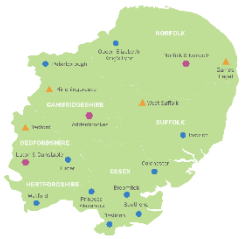

In-Utero Transfer Policy: East of England

June 2024

East of England Neonatal Operational Delivery Network
Collaborative working to deliver high quality care to our babies and their families

In-Utero Transfer Policy: East of England

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Approved by:

Neonatal Clinical Oversight Group	*12th June 2024*
East of England Maternity Services (6 LMNS)	12th June 2024
Clinical Lead – Dr Mathew James	12th June 2024
Regional Maternity and Clinical Network	12th June 2024
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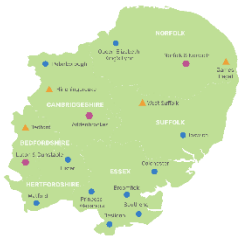
East of England Ambulance Service Clinical Lead – Daimon Wheddon, Kerrie Wykes and Chris Hewetson	12th June 2024
Emergency Bed Service & PaNDR – Dr Samantha O'Hare – Eileen Clarke	12th June 2024
Parents Advisory Panel	12th June 2024



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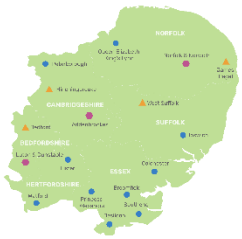
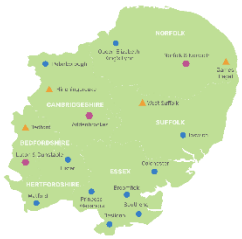


Glossary of terms

BAPM	British Association of Perinatal Medicine
CCG	Clinical Commissioning groups
COG	Clinical Oversight Group
EBS	Emergency Bed Service
EoE	East of England
IUT	In utero transfer
IUT	Intra utero transfer
LMNS	Local Maternity and Neonatal Services
LNU	Local Neonatal Unit
MatNeoSip	Maternity and Neonatal Safety Improvement Programme
MBRRACE	Mothers and babies; Reducing Risk through Audits and Confidential Enquiries across the UK
MVP	Maternity Voices Partnership
NICE	National Institute for health and Care Excellence
NICU	Neonatal Intensive Care Unit
NOK	Next of Kin
ODN	Operational Delivery Network
ONS	Office for National Statistics
PaNDR	Paediatric and Neonatal Decision Support and Retrieval Service
PPROM	Preterm Premature Rupture of membranes
SBARD	Situation, Background, Assessment, Recommendations & Decision
SCU	Special Care Unit
SOP	Standard operating procedure
STP	Sustainability and transformation Partnership



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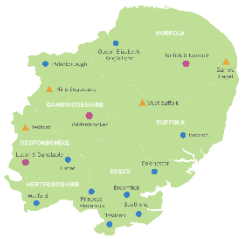
Equality, Diversity & Inclusivity Statement

This policy document aims to meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document ensures that no one receives less favourable treatment on the protected characteristics of their age, disability, sex, gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. The East of England Neonatal ODN advocates due regard to the various needs of different protected equality groups in our network. The East of England Neonatal ODN acknowledges the additional challenges that gender identity can have. We are aware that there is not yet universal language that addresses all families accessing maternity and neonatal care. We will always use the individual's preferred language, name, pronouns or terminology that they are most comfortable with, as we recognise the importance of providing inclusive and respectful perinatal information and support to all pregnant women, pregnant people, mothers, parents and families. Within this document, the terms woman/ mother is used to reflect all choices.



East of England Neonatal Operational Delivery Network

Collaborative working to deliver high quality care to our babies and their families

1. Introduction

The EOE Regional Maternity team, Neonatal ODN and Health Innovation East through the Maternity and Neonatal 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.

According to the Office for National Statistics (ONS, 2022), in England and Wales 7.6% of the total births were preterm. Within these:

- 6% were under 28 weeks gestation;
- 10% were between 28-32 weeks;
- 83% were between 32-37 weeks.

The care and survival rates of very preterm babies (<27 weeks or <28-week multiples, <800 gms) is greatly improved through access to onsite 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 foetal/maternal outcomes) will further exacerbate this worry.

Based on the MBRRACE-UK reports for births 2016 to 2021 neonatal mortality rates by mothers' socio-economic deprivation quintile of residence is higher for the most deprived quintile. Wide ethnic inequalities in perinatal mortality continue, but stillbirth and neonatal mortality rates for babies of Black ethnicity increased at a higher rate than for babies of Asian and White ethnicity. Babies of Black ethnicity now have the highest rates of both stillbirth and neonatal death.
Therefore, it is important to ensure that personalised holistic care is delivered to all women to address any health inequalities identified within the optimisation of the preterm baby.
Things that may need to be considered as part of the care package is provision of INTERPRETING SERVICES & TRANSLATION: To support organisations to ensure there is access to high quality interpreting services is available in a timely manner. As well as signposting and involvement from community groups or cultural ambassadors.

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 (neonatal and obstetric consultants, neonatal and maternity operational managers).
- To provide a systematic regional shared document to promote survival of our extremely preterm babies and minimise morbidity (BAPM, 2018).

- To achieve the best clinical outcomes based on more pregnant women (<27 weeks or <28-week multiples gestation, <800gms) being transferred prior to delivery to a cluster maternity unit with an aligned NICU.

- To address any delays in locating a maternity bed aligned with a neonatal cot by using the EBS 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 a lack of maternity bed or neonatal cot 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.

- To give clarity to the operational processes for transfers from one maternity unit to another.

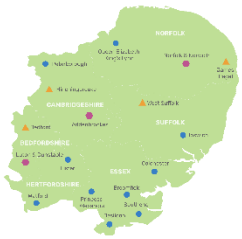
There are 6 LMNS within East of England and a total of 17 maternity and neonatal units. The national expectation is that all maternity units with a SCU should transfer women in labour with pregnancy between 27 and 30 weeks above 800g to their LNU (NHS England, 2024). An LNU should transfer women in labour with pregnancy <27 weeks gestation or <28 weeks gestation multiple birth and <800grams to a maternity unit with a NICU attached to increase the likelihood of the baby having 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
- Maternal, foetal or paediatric care requiring specialist medical care where urgent delivery is indicated (e.g. a woman requiring specialist haematological services)
- Bed/cot capacity or staffing concerns.

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 2). 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 smooth as possible. The use of the SBARD will ensure that any key information about the woman is not missed/omitted.



East of England Neonatal Operational Delivery Network

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All Transfers out

- **Best practice** is to facilitate a discussion with an Obstetric and Neonatal consultant at both the transferring and receiving unit prior to arranging transfer (see guidance below).

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 is recognised that out of hours the Obstetric consultant might not be physically 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 with the senior medical team.

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

- All pregnant women require an assessment by the referring hospital, regarding balance of risk/benefit of transfer. Compromising the health of the mother and /or the significant risk of delivery en route would be an absolute contraindication to transfer and consideration must be taken to deliver and transfer following stabilisation.

- **It is 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 this policy recognises for consent to be valid, women must have effective information about the options available. Therefore discussion must include a detailed explanation by a clinician of the proposed plan of care. For further information regarding consent and shared decision making please read the latest publication from NICE (2021).

- Maternal agreement needs to be obtained prior to transfer. This should be documented in the maternal healthcare record. This should involve counselling to obtain informed consent with respect given to decisions including not transferring (especially for babies at very low gestations who have multiple risk factors for a poor outcome) 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 woman 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 woman 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) and Neonatal Critical Care Specification (2024)

Arranging transfer

Based on the Neonatal Critical Care Review (2019), 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 circumstances, some women have had to be transferred long distances from home placing pressure on the family both financially and emotionally.

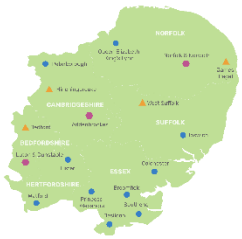
- The EBS is responsible to locate bed/cot for both in-utero and ex utero transfers (Appendix 3).

- 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. EBS should be updated twice daily and the ODN is updated daily via the daily situation report/ weekly within the neonatal regional capacity/repatriation meetings to ensure appropriate flow. In addition this information is shared with the ODN Director twice daily.

It is recognised that there may be sudden changes within the clinical setting; therefore, continuous maternity and neonatal updates would be essential in times of escalation to the Chief Midwifery Officer and ODN Director.

It is important that both the NICUs and maternity services consider their responsibility to the woman and unborn baby and accept all transfers unless there is no way it can be facilitated. In instances where there is unavailability of maternity bed/neonatal cot, the Maternity and Neonatal teams should escalate promptly in accordance to their local policy.

- Relevant external organisations should also be informed, within 48 hours if there is no maternity bed/neonatal cot in the region via telephone/email (EBS, Neonatal ODN & Regional Chief Midwifery Officer) within office hours. (Appendix 3).



Transferring the women

- There is a National Framework for Inter-Facility Transfers to follow when calling 999 or local health care professional number for ambulance control.
- In emergency cases that require immediate transfer, on telephoning ambulance control you will be asked

  "Do you need our clinical help right now to deliver an immediate life-saving intervention or are you declaring an obstetric emergency?"

- **Answer NO**, you will be directed to Q2 (If you answer yes, you may receive a solo responder in response to an immediate threat to life e.g. out of hospital cardiac arrest)

  Q2*"Is there a need for an immediate intervention that cannot be carried out at the current facility and is the patient at immediate risk of death or life changing loss of a limb or sight?"*

- **Answer YES and require the CCORD for the call to be placed as a C2 priority,** which moves it to the top of the C2 stack. (This activates the process for emergency response required, C2. National targeted response time of 18 minutes with 9/10 responded to within 40 minutes) See flowchart on Appendix 4.

- In cases where there are medical concerns, a risk assessment must be completed (by the sending hospital as they have overall clinical responsibility until the patient is handed over to the receiving unit) to assess if there is a need for additional staff for the transfer (obstetric/anaesthetic). If there is a high risk for transfer to be detrimental to maternal and neonatal health, the 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 5). **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 should be taken on transfer (Appendix 6).

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 (2022).

Women in preterm labour, consider the following.

- Antenatal corticosteroids - should be offered to women between 24+0 and 34+6 weeks' gestation in imminent preterm birth is anticipated (either due to established preterm labour, preterm pre labour rupture of membranes [PPROM] or planned preterm birth). They are effective in reducing neonatal respiratory morbidity and other complications of prematurity. Benefits are also seen when the first dose is given within 24 hours of birth and antenatal corticosteroids should still be given if birth is expected within this time (Follow RCOG Green-top Guideline No.74) LINK
- Intrapartum antibiotics prophylaxis to be offered to women in established preterm labour
- Magnesium Sulphate offered to women where preterm birth is imminent or planned. PReCePT (Prevention of cerebral palsy in pre-term labour) initiative, to help prevent cerebral palsy in pre-term babies through the increased practice of giving magnesium sulphate to women in pre-term labour. LINK RCOG

- Tocolysis – please follow Preterm labour and birth NICE guideline [NG25] 2022 on the factors to take into account when making a decision about whether to start tocolysis:

- whether the woman is in suspected or diagnosed preterm labour
- other clinical features (for example, bleeding or infection) that may suggest that stopping labour is contraindicated
- gestational age at presentation
- likely benefit of maternal corticosteroids (see the section on maternal corticosteroids)
- availability of an appropriate level of neonatal care (if there is need for transfer to another unit). See also NHS England's guidance on saving babies' lives care bundle version 2 (recommendation 5.9).
- the preference of the woman. [NICE 2015, amended 2022]

- 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 Dopplers. These individualised discussions should take place on a consultant-to-consultant basis.

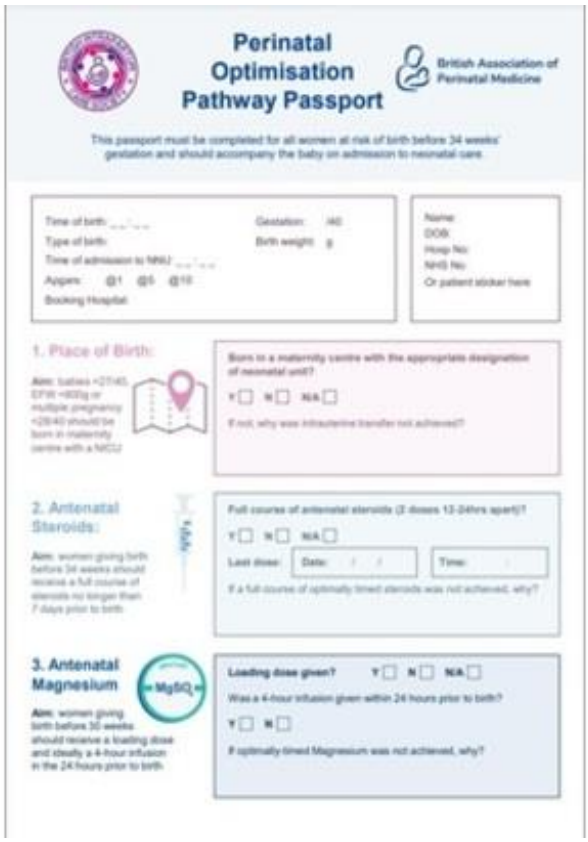
- If a woman's health is assessed to be too unstable for transfer, this decision should be reviewed, and risk assessed on a regular basis no longer than every 4 hours and transfer should be completed

if the clinical condition changes to allow safe transfer. The risks identified should be communicated to the woman.

- 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 and communicated to the woman. In the event that a woman appears to be labouring during the transfer and birth thought to be imminent, the ambulance would need to divert to the nearest maternity unit.

- Cases where there is uncertainty about whether to transfer or complex cases require discussion with both obstetric and neonatal teams.

Ensure that all discussions both internally and with external teams are documented in the medical and women's handheld notes, (where used). **Documentation may include the use of the Clinical Passport (BAPM Perinatal Optimisation Pathway Resources) adopted from the PERIPrem implementation resources. LINK**



4. Transfer for maternal indication

- Maternal condition must be medically 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 medically stable prior to transfer.

- There are occasions for maternal health that delivery of the baby may need to occur at the 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, and risk of delivery en-route is low IUT may be appropriate following consultant to consultation discussion from sending to receiving hospital.
- Risk assessments of mother and baby must be completed to determine the best outcome for both in determining whether to transfer of deliver locally and transfer the baby ex utero.
  E.g. Babies with known cardiac disease can be born in their local hospital and transferred ex-utero where clinically appropriate.

Management prior to transfer

- Referring hospital is responsible for:
  - The safe, efficient, rapid transfer of the woman,
  - An immediate reassessment of the woman prior to transfer.
- The receiving unit obstetric Consultant, 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 2) should be sent with the woman.
- In maternity/neonatal units that are paperless a printed set of notes should be sent with the woman along with her digital notes.
- In the cases where 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 healthcare professionals/social worker should be documented within the transfer notes to be handed over to the receiving hospital.
- All relevant health professionals/allied healthcare professionals/social worker should be informed directly (during office hours or duty social worker informed out of hours) 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 of 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 sending and receiving hospitals)*.
- Obstetric consultant/Senior registrar should discuss with the woman and partner (with the woman's permission), 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 if they are in threatened pre-term labour again.
- The discharge plan or home unit continued management plan should be in the woman's handheld notes and a copy sent to the woman's named obstetric consultant, home maternity unit and community midwife.
- The sending hospital neonatal team should be informed of the discharge plan.

5. 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 Local Maternity Hospital Divert Policy

6. Governance and 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 LMNS via their process and the Neonatal ODN on a monthly basis.

- In addition, an incident form to ensure this is escalated and local lessons learnt should be completed.

- Ensuring this policy is implemented in all units in the EoE.

- Feedback should be sought to monitor the experiences service users.

The EoE Neonatal ODN will monitor:

- Quarterly the number of women <27 weeks gestation delivered in a maternity unit without a NICU on site
- Quarterly the number of women <28 weeks gestation multiple births delivered in a maternity unit without a NICU on site
- The activity reports, drawings from transfer records and other key metrics provided by from The Emergency Bed Service (EBS)/ (PaNDR) to the Local Maternity & Neonatal Systems and the Neonatal Operational Delivery Network.

All the reviewed data and identified good practice will be presented at Neonatal COG, LMNS and Regional Maternity Programme Board meetings. Any safety or risk issues recognised will be escalated to the relevant governance groups and action plans agreed.

7. Utilising this policy locally

Reference to this policy to be incorporated into local clinical guidance and the policy to be available for reference on trust policy and guidance platforms (<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.

8. 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.

EoE ODN:

Based on the NHS Long Term Plan (2010), Neonatal Critical Care Review (2019), Maternity and Neonatal Delivery Plan (2023) 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 ICB/CCG/STP along with Maternity and Neonatal Voice Partnership (MNVP) and EOE Parent Advisory Group (PAG) should expect both maternity and neonatal units including LMNS, MatNeoSiP 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.

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

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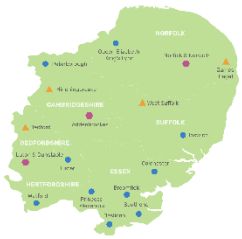


Appendix 1: Gestational Thresholds

Thresholds as described within the recently published Neonatal Critical Care Service Specification (NHS England, 2024):

Special Care Unit:

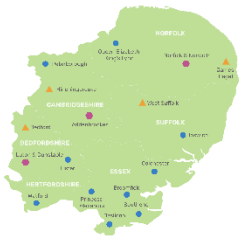
- Babies born after 29 +6 weeks GA with anticipated weight above 1000 grams. This threshold might be higher for multiples.
- Stabilisation of babies meeting the threshold of transfer, prior to transfer to a LNU or NICU.
- Care for local babies following repatriation from LNU or NICU within the region.
- Referrals for ongoing special care from other regional units who are overcapacity.
- Care for local babies' post-surgery following repatriation from surgical unit.
- Transitional care working in collaboration with postnatal services.
- Is not expected to support ongoing care beyond initial stabilisation of babies less than 29+6 weeks GA and less than 1,000grams.
- Is not expected to provide intensive care for any baby apart from initial stabilisation prior to transfer.

Local Neonatal Unit:

- Additionally, to all the services provided on a SCU, LNUs are responsible for:
    - Care of babies above 26+6 weeks (or above 27+6 weeks for multiples) providing that birth weight is above 800 grams.
    - High dependency care and special care for their local population.
    - Care for local babies repatriated from neonatal units who require high dependency or special care.
    - Ongoing care for local babies who have undergone specialist surgery following repatriation from a surgical NICU.
    - Referrals from within network neonatal units who are unable to undertake high dependency care and special care, due to capacity and/or network guidelines.

Local Neonatal Units are not expected for:

- Ongoing intensive care beyond initial stabilisation to babies less than 27+0 weeks of GA and/or below 800 grams.
- Ongoing complex intensive care beyond initial stabilisation, including babies requiring respiratory support with symptoms of additional organ failure (e.g. hypotension, DIC, renal failure, metabolic acidosis) or babies requiring the following treatment and support:
    - Support of more than one organ (ventilation plus inotropes/insulin/chest drain/exchange transfusion/prostaglandin) beyond stabilisation.
    - INO
    - HFOV
    - Therapeutic hypothermia beyond initial stabilisation
    - Prolonged intensive care (intubated ventilatory support) for greater than 48 hours.



Neonatal Intensive Care Units:

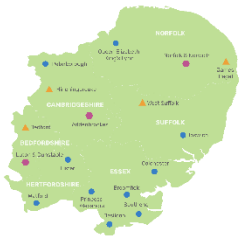
- Additionally to all the services provided on a SCU and LNU, NICUs are responsible for:
  - Neonatal intensive care for out of region neonatal units due to a lack of capacity in their own network NICU.
  - Leadership within neonatology for the neonatal ODN units and 24 hour acute clinical telephone consultations are required.
  - Care for local network babies repatriated from elsewhere requiring ongoing care from a NICU.

Appendix 2: SBARD proforma for IUT

Date & Time

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

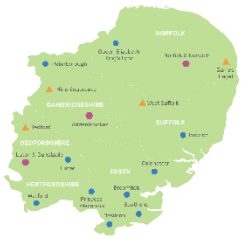
Assessment	Yes	N/A	Comments
ID Name Band & Allergy band			
Drugs administered; Steroids Tocolysis $MgSO_4$ Ongoing infusions;			*Date and time of doses*
Regular Medications (please document) (administered)			
Patient has own meds			
Drug Chart attached			
Fetal Heart Monitoring Date & time of last FH 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			



East of England Neonatal Operational Delivery Network

Collaborative working to deliver high quality care to our babies and their families

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 3: Relevant contact details within the ODN

Contact	Contact details	When to contact?
EBS	01223 274 274	Referral for ex-utero or in-utero transfer
ODN Director Liz Langham	07720313360 elizabeth.langham1@nhs.net	Capacity issues (standard office hours)
Regional Chief Midwifery officer Wendy Matthews	w.matthews3@nhs.net	Capacity issues (standard office hours)
East of England Ambulance tactical operations centre	01245 444515 Option 1 operations@eastamb.nhs.uk	

Appendix 4: National Framework for Inter-Facility transfers

3. Process flow chart

A nature of call option 'IFT' should be in operation in all ambulance trusts to operate this framework.

Emergency ambulance to be deployed

Solo rapid responder to attend e.g. cord prolapse, PPH, Not in medical facility

Appendix 5: Cluster groups & contact details

The EOE is divided into cluster groups around a 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*	*Hospital contact numbers*
Cambridge Cluster	NICU (*formerly* Level 3)	Rosie maternity unit Robinson Way, CB2 0QQ Cambridge Tel: 01223 245 151
	LNU (*formerly* Level 2)	Broomfield - Maternity Services (Level 4) Hospital Wing Broomfield Hospital, CM1 7ET Chelmsford, Essex Tel: 01245 362 305
		Colchester Hospital Turner Road, CO4 5JL Colchester , Essex Tel: 01206 747474
		Princess Alexandra Hospital Hamstel Road, CM20 1QX Harlow, Essex Tel: 01279 444455
		Peterborough City Hospital Edith Cavell Campus (Bretton Gate), PE3 9GZ Peterborough Tel: 01733 678000
	SBU (*formerly* Level 1)	Hinchingbrooke Hospital Hinchingbrooke Park, PE29 6NT Huntingdon Tel: 01480 416416
		West Suffolk NHS Foundation Trust Hardwick Lane, IP33 2QZ Bury St Edmunds, Suffolk Tel: 01284 713 000

Cluster	Neonatal Units	Hospital contact numbers
Luton Cluster	NICU (*formerly* Level 3)	Luton and Dunstable Lewsey Road, LU4 0DZ Luton Tel: 01582 491166
	LNU (*formerly* Level 2)	Lister Hospital Coreys Mill Lane, SG1 4AB Stevenage Tel: 01438 314 333
		Watford Hospital Vicarage Road, WD18 0HB Watford, Hertfordshire Tel: 01923 217339 ask for extension 7339
	SCU (*formerly* Level 1)	Bedford Hospital South Wing, Kempston Road, MK42 9DJ Bedford Delivery Suite-01234 795805 Midwifery Led Unit-01234 730417

Cluster	Neonatal Units	Hospital contact numbers
Norwich Cluster	NICU (*formerly* Level 3)	Norfolk and Norwich University Hospital Colney Lane, NR4 7UY Norwich Tel: 01603 286286
	LNU (*formerly* Level 2)	Queen Elizabeth Hospital, King's Lynn Gayton Road, PE30 4ET King's Lynn Tel: 01553 613613
		Ipswich Hospital Heath Road, IP4 5PD Ipswich Tel: 01473 712 233
	SCU (*formerly* Level 1)	James Paget Hospital Lowestoft Road, NR31 6LA Great Yarmouth Tel: 01493 452 452

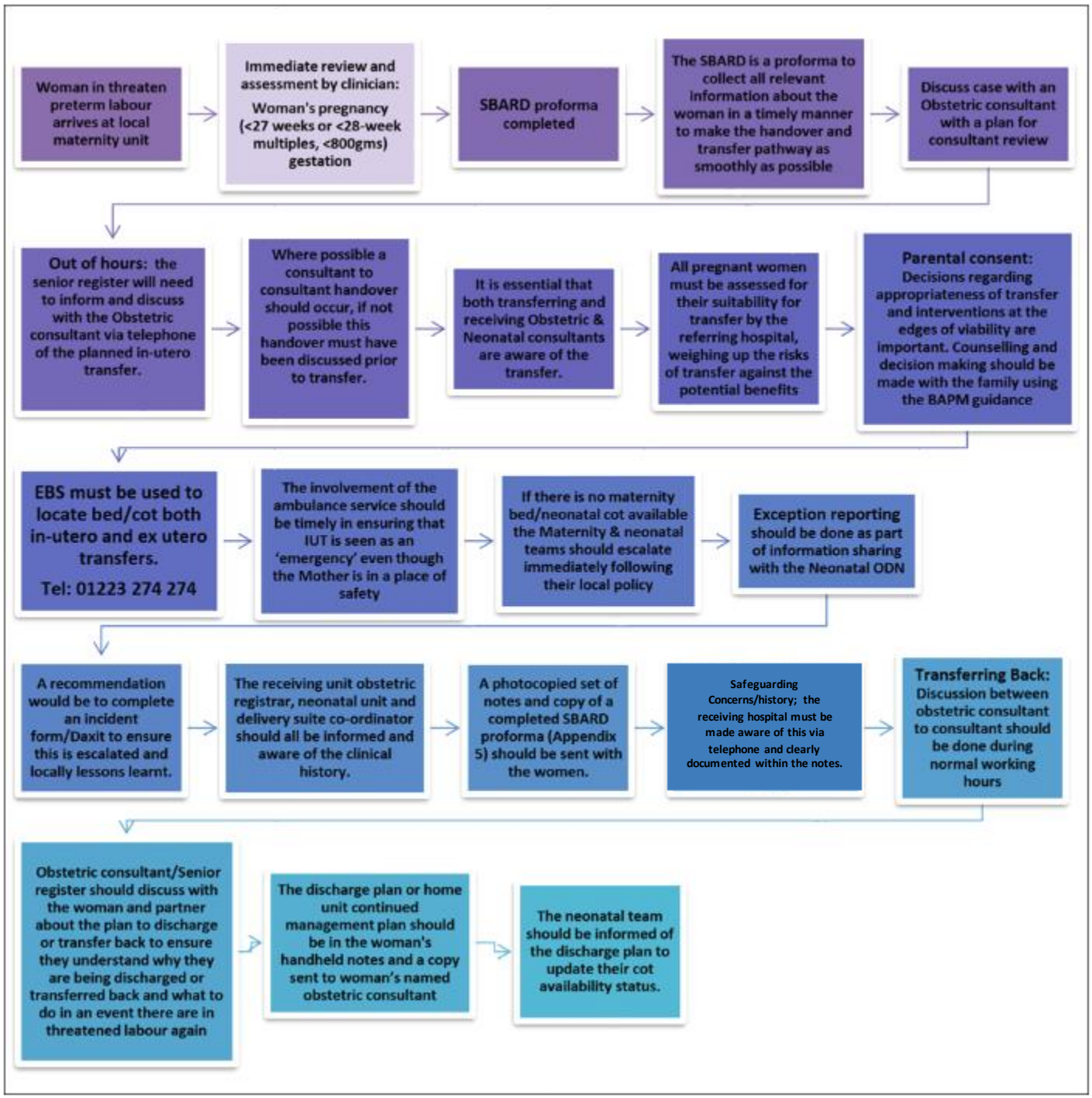
Cluster	Neonatal Units	Hospital contact numbers
Essex Cluster - pathway tertiary care - Royal London and Homerton Hospitals	LNU (*formerly* Level 2)	Basildon Hospital Nethermayne, SS16 5NL Basildon Tel: 01268 524 900
		Southend Hospital Prittlewell Chase, SS0 0RY Westcliff On Sea Tel: 01702 435 555

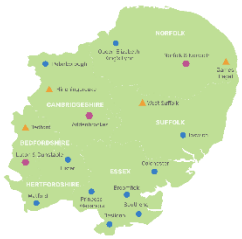
Appendix 6: Basic Neonatal Resuscitation Kit

Suggested content for In-utero transfer grab bag

Plastic bag & Hat	
Trans warmer mattress	
Stethoscope	
Ambu bag & Term and preterm masks	
Towels/blankets	

Appendix 7: In-Utero Transfer pathway





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