Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: MEDHAT EZZAT	**If you are answering on behalf of an organisation please state:**
General comments:	**Working Group Response:**
Specific comments: the document recommends at least ONE DEDICATED practitioner with ADVANCED airway capability operating on a Consultant of the Week mode for LNU (on site from 8-5pm during weekdays which is in current practice however weekend the neonatal unit is always covered the Paediatric consultant ,not a dedicated consultant , please advise	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Vikranth Venugopalan	**If you are answering on behalf of an organisation please state:**
General comments: We work in a highly active LNU. 1. Though we are complaint with the current and the new BAPm recommendation regarding our staffing levels, we did a recent survey for the resident doctors regarding their work diary and it showed that they are not getting enough breaks especially at night when we have one tier 1 and 1 tier 2 doctor with a tier 3 doctor available on call from home. We have 1:9 for tier 1, 1:8 for tier 2 and 1:8 for tier 3 during the week. We sometimes have 4-5 admissions at night and sometimes sick ones too. We have had few occasions when we had 3 sick babies being admitted within a span of 2 - 3 hours and thus the need for more staff especially at night. This has been raised as major issue in GMC survey and satisfaction survey and impacted their training. We feel strongly that there is a need for another Tier 1 staff +|- ANNP to be available at night. 2. Our rota during the week is adequate, but we do 1:3.75 during the weekend as we have split the weekend (Saturday or Sunday on call). This increases the number of weekends especially if Fridays have to be included. Suggestion should be to have 1:7/8 on calls over the weekend too. These needs to be factored in the document please. Thank you.	**Working Group Response:**
Specific comments: Staffing levels for high activity LNU. Need for another tier 1/2 at night	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Sumedha Bird	**If you are answering on behalf of an organisation please state:**
General comments: Working in a DGH with a SCBU I am in favour of the guidance and appreciate the recognition of impact of normal day to day SCBU workload and paediatric worload when looking at staffing.	**Working Group Response:**
Specific comments: My concerns are that the acute workload in both neonatal and paediatric care is 24/7 and the difference in staff at weekends would still put pressure on services (pages 15 & 16). In smaller units there is less expertise across all specialities and so reliance on paediatric staff to support (e.g. cannulating children under surgical care, supporting anaesthetics etc.) is higher, especially out of hours and weekends when senior staff from other specialities are also not around (pages 15 & 16). If tasks can be deferred (page 11) it would be helpful to know who would do these tasks. In smaller units finding, training and funding non-mefdicall staff to complete task such as SBRs and CRPs is diffcult. If these tasks are going to pass to nursing staff or, more likely in small units, midwifery staff we need buy in from the respective governing bodies to include these tasks within the nursing/midwifery roles.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Maria Francis m	**If you are answering on behalf of an organisation please state:**
General comments: Excellent. Long time coming. Hopefully a similar workstream can be considered for SCU nurse staffing in the future.	**Working Group Response:**
Specific comments: General comment. Is there an opportunity to include clear directive on 'updating' and the facility for supporting release for observational activity within the metrics? The biggest barrier to this currently reported by LNU/SCU in our region is lack of time .	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Dr Sarah Bates	**If you are answering on behalf of an organisation please state:** GWH NHS Foundation Trust Neonatal Team
General comments: 1. Awesome document - will definitely pave the way for change across the UK (as along as we can achieve the ambitious changes within an ever restricted financial envelope!). Huge thanks to all the team that contributed. 2. Throughout the document, could we ensure consistency of terminology: a. workforce requirements vs staffing standards vs workforce arrangements. Given the title of the framework, I would suggest medical workforce should replace staffing. 3. could you please include a template (as an appendix) assessment for units to assess themselves against this - every single unit will be doing a gap analysis - it would help us all to not have to reinvent the wheel! (the BAPM airway framework did this brilliantly) 4. could you please include a standard powerpoint slide set about this framework for all of the clinical leads to use when presenting their gap analysis at division/board/ODN level please	**Working Group Response:**
Specific comments: Page 4 P4 bullet point 2- grammar change - "considering activity LEVELS IN THE Neonatal unit BUT ALSO TAKING INTO CONSIDERATION other COMPETING demands outside THE Neonatal unit, SUCH AS PAEDIATRIC AND EMERGENCY DEPARTMENT ACTIVITY" P4 bullet point 6 - does the comment about inter unit transfers really need to be part of the exec summary - it is an important topic, but is it really a key element of the medical workforce standards? P4 final para: "In such instances, a comprehensive risk assessment SHOULD BE	

British Association of Perinatal Medicine

conducted by the relevant provider with ODN oversight". *could you please include a template risk assessment as an appendix - this would help standardise this P4 final para, final sentence, suggest reword. Any ongoing risk from insufficient medical workforce provision should be be logged in both the provider and ODN risk registers with a clear timeline for achieving compliance. Page 5 please confirm Respiratory care days(RCDs) includes day on which LISA administered P9 Methodology section - all important information, but disjointed and doesn't necessarily flow well - could this be separated into subsections or a table so that it is completely clear what related to workforce survey, what relates to activity data, what related to the NNAP analysis, how the median values were calculated, as this is totally crucial to underpin the recommendations. P10 What do you mean by 'a more holistic dataset' - if the working group knows what a 'gold standard' medical workforce data set looks like, include this as an appendix, as it then helps standardise these analyses for future iterations of this framework. P11 Terminology of title - 'Medical Staffing' - surely the whole document relates to Medical Workforce Recommendations - why is this a subsection? The opening para is repetition from introduction. The bullet points would be better as subheadings, as there's a couple of points about BAPM airway standards and induction, a couple about TC, some about paediatric acuity etc.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

The final para about nursing staffing should go earlier in the document in a comment on scope of the framework. P12 (similarly the table headings - change all 'staffing' to 'workforce' for consistency) P13 and 14 (similarly the table headings - change all 'staffing' to 'workforce' for consistency) Please confirm minimum WTE at each level - is this on total rota, or dedicated to neonatal services? eg: the total WTE at tier 1 and 2 is split between paeds & neonates. Please could you be clear if these workforce (Tier 1&2) expectations are across weekday and weekend - is there any differentiation? Whilst I completely understand that babies don't recognise the difference between weekday and weekend days, practically, almost every provider trust DOES have different staffing models at weekends and weekdays, and trying to get full 24-7 service cover might well not be achievable, especially within an increasingly restricted financial envelope- we might set everyone up to fail! Please could consideration be given to weekday/weekend differences. P17 Whilst I recognise this is so important (the repatriation framework covers this in great detail), it feels incongruous here. If the goal of this is to provide important context into WHY senior dedicated neonatal staff are important, then this needs to be more explicit here. For example, if the expectation is that if a baby is transferred out for uplift of care (eg sick PPHN/HIE transferred to NICU for IC), the consultant should be present to oversee the care and handover to the transfer team (I think this would be an acceptable standard) - we should say that. Or, if the expectation is that Tier 2 or 3 practitioner should be available to welcome a baby and family back to the unit after repatriation within 6 hours of transfer	

British Association of Perinatal Medicine

back, this might also be OK (or could link to NNAP parental consultation within 24h). In summary, I think this section needs a clear link to MEDICAL WORKFORCE standards or it feels incongruous	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Dr Sarah Bates	**If you are answering on behalf of an organisation please state:** GWH NHS Foundation Trust
General comments: This is part 2 of my response (ran out of space on part 1 sorry!)	**Working Group Response:**
Specific comments: Page 19 Para 1 - probably worth emphasising that investing in optimising neonatal outcomes has long term health economic benefits across health, social care, and education. Para 2 - could we be consistent - "High Activity" LNU rather than High Volume I would also rephrase this - it sounds a bit 'us v them' with neonates v paeds, and only seems focused on high activity LNUs, whereas this is important for all. Suggested: New title - Clinical Leadership for Neonatal Services: High-quality neonatal care often leads to shorter lengths of stay, reduced reliance on high-intensity neonatal care (HRG 1 & 2), and an increased emphasis on family-integrated care (HRG 4). This care model must be reinforced through appropriate resource investment, including in the clinic leadership roles. All Neonatal Services require dedicated reporting structures through divisional and corporate teams to executive level, with excellent access to their Maternity & Neonatal Board Safety Champion to ensure Neonatal Medical Workforce Issues are recognised, and responded to with support for improvement where needed. Where possible, and particularly for High Activity LNU services, this should be separate to Paediatrics, with the Clinical Lead for Neonatal Services having direct reporting to Divisional Level. The Clinical Lead for Neonatal Services role in all services should be appropriately resourced, with resource planning aligned to	

British Association of Perinatal Medicine

the unit care models and focused on optimising patient outcomes. The increasing external scrutiny and media attention across UK perinatal services has lead to ever escalating requirements placed on Clinical Leads for Neonatal Services. These include perinatal governance, PMRT, digital transformation and data requirements, service development. It is important to recognise this, and resource, with appropriate job planning for Clinical Lead roles across all Neonatal Services. Could we go as far to suggest minimum PA allocations for lead and governance roles? 1 PA minimum for clinical lead for neonatal services, and 1 PA across audit, governance, data/digital for Neonatal Services. But also recognise that this time allocation will likely, for most neonatal services, SIGNIFICANTLY under resource the time commitment required to effectively lead neonatal services, particularly in high activity LNUs. This would be SO useful and so appreciated for all of us who lead services P20 - limitations - is this needed? This almost sounds like a critique of a journal article, and not necessarily needed in a BAPM FFP. Could be amalgamated into a recommendation for future research Appendix 1 - why does this have it's own references? could these be amalgamated into overall references please Appendix B - why is it B, not 2? also - this is definitely not needed in the framework - could be additional document Appendix 3 also - this is definitely not needed in the framework - could be additional document Recommend other appendices - risk assessment template, gap analysis template, and standard slide set about the framework - all would be massively useful for all clinical leads for LNU & SCU!!!	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Sundeep Sandhu	**If you are answering on behalf of an organisation please state:**
General comments: Overall the document will be useful to help with ensuring appropriate medical staffing for neonatal units.	**Working Group Response:**
Specific comments: Comments related to page 13: For our service it will be difficult to justify having a 'dedicated' tier 1 and 2 practitioner physically located on the unit at all times as there is not enough work. Often the paediatric service is busier and it would feel uncomfortable to not use our medical team across both services. Also, having tier 1 doctors with standard airway capabilities is proving challenging as many of our doctors are GP and foundation trainees with limited experience in paediatrics and neonates and they would never be expected to attend to a preterm baby without a more experienced doctor. Tier 2 doctors have varying levels of airway skills. We only have one tier 2 doctor overnight and this document may help us to increase to a second however it will be difficult to arrange the rota so that there is someone with standard and intermediate skills at all times. Page 11: It would be good to reinforce that NIPE checks should mainly be performed by midwives as per the previous medical workforce recommendations	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Cathryn Seagrave	**If you are answering on behalf of an organisation please state:**
General comments: A good overview and will help to support (I hope) in what I have so far not been able to achieve of getting agreement for dedicated tier 2/3 for SCU cover. I do fear however that with the current climate and rota gaps/funding shortfalls that this could be used by networks to close a number of smaller SCUs (such as ours). We would need our trust to spend a significant amount on staffing to achieve this -and for people to apply for those if (ever)approved. Bring on the battle!	**Working Group Response:**
Specific comments: page 15. SCU tier 1 standard for standard airway skills is for us and I suspect many DGHs never going to be achieved as with 4 monthly rotations of GP trainees and only 1 paediatric trainee they are never going to be able to achieve more than basic standard as they never get competent at ventilation and preterm as we simply do not have them for more than a few hours stabilisation. What is the rationale for them needing to be standard and not basic in a SCU level unit where they are not stand alone cover for this and there is an immediately available tier 2 doctor? They need to use a mask and escalate so I would say for tier 1 in SCU that basic airway skills would be sufficient	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Jennifer Loughnane	**If you are answering on behalf of an organisation please state:**
General comments:	**Working Group Response:**
Specific comments: pg 13 - Standard LNU activity. Please could you clarify. Tier 1 one dedicated with standard. Tier 2 one dedicated with standard AND one immediately available with intermediate airway capability. This reads as if need 2 people on tier 2 rota in evening and night - one must be dedicated to neonates; and one must be intermediate airway capability. Is that correct?	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Eleanor Hulse	**If you are answering on behalf of an organisation please state:**
General comments: I think the document is clear and very usefully differentiates the acuity and type of unit.	**Working Group Response:**
Specific comments: In the guidance for LNU's (Pages 13 and 14) I wonder if this has been planned in conjunction with the RCPCH progress+ airway training expectations. My understanding is that intubation experience is no longer mandatory in paeds training. I do not know if it is achievable to have tier 2 staff who have intermediate airway capability particularly in DGHs that have ST3b doctors on the Tier 2 rota.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Dr Clare Cane	**If you are answering on behalf of an organisation please state:**
General comments:	**Working Group Response:**
Specific comments: APPROPRIATE REST BETWEEN SHIFTS page 11 - There is no mention about appropriate rest between shifts. Factoring this into rotas in line with BMA recommendations and the doctors charter, is also crucial. Although rotas may be compliant with 1:7 Tier 3 consultant presence, they also need to be adequately staffed to enable appropriate time off following 24hr shifts, with attention to daytime commitments, in light of the increased need for consultant presence during those shifts. WHOLE TIME EQUIVALENT: There should additionally be a mention of the minimum 7 WTE tier 3 doctors to staff rotas, inline with the BAPM staffing recommendations for NNUs , as per page 25 of the BAPM 2022 'Service and Quality Standards for Provision of Neonatal Care in the UK' SUPPORT from data manager Page 19 parag 2 goes some way to help support the Clinical Service lead role. Support from a data manager also helps to contain this role.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Ben Obi	**If you are answering on behalf of an organisation please state:** Royal Surrey Foundation Trust
General comments: The definitions as to what constitutes a busier level 1 unit seem sensible.	**Working Group Response:**
Specific comments: As a level 1 unit with a joint rota for paediatrics and neonates, the dedicated cover on SCBU from 8-1 pm will be difficult to achieve. At the weekend the team is made up on the consultant of the week, a resident consultant and two tier one doctors during the day. The resident consultant needs to know what is going on in all areas, so splitting the ward round would affect their ability to have oversight. Additional resource would be needed to support this shift 7 days a week, which in the current economic climate is going to prove difficult to achieve. Resident places are not always fully allocated by the deanery and trust grades often prefer not to work weekends.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Christopher Bell	**If you are answering on behalf of an organisation please state:**
General comments: This is a nicely structured document with clear standards and good flow.	**Working Group Response:**
Specific comments: p12- It's possible to have 3 of each criteria and therefore not be either unit type, suggest that standard activity is defined as not meeting 4 of the high criteria. p12- The "paediatric attendances to co located ED" as a solo metric is probably too imprecise to define the business of paediatric services, as it doesn't account for busy direct admission paediatric units, where the tier 2 is potentially more unavailable as the only senior decision maker, vs a larger ED with other senior trainees (and where a lot of the attendances may be minor injuries which don't need paediatric input). Could there be an alternative metric such as Paediatric Attendances to co-located ED ≥ 24000 OR Paediatric Attendances to Paediatric Admission Unit > x amount (?7500) p14- "This practitioner should not be redeployed to manage patient volume within co-located Paediatric services and Emergency Departments. Paediatric on call Tier 3 support should be sought" under tier 2 is aspirational and doesn't account for the co-dependent nature of paediatric services. It would be difficult to justify calling in the tier 3 when NNU is low activity and is being safely managed by Tier 1(s) if the registrar is available to immediately attend, even if located on a paeds ward within close proximity.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: David Bartle	**If you are answering on behalf of an organisation please state:** Exeter Consultants
General comments: We feel this is a very supportive document for staffing for LNU and SCU groups. We felt it was important that we look at this document for all LNU's and SCU's ie those that just fall into high activity as well as those that are clearly in high activity. We did not consider just for our unit	**Working Group Response:**
Specific comments: We felt that although neonatal units work on non-elective work, the work at the weekend is usually less onerous as there are fewer elective LSCS, discharge planning meetings, planned MDT meetings etc. We therefore feel that weekend working staff allocation could be less than weekday. We would feel the current staffing recommendations (previous document) would be sufficient for this. We recognise that this document is aspirational and feel the staffing standards would make units well staffed, however most LNU's and SCU's are a long way from reaching these staffing levels. The current financial climate will make it almost impossible to reach them in the near future.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Emma Biggs	**If you are answering on behalf of an organisation please state:** NHS Shropshire, Telford & Wrekin ICB
General comments: Found the document very user-friendly. The unit criteria and corresponding framework were much clearer and easier to interpret than the 2018 framework. Thank you!	**Working Group Response:**
Specific comments:	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Dominic O'Reilly	**If you are answering on behalf of an organisation please state:** FV Paediatric Consultants (covering Neonatal unit)
General comments: We as a group are concerned about the impact of this document on our LNU unit (cross cover paediatrics and neonates) were the recommendations to remain as they currently stand. Comments below are from several consultant colleagues (new paragraph per colleague): We are clearly nowhere near the Tier 1 and Tier 2 requirements, and this paper talks about NOT cross-covering. Interesting read, not sure how achievable that is across the country. We would need to pretty much double all our numbers of medics/ANPs. Seems unrealistic for us to have 2x tier 1s and 2x Tier 2 on nights. I think we meet the day/evening cover? Ensuring the airway skills of people on shift I think is important. As they say the recommendations are not based on any strong data to say that having these staffing levels makes things safer. I don't think that 2 x tier 1s on nights makes us much safer? If we add money into things, then ensuring safe nursing competency and ratios would make more sense to me. When you look at the definitions of "dedicated" and "immediately available" ... While there is one dedicated Tier 1 and Tier 2 for daytime cover, it starts getting sketchy in the evening when you have a Tier 2 who is dedicated but another Tier 2 who is either an APNP or a Tier 2 who also couldn't always be "immediately available". Immediately available means "available within few minutes when called. Any competing Paediatric workload should not deter/delay this arrangement" - you can't guarantee that for the evening and you can't even guarantee that for	**Working Group Response:**

British Association of Perinatal Medicine

the sole Tier 1 and Tier 2 overnight when they should both be "dedicated". BAPM wording is pretty strong! BAPM expects neonatal care settings to ensure full compliance to these standards. It is acknowledged that that there may be exceptional circumstances where full compliance with these standards is not immediately achievable. In such instances, a comprehensive risk assessment is conducted by the relevant provider with ODN oversight. Appropriate mitigations should be identified and formally recorded. Furthermore, this risk must be logged in both the provider and ODN risk registers with a clear timeline for achieving compliance This is a big ask - even if we do not think it's achievable, it sounds like there'll be a requirement to say why we can't achieve it and how we'll minimise risk... There is a real disconnect between what we have available and what should be available in an ideal scenario. I think it is unrealistic to suggest 2 tier 2s at nighttime given current trainee allocations and tier 2 rota.	
Specific comments:	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: James Roberts	**If you are answering on behalf of an organisation please state:** mOm Incubators Ltd
General comments: We welcome updates to the framework to: Continually evolve and optimise care. Enhance and ensure family integrated care for newborns. Support the new parent journey from birth to discharge through the use of innovative products and improved practice. Ensure appropriate allocation of workforce, creating further efficiencies. Liase with and develop practice throughout operational networks in the the United Kingdom	**Working Group Response:**
Specific comments: Page 11 - Supporting staff efficiency The mOm device can provide an integral resource to your Transitional Care unit or alternatively a Transitional Care offering outside of a formal/physical location. Recent work within multiple care settings and sites across the NHS Scotland and NHS England has proven the value of a flexible and portable highly efficient incubator for hypothermic infants.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Yasmin Ghariani	**If you are answering on behalf of an organisation please state:** Chiesi Ltd
General comments: Thank you for the opportunity to respond to the draft consultation on the proposed Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK to support the delivery of safe neonatal care. I am responding on behalf of Chiesi Ltd - for over 30 years we have been a committed and trusted partner to the NHS in neonatal care and fully support the important work of BAPM. We welcome the focus on standardising and strengthening staffing frameworks to optimise medical workforce arrangements. We strongly agree with the principle of defining clear, evidence-based minimum staffing levels with a focus on inclusion of minimum airway competencies. Chiesi has supported at ODN level to upskill staff on airway training and remain open to collaborating on tailored educational support to the needs of the workforce in LNUs and SCUs specifically to meet the standards outlined in the framework. Standardisation in this area is necessary to reduce variation in care and support improving neonatal outcomes. It also provides a foundation for sustainable service planning and workforce investment to upskill practitioners where necessary. We would support the inclusion of mechanisms for units to monitor and audit compliance with these standards and also the development of a pathway to report non-compliance with staffing standards. While staffing remains a critical challenge in neonatal units, we would add that sufficient training programmes as well as access to reliable medical equipment and software systems are also important factors that contribute to operational success and optimal patient experience. The neonatal community have often been placed in difficult predicaments whereby reduced staffing, changing curricula and lack of access to basic equipment and/or technological support systems have contributed to stress. We believe that sufficient investment must also be prioritised as part of the commitment to maintain and, where required, improve outcomes. Recently, Chiesi was involved in a collaborative working project from August 2023-August 2024 with NHS partners including a Health Innovation Network and an NHS Neonatal – Operational Delivery Network (ODN). The project entitled Neonatology Technology Enabled Care (NTEC) - available at www.chiesi.uk.com/documenti/607_neonatal-technology-enabled-care--28ntec-29-	**Working Group Response:**

British Association of Perinatal Medicine

--final-output-report--285-29.pdf - uncovered a number of recurring challenges during the landscape review of 22 NWNODN neonatal units (seven neonatal intensive care units (NICUs); 12 local neonatal units (LNUs) and two special care units (SCUs), as well as the neonatal transport service (Connect North West). It highlighted the voices from over 135 staff members and 14 patient families. This report provides recommendations for transformation, emphasising the need for investment, sustained collaboration, and a commitment to aligning digital innovation with clinical excellence. The recommendations outlined offer practical steps to guide future efforts, ensuring that neonatal care remains at the forefront of healthcare innovation. It is well recognised that NHS/industry partnerships can help achieve shared goals and ambitions to improve outcomes for patients and the NHS. The King's Fund has a range of materials highlighting the impact that such collaborations have achieved.1 A publication released at NHS Confed in 2024, entitled 'Accelerating transformation – how to develop effective NHS industry partnerships' also highlights the benefits of collaboration to improve outcomes for patients.2 We are highly supportive of this framework and look forward to reading the final publication. We would welcome the opportunity to discuss potential collaborations with BAPM in support of your quest to improve outcomes. Kind regards, Yasmin Ghariani Head of External Communications Chiesi UK and Ireland	
Specific comments: References for above statements: Anna Charles Siva Anandaciva. (2024). Available at: https://assets.kingsfund.org.uk/f/256914/x/a53a8f5edb/lifesciencesnhs_report_full.pdf. www.abpi.org.uk. (2024). Accelerating transformation: How to develop effective NHS-industry partnerships. [online] Available at: https://www.abpi.org.uk/publications/accelerating-transformation-how-to-develop-effective-nhs-industry-partnerships/.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Josie Anderson	**If you are answering on behalf of an organisation please state:** Bliss
General comments: Bliss strongly welcomes the overall increased focus in the draft framework, compared to the 2018 document, on supporting babies and their families throughout neonatal care. Embedding family support into workforce planning is essential to delivering high-quality, developmentally appropriate neonatal care. Furthermore, Bliss welcomes the document's acknowledgement in its executive summary that "family integrated care requires robust medical oversight at senior level", a notable step forward given that the 2018 framework did not reference family integrated care. However, we are concerned that the document does not define or explain what family integrated care entails. Additionally, the framework lacks further elaboration or practical guidance on what robust senior medical oversight of family integrated care looks like in practice. Given that the family integrated care model is not yet embedded in all neonatal services, particularly at senior level, we recommend that BAPM include a clear explanation or link to resources (i.e., BAPM's Family Integrated Care: A Framework for Practice, 2021) to support understanding and implementation among target users of this framework. This would help ensure that the important role of senior medical staff in overseeing family integrated care is clearly understood and actionable.	**Working Group Response:**
Specific comments: Page 17, whole page It is particularly welcome to see the focus within this document on supporting babies and families during transfer. The acknowledgement that these transitions can be extremely challenging for a whole host of reasons – not	

British Association of Perinatal Medicine

least, how daunting it is for a family to have learn afresh how the new neonatal unit operates, and to have to build that trust and familiarity from scratch, and the importance of medical professionals in enabling these transitions is a really welcome addition to this updated guideline. Families also experience practical challenges when transferring – a unit closer to home may not equate to a unit which is easier to get to, so accommodation, travel/subsistence needs & costs are likely to still be high. The 2018 document referenced the importance of this support being in place, and we recommend it is included explicitly in this document too. Page 17, paragraph 1 The draft framework rightly recognises that neonatal care is an anxious time for families and that having the right medical workforce skill mix is crucial for safe, consistent care and effective communication. However, the framework stops short of describing how senior medical staff are expected to facilitate or practically implement family integrated care on the unit to empower parents to be partners in their baby's care – including decision-making- leading to the best possible outcomes. Page 17, paragraph 2 Bliss notes the reference to 'family-centred care' here but believes this does not go far enough. We advocate for a shift towards Family Integrated Care (FICare), which goes beyond family-centred approaches by positioning as and empowering parents to be equal partners in their baby's care. This change of language better reflects the needs and rights of families with babies in neonatal care. Page 19, paragraph 2 Bliss welcomes the recognition of family integrated care within the draft standards. However, we recommend against framing it as an outcome of high-quality neonatal care. As outlined in BAPM's Family Integrated Care: A	

British Association of Perinatal Medicine

Framework for Practice (2021), delivering family integrated care is itself a key driver of improved clinical and parental outcomes, including reduced length of stay. Clarifying this distinction is important, as it shapes how the workforce standards are interpreted and prioritised: if family integrated care is viewed as a by-product rather than a fundamental component of high-quality care, it risks being under-emphasised in service design, staffing models, and investment decisions.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Dr Lorna Gillespie	**If you are answering on behalf of an organisation please state:** South Tyneside and Sunderland NHS Foundation Trust
General comments: very clear document; easy to read; flow is good general comment about terminology ANNP for workforce - may be contentious but doesn't align with global terminology of ACP (advanced Clinical Practitioner). There are no ANNP courses and these have changed to ACP courses with subspeciality training in neonates. If ACP term is used instead of ANNP, it is inclusive of all staff groups working on neonatal tier 1 and tier 2 rosters at advanced clinical practitioner level rather than being specific to neonatal nurses. ACPs can include midwifery or paramedics who have undergone ACP masters course in neonatal medicine.	**Working Group Response:**
Specific comments: data that was used for compiling high and standard activity as described in appendix A page 23: this was 22/23 which was prior to the new service specifications produced in March 23. This has changed the activity that some LNUs (especially those that may have been high activity) are undertaking. Several units have undergone further changes since the issue of very specific LNU specifications. There is no reference to this in the appendix A. There may be further changes in data and case mix as a result of the 2023 service specifications. Similar comments for number of admissions and care days. Large push in 2021 onwards via Maternity Incentive Scheme to increase babies being cared for on TC pathways and lower term and late preterm admissions. Data may now be different due these initiatives. Workload however is the same if the neonatal team is caring for those on TC pathways.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Page 12-Useful to separate out high and standard activity. There are following comments about the parameters set out as follows: Admissions: data excluding TC admissions. This may inadvertently not recognise the work of those units that have proactive TC pathways and low admission rates for those that are being managed on a TC pathway as per BAPM framework. Those units that are not following TC pathways will have higher number of admissions and this isn't necessarily a good thing. It would make more sense to include all admissions - both LNU/SCU and TC as you are also referencing TC in the staffing model. This would then encourage units to continue to reduce neonatal admissions and increase those being managed on TC pathway demands outside of neonatal unit - paediatric attendances are reasonable data to collect and we agree that useful to have this considered in the table Total care days - should this exclude HRG 2016 level 4 and 5 data? Level 4 or 5 could be on TC pathway for some units and those units will have lower total care days and higher TC days. Workload will be unchanged if the neonatal team are involved in the care of those on TC pathway including reviews. However total care days (1-5) would not necessarily reflect the work that some units are undertaking to minimise parent baby separation or are being proactive with early discharge. Staffing in table page 13. Tier 2 - this reads as if recommendations are for two tier 2 staff to be on shift for standard activity. Does it mean, if tier 2 only has standard airway capabilities, you would need additional tier 2 with intermediate airway capabilities but if the tier 2 has intermediate airway capabilities, then one would suffice. Footnotes tables 13-16 should reference ACP rather than ANNP	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Table on page 14 High activity LNU staffing two daytime practitioners on tier 2 roster to enable transitional care reviews. ACP may be on tier 1 roster (ie not working at middlegrade level) but able to support transitional care ward rounds and reviews due to their level of experience. This is different to a trust grade resident doctor who may have very little transitional care experience. Is it possible to include a foot note that the second person for the tier 2 could be an experienced additional practitioner at tier 1 who has been assessed as having capabilities to do this. They may not have full capabilities for tier 2 including overnight with consultant on call from home but have enhanced skills and capabilities that enable an enhanced tier 1 level of care during the daytime which would include the TC ward round.	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Natasha Lloyd-Lucas	**If you are answering on behalf of an organisation please state:** Coventry and Warwickshire LMNS
General comments: As an area that has a mix of Level of units, 1x Level 3 and 2x level 1 SCBU, concern is that these recommendations are based on larger units without consideration for the impact both immediately and long term to SCBUs. Neonatal is often integrated within paediatrics unlike bigger hospitals which are able to have separate teams. If the new proposal was put in place it would have an immediate financial implication on our 2 smaller units. Funding is currently exceedingly tight both at system and Trust level - funding would need to be supported nationally. Longer term if funding is not forth coming, does this then put the whole unit at risk? Without SCBU's, maternity is at risk and so is paediatrics - ultimately this would then impact on capacity in our larger units. Work to reconfigure cots is already ongoing and the wish to reduce SCBU cots without recognition for the need of additional maternity capacity in larger units - maternity and neonatal reforms need to be considered hand in hand due to the impact on each others.	**Working Group Response:**
Specific comments:	

Consultation responses – Recommended Medical Workforce Standards for Local and Special Care Neonatal Units in the UK
Consultation close date – 25/06/2025

British Association of Perinatal Medicine

Name: Penelope Young	**If you are answering on behalf of an organisation please state:** Chesterfield Royal Hospital neonatal team
General comments: We welcome a review of the previous framework to advocate for the care of babies born in centres with an LNU or SCU. However, the general consensus from our team of acute consultants and ANNPs is that we do not feel the staffing recommendations are entirely justifiable for the workload and cot numbers in our unit, which is a standard LNU. <u>Staffing recommendation in general</u> We note that the staffing recommendation is similar for a standard LNU to a NICU. A NICU could have 12 intensive care cots where we only have 3 critical care cots. A NIC should be aiming for >2000 IC days per year with a similar staffing model to a unit that is providing fewer than 1000 RCDs per year. To us this seems unequal. <u>Out of hours staffing</u> The staffing recommendation includes a tier 1 and a tier 2 dedicated to neonatal care 24/7. This would mean we should provide 4 doctors/ANNPs (2 tier 1 and 2 tier 2) overnight to run our neonatal and paediatric service. In our opinion this is not required. We feel that 2 tier 2s and 1 tier 1 doctor overnight is sufficient to provide a safe level of care to neonates, as generally overnight the workload is less. A model of 2 tier 2s at night means that there would be a dedicated tier 2 practitioner to the neonatal service and as per the BAPM neonatal airway framework we would expect the tier 2 practitioner to have intermediate airway skills. When there is a sick neonate, it is tier 3 presence that is required and not an additional tier 1 doctor. In the evenings and at weekends though, we would agree that there are benefits to a dedicated tier 2 and tier 1 to provide neonatal	**Working Group Response:**

British Association of Perinatal Medicine

care and feel our service would and does benefit from this model. <u>Tier 1 capabilities</u> Our tier 1 workforce is a mixture of GPSTs and F2 doctors, we do not have paediatric trainees. Whilst the tier 1 doctors do spend time on the neonatal unit they are primarily based on the postnatal ward and the care of the babies on the unit is very tier 2-led. Currently tier 1 need to have basic neonatal airway skills, this document suggests they require standard airway skills. Given the suggestion that the unit also needs a tier 2 with standard airway skills and another tier 2 or tier 3 with intermediate or advanced skills, we feel that basic airway skills is sufficient for our tier 1 workforce. Some of our tier 1s we are not able to get through full NLS which we feel would be a more useful requirement than standard airway capability. <u>Consultant cover</u> We agree with the need for neonatal consultant cover during the week but in our opinion onsite hours should be Mon-Fri morning only with a second consultant available should the need arise at other times. This would be more in keeping with the recommended model for a high volume SCU, remembering that 9 of our 12 cots are SC. We would need a significant increase in the consultant body in order to provide the cover suggested in the framework and we do not necessarily feel that this would lead to improved care for neonates given the expertise of the acute consultants. We acknowledge though that we are lucky to have 6 consultants with a neonatal interest who provide the current daily cover to our neonatal unit. <u>Inappropriate task list</u> We agree with this list, particularly with regard to NIPEs. A reduced dependence on the	

British Association of Perinatal Medicine

neonatal/paediatric workforce for NIPEs will free up the tier 1 practitioners to focus on non-routine neonatal care. Many thanks for accepting this late submission!	
Specific comments:	