

# **NHSE South East**

## **Regional Neonatal Critical Care Capacity and Surge Management Process**

**APPROVED**

**This document replaces any other NCC surge  
documents that currently exist**

## Contents

Scope and Aims of Document .....	3
Principles of Surge .....	3
Geography and Context .....	4
Operational Pressure Escalation Level Framework .....	6
Appendix 1 .....	14
Specific TV&W Information .....	14
Specific Kent, Surrey, and Sussex Information .....	15
Contact Numbers for Transport teams .....	16
References .....	16

## Scope and Aims of Document

This document describes the approach that both Neonatal Critical Care ODNs within the South East will take for managing Neonatal Intensive Care (NIC) capacity during a period of surge. The document also makes available information about individual Neonatal Intensive Care Providers and Service Specifications. This will provide context and assist commissioners when making decisions regarding the management of the surge process.

The neonatal surge plan has six key aims:

- To provide ongoing effective and high quality neonatal critical care to all infants in the face of expected staffing shortages and service infrastructure changes.
- Mitigate against significant risk of closure of smaller units due to staff shortages
- To support neonatal critical care capacity through timely repatriation of infants to the LNU's and SCU's and facilitation of early discharge with outreach support where this is available.
- To secure capacity to support neonatal cardiac and surgical care for infants from neighbouring regions if the national picture requires temporary reconfiguration of specialist services.
- To mitigate the negative impact of service change on families whose children are on NICU, including maintenance of shared decision-making pathways and supporting the biological relationship.
- To support Paediatric Critical Care regional escalation plans.

## Principles of Surge

- Neonatal critical care services are essential for the preservation of life by reducing the mortality and morbidity of sick and premature infants and enabling high levels of long-term survival and good outcomes when managed effectively.
- Planning for or responding to any surge should not prevent/ or impede the effective provision of critical care to those infants who require it. The service should remain equitable when demand outstrips resource.
- The ODN team, with reference to regional guidance, will update staged plans when required.
- These plans will be signed off and agreed by the NHS England Specialised Commissioning – South East Commissioning, Recovery and Transformation Committee (CRTC), which may involve changes to normal standards and pathways, and will include measures to mitigate the risk of these changes.
- The ethical framework for critical care decision making in paediatric and neonatal services has been set out by RCPCH in conjunction with NHSE and should be a key point of reference. The focus of the ethical framework provides guidance for a situation where there is extremely high demand and limited critical care capacity.
- Neonatal critical care services are essential specialised services for NHS England. Planning for or responding to capacity issues should not prevent/ or impede the effective provision of critical care to those infants who require it.
- Based on all available data, the number of infants expected to require critical care because of a winter surge is low but, in a pandemic, there may be an increase in unwell mothers that may result in babies having to be born earlier. There may also be a

substantial impact on neonatal critical care services, medical and nursing staffing, transport services, community services and family wellbeing.

- Neonatal critical care facilities are not suitable for providing adult critical care but may be suitable for providing paediatric care for a subset of young children if required to meet regional critical care demand.
- Appropriate neonatal surge planning has the potential to mitigate the impact on paediatric critical care and regional subspecialist care of challenges arising from plans in adult services in the region.
- In some provider services a Paediatric winter surge will have an indirect impact on neonatal critical care services particularly those services that share staff across paediatrics. Trusts and Providers have been asked to plan for possible changes to paediatric infrastructure to support increased activity including both medical and nursing staff re deployment within their organisations.
- Both ODNs have asked all units to consider how they can isolate and manage babies, the NICUs are planning what additional Intensive Care cots could be supported if required.

## Geography and Context

The Thames Valley & Wessex (TV&W) Neonatal ODN and the Kent, Surrey, and Sussex (KSS) Neonatal ODN consists of 26 Neonatal Units (NNUs) offering different levels of care:

### Neonatal Intensive Care Units NICU

- Oxford: The John Radcliffe Hospital (Oxford University Hospitals) provides regional tertiary medical and surgical neonatal intensive care and is co-located with the regional PICU (Paediatric Intensive Care Unit)
- Portsmouth: QAH provides tertiary medical neonatal intensive care
- Southampton: PAH UHS provides regional tertiary medical, cardiac, and surgical neonatal intensive care and is co-located with the regional PICU
- Brighton: Royal Sussex County Hospital provides regional surgical intensive care services, tertiary medical intensive care, located alongside the Royal Alexander Children's Hospital which provides paediatric HDU and full paediatric medical & surgical services for Sussex.
- Surrey: Ashford & St Peter's Hospital provide tertiary intensive care for medical patients in Surrey
- Kent: Medway Maritime Hospital provide tertiary intensive care for medical patients in Kent
- Kent: William Harvey Hospital provide tertiary intensive care for medical patients in East Kent

## **Local Neonatal Units LNUS**

Neonatal units (LNUs) provide some short-term intensive care for up to 48 hours with variable number of cots and capacity. LNU's would not ordinarily be commissioned to provide intensive care beyond initial stabilisation to babies less than 27+0 gestation and a birth weight below 800g. Complex intensive care 2-6 ITU beds in each:

- Tunbridge Wells Hospital in Kent
- East Surrey Hospital in Surrey
- Frimley Park Hospital in Surrey
- Stoke Mandeville Hospital in Bucks
- Wexham Park Hospital in Berkshire
- Milton Keynes Hospital in Bucks
- Royal Berkshire Hospital in Berkshire
- Hampshire Hospitals (Winchester and Basingstoke) in Hampshire
- University Hospital Dorset in Dorset
- Salisbury Hospital in Wiltshire
- St Richards Hospital in Sussex (in the process of redesignation to a SCU)

## **Special Care Units SCU**

Special care units (SCUs) do not provide intensive care beyond short-term stabilisation prior to transfer. The SCU's follow approved ODN pathways and are commissioned to care for all babies where births are anticipated after 31+6 weeks gestational age and the birth weight is above 1,000g:

- Conquest Hospital in Sussex
- Princess Royal Hospital in Sussex
- Worthing Hospital in Sussex
- Queen Elizabeth Queen Mother Hospital in Kent
- Darent Valley Hospital in Kent
- Royal Surrey Hospital in Surrey
- Dorchester County Hospital in Dorset
- St Marys Hospital on the Isle of Wight

Please see appendix 1 for maps of both parts of the region and specific transfer criteria for hospitals.

## Neonatal ODNs

The 2 Neonatal ODNs will coordinate plans to deliver neonatal critical care to all patients within the South East region to deal with the impact of a surge in activity either due to Winter pressures, unusual activity pressures or a pandemic.

The ODN monitors and reviews neonatal cot capacity, occupancy and staffing across the region, reviewing the impact of a surge on neonatal services. Weekly network meetings with all provider units within Neonatal ODN and bi-weekly management team meetings.

Staged plans have been developed by the ODN team, with reference to national guidance from the neonatal CRG and in consultation with network partner units. Changes in normal standards and pathways will include measures to mitigate risk.

## Operational Pressure Escalation Level Framework

The Operational Pressure Escalation Level framework is a risk assessment tool used to determine the level of pressure in the system to enable actions to be triggered and service assessed. Likely pressures include:

- Reduced medical or nursing staffing levels due to sickness or self-isolation
- Reduced staffing levels whilst staff are re-deployed to other areas in the hospital.
- Reduced cot capacity due to managing isolation areas
- Reduced availability of transfer services due to sickness or re-deployment

**The tables below describe the OPEL framework for the South East Neonatal ODNs with associated actions.** Infection Control will be managed at a trust level depending on local guidance.

OPEL level	Description	Decision level
OPEL 1 Available capacity	Cots at all levels currently available. Units within each Neonatal ODN are operating safely.	Individual trust and unit level Transport teams
OPEL 2 Reduced Capacity	Cots remain available and most babies are situated in the correct level	Individual Trust and Unit Level Transport teams
OPEL 3 Limited capacity	All NICU's on Amber for staffing > 48 hours and or all units have reached 90% Occupancy in each Network <b>OR</b> Two thirds of LNU and SCU's on Amber or above for staffing > 48 hours or more for each Network	ODN Level Managed by both ODN leads; reporting OPEL status with proposed actions to Regional leads
OPEL 4 Severely limited capacity.	All NICU's on Red staffing <b>OR</b> at 100% ITU / HDU normal occupancy in each Network for > 48 hours	Specialised Commissioning in collaboration with ROC

RAG RATING	OPEL	Triggers	ACTIONS	
			In Hours	Out of Hours
Green	OPEL 1 Available capacity	<p>Within the network</p> <ul style="list-style-type: none"> <li>NICU capacity and or skill mix is becoming limited</li> <li>LNU capacity across the network is becoming limited</li> <li>Transport capacity is becoming limited</li> </ul> <p>Services able to receive patients and maintain optimal care.</p>	<p><b><u>TRUST ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>All units to provide cot availability and staffing RAG twice daily for ODN dashboard</li> <li>Maximise repatriation and transfers – informing ODN of any issues</li> </ol> <p><b><u>Transport ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>Twice daily calls with all units (Business as usual)</li> </ol> <p><b><u>ODN ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>ODN Team to inform NHSE Regional team of situation and keep updated weekly</li> <li>ODN team to monitor Dashboards twice per day</li> <li>Weekly dashboard to NHSE/I and SE Regional Chief Midwife and Lead neonatologist</li> </ol>	<p><b><u>TRUST ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>Dashboard 12-hourly</li> </ol> <p><b><u>Transport ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>Twice daily calls with Units to update transport teams</li> </ol>

RAG RATING	OPEL	Triggers	ACTIONS	
			In Hours	Out of Hours
Amber	<b>OPEL 2</b> <b>All units able to meet most capacity requirements with some potential impact on maternity services</b>	<p>Within the network either:</p> <ul style="list-style-type: none"> <li>NICU capacity and or skill mix is regularly on Amber</li> <li>LNU capacity across the network is becoming limited</li> <li>Transport service experiencing minor delays (&lt;6hrs) short periods with no team available for uplift for capacity reasons</li> <li><b>No changes to network gestational thresholds pathways</b></li> </ul>	<p><b><u>TRUST ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>All units to provide cot availability and staffing RAG rated twice daily for ODN dashboard inc. daily collection of covid status</li> <li>Relaxation of BAPM standards of <b>HDU</b> ratio of 1:3</li> <li>Inform ODN Team of situation (Lead Nurse NCC NetworkManager Neonatal ODN's)</li> <li>The bilious vomiting pathway requires senior local clinical review and assessment. If a malrotation in a well-baby needs to be excluded as a potential diagnosis, local contrast study should be undertaken if possible.</li> <li>Repatriation from <b>NICU</b> to <b>LNU /SCU</b> prioritised to ensure NICU cots are available to maintain patient flow throughout the Network and to minimise separation of baby and parents. This may mean that routine investigation e.g., MRI after cooling, will need be done at local unit if possible.</li> <li>Babies &gt;27 weeks gestation in <b>LNUs</b> requiring intensive care for more than 48 hours should prompt senior consultation to consider whether extending this period through the exception reporting mechanism may be safer than transfer.</li> <li>If mothers are still rooming in, encourage them to fully care for their baby, and facilitate early discharge home as soon as it is safe to do so.</li> <li>Maximise use of video linking (e.g., V-create) so that all families have remote access to their baby</li> </ol> <p><b><u>Transport ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>Twice daily calls with all units</li> <li>Consider prioritisation of SE Region mutual based on clinical need of</li> </ol>	<p><b><u>TRUST ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>All units to provide cot availability and staffing RAG twice daily for ODN dashboard</li> <li>Trigger Trust Escalation procedures including consideration of cancellation of elective surgery which require PIC capacity and ability to open surge beds</li> <li>Email ODN Team to inform of escalation and actions taken on England</li> </ol> <p><b><u>Transport ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>Twice daily calls with all units</li> </ol>

			<p>TV&amp;W and KSS babies</p> <ol style="list-style-type: none"> <li>3. SOP in use for transfer of COVID + babies</li> <li>4. Repatriation of babies to hospitals closer to home should be a priority</li> <li>5. Anticipate reduction in transport service due to reduced staffing levels, will aim to keep a service going with a minimum of one team across Thames Valley &amp; Wessex</li> <li>6. Transport services no longer offering parents transport except in extreme circumstances (E.g. palliative and end of life care)</li> </ol> <p><b><u>ODN ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>1. ODN team to inform NHSE/I Regional Team (TDM for W&amp;C and Regional midwife) &amp; LMNS and keep updated daily</li> <li>2. Liaise with neighboring ODNs in London and the South West</li> <li>3. Close coordination with transport teams and unit leads to plan for rapid redistribution of activity if individual units are overwhelmed by either admissions or critical loss of staffing.</li> </ol>	
--	--	--	--	--

RAG RATING	OPEL	Triggers	ACTIONS	
			In Hours	Out of Hours
<b>RED</b>	<b>OPEL 3 Treatment available but in limited supply. Capacity may soon be exceeded if demand increases further. Decisions about treatment will be influenced by the need to prioritise.</b>	<p><b>Actions at OPEL 2 failed to deliver the required capacity</b></p> <ul style="list-style-type: none"> <li>All NICU's on Amber for staffing &gt; 48 hours and <b>OR</b> all units have reached 90% Occupancy in each Network</li> <li>Two thirds of LNU and SCU's on Amber or above for staffing &gt; 48 hours or more for each Network</li> <li><b>OPEL 3 can only be declared by the ODN in consultation with the regional team</b></li> </ul>	<p><b>TRUST ACTIONS</b></p> <p>All service delivery actions at OPEL 2 must be implemented.</p> <ul style="list-style-type: none"> <li>Relaxation of BAPM nursing standards <b>Intensive Care 1:2, High Dependency 1:3 and Special Care 1:6</b></li> <li>Relaxation of minimum medical staffing numbers ensuring safety is maintained</li> <li>Limit the need for Transport by liaising with maternity and requesting Inter-uterine Transfers where possible.</li> <li>Adjust Network pathways and review gestational pathways for <b>LNU and SCU</b></li> <li>Units should be escalating to OPEL 3 surge plans</li> <li>Risk assess availability of 24h on call experienced staff for airway management</li> <li>On a <b>case-by-case basis</b> SCU's may continue to provide non-invasive respiratory support following discussion with a level 3 NICU</li> </ul> <p>Any LNU or SCU experiencing issues should contact the ODN and NICU then inform the following personnel within 12 hours to discuss the possibility of deciding to close to admissions</p> <ul style="list-style-type: none"> <li>Internal trust systems e.g COO and ED</li> <li>Neonatal transport service teams</li> </ul>	<p><b>TRUST ACTIONS</b></p> <ol style="list-style-type: none"> <li>Complete DoS Dashboard 12-hourly</li> <li>Relevant participation in supra-regional OOH NHSE/I</li> <li>Trigger Trust Escalation procedures ensuring cancellation of elective surgery.</li> <li>Email ODN Team to inform escalation and actions via email via: <a href="mailto:england.tv-w-neonatalnetwork@nhs.net">england.tv-w-neonatalnetwork@nhs.net</a> or <a href="mailto:medwayft.kssneonatalodn@nhs.net">medwayft.kssneonatalodn@nhs.net</a></li> </ol> <p><b>Transport ACTIONS</b></p> <ol style="list-style-type: none"> <li>Twice daily calls with units</li> <li>Monitor transport dashboards and ODN dashboard and inform ODN lead nurse/ manager of any</li> </ol>

		<p><b>This can only be agreed when the Trust Maternity &amp; Obstetric lead have been informed and agreed how to manage the Labour Ward. Escalation to LMNS via Maternity HoM.</b></p> <ul style="list-style-type: none"> <li>Fully participate with any Network conference calls, ensuring appropriate personnel participate.</li> </ul> <p>On call consultant and nurse in charge are to:</p> <ul style="list-style-type: none"> <li>Manage site care capacity in line with Trust Escalation plan and with agreed outcomes from Network discussions.</li> <li>Collect &amp; report data for the SE sit rep Dashboard as per ODN arrangement</li> </ul> <p><b><u>ODN ACTIONS</u></b></p> <ul style="list-style-type: none"> <li>Liaise with seconded ODN clinical staff to link in with base trusts about the possibility of redeployment from ODN role to trust clinical role</li> <li>A conference call will be arranged by a member of the management team – list of attendees to include Network Team, Trust clinical representation, Trust operations manager Transport Teams, Senior TDM for W&amp;C, Maternity regional Lead, ICS ICC lead and LMNS representative.</li> </ul> <p>Outcomes of call to include: Proposed provider solution and timescale for this and any potential impact on network.</p> <p>Ensure comprehensive communications to all trusts within the SE about current situation.</p> <p><b><u>NHSE/I Action</u></b></p> <ul style="list-style-type: none"> <li>Inform regional team of situation and keep updated twice a day</li> <li>Ensure ICC kept up to date</li> </ul>	<p>potential hotspot areas by 0900</p> <ol style="list-style-type: none"> <li>Transport team to contact <b><u>NHSE/I</u></b> On-call Manager to inform of situation</li> </ol> <p><b><u>NHSE/I ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>On-call Manager informs on-call Director</li> <li>On-call Director convenes &amp; chairs regional call to co-ordinate response</li> </ol>
--	--	---	---

RAG RATING	OPEL	Triggers	ACTIONS	
			In Hours	Out of Hours
<b>BLACK</b>	<b>OPEL 4</b> All NICUs on Red staffing and or at 100% ITU/HDU normal occupancy in each SE network for 48 hours Prioritisation is essential.	<ul style="list-style-type: none"> <li>All Networks nationally or regionally are at OPEL 3</li> <li>No national Capacity</li> <li>All resources overwhelmed</li> <li><b>OPEL 4 can only be declared by the regional team in collaboration with the national team</b></li> </ul>	<p><b><u>TRUST ACTIONS</u></b> Managing their service in line with their site-specific escalation plans and business continuity plans during times of increasing pressure on neonatal capacity, no matter what its cause.</p> <ul style="list-style-type: none"> <li>Recall any staff redeployed to other units</li> <li>Look at potential resource from AHPs within each trust</li> <li>Cancellation of all leave</li> <li>Call all available staff to ensure the unit can remain open and babies be managed appropriately.</li> <li>LNUs and SCUs should consider whether <b>URGENT</b> transfer is required to a NICU that can manage additional activity</li> <li>Refer to surge plan recommended staff ratios then reduce nurse staff to baby ratios and utilise available additional unit staff to minimise risk including staff from other units within Network</li> <li><b>IC</b> babies 1:4 with assistance supernumary nurse in charge</li> <li><b>HD</b> babies 1:6 with assistance of suprenumarary nurse in charge</li> <li><b>SC</b> babies 1:10 with 1 x non registered nurse, additional support likely to be required depends on whether parents present. In context of unit geographical layout to maintain 24h oversight</li> <li>Liasing with maternity and requesting IUT where possible as NTS no longer available.</li> <li>Liasing with maternity and requesting IUT when maternity capacity in LNU's or SCU's can no longer support a full obstetric sevice</li> <li>LNUs &amp; SCUs use Video Tele conferencing discussion with NICU consultants to agree best location of care</li> </ul>	<p><b><u>TRUST ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>Complete DoS Dashboard 12-hourly</li> <li>Relevant participation in supra-regional OOH NHSE/I</li> <li>Trigger Trust Escalation procedures ensuring cancellation of elective surgery.</li> <li>Email ODN Team to inform escalation and actions via email via: <a href="mailto:england.tv-w-neonatalnetwork@nhs.net">england.tv-w-neonatalnetwork@nhs.net</a> or <a href="mailto:medwayft.kssneonatalodn@nhs.net">medwayft.kssneonatalodn@nhs.net</a></li> </ol> <p><b><u>Transport ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>Clarify regional bed capacity and inform neighboring retrieval teams/L3 units</li> <li>Monitor ODN dashboard and inform</li> </ol>

	<ul style="list-style-type: none"> <li>• LNU's and SCU's may be required to take babies outside normal network pathways</li> <li>• Inform ODN Team.</li> <li>• <b>Units should not close or refuse admissions unless discussed and agreed with network and regional team</b></li> </ul> <p><b><u>Transport ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>1. Twice daily calls with all units</li> </ol> <p><b><u>ODN ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>1. Escalate to NHSE/I</li> <li>2. Complete all tasks from OPEL 3</li> <li>3. Participate in national calls when required</li> <li>4. Monitor and respond to trends on ODN dashboard</li> <li>5. Ensure Dashboard shared twice daily with NHSE</li> <li>6. Link in with regional Paediatric ODNs</li> </ol> <p><b><u>REGIONAL NHSE/I ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>1. Women and Children's Lead informs NHSE/I Regional Medical Director for commissioning of OPEL 4</li> <li>2. Women and Children's Lead alongside Regional Medical Director for commissioning convenes regional call with Trusts, Transport, Regional Chief Midwife and Regional Neonatologist SE ODNs in region to co-ordinate response</li> <li>3. NHSE/I ensure Regional Communications Team is informed of situation</li> <li>4. NHSE/I regional leads inform SE ICC hub of status</li> <li>5. Post-escalation: Post incident learning shared and signed off</li> </ol>	<p>ODN Lead nurse/Manager of any potential hotspot areas by 0900</p> <ol style="list-style-type: none"> <li>3. Update NHSE/I on-call Manager and take part in any national calls that may be requested</li> </ol> <p><b><u>REGIONAL NHSE/I ACTIONS</u></b></p> <ol style="list-style-type: none"> <li>1. On-call Manager informs on-call Director</li> <li>2. On-call Director convenes &amp; chairs supra-regional call to co-ordinate response</li> <li>3. Informs neighboring regions Urgent &amp; Emergency Care Team (UEC) of escalated OPEL status</li> <li>4. Alerts national team of supra- regional status, next steps and outcomes</li> </ol>
--	---	---

## Appendix 1

### Specific TV&W Information



The below data contains average annual transfer over the last 3 year for TV & W and will be used to guide potential to flex thresholds for LNUs for in utero transfer pathways and care provision for ex utero, for some smaller units this may entail in utero transfer of all babies below 32 weeks.

All TV&W LNUS Births 2017-2019	total births in LNUS	transferred	Died	% transferred or died	Births in LNUS <1000g	Transferred <1000g	Died <1000g	% transferred or died <1000g
27 (exc <28w mult)	36	18		50%	14	5		36%
28	86	28	3	36%	18	11		61%
29	132	23	1	18%	9	4		44%
30	176	21	1	13%	7	4		57%
31	285	34	1	12%	5	2		40%
<b>Total</b>	<b>715</b>	<b>124</b>	<b>6</b>	<b>18%</b>	<b>53</b>	<b>26</b>	<b>0</b>	<b>49%</b>

**Table showing Unit Designation**

Stoke Mandeville Hospital	LNU
Wexham Park Hospital	LNU
Milton Keynes	LNU
John Radcliffe Hospital, Oxford	NICU
Reading	LNU
Dorchester	SCU
Basingstoke	LNU
Winchester	LNU
St Mary's Hospital	SCU
Poole	LNU
Queen Alexandra Hospital	NICU
Salisbury	LNU
Princess Anne Hospital	NICU
St Richard's Hospital, Chichester	LNU

Specific Kent, Surrey, and Sussex Information



**Table showing Unit Designation and Criteria for Transfer**

Medway Hospital	NICU	All babies requiring medical intensive care
Royal Sussex Hospital	NICU	All babies requiring medical and surgical intensive care
Ashford and St Peter's Hospital	NICU	All babies requiring medical intensive care
William Harvey Hospital	NICU	All babies requiring medical intensive care
Frimley Park Hospital	LNU	<27wks / <800grams / <28wks gestation twins / <30wks gestation multiples of 3+ / neonates >27wks who require >48hrs ventilation

East Surrey Hospital	LNU	<27wks / <800grams / <28wks gestation twins / <30wks gestation multiples of 3+ / neonates >27wks who require >48hrs ventilation
Tunbridge Wells Hospital	LNU	<27wks / <800grams / <28wks gestation twins / <30wks gestation multiples of 3+ / neonates >27wks who require >48hrs ventilation
Conquest Hospital	SCU	<32wks gestation and <1250grams
Princess Royal Hospital	SCU	<32wks gestation and <1250grams
Worthing Hospital	SCU	<32wks gestation and <1250grams
Queen Elizabeth Queen Mother Hospital	SCU	<32wks gestation and <1250grams
Darent Valley Hospital	SCU	<32wks gestation and <1250grams
Royal Surrey Hospital	SCU	<32wks gestation and <1250grams

\*Please note some SCU's have an approved care pathway agreed with the ODN where babies born between 30+0- and 31+6-weeks gestational age receive initial care in SCU providing the weight is above 1250g and intensive care is not required.

## Contact Numbers for Transport teams

SONeT 01865 223344

Team mobiles	Main switchboard numbers	For on call Neonatal consultant
Kent 07775 991325	01634 830000	
Surrey 07857 654648	01932 872000	
Sussex 07979 806769	01273 696955	

## References

Neonatal ODN Daily Sitrep guidance

NHSE National Neonatal Critical Care Surge guidance & escalation plan for COVID pandemic for ODNs & neonatal service providers.

NHSE Pan South Regional COVID 19 PIC Surge plan

BAPM: <https://www.bapm.org/pages/182-perinatal-covid-19-resources>

RCPCH: <https://www.rcpch.ac.uk/resources/covid-19-guidance-paediatric-services#working-in-neonatal-settings>

<https://www.rcpch.ac.uk/key-topics/covid-19>

<https://www.rcpch.ac.uk/resources/ethics-framework-use-acute-paediatric-settings-during-covid-19-pandemic>

RCOG: <https://www.rcog.org.uk/en/guidelines-research-services/guidelines/coronavirus-pregnancy/covid-19-virus-infection-and-pregnancy/>

BLISS: <https://www.bliss.org.uk/parents/support/coronavirus-covid-19-information>

PHE all information: <https://www.gov.uk/coronavirus>

<https://www.bma.org.uk/media/2226/bma-covid-19-ethics-guidance.pdf>

