Pre-market Engagement and Specification Development Meeting
National Neonatal Audit Programme

Minutes

Friday 7th November 2025, 2:00pm – 5:00pm (MS Teams)

Attendees

Pre-market Engagement

Sam Auger-Forbes
Account Manager, NEC Software Solutions

Charlotte Bradford
Network Manager, Northern Neonatal Network

Peter Bradley
Director of Services, BLISS

Rachel Corry
Parent Representative

Calvin Down
Head of Audits, RCPCH

Alan Fenton
Consultant Neonatologist, Newcastle upon Tyne Hospitals NHS Trust

Nicola Greenway
NICE Measurement Lead

Penny Harger
Relationship Officer, Peeps

Sundeep Harigopal
Clinical lead, Northern Neonatal Network

Sam Oddie
Clinical lead, RCPCH

Vicky Patel
NQICAN Chair

Mel Singh
Registries Product Manager, NEC Software Solutions

Aung Soe
Neonatal Critical Care CRG Representative (NHSE)

Adam Smith-Collins
Clinical lead, South West Neonatal Network

Stephen Wardle
President, BAPM

Rachel Winch
Project Manager, RCPCH

Pre-market Engagement and SDM

Ngozi Edi-Osagie (Chair)
National Clinical Director for Neonatology, NHS England

Stephen Anderson
Deputy Director for the Maternity and Neonatal Programme, NHS England

Louise Weaver- Lowe
Neonatal Nurse Lead, NHS England

Karen Jewell
Chief Midwifery Officer, Welsh Government

Kirstie Campbell
Head of Maternal and Infant Health, Scottish Government

Stanley Craig
Information lead for the Neonatal Network Northern Ireland (NNNI)

HQIP

Tina Strack
Associate Director

Jonathan Williams
Senior Procurement Manager

Kim Rezel
Head of Patient and Carer Engagement

Grace Cuff
Project Manager

1. Welcome & introductions

NEO opened the meeting by welcoming attendees and outlining the purpose: to gather feedback to inform the scope of the next National Neonatal Audit Programme (NNAP) tender.

2. Objectives of meeting

TS outlined the objectives of the meeting:

- NNAP is one of 40 national clinical audits, with participation from England, Wales, Scotland, and Isle of Man
- The current contract ends March 2027, and the new contract will be three years plus a two year extension
- The meeting aims to gather stakeholder input to shape the specification for the next tender
- The budget remains static, so any additions to the specification must be carefully considered
- Emphasis was placed on quality improvement, realistic delivery, and value for money.

3. Background

TS gave an overview of the audit covering metrics and outputs using the presentation in **ANNEX 1**

Metrics:

- Cover optimal perinatal care, parental partnership, care processes, and nurse staffing
- NNAP uses composite metrics to bundle related indicators (e.g. perinatal optimisation).

Outputs:

- Long reports have been replaced with 10-page "State of the Nation" summaries
- NNAP have made online improvement resources and case studies available
- Dashboards are refreshed monthly and can be filtered by geography, metric, and date range
- Data is shared with the Care Quality Commission (CQC), Get It Right First Time (GIRFT), Safety Improvement Programme (SIP), and other national programmes

KC and KJ praised NNAP's clarity and usefulness.

4. Patient and public involvement perspective

KR shared feedback from families via surveys and interviews using the presentation in **ANNEX 2**

Key concerns:

KR presented detailed insights from extensive engagement with families, charities and individuals with lived experience of neonatal care. Engagement included discussions with Peeps, Bliss, Spoons, Neomates, HQIP's lived-experience members, and parents currently involved in the NNAP programme.

Immediate Concerns and Experiences:

Families described the period of neonatal admission as deeply stressful, with the greatest concern being the immediate well-being of their baby. Parents wanted clear information on how unwell their baby was, what the actual diagnosis meant, and what treatments were required. For many, neonatal care followed an unexpected event, leaving them unprepared for the long-term implications. The emotional toll of separation from their baby was the issue raised most frequently—many neonatal units could not accommodate parents overnight, resulting in distress, anxiety and lost bonding opportunities.

Communication and Information Needs:

Parents emphasised the importance of proactive, consistent communication from clinical teams. They reported confusion when information from different staff members was contradictory, and highlighted difficulties understanding medical terms without clear explanation. Practical information, such as where to store expressed milk

or how to access parking support, was also noted as essential. Families stressed the need for staff to check understanding and ensure that parents are fully involved in discussions about their baby's care.

Family Involvement and Bonding:
Parents consistently stated that meaningful involvement in their baby's care was vital for bonding, confidence and emotional wellbeing. Skin-to-skin contact, support with feeding, participation in care activities and being present for clinical updates were all raised as important. Engagement also highlighted the varied experiences of siblings and non-birthing parents, with visiting restrictions affecting family cohesion.

Equity and Barriers to Access:
Families described challenges linked to language, culture and disability. Some parents did not fully understand why their baby had been admitted due to lack of translation support, and others struggled to navigate facilities—such as wheelchair users unable to move easily around units, or parents with hearing loss unable to hear buzzer systems.

Resources and Audit Outputs:
Parents valued clear, accessible and visually engaging materials, such as infographics and practical guides. Some expressed interest in reading audit materials during long periods spent at the cot-side, while others said they would only seek this information if they had concerns about care quality. Suggestions included adding a QR code in neonatal rooms to give families optional, discreet access to audit information without overwhelming them. Families also wanted audit findings to translate into reassurance and practical advice.

Follow-up, Transitional Care and Long-Term Needs:
A consistent theme was the lack of joined-up care following discharge. Many parents felt unprepared for life at home, experienced confusion about follow-up pathways, and did not feel supported by primary care services unfamiliar with neonatal needs, corrected age or developmental expectations. Parents also highlighted the long-term emotional and psychological impact of neonatal care and stressed the need for support beyond discharge.

Priorities for the Audit:
Families expressed a desire for an audit that reflects:

- principles of family integrated care and meaningful parental partnership
- equity across ethnicity, region, gestation and accessibility
- measures capturing bonding opportunities, skin-to-skin, feeding support and presence at key clinical interactions
- accessibility and communication needs, including for those requiring translation or adjustments
- the quality of transitional care and preparation for discharge.

Overall, families described a strong commitment to working in partnership with services and that family-centred care has a direct impact not only on babies' clinical outcomes but also on the psychological wellbeing of parents and siblings.

5. Group discussion

Parental Partnership Metric Discussion

KJ: Emphasised the importance of transitional care (preparing for home) and parental partnership

- Would like to include metrics of family experience
- Noted that implementing perinatal engagement measure core questions through CIVICA in Wales across maternity and neonates has provided valuable information.

ASC: Highlighted that some units do not have regular consultant lead ward rounds so parents often meet consultants outside of the ward round and this communication is not captured under the current parental partnership metric.

VP: Agreed with ASC that the parental partnership metric does not reflect all forms of communication, and suggested modification of the metric, rather than removal.

SO: Noted that the current metric ("parental presence on ward rounds") is flawed and has been discussed during project board meetings

- RCPCH is investing in research to define and measure true parental partnership since parental participation in ward rounds is not universally seen as a key element to effective partnership
- Highlighted that NHS England's PREM (Parent Reported Experience Measure) will launch in mid-2026.

PB: Urged not to lose the concept of parental partnership

- Stressed the distinction between experience and partnership.

PH: Noted that some families were not allowed/invited to the general consultant ward rounds due to confidentiality and to ensure the medical team can discuss neonates in depth as needed. Would like to see another way of capturing if families have had later conversations with consultants/senior medical team to receive updates on their babies

- Highlighted the importance of including both full-term and pre-term babies in the data.

RC: Brought experience as a parent representative, stating that the ward rounds are where the decisions are made about a baby and their care, highlighting the importance of maintaining a collaborative arrangement if we are to 'count' different types of engagement between parents and senior Healthcare Practitioners.

Suggested New Metrics

ASC: Would like to add retinopathy of prematurity (ROP) screening as an outcome measure to complement the process metrics.

NEO: Suggested separating brain injury as a standalone metric (currently composite).

PB: Proposed including parental accommodation and psychological support.

SO: Presented the below slides to propose a future driver diagram and workstream-based structure **(ANNEX 3):**

- Workstream 1: Perinatal optimisation
- Workstream 2: NEC prevention (e.g. breast milk, probiotics)
- Workstream 3: Outcomes (e.g. brain injury, mortality).

SO: Suggested new metrics:

- Probiotic use.

- Growth tracking.
- Parental partnership (revised).
- Two-year developmental outcomes.

SH: Suggested tracking out-of-network transfers and care days for capacity planning.

KC Noted that this would be difficult to assess by network in Scotland and suggested looking at unit-level.

SW: Would like to use transfer data to evaluate impact of capital investments (e.g. new cots).

Data Disaggregation & Equity

NEO: Supported disaggregating data by ethnicity and deprivation.

PB: Noted that ethnicity data is shared but deprivation data is complex and under review.

SO: Highlighted that there has been progress on linking maternity and neonatal datasets.

Dashboard Feedback

VP: Feedback from NQICAN members is that the dashboard is clear, accessible, and well-liked.

KC: Suggested adding metric disaggregation (e.g. by workstream) into the dashboard but emphasised that the dashboard should maintain simplicity and usability.

6. Summary and next steps

JW Introduced aspirational intent **(ANNEX 4),** noting that it:

- Allows inclusion of future metrics if funding becomes available.
- Will be a separate section in the specification.
- Is not scored in bids but shows provider capability.

JW then outlined the indicative timeline:

- Tender opens: 12 Jan 2026
- Tender closes: 11 Feb 2026
- Evaluation of bids: Feb–Mar 2026
- Contract start: 1 Apr 2027

NEO thanked participants for attending and closed the meeting.

HQIP Healthcare Quality Improvement Partnership

Neonatal audit programme – Overview (NNAP) – ANNEX 1

Tina Strack
Associate director

Aims and objectives of National Clinical Audit

- NCAs stimulate healthcare improvement through the provision of high-quality information
- Outcomes are benchmarked against national guidance and standards
- Data is most useful locally for healthcare improvement when it is timely, refreshed regularly with appropriate support
- Identify variation

NNAP audit overview

Inclusion criteria:

- NHS-funded care in neonatal units (NNUs) in England, Scotland and Wales (and Isle of Man) which provide care for babies in
  - Neonatal intensive care units (NICUs)
  - Local neonatal units (LNUs)
  - Special care units (SCUs).

Exclusion criteria:

- There are no groups excluded from the audit and all babies who receive input from neonatal staff will be included

HQIP Healthcare Quality Improvement Partnership

2025 Results

Outcomes of neonatal care

Mortality
6.4% of **7,038** babies born at less than 32 weeks died before discharge home.

4.1% **6.4%** 8.1%

0% change from previous year (2023: 6.4%)

Bronchopulmonary dysplasia (BPD)
39.8% of **7,341** babies born at less than 32 weeks developed BPD or died.

33.1% **39.8%** 44.8%

0.3% decrease from previous year (2023: 40.1%)

Necrotising enterocolitis
5.1% of **6,909** babies born at less than 32 weeks developed necrotising enterocolitis.

1.7% **5.1%** 9.2%

0.4% decrease from previous year (2023: 5.5%)

Bloodstream infection
5.1% of **7,063** babies born at less than 32 weeks had growth of a clearly pathogenic organism.

2.3% **5.1%** 6.7%

0.5% increase from previous year (2023: 4.6%)

Preterm brain injury – Intraventricular haemorrhage (IVH)
6.4% of **6,880** babies born at less than 32 weeks experienced IVH.

3.6% **6.4%** 9.4%

0.2% decrease from previous year (2023: 6.6%)

Preterm brain injury – cystic periventricular leukomalacia (cPVL)
3% of **6,871** babies born at less than 32 weeks experienced cPVL.

1.2% **3%** 4.6%

0.5% increase from previous year (2023: 2.5%)

Optimal perinatal care

Antenatal steroids
51.8% of **11,321** mothers of babies born at less than 34 weeks' were given a full course of antenatal steroids in the week prior to delivery.

46.4% **51.8%** 60.5%

1.2% decrease from previous year (2023: 53%)

Born in a centre with a NICU
80.7% of **1,920** babies born at less than 27 weeks' were born in a centre with a NICU on site.

71% **80.7%** 91.3%

1.1% increase from previous year (2023: 79.6%)

Deferred cord clamping
73.5% of **12,894** babies born at less than 34 weeks' had their cord clamped at or after one minute.

66.8% **73.5%** 80.4%

5% increase from previous year (2023: 68.5%)

Temperature on admission
77.6% of **13,077** babies born at less than 34 weeks' were admitted with a temperature within the recommended range of 36.5°C-37.5°C.

69.1% **77.6%** 82.2%

2.6% increase from previous year (2023: 75%)

Antenatal magnesium sulphate
86.7% of **3,795**mothers of babies born at less than 30 weeks' were given antenatal magnesium sulphate.

83.1% **86.7%** 90.4%

1.5% increase from previous year (2023: 85.2%)

Breastmilk feeding in first 2 days of life
66.8% of **12,874** babies born at less than 34 weeks' received their mother's milk in the first 2 days of life.

45.8% **66.8%** 82.8%

4.7% increase from previous year (2023: 62.1%)

Parental partnership in care

Breastmilk feeding at 14 days of life
80.8% of **11,601** babies born at less than 34 weeks' received their mother's milk at 14 days of life.

72.7% **80.8%** 89.6%

1.4% increase from previous year (2023: 79.4%)

Breastmilk feeding at discharge
65.8% of **11,596** babies born at less than 34 weeks' received their mother's milk at discharge.

50.1% **65.8%** 84.6%

2.7% increase from previous year (2023: 63.1%)

Parent consultation within 24 hours
94.6% of **56,864** parents had a documented consultation with a senior member of the neonatal team within 24 hours of their baby's admission.

92.2% **94.6%** 96.7%

0.5% decrease from previous year (2023: 95.1%)

Parent inclusion in consultant ward rounds
36% of **772,337** baby care days had a consultant-led ward round with at least one parent included.

25.2% **36%** 58.2%

2.7% decrease from previous year (2023: 38.7%)

Care processes and nurse staffing

On-time screening for retinopathy of prematurity (ROP)
80% of **6,725** eligible babies were screened on time for ROP.

68.9% **80%** 88.2%

1.5% increase from previous year (2023: 78.5%)

Medical follow up at two years
77.9% of **3,890** babies born at less than 30 weeks' had a documented medical follow up at the right time.

67.7% **77.9%** 85.8%

0.7% increase from previous year (2023: 77.2%)

Non-invasive breathing support
51.7% of **6,642** babies born at less than 32 weeks' received only non- invasive breathing support in the first seven days of life.

43.3% **51.7%** 61.7%

2.4% increase from previous year (2023: 49.3%)

Neonatal nurse staffing
81.5% of **124,981** nursing shifts were staffed according to recommended levels.

66.3% **81.5%** 91.1%

2.6% increase from previous year (2023: 78.9%)

Audit outputs

- Replace the annual report with an annual state of the nation summary (maximum of 10 pages and 5 national recommendations)

NNAP
National Neonatal Audit Programme

RCPCH Audits

National Neonatal Audit Programme (NNAP) Summary report on 2024 data

October 2025

Photo courtesy of Mabel Micah

HQIP
Healthcare Quality Improvement Partnership

RCPCH
Royal College of Paediatrics and Child Health
Leading the way in Children's Health

HQIP Healthcare Quality Improvement Partnership

Audit outputs

- Replace the annual report with an annual state of the nation summary (maximum of 10 pages and 5 national recommendations)
- Replace local recommendations with online improvement resources

Neonatal care

Getting it Just Right: A QI Initiative in Preterm Thermoregulation

This QI project aimed to achieve ≥80% of babies (< 34 weeks gestation) to have a normothermic (36.5–37.5°C) admission temperature taken within one hour of birth.

Read more →

POSH: Prevention of Significant Hypothermia

This QI project began in response to suboptimal numbers of preterm infants being admitted hypothermic (<36.5c) to the NICU.

Read more →

Using Two-Year Outcome Data to Drive Service Improvement for Preterm Infants in Bradford

This quality improvement project aimed to align with national standards and evaluate outcomes for neonatal care graduates, driving targeted service enhancements.

Read more →

Optimal timing of antenatal corticosteroids to improve outcomes in preterm birth

This QI project aimed to increase the proportion of women at less than 34 + 0 weeks' gestation with threatened preterm labour receiving a full course of antenatal corticosteroids within one week prior to delivery to 95% or greater by March 2023.

Snuggle and PEEP – Increasing use of non-invasive respiratory support and reducing bronchopulmonary dysplasia rates

This QI project aimed to increase the use of non-invasive respiratory support and reducing BPD rates.

More than meets the eye: understanding the impact of guideline changes on retinopathy of prematurity screening performance

This QI project analysed National Neonatal Audit Programme (NNAP) ROP data to drive improvement and reduce the risk of

NNAP webinar recording: Key findings from the 2024 summary report

Audits team

This webinar, recorded in October 2025, reviewed the key findings and national recommendations from the National Neonatal Audit Programme (NNAP) summary report on 2024 data.

Audit outputs

- Replace the annual report with an annual state of the nation summary (maximum of 10 pages and 5 national recommendations)
- Replace local recommendations with online improvement resources
- Develop a Quality Improvement plan, reviewed annually.

NNAP Healthcare Improvement Strategy

2022-2025

The overarching aim of the NNAP Healthcare Improvement Strategy is to assess whether babies admitted to neonatal units in England, Wales and Scotland receive consistent, high-quality care in relation to the NNAP audit measures that are aligned to a set of professionally agreed guidelines and standards, to identify areas for improvement and to empower stakeholders to use audit data to stimulate improvement in care delivery and outcomes.

To achieve this, the NNAP sets out four approaches to stimulating improvement:

1. High quality data outputs that identify areas for action and support stakeholders' improvement initiatives
2. Sharing of best practice and quality improvement resources
3. Collaboration and engagement with regional and national initiatives
4. Parent and public engagement

NNAP improvement goals and supporting objectives

The overall success of the strategy will be monitored against identified improvement goals which reflect existing national priorities and are consistent with quality improvement ambitions. These goals are described over a ten-year time frame, with specified year-on-year ambitions. This time frame is chosen with a realistic understanding of the plausibility of changing multifactorially mediated clinical outcomes, which themselves are thankfully not common. These goals will be subject to periodic revision by the NNAP Board.

Progress against these goals and objectives will be reported annually to the Project Board, HQIP and in the public domain.

The goals and supporting objectives set out in this document are supported by the following organisations:

- Bliss
- The Neonatal Society
- The Maternity and Neonatal Safety Improvement Programme
- British Association of Perinatal Medicine (BAPM)
- Maternity and Children Quality Improvement Collaborative, Scottish Patient Safety Programme
- Neonatal Nurses Association

Improvement goal 1:

Reduce the difference between the networks with the most negative and most positive treatment effect[1] for mortality until discharge home (3.8% based on 2021 results) by 0.3% per year over a 10-year period, with no associated increase in mortality in the network with the lowest observed rate.

Important notes for interpretation:

1. The NNAP uses a case mix/risk adjustment method called balancing, which gives a "treatment effect" for a neonatal network. A negative treatment effect suggests that the babies were more likely to survive in the network than elsewhere in the country, and a positive treatment effect suggests that the babies would have been more likely to survive had they been born and treated elsewhere.
2. Here we consider the variation between networks, and not the overall absolute mortality. It is possible, but unlikely, that overall mortality could worsen, while variation between networks reduces. Absolutely mortality will remain under review.

Audit outputs

- Replace the annual report with an annual state of the nation summary (maximum of 10 pages and 5 national recommendations)
- Replace local recommendations with online improvement resources
- Limit the number of performance metrics to 10
- Develop a Quality Improvement plan, reviewed annually.
- Make all audit performance metric results available in an interactive format online to all users

NNAP

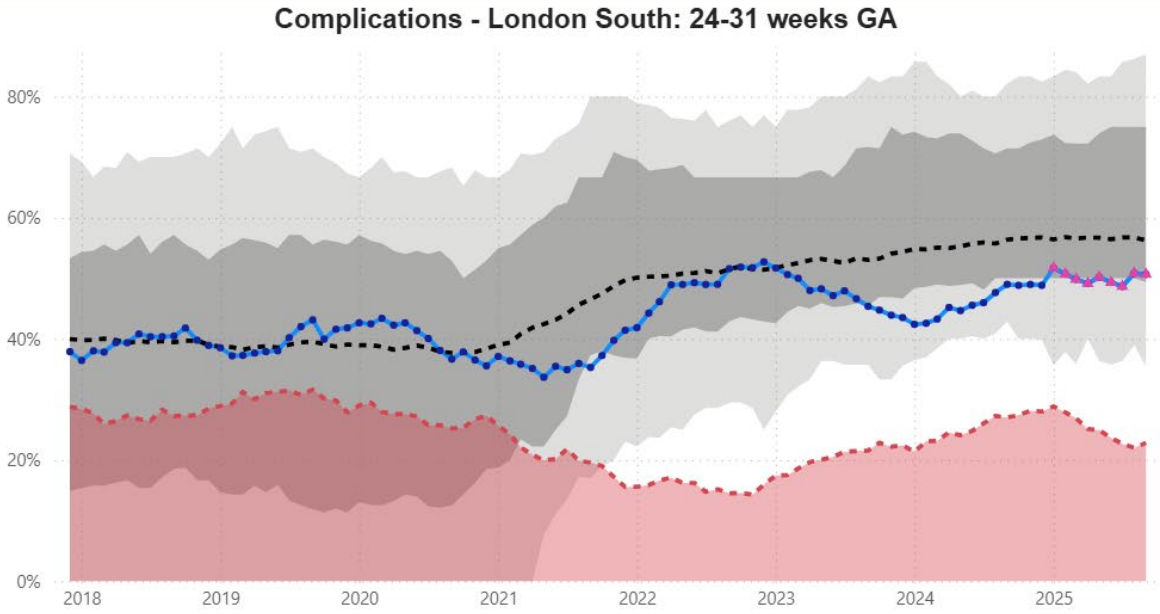
Complications of prematurity composite

Proportion of babies born between 24 and 31 weeks of gestational age who did not have a reported serious complication of prematurity (late onset infection, NEC, BPD, serious preterm brain injury and mortality)

Information

FAQ

Time series data



Select unit, network or ICS

Search

- East Midlands ODN
- East of England Perinatal ODN
- Kent, Surrey, Sussex ODN
- London ODN - North Central & East
- London ODN - North West
- London ODN - South

Select NNAP metric

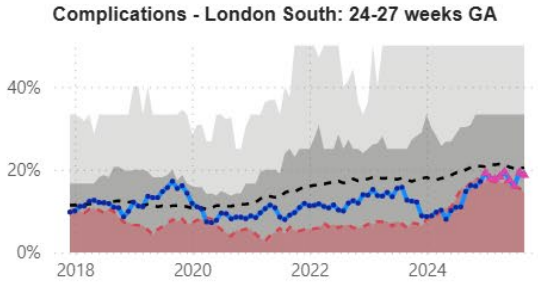
Complications of prematurity composite

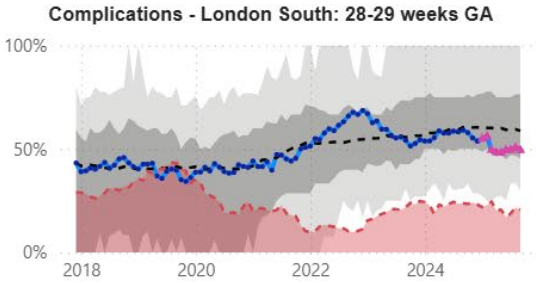
Select date range

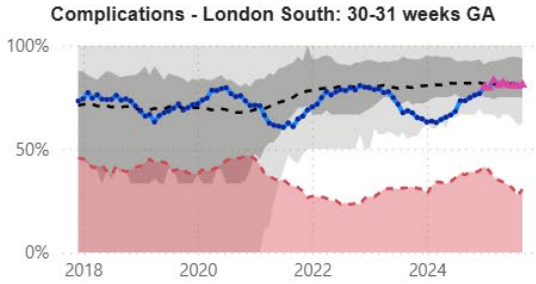
1/10/2017 9/10/2025

Scale Y axis

Chart key







Data

Audit data is used to assess compliance or performance in national initiatives:

- Care Quality Commission (CQC).
- Getting It Right First Time (GIRFT). Neonatology, Workforce
- NHS England. Specialised Services Quality Dashboards (SSQD)
- Model Health System
- NHS England. Saving babies' lives care bundle
- NHS England Maternity and Neonatal Safety Improvement Programme (MatNeoSip)
- Perinatal Excellence to Reduce Injury in Premature Birth (PERIPrem) Cymru
- The Maternity and Neonatal Safety Support Programme (MatneoSSP) Cymru

HQIP Healthcare Quality Improvement Partnership

Neonatal care– feedback from engagement with families - ANNEX 2

Kim Rezel
Head of patient and carer engagement

7th November 2025

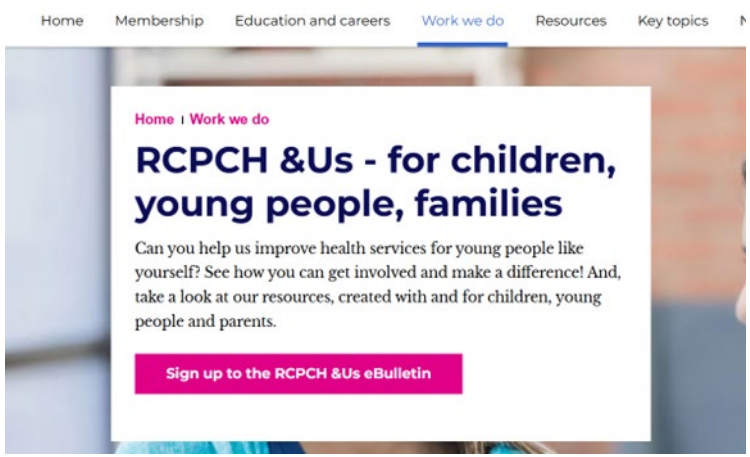
Engagement for the specification

PEEPS

Bliss
for babies born premature or sick

HQIP
service user network

spoons
neonatal family support



Purpose of engagement

- Main concerns
- What matters most to families
- What should the audit prioritise from the family perspective
- Audit information

Especially for parents and carers

- Your baby's care - this is your guide to our annual summary report
- Unit posters - these highlight how each unit is performing against a selection of audit measures and what they are doing in response to the results. Please email us at

care - NNAP parent and carer guide

The 5th edition of our Facing the Future document outlines how to deliver safe, high quality and integrated care for patients in Paediatric Emergency Departments in the UK.

See standards

We just wanted to be heard – to know our experience would make a difference to others.

Main Concerns

Whether he would live through the next hour, next evening, next week. They told me in the beginning to expect him to be severely disabled.

Whether they would make it.

Being away from her as I was admitted to a ward, I was worried about bonding. My baby had to have thermal therapy for HIE, so not being able to hold her. I was worried that I would be left out of her care.

Understanding what was happening

Main Concerns

Survival of baby and future health as well as managing a sibling during hospital stay

Being able to spend time with baby and understand what was happening

Lack of staff, lack of testing, lack of empathy, lack of understanding the seriousness of the situation

Main Concerns

She was taken in an ambulance to a hospital 3 hours away but there wasn't a bed for me in the hospital as a patient myself so I couldn't do with her. They were twins so the healthy twin stayed with me and my husband went with the poorly twin. I struggled to bond with the healthy twin because I was worried about the poorly twin 3 hours away. We didn't know if she was going to survive and I was worried I wouldn't be with her.

Main concerns

- Survival and long-term health
- Separation from their baby
- Bonding and involvement in care
- Understanding what's happening
- Facilities and support when far from home

Facilities for families to stay in the hospital particularly if you've been transferred away from your local hospital.

Needing some privacy to get to know this brand-new thing that didn't exist until some days ago away from a ward full of prying eyes

What matters to families

Communication: my local hospital didn't tell me what was happening with my daughter until last minute, when transport arrived to move us to a different hospital. My sense of purpose and the effect on my mental health: my daughter needed specialist care, so other than expressing milk I felt that I wasn't doing anything to look after my daughter. Feeding: my daughter is now bottle fed because we couldn't establish breastfeeding. I feel there needs to be a more support to NICU mums around this.

What matters to families

Support for parents to understand the processes, timescales etc. support to know you are not to blame and have done everything right (the guilt is huge), support and encouragement to really get involved with your baby's care, the trust to be able to leave them for the first time knowing they're safe and you'll be called as soon as there's an issue

What matters most to families

- **Clear, consistent communication** between maternity and neonatal teams
- **Opportunities to be involved** in care from the start
- **Help with feeding**, especially breastfeeding
- **Emotional and mental health support** and reassurance they've done everything right
- **Staffing and training** to enable family-integrated care
- **Outcomes** – long term impact
- **Smooth discharge** and continuity of care

Audit resources – what did you like?

Explained clearly

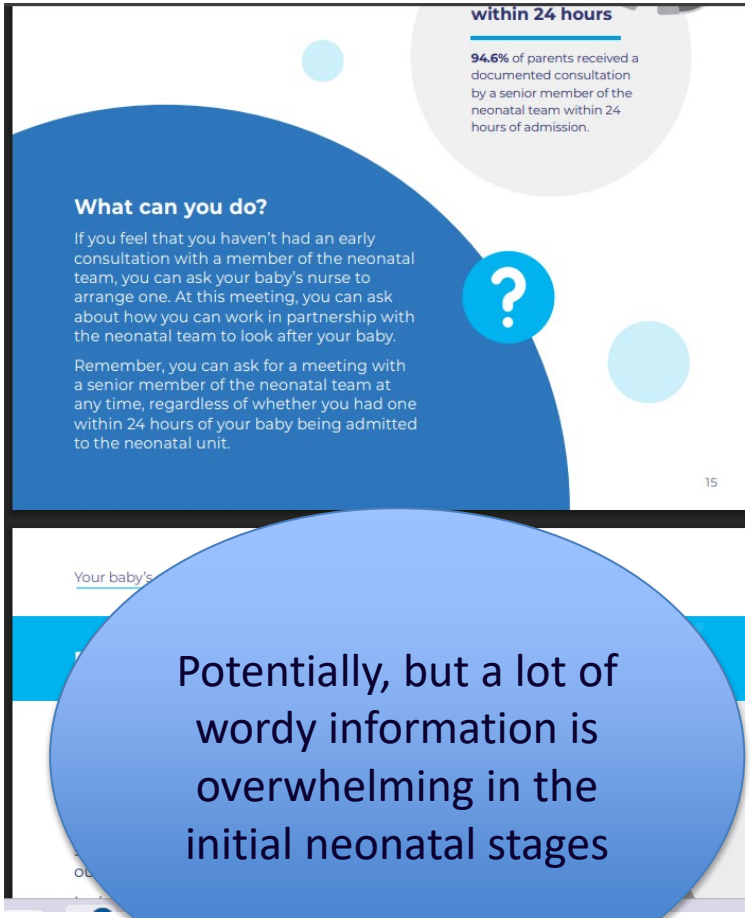
Easily understood

I like the way it is set out, use of photos and infographics makes it accessible and not too text-heavy

Audit resources – is it useful?

There's so much to digest, I focussed on information only relating to my baby and his individualised care

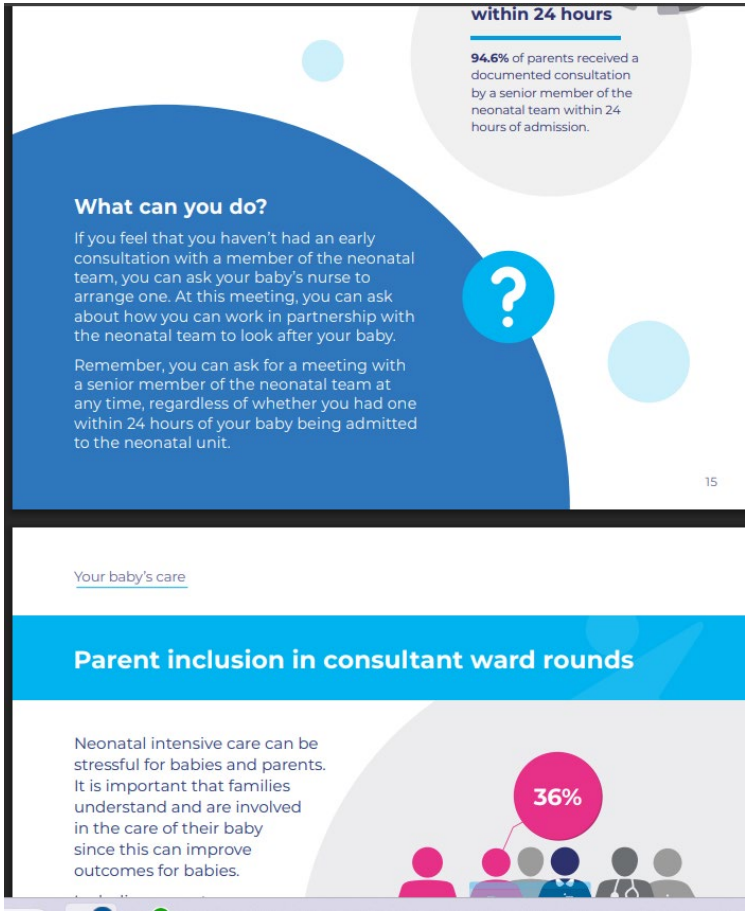
Probably. I read all the information available in the room and online when I was sat alone but I would happily have read more



Potentially, but a lot of wordy information is overwhelming in the initial neonatal stages

Audit resources – what could be more useful

It's tricky to know how parents will use/benefit from this information when on the unit - if you look up the unit/network you are in and it doesn't score as highly as others, there is no opportunity to move hospitals - this could cause parents more distress. Conversely if your unit is a "high performing" unit, this could reassure you.



within 24 hours

94.6% of parents received a documented consultation by a senior member of the neonatal team within 24 hours of admission.

What can you do?

If you feel that you haven't had an early consultation with a member of the neonatal team, you can ask your baby's nurse to arrange one. At this meeting, you can ask about how you can work in partnership with the neonatal team to look after your baby.

Remember, you can ask for a meeting with a senior member of the neonatal team at any time, regardless of whether you had one within 24 hours of your baby being admitted to the neonatal unit.

15

Your baby's care

Parent inclusion in consultant ward rounds

Neonatal intensive care can be stressful for babies and parents. It is important that families understand and are involved in the care of their baby since this can improve outcomes for babies.

36%

Key points

- Family closeness and involvement in care
- Joined-up communication across maternity and neonatal care
- Equity across ethnicity, gestation and region
- Measures of parent partnership, bonding and feeding
- Transitional care and access to emotional and psychological support

Key points

Being able to be close to your baby when they are poorly

Open friendly communication

That maternity ward staff sing from the same hymn sheet as nnu staff, and not be in a rush to discharge mum from ward when baby is still on unit

Involving parents in baby's care, ensuring they're fully informed at all times

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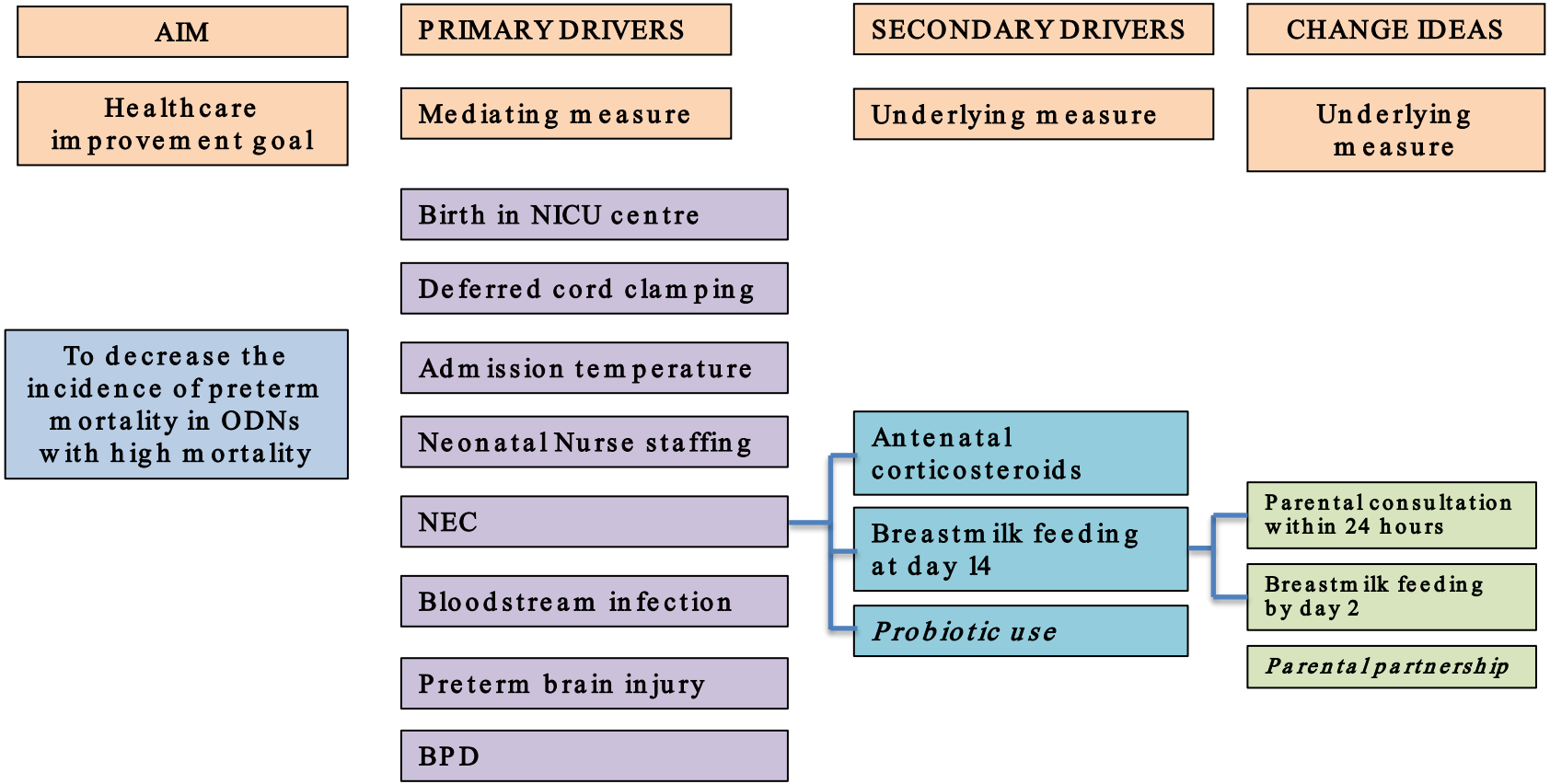
Existing NNAP measurement – ANNEX 3

1. Mortality	
2. Perinatal optimisation composite metric	• Component measures: Antenatal corticosteroids, Antenatal magnesium sulphate, Birth in a centre with a NICU, Deferred cord clamping, Normal temperature on admission
3. Complications of prematurity composite metric	• Component measures: Mortality, NEC, Bloodstream infection, BPD, Preterm brain injury
4. Consultation with parents	
5. Parental inclusion on ward rounds	
6. Feeding with mother's milk	• Component measures: Breastmilk feeding at day 14 of life, Breastmilk feeding at discharge home.
7. Follow up at two years	
8. Screening for retinopathy of prematurity	
9. Neonatal nurse staffing	
10. Non-invasive respiratory support	

RCPCH Audits



A single mediating measure is described for simplicity. In reality mediation pathways are complex and may not be fully understood. Representation is only illustrative. Drivers will play different roles within certain outcomes – e.g. antenatal steroids reduce NEC but also directly reduce mortality. Italicised measures are anticipated future measures.

RCPCH Audits

National Neonatal Audit Programme

Workstream 1: Parental Partnership in Care

1. Parental consultation within 24 hours of admission
2. Parent involvement in consultant ward rounds
3. Breastmilk feeding on day 14 of life
4. Breastmilk feeding at discharge home
5. Follow-up at two years of age

Potential for future metric development:

- Recommendations from the RCPCH&Us parent partnership work currently underway
- Elements of the maternity and neonatal PREM currently under development

Workstream 2: Care processes

1. Perinatal optimisation composite metric
2. Antenatal steroids
3. Antenatal magnesium sulphate
4. Birth in a centre with a NICU
5. Deferred cord clamping
6. Temperature on admission
7. Breastmilk feeding by day 2
8. Non-invasive breathing support
9. On time screening for ROP
10. Neonatal nurse staffing

Potential for future metric development:

- Probiotic use
- volume targeted ventilation
- hydrocortisone
- intrapartum antibiotics

Workstream 3: Outcomes of Neonatal Care

1. Mortality until discharge
2. Bronchopulmonary dysplasia
3. Necrotising enterocolitis
4. Bloodstream infection
5. Preterm brain injury
6. Intraventricular haemorrhage (IVH) 3 or 4
7. Cystic periventricular leukomalacia (cPVL)
8. Posthaemorrhagic ventricular dilatation (PHVD)

Potential for new metrics:

- Growth velocity/nutrition

RCPCH Audits

Aspirational Intent – ANNEX 4

- The specification is expected to include elements of aspiration which are ‘outside scope’ at point of award but have the **potential** to be included should the need arise, and funding is available.
- The purpose of aspirational intent is to be clear and transparent with all bidders, on the potential aspirations of the project.
- The specification will detail the aspirational measures that may be included as part of the contract at a later date, the funding range and mechanisms for invoking.
- The ability to meet these aspirational measures is **not a scored requirement**, so will have no impact on your bid responses. It will, however, give us visibility on bidder's capability to deliver these measures should the need arise, and funding becomes available.
- Aspirational intent will be managed via contract modifications and mutually agreed between HQIP and the successful provider.
- There is **no guarantee** that HQIP will invoke any aspirational measures throughout the contract lifecycle.

Timelines

- The below are to be taken as **indicative** only, and whilst the authority intends to stick to these milestones, it reserves the right to deviate.

Key Milestone	Start Date	End Date
Premarket Engagement Session	7th November 2025	7th November 2025
Tender Live	12th January 2026	11th February 2026
Deadline for Bidder Clarification Questions	-	28th January 2026 – Responses to CQs to be issued to bidders by 4th February.
Evaluator Clarifications	11th February 2026	3rd March 2026
Deadline for Response to Evaluator Clarifications	-	9th March 2026
Evaluation of Bids	11th February 2026	12th March 2026
Moderation	April 2026	April 2026
Feedback Letters Issued & Standstill Commences	July 2026	August 2026
Contract Start Date	1st April 2027	-