East of England Neonatal ODN

(Hosted by Cambridge University Hospitals)

East of England: In-Utero Transfer Policy

Version 5

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For use in

East of England Neonatal and Maternity units

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Approved by:

Neonatal Clinical Oversight Group	September 2020
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1. Introduction

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The East of England (EOE) Maternity Clinical Network, Neonatal Operational Delivery Network (ODN) and Eastern Academic Health Science Network through the National Patient Safety Improvement Programme have worked towards ensuring that every mother and baby born less than 27 weeks gestation or less than 28 weeks if a multiple pregnancy or the fetal weight is predicted to be less than<800 grams is delivered at the right hospital, receiving the right medical expertise at the right time as close to home as possible

Research has shown that there are about 60 000 babies born extremely preterm <28 weeks in UK (Reducing preterm births, 2019). These extremely preterm babies contribute to 1.4% births in UK (Reducing preterm births, 2019). The care and survival rates of very preterm babies (<27 weeks or <28-week multiples, <800gms) is greatly improved through access to onsite Neonatal Intensive Care Unit (NICU) services at the point of birth. Going into labour much earlier than expected or planned for will cause considerable stress to a family. The requirement then to transfer that family to a different hospital/region from the intended place of birth and prior to birth (to maximise and improve fetal/maternal outcomes) will further exacerbate this worry.

The intention of this regional policy is:

- To give guidance to the East of England Maternity & Neonatal units with a clear process around in utero transfers and exception reporting- acceptance/refusal
- To streamline the process by ensuring senior decision-making is part of the in-utero transfer pathway
- A systematic regional shared document to promote survival of our extremely preterm babies and minimising morbidity (BAPM, 2018).
- To achieve the best clinical outcomes based on more women (<27 weeks or <28-week multiples, <800gms) gestation are transferred in-utero to a cluster maternity unit with an aligned Level 3 neonatal unit.
- To address any delays in locating a maternity bed aligned with a neonatal cot by using the EBS (Emergency Bed Service) as the first point of contact in the in-utero transfer pathway
- To give guidance in order to reduce any unnecessary transfers out of the region due to the lack maternity bed & neonatal cot capacity within the region
- To give guidance in order to reduce the number of women delayed repatriation to their local maternity unit for continued maternity care

There are 6 Local Maternity and Neonatal Systems (LMNS) within East of England and a total of 17 maternity and neonatal units. The national expectation is that all maternity units with a Special Care Baby Unit or Local Neonatal Unit (LNU) should transfer women in-utero for pregnancy <27

weeks gestation or <28 weeks gestation multiple birth and <800grams to a maternity unit with a level 3 NICU attached to make sure the baby has a good outcome.

Transfers may be required for a variety of reasons: Indications for transfer

- Preterm labour/neonatal gestational thresholds (appendix 1)
- Antenatal diagnosis requiring surgical postnatal care
- Specialist maternal care
- Maternal or fetal indications
- Bed/cot capacity or staffing concerns
- Specialist paediatric services

2. General guidance

The decision to accept or refuse in-utero transfers from maternity units within the region must also follow a designated process to ensure that the appropriate care is delivered as close to home as possible. When starting the process of considering in-utero transfers the recommendation would be to firstly complete a SBARD (Appendix 5). The SBARD is a proforma to collect all relevant information about the woman (Situation, Background, Assessment, Recommendation and Decision) in a timely manner to make the handover and transfer pathway as smoothly as possible. The use of the SBARD will ensure that any key information about the woman would not be missed/omitted.

All Transfers out

- Must be discussed with an Obstetric and Neonatal consultant prior to arranging transfer. *The aim of consultant involvement is to ensure that the assessment of risk is appropriate and the resource implications and implications for the pregnant woman and baby are taken into account before an in-utero transfer is embarked upon.*
- Within maternity services it recognised that out of hours the Obstetric consultant might not be physical present. Therefore, the senior register will need to inform and discuss with the Obstetric consultant via telephone of the planned in-utero transfer.
- Where possible a consultant to consultant handover should occur (both Obstetric and Neonatal), if not possible this handover must have been discussed prior to transfer. *As handover option videoconferencing can be facilitated by the Emergency Bed Service*
- It is essential that both transferring and receiving Obstetric & Neonatal consultants are aware of the transfer.

- All pregnant women must be assessed for their suitability for transfer by the referring hospital, weighing up the risks of transfer against the potential benefits. Compromising the health of the mother and /or the significant risk of delivery enroute would be an absolute contraindication to transfer and consideration must be taken to deliver and postnatal transfer.
- **It important to be aware that the transferring hospital has overall clinical responsibility for the patient during transfer.**

Parental consent to the transfer

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. Within this policy any capacity for the woman to make voluntary and informed decision to consent to or refuse transfer, there must be detailed explanation by a clinician of the plan. https://www.nhs.uk/conditions/consent-to-treatment/

- Maternal agreement needs to be obtained prior to transfer. This should be documented in the maternal healthcare record. This should involve counselling by the obstetric and neonatal staff.
- The distress and inconvenience of in utero transfer needs to be recognised and its clinical indication explained to the birthing person and partner, including the lack of local facilities for higher levels of neonatal care and implications for neonatal outcome. Possible transfer of the baby (or babies) back to their original hospital, or one nearer home, after completion of intensive and/or high dependency neonatal care should also be explained.
- EoE in-utero transfer leaflet should be given to the woman & partner.
- Receiving hospital address and telephone number should be given to the partner in order to minimise any anxiety.
- In cases where, the woman has communication limitations/barriers the maternity unit would need to work within local policy to ensure the women understands the proposed plan and can give informed consent, usually by the way of an interpreter for example using language line.

Decisions regarding appropriateness of transfer and interventions at the edges of viability are important. Counselling and decision making should be made with the family using the BAPM ***Perinatal Management of Extreme Preterm Birth Before 27 weeks of Gestation (2019))***

Arranging transfer

Based on the Neonatal Critical Care Review, there is recognition that there is pressure on both maternity and neonatal services to locate a suitable maternity bed and matching neonatal cot. With the advance in technology more extremely preterm babies are surviving, therefore making it even more challenging to have enough capacity for both maternity bed & neonatal cot at the right place. In certain circumstance some women have had to be transferred long distances from home placing pressure to the family both financially and emotionally.

- Within EOE the EBS (emergency bed service) will locate bed/cot for both in-utero and ex utero transfers. (appendix 2). EBS must be used to locate both the bed and cot.
- As a recommendation the use of daily huddles/safety meetings jointly (Maternity & neonatal teams) would ensure that all staff are aware of the current bed and cot status within the Trust. *It is recognised that there may be sudden changes within the clinical setting, therefore continuous maternity and neonatal updates would be essential.*
- **It is important** to note that the Tertiary units (Level 3) need to consider their responsibility to the woman and unborn baby and accept all transfers unless there is no way it can be facilitated. If referrals by a tertiary unit are declined, then this will need to be escalated to the Neonatal ODN Director.
- In cases, there is no maternity bed/neonatal cot available the Maternity & neonatal teams should escalate immediately following their local policy.
- Phone the EBS and they will support in locating a bed and cot outside the East of England region.
- Relevant external organisations should also be informed if there is no maternity bed/neonatal cot in the region via telephone/email (EBS, Neonatal ODN & Regional Chief Midwifery Officer).

Transferring the women

- We need to consider the involvement of the ambulance service timely in ensuring that IUT is seen as an ‘emergency’ even though the Mother is in a place of safety. This impacts of the timeframe of ambulance availability.
- In urgent cases, the transfer should be triaged as an Obstetric Emergency and categorised as a ‘C1’ call, which is the highest acuity level of call.
- The term ‘Obstetric Emergency’ needs to be used when requested this level of transportation via EoE Ambulance. *In Surge levels there may be a delay, but under the C1 criteria EoE ambulance would look to dispatch the nearest available resource.*
- Obstetric Emergency and categorised as a ‘C1’ call could ensure a ambulance is dispatched to your maternity service within 10-30 mins. *Early preparation including handovers and documentation is key to minimise delays.*

- **It is important to ensure that a discussion between the two consultants has happened prior to the decision to transport and therefore the senior decision making would have taken place.**
- Women being transferred must be escorted by a midwife with the relevant training to transfer a mother.
- In cases there are other medical concerns a risk assessment must be completed to assess if there is a need for additional staff for the transfer (obstetric/neonatal/paediatric/anaesthetic).
- **Important:** If there is sufficient risk for a doctor to be required for transfer then the condition of the mother or fetus is such that delivery should occur locally, and postnatal ex-utero transfer arranged.
- Transfer of women who are (<27 weeks gestation/28 weeks multiple/<800g pregnancy) should be to their cluster group tertiary centre (appendix 3) only in exceptional circumstances should this not occur. **The one exception to this is**:
    - Luton cluster where infants require surgical intervention immediately after birth; these women will have antenatal plans for place of delivery in a surgical centre. This should be clearly documented and available to view.

- Transfer of women (>27 weeks/28 weeks multiple/>800g pregnancy) should be referred to EBS who will locate a cot and maternity unit. Where possible this will be within the referring units cluster group.
- The number of qualified staff required to escort a woman with a multiple pregnancy should be individualised dependant on the clinical risk.
- A basic neonatal resuscitation kit will be taken on transfer Appendix 4

3. Preterm labour

Diagnosis of preterm labour can be difficult. Ideally the diagnosis should be made on clinical findings of regular uterine contractions and change in the cervix, however waiting for these signs may mean that transfer to a tertiary centre is no longer possible.

Predictive test screening is available and should be used where possible to ensure the right women are transferred. The recommendation would be to follow local guidance on predicting preterm labour and birth. The current national guidance is based on the NICE guideline (NG25) Preterm labour and birth (2019) https://www.nice.org.uk/Guidance/NG25

Women in preterm labour should be given

- Antenatal steroids (22+0 - 33+6) https://www.nice.org.uk/guidance/qs135/chapter/Quality-statement-5-Corticosteroids-for-women-between-240-and-336-weeks-of-pregnancy
- Magnesium Sulphate (less than 29+6 weeks consider 30 - 33+6 weeks as per PReCePT protocol)
- Tocolytics should be considered for transfer even with Preterm Pre-Labour Rupture of Membrane (PPROM)
- There may be women where transfer is indicated who are not in preterm labour for example pre- eclampsia, or severe fetal growth restriction with abnormal fetal Doppler's. These individualised discussions should take place on a consultant to consultant basis
- If women are felt to be too unstable for transfer, this decision should be reviewed, and risk assessed on a regular basis no longer than every 4 hours and transfer should be completed if the clinical condition changes to allow safe transfer.
- Important to note that with any in-utero transfers there will always be an element of risk associated with any transfer, therefore regular risk assessment will be vital during the transfer.
- Cases where there is uncertainty about whether to transfer or complex cases may require discussion with both obstetric and neonatal teams, EBS can facilitate this via teleconferencing with all clinicians involved.
- Ensure that all discussions both internally and with external teams are documented in the medical and women's handheld notes.

4. Transfer for maternal indication

- Maternal condition must be medical stable for transfer. The ambulance crew and midwife cannot be expected to deal with unstable blood pressure or significant ante partum haemorrhage. Therefore, the women must be stable prior to transfer
- There are occasions for maternal health that delivery of the baby may need to occur at current hospital with ex-utero transfer of the baby (e.g. severe pre-eclampsia, liver or renal disease).

Transfer for specialist paediatric services

- In this situation assuming there are no maternal issues the only major concern is ensuring delivery does not occur en-route.
- Babies for example with known cardiac disease can be born in their local hospital and transferred ex-utero where clinically appropriate.

- In the situation the woman appears to be labouring during the transfer and birth thought to be imminent then the ambulance would need to go directly to the nearest maternity unit.

Management prior to transfer

- Referring hospital is responsible for the safe, efficient, rapid transfer and the woman.
- Furthermore, the referring hospital must repeat assessment immediately prior to transfer.
- The receiving unit obstetric registrar, neonatal unit and delivery suite co-ordinator should all be informed and aware of the clinical history.
- A photocopied set of notes and copy of a completed SBARD proforma (Appendix 5) should be sent with the women.
- Only if not duplicating information then the woman's hand-held notes can also be photocopied and sent as well.
- In maternity/neonatal units that are paperless a printed set of notes should be sent with the women along with her digital notes (*this will add in the case of any urgent diversion/delay in information being sent by email)*
- If the unborn child has any safeguarding concerns/children's social care involvement/communication limitations/barriers/mother known to the mental health or perinatal health services, the receiving hospital **MUST** be made aware of this via telephone and clearly documented within the notes.
- The contact details of any relevant health professionals/allied health/social worker should be documented within the transfer notes to be handed over to the receiving hospital.
- All relevant health professionals/allied health/social worker should be informed immediately of the transfer of the women via telephone & email to ensure there is swift follow up/handover of care.

Transfer back to referring hospital

If after 48 hours delivery is not thought to be imminent and following discussion with the home unit discharge or transfer back should be considered,

- Discussion between obstetric consultant to consultant should be done during normal working hours
- **Out of Hours**: where possible home unit discharge or transfer back should be discussed and organised during normal working hours. *(Only in urgent cases and would need to be agreed by both obstetric consultants from discharging and receiving hospitals)*

- Obstetric consultant/Senior register should discuss with the woman and partner about the plan to discharge or transfer back to ensure they understand why they are being discharged or transferred back and what to do in an event there are in threatened labour again.
- The discharge plan or home unit continued management plan should be in the woman's handheld notes and a copy sent to woman's named obstetric consultant.
- The neonatal team should be informed of the discharge plan to update their cot availability status.

Hospital diversion

- All such correspondence to do with divert from normal process should go via East of England Ambulance tactical operations centre on 01245 444515 Option 1 email – operations@eastamb.nhs.uk
- For more details please also read the Hospital Divert Policy

5. Monitoring

- EBS completes records for all in utero referrals. This will include reasons why the woman was not transferred. They do not keep records of those not referred.
- Delivery of any baby (<27 weeks, <28 week multiple, <800g) in a maternity unit without a co-located NICU requires exception reporting to the Neonatal Operational Delivery Network. This information should also be shared with the units local LMNS.
- In addition, a recommendation would be to complete an incident form/daxit to ensure this is escalated and locally lessons learnt.

6. Utilising this policy locally

Ensuring this policy is utilised for all or nearly most of the pregnant women (<27 weeks/<28 weeks multiple/<800grams) gestation will be based on the implementation of the policy within local systems. The responsibility lies with the lead professionals both non-clinical and clinical within Maternity and Neonatal services. Throughout the policy the process has been shaped with an integrated care approach to safe patient care.

The benefits of utilising this policy will result in;

1. A reduction in delayed in-utero transfers due to improvement of timely communication with key professionals/systems.
2. An improvement on the patient flow pathways.
3. An improvement on the women and baby outcomes based on Qualitative and Quantitative local/regional/national data.

4. Increased survival rates of the (<27 weeks gestation babies/<28 weeks multiple/<800grams) based on Public Health and MBRRACE figures

7. Policy Summary

Maternity and Neonatal units:

Should make sure that their senior team is aware of mechanisms for accessing clinical advice, and for escalating to the network when an offer of in-utero transfer within the regional maternity systems has been declined.

Networks:

Based on the NHS Long Term Plan (2019), Neonatal Critical Care Review and other relevant national guidance there is already a mechanism for overseeing the optimal management of cot capacity within EOE region. There will continue to be a network oversight and assurance that more than 85% maternal and/or neonatal transfers are regionally.

Commissioners and service reviewers:

The EOE CCG/STP and MVP should expect both maternity and neonatal units including LMNS, MatNeo SiP and networks to have the above mechanisms in place to have a clear understanding and evidence based on the quality improvement and function related to this policy.

8. Governance and monitoring

The Neonatal ODN will monitor the number of women delivered <27 weeks or multiple <28 weeks gestation delivered in a maternity unit without a NICU on site. Every four months the Neonatal ODN will report the reviewed data at the Neonatal Clinical Oversight Group, Local Maternity & Neonatal Systems and Regional Maternity Programme Board meetings. Any identified good practice shared; however, any risks or safety issues will be escalated early to the relevant governance groups and action plan agreed**.**

- Quarterly review of the number of women <27 weeks gestation delivered in a maternity unit without a NICU on site
- Quarterly review of the number of women <28 weeks gestation multiple births delivered in a maternity unit without a NICU on site

- The Emergency Bed Service (EBS)/(ANTS) to provide activity reports, drawing from its transfer records and other key metrics as appropriate, to the Local Maternity & Neonatal Systems and the Neonatal Operational Delivery Network.

9. Related Guidelines/SOP

- Clinical guideline: Patient Flow EOE
- Trust guideline for the management of Preterm Birth 26-36 weeks (Norfolk & Norwich)
- In-Utero Cot/bed locating by the Emergency bed service (EBS) – ANTS
- Transfer of mothers and babies to different care setting (Mid Essex Hospital Services)
- Norfolk and Waveney STP Operational plan for our local Maternity System
- EBS In-utero referral
- Incident reporting communication document:<27 weeks delivery in a centre without a NICU
- Reporting Protocol: Ambulance Divert Requests (2016)

Thank you

To all the East of England Maternity and Neonatal Teams that contributed to the development of this policy. Also, a thank you to the professionals that contributed as reviewers to ensure the information was related to current evidence and clinical practice.

Acknowledge London Regional Maternity Team for their support in developing this policy.

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References

1. British Association of Perinatal Medicine. Service Standards for Hospitals providing Neonatal Care (3rd edition). London: British Association of Perinatal Medicine; 2010. p. 1–22.
2. British Association of Perinatal Medicine. Guidance on Cot Capacity and the use of nurse staffing standards (June 2018)
3. BAPM (2019) Perinatal management of Extreme Preterm Birth before 27 weeks of gestation. A framework for practice
4. BAPM (2019) Calculating unit cot numbers and nurse staffing establishment and determining cot capacity. A framework for practice supplementary
5. British Association of Perinatal Medicine. Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: A framework for Practice (November 2018)
6. Department of Health. Toolkit for High-Quality Neonatal Services. London; 2009.
7. Each Baby counts (2018) progress report (Royal College of Obstetricians and Gynaecologists
8. 15 Steps for maternity: Quality from the perspective of people who use the maternity service (2018)
9. Hamilton KESC, Redshaw ME, Tarnow-Mordi W. Nurse staffing in relation to risk-adjusted mortalityinneonatal care. Arch Dis Child Fetal Neonatal Ed. 2007;92(2):99–103.
10. Helenius et al (2019) BMJ Association of early postnatal transfer and birth outside a tertiary hospital with mortality and severe brain injury in extremely preterm infants: observational cohort study with propensity score matching
11. Marlow N et al (2014) Perinatal outcomes for extremely preterm babies in relation to place of birth in England: the EPICure 2 study
12. Maternity and Neonatal Health safety collaborative (2017) The Three year programme to support improvement in the quality and safty of maternity and neonatal units across England
13. Milligan DWA, Carruthers P, Mackley B, Ward Platt MP, Collingwood Y, Wooler L, et al. Nursing workload in UK tertiary neonatal units. Arch Dis Child. 2008;93(12):1059–64.
14. Gale C, Santhakumaran S, Nagarajan S, Statnikov Y, Modi N. Impact of managed clinical networks on NHS specialist neonatal services in England: population based study. Vol. 344, BMJ. 2012. p. e2105.
15. National Quality Board. Safe, sustainable and productive staffing: An improvement resource for neonatal care. London; 2018.
16. National Maternity Review: Better Births, Improving Outcomes of Maternity Services in England. A five Year

Forward: View for Maternity Care (2016)
17. NHS Improvement : Supporting safety champions (February 2018) A guide to support maternity safety champions
18. NHS Long term Plan (2019)
19. The NHS Long term Plan Implementation Framework (2019)
20. Oxford Academic health science network (2015) Place of Birth of Extremely Preterm Babies in the Thames Valley Neonatal Network
21. PReCePT (2018) http://www.ahsnnetwork.com/about-academic-health-science-
22. Pan-London(2019) Guideline for in utero transfer
23. Public Health England (January 2019) Population health in pregnancy and early life to reduce stillbirth and infant death: a planning tool for understanding risks and exploring inequalities
24. Reducing Preterm Birth: Guidelines for Commissioners and Providers (UK Preterm Clinical Network) 2019
25. Saving Babies's Lives Version 2: A care bundle for reducing perinatal Mortality (March 2019)
26. Tackling inequalities in maternal and perinatal mortality rates (Professor Jacqueline Dunkley-Bent) 2019
27. Implementing Better Birth births: A resource pack for Local Maternity Systems (March 2017) Five Year Forward View
28. Implementing the Recommendations of the Neonatal Critical Care Transformation Review (2019)
29. Healthy Child Programme
30. Preterm Prolonged Rupture of membranes https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.15803

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Appendix 1: Abbreviations

ANTS	Acute Neonatal Transfer Service
EoE	East of England
BAPM	British Association of Perinatal Medicine
SBARD	Situation, Background, Assessment, Recommendations & Decision
EBS	Emergency Bed Service
NICE	National Institute for health and Care Excellence
PPROM	Preterm Premature Rupture of membranes
MBRRACE	Mothers and babies; Reducing Risk through Audits and Confidential Enquiries across the UK
CCG	Clinical Commissioning groups
STP	Sustainability and transformation Partnership
MVP	Maternity Voices Partnership
ODN	Operational Delivery Network
IUT	In utero transfer
SOP	Standard operating procedure

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Appendix 2

Gestational Thresholds

Thresholds as described within BAPM categories of care.

LNU

- Babies <27wks or <800g in a LNU beyond 1 day of life (except London ODN which doesn't use the beyond 1 day of life criteria)
- Babies receiving intubated ventilatory support for greater than 48 hours beyond 1 day
- Babies receiving ventilation via a tracheal tube AND Inotrope, prostaglandin infusion, insulin infusion, a chest drain, or had an exchange transfusion in a LNU beyond 1 day
- Babies with hypotension, disseminated intravascular coagulation (DIC), renal failure, or metabolic acidosis
- Babies who received nitric oxide, HFOV, or therapeutic hypothermia

SCBU

- Babies <30wks or <1000g in a SCBU beyond 1 day of life (except London ODN which doesn't use the beyond 1 day of life criteria)
- Babies receiving IC in a SCBU beyond 1 day
- Babies receiving inotrope, prostaglandin infusion, insulin infusion, have a chest drain, or had an exchange transfusion in a SCBU beyond 1 day
- Babies receiving intubated ventilatory support for greater than 48 hours beyond 1 day
- Babies with hypotension, disseminated intravascular coagulation (DIC), renal failure, or metabolic acidosis

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Babies who received nitric oxide, HFOV, or therapeutic hypothermia

Appendix 3 - EBS details

To make a referral for ex-utero or in-utero transfers

Please call EBS on

01223 274 274.

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Appendix 4: Cluster groups & contact details

The EOE is divided into cluster groups around a tertiary NICU. These pathways do not necessarily match LMNS/STP geography.

The cluster group contact phone numbers should only be used for communication once the cot/ bed has been located by the EBS not for units to make the initial contact.

Cluster	Neonatal Units levels	Hospital contact numbers
Cambridge Cluster	NICU (Level 3)	Rosie maternity unit Robinson Way Cambridge CB2 0QQ Tel: 01223 245 151
	LNU (Level 2)	Broomfield Maternity Services Level 4 Hospital Wing Broomfield Hospital Chelmsford Essex

		CM1 7ET Tel: 01245 362 305
	LNU (Level 2)	Colchester Turner Road Colchester Essex CO4 5JL Tel: 01206 747474
	LNU (Level 2)	Princess Alexander Hospital Hamstel Road Harlow Essex CM20 1QX Tel: 01279 444455
	LNU (Level 2)	Peterborough Edith Cavell Campus, Bretton Gate, Bretton, Peterborough PE3 9GZ Tel: 01733 678000
	SCBU (Level 1)	Hinchingbrooke Hospital, Hinchingbrooke Park, Huntingdon PE29 6NT Tel: 01480 416416
	SCBU (Level 1)	West Suffolk West Suffolk NHS Foundation Trust Hardwick Lane Bury St Edmunds Suffolk, IP33 2QZ Tel: 01284 713 000
Luton Cluster	NICU (Level 3	Luton and Dunstable Lewsey Road, Luton LU4 0DZ Tel: 01582 491166
	LNU (Level 2)	Lister Lister Hospital, Coreys Mill Lane, Stevenage, SG1 4AB Tel: 01438 314 333

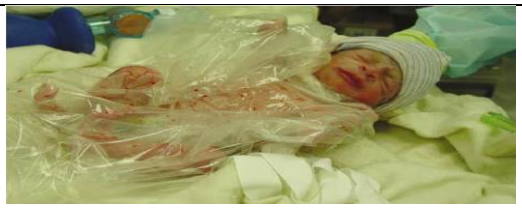
	LNU (Level 2)	Watford Vicarage Road, Watford, Hertfordshire WD18 0HB Tel: 01923 217339 ask for extension 7339
	SCBU (Level 1)	Bedford South Wing, Kempston Road, Bedford MK42 9DJ Delivery Suite-01234 795805 Midwifery Led Unit-01234 730417
Norwich Cluster	NICU (Level 3)	Norfolk and Norwich Norfolk and Norwich University Hospital Colney Lane Norwich NR4 7UY Tel: 01603 286286
	LNU (Level 2)	Queen Elizabeth Hospital, King's Lynn Gayton Road King's Lynn PE30 4ET Tel: 01553 613613
	LNU (Level 2)	Ipswich Heath Road Ipswich IP4 5PD Tel: 01473 712 233
	SCBU (Level 1)	James Paget Lowestoft Road Great Yarmouth NR31 6LA Tel: 01493 452 452
Essex Cluster - pathway tertiary care - Royal London and Homerton Hospitals	LNU (Level 2)	Basildon Nethermayne Basildon

		SS16 5NL Tel: 01268 524 900
	LNU (Level 2)	Southend Prittlewell Chase Westcliff On Sea SS0 0RY Tel: 01702 435 555

Appendix 5

Basic Neonatal Resuscitation Kit

Suggested content for In-utero transfer grab bag

Plastic bag & Hat	

Transwarmer mattress	
Stethoscope	
Ambu bag & Term and preterm masks	
Towels/blankets	

Appendix 6: SBARD proforma for IUT

Date & Time

SBARD proforma for IUT	
Situation	**Patient Name and NHS Number (Addressograph if room)**

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Need for transfer discussed with Patient and consent given	**Yes**	**No**	**Additional Information**				
Emergency Bed Service contacted	**Yes**	**No**	**If no, why not?**				
Patient NOK/significant other aware of transfer	**Yes**	**No**	**If no, why not?**				
Ambulance Arranged	**Yes**	**No**	**Date**		**Time**	**Ref no**	
Transfer arranged by : (Print name)			**Date**			**Time**	
Hospital arranging transfer out :-							
Name of Consultant on call :- **Obstetrician**			**Neonatologist**				
Hospital receiving Transfer :-							
Name of receiving consultant: - **Obstetrician**			**Neonatologist**				
Consultant to Consultant discussion :- Yes/No, if no why not							

Background

Gravida **Parity** **Singleton/Multiple pregnancy ……..**	
Gestational age:- **EDD:-**	
Past Medical/Surgical History	
Past Obstetric History	
Reason for Admission :-	
Reason for Transfer :-	
Safeguarding/ Mental Health issues :-	
Communication Problems :- **Ist Language; is a translator required?**	
Known Allergies	

Patient Name NHS Number

Assessment	**Yes**	**N/A**	**Comments**
ID Name Band & Allergy band			

Drugs administered; Steroids **Tocolysis** $MgSO_4$ **Ongoing infusions;**			**Date and time of doses**
Regular Medications (please document) (administered)			
Patient has own meds			
Drug Chart attached			
Fetal Heart Monitoring **Date & time of last FH auscultation**			**Baseline -**
Observations within normal range **BP, Pulse, Resps, Temp, O2 Sats, Urine Output**			**(If no state why)**
Bloods Hb, blood group, screening tests			
Vaginal Assessment (findings)			
PV loss, specify date/time/colour			
Spontaneous Rupture of Membranes date/time			
HVS			
Biomarker used			**Fibronectin/Actim Partus/Partosure** **Positive / Negative**
Indwelling device (catheter/Cannula)			**Time and Date inserted**
USS findings including presentation			
Uterine activity: Tightening/contractions			**: 10**
Anti Embolic Stockings			
MRSA Status			
Copy of hand held notes with patient			
Shift Leader at receiving hospital telephoned at time of departure for transfer			
Photocopy of completed SBAR in notes of hospital arranging transfer out			

Recommendations	**Comments**

Decision	
Date and Time decision was made	**Date and Time Patient left the Trust**

Completed by **Print name**		**Signature**	
Designation		**Date & Time**	

Appendix 7: Exception reporting

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Incident Reporting Communication Document: <27-week delivery in a centre without a NICU.

Unit Name:					
BadgerNet Number:	Infant Name: (initials only for emailed copy to Network)				
Date / time of admission of mum:	Date / time of delivery:	Gestation at birth:			
Were efforts made to undertake an in- utero transfer prior to delivery?		**Yes**		**No**	X
If no which of the following statements apply		Please tick			
Tertiary NICU unable to accept.					
Tertiary Obstetric service unable to accept.					
Delivery occurred prior to transfer.					
Maternal condition unsafe for transfer.					
Delivery indicated immediately.					
Who was the transfer discussed with (obstetric consultant, neonatal consultant, senior midwife labour wd, NNU in charge					
Other reasons – please state:					
Prior to delivery did communications take place with a tertiary NICU consultant?		**Yes**		**No**	
If no, why not?					
If yes, name / title of contact at tertiary unit:					
Prior to delivery did communications take place with a senior midwife on labour ward of the NICU?		**Yes**		**No**	
If no, why not?					

If yes, name / title of contact at tertiary unit: N/A				
Were there any significant documented antenatal concerns in the 2 weeks prior to delivery?	**Yes**		**No**	
If yes, what were they?				
Did you report this as clinical incident within your Trust?	**Yes**		**No**	
If yes, has it been reviewed locally?	**Yes**		**No**	
Name / title of reviewer(s): Risk Management				

Incident Reported by:	
Name and Title:	Date:
Organisation:	

Please email to **kelly.hart5@nhs.net**

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Appendix 8: In-Utero Transfer pathway

Woman in threaten preterm labour arrives at local maternity unit

Immediate review and assessment by clinician:
Woman's pregnancy (<27 weeks or <28-week multiples, <800gms) gestation

SBARD proforma completed

The SBARD is a proforma to collect all relevant information about the woman in a timely manner to make the handover and transfer pathway as smoothly as possible

Discuss case with an Obstetric consultant with a plan for consultant review

Out of hours: the senior register will need to inform and discuss with the Obstetric consultant via telephone of the planned in-utero transfer.

Where possible a consultant to consultant handover should occur, if not possible this handover must have been discussed prior to transfer.

It is essential that both transferring and receiving Obstetric & Neonatal consultants are aware of the transfer.

All pregnant women must be assessed for their suitability for transfer by the referring hospital, weighing up the risks of transfer against the potential benefits

Parental consent:
Decisions regarding appropriateness of transfer and interventions at the edges of viability are important. Counselling and decision making should be made with the family using the BAPM guidance

EBS must be used to locate bed/cot both in-utero and ex utero transfers.
Tel: 01223 274 274

The involvement of the ambulance service should be timely in ensuring that IUT is seen as an 'emergency' even though the Mother is in a place of safety

If there is no maternity bed/neonatal cot available the Maternity & neonatal teams should escalate immediately following their local policy

Exception reporting should be done as part of information sharing with the Neonatal ODN

A recommendation would be to complete an incident form/Daxit to ensure this is escalated and locally lessons learnt.

The receiving unit obstetric registrar, neonatal unit and delivery suite co-ordinator should all be informed and aware of the clinical history.

A photocopied set of notes and copy of a completed SBARD proforma (Appendix 5) should be sent with the women.

Safeguarding concerns/history the receiving hospital MUST be made aware of this via telephone and clearly documented within the notes.

Transferring Back:
Discussion between obstetric consultant to consultant should be done during normal working hours

Obstetric consultant/Senior register should discuss with the woman and partner about the plan to discharge or transfer back to ensure they understand why they are being discharged or transferred back and what to do in an event there are in threatened labour again

The discharge plan or home unit continued management plan should be in the woman's handheld notes and a copy sent to woman's named obstetric consultant

The neonatal team should be informed of the discharge plan to update their cot availability status.