

Perinatal Services

<p>Purpose</p>	<p>To deliver The Best Start recommendations relating to perinatal care which will focus care for the most complex mothers and babies and develop standardised pathways and structures for care.</p>
<p>Remit</p>	<p>The group will be tasked with:</p> <ul style="list-style-type: none"> • Make a recommendation for moving to five and ultimately three Neonatal Intensive Care Units in Scotland and recommendations for locations of specialist maternity care; • Develop a national framework for standards for timely medical care out with a maternity setting; • Develop national framework for practice with pathways for newborn care and referral; • Develop a national neonatal transfer risk assessment tool, cot locator system, and a cot availability protocol; • Development of neonatal transfer staffing model
<p>Membership</p>	<p>Chairs: Heather Knox Rod Harvey</p> <p>Members: TBC</p>
<p>Governance</p>	<p>The sub group will report to the Implementation Programme Board on a quarterly basis.</p> <p>Secretariat will be provided by the Scottish Government within resources allocated to the programme.</p>
<p>Timescales and Organisation</p>	<p>The sub group will meet a minimum of quarterly, but with additional meetings arranged as required.</p> <p>Once established, it is expected that the sub group will develop an initial project plan by December 2017 to allow recommendations on moving to five and then three Neonatal Intensive Care units to be given to the Programme Board by the first half of 2018.</p>
<p>Recommendations Covered</p>	<p>28: Specialist medical input: Where a woman has a medical condition which requires additional specialist medical input, this should be provided in a timely manner from an identified named physician in that medical speciality, with an interest in pregnancy, and may need to be managed at a regional or national level. Midwifery care should continue throughout from the primary midwife, as part of the multi-disciplinary team. Units providing the most specialised maternity and neonatal care should be co-located.</p>

	<p>29b: Maternity care out with maternity unit: Where women present outwith maternity settings they should be reviewed by the maternity team in a timely manner to ensure pregnancy-appropriate medical care occurs at all times, in all locations. Standards for this should be agreed nationally.</p>
	<p>30b: Fetal medicine information for parents: Each unit must identify a lead obstetrician who has or who will develop appropriate expertise in fetal medicine. There must be good ongoing communication with and information for parents as well as robust referral pathways in each Board to ensure strong links between local and regional/national centres.</p>
	<p>42: Neonatal End of life: Inpatient and community services should integrate end of life care pathways to support families in their choice if they would like their dying baby to be at home or in a hospice.</p>
	<p>44: Levels of neonatal care: New models of neonatal care should be based on the BAPM definitions to increase consistency of practice and facilitate benchmarking with other neonatal units across the UK.</p>
	<p>45: Neonatal intensive care: The new model of neonatal services should be redesigned to accommodate the current levels of demand, with a smaller number of intensive care neonatal units, supported by local neonatal and special care units. Formal pathways should be developed between these units to ensure that clear agreements are in place to treat the highest risk preterm babies and the sickest term babies in need of complex care in fewer centres, while returning babies to their local area as soon as clinically appropriate. Three to five neonatal intensive care units should be developed, supported by 10 to 12 local neonatal and special care units.</p>
	<p>47: Neonatal Framework for Practice and support: A national Framework for Practice should be developed which outlines clear pathways for newborn care and referral. This framework should also support the development of consistent and equitable specialty paediatric and allied health professional support for local neonatal units.</p>
	<p>48: Neonatal Community Service: A national model for a seven-day neonatal community service should be developed, with appropriate skill mix, robust guidelines and medical support to support early facilitated discharge and ongoing care pathways.</p>
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	<p>prompt identification of neonatal cot availability should be developed which is accessible through a single point of contact.</p> <p>57: Cot availability: Nationally agreed pathways for declaring cot availability should be agreed and formal processes should be in place for management of periods of unusually high activity.</p> <p>58: Staffing neonatal transport: All staff involved in neonatal transfers must have appropriate training, with neonatal transfers being subject to regular review and audit processes.</p> <p>59: Staffing neonatal transport: A further, detailed review of transport services should be undertaken, led by the neonatal transport service, to examine the best model for staffing of the service, including the potential for integration with neonatal unit staffing models.</p>
<p>Values and Behaviours</p>	<p>Members of the sub group agree to lead this work by setting a good example of working together. This includes understanding that some compromise may be necessary in order to reach agreement about implementation. Once agreement is reached the sub group will fully support it and act accordingly. Specifically this should include:</p> <ul style="list-style-type: none"> • We will share information freely • We should challenge positively • We should always try and attend these meetings • Decisions will be made whether everyone is there or not and we have to support the decision providing a quorum is reached • We should be respectful toward each other and recognise that challenge can be positive • We should all have the will to resolve issues even if it is against our own wishes • We should speak with one voice outside of meetings • We will preserve the confidentiality of papers and discussions. • We will not discuss or disclose any programme related management information without prior agreement from Chairs, apart from where necessary to consult with constituent groups in the context of our representative roles.

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Purpose	To deliver The Best Start recommendations relating to neonatal intensive care which will focus care for the most complex mothers and babies and develop standardised pathways and structures for care.
Remit	<p>The Group's primary purpose is to</p> <ul style="list-style-type: none"> • (i) Oversee a programme of preparatory work required ahead of full implementation of the new model of neonatal intensive care, following the pause brought about by covid, including: <ul style="list-style-type: none"> ▪ Consideration of cot capacity data and the impact of this on a phased implementation plan; ▪ Develop a phased implementation plan; ▪ Consideration of the readiness of the final three NICUs. • (ii) Reporting progress and highlighting delays and any issues with implementation of delivery of the new model of neonatal care to the Implementation Programme Board.
Membership	<p>Chair: Andrew Murray, Medical Director NHS Forth Valley</p> <p>Members:</p> <ul style="list-style-type: none"> • Alison Wright, Advanced Neonatal Nurse Practitioner, NHS Tayside, Chair of Scottish Neonatal Nurses Group • Tara Fairley, Clinical Lead, National Maternity Network. • Caroline Lee-Davey, Chief Executive, Bliss • Lesley Jackson, Clinical Lead, National Neonatal Network; • Carsten Mandt, Scottish Perinatal Network Programme Manager, • Allan Jackson, Clinical Lead, ScotSTAR; • Colin Peters, Clinical Director for neonatology NHS GG&C • Corrine Love, Senior Medical Officer Maternity & Woman's Health, Scottish Government/NHS Lothian • Shetty Bushan, Lead clinician and neonatologist NHS Tayside & Scottish Neonatal Consultants Forum • Kenny Mitchell, Scottish Ambulance Service • Eddie Doyle, Professional Advisor Paediatrics, Scottish Government/NHS Lothian • HOMs rep (Mary Ross Davie/Laura Boyce) • NICU rep Lothian (Ben Stenson) & Glasgow • LNU/SCU rep: Philine Van Der Heide (NHS Highland)

	<ul style="list-style-type: none"> • NICU Managers rep • General Management (Jamie Redfern or Allister Short) • Tony Nicol, Obstetric CD, NHS Tayside
Governance	<p>The sub group will report to the Implementation Programme Board on a quarterly basis, which also serves as the Scottish Perinatal Network Oversight Board.</p> <p>Secretariat will be provided by the Scottish Government within resources allocated to the programme.</p>
Timescales and Organisation	<p>The sub group will meet a minimum of quarterly, but with additional meetings arranged as required.</p>
	<p>44: Levels of neonatal care: New models of neonatal care should be based on the BAPM definitions to increase consistency of practice and facilitate benchmarking with other neonatal units across the UK.</p> <p>45: Neonatal intensive care: The new model of neonatal services should be redesigned to accommodate the current levels of demand, with a smaller number of intensive care neonatal units, supported by local neonatal and special care units. Formal pathways should be developed between these units to ensure that clear agreements are in place to treat the highest risk preterm babies and the sickest term babies in need of complex care in fewer centres, while returning babies to their local area as soon as clinically appropriate. Three to five neonatal intensive care units should be developed, supported by 10 to 12 local neonatal and special care units.</p> <p>47: Neonatal Framework for Practice and support: A national Framework for Practice should be developed which outlines clear pathways for newborn care and referral. This framework should also support the development of consistent and equitable specialty paediatric and allied health professional support for local neonatal units.</p>
Values and Behaviours	<p>Members of the sub group agree to lead this work by setting a good example of working together. This includes understanding that some compromise may be necessary in order to reach agreement about implementation. Once agreement is reached the sub group will fully support it and act accordingly. Specifically this should include:</p> <ul style="list-style-type: none"> • We will share information freely within meetings • We should challenge positively • We should always try and attend these meetings • Decisions will be made whether everyone is there or not and we have to support the decision providing a quorum is reached

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