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Neonatal Services (Intensive Care, High Dependency and Special Care)

Service Specification: SS263

August 2024

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SERVICE SPECIFICATION:
SS263 NEONATAL SERVICES (INTENSIVE CARE, HIGH DEPENDENCY AND SPECIAL
CARE)

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Statement

NHS Wales Joint Commissioning Committee (NWJCC) will commission Neonatal Services in accordance with the criteria outlined in this specification.

In creating this document NWJCC has reviewed the requirements and standards of care that are expected to deliver this service.

Welsh Language

NWJCC is committed to treating the English and Welsh languages on the basis of equality, and endeavour to ensure commissioned services meet the requirements of the legislative framework for Welsh Language, including the [Welsh Language Act \(1993\)](#), the [Welsh Language \(Wales\) Measure 2011](#) and the [Welsh Language Standards \(No.7\) Regulations 2018](#).

Where a service is provided in a private facility or in a hospital outside of Wales, the provisions of the Welsh language standards do not directly apply but in recognition of its importance to the patient experience, the referring health board should ensure that wherever possible patients have access to their preferred language.

In order to facilitate this, NWJCC is committed to working closely with providers to ensure that in the absence of a Welsh speaker, written information will be offered and people have access to either a translator or 'Language-line' if requested. Where possible, links to local teams should be maintained during the period of care.

Decarbonisation

NWJCC is committed to taking assertive action to reducing the carbon footprint through mindful commissioning activities. Where possible and taking into account each individual patient's needs, services are provided closer to home, including via digital and virtual access, with a delivery chain for service provision and associated capital that reflects the NWJCC commitment.

Disclaimer

NWJCC assumes that healthcare professionals will use their clinical judgment, knowledge and expertise when deciding whether it is appropriate to apply this document.

This document may not be clinically appropriate for use in all situations and does not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, or Local Authority.

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NWJCC disclaims any responsibility for damages arising out of the use or non-use of this policy.

1. Introduction

This document has been developed as the Service Specification for the planning and delivery of neonatal services in Wales. This service will only be commissioned by the NHS Wales Joint Commissioning Committee (NWJCC) and applies to residents of all seven Health Boards in Wales.

1.1 Background

Neonatal care is the type of care a baby born premature or sick receives in a neonatal unit.

Units are a part of hospitals which provide care for babies who are born either prematurely (before 37 weeks' gestation), with a medical or surgical condition which needs treatment, or at a low birthweight.

1.2 Aims and Objectives

The aim of this service specification is to define the requirements and standard of care essential for delivering neonatal care.

The objectives of this service specification are to:

- ensure babies are born in the right place to access the care that they need immediately after birth
- ensure commissioning of neonatal care is evidence based
- ensure equitable access to Neonatal care
- ensure care is delivered close as possible to patient home where clinically appropriate
- improve babies' chances of survival by supporting optimal outcomes in all aspects of development and minimise the morbidity associated with being born either premature or term and sick.
- provide family-integrated care, a model of neonatal care which promotes a culture of partnership between families and staff; enabling and empowering parents to become confident, knowledgeable and independent primary caregivers promote the uptake and duration of breastfeeding supporting families to make informed decisions about how to feed their baby in line with Welsh Government objectives
- improve quality and continuity of care for neonates by working in partnership with other provider units
- ensure that appropriate arrangements are in place to provide care for the postpartum mother. Mother and baby should be co-located, where possible to facilitate early nutrition, bonding and family integrated care

1.3 Population Covered

Neonatal care is for babies up to the age of 44 weeks corrected gestational age¹ requiring intensive care, high dependency care or special care.

1.4 Current Services

Current Neonatal services provide care for babies up to the age of 44 weeks corrected gestational age and younger that require on-going medical or surgical care within a variety of settings dependent on their clinical condition and needs. Dedicated Neonatal transfers services will ensure the safe retrieval and transfers of neonates to an appropriate setting.

1.5 Category of Care

Intensive Care

Intensive care is the care provided for babies who are the most unwell or unstable and have the greatest needs in relation to staff skills and staff to patient ratios.

The British Association of Perinatal Medicine (BAPM) definition of Intensive Care as:

- Any day where a baby receives any form of mechanical respiratory support via a tracheal tube
- **BOTH** non-invasive ventilation (nasal CPAP, SIPAP, BIPAP, HHFNC) and Parenteral Nutrition (PN)
- Day of surgery (including laser therapy for ROP)
- Day of death
- Any day receiving any of the following:
 - Presence of an umbilical arterial line
 - Presence of an umbilical venous line
 - Presence of a peripheral arterial line
 - Insulin infusion
 - Presence of a chest drain
 - Exchange transfusion
 - Therapeutic hypothermia
 - Prostaglandin infusion
 - Presence of repleg tube
 - Presence of epidural catheter
 - Presence of silo for Gastroschisis

¹ [6e69e665-7b75-41c7-b2ee-ed8768122c06 \(vuelio.co.uk\)](https://www.vuelio.co.uk) NHS England Neonatal Critical care service specification currently out for consultation

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- Presence of external ventricular drain
- Dialysis (any type)

High Dependency

High dependency is the care provided to babies who require highly skilled staff, but where the ratio of nurse to patient is less than intensive care.

BAPM definition of High Dependency Care is where a baby does not fulfil the criteria for intensive care, and where any of the following apply:

- Any day where a baby receives any form of non-invasive respiratory support (e.g. nasal CPAP, SIPAP, BIPAP, HHFNC)
- Any day receiving any of the following:
 - parenteral nutrition
 - continuous infusion of drugs (except prostaglandin &/or insulin)
 - presence of a central venous or long line (PICC)
 - presence of a tracheostomy
 - presence of a urethral or suprapubic catheter
 - presence of trans-anastomotic tube following oesophageal atresia repair
 - presence of NP airway/nasal stent
 - observation of seizures / cerebral function monitoring (CFM)
 - barrier nursing
 - ventricular tap
 - Infusion of blood products (red cells, fresh frozen plasma, platelets, cryoprecipitate, intravenous immunoglobulin).

1.6 Relationship with other documents

This document should be read in conjunction with the following documents:

- **NHS Wales**
 - All Wales Policy: [Making Decisions in Individual Patient Funding requests \(IPFR\)](#).
 - [All Wales Neonatal Standards 3rd Edition \(nhs.wales\)](#)
 - [Improving Together for Wales 2023](#)
- **NHS Wales Joint Commissioning Committee policies and service specifications**
 - Neonatal Transport Service Specification (CP190), November 2020 (in development)

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- Neonatal Services (Intensive Care, High Dependency and Special Care) Commissioning Policy (CP263), In development, 2024
- **National Institute of Health and Care Excellence (NICE) guidance**
 - Neonatal Specialist Care, [NICE Quality Standard \(QS4\)](#), October 2010
 - Specialist neonatal respiratory care for babies born preterm, [NICE Guideline \(NG124\)](#), April 2019
 - Preterm labour and birth. [NICE Guideline \(NG25\)](#), June 2022
 - Neonatal infection, [NICE Quality Standard \(QS75\)](#), December 2014
 - Jaundice in new-born babies under 28 days, [NICE Clinical Guideline \(CG98\)](#), October 2016
 - Jaundice in new-born babies under 28 days, [NICE Quality Standard \(QS57\)](#), March 2014
 - Developmental follow-up of children and young people born preterm, [NICE Guideline NG72](#), August 2017
 - [Neonatal parenteral nutrition Nice guideline \(NG154\) February 2020](#)
 - Developmental follow-up of children and young people born preterm, [NICE Quality Standard \(QS169\)](#), May 2018
- **Relevant NHS England policies**
 - [Neonatal Critical Care \(Intensive Care, HDU and Special Care\), E08/S/a, 2015](#)
 - [Specialised Services Quality Dashboard \(SSQD\): Neonatal Critical Care \(Intensive Care, HDU and Special Care\), E08/S/a, 2022/23](#)
 - [NHS England and NHS Improvement, Implementing the Recommendations of the Neonatal Critical Care Transformation Review, January 2020](#)
 - [NHS Improvement on behalf of the National Quality Board \(NQB\), Safe, sustainable and productive staffing: An improvement resource for neonatal care, June 2018](#)
- **Other published documents**
 - [Service and Quality Standards for Provision of Neonatal Care in the UK | British Association of Perinatal Medicine \(bapm.org\)](#)
 - <https://www.bapm.org/resources/157-calculating-unit-cot-numbers-and-nurse-staffing-establishment-and-determining-cot-capacity>
 - [The British Association of Perinatal Medicine, Optimal arrangements for Local Neonatal Units and Special Care Units in the UK including guidance on their staffing: a framework for practice, November 2018](#)
 - [The British Association of Perinatal Medicine, Neonatal Service Quality Indicators: Standards relating to Structures and Processes supporting Quality and Patient Safety in Neonatal Services, June 2017](#)
 - [GIRFT Programme National Specialty Report: Neonatology, April 2022](#)

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- [GIRFT Programme National Specialty Report: Neonatology – Workforce, April 2022](#)
- [Royal College of Midwives and Royal College of Obstetricians and Gynaecologists Review of Maternity Services at Cwm Taf Health Board, January 2019](#)
- [Bliss Baby Charter: Helping to make family-centred care a reality on your neonatal unit 2020](#)
- [Royal College of Obstetricians and Gynaecologists \(RCOG\) in partnership with the Royal College of Midwives \(RCM\), the Royal College of Paediatrics and Child Health \(RCPCH\) and the London School of Hygiene and Tropical Medicine \(LSHTM\), National Maternity and Perinatal Audit: Organisational report 2017](#)
- [The BAPM Service and Quality Standards for provision of neonatal care in the UK, November 2022](#)
- [BDA-Dietitian Staffing on Neonatal Units September 2022](#)
- [RCOT-Occupational Therapy in neonatal services and early intervention, 2nd edition, 2022](#)
- [Home - Family Integrated Care Website link](#)
- [Psychology Staffing on the Neonatal Unit July 2022\(acpuk.org.uk\)](#)
- [Perinatal Management of Extreme Preterm Birth Before 27 weeks of Gestation \(2019\) | British Association of Perinatal Medicine \(bapm.org\)](#)
- [UNICEF UK Baby Friendly Initiative - Guide to the Neonatal Standards](#)
- [all-wales-breastfeeding-five-year-action-plan-july-2019_0.pdf \(gov.wales\)](#)
- [RCSLT staffing recommendations for NNU version2 June 2023](#)
- [Pharmacy Staffing Standards for Neonatal Services \(2022\)](#)
- [Physiotherapy Staffing Recommendations for Neonatal Units in the UK ACP July 2023](#)

2. Service Delivery

The NHS Wales Joint Commissioning Committee will commission the service of Neonatal care for neonates up to the age of 44 weeks corrected gestation, in line with the criteria identified in this specification.

2.1 Service description

There are currently three Neonatal Intensive Care units (one of which provides neonatal surgery) and three Special Care Units in South Wales and two Special Care Units and one sub-regional Neonatal Intensive Care Centre (SurNICC) in North Wales.

NWJCC also commissions Neonatal activity from across NHS England. Babies accessing care in NHS England will access care from Neonatal Intensive Care Units, Local Neonatal Units and Special Care Units.

2.1.1 Special Care Unit

A Special Care Unit (SCU) should provide:

- Neonatal services that commensurate with national guidelines and professional standards where singleton births are anticipated after 31+6 weeks' gestational age provided the anticipated birth weight is above 1,500g and multiple births from 34 weeks' gestational age.²
- Care pathways that define antenatal factors or conditions present soon after birth which increase the likelihood that transfer to a Neonatal Intensive Care Unit (NICU) for complex or prolonged neonatal intensive care OR a Local Neonatal Unit for short term neonatal intensive /high dependency care will be required, the transfer should where possible take place in-utero to ensure access is available to the appropriate treatment immediately post birth.
- Stabilisation of babies prior to transfer to a Local Neonatal Unit (LNU) or NICU predominantly, but not exclusively for intensive care. This would include surgical, cardiac and other subspecialty input.
- Care for local babies with high dependency or special care needs following repatriation from LNUs or NICUs within the network or from out of area in accordance with approved care pathways. When babies are stable, having received care in an appropriate NICU, it may be appropriate for these babies to be repatriated even when they are <32 weeks or multiple births <34 weeks CGA and / or less than 1500g.
- Referrals for ongoing special care from other network neonatal units who are unable to undertake this work due to capacity reasons.

² [Service and Quality Standards for Provision of Neonatal Care in the UK | British Association of Perinatal Medicine \(bapm.org\)](#)

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- Care for local babies post specialist surgery following repatriation from the network surgical unit or step down from other LNUs in accordance with approved care pathways.

A Special Care Unit will not be expected to provide the following except under exceptional circumstances which have been agreed and formally documented by the Network NICU on an individual case basis:

- Care beyond initial stabilisation to babies less than 31+6 weeks of gestation.
- Care beyond initial stabilisation to babies with a birth weight <1500gms.
- Intensive care for any baby apart from initial stabilisation prior to transfer.

2.1.2 Local Neonatal Unit (LNU)

Local Neonatal units should provide all the services that are provided by SCU's and should also provide:

- Neonatal services that commensurate with national guidelines and professional standards where, births are anticipated after 26+6 weeks' gestational age providing the anticipated birth weight is above 1000gms and multiple births from 28 weeks' gestational age depending on staffing levels and unit capacity.
- High dependency care and special care for their local population.
- Care for local babies repatriated from neonatal units who require ongoing high dependency or special care.
- Ongoing care for local babies who have undergone specialist surgery following repatriation from a surgical NICU.
- Referrals from within network neonatal units who are unable to undertake high dependency care and special care, due to capacity reasons and/or network guidelines.
- Where possible, the transfer of women in-utero to the Network NICU when gestational age, anticipated birth weight or need for complex or prolonged intensive care is anticipated.
- Limited intensive care (i.e. usually less than 24 hours) in accordance with approved care pathways. This may include short periods of invasive ventilatory support, however the clinical condition of any baby requiring this care should be discussed with a consultant in the Network NICU by 24 hours and every 24 hours thereafter if intubated ventilatory support continues. In these instances, an agreed management plan, including decisions regarding transfer criteria, should be documented.
- Initial stabilisation prior to transfer for babies requiring complex or ongoing (i.e. prolonged) intensive care. These babies will be transferred to the nearest NICU in accordance with approved care pathways.

LNUs should admit more than 25 very low birth weight (VLBW) (i.e. birth weight <1500g) babies per year and undertake 500 combined intensive and high dependency days per

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year working towards undertaking more than 1000 combined intensive and high dependency days per year. There may be a small number of exceptions for geographically remote services where the alternative would result in very long travel times. However, these exceptions should be agreed with commissioners prior to local implementation and be subject to quarterly review to ensure that safety and quality are not compromised.

A Local Neonatal unit will not ordinarily be commissioned to provide:

- On-going intensive care beyond initial stabilisation and intensive care to babies less than 27+0 weeks of gestation
- On-going intensive care beyond initial stabilisation to babies with a birth weight below 1000gms.
- Complex intensive care including babies requiring respiratory support with symptoms of additional organ failure (e.g. hypotension, disseminated intravascular coagulation (DIC), renal failure, metabolic acidosis) or babies requiring the following treatment and support:
 - Support of more than one organ, for example ventilation via a tracheal tube plus any one of the following: Inotrope infusion, insulin infusion, presence of a chest drain, exchange transfusion and prostaglandin infusion.
 - Inhaled Nitric Oxide (INO)
 - High frequency oscillatory ventilation (HFOV)
 - Therapeutic hypothermia beyond initial stabilisation.
 - Prolonged Intensive care (intubated ventilatory support) for greater than 48 hours.

2.1.3 Sub-Regional Neonatal Intensive Care Centre

A Sub Regional Neonatal Intensive care Centre (SuRNICC) is an enhanced LNU therefore in addition to the all of the services provided by SCU's and LNU's should provide:

- Neonatal services commensurate with national guidelines and professional standards where; births are anticipated after 26+0 weeks' gestational age providing the anticipated birth weight is above 1000gms. This threshold may be higher for multiple births dependent on staffing and capacity.

2.1.4 Neonatal Intensive Care Unit (NICU)

A Neonatal Intensive Care Unit should provide:

- Neonatal services that commensurate with national guidelines and professional standards where births are anticipated from 22+0 weeks' gestation (Perinatal Management of Extreme Preterm Birth Before 27 weeks of Gestation: A BAPM Framework for Practice (2019)).

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- Intensive care for all babies born within the network according to approved care pathways including those less 27+0 weeks' gestation, or with a birth weight <1000gms and any baby requiring complex or prolonged intensive care.
- Neonatal intensive care services for other neonatal networks or out of area neonatal units due to lack of capacity in their network NICU. This also requires discussion with the regional neonatal transfer service.
- Leadership within neonatology for other units and 24-hour acute clinical telephone consultations as required by the network hospitals and, if required neonatal transport services. Where more than one NICU within the Network there will be a sharing of responsibility to provide 24-hour acute clinical consultations.
- Care for local network babies repatriated from elsewhere requiring ongoing care from a NICU.

Neonatal Intensive Care Units should admit more than 100 very low birth weight (VLBW) (i.e. birth weight <1500g) babies per year and should be undertaking more than 2000 intensive care days per year, or working towards this number. There may be a small number of exceptions for geographically remote services where the alternative would result in very long travel times. However, these exceptions should be agreed with the commissioners prior to local implementation and be subject to quarterly review to ensure that safety and quality are not compromised.

A Neonatal Intensive Care Unit would not necessarily be expected to provide the following, which are only available in specialist centres to optimise outcome and remove inequity:

- Extra - Corporeal Membrane Oxygenation (ECMO)
- Surgical care
- Specialised cardiac care

2.1.5 Neonatal Surgical Intensive Care Unit

Neonatal Surgical Intensive Care Units should provide all the services provided by NICUs and provide neonatal surgical care as part of an approved pathway, and:

- Units providing surgical care should have staff with appropriate skills and knowledge to deliver high quality surgical care.
- Parents should be sufficiently informed of the risks and potential outcomes of surgery, the need for consent must be explained, and decisions should be made in partnership with parents and fully documented.
- There should be a surgically experienced nurse on every shift able to give nursing surgical advice to other units.
- There should be a designated lead specialist paediatric surgeon for the surgical neonatal unit and 24-hour consultant paediatric surgical cover.

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- In designing neonatal surgical care pathways, particular attention should be taken to ensure that appropriate arrangements are in place to provide care for the postpartum mother. Mother and baby should be co-located, where clinically appropriate to facilitate early nutrition, bonding and family integrated care. This will help to ensure continuity of care between medical and surgical services.

2.2 Referral Criteria

Neonatal services should accept referrals from:

- Obstetric, maternity or Fetal medicine services. Within the antenatal period, high risk mothers or mothers with high risk babies will generally be under the care of an obstetrician and delivery planned to take place within a provider with the required designation of neonatal unit.
- Other providers of neonatal services within defined regional pathways. Pathways should clearly articulate the designation of unit required and referrals managed across these designations. When the baby's condition has stabilised, ongoing care will be undertaken at a designated provider closer to the family's home.

Referrals should meet one of the following criteria:

- From co-located maternity services in discussion with relevant medical staff.
- Within the network as per approved in utero transfer pathways and in discussion with parents and relevant multi-professional senior staff (to include direct consultant-to-consultant dialogue when required)
- Within referral thresholds from within the region as per approved network policies and following discussion with parents and multi-professional senior staff, including consultant-to-consultant dialogue when required.
- From other NNUs for referrals for specialist care (e.g. surgery) or diagnostic procedures and following discussion with parents and multi-professional senior staff, including consultant-to-consultant dialogue when required.
- From outside the network when capacity allows following discussion with the transport service and following discussion with parents and multi-professional senior staff, including consultant-to-consultant dialogue when required.
- From other units which are closed due to capacity, staffing or infection outbreaks and following discussion with parents and multi-professional senior staff, including consultant-to-consultant dialogue when required.
- The care, prioritisation and urgency of any transfer required will be based upon the individual needs of the baby, network policies / guidelines.
- Referrals will be accepted by the neonatal unit based on the baby's need and in accordance with referral criteria and the designation of the individual unit.
- Transfers should be discussed with the transport service and should follow the criteria as set out in the neonatal transfer service specification.

2.3 Staffing

Neonatal services providers should ensure that:

- Medical, nursing, pharmacy, psychology and Allied Health Professional (AHP) staff with specialist skills, and the appropriate numbers of staff are in place to deliver the level of care required for that Neonatal Unit.
- Ongoing development and modernisation of the workforce is reviewed annually to ensure skills meet future service requirements.
- Units across the Network work with commissioners to produce annually updated workforce plans, with workforce transformation considered for gaps or anticipated gaps in nursing, medical and AHP staffing.

2.3.1 Essential Staff

Dependent on the size and designation of a unit there are a number of essential staff groups that contribute to the care of neonates. Close and co-operative working between units is essential to maintain skills for all members of the neonatal workforce, to optimise cot capacity, streamline flow and help manage the workforce, especially when acute staffing issues arise. Units should consider periodic secondment of neonatal unit staff to other NNUs across the region to share experience, promote understanding and maintain skills. Simulation training, in conjunction with midwifery and obstetric colleagues as appropriate should be an integral part of all neonatal activity

Each unit will be required to ensure there is access to the following professionals:

- Consultant Neonatologist
- Consultant Paediatrician
- Consultant Paediatric Surgeon³
- Junior Medical Staffing (across all Tiers)
- Neonatal Nursing (including training, outreach and infant feeding / lactation)
- Advanced Neonatal Nurse Practitioner
- Infant Feeding Lead
- Specialist Neonatal Physiotherapist
- Specialist Neonatal Speech and Language Therapist
- Psychologist
- Pharmacist
- Specialist Neonatal Dietitian
- Specialist Neonatal Occupational Therapist
- Paediatric Ophthalmologist
- Neonatal Outreach Team
- Radiologists

³ [The Surgical Neonate : Advances in Neonatal Care \(lww.com\)](http://www.lww.com)

- Social Worker

2.3.2 Medical Workforce

- NICU providers should ensure that medical staff numbers are consistent with those recommended in [Optimal Arrangements for Neonatal Intensive Care Units in the UK \(2021\): A BAPM Framework for Practice](#).
- LNU and SCU providers should ensure that medical staffing numbers are consistent with those recommended in [Optimal Arrangements for Local Neonatal Units and Special Care Units in the UK \(2018\): A BAPM Framework for Practice](#).
- Each Neonatal Unit should ensure adequate time in consultant job plans for a named clinical lead, a named education/training lead and for each consultant providing educational supervision.
- Provider Neonatal Unit's should produce an annually updated gap analysis of medical staffing for submission to the Commissioner.

2.3.3 Nursing Staff

Each Neonatal Unit should implement or work towards an agreed plan with commissioners for nurse staffing levels based on the following staff to baby ratios for direct patient care, as described in the [Toolkit for High Quality Neonatal Services \(2009\)](#) and recommended by the British Association of Perinatal Medicine (BAPM) and the Neonatal Nurses Association (NNA):

- Intensive Care 1:1 staff-to-baby ratio
- High Dependency 1:2 staff-to-baby ratio
- Special Care 1:4 staff-to-baby ratio
- A minimum of one nursing coordinator per shift i.e. a supernumerary team leader additional to the staff caring for the babies on each shift

Each Neonatal Unit should ensure that a minimum of 70% (special care) and 80% (high dependency and intensive care) of the nursing and midwifery establishment hold Nursing and Midwifery Council (NMC) registration.

Each Neonatal Unit should ensure that a minimum of 70% of registered neonatal nursing establishment hold a post registration qualification in specialised neonatal care (Qualified in Specialty (QIS)).

Neonatal nursing establishments in each unit should be calculated against activity with an uplift of 26.9%⁴ to accommodate expected leave (annual, sick, maternity, paternity,

⁴ [Nurse Staffing levels \(Wales\) Act 2016: statutory guidance \(version2\) Welsh Government published March 2021](#)

mandatory training and continuous professional development (CPD), based on an 80% occupancy level.

2.3.4 Other Professional Groups

Neonatal units require key contributions from an essential group of Allied Health Professionals (AHPs), specialist neonatal infant feeding roles, Psychologists and Pharmacists who have special expertise in their discipline. The role of these professional groups play an essential role in the neonatal MDT. Timely intervention with advanced knowledge and skills in a complex and vulnerable population impacts positively on length of stay and improves neurodevelopmental and other health outcomes as well as family experiences.⁵

Providers should ensure AHP staffing provision and competencies are in accordance with the following recommendations:

Dietetics⁶

Specialist Neonatal Dietitians are highly trained professionals that are skilled at assessing, diagnosing and managing the nutritional needs of neonates. They should have a detailed understanding and be able to interpret current clinical evidence and guidelines for neonatal parenteral and enteral feeding to optimise nutrition. They are able to apply strategies to both individualised and standardised practice in order to meet the complex nutritional needs of preterm infants. The inclusion of a dietitian in the neonatal team results in significant improvement in early nutrition, increased weight gains, reduced length of stay and reduces risk of comorbidities.

Occupational Therapy⁷

Specialist Neonatal Occupational Therapists (OTs) are specialists in supporting parent infant co-occupations, infant neuro-behavioural regulation and sensory development. Use of specialist skills, knowledge of infant neuro-behavioural and neuro-motor development and analysis of the impact of the physical/sensory/psychosocial environment which will help to optimise infant development and enable the delivery of family integrated care.⁸

⁵ [BAPM Service Quality Standards FINAL.pdf \(amazonaws.com\)](#)

⁶ [BDA-Dietitian staffing on NNU](#)

⁷ [BAPM Service Quality Standards FINAL.pdf \(amazonaws.com\)](#)

⁸ [Occupational therapy in neonatal services and early intervention RCOT 2nd edition 2022](#)

Physiotherapy⁹

A Specialist Neonatal Physiotherapist must be able to provide highly specialised observation, assessment and intervention in movement, gross motor and postural control in the rapidly changing physiology and behavioural stability of neonates. Early identification of motor problems ensures that neonates can receive diagnostic specific intervention. They will work alongside families, supporting physical interaction and neurodevelopmental appropriate postural and movement activities to optimise infant brain development as well as supporting strong parent infant relationships.

Speech and Language Therapy

Specialist Neonatal Speech and Language Therapists (SLTs) are specialists in feeding, swallowing and early communication. They support the assessment and management of sucking and swallowing difficulties in complex neonates and their expertise in early communication development supports parents and the MDT to maximise early language development and long-term communication outcomes.¹⁰

Table 1 – AHP Staffing Recommendations (BAPM)

AHP Speciality	WTE per designated NICU cot	WTE per designated HDU cot	WTE per designated SCBU cot	WTE per designated TC cot
Dietetics	0.1	0.05	0.033	0.033
Physiotherapy	0.05	0.05	0.05	0.05
Occupational Therapy	0.05	0.05	0.05	0.02
Speech & Language Therapy	0.05	0.05	0.04	0.02

Pharmacy

Acute and clinically complicated neonatal cases require clinical pharmacy, aseptic services and dispensary support to;

- review the clinical appropriateness of prescription therapy
- advise on drug dosing and choice and stability, compatibility and clinical monitoring
- ensure safe and effective and economic use of high risk drug therapy
- prepare and dispense unlicensed or off-label, complex intravenous therapies, parenteral nutrition and specially manufactured, imported and unlicensed medicine.
- support families to administer medicines where appropriate
- help facilitate safe and timely discharge of patients with a medicines plan.

⁹[Physiotherapy Staffing Recommendations for Neonatal Units in the UK APCP July 2023](#)

¹⁰[RCSLT staffing recommendations for NNU version2 June 2023](#)

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Neonatal Units should support the training, development and appointment of prescribing pharmacists.

The Neonatal and Paediatric Pharmacists Group in conjunction with the Chief Paediatric Pharmacists Group [Pharmacy Staffing Standards for Neonatal Services](#) (2022), recommends:

- In centres with neonatal ICU or HDU cots, the lead senior pharmacist time should be funded at a Band 8a or equivalent as a minimum. Clinical pharmacist cover can, however, be provided by a Band 7 or equivalent with support.
- In centres with only SCBU cots, the lead pharmacist time should be funded at a minimum of AFC Band 7 or equivalent, with appropriate support from a more senior pharmacist as required.

	WTE per designated NICU cot	WTE per designated HDU cot	WTE per designated SCBU cot	WTE per designated TC cot
Pharmacist	0.12	0.06	0.03	0.03

Psychology

Admission to a Neonatal Unit (NNU) has many potential negative psychological consequences for the parents, the neonate, siblings and the parent-baby relationships. Working within the neonatal environment can also have significant psychological impact on the staff themselves.

Psychological interventions provided within a Neonatal Unit have been shown to reduce these difficulties for staff and for families during their admission, as well as following discharge from the unit.

The Psychology Leads for the Neonatal Operational Delivery Networks across England developed [Recommendations for Psychological Provision on the Neonatal Unit](#) and recommends the following staffing ratios:

Level of care	WTE per 20 cots	WTE per 3 units (hub)
Inpatient (minimum)	1 WTE (8a)	0.4 WTE (8b.c) ³
Inpatient (higher) ^b	1.2 WTE (8a)	0.6 WTE (8b/c) ³

These staffing ratios (shared across a number of units) enables clinical supervision and governance to be provided in alternative ways depending on local provision.

These staffing ratios should be considered where there are a number of risk factors which heighten the likelihood of infant, parental or staff distress (including but not limited to: higher degree of English as an additional language; higher number of deaths, being a surgical unit; higher rates of social care issues; very large staff teams; specific challenges for staff).

2.4 Family Integrated Care

Each neonatal unit should provide Family Integrated Care (FI Care),¹¹ which promotes a culture of partnership between families and the MDT; enabling and empowering parents to become confident, knowledgeable and independent primary caregivers. A FI Care philosophy nurtures families into this role by listening to them, building on their strengths, and encouraging their participation in experiences and decision-making to enhance control and independence. All members of the MDT play a role in the facilitation of FI Care.

Parents should be supported to be fully involved in the decision-making and care for their baby and empowered to deliver this care and decision-making in partnership with the clinical team. This will include ensuring parents have 24-hour access to their baby, including during ward-rounds, where parents are supported to be fully involved in these discussions.

Facilities and resources should be available to enable parents/carers to be resident with their baby for as long as they want and are able to be. This includes:

- sufficient accommodation on or close to the neonatal unit for families
- facilitating, where appropriate, sibling visits to the unit
- private and comfortable breastfeeding/expressing facilities
- an area for making drinks and preparing simple meals
- a private room for confidential conversations and any other relevant facilities to support family-centred care and parental involvement in delivering care to their baby
- leaflets and signposting to support such as travel cost reimbursement.

¹¹ [BAPM FICare Framework November 2021.pdf \(hubble-live-assets.s3.amazonaws.com\)](https://hubble-live-assets.s3.amazonaws.com/BAPM_FICare_Framework_November_2021.pdf)

2.5 Repatriation

Effective and timely repatriation for ongoing care, is essential for effective use of capacity.¹² All units should take responsibility and play their part to ensure that babies are cared for in an appropriately skilled unit in a timely manner.

The decision to repatriate can be complex and needs to be agreed between the referring and receiving clinical teams in conjunction with the family, appreciating that the decision to repatriate can be unsettling for families. Psychological support from both the service and local teams will be a core aspect of repatriation.

Repatriation depends on a number of different factors including:

- clinical stability
- projection of ongoing needs
- family situation
- resources (staffing, expertise, capacity and transport).

Service providers should regularly consider and review the timing of repatriation in line with the criteria set out in this document. The receiving unit should accept a repatriation admission within 48hrs of the initial request.

Every effort should be made by the receiving unit to rectify any staffing issues to facilitate transfer and free up intensive care capacity within the network.

Staffing numbers and skill mix on both units should be reviewed by senior clinical managers, and a fair and transparent risk assessment should be undertaken before a request for repatriation is refused.

Should any unit not be able to accept an uplift of care, repatriation or transfer within 48 hours for any reason other than physical capacity (when at commissioned levels), an exception report by the referring unit should be completed and sent to NWJCC as in included in Appendix A.

2.6 Discharge

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 family life in the community.

¹² [Safe and Effective repatriation of infants a framework for practice BAPM June 2023](#)

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Neonatal service providers should ensure babies are discharged from neonatal care as soon as their condition allows, and after collaborative discussion with paediatric services for ongoing outpatient care when required and taking into consideration the support needed for the baby and parents/carers.

Discharge planning should be facilitated and coordinated from initial admission to discharge date, to ensure both the baby and their family receive the appropriate care and access to resources. This includes decisions about any continuing care needs that the mother, baby and family may have to make following discharge from in-patient care.

Pre-discharge planning should involve parents/carers, other key family members, GP, Health Visitor, the acute Neonatal MDT, the care co-ordinator and if appropriate, social care. A neonatal unit based outreach service or other designated neonatal unit staff should coordinate this for complex or long stay patients or patients with any safeguarding concerns. Parents/families should be given details of who to contact if they have concerns with their baby's condition or medicine post discharge.

All key professionals should receive copies of the discharge plan at time of discharge, including details of when the patient will next be seen and by whom, and emergency contact details. Before discharge, parents should be advised about their babies' medication and its side-effects, supported to administer all medicines and provided with appropriate advice on safe usage.

Following discharge, the baby and family should be contacted by a health visitor or other designated community professional in primary care within one week. Neonatal Units should have written local criteria for higher risk follow-up arrangements.

Care plans should reflect a multi-disciplinary approach to neonatal care, both within primary care and community teams. Local services, including neonatal, midwifery and primary care professionals should provide follow-up support to babies and families in the community after they have been discharged, and help to ensure that there is a seamless transition from in-patient stay back into family life.

Ongoing admission of babies with delayed discharge for social or community resource reasons should be discussed with the NWJCC Quality Team as soon as the delay is anticipated.

2.7 Follow-up

Babies born at less than 30 weeks gestation or with a high risk of neurodevelopmental problems should receive enhanced neurodevelopmental surveillance post discharge in accordance with the [NICE Guideline: Developmental follow-up of children and young](#)

[people born preterm \(2017\)](#). This will be undertaken by local paediatric teams in the babies resident Health Board.

Babies born before 30 weeks' gestational age are suspected of being at increased risk of developmental problems or disorders, should receive enhanced neurodevelopmental surveillance and access to therapy services if required post discharge, taking into account the presence and severity of risk factors. Risk factors include:

- Brain lesions on neuroimaging likely to be associated with developmental problems or disorders (e.g. severe intraventricular haemorrhage (IVH) or cystic periventricular leukomalacia (PVL)) Grade 2 or 3 neonatal hypoxic ischaemic encephalopathy (HIE)
- Neonatal bacterial meningitis
- Neonatal Herpes simplex encephalitis
- Severe jaundice requiring exchange transfusion

Parents or carers of a babies requiring enhanced neurodevelopmental surveillance post discharge should be provided with:

- an agreed discharge plan, which includes details of follow-up
- a single point of contact for outreach care within the neonatal service.

Babies born preterm who are eligible for enhanced neurodevelopmental surveillance should have at least 2 follow-up appointments with local paediatric teams in the first year and an assessment at 2 years' age corrected for prematurity that focus on development. The results of the 2-year corrected gestational age assessment should be entered into the baby's electronic records.

Babies born <28+0 weeks' gestation should have a formal assessment, including a general cognitive test at 4 years as specified in the NICE guideline ([NG72](#)).

2.8 Interdependencies with other services or providers

Maternity

Maternity care is interdependently linked to neonatal care. Neonatal service providers and Maternity providers should work closely together to deliver the best outcomes for women and their babies who need specialised care, whilst ensuring that high quality care is provided and delivered as close to home as possible. This includes ensuring when possible that mother and baby should be co-located, to facilitate early nutrition, bonding and family integrated care.

There should be adequate capacity within the local clinical pathways to accommodate the need for high risk mothers as well as specialist medical/surgical care for neonates

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following delivery, with safe return of babies and families to their local hospital as soon as is clinically appropriate.

Anaesthetics

Anaesthetists who care for neonates should have received appropriate training and service providers should ensure that at annual appraisals competence in anaesthesia and resuscitation is deemed adequate for the cases undertaken by that individual.^{13, 14}

Paediatrics and PICU

Some babies require care which is ongoing and beyond the scope of the neonatal services. There needs to be established links with local hospital paediatric services including Paediatric Critical Care (PCC), community paediatric services and primary care.

The list includes, but is not limited to, the following related services:

- Congenital heart disease services
- Community paediatric services
- Primary care and social care
- Children's Centres, ambulance services
- Perinatal mental health services
- National screening and laboratory services
- Neonatal surgical services
- Neonatal supra-specialist services

Neonatal Transport

Transfer of babies will be co-ordinated by the regional neonatal transfer service, in South Wales Cymru inter Hospital Acute Neonatal Transfer Service (CHANTS) which is a 24 hour, seven days a week service and The North Wales Neonatal Transport Service (North Wales NTS) provides a service from 8am-8pm, seven days a week. The North Wales NTS works in partnership with CONNECT North West¹⁵, the Neonatal Transport Service for the North West of England and North Wales and provides the remaining 12-hour service from 8pm-8am in accordance with the All Wales Neonatal Transport Service Specification (CP190).

¹³ <https://www.rcoa.ac.uk/training-careers/training-hub/2021-anaesthetics-curriculum>

¹⁴ [The Good medical practice framework for appraisal and revalidation \(gmc-uk.org\)https://www.gmc-uk.org/-/media/documents/the-good-medical-practice-framework-for-appraisal-and-revalidation---dc5707_pdf-56235089.pdf](https://www.gmc-uk.org/-/media/documents/the-good-medical-practice-framework-for-appraisal-and-revalidation---dc5707_pdf-56235089.pdf)

¹⁵ <https://connectnw.baby>

Imaging

Diagnostic imaging services are provided by professionals with expertise in paediatric and neonatal imaging. Imaging services should be available 24 hours a day 7 days a week within the Network.

Palliative Care

Palliative care for babies with life-limiting conditions is an active and total approach to care, from the point of diagnosis or recognition, throughout the child's life, death and beyond. Providers should work with the All Wales Paediatric Palliative Care Network, framework. Providers should ensure families have access to:

- Bereavement Services; and
- Hospice Care

2.9 Acceptance Criteria

The service outlined in this specification is for patients ordinarily resident in Wales, or otherwise the commissioning responsibility of the NHS in Wales. This excludes patients who whilst resident in Wales, are registered with a GP practice in England, but includes patient's resident in England who are registered with a GP Practice in Wales.

The service will accept inward referrals from obstetric, maternity or fetal medicine services. Within the antenatal period, high risk mothers or mothers with high risk babies will generally be under the care of an obstetrician. When the baby's condition has stabilised, ongoing care will be effectively undertaken at a designated provider closer to the family's home.

2.10 Service provider / Designated Centre

The commissioned number of cots at each unit is noted in Appendix B

Neonatal Surgical Intensive Care Units

Children's Hospital for Wales
Heath Park
Gabalfa
Cardiff CF14 4XW

Alder Hey Children's Hospital
Eaton
Liverpool
L12 2AP

Neonatal Intensive Care Units

The Grange University Hospital
Caerleon Road
Llanfrechfa
Cwmbran
NP44 8YN

Singleton Hospital
Sketty Lane
Sketty
SA2 8QA

SurNICC

Glan Clwyd Hospital
Rhuddlan Road
Rhyl
LL18 5UJ

Special Care Baby Units

Ysbyty Wrexham Maelor
Croesnewydd Road
Wrexham
LL13 7TD

Ysbyty Gwynedd
Penrhos Road
Bangor
LL57 2PW

Glangwili Hospital
Dolgwilli Road
Carmarthen
SA31 2AF

Princess of Wales
Coity Road
Bridgend
CF31 1RQ

Prince Charles
Gurnos Road
Merthyr Tydfil
CF47 9DT

2.11 Exceptions

If the patient does not meet the criteria for treatment as outlined in this policy, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the All Wales IPFR Panel.

If the patient wishes to be referred to a provider outside of the agreed pathway, an IPFR should be submitted.

Further information on making IPFR requests can be found at: [Individual Patient Funding Requests](#)

3. Quality and Patient Safety

The provider must work to written quality standards and provide monitoring information to the lead commissioner. The quality management systems must be externally audited and accredited.

The centre must enable the patients, carers and advocates informed participation and to be able to demonstrate this. Provision should be made for patients with communication difficulties and for children, teenagers and young adults. This should include communication and information in accessible formats, Welsh language and other language/translation support.

3.1 Quality Indicators (Standards)

Locally defined outcomes

The Neonatal service should aim to deliver the following:

- Babies are delivered at a unit appropriate for the care of the mother and the baby.
- Babies are cared for at the appropriate type of unit for their needs.
- Mothers and babies remain in the same hospital for their care when clinically safe to do so.
- Neonatal units are staffed and skilled to the appropriate levels to optimise care of their babies in line with National Standards.
- Families report positive experiences in neonatal services.
- Parents report partnership in care.
- Parents and babies are supported on discharge.
- Robust data are collected and collated to inform the commissioning process.

Provider outcomes

The provider must report to NWJCC:

- All National Reportable Incidents (NRI'S)
- Complaints
- Themes and trends from NRI's, complaints and DATIX reports
- Workforce numbers across all professional groups that impacts on the service's ability to deliver commissioned activity levels
- Admission refusals (Exception report Appendix A)
- Repatriation delays
- Capacity Transfers due to lack of cots in regional centres
- Commissioning related Datix submissions
- Quality Improvement initiatives

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- PREMS/PROMS
- Staff well-being and support

3.2 National Standards

The provider must comply with the submission of data to all relevant National Registries. NWJCC will work with the Maternity and Neonatal Network in the assessment of outcomes.

- BAPM Neonatal Service Quality Indicators
- Toolkit for High-Quality Neonatal Services
- British Association of Perinatal Medicine Service and Quality Standards
- All Wales Neonatal Standards 3rd Edition
- NICE Quality Standards

3.3 Other quality requirements

- The provider will have a recognised system to demonstrate service quality and standards.
- The service will have detailed clinical protocols setting out nationally (and local where appropriate) recognised good practice for each treatment site.
- The quality system and its treatment protocols will be subject to regular clinical and management audit.
- The provider is required to undertake regular patient/staff surveys and other methods of collating feedback and develop and implement an action plan based on findings. All communication with family's needs to be in an accessible format.

4. Performance Monitoring and Information Requirement

4.1 Performance Monitoring

NWJCC will be responsible for commissioning services in line with this policy. This will include agreeing appropriate information and procedures to monitor the performance of organisations.

For the services defined in this policy the following approach will be adopted:

- Service providers to evidence quality and performance controls
- Service providers to evidence compliance with standards of care

NWJCC will conduct performance and quality reviews on an annual basis

4.2 Key Performance Indicators

The providers will be expected to monitor against the full list of Quality Indicators derived from the service description components described in Section 2.2.

The provider should also monitor the appropriateness of referrals into the service and provide regular feedback to referrers on inappropriate referrals, identifying any trends or potential educational needs. This should also include timeliness of referring/accepting repatriation to local units.

4.3 Date of Review

This document is scheduled for review before 2027, where we will check if any new evidence is available.

If an update is carried out the policy will remain extant until the revised policy is published.

5. Equality Impact and Assessment

The Equality Impact Assessment (EQIA) process has been developed to help promote fair and equal treatment in the delivery of health services. It aims to enable NHS Wales Joint Commissioning Committee to identify and eliminate detrimental treatment caused by the adverse impact of health service policies upon groups and individuals for reasons of race, gender re-assignment, disability, sex, sexual orientation, age, religion and belief, marriage and civil partnership, pregnancy and maternity and language (Welsh).

This policy has been subjected to an Equality Impact Assessment.

The Assessment demonstrates the policy is robust and there is no potential for discrimination or adverse impact. All opportunities to promote equality have been taken.

6. Putting Things Right

6.1 Raising a Concern

Whilst every effort has been made to ensure that decisions made under this policy are robust and appropriate for the patient group, it is acknowledged that there may be occasions when the patient or their representative are not happy with decisions made or the treatment provided.

The patient or their representative should be guided by the clinician, or the member of NHS staff with whom the concern is raised, to the appropriate arrangements for management of their concern.

If a patient or their representative is unhappy with the care provided during the treatment or the clinical decision to withdraw treatment provided under this policy, the patient and/or their representative should be guided to the LHB for [NHS Putting Things Right](#). For services provided outside NHS Wales the patient or their representative should be guided to the [NHS Trust Concerns Procedure](#), with a copy of the concern being sent to NWJCC.

6.2 Individual Patient Funding Request (IPFR)

If the patient does not meet the criteria for treatment as outlined in this policy, an Individual Patient Funding Request (IPFR) can be submitted for consideration in line with the All Wales Policy: Making Decisions on Individual Patient Funding Requests. The request will then be considered by the All Wales IPFR Panel.

If an IPFR is declined by the Panel, a patient and/or their NHS clinician has the right to request information about how the decision was reached. If the patient and their NHS clinician feel the process has not been followed in accordance with this policy, arrangements can be made for an independent review of the process to be undertaken by the patient's Local Health Board. The ground for the review, which are detailed in the All Wales Policy: Making Decisions on Individual Patient Funding Requests (IPFR), must be clearly stated

If the patient wishes to be referred to a provider outside of the agreed pathway, and IPFR should be submitted.

Further information on making IPFR requests can be found at: [Individual Patient Funding Requests](#)

Annex i Abbreviations and Glossary

Abbreviations

AFC	Agenda for Change
AHP	Allied Health Professional
AWMSG	All Wales Medicines Strategy Group
BAPM	British Association of Perinatal Medicine
BDA	British Dietetic Association
BFI	Baby Friendly Initiative
BIPAP	Bi-level Positive Airway Pressure
CF	Cerebral Function
CGA	Corrected Gestational Age
CHANTS	Cymru inter Hospital Acute Neonatal Transfer Service
CPAP	Continuous Positive Airway Pressure
CPD	Continuous Professional Development
CSP	Chartered Society of Physiotherapists
DIC	Disseminated Intravascular Coagulation
ECMO	Extra-Corporeal Membrane Oxygenation
EQIA	Equality Impact Assessment
FIC	Family Integrated Care
GIRFT	Getting It Right First Time
GP	General Practice
HD/HDU	High Dependency/High Dependency Unit
HFOV	High Frequency Oscillatory Ventilation
HHFNC	Humidified High-Flow Nasal Cannula
HIE	Hypoxic Ischaemic Encephalopathy
IBCLC	International Board Certified Lactation Consultant
IC/ICU	Intensive Care/Intensive Care Unit
INO	Inhaled Nitric Oxide
IPFR	Individual Patient Funding Request
IVH	Intraventricular Haemorrhage

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LNU	Local Neonatal Unit
LSHTM	London School of Hygiene & Tropical Medicine
MDT	Multi-Disciplinary Team
NHS	National Health Service
NICE	National Institute of Health Care Excellence
NICU	Neonatal Intensive Care Unit
NMC	Nursing & Midwifery Council
NNA	Neonatal Nurses Association
NNU	Neonatal Unit
NRI	National Reportable Incident
NTS	Neonatal Transport Service
NWJCC	NHS Wales Joint Commissioning Committee
OT	Occupational Therapist
PCC	Paediatric Critical Care
PICC	Peripherally Inserted Central Catheter
PICU	Paediatric Intensive Care Unit
PN	Parenteral Nutrition
PREM	Patient Reported Experience Measure
PROM	Patient reported outcome measure
PVL	Periventricular leukomalacia
QIS	Qualified in Speciality
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians & Gynaecologists
RCOT	Royal College of Occupational Therapists
RCPCH	Royal College of Paediatrics & Child Health
RCSLT	The Royal College of Speech and Language Therapists
ROP	Retinopathy of Prematurity
SCU/SCBU	Special Care Unit Special Care Baby Unit
SiPaP	Synchronized inspiratory positive airway pressure
SMC	Scottish Medicines Consortium
SLT	Speech & Language Therapist
SurNICC	Sub-Regional Neonatal Intensive Care Centre
TC	Transitional Care
UNICEF	United Nations International Children's Emergency Fund

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VLBW	Very Low Birth Weight
WHO	World Health Organisation
WTE	Whole Time Equivalent

Glossary

Individual Patient Funding Request (IPFR)

An IPFR is a request to NHS Wales Joint Commissioning Committee (NWJCC) to fund an intervention, device or treatment for patients that fall outside the range of services and treatments routinely provided across Wales.

NHS Wales Joint Commissioning Committee (NWJCC)

NWJCC is a joint committee of the seven local health boards in Wales. The purpose of NWJCC is to ensure that the population of Wales has fair and equitable access to the full range of Tertiary Services. NWJCC ensures that services within our portfolio are commissioned from providers that have the appropriate experience and expertise. They ensure that these providers are able to provide a robust, high quality and sustainable services, which are safe for patients and are cost effective for NHS Wales.

Appendix A – Exception Report

Neonatal referral refusal document

Date	
Time	

Unit Occupancy

Number of Neonatal nursing staff on shift	
Number of IC beds occupied	
Number of HDU beds occupied	
Number of SC beds occupied	

Referral Detail

Referring Hospital	
Patients Health Board	

Referral Reason

Uplift/Emergency Transfer	
Repatriation	
In utero transfer	
delay in delivery of baby that would require neonatal admission	
capacity transfers OUT of a unit	

Outcome

Stayed at local hospital	
Transported by CHANTS to another unit	
Destination Unit	

All exception reports to be submitted to NWJCC on the 10th of every month (to cover the refusal data from the previous month) via email to nwjccinformation@wales.nhs.uk

Appendix B – Cot configuration

Unit:	NICU	HDU	SCBU
Aneurin Bevan UHB (Grange University Hospital)	6.00	9.00	17.00
Cardiff & Vale UHB (Children’s Hospital for Wales)	11.00	12.00	14.00
Cwm Taf Morgannwg UHB (PCH)	0.54	3.00	9.00
Cwm Taf Morgannwg UHB (POW)	0.25	2.00	7.00
Hywel Dda UHB (Glangwili)	0.09	3.00	7.00
Swansea Bay UHB (Singleton)	6.00	9.00	9.00

The table below notes the number of cots available across North Wales (Bestsi Cadwaladr UHB)

Unit:	NICU	HDU	SCBU
Ysbyty Glan Clwyd Hospital	5	5	9
Ysbyty Gwynedd Hospital	1	2	7
Wrexham Maelor Hospital	1	2	9