# Neonatal Transitional Care Report

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# Preface

This report presents a scoping review of transitional care services across the Southeast region (both Thames Valley and Wessex, and Kent, Surrey, and Sussex Operational Delivery Networks).

In context with the British Association of Perinatal Medicine (BAPM) neonatal transitional care framework for practice (BAPM, 2017) and further national recommendations from the National Critical Care Review (NCCR) (NHS England, 2019), Service Standards (BAPM, 2022), and the Three-Year Delivery Plan for Maternity and Neonatal Services (NHS England, 2023), there is a need to ensure our transitional care services are equitable and meet the needs of the babies and families.

Transitional care is a critical part of the neonatal care pathway enabling mother and baby to stay together. It is also at the interface of neonatal and maternity services coming together and a hub of perinatal multidisciplinary working. It is essential that we continue to strive towards minimal parent separation and develop our services for optimum health outcomes.

This report provides an insight into transitional care services within the Southeast region. By reviewing transitional care against the BAPM recommendations, models of service, workforce, and the care pathways it enables recommendations to be made and for us to learn from best practice.

"Every newborn baby should be with their mother if at all possible; implementation of NTC within all UK maternity services has the potential to make this happen. The question should not be whether mother and baby can be cared for together, but rather why should they be separated." (BAPM, 2017)

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# Executive Summary

Neonatal Transitional Care (NTC) is an area of care where neonatal and maternity services collide. Mother and baby can be cared for together on or near the postnatal ward and avoid the separation that can occur when babies are admitted to the neonatal unit. With the support of the maternity incentive scheme (NHS Resolution, 2025) and a national framework (BAPM, 2017) all hospital trusts across the Southeast are working hard to improve NTC services and meet the standardised criteria.

In both Thames Valley and Wessex (TVW), and Kent, Surrey, Sussex (KSS) Operational Delivery Networks (ODNs), models of care, whether predominantly neonatal or maternity led, vary due to workforce, experience, budgets, and estates. This varying practice across the Southeast is compounded by barriers to establishing aspects of NTC. Challenges include cross boundary working, a stretched workforce, maternity wards occupancy, and limited education opportunities currently available.

Nevertheless, with increasing networking opportunities and establishing a Southeast transitional care working group there is a strong foundation to enhance our transitional care services by learning from the parents and other providers. By building shared resources we can increase learning opportunities for students as well as our transitional care teams.

Psychological professionals, allied health professionals (AHPs), pharmacists, and neonatal outreach teams all have a vital role to play in supporting babies, families, and staff. When adequately resourced and integrated into NTC, these professionals can provide specialist input that enhances the quality and continuity of care, promotes parental wellbeing, and supports the workforce.

Caring for NTC babies is not increasing the number of babies in the wider neonatal care system, but it is changing the environment and the skillset of the staff caring for them. By encouraging multidisciplinary working, sharing our skillsets, and continual network oversight there are opportunities to standardise data collection, and build higher quality and sustainable NTC services within the region.

# Introduction

Neonatal Transitional Care (NTC) has been defined as “care additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals” (BAPM, 2017). It provides a valuable additional service option to ensure babies are cared for in the right place. This aims to prevent unnecessary admissions to the neonatal unit, avoiding separation of mother and baby (McEwan, 2020) and, consequently, has a multitude of benefits (refer to Appendix 1).

NTC is not a new concept, as it was discussed over 30 years ago (Whitby, 1983) but the definition has been reworded over the years to aid confusion in defining this level of neonatal care. A supportive framework has now been published (BAPM, 2017) and this is currently being updated. It outlines the criteria on what would be considered as normal newborn care, additional special care, and transitional care (refer to Appendix 2). It also makes recommendations including working with the families and neonatal outreach services to ensure a seamless transition to home. However, despite a national framework there remains variance in practice.

Some hospitals have ‘transitional care’ designated cot spaces for babies meeting the NTC criteria, yet NTC can also be seen as a concept rather than a place (McKeon-Carter, 2018). These various models of delivering NTC are all in line with the philosophy of delivering family-integrated care but can vary in quality and standards. It is our intention to review these services and make recommendations for continuous service improvement.

# 1 The National Context

Following the publication of *A Framework for Neonatal Transitional Care* (BAPM, 2017) there have been several national drivers to strengthen the need for NTC service development.

The *Neonatal Critical Care Review* (NCCR) (NHS England, 2019) set out actions for transforming neonatal care. It stated that:

"The vision for neonatal services is a seamless, responsive, and multidisciplinary service built around the needs of new-born babies and the involvement of families in their care. High quality neonatal care will be networked together across England, to improve outcomes for all families, provide safe expert care as close to their home as possible, and keep mother and baby together while they need care."

The three main commitments are to develop neonatal capacity, further develop the expert neonatal workforce, and enhance the family experience. NTC services can play a key part in achieving this vision for neonatal services across England.

The British Association of Perinatal Medicine (BAPM) have continued to support NTC service development and made further recommendations in the most recently published *Service and Quality Standards for Provisions of Neonatal Care in the UK* (BAPM, 2022) stating that "each neonatal unit should have arrangements to provide NTC as appropriate, thus minimising parent-baby separation".

NHS England have acknowledged the value in offering NTC to families for over 10 years and it is outlined in the neonatal critical care service specifications (NHS England, 2024) as part of the optimum neonatal care pathway. Furthermore, NTC services have been part of the national safety initiatives and financial incentive schemes. The Maternity Incentive Scheme (NHS Resolution, 2025) forms part of the Clinical Negligence Scheme for Trusts (NHS Resolution, 2025) and safety action 3 requirement states:

"Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?"

The *Avoiding Term Admissions into the Neonatal Unit* (ATAIN) programme report (NHS Improvement, 2017) emphasises the implications of mother and baby separation for long-term

outcomes. Consequently, it recommends that clinicians and commissioners work together to consider the role NTC has locally in reducing unnecessary admissions. There are also strong recommendations that neonatal outreach services are developed to accompany neonatal transitional care (Neonatal UK Partnership Board, 2023).

All these national drivers, in collaboration with the recent *Three-year delivery plan for maternity and neonatal services* (NHS England, 2023), reinforce the need for more personalised and equitable care for women, babies, and families. Now is the time to look at this further within the Southeast region.

# 2 Scoping Project

## 2.1 Aims of project

To gain insight into:

- NTC service models being delivered in the Southeast region
- Workforce models
- Parent feedback
- Patient pathways
- Challenges in service development

## 2.2 Methodology

Data for this scoping report was initially collected by the TVW lead care coordinator during March 2023 – August 2023 using a validated questionnaire from East of England ODN. It was sent to all fourteen neonatal units in TVW network (refer to Appendix 3). Information was then updated in November 2024. All leads for NTC in TVW were invited to participate in an online meeting and questionnaires were circulated before the meeting. Leads confirmed the accuracy of the data. All 14 TVW neonatal/NTC units participated. From 1st April 2025 University Hospitals Dorset (UHD) Poole moved to The Royal Bournemouth site; the scoping included in this report is of the NTC provision at UHD Poole.

In March 2025, the lead for outreach for TVW and KSS ODN joined the project, and information was updated by the leaders of NTC in both TVW and KSS ODNs and mapped against the NTC framework criteria (BAPM, 2017). Recent scoping information obtained includes all thirteen neonatal units in KSS ODN (refer to Appendix 4), gained from unit visits and the KSS ODN transitional care meeting.

The parent voice within this report has been obtained from a Maternity and Neonatal Voices Partnership (MNVP) in TVW ODN. There were no lived experiences of NTC within the current TVW Parent Advisory Group (PAG). Due to the limited time period parents were not contacted through the KSS PAG.

In July 2025 the ODN's AHP and psychology colleagues were invited to give additional feedback on the NTC Scoping report, regarding workforce. Their comments have been included within the scoping report revision.

# 3 Current NTC provision in TVW ODN

## 3.1 NTC Service Models and Workforce

NTC services in TVW ODN are offered predominantly situated on the postnatal wards as either a designated ward area or identifying babies who meet transitional care criteria throughout the maternity department. The service models and workforce vary (Refer to Appendix 5).

### 3.1.1 Service Models

From April 2025 there will be a neonatal transitional care service in all 14 TVW ODN neonatal units, and each have developed a clear standard of practice. The newest of which has launched in March 2025 in Milton Keynes Hospital.

12 hospitals have an allocated number of 'transitional care' beds on or near the postnatal ward, varying from 4-8, although often expand this if required. Salisbury and Dorchester hospitals have a flexible service model in that transitional care babies can be cared for either on the postnatal ward or on the neonatal unit with their mother.

### 3.1.2 NTC Workforce

The majority of NTC services are located on or closely linked to the postnatal ward, where mothers are cared for by a registered midwife. Dependant on the workload and numbers of babies, this midwife may be allocated other mothers on the postnatal ward. The midwife also supports a junior member of staff to assist in caring for the babies' additional needs, or in some cases the support comes from an allocated NTC nurse from the neonatal unit. The junior member of staff can be a midwifery support worker (MSW), a nursery nurse, or a healthcare assistant (HCA). In some cases, like in Basingstoke, Winchester, and Southampton, this staffing

group are part of the neonatal team, whilst in others the staff are utilised from the midwifery workforce.

The staffing ratios for NTC can also vary for all staff disciplines. For example, Wexham Park and Poole hospitals have one midwife and one MSW/HCA to care for up to 8 women and babies, whereas Basingstoke has the same staffing ratios for 4 women and babies. The midwifery staffing ratio often remains up to 1:8 whereas Southampton will aim to have 2 nursery nurses supporting NTC if there are more than 6 babies.

Staffing recommendations for Psychology Professionals and Allied Health Professionals (AHPs) - including physiotherapists, speech and language therapists, occupational therapists, and dietitians - to support NTC are outlined in national guidance (https://www.bapm.org/pages/198-neonatal-specialties). However, there is currently no funded input for any professional group into TVW transitional care services. Where support is provided, it is largely offered on an informal or goodwill basis, often in addition to existing neonatal responsibilities.

Given the absence of dedicated provision, limited workforce capacity for both AHPs and Psychology Professionals is typically directed toward inpatient neonatal unit care. Further benchmarking will be important to assess the scale of this gap. Both AHP and psychological professional bodies continue to publish evidence demonstrating how their input can add value in transitional care, particularly in supporting feeding, neurodevelopment, parenting, and family emotional wellbeing.

#### 3.1.3 Scoping against BAPM Criteria for NTC

***Gestation, weight, and nasogastric tube feeding*** *(Refer to Appendix 6)*
6 out of 14 hospitals (Southampton, Basingstoke, Reading, Winchester, Dorchester, Salisbury) will admit babies to NTC babies from >34weeks gestation, >1.6kgs, and will accept nasogastric tube feed babies. Salisbury hospital has developed two care pathways to accommodate this: a neonatal unit TC pathway when the parent is resident with their baby, and a midwifery pathway on the postnatal ward. Some NTC units, such as in Oxford and Stoke Mandeville are meeting the BAPM standard for gestation but do not accept nasogastric tube feed babies. Therefore, not likely to have babies born at 34 weeks directly admitted to NTC.

NTC in Portsmouth, Oxford, Stoke Mandeville, and the postnatal side of NTC in Salisbury all do not accept babies on nasogastric tube feeds, therefore, will not accept babies with congenital anomalies requiring tube feeds. This also means that babies admitted from the community with weight loss requiring tube feeds will be admitted to the neonatal unit.

***Intravenous antibiotics***

In Winchester, there is a designated bay for NTC. However, a baby requiring intravenous antibiotics (IVAB) may not be admitted to NTC. This is reflective of other NTCs with designated areas. Due to there being high numbers at times they are often not grouped with other NTC babies, or don't meet local criteria for NTC.

Another area of difference is in the care of babies with neonatal abstinence syndrome. Reading will accept babies on NTC who require medication whereas, in Southampton those babies would require admission to the neonatal unit.

***Haemolytic disease requiring phototherapy***

All babies requiring double phototherapy are considered transitional care and are admitted to the neonatal unit if requiring triple phototherapy lights.

***Temperature***

All trusts have NTC facilities to ensure babies who need additional support with temperature are supported and not separated from their mothers for this sole reason.

***Transfer from Neonatal units to NTC***

The pathways of babies being transferred from the neonatal unit often depends on the age of the baby. Due to NTC being closely linked to the postnatal ward many NTCs will not readmit the mother and baby if they are out of the remit of midwifery care, or the mother is fit for discharge.

# 4 NTC Services in KSS ODN

## 4.1 NTC Service Models and Workforce

NTC services in KSS ODN are offered predominantly situated on the postnatal wards as either a designated ward area or identifying babies who meet transitional care criteria throughout the maternity department. The service models and workforce vary (Refer to Appendix 5).

### 4.1.1 Service Models

8 units out of 13 have well established NTC pathways. Brighton and Hayward Heath, East Surrey, Dartford, and Hastings are all working towards developing their NTC pathways.

9 hospitals have an allocated number of 'transitional care' beds on or near the postnatal ward, varying from 4-8, although often expand this if required. Medway, and St Peters are examples of neonatal led designated bays. East Surrey is working on a more flexible model in that transitional care babies can be cared for either on the postnatal ward or on the neonatal unit with their mother.

### 4.1.2 NTC Workforce

With the majority of NTC services being on or closely linked to the postnatal ward the mothers are cared for by a registered midwife. Dependant on the workload and numbers of babies, this midwife may be allocated other mothers on the postnatal ward. The midwife also supports a junior member of staff to assist in caring for the babies' additional needs, or in some cases the support comes from an allocated NTC nurse from the neonatal unit. The junior member of staff can be a midwifery support worker, a nursery nurse, or a healthcare assistant. In some cases, such as at Medway, this staffing group are part of the neonatal team, whilst in others the staff are utilised from the midwifery workforce.

The staffing ratios for NTC can also vary for all staff disciplines and there are differing workforce expectations and demands for NTC from the neonatal unit. In Ashford, and Margate a registered nurse acts as a 'TC link nurse' and is given the responsibility of supporting NTC babies.

### 4.1.3 Scoping against BAPM Framework for NTC

***Gestation, weight, and nasogastric tube feeding*** *(Refer to Appendix 6)*
Medway, East Surrey (Neonatal), and Chertsey are the only NTC services meeting BAPM standards for TC on gestation (>34wks), weight (>1.6kg) and offering nasogastric tube feeding. Frimley and Guildford also offer nasogastric tube feeding on NTC but have weight limits of 1.7kg and 1.8kg.

Margate, Tunbridge Wells, and Ashford all meet the BAPM standard for gestation but do not accept nasogastric tube feed babies. Therefore, not likely to have babies born at 34 weeks

directly admitted to NTC or take babies requiring tube feeds for weight loss or congenital anomalies.

***Intravenous antibiotics***

In Tunbridge Wells, there is a designated bay for NTC. However, a baby requiring intravenous antibiotics (IVAB) would not be a sufficient admission criteria. These babies are cared for on the postnatal ward. This is reflective of other NTCs with designated areas. Due to there being high numbers at times they are often not grouped with other NTC babies.

The majority of IVABs are given by the neonatal staff away from transitional care either on the neonatal unit or another designated area. In Medway, Brighton, and East Surrey they are given at the cot side by either midwifery or neonatal nursing staff. The antibiotics regime differs in each hospital (Cefotaxime or Benzylpenicillin/Gentamicin) and timings vary (sometimes at midnight).

Any baby requiring medication for Neonatal Abstinence Syndrome will be admitted to the neonatal unit.

***Haemolytic disease requiring phototherapy***

Tunbridge wells currently do not have phototherapy babies on NTC, and these babies are admitted onto the neonatal unit.

***Temperature***

All trusts have NTC facilities to ensure babies who need additional support with temperature are supported and not separated from their mothers for this sole reason.

***Transfer from Neonatal units to NTC***

The pathways of babies being transferred from the neonatal unit often depends on the age of the baby. Due to NTC being closely linked to the postnatal ward many NTCs will not readmit the mother and baby if they are out of the remit of midwifery care, or the mother is fit for discharge.

## 4.2 Challenges for providing NTC

### 4.2.1 Who is considered NTC? and data collection.

Whilst completing this scoping project it has become apparent that what some refer to as NTC are those babies being cared for in the designated NTC bays on the postnatal ward and may exclude groups of babies that could be defined under the BAPM criteria but nursed on the postnatal ward area (such as those receiving IVAB). There are also a cohort of babies that are 'rooming in' on the neonatal unit that could be categorised as transitional care. Therefore, despite there being a BAPM framework for NTC criteria, there remains some variance in which babies would be considered as NTC in each Hospital Trust. It is imperative to consider this when collating network data around NTC. All trusts are collecting data around babies who are considered NTC, but clarification will be required as to what that data reflects. Challenges occur especially when NTC babies move between different departments.

### 4.2.2 Babies with nasogastric tube feeds on NTC.

Being able to care for babies with nasogastric tube feeds is key to providing an NTC service that prevents unnecessary admissions to the neonatal unit. However, upskilling midwifery staff to support parents to administer nasogastric feeds can be a challenge, especially within staffing constraints across maternity and neonatal units. However, with some parents carrying out nasogastric tube feeds on the neonatal unit, and then going home with the support of outreach services, there is scope for this pathway to be introduced to NTC.

### 4.2.3 Escalation pathways.

With midwifery teams caring for mothers on the postnatal ward, many aspects of caring for the baby is carried out by junior members of the team. For many nursery nurses and support workers their experience has resulted in them being skilled and knowledgeable in caring for NTC babies. However, when having to escalate concerns, the junior members of the team will often turn to medical staff or neonatal unit staff. In these cases, there has been some concern raised around the potential of de-skilling midwives.

### 4.2.4 Workforce demands.

NTC can be a challenge in balancing workforce demands for maternity and neonatal teams. With an ever-increasing workload, NTC is an aspect of shared care that can be seen as additional workload for both areas of expertise which proves to be a challenge in managing. It requires a high level of communication and negotiating.

### 4.2.5 Education and training for NTC.

The NTC framework (BAPM, 2017) recommends that "all NNUs and networks should promote access to training courses in order to help both neonatal and midwifery staff to develop their skills, and to ensure that they understand the benefits of, and are confident in delivering, a family-centred approach to neonatal care". Unfortunately, there is only one regional specialist course that is available specifically designed for NTC staff and it is provided by the East of England ODN. The majority of NTC staff have not accessed this course. Therefore, any training received has been at Trust level.

### 4.2.6 NTC and neonatal outreach services.

Neonatal outreach services can support families from NTC. However, there are limited outreach services across the Southeast and some have just started to link with NTC. Until outreach services develop and expand (BAPM, 2025) there is a risk of NTC babies being seen as 'bed blockers' on the postnatal wards.

### 4.2.7 NTC and Allied Health Professionals (AHP's)

With an increasing presence of babies receiving specialist care from AHPs on the neonatal unit, families are benefiting from improved health outcomes. However, the shortfall in AHPs working on the neonatal units results in being limited in the support that they can give to NTC families. As the workforce grows, consideration will have to be given as to how they can support NTC families, otherwise families may miss out on getting this level of specialised support.

### 4.2.8 NTC and Psychological Professionals

Parents of babies requiring transitional care often face a range of emotional and psychological challenges, including birth trauma, anxiety, difficulty bonding, and concern about their baby's health and development. Psychological professionals, particularly those with perinatal or neonatal expertise, are well placed to provide specialist support that can improve both family wellbeing and longer-term outcomes for babies.

Despite national recognition of the importance of parental mental health and early relational support, there is currently no dedicated psychological provision for families within

NTC settings across the Southeast. Where psychological support is accessed, it is often limited, informal, or provided as part of wider neonatal services. This lack of resource means many families in NTC may not receive timely or appropriate support for their psychological needs.

As part of developing holistic and family-centred care, consideration should be given to how psychological professionals can be embedded within NTC models. Alongside AHPs and outreach teams, they have an important role in supporting not only families, but also the staff teams caring for them.

## 4.3 Parent voices

Stacey Crane's daughter Ivy-Rose Tiller-Stevens was identified as suitable for the transitional care unit at Basingstoke hospital shortly after birth as she needed to be monitored to ensure she didn't lose too much weight or become jaundiced.

Stacey said: "I would not have wanted to have been away from Ivy-Rose, so it's great that they have created this unit. It's fantastic to be able to bond and be together, but still get all of the help and support we both need. The staff have been really helpful and given me lots of advice." (Crane, 2018)

## 4.4 Recommendations and opportunities for the future

- **Standardising data collection.** BAPM defined NTC babies are in postnatal wards, labour wards, and neonatal departments. Any regional data in TC will have to capture babies in all areas.
- **Additional NTC parent feedback.**
- **Reinforcing escalation pathways involving both neonatal and midwifery teams**.
- **Education course development for midwives, nursery nurses and neonatal staff on NTC babies and families**.
- **When established, NTC can be offered as an area for student placement for both nursing and midwifery students.**
- **NTC Network Guideline development.** Helping to standardise practise.
- **Working in collaboration with LMNS groups on NTC.**
- **A Transitional Care Southeast Networking Group.** During this scoping project a multidisciplinary group has been set-up inclusive of all staff working in NTC.
- **Develop outreach services to facilitate a supportive discharge from NTC.** Hospital at home services from NTC could assist in maintaining patient flow.

- **Strong multidisciplinary leadership** for NTC.
- **Benchmarking AHP and Psychology Workforce** in Southeast Networks NTC
- **AHP and Psychology Provision to NTC** should be routinely monitored

## 4.5 Conclusion

Despite NTC being a primary area of focus within the clinical negligence scheme for trusts (CNST) (NHS Resolution, 2025) for several years now, there remains regional variance in service delivery, and a lack of oversight of NTC services. However, neonatal networks can play a vital role in improving the delivery of NTC by placing focus on monitoring NTC activity across the network, offering NTC specific education, benchmarking, and peer support opportunities. In completing this scoping project, it has led to the development of a newly established regional NTC networking group, and this has shown potential in the sharing of some best practice and learning from one another.

During the timeline of this report, inconsistencies across KSS in IVAB delivery on NTC has been highlighted and the network pharmacy group are going to continue to support the NTC group to make practice improvements in this area. This is only one example of how we can improve NTC experience, but there is opportunity to tackle the barriers to NTC and build on all the recommendations and opportunities highlighted within this report.

During the limited timeframe in writing this report it is acknowledged that there is limited parent feedback and best practice examples included. However, this work will continue to strive to improve the NTC experience for our families across the Southeast.

# Appendix 1 – Benefits of NTC

- Avoids term admissions to the NNU
- Alleviates operational constraints such as bed-blocking in the NNU
- Prevents parental anxiety and promotes good maternal mental health
- Increases breastfeeding rates in late preterm infants
- Improves the neonatal experience for the parents and the baby
- Enhances parental confidence and bonding with their baby
- Minimises length of hospital stay and reduces re-admission rates
- Identifies a date of discharge at admission
- Increases prompt discharge of babies born ≥ 34 weeks' gestation
- Facilitates effective discharge planning for complex babies
- Improves multidisciplinary collaborative work

(McKeon-Carter, 2018)

## Appendix 2 – BAPM Criteria for Normal newborn care, additional neonatal special care, and NTC.

**Normal newborn care**

*Care given by mother with support from a midwife. Should be managed in a postnatal setting or home.*

Includes:

- Immediate review of baby after birth, including observation of vital signs.
- Newborn initial physical examination (routine examination of newborn)
- Newborn blood spot screening
- ≥36+0 weeks' gestation and birth weight >2kg

- enhanced monitoring (NEWTT or equivalent) for early detection of deterioration in babies with risk factors in first 12 hours of life
- thermoregulatory management monitoring
- blood glucose and following a management and prevention of hypoglycaemia policy for babies at risk of hypoglycaemia
- supporting establishment of infant feeding
- monitoring serum bilirubin for babies with exaggerated physiological jaundice
- investigation and support for infants with congenital abnormalities who do not otherwise fulfil criteria for higher category of care
- support for babies with social care

**Additional neonatal care (for fulfilling criteria for HDU or NICU)**

*Care described by Neonatal HRG's (2016) as criteria for special care either given with (XA04Z) or without (XA03Z) carer present.*

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

- presence of an indwelling urethral or suprapubic catheter
- oxygen by low flow nasal cannulae
- feeding by orogastric, nasogastric, jejunal or gastrostomy tube
- care of a stoma
- intravenous (IV) medication or IV fluids not specified in criteria for intensive or high dependency care
- drug treatment for neonatal abstinence syndrome, and requiring 4 hourly (or more frequent) monitoring
- birth weight < 2000 g, for the first 48 hours after birth
- gestation at birth 35 weeks, for the first 48 hours after birth
- gestation at birth 34 weeks, for the first 7 days after birth
- gestation at birth < 34 weeks, until discharge from hospital

## Transitional care

*Care additional to normal infant care, provided in a postnatal clinical environment by the mother or an alternative resident carer, supported by appropriately trained healthcare professionals.*

a) Includes **from birth**:
- Gestational age 34+0 to 35+6 weeks who do not fulfil criteria for intensive or high dependency care
- Birth weight > 1600 g* and < 2000 g who do not fulfil criteria for intensive or high dependency care (qualified recommendation)
- Risk factors for sepsis requiring IV antibiotics, but clinically stable
- Congenital anomaly likely to require tube feeding
- At risk of haemolytic disease requiring immediate phototherapy**

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

c) Includes babies **readmitted from the community**:
- Excessive weight loss and/or poor suck feeding requiring complementary nasogastric tube feeds
- Haemolytic disease requiring enhanced phototherapy and/or assessment of serum bilirubin 4-6 hourly**

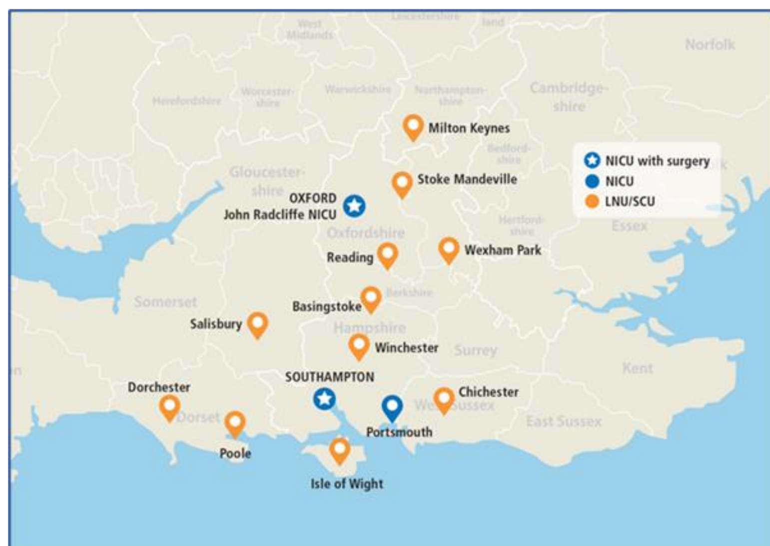
d) Includes babies **"stepping down" from the NNU**:
- Corrected gestational age > 33+0 weeks and clinically stable
- Current weight more than 1600 g and maintaining temperature
- Monitoring of vital signs required no more frequently than 3 hourly***
- Tolerating 3 hourly nasogastric tube feeds and maintain
- Stable baby with sepsis requiring ongoing IV antibiotics
- Continuing phototherapy when serum bilirubin has stabilised following IV immunoglobulin or exchange transfusion
- Additional needs (e.g. nasogastric feeding, home oxygen) rooming in before discharge
- Palliative care when parent/carer doing most of the care.

*It is to be expected that all babies weighing < 1600 g will be admitted initially to a NNU for observation of feeding and temperature control

** In NHS England these babies will not be coded as NTC unless they require additional treatments (e.g. nasogastric feeding), but it may be appropriate in some circumstances to accommodate them in a NTC setting, rather than a postnatal ward. Babies with non-haemolytic jaundice will usually be cared for in a postnatal ward.

***We recommend that larger NTC facilities are considered in when developing or reorganising maternity and neonatal services, with consideration being given to babies requiring more frequent monitoring or feeding to be cared for with their mother resident.

# Appendix 3 – TVW ODN Configuration




Neonatal units deliver 3 types of care (Intensive care, high dependency, and special care). There are three levels of neonatal unit providing care. Some NHS Trusts host more than one neonatal unit.

**Neonatal Intensive Care Units (NICU)** provide care for the whole range of neonatal care. They are staffed to care for the sickest and most immature babies and staff work closely with their local maternity teams and fetal medicine services. The NHS England Neonatal Critical Care service specification [E08/S/a] indicates that all women and their babies who are born <27 weeks of gestation or birthweight <800g, and multiple pregnancies <28 weeks of gestation, should receive perinatal and early neonatal care in a maternity service with a NICU facility.

**Local Neonatal Units (LNU)** provide care for all babies born at their hospital at 27 weeks of gestation or more, >800g birthweight or multiple pregnancies >28 weeks (which includes short-term intensive care where necessary) and they may receive babies 27-31 weeks who require high dependency care.

**Special Care Units (SCU)** provide local care for babies born at 32 weeks or more and >1000g birthweight who require only special care or short-term high dependency care. All pregnant women who fall outside these categories or babies who unexpectedly need intensive care are transferred to an appropriate unit in the local care pathway.

TVW consists of 14 neonatal units:

| NICU | LNU | SCU |
|---|---|---|
| Oxford | Milton Keynes | Basingstoke (SCU+) |
| Portsmouth | Poole (Royal Bournemouth April 2025) | Chichester |
| Southampton | Reading | Dorchester |
| | Salisbury | Isle of Wight |
| | Stoke Mandeville | Winchester (SCU+) |
| | Wexham Park | |

# Appendix 4 – KSS ODN Configuration

Neonatal units deliver 3 types of care (Intensive care, high dependency, and special care). There are three levels of neonatal unit providing care. Some NHS Trusts host more than one neonatal unit.

**Neonatal Intensive Care Units (NICU)** provide care for the whole range of neonatal care. They are staffed to care for the sickest and most immature babies and staff work closely with their local maternity teams and fetal medicine services. The NHS England Neonatal Critical Care service specification [E08/S/a] indicates that all women and their babies who are born <27 weeks of gestation or birthweight <800g, and multiple pregnancies <28 weeks of gestation, should receive perinatal and early neonatal care in a maternity service with a NICU facility.

**Local Neonatal Units (LNU)** provide care for all babies born at their hospital at 27 weeks of gestation or more, >800g birthweight or multiple pregnancies >28 weeks (which includes short-term intensive care where necessary) and they may receive babies 27-31 weeks who require high dependency care.

**Special Care Units (SCU)** provide local care for babies born at 32 weeks or more and >1000g birthweight who require only special care or short-term high dependency care. All pregnant women who fall outside these categories or babies who unexpectedly need intensive care are transferred to an appropriate unit in the local care pathway.

KSS consists of 13 neonatal units:

| NICU | LNU | SCU |
|---|---|---|
| Ashford | East Surrey | Dartford |
| Brighton | Frimley | Guildford |
| Medway | Tunbridge Wells | Hastings |
| St Peters | | Haywards Heath |
| | | Margate |
| | | Worthing |

# Appendix 5 – NTC Service Models & Workforce

**TVW ODN**

| Area | Designated beds or virtual | Model | Workforce |
|---|---|---|---|
| Southampton | 6 (up to 10) | On postnatal ward. Band 7 neonatal lead for TC. | Band 6 neonatal lead works closely with postnatal and midwifery leads. Nursery Nurses from neonatal staffing. |
| Portsmouth | 8 | On postnatal ward and initially managed by maternity services. Now working collaboratively with the neonatal unit. | Midwife and MSW. |
| Oxford | 7 | On postnatal ward. Maternity Led. Have support from the neonatal team. | Midwife and MSW and Maternity Assistant Practitioners (MAPS) |
| Milton Keynes | 7 | Next to postnatal ward and neonatal. Opened March 2025. | Midwife and Nursery Nurses from neonatal staffing. |
| Stoke Mandeville | 6 | On postnatal ward (Bay 11 plus side room) | Midwife and Nursery nurse. A NNU Nurse is allocated as link nurse for TC prior to shift handover. |
| Wexham Park | 8 | On postnatal ward (4 x 4-bedded bays) | Midwife and Maternity Care Assistant |
| Basingstoke | 4 | On postnatal ward | Midwife and Nursery nurse from neonatal staffing |
| Poole | 8 | On postnatal ward (Moving hospitals April 2025) | Midwives and maternity support worker. |
| Reading | 5-6 | On postnatal ward (Bay 8 and room 9) Scope for additional bed if needed. | Midwife and nursery nurse from neonatal staffing. |
| Salisbury | Virtual | Can provide NTC on NNU and postnatal ward | Adaptive to patient need. Either maternity staffing or neonatal. |
| Winchester | 6 | On postnatal ward | Registered neonatal nurse and/or nursery nurse |
| Dorchester | Virtual | On postnatal ward or NNU | Midwives and neonatal staff care for babies if identified as NTC |
| Chichester | 4-6 | On postnatal ward | Midwives and maternity nursery nurses |
| Isle of Wight | Virtual | On postnatal ward | Midwives and neonatal nurses and nursery nurses |

**KSS ODN**

| Area | Designated beds or virtual | Model | Workforce |
|---|---|---|---|
| Medway | 8 | Designated bay near postnatal ward (Neonatal led) | Midwives, Neonatal Nurses and nursery nurses. |
| Brighton | 4 | Designated space in postnatal ward, working on developing further NTC provision | Currently overseen by maternity team, with neonatal nursing cover to administer IVABs. |
| Chertsey (St Peters) | 8 | Designated space | Midwives, neonatal nurses and nursery nurses. Led by ANNP. |
| Ashford | 4 | On postnatal ward | Midwives, nursery nurses, NTC nurse allocated (NICU based) |
| East Surrey | 4 (NNU) Building NTC on postnatal | Neonatal, and allocated spaces on maternity | Midwives, nursery nurses on postnatal. Neonatal staff on NNU. |
| Frimley | 8 | 2 x 4-bedded bays on postnatal ward | Midwives and Maternity Support Workers |
| Tunbridge Wells | 6 | On postnatal ward | Midwives and maternity nursery nurses. |
| Dartford | Virtual | Can provide NTC on NNU and postnatal ward | Midwives and neonatal nursery nurses. |
| Margate | 4 | On postnatal ward | Midwives, nursery nurses, NTC Nurse allocated (NICU based) |
| Guildford | 6 | Designated space near postnatal | Midwives, nursery nurses. |
| Haywards Heath | 0 | Ad hoc ability to provide NTC, Recognise, working to improve provision | Currently cared for by midwifery team, with input from neonatal nursing staff to administer IVAB. |
| Worthing | 6 | Bay near Special care | Midwives, Nursery nurses |
| Hastings | Virtual | On postnatal ward | Midwives, Maternity Nursery Nurses |

# Appendix 6 – Criteria to NTC admission (Gestation, Weight, and Nasogastric Tube Feeding)

**TVW ODN**

| Region | Gestation | Weight | NGT |
|---|---|---|---|
| Southampton | >34wks | >1.6kg | Yes |
| Portsmouth | >34wks | >1.8kg | No |
| Oxford | >34wks | >1.6kg. | No |
| Milton Keynes | >35wks | >1.8kg | Yes |
| Stoke Mandeville | >34wks | >1.6kg (&<2$^{nd}$ centile) | No |
| Wexham Park | >34wks | >1.7kg | Yes |
| Basingstoke | >34wks | >1.6kg | Yes |
| Poole | >35wks (34wks go to NNU first) | >1.7kg | Yes |
| Reading | >34wks | >1.6kg (1.6-1.9kg assessed on NNU first) | Yes – 3hrly+ |
| Salisbury | >35wks | <2kg (NNU TC) >2kg (Postnatal TC) | Yes – NICU NTC No - Postnatal |
| Winchester (SCBU+) | >34wks | >1.6kg | Yes |
| Dorchester | >34wks | >1.6kg (or term & <2$^{nd}$ centile) | Yes - 2hrly+ |
| Chichester | >35wks | >1.6kg | Yes – 3hrly+ |
| Isle of Wight | >35wks | >2kg | Yes |

**KSS ODN**

| Region | Gestation | Weight | NGT |
|---|---|---|---|
| Medway | >34wks | >1.6kg | Yes |
| Brighton | >35wks | >1.8kg | No |
| Chertsey (St Peters) | >34wks | <2kg (not needing NICU/HDU) | Yes |
| Ashford | >34wks | >1.6kg | No |
| East Surrey | >35wks | >1.8kg | Yes – NICU NTC No - Postnatal |
| Frimley | >34wks | >1.7kg | Yes |
| Tunbridge Wells | >34wks | >1.6kg | No |
| Dartford | >35+6wks | >1.8kg | No |
| Margate | >34wks | (<10$^{th}$ on chart) | No |
| Guildford | >34wks | >1.8kg | Yes |
| Haywards Heath | >35wks | >1.8 kg | No |
| Worthing | >35wks | >1.8kg | No |
| Hastings | >34wks | >1.8kg | No |

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