London Neonatal
OPERATIONAL DELIVERY NETWORK

Best Practice Implementation & Audit Tools

Neonatal Allied Health, Psychological Professionals & Pharmacists

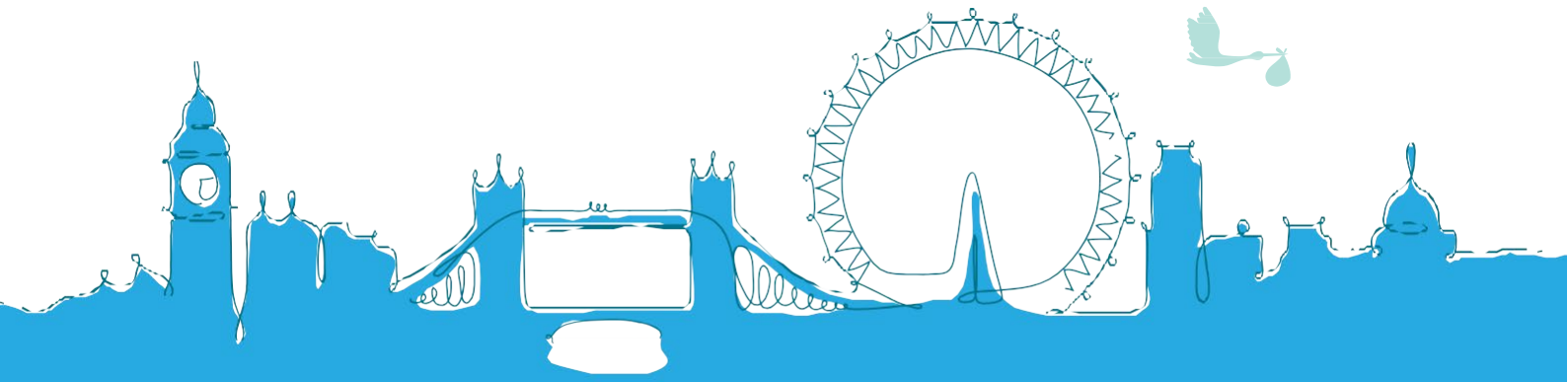

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Table of Contents

Implementation guide: The AHPPP best practice guidance 4
Neonatal AHPPP Team Audit Tool 6
Neonatal Dietetic Service Assurance Tool 14
Neonatal Occupational Therapy Service Assurance Tool 19
Audit form: Occupational therapy in neonatal services and early intervention – practice guideline (2nd Edition) 22
Neonatal Pharmacy Service Assurance Tool 35
Neonatal Physiotherapy Standards of Care Measure 40
Neonatal Psychological Service Assurance Tool 49
Neonatal Speech and Language Service Assurance Tool 57

Implementation guide: The AHPPP best practice guidance

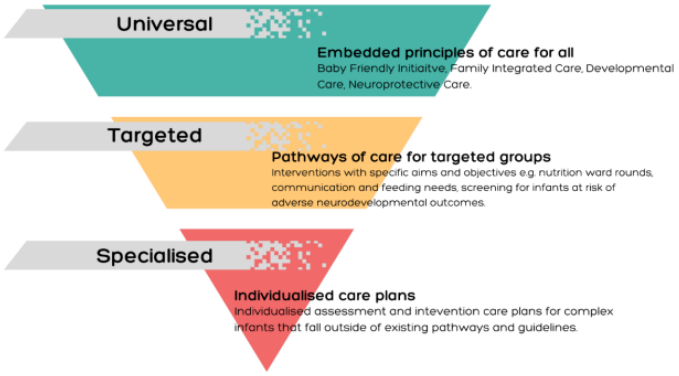


Figure 1 –U/T/S model.

The London AHPPP best practice guide covers Allied Health (PT, OT, SLT, Dietetics) Pharmacy and Psychological professionals. It outlines how AHPPPs work collaboratively in neonatal units and their involvement in early intervention & prevention, support for families, involvement in transfer & discharge, training and development. AHPPP's are also involved in general unit business such as MDT meetings, governance and FICARE initiatives. There are sections for each of the 6 professional groups which set out, in detail, their expected roles and responsibilities when working on a neonatal unit and how they contribute to the care of infants, families and staff. The sections are organised using the Universal/targeted/specialist model (see figure 1).

Using the best practice guide in neonatal services

Where do I start?

The first step is to use the best practice guide **audit tools.** There is an AHPPP generic audit tool and then 6 individual profession tools.

When using the generic AHPPP audit tool, you will need to ensure that you are reviewing the practice of all six professions (SLT, PT, OT, Dietetics, Pharmacy and Psychological professionals) If that profession is not represented on your unit, you should involve the appropriate London Operational Delivery Network AHPPP lead.

Specialised – Individualised care plans

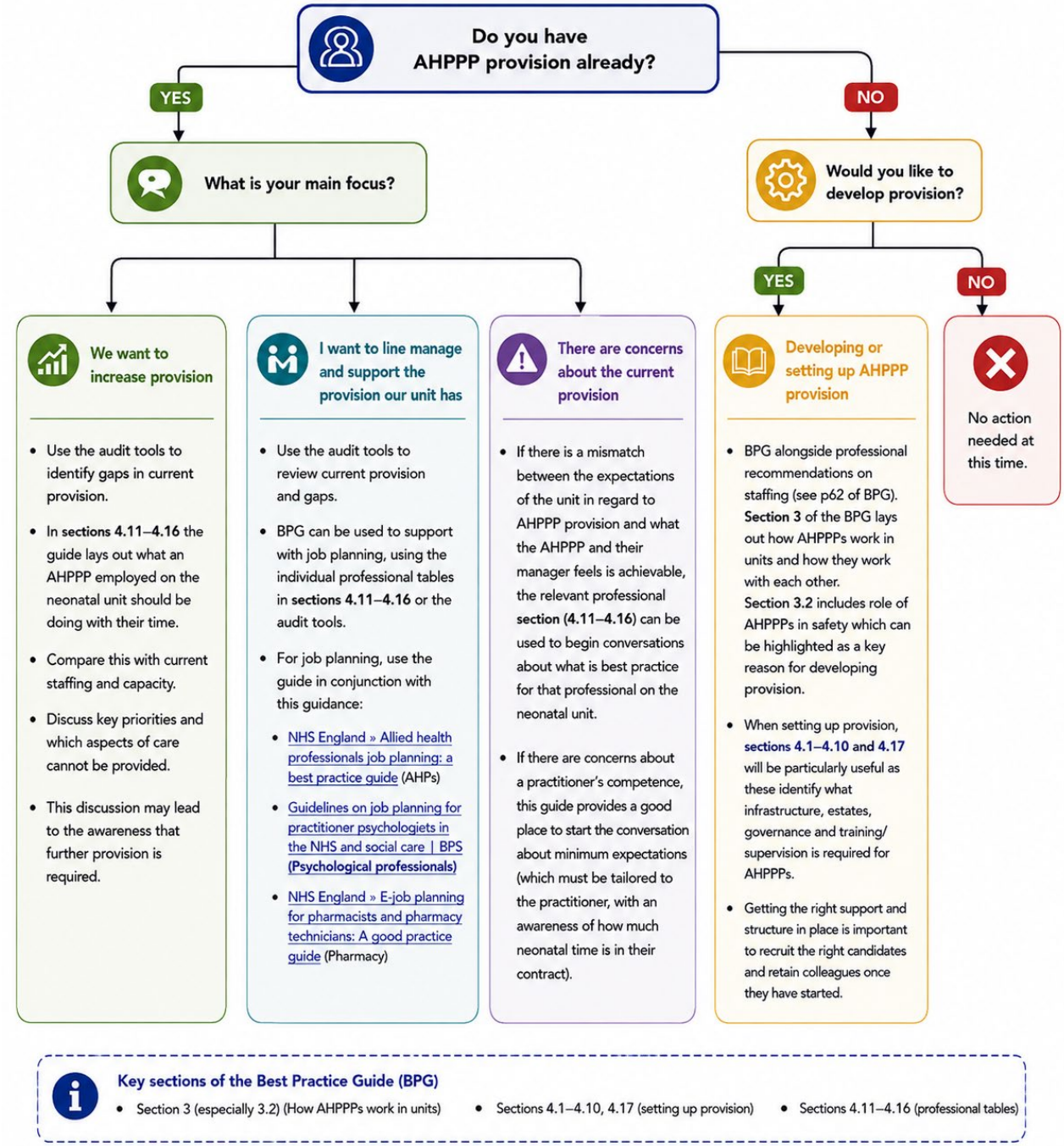
Item	RAG (Red/ Amber/ Green)	Evidence (where available)	Action required?	Comments
Attend MDT meetings / discharge planning for complex infants			Yes ☐ No ☐ N/A ☐	
Any direct patient activity during admission			Yes ☐ No ☐ N/A ☐	
Any direct patient activity after discharge			Yes ☐ No ☐ N/A ☐	
Provide individualised early intervention and support			Yes ☐ No ☐ N/A ☐	
Support infants and families on palliative pathway			Yes ☐ No ☐ N/A ☐	

If you have a gap in provision, or a smaller amount of provision than recommend you can use the individual profession's tool. We recommend reviewing the tool with a member of the relevant professional group to identify which elements are currently delivered as standard on your unit, with support from the ODN.

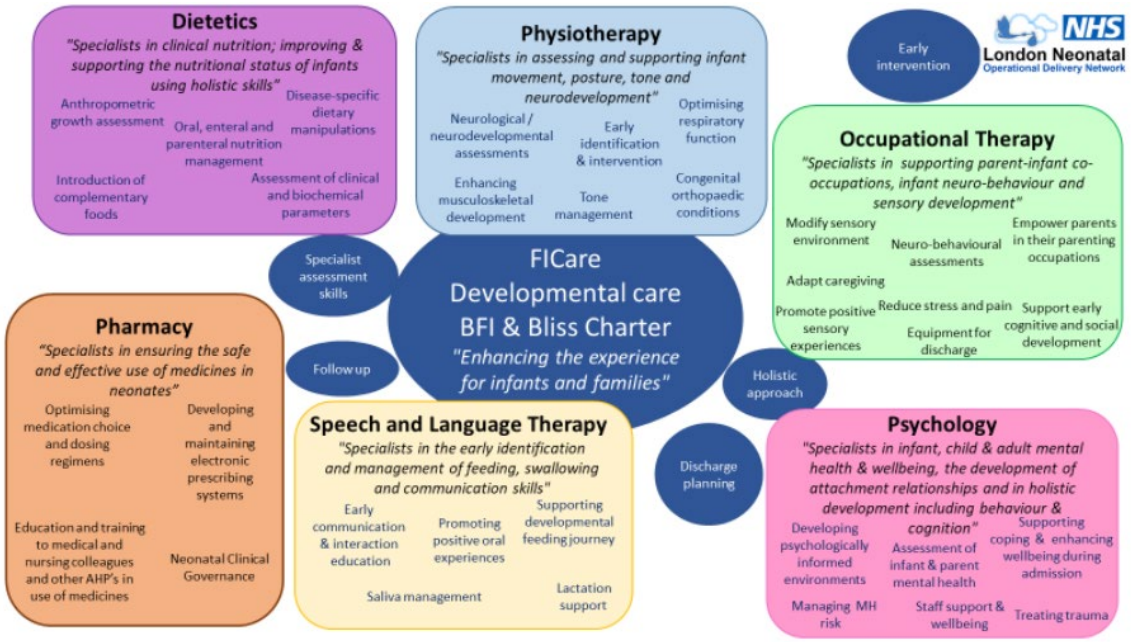
These tools allow you to review the provision you *are* or *are not* currently able to provide. You are asked to give a RAG rating to say whether that item happens *all the time*, *some of the time* or *not at all*. This tool will give you an idea of which areas need development. You can then proceed, using the sections of this implementation guide (see below).

This audit tool is useful to identify where there are areas of good practice and where there are gaps in your AHPPP provision. Once you have this overview, you can progress to thinking about next steps, which might be to develop a business case, using the tool as evidence in a safer staffing submission or a risk assessment. You can also use the tool to support the development of neonatal AHPPP professional practice.

Once you have used the audit tool, you can then use the best practice guide (BPG) to support your service development.



Neonatal AHPPP Team Audit Tool



Allied health professionals, Psychological professionals and pharmacists each bring a unique skill set to the neonatal unit. This is laid out using the universal/targeted/specialist model in the AHPPP best practice guide London-Neonatal-Network-AHPPP-Best-Practice-Guide-2025secure.pdf

In addition to their specialist skills, AHPPPS also bring overlapping skills and expertise which can support the holistic care of infants, families and staff. This audit tool is to help you review your general AHPPP provision on your neonatal unit. It covers the generic roles which all AHPPPs can play and how they can support the unit as a whole.

This audit tool should be undertaken collaboratively with representation from the full neonatal AHP/AHPPP team. A "green" RAG rating should only be awarded where the relevant provision is delivered as part of an integrated multidisciplinary neonatal AHP/AHPPP service, rather than where provision is delivered by a single profession. This aims to identify future areas of development for each member of the AHPPP service, including need for an increase in service provision to enable the team to achieve a green RAG rating.

There are also audit tools for many of the individual professions. Please contact your ODN lead for these.

Unit/trust name _____ Unit designation: NICU / LNU / SCU

Unit clinical lead _____ Unit matron _____

	Unit Physiotherapist(s)	Unit Dietitian(s)	Unit Occupational therapist(s)	Unit Psychological professional (s)	Unit Speech and language therapist(s)	Unit pharmacist(s)
Staffing recommendations	Physiotherapy	Dietetics	Occupational Therapy	Psychological Professionals	Speech & Language Therapy	Pharmacy
Name						
WTE (protected neonatal time)						
Banding						
WTE (unprotected – e.g. other source, good will)						
Total WTE						
% of national minimum standard						

SPECIALISED – Individualised care plans

Item	RAG (Red/ Amber/ Green)	Evidence (where available)	Action required?	Comments
Attend MDT meetings / discharge planning for complex infants			Yes ☐ No ☐ N/A ☐	
Any direct patient activity during admission			Yes ☐ No ☐ N/A ☐	
Any direct patient activity after discharge			Yes ☐ No ☐ N/A ☐	
Provide individualised early intervention and support			Yes ☐ No ☐ N/A ☐	
Support infants and families on palliative pathway			Yes ☐ No ☐ N/A ☐	

TARGETED: Pathways of care for targeted groups

Item	RAG (Red/ Amber/ Green)	Evidence (where available)	Action required?	Comments
Attendance at medical ward rounds			Yes ☐ No ☐ N/A ☐	
Attend and/or lead on MDT/Developmental ward round			Yes ☐ No ☐ N/A ☐	
Support with repatriation to other units			Yes ☐ No ☐ N/A ☐	
Support discharge planning process and procedures to promote a seamless transition from the NNU to home			Yes ☐ No ☐ N/A ☐	
Training/education to support neonatal outreach team and/or HVs in caring for babies in community			Yes ☐ No ☐ N/A ☐	

Accessing appropriate neonatal courses and mandatory training e.g., Neonatal life support, Infant feeding			Yes ☐ No ☐ N/A ☐	
Workforce planning to support recruitment and retention of AHP services			Yes ☐ No ☐ N/A ☐	

UNIVERSAL: All families, all of the time

Area	AHPPPs:	RAG (Red/ Amber/ Green)	Evidence (where available)	Action required?	Comments
Family Integrated Care / BFI / Bliss	Involvement in parent education (group and individual).			Yes ☐ No ☐ N/A ☐	
	Involvement in staff education (group and individual).			Yes ☐ No ☐ N/A ☐	
	Assist in embedding FiCare through all parent / staff contacts and the development and delivery of parent group education sessions, including provision of suitable supportive family resources			Yes ☐ No ☐ N/A ☐	
Developmental Care	Are involved in education/promotion across unit.			Yes ☐ No ☐ N/A ☐	
	Lead and support unit initiatives/projects.			Yes ☐ No ☐ N/A ☐	
	Provide individualised advice for infants e.g. via developmental ward round.			Yes ☐ No ☐ N/A ☐	
	Provide advice on adaptation of neonatal environment and care strategies.			Yes ☐ No ☐ N/A ☐	

	Provide equipment recommendations to support safety, comfort and regulation.			Yes ☐ No ☐ N/A ☐	
Psychologically (and trauma) informed care	Received training in trauma informed care, providing a general awareness of how to provide care in a trauma-informed way			Yes ☐ No ☐ N/A ☐	
	Know how to respond in the moment to families in distress (however this manifests) and seek further support/signpost as necessary.			Yes ☐ No ☐ N/A ☐	
	Commit to the values of empowerment, control, transparency and accountability in all practice with families and staff (include evidence)			Yes ☐ No ☐ N/A ☐	
Education	Provide education to parent / caregivers and families			Yes ☐ No ☐ N/A ☐	
	Provide staff education– neonatal MDT, but also wider paediatric and community staff where appropriate			Yes ☐ No ☐ N/A ☐	
Collaborative working	Have representation at: MDT meetings, holistic care, discharge planning meetings, guideline development, unit meetings			Yes ☐ No ☐ N/A ☐	
	Keep effective channels of communication up to date, with clear contact directory and role definitions			Yes ☐ No ☐ N/A ☐	
Quality Improvement / Research	Are involved in unit QIPs			Yes ☐ No ☐ N/A ☐	
	Are involved in research and service evaluations			Yes ☐ No ☐ N/A ☐	

Addressing health inequalities	Active efforts to engage and support families and staff who may have experiences of marginalisation, racism or discrimination			Yes ☐ No ☐ N/A ☐	
	involved in ongoing work to make services genuinely accessible and relevant to all			Yes ☐ No ☐ N/A ☐	
Family resources	Development of resources for families in collaboration with the MDT, including family induction packs, and information to support families during and post-admission.			Yes ☐ No ☐ N/A ☐	
Professional management	Self-regulate even in situations of high expressed emotion (with suitable organisational support provided, such as reflective practice, supervision, EAPs)			Yes ☐ No ☐ N/A ☐	
	Demonstrate awareness of limits of competence & ways in which to signpost parents or staff onwards to more appropriate provision or resources as required			Yes ☐ No ☐ N/A ☐	

RAG ratings:

Red = Not happening at present, not started
Amber = Planning stage/in progress/partly happening
Green = This is business as usual and happens routinely, all of the time

ACTION PLAN

Following the audit, our key areas of focus to develop AHPPP provision are:

1:
2:
3:

In order to do this, we have set the following SMART targets:

What are we are going to do? (be specific & realistic about what is achievable)	By when will we have done this?	How will we measure whether we have been successful?

Suggestions for targets might be:

- Add gaps in specific professional groups to the risk register
- Record episodes for every time a baby/family/staff member would have benefited from AHPPP support but it was not available
- Consider raising a DATIX report whenever a risk could not be managed because of the absence of AHPPP (e.g. suicidal parent, therapeutic equipment not being able to be provided)
- Develop a business case to develop provision for one or more professional group

- Send the invite to the MDT/ward round/other meeting to the AHPPP team
- AHPPP team to allocate someone to attend the MDT/Ward round/other meeting each week
- Complete the ODN AHPPP workforce plan
- Contact the ODN AHPPP team to get support with business plan/workforce plan/job planning/recruitment/other task

Neonatal Dietetic Service Assurance Tool

This tool is designed to support services in auditing their neonatal dietetic provision against our Best Practice Guide for Neonatal Allied Health, Psychological Professionals and Pharmacists. It can be used for self-assessment, quality improvement, and service development. For each element, assess your service's level of observance, provide evidence if available, and note required actions.

Unit/Trust name: _____ Unit designation: NICU ☐ LNU ☐ SCU ☐ with TC ☐

Unit Clinical Lead: _____ Unit Matron: _____

Unit Dietitian(s): _____

Unit dietetic provision (WTE): _____ Percentage of national minimum standard met: _____%

Section 1: Universal Care – Embedded Principles for All

Element	RAG score (Red/Amber/Green)	Evidence (where available)	Action Required	Comments
Dietitian presence on unit to support early family conversations and relationship building.			Yes ☐ No ☐ N/A ☐	
Support/contribute to unit BFI / FiCare / Bliss accreditation.			Yes ☐ No ☐ N/A ☐	
Advocate breast milk as first feed choice for all infants.			Yes ☐ No ☐ N/A ☐	
Lead on development of local nutrition-based policies.			Yes ☐ No ☐ N/A ☐	
Provide training/education for staff and parents on growth and nutrition.			Yes ☐ No ☐ N/A ☐	

Support/lead nutrition-related audit, QI, and research projects.			Yes ☐ No ☐ N/A ☐	

RAG Scoring: Green = 1, Amber = ½, Red = 0. Maximum score = 30.

Section 2: Targeted Care – Pathways for Specific Groups

Element	RAG score (Red/Amber/Green)	Evidence (where available)	Action Required	Comments
Expert input for extremely preterm infants and those requiring PN.			Yes ☐ No ☐ N/A ☐	
Support for transition from PN to EN, and EN to oral feeding.			Yes ☐ No ☐ N/A ☐	
Support for breastfeeding / expressing mothers.			Yes ☐ No ☐ N/A ☐	
Appropriate use of breast milk fortifier and preterm formula.			Yes ☐ No ☐ N/A ☐	
Support for families under Neonatal Outreach with growth/feeding issues.			Yes ☐ No ☐ N/A ☐	
Implementation of guidance on PN, EN, donor milk, HMF, formula, micronutrients.			Yes ☐ No ☐ N/A ☐	
Facilitation of student/HCP training and clinical supervision.			Yes ☐ No ☐ N/A ☐	
Contribution to unit/network QI, audits, and workstreams.			Yes ☐ No ☐ N/A ☐	

RAG Scoring: Green = 1, Amber = ½, Red = 0. Maximum score = 30.

Section 3: Specialised Care – Individualised Plans

Element	RAG score (Red/Amber/Green)	Evidence (where available)	Action Required	Comments
Individualised dietetic assessment, intervention, and follow-up for complex needs (e.g. NEC, malnutrition, syndromes, reflux, neurological impairment).			Yes ☐ No ☐ N/A ☐	
Timely review and monitoring in collaboration with MDT.			Yes ☐ No ☐ N/A ☐	
Dietetic input for palliative care.			Yes ☐ No ☐ N/A ☐	
Education/co-production with parents/carers on feeding plans.			Yes ☐ No ☐ N/A ☐	
Regular audit/evaluation of dietetic service provision.			Yes ☐ No ☐ N/A ☐	

RAG Scoring: Green = 1, Amber = ½, Red = 0. Maximum score = 30.

Section 4: Transitional Care (NTC)

Element	RAG score (Red/Amber/Green)	Evidence (where available)	Action Required	Comments
Support BFI / FiCare implementation in NTC.			Yes ☐ No ☐ N/A ☐	
Promote neurodevelopmentally appropriate measurements & feeding practices.			Yes ☐ No ☐ N/A ☐	
Provide parent feeding support (early breast milk, expressing support).			Yes ☐ No ☐ N/A ☐	
Guidance on enteral feeding, HMF use, micronutrients, specialist formulas.			Yes ☐ No ☐ N/A ☐	

Support infants transitioning from NNU requiring ongoing dietetic input.			Yes ☐ No ☐ N/A ☐	
Prevent readmissions due to feeding/growth issues.			Yes ☐ No ☐ N/A ☐	

RAG Scoring: Green = 1, Amber = ½, Red = 0. Maximum score = 30.

Section 5: Governance and Service Development

Element	RAG score (Red/Amber/Green)	Evidence (where available)	Action Required	Comments
Service funding and job planning in place and maintained.			Yes ☐ No ☐ N/A ☐	
Clinical supervision (internal/external) provided when needed.			Yes ☐ No ☐ N/A ☐	
Escalation pathway for clinical concerns in place.			Yes ☐ No ☐ N/A ☐	
Contribution to relevant clinical unit or network guideline development/updates.			Yes ☐ No ☐ N/A ☐	
Engagement with regional / national groups (e.g. pan-London Dietitian meetings, LNNG, NDiG).			Yes ☐ No ☐ N/A ☐	

RAG Scoring: Green = 1, Amber = ½, Red = 0. Maximum score = 30.

Overall RAG score in relation to the Best Practice Guide (Neonatal Dietetics): _____/30 = _____%

Priority areas for action:

1.	
2.	
3.	

Neonatal Occupational Therapy Service Assurance Tool

This assurance tool combines aspects of the Best Practice Guide for Neonatal Allied Health, Psychological Professionals and Pharmacists and utilizes the *Royal College of Occupational Therapy audit tool form: Occupational Therapy in neonatal services and early intervention practice guideline* to evaluate neonatal occupational therapy service delivery against national best practice guidelines. It can be used for **self-assessment, quality improvement, governance assurance, and service development.**

Implementing the Neonatal OT Service Assurance Tool:

The tool should be completed by the unit Occupational Therapist/s in conjunction with the London ODN OT lead. For each element, assess your service's level of provision and consider universal, targeted and specialist services. Provide evidence where available and RAG rate and score each element (Red, Amber, Green) to reflect the level and quality of service. Document required actions and complete summary.

Red (Score = 0)	Not completed/very limited/not yet started (<40% completed) e.g. due to limited OT capacity or service priorities
Amber (Score = 1)	Partially completed/or inconsistent (70-40% completed) e.g. service provided to certain populations but not all
Green (Score = 2)	Fully completed/ embedded within routine practice/ offered consistently (70%-100% completed)

Neonatal Unit: _____ **Unit designation:** NICU ☐ LNU ☐ SCU ☐ with TC ☐

Clinical Lead: _____ **Matron:** _____

Occupational Therapist/s (name and banding): _____

Occupational therapy provision (WTE): _____

Percentage of national minimum standard: _____

	Observance (Red, Amber, Green)	Score (0,1,2)	What is your current practice? How do you evidence this?	Comments Actions to be taken by whom and when
Sustainable funding, workforce planning, and succession planning in place				
OT service provided to transitional care				
Working collaboratively with the MDT				
OT representation at all relevant unit meetings and working groups e.g. clinical meetings, governance meetings				
OT involvement in FICARE				
OT involvement in Quality improvement/audit				
OT involvement in research				
Access to appropriate neonatal clinical supervision				
Access to neonatal peer supervision				
Clear escalation pathway for concerns				
Contribution to relevant clinical unit or network guideline development/updates. e.g. relevant guidelines				

Engagement with regional / national groups (e.g. pan-London therapies meeting, RCOT communities)				

Summary

Overall observance to Neonatal OT Practice guidelines: _____/35 _____%

Workforce, Service development and Governance overall observance: _____/12 _____ %

Total _____/47 _____ %

Total number of Red_____ Amber _____ Green _____

Priorities for action:

1.	
2.	
3.	

Audit form: Occupational therapy in neonatal services and early intervention – practice guideline (2nd Edition)

Audit Form

This audit tool is to be used with the evidence-based practice guideline *Occupational therapy in neonatal services and early intervention – 2nd edition* (RCOT 2022).

These evidence-based recommendations are not intended to be taken in isolation and must be considered in conjunction with the contextual information provided in the full guideline, together with the details on the strength and quality of the recommendations. The recommendations are intended to be used alongside clinical expertise and, as such, the occupational therapist is ultimately responsible for the interpretation of the evidence-based guideline in the context of their specific circumstances and the people accessing their services.

The full practice guideline together with implementation resources can be found on the Royal College of Occupational Therapists website: **https://www.rcot.co.uk/practice-resources/rcot-practice-guidelines**

Reference

Royal College of Occupational Therapists (2022) *Occupational therapy in neonatal services and early intervention. 2nd ed.* London: RCOT.

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Date of audit		Auditor		Role	
Location		Review due date			

Recommendations

Occupation-based assessments		What is your current practice? How do you evidence this?	Comments Actions to be taken by whom and by when
1.	**It is recommended** that occupational therapists safely and appropriately assess the neurobehavioural status of the high-risk infant, in order to plan/deliver developmentally supportive care.		
2.	**It is recommended** that occupational therapists assess neurobehavioural and neurodevelopmental status to provide guidance and identify infants appropriate for developmental follow up following discharge.		
3.	**It is recommended** that occupational therapists liaise with community teams and assess neurodevelopmental status for high-risk infants in the first two years of life to provide guidance and implement early intervention services where indicated.		

Developmentally supportive care		What is your current practice? How do you evidence this?	Comments Actions to be taken by whom and by when
4.	**It is recommended** that developmentally supportive care principles are implemented for high-risk infants admitted to neonatal units to enhance short term health and developmental outcomes.		
5.	**It is recommended** that occupational therapists promote an appropriate developmental environment, based on the infant's age and status and individual needs.		

Pain management		What is your current practice? How do you evidence this?	Comments Actions to be taken by whom and by when
6.	**It is recommended** that occupational therapists promote the use of non-pharmacological pain management strategies (e.g. skin-to-skin care, facilitated tucking etc) by all caregivers (parents and practitioners) for pain management during appropriate, planned, painful caregiving procedures.		

7.	**It is recommended** that occupational therapists support parent understanding and engagement in appropriate pain management strategies to enable them to provide sensitive support to their infants and promote parent self-efficacy.		
8.	**It is recommended** that occupational therapists work with the neonatal team to promote routine assessment of neonatal pain and identification of appropriate pain management strategies.		

Skin-to-skin (kangaroo) care		**What is your current practice? How do you evidence this?**	**Comments** **Actions to be taken by whom and by when**
9.	**It is recommended** that occupational therapists collaborate with the neonatal team to facilitate parent engagement in skin-to-skin care for high-risk infants to promote pain management, physiological regulation and infant weight gain.		
10.	**It is recommended** that occupational therapists collaborate with the neonatal team to facilitate parent engagement in skin-to-skin care for high-risk infants to promote breastmilk feeding, parent wellbeing and parent self-efficacy.		

Touch		What is your current practice? How do you evidence this?	Comments Actions to be taken by whom and by when
11.	**It is recommended** that occupational therapists facilitate the provision of positive touch and infant massage* by parents/primary caregivers to decrease infant stress and improve state and physiological regulation.		
12.	**It is recommended** that occupational therapists facilitate the provision of positive touch and infant massage* by parents to decrease parent anxiety and promote parent mood and parent-infant relationship. * NB: Please see information in section 5.5.1 of the full guideline regarding the requirement for specialist training/certification to facilitate parent-delivered infant massage with high-risk infants in the neonatal unit setting.		

Postural support		What is your current practice? How do you evidence this?	Comments Actions to be taken by whom and by when
13.	**It is recommended** that occupational therapists collaborate with the neonatal team to facilitate individualised postural support recommendations for infants that promote infant motor outcomes, self-regulatory behaviours and prevent respiratory compromise.		
14.	**It is recommended** that occupational therapists review the selection and use of neonatal postural support aids for their ability to promote infant motor outcomes, the development of infant postural control and self-regulatory behaviours.		
15.	**It is recommended** that occupational therapists use a postural support assessment tool to support the education of the neonatal team and promote individualised positioning of high-risk infants in the neonatal unit.		

Infant feeding		What is your current practice? How do you evidence this?	Comments Actions to be taken by whom and by when
16.	**It is recommended** that occupational therapists collaborate with the neonatal team to support parents in reading and responding to infant feeding readiness cues to promote the co-occupation of feeding in the neonatal unit and following transition to home.		
17.	**It is recommended** that occupational therapists promote an appropriate environment in the neonatal unit to support parent/infant participation in early feeding experiences. Environmental support factors may include space, seating, privacy, sensory environment and NICU culture.		

Parent engagement		What is your current practice? How do you evidence this?	Comments Actions to be taken by whom and by when
18.	**It is recommended** that occupational therapists work with parents of high-risk infants to support parenting roles and relationships, and to provide sensitive and appropriate parent engagement in the infant's care in the neonatal unit.		

19.	**It is recommended** that occupational therapists facilitate the development of co-occupations related to activities of daily living (including, but not limited to, feeding, bathing, nappy changing, dressing and play activities of daily living) with preterm and low-birthweight infants to ensure sensitive and appropriate caregiving and promote occupational performance of infants and parents.		
20.	**It is recommended** that occupational therapists working with families of high-risk infants build a positive therapeutic collaboration with parents to enhance parental learning about their infant both during and following the transition to home.		
21.	**It is suggested** that occupational therapists explore both traditional and innovative methods (e.g. videoconferencing) of supporting families post- discharge from the neonatal unit as a means of promoting parent confidence and competence in caring for their infant following the transition to home.		

Parent support		What is your current practice? How do you evidence this?	Comments Actions to be taken by whom and by when
22.	**It is recommended** that occupational therapists support engagement in parenting occupations in the neonatal unit and following discharge (including, but not limited to, reading infant cues, guided participation in care, skin-to-skin, positive touch and holding) to promote decreased parent stress and positive improvements in parent–infant relationship and self-efficacy.		
23.	**It is recommended** that occupational therapists employ parent-focused interventions that incorporate parental attunement in order to reduce the psychosocial impact of delivering a high-risk infant, foster sensitive nurturing behaviour and promote the cognitive development of preterm infants.		
24.	**It is suggested** that occupational therapists engage parents in brief activity-based interventions during their infant's admission to the neonatal unit and that this can have a short-term effect in lowering parent anxiety.		

25.	**It is recommended** that occupational therapists consider the use of e-health interventions (e.g. web-based platforms, mobile apps, video-conferencing etc) to support parent engagement, particularly when parent presence may be interrupted.		
26.	**It is recommended** that occupational therapists employ the use of parent-focused psychosocial interventions to decrease parent stress and anxiety and promote parent coping, confidence and early parent-infant relationships.		

Identifying developmental concerns		**What is your current practice? How do you evidence this?**	**Comments** **Actions to be taken by whom and by when**
27.	**It is recommended** that occupational therapists should be involved in the screening and assessment of high-risk infants for problems related to cognitive performance and social interaction, to support the development of the infant's occupations, with referral to early intervention services as indicated.		

28.	**It is recommended** that occupational therapists should be involved in the screening and assessment of high-risk infants for problems related to functional motor skills, to support the development of the infant's occupations, with referral to early intervention services as indicated.		
29.	**It is recommended** that occupational therapists should be involved in the screening and assessment of high-risk infants for problems related to sensory processing difficulties, to support the development of the infant's occupations, with referral for early intervention services as indicated.		

Early intervention		**What is your current practice? How do you evidence this?**	**Comments** **Actions to be taken by whom and by when**
30.	**It is recommended** that occupational therapists provide early developmental intervention programmes for preterm infants to promote improved cognitive performance through the preschool years.		
31.	**It is recommended** that occupational therapists provide home-based early intervention programmes for infants born <30 weeks' gestation in the first year of life as this may result in decreasing parent anxiety.		

32.	**It is recommended** that occupational therapists facilitate individualised functional motor interventions for high-risk infants and young children to promote engagement in early occupations such as play, exploration and participating in personal care (activities of daily living).		
33.	**It is recommended** that occupational therapists incorporate home routine/occupation-based approaches in early intervention programmes for children at risk for developmental delay as a means of promoting occupational performance.		
34.	**It is recommended** that occupational therapists be routinely referred preterm infants with the following co-morbidities: septicaemia, extremely low birthweight (ELBW), chronic lung disease, periventricular leukomalacia (PVL) or intraventricular haemorrhage (IVH) (grade III–IV), for early intervention.		

35.	**It is recommended** that occupational therapists working in early intervention settings with high-risk infants consider key elements when building a therapeutic collaboration with parents – promoting effective collaboration amongst multiagency providers, supporting family social/emotional needs in addition to infant developmental concerns, and consistency of service provision.		

Neonatal Pharmacy Service Assurance Tool

This tool is adapted from the Best Practice Guide for Neonatal Allied Health, Psychological Professionals and Pharmacists and is designed to support services in auditing **neonatal pharmacy provision** against best practice standards for neonatal care. It can be used for **self-assessment, quality improvement, governance assurance, and service development**.

For each element, assess your service's level of observance, provide evidence where available, and record required actions.

Unit / Trust: _____
Clinical Lead: _____

Unit designation: NICU ☐ LNU ☐ SCU ☐ with TC ☐
Lead Neonatal Pharmacist: _____

Neonatal pharmacy provision (WTE): _____
Unprotected WTE: _____

Protected neonatal WTE: _____

Estimated % of national minimum standard NPPG-Neonatal-Staffing-Standards-V2.pdf met: _____%

Section 1: Universal Care – Embedded Principles for All

Element	Observance (Red/Amber/Green)	Evidence *(where available)*	Action / Comments
Regular pharmacist presence on the neonatal unit to support safe medicines use and early MDT engagement		*e.g. job plan, rota*	
Active contribution to family-centred care (FiCare), BFI, and shared decision-making regarding medicines		*training records, SOPs*	

Promotion of medication safety culture (error reporting, learning from incidents)		*DATIX reports, QI work*	
Lead or contribute to development of neonatal medicines policies, guidelines, and SOPs		*local guidelines*	
Provide medicines-related education for staff and parents/carers		*teaching materials*	
Participation in audit, quality improvement, or research related to neonatal medicines		*audit/QI reports*	

Scoring: Green (70–100%) = 1 | Amber (40–69%) = 0.5 | Red (<40%) = 0

Section 2: Targeted Care – Pathways for Specific Groups

Element	**Observance (Red/Amber/Green)**	**Evidence** ***(where available)***	**Action / Comments**
Expert pharmaceutical input for extremely preterm infants and critically unwell neonates		*case studies, ward rounds*	
Leadership and oversight of parenteral nutrition (PN) prescribing, compounding, and monitoring		*PN SOPs, audit data*	
Support safe transition from PN to enteral nutrition (EN), including electrolyte and micronutrient management		*guidelines, case reviews*	
Optimisation of antimicrobial therapy (choice, dosing, TDM, stewardship)		*AMS audits, TDM records*	

Medicines optimisation for infants with renal, hepatic, or cardiac impairment		*clinical interventions*	
Oversight of use of high-risk medicines (e.g. opioids, inotropes, insulin, prostaglandins)		*risk assessments*	
Support training and supervision of pharmacy staff, trainees, and students		*training plans*	
Contribution to unit or network-wide medicines-related QI workstreams		*project documentation*	

Scoring: Green (70–100%) = 1 | Amber (40–69%) = 0.5 | Red (<40%) = 0

Section 3: Specialised Care – Individualised Pharmaceutical Care

Element	**Observance (Red/Amber/Green)**	**Evidence** *(where available)*	**Action / Comments**
Individualised pharmaceutical care plans for complex cases (e.g. NEC, seizures, metabolic disorders, cardiac disease)		*case studies*	
Regular medicines review and dose adjustment in collaboration with the MDT		*ward round records*	
Pharmaceutical input into palliative and end-of-life care (symptom control, compassionate use medicines)		*care plans*	

Parent/carer education and counselling on medicines (administration, storage, safety)		*eaflets, documentation*	
Routine evaluation of pharmacy service impact and outcomes		*service evaluations*	

Scoring: Green (70–100%) = 1 | Amber (40–69%) = 0.5 | Red (<40%) = 0

Section 4: Transitional Care and Discharge

Element	**Observance (R/A/G)**	**Evidence** *(where available)*	**Action / Comments**
Medicines optimisation for infants in Neonatal Transitional Care (NTC)		*SOPs*	
Accurate medicines reconciliation at admission, transfer, and discharge		*reconciliation audits*	
Provision of clear, parent-friendly discharge medication information		*discharge checklists*	
Liaison with community pharmacy, GP, and neonatal outreach teams		*communication records*	
Prevention of readmissions related to medicines issues (e.g. dosing errors, supply problems)		*ncident reviews*	

Scoring: Green (70–100%) = 1 | Amber (40–69%) = 0.5 | Red (<40%) = 0

Section 5: Governance, Workforce, and Service Development

Element	Observance (Red/Amber/Green)	Evidence *(where available)*	Action / Comments
Sustainable funding, workforce planning, and succession planning in place		*workforce plans*	
Access to appropriate clinical supervision and peer support		*supervision records*	
Clear escalation pathways for medicines-related clinical risk		*SOPs / flowcharts*	
Pharmacy representation at neonatal governance, safety, and MDT meetings		*meeting minutes*	
Engagement with regional and national neonatal pharmacy networks		*meeting notes*	

Scoring: Green (70–100%) = 1 | Amber (40–69%) = 0.5 | Red (<40%) = 0

Overall Observance Score: _____ / 30 = _____ %

Priority Areas for Action

1.	
2.	
3.	

Neonatal Physiotherapy Standards of Care Measure

This tool is designed to support services in auditing their neonatal physiotherapy provision against our Best Practice Guide for Neonatal Allied Health, Psychological Professionals and Pharmacists. It can be used for self-assessment, quality improvement, and service development. It should be completed by the unit physiotherapist (or neonatal matron/clinical lead if no physiotherapist available) in conjunction with the London ODN lead physiotherapist. For each element, assess your service's provision and score in line with guidance, provide evidence if available, and note required actions.

Neonatal Unit: _____

Unit designation: NICU ☐ LNU ☐ SCU ☐

Clinical Lead: _____

Matron: _____

Physiotherapist(s): _____

AfC Banding: _____

Funding stream: _____

Physiotherapy provision (WTE):	
Percentage of national minimum standard:	
Overall Score (see below):	
Action required?	Yes ☐ No ☐
Comments:	

Section 1: Developmental care

Element	**Evidence** *(e.g. SOP/guideline/job plan/etc.)*	**Action required?**	**Comments**
Physiotherapist plays an active role in providing developmental care on the unit (e.g. individualised advice for infants/families, ward rounds etc.)		☐ Yes ☐ No ☐ N/A	

Physiotherapist is involved in (or leads on) MDT education and training to promote developmental care		☐ Yes ☐ No ☐ N/A	
Physiotherapist is involved in (or leads on) parent and family teaching to build awareness of developmental care		☐ Yes ☐ No ☐ N/A	
Physiotherapist has attended additional training courses such as Brazelton/ FINE		☐ Yes ☐ No ☐ N/A	
Overall score (see below)			

Section 2: Family Integrated Care

Element	**Evidence** ***(e.g. SOP/guideline/job plan/etc.)***	**Action required?**	**Comments**
Physiotherapist embeds FICare principles in their practice ensuring parents/guardians are empowered in their baby's care		☐ Yes ☐ No ☐ N/A	
Physiotherapist is involved in (or leads on) FICare training and education for the MDT		☐ Yes ☐ No ☐ N/A	
Physiotherapist is involved in (or leads on) FICare training and education for parents and families		☐ Yes ☐ No ☐ N/A	
Overall score (see below)			

Section 3: Neurodevelopmental input

Element	Evidence *(e.g. SOP/guideline/job plan/etc.)*	Action required?	Comments
Individualised physiotherapy assessment provided for high risk infants: • Preterm infants (<30/40) • High risk term infants • Other risk factors		☐ Yes ☐ No ☐ N/A	
Specialist neurological / neurodevelopmental assessments used (e.g. Prechtl GMA, LAPI, HNNE, TIMP)		☐ Yes ☐ No ☐ N/A	
Provision of individualised developmental support and early intervention		☐ Yes ☐ No ☐ N/A	
Overall score (see below)			

Section 4: Orthopaedic / MSK

Element	Evidence *(e.g. SOP/guideline/job plan/etc.)*	Action required?	Comments
Physiotherapy assessment provided for MSK / congenital orthopaedic concerns on unit		☐ Yes ☐ No ☐ N/A	
Inpatient treatment / management provided (by NNU physiotherapy team or other service)		☐ Yes ☐ No ☐ N/A	
Overall score (see below)			

Section 5: Respiratory

Element	Evidence *(e.g. SOP/guideline/job plan/etc.)*	Action required?	Comments
Physiotherapist provides assessment and universal advice or intervention for infants with respiratory compromise		☐ Yes ☐ No ☐ N/A	
Physiotherapist provides targeted or specialist advice or intervention for infants with respiratory compromise		☐ Yes ☐ No ☐ N/A	
Out of hours service available for **preterm** or **term** infants (specify extended hours / weekend / overnight)		☐ Yes ☐ No ☐ N/A	
Training and education provided to neonatal staff (medical and nursing) to optimise airway clearance		☐ Yes ☐ No ☐ N/A	
Service specification available for respiratory physiotherapy service OR use of ODN respiratory management and airway clearance guideline		☐ Yes ☐ No ☐ N/A	
Overall score (see below)			

Section 6: Neurodevelopmental follow up

Element	Evidence *(e.g. SOP/guideline/job plan/etc.)*	Action required?	Comments
Physiotherapist present in follow up clinics, in line with NICE guidelines		☐ Yes ☐ No ☐ N/A	

Specialist assessments used in clinic (such as Prechtl GMA, HINE, AIMS)		☐ Yes ☐ No ☐ N/A	
Overall score (see below)			

Section 7: MDT working

Element	**Evidence** ***(e.g. SOP/guideline/job plan/etc.)***	**Action required?**	**Comments**
Physiotherapist attends regular neonatal unit meetings such as MDT / discharge planning / psychosocial		☐ Yes ☐ No ☐ N/A	
Physiotherapist attends neonatal training and teaching available on unit		☐ Yes ☐ No ☐ N/A	
Physiotherapist leads training and teaching for MDT neonatal staff		☐ Yes ☐ No ☐ N/A	
Overall score (see below)			

Section 8: Projects / service improvement

Element	**Evidence** ***(e.g. SOP/guideline/job plan/etc.)***	**Action required?**	**Comments**
Physiotherapist is involved in service improvement projects on the neonatal unit		☐ Yes ☐ No ☐ N/A	

Physiotherapist is involved in formal research projects		☐ Yes ☐ No ☐ N/A	
Physiotherapy resources available for staff and/or families		☐ Yes ☐ No ☐ N/A	
Overall score (see below)			

Section 9: Resources / development opportunities

Element	**Evidence** ***(e.g. SOP/guideline/job plan/etc.)***	**Action required?**	**Comments**
Education and training (courses) available for physiotherapist to attend		☐ Yes ☐ No ☐ N/A	
Career progression opportunities, such as different banding on neonatal unit		☐ Yes ☐ No ☐ N/A	
Overall score (see below)			

Total score all areas: **/50** ____**%**

Priority areas for action:

1.	
2.	

3.	

Scoring

Sector	Score	Description
Staffing provision	0	No current service and no plan for business case
	1	No current service but workforce plan and business case in progress
	2	Ad-hoc in reach for particular high need caseload (often from paeds, unfunded)
	3	More regular service but staffing significantly low (<50%)
	4	Consistent service but staffing below recommendations (50-90%)
	5	Fully staffed to current staffing recommendations (>90%)
Developmental care (DC)	0	Physiotherapy do not currently input to DC, or DC not considered
	1	Consideration of DC given when assessing/treating infant
	2	Ad-hoc DC support provided to infants by physiotherapist
	3	Regular DC support, but no involvement in teaching/education
	4	Regular DC input and some teaching/education to staff and parents
	5	DC principles underpinned in audit and continued education to staff and parents
Family Integrated Care (FIC)	0	No current physiotherapy input to service
	1	Some consideration of FIC given when physio assessing/treating infant
	2	Parents regularly involved with therapy, and physio has good understanding of FIC
	3	Physio involvement in FIC principles on unit, but no teaching/education to staff or parents
	4	Regular FIC input and some teaching/education on unit and parents
	5	FIC principles underpinned in audit and continued education to MDT and parents
Neurodevelopmental input	0	No current service
	1	Screening for specific caseload only (often when ad-hoc service only)
	2	As above, but also able to provide some limited intervention
	3	Assessment/intervention pathway for some infants at risk
	4	Targeted/specialist assessments for infants and some Early Intervention (EI) provided
	5	Targeted/specialist assessments and EI service for all infants at risk

Orthopaedic/ MSK	0 1 2 3 4 5	No current service Occasional ad-hoc service staffed by paeds/non-neonatal team Ah-hoc service staffed by paeds or neonatal with some specialist training Ad-hoc service staffed by specialist neonatal/ortho team 5 or 7 day service with SOP for OOH management 5 or 7 day service with SOP and specialist clinics in-house
Respiratory	0 1 2 3 4 5	No current respiratory service Occasional ad-hoc respiratory service staffed by paeds/non-neonatal team Ad hoc service staffed by paeds or neonatal with some specialist training Universal advice or intervention offered, with some MDT training for optimising management Universal and targeted advice and intervention provided, with some MDT training. Full respiratory physiotherapy service provided, with specialist neonatal skills and embedded MDT training as per ODN guideline.
Neurodevelopmental follow up	0 1 2 3 4 5	No current service Occasional PT involvement when required Access to PT or irregular input to follow up PT in follow up, no standardised assessments used PT in follow up using standardised assessments. Not meeting NICE standards PT embedded in follow up, adhering to NICE standards as minimum
MDT working	0 1 2 3 4 5	No current service MDT know how to refer to physio Regular referrals made, physio considered during MDT/ward rounds Physio present on unit and some involvement in MDT, occ teachings Embedded into team, some regular meetings and education Embedded into MDT, frequent meetings and teachings/education
Projects/ service Development	0 1 2 3 4 5	No current service Occasional input to QI projects on the unit or PT neonatal focused Involvement in a few QI projects on the unit Leading with QI projects specific to neonatal unit Regular involvement and leading of PT QI projects and/or research Regular involvement & leading of MDT QI projects and research

Resources/ development opportunities	0	No current service
	1	No neonatal specific resources, use of paeds/generic ones only
	2	Some resources but no training opportunities
	3	Some resources, and some training opportunities (i.e. B6 rotational post)
	4	SOP/pathways available, some career progression (different banding in team)
	5	SOP/pathways available, good opportunities for career progression

Neonatal Psychological Service Assurance Tool

This audit tool is adapted from the Best Practice Guide for Neonatal Allied Health, Psychological Professionals and Pharmacists. It is designed to support services in auditing **neonatal psychological provision** against best practice standards for neonatal care. It can be used for **self-assessment, quality improvement, governance assurance, and service development**.

For guidance on how to use this tool, alongside the best practice guide (linked above) see the implementation guide. This tool is to help you think about the kind of provision you want to deliver, and to talk with your unit senior team about what is feasible within the staffing you have. Used regularly, this tool can allow for reflection on the care you are providing and how you would like to develop it in the future and may be helpful to use in supervision and line management discussions. It can also support the evidence required for a business case to develop your clinical provision.

For each element, assess your service's level of observance, provide evidence where available, and record required actions. Note that the standards apply to neonatal care from NICU to transitional care. Where the same service is not offered in transitional care, please note this in comments. The tool uses the universal/targeted/specialist model. See the best practice guide or staffing standards for more on this model.

Unit / Trust: _____ **Unit designation:** NICU ☐ LNU ☐ SCU ☐ and TC ☐

Clinical Lead: _____ **Lead Neonatal Psychological professional:** _____

Neonatal psychological professional provision (WTE): _____ **Protected neonatal WTE:** _____ **Unprotected WTE:** _____

Estimated % of national minimum staffing standard and BAPM quality standards met: _____%
To achieve all the items laid out across this tool you would need at least minimum staffing standards.

Section 1a: Specialised Care – Individualised Psychological Care for infants, parent-infant and parent/carers

Element	Observance (Red/Amber/Green)	Evidence *(where available)*	Action / Comments
Formulation led psychotherapeutic assessment and intervention for families with complex, clinical, or chronic experiences of psychological difficulty		*care plans, case studies case studies*	(including complex bereavement)
Parent-infant interventions		*care plans, case studies ward round records*	e.g. video interactive guidance, parent-infant psychotherapy, Watch Wait Wonder
Individual talking therapies adapted to context		*care plans, case studies*	(e.g. ACT, CFT, CBT, NET, EMDR)

Couple and family therapy to support family functioning		*leaflets, documentation*	
Risk assessment and management for adults presenting with significant risk of harm to self or other.		*care plans, case studies*	
Working within the MDT when there are safeguarding concerns due to parental mental health concerns or issues around capacity, consent or relationship complexity.		*SOP, policies, case studies*	

Section 1b: Specialised Care – Individualised Psychological Care for staff (individual and group)

Element	**Observance** (Red/Amber/Green)	**Evidence** *(where available)*	**Action / Comments**
Dialogical or systemic intervention to support repair of staff-family relationships following significant ruptures.		*case studies, training plans*	
Short package of therapeutic sessions for staff members in specific situations		*Case studies*	
For longer-term work, referrals to appropriate services		*Audit data*	
Collaborating with management, to provide assessment and signposting for staff experiencing significant psychological difficulty for whom alternative staff wellbeing support is not accessible.		*leaflets, documentation, policies*	
Clinical Supervision of trainee psychologists and psychotherapists in line with professional bodies requirements		*SOPs*	

Section 1c: Specialised Care – Individualised Psychological Care for system (unit environment, organisational culture)

Element	**Observance** (Red/Amber/Green)	**Evidence** *(where available)*	**Action / Comments**
Specialist organisational development interventions in situations of significant systems-based challenge.		*Case studies*	Might include pre/debriefs, meetings with managers, consultation, training, drop in availability and other interventions as needed

Section 2a: Targeted Care – Pathways for families (Infant, parent-infant and parent/carer)

Element	Observance (Red/Amber/Green)	Evidence *(where available)*	Action / Comments
Facilitation of formulation-led care planning for infants and families through psychosocial or similar psych-led meetings.		*Psychosocial meeting notes, case studies*	
Supporting parents and staff to connect with infants' experiences and needs through brief evidence-based parent-infant interventions		*SOPs, audit data, case studies*	e.g. NBO
Symptom/risk monitoring for families.		*guidelines, case reviews*	
Single session/brief support focused on distress reduction, developing coping skills, adjustment to diagnosis, decision making, adjustment to transition, end of life care and bereavement.		*Case studies, audit data*	
Informing family care plans based on individual therapeutic work.		*Care plans, case studies*	
Co-ordinating with external agencies to create packages of effective support.		*Care plans, Service resources, SOP, policies*	

Section 2b: Targeted Care – Pathways for staff (individual and team)

Element	Observance (Red/Amber/Green)	Evidence *(where available)*	Action / Comments
Single session/brief individual wellbeing support to staff for work-related psychological needs.		*case studies, audit data*	
Collective responses following specific episodes		*SOPs and policies/planning, case studies*	e.g. debrief-to-manage, PETR, collective trauma responses such as Tree of Life workshops.
Consultation to staff about the psychological aspects of their work with specific families.		*MDT minutes, case studies*	
Training needs analysis of psychological aspects of team's care including induction of new staff Includes both stand-alone psychological training & collaboration with other professionals		*Training needs analysis Induction timetables*	e.g. SLT re emotional difficulties around feeding/with specialist nurses re palliative & bereavement care
Enhanced training for staff (e.g. trauma informed champions) in psychological practice.		*Training plans*	

Bespoke and targeted support for staff working with specific groups		*Policies, SOPs, case studies*	e.g. extreme pre-term babies, babies & families in palliative care or bereavement, safeguarding work
Provision of restorative and developmental supervision for specific members of staff with psychosocial responsibilities			(e.g. PNAs, family liaison nurses, FiCare leads, unit leads) Specify if planned or ad hoc

Section 2c: Targeted Care – Pathways for system interventions (unit environment and organisational culture)

Element	**Observance** (Red/Amber/Green)	**Evidence** *(where available)*	**Action / Comments**
Consultation, supervision & training for staff in management positions re compassionate leadership when difficulties arise.		*Training plans, minutes*	
Developing programmes of work which include co-produced training around culture, team working and psychological safety where teams request more support or needs are identified		*Programmes of work training plans*	
Supervision of research (masters/doctoral level) which explores the lived experience of families or staff on the NNU, and which can be useful to improve care, safety & quality		*Research (published or disseminated), research meeting minutes*	
Developing unit guidance on all aspects of biopsychosocial care and collaborating on guidance related to team structure and functioning and addressing challenges.		*Unit guidance and policies*	

Section 3a: Universal Care – Embedded Principles for Families (Infant, parent-infant and parent/carer)

Element	**Observance** (Red/Amber/Green)	**Evidence** *(where available)*	**Action / Comments**
Universal programme for screening (see 'Identifying needs' document)		*e.g. job plan, rota*	
Collaborative team working involving participation in MDT ward rounds, MDT meetings, Fi care, psychologically informed neuroprotective and developmental care		*Meeting minutes, policies, QI work*	

Facilitation of parent/carer education alongside other members of MDT.		*Group session plans*	
Facilitation of support groups for parents.		*Group session plans*	
Clear signposting for families to psychosocial support within and beyond unit: By psychological professional Including production or promotion and dissemination of psychoeducational resources for families		*Training materials* *Case studies Leaflets and other resources*	
Clear signposting for families to psychosocial support within and beyond unit: Through education to create a knowledgeable MDT			

Section 3b: Universal Care – Embedded Principles for Staff (individual and team)

Element	**Observance** (Red/Amber/Green)	**Evidence** *(where available)*	**Action / Comments**
Production or promotion & dissemination of psychoeducational resources (focused on psychological needs of staff).		*Resources,*	
Production and dissemination of psychoeducational resources for staff (focused on needs of infants & families).		*Resources, training records*	
Facilitation of reflective spaces for staff (formal, planned sessions)		*e.g. job plan, rota,*	(e.g. group or individual supervision, reflective practice, Schwartz rounds, collective compassion practices).
Capacity for informal reflective discussion in established meetings (ward round/MDT) and corridor (or similar ad hoc) conversations			
Provision of teaching and training in psychological aspects of neonatal care (note where, which groups, topics etc). Include here making PINC (e-learning for health LINK) modules available		*teaching materials, evaluation data*	RAG rating will depend on regularity, accessibility, evaluation data

Section 3c: Universal Care – Embedded Principles for the system (unit environment, organisational culture)

Element	**Observance** (Red/Amber/Green)	**Evidence** *(where available)*	**Action / Comments**
Promoting recognition of distress in all its forms through informal (e.g. meetings, consultations) & formal settings (e.g. training)			
Advocacy for and actively inviting coproduction of services via meetings, engagement activities & for research & resources.		*e.g. minutes, resources*	Includes providing consultation & support for any peer projects
Use of feedback processes ensure provision of a quality, inclusive and sustainable psychological service.		*Measures, audit reports, DATIX/complaints*	
Conducting audit and engaging with service user feedback to assess and develop psychological aspects of neonatal care		*Measures, DATIX reports, QI work*	
Developing opportunities for trainee placement or research activity		*local guidelines*	
To offer a psychological perspective to the development and review of staff- and family-facing policies and procedures		*Policies*	
To develop psychologically informed environments through attention to the environment, staff training & policies		*Policies, minutes, pictures*	Involves embedding of psychological care into all aspects of care, both direct clinical care and including policies and procedures
Regular presence on the unit outside of formal sessions or meetings, with capacity for observation of, and reflection on babies, families, staff & environment to develop compassionate understandings and provide containment		*Case studies, staff feedback, observation case notes*	
Developing unit guidance on all aspects of biopsychosocial care and collaborating on guidance related to team structure & functioning and addressing challenges.		*Unit guidance and policies*	

Section 4: Transitional care, Discharge, outreach and outpatient care

Element	**Observance** (Red/Amber/Green)	**Evidence** *(where available)*	**Action / Comments**
Support with unit guidance on all aspects of TC, outreach & follow up, inc. development of psychologically & trauma informed clinics & outreach and collaborating on guidance related to team structure and functioning		*SOPs, unit guidance and policies*	*LINK to outreach staffing standards for psych).*

Single session/brief support focused on distress reduction, developing coping skills, adjustment to transition related to repatriation, discharge or outpatient care		*Case studies*	*(LINK to TC guidance)*
Facilitation of handover and referral to other psychological professionals and to community services for families when needed		*Case studies*	
Advocating for psychological provision in outreach teams & outpatient care (such as follow-up & neurodevelopmental clinics)			

Section 5: Governance, Workforce, and Service Development

Element	**Observance** **(Red/Amber/Green)**	**Evidence** ***(where available)***	**Action / Comments**
Adopt a consistent approach of psychological model between support for staff and families to facilitate care			
Sustainable funding, workforce planning, and succession planning in place		*workforce plans*	
Access to appropriate neonatal- specific clinical supervision		*supervision records*	
Access to meaningful peer support spaces to connect with other neonatal psychological professionals			
Reliable access to suitable clinical rooms for seeing families and staff (quiet, confidential, close to unit, not interrupted)			
Reliable access to office space on or close to the unit to complete administration whilst continuing to provide embedded care			
Clear escalation pathways for clinical risk		*SOPs / flowcharts*	
Psychological representation at neonatal governance, safety, and MDT meetings		*meeting minutes*	
Engagement with regional and national neonatal psychological networks including submission of data to regional team on a quarterly basis and attendance at LNPP meetings and peer supervision		*meeting notes, data submissions, caseload monitoring stats*	
Complete clinical records in line with the Best practice in record keeping guidance (LINK)			

Where the line manager is not a psychological professional, the governance for non-psychological professionals LINK () document is discussed at least annually		*meeting notes from line management meeting, job planning*	
Annual appraisal which includes a representative from your profession as well as line manager		*meeting notes*	
Proactively work to address health inequalities through both individual approach and work with staff teams in training, reflective practice, meetings and other settings		*meeting notes, project plans*	

Overall Observance Score (green items): _____ /66 = _____ %

Priority Areas for Action

1. _____
2. _____
3. _____

On this page, please keep a note of your reflections, thoughts and areas you want to follow up on. Qualitative reflections both related to process of completing this audit tool, and what it brings up for you about your work and the functioning of the unit can be helpful to capture.

RAG rating

Red = Not happening at present, not started

Amber = Planning stage/in progress/partially happening

Green = this is business as usual and happens routinely, all the time

Please note in comments if the same provision is available routinely, including when there is sickness, annual leave, or absence for training or other reasons

Neonatal Speech and Language Service Assurance Tool

This audit tool is adapted from the London-Neonatal-Network-AHPPP-Best-Practice-Guide-2025secure.pdf.and cross references the RCSLT Neonatal Speech and Language Therapy Identification Tool (2025). It is designed to support services in auditing **neonatal SLT provision** against best practice standards for neonatal care. It can be used for **self-assessment, quality improvement, governance assurance, and service development** in conjunction with the Neonatal SLT mapping tool included in the RCSLT Neonatal Speech and Language Therapy Identification Tool.

For each element, assess your service's level of observance, provide evidence where available, and record required actions. Note that the standards apply to neonatal care from NICU to transitional care. Where the same service is not offered in transitional care, please note this in comments.

Unit / Trust: _____ **Unit designation:** NICU ☐ LNU ☐ SCU ☐ and TC ☐

Clinical Lead: _____ **Lead Neonatal SLT professional:** _____

Neonatal SLT provision (WTE): _____**Recommended neonatal WTE:** _____

Estimated % of national minimum staffing standard and BAPM quality standards met: _____

Section 1: Specialised Care – Individualised specialist pre-feeding, feeding, swallowing and communication assessment and management in infants identified to have conditions with a known risk of associated feeding, speech, language and communication difficulties *Refer to the RCSLT Neonatal SLT Identification Tool for Specialist level criteria

	Standard	How this is evidenced	Evidence/examples (where available)	Rag Rating	Action / Comments Yes/No/NA
1	Use of Identification tool to screen caseload for babies meeting specialist criteria (frequency should align with protected neonatal SLT provision – see mapping tool in RCSLT Neonatal SLT Identification Tool)	Active screening of handover sheet (frequency dependent on provision)			
2	1:1 Assessment and clinical management for Specialist	Database identifying specialist/targeted/universal			

	level babies: problem identified/expected and first contact within 48 hours	caseload (service offer dependent on provision)			
3	Direct specialist assessment and management for early language and communication, feeding and swallowing, delivered within a holistic, family integrated framework	Assessment is carried out in partnership with parents and where possible, the cotside nurse is present Management considers parental feeding goals and includes individualised coaching as needed. Recommendations align with neonatal unit feeding practice as per unit specific or ODN guidelines			
4.	Apply knowledge of developmentally supportive, neuroprotective and cue-based care to communication and feeding interactions with the baby	Interactions and feeding support are responsive to baby's behavioural cues, readiness and physiological stability SLT models and promotes cue-based, infant-led approaches with parents and the MDT			
5.	Individualised coaching and support for parents around their baby's early feeding and cue based breast and bottle feeding experiences with modified plans as required	Time made to work collaboratively with parents and model strategies			

6	Individualised coaching and support for nursing colleagues around supporting babies with more specific feeding strategies/interventions	SLT works collaboratively with nursing colleagues to model strategies.			
7	Individualised coaching and support for parents around supporting early language and interaction with specialised programme as needed: Parent-Child Interaction Language specific intervention Other not named here: Please add	Time made to work collaboratively with parents and model strategies			
8	Provision of specialist assessments related to feeding (where applicable to setting) VFSS Fees Ultrasound imaging Other not named here: Please add	Specific service pathway in place			
9	Provision of specialist interventions related to feeding (where applicable to setting) Sham feeding Salvia management Other not named here: Please add	Specific service pathway in place			

10	Attendance at specialist ward rounds to support babies with more complex needs	Regular attendance at specific ward round/s or MDT to discuss specialist input (ITU/Gastro/Surgical/Respiratory)			
11	Contribution to MDT patient-specific discussions and discharge planning for babies known to the service, including onward referral, transition to in-house paediatric services and care coordination.	Attendance at patient specific meetings for individual care according to provision Direct communication with receiving acute/community SLT			

Scoring: Green (70–100%) = 1 | Amber (40–69%) = 0.5 | Red (<40%) = 0

Section 2: Targeted Care – Early intervention and surveillance of babies at moderate risk of poor feeding and communication outcomes

	Standard	How this is evidenced	Evidence (where available)	Score	Action / Comments
1	Use of Identification tool to screen caseload for babies meeting targeted criteria (frequency should align with protected neonatal SLT provision – see mapping tool in RCSLT Neonatal SLT Identification Tool)	Active screening of handover sheet (frequency dependent on provision) Database identifying specialist/targeted/universal caseload (offer dependent on provision)			

		Agreed system for reporting meeting service standards			
2	Defined pathway for babies meeting targeted criteria	Babies meeting agreed targeted criteria are identified through a consistent triage/referral process and allocated to a defined SLT pathway. The pathway is actively communicated to parents and the MDT, including rationale for SLT involvement.			
3	Defined packages of care for babies meeting targeted criteria	Babies meeting agreed targeted criteria are identified and allocated to a defined SLT package of care (e.g. frequency, intensity, focus of intervention) SLT delivers standardised but individualised intervention pathways based on level of need (e.g. feeding support, SLC support, parent coaching, review frequency) Packages of care are communicated clearly to parents and MDT, including expected goals, duration, and review criteria			

4	Cot side parental education for families with babies meeting the targeted criteria	Topics could include: Early feeding experiences (pre feeding) Transition from tube to suck feeding Promoting supportive feeding strategies (pacing, positioning etc). Supporting early language and interaction development.			
5	Ward round attendance for babies meeting targeted criteria. This may include:	Early intervention ward round (ITU) Developmental care ward round Feeding and nutrition ward round MDT ward round (SCBU/HDU) Family led ward round			e.g. NBO
6	Screening and surveillance of feeding and language milestones due to risk factors	Providing information at pivotal points in the journey Monitoring progress Identification of need for specialised input			

Scoring: Green (70–100%) = 1 | Amber (40–69%) = 0.5 | Red (<40%) =

Section 3 Universal Care – Family Integrated Care/Developmental Care/UNICEF Baby Friendly Initiative

Standard		How this is evidenced	Evidence	Score	Action / Comments
Family Integrated Care (FiCare)					
1	Supporting parents as partners in their baby's care by helping them recognise their role in supporting speech, language and communication development.	SLT contributes to education/support delivered via: Parent group Information board			

		Padlet Leaflets Webinars			
2	Supporting parents to understand their role in facilitating their baby's feeding development and fostering a responsive feeding relationship.	SLT contributes to education/support delivered via: Parent group Information board Padlet Leaflets Webinars/Video resources			
3	Staff training on how to support parents in supporting their baby's early language and communication development.	SLT contributes to: Induction teaching for doctors Induction teaching for nurses Refresher teaching for doctors Refresher teaching for nurses			
4	Staff training on how to support parents to support their baby's feeding journey.	SLT contributes to Induction teaching for doctors Induction teaching for nurses Refresher teaching for doctors Refresher teaching for nurses			
5	Curriculum for families covers a range of topics which may include:	Early feeding experiences (pre-feeding) Transition from tube to suck feeding Cue based breast and bottle feeding			

		Early language and communication			
6	Promotion of language resources and interventions for parents and neonatal team members including appropriate equipment	Book start bags for families Neonatal Library EI smart leaflets Signposting to websites/charities Linking to charities Information board Padlet Leaflets Webinars Awareness days: World Book Day, Baby			
Developmental Care					
1	Contribution to unit staff teaching via cotside teaching to promote early feeding experiences e.g. Supportive tube feeding, Sensitive mouthcare, Non-nutritive Sucking and cue based breast and bottle feeding	Early feeding experiences (pre-feeding) Transition from tube to suck feeding Cue based breast and bottle feeding Early language and communication			
2	Advocate for equipment to support early feeding experiences and enable responsive cue-based breast and bottle feeding	Access to: Soothers of different sizes Slow flow teats Stools Pillows			
UNICEF Baby Friendly Initiative (BFI)					
1	Contribution to Baby Friendly Initiative unit education strategy as part of the MDT	SLT contributes to: Induction teaching for doctors			

		Induction teaching for nurses Refresher teaching for doctors Refresher teaching for nurses			
2	Contribution to information sharing to promote lactation, breastfeeding and responsive bottle feeding alongside the Neonatal Infant Feeding Lead/s and as part of the MDT	SLT contributes to: Parent group Information board Padlet Leaflets Webinars			
3	Advocating for equipment to improve feeding experiences for Mothers as part of the MDT	SLT may: Supporting funding/charity bid Supporting scoping of equipment Highlighting gaps in equipment			
4	Supporting unit Neonatal BFI Lead in BFI accreditation process as part of the MDT to support the BFI lead.	SLT contributes to: Carrying out skills reviews Carrying out parent audits Contributing to upskilling sessions			

Scoring: Green (70–100%) = 1 | Amber (40–69%) = 0.5 | Red (<40%) = 0

Section 4: Quality Improvement/Audit/Research

	How this is evidenced	Standard	Evidence (where available)	Score	Action / Comments
1	Carrying out MDT audits of supportive feeding strategies or early language and communication strategies	Supporting Quality Improvement /Audit and Research			

	Quality improvement projects e.g. SLC development and cue-based feeding				

Scoring: Green (70–100%) = 1 | Amber (40–69%) = 0.5 | Red (<40%) = 0

RAG ratings:

Red = Not happening at present, not started. High need for further staffing resource

Amber = Planning stage/in progress/partly happening. Moderate need for more staffing

Green = This is business as usual and happens routinely, all of the time

Overall Score: _____ /31 = _____ %

Priority Areas for Action

1.

2.

3.

Timeline for targeting: 1 month ☐ 3 months ☐ 6 months ☐