

Specialist neonatal respiratory care for babies born preterm

Quality standard

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This standard is based on NG124.

This standard should be read in conjunction with QS169, QS160, QS135, QS131, QS75, QS57 and QS32.

Quality statements

Statement 1 Preterm babies having respiratory support soon after birth and before admission to the neonatal unit are given continuous positive airways pressure (CPAP), if clinically appropriate, rather than invasive ventilation.

Statement 2 Preterm babies who need surfactant are given it using a minimally invasive technique if they do not need invasive ventilation.

Statement 3 Preterm babies having invasive ventilation are given volume-targeted ventilation (VTV) in combination with synchronised ventilation.

Statement 4 Preterm babies have a target oxygen saturation of 91% to 95% after stabilisation.

Statement 5 Parents and carers of preterm babies who are having respiratory support are helped to care for their baby.

Quality statement 1: Respiratory support soon after birth

Quality statement

Preterm babies having respiratory support soon after birth and before admission to the neonatal unit are given continuous positive airways pressure (CPAP), if clinically appropriate, rather than invasive ventilation.

Rationale

Using CPAP, when clinically appropriate, to stabilise preterm babies reduces the use of unnecessary invasive ventilation. It can also reduce mortality before discharge and the incidence of bronchopulmonary dysplasia (BPD) in babies at 36 weeks postmenstrual age. BPD can result in longer hospital stays and readmission after discharge, and can have a significant impact on quality of life for babies and their families and carers.

Quality measures

Structure

a) Evidence of local arrangements to ensure that preterm babies having respiratory support soon after birth and before admission to the neonatal unit are given CPAP where clinically appropriate.

Data source: Local data collection, for example, audits of stabilisation protocols.

b) Evidence of staff training available for neonatal CPAP.

Data source: Local data collection, for example, provision of training courses in neonatal CPAP.

Process

a) Proportion of preterm babies born under 28 weeks of pregnancy who had invasive ventilation in the delivery room.

Numerator – the number in the denominator who had invasive ventilation in the delivery room.

Denominator – the number of preterm babies born under 28 weeks of pregnancy.

Data source: Local data collection, for example, local audit of patient records on BadgerNet neonatal electronic patient record or similar patient records system. For measurement purposes, 'in the delivery room' means 'soon after birth and before admission to the neonatal unit'. In order to use existing data collection invasive ventilation is measured. Numbers are expected to reduce when the quality statement is implemented.

b) Proportion of preterm babies born between 28 weeks and 31 weeks plus 6 days of pregnancy who had invasive ventilation in the delivery room.

Numerator – the number in the denominator who had invasive ventilation in the delivery room.

Denominator – the number of preterm babies born between 28 weeks and 31 weeks plus 6 days of pregnancy.

Data source: Local data collection, for example, local audit of patient records on BadgerNet neonatal electronic patient record or similar patient records system. For measurement purposes, 'in the delivery room' means 'soon after birth and before admission to the neonatal unit'. In order to use existing data collection invasive ventilation is measured. Numbers are expected to reduce when the quality statement is implemented.

c) Proportion of preterm babies born between 32 weeks and 36 weeks plus 6 days of pregnancy who had invasive ventilation in the delivery room.

Numerator – the number in the denominator who had invasive ventilation in the delivery room.

Denominator – the number of preterm babies born between 32 weeks and 36 weeks plus

6 days of pregnancy.

Data source: Local data collection, for example, local audit of patient records on BadgerNet neonatal electronic patient record or similar patient records system. For measurement purposes, 'in the delivery room' means 'soon after birth and before admission to the neonatal unit'. In order to use existing data collection invasive ventilation is measured. Numbers are expected to reduce when the quality statement is implemented.

Outcome

Number of preterm babies with BPD.

Data source: The National Neonatal Audit Programme (NNAP) measures the number of eligible babies alive at 36 weeks with sufficient data to attribute BPD outcome.

What the quality statement means for different audiences

Service providers (such as maternity and delivery units, and neonatal units, including special care units, local neonatal units and neonatal intensive care units) ensure that systems are in place for preterm babies to be given CPAP, when it is clinically appropriate, if they need respiratory support soon after birth. They ensure that healthcare professionals are trained to provide CPAP and can identify when invasive ventilation is clinically needed.

Healthcare professionals (such as midwives, specialist neonatal nurses, specialist neonatal consultants and other paediatric specialists working with babies born preterm) use CPAP for preterm babies who need respiratory support soon after birth, if clinically appropriate. They are trained to administer CPAP and to identify when invasive ventilation is clinically needed and provide this if necessary.

Commissioners (such as clinical commissioning groups and NHS England) ensure that the services they commission use CPAP for preterm babies who need respiratory support soon after birth, if clinically appropriate.

Preterm babies who need help with their breathing soon after birth are given continuous positive airways pressure (known as CPAP) if it is suitable for them. This is when blended

air and oxygen is given through a mask or through tubes into the nose to support breathing. It is preferable to using a ventilator, which has a higher risk of other problems leading to a longer stay in hospital and readmission after discharge.

Source guidance

Specialist neonatal respiratory care for babies born preterm. NICE guideline NG124 (2019), recommendation 1.2.1

Definitions of terms used in this quality statement

Bronchopulmonary dysplasia (BPD)

A chronic lung disease that develops in preterm babies. [NICE's guideline on specialist neonatal respiratory care for babies born preterm, supplement 1: glossary and abbreviations]

Clinically appropriate

It would not, or is unlikely to, be clinically appropriate to use CPAP in the following circumstances:

- for babies who are persistently not breathing after initial stabilisation
- for babies with an unstable heart rate, or whose oxygen saturations are not improving, despite high oxygen levels and standard newborn life support
- for some extremely preterm babies for whom invasive ventilation may be more appropriate.

Clinical judgement should be used to decide whether invasive ventilation with surfactant is more appropriate in the delivery room for babies born very early. Some extremely preterm babies may not have the necessary respiratory drive for CPAP to be effective, and the failure rate of non-invasive ventilation is higher for these babies. [NICE's guideline on specialist neonatal respiratory care for babies born preterm, rationale and impact section for recommendation 1.2.1, evidence review on respiratory support, and expert opinion]

Invasive ventilation

Administration of respiratory support via an endotracheal tube or tracheostomy, using a mechanical ventilator. [[NICE's guideline on specialist neonatal respiratory care for babies born preterm](#), terms used in this guideline section]

Quality statement 2: Minimally invasive administration of surfactant

Quality statement

Preterm babies who need surfactant are given it using a minimally invasive technique if they do not need invasive ventilation.

Rationale

Surfactant can be given to preterm babies using a minimally invasive technique if they are not on invasive ventilation. Using a minimally invasive technique reduces the risk of bronchopulmonary dysplasia (BPD) and pneumothorax (collapsed lung).

Quality measures

Structure

a) Evidence of local arrangements to ensure that preterm babies who need surfactant receive it using a minimally invasive technique if they do not need invasive ventilation.

Data source: Local data collection, for example, clinical protocols on surfactant administration and clinical governance oversight.

b) Evidence of staff training in a minimally invasive surfactant administration technique.

Data source: Local data collection, for example, the number of staff trained in a minimally invasive surfactant administration technique.

Process

a) Proportion of preterm babies born under 28 weeks of pregnancy who are given surfactant using a minimally invasive technique.

Numerator – the number in the denominator who are given surfactant using a minimally invasive technique.

Denominator – the number of preterm babies born under 28 weeks of pregnancy who are given surfactant.

Data source: Local data collection, for example, local audit of patient records.

b) Proportion of preterm babies born between 28 weeks and 31 weeks plus 6 days of pregnancy who are given surfactant using a minimally invasive technique.

Numerator – the number in the denominator who are given surfactant using a minimally invasive technique.

Denominator – the number of preterm babies born between 28 weeks and 31 weeks plus 6 days of pregnancy who are given surfactant.

Data source: Local data collection, for example, local audit of patient records.

c) Proportion of preterm babies born between 32 weeks and 36 weeks plus 6 days of pregnancy who are given surfactant using a minimally invasive technique.

Numerator – the number in the denominator who are given surfactant using a minimally invasive technique.

Denominator – the number of preterm babies born between 32 weeks and 36 weeks plus 6 days of pregnancy who are given surfactant.

Data source: Local data collection, for example, local audit of patient records.

Outcome

a) Incidence of pneumothorax in preterm babies.

Data source: Local data collection, for example, audits of patient records.

b) Number of preterm babies with BPD.

Data source: The [National Neonatal Audit Programme \(NNAP\)](#) measures the number of eligible babies alive at 36 weeks with sufficient data to attribute BPD outcome.

What the quality statement means for different audiences

Service providers (such as neonatal units, including special care units, local neonatal units and neonatal intensive care units) ensure that processes are in place and healthcare professionals are trained to administer surfactant using a minimally invasive technique to preterm babies who do not need invasive ventilation.

Healthcare professionals (such as specialist neonatal nurses, specialist neonatal consultants and other paediatric specialists working with babies born preterm) do not intubate preterm babies to give surfactant to babies who do not need invasive ventilation. They use a minimally invasive technique if surfactant is needed.

Commissioners (NHS England) ensure that they commission services that use minimally invasive techniques to administer surfactant to preterm babies who do not need invasive ventilation.

Preterm babies who need surfactant to help them breathe are given it in a way that has the least risk of problems. This is done through a thin tube into the baby's nose or mouth and passed into their airway. If the baby needs help with breathing using a ventilation machine with a tube that passes into the windpipe, surfactant is given through the tube that is already in place.

Source guidance

[Specialist neonatal respiratory care for babies born preterm. NICE guideline NG124 \(2019\), recommendation 1.2.3](#)

Definitions of terms used in this quality statement

Bronchopulmonary dysplasia (BPD)

A chronic lung disease that develops in preterm babies. [[NICE's guideline on specialist](#)

neonatal respiratory care for babies born preterm, supplement 1: glossary and abbreviations]

Invasive ventilation

Administration of respiratory support via an endotracheal tube or tracheostomy, using a mechanical ventilator. [NICE's guideline on specialist neonatal respiratory care for babies born preterm, terms used in this guideline section]

Minimally invasive technique

Administration of surfactant through a thin endotracheal catheter without insertion of an endotracheal tube or invasive ventilation. Minimally invasive techniques are:

- minimally invasive surfactant therapy (MIST)
- less invasive surfactant administration (LISA)
- avoidance of mechanical ventilation (AMV).

[NICE's guideline on specialist neonatal respiratory care for babies born preterm, terms used in this guideline section and evidence review on respiratory support]

Quality statement 3: Invasive ventilation

Quality statement

Preterm babies having invasive ventilation are given volume-targeted ventilation (VTV) in combination with synchronised ventilation.

Rationale

VTV in combination with synchronised ventilation has a lower mortality rate before discharge in preterm babies compared with other invasive ventilation techniques. It also reduces the risk of bronchopulmonary dysplasia (BPD) and pneumothorax (collapsed lung), and the number of days on invasive ventilation.

Quality measures

Structure

Evidence of local arrangements to ensure that preterm babies having invasive ventilation are given VTV in combination with synchronised ventilation.

Data source: Local data collection, for example, clinical protocols.

Process

a) Proportion of preterm babies born under 28 weeks of pregnancy having invasive ventilation who were given VTV in combination with synchronised ventilation.

Numerator – the number in the denominator who were given VTV in combination with synchronised ventilation.

Denominator – the number of preterm babies born under 28 weeks of pregnancy having invasive ventilation.

Data source: Local data collection, for example, local audit of patient records.

b) Proportion of preterm babies born between 28 weeks and 31 weeks plus 6 days of pregnancy having invasive ventilation who were given VTV in combination with synchronised ventilation.

Numerator – the number in the denominator who were given VTV in combination with synchronised ventilation.

Denominator – the number of preterm babies born between 28 weeks and 31 weeks plus 6 days of pregnancy having invasive ventilation.

Data source: Local data collection, for example, local audit of patient records.

c) Proportion of preterm babies born between 32 weeks and 36 weeks plus 6 days of pregnancy having invasive ventilation who were given VTV in combination with synchronised ventilation.

Numerator – the number in the denominator who were given VTV in combination with synchronised ventilation.

Denominator – the number of preterm babies born between 32 weeks and 36 weeks plus 6 days of pregnancy having invasive ventilation.

Data source: Local data collection, for example, local audit of patient records.

Outcome

a) Number of days preterm babies spend on invasive ventilation.

Data source: Local data collection, for example, audits of patient records.

b) Incidence of pneumothorax in preterm babies.

Data source: Local data collection, for example, audits of patient records.

c) Number of preterm babies with BPD.

Data source: The [National Neonatal Audit Programme \(NNAP\)](#) measures the number of eligible babies alive at 36 weeks with sufficient data to attribute BPD outcome.

What the quality statement means for different audiences

Service providers (such as neonatal units, including special care units, local neonatal units and neonatal intensive care units) ensure that systems are in place for preterm babies to be given VTV with synchronised ventilation if they are having invasive ventilation. Most units have flow sensors for triggered ventilation and the same sensor can be used for VTV.

Healthcare professionals (such as specialist neonatal nurses, specialist neonatal consultants and other paediatric specialists working with babies born preterm) ensure that they use VTV with synchronised ventilation for preterm babies who are having invasive ventilation.

Commissioners (NHS England) ensure that the services they commission provide VTV with synchronised ventilation to preterm babies having invasive ventilation.

Preterm babies using a ventilation machine to help them breathe are given a type of ventilation that lets healthcare professionals control and maintain the volume of gas the baby receives per breath. This may reduce the risk of other problems and the number of days they need to spend in hospital.

Source guidance

[Specialist neonatal respiratory care for babies born preterm. NICE guideline NG124 \(2019\), recommendation 1.2.7](#)

Definitions of terms used in this quality statement

Bronchopulmonary dysplasia (BPD)

A chronic lung disease that develops in preterm babies. [[NICE's guideline on specialist neonatal respiratory care for babies born preterm, supplement 1: glossary and abbreviations](#)]

Invasive ventilation

Administration of respiratory support via an endotracheal tube or tracheostomy, using a mechanical ventilator. [[NICE's guideline on specialist neonatal respiratory care for babies born preterm](#), terms used in this guideline section]

Quality statement 4: Oxygen saturation

Quality statement

Preterm babies have a target oxygen saturation of 91% to 95% after stabilisation.

Rationale

Aiming for an oxygen saturation level of between 91% and 95% can reduce mortality, particularly in babies born very preterm (between 28 weeks and 31 weeks plus 6 days) and extremely preterm (under 28 weeks). Setting a target oxygen saturation level of less than 91% increases the risk of mortality and morbidity.

Quality measures

Structure

Evidence of local arrangements to ensure that preterm babies have a target oxygen saturation of 91% to 95% after stabilisation.

Data source: Local data collection, for example, audits of oxygen administration protocols.

Process

Proportion of preterm babies who have a target oxygen saturation set at between 91% and 95% after stabilisation.

Numerator – the number in the denominator who have a target oxygen saturation between 91% and 95%.

Denominator – the number of preterm babies receiving oxygen after stabilisation.

Data source: Local data collection, for example, audits of patient records.

Outcome

Mortality rates in preterm babies.

Data source: Local data collection, for example, audits of neonatal mortality rates. The [National Neonatal Audit Programme \(NNAP\)](#) collects data on mortality in preterm babies, which will be published by local neonatal networks from 2020.

What the quality statement means for different audiences

Service providers (such as neonatal units, including special care units, local neonatal units and neonatal intensive care units) ensure that systems are in place for preterm babies to have a target saturation level of 91% to 95%. They ensure that healthcare professionals are aware of this target.

Healthcare professionals (such as specialist neonatal nurses, specialist neonatal consultants and other paediatric specialists working with babies born preterm) ensure that oxygen saturation targets for preterm babies are between 91% and 95%. They monitor this using continuous pulse oximetry, supplemented by arterial sampling if clinically indicated.

Commissioners (NHS England) ensure that they commission services that specify target oxygen saturation levels of 91% to 95% in preterm babies.

Preterm babies have the amount of oxygen in their blood (oxygen saturation) monitored, with the aim of achieving a safe level (between 91% and 95%).

Source guidance

[Specialist neonatal respiratory care for babies born preterm. NICE guideline NG124 \(2019\), recommendation 1.4.2](#)

Definitions of terms used in this quality statement

Stabilisation

Facilitating and supporting a smooth transition from fetal to neonatal life. The process involves careful assessment of heart rate, colour (oxygenation) and breathing, and providing appropriate interventions where indicated.

Be aware that some pulse oximeters can underestimate or overestimate oxygen saturation levels, especially if the saturation level is borderline. Overestimation has been reported in people with dark skin. See also the [NHS England Patient Safety Alert on the risk of harm from inappropriate placement of pulse oximeter probes](#). [NICE's guideline on specialist neonatal respiratory care for babies born preterm, recommendation 1.4.2 and terms used in this guideline section]

Quality statement 5: Involving parents and carers

Quality statement

Parents and carers of preterm babies who are having respiratory support are helped to care for their baby.

Rationale

Involving parents and carers in planning and delivering day-to-day care for their preterm baby while in hospital, for example feeding and nappy changing, can help to support parent and carer mental health and attachment, and improve confidence. If parents and carers are confident to manage their baby's condition and able to use specialist equipment safely at home, their baby may be able to come home earlier. Poor mental health can affect bonding between parents and carers and their baby, so access to psychological support can be beneficial.

Quality measures

Structure

a) Evidence of local arrangements to ensure that parents and carers of preterm babies having respiratory support are involved in discussions and decisions about their baby during ward rounds.

Data source: Local data collection, for example, protocols to involve parents and carers during ward rounds. The [National Neonatal Audit Programme \(NNAP\)](#) measures the proportion of admissions where parents were present on a consultant ward round on at least 1 occasion during their baby's stay.

b) Evidence of local arrangements to ensure that parents and carers of preterm babies having respiratory support have 24-hour access to their baby.

Data source: Local data collection, for example, protocols on parent and carer access to preterm babies while in a neonatal unit.

c) Evidence of local arrangements to ensure parents and carers of preterm babies having respiratory support are involved in their baby's day-to-day care and are able to use specialist equipment on discharge.

Data source: Local data collection, for example, protocols to involve parents and carers of preterm babies having respiratory support in their baby's care.

d) Evidence of local arrangements to ensure that parents and carers of preterm babies having respiratory support are offered psychological support while their baby is on respiratory support.

Data source: Local data collection, for example, availability of professionals trained to deliver psychological support to parents and carers of preterm babies.

Process

a) Proportion of parents and carers of preterm babies having respiratory support who are involved in discussions and decisions about their baby during ward rounds.

Numerator – the number in the denominator who are involved in discussions and decisions about their baby during ward rounds.

Denominator – the number of parents and carers of preterm babies having respiratory support.

Data source: Local data collection, for example, audits of patient records of the frequency that parents and carers participated in ward rounds during their baby's admission.

b) Proportion of parents and carers of preterm babies having respiratory support who have 24-hour access to their baby.

Numerator – the number in the denominator who have 24-hour access to their baby.

Denominator – the number of parents and carers of preterm babies having respiratory support.

Data source: Local data collection, for example, audits of patient records and surveys of parents' and carers' experience.

c) Proportion of parents and carers of preterm babies having respiratory support who are involved in providing their baby's day-to-day care.

Numerator – the number in the denominator who are involved in providing their baby's day-to-day care.

Denominator – the number of parents and carers of preterm babies having respiratory support.

Data source: Local data collection, for example, audits of patient records.

d) Proportion of parents and carers of preterm babies who will need respiratory support following discharge who receive training to use specialist equipment before their baby is discharged.

Numerator – the number in the denominator who receive training to use specialist equipment before their baby is discharged.

Denominator – the number of parents and carers of preterm babies who will need respiratory support following discharge.

Data source: Local data collection, for example, audits of parent training logs and patient records.

e) Proportion of parents and carers of preterm babies having respiratory support who can access psychological support while their baby is on the neonatal unit.

Numerator – the number in the denominator who can access psychological support.

Denominator – the number of parents and carers of preterm babies having respiratory support on the neonatal unit.

Data source: Local data collection, for example, audits of patient records.

Outcome

Proportion of parents and carers of preterm babies who had respiratory support who feel confident to care for their preterm baby at home.

Numerator – the number in the denominator who feel confident to care for their preterm baby at home.

Denominator – the number of parents and carers of preterm babies who had respiratory support.

Data source: Local data collection, for example, surveys of parents' and carers' experience.

What the quality statement means for different audiences

Service providers (such as neonatal units, including special care units, local neonatal units and neonatal intensive care units) ensure that systems are in place for parents and carers to be supported to be involved in their baby's care. This can be through participation in ward rounds, providing day-to-day care and, if their baby is being discharged on respiratory support, understanding how to use specialist equipment at home. They also ensure that parents and carers have access to their baby 24 hours a day and that psychological support is available while their baby is on the unit.

Healthcare professionals (such as specialist neonatal nurses, specialist neonatal consultants, allied health professionals and other paediatric specialists working with babies born preterm) engage with parents and carers to ensure they are provided with all the necessary information to help them understand their baby's condition and management, and to make informed decisions about their baby's care. This includes providing support and guidance for parents and carers, making them aware of psychological support that is available, providing constructive and supportive feedback about how to care for their baby and, if their baby is being discharged on respiratory support, support to use specialist equipment at home.

Commissioners (NHS England) ensure that they commission services that help parents and carers to be involved in their baby's care.

Parents and carers of preterm babies having help with their breathing in hospital are supported by their healthcare professionals to care for their baby. They have access to their baby 24 hours a day and are involved in ward rounds and in the planning of their baby's care. They are helped to be confident to provide their baby's day-to-day care, for example feeding and nappy changing, and if their baby is being discharged on respiratory support, they are supported to use specialist equipment at home. They are also made aware of the psychological support that is available to them.

Source guidance

Specialist neonatal respiratory care in babies born preterm. NICE guideline NG124 (2019), recommendations 1.6.5, 1.6.7 and 1.6.8

Definitions of terms used in this quality statement

Help to care for their baby

Parents and carers are involved in planning and providing their baby's day-to-day care, for example, feeding and nappy changing. They are encouraged and supported to participate in discussions and decisions about their baby during ward rounds, providing input into planning care. They are given constructive and supportive feedback about how to care for their baby and, if their baby is being discharged on respiratory support, how to use specialist equipment at home. [NICE's guideline on specialist neonatal respiratory care for babies born preterm, recommendations 1.6.5 and 1.7.4 and expert opinion]

Respiratory support

This includes invasive ventilation, non-invasive ventilation or oxygen therapy. [Adapted from NICE's guideline on specialist neonatal respiratory care for babies born preterm, supplement 1: glossary and abbreviations and expert opinion]

Equality and diversity considerations

Parents and carers should have access to an interpreter or advocate if needed.

Parents and carers who are very young or who have a learning difficulty may need

additional support when their baby is being cared for. Healthcare professionals should discuss what support they need with them, for example, involving other members of their family or their social and support workers.

It may be difficult for some parents and carers to visit every day and be involved in their baby's care, for example, because of the costs of travel, accommodation and subsistence. Parents and carers should be advised of any support available to them on admission to the neonatal unit, including the availability of accommodation and support with subsistence costs. This may be available directly through the neonatal unit or through charities. Healthcare professionals should continue to involve parents and carers in their baby's care as much as possible.

Update information

Minor changes since publication

March 2023: We added text to the definitions section of statement 4 to indicate that pulse oximetry may be less reliable in people with dark skin. We also added a link to the NHS patient safety alert on the risk of harm from inappropriate placement of pulse oximeter probes.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the [resource impact statement for NICE's guideline on specialist neonatal respiratory care for babies born preterm](#) to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- [Bliss](#)
- [Neonatal and Paediatric Pharmacists Group](#)
- [Royal College of Nursing \(RCN\)](#)
- [Royal College of Paediatrics and Child Health](#)