Transfers by Ambulance (Maternal)

Classification :	Guideline
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Authors Division:	Women and Children's Health
Departments/Group this Document applies to:	All Obstetric, midwifery and NNU staff

Approval Group: Maternity Guideline Review Group Women's Health CIG	**Date of Approval:**	23/12/2020
	Last Review:	09/2020
	Review Date:	23/12/2023

Unique Identifier: MIDW/GL/54	**Status:** Approved	**Version No:** 6

Guideline to be followed by (target staff): This guideline applies to all obstetric staff and Midwives providing care within the Maternity Unit. There are no implications for training. This guideline aims to provide a standardised process for the safe and appropriate transfer of the woman.

To be read in conjunction with the following documents:

- Milton Keynes University Hospital NHS Foundation Trust. *Maternity health records and recordkeeping guideline.* MIDW/GL/140. Version 5, 2018.
- Milton Keynes University Hospital NHS Foundation Trust. *Multi-professional handover of care (Maternity).* MIDW/GL/100. Version 6, 2020.
- Milton Keynes University Hospital NHS Foundation Trust. *NNU escalation plan.* DOC85. Version 2, 2015.

Are there any eCARE implications? No

CQC Fundamental standards:

Regulation 9 – person centred care
Regulation 10 – dignity and respect
Regulation 11 – Need for consent
Regulation 12 – Safe care and treatment
Regulation 13 – Safeguarding service users from abuse and improper treatment
Regulation 14 – Meeting nutritional and hydration needs
Regulation 15 – Premises and equipment
Regulation 16 – Receiving and acting on complaints
Regulation 17 – Good governance
Regulation 18 – Staffing
Regulation 19 – Fit and proper

Disclaimer

Since every patient's history is different, and even the most exhaustive sources of information cannot cover every possible eventuality, you should be aware that all information is provided in this document on the basis that the healthcare professionals responsible for patient care will retain full and sole responsibility for decisions relating to patient care; the document is intended to supplement, not substitute for, the expertise and judgment of physicians, pharmacists or other healthcare professionals and should not be taken as an indication of suitability of a particular treatment for a particular individual.
The ultimate responsibility for the use of the guideline, dosage of drugs and correct following of instructions as well as the interpretation of the published material **lies solely with you** as the medical practitioner.

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Guideline Statement

This document refers to the management of maternal transfer by ambulance. It does not deal with elective transfer of care or the on-going management following the routine detection of fetal anomalies.

The management of women with regard to transfer by ambulance should include Consultant Obstetric and senior neonatal staff in addition to the most senior Midwife available, at both the referring and (potential) receiving units. This must include an assessment of the relative benefits and risks of transfer to both maternal and fetal health.

Communication between all parties at both hospitals, including the mother; is critical. There must be clear and agreed delineation as to who is responsible for maternal care at each stage of the transfer process.

Objectives

- Standardise process for transferring and handing over care
- Safe delivery of woman
- Reducing risk to mother and baby
- Reducing the need to separate mothers and babies during the postnatal period

Executive Summary

- Indications for maternal transfer
- Contradictions for maternal transfer
- Process for inter utero transfers
- Postnatal transfer of mother

1.0 Roles and Responsibilities:

1.1 The Obstetric team is responsible for identifying women who need transfer to another hospital

1.2 The Maternity Unit Manager/Shift Co-ordinator will contact all known hospitals to identify available cots

1.3 The bed manager is responsible for liaising with Thames Valley Emergency Access (TVEA) and Maternity Unit Manager/Shift Co-ordinator

1.4 The transferring Midwife is responsible for providing all care to the woman during the transfer including an accurate and safe handover of care to the receiving unit. This should include copies of all E-Care drug, observation charts, blood and other screening tests and relevant medical/midwifery documentation. The Obstetrician/Paediatrician must provide an explanation to the woman, partner/family, reasons for referral and which hospital can accept

2.0 Implementation and dissemination of document

This guideline is available on the Trust intranet and has followed the full guideline review process prior to publication.

There are no implications for training.

3.0 Processes and procedures

In-utero transfer

3.1 Indications for transfer

- Severe prematurity (See Appendix 1)
- Medical/Obstetric / Neonatal requirement for enhanced care for mother or unborn baby
- Neonatal Unit (NNU) at capacity. Please see Paediatric/NNU Escalation policy.
- Lack of availability of neonatal cot of the appropriate level; Neonatal team request due to staffing / workload ratio
- Labour Ward capacity – staffing / workload ratio

3.2 Contraindications for transfer

- Receiving Obstetric unit or NNU unable to accept transfer
- Mother declining transfer
- Significant risk of birth occurring during transfer
- Known fetal compromise requiring immediate delivery
- Unstable maternal condition likely to require medical intervention during transfer (e.g. active antepartum haemorrhage, uncontrolled hypertension)
- Any other unstable maternal condition

3.3 Other clinical Considerations

3.3.1 Preterm Labour

Fewer than 50% of women presenting with suspected preterm labour will give birth during the current episode.

Fetal Fibronectin Testing

The National Institute of Health and Care Excellence (NICE) recommend the diagnostic test Fetal fibronectin (fFN) for detecting the likelihood of pre-term labour.

fFN is a protein produced during pregnancy, which functions as a 'glue' attaching the fetal sac to the uterine lining. The presence of fFN during weeks 22-36 of a high-risk pregnancy, along with symptoms of labour suggests that the 'glue' is disintegrating ahead of schedule and raises the possibility of preterm delivery.

Cervical Dilation

Assessment of cervical dilatation by digital vaginal examination or by Vaginal Ultrasound can assist in the prediction of preterm birth.

The decision to transfer must be reconsidered in the following:

- Risk of Delivery during transfer
- Negative Fetal Fibronectin test
- There is no cervical change
- Cervical length >20mm

3.3.2 Pre-labour Preterm Rupture of Membranes (PPROM)

The median latency between rupture of membranes at 25-31 weeks' gestation and birth is 10 days and 30% of women will not have given birth by 20 days.

Transfer following PPROM should NOT be considered if there is evidence of uterine activity or clinical chorioamnionitis (1 or more of following signs):

- Maternal pyrexia
- Maternal/fetal tachycardia
- Uterine tenderness
- Offensive liquor

Uterine contractions following PPROM are associated with a shorter interval to birth than with intact membranes.

Tocolysis – can be used to delay birth to ensure safe transfer. It is not required unless there is clinical evidence of uterine activity. If used the efficacy of tocolysis must be assessed before transfer i.e. evidence of a complete cessation of uterine activity for at least 1 hour and no cervical change over this time.

Cervical assessment should be performed immediately prior to transfer (digitally or using transvaginal ultrasound).

3.3.3 Maternal consent

Maternal agreement needs to be obtained prior to transfer and this should be documented appropriately. This will usually require joint counselling by obstetric and neonatal staff.

Counselling should be supplemented with written information whenever possible. It is important to explain that the baby or babies may be transferred back to their home hospital or a hospital nearer to home, at a later stage.

Where a woman is declining transfer to another unit, she should be given the opportunity to explore her concerns. The mother/parents need to understand that, in the event of an intra-uterine transfer being declined, the baby will be assessed after birth and if still indicated, ex-utero transfer may need to be arranged if this is in the baby's best interest.

Where an intra-uterine transfer has been declined by the mother there needs to be clear documentation that the risks and benefits both to her and subsequently to her baby have been explained and understood.

4.0 Process for in utero transfer from Milton Keynes Maternity Unit to another hospital

(see Appendix 1)

Please refer to Appendix 1 regarding in utero transfer to OUH (John Radcliffe).

4.1 The Obstetric team is responsible for identifying women who need transfer to another hospital requiring specialist clinical care for both mother and or baby. The on call Obstetric Consultant/Registrar is responsible for communicating the background history, risk assessment and recommended management plans to the obstetric team of the receiving hospital or department. This should be clearly documented within the maternal records and include a covering letter to the receiving unit or department.

4.2 The Maternity Unit Manager/Shift Co-ordinator will contact all known hospitals to identify available cots, if no cots are available from the Transfer Out List held on labour ward, then the bleep holder should liaise with the Clinical Site Manager and Bed Manager to request that he/she contact TVEA who will identify the location of cots or beds in other parts of the country.

The Midwife or Obstetrician will then liaise with the nursing/midwifery staff of unit where capacity has been identified by TVEA to confirm availability and acceptance of the transfer. In Utero Transfer Form (Appendix 3) needs to be commenced

4.3 The receiving unit should be contacted by the on-call Registrar / Consultant or Maternity Bleep Holder to provide a telephone summary of the background history, risks and recommended management plans using SBAR (Situation, Background, Assessment and Recommendation). Ensure the ward or department can accommodate the woman and is aware of the approximate transfer times.

4.4 The Maternity unit manager should contact ambulance control to arrange an ambulance for the transfer giving details of the dependency and priority required. Contact number: 0300 1239826

4.5 The name of the doctor agreeing to accept the case and the Consultant to whom the woman will be transferred should be clearly documented in the maternal records.

4.6 As a minimum, a Midwife should accompany a woman being transferred. In all cases consideration should be given to providing a medical escort. The medical escort may include one or more of the following:

- Obstetrician
- Paediatrician
- Anaesthetist

4.7 The Midwife is to ensure in-utero transfer equipment is taken with the mother. This includes a sonicaid to monitor fetal well-being where appropriate and delivery pack, instruments and syntometrine/syntocinon. If specialist equipment is required for transfer this must be identified by the appropriate speciality.

5.0 Process for transfer from home to Milton Keynes Maternity Unit

5.1 When the Community Midwife has made a decision to transfer a woman from home to hospital then she should contact the Maternity Unit Manager and Labour Ward Co-ordinator advising of the transfer and giving the background history, current assessment and recommendations using SBAR. The transfer should be expedited in line with the Community Midwifery Guidelines.

5.2 The Community Midwife dials 999 for an ambulance and travels in with the woman. The second on call Midwife should ensure that all equipment is collected, ensures that the birthing partner is informed of where to go on arrival at the hospital and returns to the hospital with equipment and any clinical waste.

6.0 Postnatal transfer of mother

Where possible, we aim to keep mothers and babies together to develop mother/baby relationship, which improves breastfeeding outcomes and may reduce the risk of postnatal depression.

When mother and baby cannot be transferred together arrangements to transfer mother separately should be made as soon as possible

Postnatal transfer may also be required for maternal reason only

The following pathway (Appendix 4) should be used when considering postnatal transfers.

7.0 Handover of Care

This must occur between all members of the multidisciplinary team when shifts change. When women are transferred to a different location to receive care handover of plans of care should take place. It should always be clearly documented who is responsible for the care of the woman at that time. There should be clear concise communication and handover of information at all times between the multidisciplinary team using SBAR, especially where there are concerns in relation to child protection issues, mental health, obstetric and medical issues.

Midwives have a duty to communicate fully and effectively with colleagues, ensuring that they have all the information they need about the women in their care. (NMC, 2015; Updated 2018)

8.0 Record Keeping

8.1 In utero transfer

- **Before transfer a duplicate copy of any hand-held maternal records must remain within the maternity unit. The original maternal records must go with the woman to the receiving unit and a print out of E-Care records such as drugs and observation charts, blood and other antenatal screening results.** Please refer to Maternity Health Records and Record Keeping policy.

- The on-call Registrar/Consultant should write a letter to the receiving hospital with a summary of the past medical history, present identified problems, interventions, treatment and any recommended management plans within a SBAR format.

- The Midwife will document assessments, plans of care, treatments and intervention any discussion undertaken and all observations taken during transfer. Documentation of handover at receiving unit following the principles of SBAR should also be made.

8.2 Transfer to hospital from community during the intrapartum period

- If transferred to the hospital from a home birth it is required the Midwife should document:
  - Reason for transfer
  - Actions taken
  - All clinical observations undertaken during transfer**.**

  A Datix and In Utero Transfer Form (Appendix 3) should be completed for all transfers

8.3 Postnatal transfer

- A record of all midwifery and medical assessments and plans of care should be documented

- Midwives will document all care provided, including that provided during transfer

9.0 Statement of evidence/references

Adams, E., Puddy, V. and Outram, G.; Thames Valley & Wessex Neonatal Operational Delivery Network (2014; Last updated 2018) *Policy for exception reporting of neonates who meet criteria for transfer to NICU/LNU.* [Online]. Available from: https://southodns.nhs.uk/wp-content/uploads/2020/01/Exception-Reporting-Policy-Final.pdf [Accessed 18 November 2020]

Adams, E., Puddy, V. and Outram, G.; Thames Valley & Wessex Neonatal Operational Delivery Network (2014; Last updated 2018) *Policy for transfer of infants to a NICU/LNU.*[Online]. Available from: https://southodns.nhs.uk/wp-content/uploads/2018/11/Transfer-Policy-for-LNU-SCU-2018-Final-Version-ratified-Sept-2018.pdf [Accessed 18 November 2020]

British Association of Perinatal Medicine (2019) *Perinatal management of extreme preterm birth before 27 weeks of gestation: a framework for practice.* [Online]. Available from:https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019 [Accessed 17 November 2020]

Edwards, K. and Impey, L. (2020) Extreme preterm birth in the right place: a quality improvement project. [Online]. *Archives of Disease in Childhood - Fetal and Neonatal Edition*,105:445-448. Available from: http://dx.doi.org/10.1136/archdischild-2019-317741 [Accessed 17 November 2020]

Fenton, A., Peebles, D. and Ahluwalia, J. for British Association of Perinatal Medicine (2008)*Management of acute in-utero transfers: a framework for practice*. [Online]. Available from:https://hubble-live-assets.s3.amazonaws.com/bapm/attachment/file/35/IUTs_Jun08_final.pdf[Accessed 18 November 2020]

Marlow, N. et al. (2014) Perinatal outcomes for extremely preterm babies in relation to place of birth in England: the EPICure 2 study. [Online]. *Arch Dis Child Fetal Neonatal Ed,* 99:F181– F188. Available from: http://dx.doi.org/10.1136/archdischild-2013-305555 [Accessed 17 November 2020]

National Institute for Health and Care Excellence (2018) Biomarker tests to help diagnose preterm labour in women with intact membranes. [Diagnostics guidance DG33]. [Online]. Available from: https://www.nice.org.uk/guidance/dg33/ [Accessed 18 November 2020]

NHS Improvement [2018] *SBAR communication tool – situation, background, assessment, recommendation.* [ACT Academy Online library of Quality, Service Improvement and Redesign Tools]. [Online]. Available from: https://improvement.nhs.uk/documents/2162/sbar-communication-tool.pdf [Accessed 18 November 2020]

Nursing & Midwifery Council (2015; Updated 2018) *The code: professional standards of practice and behaviour for nurses, midwives and nursing associates*. [Online]. January 2015; Updated 10 October 2018. London: NMC. Available from:https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf [Accessed 18 November 2020]

Oxford AHSN Maternity Network (2016) *Place of birth of extremely premature babies in the Thames Valley network area – an update.* [Online]. Available from:http://www.oxfordahsn.org/wp-content/uploads/2015/05/FINAL-Place-of-Birth-A-Year-On-July-2016.pdf [Accessed 17 November 2020]

10.0 Governance

10.1 Document review history

Version number	Review date	Reviewed by	Changes made
5	01/2021	N Payne/E Patton	Reviewed and updated.
5.1	December 2018	L. Stratton-Fry/K.Smith	Appendix 3 information added about steroids and magnesium in relation to PRecept study

10.2 Consultation History

Stakeholders Name/Board	Area of Expertise	Date Sent	Date Received	Comments	Endorsed Yes/No
Kirsty Felce	Audit and Risk Midwife	22.1.18	29.1.18	No	Yes
Julie Cooper	Head of Midwifery	22.1.18	29.1.18	Yes	Yes
Mary Plummer	Matron, Maternity Inpatients	22.1.18	29.1.18	No	Yes
Lydia Stratton-Fry	Labour Ward Manager	22.1.18	29.1.18	No	Yes
Nidhi Shandil-Singh	Consultant, Obs and Gynae	22.1.18	29.1.18	No	Yes
Nandini Gupta	Consultant	22.1.18	29.1.18	No	Yes
Bernadetta Sawarzynska-ryszka	Associate Specialist, Anasthetics	22.1.18	29.1.18	No	Yes
Stakeholders Name/Board	**Area of Expertise**	**Date Sent**	**Date Received**	**Comments**	**Endorsed Yes/No**
Kirsty Felce	Audit and Risk Midwife	22.1.18	29.1.18	No	Yes
Julie Cooper	Head of Midwifery	22.1.18	29.1.18	Comments sent back to author	Yes
Mary Plummer	Matron, Maternity Inpatients	22.1.18	29.1.18	No	Yes
Lydia Stratton-Fry	Labour Ward Manager	22.1.18	29.1.18	No	Yes
Nidhi Shandil-Singh	Consultant, Obs and Gynae	22.1.18	29.1.18	No	Yes

Nandini Gupta	Consultant	22.1.18	29.1.18	No	Yes
Bernadetta Sawarzynska-ryszka	Associate Specialist, Anasthetics	22.1.18	29.1.18	No	Yes

5.3 Audit and monitoring

Audit/Monitoring Criteria	Tool	Audit Lead	Frequency of Audit	Responsible Committee/Board
a) Number of in utero transfer to other maternity unit b) Number of postnatal transfers for maternal reasons c)) Number of women transferred in labour from home to hospital d) The outcomes following transfer (where appropriate) - the timing of delivery, hospital where eventually delivered, neonatal outcome, maternal outcome	Datix Audit	Labour Ward Manager	Case by case	Labour Ward Forum Women's Health CIG Perinatal M & M Maternal and Neonatal Quality Improvement Group

5.4 Equality Impact Assessment

As part of its development, this Guideline and its impact on equality has been reviewed. The purpose of the assessment is to minimise and if possible remove any disproportionate impact on the grounds of race, gender, disability, age, sexual orientation, religion or belief, pregnancy and maternity, gender reassignment or marriage and civil partnership. No detriment was identified. Equality Impact assessments will show any future actions required to overcome any identified barriers or discriminatory practice.

Equality Impact Assessment			
Division	Women and children	Department	Maternity
Person completing the EqIA	Erica Puri	Contact No.	Ex 87153
Others involved:		Date of assessment:	03/2021
Existing policy/service	Yes	New policy/service	No

Will patients, carers, the public or staff be affected by the policy/service?	Yes
If staff, how many/which groups will be affected?	*All staff*

Protected characteristic	Any impact?	Comments
Age	NO	Positive impact as the policy aims to

Disability	NO	recognise diversity, promote inclusion and fair treatment for patients and staff
Gender reassignment	NO	
Marriage and civil partnership	NO	
Pregnancy and maternity	NO	
Race	NO	
Religion or belief	NO	
Sex	NO	
Sexual orientation	NO	

What consultation method(s) have you carried out?
Emails , maternity guideline group and maternity CIG
How are the changes/amendments to the policies/services communicated?
Emails. Guideline group, maternity CIG
What future actions need to be taken to overcome any barriers or discrimination?

What?	Who will lead this?	Date of completion	Resources needed
Review date of EqIA	23/12/2023		

Appendix 1: Change to requesting In Utero Transfer to OUH (John Radcliffe)

Network PTL transfer policy change v2 15/12/2014 Urgent in utero transfer to the John Radcliffe Hospital In: Oxford AHSN Maternity Network (2016) *Place of birth of extremely premature babies in the Thames Valley network area – an update.* [Online]. Available from:http://www.oxfordahsn.org/wp-content/uploads/2015/05/FINAL-Place-of-Birth-A-Year-On-July-2016.pdf [Accessed 17 November 2020]

Where there is a risk of extreme preterm delivery, either iatrogenic or spontaneous, in utero transfer to a neonatal unit is advised by BAPM: extreme preterm birth is associated with a decrease in neonatal mortality and morbidity if it occurs in a level 3 neonatal unit (Marlow et al 2014). Currently, in the Thames Valley network, over 50% of extremely preterm babies are born outside the level 3 centre. This issue is currently the subject of much scrutiny and is likely to be assessed as an important measure of the quality of a maternity unit's performance at some stage in the near future.

An audit by the Maternity Network of the AHSN has identified, perhaps not surprisingly, that in utero transfer within the Thames Valley to the John Radcliffe Hospital as the local Level 3 neonatal unit can be difficult to achieve, and the John Radcliffe Hospital's refusal to take in utero transfers has been a reason why delivery has taken place outside a Level 3 neonatal unit. It is also recognised that capacity alters rapidly over a short time frame and that delivery may occur days later than transfer and therefore neonatal capacity at the exact time of referral may be irrelevant.

Requests for urgent in utero transfer to the John Radcliffe Hospital should initially be directed to the Consultant Obstetrician on call, rather than the neonatal unit.

From 8am-5pm this call should be made to the Delivery Suite (01865 221988/7), with the specific request to speak to the Consultant Obstetrician on Delivery Suite.

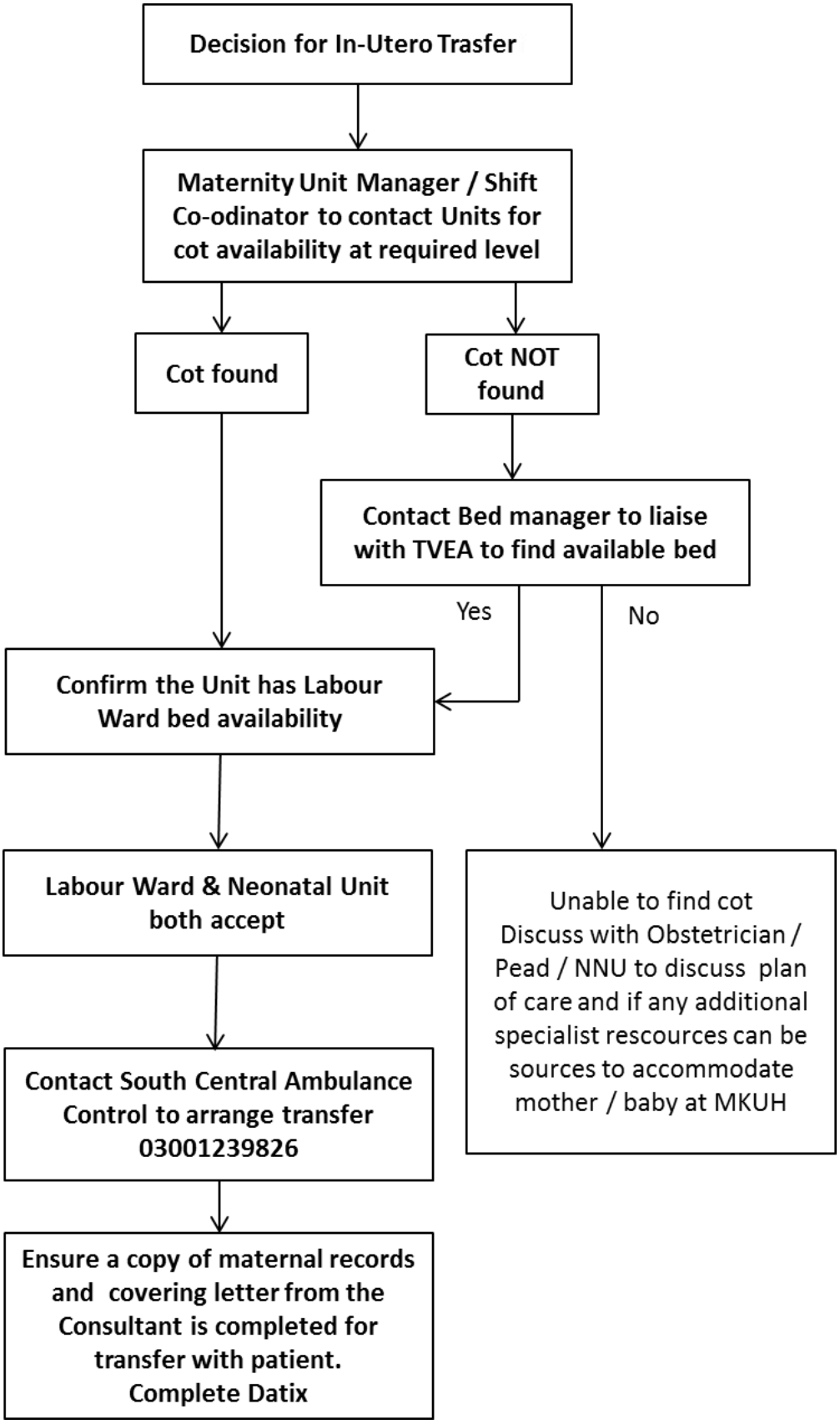
From 5pm to 8am, the call should be to the hospital switchboard (01865 741166), with the request to speak to the Consultant Obstetrician on call.

Only in exceptional circumstances (such as imminent delivery and neonatal unit red alert) will transfer be declined. If transfer is declined by either the neonatal unit or the Delivery Ward, without speaking to the consultant on call, then please request specifically to speak to the consultant on obstetrician on call.

We very much hope that this will make IUT easier and therefore increase patient safety in these extreme circumstances. If however, the John Radcliffe Hospital is unable to accept delivery, every effort should be made to move the mother to an alternative level 3 unit. We would be grateful if this information is disseminated locally.

Marlow, N. et al. (2014) Perinatal outcomes for extremely preterm babies in relation to place of birth in England: the EPICure 2 study. [Online]. *Arch Dis Child Fetal Neonatal Ed,* 99:F181– F188. Available from: http://dx.doi.org/10.1136/archdischild-2013-305555 [Accessed 17 November 2020]

Appendix 2: Maternal Transfer Antenatal



The following neonatal units will accept Neonates in utero 25 + 6 weeks gestation
(Please indicate if able to accept)

Hospital	NNU	Labour Ward
John Radcliffe, Oxford 01865 221059 (NNU) 01865 221651 (LW)		
Royal Berkshire, Reading 01183 227430 (NNU) 01183 227303 (LW)		

The following neonatal units will accept Neonates in utero 26 weeks – 27 + 6 gestation

Hospital	NNU	Labour Ward
John Radcliffe, Oxford 01865 221059 (NNU) 01865 221651 (LW)		
Royal Berkshire, Reading 01183 227430 (NNU) 01183 227303 (LW)		
Wexham Park, Slough 01753 634533 (NNU) 01753 634521 (LW)		

The following neonatal units will accept Neonates in utero 28 weeks or more

Hospital	NNU	Labour Ward
Royal Berkshire, Reading 01183 227430 (NNU) 01183 227303 (LW)		
Wexham Park, Slough 01753 634533 (NNU) 01753 634521 (LW)		
Stoke Mandeville, Aylesbury 01296 316115 (NNU) 01296 316756 (LW)		

John Radcliffe will not accept infants at 28 weeks or more unless there is specific maternal or infant reasons which mean the mother/infant cannot be looked after elsewhere

Hospital	NNU	Labour Ward
Luton and Dunstable 01582 491166 / NNU 01582497315		
Bedford 01234 355122		
Northampton 01604 634700		
Kettering 01536 492000		
Addenbrooks 01223 245151/ Rosie NNU 01223217648		
Hitchingbrook 01480 416416		
Leicester General 03003 031573		
Leicester Royal Infirmary 03003 031573		
Warwick 01926 495321		
Birmingham City Hospital 01214 242000		
Birmingham Women's 0121 4721377		
Royal Berkshire Reading 01183 225111		
Queen Charlottes London 0208 3831111		
Wexham Park Slough 01753 633000		
Royal Free London 02077 940500		
Guys and St Thomas London 02071 887188		
Horton Hospital Banbury 01865 741166 (32 single, 34 twins)		
Kings College London 02032 999000/ 02031 627543		
Peterborough 01733 874000		
Walgrave Coventry 0247 6964000		
Emergency Bed Service London 0207 4077181		

Appendix 3: In Utero Transfer Form

Surname _____

First Names _____

D.O.B. _____

Hospital No _____
Or affix patient label

Date: ……

Consultant: ……

Midwife: ……

Level Unit Required: ……

Gestation: …….. Parity ……

Obstetric/Medical History

……
……
……
……
……

Preterm In utero Transfer

Steroids given Y/N Date given…….Date given….....
Magnesium Sulphate given Y/N Date given……..

Reason for Transfer

……
……
……

Decision to Transfer

……
……
……

Time Phoning commenced …… Time bed/cot found ……

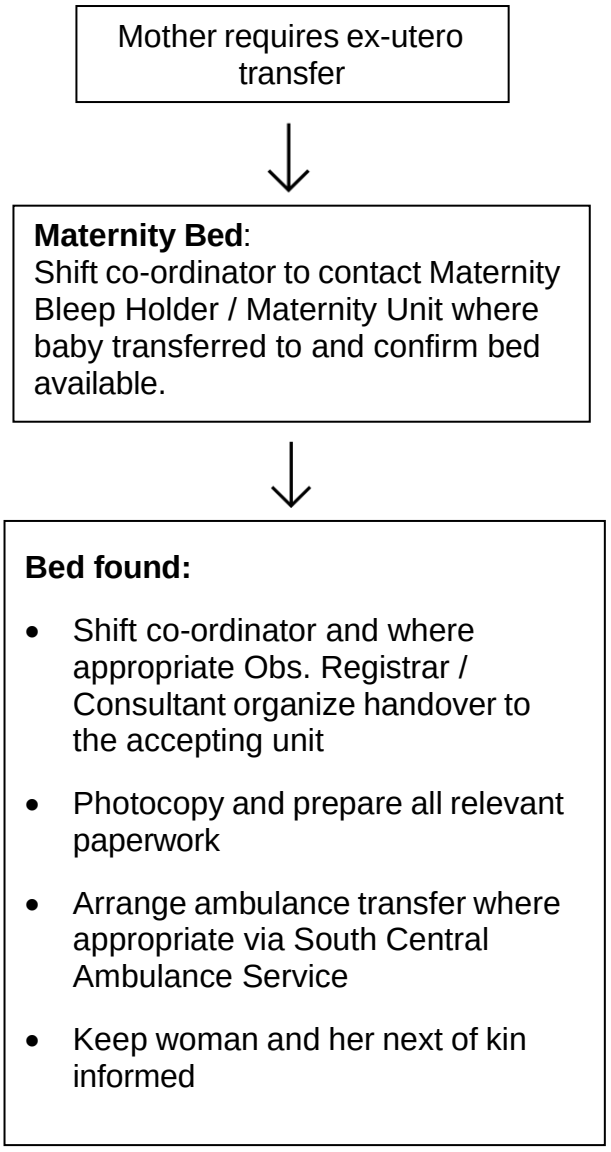
Level of Transferred Required ….....
(eg. Time Critical) ……... Name of accepting Person (inc title) …….

Ambulance booked at …….. Time Transferred out……

Radar Completed Yes / No Midwife signature……..

Web No: …… Doctor signature……

Appendix 4: Maternal Transfer Postnatal



Remember:

- to document everything in woman's notes
- keep woman and her next of kin informed
- all transfers need to be reported via Datix