



British Association of Perinatal Medicine
A Framework for Neonatal Transitional Care

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Executive Summary

Keeping mothers and babies together should be the cornerstone of newborn care. Neonatal Transitional Care (NTC) supports a resident mother as the primary care provider for a baby with care requirements in excess of normal newborn care, but who does not require continuous monitoring in a special care baby unit. Implementation of neonatal transitional care has the potential to prevent thousands of admissions annually to UK neonatal units, and also to provide additional support for small and/or late preterm babies and their families. NTC also helps to ensure a smooth transition to discharge home from the neonatal unit for many sick or preterm babies who have spent time in a neonatal unit, often at some considerable distance from home.

Following consultation with midwifery, neonatal nursing, obstetric and neonatal medical staff, BAPM has compiled this Framework for Practice for the provision of NTC in the UK. We have considered those groups of babies for whom NTC should be a standard of care, and how and where NTC should be provided. NTC is a *service*, rather than a *location*, and thus need not be dictated by building or geographical constraints. We offer recommendations for staffing of NTC services, with consideration of the care needs of both mother and baby. Successful implementation of NTC demands joint working between midwifery and neonatal nursing staff as well as paediatric services.

NTC is integral to the philosophy of family-centred care and services should be designed with the needs of the extended family in mind. NTC should link seamlessly to community care, facilitating early discharge and appropriate post-discharge support for families.

Commissioners and providers should agree a common definition of NTC and work together to ensure consistent delivery of equitably remunerated, high quality NTC. Audit and evaluation of both NTC and community neonatal services are essential and should utilise a single national data recording system. Parental feedback should be actively sought by all NTC services, and the results acted upon.

All newborn babies deserve to be with their mother if at all possible; implementation of NTC within all UK maternity services has the potential to make this happen.

Membership

The composition of the group is as follows:

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Introduction:

Neonatal Transitional Care (NTC) supports a resident mother as the primary care provider for a baby with care requirements in excess of normal newborn care, but not including continuous monitoring in a special care baby unit⁽¹⁻³⁾. NTC avoids separation of mother and baby and facilitates parenting and attachment and the establishment of infant feeding, whilst enabling safe and effective management of a baby with additional care needs. The concept of NTC is not new, having been proposed by Whitby over thirty years ago⁽⁴⁾.

NTC may apply to newborns with moderate additional care needs (e.g. late preterm babies or babies showing signs of neonatal abstinence syndrome), or to older babies transitioning from a neonatal unit (NNU) to home⁽³⁾. NTC is multidisciplinary, takes account of both the mother and baby's physical and emotional needs and is flexible and responsive to mother and baby as well as the rest of the family. Provision of NTC achieves the overarching principle of keeping mother and baby together, and helps to support early discharge of mother and baby, thus ensuring truly family-centred care. A recent systematic review concluded that "*transitional care benefits the health outcomes of moderately compromised infants and mothers in terms of de-medicalising care, improving mother and baby attachments, avoiding separation, developing parenting skills for dependent infants and raising the potential for shorter length of hospitalization*"⁽⁵⁾.

Many maternity and neonatal services already provide elements of NTC, which may or may not be formally recognised. Service provision and appropriate remuneration for services vary widely between facilities. Some exemplary models of care exist, supported by dedicated and enthusiastic staff; in other areas, progress has been hampered by a variety of real and perceived issues. Barriers to provision of NTC include lack of confidence in delivering NTC among midwifery and neonatal staff, geographical footprint/accommodation constraints and

staffing resource. Commissioning and remuneration may also be significant factors in some areas. Properly resourced and managed, NTC should improve the maternity and neonatal experience for the mother, her baby and her partner as well as the extended family, resulting in greater parental confidence, improved breast feeding rates and earlier discharge home for babies with moderate additional care needs. NTC should additionally help to prevent blocking of NNU cots for babies requiring more intensive levels of care, improving acceptance of NNU admissions at both unit and network level.

NTC may be undertaken in a postnatal ward, in a designated transitional care unit or in a combination of such settings. Wherever the location, the interdisciplinary approach of both midwives and neonatal staff is important in facilitating delivery of high-quality care to both mothers and babies ⁽⁵⁾ and NTC should link seamlessly with community services. On the very rare occasion when it is not possible for a mother to care for her baby, it may be appropriate to designate an alternative resident primary care giver and support them to provide NTC in lieu of the mother.

The aim of this Framework for Practice is to describe standards for NTC care within the UK National Health Service. The document specifies those babies for whom NTC should be the standard of care and describes service delivery including provision of family-centred care and interface with community neonatal and/or paediatric services. The importance of education and training of staff, monitoring and evaluation of service and the role of neonatal clinical networks is highlighted. We hope that this Framework for Practice will help to keep mothers and babies together, standardise care for babies with moderate additional care needs and their families, clarify issues around commissioning/payment for service and ensure appropriate audit and clinical governance.

Definitions:

In describing standards for NTC, it is important to explore existing definitions of “normal newborn care”, and to consider the role of the midwife in helping a mother to care for her newborn.

The International Confederation of Midwives ⁽⁶⁾ notes that *“The midwife..... works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period.....and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community.”*

More details are provided by NICE ^(7,8), which recommends that the midwife should:

- *“Avoid separation of a woman and her baby within the first hour of the birth for routine postnatal procedures, for example, weighing, measuring and bathing, unless these measures are requested by the woman, or are necessary for the immediate care of the baby*
- *Encourage initiation of breastfeeding as soon as possible after the birth, ideally within 1 hour.....and provide a supportive environment for breast feeding*
- *Record head circumference, body temperature and birth weight soon after the first hour following birth*
- *Undertake an initial examination to detect any major physical abnormality and to identify any problems that require referral”*

Normal newborn care:

Normal newborn care is delivered by a mother with the support and guidance of her midwife, either in a labour suite, a postnatal ward or at home. Normal newborn care includes immediate review of the baby after birth to detect major physical abnormality, establishment of feeding and ongoing assessment of infant well-being, including observation of vital signs. The Newborn Initial Physical Examination (NIPE) may be undertaken by the midwife, who will also normally facilitate newborn bloodspot screening.

The following care activities for otherwise healthy term babies should be considered part of normal newborn care and should be managed by the midwife in the relevant postnatal setting:

- Enhanced monitoring (NEWTT or equivalent⁽⁹⁾) for early detection of deterioration in babies with risk factors
- thermoregulatory management
- monitoring blood sugars for babies at risk of hypoglycaemia, including those born to mothers with diabetes
- monitoring serum bilirubin for babies with exaggerated physiological jaundice who do not require phototherapy

Special care:

BAPM Categories of Newborn Care (2011) ⁽²⁾ defines criteria for special care, and does not specify a different set of criteria for transitional care.

Special care is defined within the BAPM document as:

“Any day where a baby does not fulfil the criteria for intensive or high dependency care and requires any of the following:

- *oxygen by nasal cannula*
- *feeding by nasogastric, jejunal or gastrostomy tube*
- *continuous physiological monitoring (excluding apnoea monitor)*
- *care of a stoma*
- *presence of an IV cannula*
- *baby receiving phototherapy*
- *special observation of physiological variables at least 4 hourly”*

With appropriate training and resource, the majority of these criteria for special care could reasonably be undertaken at home and so, provided that the mother can be resident with her baby, they should not preclude NTC.

Transitional care:

At present, there is no universally accepted definition of NTC within UK maternity and neonatal services.

The Department of Health Toolkit for High Quality Neonatal Services (2009) did not specifically explore NTC, but noted that *“special care, which occurs alongside the mother but takes place outside a neonatal unit, in a ward setting is often called transitional care”*⁽¹⁰⁾.

In its service specifications for Neonatal Critical Care (EO8/S/a), 2013-14, NHS England Commissioning describes HRG XA04Z as *Special Care with Primary Carer Resident*, noting that this is often referred to as transitional care ⁽¹¹⁾. Consistent with BAPM ⁽²⁾, this document states that NTC can be delivered in two service models, either within a dedicated transitional

care ward or on a postnatal ward, but that the primary carer must be resident with the baby and providing care. Additional support for the mother in caring for her baby should be provided by a midwife and/or healthcare professional trained in delivering elements of neonatal special care but not necessarily with a specialist neonatal qualification. It is noted that maternity care for newly delivered women must be provided by a midwife.

We propose the following definition for NTC:

“Neonatal Transitional Care (NTC) is care additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals”.

With the exception of unstable neonates requiring continuous monitoring and/or short term provision of supplemental inspired oxygen, the majority of additional neonatal care requirements currently defined as special care should be considered appropriate for NTC, and the mother facilitated to provide resident care for her baby whenever possible.

Benefits of transitional care:

For mother:

***No separation from baby and thus enhanced attachment
24 hour access to knowledgeable, practical support with feeding
Parenting support and encouragement as required – helping to build self-
efficacy
Immediate access to skilled midwifery support for routine postnatal care
Family-friendly environment***

For baby:

***Optimised attachment process
Maximal opportunities for skin-to-skin contact
Facilitation of baby-led feeding and establishment of breast feeding
Improved parental confidence
Potentially reduced risk of hospital-acquired infection
Access to prompt medical review/intervention if required***

For maternity and neonatal services:

***Reduced length of neonatal stay
Improved team working within maternity and neonatal services
Greater parental confidence, with reduced rates of re-admission
Increased breast feeding rates
Improved neonatal patient flow with potential for more efficient use of NNU
cots***

Implementation of NTC:

Babies who require NTC must be properly and timeously assessed by an appropriately experienced and trained member of midwifery and/or neonatal staff, according to locally agreed guidelines. Babies may be identified and assessed at several locations and time points:

- ***Antenatally or immediately after birth***, in the labour ward, midwifery birthing suite or at home: babies identified as likely to have moderate additional care needs, e.g. late preterm, known or suspected chromosomal anomaly.

- ***Within a few hours of birth***, on the postnatal ward or at home: babies who are well at birth but subsequently develop problems, e.g. hypoglycaemia requiring 3 hourly nasogastric tube feeds, neonatal abstinence syndrome requiring treatment.
- ***Within a few days of birth***: babies readmitted from the community who have developed additional care needs but are clinically stable, e.g. jaundice, poor feeding.
- ***Later in the neonatal or post-neonatal period***: babies who were initially cared for on the NNU who are now fit to be cared for by their mother with some extra support (“step down” care, or “rooming in”).

a) Criteria for NTC for babies from birth:

- Gestational age at 34⁺⁰ to 35⁺⁶ weeks, for the first 1 -2 days of life
- Birth weight > 1600 g
- Predicted requirement for 3 hourly nasogastric tube feeds
- Risk factors for sepsis and requiring intravenous (IV) antibiotics, but clinically stable
- Congenital anomaly likely to affect feeding
- At risk of haemolytic disease, requiring immediate phototherapy
- At risk of neonatal abstinence syndrome*

*Depending on local experience and practice; some units will prefer to manage asymptomatic babies at risk of NAS in a postnatal ward

b) Additional care needs developing on the postnatal ward or at home:

- Inability to maintain temperature following an episode of rewarming and despite skin to skin contact and/or adequate clothing
- Stable baby who has developed (or been identified as having) risk factors for sepsis, requiring IV antibiotics
- Inability to establish full suck feeds; predicted to require 3 hourly nasogastric tube feeds
- Significant neonatal abstinence syndrome requiring oral medication or additional feeding support
- Haemolytic disease requiring enhanced phototherapy and/or assessment of serum bilirubin 4 – 6 hourly

c) Babies readmitted from the community:

- Excessive weight loss requiring additional feeding support
- Poor suck feeding requiring complementary nasogastric tube feeds
- Jaundice requiring phototherapy

d) Babies “stepping down” from the NNU:

- Corrected gestational age > 33⁺⁰ and clinically stable
- Current weight more than 1500 g and maintaining temperature
- Monitoring of vital signs required no more frequently than 4 hourly
- Tolerating 3 hourly nasogastric tube feeds and maintaining blood sugars
- Stable baby with sepsis requiring ongoing IV antibiotics
- Continuing phototherapy when serum bilirubin has stabilised following IV immunoglobulin or exchange transfusion
- Baby with complex needs (eg NG feeding, home oxygen, etc) rooming in before discharge
- Palliative care when parent/carer doing most of the care

Service delivery:

NTC can be delivered in one of two service models, either within a dedicated transitional care ward or on a postnatal ward. Whatever the location, NTC should be considered a service, rather than a place in which care is delivered.

To fulfil the criteria for NTC, the **primary carer must be resident with the baby** and providing at least some of the baby's care. Consideration needs to be given to the care of both mother and baby, as this is likely to change with time. For example, in the first 24-48 hours after birth the mother may require regular monitoring and/or treatment, whereas in the case of an ex-preterm baby rooming in with his mother prior to discharge it is anticipated that the mother will be self-caring. Ability to evaluate and respond to the care needs of both mother and baby in a flexible manner is essential in providing safe and effective NTC and will necessarily involve a multidisciplinary collaborative working approach to ensure a family-centred care model. In the rare situation in which the mother is too unwell to provide care for her baby, every effort should be made to keep mother and baby together, but there should be an additional named, primary carer resident with the baby.

A designated transitional care ward with its own staffing structure presents the ideal scenario in which to deliver NTC, but this will not be feasible in many existing services, and should not exclude the development of a NTC service. 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. Within the Department of Health Building Note 09-03 – Neonatal Units (2013) ⁽¹²⁾ it is recognised that “transitional care” may take place either in multi-bed bays generally associated with postnatal beds, or in single rooms, generally associated with the NNU.

Staffing requirements for NTC:

Staffing for NTC will include midwifery, neonatal nursing, medical and ancillary staff.

Midwifery:

Appropriate midwifery staffing for care of the postnatal woman is outlined in ‘Birthrate Plus®’, NICE guidance and the Scottish Workload and Workforce Tool ⁽¹³⁻¹⁵⁾. The recommended staffing ratio for women receiving standard postnatal care is between 1:5 and 1:8 (1 midwife to every 5 to 8 women) depending on complexity, although this is currently under review. Maternity complexity is likely to be higher for mothers of newborns requiring NTC, but this may be offset in part by healthy, “rooming-in” mothers of babies readmitted from home, or graduates from the NNU. If a designated NTC ward has only a small number of beds, there must be a mechanism in place to cover breaks if there is only 1 qualified midwife on a shift.

Neonatal Nursing:

There should be a designated neonatal nursing lead (Band 7) for NTC but it is not necessary for all neonatal nursing staff providing NTC to be qualified in specialty. All NNU neonatal nursing and ancillary staff may conveniently rotate through NTC, but a core team, including neonatal staff dedicated to discharge planning and community outreach is essential to ensure continuity of service. Collaboration with the midwifery team, health visitor and (where appropriate) paediatric and/or safeguarding teams is also essential. *In addition to* midwifery input, the ratio of neonatal nursing staff to babies receiving NTC should be at least 1:6, depending on maternal and neonatal dependency.

The Head of Midwifery will normally be responsible for midwifery staff working in a NTC environment; we recommend that there is joint working between midwifery and neonatal nursing management within organisations to determine appropriate staffing for the NTC service. Overall clinical responsibility for a mother who is not fit for discharge will rest with the senior midwife on shift, in collaboration with the obstetric team as indicated. All staff working within a NTC service should be adequately trained and working under a framework of sound leadership and locally agreed policies and guidelines, with clear lines of responsibility.

Ancillary nursing staff:

Suitably trained nursery nurses and/or maternity care assistants (MCA) offer invaluable support within NTC. Following completion of appropriate training and assessment, either a nursery nurse or MCA may take responsibility for an individual baby (nursery nurse) or mother and baby (MCA), reporting to the midwife or neonatal lead for NTC.

Medical:

All babies receiving NTC must have a named paediatric or neonatal consultant. Clear and agreed local arrangements must be in place for allocation of the named consultant, recognising that he/she may have very little direct clinical input on a day to day basis. There should be clear arrangements for daily review of babies, but this need not necessarily involve medical staff in person. Appropriately supervised trainee medical staff or advanced nurse practitioners may provide support to NTC, which offers a rich environment for learning and for observing family-centred care in practice.

Family-centred care:

NTC is integral to the philosophy of family-centred care, where the baby is placed at the heart of the family, with parents as partners in their baby's care. By keeping mother and baby together, NTC facilitates kangaroo mother care, breast feeding and comfort holding, and helps to support parents as the primary care giver for their baby. The benefits of NCT include: reduced length of hospital stay and readmission rates; enhanced parental confidence and bonding with their baby; support for baby's development with improved chances of a healthier future ⁽¹⁶⁾.

The Bliss Baby Charter ⁽¹⁷⁾ provides a clear framework for units to audit and benchmark their current family-centred practice and to make meaningful plans for improvement. In order to facilitate a high quality family-centred approach to care within NTC, we recommend that certain key elements are in place on a unit:

Engaging the whole family:

The parent(s) are the most constant influence on a baby's development and should be inputting fully into care decisions for the baby. 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. Parents should be able to remain with their baby throughout the ward round; with appropriate discretion, this need not impact upon the confidentiality of other babies and their families. A clear and consistent visiting policy should be available for extended family members ⁽¹⁸⁾.

Facilities:

In order to keep families together and remove any barriers that may interfere with them playing a part in their baby's care, families receiving NTC should have access to the following:

- 24 hour access to nutritious food and drink without charge for the resident carer, and ideally for both parents
- clean and adequate kitchen facilities with provision to prepare hot meals
- access to an overnight bed for the partner to stay by the cot-side with the mother and baby, when appropriate
- shower facilities for resident parents
- areas for siblings to be kept occupied, with consideration given to providing periods of supervision
- a family room that is comfortably furnished and provides access to relevant hospital and local support information
- financial support, including free parking for partners

Emotional support for the family:

The experience of having a premature or sick baby can have adverse effects on the emotional well-being of family members. Units should provide access to dedicated psychosocial support, establishing a clear referral process to this support and/or be able to signpost families to local support services.

Information:

Clear and consistent information about their baby's condition and the care they require should be shared regularly with parent(s). This information should be consistent across the neonatal network and should be given in a supportive and nurturing environment in order to encourage and empower parents to take the lead role in their baby's care and make informed decisions. Parents should be encouraged to ask questions and to input their own suggestions into their baby's care plans. Where English is not the first language, translation services should be offered.

Equipping and supporting staff:

All NNUs and networks should promote access to training courses in order to help staff to develop their skills, and to ensure that they understand the benefits of, and are confident in delivering, a family-centred approach to neonatal care. Family-centred care must be flexible, and able continually to adapt to emerging family needs.

Interface between NTC and community services:

Extending care into the community in the initial period after hospital discharge is an essential component of a high quality, effective neonatal service. The service specification for Neonatal Critical Care for NHS England promotes such service integration, recommending that "*by working closely with community services, neonatal services support babies and their families in the transition and adjustment from an in-patient stay on a neonatal unit to restored family life in the community*" ⁽¹¹⁾. Availability of appropriate community neonatal liaison/outreach (hereafter described simply as "community neonatal services") support following discharge is also recommended within NHS Scotland's Neonatal Care in Scotland, A Quality Framework ⁽¹⁹⁾.

For a majority of babies with moderate additional care needs, discharge home should follow a period of NTC, but for some babies and their families this may not be possible or appropriate (e.g. when alternative care arrangements for older siblings are impractical). No matter the baby's level of care immediately prior to discharge, in order to deliver truly family-centred care, it is essential that both NTC services and NNU inpatient services link seamlessly between the neonatal and/or maternity unit and community neonatal services. This will help to maintain relationships built between parents and staff members prior to discharge and will best be achieved by key members of the NTC team providing aspects of care in both inpatient and outpatient domains.

Community neonatal services should be available seven days per week, with out-of-hours support to families available from members of the NTC team when required. This should be underpinned by the principle that parents will have been educated and supported by the wider neonatal and midwifery team to become the primary care giver prior to discharge, and will be equipped to deliver the required care for their baby at home.

Organisation and delivery of a community neonatal service:

Team members should include a composite of registered and non-registered neonatal and paediatric nursing staff (bands 3-7) with knowledge and skills appropriate to their role and seniority within the team. There should be a separate designated neonatal nursing lead (Band 7) for the community neonatal service, although within smaller neonatal units this post may be shared with the NTC service. Periodic rotation of community neonatal service team staff into the NTC team and/or local special care baby unit should be embedded into the concept of team integration between hospital and community services. For some facilities, services will best be delivered by a fully combined NTC/community neonatal team.

Robust guidelines to promote early facilitated discharge and on-going care pathways for babies from neonatal and maternity services should be developed in order to guide service delivery, and shared-care services should be developed with existing paediatric community care teams and health visitors. Each community neonatal service should have guidelines for immediate advice and escalation of care as required.

Parents must be given appropriate information, including contact details for out of hours support. Technology solutions, including tele-health, should be utilised to complement phone calls and help to promote safe, efficient and effective care, particularly in remote and rural settings.

Monitoring and evaluation:

There should be a consistent national approach towards audit and evaluation of both NTC and community neonatal services, which utilises a single national data recording system capturing standard data items. Practical and cost implications of such data collection require to be explored, particularly for those babies who receive NTC within a postnatal ward and are never formally admitted to a NNU. There will also be a need to monitor any impact upon maternity beds of delivering NTC within the maternity facility.

It is anticipated that provision of NTC will reduce NNU admissions, facilitate neonatal patient flow, reduce both avoidable term admissions and transfer of mothers and babies between facilities for reasons of capacity, and result in earlier discharge together of mother and baby. Collection of accurate data around NTC is essential, to ensure that these aims are achieved.

Utilisation of community neonatal services should also be recorded and regularly reviewed, with resources deployed according to need. Data collection should assess the impact of

NTC and community neonatal service development on acute inpatient neonatal cot occupancy as well as readmissions to neonatal or paediatric services.

Parental feedback should be actively sought by all NTC services and the results acted upon, to ensure a truly family-centred care model which is acceptable to parents and families.

Commissioning services:

There are currently significant differences across the UK with regard to recognition and funding of NTC, which should be (but is currently not commonly) commissioned as a separate service.

Commissioners and providers must agree a common definition of NTC and a consistent method of recording the relevant maternity and neonatal data, and work together to ensure consistent national delivery of an equitably remunerated, high quality NTC service.

Role of Clinical Networks:

A recent survey of 140 units in England undertaken on behalf of the Neonatal Clinical Reference Group demonstrated huge variation in relation to delivery, classification and commissioning of NTC⁽²⁰⁾. Only 46% of units had any kind of designated NTC either on the postnatal ward or neonatal unit, and only 50% of units had clarity about the NTC funding stream. 14% of NNUs operated on a fixed payment model for NTC, and 36% on a *per patient* model⁽²⁰⁾. Within the *per patient* model, national variation ranged from £235 to £568 with an average price per day of £405.88⁽²⁰⁾.

The ODNs can play a vital role in improving the delivery of NTC, and should focus on facilitating, coordinating and monitoring NTC activity across the network. This will help to ensure all families and babies receive a similar high standard of care, with consistent and clear messages about when, and for which babies, NTC is appropriate. ODNs should engage in discussion between commissioners and providers, and encourage use of the same national neonatal dataset to allow accurate reporting and consistent payment.

ODNs can also play an important role in supporting training and education for staff to help to equip them with skills and knowledge to facilitate delivery of family-centred care.

Within the devolved nations, where arrangements for payment of service differ from ODNs, it is similarly crucial that networks prioritise and facilitate the consistent delivery of NTC.

Vignettes:

“My husband could come and go with my other daughter which was nice especially when I was put in my own room, **it felt like we could be a family of 4 for the first time**. My husband would come up each day and would be totally involved with all aspects of care. We were trained in paediatric first aid before being able to leave with her. It started to feel like a home from home after a while...”

“I went into transitional care with my son who had spent the previous 10 weeks in NICU after being born at 25 weeks. It was invaluable after watching such a tiny vulnerable baby who was so reliant on machines and nurses. **Obviously it made us nervous to take the care on ourselves but TCW made sure they were there for me if I needed it but gave me the confidence and assurance that I could do it myself**. My husband always got involved when not at work. **It felt like we were in entirely in charge of looking after our son with support should we need it**. Kitchen facilities were disappointing, there was no opportunity to make a drink or anything throughout the day, although there were regular tea rounds - just at set times. Otherwise it was great.”

“As a mum, I wanted nothing more than to be under the same roof as my babies and to be able to care for them myself. It wasn't normal to go home without them every day and as a mum this is the most painful thing to go through. Whilst I appreciated my girls still needed input from medical and midwifery staff, they needed their mum and dad equally as much. The TCU enabled us to be together and **allowed me to fulfill my role as a mum**. It was the closest thing we could get to being home as a family and it was **vital for my mental wellbeing in those early weeks**. Our 10 day stay in the TCU allowed our babies to get ready for home and **allowed us to properly bond with them** in the privacy of our own room, and with the help of the TCU staff **we gained confidence in caring for our tiny babies ready for when we got home**. I only have happy memories of my time in the TCU, we were together and the staff were amazing in their support to us. My husband was able to stay with us at weekends when he was off and the staff made him so welcome - that too was so important to me. We were able to be a family.”

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