BDA The Association of UK Dietitians
Neonatal Dietitians
Affiliated with the Paediatric Specialist Group
Winner – Sub Group of the Year 2024

Framework for Dietetic management of Neonatal outreach and Follow up services

October 2025

Endorsed by
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Contents

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Peer Review

Comments from numerous professional organisations were sought prior to publishing this document. We greatly appreciate the time that has been taken to do this and the comments received which have helped to finalise and further shape this framework. Many thanks to the following:

- Association of Paediatric Chartered Physiotherapists (APCP) Neonatal Committee – Phillippa Ranson on behalf of committee members
- British Association of Neonatal Neurodevelopmental Follow Up (BANNFU) – Hilary Cruickshank, Chair
- British Dietetic Association (BDA), Neonatal Dietitians interest Group (NDiG) – Committee members
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Thanks also to Kathryn Miller, Specialist Paediatric Dietitian (Royal Hospital for Children and Young People, Edinburgh) for checking the final draft.

2. Abbreviations and Definitions

Abbreviations:

AHP	Allied Health Professional (Dietetics, Occupational Therapy, Speech and Language Therapy, Physiotherapy)
AHPPP	Allied Health Professional (Dietetics, Occupational Therapy, Speech and Language Therapy, Physiotherapy), Psychological professionals and Pharmacy
BAPM	British Association of Perinatal Medicine
BDA	British Dietetic Association
CGA	Corrected Gestational Age
GA	Gestational Age
MDT	Multidisciplinary Team
NCOT	Neonatal Community Outreach Team
NDiG	Neonatal Dietitians interest Group
NNOG	Networks Neonatal Outreach Group
WTE	Working Time Equivalent

Definitions:

For the purpose of this document:

- **Model 1 :** Dietetic support embedded **within** outreach teams – see chapter 5
- **Model 2:** **Independent** dietetic interventions/support delivered beyond the scope of outreach services – see chapter 6

3. Introduction

In 2022, a scoping survey carried out by the British Dietetic Association (BDA) Neonatal Dietitians interest Group (NDiG) demonstrated differences in management and lack of consensus across the UK as to how babies and families are supported from a dietetic perspective, following their neonatal inpatient journey. (See results in Appendix 1)

Aim

The aim of this document is to improve consistency by providing caseload management strategies and staffing recommendations for specialist neonatal dietitians to support babies and families. The preparation for nutrition management at home starts during the inpatient stay which may also be referred to as the phase of acute neonatal care. This should merge into collaborative care with outreach and community multidisciplinary team (MDT) services and continue into ongoing intervention, as required, when the infant has transitioned home with their family. Due to the paucity of data around neonatal dietetic care after discharge from acute care, these recommendations have been developed using data available from existing services, expert opinion and current best practice.

Scope of document

This framework has been written as a guide to support the ongoing evolution of specialist neonatal dietetic support embedded within outreach services (Model 1) and follow up (Model 2) in the UK. To meet the needs of all babies and families who have experienced neonatal care these models of dietetic service may co-exist in the organisation or system. It is not possible to provide definitive recommendations in view of the significant variation in practice that currently exists. This document therefore serves as a baseline to audit and build upon.

Babies included:

- Any baby discharged from acute neonatal care who remains under follow up by a neonatologist or paediatrician with an interest in neonatology **until 6 months corrected gestational age.**

Babies not included

Babies whose care is led by specialist paediatric dietitians at a regional or tertiary centre. This may include but is not exclusive to the following:

- Inborn errors of metabolism
- Congenital abnormalities
- Congenital hyperinsulinism
- Surgical babies
- Cystic Fibrosis
- Diabetes Insipidus
- Cleft lip & palate / other oro-pharyngeal malformation

- Babies requiring parenteral nutrition at home
- Babies requiring tube feeding that is likely to continue >1 - 3 months post term corrected gestational age

Who are we most concerned about?

Babies who are at risk of malnutrition following transition home are as follows:

- Born at <34/40
- Babies with an associated comorbidity of prematurity which impacts nutrition and growth
- Late preterm babies
- Babies weaning off tube feeds and establishing oral feeding at home

Outcomes of this document

- To define the indications and frequency for ongoing neonatal dietetic input after babies leave acute neonatal care.
- Set prioritisation criteria for specialist neonatal dietetic input within outreach services as well as ongoing follow up post-acute neonatal care.
- Define the length of time a baby should remain under the care of a specialist neonatal dietitian in the community before transferring care to a suitable paediatric dietetic service.
- Provide staffing recommendations to calculate time required for outreach and ongoing follow up by a specialist neonatal dietitian.

4. Background and purpose

Evolution of specialist neonatal dietetic input in the UK

Specialist neonatal dietetic services have grown in recent years within the UK following the publication of several reports[1, 2, 3] particularly in NHS England. Neonatal dietetic staffing recommendations for acute neonatal care are available and should be used in conjunction with this guidance to establish full neonatal dietetic staffing to meet the needs of babies and families [4]. The need for specialist neonatal dietitians is well recognised [5, 6, 7, 8] and widely discussed as evidenced in transformational documents such as:

- Neonatology - Workforce GIRFT Programme National Specialty Report. (2022)[3]
- The BAPM service and quality standards for provision of neonatal care (2022)[9].
- The Neonatal critical care service specification (2024)[10] for NHS England where dietitians were noted to be one of the essential AHPs to champion the need to support neonatal care. that looks forward to improving longer term outcomes for babies and their families.
- The service delivery framework (2023)[11] for the transformation of neonatal services in Scotland with dietitians noted to be one of the AHP groups fundamental to providing the best possible neonatal care for babies admitted to neonatal units and their families.
- The All-Wales Neonatal Standards (2017)[12] which stated that all NNUs should have appropriately funded dietetic care provided by highly specialist dietitians.

Although there is much support for these acute staffing recommendations, they are focused primarily on the provision of acute care to support babies and families while they are in hospital. Despite these recommendations, the levels of funding still fall significantly short as highlighted in the Scottish neonatal AHP workforce review report [13] as well as the BLISS report on AHPPP roles in neonatal care[14.] It is clear however, that there is a need to consider the full spectrum of neonatal care which extends beyond the acute phase into the transition of babies and their families to home. Although this framework will discuss the need to establish staffing recommendations for dietetic services post-acute neonatal care, it is acknowledged there is an ***urgent need to establish funding to meet full staffing recommendations for acute dietetic services to ensure optimal post-natal nutritional outcomes in the longer term.***

Importance of ongoing neonatal dietetic assessment and intervention following transition home

It is well known in the preterm population that growth faltering and undernutrition is linked to poor neurodevelopment outcomes. To support the prompt recognition and appropriate intervention, ESPGHAN 2025 [15] recommend close monitoring of growth

and nutritional assessment after discharge to identify those at high risk and provide individualised nutritional support where needed. When babies and families are preparing for home individualised consideration for their nutrition needs are based on the following basic objectives:

Objectives of infant nutrition after discharge from neonatal intensive care, which must be supported[16]:

- Requirement to have an adequate intake to maintain hydration
- Provide adequate nutrition for growth and development
- Support the family's desired infant feeding plan

An experienced and appropriately trained specialist neonatal dietitian is uniquely qualified to advise on nutrition and growth in this population during this vulnerable transition to home. Neonatal dietitians play a key role in the wider multidisciplinary team (MDT) providing ongoing support at this critical time.

Neonatal dietitians provide support to make clinically effective nutritional interventions in partnership with families and the neonatal MDT team, particularly regarding the management of feed choices and feeding methods in the complex baby post-acute care. Babies may have accrued nutritional deficits from their in-hospital stay and have increased nutritional requirements for growth and development. Complex feeding plans may be required as well as additional support for families to facilitate decision making. As part of the MDT, neonatal dietitians advise on how to optimise nutritional intake; assist with successful transition from tube to oral feeding; support establishment of breastfeeding; the use of multi nutrient fortifier; choice of formula where appropriate and the monitoring and interpretation of growth measures.

Dietetic Scoping Survey

A UK wide scoping survey of paediatric and neonatal dietitians was carried out by NDiG in 2022 (See Appendix 1) This aimed to understand the current practice of dietetic management of babies following acute care on the neonatal unit. The survey highlighted a large variation in the availability, type, and length of dietetic input. The inconsistency of dietetic input was clear which strengthened the need to develop guidance that identifies the following:

1. Babies who are at risk of malnutrition requiring specialist neonatal dietetic intervention before 6 months post term.
2. The frequency of review.
3. The length of ongoing follow up required by a specialist neonatal dietitian.
4. The commissioning of neonatal dietetic outreach and individualised dietetic interventions.

5. Neonatal dietetic outreach services (Model 1)

Definition and Purpose

The Networks Neonatal Outreach Group (NNOG) have defined neonatal outreach services as:

A service delivered by expert multidisciplinary teams of neonatal staff with enhanced skill sets. Delivered over a defined timeframe to empower and support families to provide the ongoing care needs of their baby, offering a seamless transition from hospital care to home and community services. [17]

The recently published Neonatal Outreach Service: A BAPM Framework for Practice (April 2025)[17] highlights that outreach services are not a separate entity but part of the continuum of care. This is important to note and challenges the thinking that babies simply receive acute care leading on to follow up appointments once at home. Outreach services are not universally available across the UK but even in areas where they exist, there is inequity of access. A growing number of neonatal units in the UK fund a nurse led outreach team to aid transition home and support earlier discharge from acute neonatal care. These teams create extra capacity for neonatal care by providing a hospital at home service which empowers families to care for their babies with short term additional care needs. Outreach services have been shown to reduce length of hospital stay and readmission rates; enhance parental confidence and bonding with their baby as well as support their development[18].

Enabling babies to be discharged home sooner from their in-hospital stay, comes with many benefits as noted above but there are nutritional and feeding implications which are important to consider and support. Continued nutrition intervention following acute care is essential to support development and growth because in this population of babies, nutritional requirements remain high, oral feeding maturation may not have fully developed and parents/caregivers need extra support in this initial early period following transition to the home environment. Furthermore, short-term nasogastric tube feeding may be required to support transition to oral feeding. In addition, growth is most frequently impacted in the period immediately after discharge from acute care[19]. It is recommended that dietitians within an outreach service should attend any transition planning ward rounds/discussions as well as the outreach MDT meetings to advise on nutritional care plans as well as identify those who may require direct dietetic intervention. (See Appendix 2 for further examples of the outreach dietetic role.)

Neonatal dietitians have identified the need to work as an integral member of the outreach team and have been evolving their model of dietetic support in the UK in recent years to provide effective nutritional intervention. Unfortunately, this has largely been with a backdrop of inadequate or no additional funding to build these services.

Guidance for prioritisation for dietetic input within outreach services

To ensure that at-risk babies are identified and receive timely dietetic input; Table 1 provides a guide to prioritisation of those referred to the outreach caseload. This dietetic input can be provided either directly (direct contact with families) or indirectly (working/advising via outreach nursing teams) depending on the local services available. Frequency of contact is defined within the BAPM Neonatal Outreach Framework and will fluctuate depending on the needs of the baby and family. This is to be considered as a guide only as data collection and audit will continue to develop this in the years ahead.

Table 1
Model 1 Prioritisation for specialist neonatal dietetic referral for babies under the care of outreach teams *

High priority	• Suboptimal growth for babies<44/40 CGA defined as static weight or weight loss for over 1 week duration • Babies already identified as requiring ongoing neonatal dietetic follow up after transitioning home
Medium priority	• Suboptimal growth for babies >44/40 CGA: Weight loss defined as deviation from established weight centile of 1 centile space • Advice on breastfeeding • Use of multi nutrient fortifier at home • Babies receiving or requiring initiation of specialist formula (excluding nutrient enriched post discharge formulas)
Low priority	• Introduction of complementary foods • Metabolic bone disease • Queries relating to vitamin & iron supplementation

*This list is not exhaustive and should not replace clinical judgement

6. Neonatal dietetic follow up care (Model 2)

Definition and Purpose

Many babies and families will require ongoing individualised specialist neonatal dietetic input beyond the scope of outreach dietetic services or where these don't yet exist. To improve outcomes for babies and families, there is an urgent need to develop referral guidelines for ongoing specialist neonatal dietetic support post-acute care, as well as guidance on the seamless transition to paediatric dietetic services. Feeding, nutrition and growth issues are increasingly well known for being a common source of anxiety for families in this population after transition home. Linking with the existing services such as neurodevelopmental surveillance clinics and consultant follow up clinics helps support families by reducing the number of separate visits to the hospital. It also allows neonatal dietitians to collaborate and share information with the wider neonatal follow up teams.

Until more evidence and data has been developed in this area, this framework aims to provide a best practice standard of care for ongoing specialist dietetic support after transition home.

Table 2 (Model 2) sets a baseline standard for prioritising referrals to a follow up service. Please note this is not a finite list and will be further developed following audit and data collection. ***The frequency of contact will fluctuate to meet the needs of babies and families and should be individualised accordingly.***

We recommend that neonatal dietetic care continue until 6 months corrected age, at which point babies should be transitioned to paediatric dietetic services where baby and family needs will be better met.

Table 2
Model 2 Prioritisation for specialist neonatal dietetic referral and frequency of dietetic intervention*

High	• Newly discharged baby for growth monitoring • Nutritional intervention/monitoring for suboptimal growth of a baby <44/40 • Review of multi nutrient fortifier • Babies with an associated comorbidity of prematurity which impacts on nutrition and growth • Support for weaning off nasogastric tube feeds and establishing oral feeding	**Weekly contact**
Medium	• Baby on specialist term formula • Nutritional intervention/monitoring for suboptimal growth of a baby >44/40	**2 -4 weekly**
	• Babies > 44/40 well established on specialist formula with expected growth trajectory • Specialist complementary feeding advice	**4-6 weekly**
Low	• Advice on vitamin or mineral supplements • Advice on use of nutrient enriched post discharge formula • Review of growth chart and reassurance • Introduction of complementary feeding	**Single contact (One off appointment to resolve an issue)**
	• Telephone advice regarding appropriate formula or vitamin and mineral supplementation to health visitor	**Consult (Advice given via other HCP)**

*This list is not exhaustive and should not replace clinical judgement

7. Establishing the specialist neonatal dietetic workforce for outreach and follow up care

Dietetic staffing recommendations

Although existing NDiG staffing recommendations[4] provide limited guidance on the time required to support babies and families under outreach care and provide follow up clinics (0.15wte/clinic or ½ day support), further detail is required to encapsulate the wider and evolving dietetic support role for babies and families who are transitioning to home under neonatal outreach services. This section provides details on the ***additional staffing required for dietetic outreach and follow up care.***

Currently there are no staffing recommendations for any neonatal AHP within neonatal outreach services and little evidence on which to set a starting point, however the Neonatal Outreach Service BAPM Framework for Practice[17] has suggested a *baseline recommendation for the nursing workforce of 1.0 wte per 800 live births in addition to the Lead Neonatal Outreach Nurse role*. As neonatal dietitians are an integral part of the multidisciplinary neonatal outreach team it seems appropriate to align dietetic staffing alongside the nursing staff recommendations. The following recommendations are for **clinical time** required for dietetic staffing within the outreach team:

Staffing recommendations for neonatal dietetic input embedded within outreach services (Model 1)

- 0.05 WTE specialist neonatal dietitian per **funded** 1.0 wte neonatal outreach nurse (excluding lead nurse role)
- There is a minimum requirement for 0.1 wte specialist neonatal dietitian per unit for the outreach service
- This WTE is in addition to existing acute unit staffing requirements
- ***It is essential that specialist neonatal dietetic staffing develops alongside evolving outreach nursing teams and must be included in all funding applications.***
- Data collection and audit as per chapter 9 is essential to assess staffing adequacy in the coming years and allow these recommendations to develop.

Dietetic staffing recommendations for neonatal outreach services can be calculated according to the availability of local outreach nursing services. See Tables 3, 4 and 5 below.

Table 3 Example of individual hospital outreach service model

Number of live births	BAPM recommendations for neonatal outreach nursing	Dietetic recommendations 0.05wte per 1wte neonatal outreach nurse	Recommended dietetic time
1100	1.37wte	0.07wte	0.1wte
5000	6.25wte	0.3wte	0.3wte
9300	11.6wte	0.58wte	0.6wte

Table 4 Example of hub and spoke outreach service model[16]

System/ regional units	No. of live births	BAPM recommendation for neonatal outreach nursing	Dietetic recommendation 0.05wte /1wte neonatal outreach nurse	Recommended dietetic time for system wide outreach team**
Hospital 1 NICU	6,600	8.25wte	0.4wte	0.7 wte
Hospital 2 SCU	1,800	2.25wte	0.1wte	
Hospital 3 SCU	3,300	4.0wte	0.2wte	

Table 5 Example of dietetic staffing to support *actual* current outreach nursing team

	No. of live births	BAPM nursing recommendation 1.0wte per 800 live births	Recommended Dietetic staffing 0.05wte per 1wte nurse post	Actual outreach nursing team	Dietetic staffing recommended to support actual current outreach nursing team
Hospital 1	6000	7.5wte	0.4wte	6.4wte	0.3wte
Hospital 2	5000	6.25wte	0.3wte	1.7wte	0.1wte
Hospital 3	1700	2.1wte	0.1wte	1.4wte	0.1wte

Staffing recommendations for neonatal dietetic follow up services (Model 2)

- Staffing recommendations for ongoing clinical time required for follow up is as per the NDiG staffing recommendations i.e. 0.15wte per ½ day clinic[4]
- Data collection and audit as per section 7 is essential to assess adequacy in the coming years.
- The number of clinics required will depend on the clinical need which will be determined by existence of outreach services, referral criteria and caseload.
- The service model will be influenced by local pathways and governance.

Table 6 Example calculation for clinical time required for a *complete dietetic service for model 1 & 2*

			Clinical Dietetic Time
Dietetic Support for Outreach Team (model 1)	Based on local funded team of 4.0 nursing staff BAPM	Recommendation of 0.05wte dietitian /1 wte nurse = 0.2wte	0.2wte
Dietetic Support for clinics (model 2)	Based on 2 clinics per week	Recommendation of 0.15wte per clinic = 0.3wte	0.3wte
Total dietetic recommendation for clinical time required			**0.5wte**

Wider staffing considerations

The recommendations in the tables above are for clinical time required only for ongoing dietetic services following transition home. The BDA has recently updated key documents for workforce planning: 'Safe staffing and Safe Workload Guidance' for the dietetic profession.[20] This should be used to inform and support decision making on safe staffing levels including non-clinical time required for each post.

8. Neonatal Dietetic Knowledge and Skills

Specialist neonatal dietitians working in this field must first establish a strong foundation by completing core competencies essential for optimal dietetic management at home. The BDA (NDiG) Knowledge and Skills Framework[20] comprehensively outlines the clinical competencies required for dietitians involved in neonatal services as noted in the figure below.

Foundation Level	Enhanced Level - as for Foundation plus	Advanced Level - as for Enhanced plus	Surgical unit - as for Advanced plus
Post discharge • Support of feeding ready for discharge (breast/formula) • Appropriate use of post discharge formula • Understanding of the role of post discharge fortifier • Appropriate use of post discharge vitamin & iron supplementation • Collaborative working with neonatal community outreach team and a clear pathway of escalation / ongoing care as required • Knowledge of preterm weaning	Oral feeding development • An understanding of the role of SALT on the NNU • How different feeding methods are used dependent on gestational age, maturity, development and feeding skills (e.g. orogastric, nasogastric, breast, bottle) Post discharge/Transfer of care • Appropriate use of post discharge fortifier • Knowledge of community support teams and pathways for referral	Post discharge/Transfer of care • Ensures the smooth transition of dietetic care for 'out of area' babies to their local units. This includes contacting the local dietitian regarding ongoing care needs	Post discharge/Transfer of care • Ensures the smooth transition of dietetic care for repatriated surgical babies. Providing ongoing dietetic review and advice on nutritional interventions in liaison with local team as required. Arranging surgical follow up as needed

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Neonatal dietitians working in outreach care should also familiarise themselves with the education and training section in the BAPM outreach services framework.[15]

9. Data collection and audit

It is everyone's responsibility within the outreach team to collect data and audit practice to ensure that services can be evaluated and evolve. There must be a national approach to collecting data as highlighted by the Neonatal Outreach Service BAPM Framework for Practice[15] which also includes feedback from the service user. Collaboration is needed within the local team to establish a dashboard so that data collection occurs effectively.

Although this document has been developed using expert opinion and current best practice there is little evidence to set conclusive standards specifically for neonatal dietetic input for babies following their transition home from acute care. It is essential therefore that dietitians are also involved in collecting data for further development of this guidance. BAPM[16] have made data collection recommendations specifically for Allied Health Professionals (AHPs) working in outreach care:

- Number of direct patient contacts and reason for referral
- Number of indirect patient contacts and reason for concern (outreach seeking advice etc)
- Attendance of AHPs/Psychology team at MDT outreach ward round

This is not an exhaustive list however and local outreach teams should decide if additional parameters should be collected.

10. Appendices

Appendix 1: Poster presented at BAPM Spring Conference April 20

Determining the landscape of specialist neonatal dietetic follow up in the UK

Blair, H[1], Clarke, S[2], Arnold, K[3], Fox, R[4], Pountney, R[5], Sabey, S[6]

1. Simpson Centre for Reproductive Health, Edinburgh, 2. West Midlands Perinatal Network, 3. King's College Hospital NHS Foundation Trust, 4. University Hospitals of Leicester NHS Trust , 5. Bradford Teaching Hospitals NHS Foundation Trust, 6. Surrey & Sussex Healthcare NHS Trust

Background

- Specialist neonatal dietitians are uniquely qualified to support the nutrition and growth needs of infants transitioning home from the neonatal unit (NNU)
- Currently there are no staffing recommendations or published evidence to guide the evolution of the neonatal dietetic outreach and outpatient role in the UK
- There is an increasing pressure to develop a dietetic service that meets the needs of babies and families as part of the continuum of neonatal care

Aim

To understand current dietetic management for babies following their transition home from NNU

Methods

A UK wide electronic scoping questionnaire was developed by the Neonatal Dietitians interest Group (NDiG) in 2022 and sent to neonatal and paediatric dietitians in the UK

Results

- 125 neonatal and paediatric dietitians responded from all 4 nations of the UK with the majority being from England (79%)
- Dietetic care varies widely in type and length of follow up as seen in Figures 1.0 , 2.0 and Table 1.0
- 94% provided some form of dietetic follow up post- acute neonatal care
- Most respondents (56%) were based in Trust/Health Board with a medical or surgical NICU on site but only a quarter had >50% of their posts available to support neonatal inpatients
- Over half (53%) of respondents either had no time or <25% of their post to provide inpatient care on the neonatal unit
- **There was a wide variation in opinion regarding when a baby should be transferred from neonatal to paediatric dietetic care**
- 79% of dietitians surveyed liaise with other health care professionals (E.g. NCOT) to support families' post-acute care
- The main follow up mode of support for families was via ad hoc phone calls, which was likely due to inadequate funding for dedicated clinical support

FIGURE 1.0 COMMON REASONS FOR REFERRAL TO A NEONATAL DIETETIC CLINIC

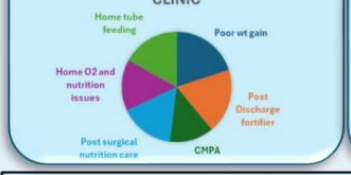

FIG 2.0 LENGTH OF TIME FOR DIETETIC FOLLOW UP

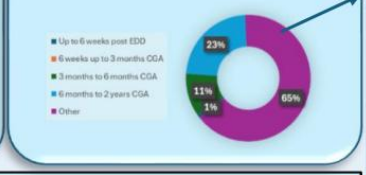

Fig 3.0: Dietetic follow up methods following transition home from the NNU

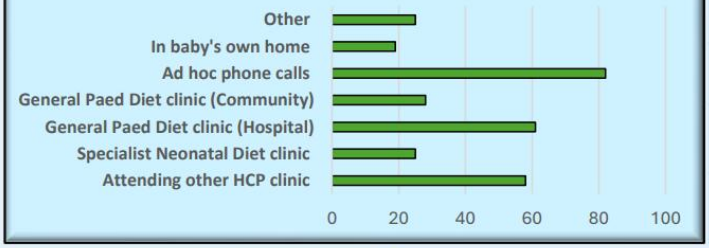

Table 1.0:
Comments on length of follow up from 'other'

Difficult to know when it's appropriate to transfer care of a neonatal patient to paediatrics from a dietetic perspective
No set timescale - often not until weaned off home fortifier and/or growth pattern is stable enough to handover to health visitors
Varies depending on dietetic need and medical condition
No specific time. Ongoing if required e.g. with feeding tube dependent infants
Not time dependent, we review until they are growing well and not on any specialist formula/diet
Can be up to 18 years old if the child has long term conditions e.g. neurological issues, short bowel etc
Depends on clinical need can be up to 9-12 months or longer for those with neuro issues

Conclusion

- There is significant variation in the availability, type, and length of dietetic input following transition home from the NNU, demonstrating inconsistency and inequity of service

Recommendations:

- Guidance is needed to define which babies require ongoing specialist neonatal dietetic intervention as well as define the length and frequency of dietetic review
- Neonatal dietetic staffing recommendations are urgently required to deliver outreach and follow up services for this group of vulnerable babies and families
- These recommendations are currently being developed by NDiG

Appendix 2: Real life current examples of the collaborative role of the neonatal dietitian in outreach services

In 2024, members of NDIG were asked to share examples of how they worked within and alongside other members of the MDT. These examples could be used to further inform dietetic service development.

Examples of the neonatal dietetic role in outreach services	Benefits
Pre discharge	
The neonatal dietitian provides weekly reviews for complex babies/families to prepare for home	This allows expectations to be set when baby and family are cared for within outreach
Collaboration of the neonatal dietitian and NCOT to develop a management plan pre discharge for babies going home early with an NGT in place	Facilitates an earlier transition home from acute care to enable families and babies to receive care in their own home with NCOT support.
NCOT and dietitian review babies together prior to discharge home and provide relevant patient information and agree next steps in care plan	NCOT and dietitians support the families to understand the next stages for home from a growth and nutrition perspective
Community Ward Rounds/ MDT discussions	
Attendance at weekly or fortnightly community ward rounds with NCOT and other staff (e.g. Infant feeding advisor, psychology, medical team etc) to discuss case notes which includes nutrition and growth for babies/families on the outreach caseload.	Dietitians provide a consult based on information for babies/families provided by NCOT in addition to growth chart review. This may be all that is needed to guide NCOT to support the baby/family with nutrition issues without having to involve the dietitian directly. If required, formal/direct dietetic referrals can be made at this time also.
Work closely with NCOT and the MDT to wean babies off NGT feeds at home while supporting appropriate growth.	Some babies can wean off NGT feeds with NCOT support alone but some may require additional support in collaboration with the dietitian as well as speech and language therapy.
Specialist clinics	
Dietetic attendance at a weekly Neonatal Outreach Wellbeing Clinic to provide a 'one-stop-shop' for babies and families to access the support they need post discharge	This has been seen to have multiple benefits. For health care professionals it optimises multidisciplinary team working and communication as well as reducing travel time for professionals covering a widespread geographical caseload. For families, it reduces the number of health care related appointments and outpatient hospital attendances and provides opportunities for families to socialise together and give and receive informal peer support.

Supporting Nutrition care indirectly via NCOT home visits	
Co-develop nutrition checklist with NCOT to gather nutrition and feeding information from families 4- 7 days post discharge when NCOT visits them at home.	As the dietitian does not have the capacity to visit babies/families at home this allows NCOT to not only continue to be the consistent source of information and support the family but also ensure that the dietitian has the correct information available to advise during a team review meeting without the need to get directly involved
Supporting literature/educational resource development as part of the MDT	
Development of information leaflets for families and local protocols to support post discharge fortifier use	Ensures appropriate and consistent use of fortifier post discharge and ensures that families and staff understand how to use this product safely
Development of specific post discharge nutrition teaching programme/ webinars for all NCOTs in the region	Supports NCOT services to be updated by experienced neonatal dietitians on the latest evidence, sharing knowledge and skills, as well as local audit data on optimising nutrition during the outreach period. Standardising quality of care across the Region/ Network
Co- developed protocol for discharge with NGT	This has enabled babies to get home sooner and establish breast/bottle feeding.
Co-developed protocols on post discharge formula use and vitamin/iron supplements	This encourages appropriate use of specialist formula and additional supplements
Co-developed a series of videos locally with NCOT to educate parents.	Topics included feeding, communication, skin to skin, nutrition and development. This can be accessed by the parents via QR codes
The dietitian is a member of a task and finish group to develop and establish criteria for early home tube feeding to support earlier transition to home	The Dietitian collaborates with nursing and medical colleagues to update current guidance and establish consensus
Development of a monthly discharge planning focus group. This involves Allied Health Professionals, Infant feeding Advisor, Charge nurses, staff nurses, nursery nurses and NCOT	The aim of this group is to enhance the discharge process to ensure a streamlined transition for babies and families. The group focuses on 4 main outcomes: improving compliance with staff, completing discharge checklist, reviewing feedback from family questionnaires, review of Parent Craft Group and home NGT feeding.
Audit	
Gathering and analysis of data on local nutrition protocols	Review of growth and nutritional intakes based on local or national protocols/guidance allows practice to be evaluated and improved e.g. post discharge fortifier protocol

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