Consultation responses – Neonatal Outreach Service Framework
Consultation close date – 10 January 2025

British Association of
Perinatal Medicine

Name: Shavin Chellen	**If you are answering on behalf of an organisation please state:**
General comments: Haven't read the whole document yet, but looks good	**Working Group Response:** **The figure relates to all live births per Trust, system or region.**
Specific comments: I wanted to ask about the following sentence on page 34. "Using this approach, a baseline recommendation of one WTE member of nursing workforce per 800 births was established. The lead Neonatal Outreach Nurse role must be additional to this." Does the term births relate to all births in the region looked after by the neonatal unit. Or births that require neonatal admission?	

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Name: Gina Outram	**If you are answering on behalf of an organisation please state:**
General comments: Excellent comprehensive document , a lengthy read , but really good to see that the forward was written- by a service user	**Working Group Response:** **Pg 11- States named consultant has oversight of neonatal outreach service and they are part of the neonatal acute team.** **Pg 12 – Added** **Pg 18 – Added** **Pg 26 – community midwives and pharmacy added. AHP's already in document** **Pg 32 – To limit this being a limiting factor in developing outreach wording changed in last paragraph to clearly acknowledge AHP workforce levels in the units having a significant impact on needs in the community.**
Specific comments: Governance section page 11 - more clarity about accountability/responsibility for management plans and sign off - is this the responsibility of the GP or Hospital Consultant ? Page 12 - last bullet point ref patient safety incidents should you include wider stakeholders e.g GP's , HVs and or Community Midwives ? Supporting families to transition to home section page 18 - include Open access criteria and opportunities to room in prior to transition to home, out of hours medical support Maintaining Skills and Competence section page 26 - include shadowing maternity staff in a TC care setting , MDT shared learning opportunities with community midwives and HV's AHPs Pharmacists etc e.g SBR's , feeding plans , home phototherapy , developmental care plans, medicines management - 3 year delivery plan recommends learning together to reduce silo working and improve patient safety AHP Pharmacy workforce section page 36 states :"Urgent focus must be given to fully establishing acute unit AHP and pharmacy workforce standards before the outreach workforce is developed." Is this a realistic expectation or a limiting factor in development of Outreach services ? Would agree that the outreach service would not be gold standard without AHPs but disagree that this is should limit the development of outreach services.	

page 47 - example of good practice in Medway - it states the following "At discharge the team will be present on the day to ensure parents are prepared, resus training given alongside other discharge tasks, e.g. safer sleep. The nursing team complete other parent teaching like bathing, making up formula, medication giving, etc.)." I would question that this is good practice on the day of discharge , when parents are stressed , surely this should be done prior to the day of discharge Really like the Peterborough City Hospital East of England Model	**Pg 47 - Amended**

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Name: Tendai Nzirawa	**If you are answering on behalf of an organisation please state:**
General comments: Thank you for taking time to put together this working group and putting together this document.	**Working Group Response:**
Based on my reading, there is no mention about Equality, Diversity & Inclusion in general or even considering conducting a Equality Impact Assessment when establishing any new service or making any major changes to ensure all families especially those that are likely to experience poor outcomes or who may be living in the most deprived have tailored neonatal outreach support.	**Thank you- we have strengthened this within the document**
The title 'nurse' or 'neonatal nurse' was used very minimum in the document, at times no mentioned at all. Although the service is delivered by a multi-professional team, who brings lots of support, expertise and knowledge. Its important to ensure when a service is being delivered by the nurse for example home visit etc its clearly stated nurse/registered nurse QIS. According to the Royal College of Nursing, protection of the title of nurse is in the interests of patient safety as well as the profession. Based on some of the quotes and survey included the role of the neonatal outreach nurses is pivotal to the success of the Neonatal Outreach Teams.	**Nurses are key to delivering care - Focus is on the delivery by a multi professional team**
There needs to be clearer guidance around the ratio of only one Neonatal Outreach Nurse for every ??? infants as well the other members of the team, Neonatal Outreach Nursery Nurse and AHP.	**This is impossible to calculate in this way at this time as babies needs will differ depending on care needs. More data is required to be able to define this staffing need further.**
Page 34 Using this approach, a baseline recommendation of one WTE member of nursing workforce per 800 births was established. The lead Neonatal Outreach Nurse role must be additional to this. Question: 1) At the start were there been any invitations to the Neonatal Nurses Association and Bliss	**Pg 34 Recruitment for the working group followed BAPM processes. The Neonatal Networks Outreach Group also supported. Within that group there are parent**

Baby Charity to be part of the Members of the working group?	**engagement leads, NNA members, and Bliss representatives.**
Specific comments: Page 11 - Each outreach service should have a senior team lead at local level. COMMENT its not clear who is the senior team lead is, is this a neonatal lead nurse, AHP or Neonatologist? Page 12 - Network/Regional Lead role for neonatal outreach services should report into neonatal network management teams and share practice/guidance with Local Midwifery and Neonatal Service structures (LMNS's). COMMENT are you referring to Local Maternity and Neonatal System - part of the Integrated Care System or the hospitals or both? Page 12 - Patient safety incidents (including medicine incidents) should be reported, and any learning shared through provider trusts and network governance procedures. COMMENT will this link to The Patient Safety Incident Response Framework (PSIRF), if so this is the opportunity to mention it so that the Neonatal Outreach is not in isolation of the wider work happening in the Trust and National. Page 14 - Contacts and translation services - COMMENT This section does not mention anything about ensuring that where possible enough should be made to book face to face interpreters. Sadly, there is worse outcomes from women/birthing people who are migrates or request interpreter however do not always get the support. (According to The MBRRACE-UK collaboration, which is co-led by the TIMMS group at the University of Leicester and Oxford Population Health's National Perinatal Epidemiology Unit, published the results of a confidential enquiry into the care of recent migrant women with language barriers who have experienced a stillbirth or neonatal death. 96% of the women had a documented need for an interpreter but 73% of documented contacts with healthcare services took place without a professional	**Pg 11 This is detailed in the workforce section and signposted from pg 11.** **Pg 12 Wording changed to both.** **Highlighted in last paragraph that Patient safety incidents should follow local reporting procedures.** **Thank you for raising this important point. Pg 14 face to face interpretation where possible added to document.**

interpreter from either an in-person interpreter or professional telephone interpreters. Half of the contacts took place without any interpreter; Language barriers significantly impacted recently arrived migrant women's access to maternity services, with challenges persisting from initially contacting maternity care providers through postnatal, bereavement, and follow-up care). Page 14 - LEVEL TWO Growth monitoring, infant and parent well-being checks, bereavement support, safeguarding, Neonatal Abstinence Syndrome. COMMENT Based on previous experience the recommendation would be to move bereavement support and safeguarding to LEVEL THREE - category of support. At least a home visit when they are safeguarding concerns or a child in need plan etc ensures that the safety of the infant and family is assessed and properly supported outside the neonatal unit. Other areas around safe sleeping etc can be properly taught and/or supported in the home environment. Page 18 - We recommend: COMMENT Would recommend where by the family may need additional support due to baby's health needs Home oxygen, NGT etc to consider having a Discharge planning meeting, to give the family and professionals to discuss and make a plan together. As well, agree discharge date. A Discharge planning meeting is also highly recommended when there is safeguarding support or plan to ensure all health and social care professionals are aware of the safeguarding concerns, named professionals to escalate and there is transparency with the family about the plan.	**There is a need for multi-agency working for at risk families. Outreach teams need to work alongside community universal services and social care agencies. The examples of support levels are minimum- and family need and individualised care will always need to be assessed.** **We recommend that good communication amongst the team is required. The decision to have a discharge planning meeting should be individualised at the point of care.**

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Name: Suzanne Sweeney	**If you are answering on behalf of an organisation please state:** London Neonatal Operational Delivery Network
General comments: A well written and thorough resource which will be very helpful in the development of much needed neonatal outreach services - Thank you for drafting this guidance. General note - Throughout document 'psychologist' might be best replaced by 'registered psychological professional'. This is important because the other roles are all protected titles but 'psychologist' on its own is not, and we need to ensure the right staff with appropriate training and qualifications are taking on these roles.	**Working Group Response:** **Thank you - amended** **Pg 11 There is ODN representation on the BAPM Working Group. This is a national document across the whole of the NHS. Whilst we agree funding stream has not been identified it should be considered as part of the leadership structure at network level. Commissioning is out of the scope of this document.** **Pg 7 Added**
Specific comments: Page No: 11 Leadership in Outreach - Regional/Network Level Whilst the network welcomes guidance regarding the development of a designated regional/network lead role for neonatal outreach/oversight of services there is no clear mechanism for the funding of this role. Whilst we appreciate that this guidance is aspirational, given the current financial constraints on regions, it is unlikely to be funded at this time, placing additional pressures on networks with very limited funding. It would have been helpful for ODN leads to be consulted on this prior to adding in the guidance. Page No: 7 - We would like to add to the sentence as compassion is mentioned in the 3 year delivery plan and has shown to be lacking The aim of these key recommendations is to ensure that all outreach services are safe, high quality, compassionate and continue to develop to meet the needs of the babies and families. between points 5. And 6. We would like to add an extra key recommendation All outreach services are delivered in a psychologically informed way, also bringing the principles of	

family integrated care, compassionate care and compassionate care into the work done in the home with families.	**Added to recommendation 2**
Page No: 9 - V minor, but on the first quote in the blue box, the quotation marks at the end need deleting. Could add a paragraph here about the evidence base and policy directives for developing psychologically informed services. This could sit between the two quotes or just below them. Something like this: Multiple recent reviews and directives (e.g. Ockenden review, Kirkup review, birth trauma enquiry, pre term birth enquiry) have highlighted the need to provide compassionate, trauma informed neonatal care. There are now plans and projects in place to deliver this kind of care across all neonatal units in England, recognising that the care delivered to families needs to be consistent, considerate and with the parents and baby's history, needs and challenges held in mind. Staff wellbeing is vital to the delivery of psychologically informed care in neonatal units and the same is true for outreach services and those which develop in the future. It is no longer enough to deliver medical care without attending to the holistic needs of infants, families and staff. This will need to be a key consderaion as outreach services develop, with all staff having the training and support they need to deliver psychologically informed care in every interaction and clinical service delivery. At the point of care, this demands minimal additional time or resource, but it requires robust planning, training and ongoing support for teams.	**Pg 9 Quotation Changed** **Thank you for this comment. We have included the need for psychologically informed services in the section on education and training.**
Page 10: bullet pointed list. Under point 7 (- improves family experience...) It isn't just financial pressure that is reduced but also psychological pressure. Can we add this to the sentence?	**Pg 10 - Added**
Page 11: 'leadership in outreach' section. really good to include this section. Can we add to third bullet point:	

Cultivate a culture of safe, compassionate outreach and hospital at home practices. Page 12: - under 'information governance' do we need to consider how this might work when the parents are the focus of care (for example if they have a mental health need and are being referred to an appropriate service?). Can we add a point about contributing to the parents' notes where necessary? under 'reporting' it would be good to have something here which acknowledges that national and regional data sets gather important data, but not always the data which matters to parents (e.g. How consistent their care was, compassionate care, being listened to etc). It would be good to have a way of capturing the things that matter to families, because we know that the data which is captured often becomes what is valued, instead of what might be really important to good quality services.	**Pg 11 - Added** **Pg 12 Added** **Added service user feedback to reporting section (also discussed in data section)**

Name: Suzanne Sweeney	**If you are answering on behalf of an organisation please state:** London Neonatal Operational Delivery Network
General comments: N/A	**Working Group Response:**
Specific comments: Network Feedback Part 2 Page 13: - excellent list. We worry about 'parental wellbeing checks and follow-up because I think many universal services and neonatal outreach/follow up clinics would say they were already doing this, but this is not being done in a robust, evidence based or appropriate way. Can this sentence be made stronger to highlight that '...and how are you mum?' isn't enough to assess parental wellbeing and functioning. Perhaps something like 'Robust parental wellbeing checks and follow-up from appropriately trained staff (including signposting and support to access community mental health and other services), or having a similar caveat as you have on the 'bereavement support' bullet (with appropriate training and supervision in place for staff to provide this at a universal level) Page 14:- really pleased to see section on using translators and families with low literacy. Thank you for including. Peer support groups are undoubtably helpful. Guidance on these is important to ensure are participants are safe and kept well. Could the guidance just allude to the need for governance and support around these groups. Page15: Penultimate paragraph sentence 'However, differing medical criteria between hospital Trusts and across regions has resulted in some families not 'qualifying' for outreach support which has influenced poorer health outcomes and parental wellbeing.' We are not sure this fully captures the issue. Separating out parental wellbeing makes it sound as though this is not a health outcome, when in fact I would say mental health and wellbeing outcomes are health outcomes. But	**Pg 13 Wording changed and Appendix K link added to text** **Peer support groups recommended are facilitated and organised by outreach nursing staff so fall under the governance processes of the service.**

also, poorer parental mental health directly impacts infant health and wellbeing so separating in this may may not show the extent to which parents need support in order for their infant to be well. Therefore could suggest: However, differing medical criteria between hospital Trusts and across regions has resulted in some families not 'qualifying' for outreach support which has influenced poorer health outcomes for the infant and poorer outcomes for parents and families, particularly in relation to their wellbeing which in turn negatively impacts infant health and wellbeing outcomes.	
Page 17: - this is all excellent. Thank you for including this.	**Pg 15 wording changed accordingly**
Page 19: Sentence after first two blue boxes: Neonatal outreach teams should have enhanced skills and knowledge to recognise and signpost for mental health concerns in the family (see education section). Add This will require adequate Psychological professional time to deliver skills training and support and supervise teams around mental health and wellbeing.	**Already referenced throughout document**
Page 20: Second bullet point starting 'with the the current limited AHP and psychology...' Please can we add to this Outreach provision should not take away from or diminish inpatient provision which is currently low and underfunded in all neonatal units. AND Where support comes from community AHP or psychology services, adequate training and support needs to be provided to ensure that these teams understand the needs of neonatal families. This training and support could come from in-unit teams or at regional level but needs to be funded.	**We agree that these services are integral and should not be diminished to provide service to outreach care. And this has been added to the text of this section.** **Referenced in education and training section**
Page 36: - see comment re data re page 12. We need to also ensure that data which captures experience of families is also being gathered so it's great that this is included in the table on P37. Thank you. It would also be good to gather data on staff teams including sickness absence, turnover and staff wellbeing. Evaluations from training with assess utility of training in role and	

quality of training would also support us to offer the right training to these teams and to universal services teams. .	**Agree data collection of this is important but should be a wider neonatal data collection and outside scope of this document.**

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Name: Rebecca Davidson	**If you are answering on behalf of an organisation please state:** Pre 5 complex needs team NHS Lanarkshire Scotland
General comments: The document looks detailed and informative. It encompasses the need for a wider multi-agency team which is reassuring.	**Working Group Response:** Thank you for this information
Specific comments: It may be helpful to know that the UK Speech and Language Therapy CEN for neonates who determined the algorithm for numbers of SLT in neonatal units is currently focusing on an algorithm for SLT whole time equivalents required to support neonates within the community setting.	

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Name: Jacki Dopran	**If you are answering on behalf of an organisation please state:** Herts and West Essex Local Maternity and Neonatal System
General comments: Thank you for this framework draft, it is long overdue and a really excellent document	**Working Group Response:**
Specific comments: On page 19, Safeguarding, really good to see the information on lone workers. Our LMNS has a community working group to support development of outreach work and the factor that comes up most frequently as a risk, is the lone working and lack of oversight in the Trusts to support their workers, often the Trust security and corporate teams are not aware there is a neonatal outreach service. Please could there be additional detail around documented risk assessments for lone worker for visiting babies and families homes, this could include interfaces to the wider hospital groups who undertake outreach and full awareness of "no-go" areas in the community foot print and also where x2 workers should attend . We also found that some outreach services were sharing mobiles and the quality of the phones was poor, a comment around appropriate apps and quality of mobile of devices would be very valuable. The RCN guidance is very valuable see: https://www.rcn.org.uk/Get-Help/RCN-advice/prioritising-personal-safety. Data: The neonatal Badger system has a community module which in HWE we have found to be very supportive for base line data. Historical commissioning QIPPs may also be of help in data gathering to get a base line, as these looked at LOS for booked and born babies and strongly supported pathways to the community setting - great for the babies and families Thank you again to the BAPM and the working group for this work.	**Pg 19 – Thank you for the information. The need for risk assessments included.** **Thank you for this information.**

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Name: Maria Francis	**If you are answering on behalf of an organisation please state:**
General comments: Largely a positive step in the drive to improve and standardising community care	**Working Group Response:**
Specific comments: Not specifically localised, although relating to the educational needs of staff providing NCOT services.(Education and Training pg 26) Much is made of the need for 'services ..not be seen as a separate entity but as part of this continuum of care..' and the need for 'enhanced knowledge and skills in the care of babies', including an anecdote from a parent perturbed by the lack of careers inexperienced in the extremely preterm baby' but then advocate that nurses do not need to be QiS before working in the community setting? If NCOT staff are to 'be drawn from experienced staff' and the robust national drivers are that all nurses working in Neonatal settings be QiS, then having non QiS nurses is contradictory, and diminishes the quality of care offered to families in the community. Whilst there is a place for non registered staff, and learning opportunities for nurses pre and mid QiS, it is imperative that staff being tasked with decision making and potentially delivering 'hospital at home' services, be appropriately trained…ergo QiS. Much work has been done to move away from the idea that QiS is only necessary to look after babies in acute critical settings, and is part of a continuum of learning essential for ALL registered staff in speciality. To not advocate for this in the framework would be a backward step in the continuing care of neonates post hospital discharge. No nurse leaving university is equips with the required knowledge and skills needed to deliver neonatal care , and to potentially offer an 'out' in term of core neonatal education should not be encouraged.	**Thank you for this insight. The Framework group feel quite strongly that there are many groups of staff experienced in neonatal care who are non QIS. Non-QIS staff (including experienced peadiatric community nurses, health visitors and midwives) can have a role in outreach services with the support/supervision of QIS staff. The make-up of the outreach team will depend heavily on the size of the team, the level of services offered, and local population needs. The essential element of having non QIS staff working in outreach care are robust supervisory and escalatory pathways as well as a robust foundation training programme for all staff undertaking outreach support (see Education and Training section)** **This also supports career progression for nursing staff with a desire or flair for working in outreach care who may then take the opportunity to undertake QIS training whilst in the outreach role.**

Additionally, can clarity be given re: the governance responsibility of any potential ODN Lead role. ODNs do not have governance responsibility for clinical services.	**Wording changed in leadership in outreach section**

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Name: Claire Inglis	**If you are answering on behalf of an organisation please state:** Leicester Neonatal Service & East Midlands Network Lead
General comments: Feedback from Leicester Neonatal service in relation to the draft BAPM National Neonatal Outreach Framework & East Midlands ODN 1. Concern in relation to practically being able to offer the service to ALL families whom have experienced specialist neonatal care. Concerns this may dilute the service and affect the ability to provide the support to those in greatest need .Time to be able to triage the level of support required by ALL families in a large tertiary center. There needs to be a minimum standard nationally agreed outreach criteria that ALL units should follow and work towards (which is not clear in the framework) before trying to establish a service that is offered to ALL. Maybe a stepped approach whereby if a minimum standard agreed criteria is achieved then offer families ability to self refer in for additional support or staff consultant referral outside of standard criteria (However would need the additional funding to be able to deliver). Any additional staffing will of course also deplete QIS workforce of which there is a National shortage. Therefore best option to be able to deliver a robust equitable service nationally to a defined higher risk group or clear group of babies eg tube feeding , oxygen , phototherapy , All babies less than 32 weeks <1.8kg BW etc . Units can then be assessed as to whether they are meeting this before moving onto to deliver to All. Maybe a bit like a BFI or BLISS accreditation. Achieving Level 1,2 or 3 . Or bronze , silver , gold , platinum .	**Working Group Response:** **Agree that meeting these standards will require local services review, development planning, and review of staffing capacity.** **The fundamental elements of care are detailed in the service delivery section of the framework. (pg 14 service delivery standards).** **This will have to be determined locally based on service model, elements of care offered, and staffing.** **Out of the scope of the document**

At the moment it is too woolly to be able to assess each unit & identify gaps or standardize 2. There needs to be more guidance as to how to categorize the level of care provided, so that every unit records data in the same way. Daily like on badger or would weekly for each baby at home work better ? – recording the highest level for baby for the week . 3. Categories of care – is this to be only applied to Outpatients ? Or can it be applied to family support pre discharge home? If not it is important to establish what workforce time is required in addition to provide this inpatient support / parental education etc . For example : 1 WTE for Inpatient work perhaps in addition to outpatient support . 4. What is the visionary service to be offered in terms of bereavement or NAS? At what level of involvement eg Phone calls, Home visits post bereavement, treatment at home for NAS or observation What if another team already provides this service in different units? For example Home phototherapy maybe already be in operation but provided by community Paediatrics or midwifery? Home oxygen maybe provided by community Paediatrics. Would the outreach team change their practice to take over this care up to 6 months then refer on? Maybe already a designated bereavement service that keeps in contact with the family outside of Outreach? Perhaps support still required for Parents of multiples whom the outreach team would support families of surviving babies in the community. Therefore need the skills required. Maybe differences between services in each unit. Therefore clear defined level of support required in order to establish if more service provision is required. If the current service provider cannot provide a nationally defined level of support , do outreach compliment to fill the void .	**Must be responsive to local need and reflect the service delivery standards.** **Out of scope of document but NNOG plan to look at in the future.** **Staffing recommendations are based on data from services providing the full service delivery standards.** **Categories of care are only applicable for patients in their own home.** **To be determined at local level.** **Consideration needs to be given as to whether other services are meeting all needs of the individual family. A combination of services input may be required.** **There is a maximum recommendation for handover to paediatric services by 6 months post discharge. There may be cases where it is appropriate for earlier transition to paediatric services.** **?Add in conjunction with local specialist services.**

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Specific comments: Please see above comments in question 5	

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Name: Kim Edwards	**If you are answering on behalf of an organisation please state:**
General comments: A very detailed comprehensive co-produced document the appendices can add some distraction to your chain of thought. The models of provision across hub and spoke and LMNS footprint were very clear and detailed. Obviously the quantification of the workforce will be an on going piece of work. Will this be done in parallel with the training and education requirements? Should it be mandated that all staff rotate back into the unit for maintenance of skills and knowledge? The collaboration with the Third Party Sector . As one of the Lead Nurses involved with the work around increasing clinical placements for undergraduates it is good to see it identified in the framework as a placement opportunity In hub and spoke model consideration of line management responsibilities. The case studies bring the document to life. Thank you.	**Working Group Response:** **Out of scope of this document** **Thank you for your positive comments**
Specific comments: Pg 11 Leadership in Outreach should the lead role have both leadership and management responsibilities of the team managing sickness and appraisals workforce planning etc Pg 12 Under Governance should you reflect coaching and mentoring as well as supervision and peer support.	**Determined locally- this will depend on the size and structure of the team/unit** **Added**

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Name: Miles Wagstaff	**If you are answering on behalf of an organisation please state:**
General comments: I like it. Its quite long, and I must admit I haven't necessarily read the whole thing word by word...	**Working Group Response:** **Thank you. Formatting changes have been made**
Specific comments: Some of the formatting needs tweaking - for example, on the 'summary of recommendations' page, some paragraphs have a space before the words start, others not. In the summary, some (most) recoomendations are 'should' or 'need to' or 'requires' - this is lacking in recommendations 10 and 12. I get they are recommendations, but they just read differently to the others. (Nothing major!)	

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Name: Michelle Sweeting RCSLT Neonatal CEN & ODN SLTs commen	**If you are answering on behalf of an organisation please state:** Royal College of Speech and Language Therapists Neonatal Clinical Excellence Network and Neonatal Operational Delivery Network SLTs
General comments: Thank you so much for including SLTs as part of the AHPPPs in this framework. We are delighted that there will be a framework to guide commissioners and trusts in how to implement this service for babies and families. I am unable to submit all of the comments in box 6! So I will submit in parts. Any problems please let me know, I am happy to send in Word format if that is easier?	**Working Group Response:** **Thank you for your positive feedback**
Specific comments: P7 Para 2 Bullet point 3 - Is this specifying specialist neonatal outreach rather than services provided by paediatric nurses, medics and AHP's? It seems an important differentiation to make P8 Para 7 Scope and purpose - "support the development of services" should this read multi-professional services? P9 Para 5 - "working models of care" – should availability/funding of working models be noted here as may not have AHP funding? P10 Para 3 – "The evidence around neonatal outreach services is growing (see Appendix A and Appendix C for supportive literature)" - It would be helpful if the evidence could be linked to the statements here even if it is the number of reference P10 para 3 – "Linking primary and secondary neonatal and paediatric services." Will there be any acknowledgement of the potential challenges too if outreach is not appropriately funded as a multi-professional resource e.g. reduced access to timely specialist feeding, AHP and Psychology support to optimise feeding outcomes. There will be the likelihood of later recognition of feeding difficulties (as they will be	**Pg7 – Neonatal outreach is inclusive of all members of the MDT supporting families in the transition to home as defined on pg 9.** **Pg8 - Outlined in neonatal outreach definition** **Pg 9 – This paragraph summarises the study in appendix and funding not researched.** **The references added here are support more than one element of the benefits of outreach care and the working group felt it was not beneficial to link the evidence in this way** **Agree that the standards will require additional funding in some regions.**

discharged earlier at the point of starting sucking feeds), fragmentation of MDT decision making which happens for inpatients. Parents potentially needing to travel with their baby earlier to see specialist services. The benefits will depend on appropriately resourced outreach models.	
P11 Para 1 - “Lead innovative and family integrated care practices in the home.” If the baby is at home, FiCare doesn’t seem an appropriate term. Would “collaboration/enabling/empowering/family delivered” be more appropriate	**Pg 11 – The family integrated care principles are applicable in the home environment, especially in delivering hospital at home programmes.**
P11 Para 1, P45 9th bullet point, P56, Appendix 1 Para 2 – “Ensure good communication with stakeholders.” Consider change to “interest holder” “Interest-holders”: A new term to replace “stakeholders” in the context of health research and policy - Akl - 2024 - Cochrane Evidence Synthesis and Methods - Wiley Online Library Noted 3 times in the document	**Noted – thank you However we feel this is not a terminology recognised at this time.**
P11 Para 5 - ”parents or carers.” Change to baby, parents and/or carer	**Pg 11 Wording Changed**
P11 Para 5 - “Teams should agree a suitable schedule of meetings with the neonatal unit multi-disciplinary team (including consultant/designated ANNP, psychologists, and allied health professionals) to discuss the patients in the community.” This seems to imply that these people are not part of the outreach team.	**Pg 11 Rephrased this sentence to reflect MDT outreach team**
P12 Para 1 - “All outreach staff should be working to agreed competencies and educational standards. (see Education and training section)” add in scope of practice as well	**Pg 12 Added**
P12 Para 2 - “Outreach teams should include AHPs and psychologists trained in neonatal care where fully funded unit neonatal staffing recommendations are met.” This is a high criterion and we can only think of one unit that has full AHP funding in London. So will full inpatient funding be needed before we can get	**Pg 12 AHP and psychologists should be part of the outreach service however, as highlighted, with limited funded posts/people in post we**

“additional” funding for outreach posts? This is what is implied here. P12 Para 2 “Additional funding may be required to further develop AHP and psychology services to meet the demand of support required by families under the care of outreach teams. In the absence of sufficiently funded services local escalation pathways should be developed.” “will” instead of the word “may”. Replace “under” with “as part of”. Otherwise it sounds like the AHPs sit outside of the outreach team What is meant by “local escalation pathways”? P12 Para 3 - “Ideally, all notes should be accessible to other community professionals such as GPs, Health Visitors and community AHPs.” Could be linked to BAPM Electronic Health Record work. P12 Para 4 - Reporting - Is there an appendix document that could give examples of suggested data collection points? Maybe with a hyperlink to Table 1	**wanted to acknowledge that this will influence the needs of the families and the capacity of AHP’s to care for babies in the community.** **Unchanged as there are some areas that are funded already.** **Wording changed** **Where there is no neonatal AHP local pathways of escalation should be developed, i.e. to paediatric service.** **Pg 12 – Agree.** **Pg 12 – Hyperlink added to refer to data section**

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Name: Michelle Sweeting	**If you are answering on behalf of an organisation please state:** RCSLT Neonatal CEN & ODN SLTs (part 2 of response)
General comments: See part 1	**Working Group Response:**
Specific comments: P13 Para 2 - “Growth monitoring and well-being checks.” Does this imply to health visitors they no longer will need to do this? Is there a potential of loss of building HV relationship that is needed to continue after neonatal outreach have discharged that could be interrupted by this and amended by a wording tweak? P13 Para 2 - “ Infant basic life support training with parents/carers, safe sleep guidance and other health promotions.” Would this be done before they transition to home or would the outreach team come in to the unit to do this? P14 Para 1 - “These can only be offered by outreach teams operating a robust seven-day-a-week service:”. How is robust defined? Staffing, MDT workforce? P14 Para 2 – “Direct face-to-face contact:” What about on the ward - one of the Bliss Baby Charter elements around meeting outreach teams on the ward before going home? What about the families that transfer at 44 weeks+ to children’s wards? Would they be seen there? P14 Para 4 - Home visits – could AHP input not be delivered in the home as well as being mentioned in the Outreach Nurse led clinics. P14 Para 4 - “Peer support groups” – this does not need to be outreach nurse lead – maybe consider deleting as it could be run by a number of professionals or unit charities. P15 Para 1 - Video call – remove brand name “Attend Anywhere” as could be seen as marketing bias P15 Para 3 - “The vision for neonatal outreach services is that all babies and families who have experienced neonatal care have equal access to	**Pg13 – Working added ‘In conjunction with universal neonatal services’** **Pg 13 para – Health promotion advice can be given by either the unit staff or outreach teams. Meeting needs for parental knowledge and skills should be determined locally.** **Pg 14 Para 1 - Robust (dfn: able to withstand or overcome adversity) is a sustainable service offering 7 days a week care. I.e. contingencies for annual leave/sickness cover.** **P 14 Para 2 – Section wording changed to highlight section is referring to community care.** **Need for presence on the neonatal unit stated in ‘readiness to transition to outreach care’ section** **Guidance for families transferring from Neonates to Paediatric services currently under review.** **P14 Para 4 Home Visits– Locally decided dependant on best use of resources available.** **Other peer support groups are out of scope of this document** **P15 Para 1 – Removed** **Thank you for your comment**

expert neonatal teams to support the transition from unit to home relative to their need.” We think it is good that “all” babies are included as often late preterms are often excluded and often still need support from experts and early identification of needs will really make a difference to the babies and their families. P16 Para 3 - Table 1 - 3rd column, 3rd row – “Growth and feeding monitoring”. P17 Para 2 – “Feeding effectively at regular intervals by the preferred method on a stable feeding regimen for 48 to 72 hours prior to transfer home. This can include top ups by nasogastric tube. Parents should be confident in assessing feeding effectiveness using appropriate feeding assessment tools (see Appendix G for guidance on effective feeding and feeding assessment tools).” - This does not sound very responsive or cue based. Maybe rephrase to Feeding by breast and/or bottle in response to feeding cues 8-10 times in 24 hours for 48-72 hours. P17 Para 3 - “Specialist referrals for ongoing care - Liaison with neonatal/paediatric AHPs, psychology, the paediatric acute and/or community team.” As this is pre-transition home it should be neonatal AHPs not paediatric Will outreach cover stoma care, replogles, oesophagostomy- if not add surgical or medical clinical specialities as well. P20 Para 3 - “most local outreach service to the family's home address.” - Most community services in the NHS are commissioned on GP locality rather than address due to funding streams etc. It would be helpful to align this guidance with other guidance being used in ICBs and community Trusts. P20 Para 4 - Car (can be own transport with…) needs access to satnav P22 section “Services models” - “Service models” – it isn’t clear from the document who should be funding this. Would it be ICBs commissioning provider trusts?	**P16 Para 3 – Wording Changed** **Amended to include response to feeding cues** **For those infants requiring longer term care at point of transfer home, their care needs maybe be best met by specialist paediatric services.** **What if no neonatal AHP, would it then be paediatric?** **Added ‘diagnosis-specific specialist nurses/teams** **Neonatal Outreach is a hospital-provided service.** **Out of scope of document- local policy** **Commissioning pathways are out of scope of this document.** **Commissioning out of scope. States LMNS/Systems Which covers ICB.** **We felt this section flows with relevant information and background.**

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P25 Table 2 – Should ICB's be mentioned here for commissioning services across LMNS's in the regional/network section P26 Education and training - There is some repetition in the document from the previous section on education – could they be combined to shorten the document and help with flow? P28 Table 3 - This seems to only relate to knowledge and skills for nursing and not to other HCPs such as AHPs and related competencies in line with their scope of professional practice working with neonates.	**Tabel 3 column one is core knowledge for all staff working in outreach teams. Profession specific expertise is referred to elsewhere in this section. Added text 'meet profession specific competencies for outreach care, where these exist'**

Name: Michelle Sweeting	**If you are answering on behalf of an organisation please state:** RCSLT Neonatal CEN & ODN SLTs
General comments: See part 1	**Working Group Response:**
Specific comments: Part 3 of 3	
P28 Table 3 Column 1 row 8 - "Basic awareness of child development and movement patterns" consider rewording to encompass breadth of awareness of all core infant developmental milestones e.g. social-emotional, cognitive, communication, feeding and movement	**Wording changed**
P31 Figure 1 – Shouldn't AHPPPs sit alongside nursing colleagues on this diagram? Or otherwise as part of the team around the baby and family. The medical team is absent here as well. Maybe the diagram could be relationship/co-dependency based rather than a hierarchy shape? A gold standard service model would be ideal to depict here.	**Thank you- we have amended**
P32 Para 5 – "Even in those areas where staffing recommendations are met there is often still insufficient capacity to take on the additional work required for outreach." Outreach funding would need to be on top of WTE inpatient funding. This seems to imply it would come from a funded inpatient service.	**Wording changed to be clearer around additional funding required to support outreach services** **Funding for outreach services has yet to be determined for any discipline.**
P32 Para 6 - "Urgent focus must be given to fully establishing acute unit AHP and pharmacy workforce standards before the outreach workforce is developed". This created a lot of discussion from our members. We are not sure that this is the main reason for not looking at funding the AHP outreach workforce. Early intervention is important during the inpatient stay but as the babies will be going home earlier they will need ongoing neuroprotective care to optimise outcomes including support with establishing feeding. If anything outreach without AHP support will take away what the babies and families could have received if they remained inpatients for longer. This again	**This aims to reflect the development of embedded inpatient AHPP services will impact on early intervention, the neonatal journey, education and upskilling of staff and families – which in turn will enhance transition to home......** **Reworded the sentence to reflect this** **Agreed that earlier discharge should not limit the specialist support given to families.**

seems to imply that the outreach service is going to come from the inpatient funding (when fully funded) rather than additional funding.	
P33 Para 4 - “data clerk” could this be a data manager? Admin support will be needed for booking appointments, updating databases, sending reports, ordering equipment etc.	**To be locally decided**
P39 NNOG parent survey - Where there any unrepresented groups? Did you get responses from anyone who had English as an additional language, learning disabilities, teenage pregnancies, or do you need to acknowledge there are some marginalised groups that are yet to be represented?	**These demographics were not collected as part of the data. We acknowledge that feedback from these groups is essential to shape ongoing services in neonatal care**
P50 - “Liaising with AHPs” Stoke Mandeville Hospital (Thames Valley & Wessex ODN)” This being used as an example for SLT in the team needs to have the context that the SLT team have no funding to provide this service and it currently comes out of SLT therapies budget and is not future proofed if there was a change in service manager.	**Returned to author for review**
P52 Para 1 - ‘Responsively’ and ‘at regular intervals’ are opposing statements - needs correcting please as incorrect application of terminology. Also effective, consistent oral feeding would imply there’s little need for home tube feeding and doesn’t seem correct? Effective oral feeding is not the same as responsive feeding. Suggested rewording “Babies can be fed in response to feeding cues by breast and/or bottle in response to feeding cues 8-10 times in 24 hours for 48-72 hours. They should be demonstrating responsive feeding to maintain nutritional intake to support growth.”	
P52 Para 4 - Suggest replacement for “yet skilled feeders” to “Whilst some babies may be able to feed, skilled feeding, co-ordination and organisation does not occur until post-term.”	**Wording changed**
P57 Para 2 - “During the introduction of AHPs to neonatal services” did you mean “integration” rather than introduction?	**Intended to be introduction.**

P57 Para 3 - integration into neonatal outreach services"- AHPs have already been providing these services with health visitors for many years P58 Para 3 – Speech and Language Therapist – section – we have contacted Beth SLT in Worcester, as CEN members to support with rewording her section directly. This will be sent to Sara Clarke as soon as possible for updating. P65 – post discharge – change to ?"transition to home"	**Wording changed**

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Name: Emma Capewell	**If you are answering on behalf of an organisation please state:** NHS Highland
General comments: I am commenting on behalf of NHS Highland. Our Neonatal Unit is a level 2 neonatal unit, situated in Raigmore Hospital, Inverness. We have capacity for 14 babies or 16 points as defined by the British Association of Perinatal Medicine (BAPM) 2011. We admit between 200 to 300 babies a year for neonatal care. We serve the Highland Council area of 26484 square kilometres, including several islands, and we have the lowest population density in the UK at 8 people per square kilometre. Examples of travel times by car include 2h45min to Durness, 3h to Uig, 3h to Acharacle etc. We currently have a limited neonatal outreach service for 6 hours a week, offering telephone or video appointments to families of infants less than 32 weeks / <1500g BW / cardiac issues / terminal care. Babies on home oxygen or requiring long-term nasogastric tube feeding are cared for by the childrens community nursing team. Our geography and low population density make us unique within the UK and we would welcome any advice or input from your team as to how we might practically be able to implement your recommendations.	**Working Group Response:** **Thank you for your comments. There will be a launch of this framework and supportive discussion on implementing recommendations to come.**
Specific comments:	

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Name: Dr Susan Kamupira	**If you are answering on behalf of an organisation please state:** Newborn services, St Mary's Hospital , Manchester University Hospitals NHS Trust
General comments: Pathway for follow up of babies that are being discharged following surgical care would be good . Often these babies have prolonged admission on the neonatal unit and may have specific requirements e.g stoma care but also monitoring of growth and feeding support.	**Working Group Response:** **Thank you for your comment. The framework recommends all babies transitioning from neonatal care should have access to outreach care, alongside care from specialist teams as required.**
Specific comments: Page 13-14. Service delivery standards- Outreach teams offering end of life care at home- this would require significant input into resources and would be better provided via palliative care service due to support required which may include out of hours work. Page 16 - Recommendation of telephone check on all babies transitioning home from neonatal care- it maybe useful for this to be provided to babies that have had more than a brief admission to NICU- We currently offer outreach follow up if babies have been admitted for more than 7 days.	**Thank you. Wording changed to reflect outreach working alongside palliative care services.** **We are seeing increasingly shorter stays in TC as well as NNU. Our vision is for all families to have equitable access to outreach irrespective of the time spent in under the care of acute neonatal services.**

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Name: Amanda Lawes	**If you are answering on behalf of an organisation please state:** Neonatal Network OT Leads group
General comments: We strongly support this document and especially they key role AHPP professionals provide to Outreach services. It would be helpful if all the quotes used consistently state where they've come from e.g. parent. The purpose of this document is excellent and clarifies what it does and doesn't offer in a very clear manner. Visual examples of training are very good. Varied example of practice are also excellent and can be used to inform the development of new/future services. This is an excellent document and huge thanks to the hard work of the authors for collating this -Fantastic work!	**Working Group Response:** **Thank you for your support and positive feedback.** **All quotes stated are from parents who completed the NNOG survey. Stated in introduction.**
Specific comments:	
Page 9 - agree that working across boundaries is positive and aspirational but in practical terms can be challenging, draining on resources. Good to look at digital resources to support this where possible.	**Agree. To be locally discussed amongst teams.**
page 10 - inconsistent use of full stops in bullet points.	**Amended**
page 11- Leadership in Outreach: should also involve harnessing effective /embedded co-production in shaping services.	**Added**
page 13 -could this also highlight Community AHP groups or national charity run peer support groups.	**Community led or charity run peer support groups are out of the scope of this document**
page 13 -service delivery standards : The appendix refer to developmental support and need for AHP provision as part of outreach, therefore this should be mentioned within the 'service delivery standards' bullet points on page 13 e.g. consideration of development within critical period of neuroplasticity.	**AHP's are inclusive of the outreach service so haven't segregated disciplines. Added development tot this service delivery**
page 15 -may be worth acknowledging technology/data poverty as not all families will have access to phones/laptop/data.	

page 16 - Categories of Outreach support - would minimum level of support for babies with NAS fit better in level 3? page 32- AHP workforce-although important to establish acute AHPs as a matter of urgency - also important to consider requirements for AHP input into outreach at planning/development of services - to ensure all funding options/models are considered . page 37 - Family experience: ensure feedback is from wide representation of families. Use EDI actively to achieve this. page 37 -Recommendations for data collection: says seek advice from unit/psych for tools for parent confidence, parent infant relationship and parental mental health- should also include OT as also specialists in parent/infant relationships . page 62 OT support - maybe change parent engagement to family support - to highlight importance of family unit and recognize individual make up of family unit rather than solely parents.	**Added to Contacts section** **This is minimum and level of need to be determined on case by case basis. If baby/carer required level 3 care this can be delivered.** **Thank you – wording amended to reflect this** **Added** **Added** **Amended wording**

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Name: Julia Cooper	**If you are answering on behalf of an organisation please state:** East of England Neonatal Care Coordinators supporting EoE Outreach Group
General comments: *When more data comes in we will be able to quantify a maximum caseload for outreach services, staffing levels, geographic areas etc *Mentioning general support and advice, all be singing from the same hymn sheet as parents often mention they have conflicting advice. *Would be nice to integrate the Health Visitors more, finding that they often step back when we are in situ for weeks at a time. * The priority at the moment should be getting this service in place for every neonatal unit, rather than enhance the units that are already able to offer an excellent service * Ensuring there is adequate staffing to meet the demands in the current climate will be extremely challenging without capital input *There should be an agreed time limit to the service, e.g. neonatal commissioning 44/40 *LMNS Hub and Spoke Model although a good idea in theory would not work when working under 2 ODN's *To implement the framework capital funding would be needed *Education package would be needed to support package - at regional or national level? *A timeframe for full implementation would be helpful *No mention of national tariffs	**Working Group Response:** **Thank you for your feedback.** **Increasing standardised data collection is essential to support future planning.** **We actively encourage multiagency working to support transition home** **Commissioning of services is out of the scope of this document** **Agreed** **This is included in the document** **We hope to see this develop regionally and nationally with the publication of this framework** **Out of the scope of this document** **Current services offer a range of length of outreach care. The working group agreed that baby and family care needs are best met by neonatal teams until 6months after discharge** **This will need further scoping and depend on regional activity.** **Thank you for feedback**
Specific comments: *Page 7 Recommendations up to 6 months post discharge - hoe are they funded post 44 weeks *Page 11 - Leadership - Network WTE requirement not addressed *Page 11 Governance - I love the fact that there should be a named consultant that has dedicated time allocated for oversight of the	

outreach service as sometimes getting hold of a consultant sometimes can be challenging when things are busy even their named ones.	
*Page 13 - *Bereavement paediatric community teams are excellent at offering end of life care, the neonatal teams can prepare babies for discharge but surely this specialist team are better placed to give this care	**Consideration of supporting families with surviving babies from multiple births. As well as working alongside specialist services to support palliative care**
*Page 15 Parental wellbeing checks: I feel we don't always do enough of these and using the video attend anywhere again will most definitely help with this	**Thank you**
*Page 15 - Regular MDTs for caseload review - encourages positive working relationship	**Agreed**
*Page 16 - Having the Categories of Neonatal outreach support levels will be really helpful for example it will reduce time on the road travelling to parents when a call may well suffice if parents are happy	**Agreed – flexibility to meet baby and family need**
*Page 19 - Safeguarding families and staff- who pays for breakdown cover?	**Refer to local policy on use of own car**
*Page 33 Data collection and administrative roles - WTE requirement not addressed	**This will need to be determined locally taking into consideration the role required and service model of the outreach delivery.**
*Page 33 Data collection - will there be a national dashboard	**This will be ongoing work linked via NNOG**

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Name: Hannah Cashin	**If you are answering on behalf of an organisation please state:** NDiG document review group and NDiG outreach/follow up working group
General comments: It is a great document and a good start as a framework for outreach services. Positive feedback around the quotes interspersed in the document, the infographics for the NNOG parents survey, the examples of good practice, and the examples to highlight the role of the MDT is really effective.	**Working Group Response:** **Thank you for your positive feedback**
Specific comments: 1. Scope of the document - a general comment The definition of a neonatal outreach service (P9) clearly states that this service is a multidisciplinary team of staff however it seems like the majority of the document is really about nursing teams/structure/knowledge/skills. The AHP and medical sections seem to be a bit of an 'add on' and are either a bit vague or relegated to the Appendix. Clearly, reworking the document would be difficult however it may need to be highlighted early on that this document is really about nursing - maybe even in the title. It's a reflection of how NCOT services have evolved so far so maybe a future document would be more inclusive of medical and MDT guidance. 2. Governance Teams should agree a suitable schedule of meetings with the neonatal unit multi-disciplinary team (including consultant/designated ANNP, psychologists, and allied health professionals) to discuss the patients in the community. It feelt a bit vague bunching AHPs together as there is no explanation about the specific skills set that AHPs bring, however these are nicely explained in the appendices, so you could get through the whole document and not understand why we can improve outcomes.	**The MDT group felt no further adaptations needed. The document aims to highlight the need for multi professional working in this area** **Specifics of interventions and outcomes for AHPPs are detailed in the appendices.** **And are listed in contents at front of document.**

3. Referral pathways Suggested change of wording - “Additional funding WILL BE required to further develop AHP and psychology services…” 4. Levels of support in the community It was suggested that babies probably don't need the same level of care or access for example a term baby with a 1 day admission who can return to normal post-natal care. 5. Service models “With the current limited AHP & psychology availability across UK neonatal units, support may come from NNU AHP/psychology staff or community AHP/psychology staff depending on available resource, service model and funding. Some outreach service models may need support to ensure adequate access to AHP/psychology input is in place” – it was suggested that this is quite vague, should this not say “all outreach service models need to be supported by AHP/psychology though no standardised recommendations currently exist”. 6. Education and training - All about nurse training and not really AHPs. This probably needs to say something about the role of other AHPs advising nursing staff and supporting parents with their babies where relevant. It should say that nursing staff reviewing babies need an ability to screen for other services within the MDT to ensure they get the right information to refer to OT/physio/psychology/dietetics during the outreach care period. We need to be careful not to say that nurses can do all of our roles until the babies are faltering/not developing etc. Table 3 is not very clear - what is it showing? Is this training needs for the different roles or 2 different things, training needs and then different speciality roles within outreach? 8. AHP Workforce It was understood the reason for this being in the document with the aim of funding inpatient services first and reducing the need for long term follow up, however, the way this section is	**Some services are already funded** **Our vison is equity of access dependant on need for all families who have experienced neonatal care.** **The essential contributions of non- nursing staff to outreach care is embedded throughout this document. This section identifies the need to ensure access to these professional groups.** **Table 3 column one is core knowledge for all staff working in outreach teams. Profession specific expertise is referred to elsewhere in this section. Added text ‘meet profession specific competencies for outreach care, where these exist’** **The text also includes reference to training others, with some of the core knowledge and skills training in the table and text of this section coming from specialist AHPs and psychological professionals.** **The wording has been amended to strengthen the requirement for funded AHP services for outreach.**

laid out under sells the essential input of AHP teams who are being drawn into helping out nursing staff seeing babies in outreach settings as outreach services essentially provide additional capacity for hospital at home services similar to inpatient care as babies are d/c earlier whilst still transitioning to oral feeding and reducing down fortified milks prior to reaching term age...this is later said as well but earlier in the document is not mentioned. The 2nd and 3rd priorities are growth and feeding, nurses are not infant feeding/ BFI trained and as such I think we need to be saying more clearly that the dietitian would be the should be advising alongside infant feeding team where there are feeding difficulties. 9. Data collection section on page 37 – It was suggested to separate number of referrals from number of contacts and collect both. This will help identify shortfalls in service provision.	**The need for a multi professional approach is integral to the success of outreach care and is embedded in the definition of outreach care and throughout the document as a fundamental requirement.** **To aid the reader's understanding of the expertise of individual professional groups and benefits in outreach care we have added extensive details in the appendices.** **Local data collection on unmet need is advised to guide service development.**

Name: Hannah Cashin	**If you are answering on behalf of an organisation please state:** NDiG document review group and NDiG outreach/follow up working group
General comments: See previous submission.	**Working Group Response:**
Specific comments: Submission 2 as I ran out of space on the first one. Continued.... 10. Appendix H These are really good examples of service models across the UK with useful detail on workforce. It would be really helpful if the services described were able to share any data on the demand on their services, numbers seen, caseload etc. Would be helpful for people to benchmark against when setting up new services. 11. Appendix J Had to be read a couple of times by numerous people. It is actually a description of the experiences in Worcester rather than a general description of the role of the various AHP services. It could be reworded. The layout of this section is a little confusing specifically related to Worcester team and the next bit was dietetics in general. If the document was reworked to be more inclusive of the role of AHP services in outreach then these descriptions could be reworded and added into the main body of the document rather than the appendix. I suppose the lead authors need to decide whether it is essentially a nursing document or is more inclusive (see point 1 on previous submission). SLT “Prior to discharge a plan can be developed where needed where extra support is required when the baby is needing overcome oral feeding challenge” Suggested amendment – “Prior to discharge a plan can be developed where extra	**Agreed- this networking/peer support is available via NNOG** **Thank you for your comments: but this is an EXAMPLE of AHPP working from an LNU. This is a review of how they have worked together to embed AHP & psychology services in their established outreach service.** **It is not a service specification, rather more personal experiences.** **Role descriptors for dietetics are included in this appendix.**

support is required for babies to help overcome feeding challenges”. The quote also could do with reworking as doesn't quite make sense Dietitian reworked this bit. “Identifying early faltering growth is key both on the neonatal unit and in community. When growth is a concern, a feeding plan should be made prior to discharge. This will usually involve the multi-disciplinary team, consisting of SALT and infant feeding lead for lactation advice. Outreach staff should be skilled at spotting faltering growth early and liaising with the dietitian. Depending on service provision, they may contact parents directly by telephone or by attending a joint clinic appointment”. More information on dietetics can be seen on the next page when discussing the role of the neonatal dietitian in neonatal community outreach services – can the above paragraph be linked somehow? There was uncertainty around the appropriateness to define that a neonatal dietitian would go to a paediatric ward. If babies are admitted to childrens wards then they are seen by paediatric dietitians not neonatal dietitians. If babies are readmitted to the paediatric ward for faltering growth and are still under the care of outreach services the dietitian will be involved to review the baby. Typo page 60 – “This means that any existing unit neonatal dietetic services are often stretched”.	
12. Table on Page 61 – “Work closely with NCOT to wean babies off NGT feeds at home while supporting appropriate growth” is entered in the table twice – is this intentional?	**Yes- as this intervention falls into several categories of outreach working**
13. Table on Page 61 – ‘fortifier’ should probably be multi-nutrient fortifier	**amended**

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Name: Christian Chadwick	**If you are answering on behalf of an organisation please state:** NPPG: Neonatology sub-group
General comments: It is a long document with an overwhelming amount of detail. The mentions of AHPs, psychology and pharmacy are confusing: Sometimes AHP is used to incorporate other professions, where sometimes all three are mentioned or only two (some examples are included in the specifics section below but not exhaustive).	**Working Group Response:** **Thank you. As this is the first document to describe an extremely diverse service the working group prioritised the focus for the content.** **Amended where necessary to ensure clarity**
Specific comments:	
Page 3. Stephen McInerney is listed in the members as representing NPPG but we are not sure if that is accurate. Should be listed as his job title because, although he is a member of the NPPG, he isn't representing NPPG on the working group per se.	**Stephen was put forward by the Neonatal committee of NPPG for the NPPG stakeholder seat on the working group.**
Page 4. TVW not defined on abbreviations	**Added in full**
Page 11 (final bullet point). could include clinical pharmacist on list of MDT. Not covered by AHP	**added**
Page 13. It's a good goal to have 7 days a week service but should acknowledge that various MDT roles are not even 7 days a week for inpatients.	**Acknowledged**
Page 16. no definition given for AHPPP. Assume it's AHP, psychology & pharmacy but pharmacy hasn't been mentioned on the preceding pages (e.g. clinics on page 14).	**Added and amended**
Page 23. Refers to AHPPs, which again is undefined but seems to be AHP and psychology. No mention of pharmacy on this page even though pharmacy is mentioned on page 22.	**Added and amended**

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Name: Maya Parkin	**If you are answering on behalf of an organisation please state:** Bliss Charity
General comments: FICare: To ensure all readers have a good understanding of Family Integrated Care, provide signposting to a resource on, or an explanation of, FICare. Feedback mechanisms: One of the key recommendations is that "neonatal outreach services should be responsive to parent/carer need and feedback", however there is no further explanation in the document regarding how to do so. It would be beneficial to strengthen this section to include an explanation of the importance of creating robust feedback mechanisms, which should be accessible for all families, seek to specifically understand the experiences of groups impacted by health inequalities, and that this feedback should be translated into tangible improvements to services. Health inequalities: A crucial consideration that is missing from the Framework is how Neonatal Outreach Services can reach, engage with and provide individualised support for marginalised communities. These groups disproportionately face barriers to accessing care. For example, Black and Asian families, families experiencing social deprivation, non-birthing parents and young parents below the age of 18. The following four points are suggested improvements for how to framework can be more cognisant of health inequalities. 1. Equity in Access to Services. The Framework recognises the existence of a "postcode lottery" in neonatal outreach care and acknowledges that geographic boundaries and service availability create inequities. However, it does not explicitly address how these inequities disproportionately affect marginalised communities. Marginalised	**Working Group Response:** **Thank you - We have signposted to BAPM Ficare Framework for Practice** **One of the fundamental principles of the document is that services are responsive to baby and family need. This is highlighted in service delivery and data sections.** **Further work on collecting parent/carer feedback (data) will be ongoing at NNOG and regional/network and local level.** **This is urgent and essential to inform service development.** **Thank you for this exceptionally important narrative around health inequality. The Framework group acknowledge the complexity of delivering services for these marginalised groups. This document promotes a service that meets the needs of all families who have received neonatal care. It supports multi agency working to ensure all families have equitable access to individualised care that meets the explicit needs of each baby and family. Service development must be in partnership with service users – and this is integral to the Framework.** **The framework group also acknowledge that the complexity of meeting the needs of marginalised families is not isolated to outreach care and should underpin all health and social care.**

families may already face barriers such as language difficulties, distrust of healthcare systems, or lack of access to transportation. Without targeted strategies, these families could remain underserved despite the framework's recommendations for equitable service. 2. Tailored Approaches for Marginalised Communities. While the framework includes guidelines for adapting services based on geography and family needs, it does not emphasise the importance of tailoring services for marginalised groups. These groups often have unique cultural, socioeconomic, and systemic challenges that require specific outreach and support approaches. For example: • Engaging trusted community organisations to build trust. • Providing materials in multiple languages and accessible formats. • Training outreach staff in cultural competence. 3. Data Collection and Monitoring. The framework highlights the need for data collection and audits but does not specify the collection of data on health disparities or the use of data to address inequalities. Tracking the demographics and outcomes of outreach service recipients would help identify gaps and improve service delivery to marginalised groups. 4. Systemic Barriers. There is no explicit discussion of systemic barriers that marginalised families may face, such as housing instability, food insecurity, or discrimination in healthcare settings. Neonatal outreach services must collaborate with social services and community organisations to address these underlying issues. Staff working in outreach services should be given the training and information needed to support this. Recommendations for strengthening the framework through a lens of health inequalities:	

• Incorporate Equity Metrics: Require data collection on service access and outcomes disaggregated by socioeconomic status, ethnicity, and other relevant demographics. • Targeted Training: Mandate training for neonatal outreach teams in cultural competence and implicit bias. • Community Partnerships: Establish partnerships with local community organisations to better reach and support marginalised families. • Parent Feedback: Ensure that robust feedback mechanisms are in place to collect and act on parent feedback to ensure that all voices are heard.	
Specific comments: Page 18: ‘Supporting families through the transition to home process’ could include signposting to/hardcopy of Bliss’ “Going home from the neonatal unit – a guide” booklet. This booklet is available to download from: https://www.bliss.org.uk/parents/going-home-from-the-neonatal-unit.	**Agree- signposting to local and national resources should be included in knowledge and skills frameworks for parents/carers**

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British Association of Perinatal Medicine

Name: Jo Bruce	**If you are answering on behalf of an organisation please state:** Liverpool Womens Hospital Neonatal Intensive Care Unit
General comments: 1) I think this is a great and much needed framework. My main issue is around virtual and telephone contact. For some families this may be appropriate. However, in families were there are challenging social circumstances (neonatal abstinence syndrome is the one cited here), more intensive face to face contact seems important to me. Sadly, we only have to look at what is on the news almost weekly-baby and child deaths, where the families were often known to many services but warning signs were missed. I have personally encountered two cases where health professionals were falsely reassured through virtual contact. Community outreach services are in a prime position to identify and escalate early concerns. I would therefore advocate for safeguarding, bereavement support and neonatal abstinence syndrome be escalated from level 2 to level 3 support as per this framework. 2) I would agree with thee above response regarding certain categories being escalated to sit under level 3 support and wonder if this could be fed back as part of working group. Many thanks for all the work that has gone into this, 3) I think this sounds an ideal Follow up plan to aim for involving the whole MDT to support the needs of the family unit. Although, seems a long way off for us. In the shorter term, the idea of MDT drop in clinics possibly sounds more achievable and very beneficial to families. The parent peer support groups also sound like they are very well received by families. Supporting all NICU babies and small baby pathway, including ngt, phototherapy would be	**Working Group Response:** **Thank you for your positive feedback & examples of care levels to inform the group** **The decision around levels of care will be determined by local teams based on family need and multi agency team working. The Framework group acknowledge that outreach service may not be able to provide every support/care needed by families and recognise the importance of multi agency working in certain circumstances.** **Thank you for your comments**

ideal but obviously need large increase in staffing numbers. 4) Its great and offers a staffing model for future business cases I think its way too long though There are too many examples of things at the end I am not sure people are going to read it all 5) Amazing and long awaited framework with a lot of essential details. Staffing levels and appropriately trained and experienced staff are the principal starting point, and from there the service can then be extended safely and appropriately. Every geographical area will have their own issues and complications to work with, but once the service is able to work to a full capacity, staffing level wise, the framework leads to very successful support network for the families who need NCOT care to feel supported with their baby at home.	**Thank you for your comments. We appreciate that this is a long document – but as this is the first time outreach has been described in such detail it was important to cover as many aspects as possible.** **Thank you for your positive comments**
Specific comments: Page 12: referral pathways/ escalation should include support from a dedicated neonatal dietitian Page 12: information governance – there should be info available re: safeguarding aspects Page 12: reporting – NCOT activity/data should be captured as part of the neonatal dashboard Page 13: service delivery – the future could include involvement in neonatal research support. Also involvement in surgical care (ex: wound management/stoma care/silo care/broviac care etc)	**Agree- content reflects this** **Covered in service delivery- safeguarding section. Strengthened text here** **Recommendation to report to local and national data sets** **Research included as key recommendation** **Local services will determine specialist outreach care pathways**

Consultation responses – Neonatal Outreach Service Framework
Consultation close date – 10 January 2025

British Association of Perinatal Medicine

Name: Jo Bennett	**If you are answering on behalf of an organisation please state:** South West Neonatal Network Outreach Group
General comments: Very helpful framework with helpful examples of practice in the appendices and all information in the body of the framework supported by parent comments.	**Working Group Response:** **Thank you for your positive feedback** **Neonatal outreach should be available for all babies transitiong home from neonatal care (NNU/TC)** **The desire is that baby and family level of care will be individualised, and needs met by the outreach service. The level of care may fluctuate during the baby's time under outreach service depending on need. This is included in the text of the document.** **Nurse staffing recommendations have been based on benchmarking of robust hospital at home services. There will need to be a staged approach for building teams to this level in terms of staffing and service delivery.** **We have amended wording in this section to reflect this.**
Specific comments: Categories of neonatal outreach support level (page 16) Could there be more clarity in this section. Level one, single telephone contact – is that for all babies who had a neonatal admission e.g would this include a baby going home from the postnatal ward who was initially admitted to the NNU for 24 hours or so? Or is this for all babies discharged home direct from neonatal services NNU/TC? Is it too open e.g a 24 week infant who has had a good journey and being discharged home not on oxygen, looking at the table could indicate a phone call only. From a business case perspective, management may look at it and see the minimum level of support only. Some clarity that a baby can enter on any level of the table. Calculating workforce requirements for outreach services. Nursing Workforce (page 33) Several teams have used this calculation and staffing levels seemed almost unachievable. Although recognise this might be gold standard and something to aim towards but could there be a staged approach in increasing staffing to work towards a 7/day service? Or is there another way of calculating staffing? We recognise that staffing needs to increase for the outreach workforce to be able to deliver a 7 day/week service. Is there also recognition of	

the complexity of care of infant needs that different services might see?	
Education and training (page 26) Point 5 on psychologically informed care, could there be recommendations for psychological training for outreach nurses e.g motivational interview training such as health visitors have.	**Agreed- there are some resources for supporting neonatal teams in this area already. Further collaborative work will need to take place to develop local/regional and national training now that this has been defined in this Framework.**
Transitioning from neonatal outreach services (page 20-21) The recommendation of 6 months is helpful to see, particularly where there can be some difficulty in transitioning infants on low flow oxygen to paediatric services.	**Agreed**

Consultation responses – Neonatal Outreach Service Framework
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Name: Clair Scaife	**If you are answering on behalf of an organisation please state:** Y&H surgical in Children ODN
General comments: Submitted on behalf of the Y&H SiC ODN in response to BAPM neonatal outreach draft. 10.1.25 These are responses gathered from senior neonatal surgical nurses within the Yorkshire and Humber ODN. Collated by Clair Scaife Lead Nurse surgery in children Y&H ODN, with additional comments from Ian Sugarman Y&H Clinical Lead Surgical ODN. This is a lengthy document which provides a good framework for an outreach service for medical preterm babies within a Tertiary framework. It is easy to read and understand and is comprehensive. The Parent feedback is good. However, there is very little mention of surgical babies (only one reference to surgery in the document) which is an important omission due to the increased number of complex surgical babies surviving. Many neonatal surgical babies will go home needing surgical outreach service including surgical care at home such as stoma, bowel washout and catheter care. This takes time to support families and neonates for this care. All babies can receive neonatal outreach from 5 days of life. However, it does not describe the criteria or define the patient. For the Surgical neonate there is no detail. For completeness the document should include surgery and neonatal complexities. The document describes medical preterm outreach babies and needs to have surgery weaved throughout document. Furthermore, it needs to have more MDT inclusion in outreach services including AHP provision. Our recommendations are adding and integrating to this document; Define patient, what is neonatal outreach, what fits outreach	**Working Group Response:** **Thank you for your positive feedback** **Agreed- and specialist services to support these infants need to be developed locally alongside outreach care. Depending on the specialist services offered by the unit this may include surgical or cardiac specialists etc within the outreach team. This must be determined locally to meet needs of the population.** **The working group strongly recommends outreach services ALL babies and families who have experienced neonatal care have equitable access to outreach services irrespective of any co-morbidities. Those with ongoing medical or surgical needs may need additional support/care packages from other specialists or external agencies – but this is not in place of outreach care rather working together to provide care needs.** **The working group have moved away from ‘criteria’ for outreach instead are recommending equitable access to outreach for ALL babies who have experienced neonatal**

criteria and how to integrate surgical outreach for the neonate including the MDT. For Trust and services looking at setting up a neonatal outreach service having this criterion added to this national credible document may support with business cases and pathways for Trusts. In summary it's a good document but there is minimal content for the surgical neonate. The Surgical neonate provision is not well defined. It would be more robust to weave surgery into the current document. For Trusts aspiring to set up Neonatal outreach including surgery and for Trusts that currently have neonatal outreach being more explicit for surgical outreach would support them including future proofing these services. Networks are mentioned at several points in the document, but it should be noted that whilst they can provide support, they do not hold any decision-making powers. This is large piece of work which for some Trusts is aspirational at this stage. Some centres are already up and running but for others there would be a massive set up cost involved. Organisations looking to take this on are likely to seek evidence that this would result in an increase in bed availability, decrease transfers and reduce the number of readmissions. Commentary on the likely take up by Trusts would be useful.	**care. Irrespective of their medical or surgical complexities.** **Thank you for your support of AHP inclusion. The inclusion of the full MDT is embedded throughout the document. Our vison and dfn for outreach is delivered by multiprotection teams with expertise in neonatal care.** **Thank you for this comment.** **Networks are indeed supportive organisations who can facilitate networking, benchmarking, education and training etc. They also hold reporting pathways to national strategic healthcare committees.** **Whilst we agree that outreach teams can support neonatal care delivery in hospitals by increasing capacity – their primary aim is to be a continuum of care for babies and their families in the transition phase from hospital to home improving experience and outcomes.** **See appendix C for published evidence on quantitative and qualitative benefits of outreach care.**
Specific comments: As above	

Consultation responses – Neonatal Outreach Service Framework
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Name: Fiona Metcalfe	**If you are answering on behalf of an organisation please state:** National Neonatal surgical interest group (NNSIG)
General comments: It is exciting to see this document published. Well, done to all involved a big piece of work. Overall the NNSIG like the framework with its understanding of the needs for families and neonates. The models of service provision and delivery are well described and offers a good benchmark for budding services or those wanting to review their service provision. It aligns with all the national recommendations from NCCR, BAPM, 3-year delivery plan, neonatal critical care service specification. The evidence base for the need and benefits of neonatal outreach services, is well demonstrated and represented. You highlight the important need for audit and research moving forward to help understand appropriate service caseloads, acuity, and workforce needs. This is an equally important for provision for surgical neonates and care pathways. The main points to raise from NNSIG is around the surgical neonate and family. We acknowledge that the framework represents the preterm medical neonate very well. Whilst the document has many good recommendations and examples of service provision for preterm babies, there appears to be little discussion about the most complex babies such as the surgical neonates. There is a feeling that all the points contained within this document are applicable to surgical outreach also. Neonatal surgical outreach service is an essential specialist service required to enable an early, safe and effective discharge of complex surgical infants from Neonatal units. Experienced surgical outreach nurses undertake a wide range a complex nursing procedure within the home environment, which are currently not provided by the other universal	**Working Group Response:** **Thank you so much for your positive response.** **The working group agrees and equitable access to outreach for all babies who have experienced neonatal care is essential. This may mean service model that includes specialist nurses at local level to support this element of care for complex infants.**

community services e.g. Health visitors and Children's community nursing teams, medical neonatal outreach. I will list the points of feedback. • The start of the document does not clearly define the patient population for neonatal outreach services. It does say: All babies and families who have experienced specialist neonatal care should have equitable access to a multi-disciplinary, robust 7-day a week neonatal outreach service to support their transition from hospital to home. • The document is not explicit enough about the service needs of the sick term, near term neonate, those with complex co-morbidities or the surgical neonate. It seems to describe only medical, preterm needs. This is essential but needs to be broadened.	**The working group strongly recommends outreach services ALL babies and families who have experienced neonatal care have equitable access to outreach services irrespective of any co-morbidities. Those with ongoing medical or surgical needs may need additional support/care packages from other specialists or external agencies – but this is not in place of outreach care rather working together to provide care needs.** **The working group have moved away from 'criteria' for outreach instead are recommending equitable access to outreach for ALL babies who have experienced neonatal care. Irrespective of their medical or surgical complexities.**
• Surgical neonates have specific needs which are different to medical neonates. They often require extended nutritional monitoring and dietetic input due to short bowel, gut dysmotility. We are seeing more of such patients due to increase in extreme preterm survival following NEC.	
• The document does not have AHP provision integrated and embedded within the pathways- dietetic is especially essential for preterm, term and surgical neonates.	**Thank you for your support of AHP inclusion. The inclusion of the full MDT is embedded throughout the document. Our vison and dfn for outreach is delivered by multiprotection teams with expertise in neonatal care.**
SLT's would like to flag that some families require specialist surgical neonatal outreach/ transition care as a core part of MDT neonatal outreach as it's only very briefly touched upon. We really need these 'outreach' services to be integrated and collaborative across all aspects of the MDT and wondered if the nuanced specialist of surgical specialist nurses is maybe a bit under-represented.	**We have strengthened wording around specialist care for babies with complex needs.**
• The surgical neonate is mentioned very briefly in one/two points only. The provision for the surgical neonate eg with a stoma, catheter, surgical feeding tube, wound care, VP shunt care and monitoring etc is not defined or demonstrated within the document.	**The working group recommends ALL babies who are being transitioned to home from neonatal care should have equitable access to outreach. It is impossible to define all co-morbidities within this document for the fear of exclusion. We have included some surgical examples in the levels of care table.**

• There are tertiary services that run neonatal surgical service alongside neonatal outreach. A wheel and spoke model of speciality neonatal surgical outreach could be included to feed into existing regional/local neonatal outreach services as an example of a model. This may be aspirational for some centres but an important one to have an opportunity to support in the future. • There are neonatal surgical outreach services in some tertiary centres but equally to neonatal outreach,	**The development of any specialist skill sets/services within or alongside outreach needs to be determined locally to meet needs of the population and an integral part of service planning and development.**
Specific comments:	

Consultation responses – Neonatal Outreach Service Framework
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Name: Cheryl Curson	**If you are answering on behalf of an organisation please state:**
General comments: I think this is a really great piece of work, and a good start to a framework for NCOT services, which will need to evolve over time. Regular reviews should be scheduled to updated the framework as the landscape of neonatal care changes and some of the unknowns referred to in the document are resolved. Please proof read to ensure consistent tense, punctuation and correct titles for national documents. This should align with other frameworks to ensure consistency of messaging. Parent stories are distracting embedded throughout the document- would suggest these are organised by theme and grouped together. Some the language does not adequately describe the point being made e.g. holistic oversight (p11) and could be more concise. The framework is comprehensive, but very long and not always easy to follow in terms of flow. Could the supporting info and exemplars be available in a separate document-70 pages is very long for a BAPM framework and those without an invested interest may disengage.	**Working Group Response:** **Thank you for your positive response** **Agreed** **Thank you for this feedback** **The working group, including our parent representative and family engagement lead, feel strongly that the quotes demonstrate we are listening to families, support the text content and recommendations within the document and 'bring the document to life' threaded through the text.** **Thank you – we have reviewed the text** **Thank you for this feedback. As the document is the first time neonatal outreach has been described in such detail there was a large amount of content that was essential to include.** **This is embedded in the definition of neonatal outreach. We have also linked to BAPM FICare Framework.**
Specific comments: Very powerful introduction from Emma Johnston It should be clearly stated that outreach is neonatal special care delivered in the community with parents empowered to be the primary caregiver- this should be consistent terminology in line with the FICare framework. There is inference that the ODN holds the governance for providers of NCOT services- is it more assurance that is expected of ODNs given that they cannot hold or manage risk, or that they will commission NCOT services for their region? If services are expected to follow network guidelines as per the service specs-	

then this would require work to standardise and streamline across regions improving consistency of care for families. P11 Leadership- outcomes should be clear. What is cohesive vision, holistic oversight. P11 Leadership at Trust/ICB level - which professional group are we referring to- should be clear if this is a nurse or advanced practitioner or doctor. Is this service management or leadership or both? P12 P1 restorative clinical supervision and safeguarding supervision is required P12 patient safety incidents to include near misses- should be development of a standard trigger list for incident reporting related to broader care provision e.g. systems, processes, safeguarding of patients, families and staff not just patient safety P13 Service delivery standards-multi-disciplinary team planning should include health visitor, GP, social care/others as required . Some of the parent information and skills would be the responsibility of unit staff prior to transition P13 Bereavement support- don't disagree as agree this should be universal for ALL neonatal staff and is included in the new neonatal education standard. What is the expectation of NCOT staff around this as it is very specialised area of care- are we anticipating future delivery of palliative and EOL care by NCOT teams as suggested (although only EOL not PC is mentioned)? There is currently not 24/7 community children's nursing care for PC/EOL care and an all-age approach to provision is a development to address this. This needs significantly more infrastructure and resources than just 7 day/daytime NCOT nurses so I feel this should be removed and included in a future version of the document unless it is worked through clearly here. Focus on getting the basics (including home phototherapy) embedded to a consistently high standard. P14 Outreach nurse LED clinics- relocation makes the logistics easier for the families too-	**Agree- we were delighted to have amazing parent representation** **Amended language** **Amended language** **This section signposts to workforce for detail. Senior leadership can be provided by most appropriate professional group to be determined by service model** **Consideration of supporting families with surviving babies from multiple births. As well as working alongside specialist services to support palliative care. We have added clarity on this point.**

cost, parking and travel time- additional stressor for families. Services are moving into the community, and clinics should follow the same model whether that uses community hubs, family hubs or an alternative. Co-location with the services that families need to access e.g. those available in family hubs allows broader support to be accessed more easily. P15 Levels of support in the community- I agree absolutely that every family should receive a check in on transition home after being admitted to the neonatal unit or transitional care. Not sure NCOT services are best placed to do this if they have not/are not going to be providing the ongoing care for the family. This should be in conjunction with robust discharge coordination or FICare leadership- it maybe the role of those professionals to touch base with families who are not going to require ongoing NCOT support- they will know the families better. Alternatively, a model where discharge coordination is embedded in the NCOT team, or where staff work between NCOT and the unit so they know the families on the unit before they go home.	**Agreed** **Agreed thank you for this feedback– the logistics of the delivery of this will be dependent on local pathways**

Consultation responses – Neonatal Outreach Service Framework
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Name: Cheryl Curson	**If you are answering on behalf of an organisation please state:**
General comments: As previous response	**Working Group Response:**
Specific comments: P14 Outreach nurse-led clinics- relocation also makes the logistics easier for the families too- cost, parking and travel time- additional stressor for families. Services are moving into the community, and clinics should follow the same model whether that uses community hubs, family hubs or an alternative. Co-location with the services that families need to access e.g. those available in family hubs allows broader support to be accessed more easily. Page 15 levels of support in the community- I agree absolutely that every family should receive a check in on transition home after being admitted to the neonatal unit or transitional care. Not sure NCOT services are best placed to do this if they have not/ are not going to be providing the ongoing care for the family. This should be in conjunction with robust discharge coordination or ficare leadership- maybe the role of those professionals to touch base with families who are not going to require ongoing NCOT support- they will know their families better. Alternative is a model where discharge coordination is embedded in the NCOT team, or where staff work between NCOT and the unit so they know the families on the unit before they go home.	**Repeated comment**
P21 Parentcraft- Outdated term, please change to parents skills/information/knowledge. This should be embedded from the beginning of the baby's admission, individualised to the families' needs. Parents should be confident to be the primary caregiver well before transition to home- NCOT and HV can support additional learning.	**Amended**
P21 NCOT should not just have an awareness of support networks available for families in their	**Agreed, additional wording added**

local area but be actively building good relationships with the services.	
P21 Service models What is the definition of a continuous 7 day a week service? a 24-hour seven day a week service, or daytime hours e.g. extended daytime 8 till 8 or a shorter e.g. 8-5. This should be clarified.	**Service should be available every day. Hours to be determined by local need and staffing. Added to document**
What is the role of Nurse Consultants in NCOT services- an ANNP would still require consultant supervision and support.	**The recommendation is all services require a designated consultant lead for escalation of concerns and to support service development and delivery.**
Accessible services- needs to be consideration of all the vulnerabilities and individual need of families e.g. cultural, disability, learning needs, care experienced	**Strengthened language**
P22 all service models must follow a collaborative approach- the expectations and role of each professional group needs further clarification	**Roles and examples of intervention/support of AHPs and psychological professionals working in outreach care are included in the appendices and in development by professional bodies**
P23 network/regional hub-recognition that this might lead to efficiencies, improve consistency, reduce unwanted variation in services- all models will need strategic leadership and administrative support.	**Added**
P26 Education and training This should mirror the new education standards and avoid referring to QiS/Non-QiS - this is unhelpful	**The terminology used here is to distinguish between QiS qualified neonatal staff and other nursing staff who may be employed within outreach teams such as community children's nurses, midwives, and/or staff nurses working with health visitors**
I agree education and training must be relevant to outreach care but staff must be supported to access other neonatal training that will allow them the ability to professionally develop/maintain skills in acute care, not be limited to working solely in outreach care which could limit flexibility and be career-limiting (feedback from survey conducted in region highlighted NCOT staff want to access a broader range of education)	**The working group agree with this comment but felt this was outside of the scope of this document**

Name: Cheryl Curson	**If you are answering on behalf of an organisation please state:**
General comments: As previous	**Working Group Response:**
Specific comments:	
P26 Core knowledge and skills for outreach staff will differ whether registered or non-registered staff	**The working group felt the core knowledge and skills provided baseline knowledge and skills for ALL staff working in outreach services, irrespective of professional group.**
P28 Disagree with the content in table 3, this needs to be reviewed. Many of the enhanced knowledge and skills listed are actually core skills for working in a unit or community setting. Some of the content contradicts recommendations earlier in the document e.g. universal bereavement training	**Thank you for your comments. The working group felt it important to define knowledge and skills for all professional groups working in outreach services.**
I wonder if there should be a recommendation that neonatal community outreach nursing needs to follow health visiting or district nursing with perhaps a module that follows post-registration specialist training/or runs alongside it – which could support the skills and knowledge already gained to be adapted to the community setting with all the nuances of caring for babies and families in their own home	**Thank you for your feedback. The delivery of this outreach specific training is outside the scope of this document and will require further focus locally and nationally.**
P36 Data collection and administration Each team needs an administrator/administrative support to allow them to focus on clinical care- not necessarily a data clerk.	**amended**
P37 MDS- should be reviewed e.g. should contacts and support needed be a national metric rather than type of contact?	**Thanks amended**
P45 Role descriptor This should be reviewed- doesn't leadership and governance of services lie with the provider organisation? ODNs can guide and support but cannot mandate what providers do. What is the purpose of on-site presence? Will there be funding for this role when they are pre-existing high priorities that are not yet funded (Family Care, Bereavement and Palliative care)? There are lots of positives to such a role, but expectations within this that are not achievable.	**Amended governance to oversight. On site presence is to foster collaborative working with all outreach teams and gain understanding of local challenges and successes.** **Commissioning is out of scope of this document**

How will the role work with existing ODN leads for family experience- care coordinators and PFEL?	

Name: Penny Davies	**If you are answering on behalf of an organisation please state:**
General comments: Can I request that thought is given to using the full professional titles more frequently, for those within the AHP group, within the document, rather than reducing them to the group term AHPs. This would give these professions more equal salience as important contributers to neonatal outreach with other professional groups.	**Working Group Response:** **Thank you for this comment- the MDT working group felt readability was easier using AHP.**
Specific comments: Is the information in appendix G appropriately located as an appendix? I would argue that some of this information needs to be included within the main body of the document.	**A description of effective feeding is included in readiness for home. More detail is added here for reference.**

Consultation responses – Neonatal Outreach Service Framework
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Name: judith angell	**If you are answering on behalf of an organisation please state:**
General comments: This is great reflecting the philosophy of FiC and outreach. Recognises the different progression points, finances and location of individual services. Inclusion of the MDT is important. Recognising the need to establishing a specialist course to ensure quality and knowledge similar to the neonatal QIS programme would be a useful future goal.	**Working Group Response:** **Thank you for your positive comments. Further attention needs to be given to developing specific courses to support education and training of all outreach staff.**
Specific comments:	

Name: Sarah Brooks	**If you are answering on behalf of an organisation please state:**
General comments: Fantastic piece of work, so much detail has gone into this, really looking forward to the future of outreach. I have loved reading the information provided by the other services and the examples of good practice.	**Working Group Response:** **Thank you for your positive comments**
Specific comments: PG 16 Level 2 Outreach support NAS- 1-2 weekly phone-calls, if baby is on medication would need more face to face. As page 14 suggest this support can be offered by outreach teams operating a robust seven day a week service. I would class this visit as a level 3 to properly assess symptoms and medication management, while supporting those caring for the infant.	**The level of care can be individualised and will be dependent on baby and family need and collaborative working with universal services and external agencies. This has been added to the document**

Consultation responses – Neonatal Outreach Service Framework
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Name: Heidi Green	**If you are answering on behalf of an organisation please state:**
General comments: Really pleased to see this publication, well needed. I appreciate the focus on other aspects of outreach role such parental engagement events being included , also inclusivity for all babies to have this offer of outreach. This is evident in lots of term and late preterm infants and families in see in my clinic who would benefit from this 'step down' and seamless transition to home especially as lower gestation and weight. Well structured document and all encompassing.	**Working Group Response:** **Thank you for these positive comments**
Specific comments: I believe workforce calculations should be based on average annual admission rate including TC with a 20%(for example) increase for community 'readmissions'. If robust infant feeding services are developing (perhaps another BAPM workforce standard required) this will see reduction in need in physiological jaundice , weight loss etc. We would never be able to support proposed recommendations for WTE nor have enough work for that level of workforce. I would have liked some more reference to staffing such as minimum of band 7 lead with band 6 direct support/Senior CNO support - other bands after that less relevant unless in level 3 unit or surgical then greater number of more experienced/Senior CNON needed.	**Workforce recommendations have been modelled on current services that offer equitable access to all levels of outreach care. These workforce figures will need to modelled and reviewed with robust data collection.** **Workforce structure needs to be determined locally based on the service model and levels of care offered, including the requirement of staff with specialist skill sets. The recommendation on individual team structure is outside of the scope of this document.**

Cheryl Titherly (she/her)
Chief Executive
Neonatal Nurses Association

Hello Kate,

A member of ours shared the draft BAPM Outreach Framework with us. We are pleased to see a focus on neonatal outreach service needs. BAPM have created a comprehensive document with powerful parental vignettes.

However, we would like to see the explicit inclusion of complex, term and surgical neonates. The draft currently lacks focus on surgical neonates or term, sick neonates with complex care needs and how the MDT integrated speciality pathways should be imbedded as part of core neonatal outreach MDT care.

The working group strongly recommends outreach services ALL babies and families who have experienced neonatal care have equitable access to outreach services irrespective of any co-morbidities. Those with ongoing medical or surgical needs may need additional support/care packages from other specialists or external agencies – but this is not in place of outreach care rather working together to provide care needs.

The working group have moved away from 'criteria' for outreach instead are recommending equitable access to outreach for ALL babies who have experienced neonatal care. Irrespective of their medical or surgical complexities.

In relation to the workforce, the document poses more questions than answers for services to develop their outreach nursing/ancillary workforce. We'd like to see BAPM make a 'best estimate' of whole time equivalent for case load and include suggestions to pilot with a view to amend the document.

Workforce recommendations have been modelled on current services that offer equitable access to all levels of outreach care. These workforce figures will need to modelled and reviewed with robust data collection. Current data does not support any further workforce recommendations – but with robust national data sets there will be an opportunity to refine this further.

The draft mentions 'registrar'. This role does not exist https://www.rcpch.ac.uk/education-careers/apply-paediatrics/sub-specialties

Amended

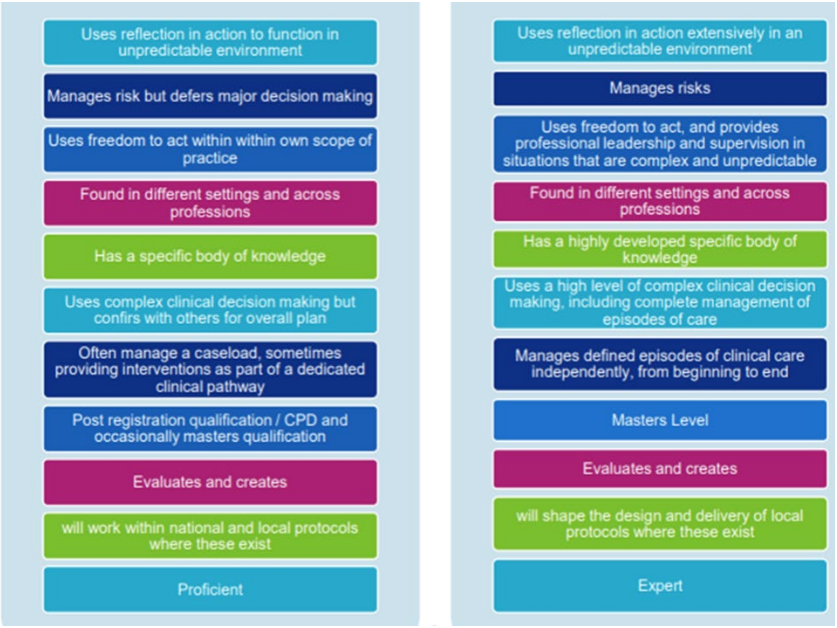
It needs to refer to Tier 2/ST 5-7 as outlined in BAPM Optimal arrangements for medical staffing (which you have published for NICU and LNU) https://hubble-live-assets.s3.eu-west

British Association of Perinatal Medicine

1.amazonaws.com/bapm/file_asset/file/131/Optimal_Arrangement_for_NICUs_revision_10-6-21.pdf Added/amended

On page 28 the level of knowledge and skills are referred to as core, enhanced and advanced. The wording used doesn't seem to fit with the national guidance on enhanced and advanced practice and the examples given should be more explicit using terminology within the existing frameworks, such as the one below by Alison O'Leary. Particularly the limitations within enhanced practice relating to working within dedicated clinical pathways, local protocols and deferring to others for overall plan:

Thank you for this feedback. The knowledge and skills are specific to the whole multi professional outreach service and do not override frameworks such as this which the working group agree should be used when developing role descriptors for outreach roles.


Uses reflection in action to function in unpredictable environment
Manages risk but defers major decision making
Uses freedom to act within within own scope of practice
Found in different settings and across professions
Has a specific body of knowledge
Uses complex clinical decision making but confirs with others for overall plan
Often manage a caseload, sometimes providing interventions as part of a dedicated clinical pathway
Post registration qualification / CPD and occasionally masters qualification
Evaluates and creates
will work within national and local protocols where these exist
Proficient

Uses reflection in action extensively in an unpredictable environment
Manages risks
Uses freedom to act, and provides professional leadership and supervision in situations that are complex and unpredictable
Found in different settings and across professions
Has a highly developed specific body of knowledge
Uses a high level of complex clinical decision making, including complete management of episodes of care
Manages defined episodes of clinical care independently, from beginning to end
Masters Level
Evaluates and creates
will shape the design and delivery of local protocols where these exist
Expert

I hope you find our feedback useful.

Many thanks and best wishes for a restful Christmas and New Year

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British Association of
Perinatal Medicine

London Neonatal ODN comments:

BAPM Framework
Neonatal Outreach Se

British Association of Perinatal Medicine

Stella Rafferty
Specialist Societies Co-ordinator

Dear Laura

I am really sorry I missed the deadline. Is it still possible to submit BMFMS feedback on this framework. The comments below are from our RCM rep on the committee:

Just a few comments from the RCM re the Neonatal Outreach Guidance:

1. In the information governance section, bullet 4, p.12 - please add midwives to this list. Families are often still under midwifery care at the point of neonatal unit / transitional care discharge (midwifery care may be given up to 6 weeks following birth, although usually 2-4 weeks) There is currently no mention of communication with midwives anywhere in the document, particularly important for the community midwifery teams to have neonatal outreach care plans shared with them if the family are still under maternity services.

Added midwifery services

2. p.21 - The first sentence implies that neonatal outreach starts at 6 weeks - needs to be clearer that the variation is the end time for the service.
   Added text to clarify this point

3. Recommend a more ethnically diverse image on the first page - the majority of BAPM documents seem to feature only white mothers and babies. Thank you for this comment.

Great to see this guidance - definitely much needed. Thanks for your positive comments

Many thanks
Stella

Consultation responses – Neonatal Outreach Service Framework
Consultation close date – 10 January 2025

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SARAH OWENS

Lead Nurse Neonatal Outreach Service

Swansea Bay UHB / Bwrdd Iechyd Prifysgol Bae Abertawe

Please accept the following comments relating to the draft Framework Neonatal Outreach.

We have considered the framework and consulted together in a MDT approach. The team included, Neonatal Consultant, Neonatal outreach nurses, SLT, Psychologist, Physiotherapists, Neonatal discharge liaison nurse, Infant feeding co-ordinator. All professionals have years of experience within neonatology and within offering outreach services, although this is limited for AHP's.

Thank you to your team for reviewing this document

- This guidance is a comprehensive piece of work and it's encouraging to see AHP and Psychology services included and valued. It is important to highlight that no Neonatal unit in Wales meets the BAPM recommended staffing requirement for, AHPs and Psychology, so offering outreach is very challenging, when its offered the time is usually taken from our already underfunded neonatal inpatient service. Hopefully this guidance can guide health boards to consider offering specific funding for outreach in addition to inpatient services (which are already stretched). Likewise within Wales there is no Healthboard offering a 7 day a week service and in Swansea Bay we strive our very best to provide a high quality service to the most vulnerable babies in our community with a very small neonatal outreach nursing team.

- In general we agree and welcome the proposed framework. One area that we strongly disagree with as a multidisciplinary team is the proposed idea of time limiting follow up to 6 months of leaving hospital. As a team providing gold standard care, as per NICE guidelines 2017, we provide follow up until 2 years for all high risk pre-terms. While we appreciate the framework considers all babies who have entered special care and therefore there will be many who will not require such

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enhanced follow up, we do not think it good practice to decide a time frame of 6 months to a certain cohort and we feel this point should be considered and that a universal timescale should not be suggested. For example an ex preterm with chronic lung disease still on home oxygen 6 months after discharge would not benefit from a transfer of care to a paediatric team where experience of pre-terms and weaning of oxygen for chronic lung disease is not their area of expertise. For the sake of a few months this would cause anxiety and likely set-backs for the patient. While we are speaking as an experienced team providing MDT follow up until 2 years with excellent outcomes we also have feedback from veteran parents that have confirmed that they hugely benefit from enhanced neonatal outreach for longer than 6 months, because the neonatal outreach team have specialist expertise with this population and a deeper understanding of their early journey, which is paramount. We ask you to strongly consider if a timescale needs to be included and if so would around the age of 1 year be more appropriate or would you consider a statement of exception within this.

Thank you for this feedback. The working group felt that neonatal outreach services by definition were to support transition to home and were time limited. The continuation of care under outreach teams is often dictated by available children's community services. However, the working group felt that babies and family's needs beyond 6months of age were in general better met by community teams who are highly skilled in supporting the needs of the complex child. This will of course have local variation, but when commissioning services there needs to be a focus on the early transition to home from neonatal care. As stated, neonatal follow up programme recommendations will continue beyond this age range and is out of the scope of this document.

- From a SLT perspective, within Swansea Bay (and likely in many other areas), there is a group of babies who would benefit from enhanced outreach from SLT to support their feeding development, alongside the Neonatal Outreach Nurses, which would likely prevent longer term feeding difficulties. It is well documented that there is a high prevalence of feeding difficulties amongst preterm babies and those that have spent time on NICU. However, some of these babies do not meet the criteria for specialist core services as they are just below the threshold. For example, an extreme preterm who goes home with NGT and oxygen and is still establishing oral feeding yet does not have a functional swallow difficulty. Also, babies who do have a functional swallow difficulty may wait up to 8 weeks to be seen by core specialist service so bridging this gap with enhanced outreach is so important for our NICU families. Feeding difficulties cause parents/carers high levels of anxiety, effects daily wellbeing and parent-infant relationship and attachment.

This pathway can be developed to meet local need. Standards for dedicated outreach support from AHPs and psychological services are under development by national profession specific groups and is an area for expansion of care as outreach services develop. However, neonatal services should not 'fill gaps' where paediatric services need to develop.

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We welcome the introduction of the framework and look forward to seeing the final version this year.

Kind regards

On behalf of the Swansea Bay Neonatal Team

Sarah