Royal Cornwall Hospitals
NHS Trust

Neonatal Outreach Service Operational Clinical Guideline

V1.0

December 2025

1. Aim/Purpose of this Policy

The aim/purpose of this policy is to give guidance and support:

- To outline service main aim and purpose of operation.
- To demonstrate how the service delivers care.
- Key principles involved in the delivery of care.
- Guidance for new and existing staff.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. The main aim of service provision:

- Facilitation of early hospital discharge of babies with on-going medical/nursing needs.
- Provision of a seamless transition from hospital to home, supporting multidisciplinary team planning for transition.
- Partnership working with families to reduce hospital induced psychological pressure and heightened anxiety around discharge.
- Provision of a skilled resource for the family.
- Minimising the incidence of readmission through neonatal nursing support in the community.
- Reduces the length of stay on the Neonatal and Transitional Care units.
- Supporting safeguarding needs and liaison with social care.
- Advocating for the family between hospital and community care.

There is strong evidence "Getting it right first time" (GIRFT 2022) that babies are being kept in neonatal units for longer than is necessary when less intensive community support would keep babies safe and with their families. Early discharge would better utilise special care cots having an impact on patient flow and improving overall service provision. With BAPM (British Association of Perinatal Medicine) (2025) recommending the resourcing of additional staff to support families at home to meet the national benchmark of reduced mother and baby separation.

2.2. Inclusions:

- Infants who are born at Royal Cornwall Hospital (RCHT) or who have been born outside of Cornwall and returned for inpatient care at RCHT or into the Community under the care of a local Consultant- and meet referral criteria.
- Infants who have been resident on the Neonatal Unit (NNU) or Transitional Care Unit (TCU), for a period before discharge.
- Infants who are registered with a Cornwall GP and are under the care of a RCHT Neonatal or Paediatric Consultant.
- Parents and carers who have demonstrated confidence and competence in specified aspects of nursing care.

2.3. Exclusions:

- Every family has the right to decline the use of Neonatal Outreach, this decision will be respected, and the baby will remain in hospital until medically fit for discharge.
- Babies who remain under the care of UHP (University Hospitals Plymouth) or NDDH (North Devon District Hospital) who live within the boundaries of Cornwall e.g.: Bude/Torpoint.

2.4. Service provision:

Clinical Operational Hours 68.5 hours per week (inclusive of 7.5 hours dedicated to Cleft Service).

Monday to Friday 08:30 to 16:30 Out of hours; parents are advised to phone their GP or out of hours service. (111).

Open access to Polkerris Ward (PAU) is organised for infants on home oxygen or NGT (nasogastric tube) feeding- parents will be advised to contact PAU out of hours for respiratory related concerns or for the replacement of an NGT.

2.5. The Neonatal Community Outreach Team consists of:

- Band Seven TC/Outreach Team Lead.
- One x Band Six Senior Community Neonatal Nurse- Cleft Clinical Nurse Specialist.
- Two x Band Six Senior Community Neonatal Nurses.

The Neonatal Community Outreach Service (NCOT) will provide band six or seven cover each day Monday to Friday 0830 to 1630 workload, visits and planned neonatal unit attendance should be reviewed prior to the start of each day and visits allocated according to need and in accordance with the caseload planner for that week.

A member of the NCOT will endeavour to be present on the NNU daily (Mon-Fri) dependent upon caseload capacity, to liaise with the NNU nurse in charge regarding inpatient referrals to NCOT, initiate contacts with families and review parental preparedness for home.

2.6. Current referral criteria to the Neonatal Outreach Team.

- =<34 weeks gestation at birth.
- <2kg at discharge.
- >7/7 NNU or Transitional Care stay.
- Home oxygen therapy.
- Complex needs.
- Home NGT feeding.
- Cleft lip and/or palate

Referrals to the Neonatal Community Outreach Team (NCOT) should be made at the earliest possible opportunity once identifiers are indicated. For non-urgent referrals this can be done by completing the maxims online internal referral form- see appendix 3.

Ward staff and Neonatal Outreach will work in partnership to educate and empower parents/carers to care for their baby and complete any necessary competencies prior to discharge home.

Service aim would be to complete all parent craft and competencies at least 24hrs prior to agreed date of discharge. (See Discharge Planning from the Neonatal Unit Clinical Guideline.

2.7. Current criteria for discharge to the Neonatal Outreach Team.

Infants who are:

- With Consultant oversight the infant has an established feeding plan is in place and has evidenced by satisfactory growth.
- Maintaining temperature in open cot for over 48 hours.
- No longer requiring monitoring- off for at least 48 hours.
- Infant is establishing full oral feeds and taking at least 50% of their requirement within a 24-hour period e.g. completing four full oral feeds or

eight half feeds with NG top ups.

- Babies of at least 34 weeks gestation.
- Weight of over 1.8 kg (less at consultant discretion and MDT discussion)- and has completed a satisfactory car seat challenge.
- 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- and has completed a satisfactory car seat challenge.
- Babies who have been identified as having long term medical needs (excluding home low flow oxygen – short term tube feeding) will be referred to the Community Children's Nursing (CCN) team at the earliest possibility. See appendix 3. The allocated CCN will be invited to planned progress and/or discharge planning meetings. Consequent post discharge home visiting will be arranged based on NCOT criteria.
- Babies who have been identified as having a cleft lip/palate who have been reviewed by the Cleft Nurse Specialist/Bristol Cleft Team/NCOT team member and who have an appropriate feed plan in place and are deemed medically fit for discharge.

2.8. Neonatal Community Outreach Contacts.

Please see 'Neonatal Outreach Standard Operating Procedure' Appendix 4.

2.9. Nursing interventions.

Please see Neonatal Community Outreach Nursing Interventions Appendix 5.

2.10. Considerations of service delivery- potential to be compromised.

2.10.1. Annual leave.

The Neonatal Outreach team will endeavor to provide a full service 0830 to 1630 Monday to Friday. Regular team meetings and liaison between team members will ensure leave is allocated in a timely and efficient manner without impact to service delivery.

2.10.2. Sickness.

In the event of sickness and no subsequent outreach cover, it will be the requirement of the NNU Nurse-in-Charge to access the Outreach calendar and caseload planner to appoint a suitably qualified staff member arrange telephone calls and reschedule all booked visits for that day.

An assessment can be completed over the phone of the infants temperature, feeding regime, bowel and bladder actions and whether there are any identified NGT or LFo2 issues.

A visit should be arranged or the next available date. If after telephone assessment a visit is deemed necessary for that day then arrangements

should be made for parents/carers to bring their baby to the Neonatal Unit/PAU/GP for assessment (NGT change/weight/observations. The telephone conversation and any subsequent actions should then be documented in the NCOT patient notes on Badger Net Community follow up.

2.10.3. Extreme weather:

If extreme weather is forecast then Outreach Nurse should plan visits carefully (performing these earlier in the day if possible) Where visits are not deemed possible or safe then parents/carers should be contacted, and telephone assessment made of baby. Where able, re-book the visit or if necessary, arrange for local assessment by Health Visitor/GP.

2.10.4. Vehicle breakdown.

Outreach staff are to ensure their vehicle is regularly serviced and maintained and any faults repaired promptly. Staff should have an appropriate vehicle breakdown cover. In the unfortunate event of a breakdown staff should pull over in a safe place and await assistance. Telephone Neonatal Unit Nurse-in-charge and inform them of the situation. Telephone parents/carers booked for that day and inform them of the situation, where it is possible re-arrange visits for the next available day. If a visit is required for that day (e.g. re-siting of displaced NGT) arrangements should be made for parent/carer to bring baby to PAU.

2.10.5. Lone worker.

Outreach Nurse to adhere to Trust Lone worker policy. Where possible arrange visits in daylight hours. Activity for the day should be correctly inputted onto the Outreach Outlook calendar with visits titled with patient initials and area of visit. Ensure mobile phones are fully charged before going out on visits. Record details (i.e. Address/any required patient detail) of each visit prior to commencing journey. If upon arriving at an address the Outreach Nurse deems the visit to be 'unsafe' arrangements should be made for a 2-person visit on another day. (or the parent/carer to bring baby to Clinic and meet with Outreach Nurse). During the day's visits any patient identifiable information materials will be kept securely in the boot of a locked car and returned to the office/secure at home at the end of the day.

2.11. Safeguarding.

Please refer to RCHT Safeguarding Children Policy.

- Contact police if immediate danger.
- Identify and record the facts.
- Discuss the concerns with immediate manager and the Safeguarding Team.
- Consider what needs to be shared with the baby's parents/carers regarding the referral.

- Telephone the MARU (Multi Agency Referral Unit) to refer: 0300 1231 116. (Emergency duty team, for urgent referrals after 17:15 or at the weekend call out of hours service on 01208 251300).

- Complete the MARU referral and email multiagencyreferralunit@cornwall.gov.uk.

- Email a copy of MARU to RCHT Safeguarding Team and print a copy for patient records.

- Neonatal Outreach Team to access Safeguarding Supervision at a minimum of three monthly or more frequently in complex cases. Safeguarding supervision can be provided by a member of the Children's Safeguarding team.

A member of the NCOT will attend the 'Baby in Family' weekly meetings .The purpose of the meeting is to ensure that neonatal patients and families will have any non-medical and social needs or issues identified, and plans put in place to facilitate timely discharge with appropriate support while an inpatient or following discharge. All neonatal inpatients are discussed weekly.

2.12. Documentation.

Documentation will adhere to the NMC Code relating to records and RCHT Recordkeeping Guidelines

Following each contact with families, a full detailed summary of discussion and ongoing plan should be inputted onto the Badger Net system under the 'Community Follow Up' page.

Following discharge from the NCOT service see appendix 6 for correct discharge documentation process.

The Outreach 'Caseload Planner' is a live working document and accessible at S:\RCH-WCSH\Neonatal\Neonatal OUTREACH\CASELOAD PLANNER – this will be updated and at the end of the working week and a copy for the following week will be added to the shift leader handover folder for reference.

2.13. Audit.

Monthly admission/discharge figures will be produced.

Monthly data will be collected in line with the BAPM framework to identify categories of neonatal outreach support level 1-3.

Yearly audit will be carried out highlighting workload, usage and aim to show improvement in the service.

Information for audit purposes can be drawn from the PAS system from contact outcomes.

Regular service user feedback should be obtained to measure service quality and enable service improvement.

3. Monitoring compliance and effectiveness

Element to be monitored	Compliance with policy/key changes to practice
Lead	Neonatal Outreach Team.
Tool	Adherence to guidelines will be monitored as part of the ongoing audit process on an Excel template.
Frequency	As dictated by audit findings.
Reporting arrangements	Consultant led Neonatal Audit and Guidelines group.
Acting on recommendations and Lead(s)	Any incident arising or audit findings will be discussed and presented at the specialty risk management meeting/specialty Governance meeting.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within three months, immediately if required. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff/stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Neonatal Outreach Service Operational Clinical Guideline V1.0
This document replaces (exact title of previous version):	New Document
Date Issued/Approved:	December 2025
Date Valid From:	December 2025
Date Valid To:	December 2028
Directorate/Department responsible (author/owner):	Neonatal Outreach Service
Contact details:	01872 252667
Brief summary of contents:	This document outlines the Neonatal Outreach Service's aims and purposes of operation, demonstrates how the service delivers care, the key principles involved in the delivery of care and provides guidance for new and existing staff.
Suggested Keywords:	Outreach/neonatal.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Neonatal Audit and Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None required
Related Documents:	GIRFT. BAPM Framework. Lone Worker Policy.

Information Category	Detailed Information
	NNU Discharge Guideline. Safeguarding Children.
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/Neonatal

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
November 2025	V1.0	Initial issue.	Neonatal Outreach Service

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Neonatal Outreach Service Operational Clinical Guideline V1.0
Directorate and service area:	Neonatal
Is this a new or existing Policy?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Neonatal Outreach Service
Contact details:	01872 252667

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This document outlines the Neonatal Outreach Service's aims and purposes of operation, demonstrates how the service delivers care, the key principles involved in the delivery of care and provides guidance for new and existing staff.
2. Policy Objectives	As above.
3. Policy Intended Outcomes	To improve the well-being of patients by offering the appropriate management of patients.
4. How will you measure each outcome?	Audit/Multidisciplinary team weekly discussion/incidents/risk management.
5. Who is intended to benefit from the policy?	Patients and their families.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/groups:** Neonatal Audit and Guidelines Group.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	Any information provided should be in an accessible format for the parent/carer/patient's needs- i.e. available in different languages if required/access to an interpreter if required.

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those parent/carer/patients with any identified additional needs will be referred for additional support as appropriate- i.e. to the Liaison Team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g. easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat/administer a blood product/component and respond accordingly.
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Neonatal Audit and Guidelines Group.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis.

Appendix 3. Referral to Neonatal Community Outreach Team via Maxims

1. Patient search (name or hospital number)- identify correct patient.
2. Top right-hand corner click on ‘More’.
3. Left hand screen- ‘refer to service’- enter Neonatal Outreach Outpatient service.
4. Service specific questionnaire will load (including referral criteria)- complete with as much detail as possible.
5. You will need to enter some clinical details in the left-hand section.
6. Once completed press save.

For urgent referrals please contact the team via telephone on any of the mobile numbers below.

1. 07920 294336.
2. 07826 913471.
3. 07826 935509.

Once the referral has been received and families accepted onto the NCOT caseload a copy of NCOT’s current caseload can be found at:

S:\RCH-WCSH\Child Health\Medical\Neonatal OUTREACH\CASELOAD PLANNER.

A copy of the weekly caseload will be added to the shift leader handover folder on the shared drive for access by NNU shift leaders as required.

Referral to Children Community Nursing Team:

Call the team on 01872 246 956 and ask to speak to the triage nurse for the day. Referrals can be accepted from any professional involved with the child or young person.

Appendix 4. Neonatal Community Outreach Team Standard Operating Procedure.

Initial Contact.

Once notified of an Infant requiring NCOT service input, it is the responsibility of the NCOT to arrange an initial contact with the parent/carer of the infant. This will usually be completed during the NCOT attendance on the NNU where possible by the named NCOT nurse. The purpose of this initial contact is to introduce parents to the service and staff.

The NCOT nurse will explain how the team can help them prepare for discharge and support the family to care for their baby at home. Answering and signposting any questions and or concerns they may have around taking their baby home, inclusive of nursing, medical, social, emotional and wellbeing needs. A service leaflet is to be given to all NCOT service users during this initial meeting.

Discharge Planning and Neonatal Community Outreach.

A member of the NCOT service will regularly attend the discharge planning ward round to identify new referrals, initial contacts needed and ongoing outstanding discharge planning needs e.g. Parent Skills.

All discharge preparation, teaching and planning will be supervised by the allocated staff nurse/named nurse and should be documented in the appropriate places. See Discharge Planning on the Neonatal Unit 2021. However, the NCOT service will support with ongoing discharge planning, parent skills and parent craft where current caseload management allows.

The NCOT service may offer bespoke parent craft sessions to families prior to discharge, caseload management allowing. These will be identified during discharge planning ward rounds and may include but are not limited to:

- Wrapped bathing.
- Making up formula feeds and sterilizing.
- Skin care.
- Home safety.
- BLS (Basic Life Support).
- Safe sleeping.
- Holding reassurance and baby massage (In term infants).

For infants with complex needs or those born at < 30 weeks gestation it is desirable to arrange a progress meeting at approximately 34 weeks gestation and usual to arrange a multi-disciplinary team discharge meeting at least one week prior to expected discharge date. These meetings help to ensure optimal communication and a well-coordinated discharge. See Discharge Planning from the Neonatal Unit.

These meetings should be co-ordinated by a responsible NNU Shift lead Band Six or Band Seven or a member of the senior NCOT Team if requested. Minutes of these meetings will be taken by the NCOT member attending and will be recorded in the infants Badger notes in the 'Community Follow Up section' and a copy added to the nursing notes. In complex cases it is desirable for a member of the medical team to be present.

Meetings can be held in person on the NNU or via MS Teams for parents and members of the MDT who may not be able to attend at the given time.

Likely attendees including but not limited to:

- Neonatal Outreach Nurse.
- Neonatal Consultant.
- Community Paediatric Nurse.
- Health Visitor.
- Babys Named Nurse/Nurse in Charge.
- Parents.
- Social Worker.
- Physiotherapist.
- Speech and Language Therapist.
- Occupational Therapist.
- Specialist Nurse or Doctor relating to the child's condition.

Pre-Discharge Contact.

Contact should then be made with parents/carers to finalise plans for taking their baby home, addressing any outstanding needs/concerns and arrange the first discharge follow up, stating time, date and platform to be used. This contact may be in person or via telephone depending on team capacity.

First Discharge Follow Up.

Follow up/home visit should be coherent with Badger Net 'Community Follow Up-First Visit' and inclusive of:

- Weight growth monitoring and assessment.
- Observations activity, colour, perfusion, (oxygen saturations, heart rate, respiratory effort, and rate if requiring LFo2).
- Feeding- i.e. volumes/frequency/type/breastfeeding support.

- Supplies- Medications, Prescriptions, Equipment.
- Parent and Carer Education- revisiting of all pre discharge teaching with emphasis on: Safe sleeping, ICON, and preparation of feeds.
- Emotional Wellbeing and Support (Peer/family support).
- Follow up appointments/schedules/next NNO contact/plan.

Further Home Visits.

All home visits will be recorded on Badger 'Community Follow Up' page and will be contemporaneous and in line with NMC Code of Practice No:10. **Keep clear and accurate records relevant to your practice and Trust policy.**

Neonatal Outreach Wellbeing Clinic.

Bi-weekly clinics are operated from the Perranporth Family Hub – these clinics are open to AHP's working with the families under the care of the NCOT and are utilised to reduce travelling, offer peer support and offer targeted teaching/support to families. The clinic provides a safe environment for families of NNU/TC infants and attendance is invite only.

Discharge from Neonatal Outreach Team.

Babies can be seen for varying lengths of time, depending on nursing need and reason for referral.

All infants who continue to require oxygen at six months of age (corrected), will initiate a conversation with the CCN team. The CCN team do not currently accept infants with an ongoing LFo2 requirement due to neonatal chronic lung. However, an accurate recording of numbers/families affected may influence future practice.

All infants who remain on the NCOT caseload and continue to require oxygen at 12 months of age without the ability to wean will require a review with the respiratory Consultant and be arranged by the infants named Consultant.

'*Failure to reduce home oxygen supplementation after one year should lead to a referral to respiratory specialist to rule out concomitant conditions' (Paediatric Pan London Oxygen group 2021*).

Appendix 5. Neonatal Community Outreach Nursing Interventions

Home Nasogastric Tube Feeding.

Parents/carers will have been working in partnership with nursing staff to become competent in giving nasogastric tube (NGT) feeds. They will have completed a 'NGT Feeding' booklet and will be required to complete an NGT competency and risk assessment for NGT Feeding at home.

If appropriately identified and in consultation with the MDT a 'Passing a NGT Competency for Parents/Carers' may be completed for a NGT to be passed in the home by the primary care giver.

All infants requiring NGT feeding at home will have open access to the Paediatric Admissions Unit (PAU) for feeding concerns and out of hours replacement of NGT. Infants' details will be added to the working document via the shared drive S:\RCH-WCSH\Child Health\Medical\Long Term Open Access on the neonatal tab.

A robust transitional and post discharge feeding plan is a necessity and will be coordinated by the NNU, NCOT, Neonatal Dietitians and the Infant Feeding Teams in consultation with the family.

They will be provided with a supply of 10ml and 20ml syringes, PH indicators, a spare NGT and adhesive. Pre-made packs are available on the NNU.

Parents will receive a home visit within 24 hours of discharge if the infant is discharged home with a Nasogastric tube South West Neonatal Network Guideline .

Infants will be visited bi-weekly for NGT change and assessment of growth – liaison with the Health Visiting teams is imperative to avoid duplication or inadequate support to families.

Early recognition of feeding difficulties and referral to the Infant Feeding Team and/or Neonatal Dietetic team will be conducted in a timely manner to avoid faltering growth and parental anxiety.

Home Oxygen.

Parents/carers of babies who require oxygen at home will be provided with specific training to ensure they are aware of what equipment they will be provided with, how to use equipment and how to care for their baby at home on oxygen.

Once an infant is identified as likely to require oxygen at home the parents/carers will be given a 'Going Home on Low Flow Oxygen' leaflet/booklet and will be required to complete the home oxygen competencies prior to discharge. Where possible the Neonatal Outreach Team will arrange an appointment to meet with parents on the unit to discuss competencies and identify any areas of need/concern.

Once oxygen saturation downloads are satisfactory and baby's oxygen requirement is stable usually anywhere between 0.01 – 0.5/litres per minute. A home visit prior to oxygen

ordering and installation will be necessary to ensure the baby's home is suitable for discharge on home oxygen and to complete the Home Oxygen Safety Assessment and consent (IHORM and HOCF).

Once complete home oxygen can be ordered. This is usually actioned by the Outreach team, but online ordering can be completed by a trained member of staff within NNU who has undertaken the air liquide portal training.

A multidisciplinary team meeting will be required for any baby going home on oxygen.

Usually, it is not appropriate to discharge a baby who requires oxygen therapy at home and remains fed via a nasogastric tube of any volume. An individual Consultant case review would be required with a joint Parent, Consultant, Outreach partnership agreement for discharge in such cases.

All infants requiring home oxygen will require open access to the Paediatric Admissions Unit (PAU) for respiratory concerns out of hours. Infants' details will be added to the working document via the shared drive S:\RCH-WCSH\Child Health\Medical\Long Term Open Access on the neonatal tab.

Discharge should ideally take place in the morning to allow parents to transition safely home and allow for follow up within Outreach service hours. A home visit will be arranged within 24 hours of discharge to support the family, monitor observations, and ensure correct set up and administration of oxygen. They will then be visited weekly for the first four weeks; this will allow the Outreach team to assess wellbeing and support parents/carers.

Within one week of discharge, overnight oxygen saturation monitoring ('download') should be completed to ensure the amount of oxygen being delivered remains satisfactory. Unless concern arises another 'download' should then be repeated at three-four weeks post discharge and be reviewed by a consultant for a plan for weaning LFo2 to commence. Once oxygen weaning commences, visits will be arranged, in accordance with the o2 guideline and the Paediatric Pan London Oxygen group (PPLOG 2021) weaning LFo2 plan. This will be in direct collaboration with the family and consider the infant's progress. Where possible this should alternate with other health professionals supporting the family, e.g. Health visitors. Following any changes to the amount of oxygen being delivered, if possible a visit should be arranged within 24 hours to monitor observations and an overnight download completed within one week of weaning Oxygen Saturation Download Neonatal Clinical Guideline.

Oxygen will remain in the home for up to three months following weaning into air- taking into consideration winter months and stability of infant

Once a baby is weaned into air with x two satisfactory overnight downloads, at least four weekly home visits to monitor observations for three months is required.

If a baby reaches 12 months (corrected gestational age) and remains on LFo2 with no evidence of weaning of LFo2 starting, then they should be considered for referral to the CCN and Respiratory Team for continuity of care. (Desirable).

Growth Monitoring and Open Access.

- **Infants born at < 34/40.**

  All infants born at less than 34 weeks gestation will be offered one x post discharge home visit for review of feeding and growth monitoring regardless of nursing need – thereafter liaison with the babies Health Visitor will continue until the 4th week post discharge or until the baby has reached term equivalent age. Families will be made aware they have OPEN ACCESS to telephone support from the NCOT.

- **Infants with a prolonged NNU or TC stay of >7 days.**

  All infants identified as having a prolonged NNU or TC stay will be offered OPEN access to four weeks post discharge telephone support with a minimum of two attempted follow up calls to ascertain ongoing progress and level of community support.

- **Infants discharged < 2Kg.**

  All infants discharged from the NNU or TC at < 2Kg will have a robust feeding plan – and home visiting plan in place (if appropriate) for enhanced growth monitoring. Visits will be coordinated with local Midwifery and Health Visiting teams.

Infants with cleft lip and or palate.

Cornwall Neonatal Community Outreach provide 0.2WTE (7.5 hours included in the current operational Hours) weekly of CNS support for infants born with a cleft lip and/or palate.

Referral will be received locally from central hub in Bristol.

An antenatal contact will be made within 24 hours of the referral being received to give information and advice, arrange a home visit/face to face contact to discuss in more detail the care of a baby born with a cleft.

A subsequent contact will be made at approximately 36 weeks antenatal to refresh any information already received.

A birth visit is expected within 24 hours of notification of birth – unless over the weekend when support will be offered by the on-call CNS within the Bristol team. Cleft type to be confirmed – feeding advice and plan to be implemented at this contact.

Cleft patients are to remain on the link cleft nurse(s)' caseload for up to 13 months following birth. Caseload should be transferred back to the Lead Cleft CNS in the SWCS Bristol office following surgery or at 13 months if patient's first surgery has not been completed. *Source: Sub-contract for the Provision of Link Cleft Lip and Palate Link Cleft Nurse(s) 2024.*

Nirsevimab

Neonatal Outreach will be responsible for identifying the infants on their caseload who meet the criteria for Nirsevimab, at the beginning of the RSV (respiratory syncytial virus) season. In liaison with the NNU Consultant team each infant will have an ‘authorisation form’ (Blueteq) generated. Blueteq requests and handwritten prescriptions will be requested by the medical team. Nirsevimab clinics will be undertaken by two outreach nurses or one outreach nurse and a neonatal nurse who has completed the on-line/face to face immunisation training. Nirsevimab clinics will operate during the second half of September and first half of October - depending on numbers of eligible infants- all clinics need to be booked by the nominated administrator for that year and will be held on the Gwithian unit at RCHT. All infants will have a ‘notification of immunisation form completed and sent to hil.dcios.swchis@nhs.net and their patient records and PCHR (red book) will be completed accordingly.

Appendix 6. Neonatal Community Outreach Discharge Documentation Pathway.