Tiered Networking Arrangements for Perinatal Care in NSW

Summary This Policy Directive provides guidance for NSW Local Health Districts (LHDs), Sydney Children’s Hospitals Network and services in the Australian Capital Territory (ACT) on the structure, functioning and governance of Tiered Perinatal Networks.

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Secretary, NSW Health
This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.
TIERED NETWORKING ARRANGEMENTS FOR PERINATAL CARE IN NSW

PURPOSE
This Policy Directive provides guidance for NSW Local Health Districts (LHDs), Sydney Children’s Hospitals Network and services in the Australian Capital Territory (ACT) on the structure, functioning and governance of Tiered Perinatal Networks (TPN).

The TPNs provide a structure to support pregnancy and birth care through the appropriate use of maternity and neonatal services (capability); access to care appropriate to the level of assessed patient need (patient flow); and a ‘whole of health’ approach to the management of demand (capacity).

This Policy refers to women with high risk pregnancy complications requiring referral and/or transfer of care to a higher-level facility. It describes maternal and neonatal services in NSW, their TPN arrangements, the statewide Default Protocol, bed policy, and the requirement for LHD escalation processes.

MANDATORY REQUIREMENTS

- Access to higher level obstetric care for women with time critical pregnancy complications must not be delayed due to “no-available” maternal or neonatal beds. Every hospital is linked with a network of designated referral hospitals to provide higher level obstetric care for the women of that TPN.
- The statewide Default Protocol must be invoked when a woman requires time urgent critical care not available at the referring hospital; the woman must be transferred immediately to the Level 6 facility within the TPN irrespective of bed status.
- Obstetric consultancy advice must be available 24/7 in each TPN.
- Each TPN must have a documented and implemented Operational Plan. The Operational Plan should provide a description of usual business as well as processes for escalation where demand exceeds capacity.
- The Patient Flow Portal’s Electronic Patient Journey Board must have manual updates in real time (at least every 4 hours for neonatal units and every 8 hours for maternity units) to ensure that information is accurate and reflective of issues which can affect bed availability such as staff resources.

RESPONSIBILITIES

Local Health District Chief Executives responsibilities:

- ensuring implementation of the Policy and the delegation of clinical leadership and decision making to ensure clinically appropriate maternal transfers occur in appropriate timeframes
- engaging relevant clinicians and ensuring that consistent Operational Plans are developed, distributed to and implemented in relevant clinical areas
ensuring clinical advice and/or support, escalation pathways and referral procedures are documented and implemented to ensure access to definitive care in an appropriate timeframe

ensuring obstetric and neonatal care needs of that LHD and other LHDs within its TPN where specified. This includes the provision of clinical advice and ensuring access to appropriate treatment

ensuring that all options for placement of women with high risk pregnancy complications within the originating LHD have been explored. This includes appropriate transfers within the LHD to lower level facilities to create capacity

ensuring the continued effective operation of the Tiered Networking Arrangements for Perinatal Care in NSW

ensuring formalised intra and inter-LHD referral and/or cross jurisdictional arrangements exist for women with high risk complications needing a higher level of definitive care. These arrangements should also include ongoing formal communication with review and feedback

ensuring that compliance with this policy is audited and data is regularly monitored in collaboration with intra and inter-LHD stakeholders as a marker of system performance.

Maternity services (Levels 4, 5 & 6) and Neonatal services (Level 4, 5 & 6) responsibilities:

ensuring the information in the Patient Flow Portal (PFP) is current and correct at the nominated frequency

bed finding for time-critical and non time-urgent perinatal cases

providing consultation to clinicians at lower level facilities 24 / 7 as required

supporting shared care arrangements for women and / or neonates when care can be provided at a lower level service with appropriate support

taking 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).

Other maternity facilities in the TPN (level 2, 3) responsibilities:

accepting referrals, transfers and return transfers from within the TPN commensurate with their service capability.

Patient Flow Units / personnel responsible for transfer coordination including Bed Managers, After Hours Managers, Nurse/Midwifery Manager and Midwifery Unit Manager/Midwife In-Charge:

facilitating referrals for all time-critical and non time-urgent perinatal cases

implementation of strategies to facilitate utilisation of communication pathways within and between LHDs/ TPNs to facilitate effective and efficient transfers.
ATaCHMENTS

1. Tiered Networking Arrangements for Perinatal Care in NSW: Procedures
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1 BACKGROUND

1.1 Purpose

This Policy Directive provides guidance for NSW Local Health Districts (LHDs), Sydney Children’s Hospitals Network and services in the Australian Capital Territory (ACT) on the structure, functioning and governance of Tiered Perinatal Networks (TPN).

The eight NSW/ACT TPNs support capability, patient flow and capacity by providing:

- a defined scope of service capability and responsibilities for each maternity and neonatal service
- defined pathways for consultation, referral and/or transfer when higher level pregnancy and/or birth care is required (escalation of care); referral and transfer when higher care is no longer needed (de-escalation of care and return transfer)
- a structure for ‘shared care’ between maternity services of different capability levels; and ‘shared care’ between neonatal services of different capability levels
- a structure for a cross-service approach to monitor and manage service demand.

The overall aim of effective TPN arrangements is to achieve the right care, in the right place, at the right time for women as close to home as possible. On most occasions when a woman requires care for high-risk pregnancy issues, this should be provided within the TPN.

Aboriginal women are more likely than non-Aboriginal women to require transfer due to higher rate of pre-term births. In 2018, 11.1% of Aboriginal women had preterm births (babies born prematurely, or before 37 weeks gestation) compared to 7.5% of non-Aboriginal women\(^1\). The implementation of this Policy is anticipated to deliver increased benefits to this group.

1.2 About this document

This Policy replaces the Policy Directive PD2010_069 Critical Care Tertiary Referral Networks (Perinatal). This Policy should be read in conjunction with:

PD2018_011 NSW Critical Care Tertiary Referral Networks and Transfer of Care (Adults)
GL2018_018 NSW Maternity and Neonatal Service Capability Framework

1.3 Scope

This Policy refers to care of women with a high-risk pregnancy requiring referral and transfer of care to a higher-level facility. It describes maternal and neonatal services in NSW, their TPN arrangements, the Statewide Default Protocol, and the requirement for LHD Operational Plans and escalation pathways. Reference is made to outborn (born outside a tertiary facility) or unwell newborns who require higher level care at birth but does not include advice on the movement of unwell newborns in other circumstances.

\(^1\) Pre-term births by mother’s Aboriginality, [NSW Health Stats](#)
1.4 Key definitions/ glossary

**Aeromedical Control Centre (ACC):** A NSW Ambulance control centre providing clinical support and advice, transport and escort services for patients requiring transfer/medical retrieval.

**Electronic Patient Journey Board (EPJB):** A module within the Patient Flow Portal (PFP) designed to facilitate Care Coordination as part of the Patient Flow Systems Framework.

**Inter Hospital Transfer (IHT):** A function in the PFP which allows the electronic system to create an IHT for a seamless and coordinated transfer between the requesting and accepting facilities.

**Maternal Priority 1-5 (MP1-5) categories:** The category related to the medically agreed timeframe for transfer, consultation or referral which determines the risk and urgency of the transfer.

**Newborn and paediatric Emergency Transport Service (NETS):** NSW Statewide emergency service for medical retrieval of critically ill newborns, infants and children.

**Patient Flow Portal (PFP):** Electronic system which provides information about patient occupancy and available maternal and neonatal beds across NSW to inform coordination of patients moving through care.

**Patient Flow Unit (PFU):** Responsible for managing patient flow within a given facility or LHD. In rural areas this function may be carried out by roles such as bed manager or after-hours manager in consultation with the Maternity/ Birth Unit Manager/ In-Charge.

**Patient Transport Services (PTS):** NSW Health service for patients who require transport to, or from, a health facility such as a hospital or rehabilitation unit but do not need a time-critical emergency ambulance.

**Service capability:** Describes the scope of planned activity and clinical complexity that a service is capable of safely providing. Each maternity and neonatal service has a designated service capability from Level 1 (no planned Maternity) to Level 6 (Tertiary Care). LHDs are responsible for determining and maintaining the service capability of their maternity and neonatal services.

**Shared Network Care:** Where all or part of a woman’s pregnancy care can be provided at a service with the support of a networked service of higher service capability. This may include, but is not limited to, outreach clinics, telehealth, telemedicine and remote consultation between clinicians.

**Statewide Default Protocol:** When a woman requires time urgent critical care not available at the referring hospital, the woman must be transferred immediately to the Level 6 facility within the TPN irrespective of bed status.

**Statewide Obstetric Consultation (SOC) Service:** A service provided by Statewide Obstetric Consultants (SOCs) who provide secondary advice and support for Obstetric Consultants from Level 6 TPN facilities, and NETS and NSW Ambulance/ ACC personnel.
Statewide Obstetric Consultants (SOCs): SOCs (formerly known as PAL Consultants) provide secondary obstetric advice and support for TPN decision making. They also assist NETS and NSW Ambulance/ACC personnel if secondary specialist advice is required during transfer.

Short Term Escalation Plan (STEP): An established set of activities/tasks to address a short-term unforeseen demand/capacity mismatch. Demand escalation includes both strategic planning to manage expected demand and short-term escalation to manage immediate demand mismatches.

Supra-LHD Services: Specialised services provided on behalf of the State for the care of women and babies who require a higher level of care within and outside their network. All Level 6 Maternity and Level 6/5 Neonatal Services are Supra LHD Services.

Tiered Perinatal Network (TPN): A formalised arrangement between maternity and neonatal services within and across LHDs in NSW and the ACT that are linked with a tertiary (Level 6) hospital to provide support where higher level care is required. The TPN recognises the capability, capacity, responsibilities and expertise of each facility in the network.

Transfer coordination: Bed finding and care coordination are local responsibilities. Transfer coordination of the inter-facility transfer of maternity patients is conducted in consultation with the Obstetric Consultant, Registrar and receiving facility. This function may involve but may not be limited to personnel from the PFU, after hours Nurse/Midwifery Manager and Midwifery Unit Manager/Midwife In-Charge. Clear delegation of local roles and responsibilities for transfer coordination should be included in local Operational Plans.

2 MATERNITY AND NEONATAL SERVICES IN NSW

Integrated maternity and neonatal services support women and their babies with seamless access to the right care, at the right place and at the right time. Integrated care also supports the provision of evidence based, safe, high quality and effective healthcare as close to home as possible. The following elements support the effective functioning of the maternity and neonatal services in NSW.

2.1 Tiered Perinatal Networks (TPNs)

The TPNs support integrated maternity and newborn care. Integrated care is a key direction in the NSW State Health Plan Towards 2021; the NSW Rural Health Plan Towards 2021; and Healthy, Safe and Well: A Strategic Health Plan for Children, Young People and Families 2014 – 2024.

The TPNs link each Level 6 Maternity and Level 5/6 Neonatal service in NSW and the ACT with a designated group of maternity and neonatal services of lower service capability. The TPNs may encompass maternity and neonatal services within a single LHD or maternity and neonatal services across two or more LHDs. NSW Maternity and neonatal services in state border areas may link to services with higher service capability in bordering states and territories including the ACT, South Australia, Queensland and Victoria.
The TPNs are configured around the seven Level 6 Maternity/Level 5/6 Neonatal Services in NSW and the tertiary maternal and neonatal services in the ACT. The TPN configuration is outlined in Table 1.

Table 1: Tiered Perinatal Network Configuration

<table>
<thead>
<tr>
<th>NETWORK</th>
<th>Linked LHD services *</th>
</tr>
</thead>
</table>
| Centenary Hospital for Women and Children (ACT) | • ACT Health facilities  
  • Southern NSW  
  • Murrumbidgee (parts of Murrumbidgee link with Victoria) |
| John Hunter Hospital | • Hunter New England  
  • Mid North Coast  
  • Northern NSW (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 (Far West links with South Australia and Victoria) |
| Royal North Shore | • Northern Sydney  
  • Central Coast |
| Westmead | • Western Sydney |

* Includes maternity and neonatal services and facilities without planned birthing services

The TPNs also support non-birthing services and private maternity facilities within their designated Network.

The Level 6 tiered maternity facilities have an important supra-LHD role to provide care to women and babies who reside outside their network when required.

Complex medical or surgical conditions of the woman and/or fetus will require more complex decision making. Care at/transfer to a facility outside the TPN may be required
based on clinical needs; care planning including timely referral is recommended to ensure appropriate care.

Complexities will include:

- anticipated surgical care for the neonate will need to be aligned with Level 6 neonatal facility
- women with complex medical or surgical conditions, that may or may not be obstetric related, will require care at a facility with the service capability corresponding to the clinical needs.

Care of women and neonates with complex surgical and/ or medical needs is outside the scope of this document.

2.2 Service capability

The integrated model of maternity and newborn care requires each service to have:

- an agreed designated and understood service capability
- collaborative relationships with other maternity and neonatal services both within their LHD and their TPN.

Service capability describes the scope of planned activity and clinical complexity that a service is capable of safely providing. Each maternity and neonatal service has a designated service capability from Level 1 (no planned Maternity) to Level 6 (Tertiary Care). LHDs are responsible for determining and maintaining the service capability of their maternity and neonatal services.

The GL2018_018 NSW Maternity and Neonatal Service Capability Framework (the Framework) details the scope of planned clinical activity for each service capability level which supports a shared understanding of the capability of each maternity and neonatal service. The Framework complements the NSW Health Guide to the Role Delineation of Clinical Services (2016) which describes the minimum support services, workforce and other requirements for clinical services.

Maternity and neonatal services must meet the requisite role delineation requirements for its service capability level. If a service change occurs at any facility a reassessment should be attended to ensure the activity matches the capability of the service in line with GL2016_018. This reassessment should be communicated to NSW Ministry of Health.

2.3 Statewide Obstetric Consultation (SOC) Service

Primary advice regarding consultation, referral or transfer will be provided by a senior clinician within a requesting facility’s own TPN. The requesting facility will contact the Obstetric Consultant via the contact details specified on the PFP, via identified processes in the local Operational Plan, or via an automated telephone service recorded on the current PAL contact number.

On occasion, the Level 6 Obstetric Consultant may require support in relation to complex clinical decision making. NETS and NSW Ambulance/ ACC may also on occasion require
secondary specialist advice during transfer. If secondary advice is required, the Level 6 Obstetric Consultant, NETS and/or NSW Ambulance may contact the SOC Service. SOCs provide:

- secondary advice and support for TPN decision making
- final decision making for the transfer.

### 2.4 Patient Flow Portal (PFP)

The PFP will facilitate transfer and bed management strategies. Bed capacity will be visible via the Electronic Patient Journey Board (EPJB), which is a key tool of the PFP. The PFP should:

- be considered as an accurate census of bed capacity and availability within a facility as it is linked to the Patient Administration System (PAS) and will recognise every woman and baby admitted for care
- include the following responsibilities to ensure accuracy:
  - the transferring facility to complete the Inter Hospital Transfer (IHT) fields
  - the receiving facility to accept the IHT for planned transfer
- be accessed whenever bed finding is required
- identify two named Obstetric Consultants (On-Call consultants 1 and 2) for the facility for timely access for consultation and advice
- nominate ‘On-Call Consultant 1’ as the accepting consultant for transfers on the PFP and with Ambulance
- be used to capture data on maternal transfers that can be used as a measure of system performance.

In NSW, all maternity Level 4, 5, 6 facilities have mandatory manual updates in real time (at least every 4 hours for neonatal units and every 8 hours for maternity units) to ensure that information is accurate and reflective of issues which can affect bed availability such as staff resources. These Level 4, 5 and 6 facilities will also be responsible for ensuring the name and contact details for the Obstetric Consultants in each TPN are displayed on the PFP to facilitate contact when escalation is required.

### 2.5 Patient Flow Unit (PFU)

The PFU is responsible for managing patient flow within a given facility or LHD. The role of the unit and/or delegated personnel is essential where demand exceeds capacity and/or where escalation is required to ensure effective and efficient patient flow.

Established communication pathways and processes for PFUs within and between TPNs will be required to ensure effective negotiation when transfer is needed.
2.6 Newborn and paediatric Emergency Transport Service (NETS)

NETS should be contacted to provide emergency transport of those outborn or unwell newborns who require higher level care at/or following birth. Following discussion with NETS, the transferring facility is to complete the IHT for the newborn requiring transfer.

3 KEY ELEMENTS OF TPN ARRANGEMENTS

3.1 Principles

Each TPN is ultimately responsible for managing the service demands of its’ respective catchment population. Higher level facilities are responsible for providing support, advice and management of the women who may require transfer within and across TPNs. Whenever a transfer is required the following principles apply:

- No woman should be moved out of her TPN without the advice of the TPN Level 6 Obstetric Consultant.
- Women and their families are provided with timely and accessible information on the transfer process and offered support through Aboriginal Health Liaison Officers (AHLOs), Aboriginal Maternal and Infant Health Service (AMIHS) staff, interpreters and/or other support services as required.
- The decision to transfer and determination of the urgency of transfer (medically agreed timeframe) must be made through discussion between the Obstetric Consultants at the referring and accepting facilities.
- Management of urgency and risk is aligned to the Maternal Transfers Decision Making Tool (Attachment 2).
- Access to appropriate care in time-critical situations must not be delayed due to maternal or neonatal bed finding.
- The neonatal team will be closely involved in the decision making/ care planning for planned high risk births or involved in the care of urgent transfers. However, where birth is not planned or anticipated within the next 12 hours, a neonatal bed is not required and obstetric decision making takes precedence.
- Consultant roster must be made available with contact numbers provided.
- No Level 6 to Level 6 maternal transfers should occur from 32 weeks. An exception could be where specific Level 6 neonatal services (e.g. surgical, cardiac etc) are required.
- If during a transfer, there is deterioration in maternal condition the NSW Ambulance / ACC should contact the Obstetric Consultant at the receiving facility for advice and transfer logistics.
- Higher level facilities are responsible for supporting the woman until transfer is complete.
3.2 TPN Operational Plan

Each TPN is required to develop an Operational Plan for their maternity and neonatal services which will describe business as usual within the TPN and the escalation pathways required when business falls outside usual activity/demand.

The Operational Plan should detail:

- the networked services and their designated service capability
- the governance process that articulates the responsibility and accountability of each facility as part of the TPN. This should include the clinical responsibilities for delivery of care as well as the organisational processes required for managing demand and escalation
- risk identification in the TPN related to the clinical presentations identified in the Maternal Transfers Decision Making Tool (Attachment 2)
- pathways and processes for consultation, referral, transfer of care and/or shared care within the TPN
- transfer processes, including for time critical cases
- processes for assessment and management of service demand
- responsibilities of the Transfer Coordination role/s in each facility/LHD.
- strategies to facilitate communication pathways for PFUs within and between TPNs
- a communication contingency plan
- data capture and monitoring
- process for case review and analysis of trended data that includes all aspects of transfers including advice, escalation, communication, coordination and outcomes.

3.3 Maternal Transfers Decision Making Tool

The Maternal Transfers Decision Making Tool (Attachment 2) supports the decision making process for maternal transfers by providing a standardised approach to the assessment of urgency and risk of specific clinical presentations. The Tool should be:

- referred to after assessment of the woman to determine, the need for transfer, the medically agreed timeframe in which transfer should occur and the most appropriate mode of transfer and escort required
- used in conjunction with the TPN/LHD Operational Plan to facilitate decision making for transfer based on specific geographical location and transport logistics
- used by the referring facility when communicating to the accepting facility to accurately communicate the level of urgency and risk.
3.4 Bed management strategy

Each TPN is responsible for managing the care needs of its catchment population. The Plan will describe the processes for monitoring and responding to fluctuations in demand including:

- process for regular surveillance and monitoring of demand and bed capacity within services and across the TPN
- local and TPN bed management strategies when demand exceeds available bed capacity such as:
  - expediting planned discharges
  - identifying potential earlier discharge with follow up
  - identifying those women who can be transferred to a facility of lower service capability (including return transfer within the network)
  - internal transfer within a facility (where appropriate)
  - procedure to accommodate above the commissioned bed numbers for short periods
  - review of elective admissions that can be safely postponed
- the PFP will be accessed to identify bed status and capacity in other facilities to assist with decision making
- when a woman requires time urgent critical care, not available at the referring hospital, the woman must be transferred immediately to the Level 6 facility within the TPN (or relevant facility where cross border arrangements are applicable) irrespective of bed status.

3.5 Short Term Escalation Plans (STEPs)

In line with the NSW Health Demand Escalation Framework, each facility is required to have escalation pathways that define the processes to manage access and demand. The escalation pathways should be formalised across the TPN to provide care for women as close to home as possible.

This should include:

- the agreed STEPs which define in detail what constitutes STEP 1-4
- the process for escalation when the capacity of the TPN has been exceeded and a transfer to a different TPN may be required
- the communication pathway to the Executive of the facility/ LHD until the situation is resolved.
4 LIST OF ATTACHMENTS

The following resources have been developed to assist policy implementation and transfer decision making:

1. Policy Implementation Checklist
2. Maternal Transfers Decision Making Tool
### 4.1 Attachment 1: Policy implementation checklist

**LHD / Facility:**

<table>
<thead>
<tr>
<th>IMPLEMENTATION REQUIREMENTS</th>
<th>Not commenced</th>
<th>Partial compliance</th>
<th>Full compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Development and documentation of Tiered Perinatal Network Operational Plans that describe the service capability of all facilities, the risk assessment and governance processes for business as usual and clinical escalation pathways and demand escalation frameworks to ensure patient flow</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Notes:</td>
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<td></td>
</tr>
<tr>
<td>Development of pathways and communication processes between Networked LHDs to ensure streamline referral and transfer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate identification and training of clinical and administration staff in PFP and Emergency Access View applications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specific cross-jurisdictional border arrangements as required are in place for consultation, referral, shared network care and/or transfer of women for care appropriate to the level of assessed need as required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orientation for maternity staff to the Tiered Perinatal Network Operational Plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
<td></td>
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<tr>
<td>CE to ensure that compliance with this policy is audited and data is regularly monitored in collaboration with intra and inter-LHD stakeholders as a marker of system performance.</td>
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<tr>
<td>Notes:</td>
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</tbody>
</table>
### 4.2 Attachment 2: Maternal Transfers Decision Making Tool

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

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*Requires consultation with Obstetric Consultant

**May benefit from advice with the SOC Statewide 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

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NSW GOVERNMENT

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