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Scottish  
Perinatal  
Network  
NEONATAL



# National Neonatal Discharge Planning and Follow-up Framework

**Principles of Discharge Planning  
and Neonatal Follow Up  
A Framework**

Version1.0

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## 1 Introduction and Context

The review of neonatal and maternity services across NHS Scotland recognised that many babies requiring special care could be discharged home earlier if appropriate neonatal/community services were in place and highlighted that significant variance existed across NHS Scotland.

As some aspects of neonatal care will be required to be delivered in fewer Neonatal Intensive Care Units (NICUs) whilst ensuring families receive as much care and follow-up as possible as close to home, the review also recognised the importance of a consistent approach to repatriation across neonatal services.

Additionally, the review noted that neonatal care should continue after the baby is discharged home and recommended that a consistent follow up process, supported by clear guidelines should be developed to support families at home. This resulted in specific recommendations relating to discharge planning and neonatal follow-up being included within the review report *The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Services in Scotland* (Scottish Government, 2017).

The National Discharge Planning Group Chaired by Dr Morag Campbell, NHS GG&C, and Ms Alison Wright, NHS Tayside, was convened on behalf of the Perinatal Group of Best Start in April 2018 to consider the actions required to fulfil recommendations 47, 48 and 49 of Best Start and to develop a Framework for Practice reporting back to the Perinatal Group and thereafter to the Implementation Board of Best Start.

The Group included multi-disciplinary representation from each Health Board across NHS Scotland with membership specifically targeted at individuals directly involved in this aspect of neonatal care. Recognising the pivotal role of Health Visitors and the need to align with GIRFEC principles representation from Health Visiting colleagues was also secured and comprehensive feedback obtained via the Health Visitors Leads Network.

Four subgroups were identified to contribute to this framework:

1. Discharge Planning
2. Repatriation
3. Models of Liaison
4. Follow-Up

Two well-attended workshops took place to progress this framework with subsequent stakeholder consultation prior to the compilation of this framework.

This Framework describes the overarching principles to support the delivery of the specific recommendations within Best Start. A number of appendices are included to support implementation, sharing of resources and consistency of practice. It is envisaged that Health Boards and individual units will use this framework to support local service delivery recognising that some variation will occur as a consequence of demographics, and geography.

The National Neonatal Network will support units in the implementation of these principles highlighting progress as well as areas of on-going challenge by interval audit. The National Neonatal Network will also be responsible for hosting the accompanying resources and parental information to support the implementation of this framework.

## 2 Scope

This framework is applicable to all neonatal units and the National Neonatal Transport Service within NHS Scotland. Given the range of possible discharge destinations from neonatal care and acknowledging the key role of Health Visitors the content of this framework is also applicable to Paediatric Services and Health Visitors across Scotland.

## 3 Principles of Effective Discharge Planning

Discharge is not an isolated event; it is a continuous process that begins at or soon after admission. Parents / carers should be partners in this process, and parental and infant readiness for discharge should be evaluated regularly throughout. Adopting this approach aims to ensure a safe and timely transition to home, whilst reducing re-admission rates.

### Core tenets of effective discharge planning

- The "3C's" of discharge planning (adapted from *Discharge Planning Report: Best Practice in Transitions of Care*<sup>1</sup>) are **communication**, **coordination** and **collaboration**.

### Communication

- Units should ensure early, regular and effective communication with:
  - Parents / nominated carers
  - Relevant community teams, e.g. community midwives, health visitors, general practitioners, social care
  - Relevant hospital teams, e.g. surgeons, medical specialists, allied health professionals, specialist nursing teams
  - The family's local base hospital
- A provisional discharge date should be identified as soon as feasible by the clinical team and communicated to parents / carers. Parents should be involved in discharge planning alongside the multi-disciplinary team.
- Note that the estimated date of delivery is no longer felt to be an appropriate discharge date for many preterm infants<sup>2</sup>.

- Units should ensure that parents / carers should have the following at discharge:
  - Discharge information leaflet appropriate to the diagnosis for their baby and ongoing care package.
  - A copy of the medical discharge summary.
  - Relevant emergency contact numbers
  - Times and dates of planned follow up
  - Details on accessing a trained healthcare professional for emotional/psychological support during and post discharge.

### Coordination & Collaboration

- Units should ensure that discharge planning involves the family and all relevant teams with proactive sharing of key information.
- All units should adopt a standardised approach (pathway), based on established good practice (*Appendix 1*), which may be adapted to reflect local service delivery.
- All units should ensure processes are in place to allow early identification of those babies who require a more formalised multi-disciplinary team / discharge planning meeting:
  - Complex medical or surgical needs.
  - Safeguarding or psychosocial concerns.
- All units should have identified discharge planning co-ordinators within neonatal units and collaborative pathways established with local services to prevent avoidable delays in discharge.
- All units should utilise a standardised discharge checklist to ensure that the planning process is completed (*Appendix 2*).
- All units, with support from the National Neonatal Network, should ensure IT infrastructure is in place or developed to facilitate on-going effective information sharing between hospital and community teams.

## 4 Principles of Effective Repatriation

'Repatriation' involves the timely return of a baby/babies to their booking unit or to the closest appropriate unit meeting their current care requirements; this may also be to a paediatric ward or a specialised paediatric service. The principles described are applicable regardless of the repatriation destination. Repatriation is integral to the effective delivery of integrated neonatal care across NHS Scotland. To ensure effective, family focused and consistent repatriation across units:

- Neonatal services across Scotland will work collaboratively to deliver these principles to ensure every baby is cared for in the most appropriate unit for their care requirements, underpinned by the philosophy that units work together in a National Neonatal Network, with regular and consistent communication between clinical teams.
- All service users of neonatal care in Scotland should receive standardised written information at the time of initial admission or antenatally where neonatal care is anticipated. This information explains how neonatal care is delivered in NHS Scotland, the concept of the National Neonatal Network, a description of the different types of units and the anticipation of planned repatriation to local units as soon as care requirements allow. This is available from the Scottish Perinatal Network website: [perinatalnetwork.scot](http://perinatalnetwork.scot).
- Individualised assessments of readiness for repatriation must be specific to each baby, recognising the clinical needs, available expertise and facilities and the unit-specific criteria in the preferred Local Neonatal Unit (LNU)/Special Care Unit (SCU).
- Whenever possible multiple births should be repatriated together to minimise separation of families
- Planning should include referral to the Neonatal Transport Team one working day before anticipated repatriation to facilitate planning and workload prioritisation. "Same day" repatriation requests should be reserved solely for capacity emergencies and should be the exception rather than standard practice. All units will follow the agreed national process for arranging repatriation/elective transfers to optimise efficient use of resources and the ScotSTAR team. (*Appendix 3*)
- Ensuring the availability of a maternal bed or a maternal bed within a Transitional Care area should be included within repatriation planning in appropriate cases.

- Robust handover processes for the transfer of clinical information are pivotal to underpin this model of neonatal care. Direct communication between clinical staff in both units should occur during this time period to:
  - facilitate the exchange of clinical information including all contacts/teams and support mechanisms involved with the family. This may include ongoing input from specialised nursing teams, psychology input or family support for example.
  - identify any outstanding investigations, timescales for these and responsibilities for communicating results and decisions about future management
  - clearly document plans for follow-up in keeping with the agreed National Framework
  - Summarise the knowledge and expectations parent/carers/family.
- Families should be involved in repatriation discussions occurring between units (e.g. offered the opportunity to be involved in a videoconference (VC) consultation or to visit the receiving unit). Once repatriation has been agreed and scheduled, families should be provided with information about the destination unit and a designated contact within the receiving unit. If the destination unit is unfamiliar to the family, they should be offered a prior visit to the unit and an opportunity to meet the clinical team.
- All units will follow consistent infection prevention and control policies including the clinical risk assessment for microbiological screening on admission and transfer between units, <http://www.nipcm.hps.scot.nhs.uk/content-items/clinical-risk-assessment-for-microbiological-screening-on-admission-or-transfer-to-a-neonatal-unit/> (*Appendix 4*)
- There is no requirement for single room isolation following a transfer/repatriation between units unless:
  - There are known CPE risk factors – isolation is necessary whilst awaiting screening results
  - There is a current outbreak in the referring unit – isolation may be required depending on situation specific advice from IPCT from referring unit.
  - Baby or mother is known to be colonised by a multi-resistant organism –isolation may be required depending on patient specific advice from IPCT from referring unit.
- Receiving units and paediatric services where applicable have a responsibility to create downstream capacity to facilitate the repatriation of a baby within 48-hours of the initial request, to protect NICU capacity for the smallest and sickest babies and to ensure that families are moved closer to home as soon as possible

- An inability to accept a repatriation transfer within the agreed timeframe and the reason why (unit capacity, staffing, infection control issues) must be escalated to that unit's senior hospital management and will be recorded in a consistent manner using exception reporting at Network level (*Appendix 5*). Reporting on the frequency and reasons for such exceptions will be a core responsibility of the National Neonatal Network.

## 5 Models of Liaison Services

- Parental preparation
 

Throughout the patient journey, there should be a focus on facilitating parents to be the primary carer for their baby from the earliest opportunity. Parents should be supported through appropriate training to be involved in their baby's care and to carry out day-to-day care, to prepare them to meet their baby's ongoing needs at home.
- Neonatal community liaison services must be provided over seven days, ensuring safe transition of babies to the community setting. Depending on clinical demand and geography, a seven-day service may be delivered using telephone, face-to-face visits, utilising e-Health, or any combination of these approaches.

Units will:

- Ensure criteria exist to define eligibility for visits by the neonatal liaison service. Criteria should include those agreed as minimum criteria for visits:
  - <32 weeks gestation
  - an on-going medical need (e.g. domiciliary oxygen, NG feeds)
  - consideration if discharge weight < 1.8Kg
- Ensure parents are given the opportunity to meet the community team as early as possible.
- Follow a standard community liaison framework; however, this may be individualised to the needs of each baby and family and relevant to local factors such as expertise, resource and geography.
- Ensure that a process is in place for a handover of information to Health Visiting services that aligns with GIRFEC principles and values where there is no identified need for neonatal community liaison services.

- Ensure there is a robust referral pathway for babies who are being transferred to Community Paediatric Liaison Nurses, where this is applicable locally.
- Ensure the seven-day service meets the local geographical need, utilising technology as appropriate for reviews e.g. "Attend Anywhere" or "vCreate".
- Neonatal community liaison follow-up will be provided by a team of nurses utilising a skill mix and expertise appropriate to the scope of the service dependent on activity and geography.

Units will:

- Have a designated lead for neonatal community liaison services who provides leadership, strategic direction and support to the team.
- Ensure that the skill mix within the team is appropriate to the requirements of the local area to deliver a robust seven-day service, appreciating this can be delivered by various modalities e.g. telephone.

Communication

- Units should establish a multidisciplinary team weekly meeting with a designated Consultant to discuss any concerns about babies out in the community, babies attending clinic and discharge planning of babies in unit.
- Each unit will ensure that information is available to inform parents/carers about the liaison service and the roles of staff within this service.
- Each unit will have clear onward referral pathways in place to escalate concerns noted by members of the community liaison team.
- Each unit will use technology and e-health to provide an efficient and effective community liaison support service.
- Units will undertake telephone/ "Attend Anywhere" consultations where practicable.
- Each unit will engage in audit and benchmarking activities to contribute to the National Neonatal Audit Project (NNAP) as a minimum, and to demonstrate that these key principles are achieved.
- Each unit should have an identified lead for community follow up to ensure optimal data completeness and effective liaison between boards.
- Each unit will reflect on outcome data and service user experience to inform service developments locally and across the Network.

## 6 Principles of Delivering Neonatal Follow-Up

Preterm infants and infants who have difficulties at the time of birth require a co-ordinated and structured approach to developmental follow-up.

All units should:

- Introduce the concept of neonatal follow-up early in the patient journey and revisit the conversation throughout the admission.
- Apply a structured follow-up framework; however, this may be individualised to the needs of each baby and family and reflect local service delivery.
- Provide enhanced surveillance and support as per NICE (2017) guidance for all babies <30 weeks gestation and those with additional risk factors *as a minimum*.
- Recognise that babies born at <32 weeks gestation or with a birth weight <1500g are considered at high risk of neurodevelopmental sequelae and a multidisciplinary program of neonatal follow-up is recommended (British Association of Perinatal Medicine, 2010).
- Recognise that babies born at 32+0 to 33+6 weeks gestation remain at elevated risk of neurodevelopmental sequelae and tailored care pathways should be designed to support developmental surveillance in this group.
- Ensure that babies born at 34+0 or above with no additional risk factors will follow the Universal Screening Pathway provided by the Health Visiting service in line with developmental follow-up guidance (NICE, 2017) and the postnatal care guideline (NICE, 2015).
- Ensure the principles and approach of GIRFEC underpins the communication between health professionals and planning of follow-up arrangements for all babies.
- An example of neonatal follow-up triage is provided in *Appendix 6 and 7*.

Neurodevelopmental follow-up will be provided by a multidisciplinary team with expertise in neonatal neurodevelopmental assessment. The multidisciplinary team could include neonatologists, allied health professionals, community liaison staff, general practitioners and paediatricians. The team will support and empower families to act as an advocate for their child.

- Professionals who provide services to neonates require a highly complex set of skills including enhanced assessment, observation, intervention, evaluation and interpretation of findings for the preterm and high-risk infant population in a follow-up setting. This includes advanced

clinical training in the neonatal setting and sound theoretical and evidenced based knowledge underpinning their practice.

- Some professions will have additional supporting documents detailing skills and experience required more specifically (Association of Paediatric Chartered Physiotherapists (APCP), 2011; Royal College of Occupational Therapists (RCOT), 2017; British Dietetic Association (BDA), 2018; Royal College of Speech and Language Therapists (RCSLT).
- Health Visitors, General Practitioners and family nurse practitioners will have access to specific support and resources to enhance understanding of preterm development and common developmental problems encountered by high-risk infants.

Standardised information is available to compliment the discharge process, supporting parents in the transition to home and promoting ongoing development

- All parents whose babies will be returning to a neonatal follow-up clinic will receive the national leaflet 'Ready for Home'. This is available from the Scottish Perinatal Network website: [perinatalnetwork.scot](http://perinatalnetwork.scot).
- The 'Ready for Home' leaflet may be supported by further information about specific follow-up pathways in local areas if required.
- All parents of babies not returning to clinic will be signposted to resources to allow them to support development of their baby. A selection of resources are available to support health care professionals and families. These can be found at the Scottish Perinatal Network website: [perinatalnetwork.scot](http://perinatalnetwork.scot).

Each unit will have clear onward referral pathways where developmental concerns are identified (e.g. ophthalmology, neurology, AHP's, Community Paediatrics).

Each unit will consider how technology and eHealth can be used to support the implementation of effective support and surveillance.

Each unit will engage in audit and benchmarking activities and demonstrate that these key principles are achieved. Each health board will contribute to the National Neonatal Audit Project (NNAP).

Each unit should have an identified lead for follow-up data to ensure optimal data completeness, which may include liaising with other Health Board leads (a list of neonatal outcome data leads to be hosted on National Neonatal Network website).

Each unit will participate in data sharing events to share experiences and learning between units.

All units will reflect on outcome data and service user experience to inform service developments locally and across networks.

## 7 References

1. Discharge Planning Report: best practice in transitions of care 2016. The Queen's Nursing Institute, London.
2. Seaton et al (2018) "Estimating neonatal length of stay for babies born very preterm". *Arch Dis Child Fetal Neonatal Ed* 2018;0:F1-F5.
3. British Association of Perinatal Medicine (BAPM) (2010) *Service Standards for Hospitals providing Neonatal care*. 3<sup>rd</sup> ed.
4. Brady, A. and Smith, P. (2011) *A Competence Framework and Evidenced-Based Practice Guidance for the Physiotherapist working in the Neonatal Intensive Care and Special Care Unit in the United Kingdom*. Association of Paediatric Chartered Physiotherapists, London.
5. British Dietetic Association (2018) *Competencies for Neonatal Dieticians: Neonatal Sub-Group Recommendations*. British Dietetic Association, Birmingham.
6. Gibbs, D. and Thompson, A. (eds) (2017) *Occupational therapy in neonatal services and early intervention: Practice guideline*. Royal College of Occupational Therapists, London.
7. National Institute for Health and Care Excellence (NICE) (2017) *Developmental follow-up of children and young people born preterm*. NICE guideline 72.
8. National Institute for Health and Care Excellence (NICE) (2015) *Postnatal care up to 8 weeks post birth*. NICE [online]. Available from: <https://www.nice.org.uk/guidance/CG37>.
9. *Getting it right for every child* (GIRFEC). Available from: <https://www.gov.scot/policies/girfec/>.
10. Scottish Government (2017) *The Best Start: A five-year forward plan for maternity and neonatal care*.

## 8 Group Membership

Discharge Planning Group		
Judith Simpson (Lead)	Consultant Neonatologist	NHS GGC
Tanya Dunbar (Lead)	Community Liaison Nurse	NHS Tayside
Morag Campbell (Facilitator)	Consultant Neonatologist	NHS GG&C
Alison Blair	Sister Midwife Neonatal	NHS FV
Beth Black	Community Liaison Nurse	NHS Fife
Christine MacIntosh	Senior Charge Nurse	NHS GG&C
Gill Stewart	Community Liaison Nurse	NHS Lothian
Jane Telfer	Senior Charge Nurse	NHS Lanarkshire
Janice Heggie	Senior Charge Midwife Designate	NHS GG&C
Joanne Cattan	Qualified in Speciality Neonatal Nurse	NHS GG&C
Laura Cardwell	Qualified in Speciality Neonatal Nurse	NHS GG&C
Lynda Graham	Physiotherapist	NHS A&A
Marjory Clark	Senior Charge Nurse	NHS GG&C
Julie Cruickshanks	Neonatal Midwife	NHS GG&C
Stephanie Hughes	Community Liaison Nurse	NHS Lothian
Sumaiya Mohamed Cassim	Consultant Neonatologist	NHS Lanarkshire
Kate McLean	Health Visitor	NHS Tayside
Lizzie Beattie	Parent Representative	

Repatriation Group Membership		
Una Macfadyen (Lead)	Consultant Paediatrician	NHS FV
Nicole Bauwens (Lead)	Neonatal Unit Manager	NHS Grampian
Lesley Jackson (Facilitator)	Consultant Neonatal Medicine	NHS GG&C
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Gill Currie	Occupational Therapist	NHS Lanarkshire
Helen Peck	Tamba	TAMBA
Jane Anderson	High Dependency/Special Care Co-ordinator	NHS Lothian
Kathleen Brown	Consultant Neonatologist	NHS Tayside
Kirsty MacInnes	Best Start Project Midwife	NHS FV
Lorraine McGrory	Consultant Neonatologist	NHS Lanarkshire
Lynette Mackenzie	Clinical Nurse Manager	NHS Fife
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Susan Kayes	Health Visitor	NHS Lanarkshire
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Models of Liaison Group Membership		
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Mary Law	Senior Charge Nurse	NHS Highland
Mo Smith	Senior Charge Nurse	NHS D&G
Moira Walls	Community Liaison Nurse	NHS Tayside
Martina Rodie	Consultant Neonatologist	NHS GG&C
Lynn Kuz	Charge Nurse	NHS Fife
Lynne Kerr	Clinical Nurse Manager	NHS Lothian
Jo Tinder	Staff Nurse	NHS Grampian
Diane Macluskey	Community Liaison Nurse	NHS GG&C
Elizabeth Black	Charge Nurse	NHS Fife
Jean Cowie	Principal Educator NHS Education for Scotland	NMAHP

Follow Up Group Membership		
Suzanne Offer (Lead)	Physiotherapist	NHS Highland
Magda Rudnicka (Lead)	Consultant	NHS Lothian
Alison Wright (Facilitator)	Neonatal Unit Manager/ANNP	NHS Tayside
Alison Currie	Physiotherapist	NHS Tayside
Alison Robertson	Clinical Psychologist	NHS GGC
Augusts Anenih	Consultant Neonatologist	NHS Lanarkshire
Christine Thompson	Children's Community Nurse	NHS Lothian
Helen Wildbore	Healthcare Engagement Manager	Bliss
Hilary Cruickshank	Clinical Specialist Neonatal Physiotherapist	NHS Lothian
Lorna MacKenzie	Senior Charge Nurse	NHS GGC
Lorraine Cairns	Neonatal Dietician	NHS GGC
Louise Leven	Consultant Neonatologist	NHS GGC
Lyndsay Mcalorum	Speech and Language Therapist	NHS GGC
Natalie Robertson	Charge Nurse	NHS GGC
Rosemary Abara	Consultant Neonatologist	NHS Lanarkshire
Rosemary Robertson	Health Visitor	Sth Ayrshire HCSP
Tracy Mitchell	Nursery Nurse/Outreach	NHS Grampian
Zoe Whyte	Occupational Therapist	NHS Tayside

## 9 Acknowledgement

With acknowledgement to Dr Claire Smith, Consultant Neonatal Medicine, NHS Lothian, for her assistance in producing the recommendations relating to infection control requirements in the context of repatriation and transfer between units.

## 10 Appendices

Appendix 1: Discharge Planning Pathway

Appendix 2: Example of Discharge Checklist

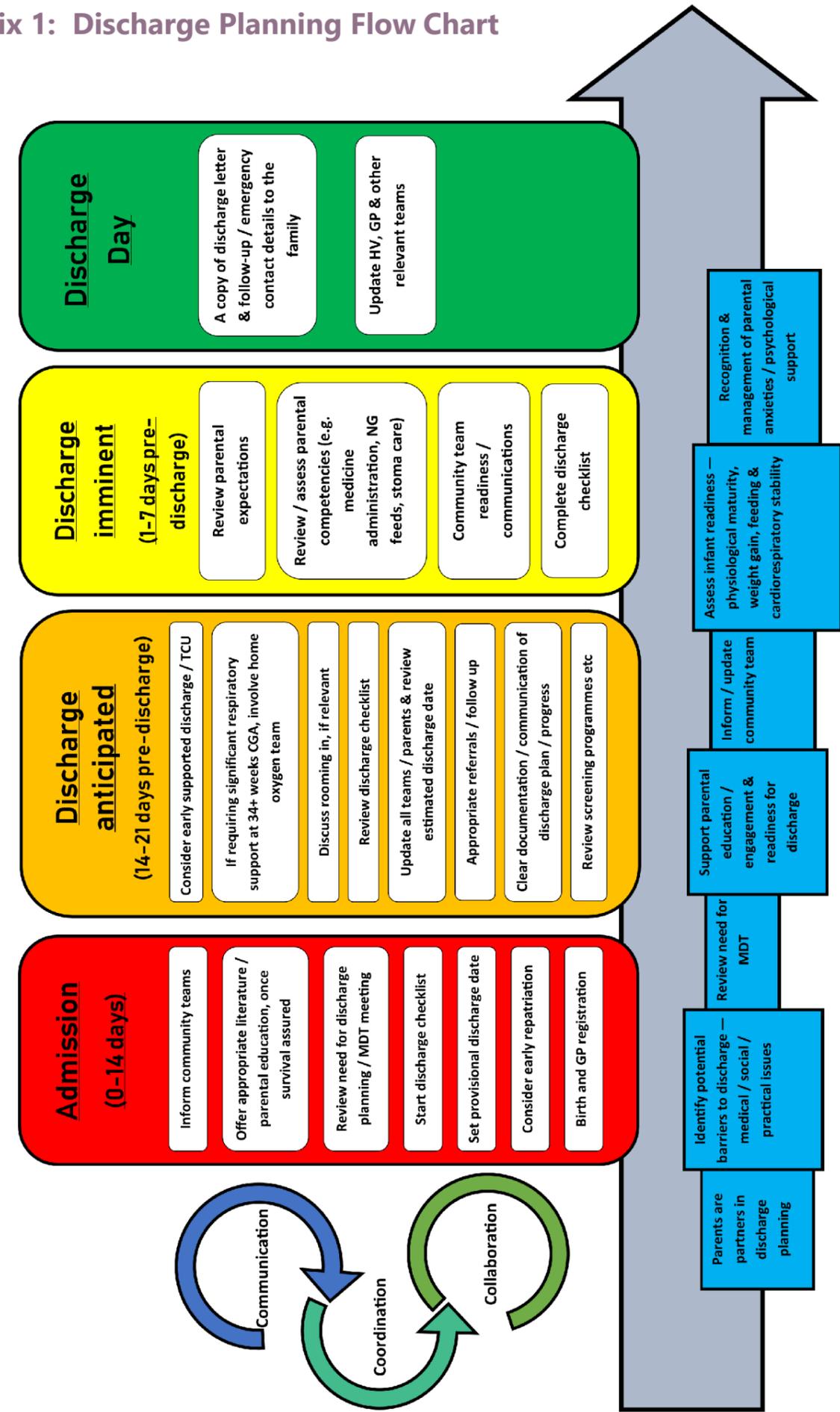
Appendix 3: ScotSTAR Repatriation Transfer Documentation and Booking Process

Appendix 4: Infection Control Recommendations relating to Transfers between Neonatal Units

Appendix 5: Exception Reporting Tool Repatriation Transfers Neonatal Services NHS Scotland

Appendix 6 and 7: Triage Process for Follow Up

# Appendix 1: Discharge Planning Flow Chart



## Appendix 2: Example of Discharge Planning Checklist

<b>Hearing test</b>	® yes	® date	® no
<b>Community team informed</b>	® yes (if yes drop box)		® no
<b>Drop box</b>	<ul style="list-style-type: none"> <li>• Neonatal liaison</li> <li>• Community paediatric team</li> <li>• Cardiac nurse</li> <li>• Other</li> </ul>		
<b>Health visitor informed of discharge</b>	® yes	® date	® no
<b>GP informed of discharge</b>	® yes	® date	® no
<b>Community midwife informed of discharge</b>	® yes	® date	® no
<b>Birth registered</b>	® yes	® date	® no
<b>Address checked</b>	® yes		® no
<b>Car seat</b>	® yes		® no
<b>Car seat challenge</b>	® yes	® date	® no
<b>Breast pump returned</b>	® yes	® date	® no
<b>Check freezer for breast milk</b>	® yes		® no
<b>Basic life support</b>	® yes	® date	® no
<b>Drugs ordered</b>			
<b>Drugs given to parents</b>	® yes	® date	® no
<b>Clinic appointments made</b>	® yes (if yes drop box)		® not required
<b>Drop box</b>	<ul style="list-style-type: none"> <li>• Neonatal clinic</li> <li>• Eye clinic</li> <li>• BPD clinic</li> <li>• Cardiology</li> <li>• Genetic</li> <li>• Orthopaedic</li> <li>• Other</li> </ul>	<ul style="list-style-type: none"> <li>® referral made</li> </ul>	<ul style="list-style-type: none"> <li>® appointment time</li> </ul>
<b>Home oxygen</b>	® yes (if yes drop box)		® not required
<b>Drop box</b>	<ul style="list-style-type: none"> <li>• Oxygen in place</li> <li>• Home oxygen plan completed</li> </ul>	<ul style="list-style-type: none"> <li>® yes</li> <li>® yes</li> </ul>	<ul style="list-style-type: none"> <li>® no</li> <li>® no</li> </ul>

<b>Newborn Bloodspot Screening Test</b>	® yes	® date	® no
<b>Day 28 repeat test required/completed</b>	® yes	® date	® not required
<b>Discharge planning meeting</b>	® yes	® date	® not required
<b>Social work involvement</b>	® yes (if yes drop box)		® no
<b>Drop box</b>	<ul style="list-style-type: none"> <li>• Social worker aware of discharge</li> <li>• Baby on child protection register</li> <li>• Going home with family</li> <li>• Foster family details and address</li> </ul>	<ul style="list-style-type: none"> <li>® yes</li> <li>® yes</li> <li>® yes</li> </ul>	<ul style="list-style-type: none"> <li>® date</li> <li>® date</li> <li>® no</li> </ul>
<b>Immunisations</b>	® yes (if yes drop box)		® no
<b>Drop box</b>	<ul style="list-style-type: none"> <li>• 6-in-1 vaccine (diphtheria, tetanus, pertussis, polio, haemophilias, hepatitis B)</li> <li>• MenB</li> <li>• Pneumococcal vaccine</li> <li>• Rotavirus</li> <li>• RSV (if clinically applicable) and FU doses arranged</li> </ul>		<ul style="list-style-type: none"> <li>® date</li> <li>® date</li> <li>® no</li> </ul>
<b>Newborn baby examination</b>	® yes	® date	
<b>Hip USS required</b>	® yes		® no
<b>If required Hip USS ordered</b>		date ordered	
<b>Discharge summary given to parents</b>	® yes	® date	
<b>Discharge letter copy to</b>	GP	® yes	® date
	HV	® yes	® date
	Community midwife	® yes	® date
<b>Information leaflets given to parents</b>			
<b>Drop box</b>	<ul style="list-style-type: none"> <li>• Cot Death</li> <li>• Bliss 'Taking Your Baby Home'</li> <li>• Home Oxygen</li> <li>• Ready for Home</li> <li>• Other</li> </ul>		<ul style="list-style-type: none"> <li>® date</li> <li>® date</li> <li>® no</li> </ul>
<b>Emergency contact details</b>	® yes	® date	
<b>Point of Contact established for post-discharge questions/queries</b>			

### Appendix 3: ScotSTAR Repatriation Transfer Documentation and Booking Process



#### Pre transport checklist for referral units *Elective Transfers*

Ref Unit	Rec Unit	Date of transfer
Name	CHI	
<b>DAY BEFORE TRANSFER</b>		<i>Tick when completed</i>
Has the referral been made to the receiving unit and the patient accepted		
Transfer letter completed and two copies available. All relevant screening communicated in badger letter		
Other paperwork in an envelope for receiving unit photocopied and available (This might include drug kardex, growth chart, fluid/feeding charts etc)		
Relevant subspecialty team(s) informed (if applicable)		
Relevant liaison services informed (if applicable)		
Parents' details completed on Nursing transfer form or equivalent document ( <i>names, telephone numbers</i> )		
Parents informed of transfer <i>and given information leaflet</i>		
Parents informed that any personal effects are packed ( <i>one small bag please, this includes babies toys etc</i> ). Note: For journeys by aircraft luggage must weigh <10kg total) <b>WE CANNOT TAKE CARSEATS.</b>		
Has the patient had any positive infection screening ( <b>team must be made aware</b> )		
Elective referral form emailed to ScotSTAR		

<b>ON THE DAY OF THE TRANSFER</b>	
EBM collected if appropriate ( <i>we carry a freezer bag</i> ) <b>MAX OF 48HRS SUPPLY</b> ( <i>please note additional supplies of EBM are the responsibility of the parents to transport, as we do not have the ability to provide additional appropriate storage on the journey</i> )	
Identify appropriate individual to provide comprehensive verbal handover to the ScotSTAR team.	
All IV fluids drawn up in 50ml or 60ml syringes (If required)	
Bloodspot / pre transfusion bloodspot card available (if applicable)	
If parents/carer travelling with the team, are they aware of ETA of the team. (The team will be unable to wait around for parent to arrive)	

### ScotSTAR Neonatal Team- Elective Referrals

Elective transfers are an integral function of neonatal networks. They facilitate appropriate use of resources within units and most importantly they ensure delivery of family centered care. By using the following guidance for elective referrals we can maximise the use of transport resources and ensure prompt and timely transfer, including the following:

Repatriation to base hospital, Transfer for appointments out with base hospital (might include imaging) Transfer for admission and elective investigations, Transfer for elective surgery

#### ROUTINE ELECTIVE REFERRAL PROCESS

All referrals for Elective transfer must reach the ScotSTAR Team as soon as possible and before 0600 on the morning of the transfer date, to allow coordination of the national transport workload.

Referrals will be by email to [scotamb.scotstarelective@nhs.net](mailto:scotamb.scotstarelective@nhs.net) using the standardised referral form.

Please note, while every effort will be made to undertake elective referrals as requested, the ability of the service to manage all referrals will be dependent on various factors, including: journey times, the number of referrals received, weather conditions, simultaneous emergencies etc. The teams will endeavour to keep referring units up to date with progress and estimated timescales for transfers; however this is often a dynamic situation that is subject to change at short notice.

#### REFERRALS FOR ELECTIVE TRANSFER RECEIVED THE SAME DAY OR OUT OF HOURS

Referrals for elective transfer received the same day have a significant impact on both emergency and elective workload. We will consider these requests on a case by case basis. Please make every effort to refer in advance as described above.

**PLEASE CONTACT THE LOCAL TEAM BY PHONE FOR ADVICE RATHER THAN EMAILING. IF THE TEAM ARE UNAVAILABLE PLEASE LEAVE A MESSAGE AND THE REFERRAL WILL BE DEALT WITH ON THEIR RETURN TO BASE.**

ELECTIVE REFERRALS MADE AFTER 0600 WILL BE SCHEDULED FOR THE NEXT DAY UNLESS CAPACITY EXISTS ON THE SAME DAY.

OUT OF HOURS REFERRALS FOR AN ELECTIVE TRANSFER DEMAND USE OF EMERGENCY RESOURCES AND ARE AT HIGHEST RISK OF BEING DEFERRED TO THE NEXT WORKING DAY.

#### EMERGENCY REFERRALS - NON CLINICAL

If an infant requires transfer out of hours because of unit capacity issues and the transfer cannot be deferred to the next working day it will be treated as an **emergency transfer** for cot capacity.

EMERGENCY REFERRALS FOR NON CLINICAL REASONS SHOULD BE PHONED VIA THE SCOTSTAR EMERGENCY NUMBER **03333 990 222**

**THE CALL SHOULD BE MADE BY THE CONSULTANT IN THE REFERRING UNIT**

SUCH REFERRALS DEMAND USE OF EMERGENCY RESOURCES AND MAY IMPACT ON EMERGENCY TRANSFERS INDICATED FOR CLINICAL REASONS

Appropriate planning during daytime hours and initiating elective transfers at the earliest opportunity should obviate the need for such transfers.

ScotSTAR Neonatal Elective Referral Form		
Date transfer required: <b>Select Date</b>	Date of referral: <b>Select Date</b>	
Appointment Time (if applicable) <b>Select Hour</b> : <b>Select Minutes</b>		
Referring Hospital: <b>Hospital</b> Other: <b>Enter if location not listed</b> Department: <b>Department</b>	Receiving Hospital: <b>Hospital</b> Other: <b>Enter if location not listed</b> Department: <b>Department</b>	
Name of Referrer: <b>Referrer</b>	Contact Number: <b>Contact Number</b>	
Reason for Transfer: <b>Reason</b>	Other reason for transfer: <b>Enter other reason if not listed</b>	
Patient Details		
Name: <b>Name</b>		
CHI: <b>CHI</b>	Gestation at birth: <b>Weeks</b> Weeks <b>Days</b> Days	Birth Weight: <b>Birth Weight</b>
Sex: <b>Sex</b>	Current gestation: <b>Weeks</b> Weeks <b>Days</b> Days	Current Weight: <b>Current Weight</b>
Brief History: <b>Enter history here</b>		
Current Clinical Condition:		
Respiratory: <b>Respiratory Support</b> FiO <sub>2</sub> : <b>Oxygen</b>  (if applicable) Mode: <b>Enter here</b> Pressures: <b>Enter here</b> Tidal Volume: <b>Enter here</b> Rate/ Flow: <b>Enter here</b>	Total ml/kg/day: <b>Enter here</b> Feeding type: <b>Type</b> Feeding method: <b>Type</b> Feeding frequency: <b>Frequency</b>  IV Access: <b>Yes/No</b> Arterial Access: <b>Yes/No</b> Central/PICC line: <b>Yes/No</b>	IV infusions / drugs: <b>Fluid/Drug 1</b> <b>Fluid/Drug 2</b> <b>Fluid/Drug 3</b> <b>Fluid/Drug 4</b> <b>Fluid/Drug 5</b> <b>Fluid/Drug 6</b> <b>Fluid/Drug 7</b>
Other relevant details: <b>Enter here</b>	Current Phototherapy: <b>Yes/No</b>	Cool bag for EBM: <b>Yes/No</b>
	Social Issues (only those relevant to Transport): <b>Yes/No</b> Parents / Carer travelling: <b>Accompanied</b> Weight of Parent/ Carer (journeys by aircraft only): <b>Enter here</b>	
Receiving unit aware of transfer: <b>Yes/No</b> Date receiving unit aware: <b>Select Date</b>		
Infectious Disease Risk:		
Has mother or baby been colonised with MRSA at any time: <b>MRSA</b>		
Has the mother or baby been an inpatient in a hospital outwith Scotland in the last year: <b>Outwith Scotland</b> If yes, please specify location: <b>Enter location here</b>		
Is the referring unit currently experiencing infectious outbreak/undertaking enhanced infection precautions: <b>Yes/No</b> If yes, please specify reason: <b>Enter reason here</b>		
<i>If yes to any of the above, the receiving unit must be made aware by the referring team and an appropriate plan agreed for how the patient will be managed on arrival</i>		

Please now email this form to [scotamb.scotstarelective@nhs.net](mailto:scotamb.scotstarelective@nhs.net) with the email subject as:  
 ☑Elective transfer request (**Baby's name**): **referring hospital to receiving hospital**"

To be completed by ScotSTAR		
Date Received: <b>Select Date</b>	Team allocated: <b>Team</b>	Time: <b>Select Hour</b> : <b>Select Minutes</b>
Clinical update : <b>Enter here</b>	Bed Confirmed: <b>Yes/No</b>	Time slot allocated for Job: <b>Enter here</b>
	Transfer completed: <b>Yes/No</b> Date: <b>Select Date</b> Time: <b>Select Hour</b> : <b>Select Minutes</b>	
If transfer cancelled: <b>Cancellation</b> Date: <b>Select Date</b> Time: <b>Select Hour</b> : <b>Select Minutes</b> Reason: <b>Enter here</b>		

Clinical Risk Assessment for Microbiological Screening of Neonates on Admission or Transfer

	<p><b>Carbapenemase Producing Enterobacteriaceae (CPE)</b></p> <p>Mother or baby meets CPE risk factors:</p> <ul style="list-style-type: none"> <li>• mother is known to be or has been positive for CPE.</li> <li>• mother has received hospital care outside of Scotland in the past 12 months.</li> <li>• baby has received hospital care outside of Scotland in the past 12 months.</li> </ul> <p><b>CPE screening guidance:</b>  <a href="https://www.hps.scot.nhs.uk/halic/amr/resourcedetail.aspx?id=478">https://www.hps.scot.nhs.uk/halic/amr/resourcedetail.aspx?id=478</a></p>	<p><b>Meticillin resistant Staphylococcus aureus (MRSA)</b></p> <ul style="list-style-type: none"> <li>• mother is known to be or has been positive for MRSA.</li> </ul> <p><b>MRSA screening guidance:</b>  <a href="https://www.hps.scot.nhs.uk/pubs/detail.aspx?id=1639">https://www.hps.scot.nhs.uk/pubs/detail.aspx?id=1639</a></p>	<p><b>All other organisms</b></p> <p>Where:</p> <ul style="list-style-type: none"> <li>• there is a current incident or outbreak in the transferring unit.</li> <li>• baby or mother is known to be colonised or infected with an MDRO (other than CPE or MRSA).</li> <li>• baby is due to undergo cardiac surgery this admission*.</li> </ul> <p>*screening for additional organisms may be advised under local cardiac unit screening policy, take advice from consultant in charge.</p>
<p><b>Sites to be screened on baby</b></p>	<p>Obtain faecal samples (discuss with IPCT)</p> <ul style="list-style-type: none"> <li>• normally a total of 3 samples, each a minimum of 48-hours apart.</li> <li>• Follow IPCT advice</li> </ul>	<p>Take nasal swab (discuss with IPCT)</p>	<p>Follow Infection Prevention and Control Team (IPCT) advice on screening required (including frequency).</p>
<p><b>Infection Prevention &amp; Control Precautions</b></p>	<ul style="list-style-type: none"> <li>• Manage baby in a single room using contact precautions (including disposable gloves and apron) until results available.</li> <li>• If results are positive continue to isolate and follow CPE guidance above.</li> </ul>	<ul style="list-style-type: none"> <li>• There is no need to prioritise baby for a single room while awaiting results, use contact precautions (including disposable gloves and apron).</li> <li>• If positive, consider isolating the baby in a single room using contact precautions (disposable gloves and apron) and follow MRSA guidance above.</li> </ul>	<p>Follow IPCT advice and appropriate guidance relating to incident or outbreak including whether or not baby would need managed in a single room.</p>

Test version 0.2: November 2018

Clinical Risk Assessment for Microbiological Screening of neonates on Admission or Transfer

Child name: .....

CHI number: .....

Admission/Transfer date: .....

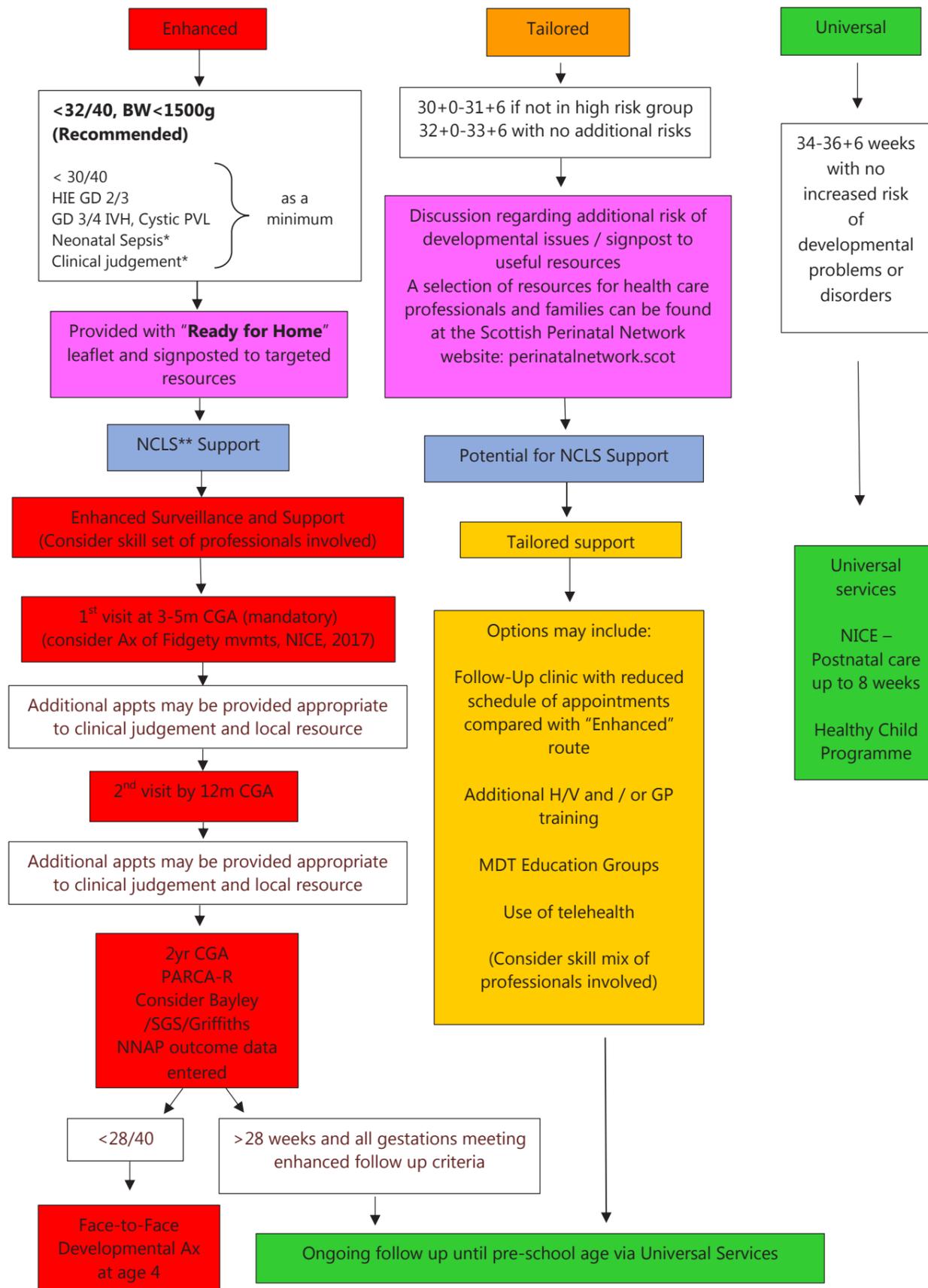
	Yes	No	Results
<b>CPE</b>			
Has baby been screened for CPE?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>MRSA</b>			
Has baby been screened for MRSA?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>All other infectious agents</b>			
Has baby been screened on transfer for another infectious agent?	<input type="checkbox"/>	<input type="checkbox"/>	

## Appendix 5: Draft Exception Reporting Neonatal Repatriation Transfers

Exception Reporting Repatriation Transfers NHS Scotland				
Please complete the shaded boxes				
<b>Repatriation Status</b>				
Category of Repatriation Exception				
<b>Clinical details</b>				
Name				
Date of Birth	dd/mm/yyyy			
CHI Number				
<b>Exception Reporting completed by</b>				
<b>Name:</b>	<b>Role:</b>			
<b>Email:</b>				
<b>Referring Unit</b>				
Please select from drop down list				
<b>Date reported ready for transfer and recorded in BadgerNet by referring unit</b>	Date	dd/mm/yyyy	Time	hh:mm
<b>Reason for delayed / refused repatriation</b>				
Please select from drop down list				
<b>* Other - Please describe in free text box below</b>				
<b>Summary of scenario and discussions</b>				
<b>Destination Unit</b>				
Please select from drop down list				
<b>Names of individuals involved in discussions at destination unit:</b>				

<b>Description of discussions</b>				
<b>Outcome</b>				
Please select from drop down list				
<b>* Transferred to a different unit</b> (please provide unit)				
<b>Date repatriation transfer occurred</b>	Date	dd/mm/yyyy	Time	hh:mm
<b>Copy emailed to National Neonatal Network</b>	Date	dd/mm/yyyy	Time	hh:mm

## Appendix 6 - Example pathway for infants requiring neonatal follow-up



Consider providing enhanced developmental support for children who do not have any of the above risk factors but who are thought, using clinical judgement, to be at risk, taking in to account the presence and severity of risk factors.

At all points in the pathway professional should consider if referral to community paediatric developmental services is required.

\*\* **Neonatal Sepsis** – As per clinical judgement. Neonatal meningitis, chorioamnionitis and neonatal herpes simplex virus should raise clinical suspicion more than raised CRP in isolation.

\*\*\* **NCLS – Neonatal Community Liaison Service**

### 4-year developmental review

See NICE, 2017 for further detailed recommendations about the 4-year developmental review.

### Universal Services

All babies irrespective of gestational age at birth or other risk factors will receive universal services in addition to any enhanced or tailored support or surveillance.

### Skill Mix

Refer to profession specific documents for further guidance regarding appropriate AHP experience, qualifications and training.

### Glossary of Abbreviations

Grade 2/3 HIE: Moderate and Severe Hypoxic Ischaemic Encephalopathy

Grade 3/4 IVH: Grade 3 and 4 (ventricular dilatation and parenchymal extension) intra-ventricular haemorrhage.

Cystic PVL: Cystic Periventricular Leukomalacia, is a type of brain damage that involves the periventricular white matter of the brain. Damage to the white matter results in the death and decay of injured cells, leaving empty areas in the brain — called lateral ventricles, which fill with fluid (a condition called leukomalacia).

CGA Corrected Gestational Age

PARCA-R: The Parent Report of Children's Abilities-Revised (PARCA-R) is a questionnaire for assessing cognitive and language development in very preterm infants.

SGS: Schedule of Growing Skills (SGS) is an invaluable tool for professionals who need to establish the developmental levels of children. The individual assessment can be used at any time with children from birth to 5 years, enabling professionals to assess them as and when appropriate and convenient.

NNAP: The National Neonatal Audit Programme. The NNAP uses routinely collected data to support quality improvement in neonatal units.

## Appendix 7 – Example pathway for infants requiring neonatal follow up

	<b>ENHANCED</b>	<b>TAILORED</b>	<b>UNIVERSAL</b>
<b>Birth through 2 years (corrected age)</b>	<p><b>Consider for children born &lt;30weeks or 30-36+6 weeks with risk factors*</b></p> <p>Support at home should be provided by a neonatal liaison nurse or nurse with expertise in neonatal development with input from a neonatologist or paediatrician with relevant neonatal expertise.</p> <p>Consider providing support via: home visits, telephone helpline, text messaging service, leaflets or electronic communication.</p> <p>At discharge families should have a single point of contact within the neonatal service.</p> <p><u>Surveillance Face to Face Assessments</u></p> <p>Performed by the multidisciplinary team <b>A</b>  <b>minimum of 2 in the first 12 months.</b>            1<sup>st</sup> visit between 3 and 5 months CGA            2<sup>nd</sup> visit by 12 months CGA.</p>	<p><b>Consider for children born 30+0-33+6 weeks</b></p> <p>Support tailored to the needs of the child and family should be delivered by a group of appropriately experienced professionals. This may include: neonatal liaison nurse or nurse with expertise in neonatal development, a neonatologist or paediatrician with relevant neonatal expertise, AHP, GP, or paediatric services.</p> <p>Consider providing support via: home visits, telephone helpline, text messaging service, leaflets or electronic communication.</p> <p>Robust links between Health Visitors and the neonatal team are essential.</p> <p>At discharge families should have a single point of contact within the neonatal service.</p> <p><u>Surveillance Face to Face Assessments</u></p> <p>Performed by appropriately trained professional (as above) at intervals and in a setting appropriate to the needs of the child.</p>	<p><b>All Children</b></p> <p>Surveillance from the Child Health Programme</p> <p><u>Universal Health Visiting Pathway in Scotland – Pre-Birth to Pre-School</u></p> <p><u>The Scottish Child Health Programme: Guidance on the 27-30 month child health review</u></p>

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	<p>Each assessment should include a discussion with parents about any concerns they have about their child's development; an assessment of the child's development including vision and hearing; a health assessment and measurement of weight, length and OFC.</p> <p>If developmental problems are found this should be discussed with the parents or carers and the child referred on to the appropriate local pathway. Results of each assessment should be communicated to the general practitioner, health visitor and any other professional involved in the child's care.</p>	<p>Continuous assessment of follow up needs is essential with additional input accessed as required.</p> <p>When discharged from hospital follow up, clinicians should provide families with information on 'red flags' in all main areas of development and encourage parents to seek advice if concerns.</p>	
<b>Age 2 (corrected age)</b>	<p><u>Face to face developmental assessment at 2 years CGA</u></p> <p>Provided by MDT to include as a minimum</p> <ul style="list-style-type: none"> <li>- Health and developmental assessment</li> <li>- Parent Report of Children's Abilities-Revised (PARCA-R) questionnaire (completed between 22 and 26 months CGA)</li> <li>- Ensure checks of vision and hearing have been carried out in line with national recommendations</li> </ul>		

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	<p>A standardised developmental assessment (e.g Bayley, SGS, Griffiths) can be performed in addition to the above as per local policy.</p> <p>Record the outcome of the 2 year assessment for national audit.</p> <p>Communicate results with general practitioner, health visitor, neonatologist at hospital of discharge and any other professional involved in the child's care. Robust links between the Neonatal team and Health Visitors are essential.</p>	
<b>Age 2 to 4 years (Chronological Age)</b>	Surveillance from the Child Health Programme (links as above)	
<b>Age 4 years</b>	<b>Children born &lt; 28 weeks gestation</b>	
	<p><u>Face to Face Developmental assessment at 4 years</u></p> <p>Provided by an educational or clinical psychologist or a paediatrician with expertise in neurodevelopmental assessment. Assessment should include;</p> <p>Parent questionnaire</p> <p>-Strengths and Difficulties Questionnaire (SDQ) or the Ages and Stages 48 month Questionnaire</p> <p>Standardised IQ test</p> <p>-Wechsler Preschool and Primary Scales of Intelligence 4<sup>th</sup> Edition (WPPSI) should be used (if the WPPSI is not suitable eg because of sensory or motor impairment use a suitable alternative)</p> <p>If cerebral palsy has been diagnosed, complete a GMFCS score.</p>	

	<p>A summary of the assessment, detailing the child's strengths, difficulties and any developmental problems identified should be discussed with the family. A management plan should be developed with the family. This information should be shared (with parental consent) with educational services, the neonatologist and any other professional involved in the child's care.</p>	
	<p><i>* Risk factors include: a brain lesion on neuroimaging likely to be associated with developmental problems or disorders (for example, grade 3 or 4 intraventricular haemorrhage or cystic periventricular leukomalacia), grade 2 or 3 hypoxic ischaemic encephalopathy, neonatal bacterial meningitis, herpes simplex encephalitis, severe hypoglycaemia. Consider providing enhanced developmental support for children who do not have any of the above risk factors but who are thought, using clinical judgement, to be at risk, taking into account the presence and severity of risk factors.</i></p>	





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🌐 [perinatalnetwork.scot](http://perinatalnetwork.scot)

