British Association of Perinatal Medicine

Consultation Responses

Sara Clarke
Senior Specialist Neonatal Network Dietitian
Birmingham Women's & Children's NHS Foundation Trust

Whilst I appreciate this document is mainly focussed on levels of medical staffing and recommended unit activity, where AHP services are mentioned the current recommended AHP staffing reference materials should be used. It is essential that AHP services receive appropriate support from BAPM if we are to grow respect and understanding of how our roles benefit optimal outcomes as defined in this document: defined as providing a combination of the lowest mortality and morbidity, the best baby and parent experience and the best cost effectiveness.

Hilary Cruickshank added: Can I just highlight this for the Exec I totally agree, we really need to use the most up to date guidance on staffing levels. Each speciality has their own staffing recommendations published in 2018, I have **attached** the Physio ones. It would be good to hold these all in one place perhaps something BAPM could accommodate.

Sara then added: Competencies - https://www.bda.uk.com/uploads/assets/bf9dfd91-0475-4894-8560c8b183f171fc/BDA-Formatted-Competencies.pdf
Staffing - https://www.bda.uk.com/uploads/assets/ab614d3e-e095-4e4f-96ae1458204e8810/BDA-Formatted-Staffing-Recc.pdf

Page number/ heading / general comments	Line number/ 'general' for comments	Comments Please insert each new comment in a new row.	Response
10	Last line	References for AHP staffing are outdated and do not reflect current published AHP staffing recommendations as laid out by individual professional bodies	Updated thank you
11	Reference 1-3	These are not current references for AHP staffing in UK NNU's - professional body recommendations for staffing and competencies should be considered here	Updated thank you

Nigel Gooding
Neonatal and Paediatric Pharmacist Group (NPPG) Chair

Please find attached the response to this consultation from the Neonatal and Paediatric Pharmacists Group (NPPG). Also, please would it be possible for NPPG to be included as a stakeholder for any documents being produced that either include medicines or references to pharmacy, as we would be very keen to support this.

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10 Nursing and Allied Health staffing of NICUs	All NICUs should deliver the recommended level of therapy and other Allied Health Professional support. [1,2,3]	For pharmacy resource for neonatal units, there are now published standards recommended by the Neonatal and Paediatric Pharmacists Group. Please would it be possible to reference these standards against this point. The standards can be found at http://nppg.org.uk/wp-content/uploads/2018/10/NPPG-Neonatal-Pharmaciststaffing-recommendations-published-with-RPS-Oct-2018.pdf	Updated thank you

Lesley Jackson
Consultant Neonatal Medicine, Royal Hospital for Children Glasgow and Clinical Lead Scottish Neonatal Network

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P4	Bullet point 5	The summary of recommendations includes a recommendation on the staff group responsible for undertaking the NIPE. This is not mentioned further in the text. Some expansion would be useful for service planning of this aspect of care; specifically to inform discussions with maternity and midwifery service leads. .	NIPE should be performed by midwives as described in Better Births (for England) but this is not part of the focus for this framework. I don't know if there is a similar recommendation for the devolved nations.
Overall		The recommendations within this updated draft align with the principles and	Agree thank you

comment		recommendations of Best Start- a 5-year forward plan for Maternity and Neonatal services in Scotland. As such this is a welcomed update to inform planning of neonatal services within NHS Scotland, adding further to the evidence base that neonatal intensive care should be concentrated in a smaller number of centres in order to: • Optimise clinical outcomes • Ensure staff treat a sufficient number of cases to maintain skills • Maximise the utilisation of specialist staff, associated equipment and facilities The recommendation on support to families with accommodation and parking is welcomed by Scottish Neonatal services, as is the emphasis on the importance of *in-utero* transfer and network review of early *ex- utero* transfers where an *in utero* transfer did not occur. This has already been agreed as a priority in the work plan of the Scottish Perinatal Network.	
P9		Recommendation ALL NICUs should submit outcome and benchmarking data to benchmarking organisations. This is a timely and helpful recommendation to include in this draft framework. From the perspective of Scottish Neonatal Services NICUs and neonatal services across NHS Scotland support this, appreciating the importance of participating in such benchmarking programmes.	Agree thank you

Babu Kumararatne
Consultant Neonatologist, Royal Wolverhampton Hospital

This is a personal response not an ODN response.

Page number/ heading / general comments	Line number/ 'general' for comments	Comments Please insert each new comment in a new row.	Response
Page 4 Line3	Recommendations	NICU need >2000 HRG 1 days (2016) But evidence is for > 2000 respiratory care days .HRG 1 2016 defines as invasive ventilation or Non invasive ventilation + TPN . . Should it not be > 2000 respiratory care days .	This was changed in the Neonatal Critical Care Review and in the Service Specification in order to make the definition easier to define. It is therefore appropriate to use the same here.

		Should there not be a recommendation saying babies < 29 wks should not transferred from NICU to NICU before 72 hrs for capacity reasons .	This has been added for clarification.

Arthi Lakshmanan
Consultant Neonatologist, Neonatal Unit, University Hospitals of Coventry & Warwickshire NHS Trust

This is a combined response from our UHCW neonatal team. Consultation Response Form from University hospital of Coventry and Warwickshire (UHCW).

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4/ Recommendations	3	ODN pathways – there must be robust pathways developed by the network. ODNs should not use the staffing as excuse.	Agree, this has been added for clarification.
4/ Recommendations	4	This is ambitious and often not achieved currently. What will be the consequence of non-compliance?	Not sure what this refers to. If it is the statement about surgery it is prefaced by 'If geography allows'. It is recognised that not all NICUs can have collocated paediatric surgery but where possible the two should be collocated.
4/ Recommendations	6	Is this additional cover purely for NIC - what about the HDU/SC activity also?	There is a statement about HDU and SC activity along with intensive care. It was felt to be clearer to define activity in terms of the IT days
4/ Recommendations	7	Is this 12 hour cover for 7 days a week or only for the working week? Instead can we not mandate a consultant led ward rounds every 12 hour period?	7 days. Whilst we understand that presence for handover rounds is probably the most important presence for a greater period of time is felt to be needed as a standard but the wording has been changed to emphasise the importance of handovers
5/ Purpose of framework	2nd paragraph	This statement is the crux of the framework and should be strengthened. BAPM recognises the need to reconfigure obstetric services to ensure best outcomes for mothers and babies and should word this stronger	Agree this is vital but this framework cannot mandate reconfiguration of services
7/Medical staffing of neonatal intensive care units	1st paragraph/ line 6	We do not have any recommendation for ANNP suitability to work on tier 2 rota. BAPM should come with appropriate competencies for this.	This is covered in the new BAPM ANNP framework
9/ Recommendations	5th point	BAPM should strongly recommend this transfer should happen regardless of labour ward capacity. There should be a recommendation that labour ward should create space and prioritise such IUT by creating labour ward capacity (Eg; transferring out elective induction of labour for term and near term babies who do not need NIC care)	Agree this is important but it is not the role of this framework to define how this should occur. Each Network (and Trusts within them) are responsible for ensuring that there is capacity and that appropriate babies are delivered in the right place.
9/ Recommendations	6th point	Who should review such cases – labour ward or neonates or network?	It is clear that this should be a Network level review

9/ Recommendations	8th point	Free parking – it is another ambitious target which is often not achieved as evidenced by the national critical care review data	Agree but it should be and is therefore an important standard.

Karen Mainwaring
Senior Lead Nurse, North West Neonatal Operational Delivery Network

Please see attached the NWNODN response which has been collated from Clinical Leads and Lead Nurses from across the NW.

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	General	The revision lacks nursing and AHP input and feels weaker for it. It feels as though BAPM are looking to be more inclusive in their membership/representation and therefore it would be helpful to demonstrate this in the inclusion of these staff groups when considering the "Optimal Arraignments for NICUs.."	Agree and all new frameworks now have appropriate nursing and AHP and parent input. This was a review of a previous framework
Page 4	Bullet 3	*The threshold may be higher for multiple births, depending on agreed ODN pathways, which will be dependent on capacity. E*very LNU should be working to the service spec which states the above along with <28 weeks for multiple births.	Agree, this is now in line with the wording in the service specification
Page 7	3	*As a result of this the antenatal transfer and delivery of all babies <28 weeks' gestation in a maternity unit with a co-located NICU is now recommended* – this should be changed to make it consistent with a similar statement (page 9) which states *Women threatening preterm labour or at high risk of delivering before 27 weeks' gestation should be transferred to a hospital with a NICU.* **We suggest changing both to read '< 27+0 weeks' gestation'**	Agree, this is now in line with the wording in the service specification
Page 7	Paragraph 3	*Augmentation at tier one is provided by extending nurse practice and/or a second junior doctor or ANNP.* **We suggest this should read: Augmentation at tier one can be provided by extending nurse practice and/or a second junior doctor or ANNP.**	Agree changed
Page 9	Bullet 1	*Neonatal Intensive Care Units in the UK should have a throughput of at least 100 VLBW infants per year* *Please clarify if this refers to new admissions or new + re-admissions.* **We suggest this should read 'new VLBW admissions'.**	Agree this is now changed
Page 9	Bullet3	Neonatal Networks that include NICUs admitting less than 50 VLBW or carrying out <2000 intensive care days should develop plans to amalgamate	Agree this is now changed and is in line with the wording in the service specification

		NICUs. We disagree with this threshold because it implies NICUs admitting 50-99 VLBW babies have sufficient activity and are exempt from a requirement to reconfigure**. We suggest changing this to read 'less than 100 VLBW'**	
Page 9	Bullet 6	Where possible all anticipated VLBW referrals into NICUs should be in utero. Where transfer is ex utero there must be case review at network level. Why does this refer to VLBW babies when the recommendation is for < 27w to be transferred (see bullet 5)? **We suggest changing this to read 'anticipated deliveries < 27+0 weeks' gestation'.**	Agree this is now changed and is in line with the wording in the service specification
Page 9	Bullet 8	*All NICUs should adhere to the Bliss Baby Charter Standards and offer accommodation on or near the unit.* How much accommodation is appropriate? **We suggest specifying number of parents' rooms as a ratio to total capacity/intensive care capacity/activity.**	Agree this would be useful but was not within the remit of this framework. It is something BAPM will consider separately.
Page 9	Medical staffing of NICUs	This section is confusing because the recommendations alternate between those for units > 2500 IC day and those 4000 IC days **We suggest it should be formatted/tabulated to have separate sections to describe requirements for units > 2500 IC day and those 4000 IC days**	In order to make it clearer a table has been added as suggested.
Page 9	Lower section, bullet 1	This point appears only to relate to out of hours staffing. **We suggest that it should be clarified that it applies to minimum staffing throughout the day.**	This is now changed
Page 10	Bullet 1	*NICUs with more than 2500 intensive care days per annum should double tier 2 cover day and night.* It's not clear why tier 2 and not tier 1 (or both). **We suggest this should be tier 1 and 2**.	This was discussed and it was felt that a larger number of IT days would increase complexity which would require more tier 2 input. Trusts can choose to add more tier 1 support if that is felt necessary but it wasn't felt essential.
Page 10	Bullet 5	*NICUs undertaking more than 2500 intensive care days per annum should consider the presence of at least 2 consultant led teams during normal weekday daytime hours*. What constitutes a consultant-led team? **We suggest clarifying that this means a full team at tier 1/tier 2 and tier 3 during daytime hours and maintaining consistency with bullet 1 above.**	This has been clarified
Page 10		**Nursing and Allied Health Staffing of NICUs** **We suggest this section should be stronger** **Nursing –** suggest describing the quality nursing roles in line with DOH Toolkit **AHPs** pull the national staffing standard from each professional body and describe it in this document The above points would be for ease of the reader/reference when service leads are putting together businesses cases etc.	The national standards for each AHP group have now been included and referenced. It was not within the terms of reference for this framework to describe nursing as this is covered in other standards.

Oliver Rackham
Neonatal Consultant, Bwrdd Iechyd Prifysgol, Betsi Cadwaladr, University Health Board

Page number/ heading / general comments	Line number/ 'general' for comments	Comments Please insert each new comment in a new row.	Response
P3	General	Working group very medical. Only one ANNP on original group. All doctors for revision. No nurses, AHPs or parents	Agree and all new frameworks now have appropriate nursing and AHP and parent input. This was a review of a previous framework
P4		Could define VLBW and state the HRG and BAPM categories Weights should be in kg (the SI unit for weight) Expand LNU / SC (first use) as you have for NICU Does tier 1 have to be medical? That should be two sentences. Don't need capital "I" for intensive care (or use capital "C" as well)	These are referenced This has been changed This has been changed No tier 1 can be ANNP. This is stated
P7	"medical staffing" para, line 3-4	Some ODNs have ST3 trainees in tier 2 posts; is that therefore against this "optimal" arrangement?	It is up to individual Trusts to define which professionals work on each tier
P9	1st bullet	kg please	OK
	2nd bullet	HRG 1, BAPM level 1	Already defined and referenced
	4th bullet	Should all NICUs in a network provide this? Doesn't sound practical or necessary. Especially for cardiac surgery.	The statement about surgery it is prefaced by 'If geography allows'. It is recognised that not all NICUs can have collocated paediatric surgery but where possible the two should be collocated.
	6th bullet	"Must" is a strong recommendation. What level review is advocated?	Changed to should. Review should be by network
	7th bullet	An optimal NICU should have more than just adequate cot space – there are other requirements on space, sluice, storage, offices, etc	Agree this is covered in the HBN which is referenced.
	8th bullet	Thank you	
P10	5 - 6th bullets	If >2500 IC days "should" consider 2 or more consultant led teams, then surely >4000 "must" have 2 or more teams, and should consider 3?	This is clarified and a table added
	7th bullet	Trusts or Health Boards	
	Nursing and AHPs	Is psychology and bereavement support supposed to be included in this? Would be nice for that to be explicit.	Agree this is important but this wasn't part of the terms of reference for this framework