Principles of In-Utero Transfer

Southeast Regional Maternity Team NHS England

NHSE

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Abbreviations	
IUT	In-utero transfer
NNU	Neonatal Unit
NICU	Neonatal Intensive Care Unit
LNU	Local Neonatal unit
SCBU	Special Care Baby Unit
SBARD	Situation, Background, Assessment, Recommendations, Decision
NLSRCUK	Newborn Life Support Resuscitation Council UK

Amendment History			
Date	Version	Author/Contributor	Amendment Details
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22.09.22	0.2	Regional Maternity Deputy Chief Midwife Regional Chief Midwife Regional Lead Obstetrician Consultant Regional Lead Neonatologist Consultant Clinical Network lead SE Maternity Consultant Neonatologist Southampton	Amendments following the first consultation
31.10.22	0.3	Regional Maternity Deputy Chief Midwife Regional Chief Midwife Regional Lead Obstetrician Consultant Regional Lead Neonatologist Consultant Clinical Network Lead SE Maternity	Incorporated comments
02.11.22	0.4	Regional Maternity Deputy Chief Midwife Regional Chief Midwife Regional Lead Obstetrician Consultant Regional Lead Neonatologist Consultant Clinical Network Lead SE Maternity Operational Delivery Networks Southeast Coast Ambulance Trust Directors/Heads of Midwifery SE Trusts LMNS Senior Responsible Officers Specialised Commissioning NHSE Wider System NHS Maternity and Neonatal Colleagues	Incorporated comments
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26.01 23	1.0	Regional Maternity Deputy Chief Midwife Regional Lead Obstetrician Consultant Regional Lead Neonatologist Consultant Operational Delivery Networks	Agreed document as final

Contents

1. Introduction

1.1. The In-Utero Transfer (IUT) Principles is a guidance document and has been developed in collaboration with:

- Kent and Medway Local Maternity and Neonatal System
- Surrey Heartlands Local Maternity and Neonatal System
- Sussex Local Maternity and Neonatal System
- Frimley Local Maternity and Neonatal System
- Southampton, Hampshire, Isle of Wight and Portsmouth Local Maternity and Neonatal System
- Buckinghamshire, Oxford and Berkshire Local Maternity and Neonatal System
- Southeast Coast Ambulance Service NHS Trust (SECAmb)
- South Central Ambulance Service (SCAS)
- Southeast Region NHS England Maternity Team
- Southeast Region Operational Delivery Networks (ODN)
- NHSE Southeast Region Specialist Commissioners of Neonatal Services

This guidance has been informed by the East of England In-Utero Transfer Policy and thanks are extended to the Northeast Regional Maternity Team for their consent to adopt some of their information.

2. General Guidance

2.1. This policy has been developed to enable maternity and neonatal services to align their pathways to a standardised regional process. Maternity or in-utero transfers may be required for a variety of reasons.

Clinical indications for transfer:

- Preterm labour/neonatal gestational thresholds (appendix 1)
- Antenatal diagnosis requiring surgical postnatal care
- Requiring specialist maternal care
- Maternal or fetal indications/concerns
- Requiring specialist neonatal services

2.2. There are other factors that lead to diversion and decisions should be considered on a case-by-case basis.

Reasons for transfer may include:

- Bed/cot capacity or staffing shortage in maternity/NNU
- Inappropriate experience and skill mix in maternity/NNU
- Infection Prevention & Control issues in maternity/NNU – follow local IPC policy
- A major incident or power failure in maternity/NNU. Providers should follow business continuity plans

In these circumstances, local escalation, and associated actions (e.g., flexing of staff) within the provider trust should be followed before a transfer is considered.

2.3. The decision to accept or refuse in-utero transfers from maternity units within the region must follow a designated process to ensure that the appropriate care is delivered as close to home as possible.

2.4. Standardised information should be completed for in-utero transfers using the standardised proforma i.e. SBARD. The SBARD (Situation, Background, Assessment, Recommendation and Decision) is a proforma to collect all relevant information about the woman/birthing person to support the safe handover of care and to facilitate the timely transfer.

3. Principles

3.1. The following Principles are for use as guidance for all SE maternity and neonatal units in relation to IUTs.

1.	During the antenatal period parents who have presented with maternal or fetal risk factors should be counselled on a networked shared care model in the preterm birth clinic i.e. • delivery may not be appropriate or possible at their booking hospital of choice if specialist maternity or neonatal care is needed for their baby • if their site of choice has a NICU and there are limited maternity beds/cots available Antenatal counselling should be an opportunity to explain pathways of neonatal care of fetal medicine / maternal medicine including transfer of care back to the local neonatal service when this is appropriate.
2.	Transfers of care should occur when a higher level of maternity or neonatal care is required, or when the unit does not have neonatal cot capacity.
3.	In cases where there is no maternity bed/neonatal cot available within the unit/provider trust the maternity & neonatal teams should escalate immediately following their local policy. If there is no maternity bed/neonatal cot within networked pathways of care in the region the relevant external organisations should also be informed via telephone/email (Neonatal ODN & Regional Chief Midwifery Officer).
4.	The maternity bed and neonatal cot locator dashboard PERIDASH (appendix 9) should be used to identify capacity at an appropriate neonatal service provider.
5.	Transfer of women in premature labour with babies of moderate to late gestation (Appendix 1) for staffing and cot capacity reasons should be avoided. Care provision for this group may be provided within transitional care units. Local escalation and contingency plans should be considered i.e. flexing BAPM neonatal nurse staffing ratios. A local risk assessment should be undertaken prior to maternity transfer for staffing /capacity.

6.	Decision-making for in-utero transfers for preterm delivery at extreme preterm gestations should involve senior clinicians. Counselling and decision-making should be made with the family using the BAPM Framework of Practise Perinatal Management of Extreme Preterm Birth Before 27 weeks of Gestation (2019).
7.	All in-utero transfers must be discussed and agreed upon by the maternity coordinator or senior midwife and the transferring Obstetric and Neonatal/paediatric consultants, or if unavailable by the registrar after they have discussed with the consultant, prior to arranging the transfer. The risk of delivery enroute should be considered prior to transfer and would be an absolute contraindication to transfer. In this situation, local delivery and postnatal transfer should be considered.
8.	Where possible a consultant-to-consultant handover from both the transferring and receiving units should occur (both Obstetric and Neonatal) using the SBARD, form. If the consultant is not available this handover must be undertaken by a tier 2/registrar prior to transfer. The transferring hospital has overall clinical responsibility for the patient during transfer.
9.	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. In cases where there are other maternal medical concerns, a risk assessment must be completed to assess if there is a need for additional staff for the transfer.
10.	Maternal agreement needs to be obtained prior to transfer. There must be valid consent (voluntary and informed), and the person consenting must have the capacity to make the decision. Where consent is not obtained there must be a detailed explanation of the plan, written by the clinician, and clearly documented in the maternal healthcare record.
11.	Maternity bed and neonatal cot status should be included in a joint daily maternity and neonatal team safety huddle in provider trusts. Maternity and neonatal cot status should be submitted to the SE Regional Maternity bed and Neonatal cot Peridash system twice daily. As changes occur in maternity and neonatal services an update of the dashboard bed/cot availability is recommended.
12.	A joint maternity/neonatal safety huddle/review by the senior maternity, obstetric and neonatal teams in the receiving unit should take place prior to all maternity transfers for capacity/staffing. In these circumstances, local escalation processes within the provider trust should be followed prior to transfer.
13.	Maternity and neonatal services with on-site NICU (Neonatal intensive care units, tertiary units Level 3) should prioritise in-utero transfers for neonatal intensive care (less than 27 weeks gestation) **as per local pathways for their LNUs and SCUs**. Services should also consider transfers from within the whole network when this can be safely facilitated
14.	The involvement of the ambulance service should be timely to ensure that transport is prioritised for in-utero transfers in maternity and neonatal care, even though the mother/birthing person is in a place of safety. Multi-disciplinary team clinical

	judgement should be used in deciding whether the IUT warrants a category 2 or 3 ambulance request for transfer. The woman/birthing person being transferred must be escorted by a midwife with the relevant training to transfer an adult.

4. Diagnosing Preterm labour

4.1. 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.
To ensure the right women are transferred clinicians should follow national guidance on predicting preterm labour and birth https://www.nice.org.uk/Guidance/NG25 and it is highly recommended that clinicians download and use the QUiPP App QUiPP: A tool to predict spontaneous preterm birth (freely available from the App store on iPhone) to aid their clinical decision-making.
The QUiPP App has been developed by Genetic Digital and was funded by Guys and Thomas's Charity, the National Institute of Health Research, Tommy's Charity and the Kings College Innovation Prize. The app first asks if the woman/birthing person is asymptomatic or symptomatic, and then the user submits answers to 7 short questions as below:

1) Symptoms suggestive of abnormal or premature uterine activity
2) Previous cervical surgery
3) Previous spontaneous preterm birth
4) Previous pre-term premature rupture of the membranes (PPROM)
5) Number of fetuses
6) Gestation of test
7) Shortest cervical length
8) Fetal fibronectin (fFN) test result

The App will then calculate the probability of spontaneous delivery.

4.2. Women/birthing people in preterm labour should be:

- Offered antenatal steroids if below 34 weeks gestation.
- Offered Magnesium Sulphate if below 30 weeks gestation. Note this can only continue during the transfer if there is a midwife accompanying the woman/birthing person as it is not within the scope of ambulance crews.
- Tocolytics (unless contraindications) should be considered for transfer even with Preterm Pre-Labour Rupture of Membrane.
- Intrapartum Antibiotics - the use of antibiotics 4 hours before birth significantly improves survival outcomes.
  All women less than 37 weeks gestation should receive intravenous intrapartum antibiotic prophylaxis to prevent early onset neonatal Group B Streptococcal infection irrespective of whether they have ruptured membranes (Royal College of Gynaecologists)
- There may be women for whom transfer is indicated for maternity care 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.

4.3. If maternity in-utero transfer is not undertaken due to safety reasons/unstable for transfer, this decision should be reviewed, and risk assessed on a regular basis at least every 4 hours, and transfer should be completed if the clinical condition changes to allow a safe transfer. There is an element of risk with all in-utero transfers, therefore regular risk assessment will be vital during the transfer. In cases where there is uncertainty about whether a transfer is appropriate i.e. complex maternal or fetal cases, discussion with both obstetric and neonatal senior teams should take place. Ensure that all discussions both internally and with external teams are documented in the medical and women's handheld notes. A maternal/birthing person's health should always take a priority.

5. Transfer for maternal indication

5.1. The maternal condition must be medically stable for transfer to higher-level maternity care. There are occasions when maternal health will dictate that delivery of the baby may need to occur at a current hospital with an ex-utero transfer of the baby (e.g. severe pre-eclampsia, liver or renal disease, abruption, sepsis).

6. Transfer for specialist neonatal services

6.1. In this situation, most women will have been booked for delivery in a centre with neonatal intensive care and specialist neonatal services. If a labouring woman/birthing person presents to her local hospital, an assessment will need to be made to determine if an in-utero transfer is possible or if transfer ex-utero after delivery is a preferred safer option. Local neonatal teams should be involved to facilitate local care and early escalation to NICU and neonatal transport services as needed. In the situation where the woman/birthing person appears to be labouring during the transfer and birth is thought to be imminent the ambulance should go directly to the nearest maternity unit.

7. Consent to transfer

7.1. The emotional and social impact of an in-utero transfer for the birthing person needs to be recognised. The rationale and its clinical indication should be explained to the birthing person and partner by the clinician in charge of the transfer, including networked pathways of care for higher levels of neonatal care and implications for the neonatal outcome. The receiving unit should try and accommodate birth partners to remain with the woman where possible. Repatriation to their local neonatal service i.e. originally booked hospital, or one nearer home, after completion of intensive and/or high-dependency neonatal care should also be explained.

7.2. All available information on the receiving hospital including address and telephone number should be provided to the woman/ birthing person and partner/support person to minimise any anxiety Parents should be signposted to additional information on neonatal services

7.3. within the region e.g. Thames Valley Wessex and Kent, Surrey and Sussex Operating Delivery Network websites for parent information.

7.4. In cases where the woman/birthing person/birthing person 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. Family members should not be asked to interpret for the clinicians or the woman/birthing person.

8. Planning the transfer of women/birthing people

8.1. The SE maternity PERIDASH bed/cot finding IT system should be used to identify where there is an available maternity bed and appropriate level neonatal cot. This system provides information on care provision at different neonatal service providers, including neonatal intensive care units (NICUs), local neonatal units (LNUS) and neonatal (special care units) SCU within the region. This will enable maternity teams to identify the appropriate location to arrange in-utero transfers **Once a bed/cot is identified a phone call must be made by the senior midwife with operational responsibilities (e.g. bleep holder/care coordinator) to establish that the beds are open for admissions and are not restricted by staffing/acuity levels.**

8.2. Where possible transfers should be within the referring unit's networked pathways of care. The number of qualified staff required to escort a woman/birthing person with multiple pregnancies should be individualised depending on the clinical risk to both the transferring woman and to the remaining women on the unit. Consideration should be given to the remaining staff numbers on the unit and the ability to provide one to one care.

9. Management prior to transfer

9.1. The referring hospital is responsible for the safe, efficient, rapid transfer of the woman/birthing person. The referring hospital must repeat the 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 a copy of a completed SBARD proforma should be sent with the women/birthing person. The woman/birthing person's hand-held notes can also be photocopied and sent in addition. In maternity/neonatal units that use electronic patient records a printed set of notes should be sent with the women along with her digital notes.
If it has been confirmed that both transferring and receiving trusts are using a compatible EPR system i.e. Maternity Badgernet, the records may be transferred electronically.

9.2. 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, this must be communicated to the receiving hospital, and it should be clearly documented within the transfer notes. The contact details of any relevant health professionals/allied health professionals/social workers should be documented within the transfer notes to be handed over to the receiving hospital. All relevant health professionals/allied health/social workers should be informed immediately of the transfer of the women via telephone & email to ensure there is swift follow-up/handover of care.

10. During transfer

10.1. Only women/birthing people who are not expected to deliver in the next hours are suitable for transfer, where birth is imminent delivery must take place in the current unit with any change to a different level of NNU organised for post-delivery.

10.2. In a vehicle, without a registrant, the midwife is in charge but a grade 1 backup, which could be a Critical Care Paramedic (if available) can be requested. The midwife is best placed to care for the woman and the crew are generally experts in resuscitation, but the crew and midwife should work where they feel most comfortable.

10.3. The driver of the vehicle is ultimately responsible for all the passengers and must not be asked to let the woman/birthing person remain unsecured as this would mean to drive illegally.

10.4. Whilst all efforts are made to ensure women/birthing people deliver in the right place if a baby should deliver during ambulance transfer the following should be noted:

- All ambulances **should** have minimum equipment for newborn resuscitation (appendix 3), SCAS do not have hats

- The transferring trust must check there is a basic newborn resuscitation kit available in the ambulance because if the ambulance crew is dispatched straight from another paediatric transfer without time to restock it is not guaranteed that the full neonatal resuscitation kit will be available

- Immediate care of the baby depends on the gestation and the clinical condition. The Resuscitation Council has published detailed guidance (Newborn resuscitation and support of transition of infants at birth Guidelines) regarding immediate care.

11. Transfer back to referring hospital

11.1. If after 48 hours delivery is not expected to be imminent, and following discussion with the home unit, discharge or transfer back should be considered. Discussions between obstetric consultants should be done during normal working hours.

11.2. Out of Hours situations

Where possible home unit discharge or transfer back should be discussed and organised during normal working hours. Out of hours transfers should only happen in urgent cases and would need to be agreed upon by both obstetric consultants from discharging and receiving hospitals. The Obstetric consultant/Senior registrar should discuss with the woman/birthing person/birthing person and partner the plan to discharge or transfer back to ensure they understand why this is happening and what to do in the event they are in threatened labour again.

11.3. The discharge plan or home unit continued management plan should be in the woman/birthing person's handheld notes and a copy sent to the woman/birthing person/birthing person's named obstetric consultant. If the trust is using EPR these should be printed and handed to the patient.

12. Monitoring

12.1. The Neonatal ODN /LMNS and the regional team have a responsibility for monitoring the following births in a maternity service without an onsite NICU:

- Babies before 27 weeks gestation
- Babies born in multiples when less than 28 weeks gestation
- Babies born with a birth weight under 800g

References and links

Antenatal Optimisation Toolkit | British Association of Perinatal Medicine (bapm.org) Oct20

Care of Women Presenting with Suspected Preterm Prelabour Rupture of Membranes from 24+0 Weeks of Gestation (Green-top Guideline No. 73) | RCOG

New BAPM Framework on Extreme Preterm Birth Published | British Association of Perinatal Medicine (2019)

Neonatal Critical Care Review (swneonatalnetwork.co.uk) (2019)

Newborn resuscitation and support of transition of infants at birth Guidelines | Resuscitation Council UK

NICE guideline (NG25) Preterm labour and birth (2019) https://www.nice.org.uk/Guidance/NG25

QUiPP: A tool to predict spontaneous preterm birth

Related documents

These can be found here: Home - Welcome (southeastclinicalnetworks.nhs.uk)

SCAS IFT Booking Guidance Hampshire

SCAS IFT Booking Guidance Thanes Valley

Clinical Pathway- Complicated Labour Unwell

Newborn Pathway- FINAL CP Issue 2021-001

2023-01 SECAmb Suspected Preterm Labour Guidance v1.1.0

Appendix 1 Gestational Thresholds in utero transfer for neonatal care

NICU

Babies less than 27 weeks or less than 800gms (multiples < 28 weeks)

LNU

Babies less than 27weeks or less than 800gms

SCBU

Babies less than 32 weeks

Appendix 2 SBARD Form

Situation							
Need for transfer discussed with patient and consent given	**Yes**	**No**	**Additional Information**				
Cot/bed locator system used	**Yes**	**No**	**If no, why not?**				
Patient next of Kin/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, i f not why							
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: - **First language; is a translator required?**							
Known Allergies							

Assessment	**Yes**	**N/A**	**Comments**
ID Name Band & Allergy band			
Drugs administered: • **Steroids** • **Tocolysis** • **MgSO4** • **Antibiotics** **Ongoing infusions**			**Date and time of doses**

Regular Medications (please document) **Medications administered?**			
Patient has own meds			
Drug Chart attached			
Fetal Heart Monitoring **Date & time of last FH auscultation**			**Baseline -**
Observations within normal range **BP, Pulse, Respirations, Temp, O2 Sats, Urine Output**			**(If no state why)**
Bloods Hb, blood group, screening tests, CRP			
Vaginal Assessment (findings)			
PV loss, specify date/time/colour			
Spontaneous Rupture of Membranes date/time			
High vaginal swab			
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/CPE Status			
Copy of handheld 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			**Signature**

Appendix 3 Minimum equipment for newborn resuscitation

Resuscitation Council UK

Minimum equipment for newborn resuscitation and the support of transition of infants at birth in the pre-hospital setting

Introduction

This equipment list, developed for Resuscitation Council UK Newborn Life Support Subcommittee by the Pre-Hospital Newborn Life Support working group, represents a minimum recommended standard for those delivering care for planned or emergency births in the out-of-hospital setting.

All items should be latex free.

Thermal care

- Towels x 4
- Hat (small and large) x 2
- TransWarmer © (or similar)
- Clear plastic bag.

Airway management

- Portable suction equipment – battery operated with adjustable pressure (manual acceptable)
- Paediatric Yankeur catheter x 2
- i-gel/LMA size 1
- Laryngoscope with size 1 blade
- Sachet of lubricant gel
- 5 mL syringe (if inflatable cuffed LMA carried).

Breathing support

- Self-inflating paediatric resuscitation bag (approximately 500 mL volume)
- Face masks for positive pressure ventilation – appropriate to all gestations (e.g. Size 00, 0 and 1)
- Paediatric nasal cannula.

Additional items

- Cord clamps x 3
- Sharp scissors/umbilical cord scissors
- Gauze
- Clinical waste bag x 2
- Stethoscope
- Gloves
- Patient ID bracelet x 2
- Axilla thermometer
- Copy of the NLS algorithm
- Oxygen cylinder and saturation monitor with an appropriate probe.

Appendix 4 Neonatal Unit Designation

Stoke Mandeville Hospital	LNU
Wexham Park Hospital	LNU
Milton Keynes University Hospital	LNU
John Radcliffe Hospital, Oxford	NICU
Royal Berkshire Hospital	LNU
Dorset County Hospital Dorchester	SCU
Basingstoke and North Hampshire Hospital	LNU
The Royal Hampshire County Hospital	LNU
St Mary's Hospital, Isle of Wight	SCU
Poole Hospital	LNU
Queen Alexandra Hospital, Portsmouth	NICU
Salisbury District Hospital	LNU
Princess Anne Hospital, Southampton	NICU
St Richard's Hospital, Chichester	SCU
Ashford and St Peters Hospital	NICU
Surrey and Sussex Hospital	LNU
Frimley Park Hospital	LNU
Royal Surrey Hospital	SCU
Worthing Hospital	SCU
Princess Royal Hospital	SCU
Royal Sussex Hospital	NICU
The Conquest Hospital	SCU
Pembury Hospital, Tunbridge Wells	LNU
Medway Maritime Hospital	NICU
William Harvey Hospital	NICU
Queen Elizabeth Queen Mother Hospital	SCU
Darent Valley Hospital	SCU

Appendix 5 Unit Designation and provision of care as per neonatal service specification

Kent, Surrey and Sussex	Unit Designation	Provision of care as per Neonatal Service Specification
Medway Hospital	NICU	Provides medical intensive care for all babies from 22+6 weeks
Royal Sussex Hospital	NICU	Provides medical and surgical intensive care for all babies from 22+6 weeks
Ashford and St Peter's Hospital	NICU	Provides medical intensive care for all babies from 22+6 weeks
William Harvey Hospital	NICU	Provides medical intensive care for all babies from 22+6 weeks
Frimley Park Hospital	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
East Surrey Hospital	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
Tunbridge Wells Hospital	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
Conquest Hospital	SCU	Provides care for babies >32wks gestation and >1250grams
Princess Royal Hospital	SCU	Provides care for babies >32wks gestation and >1250grams
Worthing Hospital	SCU	Provides care for babies >32wks gestation and >1250grams
Queen Elizabeth Queen Mother Hospital	SCU	Provides care for babies >32wks gestation and >1250grams
Darent Valley Hospital	SCU	Provides care for babies >32wks gestation and >1250grams
Royal Surrey Hospital	SCU	Provides care for babies >32wks gestation and >1250grams

Thames Valley	Unit Designation	Provision of care as per Neonatal Service Specification
Oxford University Hospitals	NICU	Provides medical intensive care for all babies from 22+6 weeks
Buckinghamshire Healthcare Trust	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
Frimley Wexham Park Hospital	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
Milton Keynes University Hospital	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
Royal Berkshire Hospital	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
Wessex		
Queen Alexandra Portsmouth Hospital	NICU	Provides medical intensive care for all babies from 22+6 weeks
University Hospital Southampton	NICU	Provides medical intensive care for all babies from 22+6 weeks
Basingstoke Hampshire Hospitals	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
Winchester Hampshire Hospitals	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation n
University of Dorset Hospital (Poole)	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
Salisbury Hospital	LNU	Provides care for babies >27wks singletons / >800grams / >28wks gestation twins / >30wks gestation multiples of 3+ / babies >27wks who require <48hrs ventilation
Dorset County Hospital	SCU	Provides care for babies >32wks gestation and >1250grams
Western Sussex Hospital (St Richards)	SCU	Provides care for babies >32wks gestation and >1250grams
Isle of Wight	SCU	Provides care for babies >32wks gestation and >1250grams

*Note some SCUs have an approved care pathway agreed with the ODN where babies born between 30+0- and 31+6-weeks gestational age receive initial care in SCU providing the weight is above 1250g and intensive care is not required.

Contact Numbers for Transport teams

Hampshire Thames Valley SONeT - 01865 223344

For on-call Neonatal consultant	**Main switchboard numbers**		
Kent 07775 991325	01634 830000	Sussex 07979 806769	01273 696955
Surrey 07857 654648	01932 872000		

Appendix 6 Incident Reporting Communication Document: less than 27 weeks delivery in a centre without a NICU

Unit Name:						
BadgerNet Number:	Infant Name: (initials only for an 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 ward, 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**	

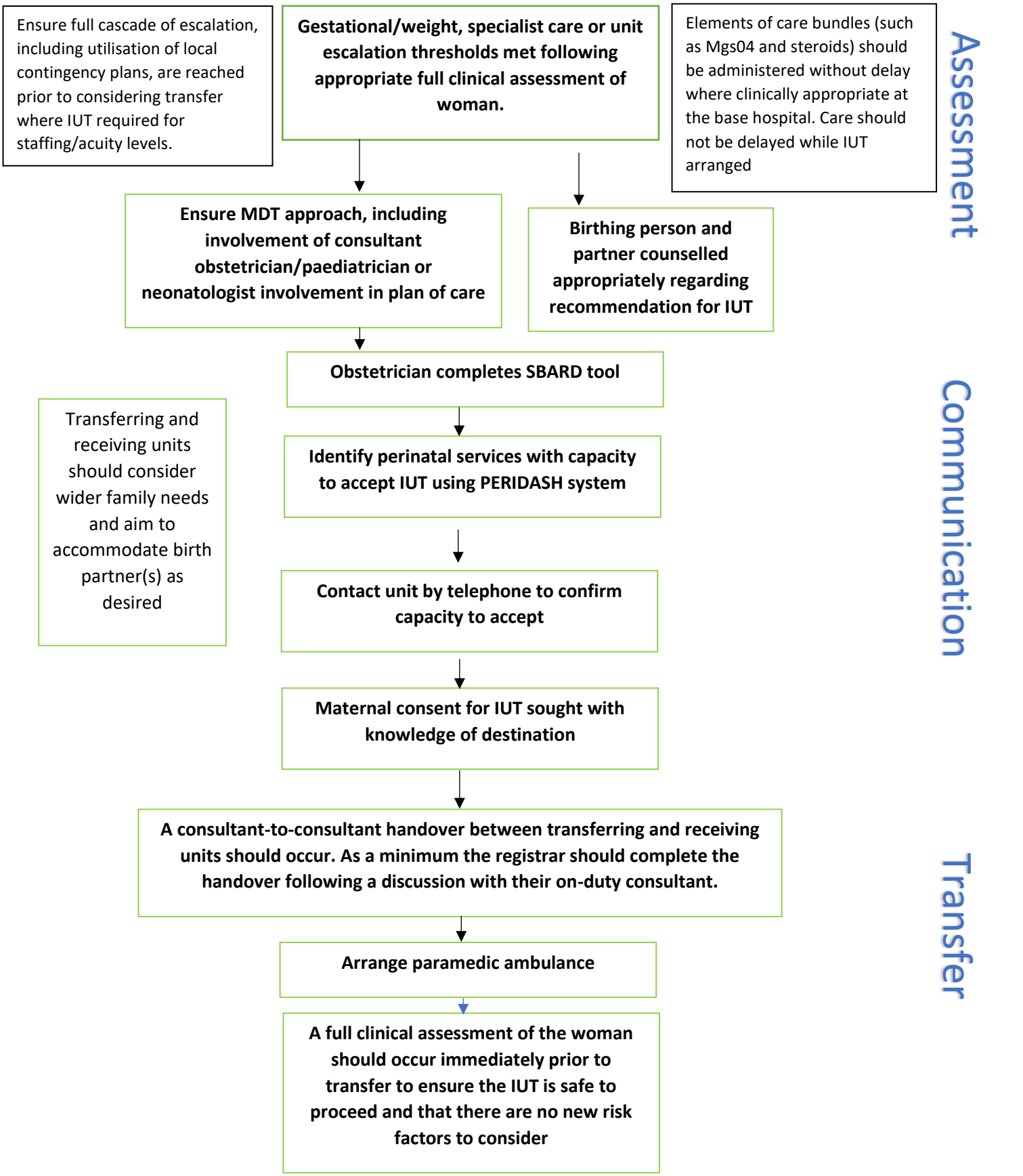
Name / title of reviewer(s): Risk Management	
Incident Reported by:	
Name and Title:	Date:
Organisation:	

Appendix 7- Useful contact numbers

HOSPITAL TELEPHONE NUMBERS		
Kent and Medway		
MEDWAY FOUNDATION TRUST (FT)	SWITCH	01634 830000
	NICU	01634 825125
	LW	01634975108
DARTFORD AND GRAVESHAM NHS FT	SWITCH	01322 428100
	SCBU	01322428795 – Walnut Ward
	LW	4925/4313
EAST KENT HOSPITAL TRUST NHS FT	SWITCH	01227 866450
	NICU Ashford William Harvey	01233 616204
	SCBU Margate QEQM	01843 234260
	LW	01233 616124/ 01843 234290
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	SWITCH	01892 823535
	LNU	01892 633359 / 638360
	LW	
Sussex		
EAST SUSSEX HOSPITAL NHS TRUST CONQUEST HOSPITAL	SWITCH	0300 131 4500
	SCBU	(01424) 757033
	LW	0300 131 4500
UNIVERSITY OF SUSSEX NHS TRUST • St Richards Hospital • Chichester	SWITCH	01243 788122
	SCBU	Ext 32986
	LW	Ext 32961 / 32962
UNIVERSITY OF SUSSEX NHS TRUST • Worthing Hospital • • • Royal Sussex County	SWITCH	01903 205111
	SCBU	Ext 84682
	LW	Ext 85138 / 85262 / 85943
	NICU	01273696955 Ext 63450
Surrey		
SURREY AND SUSSEX HOSPITALS NHS FT	SWITCH	01737 768 511
	LNU East Surrey	01737 231 765
	LW	01737 231764.
ROYAL SURREY COUNTY NHS FT	SWITCH	01483 571 122
	SCBU	01483 464 834
	LW	01483 464 133

ASHFORD AND ST PETERS NHS FT	SWITCH	01784 884488/ 01932 872000
	NICU	01932 722667
	LW	01932 722663
BOB		
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	SWITCH	01296 315000
	LNU	01296 316113
	LW	01296 316102
OXFORD UNIVERSITY HOSPITAL NHS FT	SWITCH	0300 304 7777
	NICU	01865 221355
	LW	01865 221198 or 01865 221987
ROYAL BERKSHIRE NHS FT	SWITCH	0118 322 7431
	LNU	0118 322 5111
	LW	0118 322 7304
Frimley		
FRIMLEY HEALTHCARE NHS FT	SWITCH	0300 6145000
	LNU	0300 6134357
	LW	0300 6134527
SHIP		
UNIVERSITY HOSPITAL OF SOUTHAMPTON NHS TRUST	SWITCH	023 8077 7222
	NICU	023 8120 6001
	LW	023 8120 6002
ISLE OF WIGHT NHS TRUST	SWITCH	01983-822099
	SCU	01983 822099 Ext. 4337
	LW	01983 534392
PORTSMOUTH HOSPITAL NHS TRUST	SWITCH	02392 286000
	NICU	02392 283231/32
	LW	0300 1239001
HAMPSHIRE HOSPITAL NHS FT	SWITCH	01256 473202
	LNU	01256 313686/ 01962 824200
	LW	0300 123 9001
The following sites sit outside the SE region but are part of the neonatal care pathway for babies <27 weeks with the exception of Dorchester in the Thames Valley and Wessex Neonatal ODN		
Poole	LNU	HDU 0300019330 SCU 03000192366
Dorchester	SCU	SCU 01305251150
Salisbury	LNU	01722 425180
Milton Keynes	LNU	01908 995591

Appendix 8 Flow chart summarising IUT process



Appendix 9 PERIDASH SE Region Maternity bed and Neonatal cot locator Submission Guide

The dashboard is used to update Maternity and Neonatal providers and the regional teams of open staffed maternity beds and neonatal cots. All data on the dashboard is accessible to local teams for use to support their service.

The dashboard can be found here: South East Perinatal Maternity Bed and Neonatal Cot Locator - Power Apps. The Peridash map is designed to be viewed on a PC, although it can be accessed on a mobile phone.

All hospitals within Thames Valley & Wessex and Kent Surrey and Sussex Neonatal Operational Delivery Networks are responsible for submitting twice daily data to the Perinatal Maternity bed and Neonatal cot locator (Peridash) before 0845 and 1545.

The inpatient daily data submission form can be accessed in three different ways:

1. Hyperlink South East Perinatal Maternity Bed and Neonatal Cot Locator - Form v1 (office.com) This can be saved as a favourite on browsers.
2. QR code. This will be made available for printing and can be put on ward boards/desks/posters. The QR code can be scanned by a mobile device and links to the form.
3. Button on dashboard. On the dashboard itself on the top right corner there is a “Daily Data MS Forms” button.

The form can be accessed on PCs, mobile phones or tablets.

Two daily updates are mandatory; however, units are encouraged to update the dashboard as their situation changes throughout the day. This is to avoid phone calls asking for beds and cots that are no longer available or to show capacity that has become available.

- Maternity should only declare staffed and open Labour ward maternity beds.
- SCU and LNU’s should only declare staffed and open HDU or SCU cots.
- NICU’s should only declare staffed and open ITU, HDU and SCU cots.

Maternity and Neonatal step by step guide

1. Access form via hyperlink, QR code or button on dashboard

2. Fill out page one by entering date, AM or PM submission and whether the submission is for a Maternity or neonatal unit.

3. Click **Next**

South East Perinatal Maternity Bed and Neonatal Cot Locator - Form v1

...

* Required

1. Date of Submission *

Please input date (dd/MM/yyyy)

2. AM or PM Submission *

- AM
- PM

3. Maternity or Neonatal Submission *

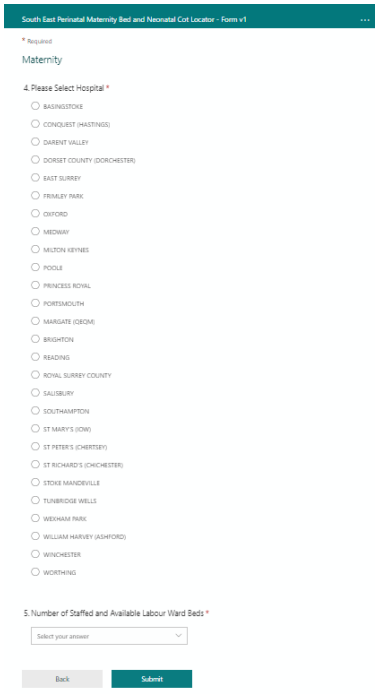
- Maternity
- Neonatal

Next

For Maternity wards only

4. Select hospital

5. Select the number of staffed and available labour ward beds



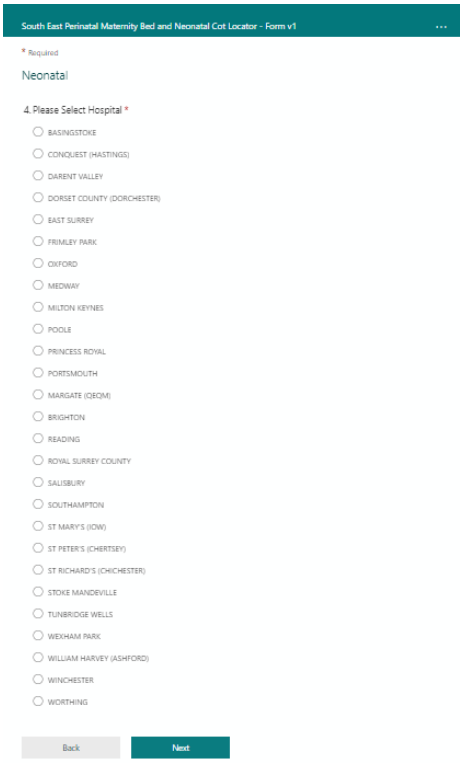
6. Click **Submit**

The data is now registered

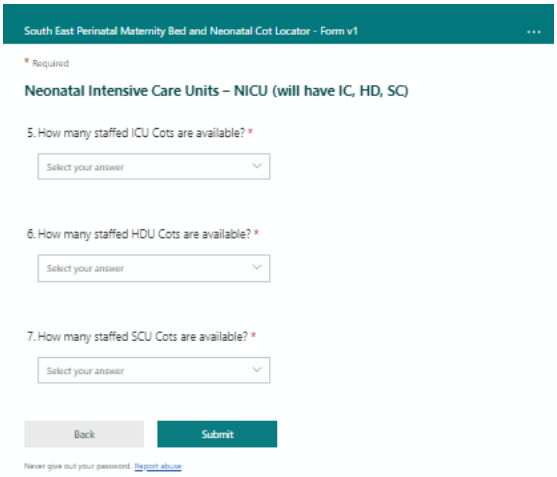
For neonatal units only

4. Select hospital

5. Click **Next**



6. Select the number of cots available of each type: ICU, HDU and SCU



Please note: ICU cot input will be required by NICUs and HDU cot input will only be required by NICUs and LNUs.

7. Click **Submit**