All Wales Maternity & Neonatal Guidelines

All Wales Guideline for Maternity Transfers from Community and Freestanding Midwifery Units

Documents to read alongside/ support this guideline	All Wales Midwifery-Led Care Guidelines

Version Control					
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1		**Bethan Jones** – Local Perinatal Safety Champion – Welsh Ambulance Service NHS Trust (WAST) **Cara Moore** – Lead Midwife – Maternity and Neonatal Network **Colette Sanders** – Community Midwife Operational Lead CVUHB **Jenilee Harrison** – Safety and Learning Advisor Welsh Risk Pool **Joanna Jones** – Band 7 Lead North Community ABUHB **Rhiannon Griffiths** – Midwifery Matron Community SBUHB **Sarah James** – Consultant Midwife - CVUHB **Shelly Higgins** – Consultant Midwife Clinical Lead – Wales Maternity & Neonatal Network **Steve Magee** – Regional Clinical Lead Consultant Paramedic WAST	20th November 2023	November 2026	24th November 2023
Further to an agreement at the Wales Maternity Guidelines Committee (WMGC) meeting on 26th January 2024, the WAST scripts (previously Appendix D) has been removed from V1 ratified in November 2023).					

Disclaimer: These guidelines have been ratified at the Maternity/Neonatal Guideline Meeting; however clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline uses the terms ‘woman’ or ‘mother’ throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth. Similarly, where the term ‘parents’ is used, this should be taken to include anyone who has main responsibility for caring for a baby. It is recognised that there are many different family arrangements.

Contributors:

Mike Jenkins – Regional Clinical Lead (WAST)

Wendy Herbert – Assistant Director of Quality and Nursing (WAST)

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1. Introduction

This guideline aims to cover for instances where transfer is required from community or a Free-Standing Midwifery Unit (FMU). Whilst the scope is predominantly for instances where transfer is required in labour or shortly after birth, the principles can be used in all cases when transfer is required from these settings.

The All-Wales Midwifery-Led Care Guidelines outline clinical reasons where exiting midwifery-led care and possible transfer in labour or the immediate postnatal period for maternal, fetal or neonatal reasons may be warranted, these are varied, and the majority are not for life-threatening emergencies.

National data suggests that the chance of intrapartum transfer is 36-45% for first time mothers in labour or immediately after birth from home or Free-Standing Midwifery Unit (FMU). This rate falls to 9-12% for subsequent births[1].

During the COVID-19 pandemic there was national concern around the potential impact of COVID-19 on Ambulance resources and there have been further challenges in response times to maternity services from Welsh Ambulance Service NHS Trust (WAST) predominantly related to lost hours due to delayed handover at hospitals. This has threatened the ability to transfer women and/or babies for appropriate medical review and care when required. In very rare cases this delay may increase morbidity/mortality linked with delayed treatment.

There is currently no accepted standard in relation to reasonable transfer times for maternity cases. The risk potential of any individual delay (there is no nationally recognised definition of a delay in maternity services) in transferring a maternity case is unknown. In most cases, it is predicted it would not lead to harm as most transfers are for non-urgent clinical indications and around 6% of transfers are considered emergency transfers for life threatening events[1,2]. Robust communication between maternity and ambulance services is essential to enable timely transfer between settings when required. In some instances, there will also be the need to communicate between services in relation to cases during pregnancy to ensure good multidisciplinary working and appropriate information sharing.

2. Objective:

This document provides;

- Detail to support communication and provision of information for women and families in relation to transfer in labour or shortly following birth.
- A process for managing transfer of women and neonates receiving maternity care in FMU or in the community in Wales, including assessment of appropriate mode of transport.
- Principles for safe transfer
- Detail to support robust communication with ambulance services when required.
- Process for escalation when a call is not graded as expected
- Detail in relation to escalation within WAST
- Detail to support communication with the ambulance services in relation to pre-birth planning.
- Principles for reporting, auditing and monitoring

3. Abbreviations:

- **AWCPNL** – All Wales Clinical Pathway for Normal Labour
- **FMU** – Freestanding Midwifery Unit
- **OU** – Obstetric Unit
- **RCOG** – Royal College of Obstetricians and Gynaecologists
- **SBAR** – situation, background, assessment, recommendation
- **WAST** – Welsh Ambulance Service NHS Trust

4. Provision of information for women and families relating to transfer in labour:

There should be a balanced discussion weighing up the individual risk factors for all pregnant women on the options for place of birth. This should include the benefits of and possible risks with each birth setting. Appendix 2 in the All-Wales Midwifery-Led Care Guidelines provides guidance on assessment of suitability for labour and birth within a midwifery-led setting. This should be used to support individualised care planning.

Guidance recommends that all women who choose to birth outside a hospital setting must be provided with accurate and up to date written information about the transfer times to the consultant obstetric unit[3]. Health Boards will need to decide how this information is made available locally, for example through leaflets or posters or signposting to local website.

Data including the likelihood of transfer happening should be discussed from the Birth Place Decision leaflet provided to all women during their pregnancy (localised versions may be available).

To support informed decision-making, pregnant women should be;

- Informed that there might be a possibility of the need to transfer during labour, or in the immediate postnatal period from a midwife-led setting to an obstetric unit and that this may result in a delay in care.
    - For nulliparous women the likelihood of needing to transfer in from home is 45%, with 36–40% transfer rates for midwifery-led units[1]
    - For multiparous women the transfer rate from home or a midwifery unit is around 10% [1]
    - For both nulliparous and multiparous women FMU's offer the lowest rates of transfer[1]
- Provided with localised data including any delays relating to transfer[3]

- Informed about the possible reasons for transfer, modes of transport available, distances and travel times for transfers[3]
- Informed about how transfers are managed within a midwifery-led setting including the skills and equipment that midwives have access to.
- Informed that there could be a delay in getting an ambulance during times of high activity. The Welsh Ambulance Service NHS Trust has confirmed that it will attend maternity calls and they will be prioritised accordingly, but there may be a delay.
- Informed that transfer in emergency situations is always to the nearest obstetric unit or designated receiving hospital in the Health Board providing care, regardless of where antenatal care has been received and that a midwife will be present throughout the process.
- Informed on how their birth partner will be expected to travel depending on mode of transport used.
- Informed on how a neonate will be transferred if required.

Discussion about transfer from home or FMU should be balanced and consider the chances of transfer **not** being required as well as the differences in possible intervention by planning a birth in an obstetric unit for women who are at low risk of complications.

5. Process for transferring women and babies to an obstetric unit

Any deviations requiring transfer should be discussed with the woman and her birth partner and documented within the All-Wales Clinical Pathway for Normal Labour (AWCPNL) or other appropriate records. In all cases of transfer the full clinical picture should be assessed and transfer initiated provided it is safe to do so and the benefits outweigh the risks. In cases of transfer in labour, assessment should be made as to the likelihood of birth occurring before transfer completed.

Ongoing communication is paramount during any transfer and the midwife should address any concerns that the woman or birth partner have to allay any anxiety about the transfer[3].

Once the decision to transfer has been made, the transfer process should commence as soon as possible[3]. The woman should be supported to be as comfortable as possible.

If transferring a neonate, the mother should be able to accompany in the ambulance. A second ambulance may be required to transfer the mother depending on her clinical condition. Where possible the mother and her baby should not be separated.

If transferring the woman for emergency reasons and the baby is well, the immediate family should be asked 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 a car seat.

The criteria for selecting modes of transport in **Appendix A** should be reviewed to ascertain the most appropriate transfer method. **Take into account that multiple risk factors may increase the urgency of the transfer, particularly if they have a cumulative effect[3].**

The criteria for selecting modes of transport in **Appendix A** categorises clinical situations from A – D and the category that a condition falls into determines the recommended mode of transport.

The use of colour coding is to aid midwifery decision making but does not necessarily translate into the same colour coding that WAST use. The categories and colours used are to assist in assessing the urgency of transfer from a midwifery perspective.

Clinical judgement remains paramount in all situations and the list is not exhaustive.

The midwife who is present with the woman should coordinate the transfer, where possible, to aid effective communication of current clinical information and continuity for the woman.

In all cases, the receiving obstetric unit must be contacted at the earliest opportunity and an SBAR handover provided including detail of the mode of transport for transfer. This SBAR discussion should be with the midwife in charge. In the case of neonatal transfer, the midwife will liaise with the neonatal registrar who will inform the consultant neonatologist, stating urgency of transfer and will clarify which area the baby should be admitted to. Wherever possible midwifery staff should confirm with the obstetric unit when the transport has departed.

5.1 Transfer in own car/transport – Category A:

Where it is deemed appropriate to travel by own car/transport in accordance with Appendix A, the woman should be provided with her notes. Ensure the woman and whoever is transporting her know where they are going and are clear on how to get there. The midwife must contact the obstetric unit to follow up to ensure the woman has arrived.

In cases where a neonate is being transferred this must be in a British safety approved car seat.

Dependent on clinical picture there may be times when it is appropriate for a midwife to follow in their own transport. For example, in instances where it is has been assessed as safe for a woman to travel by own car/transport for reasons that fall outside of the criteria for selecting modes of transport in **Appendix A** (for example, if a taxi is unavailable). Assessment of this should take place through discussion with a senior midwife/manager using SBAR communication allowing full assessment of the clinical situation. The risk matrix in **Appendix B** can be used to facilitate the assessment.

5.2 Transfer by taxi – Category B:

Where it is deemed appropriate to transfer by taxi (according to criteria in **Appendix A**), the necessary company will be contacted, and transfer arranged. Health boards will need to provide the relevant taxi details for staff to use. The taxi service will be contracted by the Health Board and therefore midwives will not need to pay the driver as they are arranged through local contract. The midwife will travel with the woman. The birth partner should

travel separately, if appropriate. The midwife should take a kit bag/equipment for the transfer as per local arrangements.

In cases where a neonate is being transferred this must be in a British safety approved car seat.

If a taxi is not available, a risk assessment will need to take place to assess suitability for the woman to transfer in her own transport with the midwife following in their own transport OR whether to call the urgent care service (UCS) or ambulance for transfer. Assessment of this should take place through discussion with a senior midwife/manager using SBAR communication allowing full assessment of the clinical situation. The risk matrix in Appendix B can be used to facilitate the assessment.

5.3 Transfer by Urgent Care Service (UCS) – Category C:

Where urgent transfer is required, but paramedic assistance is not needed, the Urgent Care Service (UCS) (also known as Ambulance Care Assistant [ACA] Grade 2) can be contacted as per Appendix A – 03001239236. The UCS service respond in a standard ambulance, but the transfer will not be with blue lights/sirens and will **not** have a paramedic in attendance. These ambulances are staffed by two urgent care assistants. They carry AED's, Entonox and oxygen and staff manning them are trained in basic life support but are not trained in managing emergency childbirth. This should be used in circumstances where transport is required, and ongoing pain relief is needed as well as the ability to use a stretcher for transfer.

A clear, concise summary of the clinical presentation should be provided. The member of staff will need to request a response time during this call. In most cases this would be expected to be within an hour, and this should be asked for – **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 or consider suitability of taxi transfer (see Appendix C).**

Assessment of this should take place through discussion with a senior midwife/manager using SBAR communication allowing full assessment of the clinical situation. The risk matrix in **Appendix B** can be used to facilitate the assessment.

If at any time the clinical situation changes, the call will need to be upgraded via 999 this may require a clinician-to-clinician discussion.

The midwife will remain the lead carer in transfer via UCS and will escort the woman on the transfer.

For neonatal transfers an appropriate safety restraint/harness should be used in line with WAST protocols.

5.4 Transfer by 999-ambulance – Category D:

When required as per the criteria in **Appendix A**, a 999 ambulance will be requested for transfer with the emergency medical service (EMS). The member of staff making the call should clearly state the situation and that:

'It is an obstetric emergency and requires an immediate emergency transfer to a hospital.'

Call handlers will use predefined scripts/call cards to prioritise all calls. Call handlers are not medically trained.

Call handlers will ask for the address of the emergency, always provide the complete address as this makes the process quicker for finding the location. Consideration of use of the 'What3Words' App should be in place as this allows the location to be easily found. The member of staff making the call will be asked to confirm the address (possibly twice) and that the patient is conscious and breathing before proceeding through the scripts.

Clear communication of the clinical presentation is essential to support appropriate prioritisation of the call. Section 6 details the process for managing situations where escalation of a call is required.

The staff member will need to confirm the priority of the call. If the call is prioritised as red the nearest available resource will be dispatched. Occasionally calls in category D might be categorised as Amber-1, which are still classed as life threatening, but not posing an imminent threat to life.

See **Appendix D** for a summary of the WAST clinical model call categories.

If at any time following the initial call to 999 the clinical situation changes, then 999 will need to be called back and an additional call made.

EMS ambulances are staffed by Registered Paramedics and Emergency Medical Technicians (EMT). 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, however it should be noted that their exposure to these cases is thankfully rare.

On arrival of the ambulance the midwife should use an SBAR handover to ensure the most up to date clinical detail is provided to the crew. It is anticipated that the woman and/or baby will be transferred to the ambulance as soon as is safe to do so following arrival of the crew.

Where transfer is in an ambulance, the midwife remains the lead carer and should advise WAST staff on their arrival about:

- The reason for transfer, stating when it is an emergency
- What paramedic intervention, if any, is required to stabilise prior to, or during transfer
- The need for ongoing monitoring during transfer – for example oxygen saturation

- The likeliness of a change in clinical picture during transfer
- The level of urgency of transfer and if blue light and sirens are required
- The required destination – the nearest obstetric unit

In cases where ongoing care is required to stabilise the woman or baby prior to transfer, multidisciplinary team working will be required with pre-hospital crew support ensuring closed-loop communication is used. The midwife should remain with the woman and/or baby throughout the transfer process, unless transfer has been assessed as appropriate to be in the woman's own transport. Depending on the individual circumstances it may be appropriate for the birth partner to also travel in the ambulance. This should be discussed with the ambulance crew.

During the transfer the woman should be supported wherever possible to adopt the position most comfortable for her, in accordance with ambulance service protocols. For transfers due to fetal distress women should be advised and supported to transfer in a lateral position with hips supported by pillows. In most cases the midwife will be required to remain seated with a seat belt on during the transfer. The Motor Vehicles (Wearing of Seat Belts) (Amendment) Regulations 2015[4] state that:

- Seat belts should only be removed when a person is providing treatment which can't be delayed, either due to the nature of the treatment involved or because of the medical situation of the individual being treated.
- This includes treatment by medical personnel other than paramedics and therefore would include midwives.
- There is not a specified list of treatment that this covers, but suggestions include:
    - Undertaking lifesaving interventions on a patient
    - Haemorrhage control – including bimanual compression
    - Accessing emergency drugs, drawing them up and administering them
    - Managing an obstetric emergency

In cases where a seatbelt is removed and care needs to be provided, communication with the ambulance crew is paramount.

In cases of imminent birth, the driver should be asked to pull over.

For intrapartum transfers the fetal heart is expected to be auscultated prior to departure of the ambulance. Further auscultation of the fetal heart should only be completed if possible and safe to do so.

For neonatal transfers an appropriate safety restraint/harness should be used in line with WAST protocols.

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

5.5 Alternative modes of transport that may be used or dispatched but <u>not</u> requested by a midwife:

Cymru High Acuity Response Unit (CHARU) is a dedicated resource staffed by a paramedic or Senior Paramedic who has successfully completed additional training developed by WAST and a community PROMPT Wales course delivered by their local health board. The purpose of CHARU is to co-ordinate and provide optimal patient care, supporting decision making and delivering additional clinical care at incidents of a critical nature. They carry some additional medicines to manage pain and a mechanical CPR device for deployment in some circumstances. CHARU may respond to maternity calls to support stabilisation at the scene whilst waiting for an ambulance.

In certain situations, and where available, the Emergency Medical Retrieval Transfer Service Cymru (EMRTS – Flying Doctors) may be dispatched. If there is concern that critical care may need to be provided in a pre-hospital setting the person making the 999 call should alert the call handler as direct calls to EMRTS cannot be made. EMRTS continually screen calls to assess where critical care support by the EMRTS team may be needed. In collaboration with the midwife EMRTS consultants/team can intervene and help to provide critical care if required. A discussion will need to take place to ascertain if it is appropriate for the midwife to handover care completely or whether they may need to remain as part of the team providing care. This will happen on a case-by-case basis. **Appendix E** summarises EMRTS support for maternity and neonatal cases.

Alongside EMRTS , ACCTS Cymru (Adult Critical Care Transfer Service) is able to support the **interhospital** transfer of patients requiring enhanced care including invasive arterial monitoring , vasoactive infusion or respiratory support. ACCTS Cyrmu is a dedicated platform with a crew of retrieval and transfer practitioners (ITU background) and a doctor from a critical care specialty. It should be noted that ACCTS respond only to hospital sites not primary response in the community.

6. Escalation process for prioritisation of a call:

If a request for a call as per the criteria in **Appendix A** is not prioritised as anticipated and/or the midwife is concerned about the prioritisation they must escalate for a clinician-to-clinician discussion via the clinical support desk (CSD). Ensure that the call handling supervisor is aware of the call and the need for escalation. There is no direct number for the CSD and a call must be requested at the time that the 999 call is made. The clinician will call the midwife back and clinical concerns should be discussed, with a mutual agreement of prioritisation made. If the clinical picture changes whilst waiting for the call back, the midwife will need to ring 999 again. The risk matrix in **Appendix B** can be used to support assessment of mode of transport between clinicians. A Datix should be submitted in cases where escalation or delay has taken place.

WAST have the ability to arrange a taxi transfer in cases where they deem it suitable to do so. There are commissioning agreements in place with taxi companies and taxi transport is

something that is frequently used by WAST. If there is deemed to be a delay with provision of UCS or an ambulance and a taxi transfer could be appropriate (with midwife escort) the midwife should request this option with WAST. WAST are not responsible for arranging routine taxi transport.

Flow charts for the process for calling for 999 ambulance and UCS and subsequent escalation of calls if required are detailed in **Appendix F (999) and C (UCS).**

7. Escalation of WAST services:

The Clinical Safety Plan (CSP) provides a framework for WAST to respond to situations where the demand for services is greater than the available resources. The CSP provides a set of tactical options that are flexible and immediate so that WAST can dynamically react to situations to ensure those patients with the most serious conditions or in greatest need according to their presentation remain prioritised to receive services. During periods of high activity, the CSP level may increase, if it does then various actions come in to play such as clinical screening of calls and a "can't send" option to calls; this is where no resource will be sent. As the CSP level increases then these actions will affect more of the call categories (Green, Amber 2, Amber 1, Red).

In periods of high CSP a midwife may call 999 and be told that the ambulance cannot be sent due to prioritisation. As with all calls to the ambulance service, if the midwife feels this call needs to be escalated to a higher prioritisation, a clinician call back can be requested to discuss this further. The option of alternative modes of transport should also be considered.

8. Handover process on arrival to the obstetric unit OU:

On arrival at the obstetric unit the midwife should escort the woman and/or baby to the appropriate area. Handover should be given in an SBAR format to the appropriate medical team. A midwife-to-midwife handover alone is not usually acceptable, although where this takes place, this should be with the midwife in charge and an obstetric or neonatal review should take place within 30 minutes. A handover of care should be documented within the records.

The midwife should return to their place of work via locally agreed mechanism, usually a taxi. It is not appropriate to use WAST transportation for this means.

9. Documentation and reporting:

For transfers in the antenatal or postnatal period documentation should be within the pregnancy hand-held records or postnatal pathway, or on telephone advice forms (or locally agreed equivalent) if the discussion and assessment take place by phone.

All intrapartum transfers should have the SBAR handover form in the All-Wales Clinical Pathway for Normal Labour completed. Contemporaneous records should be completed

during transfer. Where women are transferred in their own car, they will take their handheld notes. Proformas will be used for obstetric emergencies to support documentation and will be handed over to the obstetric or neonatal team for continued use.

Each Health Board will have their own method for reporting and monitoring transfers in addition to completion of the SBAR in the AWCPNL. Reporting and monitoring provide the opportunity to review cases, lesson learn and monitor themes and trends relating to transfers. Details including time of decision to transfer, time of call for help, time of arrival of help (if applicable), departure time and arrival and handover time will provide information to monitor length or transfers and support discussion with women and families about transfers. Consideration should also be given to whether there was an alternative mode of transport used to that suggested in the flowchart and if there was any escalation of involved. If reporting through the Once for Wales Reporting Datix system, then a summary outcome should be included to aid the reviewer of the incident.

Midwives working in the community or FMU should have easy access to/or hard copies of the appendices in this document to support their practice and decision making.

10. Pre-birth care planning, cross-border working and communication:

There may be occasions when communication with the ambulance service is required during the antenatal or postnatal period, for example, safeguarding or clinical concerns for women intending to birth at home. When communicating clinical concerns with no safeguarding elements it should be ensured that this is used for women that would need considerations for working outside of normal guidance for WAST. Cases will be escalated to the appropriate ambulance service using the relevant proforma. For all cases that need to be communicated to WAST a 'Maternity Alert Notification Proforma' should be completed which will summarise the key information required as detailed in **Appendix G.**

There may also be occasions where a woman lives in an area that will be responded to by an alternative ambulance service. It may be necessary for any geographical and/or clinical alerts (or local health board equivalent), where required, to be circulated to WAST and the neighbouring ambulance service – for example West Midlands Ambulance Service. Details should include the woman's address, any access difficulties, EDD and contact number for the woman's maternity team so they can contact a midwife in a pre-hospital emergency if required.

11. Postnatal support:

All women should be offered the opportunity to talk about their birth experience during the postnatal period, but when there has been a transfer the midwife should ensure this opportunity is actively offered and ensure any question relating to the episode of care are answered. If deemed appropriate women can be referred to the birth afterthoughts/ reflections service as per local guidance.

If the woman is unhappy with aspects of her care, early resolution should be sought and if unsure, seek advice through the 'Putting Things Right' process.

12. Training:

The opportunity should be taken during Community PROMPT Wales courses to practice SBAR handover. Training should take place with WAST staff wherever possible to enable multidisciplinary teamworking. The framework in Appendix A as well as flow charts for escalation (Appendix C&F) and risk assessment paperwork (Appendix B) should be used to ensure staff have the opportunity to complete paperwork in a simulated environment. Staff should also have the opportunity to practice calling the ambulance service in a simulated setting. The scripts in Appendix D will be used to support this.

13. Monitoring, audit and compliance:

Transfers between settings should be monitored within health boards to identify themes and trends and to enable data to be gathered to share with women to support decision making about place of birth.

A suggested audit and review tool is available in **Appendix H** for use in transfers in labour or shortly after birth. Ideally this will be available in a way that allows digital monitoring within Health Boards, but a suggested paper tool is included for use.

- All Health Boards should monitor:
  - The detail of any transfer by parity, noting if the woman was midwife led care or had an individual care plan in place, stage of including; intrapartum, immediate postnatal and neonatal transfer including:
    - Time of decision
    - Time transfer initiated
    - Time of arrival of transport if required
    - Time left the birth setting
    - Time of arrival at OU
    - Time of medical review
    - Reason/category of transfer/mode of transportation
    - Where birth has occurred within 1 hour of transfer to OU
    - Clinical outcome and adverse clinical outcome
- Clinical outcomes, by parity and setting, for all women and babies (distinguished by suitability for Midwifery-led care at the onset of labour and those who are not) where onset of care in labour is provided in a midwifery-led setting (benchmarking with Birthplace[1]).
  Transfer rates by parity and reason for transfer including antenatal, intrapartum, postnatal and neonatal transfer (benchmarked Birthplace[1]).

- Transfer times using time of decision, time transfer initiated, time transportation arrival, time transport left birth area, time of arrival at OU, time of review by medical team.
- Completion of transfer SBAR document in AWCPNL.

14. References:

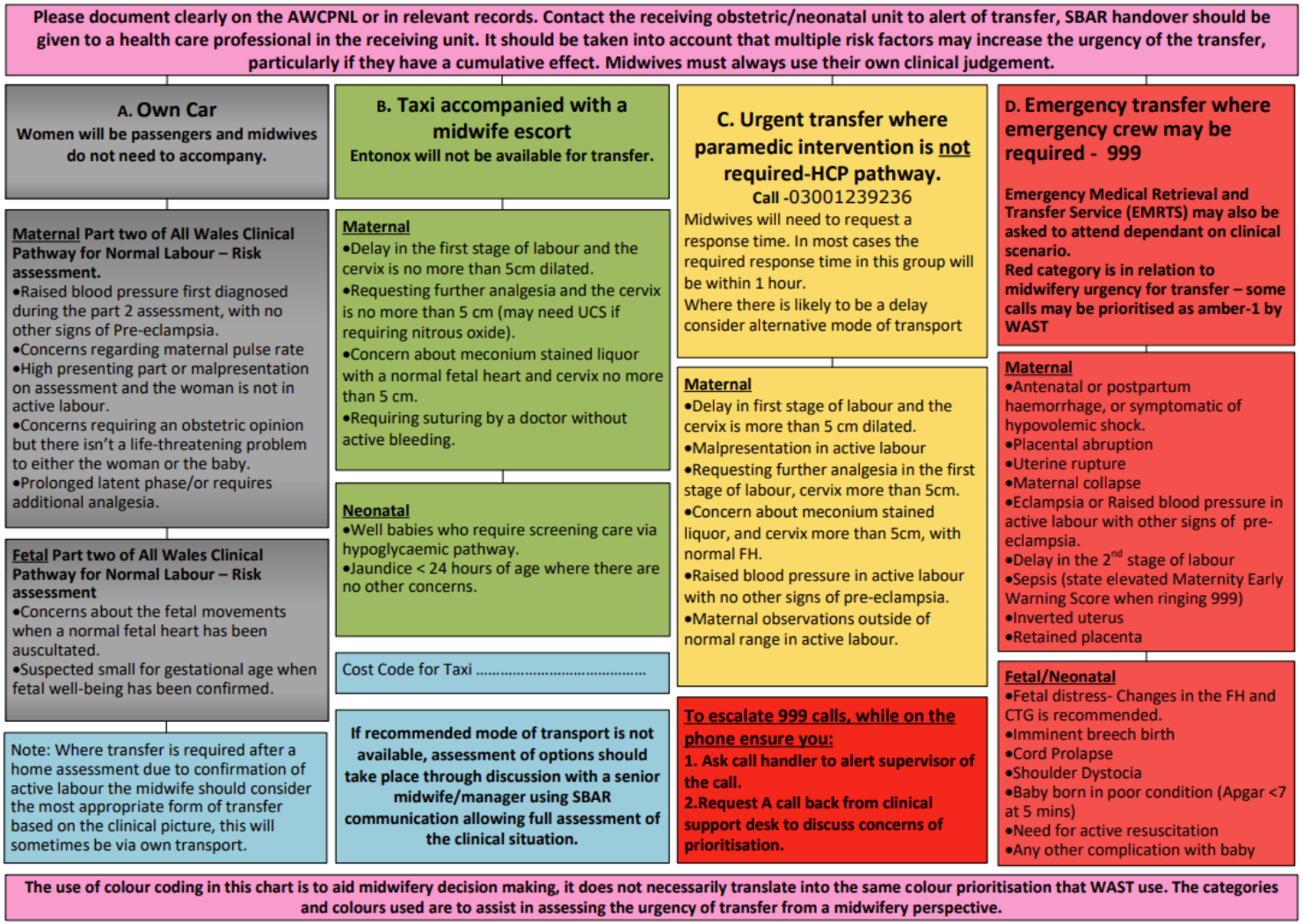
1. NPEU (2011) Hollowell J, Puddicombe D, Rowe R, Linsell L, Hardy P, Stewart, M et al. *The Birthplace national prospective cohort study. Perinatal and maternal outcomes by planned place of birth.* Birthplace in England research programme. Final Report4. NIHR service delivery and organization programme; 2011.

2. Rowe, R, Townsend, J, Brocklehurst, P., Knight, M., McCourt, C., Newman,M., Redsham, M., Sandall, J., Silverton , L,. & Hollowell, J.(2013) *Duration and urgency of transfer in births planned at home and in freestanding midwifery units in England: Secondary analysis of the birthplace national prospective cohort study.* BMC Pregnancy and Childbirth 13:224 retrieved from http:/www.biomedcemtral.com/1471-2393/13/224

3. National Institute for Health and Care Excellence (2023) Intrapartum Care NG235. NICE. Overview | Intrapartum care | Guidance | NICE

4. The Motor Vehicles (Wearing of Seat Belts) (Amendment) Regulations 2015 No. 242

Appendix A – All Wales Criteria for Selecting Mode of Transport



APPENDIX B - Mode of transport Risk assessment:

To aid decision making when considering mode of transportation and to support clinician to clinician discussions.

In this instance the risk assessment is around the impact from birth occurring during transfer or a sudden change in maternal/fetal/neonatal condition during transfer. All individual clinical information should be considered as well as distance from the obstetric unit and possible delays due to traffic. Take into account that multiple risk factors may increase the urgency of the transfer, particularly if they have a cumulative effect[3]

Measures of Likelihood:

Descriptor	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Frequency: How often might it/does it happen	This will probably never happen / recur	Do not expect it to happen / recur, but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur, but it is not a persisting issue / circumstances	Will undoubtably happen / recur, possibly frequently

Example of Measures of Impact:

Descriptor	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Examples	Minimal injury requiring minimal treatment or intervention	Minor injury or illness requiring minor intervention. Increase in length of hospital stay by 1-3 days	Moderate injury requiring intervention. Increase in length of hospital stay by 4-15 days	Major injury leading to long term inacapcity or disability. Increase of hospital stay >15 days	Incident leading to death or impacting a large number of patients. Multiple injuries or irreversible damage

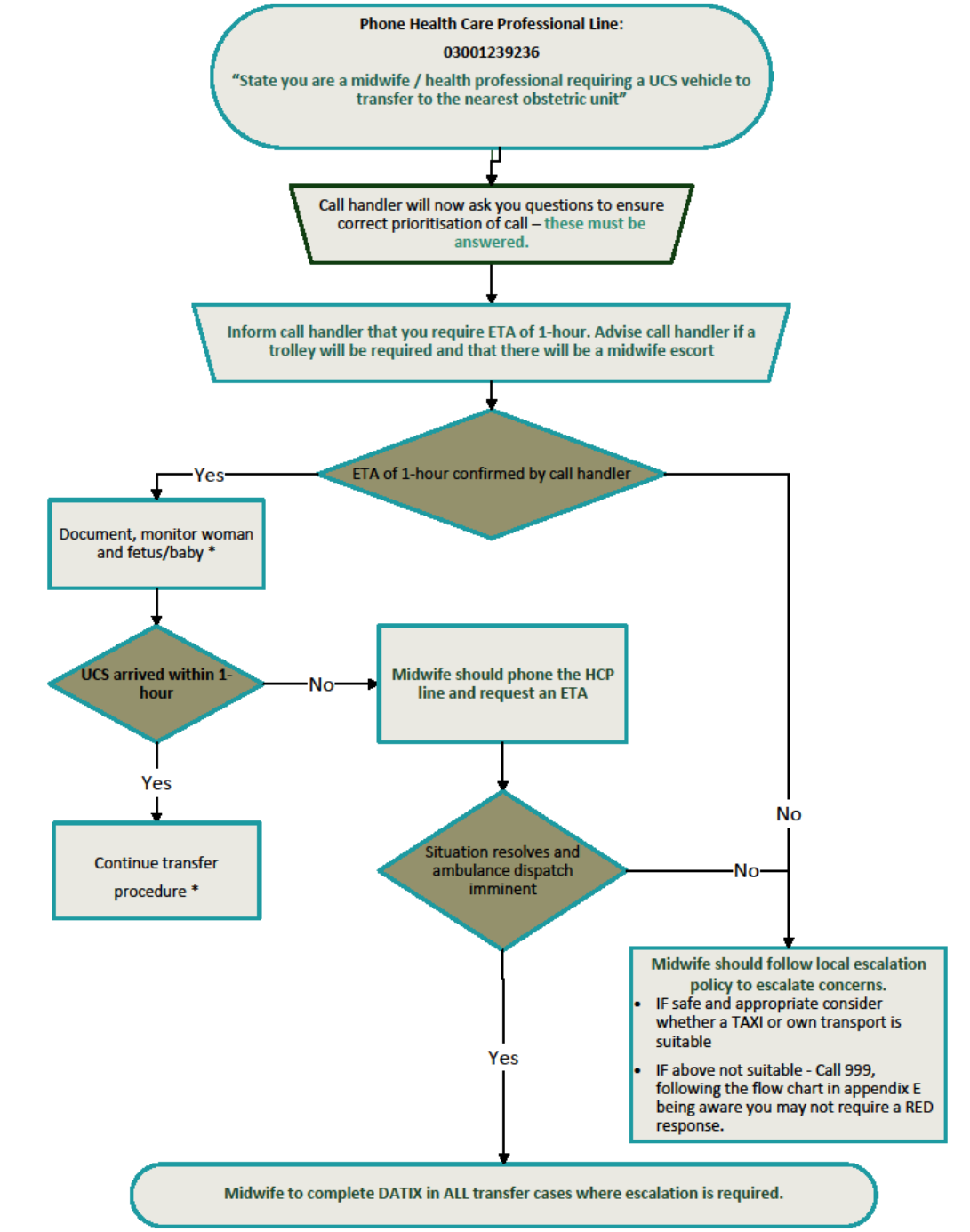
Assessment and scoring:

Likelihood **of birth occurring on the way to the obstetric unit or a sudden change or complication in maternal, fetal or neonatal condition**	**Almost certain (5)**	**5**	**10**	**15**	**20**	**25**
	Likely (4)	**4**	**8**	**12**	**16**	**20**
	Possible (3)	**3**	**6**	**9**	**12**	**15**
	Unlikely (2)	**2**	**4**	**6**	**8**	**10**
	Rare (1)	**1**	**2**	**3**	**4**	**5**
		Negligible (1)	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
	Impact **on the woman, fetus, neonate or staff if this does happen**					

Results:

Results	**1-3**	**4-8**	**9-12**	**15-20**	**25**
Recommendation	**Continue with recommended mode of transport**	**Upgrade to next mode of transport if category A, B or C**	**Use 999 ambulance for transfer**	**Use 999 ambulance for transfer.**	**Use 999 ambulance for transfer.**

Appendix C: Flowchart For Women Requiring Transfer by UCS from Community or FMU



*Ensure that if the patient's condition deteriorates, a change in the clinical picture or a need for further clinical support, another 999 call should be placed.

APPENDIX D: WAST clinical model call categories

4. SUMMARY TABLE OF THE CLINICAL MODEL CALL CATEGORIES

CALL	RESPONSE	PERFORMANCE
RED Highest Clinical Priority Response (Immediately Life Threatening/ Imminent Death) E.g. Respiratory/CardiacArrest)	• HOT response in 8minutes • Clock start at chief complaint	Performance measure=8minute arrival at incident(time critical)
AMBER 1 High Clinical Priority Response (All Other Life Threatening Emergencies) E.g. Cardiac Chest Pains / Strokes	• HOT response • Clock start at full MPDS code	Performance measure= Clinical Indicators (compliance with care bundles) for key conditions –cardiac care, stroke care, fractured hip /neck of femur
AMBER 2 Urgent Clinical Priority (Serious, But Not Immediate Life Threatening) E.g. Diabetic Problems	• HOT response • Clock start at full MPDS code • Crews should use their clinical judgement to respond in an appropriate manner. This will most often be at normal road speeds with no blue lights. •	Performance measure=Clinical Indicators (compliance with care bundles) for key conditions–cardiac care, stroke care, fractured hip /neck of femur
GREEN 2 Non Urgent Clinical Priority (Neither Serious, Nor Life threatening) E.g. Fainting – recovered & alert	• COLD response • Clock start at full MPDS code • Crews should use their clinical judgement to respond in an appropriate manner. This will most often be at normal road speeds with no blue lights.	Performance measure= Clinical Indicators (compliance with care bundles)for key conditions–cardiac care, stroke care, fractured hip /neck of femur
GREEN 3 Suitable for Clinical Telephone Assessment (CTA) E.g. Poisoning (without priority symptoms) /Spiderbite	• CTA by NHSDW • Calls excluded from CTA (E.g. patient not able to receive a return call from Clinician) are to be treated as GREEN 2	Performance measure=CTA within 10minutes,report on disposition rates(E.g. self-care, referral to another agency)

APPENDIX E: EMRTS flowchart

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	ABCDE Compromise (incl. Cardiac Arrest)
Respiratory Distress	Suspected Eclampsia
Any Unwell Baby (e.g. sepsis)	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:

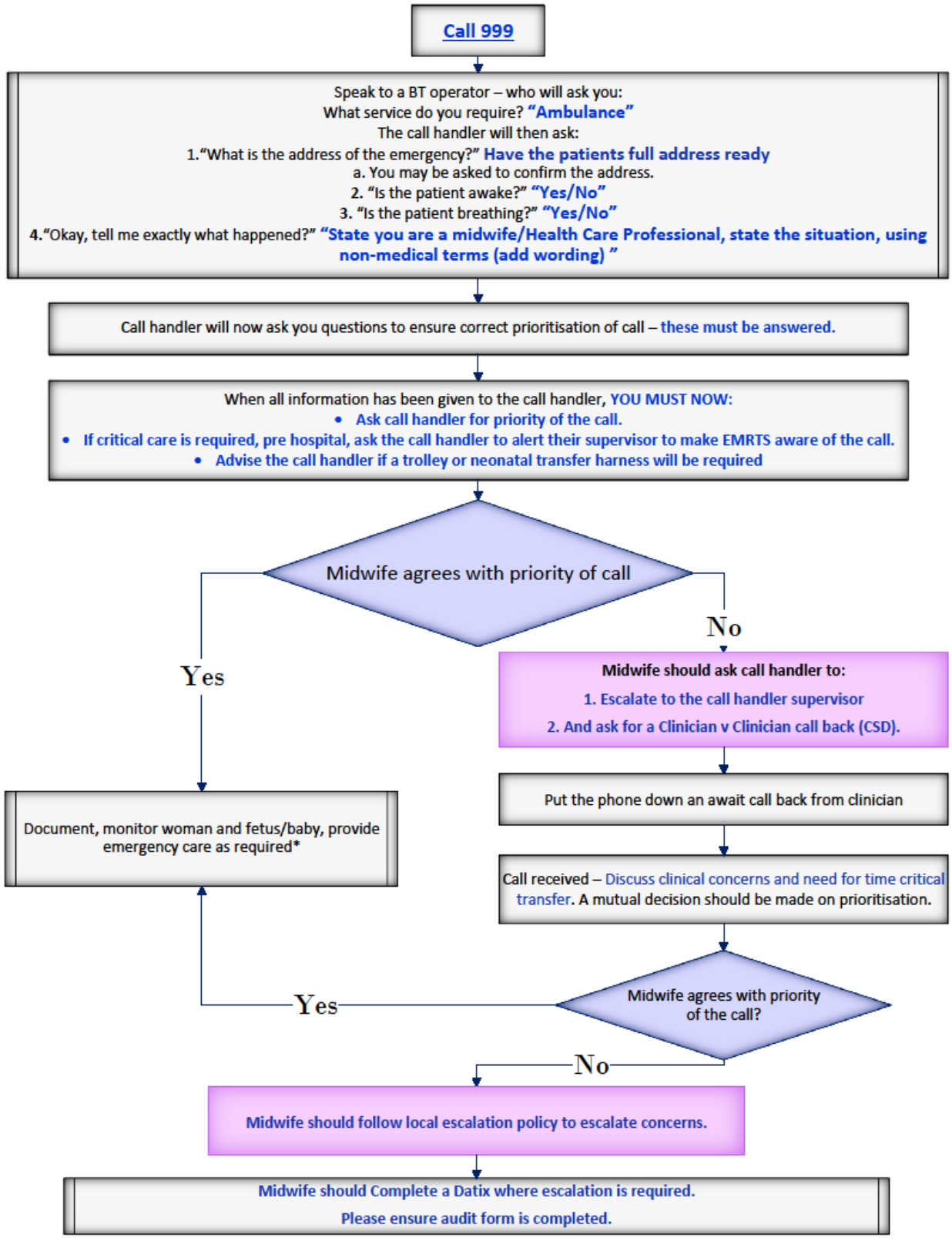
Neonates:	Mothers:
Ventilatory Support (eg BVM, CPAP, IGel, Intubation)	Intubation and Ventilation
Circulatory Support (eg IO access, IV fluids, Inotropes)	Blood & Blood Product Transfusion
Glucose and Temperature Control (Incubator System)	Haemorrhage Controlling Agents
	Peri-Mortem Caesarean Section

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.

Appendix F: 999 Flowchart



*Ensure that if the patient's condition deteriorates, a change in the clinical picture or a need for further clinical support, another 999 call should be placed. Consideration should be given for the need for EMRTS, see pathway in Appendix F.

Appendix G: Midwifery Alert Notification Proforma

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru Welsh Ambulance Services NHS Trust

Midwifery Alert Notification Proforma

Child's Name: Unborn **Mother's Name:** **Address:** **Mother's DOB:** **EDD:**	**Contact details for Professionals involved with family:** **Named Midwife:** **Midwifery Team:** **Social Worker:** **Emergency Duty Team:**
Child Protection Concerns, and/or relevant medical background details:	
Safeguarding actions, and/or treatment to be taken in an emergency that would differ from the normal process for WAST: (WAST will dispatch as per dispatch protocol) ***If completing for a flag to be added to an address, please include the time frame this will be needed for**	
Police Incident Number(if applicable)	**Is it safe to visit the home alone?**
Name of professional requesting Safeguarding Children Alert: **Agency:**	
Has parental consent been obtained:	**Date**:

Welsh Ambulance Services NHS Trust / Amb_wastsafeguarding@wales.nhs.uk

Name of professional raising alert on behalf of WAST: **Signed :** **Date:** ***********End of Document************

Appendix H

Transfer Audit Form

Please circle responses where applicable:

Date:_____

ADDRESSOGRAPH

Time decision to transfer:_____

Time transport called:_____

Time OU called:_____

Time transport arrived:_____

Time departed location:_____

Time arrived at OU:_____

Time handed over:_____

Time of medical review:_____

Transfer from:_____
Transfer to:_____

Care type: MLC Individual plan

Primip Multip Gestation:_____

Reason for transfer:_____

Stage of care:_____

Category of transfer required according to framework:

A-own car B-Taxi C-UCS D-999

Mode of transport used: Own car Taxi with midwife UCS 999

If mode of transport used was different to recommended one as per framework reason why:_____

If 999 transfer grading of call: Red Amber-1 Amber-2 Green

Escalation required to obtain mode of transport required? Yes No

Discussion with Clinical Support Desk: Yes No

If yes, Time requested:_____Time called back:_____

Call upgraded: Yes No

Escalation required to manager on-call: Yes No

Datix Submitted: Yes No **Incident number:**_____

OUTCOME:

Mode of birth:_____**MBL:**_____**Birth weight centile:**_____

Adverse primary outcome from list below: Yes No

Fractured humorous/clavicle HIE Grade: 3 Meconium Aspirate

Still birth (after presentation in labour) NN death (within 7 days) Brachial Plexus injury

Secondary perinatal or maternal from the list below: Yes No

Neonatal outcomes: • Apgar score <7 at 5 minutes • Neonatal encephalopathy any grade • Fractured skull • Cephalohaematoma • Cerebral haemorrhage • Early onset neonatal sepsis (within 48 hours of birth) • Kernicterus • Seizures • Admissions to neonatal unit within 48 hours of birth for at least 48 hours with evidence of feeding difficulties or respiratory distress.

Maternal outcome

• Maternal death (within 42 days of giving birth) • Episiotomy • Third or fourth degree perineal trauma • Blood transfusion • Admission to Intensive Therapy Unit /High Dependency Unit