Worcestershire Acute Hospitals NHS Trust

Operational Policy
Neonatal Services

Department / Service:	Paediatric Directorate Neonatal Service
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Approved by:	Paediatric Governance Meeting
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	Neonatal Unit (NNU) & Transitional Care Unit (TCU)
Target staff categories	All staff who work within the Neonatal Unit & Transitional Care at WRH

Policy Overview:
This is an Operational policy for Neonatal Services that includes the Local Neonatal Unit, Transitional Care Unit and Neonatal Outreach. These services are part of the Paediatric Directorate and the Women and Children's Division.

Latest Amendments to this policy:
Removal of the admission criteria to NNU & TCU Additional information about AHP's and new information around Quality roles within the Neonatal Unit. Other minor amendments

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1. Introduction

The Neonatal Unit is 1 of 13 units within the West Midlands Perinatal Network (WMPN). It has been designated as a Local Neonatal Unit (formerly known as Level 2).

All neonatal services are delivered via the Paediatric Directorate within the Women and Children's Division; providing immediate resuscitation and stabilisation to infants delivered within the hospital and to further deliver ongoing high quality, evidence based intensive, high dependency, special and transitional care for babies born greater than 27 weeks' gestation.

The neonatal service has a dedicated stand-alone Transitional Care Unit (TCU) for babies transitioning care from NNU to TCU and for babies who require specialist input from neonatal services that cannot be provided on a normal postnatal ward.

The neonatal service also provides 7-day neonatal outreach service.

2. Purpose

This operational policy articulates the services provided via the neonatal department and how they are planned, delivered and quality assured.

3. Scope

The scope of this policy includes all neonatal services delivered via the neonatal directorate and its staff. This includes NNU, TCU and Neonatal Outreach and excludes any services for mother and babies delivered via in-patient maternity and paediatric services.

4. Definitions

BAPM	British Association of Perinatal Medicine
HDC	High dependency care
IC	Intensive Care
NNAP	National Neonatal Audit Programme
NNU	Neonatal Unit
ODN	Operational Delivery Network
SC	Special Care
WMPN	West Midlands Perinatal Network
TCU	Transitional Care Unit
UNICEF	United Nations Children's Fund

5. Duties and Responsibilities

5.1 Duties within the Organisation

The Paediatric Directorate's leadership team is comprised of the Clinical Director, the Directorate Manager and the Matron. The Neonatal Department's management team comprises of a Lead Clinician and Ward Manager. The management team are individually and collectively responsible for the maintenance, implementation and review of this policy on a three-yearly basis in line with the trust review policy.

5.2 Identification of Stakeholders

Internal:

- All staff, clinical and non-clinical, within the Neonatal and Transitional Care units
- All specialisms taking care of neonates across the WRH site; clinical, nursing and service managers.

External:

- Regional hospitals and neonatal units belonging to the West Midlands perinatal Network (WMPN) and the Local Maternity Neonatal System (LMNS)
- Neonatal Transfer Service (NTS and KIDS)
- The Birmingham Children's Hospital
- Commissioners

6. Our Services

All services delivered via the neonatal department adopt a Family Integrated Care (FiC) approach. We support parents to be primary care givers by working as parents in partnership, being involved in care and decision making, as well as supporting their bonding and attachment in a safe environment. The department is committed to continuously enhance our capability in this area and continues to pursue full accreditation from both UNICEF's Baby Friendly Initiative (BFI) and BLISS' Baby Charter.

6.1 Neonatal

The NNU has the capacity for 18 cots and is currently commissioned for: 2 IC, 4 HDC and 12 SC beds. We have a dedicated transitional care unit for 9 women, and we can accommodate up to 12 babies due to multiple births.

The neonatal unit:

- Manages singleton neonates born from 27 weeks' gestation and multiples from 28 weeks and/or 800g or greater.
- Provides stabilisation of babies who have conditions requiring surgical intervention prior to their transfer to a regional neonatal surgical centre, usually Birmingham Children's Hospital.
- Provides resuscitation and stabilisation of babies born less than 27 weeks' gestation or any baby requiring specialist intervention such as therapeutic

hypothermia prior to their transfer to an appropriate Neonatal Intensive Care Unit (formerly known as Level 3) within the WMPN or beyond.

- Supports neonatal units within the WMPN to repatriate Worcestershire babies back to their local unit as early as clinically possible to minimize the distress and separation to parents and ensure we have the right baby in the right place at the right time.
- Provides 'step up' care for babies in Hereford who require care delivery by a Local Neonatal Unit.
- To act as a stepdown facility for babies who no longer require neonatal intensive care in a tertiary unit.

Our aims are to:

- Ensure babies and their families receive the highest quality of family integrated care.
- Provide 24-hour care covering all aspects of Intensive, High Dependency and Special Care in accordance with national standards.
- Provide pre-operative care for a pre-selected designated group of babies with antenatally diagnosed surgical conditions prior to transfer to a tertiary centre (this is normally Birmingham Children's Hospital).
- Provide a safe and clean environment to support infection, prevention and control principles for babies, visitors and staff.
- To work in conjunction with other units in the WMPN to alleviate cot capacity issues and ensure the right baby is in the right place at the right time.
- Operate a care pathway that facilitates progression of sick babies through each level of care and onto transitional care, and towards discharge home.
- Provide an environment appropriate to support developmental and family integrated care for all babies of different gestational ages born from 27 weeks' gestation.
- Provide the necessary environment to support families caring for their babies on the NNU including providing Kangaroo care.
- Provide adequate facilities and support for mothers expressing breast milk or breast feeding.
- Provide adequate facilities for families including facilities for an overnight stay.
- To work in line with accepted neonatal standards (BAPM, BLISS, and BFI).
- To participate in the National Neonatal Audit Programme (NNAP)
- Encourage and support staff education and training developments.

6.2 Transitional Care Unit

The purpose of TCU is:

- To prevent the unnecessary separation of mother and baby by keeping the family unit together.
- To improve mother and baby attachments, develop parenting skills for dependent infants and raise the potential for shorter length of hospitalisation.
- To provide holistic care to the mother and the baby by having the right staff with the right skills.

- To provide continuity in care and provide maximal opportunities for skin-to-skin contact.
- Facilitation of baby-led feeding and establishment of breast feeding or formula feeding if parents make that informed choice.
- To improve patient flow freeing up capacity for transitioning babies from NNU and therefore releasing capacity on the NNU.

Guidance criteria for babies to be admitted to TCU can be found in the Admission to Neonatal Unit, Transitional Care Unit and Post Natal Wards at Worcestershire Royal Hospital Guideline – (WAHT-KD-015-3453).

6.3 Neonatal Outreach

The purpose of the neonatal outreach is to:

- Discharge babies earlier from hospital to provide a better experience for the family
- To free up inpatient capacity to ensure that all neonates can have their care closer to home within their local maternity system / neonatal network

The criteria for babies to be referred to the outreach service include:

- Babies who are born at Worcestershire Royal Hospital (WRH), (or have been born at another hospital and returned to WRH)
- Have been resident on NNU or TCU, for a period before discharge.
- Are registered with a Worcestershire GP (this is a Countywide service)
- Parents/carers have demonstrated competence in specified aspects of care.
- Gaining weight and Consultant happy with weight gain
- Maintaining temperature in a cot for over 24 hours
- No longer needing monitoring for apnoea's (Off caffeine for 7 days) (occasionally babies may be discharged home on caffeine at consultant discretion, these babies will be provided with an apnoea alarm until 7 days after caffeine is stopped)
- Establishing full oral feeds, initially this may include supporting parents with naso-gastric feeding
- Babies of at least 34 weeks' gestation unless earlier date agreed by Paediatric Consultant
- Weight of over 1.6 kilograms (or less at consultant discretion) and demonstrating consistent weight gain
- Requiring supplementary oxygen, where oxygen saturations are stable in a set amount of oxygen, evidenced by a satisfactory overnight oxygen saturation download prior to discharge. This is offered for up to 6 months corrected gestation.
- Babies who are being monitored and cared for by following the Neonatal Abstinence Syndrome Guideline (WAHT-KD-015-3645)
- Babies requiring home phototherapy who fulfil the guideline (WAHT-KD-015-3647)

- Babies who have long term needs may initially be discharged to the Neonatal Outreach Team but may then have an assessment from the Orchard Team (Children's Community Nursing Team), who will continue their care.

6.4 24/7 consultant neonatologist advice

The Neonatal Team has access to expert support from a consultant neonatologist in the KIDS and NTS Transfer Service and the on-call consultant neonatologists at Birmingham Women's Hospital or University Hospitals Birmingham NHS Trust (Heartlands site) (both are Neonatal Intensive Care Units within the WMPN).

7. Staffing

7.1 Leadership Team

The leadership team for the Paediatric Directorate includes:

Clinical Director (CD): The CD is accountable for the delivery of services within the Paediatric Directorate and is expected to ensure all activities undertaken within the directorate are subject to robust operational, clinical and financial governance arrangements with patient safety, quality and clinical outcomes at the centre of all aspects of operational management. The CD is responsible for supporting the monthly Paediatric Governance Meeting which is the group responsible for implementing clinical governance by promoting safe and effective clinical practice within the Paediatric Directorate and reporting performance monthly to the Divisional Governance Board. The CD is also responsible for chairing the monthly Paediatric Directorate Meeting which is the group responsible for reporting on all operational performance of the directorate and reporting into the Divisional Board.

The Matron: The Matron is responsible for the day-to-day operational delivery of services within the Neonatal Department including the effective flow of neonates through the unit to ensure that they receive the right care in the right place. The Matron is also responsible for monitoring and maintaining safe staffing levels, maintaining infection prevention and control and assessing and mentoring staff to constantly strengthen clinical practice.

Directorate Manager (DM): The DM is responsible for working with the CD and DDN to ensure that robust performance management;

planning and governance mechanisms are in place in line with the Trusts policies and best practice. The DM is responsible for ensuring all planning is in line with the Trusts strategic direction and that performance is reported monthly to the Divisional Board.

7.2 Management Team

The management team for the Neonatal Services includes:

Lead Clinician (LC): The LC is responsible for clinical matters within the neonatal area, provides professional advice to the leadership team and liaises with the matron and ward manager, allied health care (e.g. pharmacist) and obstetric and midwifery teams.

Ward Manager (WM): The WM has 24-hour responsibility and supports the Matron in the operational delivery of the NNU. The WM is responsible for ensuring high standard of nursing care is always delivered through the effective management of staff and resources. The WM is also responsible for providing clinical expertise and professional/management advice and support to all members of the multidisciplinary team to co-ordinate all aspects of patient care. The WM must ensure effective training and educational programmes are available by liaising with the Clinical Educator to meet the training and educational needs of nurses in the clinical area. The WM deputises for the Matron in her absence.

See appendix 1 for Paediatric Directorate structure.

7.3 Neonatal Quality Nursing Roles

There are several Quality roles within Neonatal Services, these include:

Family Integrated Care Lead (FIC): The Family Integrated Care Lead is responsible for promoting developmentally appropriate and family integrated care and leads on the practice of individualised developmental and family integrated care

on NNU & TCU. They are a resource for both staff and parents and lead on the Baby Friendly and BLISS accreditation.

Lead Clinical Educator: The Lead Clinical Educator is responsible for developing and maintaining education and training to the neonatal team to deliver excellent patient care through having the right staff trained in the right skill at the right time. They liaise with relevant staff within the Paediatric Directorate to analyse the training needs and report compliance of essential to role training.

Lead Governance Nurse: The Lead Governance Nurse is responsible for ensuring the co-ordination of evidence-based guidelines (including SOPS, guidelines and patient information leaflets), the clinical audit programme and coproduction of services within the Children's Directorate, specifically, Neonatal Services. They also lead on promoting clinical audit and quality improvement relating to the National Neonatal Audit Programme (NNAP) and provide support with aspects of the quality governance agenda under the guidance of the Divisional Governance Lead.

PERIprem Nurse: The PERIprem Nurse is responsible for facilitating confidence & enthusiasm amongst staff in the delivery of the PERIprem bundle elements. They work collaboratively with the preterm birth Midwife and the obstetric & neonatal consultants to complete the Quad group. This core group are responsible for ongoing quality improvement projects in each of the 11 elements in PERIprem.

7.4 Medical Staffing

We have split neonatal consultant Rota since Jan'25. We have 8 consultants that provide cover for NNU. There is 24/7 cover with a consultant on site during the hours of 08.30-21:00hrs weekdays and 09:00-15:00hrs at weekends. Out of hours the consultant can be off site but within 30 minutes of the hospital and contactable at all times.

Junior medical workforce

Tier 1	Establishment
Training posts	14
Non-training	4
ANNPs	0
Total Bodies	16
Total slots	Hybrid Rota

Tier 2	Establishment
Training posts	6
Non-training Fellows	(4)
ANNPs	1
Total Bodies	9 (11)
Total clinical slots	Hybrid Rota

Tier 1
There is a tier 1 doctor designated to the NNU 24 hours per day.

Tier 2
Cover is provided from 09:00 – 17:00 hours. Out of hours tier 2 cover is shared with paediatrics.

The medical workforce at tier 2 is currently not compliant with guidance from BAPM for medical staffing: A Framework for Practice (2018).
Currently there is:

- A tier 2 doctor dedicated solely to the neonatal service during the periods of Monday – Friday 0900 – 1700rs) which are usually the busiest. There are also two Tier 2 doctors from 1400hrs providing cross cover to NNU and acute paediatrics.
- In winter - Start of October to the end of February there is additional Tier 2 cover in evenings from 1700hrs to 2100hrs
- The NNU does not have a 24/7 resident Tier 2 dedicated to the neonatal unit and entirely separate from Paediatrics.

7.5 Nurse Staffing

The nurse staffing levels required for neonatal services are clearly defined in the DH Toolkit (2009) and BAPM (2011) that states nurse-staffing levels should equate to:

- 1:1 Intensive Care (IC)
- 1:2 High Dependency (HD)
- 1:4 Special Care (SC)
- A shift leader who is supernumerary

And

- 1:4 Transitional Care (TCU)

BAPM - A Framework for Neonatal Transitional Care (NTC) (2017) recommends midwifery staffing for care of the postnatal woman is outlined in 'Birthrate Plus®', NICE guidance and the Scottish Workload and Workforce Tool (16-18). The recommended staffing ratio for women receiving standard postnatal care is between 1:5 and 1:8 (1 midwife to every 5 to 8 women) depending on complexity. Maternity complexity is likely to be higher for mothers of newborns requiring NTC, but this may be offset in part by healthy, self-caring "rooming-in" mothers of babies readmitted from home, or graduates from the NNU. In addition to midwifery input, the ratio of nursing staff for babies receiving TC should be at least 1:4, depending on maternal and neonatal dependency in the first 24 hours after delivery. Thereafter, the ratio should be at least 1:6 (1 nurse to 6 babies) as the mother's will be self-caring.

Neonatal Unit

Babies should be allocated according to the babies' level of care as per BAPM 2011 standards as outlined below:

Intensive Care

These babies have the most complex problems. A nurse should not be responsible for the care of more than 1 baby in this category and must have achieved neonatal competencies.

- Any day where a baby receives any form of mechanical respiratory support via a tracheal tube
- **BOTH** non-invasive respiratory support (e.g. nasal CPAP, SIPAP, BIPAP, duo PAP, HHHFT) **AND** Parenteral Nutrition (amino acids +/- lipids)
- Day of surgery (including laser therapy for ROP, but excluding intraocular injections e.g. Bevacizumab)
- Day of Death
- Any day with Umbilical Venous Catheter Present
- Any day with Umbilical Arterial Catheter or Peripheral Arterial Catheter Present
- Any day with a chest drain in situ
- Any day on which Insulin infusion is given
- Any day on which Prostaglandin infusion is given
- Any day on which inotrope or vasodilator (including pulmonary vasodilator) is given
- Day on which exchange transfusion occurs (includes dilutional exchange)
- Any day on which Therapeutic Hypothermia is given (hypothermia treatment given during the initial assessment period should not be counted if ongoing cooling is not required)
- Any day on which a replogle tube is present
- Any day on which an epidural catheter if present
- Any day on which an abdominal silo is present (for anterior abdominal wall defects)
- Presence of External Ventricular drain or intraventricular catheter
- Dialysis (any type)

High Dependency Care

A nurse should not be responsible for the care of more than 2 babies in this category

- Any day where a baby receives any form of non-invasive respiratory support (e.g. nasal CPAP, SIPAP, BIPAP, HHHFT)
- Any day a baby receives Parenteral Nutrition (amino acids +/- lipids)
- Any day a baby receives an infusion of blood products (red cells, fresh frozen plasma, platelets, cryoprecipitate, and intravenous immunoglobulin). It does not include infusion of albumin
- Any day on which a central venous or long line (PICC) is present
- Any day on which a tracheostomy is present
- Any day with a trans-anastomotic (TAT) tube present following oesophageal atresia repair
- Any day with NP airway/nasal stent present
- Confirmed Clinical Seizure(s) today and/or continuous CFM recording
- Ventricular tap (including via reservoir)

Special Care & Transitional Care

A nurse should not be responsible for the care of more than 4 babies in this category.

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 cannula
- Feeding by orogastric, nasogastric, jejunal tube or gastrostomy
- Care of a Stoma
- Intravenous medication not otherwise specified elsewhere
- Receiving Intravenous Sugar +/- electrolyte solutions
- Receiving drug treatment for neonatal abstinence AND on an observation scoring regimen 4 hourly or more frequently
- Birth weight ≤2kg for first 48 hours after birth
- Gestation at birth 35 weeks for first 48 hours after birth
- Gestation at birth 34 weeks for first 7 days (168 hours) after birth
- Gestation at birth <34 weeks until discharge from hospital

The Toolkit recommends that 80% of the nursing workforce is registered and of these 70 % should be qualified in speciality. We aim to send a minimum of 4 staff per year to attend the Neonatal Critical Care Pathway.

Transitional Care Unit

TCU is staffed at a ratio of 1:4 with 1 registered nurse, 1 nursery nurse and 1 midwife. Midwifery staff is managed by the Postnatal Ward Manager and sits within the midwifery establishment, and the neonatal nurse and nursery nurses are managed by

the Neonatal Unit Ward Manager and sits within the Neonatal establishment. The neonatal nurses and nursery nurses rotate between NNU and TCU.
The staffing complement on the Transitional Care Unit is as follows:

TCU	Staff
Band 6 Midwife	1wte
Band 5 neonatal nurse	1wte
Band 4 Nursery Nurse	1wte
Total	**3wte**

Staffing and acuity are reported three times a day via Badgernet and the Neonatal Sitrep and these are monitored to ensure that staffing is appropriate for the workload and acuity. There is an escalation policy in place for Safe Staffing and Appropriate Utilisation of Human Resource to provide guidance to ensure safe staffing levels for NNU and TCU and escalation process. And Cot Management and Escalation Policy to ensure the right care is being delivered to the right baby in the right place at the right time.

7.6 Neonatal Outreach Staffing

There are currently 3.0wte nurses, which includes Band 4 Nursery Nurses to cover the neonatal outreach service. They provide 7-day cover (Mon-Sun). There is also 0.2wte of administration to support the outreach service.

7.7 Administration and Clerical Staffing

The NNU has ward clerks who provide 7-day cover and an administrator whose role is to support the ward manager.

7.8 Link Roles

There are eight nursing teams led by a band 6 Junior Sister and overseen by the Ward Manager. These include **Link Nurses**	**Role**
Clinical Educator	Clinical Educator
Family Integrated Care	Sister
Breast Feeding	Sister & Nursery Nurse
PERIprem	Sister
Developmental Care (including Tissue Viability)	Occupational Therapists
Equipment/ Equipment Training	Sister
Stores and Procurement	Sister
Infection Control and Audits	IPC Link Nurses
Training & Unit Development	Sister
Transfers and Discharge Planning	Outreach Sisters
E-Roster and Annual Leave	Ward Manager
Bereavement (Support Midwife)	Sister

8. Lead Roles and Responsibilities

We have a number of dedicated roles within the directorate as follows:

Senior Team Members	
Job Title	**Allocated Time**
Clinical Director	1.0wte
Divisional Director of Nursing for Women & Children	1.0wte
Directorate Manager	1.0wte
Lead Clinician – NNU	1PA
Neonatal Matron	1.0wte
Ward Manager	1.0wte
Clinical Education Lead	1.0wte
Clinical Educator	0.6wte
Governance Lead	0.5wte

Senior Team Members	
PERIprem Nurse	0.5wte
Infant Feeding Nurse	0.2wte
Neonatal Outreach	3.0wte

8.5 Allied Health Professionals

The neonatal service is supported by a team of Allied Health Professionals (AHPs). Specialist AHP's support the team to meet complex needs of newborn babies and their parents by developing and disseminating standardized collaborative guidelines that support best practice in neonatal care. They deliver education, identify, training needs and develop resources to support teaching. Education is provided at many levels locally including induction training, neonatal nursing courses, cotside teaching, ward rounds and up-skilling existing medical and neonatal staff. Where applicable, AHP's involve parents in relevant teaching.

The AHP roles are as follows:

8.5.1 Neonatal Dietician

- Assessment of nutritional status and analysis of growth trends
- Support for breast feeding/expressing mothers and infants
- Advice on all aspects of enteral & parenteral nutrition
- Assessment of micronutrient status/ intake, sodium balance and advice on supplementation
- Advice on specialist preterm and term formulas and nutritional supplements including breast milk fortifier
- Assessment of tolerance of nutritional treatment including management of malabsorption in surgical neonates
- Education for colleagues in the classroom and cotside setting
- Nutrition resource for all colleagues.

8.5.2 Neonatal Physiotherapy

- Assess and offer advice and input with specific positioning and handling requirements.
- Assess and provide specific advice and / or treatment programs relating to babies on the NICU born with musculoskeletal abnormalities.
- Offer education, advice and support with the application of neuroprotective and developmental care principals.
- Provide education, advice and support on pre-term motor pattern development.
- Identify potential babies at risk of developmental concerns and offering caregivers advice on promoting positive developmental opportunities whilst on the unit and on discharge.
- Refer babies of developmental concern onto appropriate community services and support the link from acute to community care.

8.5.3 Neonatal Occupational Therapy

- Support baby and caregiver participation in daily co-occupations and optimising bonding opportunities.
- Offer education, advice and support with the application of neuroprotective and developmental care principals.
- Support caregivers understanding of behavioural cues of babies and how to assist with calming and regulation.
- Reduce the impact of potential stress and pain on the developing brain through the application of non-pharmacological pain management strategies.
- Promote developmentally appropriate sensory and environmental experiences in line with the preterm baby's maturation.
- Identify potential babies at risk of developmental concerns and offer caregivers advice on promoting positive developmental opportunities whilst on the unit and on discharge.
- Refer babies of possible developmental concern onto appropriate community services and support the link from acute to community care.

8.5.3 Neonatal Speech and Language Therapist

- Support a responsive progression of oral feeding to promote developmentally appropriate cue-based feeding in response to the neonate's neurological maturation.
- Advice around evidenced based management strategies for oral feeding, both breast and bottle e.g. elevated side lying feeding, pacing and identification of stress cues
- Liaison and referrals to community services to support continuity of care
- Education for colleagues in the classroom and cotside setting

8.5.4 Neonatal Psychologist

- Identify and address signs of trauma and emotional distress in families and staff
- Support parent-infant attachment in a developmentally sensitive, trauma-informed manner
- Integrate psychological care into routine neonatal care
- Prevent and reduce the impact of trauma-related disorders (e.g., PTSD, depression)
- Promote resilience in families and staff through support and education
- Liaise with community perinatal mental health services.
- Regular attendance at departmental and psychosocial meetings.

8.5.5 Neonatal Pharmacist

The neonatal pharmacist is responsible for leading and delivering a highly specialized pharmacy service to the Neonatal Unit. The pharmacist provides expert advice on pharmaceutical matters relating to neonatal service, undertakes risk management, leads audits, supports clinical trials work and ensures compliance with medicines legislation.

8.5.6 Ophthalmologist

Ophthalmologists attend the unit to undertake screening for retinopathy in the at risk population.

8.6 Operational Roles and Responsibilities

8.6.1 Shift Leader

The shift leader is responsible for the management of the babies in the Neonatal Unit and Transitional Care Unit on a day-to-day basis. The shift leader is responsible for managing capacity and flow within NNU and TCU, ensuring all women/babies are being actively managed through their clinical care pathway. The shift leader is responsible for liaising with other agencies ensuring that neonates are repatriated to their host organizations as per network pathway whilst ensuring the neonate and their families are at the center. The shift leader is responsible for maintaining clear lines of communication with both clinical and managerial staff both internally and externally to the trust. In addition, this shift leader has the necessary skills and knowledge to provide expert care to all categories of neonates and their families.

8.6.2 Advanced Neonatal Nurse Practitioner

The Advanced Neonatal Nurse Practitioner (ANNP) is responsible for making clinical judgements regarding care providing direct clinical care alongside the medical and nursing staff. The ANNP acts as a clinical specialist promoting high quality individualised patient care, utilising advanced skills and knowledge. They assist with the training and education of nursing and medical staff.

8.6.3 Neonatal Nurse

The neonatal nurses are responsible for delivering direct clinical care to babies in accordance with family integrated care. The nurses are responsible for working within clinical standards and protocols.

8.6.4 Midwife

The midwife is responsible for delivering direct clinical care to women and overseeing the care delivered to the babies by the neonatal nurses on Transitional Care in accordance with family integrated care. The midwife is responsible for working within midwifery and neonatal clinical standards and protocols.

8.6.5 Nursing Associate

Nursing associate is a new role introduced into the health and care workforce in England from 2019. It is a generic role (not defined by a field of nursing) but within the discipline of nursing. Nursing associates are intended to bridge a gap between health and care assistants, and registered nurses. They will be able to take care of SC patients, check and give oral medications and are governed by their own set of proficiencies and have a PIN number. Once they are practising, nursing associates can undertake further education and training and demonstrate additional knowledge and skills, enhancing their competence as other registered professionals routinely do.

8.6.6 Nursery Nurse

Under the direct supervision of a registered nurse, the nursery nurses support the registered nurses in assessing, planning and delivering care to the babies and meeting their daily needs and those of their families.

8.6.7 Housekeeper

The housekeeper supports the nursing teams in maintaining high standards of cleanliness of medical equipment and the environment. They support the department and staff in creating a clean and welcoming environment for babies, families and other members of staff. In addition, they ensure the equipment and furniture is maintained in a clean and fit for purpose condition.

8.6.8 Clerical and Secretarial

The medical secretaries work Monday to Friday providing support to the Paediatric Directorate consultants.

There is a Directorate General Manager supported by Business Manager and a Neonatal Administrator who provide support to the management and leadership team.

8.6.9 Ward Clerks

The ward clerks support the nursing teams by providing reception and clerical support to the Neonatal Unit, Transitional Care and the Neonatal Outreach Team. Ward clerks are responsible for ordering and maintaining stationery, telephone enquiries, admission and discharge support, maintaining and updating computerized patient records, meeting and greeting families and relatives and assisting with non-medical enquiries.

9. Governance, Clinical Risk, Quality and Safety

The Neonatal Service strives to minimize risks and maximize the quality of service to babies and their families who come under its care. The management of risk is an integral part of everyday business. Senior team members are responsible for fostering an environment whereby all staff are encouraged to report incidents and near misses, which feeds into our learning and continuous improvement through the weekly Maternity and Neonatal meeting, weekly Divisional Quality and Safety meeting, Perinatal, Maternity and Paediatric Governance Meetings amongst others.

9.1 Incident Reporting and Investigations

The mechanism for reporting incidents is the Trust online Datix system. Incidents are investigated by the local incident managers for each clinical area to establish trends or recurrent patterns of incidents and reported to the weekly incident and escalation meetings in the Division. Learning from incidents is shared via newsletters and neonatal nuggetts which are re-iterated daily at the nursing handovers and the morning huddle. Where actual or potential harm occurs, a more urgent action is

needed and the Governance Lead, Matron, Ward manager, DDN and the CD must be informed as soon as practical and appropriate steps taken to minimise harm. The family should be informed immediately, an apology given and the investigation process explained as per Duty of Candour (DOC). The incident is then investigated as per current PSIRF framework.

9.1.1 Risk Management

Clinical risks are identified through the incident investigation reports. Recognised risks which are not able to be addressed readily are placed on the Trust's Risk Register. The clinical risks are reviewed at the multi-disciplinary Directorate Governance and the performance risks are reviewed at the Directorate meeting. All risks have an oversight at the Trustwide Emerging Risk Management Committee.

9.1.2 Medical Devices Management

Medical equipment is provided and maintained under the terms of the Private Finance initiative by Siemens.

The Clinical Education team are responsible for equipment training.

9.1.3 Guidelines

The neonatal department has adopted the WMPN and WAHT guidelines that cover all aspects of patient care from admission to discharge. All guidelines adopted can be found on the Trust Intranet and are listed alphabetically so that they can be found with ease. Standard Operating Procedures (SOP's) can also be found on the Trust Intranet.

Network guidelines are updated every 3 years. Each specialist subject is allocated to a consultant within the network for review and any changes are circulated for approval. Once approved, they are circulated to the neonatal units within the network who assess the guidelines and approve the ones that are appropriate for use through internal Quality Improvement Group. Once approved guidelines are uploaded to the Intranet. Internal guidelines are updated every 3 years and SOPs annually. They also follow the same approval process. The paediatric directorate meets regularly to review all guidelines and SOPs.

9.1.4 Clinical Audit

Audit planning within the Trust is managed via an electronic system called CATS (Clinical Audit Tracking System). There is a monthly multi-disciplinary meeting where audits are presented, and recommendations are made. Prior to each meeting CATS is reviewed to ensure the audits are on track and that CARMS is up to date. Audit presentations/reports are uploaded to CATS and the actions are monitored through this system. Locally the audit data is monitored through the directorate's monthly governance report which is monitored through Divisional Governance. Nationally this is monitored through NNAP (National Neonatal Audit Programme).

9.1.5 Nursing Quality & GAP Safety Audits

Nursing Quality audits are completed weekly by the Family Integrated Care Lead/or ward manager. Gap audits are carried out weekly by the ward manager, Matron and staff members for compliance with IPC and Sharps.
Results are monitored via the monthly ward-to-board report that is presented at the monthly Directorate Governance meeting and the weekly Divisional Safety and Risk Group.

9.1.6 Documentation

On admission all infants will have an allocated patient identification number and national health number.

All staff are responsible for ensuring that all infants are admitted onto Badger and that the daily infant records are updated.
Upon discharge a Badger discharge summary is completed by the medical/ANNP staff and forwarded to the General Practitioner and Health Visitor.

9.1.7 Daily Safety Huddle

The neonatal shift leader attends the huddle on Delivery Suite at 8am & 8pm each day to plan potential deliveries and assess capacity.

The neonatal unit holds a daily safety huddle on NNU and supports effective communication and handovers for capacity and flow and the sharing of the Lesson of the Week (Neonatal Nuggets), learning lessons from incidents, and complaints. The safety huddle is attended by the TC midwife and/or neonatal staff nurse. Operational activity is managed day to day by the management team.

9.2 Divisional Meetings

9.2.1 Quality and Safety and review meetings

The Women & Children's Quality and Safety meeting occurs weekly, where incidents are discussed. Prior to this, most incidents will have already been reviewed in the Maternity and Neonatal meeting and a plan made as to what, if any, investigation beyond an incident review in Datix is required. The purpose of the meeting is to ensure any escalations are understood and discussed and this may include, but is not limited to staffing concerns, incidents, near misses, complaints and other issues that require senior oversight and discussion.

9.2.2 Governance Meeting

The Divisional Governance Meeting is held monthly. The group ensures that appropriate systems/structures are in place within the Division to meet quality governance standards in line with Trust Strategy and policies, to monitor compliance

with the standards and the achievement of quality objectives and provide assurance in these areas to the Divisional Management Team. The Paediatric Directorate Governance Meeting reports directly to this group.

9.2.3 Divisional Board

The Divisional Board is held monthly, and the purpose is to ensure the clinical, operational and financial performance and compliance of the division by robust planning, monitoring and challenge. The Paediatric Directorate reports directly to this group.

9.2.4 Performance Review Meetings

The Directorate Leadership Team presents the directorate's performance around key indicators for safety, quality & finance to the Divisional Leadership team, ensuring plans for improvement are in place and actions are completed.

9.3 Paediatric Directorate Meetings

9.3.1 Paediatric Directorate Governance Meeting

The Directorate Governance meeting is held monthly. It is a sub-group of the Divisional Governance Group and is responsible for providing assurance to the Division with respect to Neonates, Children and Young People (CYP) across the directorate. The Directorate Governance meeting is responsible for ensuring the care and treatment received by Neonates, CYP and their families is safe, effective and provides a positive experience. This will be achieved by monitoring quality and safety including compliance with national standards, providing child and family integrated care, improving the patient and family experience.

9.3.2 Paediatric Directorate Meeting

The Paediatric Directorate Meeting is a sub-group of the Divisional Board and is held monthly. The group is responsible for ensuring clinical, operational, and financial performance of the directorate by robust planning, monitoring and challenge.

9.4 Neonatal Departmental Meetings

9.4.1 Neonatal Unit Development Meeting

The Neonatal Unit Development meeting (NNUD) meets monthly to discuss and identify areas of practice and small quality improvement strategies that could be developed on the neonatal unit and TC. Membership includes neonatal consultants, ANNP, matron, ward manager, senior sisters, other nursing staff, AHPs and neonatal pharmacist.

9.4.2 The Neonatal Team Meeting

The Neonatal Team Meetings are held quarterly, and the purpose is to bring together the multi-disciplinary team, to ensure that they are made aware of and if necessary, address concerns raised through internal and external monitoring including CQC and Peer Reviews. The meetings ensure that staff in the neonatal areas including TCU are kept informed of key issues raised in Divisional and Directorate meetings that affect neonates. The group is also responsible for developing changes within their department to improve Quality, Safety and Patient Experience.

9.5 Cross Directorate Meetings

9.5.1 Perinatal Mortality and Morbidity Education Meeting

The purpose of the Perinatal Mortality & Morbidity Education Meeting is to allow shared learning from cases with significant maternal or infant morbidity, and cases of interest. The PMM meeting provides an open and transparent environment to discuss difficult and/or interesting cases and promote shared learning through shared experience.

9.5.2 Perinatal Directorate Meeting

The Perinatal Directorate Meetings are held bi-monthly and bring together multi-disciplinary teams from neonatal and maternity to discuss safety & quality improvements for both services relating to perinatal care.

9.5.3 Perinatal Antenatal Meeting

The purpose of the Perinatal Antenatal Meeting is to discuss pregnancies with known abnormalities to enable parallel planning of palliative care or other more active management of babies with expected abnormalities. The meetings involve the maternity team, neonatal and bereavement teams to form more collaborative care.

9.5.4 Perinatal Mortality Review Board

This monthly meeting allows senior clinicians to review any and all cases of perinatal mortality (stillbirths and neonatal deaths) as per the MBRRACE and Maternity (Perinatal) Incentive Scheme. All cases are reviewed using the standardized national Perinatal Mortality Review Tool to provide robust and systematic review of any perinatal death which meets the criteria advised by MBRRACE. A separate Terms of Reference is available on request which discusses this process in more detail and explains the externality process required both by MBRRACE and the West Midlands Perinatal Network.

9.6 West Midlands Perinatal Network & Local Maternity Neonatal System (LMNS)

9.6.1 West Midlands Perinatal Network

The neonatal service plays an active role in the regional Perinatal Network. The Matron and the designated Pediatrician attend the quarterly network Board meetings. The Matron also attends the quarterly Network workforce meetings, while the Ward manager attends the weekly Network Capacity meetings.

9.6.2 LMNS

The neonatal service also plays an active role in the Herefordshire & Worcestershire LMNS. The Matron and the designated Pediatrician attend both the bi-monthly LMNS Perinatal Quality and Safety Group meeting and LMNS Delivery Group meeting.

10. Parents as Partners in Care

Our approaches of delivering services to Family Integrated Care principles are consistent, and as part of this offer, the NNU and TCU is committed to ensuring that parents have their basic needs catered for to enable them to be with their baby for as long and as often as they wish. We provide them with information and education so they can be involved with informed decision making.

This starts with good quality information on admission. Parents are given information leaflets about the local neonatal service including BLISS information booklets. Condition specific information leaflets are available and given to parents' dependent on their baby's condition. The information is made available in a variety of formats to support non-English speaking or neurodiverse parents.

10.1. Safety and Security

There is a video intercom and secure entry system (swipe access) at the main entrance to the NNU and TCU. The babies have a security tag attached which is operated in line with Trust policy with alarms on all exits. All visiting social/health care professionals must show identification before they are permitted onto the unit. There is an emergency buzzer at each cot side including the parent rooms.

10.2 Open Access/Extended Family & Friends Visiting

10.2.1 NNU

Parents and siblings have 24hour access to NNU.
Visiting times for all other visitors is between 1200 hours -1900 hours, but may be subject to change in certain circumstances, e.g. Covid Pandemic.
All visitors are welcome between these times and must be accompanied by a parent.
There must be no more than 2 people at the cotside (including parents) at any one time.
Children under the age of 16 years (excluding siblings) are not permitted to the unit

10.2.2 TCU

Parents and siblings have 24 hour access to TCU.
Partners are welcome to stay overnight if their partner and baby is cared for in a side room.
Visiting times for other visitors is between 1400 hours -1900 hours. This may also be subject to change in certain circumstances.
Visitors are welcome between these times and must be accompanied by a parent.
There must be no more than 2 visitors plus the birth mother at the cot side, at any one time
Children under the age of 16 years (excluding siblings) are not permitted to the unit

10.3 Parent Feedback

Parents are invited to leave anonymous feedback via a QR code during their stay and on discharge. Feedback is collected regularly by the ward manager and shared via a 'You said-we did' poster, highlighting action taken and changes made because of feedback. Parents are further invited to leave feedback via the Neonatal Journey (parent passport). Verbal feedback is collected by the Family Integrated Care Lead. All feedback is shared with the wider team and the MNVP.

There is a designated confidential parent feedback box located at the entrance to NNU for parents wanting to leave Friends and Family feedback. This is collected by the ward clerk and/or housekeeper and feedback received monthly. Feedback is also sought via social media from our current and previous families.

10.4 Eating and Drinking

Free hot meals are made available for all birth mothers from the Postnatal meal trolley, a food box is stocked and available in the parent flat for all parents. Free hot drinks and a water cooler are also provided.
Food and drink can be purchased from the hospital restaurant, shop and onsite Coffee shop if preferred,

10.5 Parent Information

Parent information is available via:

- The Neonatal page on the Worcestershire Acute Hospitals website. Included on here is a 3D tour of the NNU as well as further information and links to relevant websites.
- Information leaflets for parents are available on NNU given on admission
- Information is also available for parents on the NNU/TCU Facebook page for those wishing to join

10.6 Car Parking

Parents can park for free throughout their stay. They are made aware of this on admission via the Welcome Booklet they receive and poster displays. The parents are supported by staff to complete the appropriate form.

10.7 Infant Feeding

There is a dedicated room for expressing breast milk and feeding. There are adequate breast pumps and privacy screens to express breast milk at the cotside. Breast pumps can be loaned for mothers when they are discharged home. All staff are trained in infant feeding and provide support to parents throughout their feeding journey.

Mothers who do not wish to breast feed upon discharge will be supported to ensure their baby has established formula feeding safely before discharge.

10.8 Parent Lounge

There is a parent lounge situated across the corridor from the NNU with facilities for parents to take some time away from the unit, make hot drinks, warm food and make use of the washer/dryer. There are toys available for siblings and a TV.

10.9 Counselling Room

The staff and parents have access to private space on NNU and/or in the Bereavement Suite for confidential or quiet discussions with parents.

10.10 Lockers

There is a lockable cupboard in the parent flat for parents to store their personal belongings. Personal items such as baby clothes, nappies etc. can be stored under the baby's incubator/cot or cot side trolley.

10.11 Parent accommodation

There are 2 bedrooms available within the parent flat situated across the corridor from the NNU. This includes shower facilities. Priority for this accommodation is given to those families who have a baby who is extremely poorly or who live a considerable distance from the hospital. There are 2 buddy beds on the unit for parents to sleep on next to their baby in a side room. Parents can use the NNU telephone, if required, however most parents have mobile 'phones and there is free Wi Fi available. The NNU also has iPads available for parents to use for facetime.

10.12 Toilets

There is a toilet in the parent flat and toilets directly outside NNU for parents to use.

10.13 Hand wash basin

There are hand wash basins located in each clinical room on NNU and at the entrance to TCU. All parents, visitors and staff are encouraged to wash their hand before entering and when leaving the NNU and TCU.

10.14 Transitional Care Unit

The Transitional Care Unit offers facilities for women to have a partner or companion stay overnight to assist with caring for their baby if a side room is available.

11. Education & Training Requirements

11.1 Mandatory Training

The Trust operates a system for monitoring and assuring compliance with target training rates. There is mandatory training that every member of staff across the Trust must complete.

- Attendance at all Statutory and Mandatory learning/training events will be recorded onto the Electronic Staff Record (ESR) system.
- Most courses are e-learning on ESR, or face-to-face training booked via ESR.
- Any non-attendance for booked places will be escalated to the relevant individual, the ward manager and the education team.
- Statutory and Mandatory Training attendance percentages are reported to line managers to monitor compliance and reported in ward to board reports and Directorate Performance Reports; they are compared against defined Key Performance Indicators (KPIs). Each department will be able to use this information for robust reporting (to the relevant committees, meetings and forums within the current Governance framework), monitoring and to produce improvement plans to assure that trajectories are met.

In addition, there are role specific training requirements called essential to role training that are monitored by the clinical education team. These should be completed and monitored with the same importance as the mandatory training.

11.2 Training for registered and non-registered nursing staff

Family integrated care is embedded throughout all our training.

11.2.1 Registered new starter

Once the pre-employment checks are completed; staff undertake a trust induction day held on the first Monday each month where the Core Skills Mandatory Training takes place followed by a local induction in the department. Nurses are normally given a period of supernumerary status for four weeks and this may be extended after consultation and depending on prior experience. There will be a series of workbooks and competency pathways relevant to the persons prior knowledge, experience and previous jobs.

Nursing staff have access to the West Midlands Perinatal Network (WMPN) education team and are encouraged to access courses provided by the Network.

All newly qualified nurses undertake the WAHT Newly Qualified Nurse Preceptorship Programme alongside the local training provided by the Neonatal Education Team and relevant development and competency pathway.

Each new member of nursing staff (newly qualified or new to neonatal care) will be required to access Foundation level training within one year of appointment, and specialist 'in a timely manner' as part of the new standards for Qualified in Speciality (QIS) training. Specialist modules (HDU/ITU) cannot be accessed without completion of a Foundation level course first. Both these components make up the QIS qualification. It is a continuum of learning from commencement of employment to ITU skills.

11.2.2 Unregistered new starter

Once the pre-employment checks are completed; **staff undertake a trust induction day held** on the first Monday each month where the Core Skills Mandatory Training takes place. Depending on the role they are employed into and previous experience some staff will also complete the HCA induction provided by the Trust, which is a 3-day course, which runs twice a month, usually held on- Wednesdays, Thursdays, Fridays. 8:30am-4:00pm. A local induction in the department will also be completed. Staff are normally given a period of supernumerary status for four weeks and this may be reduced/extended after consultation and depending on prior experience. There will be a series of workbooks and competency pathways relevant to the persons prior knowledge, experience and previous jobs.

All staff have access to the West Midlands Perinatal Network (WMPN) education team and are encouraged to access courses provided by the Network.

11.2.3 Existing Registered Nursing Staff

All staff attend one multidisciplinary training day annually where essential to role training is updated, new changes are discussed and embedded, and staff take part in team building exercises and practical skill updates. The compliance for these days is managed by the clinical education team with support from the ward manager if required. Any identified additional learning needs are obtained through the staff appraisal process, incidents and staff self-assessment. The Neonatal Ward Manager has responsibility for the training needs required and engages with the clinical education team to ensure the appropriate training takes place and that there is cohesive working.

Existing nursing staff are required to access Foundation level training if looking to complete specialist QIS training, as set out in the new QIS standards produced in 2024. Specialist modules (HDU/ITU) cannot be accessed without completion of a Foundation level course first.

11.2.4 Existing Registered Nursing Associates

All qualified Nursing Associates will have a registration and PIN number. They will be required to complete the same mandatory and essential training as the Registered Staff and will also attend the same inhouse multidisciplinary study days.

11.2.5 Existing Unregistered Staff

Nursery Nurses or Trainee Nurse Associates.

All mandatory training is accessed in the same way as registered staff, essential to role training will differ and is monitored by the Education Team. All staff in this group will be required to attend the in-house study days which are multidisciplinary within Neonatal Services.

11.2.6 Existing other ward staff

Housekeeper, Ward Administrator, Ward Clerks, Domestic.

All staff are invited to our inhouse multidisciplinary study days although it is not mandatory for them to attend. The Education Team will facilitate staff attending any additional courses that are relevant to Neonatal Services- for example family integrated care as this is relevant for all staff. Additional training and courses are available through the Apprenticeship Team for the trust and are identified during their yearly PDR and can be facilitated by the Education Team.

11.3 Medical

A paediatric departmental teaching session is held on a weekly basis, covering paediatric, neonatal and safeguarding topics.

12. Monitoring Compliance with and the Effectiveness of the policy

The neonatal department's management team is responsible for monitoring the effectiveness of this policy. This is formally reviewed during the business planning cycle on an annual basis.

13. Standards/Key Performance Indicators

This policy is based upon the national standards for neonatal care as directed by the Department of Health and the British Association of Perinatal Medicine.

14. References

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NHS Improvement (2017) *Reducing harm leading to avoidable admission of full-term babies into neonatal units: Findings and resources for improvement* [Online] Available at https://improvement.nhs.uk/resources/preventing-avoidable-admissions-full-term-babies

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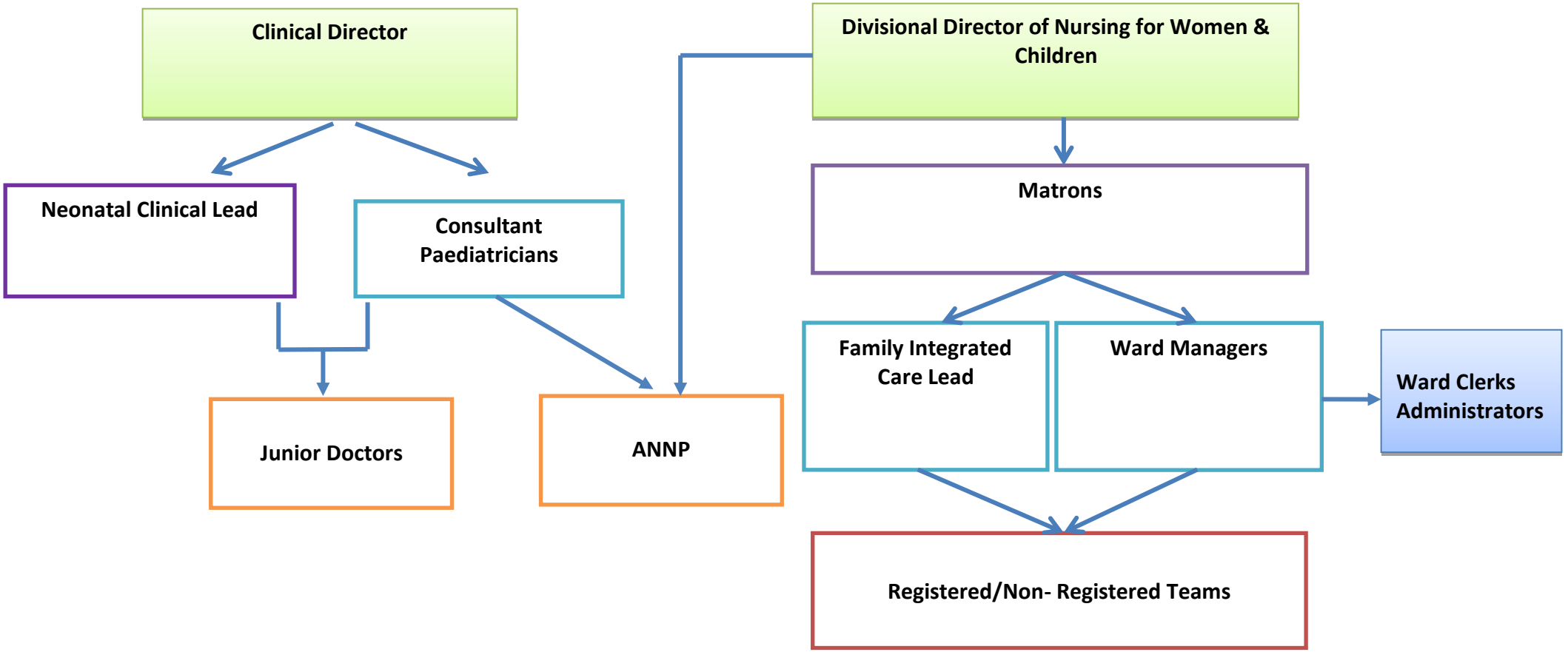
Worcestershire Acute Hospitals NHS Trust

Paediatric Directorate Structure



Supporting Document 1 – Equality Impact Assessment Form

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	✓	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Lara Greenway	**Matron for Neonatal Services**	**laragreenway@nhs.net**
Date assessment completed	**18.09.2025**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Operational Policy Neonatal Services**
What is the aim, purpose and/or intended outcomes of	Operational Policy for the Neonatal Unit

this Activity?				
Who will be affected by the development & implementation of this activity?	❑ ❑ ❑ ❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	Services required for the Neonatal Unit			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Discussed and shared document with staff. Policy approved at Governance meeting			
Summary of relevant findings	Approved			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		X		Will affect all babies admitted to the Neonatal Unit
Disability		X		Will affect all babies admitted to the Neonatal Unit
Gender Reassignment		X		Will affect all babies admitted to the Neonatal Unit
Marriage & Civil Partnerships		X		Will affect all babies admitted to the Neonatal Unit

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Pregnancy & Maternity		X		Will affect all babies admitted to the Neonatal Unit
Race including Traveling Communities		X		Will affect all babies admitted to the Neonatal Unit
Religion & Belief		X		Will affect all babies admitted to the Neonatal Unit
Sex		X		Will affect all babies admitted to the Neonatal Unit
Sexual Orientation		X		Will affect all babies admitted to the Neonatal Unit
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		X		Will affect all babies admitted to the Neonatal Unit
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		X		Will affect all babies admitted to the Neonatal Unit

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these				

actions?	
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Lara Greenway
Date signed	18.09.2025
Comments:	
Signature of person the Leader Person for this activity	Lara Greenway
Date signed	18.09.2025
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

ID	Financial Impact:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
Other comments:		
[Insert comments here]		