Policy for Exception Reporting

July 2017

1. Introduction

Neonatal care is highly technical and has developed rapidly over the past 30 years, resulting in improved outcomes for sick and very premature babies. Well organised, effective and sensitive neonatal care can make a lifelong difference to premature and sick new-born babies and their families/carers. Getting the early care right is the responsibility of the NHS at all levels. The Department of Health initiated the centralisation of specialist neonatal care within managed neonatal networks in 2003. This was further endorsed with the publications of:

- National Audit Office: Caring for Vulnerable Babies: The reorganisation of neonatal care in England (2007)
- BAPM: Management of acute in-utero transfers: a framework for practice (2008)
- BAPM: The management of babies born extremely preterm at less than 26 weeks of gestation: a framework for clinical practice at the time of birth (2008)
- DH: Toolkit for High Quality Neonatal Services in (2009)
- CESDI 27-28 study
- NICE: specialist neonatal care quality standards in (2010)
- NHS England: National Neonatal Service Specification (2013)

2. Purpose

The purpose of this policy is to describe a clear guideline and framework in order to;

- Standardise the mechanism for exception reporting of neonates who meet the criteria for uplift as set out in National Neonatal Service Specification (2013)
- Facilitate centralised collation of standardised information regarding exception reporting
- Provide a clear documentation of communication between all members of staff involved with neonatal care within South West Neonatal Network
- Provide an accurate reporting mechanism in order to assess risk within the network.
- Identify trends in patient flow.
- Collate information to address specific issues surrounding service design.
- Allow for feedback to individual units and support transport services.

3. Scope

This policy applies to all staff, patients and neonatal units that fall within the South west Neonatal Network. This includes the following hospitals.

Northern Devon Healthcare Trust	- North Devon District Hospital, Barnstaple
Royal United Hospital Bath NHS Trust	- Royal United Hospital Bath
North Bristol NHS Trust	- Southmead Hospital, Bristol
University Hospitals Bristol NHS Foundation Trust	- St Michaels Hospital, Bristol
Royal Devon and Exeter NHS Foundation Trust	- Royal Devon and Exeter Hospital
Gloucestershire Hospitals NHS Foundation Trust	- Gloucester Royal Hospital
Plymouth Hospitals NHS Trust	- Derriford Hospital, Plymouth
Great Western Hospitals NHS Foundation Trust	- Great Western Hospital, Swindon
Taunton and Somerset NHS Foundation Trust	- Musgrove Park Hospital, Taunton

Torbay and South Devon NHS Foundation Trust	- Torbay Hospital
Royal Cornwall Hospitals NHS Trust	- Royal Cornwall Hospital, Truro
Yeovil District Hospital NHS Foundation Trust	- Yeovil District Hospital

4. Introduction

The Specialised Services for Children – Definition No 23 at 23.12 Specialised Neonatal Care Services defines three levels of units:

Neonatal Intensive Care Units (NICUs) are sited alongside specialist obstetric and feto-maternal medicine services, and provide the whole range of medical neonatal care for their local population, along with additional care for babies and their families referred from the neonatal network. Many NICUs in England are co-located with neonatal surgery services and other specialised services. Medical staff in a NICU should have no clinical responsibilities outside the neonatal and maternity services.

Local Neonatal Units (LNUs) provide neonatal care for their own catchment population, except for the sickest babies. They provide all categories of neonatal care, but they transfer babies who require complex or longer-term intensive care to a NICU as they are not staffed to provide longer term intensive care. The majority of babies over 27 weeks of gestation will usually receive their full care, including short periods of intensive care, within their LNU. Some networks have agreed variations on this policy, due to local requirements. Some LNUs provide high dependency care and short periods of intensive care for their network population. LNUs may receive transfers from other neonatal services in the network, if these fall within their agreed work pattern.

Special Care Units (SCUs)

Special Care is provided for babies who require additional care delivered by the neonatal service but do not require either intensive or high dependency care. It includes babies receiving oxygen via nasal cannula, feeding by nasogastric, jejunal tube, or gastrostomy, continuous physiological monitoring, care of stoma, presence of an intra-venous (IV) cannula, receiving phototherapy or special observation of physiological variables at least 4 hourly. Some networks have agreed variations on this policy, due to local requirements.

5. Guideline

The expectation is that any neonate who fulfils the threshold for transfer for uplift in care should usually be transferred as per the following criteria:

5.1 Neonates requiring transfer from an LNU to a NICU

In line with the standard for national guidelines, a Local Neonatal Unit (LNU) will not be expected to provide care for the following babies:

- Singletons below 27+0 weeks, Multiples below 28+0 (where possible transfers should occur in-utero)
- Birth weight below 800g (in-utero transfer where birth weight is anticipated to be below 800g)
- Neonates over 27 weeks who receive ventilation for more than 48 hours and/or whose condition is deteriorating (those who are likely to require ventilation for more than 48 hours should be transferred on day 1)
- Neonates who require cooling
- Neonates requiring complex specialist care e.g. nitric oxide / HFOV, inotropes, insulin infusion, chest drain, prostaglandin infusion

5.2 Neonates requiring transfer from a SCU to an LNU or NICU

In line with the standard national guidelines, a Special Care Unit (SCU) will not be expected to provide care for neonates categorised above, plus:

- Care beyond initial stabilisation to babies less than 32 weeks gestation
- Care beyond initial stabilisation to babies less than 1000g
- Ongoing Intensive or high dependency care for any baby apart from initial stabilisation (Liaise with uplift referral centre between 6-12 hours of age)
- Babies with symptoms of hypotension, DIC, renal failure, metabolic acidosis or babies requiring the following treatment and support: Inotrope infusion, insulin infusion, presence of a chest drain, exchange transfusion, prostaglandin infusion, nitric oxide, high frequency oscillatory ventilation (HFOV) and therapeutic hypothermia.

5.3 Neonates not suitable for care in NICU

In line with the standard national guidelines, a NICU in the South West Neonatal Network will not be expected to provide care for the following babies:

- Extra-corporeal Membrane Oxygenation (ECMO), which is nationally commissioned
- Babies born <23+0 weeks gestation, where resuscitation would not normally be carried out as standard practice

5.4 Neonates requiring specialist medical, surgical or cardiac intervention post delivery

- South West neonates requiring surgical intervention will be born in-utero or transferred ex-utero to St Michael's Hospital (University Hospitals Bristol NHS Foundation Trust)
- South West neonates requiring specialist cardiac opinion/ intervention will be born in-utero or transferred ex-utero to St Michael's Hospital (University Hospitals Bristol NHS Foundation Trust)
- South West neonates requiring specialist medical treatment and care, for example renal and endocrine service, will be born in-utero or transferred ex-utero to St Michael's Hospital (University Hospitals Bristol NHS Foundation Trust)

5.5 Neonates remaining on neonatal units post 44 weeks corrected gestation.

The expectation is that any neonate who reaches 44 weeks adjusted gestation while an inpatient on the neonatal unit will be exception reported to the lead commissioner for neonatal services South West Specialised Commissioning Team.

The Specialised Services for Children – Definition No 23 at 23.12 Specialised Neonatal Care Services states:

"Neonatal services provide care for all babies who are generally (but not exclusively) less than 44 weeks post conceptual age (less than 28 days old, adjusted for prematurely)."

- The report (Appendix 4) will explain why the infant needs to remain on the neonatal unit rather than be transferred into a paediatric setting.
- The report will give an estimated time that the infant will continue to stay on the unit.
- The report will advise where the infant is expected to be transferred to when he/she leave the neonatal unit and what discharge plans are in place.
- The report will confirm that the infant is being looked after by appropriately trained staff with paediatric competencies, that equipment (including emergency resuscitation equipment) is of the right size and is immediately available.
- The report will confirm that the infant is receiving all appropriate developmental stimulation appropriate to his/her age.
- The report will advise the lead commissioner of any issues that are blocking the transfer of the infant from the neonatal unit.

6. Duties and Responsibilities

Any neonate born at a NICU, LNU or SCU who meets the individual unit threshold for transfer for uplift in care or reaches 44 weeks corrected gestation, should usually be transferred. Where a Consultant Paediatrician / Neonatologist assesses that clinically it would not be 'best practice' to transfer the named neonate, a **mutual** agreement needs to be made following a Consultant to Consultant discussion.

Where the **mutual** agreement indicates that it is considered safe to continue the care of the neonate in the referring unit and not to transfer, an exception form (Appendix 1) must be completed by the Consultant Paediatrician / Neonatologist on the unit where the baby is being cared for.

A copy of this form must be:

- Filed in the infant's notes
- Emailed to the Network Team

7. Communication Process

Daily communication between referring and receiving Consultants should take place until the individual neonate no longer meets the criteria for transfer. Exception forms (Appendix 1) should be completed if this continues for more than 48 hours.

7.1 Neonatal Units

- NICU capacity within the Network should not be a deciding factor in the non -escalation of babies for higher levels of care
- If a mutually agreed decision cannot be achieved then the baby should be transferred following the usual care pathways
- The Network Team should be informed is there is concern about this decision
- It is requested that the unit delivering continued care for the baby who requires exception reporting complete the data form and return to the Network Team.

7.2 Neonatal Network

- All completed documentation must be filed by the Network Team and made available for audit by the specialist commissioners if required
- All completed documents will be forwarded to the appropriate Clinical Lead for review
- Governance issues raised by the Lead Clinician's report regarding non-compliance, and any further action required, will be reported to Commissioners
- A monthly exception report will be circulated, by the Network Data team, after collating data from BadgerNet, highlighting any patients whom required transfer out and who did not have an exception report completed. Units will be required to give reason for non-compliance with exception reporting. On receipt of this the Network Team will assess the requirement for a more detailed report on the patient.

7.3 Network Clinical Leads

- All completed documents will be reviewed
- Any disputes or non-compliance will be case reviewed by the Lead Clinician with the relevant Consultants. A full report on the case review will be submitted to the Network Executive board and Commissioners

7.4 Neonatal Transport Teams

- In the event of capacity issues preventing an uplift of care, within region and network, it becomes the responsibility of the transport team to facilitate finding a cot of the patient. In most instances, if a Unit is caring for and infant that requires transport for uplift in care, senior nursing and medical staff will be directly engaged in the care of that patient, meaning that they do not have the resources to organise the transfer and find a cot at the same time. If there are problems with capacity of the transport team to find a suitable cot, they should recruit support from their host organisation (UHB and Derriford clinicians respectively) or discuss with the referring unit whether they are able to locate a cot.
- Following normal referral to Neonatal Transport services, if it is discovered there is no network capacity a conference call will be organised between the referring consultant, the consultant for transport and the transport team for the day to discuss the immediate clinical priorities and responsibilities of the teams involved in the care of the infant. If the baby is to be transferred out of region or to another provider, the receiving unit should also be included in the conference call. It is the responsibility of the transport teams to organise and co-ordinate the conference call.
- Please see Appendix 5 for a list of helpful phone numbers to help identify a cot.

8. Transport Contact Details

The Peninsula Neonatal Transport Service (PNTS) is based at Derriford Hospital, Plymouth and mainly covers the Southern part of the region. PNTS performs almost 400 transfers per year and offers 24 hour nursing and medical cover to support emergency transport of sick babies whenever they may need it. As well as road transport capability, PNTS also has a Civil Aviation Authority certified air transport incubator compatible with the region's Air Ambulance helicopters.

All Referrals: 01752 431850

The NEST (New-born Emergency Stabilisation and Transfer) Team is based at the University Hospitals Bristol NHS Foundation Trusts Neonatal Intensive Care Unit at St Michael's Hospital in Southwell Street. The NEST Team responds to emergency calls regarding sick new-born babies and once they have been stabilised, transports them promptly and safely between neonatal units and hospitals across the South West. The dedicated neonatal Ambulance service is provided by Bristol Ambulance EMS.

All Referrals: 01173425050

http://www.nestteam.org/

Appendix 1

Exception Reporting Communication Document

BadgerNet Number:
Infant Name: (initials only for emailed copy to Network)
Date of Birth:
Gestation:
Referring Unit:
Referring Paediatrician/Neonatologist:
Does the Baby need to be transferred?
Reason for Non-Transfer: (Brief Description)
Agreed Actions:
Receiving Paediatrician/Neonatologist:
Printed Name:
Date and Time of discussion:
Send completed form to: swneonatalnetwork@uhbristol.nhs.uk

Appendix 2

Exception Reporting - LNU to NICU

(See full policy for further criteria and definitions)

Does the patient meet any of the following criteria:

- < 27+0 weeks (Multiples below 28+0)
- Birth Weight < 800g
- Neonate > 27 weeks requiring > 48 hours ventilation
- Neonate who requires cooling
- Neonate requiring complex specialist care

→ No → Continue with care as per local policy.

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Yes → Exception to Uplift

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- Consultant for patient within LNU to liaise with NICU Consultant (Please see full policy for locality of uplift of NICU's and contact details)
- Nurse in Charge to ensure bed availability and nursing handover via telephone
- Patient should be transferred to appropriate clinical centre by the regional Neonatal Transfer Team, following referral as per transport team guideline (Details of P.N.T.S or N.E.S.T in full policy)

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Where a Consultant Paediatrician / Neonatologist assesses that clinically it would not be 'best practice' to transfer the named neonate, a **mutual** agreement needs to be made following a Consultant to Consultant discussion.

Where the **mutual** agreement indicates that it is considered safe to continue the care of the neonate in the referring unit and not to transfer, an exception form (Appendix 1) must be completed by the referring Consultant Paediatrician / Neonatologist.

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- A copy of the exception form should be printed and filed in the patient's notes.
- A email copy of the exception form should be sent to the Neonatal Network Team. swneonatalnetwork@uhbristol.nhs.uk

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Daily communication between referring and receiving Consultants should take place until the individual neonate no longer meets the profile for transfer and exception forms (Appendix 1) completed if this continues for more than 48 hours.

A monthly exception report will be circulated, by the Network Data team after collating data from BadgerNet. This will highlight any patients whom required transfer out and for whom did not have an exception report completed. Units will be required to give reason for non-compliance. On receipt of this the Network Team will assess the requirement for a more detailed back dated report on the patient.

- NICU capacity within the Network should not be a deciding factor for non-transfer
- If a mutually agreed decision cannot be achieved then the baby should be transferred following the usual care pathways
- The Network Team should be informed is there is concern about this decision
- It is requested that individual units complete the data form and return to the Network Team for patients whom qualified for exception reports.

Appendix 3

Exception Reporting - SCU to LNU/NICU

(See full policy for further criteria on LNU/NICU uplift and definitions)

Does the patient meet any of the following criteria:

- Care beyond initial stabilisation babies < 30+0 weeks gestation
- Care beyond initial stabilisation to babies < 1000g
- Intensive care for any baby apart from initial stabilisation prior to transfer
- Babies with symptoms of hypotension, DIC, renal failure, metabolic acidosis or babies requiring the following treatment and support: Inotrope infusion, insulin infusion, presence of a chest drain, exchange transfusion, prostaglandin infusion, nitric oxide, high frequency oscillatory ventilation (HFOV) and therapeutic hypothermia.

No → Continue with care as per local policy.

Yes → Exception to Uplift

- Patient should be referred to and transferred to appropriate clinical centre by the regional Neonatal Transfer Team, following referral as per transport team guideline (Details of P.N.T.S or N.E.S.T in full policy)
- Consultant for patient within SCU to liaise with LNU/NICU Consultant (Please see full policy for locality of uplift of NICU's and contact details)
- Nurse in Charge to ensure bed availability and nursing handover via telephone.

Where a Consultant Paediatrician / Neonatologist assesses that clinically it would not be 'best practice' to transfer the named neonate, a **mutual** agreement needs to be made following a Consultant to Consultant discussion.

Where the **mutual** agreement indicates that it is considered safe to continue the care of the neonate in the referring unit and not to transfer, an exception form (Appendix 1) must be completed by the referring Consultant Paediatrician / Neonatologist.

- A copy of the exception form should be printed and filed in the patient's notes.
- A email copy of the exception form should be sent to the Neonatal Network Team swneonatalnetwork@uhbristol.nhs.uk

Daily communication between referring and receiving Consultants should take place until the individual neonate no longer meets the profile for transfer and exception forms (Appendix 1) completed if this continues for more than 48 hours.

A monthly exception report will be circulated, by the Network Data team after collating data from BadgerNet. This will highlight any patients whom required transfer out and for whom did not have an exception report completed. Units will be required to give reason for non-compliance. On receipt of this the Network Team will assess the requirement for a more detailed back dated report on the patient.

- NICU capacity within the Network should not be a deciding factor for non-transfer
- If a mutually agreed decision cannot be achieved then the baby should be transferred following the usual care pathways
- The Network Team should be informed is there is concern about this decision
- It is requested that individual units complete the data form and return to the Network Team for patients whom qualified for exception reports.

Appendix 4

Exception Reporting Communication Document

(Neonates over 44 weeks corrected gestation)

BadgerNet Number:
Infant Name: (initials only for emailed copy to Network)
Date of Birth:
Gestation:
Referring Unit:
Referring Paediatrician/Neonatologist:
Does the Baby need to be transferred?
Reason for Non-Transfer: (Brief Description)
Agreed Actions:
Is the following available: Paediatric Resuscitation Equipment: Y/N Appropriate Developmental Stimulation Y/N Paediatric Competencies Y/N
Receiving Paediatrician/Neonatologist:
Printed Name:
Date and Time of discussion:
Send completed form to: swneonatalnetwork@uhbristol.nhs.uk

Appendix 5

Identifying cots

Patient identified and meets criteria requiring uplift in care

Bed **unavailable** at any appropriate unit within South West Network

Bed **available** within South West Network

Continue exception pathway and transfer as per policy. (Appendix 3 Exception Reporting Network Policy)

Peninsula Neonatal Transport Team (PNTS) responsible for supporting the following units in supporting finding beds: **Plymouth Exeter**, **Truro**, **Torbay** and **Barnstaple**.

New-born Emergency Stabilisation and Transfer Team (NEST) responsible for supporting the following units in supporting finding beds: **St Michaels**, **Southmead**, **Taunton**, **Bath**, **Yeovil**, **Swindon** and **Gloucester**.

There is an expectation that the two teams work collaboratively to ensure that there is no gap in supportive service to any unit within the Network.

Contact appropriate transport team:

PNTS: All Referrals: 01752 431850

NEST: All Referrals: 01173425050

All referrals should be made directly to the Transport teams not to the individual Units.

On liaising with the transport team, there will be a conference call to ensure the whole team is clear on their responsibilities. For example: The transport team might be required to attend the unit and clinically support the referring team in the care of the baby, leaving the base team to locate a suitable out of region cot. This is a fluid arrangement and individual circumstances will change the pathway depending on clinical priority.

Useful Contacts:

Neonatal Unit, Princess Anne Hospital, Southampton - 023 8120 6001

New-born Care Unit, John Radcliffe Hospital, Oxford - 01865 221355

Neonatal Surgical Ward, Women and children's Hospital, Birmingham - 0121 333 9022

Neonatal Intensive Care Unit, Queens Medical Centre, Nottingham - 0115 924 9924

Neonatal Intensive Care, University Hospital Wales, Cardiff - 029 2074 2680