

 **East Midlands Neonatal**

**Operational Delivery Network**



**In utero transfer (IUT) guideline for pregnancies**

**< 27 weeks singleton or**

**< 28 weeks for multiple gestation**

NHS England and NHS Improvement

# Appendix 1: East Midlands in – utero transfer record and decision-making tool

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| **This guidance has been developed to improve survival and reduce brain injury in high-risk <27 weeks infants (singleton) and multiple pregnancies <28 weeks gestation.****It is strongly recommended that In - utero Transfer is considered at the earliest opportunity.****This form should be completed for all attempted in-utero transfers for <27 weeks singleton or <28 weeks for multiple pregnancies whether successful or unsuccessful.****Transfers should be to a Level 3 NICU = <27 weeks singleton and multiple pregnancies under <28 weeks gestation or an anticipated birthweight <800g**Please see Appendix 2 for In - utero transfer decision making tool flow chartPlease see Appendix 4 for list of East Midland Neonatal Units & Contact numbers |

**1.0 Which patients are unsuitable for in utero transfer?**

**Contraindications for IUT:**

* Pregnancy < 22 weeks (if transfer is for fetal condition or threatened labour). Neonatal stabilisation may be considered for babies born from 22 weeks gestation following assessment of risk (See Appendix 2) and a multi professional discussion with parents (BAPM Framework 2019).
* Potentially lethal condition where active intervention of the fetus is not being considered even if live born. (In cases of fetal abnormalities the cases should be discussed with a fetal medicine specialist).
* Active labour where the chance of delivery in the ambulance en route is considered likely
* Maternal condition which may require intervention during transfer (for example antepartum haemorrhage or uncontrolled hypertension) or relevant to the place of delivery for maternal reasons
* Known fetal or maternal compromise requiring immediate delivery, including abnormal cardiotocography (CTG)

|  |
| --- |
| **Patient details** |
| Name: |  |
| Gestation weeks/days: | \_\_\_\_\_\_\_\_ weeks + \_\_\_\_\_\_\_ days |
| Birthweight (estimated/actual): | \_\_\_\_\_\_\_ grams  |
| Number of live fetuses: | 1 2 3 |
| NHS Number: |  |
| DOB: |  |
| Named Consultant & Trust: |  |

Please complete if not suitable for transfer:

|  |
| --- |
| **Not suitable for transfer** |
| Reason why: |

**1.1 Threatened preterm labour predictive test performed:**

|  |  |  |
| --- | --- | --- |
| **Assessment:** | **Yes/No:** | **Value:** |
| Cervical length |  |  |
| Actim Partus |  | positive/negative |
| Fetal Fibronectin |  | positive/negative |
| QUIPP App |  | % risk in 7 days =  |
| PartoSure |  | Positive/negative |

**1.2 Antenatal Steroids administered?** Yes / No

First dose given: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_

If not given, please provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Second dose given: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_

If not given, please provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**1.3 Magnesium Sulphate given?** Yes / No

Time started: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time: \_\_\_\_:\_\_\_\_

**1.4 Decision for in utero transfer:**

All potential transfers must be authorised by the on call obstetric consultant, following discussion with the on-call consultant neonatologist/paediatrician of the referring hospital. The Risk Assessment from the BAPM Framework (2019) (Appendix 3) highlights any high risk/very-high risk category babies require discussion with the on-call neonatal/paediatric consultant at the referring hospital, and following agreement for IUT, must be discussed at consultant level for both neonatal and obstetric teams. There is three staged approach for decision making, assessment of the risk for the baby if delivery occurs, counselling parents and agreeing & communicating a management plan see Appendix 3. It is imperative that a decision is made without delay to ensure those that require transfer are transferred quickly.

**1.5 Finding a neonatal cot and maternity bed**

The Referring unit will contact 365 Call Handling Service (East Midlands Neonatal ODN footprint) Tel: 0300 300 0038 to obtain cot status of appropriate neonatal unit and maternal bed availability. The referring unit must state this is for < 27 week singleton or < 28 week multiple pregnancy and a NICU cot is required at Nottingham University Hospitals (NUH) or University Hospitals of Leicester (UHL) ideally following the network referral pathways. The call handlers will take brief details (Appendix 5) so please be ready with these details.

**Please see refusal of transfer section if there are any difficulties in accessing a cot or maternity bed.**

|  |  |  |
| --- | --- | --- |
| **Unit Contacted:** |  |  |
| **Time of contact:** |  |  |
| **Discussed with:** |  |  |
| **NICU accepted?****If no, why?** |  |  |
| **Labour ward accepted?** **If no, why** |  |  |
| **Indication for not accepting transfer and comments** |  |  |

**1.6 Ambulance Service:**

East Midlands Ambulance Service (EMAS) telephone number for intra-facility transfers

 **Tel: 0115 9675099**

* Once an in- utero transfer has been accepted by the receiving neonatal and maternity unit, the referring unit should organise the transfer through EMAS.
* In- utero transfer will require EMAS Hospital category 1 priority which provides a 7-minute response. The referring unit 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? The answer should be Yes giving the reason of obstetric emergency if time critical**.**
* If the patient isn’t time critical the above question should be answered NO and then the caller will be taken through a scripted algorithm, please ask for a category of call to ensure understanding of the time frames for the specific call:
* Category 1 - 7 mins
* Category 2 - 18-40 mins
* Category 3 - 120 mins
* Category 4 - 1/2/4 Hours

Provision of an escort from the referring maternity team for the transfer will be made on a case by case basis. This decision should be made by a senior member of maternity staff on duty.

As an unplanned journey, EMAS will not guarantee that there is a paramedic on the vehicle as they are a transport platform only, if a health care professional is required to travel then the unit must send an appropriately trained member of staff.

EMAS have no responsibility to return the staff member to the unit they came from, if this is done in good faith the staff member may attend a 999 emergency as the ambulance will not be taken off the road for the return journey.

**1.7 Refusal of Transfer:**

**A decision to refuse an appropriate transfer by a tertiary neonatal team should be made only after consultation with the neonatal consultant on duty.**

**A decision to refuse an appropriate transfer by a maternity unit should be made only after consultation between the senior midwife in charge of the labour ward and the obstetric consultant on duty/call.**

**If for any reason one tertiary centre is unable to take an IUT there should be a discussion between tertiary centres with the neonatal consultant, obstetric consultant on duty and the senior midwife in charge of the labour ward. Every effort should be made to keep a baby in network.**

**1.8 Maternal agreement to be transferred: Yes / No**

Maternal agreement needs to be obtained prior to transfer. This should be documented in the maternal healthcare record. This should involve both written information which would include the East Midlands Neonatal Network Parent Information leaflet (Appendix 6) and verbal information by the obstetric and neonatal staff.

**East Midlands Neonatal Network Parent Information leaflet given**: Yes / No

|  |
| --- |
| **Indication for Transfer:** |
| **Maternal history:** |
| **Transfer discussed and agreed with Obstetric Consultant in referring unit and receiving unit: Yes / No****If not why?****Date and time:** |
| **Time decision made for transfer:** |
| **Time of call made to request the ambulance:** |
| **Time the ambulance arrived & transferred:** |
| **In the case of a delay with ambulance transfer (over 4 hours) please state why?** |

**1.9 Documentation:**

The referring team must send a photocopy of the mother’s obstetric notes and the mother’s hand-held notes should accompany the mother at transfer. The in-utero transfer record & decision-making tool should stay in the patients records at the referring centre and a copy should also be forwarded to the nominated Preterm Birth lead at the referring centre They will be responsible for following the outcome of each case.

**2.0 Safeguarding:**

Where there are safeguarding issues, any transfer of care must include information about the case and details of all key professionals. (Lead Consultant, Midwife, Health Visitor, Social worker, GP and Safeguarding Lead). It should be ensured that all staff who take over the care of the woman are aware of what the issues are and who the key professionals are. All issues and contacts should be clearly documented in the handover notes.

**2.1 Outcomes:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Tick:** | **Date:** | **Time:** |
| **In- utero transfer** |  |  |  |
| **Ex- utero transfer** |  |  |  |
| **Pregnant woman stayed in local unit** |  |  |  |

**Date baby delivered: \_\_\_\_ /\_\_\_\_ /\_\_\_\_**

**Where was baby transferred to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If transfer did not take place, please complete below table:**

|  |  |
| --- | --- |
| **Reason:** | **Please tick relevant box:** |
| Pregnant woman unwilling to accept |  |
| Clinical change (e.g. maternal deterioration/improvement/advanced labour) |  |
| No maternal bed found |  |
| No neonatal cot found |  |
| Unable to locate 2 or more cots for multiples |  |
| Delivered prior to transfer taking place |  |
| Delivered prior to transfer taking place due to ambulance delay |  |
| Escort unavailable |  |
| Other, please state: |  |

**2.2 Communication with the Referring Unit:**

In order to ensure that the referring obstetrician is aware of the outcomes of their patient, receiving neonatal units should ensure that the referring clinician is sent a copy of the relevant discharge summary (e.g. Badger) which can then be placed in the patient’s obstetric notes at the local unit. If the woman does not deliver then a discharge summary should be forwarded to the referring clinician, so the referring unit will pick up ongoing antenatal care and follow up.

In the event of a neonatal death, the neonatal unit or obstetric unit (depending upon where the death took place) should inform the referring obstetrician to ensure that local bereavement services and follow up can be made available if required.

**2.3 Data Collection:**

Data will be collected through CenTre and this will be downloaded on a monthly basis and sent to a nominated Preterm Birth lead at each trust. Each referring unit will also keep a record of all the in- utero transfer records and completed decision making tools. The Preterm Birth lead will be responsible for following up the outcome of each case and a review of all cases will take place on a quarterly basis with the Neonatal ODN and the Maternity Clinical Network.