Royal Cornwall Hospitals
NHS Trust

Complex Fetal-Neonatal Multi-Disciplinary Team (MDT) Standard Operating Procedure

V1.0

November 2025

Summary

Fetal Medicine diagnosis which will require Tertiary NICU / Specialist centre Delivery and:

- Is likely to require immediate specialist care only available in tertiary centre OR;
- is highly likely to be incompatible with survival if associated with preterm birth OR;
- Has a diagnosis where parallel palliative planning is required.

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Discussion at Fetal-Neonatal meeting- case to be emailed to attendees prior to meeting (email details to rch-tr.screening@nhs.net).

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Plan for MDT as soon as possible after 21/40 gestation involving RCHT Neonatal team, RCHT Obstetric Team, relevant NICU (Neonatal Intensive Care Unit) team (see below), and other specialties as determined by diagnosis.

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Expected need for Tertiary NICU Care.
Contact Derriford Transitional Care Consultant via Derriford Switchboard to arrange attendance/ discuss case.

Expected Need for Tertiary Surgical / Specialist Care (e.g. Cardiac / Neuro)
Contact St Michael's Transitional Care Consultant via UH Bristol Switchboard to arrange attendance/ discuss case.

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Complex Fetal Neonatal MDT- Discussion Points / Required Outcomes.

- Is active management appropriate if presents with labour / needs delivery at limits of viability?
- At what gestation would active management be appropriate at RCHT if presents with labour / needs delivery and in-utero transfer not possible?
- At what gestation would IUT to tertiary centre be appropriate if presents with labour / needs delivery and in-utero transfer possible?
- Are any case specific obstetric or neonatal steps required if baby delivers locally?
- When should these discussions be formally reviewed? Who should be involved in the review?

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Parental Discussion.

- Should involve, whenever possible, the appropriate tertiary specialists.
- Should occur following the Complex Fetal Neonatal MDT.
- Should cover discussion points above and provide opportunity to explore the parent wishes and create a collaborative outcome which considers the tertiary advice and parental voice.

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Actions.

1. Complete Complex Fetal Neonatal MDT form. Ensure copy is uploaded to E3 and Maxims
2. Attach printed Fetal Neonatal MDT form to Delivery Suite expected delivery board
3. Rediscuss and document case at each Fetal Neonatal meeting, ensuring Complex Neonatal MDT form is updated and updated version is on E3/Maxims/Delivery Suite board
4. Refer to Palliative Care Team where appropriate (Cornwall or Bristol as relevant to the case)
5. Complete RCHT TEP form where appropriate (CHAxxxx)

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Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

Congenital anomalies are associated with an increased risk of preterm birth.

2. Purpose of this Policy/Procedure

2.1. Complex congenital anomalies, extreme growth restriction, significant PPROM (Preterm Prolonged Rupture of Membranes) and pulmonary hypoplasia are all associated with significant morbidity and mortality. Wherever possible, babies who will require tertiary level NICU care should be delivered in the correct centre for that level of care[1].

2.2. Congenital anomalies are associated with a significant increased risk of preterm birth[2], and in cases where immediate tertiary management may be required, or where the effects of prematurity may preclude survival, it is important that there is consideration of the appropriateness of in-utero transfer and/ or management in an LNU (Local Neonatal Unit), in event of presentation in preterm labour or when IUT (Intrauterine Transfer) may not be possible.

2.3. There should be routine parental involvement in all decisions around care. This should be done in a timely manner, but also sensitively to allow parents time to consider and process information. It is also important that it is made clear that all decisions can be reexplored, with changes in clinical status or in case of change in parental view. It is also important to recognise the limits of medical care, and that it is not always appropriate to provide invasive/ painful treatment, when there is limited chance of altering the outcome as this will cause unnecessary suffering.

2.4. The following process should occur in cases where there is a fetal medicine diagnosis which will require tertiary NICU (Neonatal Intensive Care Unit) / specialist centre delivery and:

- Is likely to require immediate specialist care only available in tertiary centre.

  OR:

- Is highly likely to be incompatible with survival if associated with preterm birth.

  OR:

- Has a diagnosis where parallel palliative planning is required.

2.5. There should be a planned discussion in the local fetal-neonatal meeting at the earliest opportunity. If this is likely to be significantly delayed, or a sooner discussion or decision is required, the fetal medicine should contact the neonatal service consultant.

2.6. In all cases it is critical that there is appropriate involvement of local and regional expertise relevant to the case.

2.7. For cases of significant pulmonary hypoplasia / growth restriction, then the regional expertise of the tertiary NICU team in Derriford should be sought, as the normal location for care for these babies. The transitional care consultant is the appropriate consultant to contact and should be contacted by the local neonatal team for their advice and/ or to request attendance at any planned complex fetal-neonatal MDT.

2.8. For cases with significant congenital anomalies, then the regional expertise of the regional surgical/ cardiac/ neurosurgical team should be sought, as the normal location of care for these babies. The transitional care consultant is the appropriate consultant to contact and should be contacted by the local neonatal team for their advice / and or to request attendance at any planned complex fetal-neonatal MDT.

2.9. Whenever possible a complex fetal-neonatal MDT should be arranged, with involvement of the RCHT Neonatal Team, RCHT Obstetric Team, Relevant NICU team, and other specialties as determined by diagnosis. This would ideally be followed by a conversation involving the parents, or with an arranged teams / face to face meeting with the relevant specialists and / or tertiary relevant NICU team as appropriate.

2.10. The core outcomes of the MDT are outlined in the summary table. The outcome of this meeting should be documented on the complex fetal-neonatal outcome form (CHA2863).

2.11. Subsequently this form should be uploaded to E3, maxims and a copy should be printed and attached to the high-risk antenatal board on delivery suite.

2.12. If appropriate a referral to palliative care should be made.

2.13. If appropriate an RCHT TEP form should be completed and kept in the maternal handheld notes. There must be a clear re-review date on the form, and this should be noted on the fetal-neonatal MDT spreadsheet, so that it can be updated when required. This form should make clear the actions needed for unexpected home delivery and for potential hospital delivery.

3. Scope

Members of the Neonatal, Obstetric and Fetal medicine team.

4. Definitions/Glossary

LNU- Local Neonatal Unit.

NICU- Neonatal Intensive Care Unit.

MDT- multi disciplinary team.

IUT- in utero transfer.

5. Ownership and Responsibilities

5.1. Role of the Fetal Medicine / Screening Team

- See flowchart.

5.2. Role of the Neonatal Team

- Liaise with relevant tertiary team, and attend fetal neonatal meeting to discuss case +/- any ad hoc case discussion meetings.
- Ensure updated plans are uploaded to E3/eCare as appropriate.

6. Standards and Practice

The process for identification and management of these patients is outlined in the summary flowchart.

7. Dissemination and Implementation

The guideline will be embedded in the terms of reference for the fetal neonatal meeting and will be reviewed within the Neonatal Guidelines meeting 3 yearly, with ad hoc review after cases where it has been utilised.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with policy/ key changes to practice.
Lead	Neonatal Guidelines Lead.
Tool	Adherence to guidelines will be monitored as part of the ongoing audit process on a Word or Excel template.
Frequency	As dictated by audit findings.
Reporting arrangements	Neonatal Audit and Guidelines Group.
Acting on recommendations and Lead(s)	Ward managers/ matron/ consultants/ CD's etc.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months, immediately if required. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff/ stakeholders.

9. Updating and Review

The guideline will be reviewed within the Neonatal Guidelines meeting 3 yearly, with ad hoc review after cases where it has been utilised or when the network structures change .

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Complex Fetal- Neonatal Multi- Disciplinary Team (MDT) Standard Operating Procedure V1.0
This document replaces (exact title of previous version):	New document
Date Issued/Approved:	November 2025
Date Valid From:	November 2025
Date Valid To:	November 2028
Author/Owner:	Chris Bell; Neonatal Consultant
Contact details:	01872 252667
Brief summary of contents:	Process summary for babies who have complex congenital anomalies, where preterm delivery may necessitate different management, or who may have a diagnosis incompatible with survival.
Suggested Keywords:	Anomalies, antenatal, fetoneonatal, fetal neonatal.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Neonatal Audit and Guidelines Group. Maternity Guidelines Group.
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None required

Information Category	Detailed Information
Related Documents:	https://www.bapm.org/resources/palliative-care-in-perinatal-medicine-framework. https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019. Network Palliative Care Guideline. Local Preterm Counselling Guideline.
Training Need Identified:	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/ Neonatal

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
October 2025	V1.0	Initial issue	Chris Bell; Neonatal Consultant

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Complex Fetal- Neonatal Multi-Disciplinary Team (MDT) Standard Operating Procedure V1.0
Department and Service Area:	Neonatal
Is this a new or existing document?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Neonatal Audit and Guidelines Group
Contact details:	01872 252667

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	As per section 2 of the document.
2. Policy Objectives	Align treatment with best practice, and ensure parents with babies with potentially complex needs have the correct management if they deliver preterm
3. Policy Intended Outcomes	To improve the well-being of patients by offering the appropriate management of patients.
4. How will you measure each outcome?	Audit/multidisciplinary team weekly discussion/incidents/risk management.
5. Who is intended to benefit from the policy?	Patients, families, staff.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Neonatal Audit and Guidelines Group. Maternity Guidelines Group.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/ carer/ patient's needs- i.e., available in different languages if required/access to an interpreter if required.

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/ carer/ patients with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison Team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly.
Marriage and civil partnership	No	All staff should be aware of any marital arrangements that may have an impact on care (for example: separated parents, domestic abuse).
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Neonatal Audit and Guidelines Group.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis