How are we using the data?

The objective of this audit is to assess whether babies requiring neonatal care receive consistent and excellent care throughout the country. The questions relating to ante-natal steroids and ROP have robust national clinical standards. In all other cases, the audit is interested more in surveying the current situation rather than comparing the data from an individual unit against a national standard. NNAP allows units to benchmark their results against units of a similar size and level, and demonstrate year-on-year improvement.

The National Clinical Audit Advisory Group has asked all national audits, including NNAP, to contact Trusts/units which appear to be outliers in the audit. (For example, this might mean contacting those units whose reported breast-feeding rates were in the worst 5%). This would involve first ensuring that the data were complete and accurate, and if they were, entering into a dialogue with the Trust/NNU as to how the process or the outcome could be improved.

Vital to the audit is the entry of timely, accurate and complete data on every baby. The time and effort of staff to this end is highly valued.

Reporting of the data

You can compare your own unit’s data with other units’ for many of these questions in the “Reports” section of Badger, under the NNAP list. A Data Quality Report is sent to every unit on a quarterly basis.

An Annual Report is sent to the Healthcare Commission, Trust Chief Executives and Medical Directors, Neonatal Network managers, stakeholder organisations and all NNUs. This report comprises a more detailed analysis of one full year’s data. Units are identified in all NNAP reports.

If you have any questions about this audit please contact Kim Davis, the NNAP Project Co-ordinator, at: kim.davis@rcpch.ac.uk
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The National Neonatal Audit Programme began collecting data in October 2006, and all neonatal units in England were collecting and submitting data at the end of 2011.

The audit questions are reviewed and amended annually, and we will be auditing the questions below from 1 January 2012.

The audit questions cover a range of aspects of care:

There are eight clinical questions:

• Do all babies of \( \leq 28^{+6} \) weeks’ gestation have their temperature taken within an hour after birth, and what percentage are hypothermic or hyperthermic? Extreme hypo- and hyper-thermia are associated with poor outcomes. Normothermia is one outcome of careful immediate post-partum care.

• Are all mothers who deliver their babies between 24\(^{+0}\) and 34\(^{+6}\) weeks’ gestation given any dose of antenatal steroids? This is based on the RCOG green top guideline.

• Are all babies <1501g or <32\(^{+0}\) weeks at birth and still an inpatient undergoing first ROP screening as per the current guideline recommendations? This is based upon the joint RCPCH/RCOphth national ROP screening guidelines.

• How many babies born between 32\(^{+0}\) to 36\(^{+6}\) and more than or equal to 37\(^{+0}\) weeks gestation receive transitional care (HRG4), special care on a neonatal unit (HRG3), high dependency care (HRG2) or intensive care (HRG1)? A benchmarking exercise. In 2009, 6% of all babies >37\(^{+0}\) weeks received neonatal care in a NNU or on a ward with the mother.

• What percentage of babies \( \geq 35^{+0} \) weeks gestation have an encephalopathy within the first 3 calendar days of birth? This will be largely but not exclusively hypoxic-ischaemic encephalopathy. High rates may reflect sub-standard perinatal care.

• How many blood stream infections\(^a\) are there on a NNU per 1000 days of central line\(^b\) care? Here \( a \) = as defined in the above blood culture question, and \( b \) = UAC, UVC, percutaneous long line, surgically inserted long line. Long line associated blood stream infections are indicators of the quality and sterility of long line handling techniques, and it is known that infection rates can be significantly reduced by staff education and training.

• What percentage of babies admitted to a neonatal unit have one or more episodes of a pure growth pathogen from blood; one or more episodes of a pure growth of a pathogen from CSF or a mixed growth; either a pure growth of a skin commensal or a mixed growth with \( \geq 3 \) clinical signs at the time of blood sampling? Data will be linked to the presence of central lines. After correction for variables such as weight and gestation, high rates may reflect inadequate antiseptic precautions.

• Are rates of normal survival at two years comparable in similar babies from similar units? Neuro-developmental outcome is just as important as survival. Consultants report on the two year health status of the most preterm babies to enable this comparison. In 2012 we are auditing babies of <30\(^{+0}\) gestation at birth.

Two questions resulted from consultation with parent groups:

• What proportion of babies <33\(^{+0}\) weeks gestation at birth are receiving their own mother’s milk when discharged from a neonatal unit? This question replaced that about ‘receiving mother’s breast milk at any time’ during a stay on a NNU, and is a measure of outcome rather than process.

• Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission? A senior staff member is a Consultant, Associate Specialist, Specialist Registrar (SpR), Staff Grade doctor, or a Speciality Doctor/ANNP acting as a SpR.

One question is included due to its topical interest:

• Are all babies accessing neonatal services treated in their own normal Network clinical pathway (except where clinical reasons dictate)? But approximately one fifth of all babies are admitted to more than one NNU. This number needs to fall.