

## DOCUMENT CONTROL

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<b>Extreme Prematurity Guidelines v 3.1</b>			
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Extreme Prematurity Guideline v3.1

**Policy categories for Trust's internal website (Bob)**

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infant, newborn, stillbirth, intubation, death, resuscitation, outcome, disability

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## 1. Introduction

Barnstaple Special Care Unit is a level one neonatal unit. It is not designated to care for extremely premature infants. Therefore these guidelines are to guide and inform practice for resuscitation and stabilisation in the rare occasion that they cannot be transferred to a tertiary unit in utero. On these occasions Barnstaple SCU will be clinically guided by the Tertiary Unit.

## 2. Purpose

Extreme prematurity is defined as infants born at less than 26 weeks gestation. Improved Neonatal outcomes following the birth of extremely premature infants can create obstetric and neonatal ethical dilemmas. This guideline has been adapted from the Royal College of Paediatrics and Child Health (RCPCH), British Association of Perinatal Medicine (BAPM) and Plymouth NICU Management of Extreme Prematurity Guidelines

## 3. Definitions

### 3.1. Extreme Prematurity

A baby born at less than 26 weeks gestation

### 3.2. Stillbirth

An infant born without signs of life after 24 weeks gestation.

### 3.3. Neonatal Death

An infant born alive who dies within the first 28 days of life.

### 3.4. Poor outcome

Any diagnosis or illness with suspected long term consequences for the infant.

## 4. Responsibilities

### Role of the Consultant Paediatrician on call

- To inform the Peninsula Neonatal Transfer Service (PNTS) immediately there is a suspected delivery of an extremely premature infant and arrange for transfer of baby in utero if appropriate
- To be clinically guided by the tertiary unit
- To discuss with parents possible outcome and make a collaborative plan of care
- To supervise resuscitation, stabilisation and/or withdrawal of care for babies 30 weeks gestation or less.
- To keep the parents, the tertiary unit updated with the care plan and events
- To document all discussions and the agreed plan of care with parents and the Tertiary Unit

### Role of Maternity Staff

- To inform the neonatal team (consultant on call and Special Care Unit) of any suspected extreme preterm deliveries and in addition any expected deliveries of 32 weeks gestation or less.
- If possible enable in utero transfer following discussion with parents, neonatal team and tertiary neonatal unit.
- To ensure an obstetric and neonatal plan is agreed for the management of labour and delivery.
- Maintain communication with the parents of the progress of birth and condition of the baby.

## Role of Senior Neonatal Staff

- When possible supporting paediatrician at delivery
- Ensuring that the care of the neonate and the family is delivered according to agreed plan

## 5. Criteria for Transfer of a Baby from SCU to a Neonatal Intensive Care Unit (NICU)

In line with the national service specification, a Special Care Unit (SCU) will not be expected to provide care for neonates as categorised below:

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

## 6. General Principles of Management on Delivery Suite

If it appears that a mother will deliver her extremely premature baby and she cannot be transferred to a NICU in time the following principles of management should be followed. ([see appendix one BAPM Framework for Clinical Practice and flow chart appendix two](#))

- 6.1. Neonatal Consultant should be informed of pending premature delivery (including 32 week and under gestation infants) and will review all available clinical information to assist in any discussions and decisions that are likely to occur. Particular attention should be paid to the early ultrasound dating scan and the best estimation of weight and gestational age.
- 6.2. Update the Peninsula Neonatal Transfer Service (PNTS) immediately there is a suspected delivery of an extremely premature infant and arrange for transfer of baby in utero if appropriate
- 6.3. All care is clinically guided by the tertiary unit.
- 6.4. All discussions with tertiary unit and parents are documented with agreed plan of care in the maternal notes
- 6.5. Discussions with the parents should include the practicalities of commencing, withholding and withdrawing intensive care and the role of palliative/comfort care. The best available national and local data for outcomes must be made available

**See appendix three for outcome data.**

**See appendix four for the main challenges for children born at low gestational age**

**See appendix five for details of parent information.**

The following options are discussed with the parents;

- No resuscitation regardless of clinical condition
- Resuscitation (if heart rate present) regardless of clinical condition
- Resuscitation only if the baby is felt to have a reasonable chance of survival as judged at birth by a senior paediatrician attending the delivery.

*Discussion should include that the baby's on-going care would not be managed in the local SCU (other than palliative) and the baby would require transfer to a NICU following stabilisation.*

*If parents have expressed a wish for no resuscitation regardless, then this should be respected unless the gestation appears incorrect*

- 6.6. If time allows the parents should be offered the opportunity to visit the SCU.
- 6.7. If the Preterm labour progresses so rapidly that there is insufficient time to hold a detailed discussion with the parents before the baby is born. A decision about resuscitation may need to be made based on the most recent management plan, if any, and the available clinical information.
- 6.8. Parents may find the advice and support of their family, friends and spiritual advisers to be of great value at this time.
- 6.9. Check if antenatal steroids have been administered (as guided by obstetric team)
- 6.10. Check if magnesium sulphate has been administered to the mother (as guided by obstetric team)
- 6.11. Assess staffing levels and call in extra help as required:
  - Hospital switchboard can call in added Paediatric Consultant help
  - Nurse in charge SCU, Caroline Thorpe Nurse or Bleep 500 can call in extra neonatal nurse cover.

## 7. Delivery Suite Preparation

- Pre warmed room/theatre 25<sup>0</sup>C (WHO, CESDI 27/28)
- Checked and working resuscitaire with radiant heat source and sufficient gas supply.  
Use a resuscitaire with a blender and pressure limited T piece device and PEEP (set to 20/5cm)
- Suction and catheters present and working

- Resuscitaire manual heat control set to maximum with plastic bag ready
- Emergency trolley checked and available
- Surfactant accessible
- The unit may wish to use the following monitoring equipment on the resuscitaire: Pulse oximeter and temperature probe

## 8. Management in Delivery Suite

**8.1.** Consultant should always be informed of pending delivery and should attend wherever possible for babies of 30 weeks gestation or less.

**8.2.** Thermoregulation

- Maintain temperature above 36<sup>0</sup>C
- Use of plastic bag without drying reduces evaporative heat loss
- Dry head and put hat on
- Temperature should be maintained on transfer between delivery suite and NICU

**8.3.** If resuscitation is appropriate then respiratory support, including surfactant administration should be commenced without delay. Video-laryngoscope may be used to support intubation.

**8.4.** Commence resuscitation in air and increase oxygen concentration as required according to Newborn Life Support guidance and plan of care

- PEEP of minimum 5cm H<sub>2</sub>O can be provided via mask over mouth and nose, allowing the infant to breathe, during application of plastic bag and hat.
- Chest compressions and adrenaline are not ordinarily indicated.
- In accordance with the Framework to Clinical Practice (BAPM 2006) if resuscitation is initiated in infants less than 24+6 weeks, response of the heart rate to lung inflation via ETT will be critical in deciding whether to proceed with intensive care
- Transfer and stabilisation on SCU should be expedited whilst awaiting retrieval by the PNTS.
- Further care of the baby will be directed by the tertiary NICU.

## 9. Terminal/Palliative/Comfort Care

The decision to with-hold or discontinue resuscitation should be made by the consultant paediatrician or senior paediatric registrar (who will then notify the consultant).

Parents should be offered the opportunity to cuddle their dying baby. They may be placed skin to skin or wrapped in a blanket according to parent wishes.

All dying babies should be dressed or wrapped warmly or kept warm in an incubator when not being held by their parents. .

The parents must be unambiguously notified of the death of their baby by the person responsible for certifying the baby's death (either the Neonatal Consultant or SPR).

Requests for post mortem are to be made at an appropriate time after death by a senior doctor, usually the consultant.

All discussions, decision-making and care should be documented in the baby's medical records. All relevant parties must be informed of the death as soon as practicable

All means of support must be offered to the parents, (give parents information leaflet 'Parental Information and Advice Following your Bereavement').

*NB if a decision is made not to resuscitate but to undertake palliative care, then the team present at delivery must include a medical practitioner with GMC registration in order to sign a death certificate.*

## 10. Follow Up

All extremely preterm infants should be followed up for at least 4 years in order to detect disabilities and collect audit data

## 11. Cross References

- Admission of a Baby to SCU Guidelines
- Death of a Neonate cared for on SCU – Management Guidelines
- Bereavement in Maternity: Pregnancy Loss, Stillbirth and Neonatal Death Guideline
- Plastic bags to prevent heat loss – Neonatal Guidelines
- Preterm Labour Management Guidelines
- Termination of Pregnancy for Fetal Death, Fetal Abnormality or Maternal Request
- Referral of a Fetal Abnormality Guidelines
- Surfactant administration guidelines

## 12. Monitoring Compliance with and the Effectiveness of the Guideline

Staff are informed of revised documentation. There is an expectation that staff are responsible to keep updated on any improvements to practice and deliver care accordingly.

Activity for SCU including intensive care days are monitored using badger data base.

Data is also collected and monitored monthly via the South West Neonatal Network dashboard. Exception reporting occurs monthly via this dashboard for babies inappropriately cared for in SCU and those not transferred to a NICU. All infants born <32 weeks in SCU will require an exception report. This data is compared across Neonatal Units.

Intensive care incidents are monitored by the neonatal governance team and neonatal network. Incidents are reported by the Datix system and South West Neonatal Network incident reporting process.

Non-adherence is reviewed and action plans made if required. Discussion and reviews occur at South West Neonatal Network governance meetings, Trust Directorate meetings, Governance meetings and Ward meetings. Learning and action plans are cascaded at these meetings and improvements implemented. Key findings and learning points will be disseminated across network and to relevant staff.

### Standards/ Key Performance Indicators

Key Performance indicators on which to base care in the Special Care Unit are:

- Nice Neonatal Quality Standards
- NHS Toolkit for High Quality Neonatal Services
- National Neonatal Audit Programme
- NHS Standard Contract for Neonatal Critical Care
- BLISS Neonatal Audit

## 13. References (Optional)

- BAPM working group. (2008) The management of babies born extremely preterm at less than 26 weeks of gestation. A framework for clinical practice at the time of birth.  
[https://www.bapm.org/sites/default/files/files/Approved\\_manuscript\\_preterm\\_final.pdf](https://www.bapm.org/sites/default/files/files/Approved_manuscript_preterm_final.pdf) (accessed 20/9/18)
- BAPM/RCPCH (2008) Classification of health status at 2 years as a perinatal outcome – report of a working group
- Epicure (2014). {On-line} Information for parents of extremely premature babies. <http://www.epicure.ac.uk/overview/information-for-parents/> (accessed 20/9/18)
- The Epicure2 Study (2006) [On-line] <http://www.epicure.ac.uk/> (accessed 18/5/18)
- Kitchen W, Ford G W, Doyle L W, Rickards A L, Lissenden J V, Pepperell R J, Duke J E. (1985) Caesarean section or vaginal delivery at 24 – 28 weeks gestation: comparison of survival and neonatal and two-year morbidity. *Obstet Gynaecol* 66:2 149-157
- Marlow, N (2014). [on-line]. Keeping up with outcomes of infants born at extremely low gestational ages. <http://www.epicure.ac.uk/publications/> (accessed 18/5/18)

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- Plymouth NICU (2017) Management of Extreme Prematurity Guidelines
  - Royal College of Paediatrics and Child Health. (1997) With-holding or Withdrawing Life Saving Treatment in Children – A Framework for Practice.
  - Seaton SE et al. (2012) Babies born at the threshold of viability: changes in survival and workload over 20 years.. ADC-FNN Online First.
  - Thames Regional Perinatal Group. (1999) Framework for Practice Relating to the Birth of Extremely Premature Babies (22-26 weeks gestation)
  - University Hospitals Bristol (2011) Extreme Prematurity – Management in Labour Guidelines.
  - Yorkshire Neonatal Survey (2010). Field DJ, Manktelow BM, Boyle EM, Oddie S, Draper ES.

## Appendix One – BAPM Framework for Clinical Practice

**A Framework for Clinical Practice based on consensus and the most recent evidence available follows:**

### **(A) LESS THAN 23+0 WEEKS**

If gestational age is certain and less than 23+0 (i.e. at 22 weeks) it would be considered in the best interests of the baby, and standard practice, for resuscitation not to be carried out. If the parents wish they should have the opportunity to discuss outcomes with a second senior member of the perinatal team.

### **(B) 23+0 to 23+6 WEEKS**

If gestational age is certain at 23+0 – 23+6 (i.e. at 23 weeks) and the fetal heart is heard during labour, a professional experienced in resuscitation should be available to attend the birth. In the best interests of the baby a decision not to start resuscitation is an appropriate approach particularly if the parents have expressed this wish. However, if resuscitation is started with lung inflation using a mask, the response of the heart rate will be critical in deciding whether to continue or to stop and sensitively explain to the parents the futility of further interventions.

### **(C) 24+0 to 24+6 WEEKS**

If gestational age is certain at 24+0 – 24+6 resuscitation should be commenced unless the parents and clinicians have considered that the baby will be born severely compromised. However the response of the heart rate to lung inflation using a mask will be critical in deciding whether to proceed to intensive care. If the baby is assessed to be more immature than expected, deciding not to start resuscitation may be considered in the best interest of the baby.

### **(D) 25 WEEKS AND GREATER**

When gestational age is 25+0 weeks or more, survival is now considerably greater than in 1995. It is appropriate to resuscitate babies at this gestation and, if the response is encouraging, to start intensive care.

## **(E) UNCERTAIN GESTATIONAL AGE**

If gestational age is uncertain, (i.e. no dating ultrasound scan) but thought to be >23+0 weeks, an ultrasound scan by an experienced sonographer should be carried out if time permits. If the fetal heart is heard during labour, a professional experienced in resuscitation and another clinician (neonatal nurse or trainee paediatrician) should be called to attend birth. A decision should then be made, in the best interests of the baby, as to whether resuscitation should begin with mask ventilation. Once begun, the response of heart rate to lung inflation will be crucial in judging how long to continue resuscitation. If there is any uncertainty about management guidance from more senior staff should be sought urgently.

### **INTENSIVE CARE**

The response of the baby to mask ventilation is critical in deciding whether to commence intensive care. If the heart rate increases rapidly and the colour improves, appropriate ventilatory support, including intubation and surfactant therapy, should be given and the baby transferred to the neonatal unit for further assessment. There is no evidence to support the use of adrenaline by any route, or chest compressions, during resuscitation at gestational age <26 weeks. Management should be decided by doctors and nurses experienced in neonatal intensive care.

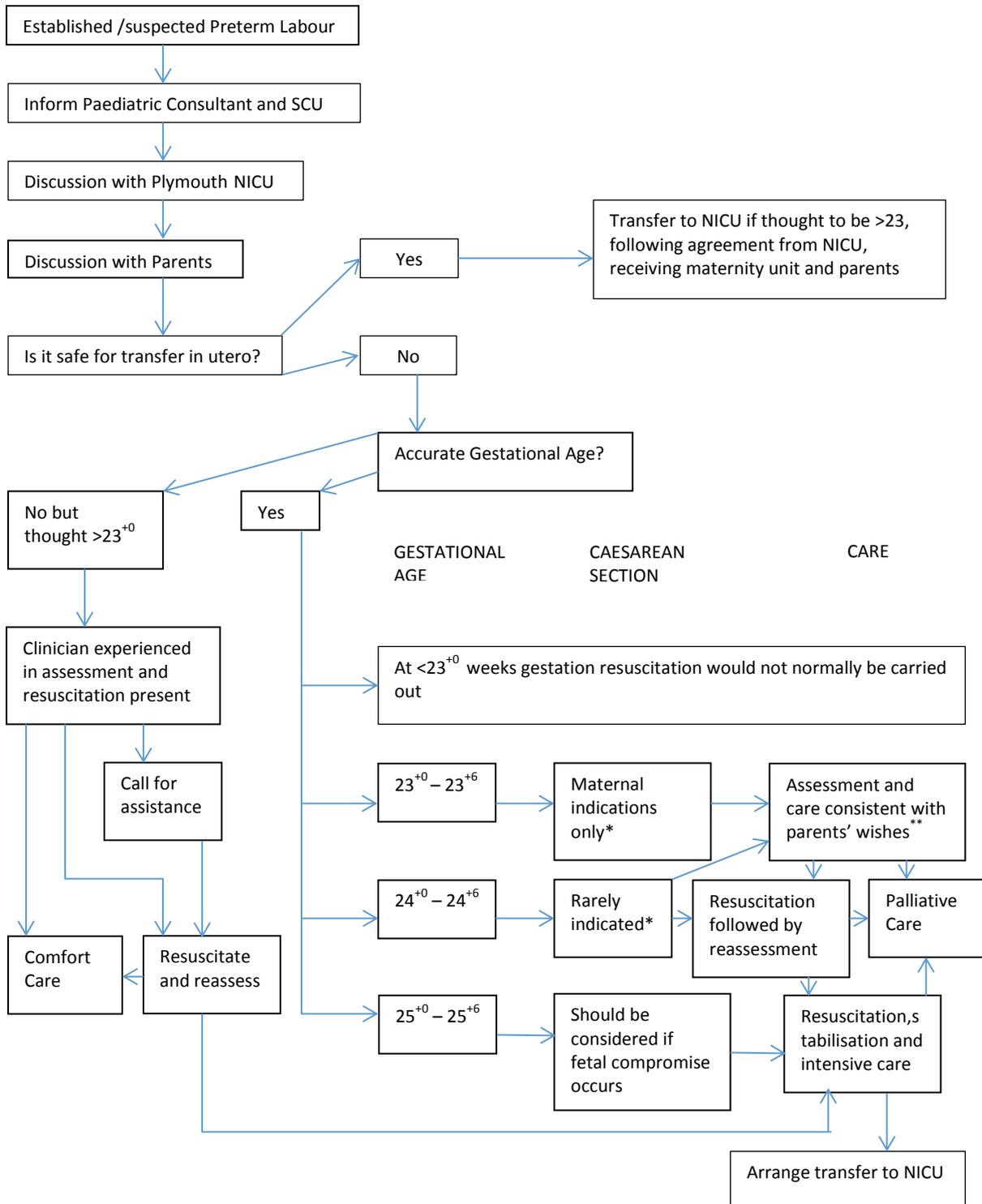
### **Withholding or withdrawing resuscitation or intensive care**

When resuscitation or intensive care is withheld or withdrawn, the baby should be given all the care needed for his/her comfort and the parents encouraged by appropriate staff to hold and spend time with their baby, if they wish, in a quiet and private location.

When a baby dies the parents should be offered bereavement counselling, including advice about postmortem examination. At an appropriate time the prognosis for future pregnancies should also be discussed.

[https://www.bapm.org/sites/default/files/files/Approved\\_manuscript\\_preterm\\_fina\\_l.pdf](https://www.bapm.org/sites/default/files/files/Approved_manuscript_preterm_fina_l.pdf) (accessed 20/9/18).

## Appendix Two – Flowchart for Management of Extreme Prematurity



\* Caesarean section offers no benefit to the foetus <25 weeks gestation and should be performed only when indicated for the health of the mother.

\*\* Survival and outcome for infants born at 23<sup>+0</sup> – 24<sup>+6</sup> is poor. Management of an infant born at this gestation should be consistent with parents' wishes but decisions made before birth is influenced by the baby's condition at birth. When parents wish resuscitation the clinician's decision to resuscitate should depend on detailed assessment of the infant's condition. Objective criteria include movements, lack of bruising, presence of spontaneous respiratory efforts and response to initial resuscitation.

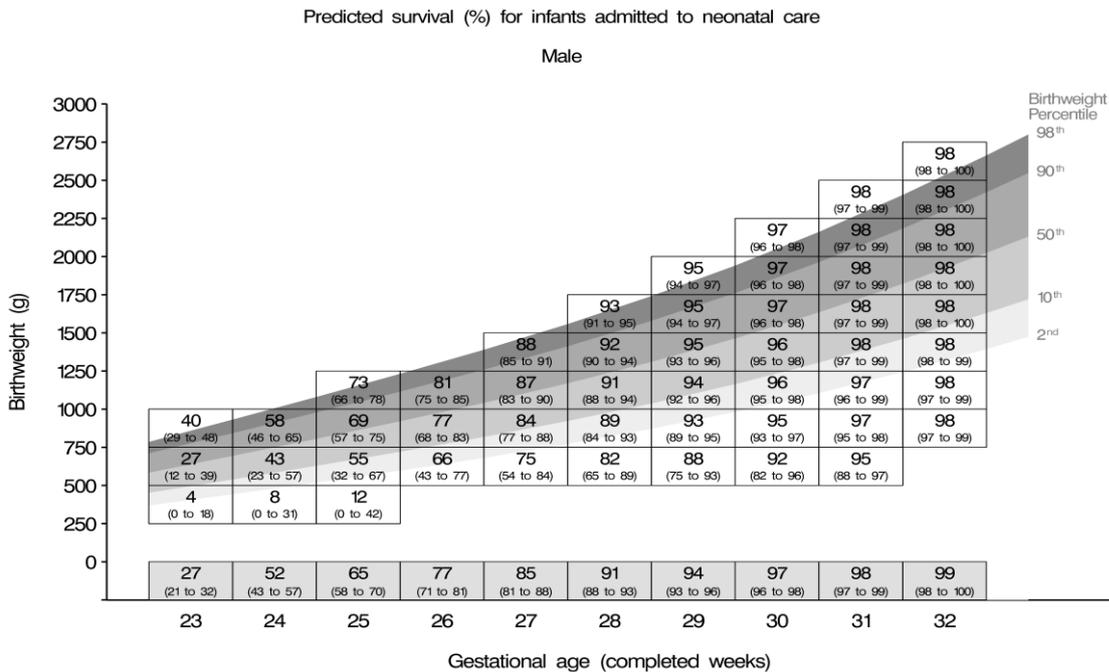
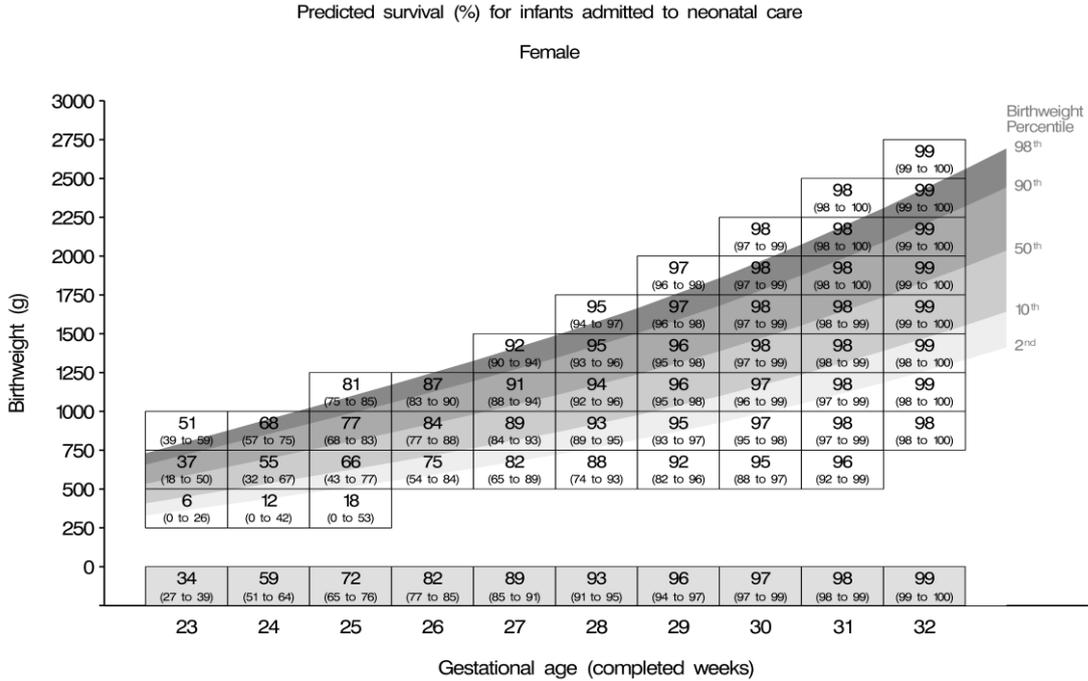
## Appendix Three - Survival data for Extreme Preterm Infants admitted to a NICU

Epicure 2 data on survival (2006) English (UK) babies admitted to NICU)

Gest (wks)	Overall Survival at onset of Labour	Survival with intended care	Survivors without disability from onset of labour	Survival without disability admitted to NICU with intended care	Survivor to 3 yrs without disability No. %	Survivors to 3 years with severe disability No. %
22	1% N=272	7% N=41	0.4%	2%	1 of 3 33%	1 of 3 33%
23	15% N=416	22% N=284	8%	11%	32 of 63 51%	17 of 63 27%
24	36% N=495	42% N=427	22%	25%	107 of 177 60%	7 of 177
25	62% N=550	66% N=514	43%	46%	236 of 341 69%	57 of 341 17%
26	75% N=594	78% N=576	59%	60%	348 of 447 77%	45 of 447 10%

Gestational age at birth	22 weeks	23 weeks	24 weeks	25 weeks	26 weeks
<b>Population</b>					
Alive at the onset of labour	272	416	495	550	594
Livebirth	152	339	443	521	580
Livebirth with intended care *	41	284	427	514	576
Admission for neonatal care	19	217	382	498	571
Deaths in Neonatal care	16	151	204	152	123
Deaths after discharge home	0	3	1	5	1
Survivors to 3 years of age	3	63	177	341	447
Survivors with severe disability §	1	17	37	57	45
Survivors with moderate disability §	1	14	33	48	54
Survivors without disability §	1	32	107	236	348
<b>Survival</b>					
from onset of labour	1%	15%	36%	62%	75%
of livebirths with intended care *	7%	22%	42%	66%	78%
of admissions for neonatal care	16%	29%	46%	69%	78%
<b>Survival without disability</b>					
from onset of labour	0.4%	8%	22%	43%	59%
of livebirths with intended care *	2%	11%	25%	46%	60%
of admissions for neonatal care	5%	14%	28%	47%	61%

## Trent Neonatal Survey on survival (2006-2010 babies admitted to NICU)



<b>Plymouth Survival data (2008-2016 babies admitted to NICU)</b>						
<b>Gestation (weeks)</b>	<b>Survival 2013 No (%)</b>	<b>Survival 2014 No (%)</b>	<b>Survival 2015 No (%)</b>	<b>Survival 2016 No (%)</b>	<b>Survival 2008-2011 No (%)</b>	<b>2012-2016 No (%)</b>
23	1 (50%)	1 (33%)	0 (0%)	0 (0%)	1 (36%)	4 (30%)
24	8 (80%)	6 (75%)	1 (20%)	5 (83%)	24 (54%)	24 (65%)
25	6 (60%)	8 (89%)	9 (100%)	7 (78%)	39 (64%)	38 (83%)
26	8 (73%)	8 (89%)	13 (87%)	19 (90%)	60 (87%)	50 (86%)
27	8 (89%)	5 (100%)	11 (100%)	13 (87%)	59 (93%)	43 (94%)
28	6 (86%)	7 (78%)	3 (75%)	12 (100%)	76 (89%)	40 (89%)

## Appendix Four - Main challenges for children born extremely preterm

### The main challenges for children born extremely preterm

Children born at extremely low gestational ages face a range of risks as they grow up. Not all babies have problems and for half of the children there are no health problems or only minor problems (for example, special needs at school to help with classwork, squints and need to wear glasses).

#### Cerebral Palsy

Although the chances of cerebral palsy at around 20% are relatively high compared to the normal population (2-4 per 1000 births), most children with cerebral palsy have mild associated disability and attend mainstream school, with only 7% have severe associated problems.

#### Learning Difficulties

A large proportion of children will need some help at school – around 2 in 3 in our study, although the proportion who go to special schools is only around 1 in 8. The main problems seem to be associated with attention in the classroom (not usually hyperactivity), and from other studies problems with short-term or working memory and slow processing of information – hence the finding in our 6 year study that it is better to break tasks into sequential steps rather than all together in the classroom.

#### Behaviour

Overall behaviour problems are found in just over 1 in 4 children. Inattention remains the commonest problem for extremely preterm children, and some children get anxious and worried with this. Some children show symptoms like autism but it is very different from the autism we see in non-preterm children and often occurs with other disabilities. Children who grow up without serious health problems rarely develop major behavioural problems in our experience.

#### Chest problems

Extremely preterm children tend to have more chestiness than their full term classmates which is related to asthma, and children take more medicines to help prevent wheeze and cough. This seems to be because the lungs have difficulty in reaching their full development after such early births. Major illness with chest problems decreases as the child grows up.

#### Growth

Although growth is slow up to six years, we have shown that height and weight are showing some catch up over later childhood and that most extremely preterm children are going into puberty at the same time as their classmates.

<http://www.epicure.ac.uk/overview/main-challenges/> (accessed 20/9/18)

## Appendix Five – Information for parents of extremely premature babies

Information available on line at:-

<http://www.epicure.ac.uk/overview/information-for-parents/> (accessed 18/5/18)

Information is also available on the Trust intranet in the Neonatal section of the patient information leaflets:-

<http://www.northdevonhealth.nhs.uk/2015/03/information-for-parents-of-extremely-premature-babies/>

