NHS Midlands Clinical Networks

NHS West Midlands Neonatal Operational Delivery Network

In utero transfer (IUT) guideline for pregnancies < 27 weeks singleton or birthweight below 800g < 28 weeks for multiple gestation

NHS England and NHS Improvement

In utero transfer (IUT) guideline for < 27 weeks singleton or birthweight below 800g and < 28 weeks for multiple gestation:

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Updated: (only if this is applicable)

Adapted by Sarah Tranter & Jenny Brown taken from the East Midlands IUT guideline for <27 weeks singleton and <28 weeks for multiple gestation and elements of the Birmingham and Solihull United Maternity & Newborn Partnership - “Opt-out” pathway for the in-utero transfer of women presenting in threatened preterm labour >/= 22+0 and < 27 weeks gestation from Worcester, Hereford and Birmingham City Hospital.

Reviewed by West Midlands Preterm Births group in May 2021 and July 2021

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1. Introduction

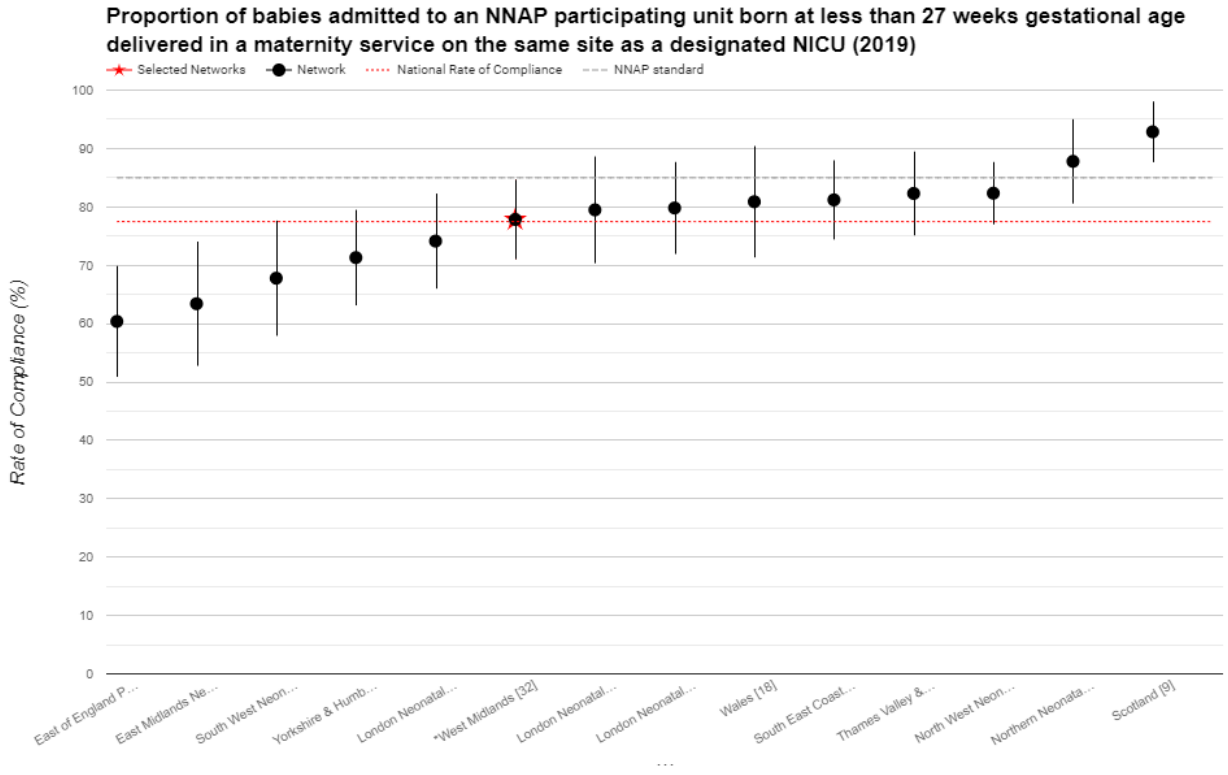
The NHS England Neonatal Critical Care service specification [E08/S/a] indicates that all women and their babies who are born < 27 weeks gestation(26+6 days and below) or birthweight < 800g and multiple pregnancies < 28 weeks (27+6 days and below) gestation should receive perinatal and early neonatal care in a maternity service with a level 3 Neonatal Intensive Care Unit (NICU) facility.

The British Association of Perinatal Medicine (BAPM) Framework 2019 has been published to assist decision making prior to and/ or at the time of birth relating to perinatal care and preterm delivery < 27 weeks gestation, or less, in the United Kingdom. In - utero transfer should be considered at the earliest opportunity when active management is planned.

Babies who are born at less than 27 weeks gestational age are at high risk of death and serious illness. National recommendations state that Neonatal Networks should aim to configure and deliver services in order to increase the proportion of babies at this gestational age being delivered in a hospital with a level 3 NICU on site. Evidence demonstrates that outcomes improve if such premature babies are cared for in a NICU from birth. Eighty-five percent (85%) of babies born at less than 27 weeks gestational age, less than 28 weeks for multiple pregnancies or birthweight <800g should be delivered in a maternity service which is on the same site as a level 3 NICU (NNAP report 2019 and NHS planning guidance 2021/22).

The National Neonatal Audit Programme (NNAP 2020) based on 2019 data identifies that 77.49% of babies born at less than 27 weeks' gestational age were delivered in a hospital with a NICU on site, demonstrating a slight notable change since 2017 when the rate was 73.9%. Two of the fourteen neonatal networks are achieving the standard of 85% which may reflect network structure as much as clinical practice. The West Midlands 2019 data demonstrates that we strive to improve to the target of 85%, recognising the geographic complexity of our region.

Figure 1: Rates of compliance for birth in a centre with a NICU: neonatal networks (2019)



With the publication of Saving Babies Lives Care Bundle V 2 and the Neonatal Critical Care Review, there is a national drive to reduce the number of babies born at <27 weeks singleton and < 28 weeks for multiple pregnancies in centres which do not have a NICU, and thus the aim is to optimise in-utero transfer (IUT) within networks wherever possible. There is strong evidence that babies who are born in centres with NICUs have improved outcomes both in terms of mortality and morbidity. Postnatal transfer of the baby (or multiples), in addition to the newly delivered mother introduces greater risks to both mother and baby. For the babies in particular, there is an associated increase in brain injury, compared to those babies born in centres with level 3 NICUs. There is also a greater incidence of maternal/baby separation at a time when the baby could be seriously unwell and parental input is required within the clinical decision-making process.

Postnatal transfer of high-risk preterm infants is not only associated with increased risk of mortality and severe brain injury, but also maternal separation and risks of inter-hospital transfer from multiple journeys (mother and her newborns). An audit of the West Midlands network of all infants <27 weeks gestational age identified over 30 pregnancies delivering in non-NICU centres in 2018. Exploration of these revealed that in almost half, there potentially was an opportunity for IUT if a clear pathway was in place and this allowed timely transfer.

The West Midlands Preterm Group has been developed which is a joint collaborative between the Midlands Maternity Clinical Network and the West Midlands Neonatal Operation Delivery Network. An In-Utero Transfer record (see Appendix 1) with guidance to standardise practice and improve the < 27 week singleton, birthweight < 800g and < 28 weeks for multiple pregnancies pathway has been developed to drive improvement across the region.

1.1 Principles to be applied:

1) Every effort will be made to accommodate requests for IUT into the level 3 hospital with a NICU. Acceptance of transfer should be the default.
2) It is strongly recommended that In Utero Transfer is considered at the earliest opportunity.
3) In situations where Maternity capacity is stretched, Delivery suite capacity and safety must be jointly assessed by the Consultant Obstetrician and the most Senior Midwife, or the Operational Manager on site.
4) In situations where Neonatal capacity is stretched, Neonatal unit capacity and safety must be jointly assessed by the Consultant Neonatologist and the most Senior Nurse, or the Operational Manager on Site.
5) 1.1 multiple pregnancies and babies <800g whether successful or unsuccessful should be completed, see Appendix 1.
6) If a woman fulfilling the IUT criteria cannot be accepted, the incident should be reported on appropriate adverse incident reporting system.
7) All women will be assessed at booking for their risk of preterm labour aligned to SBLCB v2 (Appendix F); the risk assessment result recorded in the maternity record.
8) If an increased risk of preterm birth is identified, the women should be referred to a Preterm Birth Prevention (PPC) clinic or equivalent and management comply with current national guidance. (This is an action for all maternity service providers).
9) All women within the scope of this policy will have their care optimised according to current BAPM guidance.

1.2 Risk assessment for preterm birth

All women should have an assessment of their risk of preterm birth documented at their first antenatal booking assessment.
Women with the following are considered at risk of preterm labour and birth:

- a history of spontaneous preterm birth or mid trimester loss (16 to 34 weeks gestation)
- a history of preterm pre-labour rupture of membranes <34/40
- previous use of cervical cerclage
- a history of cervical trauma (including surgery for example trachelectomy)
- a short cervix that has been identified by scan.

Women identified as being at risk of preterm birth should attend a clinic specialising in preterm birth prevention. This will allow interventions to reduce the risk of preterm birth to be targeted at high risk women aiming to reduce the incidence of preterm birth and identify women who need closer observations because of increased risk.

All women regardless or whether high or low risk of preterm birth should receive education on the signs and symptoms of preterm labour including counselling that the symptoms in earlier gestations are typically vague and include abdominal pain, contractions, tightening, sensation of pressure, urinary symptoms, abnormal vaginal discharge, fluid leakage, bleeding and back pain. Women should be informed how to seek help and advise if they are experiencing any of these symptoms.

Women with signs and symptoms of preterm labour should have a full history taken, clinical examination and speculum examination. Where appropriate this should include further risk stratification with FFN and/or cervical length measurement to identify those women in threatened preterm labour.

Threatened preterm labour consists of the largest group of mothers and neonates who will potentially require in utero transfer to ensure optimal place of birth. Yet this is not the only condition where IUT needs to be carefully considered.

Conditions such as pre-eclampsia, bleeding placenta praevia and fetal growth restriction all need careful consideration as to whether IUT is appropriate and indicated by a senior obstetrician.

1.3 Criteria for referral

All women who are considered to be at high risk of either spontaneous or iatrogenic preterm birth with a singleton pregnancy >/= 22 weeks and less than 27 weeks/multiple pregnancy >/= 22 weeks and less than < 28 weeks and/or estimated fetal weight < 800 grammes require assessment for transfer to a unit with a neonatal intensive care unit.
This in includes but not limited to:

1 Established preterm labour.
2 Preterm Premature Rupture of Membranes (PPROM) with or without signs of labour.
3 Threatened preterm labour with **positive predictive testing**. This will necessitate a QUIPP/QUIDS App risk score >/= 5% or quantitative FFN >200 ng/ml or cervical canal length <15 mm.
4 Other circumstances on a case by case basis after consultant assessment and consultant to consultant discussion.

See Appendix 7 West Midlands Preterm Birth Symptomatic Assessment Pathway

1.4 Which patients are unsuitable for in utero transfer?

Contraindications for IUT:

- Pregnancy < 22 weeks (if transfer is for fetal condition or threatened labour).
- Pregnancy from 22 -23 +6 weeks where comfort care alone has been chosen following MDT risk assessment (see Appendix 3 & 4).
- 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)

1.5 Decision for in utero transfer:

- The decision for transfer must be reviewed or discussed with the on call obstetric consultant, following discussion with the on-call consultant neonatologist/paediatrician of the referring hospital, see Appendix 2.
- Counselling and decision making should be through the BAPM framework: Perinatal Management of Extreme Preterm Birth Before 27 weeks gestation (2019), see Appendix 3. Following assessment those babies in the high or very high risk category will require discussion with the on call neonatal/paediatric consultant at the referring hospital and decision for active management will be agreed between the parents, obstetric and neonatal team, see Appendix 4 West Midlands Neonatal ODN Extreme Preterm guidance framework and flow chart for 22-23 weeks gestation.
- It is imperative that a decision is made without delay to ensure those that require transfer are transferred quickly. Please complete West Midlands IUT record, please see Appendix 1. A virtual MDT meeting should be considered to agree transfer if appropriate.

1.6 Finding a neonatal cot and maternity bed

- The Referring Maternity unit senior staff member will contact NTS call Handling Service (West Midlands Neonatal ODN footprint) Tel: 0300 200 1100 to obtain cot status of appropriate neonatal unit and maternal bed availability. For UHCW, SWFT & GEH if they have received antenatal Tertiary Fetal medicine input they should be referred to the Tertiary Unit where they have received antenatal care to ensure continuity this could be in the East or West Midlands. For East Midlands to obtain cot status call 365 Call Handler Service Tel: 0300 300 0038 and for West Midlands Tel: 0300 200 1100.

- The referring unit must state this is for < 27 week singleton or < 28 week multiple pregnancy and a NICU cot is required. The call handlers will take brief details so please be ready with these details.

- Please see Appendix 5 which outlines the West Midlands Neonatal ODN pathways into the correct place of birth. Every effort should be made to keep the mother and baby in network.

1.7 Ambulance Service:

West Midlands Ambulance Service (WMAS) telephone number for intra-facility transfers

Tel: 01384 215520

- Once an in- utero transfer has been accepted by the receiving neonatal and maternity unit, the referring unit should organise the transfer through WMAS.
- When contacting WMAS 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 response to this should be YES, and the reason of obstetric emergency if time critical should be provided. This will generate a category 1 ambulance response which provides a 7-minute response target.
- 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 target time frames for the specific call:
    - Category 2 - 18-40 mins
    - Category 3 - 120 mins
    - Category 4 - 180 mins
- Recontacting the ambulance service should only be made if the patient's condition deteriorates and not to chase the ambulance as this clogs up the 999 system.
- 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, WMAS 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.
- WMAS 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.

1.8 Refusal of Transfer:

A decision to refuse an appropriate transfer by a tertiary neonatal team should be made only after consultation with the tertiary 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 at the tertiary unit.

If for any reason a tertiary centre is unable to take an IUT there should be a discussion between the nearest tertiary centre 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.

1.9 Maternal agreement to be transferred:

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 West Midlands Neonatal Network Parent Information leaflet (Appendix 6) and verbal information by the obstetric and neonatal staff.

The West Midlands Neonatal Network Parent Information leaflet should be given.

1.10 Documentation:

The referring team must send a photocopy or electronic record 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 data lead at the referring centre. The Preterm Birth data lead will be responsible for following up the outcome of each case.

1.11 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.

1.12 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, which can then be placed in the patient's obstetric notes at the local unit. If delivery does not occur and the referring unit does not use BadgerNet than a discharge summary should be sent and forwarded to the referring clinician. Follow up should be in place with the referring unit and lead Obstetrician prior to discharge to ensure appropriate antenatal care and follow up is in place.

In the event of a neonatal death or stillbirth, 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.

1.13 Data Collection:

Data will be collected through NTS Call Handler Service and this will be downloaded on a monthly basis and sent to the network who will then distribute to the nominated IUT data lead at each trust. Each referring unit will also keep a record of all the in- utero transfer records. The IUT data lead will be responsible for following up the outcome of each case. A review of all cases will take place at the Preterm Births MDT which will be on a bimonthly basis with the Neonatal ODN and the Maternity Clinical Network.

Appendix 1 - West Midlands In-Utero Transfer Record <27 weeks

This form should be completed for all attempted in-utero transfers for <27 weeks singleton or <28 weeks for multiple pregnancies & babies <800g whether successful or unsuccessful.

It is strongly recommended that In Utero Transfer is considered at the earliest opportunity.

NICU = <27 weeks of gestation or at a birthweight <800g
LNU = ≥27 weeks of gestation and birthweight ≥800g
SCU = >32 weeks gestation who require only special care or short-term high dependency care.
Antenatally identified congenital abnormality needing delivery in specialist unit

Organisation Name: _____ Date: _____

Patient Details:

Name: _____

NHS Number: _____

Date of Birth: _____

Gestation: + weeks

Number of fetuses: 1 2 3 Other

History of SROM: Date, time: _____

Sign of chorioamnionitis: YES / NO

Vaginal bleeding: YES / NO Amount: _____

Contractions:_____

Dilatation: _____

Evidence of IUGR: YES / NO EFW in gms: _____

Last scan, date: _____

Placental site: _____

Doppler: normal / abnormal

Fetus: male / female / unknown

Use of tocolysis: YES / NO

Antibiotics: YES / NO

Date, time: _____

Any swabs taken? Date, time and results:

_____

_____

Threatened preterm labour predictive test performed:

	Tick	Value
Cervical Length		_____mm
Actim® Partus		Positive / Negative
Fetal fibronectin (fFn)		Positive / Negative _____ Ng/ml
QUIPP app		% risk in 7 days _____
PartoSure™		Positive / Negative

Steroids administered: YES / NO

Date of first dose: _____

Time of first dose: _____ : _____

Indication for transfer:

Transfer discussion with consultant on call prior to transfer: YES / NO

Time of discussed with consultant: _____ : _____

Time decision made for transfer: _____ : _____

Magnesium Sulphate administered: YES /NO

Date of first dose: _____ **Time of first dose**: _____ : _____

Cot finding route: Direct contact with neonatal unit ☐ Contact with transport service ☐

Unit / Transport service contacted:

Time contacted: _____ : _____

Time contacted: _____ : _____

Discussed with _____

Transfer accepted: YES / NO

Labour ward outcome: _____

Indication for not accepting transfer:

_____

Unit / Transport service contacted:

Time contacted: _____ : _____

Time contacted: _____ : _____

Discussed with:

_____

Transfer accepted: YES / NO

Labour ward outcome:

_____

Indication for not accepting transfer

_____

Outcome:

Transfer did not take place (tick):
Clinical change (e.g. maternal deterioration/improvement/advanced labour)
No maternal bed capacity found
No neonatal cot capacity found
Unable to locate two cots for twins
Delivered prior to transfer taking place
Delivered prior to transfer taking place due to ambulance delay
Escort unavailable
Other

Transfer Outcome:

	Tick	Date	Time
In-utero transfer		___/___/___	___:___
Ex-utero transfer		___/___/___	___:___
Pregnant woman stayed in local unit		___/___/___	___:___

Date baby delivered: ___/___/___

Comments:

Incident form completed: YES / NO

Healthcare professional completing form (print name):

Feedback on outcomes to be sent to lead Obstetric Consultant (print name):

Appendix 2: In - utero transfer decision making tool flow chart

Appendix 3: Risk Assessment from BAPM Framework 2019

A key ethical consideration for decisions about instituting life-sustaining treatment for an extremely preterm baby is the baby's prognosis – the risk of an acceptable (or unacceptable) outcome if active (survival focused) management is undertaken. If there is a plan to provide life-sustaining treatment for the baby, then it follows that the pregnancy and birth should be managed with the aim of optimising the baby's condition at birth and subsequently. We advise a stepwise approach to decision-making, involving three key stages:

1. Assessment of the risk for the baby if delivery occurs, incorporating both gestational age and factors affecting fetal and/or maternal health.

2. Counselling parents, and their involvement in decision-making.

3. Agreeing and communicating a management plan.

Parents should be counselled and joint decision making made about whether parents are keen to initiate active (survival focussed) treatment or comfort care.

The focus of care for extremely high-risk groups (as categorised below) should usually be comfort focussed but if the option of active care is agreed following careful and considered counselling then an IUT should be arranged to optimise place of birth in a NICU where further discussions around care at the time of birth will take place to agree a definitive plan.

BOX 1

Extremely high risk: The Working Group considered that babies with a > 90% chance of either dying or surviving with severe impairment if active care is instigated would fit into this category. For example, this would include:

- babies at 22^{+0} - 22^{+6} weeks of gestation with unfavourable risk factors
- some babies at 23^{+0} - 23^{+6} weeks of gestation with unfavourable risk factors, including severe fetal growth restriction
- (rarely) babies ≥ 24^{+0} weeks of gestation with significant unfavourable risk factors, including severe fetal growth restriction

High risk: The Working Group considered that babies with a 50-90% chance of either dying or surviving with severe impairment if active care is instituted would fit into this category. For example, this would include:

- babies at 22^{+0} - 23^{+6} weeks of gestation with favourable risk factors
- some babies ≥ 24^{+0} weeks of gestation with unfavourable risk factors and/or co-morbidities

Moderate risk: The Working Group considered that babies with a < 50% chance of either dying or surviving with severe impairment if active care is instituted would fit into this category. For example, this would include:

- most babies ≥ 24^{+0} weeks of gestation
- some babies at 23^{+0} – 23^{+6} weeks of gestation with favourable risk factors.

Please see BAPM Risk Assessment Flow Charts below (Figure 1 and 2):

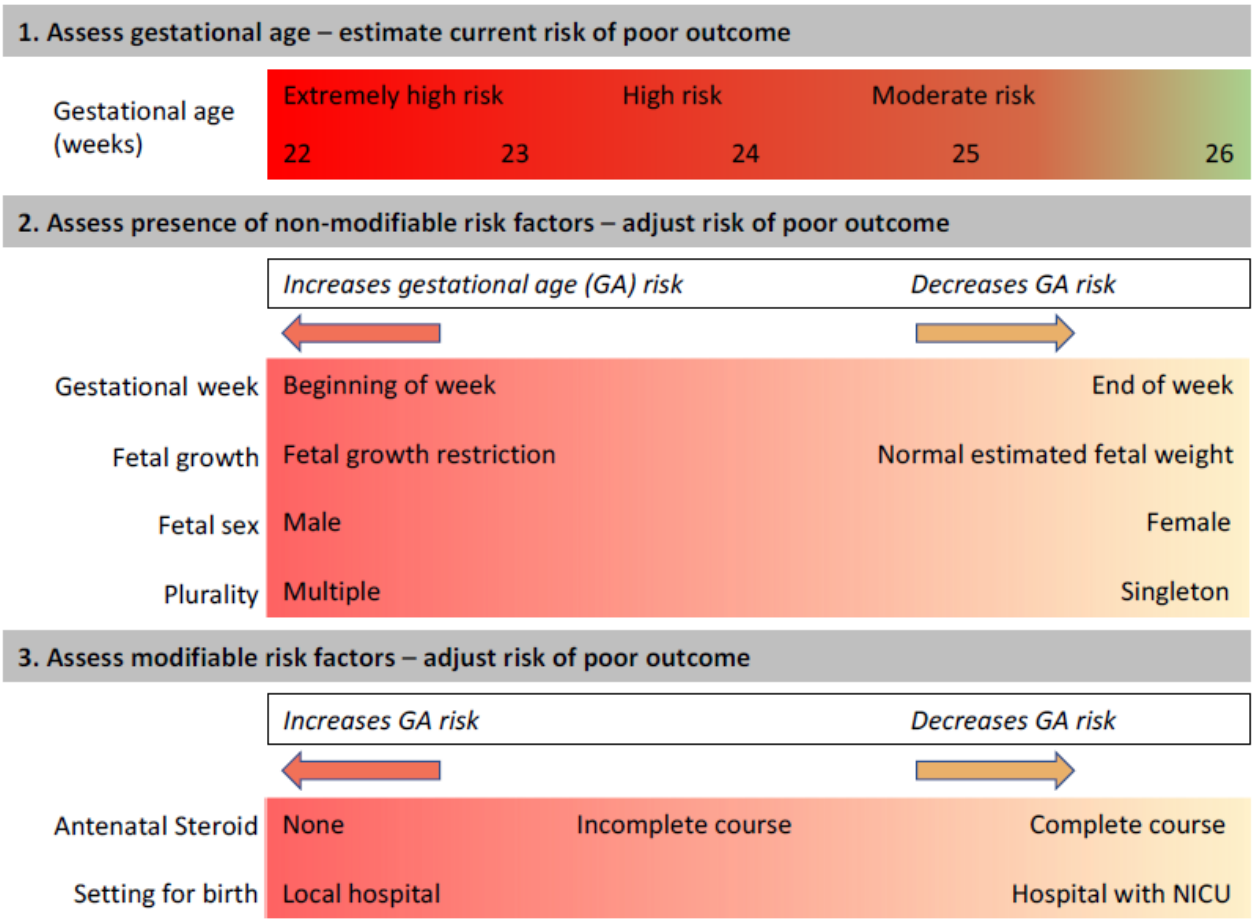


Figure 1: Proposed visual tool for refinement of risk

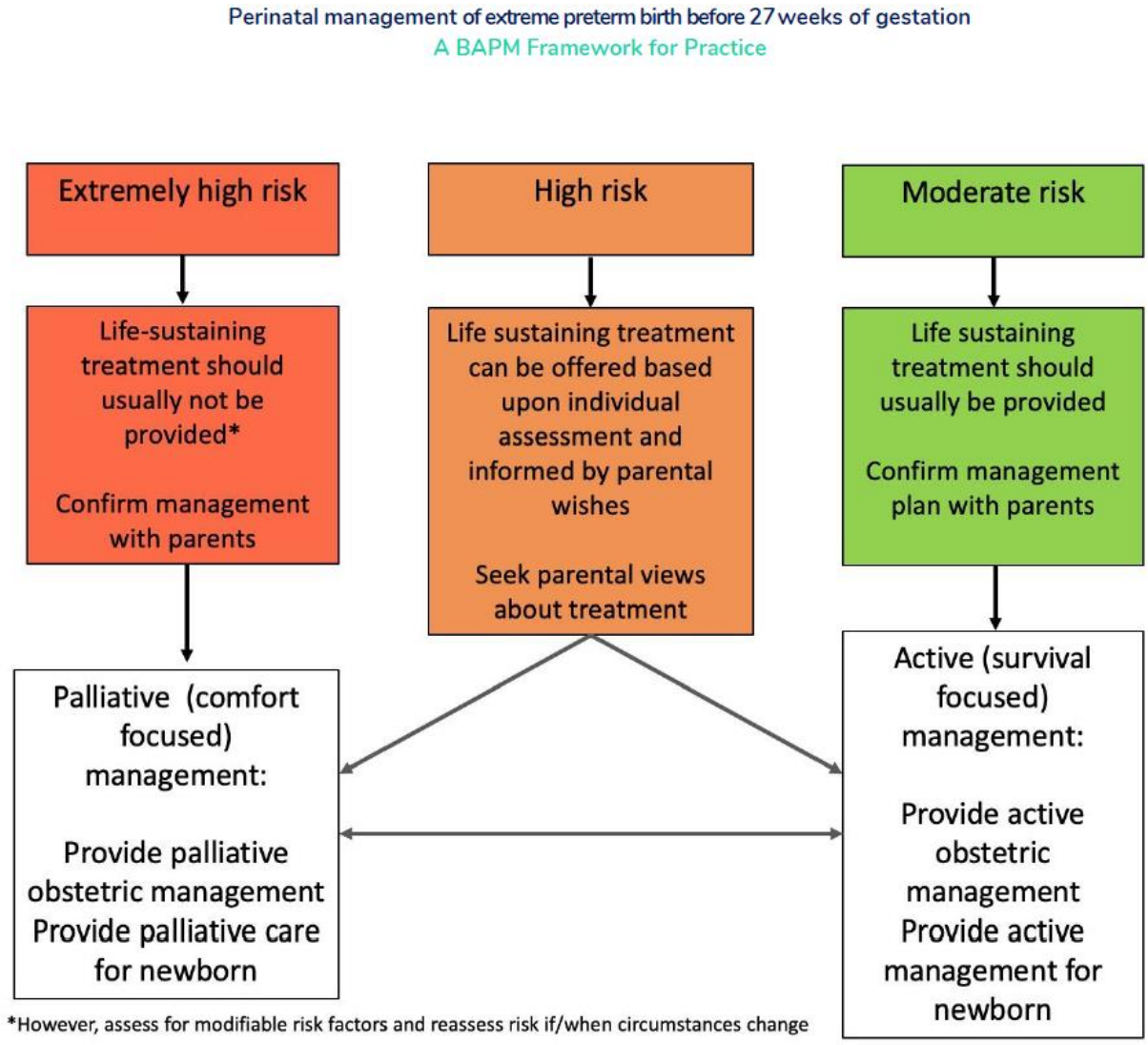
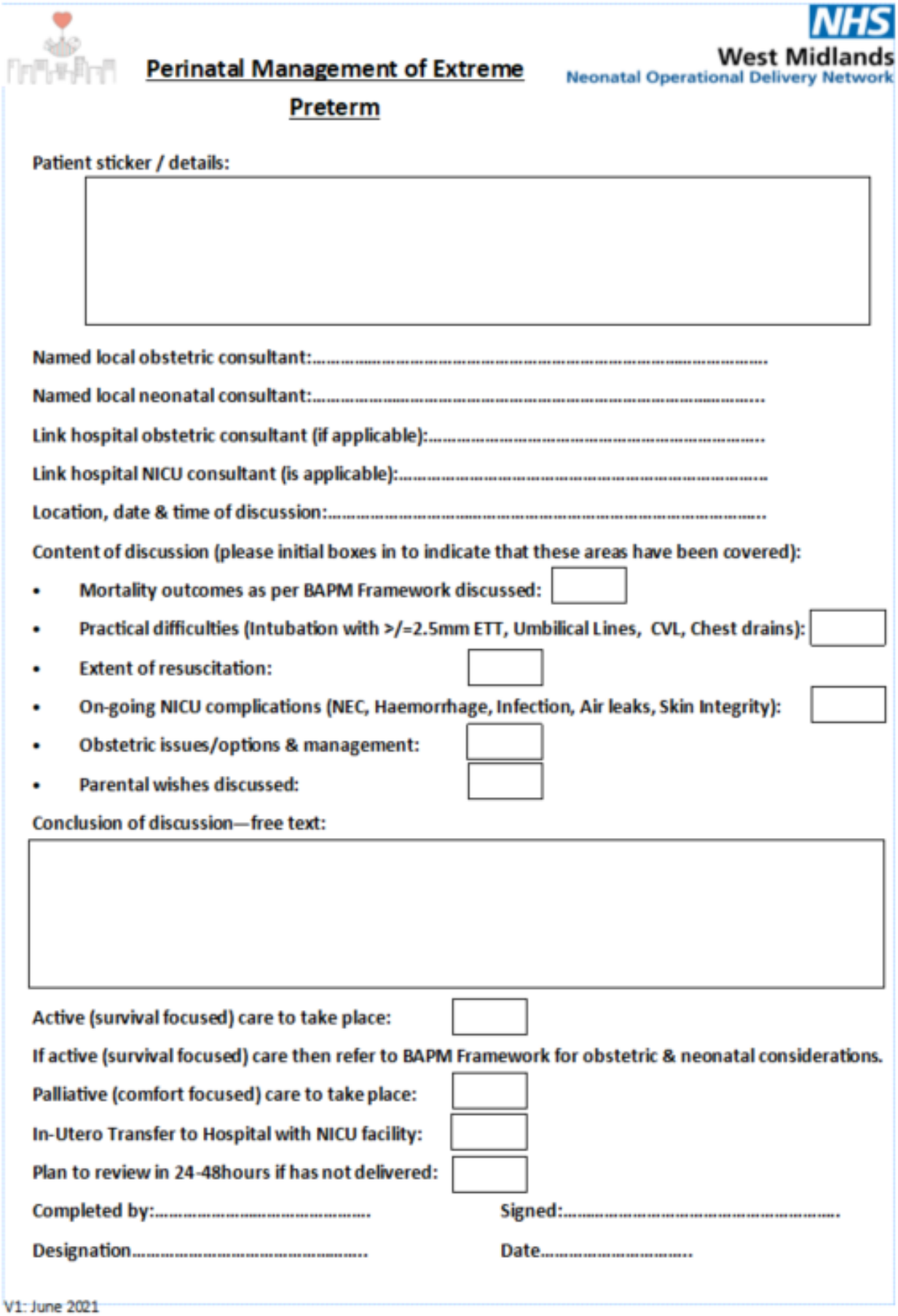


Figure 2. Decision-making around management of delivery, following risk assessment and after consultation with parents.

Taken from the BAPM Framework for Practice 2019 (https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019)

Appendix 4: WMNODN Extreme Preterm guidance framework and flowchart



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Perinatal Management of Extreme Preterm

Patient sticker / details:

Named local obstetric consultant:.....

Named local neonatal consultant:.....

Link hospital obstetric consultant (if applicable):.....

Link hospital NICU consultant (is applicable):.....

Location, date & time of discussion:.....

Content of discussion (please initial boxes in to indicate that these areas have been covered):

- Mortality outcomes as per BAPM Framework discussed:
- Practical difficulties (Intubation with >/=2.5mm ETT, Umbilical Lines, CVL, Chest drains):
- Extent of resuscitation:
- On-going NICU complications (NEC, Haemorrhage, Infection, Air leaks, Skin Integrity):
- Obstetric issues/options & management:
- Parental wishes discussed:

Conclusion of discussion—free text:

Active (survival focused) care to take place:

If active (survival focused) care then refer to BAPM Framework for obstetric & neonatal considerations.

Palliative (comfort focused) care to take place:

In-Utero Transfer to Hospital with NICU facility:

Plan to review in 24-48hours if has not delivered:

Completed by:..... Signed:.....

Designation..... Date.....

V1: June 2021

Proposed flowchart—Perinatal Management of Extreme Preterm

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West Midlands
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Woman of 22-23 weeks gestation presents to obstetric service

Obstetric service is co-located with a NICU

Perinatal team discussions should take place between consultant led obstetric & neonatal teams and parents-to-be. The BAPM framework should be used to help assess risk, prognosticate outcome and aid decision making.

An obstetric & neonatal management plan will then be formed and documented.

The parent-to-be should stay at the hospital with on-site NICU whether active (survival focused) or palliative (comfort focused) care are to be provided.

Obstetric service is co-located with a LNU or SCBU

Perinatal team discussions should take place between consultant led obstetric & neonatal teams at the local hospital and parents-to-be. Consultant-to-consultant level discussions with the hospital's link obstetric unit and NICU are encouraged. The BAPM framework should be used to help assess risk, prognosticate outcome and aid decision making.

If, after antenatal counselling, active (survival focused) care is decided upon then the parent-to-be's obstetric management should be optimised and prioritise transfer of her to an obstetric unit with an on-site NICU.

If the patient embarks on active (survival focused) care but delivers prior to transfer then a consultant led neonatal team should attend delivery. If baby survives then the neonatal consultant should liaise with a NICU consultant about an ex-utero transfer of baby. The NICU must prioritise the admission. Transfer of the mother to the NICU hospital should also be prioritised.

If palliative (comfort focused) care is to be provided then the patient should remain at the presenting hospital and receive appropriate care. The link NICU and obstetric consultants can continue to provide advice as required.

Version 2: June 2021

Appendix 5: List of West Midlands Neonatal Units & Pathways into correct Place of Birth

Level 3 (NICU):

Birmingham Women's Hospital
Mindelsohn Way
Birmingham B15 2TG
0121 472 1377
Ext

Birmingham Heartlands
Bordesley Green East
Birmingham B9 5SS
0121 424 2000
Ext

New Cross Hospital
Wolverhampton Road
WolverhamptonWV10 0QP
01902 307999
Ext

Coventry Hospital
Clifford Bridge Road
Coventry CV2 2DX
02476 964000
Ext

Royal Stoke Hospital
Newcastle Road
Stoke-on-Trent ST4 6QG
01782 715444
Ext

Level 2 (LNU):

Walsall Manor Hospital
Manor Road
Walsall WS2 9PS
01922 721172
Ext

Russells Hall Hospital
Pensnett Road
Dudley DY1 2HQ
01384 456111
Ext

Worcester
Charles Hastings Way
Worcester WR5 1DD
01905 763333
Ext

Princess Royal Hospital
Telford
Apley Castle
Telford TF1 6TF
01952 641222
Ext

City Hospital
Dudley Road
Birmingham B18 7QH
0121 553 1831
Ext

Level 1 (SCU):

George Eliot Hospital
College Street
Nuneaton CV10 7DJ
02476 351351
Ext

Warwick Hospital
Lakin Road
Warwick CV34 5BW
01926 495321
Ext

Good Hope Hospital
Rectory Road
Sutton Coldfield B75 7RR
0121 424 2000
Ext

Hereford Hospital
Stonebow Road
Hereford HR1 2ER
01432 355 444
Ex

Pathways into correct place of birth

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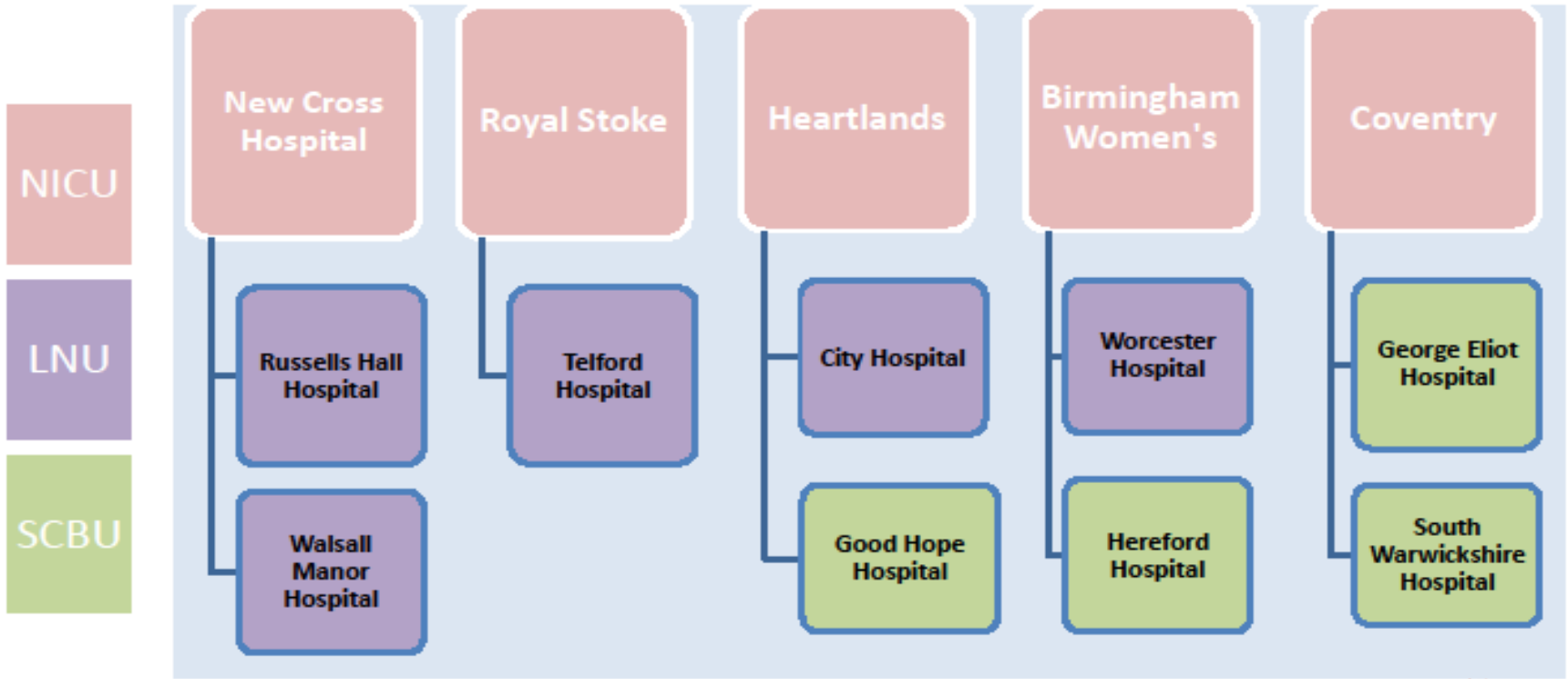

If a transfer is required please try the NICU linked to your unit in the first instance if no capacity please try nearest NICU 95% of care should be delivered in the network

Appendix 6: West Midlands Neonatal Network Parent Information Leaflet

What happens if my baby is born too soon, too small, too sick or needs surgery?

NHS West Midlands Neonatal Operational Delivery Network

You have been given this information leaflet because you have booked to have your baby at a maternity unit within the West Midlands Neonatal Operational Delivery Network (WMNODN). The hospitals in WMNODN work together to make sure families receive the care they need, as close as possible to home.

This leaflet gives information about what will happen if your baby is born too soon, too small, too sick or needs surgery. The specialist care babies need after birth is called Neonatal Care and is provided by specially trained nurses and doctors within a Neonatal Unit. About 1 in every 9 babies born will need neonatal care and the units within the West Midlands all work together to provide different levels of care. Neonatal Intensive Care is a highly specialised service and is limited to a few specialist centres in which babies are transferred between hospitals to meet their needs.

Neonatal care is highly specialised and not all Neonatal units have the facilities and staff to provide the full range of care for the smallest and sickest babies. If your baby needs neonatal care after delivery, they will be transferred to the appropriate neonatal unit depending on their needs. **This means that if your baby requires neonatal care you will NOT have a choice where this care is provided.**

"When might I or my baby be transferred to another hospital?"

If your midwife or obstetrician is concerned that your baby will need neonatal care it may be recommended that you are transferred to a hospital that has the necessary facilities for your baby **before you give birth.** This is because studies in England have shown that very premature babies do better if they are born in a hospital with neonatal intensive care units on site. However if transfer is not possible, all hospitals are able to provide the immediate care your baby needs whilst arrangements are made to transfer your baby to the nearest appropriate neonatal unit. A team of specially trained staff will safely make this transfer between hospitals .

If your hospital has a neonatal intensive care unit and your baby needs specialised care that is not so intensive your baby may need to be transferred to another unit within the network that is able to provide such care. This may need to happen in order to keep spaces in the intensive care unit for a baby that requires this level of care.

Your baby will be transferred to another neonatal unit within the West Midlands as long as there is a cot available. Very occasionally, your baby may need to be transferred to a hospital outside of this region.

Every day, the nurses and doctors will review and plan your baby's care. As soon as your baby is well enough to no longer need specialist facilities, your baby will be transferred to a neonatal unit as close to home as possible, which specialises in preparing you and your baby for discharge.

Appendix 7: West Midlands Preterm Birth Symptomatic Assessment Pathway