Pan Thames Paediatric Clinical Networks
2025/26 IPC Guidance & Inter-Hospital Transfers

Updated November 2025

NHS England

- Improve clinical care and experience for sick children and their families
- Facilitate transfers to and from critical care units as rapidly as possible
- Highlight and communicate infection risks for appropriate patient pathways

- **For all staff and carers, good hand hygiene practice, cleaning multi-use equipment and appropriate use of PPE remain key**
- **Avoid unnecessary delays, including those related to infection prevention and control (IPC) concerns.**
- **Referrals or repatriations must not be refused because of colonisation or infection – appropriate IPC precautions and prioritisation should be in place to facilitate patient flow.**

Screening Swab Results

- **Always accept screening swabs** taken in other hospitals, incl. surface swabs and viral respiratory results for patients with respiratory symptoms (including SARS CoV-2, RSV and Influenza).
- **Documentary evidence** of recent results should be provided by referring units.
- Discharge screening **before transfer** are not required.

Pre-transfer MDT Teleconference

- Children with **complex conditions** with **long inpatient admissions** will likely benefit from **pre-discharge MDT teleconferences** to cover IPC and other issues
- This will also ensure **support to families and carers** during the transition

Viral Respiratory Infections

- **Nosocomial spread** occurs with direct contact with patient and patient environment, and **resident carers** present more risk of infection spread than infants.
- **Appropriate precautions** in infection prevention and control negate the need for most cubicles.
- **Use any locally available validated tests** for SARS CoV-2, RSV, Flu A / B prior to ward admission.
- **Prioritise** those for **Aerosol Generating Procedures** (AGPs)
- **Avoid delaying transfers** whilst awaiting viral results
- **Standard IPC Precautions (SIPCs) and Transmission based precautions (TBPs)** must be undertaken at all times.

- Admission WITHOUT virology results:
  - infants with unidentified respiratory illnesses should be admitted to a cubicle, especially if to receive AGPs.
  - If cubicles are limited, it may be necessary to admit to an undifferentiated "respiratory cohort bay" for patient flow
- Admission WITH virology results:
  - **RSV or Flu A/B Positive** – isolate – if cubicles limited, infants may cohort according to relevant viral infection
  - **RSV or Flu A/B Negative** – even if other respiratory viruses positive including SARS CoV-2 – can manage in non-cohort bay / cubicle, if low risk of severe disease

Please also see the updated 2025 RCPCH National Guidance for the Management of Children in Hospital with Viral Respiratory Tract Infections at ***www.rcpch.ac.uk***

For any delays or incidents in transfers due to IPC issues not adhering to this guidance, please report to:
North Thames Paediatric Network: **england.NTPN@nhs.net**
SouthThames Paediatric Network: **england.STPN@nhs.net**

Cubicles and Side Rooms

- **Routine isolation** of children in cubicles when transferred from one hospital to another without a known or suspected infection risk is **not required**.
- Some children will always require a cubicle, but others, depending on availability and staffing, can be safely cared for in a ward area – this should follow an **appropriate risk assessment and discussions** with the medical/PID/IPC teams.
- To optimise patient flow, **de-escalation** of isolation/cohorting may be considered after 5 days in low risk non-PICU children
- During **periods of high prevalence** of respiratory viruses, **protective isolation** should be prioritised to reduce the risk of transmission of infections to **high risk children**, i.e. the **most clinically vulnerable**, which includes children with:

1. **Significant immunosuppression** e.g. – severe combined immunodeficiency; post BMT: 1st 6 months post allogeneic BMT, or 1st 3 months post autologous BMT; post solid organ transplantation, in the 1st 6 weeks following transplant.
2. **Leukaemia** – Newly diagnosed during induction (1st month) or relapsed leukaemia (case by case decision).
3. **Chronic lung disease** (BPD) and other respiratory pathologies including **cystic fibrosis**, and those on **home oxygen** and **long-term ventilatory support** (< 2 years of age).
4. Significant **upper airway pathologies** requiring ventilatory support (< 2 years of age).
5. **Uncorrected haemodynamically significant congenital heart disease; pulmonary hypertension; cardiomyopathy** (< 2 years of age).
6. **Severe neuromuscular conditions** (e.g. SMA type 1) requiring ventilatory support or regular airway clearance technologies (up to school age).

In addition, in some circumstances cubicles or side rooms are required for **specific reasons** such as end of life care, or other complex psychological / social or family concerns.

Communicable Infections

- In **communicable infections spread by airborne route**, e.g. measles, VZV, TB etc., it is necessary to **immediately isolate** in cubicles / side rooms
- Use appropriate **PPE** to prevent spread to patients / staff.
- In performing **Aerosol Generating Procedures (AGPs)**, FFP3 respirator / mask must also be worn.
- **AGPs** include, ventilation via ETT/tracheostomy in open circuit without filter, trache procedures, sputum induction and open respiratory tract suctioning beyond oropharynx.
- Children with **CRO (but not CPE) / MRSA / VRE / ESBL** on screening swabs or samples may be cared in an open ward / bay / cohorted area, **with careful IPC measures**, depending on local risk assessment and consultation with IPC (do not mix infections).

North Thames Paediatric Network
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