Tiered Perinatal Network Operational Plan

South Eastern Sydney Local Health District and Illawarra Shoalhaven Local Health District

NOVEMBER 18 2019
ENDORSED SESLHD AND ISLHD CHIEF EXECUTIVE FEBRUARY 7 2020
ENDORSED SESLHD AND ISLHD CHIEF EXECUTIVE December 6 2022

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POLICY STATEMENT

The operational plan provides a framework for safe patient flow and the management of maternal transfers within the Tiered Perinatal Network (TPN) for South Eastern Sydney Local Health District (SESLHD)/ Illawarra Shoalhaven Local Health District (ISHLHD). The operational plan is a frame of reference for the provision of optimal maternity care where referral, consultation or transfer is required with the aim of having the woman in the right place at the right time. In situations of high acuity, demand for beds may exceed capacity. This document outlines strategies to implement when beds are unavailable within the facility and processes to follow non-time urgent maternal patient transfers, when no capacity is available within the TPN.

RESPONSIBILITY

The operational plan will identify the specific responsibilities of each service in the TPN.

Higher level maternity and neonatal services have a responsibility to:

- Provide consultation to clinicians at lower level facilities 24 / 7 as required
- Support shared care arrangements for women and / or neonates when care can be provided at a lower level service with appropriate support
- Accept referrals and / or transfers from networked services when higher level care is needed (including in time critical situations and/or when bed capacity is limited)
- Take a leadership role in the TPN including education and training; quality and safety; policy and guideline development; service planning and review; and bed management (working in collaboration with networked services to monitor bed capacity across the TPN and negotiate with their networked services on bed management strategies when demand is nearing capacity).

Lower level services have a responsibility to accept referrals, transfers and return transfers from within the TPN commensurate with their service capability.

All services have a responsibility to provide care for women and/or neonates commensurate with their service capability and manage service demand within their capability.

Each Tiered Perinatal Network is ultimately responsible for managing the service demands of its catchment population. Requests for ‘out of network’ transfers must be approved by the Level 6 obstetric and neonatal consultant within the TPN, before liaising with an alternate Level 6 TPN.

The Level 6 maternity obstetric consultant will work in collaboration with the lower level Maternity Services to coordinate a communication triage strategy and develop an agreed management plan. Such plans may include:

- The woman remaining in a network facility for observation
- The woman being transferred to an appropriate facility elsewhere within the TPN
- The woman being transferred to/ or remaining in the network level 5 or 6 facility irrespective of capacity, where the transfer is time critical or no other appropriate solution is available.
- The woman being transferred to a facility in another TPN

- Where appropriate, the Executive on call may be involved in the transfer process.

REVISION HISTORY

Version	Approved By	Amendment Notes
Version 3 September - 2022	Endorsed by CE-SESLHD/ISLHD	Revision and inclusion of GL2022_002, SESLHDPD/302, National Midwifery Guidelines for Consultation and Referral 4th Edition **Inclusion of** merging of process and pathways, Maternal Transfer Process for TPN flow sheet, Demand Access Escalation STEP plans updated and hyperlinked, Appendices reduced. MP5 – referral process and SESLHD ISLHD Maternal Transfers Poster **Removal of** reference to Statewide Obstetric Consultant SOC Service
Version 2 May - 2020	Endorsed by CE-SESLHD/ISLHD May 2020	Revision and inclusion of GL2020_008, PD2020_014, GL2020_015, IB2020_015, IB2020_016. **Inclusion of** In-Utero transfer to Royal Hospital for Women from Norfolk Island **- transfer process and flow chart**
November-2019 Tiered Perinatal Network Operational Plan-SESLHD/ISLHD	Endorsed by CE-SESLHD/ISLHD 7 February 2020	New Operational Plan

LEGAL AND LEGISLATIVE REQUIREMENTS

The contents of the Operational Plan need to be read in conjunction with:

PD2020_008 Maternity - National Midwifery Guidelines for Consultation and Referral

PD2020_014 Tiered Network Arrangements for Perinatal Care in NSW

GL2020_009 Maternity - Management of Threatened Preterm Labour

PD2018_011 NSW Critical Care Tertiary Referral Networks and Transfer of Care

GL2022_002 Maternity and Neonatal Service Capability

PD2020_018 Recognition and management of patients who are deteriorating

SESLHDPR/075 Management of the deteriorating MATERNITY woman

PD2010_030 Critical Care Tertiary Referral Networks (Paediatrics)

SESLHDPD/302 Time Critical Transfers of Women at Borderline Gestation within SESLHD

PD2022_012 Admission to Discharge Care Coordination

TIERED NETWORKS:

There are 8 Tiered Perinatal Networks across the State, each Tiered Network, bar Westmead, is led by a Level 6 Birthing Unit which oversees and supports the maternity services within a number of associated LHDs. Each hospital within the network has responsibilities commensurate with their service capability.

NETWORK	LINKED LHD MATERNITY AND NEONATAL SERVICES AND FACILITIES WITHOUT PLANNED BIRTHING SERVICES (PUBLIC AND PRIVATE HOSPITALS WITHIN THE LHDs)
Centenary Hospital for Women and Children	ACT Southern NSW Murrumbidgee (noting parts of Murrumbidgee link with Victoria)
John Hunter Hospital	Hunter New England Mid North Coast Northern NSW (noting parts of Northern NSW link with Queensland)
Liverpool Hospital	South West Sydney
Nepean Hospital	Nepean Blue Mountains Western NSW
Royal Hospital for Women	South Eastern Sydney Illawarra Shoalhaven
Royal Prince Alfred	Sydney Far West (noting Far West links with South Australia and Victoria)
Royal North Shore	Northern Sydney Central Coast
Westmead	Western Sydney

SERVICE CAPABILITIES 2022

Maternity and Neonatal services are classified according to the Maternal and Neonatal Service Capability. The framework is a rigorous tool for maternity service planning and risk management, supporting the provision of safe maternity care across NSW.

Each Maternity and Neonatal Service is assessed and assigned a Service Capability Level from 1 to 6. This is the basis for planned care, with the acknowledgement that unplanned emergencies can arise, and each service must have contingency plans in place for such situations. For example, a Level 1 Service may provide antenatal care to well women with low-risk pregnancies but have no planned birthing service whilst a Level 6 Service can provide care for unwell women with high-risk pregnancies. A Level 6 Maternity Service must have access to a Tertiary Level Neonatal Service. Generally, the Neonatal Service Capability is one level below the Maternity Service Capability. Thus, a Level 4 Maternity Service may be accompanied by a Level 3 Neonatal Service.

The risk categories in the Australian College of Midwives, *National Midwifery Guidelines for Consultation and Referral* *ACM Consultation and Referral Guideline 4th ED* . When a variance from normal is identified during a woman's care, the level of consultation requires one or more actions from across the following three categories:

LEVEL	DESCRIPTION	GUIDANCE
A/A*	Discuss	Care is provided by the midwife. (Note: the midwife may discuss clinical situations with a midwifery colleague, medical practitioner, and/or health care provider, but this is not indicated).
B	Consult	Consult with a relevant medical practitioner or other health care provider.
C	Refer	Refer a woman and/or her baby to a relevant medical practitioner or other health care provider.

A: Midwife with endorsement to prescribe scheduled medicines*

SOUTH EASTERN SYDNEY LOCAL HEALTH DISTRICT (SESLHD)

Provides health care to over 940,000 residents, from Sydney's CBD to the outskirts of the southern suburbs. SESLHD has three public hospitals and four private hospitals that provide maternity services.

Royal Hospital for Women:

The Royal Hospital for Women (RHW), Sydney, has a key role in the provision of women's health care leading the way in fertility, preconception, obstetric medicine, birthing, neonatal care, gynaecology, gynaecological oncology and breast care.

Each year the hospital delivers more than 3,700 babies; cares for more than 600 premature babies; treats more than 400 women for gynaecological cancer; provides surgery for more than 80 women with breast cancer; attends to over 450 women requiring acute care services and helps more than 600 women through endo-gynaecological procedures.

Level 6 Maternity Service - Provides planned care as for level 5 and in addition:

- consultation to clinicians at lower-level facilities 24 / 7 as required
- support for shared care arrangements for women and / or neonates when care can be provided at a lower-level service where appropriate
- acceptance of referrals and / or transfers from networked services when higher level care is needed (including in time critical situations and/or when bed capacity is limited)
- a leadership role in the TPN including education and training; quality and safety; policy and guideline development; service planning and review; and bed management (working in collaboration with networked services to monitor bed capacity across the TPN and negotiate with their networked services on bed management strategies when demand is nearing capacity).
- planned care for all women regardless of gestational age or clinical risk

- state-wide high risk pregnancy care where required
- complex specialist care
- referral pathways to relevant Aboriginal programmes and services
- obstetrician-led and GP shared care, Midwifery-led models of care including Midwifery Group Practice (MGP) and Maternity Antenatal and Post Natal Service (MAPS)
- on site dedicated adult acute care Close Observation Unit
- access to adult Intensive Care Unit (ICU) at Prince of Wales Hospital

Level 6 Neonatal Service: 17 NICU cots; 28 SCN cots

- Supra Local Health District role for neonatal care (neonates who require surgical care)
- Comprehensive neonatal care for all newborns, within a multidisciplinary management model

St George Hospital:

The St George Hospital and Health Services is part of the SESLHD. It is an accredited, principal teaching hospital of the University of New South Wales and is not only the largest hospital within the Local Health District but is among the leading centres for trauma and emergency management in the State.

The Hospital has a very high trauma load and accepts referrals from outside its immediate area. The hospital's areas of special expertise also include cancer services, critical care, cardiothoracic surgery, mental health services and women's and children's health care.

Level 5 + Maternity Service - Provides planned care as for level 4 and in addition:

- antenatal, intrapartum and postnatal care for women ≥32+0 weeks gestation
- provides major and selected complex major obstetric procedures - refer to *Guide to the Role Delineation of Clinical Services Appendix I: Indicative List of Surgery for Adults*
- collaborative care is provided by midwives, junior medical officers, obstetricians and maternal-fetal medicine specialists and neonatologists
- referral pathways to relevant Aboriginal programmes and services

Should not provide:

- Care for women with triplets with other risk factors or higher order multiple pregnancy

Level 4 Neonatal Service: – 12 SCN cots + 4 surge cots

- Immediate newborn care for infants ≥ 32^{+0} weeks gestation
- Ongoing care for return transfers of preterm and convalescing infants of any weight no longer requiring higher level service ≥ 30^{+0} weeks corrected age

The Sutherland Hospital:

The hospital offers a comprehensive range of inpatient and outpatient healthcare services to the residents of the Sutherland Shire.

Level 4 Maternity Service – Provides planned acre as for level 3 and in addition:

- planned care for Women ≥ 34^{+0} weeks gestation with no identified maternal or fetal risk factors
- Obstetrician-led and Midwifery-led models of care (including MGP & MAPS).
- referral pathways to relevant Aboriginal programmes and services

Should not provide:

- planned birth of twins with additional risk factors or higher order multiple pregnancy

Level 3 Neonatal Service: 4 SCN cots + 3 surge cots + 1 resuscitation cot

- Immediate newborn care for infants ≥ 34^{+0} weeks gestation
- Ongoing care for return transfers of preterm and convalescing infants no longer requiring higher level service ≥ 32^{+0} weeks corrected age.

Norfolk Island:

Norfolk Island Health and Residential Aged Care Service offers antenatal and postnatal care and is a non-birthing site.

Prince of Wales Private Hospital:

St George Private Hospital:

Hurstville Private Hospital:

Kareena Private Hospital:

These facilities are licensed to provide:

- planned care for women ≥ 32^{+0} weeks gestation, with no additional maternal or fetal risk factors.
- immediate newborn care for infants ≥ 32^{+0} weeks gestation
- ongoing care for return transfers of preterm and convalescing infants no longer requiring higher level service ≥ 32^{+0} weeks corrected age.

ILLAWARA SHOALHAVEN LOCAL HEALTH DISTRICT (ISLHD):

Provides health care to over 400,000 residents. ISLHD has two public hospitals and one private hospital that provide maternity services.

The Wollongong Hospital:

Level 5 Maternity Service: - Provides planned care as for 4 and in addition:

- antenatal, intrapartum and postnatal care for women ≥32+0 weeks gestation
- provides Major and selected Complex Major obstetric procedures - refer to *Guide to the Role Delineation of Clinical Services Appendix I: Indicative List of Surgery for Adults*
- collaborative care is provided by midwives, junior medical officers, obstetricians and maternal-fetal medicine specialists and neonatologists
- referral pathways to relevant Aboriginal programmes and services

Should not provide planned care of:

- care for women with triplets with other risk factors or higher order multiple pregnancy
- known or suspected placenta accreta, increta or percreta

Level 4 Neonatal Service: – 12 SCN Cots

- Immediate newborn care for infants ≥ 32^{+0} weeks gestation
- Ongoing care for return transfers of preterm and convalescing infants no longer requiring higher level service ≥ 29^{+0} weeks corrected age

Shoalhaven District Memorial Hospital:

Level 3+ Maternity Service- Provides planned care as for level 2 and in addition:

- planned care for women ≥ 36^{+0} to < 42+0 weeks gestation with no additional maternal or fetal risk factors, including induction of labour, vacuum and forceps births, vaginal birth after caesarean section
- obstetric-led care, GP shared care and MAPS models of care,
- referral pathways to relevant Aboriginal programmes and services

Should not provide:

- induction of labour/augmentation with syntocinon for women with previous caesarean section
- caesarean section for major placenta praevia
- planned birth of women with multiple pregnancy

Level 3 Neonatal Service: - 6 SCN cots + 1 Resuscitation cot

- Immediate newborn care for infants ≥ 34 $^{+0}$ weeks gestation
- Ongoing care for return transfers of preterm and convalescing infants no longer requiring higher level service ≥ 32^{+0} weeks corrected age.

Milton Ulladulla Hospital:

Level 1 Maternity Service (Non birthing site): - Provides planned:

- midwifery models of care (MAPS) and GP shared care for antenatal and postnatal care
- postnatal care of newborns born at ≥ 37+0 weeks gestation without complication
- referral pathway to SDMH for intrapartum care

Wollongong Private Hospital:

This facility is licensed to provide:

- Planned care for women ≥ 34^{+0} weeks gestation with no additional maternal or fetal risk factors
- Immediate newborn care for infants ≥ 34^{+0} weeks gestation
- Ongoing care for return transfers of preterm and convalescing infants no longer requiring higher level service ≥ 34^{+0} weeks corrected age.

NETWORK MATERNITY AND NEONATAL SERVICE CAPACITY

Facility	Bed type	Physical
Royal Hospital for Women	Birth rooms	13
	Maternity Assessment Unit	2 chairs & 2 Beds
	Recovery	5
	Close Observation Unit- Acute Care Ward	5
	Postnatal Ward	40
	Antenatal Ward	12
	Well Baby Cots	57
	Neonatal Intensive Care	16
	Special Care Nursery	28
St George Hospital	Birth rooms	8
	Assessment Rooms	2
	Maternity Assessment Unit	5 beds
	Maternity Ward –Combined Postnatal/Antenatal Ward	26
	Well Baby Cots	26
	Special Care Nursery	12
The Sutherland Hospital	Birth rooms	5
	Assessment room(s)	2 + 3 chairs
	Maternity Ward – Combined Postnatal/Antenatal Ward	15
	Well Baby Cots	15
	Special Care Nursery	4
The Wollongong Hospital	Birth rooms	7
	Assessment room(s)	3 + 3 chairs
	Maternity Ward –Combined Postnatal/Antenatal Ward	28
	Well Baby Cots	28
	Special Care Nursery	20
Shoalhaven District Memorial Hospital	Birth rooms	4
	Assessment room	1
	Maternity Ward –Combined Postnatal/Antenatal Ward	12
	Well Baby Cots	12
	Special Care Nursery	6

TRANSFER PROCESSES

Decision for Transfer

- The referring obstetric registrar and/or consultant at the referring site will review the woman and make an assessment regarding her risk of preterm delivery and her need for ongoing higher level obstetric care in consultation with the Maternal Transfers Decision Making Tool.
- The decision to request transfer must be made in consultation with the referring obstetric consultant
- The referring team will assess need for tocolysis, steroids and/or magnesium sulphate ($MgSO^4$). $MgSO^4$ should not be infused during transfer.
- **The consultant at the referring site must authorise any transfer.**
- The subsequent steps taken to arrange the transfer will depend on where the patient is being transferred to.

Transfer To RHW

- **All requests** for transfer to RHW are to be coordinated through the **RHW Transfer Coordinator (TC) on 0434 565 264.**
- **DO NOT** call RHW Switch or Obstetric teams directly**.**
- For MP 1 transfer requests AT ANY TIME
    - The TC will arrange an immediate conference call with the RHW obstetric consultant and registrar and the referring obstetric consultant and registrar
- For MP2, MP3 and MP4 transfer requests between 0700-2200
    - The TC will arrange a conference call with the RHW obstetric consultant and registrar and the referring obstetric consultant and registrar
- For MP 2, MP3 and MP4 transfer requests between 2200 – 0700
    - The TC and RHW registrar may accept the transfer if there is capacity and inform the RHW obstetric consultant and team at morning handover unless consultation is required overnight
- MP1 and MP4 cases from within the TPN will be accepted at RHW regardless of NICU capacity.
- If no capacity to accept a MP2 or MP3 maternal transfer, decisions for refusal of transfer **must** be made by both the RHW consultant obstetrician and the RHW consultant neonatologist on call.

To St George Hospital (STG) Or Wollongong Hospital (TWH)

- All requests for transfer to STG or TWH are to be coordinated through the on-call obstetrics and gynaecology team.
- If required, and where applicable, a conference call can facilitate communication between involved parties across sites to reach a decision regarding transfer.

- MP1 and MP4 cases from within the TPN will be accepted regardless of neonatal nursery capacity.
- If no capacity to accept a MP2 or MP3 maternal transfer, decisions for refusal of transfer **must** be made by both the consultant obstetrician and the consultant neonatologist/paediatrician on call.
- If there is no capacity to accept the transfer, the level 5 obstetric consultant will contact the RHW via the TC on 0434 565 264.

MP5 Transfers – consultation/referral

- This category is for woman who may require consultation or referral to a higher-level facility and may be suitable for local observation in the meantime.
- Consultation at a higher-level facility may occur as an outpatient.
- If there is uncertainty regarding the most appropriate referral pathway, the consultant obstetrician at the local facility can contact and discuss with the on-call obstetrician at the level 5 or 6 facility.
- Outpatient referrals can be made to the:
    - High Risk Clinic at Wollongong Hospital
        - On call Obstetrician at Wollongong Hospital through hospital switch board 02 4222 - 5000
    - Fetal Maternal Centre (FMC) at St George Hospital
        - FMC Obstetrician at St George Hospital via the Genetics Department on 02 9113 - 3635
    - Department of Maternal Fetal Medicine (MFM) at the Royal Hospital for Women
        - Requests for outpatient MFM referral can be made to the RHW “fetus phone” 0800-17:00 on 0437 537 448.
        - Please note that this line is for referrals only and not for clinical advice.
        - In addition to calling the phone to make the referral, please also send copies of previous ultrasounds, consultations, relevant pathology and maternal blood group to (fax) 02 9382-6038.

Agreement for Maternal Transfer Priority

- The receiving obstetric team determines the Maternal Priority for transfer in collaboration with the referring obstetric team.
- Consultant to consultant contact is essential in cases of clinical uncertainty and where there may be disagreement between sites.

Ensure All Appropriate Staff Are Informed About Maternal Transfer

- Following acceptance, clinical handover should occur from the referring obstetric team to the receiving obstetric registrar (if they have not already been included in the transfer decision discussion).
- The midwives in-charge of the Birth Unit (BU) in both the referring and receiving units need to be notified of the transfer by the obstetric teams.

- The NICU team needs to be notified of imminent MP1 transfers by the receiving obstetric team.

Documentation

- Ensure appropriate clinical records are sent to the receiving hospital with the patient or are faxed ahead of transfer.
- Ensure maternal transfers minimum data set form is completed by both the referring and receiving units. Forward to the redesign leads for data capture.

Follow Administration Process and Arrange Transport

- The midwife in-charge or transfer coordinator is to:
  - place the woman on the Patient Flow Portal (PFP) as a inter hospital transfer (IHT) and arrange transport and midwifery escort.
  - inform Patient Flow Unit (PFU) at the referring and receiving hospital.
- Transfer Coordinator or the PFU is to confirm the bed in the PFP/IHT.
- The type of transport used will depend on the urgency and may be provided by state-wide services such as NSW Ambulance Service, and other Patient Transport Services (PTS).

Assessment Prior To Transfer

- This is essential to ensure the mother and fetus are stable, and that maternal transfer is still appropriate
- Repeat vaginal examination may be required.
- **Contraindications** to maternal transfer include:
  - unstable maternal condition (e.g., high risk of eclampsia, severe uncontrolled hypertension, haemorrhage)
  - when birth is imminent >26 weeks (e.g., fully dilated, rapidly progressing in labour)
  - significant fetal distress where immediate delivery is indicated, and the balance of risk is in favour of delivery at referring site with arrangement of NETS transfer of neonate to higher level facility.
- Maternal Safety Huddle Tool (Appendix 3) – Agreeance with referring and receiving hospital, logistics for transfer (NSW Ambulance/ NETS), enroute deterioration plan

Transfer Out of RHW Tiered Perinatal Network

- Transfers from RHW TPN to an external TPN can only be requested by the RHW obstetric consultant and the neonatology consultant.
- The RHW executive on call **must** be notified. LHD Executive on call to be notified of transfers out of RHW TPN due to RHW NICU capacity
- Transfer Coordinator will:

  - use the PFP Neonatal and Birthing Unit Bed Status /Emergency Access View report to identify available bed in the state
  - conference call with the RHW obstetric team, the referring obstetric team and the receiving obstetric team
  - notify the referring hospital of the agreed destination to arrange IHT, clinical handover and arrange appropriate transport.
- Where an alternate destination within NSW cannot be identified the woman will be accepted at RHW.

Return Maternity Transfers

- A maternity transfer from a higher to lower-level facility within the TPN may be appropriate when a woman no longer requires a higher level of care or reaches a gestation for which care can be provided by a lower-level facility.
- Requests for a return maternity transfer to another facility within the TPN are made by contacting the on-call O&G team at the appropriate facility
- Clinical handover between obstetric and midwifery teams must occur prior to transfer

Post Natal Maternity Transfers

- Requests for a postnatal maternity transfer to another facility within the TPN are made by contacting the TC at RHW, or on call O&G team at the other facilities
- Transfers are accepted by the obstetric consultant for the day
- Clinical handover between obstetric and midwifery teams must occur prior to transfer

Transfer To RHW From Norfolk Island (NI)

- Women who are registered to birth with QLD facilities are to be transferred to the booking facility wherever possible, and not to RHW.
- Where maternal transfer to RHW is requested, the Norfolk Island Health and Residential Aged Care Service (NIHRACS) GP and Manager is to contact the RHW Transfer Coordinator (TC) on telephone number +61 434 565 264 who will coordinate a conference call with the RHW obstetric consultant on-call to confirm that maternal transfer is required and that the woman is safe to transfer
- When the decision is made for RHW transfer, the NIHRACS GP and Manager is to:
  - arrange the patient transfer
  - contact **CareFlight +61 1300 655 855 / +61 2 98937683**
  - consider and arrange other transport providers to other possible locations via Retrieval Service Queensland (RSQ) +61 1300 799 127 and/or New Zealand airlines if **CareFlight** is unavailable
  - ensure appropriate copy of clinical records are sent to RHW
  - provide a comprehensive clinical handover, including an update with transport arrangements and the expected time of arrival at RHW

- Where there are delays or issues , the **SESLHD Organisational Performance Support Manager (OPSM)**/District executive on call should be contacted by the RHW TC

Health
South Eastern Sydney
Local Health District

Health
Illawarra Shoalhaven
Local Health District

MATERNAL TRANSFER PROCESS

The referring obstetric team assess risk of preterm delivery and need for maternal transfer

All requests for transfer to RHW are coordinated through the RHW Transfer Coordinator (TC) on **0434 565 264** who will arrange a conference call between teams

All requests for transfer to STG or TWH are coordinated through the on-call Obstetrics and Gynaecology team via birthing unit
STG 02 9113 2125 / TWH 02 4222 5270

The receiving obstetric team to confirm need for transfer, determine transfer priority and inform NCC/SCN

MP1 - Immediate Transfer	23+0-26/40 gestation when imminent birth is likely •>26 gestation with progressive cervical dilation >3cm (if safe) •Deteriorating maternal/fetal condition and planned urgent birth
MP2 - Transfer within 3 hours	TPL fFN >500 ng/ml or Cx 1-3 cm with ongoing uterine activity •PPROM with ongoing uterine activity •Deteriorating maternal/fetal condition and need for birth within 12 hours
MP3 - Transfer within 12 hours	TPL fFN 200 - 499 ng/ml or Cx 1-3cm with effective tocolysis •Deteriorating maternal/fetal condition and birth likely to be required within 12-24 hours
MP4 - Transfer within 24 hours **If within 2 weeks of service capability, can continue to observe and review at local facility** **If stable no transfer required**	TPL fFN 50 - 200 ng/ml or Cx <1cm •PPROM with no uterine activity •Maternal/fetal condition where birth likely to be required in 24-72 hours
MP5 - Consultation/ Referral for advice Continue to observe and review	fFN<50ng/ml or asymptomatic short cervix •TPL or PPROM <23/40 •Stable APH with no uterine activity •Maternal or fetal condition requiring consultation/referral with higher level facility

Facility must always accept MP1 and MP4 transfer within TPN

If STG or TWH cannot accept MP2 or MP3 transfer, contact the RHW TC on 0434 565 264

If RHW cannot accept MP2 or MP3 transfer within TPN

(as per obstetric and neonatal consultants) the

RHW team is to coordinate transfer to external TPN

RHW and LHD Exec to be informed of all external transfers

If Birth Imminent at Local Facility Paediatrician contacts NETS
1300 362 500

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MATERNAL TRANSFERS DECISION MAKING TOOL					
Maternity Priority	**MP1***	**MP2***	**MP3**	**MP4**	**MP5**
Medically agreed time frame (Time by which woman should be receiving higher level care)	Immediate Midwifery/ Medical escort required	< 3 hours Midwifery/ Medical escort required	< 12 hours Midwifery escort required	24 hours	72 + hours consultation or referral or back transfer
Transport determined by local LHD	NSW Ambulance/ ACC immediate dispatch	NSW Ambulance/ACC	NSW Ambulance/ ACC/PTS	PTS/ Private provider	PTS/ Private provider
Preterm Labour (PTL) (Regular contractions with any cervical change)	>26 progressive dilatation >3cm (if safe)	Dilated 1-3cm	Dilated <1cm and labour suppressed		
	23^{+0}–26^{+0} with imminent birth	Gestation as per tiered perinatal network operational plan			<23 weeks
Threatened preterm labour (TPL), closed cervix - quantitative fFN			≥200 ng/mL	50–199 ng/mL	<50ng/mL or short cervix without symptoms
APH (stable) In absence of uterine activity				≥ 23 weeks as per operational plan	Consult / referral
PPROM (without labour)				≥ 23 weeks as per operational plan	< 23 weeks
Multiple pregnancy complication		23^{+0}–26^{+0} weeks	>26 weeks as per operational plan		< 23 weeks
Maternal condition	Deteriorating +/- Planned urgent birth	Maternal deterioration whereby birth likely required within 12–24 hours			Consult / referral
Fetal condition	Deteriorating +/- Planned urgent birth	Fetal deterioration whereby birth likely required within 12–24 hours			Consult / referral

***Requires consultation with Obstetric Consultant**

ACC – Aeromedical Control Centre
APH – Antepartum Haemorrhage
Fetal condition – e.g. growth restriction
fFN – Fetal Fibronectin
Maternal condition – deterioration may increase MP

Medically agreed timeframe – transfer to higher level care may be impacted by geographical conditions
PTL – Pre-term labour
PPROM – Preterm premature rupture of membranes
PTS – Patient Transport Services
TPL – Threatened Preterm Labour – if cervical changes over time becomes PTL

Maternal transfers decision making tool interpretation

Purpose

The Decision Making Tool supports the process for maternal transfers by standardising assessment of urgency and risk of clinical presentations to:

- reduce clinical variation
- prioritise resources, including transport logistics across NSW
- enable women to be observed in their local facilities rather than being transferred long distances.

Scope

The tool should be used to:

- determine the need for transfer
- accurately communicate the level of urgency and risk between facilities
- assist with a medically agreed timeframe in which transfer should occur
- inform the most appropriate mode of transport and escort required

Elements

The tool contains a number of elements that together assist clinical assessment and transfer decisions. The clinical indicators combined with other factors such as the geographical location of the woman, the capacity of the facility she is located at, available service options, and factors such as weather that could impact on transport, together provide a basis for decision making.

The Tool provides a framework for categorising women (MP1 to 5) according to urgency and need. The MP categories offer a common language for discussions with TPN and transport services. The medically agreed timeframe indicates when the woman should be receiving higher level care and provides guidance for transfer times.

Clinical indicators:

- weeks of gestation
- regular uterine contractions
- cervical dilatation
- quantitative fFN score
- rupture of membranes
- Antepartum haemorrhage
- Multiple pregnancies
- Maternal condition
- Fetal condition.

Maternity Priority (MP1 – MP5) indicates the level of urgency for transfer:

- MP1 is a time critical transfer and is not to be delayed. TPN facilities must accept MP1 regardless of capacity
- MP2 timeframe is within 3 hours for transfer
- MP3 timeframe is within 12 hours for transfer
- MP4 and MP5 category may be suitable for local observation or referral to the level 4, 5 or 6 units for ongoing assessment. This assessment may be as an outpatient.
- Assessment for Multiple Pregnancy should be categorised one maternal priority higher than a singleton pregnancy.

Currency of assessment

- Regular reassessment is required to assess for change in maternal priority, which may indicate an increase in maternal priority
- Assessment just prior to transfer is essential to ensure the mother and fetus are stable, this may include a repeat vaginal examination where appropriate.

TIERED NETWORK DEMAND ACCESS ESCALATION (STEP)

Introduction

Effective bed management practice will always aim to ensure that there are sufficient beds available to meet the demands placed on the Tiered Maternal Neonatal Network - (South Eastern Sydney Local Health District (SESLHD)/ Illawarra Shoalhaven Local Health District (ISLHD)
It is recognised however that there will be times when demand may exceed availability, particularly during seasonal fluctuations and escalation from the Tiered Network will be required
In this circumstance, this plan will provide a framework for managing the situation.

Aim

The aim of the escalation plan is to provide a high-level approach for effectively managing escalation to support key services to manage capacity across each health domain.

Objective

The objective of this escalation plan is to provide:

- A focussed and timely response to predicted and actual capacity mismatch being experienced
- The plan will formalise and ensure an integrated response from all Departments and Divisions
- Efficient, robust and resilient internal operational procedures to ensure a timely and appropriate response to optimise outcomes.
- Assurance that actions taken are enabling and effective

Roles and Responsibilities

Once the escalation level is known and adequately communicated the risk status matrix processes commence. Both clinical and management team engagement across the Tiered Network is important to ensure internal pro-active approach to effective flow and capacity. Early escalation of capacity problems is key to enabling awareness to ensure patient flow is efficient and can respond to the need for increased capacity creation.

De- escalation

This process will also ensure appropriate and timely de-escalation so that all parties are aware when normal service function has resumed.
Communicated appropriately through patient flow capacity report indicating change to site status.

Patient Flow Portal (PFP) Electronic Patient Journey Board (EPJB)

Updating the bed availability and /or Consultant Details in the EPJB as changes occur:

- Paediatric and Neonatal ICUs must be updated at least every 4 hours.
- Birthing Units must be updated at least every 8 hours.

If nothing has changed since the last update, you must still go into the update window and click **No Changes**

Core Roles and Responsibilities:

General Manager: is the Executive Sponsor of patient flow, and should receive escalations of a critical nature regarding flow challenges and impediments, and should be briefed on action plans to resolve those. The General Manager is also accountable for initiating a level 3 escalation if required. The DCE is the reinforcing sponsor and delegated to assist sites accordingly at the request of the GM or DDONM.

Director/Deputy Director of Nursing and Midwifery (D/DDON&M): holds primary site responsibility for the daily operational aspects of the facility and daily management of the access agenda. The DONM collaborates to ensure that networking opportunities across the LHD and other related demand management issues are coordinated and optimised.

Patient Flow Unit (PFU) Manager - Access Demand Manager (ADM), Bed Manager (BM): Has responsibility for the Demand Management and flow of patients throughout the hospital and is the main contact and communication conduit for all issues related to patient flow at the site and has a key responsibility in managing patient flow and in the proactive management of delays. Ensuring targets are met to the best of service ability. Assists with the management of operational issues that are impacting on patient flow through the hospital. Manages the AHNM team and directly reports flow issues to D/DDON and Executive as required.

After Hours Nurse Manager (AHNM): The AHNM is the main contact and communication conduit for all issues related to patient flow after hours at the site. They also problem-solve with ward-based NUMs; and encourage discharge patients to be moved immediately to the PDU where possible (or suitable local ward area). Escalate if there are unresolvable issues and ensure communication and feedback between all ward areas is optimised; as well as over-seeing the Patient Flow Portal, demand management predictions, and applying and working within the models of care across the facility and policy directions including Inter-facility Transfer (PD2011_031)

Medical Teams/Ward N/MUM/TL: Work closely with the PFU/AHNM to identify beds currently free and available for utilisation; beds with patients for discharge who are required to remain on the ward, and that clinical rationale; patients waiting medical review for potential discharge; patients for discharge the following day that could be reviewed if escalation occurs; any practical issue that prevents patient flow/access – for example patient acuity or staffing skill mix issues.

Clinical Services, Department Heads & Allied Health: holds primary responsibility for implementing and working within the Admission to Discharge Care Coordination Policy (PD2022_012); ensuring timely ward rounds, optimised patient flow across the system, patient assessment and monitoring of clinical goals and clinical endpoints; timely execution of interventions and diagnostics. The Expected Date of Discharge/Transfer is also an important element of inpatient ward-based care.

Co- Directors/Operations Managers/ Nurse Managers: also have a daily responsibility in relation to the escalation of inpatient bed capacity management issues and in the strategic elements of the access agenda, which includes LOS management of stranded patients and development of strategies/models of care to improve patient flow through the clinical units. If there are delayed responses by inpatient teams either in the ward environment or in

response to request for review, these should be escalated to the team consultant in the first instance then the DCS.

STEP ESCALATION: Refer to local facility Demand Access Escalation (STEP)

Level 0	Core business as usual	Ensure all standard operational procedures are functioning as efficiently as possible to maintain flow
Level 1	Moderate pressure	Respond quickly to manage and resolve emerging pressures that have the potential to inhibit flow. Initiate contingencies. De-escalate when applicable.
Level 2	Severe pressure	Prioritise available capacity in order to meet immediate pressures. Put contingencies into action and bring pressures back with in organisational control. De- escalate when applicable and as soon as possible.
Level 3	Extreme pressure	Ensure all contingencies are operational to recover the situation. Executive command and control of the situation. De- escalate when applicable and as soon as possible.

STEP PLANS:

- RHW Demand Access Escalation
- TSH Demand Escalation Plan
- St George Demand Escalation Framework
- TWH STEP PLAN COVID

- The Tiered Network is responsible for establishing the mechanism for data capture for the agreed key performance indicators and the mechanism for dissemination of outcome information.
- The system should be electronic and there should be sufficient connectivity to electronic systems, such as the patient flow portal, to ensure accuracy of data
- Outcome data will be disseminated to the Maternity Divisions at each facility within the Tiered Network
- All hospitals in the TPN are to run regular audit meetings regarding maternal transfers
- In addition to the usual in-hospital Incident Management System (IMS+) process, any adverse outcomes or difficult transfers should be flagged to the RHW TPN Clinical Lead and Redesign Leads.

APPENDIX:
TIERED FACILITIES AND CONTACT DETAILS

TIERED FACILITIES AND CONTACT DETAILS

- **RHW LEVEL 6** – 02 9382 6111
  - TRANSFER COORDINATOR – 0434 565 264
  - BIRTHING UNIT – 02 93826100
  - BIRTHING UNIT MUM – 0437 762 964
  - OBTETRIC CONSULTANT MOBILE per PFP
  - MATERNAL FETAL MEDICINE (MFM) – 0437 537 448 or 02 9382 6098
    - Fax form to 02 93826038
- **ST GEORGE LEVEL 5** – 02 9113 1111 Distance Time to L6 - 30 mins
  - BIRTHING UNIT – 02 9113 2125
  - BU MUM/ T/L – 02 9113 2458
  - OBSTERIC CONSULTANT MOBILE per PFP
  - FETAL MATERNAL CENTRE (FMC) – 02 9113 3635
  - PFU – 0429 369 599 (07-2300) /0463 477 768 (07-1430)
    - AH – 0414 192 008
- **WOLLONGONG LEVEL 5** – 02 4222 5000 Distance Time to L6 - 80 mins
  - BIRTHING UNIT – 02 4222 5270 / 02 4222 5305
  - BU MUM/ T/L – 02 4222 5190
  - OBSTERIC CONSULTANT MOBILE per PFP
  - PFU – 02 4222 5000 page 109
- **SUTHERLAND LEVEL 4** – 02 9540 7111 Distance Time to L6 - 40 mins
  - BIRTHING UNIT – 02 9540 7981
  - BU MUM – 02 9540 7989
  - OBSTERIC CONSULTANT MOBILE per PFP
  - PFU – 0404 067 624
- **SHOALHAVEN LEVEL 3+** – (02) 4421 3111
  - BIRTHING UNIT – 02 4423 9207 Distance Time to L6 - 130 mins
  - BU MUM – 02 4423 9455
  - VMO CONSULTANT MOBILE
  - PFU – 02 4423 9738
- **NSW AMULANCE** – 131 233
- **NETS** – 1300 362 500
- **ACC** – Aeromedical Control Centre – 131 233
  - General admin 9553 2222

FETAL FIBRONECTIN

PeriLynx
fFN Screening Guidelines

Health Pathology

Overview

Once the analyser has determined the woman's fFN concentration, use the table below to help evaluate her risk level. These risk levels are for women experiencing signs and symptoms of preterm labour.

Interpreting fFN results	Action
fFN ≥200 ng/mL (29% chance birth WILL occur <14 days)	As for all women requiring admission **and** Commence tocolysis if delay of birth indicated and no contraindications (***MP3 category** - see Maternal Transfer Decision Making Tool)
fFN 50 – 199 ng/mL (8% chance birth WILL occur <14 days)	As for all women requiring admission **and** • Consider tocolysis if delay of birth indicated and no contraindications • Consider all clinical circumstances including previous history of PTB (***MP4 category** – see Maternal Transfer Decision Making Tool)
fFN <50 ng/mL (negative) (98% chance birth will NOT occur <14 days)	Ongoing admission following point of care testing is not required provided there are no other risk factors/ indications. Arrange follow up and provide the women with targeted information (***MP5 category** - see Maternal Transfer Decision Making Tool)

Reference: Maternity-Management of Threatened Preterm Labour (2020_009 Policy Directive)

Health
South Eastern Sydney
Local Health District

Health
Illawarra Shoalhaven
Local Health District

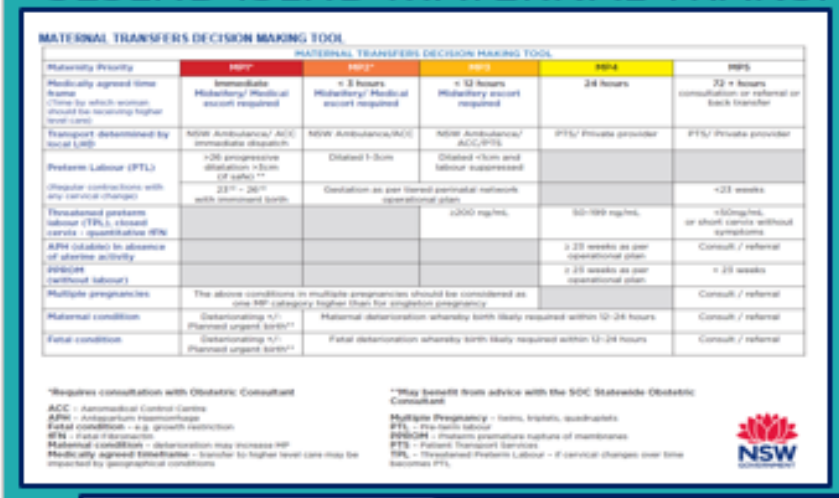
MATERNALTRANSFERS MINIMUM DATASET FORM

Maternal Transfer -Minimum Data Set

Referring Facility	Name/title of clinician: Date: Time of call:	Name of facility: Service Capability: End time of call:
Receiving Facility	Facility: Service capability: Consultant:	L6 – L6 request (yes/no)
Patient Information	Name: DOB: Gravida / Parity: EDB:	Gestation: Multiple pregnancy: (yes/no)
Reason for Transfer	TPL	fFN: Yes – result No - reason
	PTL	Cx dilatation
	PPROM	Date: Time:
	APH	Placenta Previa: yes /no Other:
	Multiple pregnancy complication	Specify:
	Deteriorating Fetal Condition	Specify:
	Deteriorating Maternal Condition	Specify:
	Relevant Medical or Obstetric Hx	
	Treatment commenced Steroids: Antibiotics Nifedipine Other	
Maternal Priority	☐ MP1 (immediate) ☐ MP2 (<3h) ☐ MP3 (<12hrs)	☐ MP4 (<24hrs) ☐ MP5 (MFMU referral) ☐ Transfer not recommended ☐ Change in MP category after initial call – specify change
Transfer Outcomes	☐ Outborn birth prior to transfer ☐ Transfer declined – outcome:	
	☐ Time of Transfer: Date/time ☐ Arrival: Date/time ☐ Birthed: Date / time ☐ Discharged home: Date /time ☐ In Utero back-transfer to referring hospital: Date/time ☐ Transfer to another facility - Date/time: Reason:	

Please return form to Maternal Transfer Redesign Lead:
SESLHD Wendy Hudson (Wendy.Hudson@health.nsw.gov.au)
ISLHD Helen Donovan (Helen.Donovan@health.nsw.gov.au)
Network Clinical Lead: Lalla McCormack (Lalla.McCormack@health.nsw.gov.au)

SESLHD ISLHD MATERNAL TRANSFERS


MATERNAL TRANSFERS DECISION MAKING TOOL

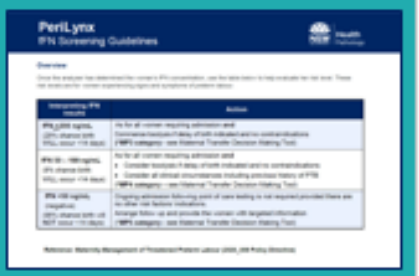
Maternity Priority	MP1*	MP2*	MP3	MP4	MP5
Medically agreed time frame (Time by which woman should be receiving higher level care)	Immediate Midwifery/ Medical escort required	< 3 hours Midwifery/ Medical escort required	< 12 hours Midwifery escort required	24 hours	72 + hours consultation or referral or back transfer
Transport determined by local LMD	NSW Ambulance/ ACC immediate dispatch	NSW Ambulance/ACC	NSW Ambulance/ ACC/PTS	PTS/ Private provider	PTS/ Private provider
Preterm Labour (PTL)	>26 progressive dilation >3cm (if safe) **	Dilated 1-3cm	Dilated <1cm and labour suppressed		
(Regular contractions with any cervical change)	23[0] – 26[0] with imminent birth	Gestation as per tiered perinatal network operational plan			<23 weeks
Threatened preterm labour (TPL), closed cervix - quantitative fFN			≥200 ng/mL	50-199 ng/mL	<50ng/mL or short cervix without symptoms
APH (viable) in absence of uterine activity				≥ 23 weeks as per operational plan	Consult / referral
PPROM (without labour)				≥ 23 weeks as per operational plan	< 23 weeks
Multiple pregnancies	The above conditions in multiple pregnancies should be considered as one MP category higher than for singleton pregnancy				Consult / referral
Maternal condition	Deteriorating +/- Planned urgent birth**	Maternal deterioration whereby birth likely required within 12-24 hours			Consult / referral
Fetal condition	Deteriorating +/- Planned urgent birth**	Fetal deterioration whereby birth likely required within 12-24 hours			Consult / referral

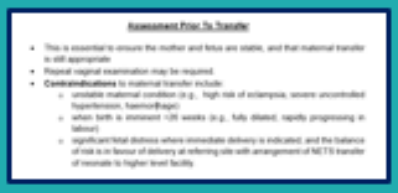
*Requires consultation with Obstetric Consultant

ACC – Aeromedical Control Centre
APH – Antepartum Haemorrhage
Fetal condition – e.g. growth restriction
fFN – Fetal Fibronectin
Maternal condition – deterioration may increase MP
Medically agreed timeframe – transfer to higher level care may be impacted by geographical conditions

**May benefit from advice with the SOC Statewide Obstetric Consultant

Multiple Pregnancy – twins, triplets, quadruplets
PTL – Pre-term labour
PPROM – Preterm premature rupture of membranes
PTS – Patient Transport Services
TPL – Threatened Preterm Labour – if cervical changes over time becomes PTL


PeriLynx
fFN Screening Guidelines


Assessment Prior To Transfer

- This is essential to ensure the mother and fetus are stable, and that maternal transfer is still appropriate
- Repeat vaginal examination may be required.
- **Contraindications** to maternal transfer include:
  - unstable maternal condition (e.g., high risk of eclampsia, severe uncontrolled hypertension, haemorrhage)
  - when birth is imminent <26 weeks (e.g., fully dilated, rapidly progressing in labour)
  - significant fetal distress where immediate delivery is indicated, and the balance of risk is in favour of delivery at referring site with arrangement of NETS transfer of neonate to higher level facility

MATERNAL TRANSFER PROCESS

The referring obstetric team assess risk of preterm delivery and need for maternal transfer

All requests for transfer to RHW are coordinated through the RHW Transfer Coordinator (TC) on **0434 565 264** who will arrange a conference call between teams

All requests for transfer to STG or TWH are coordinated through the on-call Obstetrics and Gynaecology team via birthing unit
STG 02 9113 2125 / TWH 02 4222 8270

The receiving obstetric team to confirm need for transfer, determine transfer priority and inform NCC/SCN

MP1 - Immediate Transfer	•23+0-26/40 gestation when imminent birth is likely •>26 gestation with progressive cervical dilation >3cm (if safe) •Deteriorating maternal/fetal condition and planned urgent birth
MP2 - Transfer within 3 hours	☐ TPL fFN >500 ng/ml or Cx 1-3 cm with ongoing uterine activity •PPROM with ongoing uterine activity •Deteriorating maternal/fetal condition and need for birth within 12 hours
MP3 - Transfer within 12 hours	☐ TPL fFN 200 - 499 ng/ml or Cx 1-3cm with effective tocolysis •Deteriorating maternal/fetal condition and birth likely to be required within 12-24 hours
MP4 - Transfer within 24 hours If within 2 weeks of service capability, can continue to observe and review at local facility If stable no transfer required	☐ TPL fFN 50 - 200 ng/ml or Cx <1cm •PPROM with no uterine activity •Maternal/fetal condition where birth likely to be required in 24-72 hours
MP5 - Consultation/ Referral for advice Continue to observe and review	☐ fFN<50ng/ml or asymptomatic short cervix •TPL or PPROM <23/40 •Stable APH with no uterine activity •Maternal or fetal condition requiring consultation/referral with higher level facility

Facility must always accept MP1 and MP4 transfer within TPN

If STG or TWH cannot accept MP2 or MP3 transfer, contact the RHW TC on 0434 565 264

If RHW cannot accept MP2 or MP3 transfer within TPN (as per obstetric and neonatal consultants) the RHW team is to coordinate transfer to external TPN

If Birth Imminent at Local Facility

Paediatrician contacts NETS
1300 362 500

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  - BIRTHING UNIT – 02 9113 2125
  - BU MUM/ T/L – 02 9113 2450
  - OBSTETRIC CONSULTANT MOBILE per PFP
  - FETAL MATERNAL CENTRE (FMC) – 02 9113 3636
  - PFU – 0429 369 699 (07:2300) /0483 477 768 (07:1430)
    - AIR – 0414192800
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  - BIRTHING UNIT – 02 4222 5270 / 02 42225305
  - BU MUM/ T/L – 02 42225190
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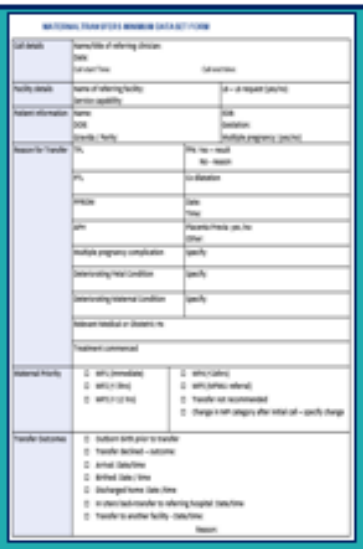
  - **General admin 9563 2222**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