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Consulted With:	Post/ Approval Committee/ Group:	Date:
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Related Trust Policies (to be read in conjunction with)	04071 Standard Infection Prevention 04265 Fetal Heart Rate Monitoring in Pregnancy and Labour 04225 Examination of the Newborn Infant 04232 Assist Medical and Midwifery Staff in the Provision of High Dependency Care and Arrangements for Safe and Timely Transfer to ITU 09090 Identification and management of patients with mental ill health during the perinatal period 08102 Management of Pregnant and Postnatal Patients who Present for Care at the Trust's Emergency Services 10001 Management and communication for handover of care in maternity 11024 Health Records Policy

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1.0	Julie Bishop		November 2003
2.0	Julie Bishop and Anne Smith		January 2006
3.0	Anne Smith		July 2009
3.1		Clarification to 3.3	February 2010
3.2	Sarah Moon	amendment in line with East of England Specialised Commissioning Group and MLS definition	August 2010
3.3	Sarah Moon	post PFI move	June 2011
4.0	Meredith Deane		November 2012
4.1	Sarah Moon	Clarification to 18.0	February 2013
4.2	Tracey Samuels	Additional to point 7.0 and Appendix D	April 2014
5.0	Sarah Moon		February 2016
5.1	Sarah Moon	clarification to points 3.2, 3.3, 3.4, 3.7, 3.8 and 3.12	13 June 2016
5.2	Sarah Moon	clarification to points 3.8 and 3.16	August 2016
6.0	Tegan Winnington	Full review	3rd June 2019

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A. Appendix A - In-Utero Transfers out of MEHT Proforma

B. Appendix B - Emergency Transfers of Patients in Labour or Sick Babies (from home or low risk units) to Broomfield Hospital Consultant Unit Proforma

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E. Appendix E- Preliminary Equality Analysis

1.0 Purpose

1.1 To support staff in providing high standard of clinical care when arranging transfer of a mother or baby.

2.0 Equality Impact Assessment

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.
(Refer to Appendix E)

3.0 Emergency Transfers of Patients in the Intrapartum and Postnatal Period or Sick Babies (from home or low risk units) to Broomfield Hospital Consultant-led Unit

3.1 The midwife responsible should assess each woman on an individual basis and decide as to whether the case warrants an urgent transfer. In the event of a true obstetric emergency arising at either of the Midwife-led Units or Community, the midwife would dial 999 and state; **"This is an obstetric emergency"**. This would instigate the call being placed as a 'priority'.

3.2 Base any decisions about transfer of care on clinical findings, and discuss the options with the woman and her birth companion(s).

3.3 If contemplating transfer of care the midwife responsible should:

- Talk with the woman and her birth companion(s) about the reasons for this and what they can expect, including the time needed to transfer;
- Address any concerns she has and try to allay her anxiety;
- Ensure her wishes are respected and her informed consent is obtained.

3.4 Transfer the woman to obstetric-led care if any of the following are observed on initial assessment:

Observations of the woman:

- Pulse over 120 beats/minute on 2 occasions 30 minutes apart;
- A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more;
- Either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart;
- A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more);
- Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive readings 1 hour apart;
- Any vaginal blood loss other than a show;
- Rupture of membranes more than 24 hours before the onset of established labour. If labour is established within 24 hours of ruptured membranes, a woman

may continue to receive low risk intrapartum care in an out of hospital setting;
- Presence of significant meconium;
- Pain reported by the woman that differs from the pain normally associated with contractions;
- Any risk factors recorded in the woman's notes that indicate the need for obstetric led care.

Observations of the unborn baby:
- Any abnormal presentation, including cord presentation;
- Transverse or oblique lie;
- Free-floating head in a nulliparous woman;
- Suspected fetal growth restriction or macrosomia;
- Suspected anhydramnios, oligohydramnios or polyhydramnios;
- Fetal heart rate below 110 or above 160 beats/minute;
- A deceleration in fetal heart rate heard on intermittent auscultation;
- Reduced fetal movements in the last 24 hours reported by the woman.

3.4.1 If none of these are observed, continue with midwifery led care unless the woman requests transfer.

3.5 If any of the factors in point 3.4 are observed but birth is imminent, the midwife responsible should assess whether birth in the current location is preferable to transferring the woman to an obstetric unit and discuss this with the coordinating midwife.

3.6 The criteria for the transfer in labour:

- Patient's request;
- Deviation from the normal fetal heart rate in labour;
  (Refer to the 'Fetal heart rate monitoring in pregnancy and labour' Register number 04265)
- Failure to progress;
- Malpresentation;
- Significant meconium-stained liquor;
- Retained placenta;
- Antepartum haemorrhage;
- Raised blood pressure / pre-eclampsia;
- Gestation less than 37 completed weeks gestation.

3.7 The criteria for the transfer of a patient and her baby in postnatal period:

- Baby with a low apgar (more than 7 at 5 minutes)/failure to respond to resuscitation;
- Baby with a suspected infection/unwell;
- Suspected congenital abnormalities;
- Suspected birth trauma;
- Prematurity;
- Jaundice requiring treatment;
- Any other reason in which the midwife feels transfer to the consultant unit is required;
- Postpartum haemorrhage;

- Perineal trauma requiring repair by obstetric registrar or consultant.

3.8 Management of the transfer should involve the following:

- The responsible midwife should give a full explanation to the patient and her birthing partner ensuring accurate documentation in the patient's healthcare records;
- The responsible midwife should contact the ambulance service by dialing 999 (if appropriate);
- The responsible midwife completion of the emergency transfer of patients in labour or sick babies proforma;
  (Refer to Appendix B)
- The responsible midwife should inform the Labour Ward Co-ordinator, stating the indications to alert the obstetric team of the impending transfer by ambulance to the Consultant-led Unit and ensure clear documentation in the patient's healthcare records;
- Organise a midwife escort;
- Re-examine the patient and assess cervical dilatation immediately prior to transfer (if in labour) to assess appropriateness of transfer;
- Maintain continuous monitoring of maternal vital signs during the journey;
- Note time of the transfer and make contemporaneous records during the journey if possible, or retrospective otherwise;
- Document all times carefully and record in the patient's healthcare records;
- Provide comprehensive verbal and written handover to the labour ward staff, to involve the completion of the SBAR handover of care proforma.
  (Refer to the guideline' Management and communication for handover of care in maternity'; register number 10001)

3.8.1 The Labour Ward Co-ordinator should:

- Alert the relevant healthcare professionals (obstetric, anaesthetic and neonatal);
- Summon assistance by contacting the on call midwife;
- Instigate appropriate emergency treatment i.e. cannulate, obtain bloods for full blood count and group and save, administer oxygen via reservoir face mask at 10 litres /minute;
- Inform the obstetric registrar or consultant on call and the Labour Ward Co-ordinator of the transfer;
- Inform the neonatal unit/paediatric registrar (if applicable);

3.9 Accompanying midwife from Midwife-led Unit to ensure that she is carrying and has checked, prior to leaving, an emergency delivery pack, including syntometrine/ syntocinon. All community midwives carry a maternity delivery pack.

3.10 All paramedics should ensure that their ambulances contain paediatric resuscitation equipment suitable for a neonate and that the equipment has been checked fit for purpose.

3.11 If the delivery is likely to occur prior to the planned hospital destination, consider a re-route to another hospital if nearer. If this option is appropriate alert the Accident and Emergency department of the imminent arrival.

3.12 If the above option is not possible or appropriate, request ambulance to stop in a safe area.

3.13 Prepare patient for the delivery and have a paramedic ready to assist with possible resuscitation of the baby. As soon as the mother and her baby are stable continue the journey, alerting the appropriate personnel at the receiving hospital.

3.14 When arranging transfer from one location to another, ensure the following:

- Before transfer, the woman is dressed, wrapped in a blanket or otherwise covered in a way that she feels is comfortable and appropriate;
- The woman is made to feel as comfortable as possible before and during transfer;
- Any ambulance staff or other personnel involved are aware that some positions may make the woman uncomfortable or afraid and could affect her labour, so she should be encouraged to choose how to move and what position to adopt if possible, in accordance with ambulance service protocols;
- Communication and companionship are maintained. Explain the arrangements for transfer to the woman and her birth companion(s). A midwife who has been involved in her care up to that point should travel with her and carry out a handover of care that involves the woman. Arrangements are in place to enable the woman's birth companion(s) to travel with her in the ambulance if that is what she wants. If this is not possible or not wanted, check that the birth companion(s) have or can arrange their own transport;

3.15 If a woman is transferred to an obstetric unit after the birth ensure that her baby goes with her where possible.

4.0 Intrauterine Transfers

4.1 The purpose of this procedure is to transfer the patient with the baby in-utero to a regional neonatal intensive care unit (Level 3) with facilities available to provide optimal care for the baby post delivery.
(Refer to Appendix C)

4.2 Minimum Standards for Neonatal Care are as follows:

- **Level 1** Normal Care Service
  All units providing normal care should:

  - Provide facilities for stabilisation of baby prior to transfer to a neonatal intensive care unit

  - Provide 4 cots per 1,000 births, including intensive care facilities for up to 2 neonates;

  - Diagnose early and make arrangements for transfer of high-risk pregnancies in utero.

- **Level 2** Supra District Services:

  - Provide back up to other units;

  - Provide 5-8 intensive care cots.

- **Level 3** Regional Perinatal Centres (e.g. Rosie, Cambridge):

    - Provide sufficient 24 hour obstetric and anaesthetic staff to care for high-risk pregnancies;

    - Collect babies from peripheral units;

    - Provide 10 -15 intensive care cots;

    - Expert medical advice/cover 24 hours.

4.3 Criteria for in-utero transfer:

- Prematurity less than 30 weeks gestation;
- Surgical abnormalities where the infant requires immediate postnatal surgical intervention;
- Medical abnormalities requiring intrauterine intervention or early delivery i.e. severe intrauterine growth retardation;
- Maternal indications including severe maternal disease requiring specialist treatment only available at specialist centres;
- Neonatal unit dependency high: one baby being ventilated and second new baby receiving nasal CPAP;
- Multiples of triplets or more;
- That the patient agrees to transfer following informed discussion by a obstetric registrar or consultant;
- Broomfield Hospital neonatal unit is full (no cots available);
- Insufficient level of staff to care for neonate.

4.4 Contra indications to in utero transfer:

- Fetal distress;
- Poor maternal health and wellbeing i.e. severe pre- eclampsia, patient shocked or bleeding;
- Established labour (contracting 1:2 associated with cervical dilatation);
- Imminent delivery (if possible to predict) within one hour of diagnosis.

4.5 A clinical assessment must be made immediately before the patient is transferred out of Labour Ward. This includes a speculum examination by the obstetric registrar or consultant on call.

4.6 The responsibilities of **Midwife in Charge** are as follows:

- To update the Neonatal Unit daily regarding any inpatients of less than 34 weeks gestation, for neonatal bed status and pre-planning of prospective in-utero transfers;
- Arrange paramedic ambulance to transport the patient to the tertiary centre once available neonatal bed located. **Telephone: 01245 443241 or 9 999** and state level of emergency;
- Arrange for the relevant patient’s notes to be photocopied by ward clerk;
- Arrange midwife escort;

- Inform Neonatal Unit of patient's admission and plan of care;
- Inform receiving unit of time of transfer;
- Enter patient's details, including hospital destination and reason for transfer in ward diary;
- Inform verbally the NNU of potential and actual in utero transfers giving the following information: name of patient, gestation, reason for the transfer, and the name of the accepting hospital;
- Complete in-utero transfer out of MEHT form and place completed form in the Lead Midwife for Acute Inpatient Services' office for collection by Neonatal Unit staff;
  (Refer to Appendix A)
- Ensure all care, conversations and decisions have been clearly documented in the patient's health care records;
- Advise escort midwife to contact the MEHT Labour Ward co-ordinator to arrange a return taxi, which is payable by MEHT via the ward cost code.

4.7 The responsibilities of **obstetric registrar** are as follows:

- To examine the patient with prior consent and confirm the need for in-utero transfer; informing the patient and her birthing partner of plan of care;
- Obstetric registrar should notify the obstetric consultant on call regarding the plan of care and document in the health care records;
- All planned in-utero transfers should be to discussed with the duty consultant obstetrician / the on call obstetric registrar and the paediatric duty consultant/ on call registrar;
- Labour Ward on call Obstetric Registrar/ Consultant to call East of England region Emergency Bed Service. Telephone: 01223 274274 for neonatal cot availability. List updated at 08:00hours and 19:00 hours;
  (Refer to appendix C for list of hospitals and direct dial numbers list)
- Once located, the registrar should contact the paediatric registrar and obstetric registrar at the proposed (level one) regional unit for cot and bed availability and give clinical handover to the receiving medical staff;
- Re-examine the patient and assess cervical dilation immediately prior to transfer;
- Ensure all care, conversations and decisions have been clearly documented in the patient's health care records.

4.8 The responsibilities of **midwife escort** are as follows:

- To ensure the patient and birthing partner are kept fully informed of time of transfer and changing plan of care;
- Ensure that the patient has an empty bladder prior to transfer;
- The accompanying midwife should ensure that she is carrying and has checked, prior to leaving, an emergency delivery pack, including syntometrine/ syntocinon and small sized neonatal ventilation masks in case spontaneous delivery occurs;
- If a syringe pump is required, ensure it is in working order and that the battery is fully charged;
- Ensure that an adequate supply of drawn up/prepared and checked prescribed drugs that the patient has in progress i.e. an atosiban infusion;
- Maintain continuous observations of the patient's condition and record contemporaneously, or as soon as possible after transfer in the health care

records;
- If spontaneous delivery is imminent, consider re-routing to another hospital, if nearer. If this option is appropriate, request that the paramedic team alert the Emergency Department (ED) of the imminent arrival;
- If the above option is not possible, request ambulance to stop in a safe area;
- Prepare the patient for delivery, have a paramedic ready to assist with the resuscitation of the baby. As soon as the mother and baby are stable continue the journey, alerting the appropriate personnel in the receiving hospital;
- Consider re-routing to another hospital if closer; if this option is appropriate, alert the ED of the imminent arrival;
- Give verbal handover to the receiving midwife/obstetric registrar/on-call consultant and give the photocopied notes to staff;
- Return any equipment to the Labour Ward, clean and ensure it is fit for re-use/put on charge if applicable;
- Restock and check the emergency delivery pack;
- If a taxi is required for the return journey, keep receipt for a refund from the petty cash office.

5.0 Neonatal Transfer to Specialist Units

5.1 The following require neonatal transfers to specialist units:

- Prematurity less than 27 weeks gestation;
- Twins less than 28 weeks gestation;
- Babies weighing less than 800g;
- Surgical conditions undiagnosed antenatally or diagnosed but where local delivery is felt to be appropriate by all concerned i.e. paediatrician, paediatric surgeon, cardio-thoracic surgeon, obstetric registrar/consultant on-call;
- Infants with very severe respiratory disease.

5.2 All the above criteria should be actively considered particularly when the neonatal unit has filled all 16 funded cots (2 intensive care cots; and 4 high dependency cots).

5.3 Each extra admission should be discussed on an individual merit. Inpatient review of cases should take place to relieve pressure on beds.

5.4 Emergency neonatal transfer is organised from the neonatal unit by either:

- The Acute Neonatal Transfer service (ANTS), http://www.ants-neonatal.org/home.html;
- The Children's Acute Transport Service (mainly for transfer to Great Ormond Street Hospital and the Brompton Hospital; especially the cardiac babies), http://site.cats.nhs.uk/;
- The Neonatal Transfer Service London, https://london-nts.nhs.uk/

6.0 Transfer of Mother and Baby to the Stand-alone Midwife-led Units from Broomfield Hospital Consultant-led Unit

6.1 Once postnatal women have 'normalised' following a high risk delivery i.e. 24 hours post Caesarean section having been reviewed and discharged by the obstetric/anaesthetic team, or if the baby is continuing with prolonged rupture of membranes (PROM)/meconium observations but otherwise well; these women are transferred to the stand alone birthing units to continue having the appropriate midwife-led postnatal care including feeding support. The criteria for transfer are as follows:

- Patients or infants requiring 12- 48 hour observations i.e. group B streptococcus (GBS)/PROM/ (significant) meconium/NAS observations in an otherwise well baby, discharged by the neonatologist;
- Patients who have had a caesarean section may be transferred 24 hours after delivery, once they have been reviewed by the obstetric/anaesthetic team, discharged from medical care and are well enough for transfer/discharge;
- Patients who have had complicated deliveries/problems i.e. blood transfusion, third degree tear and manual removal of retained placenta – the time of transfer will be at the discretion of the obstetrician and midwife, once the patient is well enough for transfer/discharge, having been discharged by the obstetric team
- Babies who do not fall into the criteria for midwife (NIPE) examinations must be examined and declared fit for transfer by a paediatrician;
  (Refer to 'Examination of the newborn'; register number 04225)
- Patients who were booked for delivery at the MLU and were transferred to the consultant unit may transfer back to the MLU for postnatal care once obstetrician has discharged from their care. Time of transfer once delivered at the discretion of the midwife and the patient.

6.2 Arrangements - ensure that any outstanding tests and investigations are actively followed up prior to transfer and handed over to receiving staff.

6.3 Check the bed availability and book a bed, inform the patient when the bed is available.

6.4 Inform Midwife-led Unit of the mother and baby's relevant obstetric/medical history and whether baby has passed urine/ meconium.

6.5 Transport to be arranged by the patient including provision of a car seat.

6.6 Prior to the transfer check mother's and baby's identity labels.

6.7 Routine postnatal observations prior to transfer, to include normal micturition and lochia.

6.8 Ensure medication to take home is prescribed and dispensed if required.

6.9 It is the midwife's responsibility to complete all documentation, including computer data and complete the patient's postnatal health care records. In addition, the midwife responsible for the woman's discharge should complete documentation on page 5 of the 'Postnatal Care Record- Baby'.

6.10 Ensure that the patient receives adequate analgesia prior to transfer.

6.11 Ensure a meal is requested if the transfer is during meal times.

6.12 Ensure that any details including rhesus status is entered into the discharge book.

6.13 Ensure that all relevant documentation are placed in a sealed envelope and given to the mother.
(Refer to Health Records Policy; register number 11024)

6.14 Once transferred enter the time of transfer on the computer record for the mother and baby.

6.15 When mother and baby are ready to leave a member of staff will inform the maternity receptionist of the mother and baby's transfer to the specific Midwife led unit and advise patient to travel directly to the unit.

6.16 Patient's transfer out of unit to be computer recorded by maternity administration staff.

7.0 Transfer of Baby to the Neonatal Unit

7.1 Midwives transferring a baby to the Neonatal Unit for on-going care and treatment, should ensure that the 'Transfer letter to the Neonatal Unit' is completed prior to transfer.
(Refer to Appendix D)

8.0 Transfer of Mother and Baby to Woman's Home

8.1 Criteria as for Midwife-led Unit transfer (refer to point 6) with the following exception:

- Patients who have had a LSCS may be discharged home 24 hours following delivery, once pronounced clinically fit for discharge.

8.2 Arrangements - midwives may discharge mothers who have had a normal/ instrumental vaginal delivery, providing the mother has had an uneventful recovery.

8.3 A six hour discharge can be offered to these patients if appropriate. Any deviation from the normal must be referred to the appropriate medical practitioner.

8.4 Patients should feel happy and confident to be discharged. They should have a contact number for emergencies and assured that their midwife will visit the next morning.

8.5 The NIPE examination should be completed within 72 hours of birth. If discharge occurs prior to 72 hours, an appointment must be made for the NIPE to be completed within 72 hours of birth.

8.6 Discharge information will be distributed on Lorenzo to the relevant community midwife team. This information should be recorded in a discharge book and phoned out on a daily basis to the community midwife or to the relevant maternity unit if the community area is not covered by Lorenzo..

8.7 Ensure that any outstanding tests and investigations are actively followed up prior to discharge home and handed over to the community midwife/GP

8.8 Transport to be arranged by the patient, including provision of a car seat.

8.9 Ensure medications to take home have been prescribed and given to the patient if applicable.

8.10 Complete all relevant documentation including computer data and complete woman's postnatal records.

8.11 Enter the time of the discharge of the mother and baby on the computer records.

8.12 Prior to discharge check the mother's and baby's identity labels.

8.13 Documents on discharge **-** for patients from Mid Essex area give the following:

- Patient's postnatal records;
- Child health record;
- NHS number and leaflet for baby;
- Discharge pack containing the following information leaflets: reducing the risk of cot death, bed sharing, infant feeding and contact numbers for breast feeding support group, how to sterilise equipment for your baby, how to register your baby and postnatal exercise sheet;
- Emergency contact telephone numbers;
- Bounty pack if patient accepts this.

8.14 For patients out of area give the following documents on discharge:

- 1 copy of the discharge letter for mother and baby;
- NHS number and leaflet for baby;
- Discharge pack;
- Contact telephone numbers;
- Bounty pack if patient accepts this.

8.15 The following documents are sent via Lorenzo to the patient's GP:

- Mother discharge letter;
- Baby discharge letter;
- Baby's NHS number.

9.0 Transfer of Mother and Baby to Woman's Home from an Outlying Hospital during the Postnatal Period

9.1 All women transferring their postnatal ongoing care from an outlying hospital to the Mid Essex Community Midwives must have their care documented in the appropriate Mid Essex Postnatal Care Records.

9.2 They should have a contact number for emergencies and assured that their midwife will visit the next morning.

9.3 They should be advised to contact their GP when they get home to inform him/her of their discharge.

9.4 It is the midwife's responsibility to complete all appropriate documentation in the woman's 'Postnatal Care Record - Mother'. In addition, the midwife responsible for the woman's ongoing care should complete the documentation of the Postnatal Care Record - Baby'.

10.0 Transfer of Care from the Community Midwife to the Patient's Health Visitor and GP

10.1 Criteria - all mothers and babies between 10 and 28 day postnatal with no deviations from the normal.

10.2 Arrangements should ensue as follows:

- Community midwife to ensure both mother and baby are fit for discharge;
- Community midwife to complete discharge notes;
- Advise the mother that she will receive a visit from her Health Visitor;
- Ensure the mother knows who to contact in case of emergency;
- Community midwife to return patient's postnatal records to maternity library (this is then married up with patient's health care records);
- Complete communication discharge summary from community midwife to health visitor;
  (Refer to page 25 of the postnatal neonatal records)
- Direct verbal handover from midwife to health visitor if there are any ongoing concerns.

11.0 Transfer to Intensive Therapy Unit (ITU)

11.1 Refer to the 'Assist medical and midwifery staff in the provision of high dependency care and arrangements for safe and timely transfer to ITU'; register number 04232)

12.0 Transfer of the Patient to Tertiary Units

12.1 This applies to patients with pre-existing medical conditions or those who develop complications, which cannot be provided at local district general hospital (Broomfield). Such patients should be referred to tertiary units that are staffed at consultant level by physicians with relevant specialised medical experience and knowledge of obstetrics.

12.2 If care is shared between the tertiary center and Mid Essex Maternity Services clinicians should ensure a plan of care is made and if any complications arise or additional risks develop close consultant-to-consultant liaison is required in order to plan and provide optimum care.

12.3 Transfer arrangements - this will depend on the patient's condition and judgment of the consultant obstetrician and consultant anaesthetist. Staff should refer to above guidance (point 4.0) for intrauterine transfer and guidelines for transferring patients to

ITU.

13.0 Mothers Requiring Transfer to Mental Health Unit

13.1 Refer to 'Identification and management of patients with mental ill health during the perinatal period'; register number 09090).

14.0 Mothers Requiring Postnatal Transfer to another Trust

14.1 Patients may be transferred to another trust to continue postnatal care when:

- Their baby has been transferred for tertiary care;
- The patient requires transfer to her original hospital of intention for confinement for continuing postnatal care.

14.2 Arrangements are as follows:

- Obstetric and midwifery assessment should be undertaken to establish if ambulance transfer is required; or if the patient can go in her own transport; or if a midwife escort is required;
- Maternity and/ or medical records for the current episode of care are to be photocopied and given with the Mid Essex Hospital Services discharge documentation;
- Midwife to contact the receiving unit to provide a verbal midwife to midwife handover of care for mother and baby if no escort is required. This action is to be documented in the health care records;
- The receiving unit is to be informed when the patient has left Mid Essex maternity services;
- Where the baby is transferred out of area for tertiary care and the patient will not be having in-patient postnatal care, the midwife arranging the patient's discharge will contact the Maternity Services for the receiving Trust to arrange continuing postnatal care. This action will be documented in the patient's postnatal records. The patient will be provided with the contact numbers for the local maternity services in case of emergencies;
- Individual arrangements for continuing postnatal care with either their named midwife or in the postnatal ward in Mid Essex Maternity Services can be made if this is the patient's choice.

15.0 Transfer from a High Risk Setting to Low Risk

15.1 On rare occasions, the situation may arise that a low risk woman finds herself in Broomfield Maternity and established labour has been diagnosed. (i.e. following an antenatal clinic appointment or a follow up in Day Assessment Unit (DAU) for a problem that has since resolved).

15.2 If the woman's status at that point is low risk and she has booked to give birth either

at home or in one of the Midwife-led Units (MLU's) and wishes to stay with this plan, then it is acceptable that she is transferred either back home or to the MLU by her own transport and without a midwife escort.

15.3 Obviously, the woman's wishes and comfort are of paramount importance, however if the midwife is concerned that the labour is advancing quickly, transfer may not be suitable and the woman should be offered to give birth in the Co-located Birthing Unit at Broomfield Hospital.

16.0 Staffing and Training

16.1 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

16.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

17.0 Professional Midwifery Advocates

17.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices. PMA's are available from 08:00 – 16:00 hours; 5 days a week rota via switchboard.

18.0 Infection Prevention

18.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

19.0 Audit and Monitoring

19.1 The emergency transfer of patients in labour or sick babies form should be completed and the original copy to be retained in the healthcare records and a further copy to be attached to the risk event form and placed in the appropriately labelled tray in the labour ward manager's office.
(Refer to Appendix B)

19.2 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy and the Maternity annual audit work plan. The Woman's and Children's Clinical Audit Group will identify a lead for the audit.

19.3 As a minimum the following specific requirements will be monitored:

- Locally or nationally developed assessment tools to ensure a consistent approach to the documentation of the transfer of care, for example SBAR (situation/background/assessment/recommendation)
- Agreed process for contacting the ambulance service in emergencies or when transfer is required;
- Documentation requirements of each staff group when undertaking an in utero transfer;
- Documentation requirements of each staff group when transferring women into hospital from the community/midwifery led unit during the intrapartum period;
- Documentation requirements of each staff group when transferring a woman and her newborn in the postnatal period;
- Process for audit, multidisciplinary review of results and subsequent monitoring of action plans.

19.4 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 19.3 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

19.5 The findings of the Woman's and Children's Clinical Audit Group will be reported to Woman's and Children's Directorate Governance meeting and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

19.6 The Woman's and Children's Clinical Audit Group will report to the monthly Woman's and Children's Directorate Governance Meeting and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

19.7 Key findings and learning points from the audit will be submitted to the Patient Safety Group within the integrated learning report.

19.8 Key findings and learning points will be disseminated to relevant staff.

20.0 Guideline Management

20.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

20.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

21.0 Communication

21.1 A quarterly ‘maternity newsletter’ is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or ‘bank’ staff have letters sent to their home address to update them on current clinical changes.

21.2 Approved guidelines are published monthly in the Trust’s Staff Focus that is sent via email to all staff.

22.0 References

Draper ES, Kurinczuk JJ, Kenyon S (Eds.) on behalf of MBRRACE-UK. (2017) MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, intrapartum stillbirth and intrapartum-related neonatal death. The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester: Leicester, 2017.

National Institute for Health and Care Excellence (2014) Intrapartum care for healthy women and babies. NICE Guideline (CG190). London: NICE

National Institute for Health and Care Excellence (2019) Intrapartum care for women with existing medical conditions or obstetric complications and their babies. NICE Guideline (NG121). London: NICE

Appendix A

Mid Essex Hospital Services NHS
NHS Trust

In-Utero Transfers out of MEHT Please complete this form for <u>all</u> patients transferred out of Maternity Services	
Surname:	
First Name:	
Hospital Number:	
NHS No:	
Singleton / Twins / Triplet ***(please circle)***	
Gestation at transfer:	
Hospital transferred to:	
Telephone number of hospital:	
Date and time of transfer:	
Transport: Essex Ambulance ***(tick)***	Other: ***(Please state)***
Details of Pregnancy:	
Reason for Transfer out: (i.e. **NNU closed; >28/40 weeks gestation)**	
Midwife Signature:	Print name:
Designation:	
Date:	
Place completed form in the Lead Midwife Labour Ward and Acute Inpatient Services' office for collection by the Neonatal Unit	

Appendix B

Mid Essex Hospital Services NHS
NHS Trust

Emergency Transfers of Patients in Labour or Sick Babies (from home or low risk units) **to Broomfield Consultant-led Unit**			
Surname:			
First Name:			
Hospital Number:			
NHS No:			
Transfer from:			
Transfer to:			
Mode: (Please tick)	Own	Ambulance	Hospital
Category: (Please tick)	Urgent	Non Urgent	
Type: (Please tick)	Paramedic	Technicians	
Notification: (doc's etc)	Yes	No	
Time of Request of Admission:			
Time of Departure:			
Time of Arrival at Destination:			
Handover of Care & to Whom:			
Completion of In Utero Transfer Form & Communication Book on Labour Ward:	Yes	No	
Completion of Transfer Form & Insertion into hand Held Records:	Yes	No	
Signature and print name of health professional completing the proforma	Print Name:	Signature:	Date/Time

The emergency transfer of patients in labour or sick babies form should be completed; the original copy to be retained in the healthcare records and a further copy to be attached to the risk event form and placed in the appropriately labelled tray in the labour ward manager's office

Appendix C

Direct Dial Numbers for Neonatal Units

Unit	Number	Called	Outcome
Bury West Suffolk	#6 450		
Colchester	#6 332		
Hammersmith	#6 372		
Harold Wood	#6 364		
Hinchinbrook	#6 369		
James Pagent	#6 376		
Peterborough	#6 409		
Norfolk and Norwich	#6 402		
Queen Charlottes	#6 414		
QE King's Lynn (not under 28/40)	#6 384		
Rosie, Cambridge	#6 310		
St Mary's, Paddington	#6 440		
Southend	#6 441		
Whipps Cross	#6 453		
Units contactable via switch:			
Basildon (not under 26/40)			
Chalk Farm			
Chelsea & Westminster			
Great Ormond Street			
Guys			
Hammersmith			

King's College			
Unit	**Number**	**Called**	**Outcome**
Lewisham			
Lister Stevenage (not under 27/40)			
Luton & Dunstable			
Medway, Gillingham			
Princess Alexandra Harlow			
QE II Welwyn Garden City			
Royal London			
Royal Sussex, Brighton			
St Thomas'			
Watford			
Whittington			
UCH			

Appendix D

Mid Essex Hospital Services NHS
NHS Trust

Women's and Children's Directorate

Transfer Letter to Neonatal Unit

Name: Gestation: D.O.B

Hospital No: NHS No: Birth Weight:

Reason for Admission to NNU

Pregnancy History

Type of Birth

Last Observations

Time: Temp: Apex: Resps: B.M:

Last Feed. Type/Time

Vitamin K Given: Yes/No Method: IM / IV / Oral

Follow up dates: 7th 28th

Safeguarding issues:

Midwife Transferring baby:

Date:

Tim

Appendix E: Preliminary Equality Analysis

This assessment relates to: Transfer of Mothers and Babies to Different Care Settings (06029)

A change in a service to patients		A change to an existing policy	**X**	A change to the way staff work	
A new policy		Something else (please give details)			

Questions	**Answers**
1. What are you proposing to change?	Full Review
2. Why are you making this change? **(What will the change achieve?)**	3 year review
3. Who benefits from this change and how?	Patients and clinicians
4. **Is anyone likely to suffer any negative impact as a result of this change?** If **no**, please record reasons here and sign and date this assessment. If **yes**, please complete a full EIA.	No
5. a) Will you be undertaking any consultation as part of this change? **b) If so, with whom?**	Refer to pages 1 and 2

Preliminary analysis completed by:

Name	Tegan Winnington	**Job Title**	Senior Midwife	**Date**	March 2019