responded to as soon as possible at normal road speed, sometimes with lights and sirens if considered appropriate.

Green calls - Not immediately serious or life-threatening Green calls are calls where there is an urgent problem which is not life threatening. Green calls are responded to as soon as possible at normal road speed without lights and sirens, sometimes green calls are responded to by self-care advice following a telephone assessment.

Health Care Professional calls – Calls placed by health care professionals via a dedicated line. Health Care Professional (HCP) calls are calls placed by healthcare professionals. Health Care Professional calls are responded to as soon as possible, within an agreed timeframe of between 1-4 hours.

Ambulance Response Capabilities:

WAST currently provides three types of clinical service:

Non-Emergency Patient Transport Service (NEPTS):

The NEPTS is the non-emergency service offered by WAST. NEPTS can provide seated ambulances or ambulances that are equipped with a stretcher. All NEPTS ambulances are equipped with an AED and oxygen and the crew are trained in first aid and manual handling. NEPTS ambulances do not provide emergency transfers and are not equipped with blue lights. NEPTS crews are able to undertake routine inter-hospital transfers. An appropriate nursing escort may be required depending on the patient's condition.

Urgent Care Service (UCS):

The UCS (formerly known as HDS – High Dependency Service) provides ambulances with a basic life support capability. UCS ambulances are staffed by two Urgent Care Assistants who are trained in ambulance aid including basic patient observation. UCA staff have a limited clinical skillset and are not trained in managing emergency childbirth. The majority of UCS ambulances are unable to provide emergency transfer as the staff are not trained in emergency driving techniques; there are some exceptions but these vary from Heath Board to Health Board. A suitable midwifery escort will be required.

Emergency Medical Service (EMS):

EMS ambulances are staffed by Registered Paramedics and Emergency Medical Technicians (EMT). Registered Paramedics are also provided in single crewed Rapid Response vehicles. An EMS crew can provide the full range of immediate aid to a seriously ill or injured patient. There is not a Registered Paramedic on every EMS ambulance. Some EMS ambulances are crewed by two EMT staff. EMS crews are able to provide emergency transfers using blue lights and all EMS staff including EMT staff are trained in emergency childbirth. Whilst Registered Paramedics are trained in emergency childbirth and common obstetric emergencies it should be noted that their exposure to these cases is thankfully rare. An appropriate midwifery or medical escort will still be required in some cases.

Appendix C - Criteria for Selecting Mode of Transport for Women and/or Babies Requiring Transfer from Freestanding Midwife-led Unit or Home

After every transfer regardless of the mode of transport, the SBAR in AWCPNL must be completed and filed. Please document clearly on the form the women's information, reason for transfer and mode of transport. All handovers should be given to the relevant clinician. Please DATIX all transfers. Midwives must use their own clinical judgement at all times.

A. Own Car

Women will be passengers and midwives do not need to accompany.

Maternal

- Raised blood pressure first diagnosed during the risk assessment, without significant symptoms of Pre-eclampsia.
- Concerns regarding maternal pulse rate
- High presenting part or abnormal presentation and the woman is not in active labour.
- Any concerns requiring an obstetric opinion but there is not a life-threatening problem to either the woman or the baby.
- Prolonged latent phase/or requires additional analgesia.

Fetal

- Concerns about the fetal movements when a normal fetal heart has been heard during auscultation using a Pinard or a sonic aid.
- Clinically small for gestational age where there are no concerns regarding fetal well being

Postnatal period

If the mother needs to be transferred and the baby is well, the immediate family should be asked if they are happy to take the baby in their car seat in their own car. If this is not possible then a member of staff can take the baby in a taxi secured in car seat.

Neonatal

- Second opinion from a paediatrician when the baby is well.
- Feeding problems
- Positive antibodies identified through cord blood sampling

B. Hospital taxi accompanied by a midwife escort

The woman will not be able to have nitrous oxide during the transfer.

Maternal

- Delay in the first stage of labour where the woman's cervix is no more than 5 cm's dilated.
- Woman requesting further analgesia and her cervix is no more than 5 cm (may need UCS if requiring nitrous oxide).
- Significant meconium stained liquor with a normal fetal heart and cervix no more than 5 cm.

Neonatal

- Well babies who required screening care via hypoglycaemic pathway.
- Baby showing signs of withdrawal from antidepressants or maternal misuse of substances
- Jaundice < 24 hours of age where there are no other concerns.

Note: Where transfer is required after a home assessment due to confirmation of active labour, the midwife should consider the most appropriate form of transfer based on the clinical picture, this will sometimes be via the woman's own transport.

C. Urgent transfer where paramedic intervention is not required-HCP pathway.

Call -03001239236

Midwives will need to request a response time. In most cases, the required response time in this group will be within 1 hour.

Maternal

- Delay in first stage of labour when the woman's cervix is more than 5 cm dilated.
- Malpresentation in active labour
- Women requesting further analgesia and still in the first stage of labour more than 5cm.
- Significant meconium stained liquor, and cervix more than 5cm, with normal FH.
- Raised blood pressure (as categorised By NICE, 2014) in active labour with no other signs of fulminating pre-eclampsia.
- Maternal observations outside of normal range in active labour (NICE 2014).

Contact receiving OU to confirm all transfers
Transfer is always to the nearest obstetric unit

Contact numbers to arrange transport:
UCS: 03001239236
Taxi: via hospital switch

D. Emergency transfer for life threatening emergency where paramedic intervention may be required- 999

Emergency Medical Retrieval and Transfer Service (EMRTS) may also be asked to attend dependant on clinical scenario this is a 24-hour service.

Maternal

- Antenatal or postpartum haemorrhage, or symptomatic of hypovolemic shock.
- Placental abruption
- Maternal collapse
- Eclampsia or Raised blood pressure in active labour with other signs of fulminating pre-eclampsia.
- Delay in the 2nd stage of labour
- Sepsis
- Inverted uterus.
- Retained placenta

Fetal/Neonatal

- Fetal distress- Changes in the FH and CTG is recommended.
- Imminent breech birth
- Cord Prolapse
- Shoulder Dystocia
- Baby born in poor condition (Apgar <7 at 5 mins)
- Need for active resuscitation

WAST Duty Manager

South East Region call: 01633 294866

To discuss with dispatch regarding ETA call: 03001239236

Appendix D

Wording to support effective communication between health professionals:

"I am a midwife/healthcare professional, the situation is….."

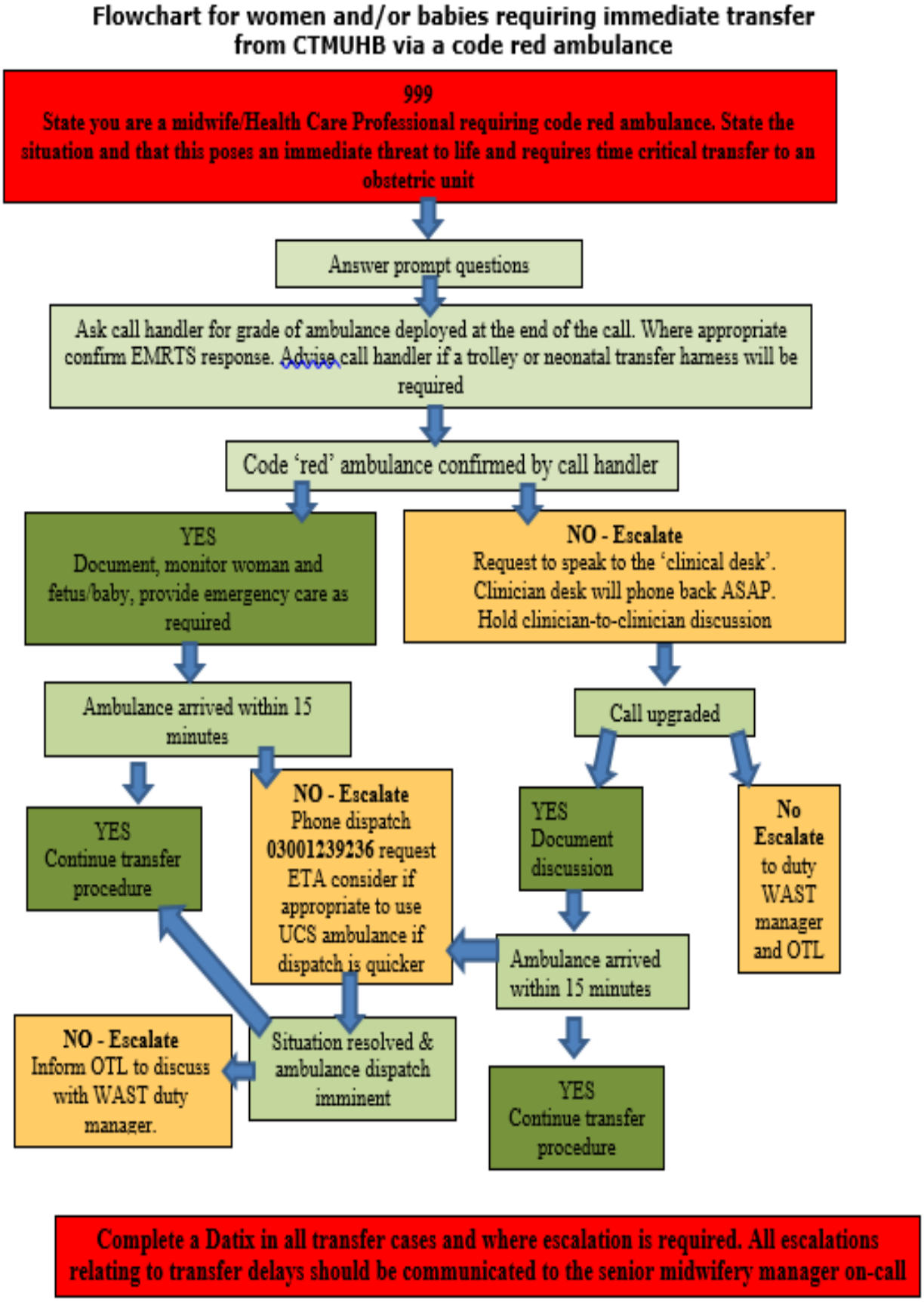
•Sepsis maternal/neonatal
•Antepartum/postpartum Haemorrhage
•Pre-eclampsia/Eclampsia
•Maternal collapse/arrest
•Fetal distress
•Delay in the 2nd stage of labour
•Cord prolapse
•Shoulder dystocia
•Inverted uterus
•Neonatal resuscitation
•Neonatal compromise.

"This poses an immediate threat to life and requires a time-critical transfer to an obstetric unit"

When the call handler asks if 'there are any high risk complications' the answer will always be **'Yes'** in this pathway.

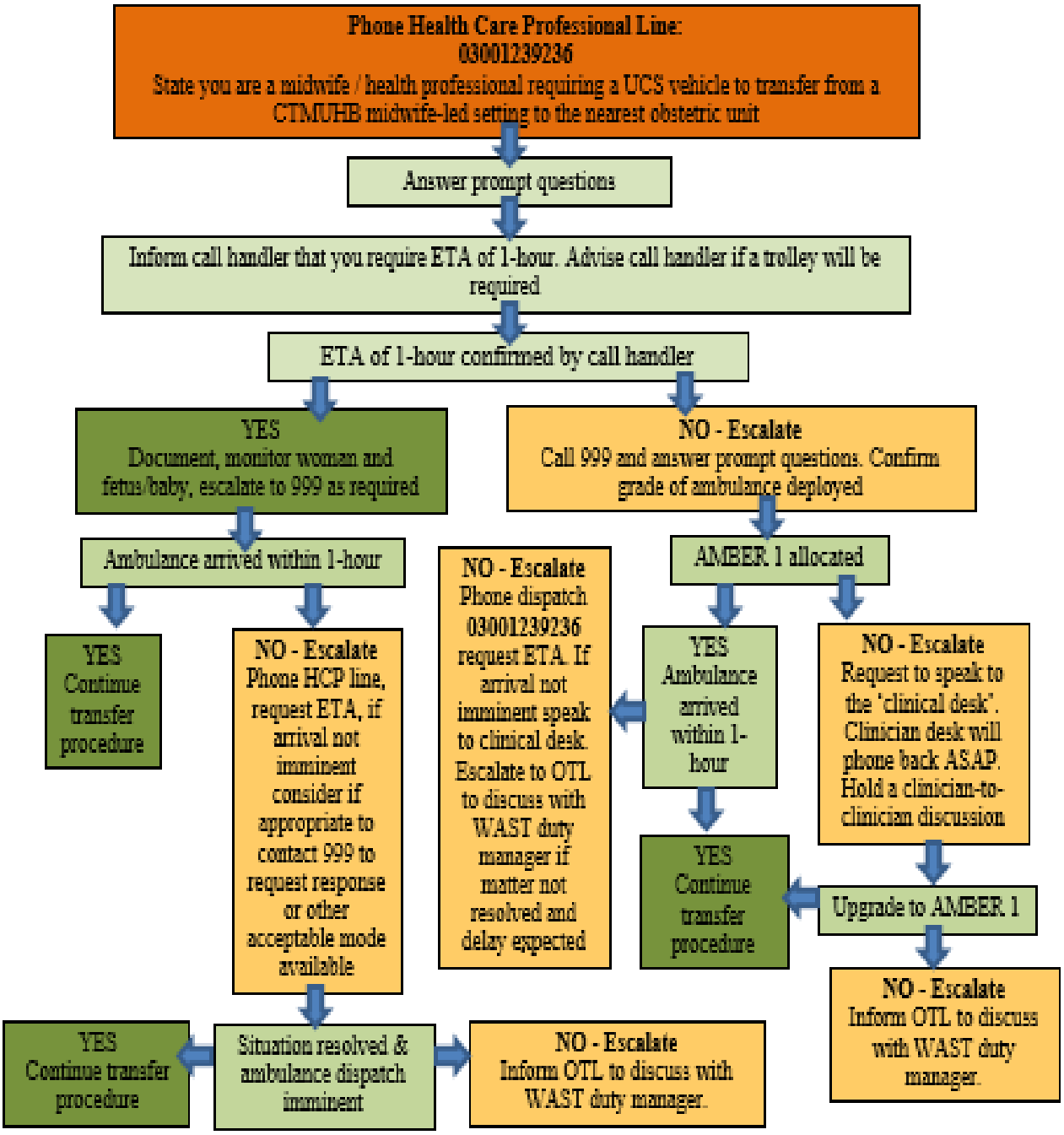
Avoid terms such as raised temperature, increased respirations, if providing any resuscitative measures to a neonate then the answer to the question 'is the baby alert and breathing' will always be **'No'**

Appendix E


Flowchart for women and/or babies requiring immediate transfer from CTMUHB via a code red ambulance
999
State you are a midwife/Health Care Professional requiring code red ambulance. State the situation and that this poses an immediate threat to life and requires time critical transfer to an obstetric unit
Answer prompt questions
Ask call handler for grade of ambulance deployed at the end of the call. Where appropriate confirm EMRTS response. Advise call handler if a trolley or neonatal transfer harness will be required
Code 'red' ambulance confirmed by call handler
YES
Document, monitor woman and fetus/baby, provide emergency care as required
NO - Escalate
Request to speak to the 'clinical desk'. Clinician desk will phone back ASAP. Hold clinician-to-clinician discussion
Ambulance arrived within 15 minutes
Call upgraded
YES
Continue transfer procedure
NO - Escalate
Phone dispatch 03001239236 request ETA consider if appropriate to use UCS ambulance if dispatch is quicker
YES
Document discussion
No Escalate
to duty WAST manager and OTL
Ambulance arrived within 15 minutes
NO - Escalate
Inform OTL to discuss with WAST duty manager.
Situation resolved & ambulance dispatch imminent
YES
Continue transfer procedure
Complete a Datix in all transfer cases and where escalation is required. All escalations relating to transfer delays should be communicated to the senior midwifery manager on-call

Appendix F

Flowchart for Women Requiring Transfer from CTMUHB – Amber Trigger



Complete a Datix in all transfer cases and where escalation is required. All escalations relating to transfer delays should be communicated to the senior midwifery manager on-call.

Appendix G

EMRTS Cymru: Support for Neonatal and Maternal Emergencies; Version 4; 03 March 2021

EMRTS Available 24hours/day, 7 days/week
Able to provide a range of critical care support for obstetric and paediatric calls:

Neonatal Emergencies:	Maternal Emergencies:
NLS Commenced Respiratory Distress Any Unwell Baby (e.g. sepsis)	ABCDE Compromise (incl. Cardiac Arrest) Suspected Eclampsia Severe haemorrhage of any kind

Neonatal and/or Maternal Emergency identified by:

- MIDWIFE in attendance (in free standing Midwife Led Unit or Home Birth)
- BYSTANDER (i.e. member of public, where midwife not in attendance)

1

Dial 999 – Call will be handled in accordance with standard WAST procedures

WAST EMERGENCY RESPONSE PROCEEDS AS NORMAL

2

EMRTS available 24hrs/day, 7 days/week

EMRTS Critical Care Hub will send EMRTS team if available

- EMRTS may need to speak to 999 caller for more info
- EMRTS will inform midwife or WAST that team is on way
- EMRTS will inform midwife or WAST if team unavailable

Please inform EMRTS if they are not required:

- Not clinically indicated (EMRTS will require a clinical update in all cases)
- Short distance from consultant led unit (eg. <15mins road transfer and resource on scene ready to go)

EMRTS Critical Care Hub: 03001232301

3

EMRTS Top Cover Consultant will provide clinical advice to midwife and/or WAST crew while EMRTS team on way

4

EMRTS arrive and treat patient using a team approach, with full involvement of the midwife and WAST crew on scene. EMRTS consultant will lead resuscitation.

EMRTS Teams can offer a range of possible interventions, including:

Neonates:	Mothers:
Ventilatory Support (eg BVM, CPAP, IGel, Intubation) Circulatory Support (eg IO access, IV fluids, Inotropes) Glucose and Temperature Control (Incubator System)	Intubation and Ventilation Blood & Blood Product Transfusion Haemorrhage Controlling Agents Peri-Mortem Caesarean Section

5

A team decision will be made on the following prior to transfer:

- Appropriate receiving hospital (all neonatal cases will be discussed with CHANTS).
- Travel by air or road (in EMRTS or WAST vehicle). Generally women in active labour will not travel by air. (Birth in flight is very difficult to manage)
- Whether mother and baby travel together or separately.