East of England Neonatal ODN
(Hosted by Cambridge University Hospitals)

Clinical Guideline: East of England Neonatal Transitional Care

Authors: East of England Neonatal Transitional Care Working Group

For use in: East of England Neonatal Transitional Care

Used by: Clinical Staff - Doctors, Nurses, Midwives, Auxiliary Staff

Key Words: Transitional, Late Preterm

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Approved by:

Neonatal Clinical Oversight Group	**Matthew James**

Ratified by ODN Board:

Date of meeting	

*** In line with local policies**

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Audit Standards:

Audit points: Objectives or activities *What outcomes or activities do you want to monitor?*	**Audit methods** *How are you going to monitor the outcomes and activities for this? Will there be a re-audit?*	**Assurance** *Where will the audit results be reported to? Where does learning from the audit take place?*
Infants meeting Transitional Care criteria admitted to the Neonatal Unit	As part of ATAIN group late preterms / Transitional Care criteria admissions should be reviewed Reasons for non-admission to Transitional Care and length of stay on NICU should be collected	East of England Clinical Oversight Group
Infants meeting Transitional Care criteria admitted to the Paediatric Ward/NICU/other ward from the community	Local level: Audit and review Reasons for non-admission to Transitional Care and length of stay should be collected	East of England Clinical Oversight Group

Glossary:

AHP Allied Health Professional

NTC Neonatal Transitional Care

TC Transitional Care

HCA Health Care Assistant

HRG Healthcare Resource Group: Healthcare Resource Groups are standard groupings of clinically similar treatments which use common levels of healthcare resource. They are currently used as a means of determining fair and equitable reimbursement for care services delivered by Healthcare Providers. Their use as consistent 'units of currency' supports standardised healthcare costing and commissioning across the NHS

MDT Multi-disciplinary team

MSW Maternity Support Worker

NGT Naso gastric tube

NN Nursery Nurse

TTO's Refers to medication to take out

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1 Background

Neonatal Transitional Care (NTC/TC) is care additional to normal care, provided in a postnatal clinical environment by the mother/birthing parent or an alternative resident carer, supported by appropriately trained healthcare professionals (BAPM, 2017).

Neonatal Transitional Care (TC) is a concept and not a physical location (BAPM, 2017). Therefore, care can be delivered in any designated area, where mothers/birthing parent and newborn babies can be cared for together when the baby requires extra care and/or observations. These babies will need additional input from Midwifery and Neonatal teams but are not unwell enough to warrant admission to the Neonatal Unit (NNU).

It is well researched that keeping mothers/birthing parent and babies together has a multitude of benefits, including but not limited to, increased breastfeeding, supporting transition to extra-uterine life, maternal and neonatal bonding, reduced length of hospital stay and rates of readmission, enhanced parental confidence and improved service user experience (BAPM, 2017). By using this Neonatal Transitional Care guideline, we can provide care via a multidisciplinary approach to mothers and their babies who previously would have been separated on admission to the Neonatal Unit.

2 Purpose

- To make care safer, more personalised, and more equitable (Three year delivery plan for maternity and neonatal services, 2023)
- To support mothers, birthing people and babies to stay together
- To prevent unnecessary re/admission of babies to Neonatal Intensive Care Unit/Other wards
- To standardise admission and discharge criteria for babies who require NTC across the East of England in line with BAPM (2017) guidance
- To support Maternity Incentive Scheme Y6 compliance with local policy/pathway of NTC admission criteria based on BAPM framework (BAPM, 2017) for Transitional Care MIS-Year-6-guidance.pdf (resolution.nhs.uk) and meeting a minimum of at least one element of HRG XA04 SCCI0075: Neonatal Critical Care Minimum Data Set (version 2) - NHS England Digital
- To provide evidence of how a multi-professional team will provide TC in collaboration with mothers, birthing people and their families

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- To support future planning of TC services and guidance

3 Criteria for Admission

Admission can be

- Direct from birthing environment following medical assessment
- From the postnatal ward following a medical assessment
- From the neonatal unit after short stay admission or when care on the neonatal unit is no longer required
- From the community / home following assessment*
- From Children's Emergency Department following a full clinical review

***NB.** Some variation will occur between units dependent on Trust service offer

Direct from birthing environment (Delivery suite, theatre, birthing centre, home birth)

- Gestational age 34+0 to 35+6 weeks
- Birth weight > 1600 g and < 2000 g who do not fulfil criteria for intensive care, high dependency or special care
- Risk factors for sepsis requiring intravenous antibiotics, but clinically stable
- Congenital anomaly likely to require tube feeding
- At risk of haemolytic disease requiring immediate phototherapy

Additional care needs developing in the birthing centre, postnatal ward or community

- Inability to maintain temperature following an episode of rewarming and despite skin to skin contact and/or adequate clothing – following medical review to rule out clinical causes of hypothermia
- Stable baby who has developed (or been identified as having) risk factors for sepsis, requiring intravenous 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 (at medical discretion)
- Haemolytic disease requiring enhanced phototherapy and/or assessment of serum bilirubin 4 – 6 hourly
- Excessive weight loss* and/or poor suck feeding requiring complementary nasogastric tube feeds

From Neonatal Unit

- Corrected gestational age > 33+0 weeks and clinically stable

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- Current weight more than 1600 g and maintaining temperature
- Monitoring of vital signs required no more frequently than 3 hourly
- Tolerating 3 hourly nasogastric tube feeds and maintaining blood glucose
- Stable baby with sepsis requiring ongoing intravenous antibiotics
- Continuing phototherapy when serum bilirubin has stabilised
- Additional needs (e.g. nasogastric feeding, home oxygen) rooming in before discharge
- Palliative care when parent/carer are providing most of the care

NB. Some variation will occur with admission criteria dependent on available facilities. For example, if family rooming in facilities on the neonatal unit are available and the birth parent is discharged you may choose to look after the infant in these rooming in facilities. This decision should be made based on clinical decisions, capacity and workforce in both areas and in collaboration with the family.

Prior to admission all families should receive a consultation with the medical team explaining the reasons for admission to a transitional care setting along with a treatment plan. The nursing/midwifery team working within transitional care should provide families with an overview of the facilities and go through the parent information leaflet with families.
Parents should have unrestricted access to their infant (BAPM, 2017) and there should be clear visiting policies which are communicated to families on admission (CQC, 2024)

4 Staffing Roles and Responsibilities

Medical staff and Advanced Neonatal Nurse Practitioners (ANNPs)- Providing Neonatal Care

Duties may include:

- Full medical admission including Badgernet Admission Summary (short stay) for all babies meeting criteria for TC* **
- Initial septic screens and prescribing of antibiotics*
- To review and act on the results of any of the NTC infant investigations depending on urgency*.
- To carry out neonatal escalation assessments of NTC Infants*
- To ensure families are regularly updated and included in the planning of care
- To provide a daily clinical review of all TC babies and record a clear management plan within the NTC babies' notes *.
- At each review:

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  - consideration should be given to the possibility of the TC baby requiring escalation to the neonatal unit or discharge from TC care to routine postnatal care or home.
  - a prescription review of any required medications should be conducted
  - the Badgernet should be updated (depending on medical demand) to enable timely discharge**
  - ordering of TTO's should be considered to avoid a delay in discharge (i.e multivitamins/preterm milk)
  - NIPE examination status should be considered*
- Medical discharge including any referrals as required (e.g midwifery, health visiting, primary care and community AHP's support)

Registered Midwives- Providing Maternal Care

Duties may include:

- To refer all babies that meet the TC criteria to the medical staff and commence neonatal observations*
- Provide postnatal care for the mother, birthing person and/or carer*.
- Depending on local policy perform NIPE if relevant training has been completed, and escalate any concerns identified*.
- Complete maternal discharge* whist ensuring:
  - the birth parent has access to continued postnatal care at the hospital, if discharge prior to the TC infant
  - that open communication is maintained between the neonatal and maternity/obstetric team to ensure that both mother/birth parent and baby can be discharged together where possible without a delay in discharge.

Midwifery Support Workers(MSW), Nursery Nurses(NN), Nurse Associates(NA), Health Care Assistants(HCA), Nurses and Midwives- Providing Neonatal Care

Duties may include:

- Neonatal observations*
- Blood sugar monitoring*
- Supporting parents to care for their infant*
- Completing the daily update on Badger** and maintaining accurate newborn notes*.
- Ensuring clear documentation of all feeds and nappy changes*
- Transferring of babies to other departments for investigations*

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- Weighing*
- Routine daily newborn checks*
- Newborn blood spot screening*
- Administer of medications as required*(Nurse/Midwife)
- Escalation of any concerns or deviations from normal parameters to medical team*
- Liaising with homecare team and overseeing preparation for discharge*

5 Staffing Models/East of England Training

Safe staffing models should be clinically competent to meet the needs of mothers, birthing people and babies in line with Trust policies. Staffing for TC may include midwifes, neonatal/paediatric nurses, medical, allied health professionals, nursery nurses, maternity support workers and auxiliary staff. Staffing models will vary depending on Trust workforce models. Examples of staffing models and Regional training can be found in **Appendix 1**.

6 Staffing Ratio

Neonatal staff

Neonatal Care ratio should be set at a 1: 4 ratio for Transitional Care babies (BAPM 2017, 2021).

Ancillary/Auxiliary staff

Suitably trained NN, MSW, HCA's may take responsibility for an individual baby (nursery nurse, MSW, HCA's) or mother and baby (MSW), reporting to the midwife or neonatal nursing lead for NTC if appropriate training and assessment has been undertaken (BAPM, 2017).

Neonatal/Maternity NTC Lead

There should be a designated Neonatal/Maternity lead (Band 7) for NTC this could be a Neonatal Nurse or Midwife (BAPM, 2017).

Midwifery

Appropriate midwifery staffing for care of the postnatal woman is outlined in 'Birthrate Plus®' and NICE guidance. 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 (BAPM, 2017, Ball and Washbrook, 1996, NICE, 2015).

Medical Staffing

Daily review of babies receiving NTC may be undertaken by appropriately supervised trainee medical staff or advanced nurse practitioners. NTC infants should have access to a named

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consultant and access to a consultant ward round to the same frequency seen for Special Care infants (BAPM, 2017).

Psychological Support
Practitioner psychologists and other accredited psychological professionals with specialist expertise in neonatology are essential members of the neonatal team. Each NNU should have dedicated psychological support embedded within the neonatal MDT, with psychological professionals working alongside their medical, nursing and AHP colleagues (BAPM, 2022). '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' (BAPM, 2017). Where psychological provisions are available, TC services should have access to psychological professionals through a clear pathway with the same provisions seen as those admitted to special care.

AHPs/ Neonatal Pharmacy
AHPs play and essential role in the neonatal MDT. Timely intervention with advanced knowledge and skills impacts positively on length of stay and improves neurodevelopmental and other health outcomes as well as family experiences (BAPM, 2022). TC services should have access to AHPs through a clear pathway with the same provisions seen as those admitted to special care.

7 Care of the Infant on Transitional Care

The BAPM (2023) Early Postnatal Care of the Moderate-Late Preterm Framework should be followed in line with local policies for the care of the infant within Transitional Care.

This Framework Covers:

- Appropriate routine monitoring to reduce risks of common neonatal conditions (hypothermia, hypoglycaemia, jaundice, feeding difficulties, respiratory distress) associated with moderate-late preterm birth.
- Minimum level of care appropriate for late preterm infants.
- Supporting development and growth.
- Supporting breastfeeding in late preterm infants.
- Appropriate discharge criteria and follow-up planning for late preterm infants.
- Post-discharge support for families of late preterm infants including liaison with community teams.

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Review recommendations for practice for neonates with varying skin tones Review of Neonatal Assessment and Practice in Black, Asian and Minority Ethnic Newborns: Exploring the Apgar Score, the Detection of Cyanosis, and Jaundice - NHS – Race and Health Observatory (nhsrho.org)

8 Escalation of the Deteriorating infant on NTC

In line NHS England's (2023) Three-year delivery plan for maternity and neonatal services all transitional care settings should be using the BAPM (2023) Newborn Early Warning Track and Trigger Framework (NEWTT 2) by March 2025 for the early recognition and escalation of the deteriorating TC infant. In the event of a sudden infant unexpected collapse the UK Resuscitation Council NLS algorithm outlines the approach to newborn resuscitation. This should be followed even if the baby is several hours or days old in line with the BAPM (2022) Sudden and Unexpected Postnatal Collapse Framework*.

NEWTT2 Escalation Record

Date: ___/___/____ Time: ____:___ **NEWTT2 score** ____

Consider a 2222 call if there are any critical observations for Tier 1 AND Tier 2 review

[ ] Score 1-3 (Request Tier 1 review within 1 hour)
[ ] Score 4-5 (request Tier 1 review within 15 minutes)
[ ] Score ≥ 6 (request Tier 1 review immediately and inform Tier 2)

[ ] Shift Leader Informed [ ] SBAR referral to Paediatric/Neonatal team

S:
B:
A:
R: I have already done____

Agreed action ___________________________ & review within_______

Referral Accepted by: [ ] Tier 1 Doctor/ANNP [ ] Tier 2 Doctor/ANNP

Referrer Name: _______________ Signature: ___________________

Grade :__________________ NMC: ____________________

9 Escalation of the Deteriorating Mother/Birthing Person on NTC

In line NHS England's (2023) Three-year delivery plan for maternity and neonatal services all transitional care settings should be using the Maternity Early Warning Scores (MEWS, 2023) for the early recognition and escalation of the deteriorating Mother/Birthing person by March 2025 (Recommended resources to support this can be found in Appendix 2) . An example of the escalation process for the deteriorating Mother/Birthing Person, taken from this scoring system, can be seen below. In the event of a Sudden Maternal/Birthing Person Unexpected Collapse the RCOG (2019) Maternal collapse algorithm (p 46, Appendix 4) outlines the approach to resuscitation, and the full RCOG(2019) Maternal Collapse in Pregnancy and the Puerperium (Green-top Guideline No. 56) should be followed*.

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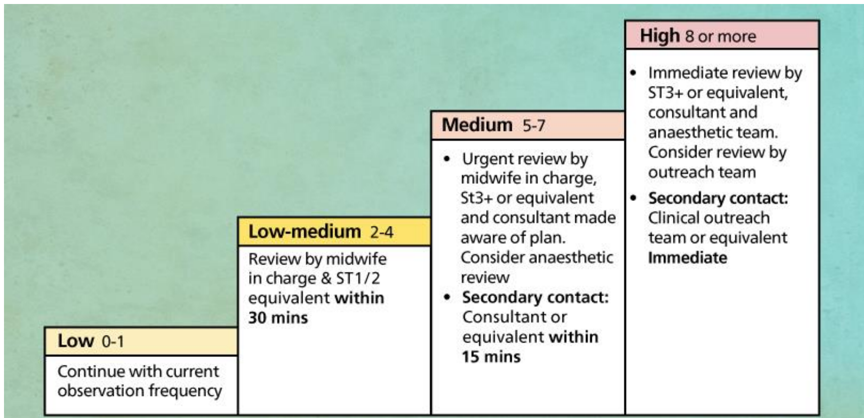

Please note maternal/birthing person escalation is to obstetric medical teams.

10 Governance/Data

All infants admitted to TC should go on Badgernet under the Transitional Care Admission**. TC admissions can be recorded under the "short" stay admission record.

Babies being transferred to TC should have their level of care changed to reflect being cared for in a TC environment. This should include updating entry that the mother/birthing person is resident and caring for baby.

Length of stay should be monitored against postnatal maternity bed capacity on badgernet **. Any infant unable to be admitted to TC due to maternity bed or TC bed shortages should be recorded, including the number of days TC was not provided. This will enable an accurate record of demand and capacity modelling to ensure mothers, birthing people and babies receive care in the right place to support future planning of TC services.

All babies readmitted from home (within 10 days of birth) who meet TC criteria and cannot be accepted on to NTC should be audited as these infants needed to be considered in future capacity planning and quality improvement work. If data is not recorded then a future tariff may be incorrectly set.

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11 Preparation for discharge

The NTC team will be responsible for delivering a comprehensive parentcraft/education programme to ensure that parents are confident and competent to care for their baby in the home environment. Sessions may include baby bathing, safe storage of breast milk, making up and storing feeds, safe sleep, NGT feeding, thermoregulation, administration of medication(to check parents/carers understand how to give the medication, what the medication is for and how to obtain further supplies after discharge), developmental support, resuscitation*.

12 Criteria for babies being discharged from NTC:

All babies cared for in NTC will be reviewed daily and discussion regarding discharge will be dependent on the clinical need for care.

Well babies can be discharged when:

- Feeding is established and baby is maintaining and/or gaining weight*
- Any courses of IV antibiotics have been completed.
- Observation within normal limits for a satisfactory clinically assessed length of time *
- NGT/Oral feeding meeting outreach criteria for discharge*
- Where NGT feeding Parents/carer signed off and confident to NGT feed at home
- Maintaining temperature without a warming mattress for at least 24-48 at clinician discretion*
- No outstanding examinations/investigations needed, or examinations/investigations still needed but medical agreement that it is safe to discharge with follow up in place
- Weight 1.6kg or above
- Phototherapy has been stopped and rebound within normal limits for discharge*

The discharge location may be any of the following:

- Normal care postnatal ward
- Usual place of residence, with community midwifery and primary care support
- Usual place of residence with neonatal outreach and primary care support*

Transfers Postnatal Ward

Babies no longer requiring TC will be identified at the daily medical ward round. Transfer or discharge will be dependent on mother's/ birthing person's health assessment which will be completed by a midwife. A copy of the baby's discharge summary and a verbal handover of the baby's care should be given to the postnatal ward staff to ensure continuity of care.

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Discharge home

TC staff should liaise with the postnatal team to clarify that the mother/birthing person is also ready for discharge home. The TC team will be responsible for organising baby's discharge and making appropriate referrals to MDTs such as GP, Community Midwifery Team, Health Visitor, Neonatal Outreach Team, Neonatal Consultant, AHP's etc.
A copy of the mother, birthing person and baby's discharge summary should be sent to the GP and community midwifery team/health visitor. A copy should also be given to the parents together with TTOs as required.

***It may also be necessary to liaise with other professionals involved in the care of the family to support discharge planning**

***Psychological support needs should also be considered at the time of discharge as this can be a period of increased distress. Close links with local perinatal and Maternity Mental Health Services are essential to facilitate timely and appropriate referrals.**

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Appendix 1- Examples of NTC Staffing models and East of England Training

Model one

- Registered nurse, neonatal competencies (not necessarily QIS) ratio 1:4
- Midwife +/or – MSW as per birth rate plus allocated for mother's care, may need to support administration of antibiotics

Model two

- Band 6/7 QIS with oversight of TC – clear reporting structure
- Nursery nurse with neonatal competencies ratio 1:4
- Midwife as per birth rate plus allocated for mother's care, may be required to support with administration of antibiotics

Model three

- Midwife 1:4 ratio to deliver care for mother and baby (neonatal competencies)
- MSW/ NN/ HCA to support with care delivery

Neonatal Transitional Care Programme

This course is aimed at all professional working in a Transitional Care or Special Care Setting and provides the fundamental knowledge and skills required to work in these areas.
This is a 16week programme. During that time the applications will be expected to carry out 2 hours self-directed learning via the bridge blended learning platform per week (32hrs total) and have the option to attend 4 virtual live study days (24hrs). They will also be expected to complete a competency document and end of programme assessment. For more info and to see contents covered please see the course handbook Transitional Care Program - East of England (eoeneonatalpccsicnetwork.nhs.uk)

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Appendix 2- Resources to Support MEWS Implementation

- **Podcast 1**
- **Podcast 2**
- **Podcast 3**
- **https://www.e-lfh.org.uk/programmes/maternal-and-neonatal-deterioration/ : this is the link to the published HEE training package.**
- **Paper that was published detailing the process of how MEWS was developed: https://bmjmedicine.bmj.com/content/3/1/e000748**

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Appendix 3- East of England Neonatal Transitional Care Working Group

Dr Sakina Ali, Luton & Dunstable Hospital Foundation Trust, Neonatal Consultant

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Christina Massey, NHS England, Quality Improvement Manager

Julie Canning, Bedford Hospital, Practice Development Nurse

Linda Queijo-Ridor, Bedford Hospital, Neonatal Matron

Maija.Blagg, West Suffolk Hospital, Neonatal Matron

Emma Hart, East and North East Essex Foundation Trust, Neonatal Matron

Gemma Lindsayhedgecock, Colchester Hospital, Practice Development Nurse

Laura Grover, Colchester Hospital, Ward Sister

Bea Smith, Norfolk and Norwich University NHS Foundation Trust, Assistant Practitioner

Jacki Dopran, Herts and West Essex LMNS, Neonatal Critical Care Transformation Project Manager

Gemma Sharpe. North West Anglia NHS Foundation Trust, Outreach Lead

Amber Dewick, The Princess Alexandra Hospital NHS Trust, Lead Midwife for Quality and Compliance

Olivier King, The Princess Alexandra Hospital NHS Trust, Ward Manager-Maternity

Katie Rippe, EoE Neonatal ODN, Parent Advisory Group Member

Metelda Varghese, The Princess Alexandra Hospital NHS Trust, Midwifery Matron

Sophie Taylor, Ipswich Hospital, Transitional care lead midwife

Catherine Lawes, Broomfield Hospital, Lead Midwife for Better Births

Amy Cunnington, West Suffolk NHS Foundation Trust, Ward Manager-Maternity Services

Anna Smith Norfolk and Norwich University NHS Foundation Trust

Sophie Ashby, Watford Hospital, Neonatal Outreach Sister

Lavina D'souza, Broomfield Hospital, Lead Midwife for Antenatal Services

*** In line with local policies**

****All trusts not using the Badgernet system should ensure they meet the data entry standards specified in the 2024 BAPM Toolkit 'Implementing a Neonatal Electronic Health Record' and BAPM (2024) Service and Quality Standards for Provision of Neonatal Care in the UK**

Laura Miller, Mid and South Essex, Head of Nursing for NICU

Katherine Nial, Southend Hospital, Maternity Matron

Maurine Westphal, Lister Hospital, Neonatal Transitional Care Lead

Ruth Duffield, Cambridge University Hospital, Deputy Ward Manager Postnates

Su Poole, Broomfield Hospital, Postnatal Ward Team Leader

Teresa Berry, EoE Neonatal ODN, Lead Neonatal Practise Development Nurse

Hayley Samways, North West Anglia, Ward Manager- Transitional Care

Joanne Govier, Norfolk and Waveney LMNS, Practise Innovation MidwifeNHS

Katie Hills

Katie Cullum, EoE Neonatal ODN, Lead Nurse for Innovation and Quality Improvment

*** In line with local policies**

****All trusts not using the Badgernet system should ensure they meet the data entry standards specified in the 2024 BAPM Toolkit 'Implementing a Neonatal Electronic Health Record' and BAPM (2024) Service and Quality Standards for Provision of Neonatal Care in the UK**

Appendix 4- Exceptional Circumstances Form

Form to be completed in the **exceptional** circumstances that the Trust is not able to follow ODN approved guidelines.

Details of person completing the form:	
Title:	Organisation:
First name:	Email contact address:
Surname:	Telephone contact number:
Title of document to be excepted from:	
Rationale why Trust is unable to adhere to the document:	
Signature of speciality Clinical Lead: Date:	Signature of Trust Nursing / Medical Director: Date:
Hard Copy Received by ODN (date and sign):	Date acknowledgement receipt sent out:

Please email form to: **kelly.hart5@nhs.net** requesting read receipt
Send hard signed copy to:
Kelly Hart, EOE ODN Office Manager
Box 402
Rosie Hospital
Robinson Way
Cambridge University Hospital

*** In line with local policies**

****All trusts not using the Badgernet system should ensure they meet the data entry standards specified in the 2024 BAPM Toolkit 'Implementing a Neonatal Electronic Health Record' and BAPM (2024) Service and Quality Standards for Provision of Neonatal Care in the UK**

Hills Road
Cambridge CB2 0SW

*** In line with local policies**

****All trusts not using the Badgernet system should ensure they meet the data entry standards specified in the 2024 BAPM Toolkit 'Implementing a Neonatal Electronic Health Record' and BAPM (2024) Service and Quality Standards for Provision of Neonatal Care in the UK**