

British Association of Perinatal Medicine (BAPM)**Evidence Submission for Amos Review March 2026**

The British Association of Perinatal Medicine (BAPM) is a professional association and registered charity. The membership overwhelming consists of all professionals working in neonatal care. BAPM's membership has grown in recent years, and now has a membership of more than 3,000 professionals including doctors, nurses, advanced neonatal nurse practitioners (ANNPs), midwives, managers, allied health professionals (AHP), pharmacists, psychologists and parent / carer reps.

BAPM's aims are to improve standards by supporting all those involved in perinatal care to optimise their skills and knowledge, promote high quality, safe and innovative practice, encourage research, and speak out for the needs of babies and their families.

Approximately 1 in 7 babies born in the UK will be admitted to a neonatal unit. It is important to recognise that families do not separate their maternity and neonatal care into separate episodes. Their pregnancy journey is complete only when they are discharged home with their baby, and for the many families whose babies undergo neonatal care, particularly those born prematurely, this can be some time after the birth of the baby. As BAPM is a neonatal organisation this response will focus on neonatal care.

We read the interim report from Baroness Amos with interest. We share her deep concern that, despite years of reports, inquiries and testimonies, women and families continue to experience poorer care, unacceptable harm and psychological trauma within maternity and neonatal services. The scale of suffering described by women and families is distressing and we acknowledge unequivocally that these experiences demand systemic change. We also recognise that this investigation represents a vital opportunity to learn, repair and transform services in a way that centres women and families' needs, whilst also enabling staff to provide safe, compassionate and psychologically informed care.

The interim report published on 26/2/26 supports the substantial evidence that harm in maternity and neonatal care is not solely the result of individual failings, but of sociocultural and system-level pressures. These include changes in the demographic, political and media landscape, workforce shortages, high levels of chronic stress and moral injury, cultural defensiveness, and fragmented care pathways. These conditions impair communication and erode relationships, making it harder for staff to acknowledge, respond compassionately to, and repair trust with women and families who experience harm.

At the same time, women and families are often navigating cumulative trauma, uncertainty, grief and a profound loss of control at a time when they are expected to trust systems and services that may have failed them. When these experiences are not adequately recognised or supported, the psychological impact can be long-lasting for parents, babies and their wider families.

We believe it is essential that the inquiry balances the lived experiences of women and families **and** the professional limits of staff working in overstretched systems. This is not to excuse poor care, but to recognise that lasting change requires learning rather than shame, accountability rather than fear and systemic reform rather than individual scapegoating.

In order to improve experience of and safety of neonatal services, we would like to see the full implementation and funding of all the recommendations of the Neonatal Critical Care Review (NCCR) published in 2019¹ and the recent House of Lords Preterm Birth report ² and the Neonatal Getting it Right First Time (GIRFT) review³. The NCCR has helped to transform neonatal services by ensuring appropriate staffing standards and continuing the centralisation of neonatal services, which will improve outcomes and safety, however, many recommendations have not yet been fully funded.

Staffing / Resources

Achieving optimal staffing within neonatal services is vital to ensure safety in this high risk, intensive speciality. Consultant availability and nurse staffing ratios have been shown to be linked to improve outcomes^{4 5}. This is not just about bedside nurse staffing but ensuring that to deliver a safe service, supporting and leadership nursing posts are filled, medical staffing is optimal and allied health professionals, pharmacist and psychologists are also in post to deliver a safe service which provides optimal family integrated care to help families cope in the difficult circumstances they face when a baby requires neonatal intensive care. These are vital to providing safe and effective neonatal care. Sufficient workforce is important, but retention of staff is also vital. To maintain retention, staff need to feel valued.

Optimal staffing in UK neonatal units therefore supports safety, continuity of care, developmental outcomes, and workforce sustainability. Optimal staffing for neonatal services is described in various frameworks and standards documents BAPM has produced^{6 7 8 9}. It is vital that to regain the trust of families, staff members are available to provide good continuity of care, communication and safe care.

Nurses: At present the neonatal workforce is commissioned for ‘cot side’ nurses only. Neonatal Transitional Care (TC) and Neonatal Outreach should also be commissioned to facilitate earlier discharge.

Nursing roles such as education, governance, family care (including bereavement and palliative care), quality improvement, infant feeding specialist, neonatal surgical nurses/surgical outreach and research are essential to support quality care and improve outcomes and will also improve the career pathway and retention. ***These roles should be adequately resourced to improve care for families, career progression and retention.***

Whilst most neonatal intensive care needs to be provided in hospital there is significant scope for earlier discharge for some babies if the right resources are in place.

Transitional Care (TC) and Outreach Services: TC is the care of babies with some additional medical needs with their mothers present and caring for them in a setting outside of the neonatal unit. Outreach or Outreach services are the ongoing care provided at home by neonatal services following the discharge of babies from the neonatal unit.

TC can allow babies who would otherwise be admitted to the neonatal unit to remain with their parent avoiding neonatal care days. This is better for the baby and family, makes establishing breast feeding easier and facilitates earlier discharge from hospital. It enables better throughput for neonatal units and avoids costs of neonatal admission.

TC and outreach services are not currently commissioned. They are provided by many hospitals though and can allow a range of support and services to be provided at home but there are large variations in the provision¹⁰. The type of care that can be provided at home may include NGT feeding, oxygen therapy, phototherapy and feeding support.

The experience of being discharged home can be a difficult period for families of babies who have been unwell. Parents must adjust to the fact that they no longer fall within the protective zone of the neonatal unit, even though some will have been discharged home with a baby who remains medically vulnerable. Parents frequently have to manage ongoing medical difficulties or additional care needs, such as tube feeding, after their baby leaves neonatal care. Readmissions to hospital are also common. A 2022 survey of parents whose children had recently received treatment in a UK NICU found that 36% “did not feel that they were well supported with their infant’s specialised care needs” following discharge home.¹¹

Achieving a smooth transition, with good support for families from neonatal care, could significantly reduce neonatal occupancy and costs.

Commissioning for neonatal services needs to be restructured to include transitional and outreach services medical and surgical which meet BAPM framework standards. It should incentivise earlier discharge (with appropriate safeguards) with appropriately funded multidisciplinary home care teams.

Specialist mental health and neonatal outreach services can also play a key role in delivering such support. However, these are not always available and there is currently no funded specialist neonatal psychological provision in outreach teams. While health visitors do reach all families, they are poorly equipped to meet the specific needs of preterm babies and their parents due to their limited training on the impacts of prematurity. A specific issue which has been recognised is health visitors lack of knowledge for caring for babies born extremely early. Better provision of Outreach nursing support could enable improved handover of these vulnerable babies to health visitors to improve longer term support for parents of babies born early.

NHS England should work with training providers to embed opportunities to develop specialist knowledge of the needs of preterm and other sick babies and their families into health visitor training and continuous professional development, with protected training time.

Medical: The biggest gap in workforce provision is in the neonatal medical workforce. This was highlighted in the GIRFT Neonatal medical workforce report.¹² This highlighted significant pressure on the whole of the neonatal workforce with shortages in medical, nursing, allied health professionals (AHP) and psychology in England.

It found that NICU compliance with medical standards¹³ varied between 70% in high-volume NICUs and 19% in low-volume NICUs. The lack of 12-hour consultant presence was the main reason for non-compliance. In local neonatal units (LNUs) lack of rota separation from general paediatrics at tier 1&2 were the main reasons for non-compliance. Vacancies against budgeted establishment were present in all units. Difficulty filling deanery training posts was the most common reason for vacancies. There is variation both in the number of medical personnel available to support neonatal care where activity levels are similar, and in the roles and responsibilities undertaken by medical staff or other staff groups across different services.

Analysis of the reasons for these gaps is required and a clear medical workforce plan for neonatal services needs to be developed.

Allied Health Professionals (AHPs): There is increasing evidence and awareness of the benefit on outcomes, AHPs contribute to neonatal care particularly for the support of parents. This group includes dietitians, occupational therapists, physiotherapists and speech and language therapists. Following recommendations from the NCCR¹⁴, NHSE

provided dedicated funding for AHP posts within acute neonatal services. Despite this funding, there is a continuing workforce deficit across all AHPs of 68% in comparison to published workforce recommendations^{15,16}.

Work is required to understand the reasons for these difficulties and to improve recruitment and retention.

Adequate funding, resources, training & career pathways are required to fully embed AHP service in teams in line with published workforce recommendations including collaboration with Higher Education Institutions (HEIs) to ensure curriculum content and projected workforce numbers are in line with the anticipated demand.

Pharmacy: Standardisation of prescribing and administering complex intravenous, continuous drug infusions, and the development of Smart Infusion Pump datasets, are essential for the pharmaceutical development and safe administration of ready-to-administer medications for the neonatal population (see later under Q3).

This is a big change in practice for individual neonatal units. Implementing standard intravenous continuous drug infusions in practice needs to be supported by neonatal unit and network pharmacists. There is currently an unequal distribution of network pharmacists across neonatal Operational Delivery Networks (ODNs) in England – only 6 out of 11 have network pharmacists in post. There are different employment arrangements at each neonatal ODN, which leads to an inequity in services which needs to be addressed.

Work is required to understand and rectify the differences in pharmacy provision between networks.

Psychology professionals: The NCCR also funded network lead psychologists as well as some hub posts (covering a Local Maternity and Neonatal System (LMNS) footprint and in-unit psychologists. Psychologists support the wellbeing needs of infants, families and staff and develop culture and psychological safety across neonatal units, essential following a number of high-profile reviews highlighting issues with team functioning and dynamics as key in serious incidents including deaths of mothers and babies.

Overall, there remains a significant gap against staffing standards for psychological professionals which reduces the capacity of psychological professionals to deliver the service, presents a risk to safety and a long-term cost to the NHS in terms of psychological sequelae of neonatal graduates, parents and staff. Psychological professionals not only mitigate the harm and distress of neonatal admission, but support and prevent further difficulties. They also have a positive impact on neonatal

staff sickness absence and retention rates so represent a cost saving when psychological professionals are fully recruited against staffing standards.

Work is required to understand why there are gaps in provision and to rectify these.

Staff Development

Development, recruitment and retention of staff in neonatal services is important in order to be able to continue to provide and maintain optimal staffing. In addition, data from NHS staff surveys¹⁷ across maternity and neonatal services identify a culture of staff feeling unheard and practising in fear. Processes for whistleblowing and raising safety concerns are viewed as ineffective. BAPM has recently published a framework about raising concerns in neonatal services¹⁸.

There are a number of things which could be done to facilitate neonatal staff recruitment and retention:-

- a.) A full NHS bursary is key to increasing registration onto university nursing degree courses (and lessening attrition). Trainee nurses can be eligible for £5k but it is means tested. These trainee nurses must work more hours to achieve their clinical expectation, therefore they are unable to work outside of their course to support their degree.
- b.) Funding Nursing Apprenticeships as a route into neonatal nursing. This will support current ancillary staff to progress to registration and will support succession and retention of staff.
- c.) Availability of training for all staff is important. This needs to be protected time for training and it needs to be funded and equitable. This should include support for all newly qualified professionals especially in the first five years with high quality inductions and preceptorship support, initiatives to improve alternative access to education including apprentices and support for nurses AHPs and medical staff.
- d.) Training is also vital to improve safety. A recent BAPM Framework on Airway Safety Standards¹⁹ highlighted experience in intubation amongst neonatal professionals has decreased because of changes in clinical practice and changes in arrangements for training. Problems with intubation have been identified by the Healthcare safety investigation Branch (HSIB) as significant issues resulting in patient harm²⁰. Ensuring airway safety is therefore critical. Providing this training requires time and resources to deliver the training and to free up staff to receive it.
- e.) To support recruitment and retention, career progression within neonatal nursing is key. This is an expert workforce who must be nurtured and encouraged to develop through structured succession planning from undergraduate, post-graduate, QIS, ENNP,

ANNP and Consultant Practitioners, alongside the quality roles. The National GIRFT report in collaboration with the NNA set out a clear career structure for neonatal nurses.

f.) Neonatal care would become more attractive as a career and retain more staff if the increased level of expertise and responsibility of neonatal nurses were recognised in a similar way to that of midwives, that is, on completion of their qualification in speciality (QIS) they should progress from an Agenda for Change band 5 to band 6 following a period of consolidation as per recommendation 3 in HEE's Neonatal Qualified in Specialty (QIS) Education and Training Review. Currently, there is inequity, and nurses will move to other specialties where they are appropriately recognised.

g.) Allied Health Professionals: Adequate funding such as bursaries and apprenticeships will entice more people to consider neonatal allied health professions as a career option and will reduce staff turnover, maximise retention and provide an attractive clear career pathway.

Neonatal / Maternity Estates

Cot Capacity

A partly centralised model using Neonatal Networks has been developed in England and Wales because being able to care for the smallest and sickest babies in the right place is fundamental to improve outcomes. There is good evidence that outcomes are better when these babies are cared for in larger NICUs¹³. The NCCR helped to provide some additional capacity however it was limited because of a lack of capital funding required for the required changes in some regions. Completing this work to ensure that the care of all babies in every network can be optimised is essential.

The new hospital programme is very important to neonatal services. A number of hospitals have poor facilities and estates affecting their neonatal services. It is important that these issues are addressed allowing expansion of neonatal capacity where required. It is also important that services are correctly configured with neonatal intensive care co-located with other children's services where possible particularly paediatric surgical services.

Parent Support and Family Integrated Care and Accommodation

Having a baby admitted to neonatal care is a disruptive and distressing experience, and one in which parents need access to the support to enable them to be partners in their baby's care. This approach, 'Family Integrated Care' (FIC), has been shown to provide short-term and long-term benefits to babies – including a shorter length of stay and improved developmental outcomes as well as improved parental mental health and family attachment and bonding²¹.

To deliver FIC, there is an urgent need for better provision of parent accommodation and facilities to enable parents to be on the unit with their baby as much as they need to^{22 23}. Accommodation provision varies significantly, and can be a barrier to parental involvement in care.

Parental accommodation has previously been identified as a priority and of significant importance in previous reviews^{24 25 26}. The House of Lords Report²⁷ stated NHS England should publish the findings of its maternity and neonatal estates survey, setting out what proportion of neonatal units are currently able to provide sufficient accommodation for all families, as per the updated service specification for neonatal critical care. The requirements to meet standards can then be assessed and where possible these should be resourced.

Work is required to determine what proportion of neonatal units are currently able to provide sufficient accommodation for all families, as per the updated service specification for neonatal critical care²¹ and create a plan to remedy this.

Digital services

Electronic Patient Records Systems

Neonatal intensive care is very dependent on technology including ventilation devices, complex monitoring, temperature control and maintenance. Data recording is essential for monitoring, safety, audit, quality improvement and research. In addition, nationally collated data is used to benchmark neonatal services and improve quality. Maternity services and neonatal services are closely linked, and data need to flow easily and reliably between the services.

Nationally reported data are only possible if data are recorded using standardised data definitions. Historically, neonatal services have been fortunate in that a single patient data record system has been used by almost all services (BadgerNet Neonatal, System C). This is unlike maternity services where many different systems exist. There needs to be links and synergy with maternity systems to ensure all necessary information is communicated and available.

Hospital trusts now use a variety of different electronic patient record (EPR) systems, and this diversity of provision threatens national data reporting. Existing dataflows can be supported and improved, and the utility of national reporting maintained and expanded by addressing the underlying problems. This requires standardised data definitions, according to a dataset designed for, and controlled by the NHS which pays for it. EPR providers should be influenced, using the NHS monopoly, to ensure EPRs collect this dataset, and the dataset should be collected, collated and held so that existing uses by audits, benchmarking, research and quality improvement activities can

continue alongside other secondary data uses, such as NHSE monitoring neonatal clinical activity in real time. Crucially, functional interoperability between NHS trusts' EPRs should be maintained so that patient data is only entered once for clinical purposes and can then be used by subsequent organisations providing care for a baby, as well as for secondary uses.

It is essential that data systems implement the principle of data entered once and used for multiple purposes. This will avoid the time wasted, and the risk of errors, in duplicated data entry.

Some professionals work between different services and different hospital trusts e.g. psychologists work between mental health trusts and acute maternity and neonatal services. We need electronic systems which communicate to ensure care that has taken place is accessible for all relevant clinicians.

The current or a revised neonatal national dataset needs to be commissioned, and the resulting national neonatal dataset should be registered by as an Information Standard, using an NHS Information Standards Notice so that an appropriate minimum dataset is collected by all providers into their EPRs.

Electronic Prescribing

Most Trusts do not currently have electronic prescribing systems despite evidence that it could significantly reduce medication errors. This is a particular problem in neonatal services where drug errors are the most frequent safety issue reported²⁸. When electronic prescribing is introduced, systems often do not have the facility for complex neonatal prescribing. More work developing and implementing a uniform national electronic prescribing system into neonatal services is required, so that professional moving between Trusts do not have to use different systems developed by each Trust.

Drug Administration Systems

Standardisation of prescribing and administering complex intravenous continuous drug infusions (and development of Smart Infusion Pump datasets) are essential for pharmaceutical development and safe administration of ready-to-administer medications for the neonatal population. Currently, creating complex data pump libraries within systems such as Smart Infusion Pumps is a resource burden to individual institutions and is open to error. National data libraries need to be produced, and shared and embedded.

This is a big change in practice for individual neonatal units. Implementing standard intravenous continuous drug infusions in practice needs to be supported by neonatal network pharmacists (see above under staffing).

Coronial system and investigation of deaths

All neonatal deaths are reviewed using the Perinatal Mortality Review Tool (PMRT). The system of review of deaths requires time and resources including external review by involvement of neonatologists from other services. This system needs improved resourcing to ensure that it occurs consistently for all deaths in all services.

All neonatal deaths are now routinely reported through the Medical Examiner (ME) system, with referral and investigation by the Coroner for any deaths where there are concerns. However, reporting of deaths and the threshold for investigations varies between Coroners and MEs in different Trusts. This can lead to inconsistency and the feeling from some families that their loss has not been investigated fully or an investigation can occur unnecessarily resulting in significant delays and uncertainty for families.

There should be national guidance from the Chief Coroner so that all deaths are dealt with consistently and investigated appropriately, so that lessons can be learned and changes implemented where necessary. The time and resources required for thorough PMRT should be available within Trusts.

Litigation System

The current system of litigation with the maternity services in the NHS results in huge costs. The National Audit Office (NAO) said an increase in the number of claims, the rising costs of each settlement, and soaring legal fees had all contributed to the government's liability in England quadrupling from £14.4bn in 2006-7 to £60bn in 2024-25. In 2024-25 damages for very high value claims (over £1m) such as child injury caused by poor maternity care accounted for 68% of total costs, despite only representing 2% of all claims, auditors found²⁹.

A system for no blame liability should be investigated. This could ensure that families are supported and compensated routinely and more rapidly and huge legal cost are avoided.

It is critical that lessons are learned and changes enacted when learning from injuries does occur though but such a system would avoid the defensiveness of hospital trusts when claims occur and might enable improved learning and change.

Organisation of Maternity and Neonatal Services within Trusts and Networks

Clinical Management in Trusts

Neonatal services are sometimes grouped together with paediatrics and sometimes with maternity services in Trusts from a management point of view. There are clear links with both and all being managed together is probably optimal.

Neonatal services should generally not be managed separately from maternity services to ensure optimal organisation, communication and co-operation between perinatal services.

Networks

Neonatal Operational Delivery Networks (ODNs) have worked well to enable neonatal services centralise the care of the smallest and sickest babies. This has allowed improvements in outcomes which are linked to the smallest babies being born in the right place. However, the links and involvement of maternity services in networks is fragmented. Midwives and obstetricians sometimes do not fully understand the priorities of neonatologists trying to centralise care or have competing priorities. Organising the safe and timely transfer of women at risk of extremely preterm delivery is sometimes difficult. ***A system of perinatal ODNs with greater involvement of obstetric, fetal medicine and midwifery services could improve organisation and priority setting.***

Addressing Inequalities

Significant inequalities have been identified in provision and outcomes from maternity and neonatal care which need to be addressed. Appointing a National Neonatal Safety Champion could drive improvements in safety, with a substantial focus on health inequalities³⁰

In addition, it would be useful to focus the next phase of the Cultural Leadership programme specifically on the provision of culturally competent support for families to tackle inequalities in parent experience in neonatal units.

There should be work on developing guidance on joining-up post-natal maternity and neonatal care to support in-patient mothers to be with their babies in neonatal care while also accessing the post-natal care and support they need³¹.

Translation services and other services to reduce inequalities

Significant health inequalities have been identified in maternity and neonatal services³². Some of these exist because of the difficulties in access to high quality translation services which are person-centred, and this is a significant problem across health services.

Access to other services, information or research which could be used to build bridges between families from marginalised groups and maternity and neonatal teams and better access for clinicians to information/resources which helps them provide better care would be valuable. Examples might include improvements in monitoring devices for non-white babies.

Investment in technologies to support high quality translation services which can be accessed 24 hours a day 7 days a week across the NHS is important.

Wellbeing support for staff

Providing neonatal care for babies and families can be stressful and at times distressing. Infants experience pain, stress and distress and parents are often distressed, and manifest this in a variety of ways. Parents have often experienced trauma in their past and during the maternity journey and can also find the neonatal unit further traumatising. Staff need to be able to deal with this and responses may be difficult for staff to make sense of or to bear. Neonatal staff are exposed to media scrutiny and comment and critical public perception on a regular basis, and have to bear the resulting increase in targets, scrutiny and continued pressure from the system they work in.

As a result, staff recruitment and retention can be challenging and there can be high rates of sickness absence in this population. We know that critical care staff are some of the most highly stressed and distressed of any healthcare staff.

To help staff meet the complex needs of babies and families and manage the psychological threats in the system, the response needs to be holistic, and provide universal care to all staff, whether or not they are actively struggling. It needs to encompass good management training and support, opportunities for team training and regular communication, availability of peer supervision (perhaps through the professional nurse advocate (PNA) model) and access to psychological professionals, who provide both individual and group interventions, and support the psychological literacy and resilience of the unit as a whole.

There is also a need for high quality staff support services within Trusts offering evidence-based interventions. For this to happen, staff support services should be within the portfolio of the Chief psychological professions officer (CPPO) and this role should be extended to acute trusts from the model found mainly within mental health.

¹ Implementing the Recommendations of the Neonatal Critical Care Transformation Review, NHS England, 2019 Available at: <https://www.england.nhs.uk/wp-content/uploads/2019/12/Implementing-the-Recommendations-of-the-Neonatal-Critical-Care-Transformation-Review-FINAL.pdf>

² Preterm birth: reducing risks and improving lives. Preterm Birth Committee, House of Lords. Nov 2024

³ Neonatology. GIRFT Programme National Speciality Report April 2022

⁴ Improved outcomes linked to nurse staffing and consultant availability

⁵ Improved outcomes linked to nurse staffing and consultant availability

⁶ BAPM Standards

⁷ Optimal Arrangements for Neonatal Intensive Care

- ⁸ Medical staffing for Local Neonatal Units and Special Care Units.
- ⁹ Improved outcomes linked to nurse staffing and consultant availability
- ¹⁰ Preterm birth: reducing risks and improving lives. Preterm Birth Committee, House of Lords. Nov 2024
- ¹¹ Katherine Sabin and Fiona Challacombe evidence given to Preterm birth: reducing risks and improving lives. Preterm Birth Committee, House of Lords. Nov 2024
- ¹² Neonatology – Workforce GIRFT Programme National Specialty Report. Eleri Adams, Kelly Harvey, Michelle Sweeting. April 2022
- ¹³ BAPM (2021) Optimal Arrangements for Neonatal Intensive Care Units in the UK; <https://www.bapm.org/resources/296-optimal-arrangements-for-neonatal-intensive-care-units-in-theuk-2021>
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- ¹⁵ BAPM AHP standards
- ¹⁶ Neonatal Critical Care Service Specification. NHS England March 2024. [Neonatal-critical-care-servicespecification-March-2024.pdf](#)
- ¹⁷ [National results across the NHS in England | NHS Staff Survey](#)
- ¹⁸ BAPM How to Raise a Concern: A Guide to Whistleblowing for Neonatal Healthcare Professionals. July 2024 https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/2729/How_to_raise_a_concern.pdf
- ¹⁹ BAPM Airway Safety Standard A Framework for Practice April 2024. [BAPM Neonatal Airway Safety Standard | British Association of Perinatal Medicine](#)
- ²⁰ Thematic Analysis of Neonatal Resuscitation in Term Neonatal Brain Injury and Early Death in England HSIB presentation at neonatal society. Nov 2024. Bowman et al.
- ²¹ O'Brien et al (2018) Effectiveness of Family Integrated Care in neonatal intensive care units on infant and parent outcomes: a multicentre, multinational, cluster-randomised controlled trial, *Lancet Child Adolesc Health*, 2(4):245-254
- ²² Flacking et al (2012) Closeness and Separation in neonatal intensive care, *Acta Paediatr*, 101(10): 1032–1037
- ²³ Lehtonen L, Lee SK, Kusuda S, Lui K, Norman M, Bassler D, Håkansson S, Vento M, Darlow BA, Adams M, Puglia M, Isayama T, Noguchi A, Morisaki N, Helenius K, Reichman B, Shah PS, on behalf of the International Network for Evaluating Outcomes of Neonates (iNeo), Family Rooms in NICUs and Neonatal Outcomes: An International Survey and Linked Cohort Study, *of Pediatrics* (2020)
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- ²⁵ Paragraph 166 HOL report
- ²⁶ Neonatal Critical Care Service Specification. NHS England March 2024. [Neonatal-critical-care-servicespecification-March-2024.pdf](#)
- ²⁷ Neonatology. GIRFT Programme National Specialty Report April 2022
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- ³¹ BLISS <https://s3.eu-west-2.amazonaws.com/sr-bliss/documents/Research-andcampaigns/Campaigns/Manifesto-July24-2-Address-inequalities.pdf>
- ³² <https://s3.eu-west-2.amazonaws.com/sr-bliss/images/Research-and-campaigns/Coordination-ofmaternity-and-neonatal-care.pdf>
- ³³ MBRRACE Perinatal Mortality Surveillance. UK Perinatal Deaths of Babies born in 2022. State of the Nation Report July 2024