Staffordshire, Shropshire & Black Country Neonatal Network

Report of Designation Workshop

1 Introduction

A workshop for members of the Staffordshire, Shropshire and Black Country Neonatal Network was held on 23rd February 2005 with the objectives:

- To agree the criteria for the designation of units
- To discuss and agree the types of unit and required staffing
- To agree the process for the designation of units and the timescale for this to happen.

Annex 1 lists those people who attended the workshop and this report summarises the discussion and conclusions that were reached.

Two presentations were given:

- What a Network should be delivering – based on a baby's journey
  Prof. Neil Marlow, Professor of Neonatal Medicine, Queen's Medical Centre, Nottingham
- Setting the scene in the Staffordshire, Shropshire and Black Country Neonatal Network – Key messages from unit data collection
  Dr Andy Spencer, Network Lead Clinician and Ruth Moore, Network Manager

Copies of these presentations were given to workshop delegates and are not reproduced here. Copies are available from ruth.moore2@nhs.net.

2 Need for change

In April 2003 the Department of Health launched the Report of the Expert Working Group on Neonatal Intensive Care Services. The Report recommends the establishment of neonatal networks and the designation of some hospitals that will be specially equipped to care for the sickest and smallest babies, with other hospitals providing high dependency care and shorter periods of intensive care as close to home as possible.

The Report of the Expert Working Group concluded that change in the current service arrangements is needed because:

- "The current pattern of transfers could be improved for parents, babies and staff.
- Neonatal intensive care is currently provided in a widely dispersed manner and there is a need for agreed national standards of care.
- Staffing issues are key to sustainability of neonatal services and the existing skills and experience should be harnessed. Yet major challenges are posed by the need for nursing recruitment to keep up with increased demand, and also by medical staffing pressure.
- There is a lack of national data regarding outcomes for intensive care.
- There is limited capacity in larger units which provide care for the most ill babies.
- The provision of transport teams by the larger units at times depletes the host unit to unacceptable levels of the staff needed to provide care in that unit."

3 Proposed criteria for the designation of units

Aim: to achieve both the best possible care for the baby, mother and family **and** reasonable value for money.

Proposed criteria:

1	Capacity and quality of each unit	• Good facilities and support should be available for parents and families. • Maternity services should have the capacity to care for the expected numbers and care required, including: o Obstetrician and midwifery staffing o Training and expertise of obstetricians and midwives, in particular, expertise in foeto-maternal medicine for level 3 units. o Facilities and equipment • Neonatal services should have the capacity to care for the expected numbers and care required, including: o Medical and nurse staffing o Training and expertise of staff on the neonatal unit o Facilities and equipment • Relevant support services should be available, including imaging and anaesthesia. • Other relevant services should be located close to the neonatal unit. • There should be a willingness to develop a coherent and cohesive service and good collaboration between maternity and neonatal services and between different levels of unit. • Level 3 units should have university links for training and research.
2	Access	The proposed configuration of units should deliver care as close to home as possible. The number and distance of transfers should be as low as possible with travel as easy as possible for families of babies transferred.
3	Realistic	The proposed configuration of units should be: • achievable within a two to five year time period • sustainable thereafter • have a reasonable level of support from parents, public, healthcare professionals, service managers and commissioners.
4	Value for money	The proposed configuration should ensure reasonable value for money.

The importance of outcome data was discussed at the workshop. It was agreed that data on outcomes of care are not yet good enough to use as part of the designation process – but that outcomes should be monitored and used as part of the evaluation of the final designation.

4 Types of Unit

The Department of Health Expert Working Group Report and the British Association of Perinatal Medicine Standards (2001) describe three levels of neonatal unit. Different interpretations of these descriptions are, however, possible. It is important that the Shropshire, Staffordshire and Black Country Network have a clear understanding of the types of unit proposed for the network. Workshop participants therefore described each level of unit in terms of mothers and babies to be cared for, transfers, care offered and staffing that should be available.

4.1 Guidelines and choice

The unit in which a mother and her baby are cared for will depend on the clinical condition of the mother and baby, taking into account the mother and her partner's preferences for location of care. Clinical guidelines covering transfer of mothers and babies will be developed and agreed within the network. The implementation of these guidelines will involve parents and discussion between units within the networks.

Sections 4.2 to 4.4 describe the usual patterns of care – as a basis for planning the configuration and capacity within the network. Care of individual mothers and babies will, of course, depend on the clinical situation and the parents' preferences.

In Sections 4.2 to 4.4 the terms intensive, high dependency and special care are as described in the BAPM Standards (2001) unless otherwise specified.

4.2 Level 1 Unit

Mothers	• Deliveries at 32 weeks gestation and above considered to be low risk. • Deliveries at 30 – 32 weeks gestation, subject to a risk assessment and in accordance with agreed clinical guidelines
Babies	• Babies needing special care • Babies transferred back (see below)
Transfer – out	• Mothers expected to deliver at less than 30 – 32 weeks gestation or with significant medical problems • Babies needing intensive or high dependency care
Transfer – in / back	• Babies on CPAP who are stable, in accordance with agreed clinical guidelines • Babies needing special care (including post-operative care for babies whose condition is stable) • Mothers from level 2 and level 3 units who fall within the clinical criteria for the level 1 unit. (NB. It is desirable that care is delivered as close to home as possible. It may, occasionally, be necessary to transfer mothers from a level 2 or 3 unit in order to free capacity in that unit or because they are no longer expected to need that level of care.)
Care	• Resuscitation, stabilisation and intubation • Non-invasive monitoring • Special care

	• CPAP only for babies transferred back following high dependency or intensive care whose condition is stable • Support for parents • Follow up for two years
Staffing	• As BAPM standards • Medical and nursing staff to have regular clinical experience in a level 3 unit in order to maintain skills

4.3 Level 2 Unit

Because of the fluctuating need for care and in order to ensure reasonable occupancy and value for money from level 2 facilities, it is expected that level 2 units will have at least 3,500 births per annum.

Mothers	• Deliveries at 28 weeks gestation and above considered to be medium risk. • Deliveries at 27 to 28 weeks gestation, subject to a risk assessment and in accordance with agreed clinical guidelines
Babies	• Babies needing short term intensive care • Babies needing high dependency care • Local babies needing special care (including post-operative care for babies whose condition is stable)
Transfer – out	• Mothers expected to deliver at less than 27 – 28 weeks gestation or with significant medical problems • Babies needing intensive care for more than 48 to 72 hours
Transfer – in / back	• Babies needing high dependency care • Mothers from level 3 units who fall within the clinical criteria for the level 2 or 1 unit. (NB. It is desirable that care is delivered as close to home as possible. It may, occasionally, be necessary to transfer mothers from a level 3 unit in order to free capacity in that unit or because they are no longer expected to need that level of care.)
Care	• Resuscitation, stabilisation and intubation • Short term intensive care - ventilation for 48 to 72 hours and, following discussion with a level 3 unit, those whose condition is expected to improve shortly thereafter. • High dependency and special care • Support for parents • Follow up for two years
Staffing	• As BAPM standards for nursing staff • Medical staff: o One consultant neonatologist o Two paediatricians with an interest in neonatology o At least two other consultant paediatricians o Middle grade rota shared with general paediatrics o SHO / ANNP rota separate from general paediatrics

4.4 Level 3 Unit

Mothers	• In-patient care of mothers expected to deliver at less than 27 weeks gestation • In-patient care of mothers at 27 weeks gestation and above who are considered to be at high risk (identified in clinical guidelines – for example, severe early onset pre-eclampsia; fibronectin positive; cervical length decrease at 24 – 27 weeks) • Outpatient monitoring of mothers according to agreed clinical guidelines – for example, severe intra-uterine growth retardation, congenital anomalies, severe TTTS and haemolytic disease.
Babies	• Babies needing intensive care (excluding short-term intensive care in level 2 units) • Babies needing intensive or high dependency care following surgery • High dependency and special care
Transfer – out	• Babies returning to level 2 and level 1 units when condition is stable • Mothers expected to need level 2 or level 1 care in order to free up capacity or because their baby is no longer expected to need intensive care.
Transfer – in	• Babies needing intensive care (excluding short-term intensive care in level 2 units) • Babies needing high dependency care (if no level 2 unit closer to home) • Babies needing surgery
Care	• Resuscitation, stabilisation and intubation • Intensive, high dependency and special care • Advice to level 2 and level 1 units • Parental support • Follow up for two years • Specialist investigations (for example, neuro-imaging and EEG)
Staffing	• Expertise in foeto-maternal medicine • Medical and nursing staffing as BAPM standards

5 Proposed designation process

The following designation process is proposed. Parent representatives will be involved throughout. There will also be discussion with Health Overview and Scrutiny Committees concerning the involvement that they would like in the process.

1	Comments on the criteria and types of units from all organisations within the network	March 2005
2	Network Board agree criteria and process	April 2005
3	Additional information requested from units	April 2005
4	Units submit additional information	May 2005

5	Capacity planning analysis	April – May 2005
6	Initial appraisal of options (Network team with external neonatologist and neonatal nurse advice)	May / June 2005
8	Workshop for organisations within the network to discuss option appraisal	June / July 2005
9	Report with recommended designation of units presented to Network Board	July 2005
10	Network Board recommendation presented to Specialised Services Commissioners	Sept 2005
11	Formal public consultation	Oct 2005 onwards

Annex 1

Workshop Participants

Name	Title	Organisation
Gina Hartwell	Senior Nurse Manager SCBU	Mid Staffordshire General Hospital
Dr Ajay Gupta	Consultant Paediatrician	Mid Staffordshire General Hospital
Sue Malbon	Directorate Manager Child Health	UHNS
Barbara Hodgkiss	Acting Clinical Nurse Manager	UHNS
Dr Kate Palmer	Consultant Paediatrician	UHNS
Jackie Jenkinson	Senior Clinical Midwife	UHNS
Pete Young	Consultant Obstetrician	UHNS
Liz McMillan	Consultant Obstetrician	Walsall Manor
Doreen Humphries	Matron	Walsall Manor
Dr Daphne Austin	Consultant in Public Health	WMSSA
Doreen Quammie	Neonatal Services manager	Russells Hall
Anand Mohite	Consultant	Russells Hall
Julia Greenaway	Neonatal sister	Russells Hall
Fiona Chambers	ANNP	Russells Hall
Melanie Trafene	Parent Rep	BUTONS
Debbie Whitby	Parent Rep	BUTONS
Ruth Moore	Network Manager	SSBC Neonatal Network
Dr Andy Spencer	Network Lead	SSBC Neonatal Network
Jon Crockett	Chair – Network Board	SSBC Neonatal Network
Sarah Carnwell	Acting Administrator	SSBC Neonatal Network
Dr Babu Kumararatne	Consultant Neonatologist	New Cross, Wolverhampton
David Churchill	Consultant Obstetrics & Gynaecology/ Perinatal Services Representative	New Cross, Wolverhampton
Clare Price	Neonatal Nurse Manager	New Cross, Wolverhampton
Dr Janet Anderson	Clinical Director – Children's Services	New Cross, Wolverhampton
Mrs Penny Venables	Director of Hospital Services	New Cross, Wolverhampton
Stuart Baird	Workforce Information Analyst	Birmingham and Black Country SHA
Dr Sanjeev Desphpande	Consultant Neonatologist	Shrewsbury & Telford
Jacqui Angell	ANNP	Shrewsbury & Telford
Julia Fryer	ANNP	Shrewsbury & Telford
Mrs J Latham	Senior Midwife	Shrewsbury & Telford
Mr A Gornall	Consultant Obstetrician	Shrewsbury & Telford
Neil Marlow	Professor of Neonatology	University Nottingham
Dr Andy Coe	Children's Commissioning Team	WMSSA
Sue Jones	Programme Development Manager Children's Services	Birmingham and Black Country SHA
Jane Eminson	Process Facilitator	
Joyce Yan	Sister on SCBU	Mid Staffordshire General Hospital
Dr Helen Sullivan	Obsterician and Gynaecologist	New Cross, Wolverhampton