BAPM Neonatal Transitional Care Framework for Practice

Response to Consultation – July, 2017

	Comment	Response
Eleri Adams, on behalf of Neonatal Critical Care CRG		
	The Neonatal Critical Care Clinical Reference Group are somewhat bemused at this new proposed document, in particular the new definition of TC as it makes little reference to the BAPM approved HRG 2016 document, which modified the BAPM categories of care, and includes strict definitions for special care and special care (carer present; aka transitional care). Indeed, it is somewhat dismissive of it. The HRG 2016 document was developed with representation from BAPM, including the President, and followed an extensive consultation process, which included the formation of a CRG cross-disciplinary transitional care working group, which defined both what was considered to be normal maternity care and what constituted transitional care. Following this agreement, the national neonatal critical care mandatory dataset (NCCMDS) has been adjusted to include the new mandatory data-items required to allow these definitions to flow through to NHS systems in England, to allow reference costs and payment to be made against this definition. Reference cost advice has also been adjusted for 2016/17 to ensure that trusts provide reference costs against this dataset. The data items for SC are the same as data items for TC/SC(carer present). The reference cost information also suggests that similar costs should be attributed to SC and TC/SC(carer present). This allows services to change their model of care and develop different care strategies going forward, to allow more activity than is currently done in special care in many hospitals to be done in family or transitional care units in the future. Currently, we are working to introduce national pricing within the next 4 years against the new dataset. Given the process and that, after several years of work, we have just made changes to the nationally agreed dataset, further changes will not be possible for many years now, without strong evidence based cost effectiveness evidence. Thus, the section on commissioning services is rather inaccurate and does not reflect current hard-won initiatives. The CRG strongly urge you to reconsider aligning your definition and the requirements for staffing and support services based on the HRG 2016 definitions and NCCMDS dataset. Furthermore suggesting a model which uses 1 to 6 nursing ratios is neither evidence-based nor in keeping with this, and suggests different criteria as a definition of TC/SC(carer present) are to be used. This document will cause significant confusion in an area where absolute clarity is required.	Thank you for this helpful response. We acknowledge a significant oversight in excluding the HRG 2016 document and have amended the draft Framework for Practice accordingly. We have noted that HRGs do not apply in the devolved nations, but that the gold standard of accommodating babies with their mothers should apply, regardless of location within the UK and pricing structures. In keeping with the ethos of NTC, we have emphasised that providers should always consider the best interests of mother and baby in deciding the location of the infant’s newborn care. Where we believe potential for discrepancy/confusion may still exist we have noted that NTC costs may not be recoverable other than as HRGXA05Z or as normal newborn care.
Sam Oddie, Consultant Neonatologist		
	I am delighted that BAPM have now formally shown their support for the provision of NTC services, and all the evidential and values based statements in this	

	document are ones with which I would tend to agree. Arguably I have biases, as my own daughter (33/40, 2320g) was nursed on a NTC for 90% of her ten day stay, and I have rounded on NTC for 9 years.	
	I am concerned that this document does not deal with the underlying question that some of us had raised with BAPM. A definition of what will be paid as NTC has already been agreed by commissioners in England (in contrast to what it says in third to last para on page 4), and indeed the HRGs and BAPM standards have been amended in line with these. It would be an oversimplication, but essentially the thinking behind this was that the baby getting "special care" was the same sort of baby as that getting "special care parent present", but that such a NTC baby would have a parent on hand. This provides a model under which it can be expected that payment can and will be agreed, under the new payment model being proposed for newborn care in England, for NTC. Logically, it is to be hoped that the payment model will incentivise NTC. Indeed this was a starting assumption of the payment group which worked in England, and in	As noted above, the CRG document HRGs 2016 has now been incorporated, and the two documents are aligned.
	which I have been a participant. I hoped that this development of standards by BAPM would describe in unequivocal terms minimum standards, and in particular staffing ratios, to match the patients who would have been described at NTC under these "HRGs". This would have prevented an inappropriate drive towards NTC being provided with excessively thin staffing ratios. This document takes a different view of what NTC is to that described in the HRGs, for reasons that are understandable, but not altogether helpful given the above. It is relevant that under the revised payment arrangements, there is an expectation that all payments for normal newborn care will cease, and the funds be directed through tariff into payments under HRGs, including that by which NTC is described. Thus, a BAPM view that NTC is broader than this specification may result in some room for debate as to whether a given staffing level in the real world can be realistically challenged.	We agree to some extent with your concerns; the aim of this BAPM Framework for Practice is to encourage babies being kept with their mums, and the provision of flexible family-centred care. The difficulties in financing such excellence of care should not deter us from seeking a truly family-friendly NTC service, but of course need to be taken into account. Flexibility in clinical practice will necessarily create some conflict with the strict criteria necessary for payment models, but should not detract from the primary aim. We recognise that the HRGs 2016 were agreed after much informed discussion and a degree of compromise, but we hope that BAPM endorsement of the overwhelming impression that a well run NTC service offers better care for mum and baby as well as the extended family, with likely longer term cost savings in terms of reduced length of stay and reduced readmission to hospital will help to support progress in this field.
	I am doubtful as to whether one member of staff to six babies can be justified, although I welcome discussion on this. Clearly the less morbid the babies, the more reasonable this is, but I fear that payment will not be agreed in England unless the revised HRGs are already being redrawn (as will obviously be the wish of some).	We have revised our recommendation to state that the staffing ratio for NTC should be 1:4 *in addition to* midwifery support for the newly delivered mother.

	This set of standards, and associated staffing, might result in one nurse looking after six quite dependent babies, and I feel could be unsafe. I do not think that neonatal services can reasonably depend on midwifery input, particularly given the lack of firm recommendation for a staffing ratio – increasingly the tendency is for midwifery to "discharge" the inpatient woman in a NTC, resulting in two "patients" (mother and baby) depending on a nurse for every baby allocated to her.	BAPM is currently feeding into a national "think tank" review of midwifery training, and enhancing midwifery skills to include at least some elements of NTC is on our agenda.
	I do not think BAPM can justify, or need to justify a minimum weight for NTC. [page 6, "(a)]	We have qualified this recommendation, with the proviso that the smallest babies may best be observed initially in a NNU to ensure adequate thermoregulation.
	I do not believe that BAPM can justify that babies of 35 weeks of good birthweight, who can do full suck feeding and can maintain temperature ought to be "paid for" as NTC.	We have aligned our recommendations to HRGs 2016, with the expectation that payment for such stable late preterm babies may offset, at least in part other babies (eg neonatal jaundice requiring phototherapy) not currently included under HRG XA04Z
	I fear inclusion of babies at risk of haemolytic disease might encourage inappropriate use of phototherapy (when prophylactic phototherapy is often unjustified and ineffective).	See above
	I am doubtful as to whether BAPM need to specify a minimum corrected gestation or birthweight for admission to NTC for step down care.	Same argument as minimum weight. We feel that, for many units, even 33 corrected weeks may be deemed too immature. We anticipate that criteria will be loosened in the future as units become more familiar with NTC
	I am certain that doing observations 3 hourly (as opposed to 4 hourly) should not preclude admission to NTC. 3 hourly feeding and 3 hourly observations often go well together.	Agree – suggested change made
	The document appears to suggest that stable blood sugars are a criterion for admission to NTC – this is at odds with the BAPM hypoglycaemia approach, which as I understand it places the emphasis on the physiology and not the location.	We do not agree with this statement. We have recommended that babies at risk of hypoglycaemia are monitored in a postnatal ward setting, and that when NG feeds are required to maintain blood sugars, this should be undertaken in a NTC setting. The BAPM hypoglycaemia guideline specifically mentions the use of buccal gel to reduce NNU admissions – the specifics of management are out with the remit of the present (NTC) document
	Medical supervision - I believe that NTC should be delivered with medical input – I think the parents expect this, and that better decisions are made when this occurs. NTC should be seen as a core neonatal service, not as an add on with an occasional visit from a doctor. If SC and SC parent present encompass the same patients, then the same level of medical supervision should be available in NTC as in the neonatal unit.	Amendment made

	Role of Clinical Networks The variation in NTC provision was one reason that the English neonatal pricing group started meeting. However, the para under "Role of clinical networks" implies these disparities are unaddressed, when in fact some significant progress has been made towards doing so in England.	The section on the role of networks has been substantially revised
Tim Watts, Consultant Neonatologist		
2	I am surprised to see no midwifery representatives on the group and 'midwives' being represented by a neonatal matron. I think the document underplays the role and competencies of midwives and other maternity staff in caring for babies – and the lack of representation from midwives is a likely explanation for this.	We wholeheartedly agree with your point. An invitation was sent to RCM when this working group was set up, and repeat invitations issued. Caroline Cowan was the midwife representative; although currently Matron in NICU, she has supported transitional care as a midwife for many years. Several of the working group are, in fact, registered midwives, although admittedly all with a neonatal bias. We have sought "post-hoc" review by practising midwives
General	Many of the suggestions made in the paper appear to reflect a particular model of NTC, perhaps one that is familiar to the working party members. It doesn't appear necessarily to reflect other possible models, particularly of medical and non-medical staffing of such areas/units.	We have taken pains to describe NTC as a general service model, noting that it may be provided either in a postnatal ward setting, or dedicated ward. We have also amended the notion of two potential models of NTC to "several"
6 a) Criteria for NTC for babies…	First bullet point 'Gestational age at 34+0 to 35+6 weeks, for the first 1 -2 days of life' This should be more specific, for example 'For the first 2 days of life, unless requiring ongoing NG feeds, IV antibiotics or meet other criteria of higher care'	The criteria have been aligned with Neonatal HRGs 2016; NG feeds and/or IV antibiotics would not preclude NTC
6 Most headings	NG feeds should be referred to in all sections as '3 hourly or less frequently', as some babies will still require NG support, but no longer need 3 hourly necessarily, but more frequently than 3 hourly should be on SCBU.	This amendment has been suggested by others and incorporated, thank you
6 Heading b), c) & d)	There needs to be more consistency and clarity across the heading for jaundice requiring phototherapy and/or monitoring. I found this quite confusing. I don't understand why 'enhanced phototherapy' and 4-6 hourly SBR is mentioned in b), when intensity of	Since phototherapy does not come into either XA03Z or XA04Z, this has been removed from the criteria for NTC.

	phototherapy and monitoring isn't mentioned in other headings. Perhaps NTC for jaundice babies should be: Babies who need phototherapy; OR Babies who are not on phototherapy but require monitoring of SBR </= 6 hourly	We have, however, included babies with haemolytic jaundice who will require closer monitoring, and babies readmitted from home whose mothers may best be cared for in NTC setting. We trust the Framework is now less confusing
6 Heading d)	Second bullet point, should read 'maintaining temperature *unsupported by heating aids and in a normal cot*'	We do not agree that a heated cot *per se* should preclude a baby being nursed with its mother, or NTC
7 'Neonatal Nursing'	This reads as though the discharge planning and community outreach should be integral only to NTC, whereas it is important to have discharge planning and outreach working across the neonatal unit and NTC (as suggested on page 10 – see below).	A good point, thank you: Amendment made
10	I agree with the statement 'it is essential that both NTC services and NNU inpatient services link seamlessly between the neonatal and/or maternity unit and community neonatal services'. However, there is no good evidence that outcomes or processes 'will best be achieved by key members of the NTC team providing aspects of care in both inpatient and outpatient domains'. The important thing is that the neonatal unit, NTC, maternity and outreach work together, not that any model, described in the document or not, has been shown to be better than another. This is an example of the document appearing to describe a model that is the experience of the working group member(s), rather than the framework describing the important basics, which may produce different models in different units.	Thank you; amendment made
10 Community neonatal service	Is this a document aiming to be a framework and to describe standards for NTC, or is the remit to also describe community outreach? If it is aiming to describe a framework & standard for neonatal outreach, this should be explicit in the title of the document. If this is an afterthought, perhaps BAPM should produce another framework document with a bit more detail about outreach standards etc	You are correct – this document has remit to describe the former; amendment made
11	I think BAPM should be stronger on the commissioning arrangements for NTC. It is not enough to say 'equitably remunerated'. Rather it is vital to insist that it is financially sustainable ie recognises the model that means both midwifery and neonatal staffing is required and therefore the tariff must cover this workforce model.	As noted above, significant amendments have been made with regard to costings and the new Neonatal HRGs. We have also emphasised the need for maternity/midwifery input

Dr Elaine M Boyle **Associate Professor in Neonatal Medicine**		
General	Unfortunately, the content of the framework is not aligned with other information available from BAPM, specifically the recent work by the Neonatal CRG and HRG Development Group, which, it appears, has already been approved by NHS England. This would lead to confusion.	This has been pointed out by others, and addressed
General	The document is rather long and wordy and it can be difficult to tease out salient points	The document has been significantly edited and amended
P1. para 4	There has been recent work on reference costs and guidance is available	Noted
P1. final sentence	"All newborn babies deserve to be with their mother". "Deserve" is a rather emotive term	Amended to "should"
P4. Normal newborn care	Definitions are not in line with those in the recent document from the CRG Pricing Group and Neonatal HRG Development Group	Amendments made
P4. Special Care and Transitional Care	The document from NHS England and National Casemix Office (December 2016) states that the new HRGs have been reviewed and approved by BAPM and replace 2011 categories of care. The new terminology of "special care, carer not resident" and "special care, carer resident" help to clarify definitions. The term, Transitional Care is no longer used. Would it be simpler to use one term? If so, the new terminology would be less open to different interpretation.	Thank you for this opinion, which is valid. We believe, however, that the term "transitional care" is widely used, and considerably less cumbersome than "special care, carer resident", so we have elected to keep it
P5. Benefits of Transitional Care	These are not referenced – if evidence does not exist, would this be more appropriately entitled "Potential benefits"?	Agree
P6. Criteria for NTC for babies from birth	Birth weight and gestational age criteria do not align with the other documents	Amendments made to align with HRGs 2016
Josie Anderson **Senior Policy and Public Affairs Officer, Bliss**		
Full document	As this standard covers the whole of the UK, it would be useful to acknowledge at points throughout the document that in Scotland transitional care is often called 'postnatal neonatal care'.	This definition has been incorporated
1	As Bliss were part of the working group who compiled these standards, it may be worth including in the executive summary that parent representative organisations or charities were also consulted.	Done
3	This page discusses briefly the benefits of transitional care for babies, mothers and neonatal units. However, implementing transitional care is	Suggested amendment made

	going to have significant implications for maternity units. Bliss would recommend the benefits of transitional care for maternity units are highlighted as well to help ensure buy-in from all affected stakeholders. For example, the additional professional development opportunities presented to midwives through transitional care could be highlighted.	
4	<u>Normal newborn care</u>: It is important to ensure this section is reviewed by RCM / midwifery education providers or similar to verify that the care activities listed are part of standard midwifery education.	RCM was represented on the working group, but following similar input, this document has been reviewed by other midwives, with current experience of working in postnatal wards. Your point about midwifery education is well made; BAPM is represented in an ongoing RCM review of midwifery education, and the need for development in NTC has been highlighted.
4	Bliss is concerned that line three of page four, which states 'normal newborn care includes immediate review of the baby after birth' contradicts the definition of normal newborn care on page three which states that unless necessary or requested by the mother, any separation should be avoided in the first hour of birth. To avoid ambiguity and misinterpretation, these lines should be amended to ensure consistency.	"None of these tasks should involve separation of mother and baby" has been added and "early" substituted for "immediate".
4/5	Add reference to Scottish Government *The Best Start* description and definition of 'postnatal neonatal care' (Chapter 6)	This has been done
5	<u>Benefits of transitional care</u> • Bliss recommends that the box is restructured so the benefits to the baby are listed first, as this is the primary patient group. • 'Family-friendly environment' to be changed to 'family-centred environment' as this is the term used throughout and ensures consistency. • Suggest moving 'improved parental confidence' from the 'for baby' sub-section to the 'for mother' sub-section. • There is potential to reference work which is being undertaken to reduce term admissions, such as the ATAIN programme, on the line which discusses more efficient use of neonatal cots.	These suggestions have all been incorporated
7	Bliss believes the line "NTC can be delivered in one of two service models, either within a dedicated transitional care ward or on a postnatal	Agreed – amended as suggested

	ward" is too prescriptive as the document earlier notes that transitional care should be considered a service, rather than a place. To enable hospitals to utilise what they have, we would recommend the wording be changed to: ''NTC can be delivered in several ways, including in such models as having a dedicated transitional care ward or on a post-natal ward.'' This is to allow for alternative solutions, such as units utilising existing rooming-in rooms on the neonatal unit, for example.	
7	"We recommend that a **designated NTC unit** is considered in the planning of all new maternity and neonatal building projects and/or reorganisation or redesign of services" – change to "designated NTC ward"	Done
7	Many of the babies who can be cared for in a NTC setting will be receiving interventions usually administered in a special care setting. Should the neonatal nursing ratio not be 1:4 as per guidelines for special care as a result? It may be useful for the rationale for this staffing ratio to be included. Bliss also believes the line ''all NNU neonatal nursing and ancillary staff may conveniently rotate through NTC'' needs clarification. Does this mean that they will, on rota basis, have shifts dedicated to the NTC or does it mean that while on shift in the neonatal unit members of the team will be expected to split their shift to oversee the mothers and babies on the NTC? If the latter, Bliss is concerned about the potential impact on neonatal nurse-baby-ratios throughout shifts, especially if the NTC is located outside of the NNU and will require an extended absence of neonatal staff.	This comment has been made by others – we have amended the recommended neonatal nurse staffing ratio to 1:4 We have softened the recommendation around rotation of staff, as this is not evidence based.
8	"Parents should be offered the opportunity to be present during ward rounds and/or consultations in NTC, and where practical, ward rounds should be scheduled to suit parents' availability." Bliss strongly recommends this wording is amended to read: "Parents should always be present and encouraged to participate in all ward rounds and/or consultations in NTC, as they would in any post-natal ward". Particularly when the mother is in situ as the primary care giver they should always be present and able to report on their baby as part of a ward round or similar consultation.	Thank you – the suggested wording has been incorporated

8	‘’We recommend that there is joint working between midwifery and neonatal nursing management…to determine appropriate staffing’’ Bliss recommends strengthening this sentence to say that joint working **must** take place as it is unlikely that an NTC area could operate efficiently without good communication, buy-in and joint working from both the maternity and neonatal staff.	Thank you – the suggested wording has been incorporated
8	Bliss believes that parents having unrestricted access to their baby should be made explicit. Suggest rewording to: ‘’Parents should have unrestricted access to their baby, including during ward rounds, and should be supported fully to have long-uninterrupted visits. A separate consistent policy should also be available for allowing siblings to visit. Where possible, this should also be unrestricted and outline clearly the reasons for any periods of time where siblings cannot visit (e.g. RSV season). A further clear and consistent policy should be available for extended family members.’’	Suggested amendments made
8	“The benefits of NCT include”. Typing error – amend to NTC.	Noted and corrected
9	<u>Facilities</u> Thought should be given as to how these will join up with existing standards on parental support for parents with a baby receiving neonatal care, to mitigate disparity in access to support between parents in NTC and parents on the NNU. Bliss would suggest that the *Framework for Neonatal Transitional Care* recommends that where the NTC is located on, or very near, to the neonatal unit, facilities such as the kitchen equipment and parent room, and access to other support like food and drink and parking vouchers should be shared between both settings. Further to this, it needs to be taken into consideration that different nations have different standards in neonatal care for parent support. For example, Scotland’s *Quality Framework* only stipulates that hot drinks should be available out of hours to families on NNU. Without additional clarification in the *Framework for Neonatal Transitional Care* and sharing of certain facilities as outlined above, there is the potential for families with babies in the same space to have access to a completely different packages of support. Bliss would also suggest making it clear that accommodation for NTC purposes is	We have noted Bliss concerns and made an amendment to note that NTC accommodation should be separate from NNU accommodation

	separate to the free overnight accommodation that should be available to families on the neonatal unit (again, please be aware of and account for national variation in standards). We would suggest this specific facility is **not** shared as it is essential to NTC and if they are regularly appropriated to provide overnight accommodation to families on the NNU this could cause patient flow issues. Further, neonatal units are required to provide overnight accommodation for families, and Bliss knows that a lack of accommodation is one of the biggest barriers to parents being with their baby in NNU. We do not want NTC accommodation being counted with the NNU accommodation when this is not available to NNU families. It may disadvantage families in the future if on paper a unit appears to have a good level of accommodation, when in reality most is dedicated to the NTC. We're already aware of Trusts including rooming-in rooms when counting their overnight accommodation, when this should be separate, and we would be keen not to exacerbate this issue further.	
9	It may be helpful to define what's meant by 'when appropriate' with regards to partners staying cot-side to avoid variation in interpretation. Bliss would suggest that unless there are safeguarding issues, it is always appropriate. For it not to be could contradict having an unrestricted visiting policy for parents.	"when appropriate" has been deleted
9	Bliss recommends the working group consider the inclusivity of the language used in this section in particular, but also throughout. For example, the mother may be supported by someone other than their partner or the baby's father, and in rare instances a carer or guardian may be responsible for the baby rather than a biological parent. We recommend a footnote be added early on in the document which explains that references to parent should be assumed to also mean carer, and references to mother's partner/partner should be assumed to mean any person who is nominated by the mother as her birth partner, or similar.	Thank you – this has been added
9	<u>Information:</u> Bliss recommends that where care plans are being discussed, this sentence is strengthened to say that care plans should be drawn up in partnership with parents, and that this includes encouraging parents to ask questions and to give their own	Suggested amendment made

	suggestions for their baby's care. Bliss would also recommend that as well as information about specific conditions being available and following a consistent approach, this section should also state that parents are signposted to appropriate local and national organisations, both for condition specific support, but also for emotional or financial support.	
9	Equipping and supporting staff A reference should also be made to maternity networks promoting similar training.	Done
10	Bliss recommends the importance of community maternity services should be referenced (including standard post-natal maternal health check-ups as well as support for maternal mental health) to link up with community neonatal services, in order to improve patient experience and potentially also reduce the number of home visits / duplication in some cases.	Done
10	Bliss would recommend that discharge for neonatal unit graduates is discussed in a separate line to discharge planning for babies whose care takes place entirely on the NTC. For NNU babies, good discharge planning should begin from admission to the neonatal unit, and their parents should have the opportunity to feed into the discharge and care plans throughout the neonatal journey. It should be ensured that there is continuity for these families as they move into the NTC	This is a point well, made, but in the interests of brevity we have not made further amendments to the document
11	Bliss would recommend that where references to commissioners and providers is used, that this is reviewed to ensure the meaning is understood by practitioners across the UK. For example, in Scotland services are not 'commissioned' so that term does not apply. We suggest these sections are developed further to be more applicable outside of England.	The sections on the role of networks, commissioners and providers have been substantially revised
Doreen Crawford **On behalf of the RCN CYP Acute Care Forum.**		
.	The RCN Children and Young People Acute Care Forum (CYP A/C Forum) which includes neonatal nurse members would endorse the ethos behind the principle of keeping mothers and infants together unequivocally. However, we would wish to express disappointment that although the RCM and the NNA were represented in the steering group which produced this document the RCN were not. RCN members include midwives and neonatal nurses, Maternity	We apologise for this oversight. We have now sought input from RCN – comments addressed below. We shall seek to include BAPM members of RCN in relevant future BAPM working groups. Are members of RCN involved in neonatal care encouraged to join BAPM?

	Support Workers and Health Care Support Staff. The RCN Forums are influential and active. The RCN has a long standing and permanent Professional Lead for Child Health on staff who has a respected National Profile. This RCN Professional Lead has been recognised by RCPCH with Fellowship. We would express the hope that this oversight is not repeated in the future This document has redefined Transitional Care (TC) and we would note that there is some tension in this new definition as it makes little reference to the BAPM approved HRG 2016 document. The HRG 2016 document was developed using a more extensive consultation process (see link to summary) and this HRG data set was subsequently endorsed by Dr Modi an RCPCH President. It was indicated that the cost of XA03Z and XA04Z i.e. the special care tariffs (regardless of parental residency or not) were similar. BAPM will be cognisant of the fact that there is currently a Neonatal Transformational Review taking place. This is being chaired by Professor Neil Marlow. This review will include, inter alia, a commissioning review of services including TC. Therefore, it may be premature of BAPM produce these standards which could be seen to pre-empt any recommendations a report from this review process may make. The recommendations for midwifery care of the mother were noted and again it might be premature of BAPM to make a pronouncement on mother to midwifery care ratios which are themselves currently under review. The amount of training and education that midwives receive in their pre-registrant programme of preparation is highly variable. Some programmes expose student midwives to very little sick infant experience. It could be suggested that these staffing ratios are not going to improve breastfeeding rates as it is arguably more difficult to establish breast feeding with smaller and less well infants than healthy term infants. The RCN will bring to the attention of BAPM that there is a growing body of evidence to support the fact that the outcomes of patients are better with higher	We acknowledge this significant oversight, highlighted by others. Amendments have been made to align the document to HRGs 2016. Professor Marlow has been consulted in the redrafting of this draft document Thank you – we agree! RCM was consulted, and inputted to this draft document. It should also be noted that BAPM is contributing to an ongoing NMC Leadership Group considering future training of midwives

	ratios of qualified staff. Specifically, we would like to take the opportunity to comment on the nurse staffing of the TC. Suggesting a model which uses a 1 to 6 nursing staff to infant care ratio is neither evidence-based nor founded on common sense. Although infants in TC, like infants in Special Care are regarded as stable, sick infants have the potential to deteriorate rapidly and could require significant neonatal nurse action. Currently the Department of Education (2017) recommends a teaching / nursery nurse staffing ratio of one staff member to every three children under two years of age. These 1:3 ratios are of course related to healthy children the RCN A/C Forum would urge BAPM to seriously reconsider any suggestion that a ratio of 1:6 for infants who have health concerns could be regarded as safe. The CYP A/C Forum would like to bring to the attention of BAPM, the RCN (2013) document on defining staffing levels for children and young people's services and also the Neonatal Toolkit (2009). The RCN 2013 document on staffing was also welcomed by a previous RCPCH President Dr Cass. Both documents recommend a ratio of a minimum of 1 nurse to 4 infants. The Toolkit did not specifically consider Transitional Care but the infants who are in such a facility are often very similar to the infants who reside in Special Care as recognised by the HRG reference costs. Indeed, there are occasions in TC when the mother goes home the infant are then transferred back to SCBU if they are not ready for discharge. Furthermore, the Toolkit like the DE (2017) did have something to say on the qualifications that staff working on the SCBU should have. The RCN A/C Forum would be concerned with a recommendation that neonatal nurses working in a TC facility did not have to be QIS. The RCN CYP A/C Forum would be extremely concerned if this document were to be released without a complete revision of nurse / midwifery staffing recommendations. At the very least these staffing recommendations have the potential to cause significant confusion.	Amendment made – this comment was raised by others.
Mary Rafferty **Nurse Consultant Lead, Health Visiting and Community Nursing in the PHA**		

mary.rafferty@hscni.net		
	The comment relates to neonates who are discharged from the neonatal unit: These infants, if more than 10 days post-delivery with their mothers and family, will transition directly to the health visiting service and do not have any input from midwifery. At time we are in discussions to determine how we can improve the knowledge of the service in relation to the challenges faced by these infants and their parents. We have identified this as a deficit and would hope that the HV could visit the family in the unit prior to discharge. In addition I am working with the regional group to develop a neonatal insert for the revised 'red book' which will hopefully assist the parents, HV service and primary care. If there is a plan to develop specialist services we would need to consider how this will sit alongside and engage with the health visiting and primary care services.	Thank you – we have highlighted the need to involve the HV in discharge planning for all babies discharged form NNU/NTC
Dr Peter DeHalpert Peter.DeHalpert@royalberkshire.nhs.uk Neonatal Network Northern Ireland		
	The Neonatal Network welcomes the direction of travel of this high level framework and agrees in principle to as portraying the spirit of what the network seeks to offer families and babies.	Thank you – there are all very relevant points. The Framework for Practice is necessarily general in its recommendations for service provision, as this will vary between areas.
	The framework however presents a challenge to deliver on in relation to the finer details of the model as it requires a paediatric, maternity and neonatal response, especially in those circumstances where mum, or mum and baby have been already discharged.	
	Further consideration is required within the framework in relation to primary and community care interfaces, to ensure continuity of care.	
	While TC service models are evolving on the ground, the full implementation of this framework will require investment and resource management.	
	There is no consistency between the standards proposed and the criteria for TC that were agreed and approved by the TC working group, the pricing group and thus the 2015 HRGs that were agreed by BAPM. BAPM itself refers to this work as the BAPM 2015 categories of care. If there is no concordance between the 2015 categories and HRG pricing and the NTC	We apologies for this significant omission - document now aligned with HRGs 2016

	standards it will be from a contracting and operational perspective be somewhat "challenging"	
Tom McEwan **Lecturer in Midwifery, (Maternal, Child & Family Health)**		
	This is a detailed and comprehensive standards document which provides a coherent and inclusive definition for NTC. It demonstrates a family centred approach and offers provision for the father, or other named carer, to allow the newborn to stay within a NTC area if the mother is too unwell to provide this care i.e. within an ITU environment etc. It provides HEI's, that provide midwifery and MCA education and training, with a focus for future programmes to ensure health professionals have the knowledge and skill to provide this long overdue level of care. Excellent work by the team.	Thank you
Dr Elizabeth Pilling **Consultant Neonatologist**		
	I am a bit confused about the difference in the definition used within this document that differs from the "new" 2015 NHS England's HRG definitions as below (I've copied and pasted all of them but not all are different or relevant). Is there any opportunity to have some consistency between these (accepting there is little evidence to sway one way or the other) as I'd be concerned about the differences.	Document now aligned with HRGs 2016
Dr. Yvonne Frier **Clinical Reader, Neonatal Intensive Care, Royal Infirmary of Edinburgh**		
4	I'm not clear what the NIPE is; in Scotland all midwives undertake 'birth examinations' and then some will do a formal 'SMMPD – Scottish Routine Examination of the Newborn programme' examination.	This has been amended
4 & 6	Blood 'sugars'; this is perhaps better expressed as blood 'glucose'.	Amended
4	Suggested criteria for special care in NTC. It's important to differentiate when treatment is for infants transitioning from fetal to newborn life, and from hospital to home as well as pathological processes. Whilst I agree many parents welcome the opportunity and are more than able to provide special care on the ward/at home it depends on the baby's journey and underlying condition. A	Thank you for this point The intention of this document is to encourage mothers and babies to be nursed together whenever possible. We hope, therefore that the role of the QIS neonatal nurse will, in the future, be more

	blanket statement saying that the 'majority of these criteria for special care could reasonably be undertaken at home ….should not preclude NTC' under estimates the knowledge and skill that a QIS neonatal nurse brings to the care and management and therefore outcomes of babies as well as the education needs and support of parents.	often carried out in a NTC setting than in a SCBU We have made some subtle amendments with the aim of selling the benefits of NTC, rather than underplaying care provided in a NNU
5	'NTC is care additional to normal care…' I feel it would be inappropriate for a baby (discharged from a NNU) with complex needs e.g. home oxygen, to be cared for on a postnatal ward prior to discharge especially if the 'appropriately trained healthcare professional' is not a QIS nurse/midwife/CSW/MCA. Equally I feel it would be inappropriate to expect a family with a baby receiving palliative care to be 'stepped down' and supported by 'new' staff in an environment where well babies are also being cared for. Could you be more specific about what is meant by a 'postnatal clinical environment'?	We agree, and have deliberately been vague in this respect as the ethos of NTC is to have mum and baby accommodated together. The exact location of "together" is not important.
5	In Scotland the QIS programme to support a nurse/midwife or CSW/MCA to provide specialised care to newborns is divided into 2 components (modules): special care/high dependency and intensive care. I would strongly recommend that the practitioners providing NTC care are at least qualified to provide special/high dependency care. As per my comment in line 3 above, by not requiring an agreed specification for the knowledge and skills to provide specialised care for babies and their families or provide the needed education and support to families under estimates the knowledge and skill that a QIS neonatal nurse brings to delivering a quality service.	We agree. The hope is that NTC will become as regular, expected and clearly identified a part of babies' care as NICU or HDU
5	I would re-label the box as 'Potential benefits of transitional care'	This has been done (same comment made by others)
6	I am surprised at some of the criteria for NTC e.g. (b) haemolytic disease; I'm not familiar with the term 'enhanced phototherapy', please explain; where more than one phototherapy device is used or high intensity lights are used, some guidelines recommend continuous temperature monitoring. For babies admitted from the community (c),	See amendments to criteria, bringing them into line with NHS England HRGs

	until what age would they be eligible for readmission to postnatal care facilities? For babies stepping down from the NNU (d) will babies be maintaining their temperatures without the support of supplemental heating devices? In routine postnatal care, babies receive monitoring of vital signs via NEWT score more often than 4 hourly; it seems counter-intuitive to have transitional care babies receiving observations no more than 4 hourly.	
7	It is inappropriate to stipulate the 'banding' of the neonatal nurse lead. Banding will be decided locally and be dependent on the configuration and delivery of services. BAPM staffing recommendation for special care provision is currently based at 1:4 with parents sometimes being resident. The primary carer should be providing the 'majority' of care rather than 'at least some of the care' especially as the suggested staffing number for a NTC is 1:6. Given the complexity of some of the babies and the inexperience of many mothers, I would have thought the staff: baby number should reflect the same as BAPM special care ratios.	It was considered by the working group that a senior nurse should be recognised as responsible for leading on NTC, and this had been approved by all other feedback, including nursing and midwifery We appreciate feedback regarding the proposed nursing staff;patient ratio. Others have also commented. Following feedback from RCN and RCM, this has been amended to 1:4
7	Additional primary carer needs some exploration as to meaning e.g. has this person the authority for decision making/consent?	Thank you for this point, which is intended to apply only very rarely when the mother is very unwell. The usual rules around parental rights and responsibilities would apply
9	The facilities specified are a wish list. It would be impractical and inequitable to provide these fro NTC parents and not parents of well babies especially if NTC was integrated into a postnatal ward environment.	We recognise this, but BAPM is committed to seeking the best possible care for babies and their families.
10	It is inappropriate to stipulate the 'banding' of the neonatal nursing team. Banding will be decided locally and be dependent on the configuration and delivery of services.	The section on community outreach has been shortened and this advice removed
11	I'm not familiar with the abbreviation ODN, please write out in full.	Operational delivery networks. Amendments made
F.M.Smith **RCN Professional Lead for Children and Young People's Nursing**		
	Many thanks for forwarding the document. It is	

	really important that the RCN has the opportunity to respond to such documents as the RCN is the largest professional nursing organisation in the UK. We have consulted with our members and have the following observations and points to make.	
	We fully support the need for transitional care. The term 'local flexibility' however on page one concerns many of members fearing that this will invariably result in the lowering of standards such that we have seen in other services where local flexibility features. Transitional care should not be seen as a 'cheap' option. It is really important that we stress and uphold national core standards for such provision, including the staffing of such units. Likewise while there is undoubtedly a need for local agreements across networks as outlined on page 6, there is a clear need for national agreed core standards so as to avoid a postcode lottery.	We intended that "local flexibility" be taken to include some babies who do not strictly fulfil the criteria for NTC being accommodated with their mother in a NTC facility (even tho' they will be not chargeable at NTC within NHS England). We hope that rewording of the document has made this clearer.
	It is noted that monitoring undertaken by midwives is crucially important as highlighted on page 4. It should however be stressed that should any of these deviations be detected then the infant would cease to be 'normal' and may require more expert care, review and intervention.	We assume that this is standard practice, and in the interests of brevity, have not added to the text
	Infants in the categories on page 4 and 5 would certainly require more than a ratio of 1:6, and there needs to be registered nursing staff who have neonatal nursing knowledge, skills and expertise within such units.	Amendment made.
	We feel that the criteria outlined on page 6 concerning care that could reasonably be undertaken at home needs clarification, particularly in terms of for example the home environment, support from community nursing required at home, as well as preparation and training for parents/carers. Is BAPM seriously suggesting that all such infants should be cared for at home? Is there a need to insert some caveats?	Thank you for this comment – amendment made.
	Our members advise us that many hospitals have local guidelines in place prohibiting infants returning to any form of neonatal care, including transitional care. Generally these infants return to	We agree, and have now noted that some babies may better be accommodated in a NTC facility than in a general paediatric ward.

	children's wards and departments. Local guidelines could result in some infants in some areas gaining admittance to Transitional Care and not in other areas. In respect of service delivery there is a need to emphasise the building requirements and configurations so as to ensure dignity of all concerned. For example a likely scenario may well be that where the infants' resident primary carer when the mother is too ill is likely to be the father resulting in the potential of a mixed sex breach if the parents are housed in bays where other maternity patients are. Midwifery staffing is under review at the current time. Our members stress the need for a firmer recommendation if there is only one qualified midwife on a shift. Telephone cover alone is not sufficient. There clearly needs to be set out in advance where staff will be drafted from should the need arise in local policies and procedures. Regarding neonatal staffing in a transitional unit, a 1:6 ratio of neonatal nurses to infants is insufficient. The ratio should clearly be 1:4. The fact that newly delivered mothers are resident with their infants means that they require midwifery support and midwifery numbers should not be considered in an equation used to determine neonatal requirements. These numbers need calculating separately for maternal and infant safety, not combined. It is really important to ensure that neonatal nursing knowledge, skill and expertise in Transitional Care units is equivalent to that within SCBU. We feel that in respect of Monitoring and Evaluation on page 11. In order to have a consistent national approach towards audit and evaluation there clearly needs to be national core standards and consistency in service provision.	The overwhelming message must be that mother an baby should be accommodated together in the facility best suited to their care requirements The specifics of parental accommodation are outwith the scope of this document; we have declared that fathers should be able to be accommodated whenever practical This has been noted. This amendment has been made