Transfer of women from Leicester General Hospital / Home / St Mary's to Leicester Royal infirmary with expected need for Neonatal Intensive Care

University Hospitals of Leicester NHS Trust

Trust ref: C1/2007

"Currently UHL utilises the terms 'woman' and 'women' within their obstetric and maternity guidelines but these recommendations will also apply to people who do not identify as women but are pregnant or have given birth."

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1. Introduction and who this guideline applies to

The aim of this guideline is to reduce the number of postnatal transfers of babies who require uplift in their neonatal care from that which can be provided at the LGH. If correct location of birth can be achieved antenatally, this will reduce the number of mothers and babies separated after birth.

The Neonatal Unit (NNU) at the LGH functions as a Special Care Unit only. This means that only babies more than 32 weeks gestation and more than 1000g can receive on-going care on this neonatal unit. In addition to this the following criteria also need to be considered:

- Complex Intensive Care: Babies requiring multi-organ intensive care should be discussed would need transfer to a Neonatal Perinatal Centre.

- Ventilation: If a baby requires on-going conventional ventilation at any point, the baby will require transfer out to a Network Perinatal Centre or appropriate Local Neonatal Unit.

- HFOV, ECMO and Nitric Oxide: Babies who are likely to require HFOV, ECMO or Nitric Oxide will need to be transferred to a specialist centre and early consideration should be given to this.

- CPAP: Babies requiring CPAP for longer than 12 hours or who are anticipated to do so will need to be transferred to a Network Perinatal Centre or an appropriate Local Neonatal Unit.

- High Flow O2: Babies requiring High Flow O2 for longer than 12 hours or who are anticipated to do so will need to be transferred to a Network Perinatal Centre or an appropriate Local Neonatal Unit.

- PN: Babies requiring PN will need to be transferred to a Network Perinatal Centre or an appropriate Local Neonatal Unit.

- Surgery: Babies who require surgery or a surgical opinion will be transferred out to a perinatal surgical centre.

- Cooling: Newly born babies who require cooling for treatment of perinatal asphyxia will be transferred to a Network Perinatal Centre.

- Suspected Congenital Cardiac Disease: Where a possible cardiac problem is suspected, after discussion with the Cardiologist, the baby should be transferred to a cardiac centre as appropriate. This is as per the EMNODN Service specifications and Care Pathways document, last updated April 2022.

Any baby anticipated to fulfil the criteria above should be delivered at the LRI.

This document sets out the procedures and processes to follow should any of these criteria be met. Each case for transfer should be considered on an individual basis using the criteria detailed below. Transfer should be discussed between Senior Midwifery and Medical Staff on duty and should have been reviewed by the SpR on duty prior to transfer and were appropriate.

If there is serious concern regarding maternal or fetal well-being, making transfer unsafe, the Obstetric Consultant on call must make the decision not to transfer and discuss with the Neonatal Consultant the rationale for the decision

These guidelines are for the use of all staff involved in the management of women who present to LGH with anticipated delivery at less than 32 weeks gestation or with a known fetal diagnosis which would require neonatal HDU or ITU care. This includes Obstetric, Neonatal and Midwifery staff.

Related Documents:

Intrapartum Care UHL Obstetric Guideline UHL ref: C60/2019
Community Midwifery Home Birth Team UHL Obstetric Guideline UHL ref: C31/2017
Preterm Labour Guidance in the Absence of PPROM UHL Obstetric Guideline UHL ref: C7/2014

Abbreviations:

BBA	Born Before Arrival
CPAP	Continuous Positive Airway Pressure
ECMO	ExtraCorporeal Membrane Oxygenation
EMNODN	East Midlands Neonatal Operational Delivery Network
HDU	High Dependency Unit
HFOV	High Frequency Oscillatory Ventilation
ITU	Intensive Care Unit
IUGR	Intra-Uterine Growth Restriction
LGH	Leicester General Hospital
LRI	Leicester Royal Infirmary
NNU	Neonatal Unit
PN	Parenteral Nutrition
PPROM	Premature Pre-labour Rupture Of Membranes

2. Criteria for transfer from LGH to LRI Maternity Unit:

An anticipated pre-term delivery before 32 weeks gestation

For example:

- PPROM
- Threatened preterm labour assessed (as per the preterm Labour Guideline)

Fetal indications for delivery prior to 32 weeks gestation

For example:

- Rhesus isoimmunisation or other anticipated fetal anaemia
- Severe IUGR – baby less than 1 kg

Fetal complications of pregnancy with expected need for Neonatal Intensive Care and/or requiring multiple investigations postnatally irrespective of gestation

For example:

- Anomalies;
  - Abdominal wall defects
  - Severe facial clefting
  - Diaphragmatic hernia
  - Cardiac malformations
  - Skeletal malformations
  - Upper bowel obstruction with polyhydramnios
  - Spina bifida
- Hydrops

This is not an exclusive list and any baby with known problems antenatally should be discussed with the Neonatal Consultant to establish if they will be able to receive appropriate care at LGH

3. St Marys and Home Births

All women who fall into the following categories MUST be transferred to the LRI regardless of hospital of choice as the baby is at increased risk of requiring resuscitation and a higher level of neonatal intervention than can be provided at LGH.

- Normal labour which has become high risk
- Delay in the second stage of labour
- Suspected fetal compromise
- APH

The following women do not need to automatically be transferred to the LRI:

- Delay in the first stage of labour with no other presenting complications.
- Meconium liquor with no further signs of fetal distress and in the absence of other risk factors or other clinical concerns.
- Maternal request for an epidural with no other presenting complications.

This not an exhaustive list; Individualised considerations should be made, if there is no fetal risk then transfer to the LGH should be considered if this is the woman's preferred place of transfer.

Communication between St Marys / Home Birth Team and the receiving unit:

- For all anticipated transfers there must be an SBAR handover to the receiving unit
- The Midwife coordinator at the receiving unit should contact the Neonatal Team prior to the transfer
- There must be a full SBAR handover on arrival at the receiving unit

4. Maternal indications for delivery prior to 32 weeks gestation

For example:

- Severe pre-eclampsia
- Bleeding placenta praevia needing delivery but safe for antepartum transfer
- Deteriorating maternal medical illness

If delivery is thought to be necessary soon the referral should be made to the On-Call Team/Delivery Suite from Consultant to Consultant.

If delivery is not required immediately but possible within days/week the transfer should be made to the relevant team (Consultant to Consultant).

5. Maternal complications of pregnancy with expected need for Neonatal Intensive Care irrespective of gestation

For example:

- Type 1, Type 2 or gestational diabetics with fetal complications – macrosomia, polyhydramnios, delivery prior to 36 weeks gestation. Not all babies in this group will require admission to the NNU and so place of delivery should be discussed with the Neonatologist.

- Women with deteriorating pre-eclampsia and fetal compromise from Pre-eclampsia should have their care undertaken at LRI.

6. Symptomatic Placenta Praevia at less than 32 weeks gestation

Where Placenta Praevia is diagnosed prior to 32 weeks but remains asymptomatic the woman's continued uncomplicated antenatal care should be at LGH.

However, she should be advised that if she becomes symptomatic with any bleeding her initial presentation for emergency assessment if still less than 32 week's gestation should be to the LRI.

Where inpatient care is necessary before 32 weeks gestation this should be arranged at the LRI. After 32 weeks on-going care her delivery arrangements could revert to LGH.

7. All triplets or higher multiples should have delivery at LRI at any gestation

The Neonatal Service would not have sufficient staff to be able to resuscitate more than two babies at the LGH site.

8. Case – by – case basis:

Clearly this list is not exhaustive and so the over-riding principles at the beginning of this document should be applied on a 'case by case' basis.

The number involved should not impact significantly on the workload in either unit, but agreement has been reached that if following transfer of a preterm pregnancy workload is stretched at the LRI discussions will take place between the Midwifery Coordinators of Delivery Suite and the On-call Consultant as to the feasibility of transferring low-risk term inductions on that day to the LGH site.

Where there is uncertainty about whether the transfer is the most suitable action the Midwife at the LGH should contact the Consultant on call for MAU at the LRI and discuss the case.

9. Education and Training

None

10. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Appropriate place of birth for babies born <27/40	Safety Dashboard	Audit team	Monthly	CMG Quality & Safety Board

11. Supporting References

EMNODN Care Pathways and Service Specification Document available on https://www.emnodn.nhs.uk

Intrapartum Care UHL Obstetric Guideline UHL ref: C60/2019
Community Midwifery Home Birth Team UHL Obstetric Guideline UHL ref: C31/2017
Preterm Labour Guidance in the Absence of PPROM UHL Obstetric Guideline UHL ref: C7/2014

12. Key Words

High dependency, Intensive care

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) J Gill - Consultant		**Executive Lead** Chief Nurse	
Original authors: Original Working Party - Consultant Obstetricians, Consultant Neonatologists Senior Midwives Intrapartum and Inpatient Care and Clinical Risk and Clinical Risk and Quality Standards Midwife			
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
July 2015	**1**	J Gill, F Cox and L Matthews	
July 2018	**1**	E Broughton	No change other than slight change to format as per Trust guideline
July 2019	**2**	J Gill, F Cox and L Matthews	Insertion of formal process for transfer from St Marys Birth Centre to the LRI
August 2022	**3**	J Gill - Consultant Neonatologist F Ford – Matron L Taylor - Clinical Risk and Quality Standards Midwife Maternity guidelines group July 2022 Maternity Governance August 2022	• Updated intro and criteria for transfer • Added abbreviations • Added related documents • Removed viral infections and chorioamnionitis after PROM from section 2 • Added section of individualised considerations for transfer to LGH v's LRI when birthing at SMBC or home • Removed substance misuse from criteria for transfer