Report on designation workshop (29 – June – 2005)

Introduction

1 In February 2005 a workshop was held for members of the network, including parent representatives. This workshop discussed:

- the reasons why change is needed,
- the current number of neonatal cots and their staffing,
- the types of unit needed in the future and their staffing
- the proposed criteria for deciding on the designation of units and
- the process to be used for the designation of units.

The process involved the setting up of a small working group to include the Network Team plus a group of advisers (Appendix 1). This small group were to evaluate a range of options which were to be approved beforehand by the board.

2 The results of the February workshop, which included description of the different levels of units, and the options to be evaluated (Table 1) were agreed by the Network Board in April 2005.

Table 1 Options to be evaluated

	A *	B	C	D	E	F	G	H	I
Dudley	3	1	1	1	2	2	1	2	3
Wolverhampton	3	2	3	3	3	3	3	3	3
Walsall	2	1	1	1	1	1	2	2	2
Shrewsbury	3	2	2	2	2	3	2	2	3
Stafford	2	1	1	1	1	1	1	1	1
Stoke	3	3	2	3	3	3	3	3	3

* Option A is the declared preferred designation by each unit in the Staffordshire, Shropshire and Black Country Network

3 Additional information on maternity and neonatal services and their staffing was collected from neonatal units. The small Working Group then met to evaluate the options against the agreed criteria. Appendix 2 summarises the information used to assess each criterion.

4 The results of the option appraisal were presented to a workshop for members of the network on the 29th June 2005. The issues raised at this workshop are summarised in section 20.

Evaluation of Options

5 Unit Evaluations

Appendix 3 summarises the evaluation of each unit against the criteria 'capacity and quality' for the possible levels of designation. Table 2 summarises these results. The working group did not consider it appropriate to evaluate Dudley as a level 3 unit or Stafford as a level 2 unit because of the amount of additional staffing that would be required. Options A and I were therefore excluded at this stage.

6 Access

The Department of Health capacity planning tool (Appendix 4) calculates the number of transfers of mothers and babies and the number of 'cot blocks'. 'Cot blocks' are times when a cot is not available for a baby and so the baby has to be transferred out of the network or cared for in an inappropriate cot. The total number of transfers and 'cot blocks' was used to indicate difficulties in access to services. Table 3 shows the total transfers plus 'cot blocks' and the total cost (as calculated by the model) for each of options B to H. A fuller analysis of the results is shown in Appendix 6. Travel distances and times were also used in evaluating access (see Appendix 5).

Table 3 Modelling results

	Option						
	B	C	D	E	F	G	H
Total transfers plus cot blocks	616	643	574	525	462	522	494
Total staff cost (£m)	12.56	12.56	12.95	13.36	14.13	13.36	13.69

Table 2 Evaluation of capacity and quality criterion

Note: All scores are out of 10.

	Option A		Option B		Option C		Option D		Option E		Option F		Option G		Option H		Option I	
Unit	Level	Score	Level	Score	Level	Score	Level	Score	Level	Score	Level	Score	Level	Score	Level	Score	Level	Score
Dudley	3	-	1	9	1	9	1	9	2	5.5	2	5.5	1	9	2	5.5	3	-
Wolverham-pton	3	8	2	9.5	3	8	3	8	3	8	3	8	3	8	3	8	3	8
Walsall	2	5	1	10	1	10	1	10	1	10	1	10	2	5	2	5	2	5
Shrewsbury	3	6	2	9	2	9	2	9	2	9	3	6	2	9	2	9	3	6
Stafford	2	-	1	6.5	1	6.5	1	6.5	1	6.5	1	6.5	1	6.5	1	6.5	1	6.5
Stoke	3	9	3	9	2	9.5	3	9	3	9	3	9	3	9	3	9	3	9
Average score		-		8.8		8.6		8.5		8.0		7.1		7.7		7.1		-

7 The Working Group considered that the level of transfers in options B and C was unacceptably high. These options were therefore excluded from further analysis. The remaining options were then evaluated against the access, realistic and value for money criteria. The scores against all criteria are shown in Table 4.

Table 4 Scores

Criteria	Options				
	D	E	F	G	H
Capacity and quality	8.5	8.0	7.1	7.7	7.1
Access	1	3	5	3	4
Realistic	5	8	6	6	5
Value for money	5	3	1	3	2

8 Options D to H all have the units at Wolverhampton and Stoke as level 3 and the unit at Stafford as level 1. The units affected by these options are therefore Dudley, Walsall and Shrewsbury. The issues for each unit are described in sections 16 to 18.

9 **Dudley**

The Working Group considered that the unit at Dudley needed investment if it is to reach the standards for a level 2 unit. The unit delivers nearly 4000 births per year and has experience of providing high dependency and intensive care. The Working Group considered that Dudley should be designated as a level 2 unit.

10 **Walsall**

Staffing of the maternity and neonatal units in Walsall is well below the levels expected for a level 2 unit. The number of births (3887) would, however, be high for a level 1 unit. The latest Black Country Review proposed clinical integration of paediatric services with Wolverhampton and merger of the two Trusts is being considered. A level 2 unit could not be sustained if in-patient paediatric services are not available at Walsall. Table 5 shows the information relating to the designation of the Walsall unit. The conclusion of the Working Group was that Walsall should be designated as a level 1 unit.

Table 5 Summary of information relating to Walsall designation

	Walsall Level 1 (Option E)	**Walsall Level 2 (Option H)**	**Difference (H – E)**
Capacity and quality score	8.0	7.1	-0.9
Access score	3	4	1
Realistic score	8	5	-3
Value for money score	3	2	-1
Total transfers plus ‘cot blocks’ (across network)	525	494	31
Transfers out of unit concerned	131	61	70
Total cost (across network) £m	13.36	13.69	0.33

11 Shrewsbury

The unit at Shrewsbury would require considerable investment in order to reach the standards for a level 3 unit. Travel distances and times to other units are, however, higher than for the other units within the network and babies from Wales also use the services at Shrewsbury. The population served is less deprived than most other parts of the network and so outcomes are likely to be better. Given the relatively small numbers of very small and very sick babies cared for by the unit, it may be difficult to recruit and retain the necessary expertise in both fetal medicine and neonatology. Table 6 shows the information relating to the designation of the Shrewsbury unit. The conclusion of the Working Group was that Shrewsbury should be designated as a level 2 unit. The Group suggest, however, that the development of clinical guidelines could allow the Shrewsbury unit to keep babies from 27 weeks gestation, because of the expertise available and the travel distances involved.

Table 6 Summary of information relating to Shrewsbury designation

	Shrewsbury Level 2 (Option E)	**Shrewsbury Level 3 (Option F)**	**Difference (F – E)**
Capacity and quality score	8.0	7.1	-0.9
Access score	3	5	2
Realistic score	8	6	-2
Value for money score	3	1	-2
Total transfers plus 'cot blocks' (across network)	525	462	63
Transfers out of unit concerned	58	0	58
Total cost (across network) £m	13.36	14.13	0.77

12 Other issues

The Working Group identified some additional issues:

- The Department of Health capacity planning tool allocates a (staffed) cot wherever there are babies needing a particular level of care. As a result, Level 1 units are allocated one intensive care and one high dependency care cot to be used by babies prior to transfer. In practice, a resuscitation and stabilisation cot is needed in level 1 units but this will not be staffed on a regular basis. The BAPM standards recommend a supernumerary nurse on each shift, part of whose role is to provide care in emergencies.

- Units care for babies of drug dependent mothers who require supervised withdrawl from drugs in different settings. In some units, most of these babies are cared for on the post-natal wards. This variation in practice impacts on the availability of neonatal care capacity. Network-wide guidelines on this issue may be helpful.

- Nurse staffing levels within the BAPM (2001) standards are considered by many nurses to be higher than is actually needed. It is, however, important that there is some standard against which the staffing in different units can be compared. The network may want to develop more appropriate nurse staffing standards for use in the network.

- The BAPM guidance on standards for obstetric services supporting each level of neonatal unit includes a requirement for feto-maternal medicine expertise to be available in a level 3 unit. It is not clear how this is defined. The Working Group used the following definition:

  At least two consultant obstetricians who either have sub-specialty training in feto-maternal medicine or who are recognised as having a special interest in feto-maternal medicine should be available. The job plan of these consultants should reflect their special interest. A range of feto-maternal medicine services should be provided, including prenatal diagnosis, genetic counselling and follow up and monitoring of babies at risk. These consultants should take a lead role in the management of in utero transfers.

- Some units have community paediatricians on the on call rota for in-patient paediatrics. The Working Group considered whether this was appropriate for level 2 units. The Group's conclusion was that all consultants taking part in the on call rota in level 2 units should undertaken at least one day-time session on the neonatal unit, have some involvement with ward rounds on the neonatal unit, have up to date NLS training and undertake some CPD of relevance to their role in neonatal care. Network-wide guidance on this subject may be helpful.

13 **Workshop discussion (29th June 2005)**

The workshop discussion identified the following issues relating to the designation process:

- Has there been enough parental involvement?
- Were all units (and the staff within all units) aware of the options being considered?
- Do the descriptions of the different levels of unit that were agreed following the February workshop accurately reflect the discussion at the workshop (especially in relation to units with over 3,500 births)?
- Has deprivation been adequately taken into account?
- Have travel times in rural areas been adequately taken into account, especially for Shropshire and mid Wales?

14 Several units wished to amend the information they had originally supplied after seeing how the information was used and interpreted. The juxta-position of the Black Country Review was considered by one unit to have had an undue influence on the outcome. Not all units were able to agree their proposed designation pending consideration of all of the above.

15 Following the workshop, all Trusts were invited to comment on the draft designation report and, in particular, on the information relating to their unit and to the proposed unit designation (Appendix 8).

16 A Black Country Review Clinical Advisory Board meeting was held on 20th and 21st July 2005. The outcome from this meeting was a proposed model for further discussion of a single maternity, level 3 neonatal and in-patient paediatric unit serving the populations of Walsall and Wolverhampton and further consideration of the sustainability of paediatric and maternity services in the future at Dudley.

17 During discussions about the process for designation of neonatal units it has become apparent that some units and individuals have reservations about the practical implications of the conclusions of the Department of Health Review Group. The Department of Health Document was used in the process as an impetus to improvement, with local flexibility to achieve good solutions across the network. Therefore it is intended that the final designation report will reflect the best interests of mothers and babies across the Staffordshire, Shropshire & Black Country network.

18 **Public and parental involvement**

To date, public and parent representatives have been involved in the following way:

- Each unit was asked to identify appropriate parent representatives to invite to the February 2005 workshop and two representatives attended.
- BLISS and a parent representative took part in the Working Group evaluating the options.
- Two parent representatives were appointed to the Network Board in June 2005.
- Two parent representatives and BLISS were invited to the June workshop, although only one parent was able to attend.
- Representatives from the Overview and Scrutiny Committees were invited to the June workshop and three attended.

All reports have been circulated to those people who have attended Workshops and Board meetings.

19 **Next Steps**

A) Updating and amending unit information
B) Check appropriateness of level one designation for units with >3500 births.
C) Re-score neonatal unit at Shrewsbury with external advisors
D) Modelling of further options with Shrewsbury as level 3 unit
E) Modelling to take account of deprivation
F) Greater consideration of travel arrangements.
G) Work with Walsall/Wolverhampton on the impact of the Black Country Review for the proposed designation.
H) Consideration of impact of Black Country Review on Dudley
I) Take account of specific comments from Trusts following workshop
J) Produce final designation report taking account of all issues raised.
K) Visits to all Trusts to discuss implications of unit designation
L) Sign off of report at October Board.
M) Final report to be posted on website
N) Wider views from users and parents (potential & actual) of neonatal services on proposed designation.

Appendix 1

Membership of Working Group for Assessment of Options

Claire Wyon	Parent representative
Laura Burt	Parent representative (BLISS)
Dr Andy Spencer	Network Lead Clinician
Ruth Moore	Network Manager / Lead Nurse
Mr David Churchill	Clinical Director, Obstetrics and Gynaecology, Royal Wolverhampton Hospitals NHS Trust
Prof Neil Marlow	Professor of Neonatal Medicine, Queen's Medical Centre, Nottingham
Tracy Woodall	Lead Nurse,
Christine Richardson	Network Manager, Central Newborn Network
Jane Eminson	Process Facilitator

Appendix 2

Information used to assess criteria

Criteria		Description of criteria	Assessed by

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 feto-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.
			• Information supplied by each unit.
			• Network team knowledge gained from visiting units.

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.	• Department of Health capacity planning tool – number of 'cot blocks' and transfers (see Appendix 4) • Travel distances and times (see Appendix 5)
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.	• View of Working Group based on all information available
4	Value for money	The proposed configuration should ensure reasonable value for money.	• Department of Health capacity planning tool – assessment of total cost. • Estimate of investment needed to reach necessary staffing – based on the information supplied by each unit.

Appendix 3

Unit Evaluations

Capacity and quality of unit: Dudley Group of Hospitals NHS Trust

Number of births July 03 – June 04: 3891

Aspect	Comments
Good facilities and support should be available for parents and families.	The unit has most of the facilities expected but does not have a day room for parents. There is a flat were parents can stay which has a kitchen – but this is not available to parents who are not staying overnight.
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 feto-maternal medicine for level 3 units. o Facilities and equipment	The expected staffing and facilities are available, with the exception of: • There is not a Specialist Registrar available to the delivery suite at all times. • Midwife staffing is not yet at the level expected by Birthrate Plus and there is no plan, agreed with commissioners, for achieving this level of staffing. • There is not always someone with skills in neonatal resuscitation available to support all deliveries although this should be achieved later this year. • Feto-maternal medicine expertise is limited and there is not a feto-maternal medicine unit within the maternity service.
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	Medical staffing meets the standards expected for a level 1 unit. There is a separate SHO/ANNP rota for the neonatal unit during the daytime but not at nights. In relation to level 3 - the middle grade rota is not separate from general paediatrics and there is not a separate rota of consultant neonatologists. There is currently one paediatrician with an interest in neonatology. In the near future, this is expected to rise to two. There will also be a joint neonatologist appointment with Wolverhampton. The nurse staffing establishment is 19% below the level recommended for the current designation of cots and there are 9% vacancies. The expected facilities and equipment are available with the exception of a second spare ventilator in case of emergencies.
Relevant support services should be available, including imaging and anaesthesia.	All services are available.
Other relevant services should be located close to the neonatal unit.	All relevant services are 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.	A range of meetings take place within Dudley. Staff from the unit participate in network meetings but there is no evidence of other links or collaboration with different levels of neonatal unit. The joint appointment with Wolverhampton should help collaboration.
Level 3 units should have university links for training and research.	There are links for nurse and ANNP training but not for research.

Level	Score (out of 10)	Reason for score
1	9	The unit meets nearly all of the requirements for a level 1 unit. Day facilities for parents are not available.
2	5.5	The SHO / ANNP rota is not separate from general paediatrics at nights. Day facilities for parents are not available. Nurse staffing is low.
3	-	Scoring against the criteria for level 3 units was not considered appropriate. Medical staffing in obstetrics and neonatology are a long way from the expected levels and the unit does not therefore have the expertise needed to care for very small and very sick babies or mothers who need to be transferred. Travel times to the unit at Wolverhampton are not long.

Capacity and quality of unit: Royal Wolverhampton Hospitals NHS Trust

Number of births July 03 – June 04: 3530

Aspect	Comments
Good facilities and support should be available for parents and families.	All facilities are available. The building is old and in need of upgrade / replacement. There are not yet agreed plans for the development of a new unit.
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 feto-maternal medicine for level 3 units. o Facilities and equipment	Most of the standards are met. Midwifery staffing is not yet at the level recommended by *Birthrate Plus* but a plan for reaching this level has been agreed with commissioners. A range of feto-maternal medicine services are available and there is a feto-maternal medicine unit within the maternity service. Feto-maternal medicine specialists do not yet manage all in utero transfers.
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	The consultant rota is not yet separate from general paediatrics but, with the appointment of one additional consultant, a 1:5 neonatal rota will be established. The middle grade and SHO / ANNO rotas are separate from general paediatrics. The nurse staffing establishment is 31% below the level recommended for the current designation of cots and there are 8% vacancies.
Relevant support services should be available, including imaging and anaesthesia.	These services are available.
Other relevant services should be located close to the neonatal unit.	ITU for mothers are in a different building.
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.	Collaborative working with Walsall is being discussed A range of meetings take place within Wolverhampton.
Level 3 units should have university links for training and research.	There are links for nurse and ANNP training but not for research.

Level	Score (out of 10)	Reason for score
2	9.5	The unit meets all the requirements for a level 2 unit. Staffing in obstetrics and neonatology is above the level needed for a level 2 unit. The building is in need of replacement and there is not yet an agreed plan for this.
3	8	Nurse staffing levels are very low. The building is in need of replacement and there is not yet an agreed plan for this. The current unit is constrained on space for additional cots but this could be addressed in a new unit.

Other issues:

1 The latest Black Country Review proposed clinical integration of paediatric services with Walsall. Merger of the two Trusts is being considered. A level 2 unit could not be sustained if in-patient paediatric services are not available at Wolverhampton. A level 3 unit with a separate rota of consultant neonatologists could be sustained.

Capacity and quality of unit: Walsall Hospitals NHS Trust

Number of births July 03 – June 04: 3887

Aspect	Comments
Good facilities and support should be available for parents and families.	All facilities are available. The unit is in a modern building that provides a pleasant environment and good facilities.
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 feto-maternal medicine for level 3 units. o Facilities and equipment	Many of the expected standards are met. The maternity unit does not have 40 hours of prospective consultant cover per week or a Specialist Registrar available to the labour ward at all times. An obstetric anaesthetist is available to the labour ward without commitments elsewhere only in the mornings. Midwifery staffing is not yet at the level recommended by *Birthrate Plus* and there is no plan, agreed with commissioners, for reaching this level.
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	The SHO / ANNP is not separate from general paediatrics. There is only one paediatrician with an interest in neonatology (post vacant). There will also be a joint neonatologist appointment with Wolverhampton. The nurse staffing establishment is 22% below the level recommended for the current designation of cots and there are 9% vacancies.
Relevant support services should be available, including imaging and anaesthesia.	The portable x-ray machine for the neonatal unit has only recently been purchased. Other support services are available.
Other relevant services should be located close to the neonatal unit.	ITU for mothers are in a different building.
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.	Collaborative working with Wolverhampton is being discussed A range of meetings take place within Walsall.
Level 3 units should have university links for training and research.	N/A

Level	Score (out of 10)	Reason for score
1	10	The unit meets the standards for a level 1 unit. Facilities for parents are good.
2	5	The neonatal SHO / ANNP rota is not separate from general paediatrics. Obstetric and midwifery staffing does not meet the expected standards (see above).

Other issues:

1 The number of births would be high for a level 1 unit.
2 The latest Black Country Review proposed clinical integration of paediatric services with Wolverhampton. Merger of the two Trusts is being considered. A level 2 unit could not be sustained if in-patient paediatric services are not available at Walsall.

Capacity and quality of unit: Shrewsbury and Telford Hospitals NHS Trust

Number of births July 03 – June 04: 4924 (5100 including births in midwifery-led units)

Aspect	Comments
Good facilities and support should be available for parents and families.	The neonatal unit has insufficient space to provide a quiet room, kitchen, toilet, washing area or facilities for parents to make refreshments. There are two parents' flats on the neonatal unit. There is no discreet area for expressing milk.
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 feto-maternal medicine for level 3 units. o Facilities and equipment	A Specialist Registrar is always available to the delivery suite but may not have three years of higher specialist training. An obstetric anaesthetist is not available to the labour ward without commitments elsewhere at nights and weekends. There are two feto-maternal medicine specialists in the unit. Midwifery staffing is not at the level recommended by *Birthrate Plus* and there is not yet a plan, agreed with commissioners, for reaching this level. The results were received in April 2005. There is not always someone with skills in neonatal resuscitation available to support all deliveries although there are plans to achieve this. There is not a second obstetric theatre close to the labour ward and available for use in an emergency.
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	Medical staffing meets the standards for a level 2 unit. There is not a separate consultant neonatologist rota. There are currently three paediatricians with an interest in neonatology (***see query below).*** A joint appointment with the unit at Stoke has just been made and will be on call as part of the Shrewsbury rota. The middle grade rota is separate from general paediatrics during the day but not at night. ***Query for Trust: The information submitted for the designation exercise said that the Trust has three dedicated neonatologists. Information submitted previously indicated that these posts were paediatricians with an interest in neonatology. Could you please clarify?*** The nurse staffing establishment is 21% below the level recommended for the current designation of cots and there are 9.5% vacancies.
Relevant support services should be available, including imaging and anaesthesia.	Access to physiotherapy and dietician support is not at the desired level.
Other relevant services should be located close to the neonatal unit.	ITU for mothers are in a different building.
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.	A range of meetings take place within Shrewsbury. Staff from the unit participate in network and regional meetings but there is no evidence of other links or collaboration with different levels of neonatal unit. The joint appointment with Stoke should help collaboration.
Level 3 units should have university links for training and research.	The unit does not consider this to be necessary.

Level	Score (out of 10)	Reason for score
2	9	Facilities for parents are not at the level expected. Consultant neonatologist levels may be above the level needed for a level 2 unit.
3	6	Facilities for parents are not at the level expected. A Specialist Registrar with three years higher specialist training and consultant anaesthetist support to the maternity service are not available at all times. There is not a separate middle grade or consultant rota for the neonatal unit. Nurse staffing levels are low.

Capacity and quality of unit: Mid Staffordshire General Hospitals NHS Trust

Number of births July 03 – June 04: 2224

Aspect	Comments
Good facilities and support should be available for parents and families.	Many of the expected standards are met but there is no system for home loan of equipment, no quiet room and no bathroom for parents to use overnight. There is the physical space to improve facilities.
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 feto-maternal medicine for level 3 units. o Facilities and equipment	The labour ward does not have a dedicated SHO at night. An obstetric anaesthetist is not always available to the labour ward without commitments elsewhere. There is no high dependency facility on the labour ward. Someone with training in neonatal resuscitation is not always available to support deliveries.
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	The SHO/ANNP rota is not separate from general paediatrics. The nurse staffing establishment is 11% below the level recommended for the current designation of cots and there are 8% vacancies. A neonatal nurse with skills in neonatal resuscitation is not always available.
Relevant support services should be available, including imaging and anaesthesia.	The unit does not have staff to support liaison with primary care teams, administrative and clerical support or medical technical officers.
Other relevant services should be located close to the neonatal unit.	Other relevant services are 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.	There is a range of meetings within Stafford. A visiting neonatologist (2 sessions) from Stoke provides some collaboration with the unit there and there is a programme for nurses to visit Stoke.
Level 3 units should have university links for training and research.	N/A

Level	Score (out of 10)	Reason for score
1	6.5	Parent facilities are in need of improvement. Appropriate support services are not yet in place. A plan to move the unit is being discussed. This would probably increase separation of mothers and babies and increase the risk of infection for babies. The score for the unit would be reduced to 3 if this plan is implemented.
2	-	Scoring as a level 2 unit was not considered appropriate. Medical and obstetric staffing are a long way from the expected levels. Parent facilities are in need of improvement.

Other issues:

1 The Trust is experiencing some difficulties in sustaining medical staffing of its in-patient paediatric services. A level 1 unit could be sustained if in-patient paediatrics was no longer on site. A level 2 unit could not be sustained without on-site in-patient paediatrics.

Capacity and quality of unit: University Hospitals of North Staffordshire NHS Trust

Number of births July 03 – June 04: 5073

Aspect	Comments
Good facilities and support should be available for parents and families.	Facilities are satisfactory and will improve in the new unit.
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 feto-maternal medicine for level 3 units. o Facilities and equipment	There is not always a dedicated SHO on the labour ward. A Specialist Registrar is always available to the delivery suite but may not have three years of higher specialist training. The unit has two feto-maternal medicine specialists and agreement to a third post. Midwifery staffing is at the level recommended by *Birthrate Plus.*
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	There is a separate rota of consultant neonatologists. The middle grade rota is separate from general paediatrics most of the time. The SHO / ANNP rota is separate from general paediatrics. The nurse staffing establishment is 11% below the level recommended for the current designation of cots and there are 9% vacancies.
Relevant support services should be available, including imaging and anaesthesia.	The neonatal unit does not have administrative and clerical support.
Other relevant services should be located close to the neonatal unit.	ITU for mothers are in a different building but will be closer in the new building.
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.	A range of meetings take place within the Trust. There is collaborative working with Stafford for medical and nursing staff.
Level 3 units should have university links for training and research.	There are university links to Keele and Staffordshire Universities and one consultant has an Honorary Reader appointment.

Level	**Score (out of 10)**	**Reason for score**
2	9.5	The unit meets all the requirements for a level 2 unit. Staffing in obstetrics and neonatology is above the level needed for a level 2 unit.
3	9	Nurse staffing levels are low. The neonatal unit middle grade rota is not always separate from general paediatrics.

Appendix 4

Department of Health Capacity Planning Tool

The Department of Health Neonatal Care Capacity Planning Tool was designed to assist networks in making decisions about the configuration of neonatal units. It models the impact of different configurations on occupancy rates, planned transfers between hospitals, the predicted level of 'cot blocking' (which may result in transfers out of the network or care in inappropriate cots) and costs.

The capacity planning tool allows for a consistent set of assumptions to be used across the units in the network. Various different assumptions were modelled. Different assumptions produced broadly similar results. The following assumptions were used in the evaluation of options:

Assumptions:	
Period of stabilisation of babies needing intensive care	Level 1 Units: 1 day Level 2 Units: 3 day
Period of stabilisation of babies needing high dependency care	Level 1 Units: 1 day
Maximum acceptable cot occupancy	70% in any unit

The model requires the destination of transfers out of each unit to be specified. The following assumptions were made about transfers:

Transfers from	Transfers for	Level 3 at Stoke only % transfers to:		Level 3 at W'ton only % transfers to:		Level 3 at Stoke and W'ton % transfers to:		Level 3 at Stoke, W'ton and Shrewsbury % transfers to:		
		Stoke	W'ton	Stoke	W'ton	Stoke	W'ton	Stoke	W'ton	Shrews bury
Dudley and Walsall	IC	100			100		100		100	
Dudley and Walsall	HD		100		100		100		100	
Wolverhampton	IC	100								
Stoke	IC				100					
Shrewsbury	IC	100			100	50	50			
Stafford	IC	100			100	70	30	70	30	
Stafford	hd	70	30	70	30	70	30	70	30	

Appendix 5

Travel distances and times

All travel distances and times are shown from the centre of the town. Travel distances and travel times for private transport are offpeak, mid-week, for the quickest route available. This may not always be the shortest route. All distances and times are one-way only.

Table A6.1 Travel distances (miles)

From town centre of:	To the neonatal unit at:		
	New Cross Hospital, Wolverhampton	Royal Shrewsbury Hospital	City Hospital, Stoke on Trent
Dudley	8		45
Wolverhampton	N/A		34
Walsall	6		35
Shrewsbury	35	N/A	42
Telford	21	19	32
Stafford	17		17
Stoke	34		N/A

Table A6.2 Travel times (private transport)

From town centre of:	To the neonatal unit at:		
	New Cross Hospital, Wolverhampton	Royal Shrewsbury Hospital	City Hospital, Stoke on Trent
Dudley	30min		1hr 5min
Wolverhampton	N/A		1hr
Walsall	25min		50min
Shrewsbury	1hr	N/A	1hr 15min
Telford	39min	25min	1hr
Stafford	35min		30min
Stoke	51min		N/A

Table A6.3 Average daytime rail travel time (including average daytime bus travel time from station to hospital)

From town centre of:	To the neonatal unit at:		
	New Cross Hospital, Wolverhampton	Royal Shrewsbury Hospital	City Hospital, Stoke on Trent
Dudley	40min		2hr
Wolverhampton	N/A		1hr 20min
Walsall	1hr 10min		2hr
Shrewsbury	1hr	N/A	2hr 10min
Telford	40min	45min	1hr 50min
Stafford	35min		50min
Stoke	55min		N/A

Table A6.4 Average daytime bus travel times

From town centre of:	To the neonatal unit at:		
	New Cross Hospital, Wolverhampton	Royal Shrewsbury Hospital	City Hospital, Stoke on Trent
Dudley	35min		2hr 45min
Wolverhampton	N/A		2hr 10min
Walsall	35min		2hr 30min
Shrewsbury	2hr 30min	N/A	1hr 50min
Telford	1hr 10min	55min	2hr 40min
Stafford	1hr 10min		1hr 15min
Stoke	2hr 30min		N/A

Appendix 6

Capacity planning results

Option A

NETWORK QUICK CALCULATOR
CRITERIA

Group: Network A1 | Blockage < | or Occupancy < 70%

OUTPUT SUMMARY

Total Cots (ICU / HDU / SCU): 19 / 11 / 92 | Total Cot Blocks: 236 | Total Transfers (Mthrs / Babies / Extras): 38 / 56 / 0

Average occupancy: 63.07% | Average %age cot blocking: 13.31% | Total Staff costs £(m): 15.65

	INPUT							CALCULATED					
				(Incl. Transfers and Extras)		PLANNED TRANSFER			(adjusted automatically)		Likely Cot Blocks		BAPM Staff
	Hospital Name	Care Level	BAPM Guide Used	Activity	Extras	OUT (Mthrs)Babies	IN (Mthrs)Babies	Occupancy	Avg. LOS	Cots	Blocks	Block %age	Costs (£X1000)
1	Royal Shre	ICU	2001	(365 days)	0		(0) 0	64.16%	7.36	3	19	16.32%	2023
2	(Level III)	HDU		(365 days)	0			63.21%	9.40	2	13	20.81%	345
3		SCU		(365 days)	0			69.41%	11.50	18	11	2.78%	673
4													
5	North Staff	ICU	2001	(365 days)	0		(10) 13	63.10%	8.39	5	15	9.69%	2414
6	(Level III)	HDU		(365 days)	0			68.24%	9.40	2	18	25.34%	345
7		SCU		(365 days)	0			69.47%	11.50	19	11	2.54%	710
8													
9	Staffordshi	ICU (Short	2001	(365 days)	0	(14) 19		34.26%	3.00	1	4	9.40%	196
10	(Level II)	HDU		(365 days)	0			61.11%	9.40	1	9	28.07%	642
11		SCU		(365 days)	0			69.58%	11.50	8	17	8.91%	299
12													
13	New Cross	ICU	2001	(365 days)	0		(28) 43	68.89%	9.91	6	20	11.51%	2609
14	(Level III)	HDU		(365 days)	0			58.63%	9.40	2	9	17.19%	345
15		SCU		(365 days)	0			66.71%	11.50	15	9	2.84%	561
16													
17	Wordsley H	ICU	2001	(365 days)	0		(0) 0	62.72%	7.36	3	17	15.23%	2023
18	(Level III)	HDU		(365 days)	0			62.59%	9.40	2	12	20.29%	345
19		SCU		(365 days)	0			68.18%	11.50	16	11	2.98%	598
20													
21	Manor Hos	ICU (Short	2001	(365 days)	0	(24) 37		54.68%	3.00	1	19	22.64%	196
22	(Level II)	HDU		(365 days)	0			62.59%	9.40	2	12	20.29%	728
23		SCU		(365 days)	0			67.72%	11.50	16	10	2.83%	598

Option B

NETWORK QUICK CALCULATOR

CRITERIA

Group: Network A1 | Blockage < | or Occupancy < 70%

OUTPUT SUMMARY

Total Cots (ICU / HDU / SCU): 23 / 13 / 92 | Total Cot Blocks: 174 | Total Transfers (Mthrs / Babies / Extras): 97 / 345 / 0

Average occupancy: 49.01% | Average %age cot blocking: 7.50% | Total Staff costs £(m): 12.563

	INPUT							CALCULATED					
				(Incl. Transfers and Extras)		PLANNED TRANSFER			(adjusted automatically)		Likely Cot Blocks		BAPM Staff
	Hospital Name	Care Level	BAPM Guide Used	Activity	Extras	OUT (Mthrs)Babies	IN (Mthrs)Babies	Occupancy	Avg. LOS	Cots	Blocks	Block %age	Costs (£X1000)
1	Royal Shre	ICU (Short	2001	(365 days)	0	(19) 39		58.17%	3.00	1	24	25.50%	196
2	(Level II)	HDU		(365 days)	0			63.21%	9.40	2	13	20.81%	816
3		SCU		(365 days)	0			69.41%	11.50	18	11	2.78%	673
4													
5	North Staff	ICU	2001	(365 days)	0		(97) 241	68.20%	9.83	18	11	2.41%	5147
6	(Level III)	HDU		(365 days)	0		15	62.75%	9.43	3	13	15.25%	431
7		SCU		(365 days)	0			69.47%	11.50	19	11	2.54%	710
8													
9	Staffordshi	ICU (Short	2001	(365 days)	0	(14) 34		12.43%	1.00	1	1	1.39%	196
10	(Level I)	HDU (Short Stay)		(365 days)	0	22		8.97%	1.00	1	0	0.74%	86
11		SCU		(365 days)	0			69.58%	11.50	8	17	8.91%	438
12													
13	New Cross	ICU (Short	2001	(365 days)	0	(22) 34		51.71%	3.00	1	16	20.36%	196
14	(Level II)	HDU		(365 days)	0		89	66.56%	9.58	5	17	11.93%	1075
15		SCU		(365 days)	0			66.71%	11.50	15	9	2.84%	561
16													
17	Wordsley H	ICU (Short	2001	(365 days)	0	(18) 69		23.99%	1.00	1	4	4.83%	196
18	(Level I)	HDU (Short Stay)		(365 days)	0	41		16.32%	1.00	1	1	2.34%	86
19		SCU		(365 days)	0			68.18%	11.50	16	11	2.98%	737
20													
21	Manor Hos	ICU (Short	2001	(365 days)	0	(24) 65		22.55%	1.00	1	4	4.30%	196
22	(Level I)	HDU (Short Stay)		(365 days)	0	41		16.32%	1.00	1	1	2.34%	86
23		SCU		(365 days)	0			67.72%	11.50	16	10	2.83%	737

Option C

NETWORK QUICK CALCULATOR
CRITERIA

Group: Network A1 | Blockage < | or Occupancy < 70%

OUTPUT SUMMARY

Total Cots (ICU / HDU / SCU) 23 / 13 / 92 | Total Cot Blocks 186 | Total Transfers (Mthrs / Babies / Extras) 102 / 355 / 0

Average occupancy 49.50% | Average %age cot blocking 7.91% | Total Staff costs £(m) 12.563

	INPUT							CALCULATED					
			BAPM	(Incl. Transfers and Extras)		PLANNED TRANSFER			(adjusted automatically)		Likely Cot Blocks		BAPM Staff
	Hospital Name	Care Level	Guide Used	Activity	Extras	OUT (Mthrs)Babies	IN (Mthrs)Babies	Occupancy	Avg. LOS	Cots	Blocks	Block %age	Costs (£X1000)
1	Royal Shre	ICU (Short	2001	(365 days)	0	(19) 39		58.17%	3.00	1	24	25.50%	196
2	(Level II)	HDU		(365 days)	0			63.21%	9.40	2	13	20.81%	816
3		SCU		(365 days)	0			69.41%	11.50	18	11	2.78%	673
4													
5	North Staff	ICU (Short	2001	(365 days)	0	(27) 44		60.65%	3.00	1	28	27.66%	196
6	(Level II)	HDU		(365 days)	0		15	62.75%	9.43	3	13	15.25%	902
7		SCU		(365 days)	0			69.47%	11.50	19	11	2.54%	710
8													
9	Staffordshi	ICU (Short	2001	(365 days)	0	(14) 34		12.43%	1.00	1	1	1.39%	196
10	(Level I)	HDU (Short Stay)		(365 days)	0	22		8.97%	1.00	1	0	0.74%	86
11		SCU		(365 days)	0			69.58%	11.50	8	17	8.91%	438
12													
13	New Cross	ICU	2001	(365 days)	0		(102) 251	68.00%	10.08	18	11	2.36%	5147
14	(Level III)	HDU		(365 days)	0		89	66.56%	9.58	5	17	11.93%	604
15		SCU		(365 days)	0			66.71%	11.50	15	9	2.84%	561
16													
17	Wordsley H	ICU (Short	2001	(365 days)	0	(18) 69		23.99%	1.00	1	4	4.83%	196
18	(Level I)	HDU (Short Stay)		(365 days)	0	41		16.32%	1.00	1	1	2.34%	86
19		SCU		(365 days)	0			68.18%	11.50	16	11	2.98%	737
20													
21	Manor Hos	ICU (Short	2001	(365 days)	0	(24) 65		22.55%	1.00	1	4	4.30%	196
22	(Level I)	HDU (Short Stay)		(365 days)	0	41		16.32%	1.00	1	1	2.34%	86
23		SCU		(365 days)	0			67.72%	11.50	16	10	2.83%	737

Option D

NETWORK QUICK CALCULATOR

CRITERIA

Group: Network A1 | Blockage < | or Occupancy < 70%

OUTPUT SUMMARY

Total Cots (ICU / HDU / SCU): 21 / 13 / 92 | Total Cot Blocks: 186 | Total Transfers (Mthrs / Babies / Extras): 76 / 312 / 0

Average occupancy: 49.96% | Average %age cot blocking: 7.16% | Total Staff costs £(m): 12.945

	INPUT							CALCULATED					
				(Incl. Transfers and Extras)		PLANNED TRANSFER			(adjusted automatically)		Likely Cot Blocks		BAPM Staff
	Hospital Name	Care Level	BAPM Guide Used	Activity	Extras	OUT (Mthrs)Babies	IN (Mthrs)Babies	Occupancy	Avg. LOS	Cots	Blocks	Block %age	Costs (£X1000)
1	Royal Shre	ICU (Short	2001	(365 days)	0	(19) 39		58.17%	3.00	1	24	25.50%	196
2	(Level II)	HDU		(365 days)	0			63.21%	9.40	2	13	20.81%	816
3		SCU		(365 days)	0			69.41%	11.50	18	11	2.78%	673
4													
5	North Staff	ICU	2001	(365 days)	0		(20) 44	68.17%	8.69	6	21	11.00%	2609
6	(Level III)	HDU		(365 days)	0		15	62.75%	9.43	3	13	15.25%	431
7		SCU		(365 days)	0			69.47%	11.50	19	11	2.54%	710
8													
9	Staffordshi	ICU (Short	2001	(365 days)	0	(14) 34		12.43%	1.00	1	1	1.39%	196
10	(Level I)	HDU (Short Stay)		(365 days)	0	22		8.97%	1.00	1	0	0.74%	86
11		SCU		(365 days)	0			69.58%	11.50	8	17	8.91%	438
12													
13	New Cross	ICU	2001	(365 days)	0		(56) 164	68.83%	9.12	11	18	5.66%	3587
14	(Level III)	HDU		(365 days)	0		89	66.56%	9.58	5	17	11.93%	604
15		SCU		(365 days)	0			66.71%	11.50	15	9	2.84%	561
16													
17	Wordsley H	ICU (Short	2001	(365 days)	0	(18) 69		23.99%	1.00	1	4	4.83%	196
18	(Level I)	HDU (Short Stay)		(365 days)	0	41		16.32%	1.00	1	1	2.34%	86
19		SCU		(365 days)	0			68.18%	11.50	16	11	2.98%	737
20													
21	Manor Hos	ICU (Short	2001	(365 days)	0	(24) 65		22.55%	1.00	1	4	4.30%	196
22	(Level I)	HDU (Short Stay)		(365 days)	0	41		16.32%	1.00	1	1	2.34%	86
23		SCU		(365 days)	0			67.72%	11.50	16	10	2.83%	737

Option E

NETWORK QUICK CALCULATOR
CRITERIA

Group: Network A1 | Blockage < | or Occupancy < 70%

OUTPUT SUMMARY

Total Cots (ICU / HDU / SCU): 21 / 13 / 92 | Total Cot Blocks: 207 | Total Transfers (Mthrs / Babies / Extras): 76 / 242 / 0

Average occupancy: 53.96% | Average %age cot blocking: 9.14% | Total Staff costs £(m): 13.362

	INPUT							CALCULATED					
				(Incl. Transfers and Extras)		PLANNED TRANSFER			(adjusted automatically)		Likely Cot Blocks		BAPM Staff
	Hospital Name	Care Level	BAPM Guide Used	Activity	Extras	OUT (Mthrs)Babies	IN (Mthrs)Babies	Occupancy	Avg. LOS	Cots	Blocks	Block %age	Costs (£X1000)
1	Royal Shre	ICU (Short	2001	(365 days)	0	(19) 39		58.17%	3.00	1	24	25.50%	196
2	(Level II)	HDU		(365 days)	0			63.21%	9.40	2	13	20.81%	816
3		SCU		(365 days)	0			69.41%	11.50	18	11	2.78%	673
4													
5	North Staff	ICU	2001	(365 days)	0		(20) 44	68.17%	8.69	6	21	11.00%	2609
6	(Level III)	HDU		(365 days)	0		15	62.75%	9.43	3	13	15.25%	431
7		SCU		(365 days)	0			69.47%	11.50	19	11	2.54%	710
8													
9	Staffordshi	ICU (Short	2001	(365 days)	0	(14) 34		12.43%	1.00	1	1	1.39%	196
10	(Level I)	HDU (Short Stay)		(365 days)	0	22		8.97%	1.00	1	0	0.74%	86
11		SCU		(365 days)	0			69.58%	11.50	8	17	8.91%	438
12													
13	New Cross	ICU	2001	(365 days)	0		(56) 135	67.62%	9.80	11	15	5.10%	3587
14	(Level III)	HDU		(365 days)	0		48	60.32%	9.54	4	11	10.34%	518
15		SCU		(365 days)	0			66.71%	11.50	15	9	2.84%	561
16													
17	Wordsley H	ICU (Short	2001	(365 days)	0	(18) 40		57.04%	3.00	1	23	24.56%	196
18	(Level II)	HDU		(365 days)	0			62.59%	9.40	2	12	20.29%	728
19		SCU		(365 days)	0			68.18%	11.50	16	11	2.98%	598
20													
21	Manor Hos	ICU (Short	2001	(365 days)	0	(24) 65		22.55%	1.00	1	4	4.30%	196
22	(Level I)	HDU (Short Stay)		(365 days)	0	41		16.32%	1.00	1	1	2.34%	86
23		SCU		(365 days)	0			67.72%	11.50	16	10	2.83%	737

Option F

NETWORK QUICK CALCULATOR
CRITERIA

Group: Network A1 | Blockage < | or Occupancy < 70%

OUTPUT SUMMARY

Total Cots (ICU / HDU / SCU): 20 / 13 / 92 | Total Cot Blocks: 204 | Total Transfers (Mthrs / Babies / Extras): 56 / 202 / 0

Average occupancy: 54.18% | Average %age cot blocking: 8.74% | Total Staff costs £(m): 14.132

	INPUT							CALCULATED					
			BAPM	(Incl. Transfers and Extras)		PLANNED TRANSFER			(adjusted automatically)		Likely Cot Blocks		BAPM Staff
	Hospital Name	Care Level	Guide Used	Activity	Extras	OUT (Mthrs)Babies	IN (Mthrs)Babies	Occupancy	Avg. LOS	Cots	Blocks	Block %age	Costs (£X1000)
1	Royal Shre	ICU	2001	(365 days)	0		(0) 0	64.16%	7.36	3	19	16.32%	2023
2	(Level III)	HDU		(365 days)	0			63.21%	9.40	2	13	20.81%	345
3		SCU		(365 days)	0			69.41%	11.50	18	11	2.78%	673
4													
5	North Staff	ICU	2001	(365 days)	0		(10) 24	64.02%	7.99	5	17	10.25%	2414
6	(Level III)	HDU		(365 days)	0		15	62.75%	9.43	3	13	15.25%	431
7		SCU		(365 days)	0			69.47%	11.50	19	11	2.54%	710
8													
9	Staffordshi	ICU (Short	2001	(365 days)	0	(14) 34		12.43%	1.00	1	1	1.39%	196
10	(Level I)	HDU (Short Stay)		(365 days)	0	22		8.97%	1.00	1	0	0.74%	86
11		SCU		(365 days)	0			69.58%	11.50	8	17	8.91%	438
12													
13	New Cross	ICU	2001	(365 days)	0		(46) 115	69.75%	9.49	9	21	7.87%	3196
14	(Level III)	HDU		(365 days)	0		48	60.32%	9.54	4	11	10.34%	518
15		SCU		(365 days)	0			66.71%	11.50	15	9	2.84%	561
16													
17	Wordsley H	ICU (Short	2001	(365 days)	0	(18) 40		57.04%	3.00	1	23	24.56%	196
18	(Level II)	HDU		(365 days)	0			62.59%	9.40	2	12	20.29%	728
19		SCU		(365 days)	0			68.18%	11.50	16	11	2.98%	598
20													
21	Manor Hos	ICU (Short	2001	(365 days)	0	(24) 65		22.55%	1.00	1	4	4.30%	196
22	(Level I)	HDU (Short Stay)		(365 days)	0	41		16.32%	1.00	1	1	2.34%	86
23		SCU		(365 days)	0			67.72%	11.50	16	10	2.83%	737

Option G

NETWORK QUICK CALCULATOR
CRITERIA

Group: Network A1 | Blockage < | or Occupancy < 70%

OUTPUT SUMMARY

Total Cots (ICU / HDU / SCU): 21 / 13 / 92 | Total Cot Blocks: 203 | Total Transfers (Mthrs / Babies / Extras): 76 / 243 / 0

Average occupancy: 53.90% | Average %age cot blocking: 9.06% | Total Staff costs £(m): 13.362

	INPUT							CALCULATED					
				(Incl. Transfers and Extras)		PLANNED TRANSFER			(adjusted automatically)		Likely Cot Blocks		BAPM Staff
	Hospital Name	Care Level	BAPM Guide Used	Activity	Extras	OUT (Mthrs)Babies	IN (Mthrs)Babies	Occupancy	Avg. LOS	Cots	Blocks	Block %age	Costs (£X1000)
1	Royal Shre	ICU (Short	2001	(365 days)	0	(19) 39		58.17%	3.00	1	24	25.50%	196
2	(Level II)	HDU		(365 days)	0			63.21%	9.40	2	13	20.81%	816
3		SCU		(365 days)	0			69.41%	11.50	18	11	2.78%	673
4													
5	North Staff	ICU	2001	(365 days)	0		(20) 44	68.17%	8.69	6	21	11.00%	2609
6	(Level III)	HDU		(365 days)	0		15	62.75%	9.43	3	13	15.25%	431
7		SCU		(365 days)	0			69.47%	11.50	19	11	2.54%	710
8													
9	Staffordshi	ICU (Short	2001	(365 days)	0	(14) 34		12.43%	1.00	1	1	1.39%	196
10	(Level I)	HDU (Short Stay)		(365 days)	0	22		8.97%	1.00	1	0	0.74%	86
11		SCU		(365 days)	0			69.58%	11.50	8	17	8.91%	438
12													
13	New Cross	ICU	2001	(365 days)	0		(56) 136	67.60%	9.76	11	15	5.08%	3587
14	(Level III)	HDU		(365 days)	0		48	60.21%	9.51	4	11	10.28%	518
15		SCU		(365 days)	0			66.71%	11.50	15	9	2.84%	561
16													
17	Wordsley H	ICU (Short	2001	(365 days)	0	(18) 69		23.99%	1.00	1	4	4.83%	196
18	(Level I)	HDU (Short Stay)		(365 days)	0	41		16.32%	1.00	1	1	2.34%	86
19		SCU		(365 days)	0			68.18%	11.50	16	11	2.98%	737
20													
21	Manor Hos	ICU (Short	2001	(365 days)	0	(24) 37		54.68%	3.00	1	19	22.64%	196
22	(Level II)	HDU		(365 days)	0			62.59%	9.40	2	12	20.29%	728
23		SCU		(365 days)	0			67.72%	11.50	16	10	2.83%	598

Option H

NETWORK QUICK CALCULATOR
CRITERIA

Group: Network A1 | Blockage < | or Occupancy < 70%

OUTPUT SUMMARY

Total Cots (ICU / HDU / SCU): 21 / 12 / 92 | Total Cot Blocks: 216 | Total Transfers (Mthrs / Babies / Extras): 76 / 202 / 0

Average occupancy: 56.64% | Average %age cot blocking: 10.64% | Total Staff costs £(m): 13.692

	INPUT							CALCULATED					
				(Incl. Transfers and Extras)		PLANNED TRANSFER			(adjusted automatically)		Likely Cot Blocks		BAPM Staff
	Hospital Name	Care Level	BAPM Guide Used	Activity	Extras	OUT (Mthrs)Babies	IN (Mthrs)Babies	Occupancy	Avg. LOS	Cots	Blocks	Block %age	Costs (£X1000)
1	Royal Shre	ICU (Short	2001	(365 days)	0	(19) 39		58.17%	3.00	1	24	25.50%	196
2	(Level II)	HDU		(365 days)	0			63.21%	9.40	2	13	20.81%	816
3		SCU		(365 days)	0			69.41%	11.50	18	11	2.78%	673
4													
5	North Staff	ICU	2001	(365 days)	0		(20) 44	68.17%	8.69	6	21	11.00%	2609
6	(Level III)	HDU		(365 days)	0		15	62.75%	9.43	3	13	15.25%	431
7		SCU		(365 days)	0			69.47%	11.50	19	11	2.54%	710
8													
9	Staffordshi	ICU (Short	2001	(365 days)	0	(14) 34		12.43%	1.00	1	1	1.39%	196
10	(Level I)	HDU (Short Stay)		(365 days)	0	22		8.97%	1.00	1	0	0.74%	86
11		SCU		(365 days)	0			69.58%	11.50	8	17	8.91%	438
12													
13	New Cross	ICU	2001	(365 days)	0		(56) 136	67.60%	9.76	11	15	5.08%	3587
14	(Level III)	HDU		(365 days)	0		7	63.27%	9.41	2	13	20.86%	345
15		SCU		(365 days)	0			66.71%	11.50	15	9	2.84%	561
16													
17	Wordsley H	ICU (Short	2001	(365 days)	0	(18) 69		23.99%	1.00	1	4	4.83%	196
18	(Level II)	HDU		(365 days)	0			62.59%	9.40	2	12	20.29%	728
19		SCU		(365 days)	0			68.18%	11.50	16	11	2.98%	598
20													
21	Manor Hos	ICU (Short	2001	(365 days)	0	(24) 37		54.68%	3.00	1	19	22.64%	196
22	(Level II)	HDU		(365 days)	0			62.59%	9.40	2	12	20.29%	728
23		SCU		(365 days)	0			67.72%	11.50	16	10	2.83%	598

Option I

NETWORK QUICK CALCULATOR
CRITERIA

Group: Network A1 | Blockage < | or Occupancy < 70%

OUTPUT SUMMARY

Total Cots (ICU / HDU / SCU): 19 / 12 / 92 | Total Cot Blocks: 225 | Total Transfers (Mthrs / Babies / Extras): 38 / 93 / 0

Average occupancy: 58.97% | Average %age cot blocking: 11.03% | Total Staff costs £(m): 15.319

	INPUT							CALCULATED					
			BAPM	(Incl. Transfers and Extras)		PLANNED TRANSFER			(adjusted automatically)		Likely Cot Blocks		BAPM Staff
	Hospital Name	Care Level	Guide Used	Activity	Extras	OUT (Mthrs)Babies	IN (Mthrs)Babies	Occupancy	Avg. LOS	Cots	Blocks	Block %age	Costs (£X1000)
1	Royal Shre	ICU	2001	(365 days)	0		(0) 0	64.16%	7.36	3	19	16.32%	2023
2	(Level III)	HDU		(365 days)	0			63.21%	9.40	2	13	20.81%	345
3		SCU		(365 days)	0			69.41%	11.50	18	11	2.78%	673
4													
5	North Staff	ICU	2001	(365 days)	0		(10) 24	64.02%	7.99	5	17	10.25%	2414
6	(Level III)	HDU		(365 days)	0		15	62.75%	9.43	3	13	15.25%	431
7		SCU		(365 days)	0			69.47%	11.50	19	11	2.54%	710
8													
9	Staffordshi	ICU (Short	2001	(365 days)	0	(14) 34		12.43%	1.00	1	1	1.39%	196
10	(Level I)	HDU (Short Stay)		(365 days)	0	22		8.97%	1.00	1	0	0.74%	86
11		SCU		(365 days)	0			69.58%	11.50	8	17	8.91%	438
12													
13	New Cross	ICU	2001	(365 days)	0		(28) 47	68.98%	9.71	6	20	11.57%	2609
14	(Level III)	HDU		(365 days)	0		7	63.27%	9.41	2	13	20.86%	345
15		SCU		(365 days)	0			66.71%	11.50	15	9	2.84%	561
16													
17	Wordsley H	ICU	2001	(365 days)	0		(0) 0	62.72%	7.36	3	17	15.23%	2023
18	(Level III)	HDU		(365 days)	0			62.59%	9.40	2	12	20.29%	345
19		SCU		(365 days)	0			68.18%	11.50	16	11	2.98%	598
20													
21	Manor Hos	ICU (Short	2001	(365 days)	0	(24) 37		54.68%	3.00	1	19	22.64%	196
22	(Level II)	HDU		(365 days)	0			62.59%	9.40	2	12	20.29%	728
23		SCU		(365 days)	0			67.72%	11.50	16	10	2.83%	598

Appendix 7

Responses received from Trusts

Our Ref: DD/GG

Women and Children's Division
Divisional General Manager's Office
Maternity Building
City General
Newcastle Road
Stoke on Trent
Staffordshire
ST4 6QG

Telephone number: 01782 552007
Fax number: 01782 710936
Email: diane.dawson@uhns.nhs.uk
Secretary E-mail: glenys.greenshields@uhns.nhs.uk

Date: 13 July 2005

Ruth Moore
Network Manager
Staffordshire, Shropshire and Black Country Neonatal Network
Room MO38, Surgical & Paediatric Development
City General Site

Dear Ruth

Re **Staffordshire, Shropshire and Black Country Neonatal Network, Unit Designation Workshop 29 June 2005 and the draft Designation of Units Report**

Thank you for your correspondence of the 4 July. I have been asked to formulate the response on behalf of the University Hospital of North Staffordshire.

Please find attached some corrections that have been made to the unit evaluation submission for the University Hospital of North Staffordshire. For ease of reference, these amendments are highlighted.

At the University Hospital of North Staffordshire, I can confirm that we are delighted at the proposed unit designation and look forward to working with Commissioners and colleagues over the next few years in taking forward the plans to achieve level three status.

Yours sincerely

Diane Dawson
Divisional General Manager
Women & Children's Division
Copy to
Dr K Reynolds
Head of Division

Dr Alexander
Clinical Director, Child Health Directorate

Mr Redman
Clinical Director, O&G Directorate

Mr P Blythin
Acting Chief Executive

Julia Bridgewater
Director of Operations

Name of Trust: University Hospital of North Staffordshire

Name & designation of person completing the form: Diane Dawson, Divisional General Manager, Women and Children's Division

Date: 15 July 2005

Please list the names & designations of who the report has been circulated to within your Trust.

Name	Designation
Dave Crowley	Chief Executive, University Hospital of North Staffordshire NHS Trust
Peter Blythin	Deputy Chief Executive, University Hospital of North Staffordshire NHS Trust
Julia Bridgewater	Director of Operations, University Hospital of North Staffordshire NHS Trust
Di Dawson	Divisional General Manager, Women & Children's Division, UHNS
Sue Malbon	Directorate Manager, Child Health, Women & Children's Division, UHNS
Ian Turner	Professional Head of Nursing, Child Health, Women & Children's Division, UHNS
Simon Atherton	Acting Directorate Manager, Obs & Gynae Directorate / Divisional Accountant Women & Children's, UHNS
Chris Thomas	Acting Professional Head of Nursing, Obs / Gynae Directorate, Women & Children's Division
Jackie Jenkinson	Senior Clinical Midwife (Modern Matron), Obs & Gynae Directorate, Women & Children's Division, UHNS
Dr John Alexander	Clinical Director, Child Health Directorate, Women & Children's Division, UHNS
Dr Kate Reynolds	Head of Division, Women & Children's Division, UHNS

Please list the names & designations of all the people who have participated in the Trust's response

Name	Designation
Di Dawson	Divisional General Manager, Women & Children's Division
Sue Malbon	Directorate Manager, Child Health, Women & Children's Division
Ian Turner	Professional Head of Nursing, Child Health, Women & Children's Division
Chris Thomas	Acting Professional Head of Nursing, Obs / Gynae Directorate, Women & Children's Division
Jackie Jenkinson	Senior Clinical Midwife (Modern Matron), Obs & Gynae Directorate, Women & Children's Division
Dr John Alexander	Clinical Director, Child Health Directorate, Women & Children's Division
Dr Kate Reynolds	Head of Division, Women & Children's Division
Mrs G. Masson	Obs and Gynae Consultant, Women & Children's Division

ADDITIONAL INFORMATION COLLECTION FORM

Hospital Trust: …University Hospital of North Staffordshire NHS Trust

1. Please indicate in the table below the facilities and support that is available for parents and families of babies being cared for on the neonatal unit.

Neonatal Unit Facilities	Yes/No	Supporting Information/Comments
Parental Information	Yes	▪ The Bliss booklet is given to every parent on admission. ▪ Currently we are looking to develop a leaflet pertinent to our unit.
Breast feeding supported through: • The provision of information • The availability of a comfortable, discreet area for expressing milk • The availability of breast pumps to all mothers • A system for home-loan of equipment. • A nominated lead nurse with responsibility for coordinating breast feeding support.	 Yes Yes Yes Yes Yes	▪ There is a dedicated breastfeeding co-ordinator ▪ Achieved Baby Friendly status for the second time in 2004 ▪ Use BLISS leaflet
Parental access to the baby at all times.	Yes	▪ Open visiting for parents available however parents are asked to step out of the room when a consultant ward round / admission is taking place
Parents are informed of their baby's condition, care plan and transfer (if necessary) and this information is updated regularly.	Yes	▪ Identified within the recent Parental Satisfaction audit within the unit
Parents of babies needing emergency transfer receive help regarding transport, hospital location, car parking and the location of the unit to which their baby is being transferred.	Yes	▪ Leaflets available to parents when traveling to different hospital locations.
A policy on financial support for families of babies receiving neonatal care is available and communicated to parents.	Yes	▪ Those families identified are asked if social service support is required, in terms of finance and baby equipment there is a Directorate charitable emergency access fund that can be used in certain circumstances

Facilities are available for parents and families, including: • A quiet room • A kitchen, toilet and washing area • Facilities for making refreshments • A changing area for other young children • A play area for siblings of infants receiving care • A telephone	 Yes Yes Yes Yes Yes Yes	▪ Parents use the family area but no dedicated changing area for other young children, however this is address within the new unit planned for 2007. There are changing facilities within the maternity reception adjacent to NICU ▪ Siblings are able to access a crèche in the maternity antenatal clinic
Overnight facilities are available for parents, including: • A room for couples • Bathroom	 Yes Yes	▪ One double room available for parents but there are other facilities available within the Trust site. In addition to 4 beds available within the family unit ▪ Within the new unit there will be 6 double rooms available ▪ No bathroom for fathers but arrangements can be made when necessary
Support services are available for parents, including: • Social worker • Religious advisers • Bereavement support • Psychological / psychiatric advice • Community support after discharge (usually health visitor, midwife or neonatal outreach nurse with community nurse training) • Multi-ethnic health advocates and interpreters	 Yes Yes Yes Yes Yes Yes	▪ On call chaplain available ▪ Identified lead bereavement support within the unit ▪ Community support and time limited counseling service offered ▪ Psychological and psychiatric advice available when requested ▪ Interpreters are arranged by appointment with the local provision or the use of language line
Access to advice and support from appropriately qualified play specialists.	Yes	▪ There are play specialists within the Directorate who will attend on the unit if requested. ▪ Have access to facilities within the children's wards when necessary

2. Please indicate in the table below the support available to the neonatal unit from allied health professionals and others.

Allied Health Professionals and Others Support	Yes/No	Supporting Information/Comments
Support staff are available covering the following roles: • Administrative, clerical and secretarial staff • Medical Technical Officers • Staff responsible for liaison with primary care teams • Audit assistants or other support for clinical staff undertaking audit.	 Yes Yes Yes Yes	▪ There is A&C support for neonatal services ▪ Identified Medical Technical Officer with base currently within NICU ▪ Trust audit department is available to support this process.

The unit has support from the following staff, who have training or appropriate expertise relevant to their role in the care of sick newborn infants and their parents: • Radiographers • Pharmacists • Physiotherapists • Dieticians • Infection control staff • Speech therapists	 Yes Yes Yes Yes Yes Yes	▪ Paediatric pharmacist visits daily Mon- Friday ▪ Has own mobile x-ray unit ▪ Shared on call radiographer within Trust ▪ Current issues with reporting x-ray from radiologist due to recruitment issues ▪ Weekly visit from dieticians, includes liaison with community NIC team ▪ Quarterly infection control audit completed. Infection control team will visit when requested ▪ Speech therapy team will visit when requested ▪ There is no dedicated paediatric OT service within the Trust
The unit has access to a 24 hour laboratory service orientated to neonatal needs.	Yes	▪ Specialist test are available using other hospitals
The unit has established liaison arrangements with local child development teams.	Yes	▪ On site Child Development Centre and access to Community Consultant team when necessary ▪ One Sure Start area has complex needs nurse
Specialist advice is available to the unit from: • Perinatal obstetrics on site • Feto-maternal medicine • Neonatal surgery and anaesthesia • Paediatric cardiology • Radiology (including ultrasound, CT & MRI) • Ophthalmology • Laboratory services o Clinical chemistry o Microbiology o Haematology and transfusion • Child development centre • Perinatal pathology • Clinical genetics, including dysmorphology • Paediatric neurology and neurophysiology • Paediatric nephrology • Audiology • Other surgical specialties (ENT, orthopaedics, neurosurgery)	 Yes Yes No/Yes Yes Yes Yes Yes Yes Yes Yes Yes No Yes Yes	▪ Neonatal surgery is performed currently at Nottingham ▪ A NIC Consultant has developed echo cardiology skills with established links to BCH ▪ Has access to CT and MRI when needs guidelines in place ▪ Ophthalmology treatment perform on NIC when necessary ▪ Genetic nurse employed by Directorate ▪ No paediatric neurology on site, have access to other units ▪ Has a paediatric audiology service ▪ Have access on site to ENT, orthopaedics surgery but also to other services PICU, gastroenterology, endocrine and diabetes, infectious diseases and a rota for paediatric anaesthesia
The unit has arrangements for access to autopsy by a trained perinatal / paediatric pathologist.	Yes	▪ This service is available at Birmingham hospitals

The neonatal unit functions operationally as part of a general paediatric service, alongside an obstetric unit.	Yes	▪ Paediatric service – Community, CDC, general paediatrics, specialist care – respiratory, gastroenterology, diabetes and endocrine, allergy, rheumatology, genetics, infectious diseases, PICU, COPD, Cystic Fibrosis, Child Protection on call team, complex care discharge co-ordinator, CONI,

3. Please indicate in the table below the equipment available on the neonatal unit.

Neonatal Unit Equipment	**Yes / No**	**Supporting Information /Comments**
Equipment for the following is available on the neonatal unit: • Resuscitation • Blood gas analysis • Phototherapy • Non-invasive blood pressure measurement • Transillumination by cold light • Portable x-rays • Instant photographs • Transport, including mechanical ventilation Units should also have 24 hour access to ultrasound scanning.	 Yes Yes Yes Yes Yes Yes Yes Yes Yes	
The following equipment is available for each cot that may be used for intensive or high dependency care: • Incubator or unit with radiant heating • Ventilator (IC only) and NCPAP driver with humidifier • Syringe / infusion pumps • Facilities for monitoring: o Respiration o Heart rate o Intra-vascular blood pressure (IC only) o Oxygen saturation o Ambient oxygen	 Yes Yes Yes Yes Yes Yes Yes Yes	▪ The unit has 4 flow drivers
The unit has an additional ventilator available to cover breakdown, servicing and unexpected need for care, and agreed arrangements for accessing a second spare ventilator should this be required.	Yes	▪ Free standing ventilators available
There are policies for the checking of equipment and all equipment is checked in accordance with the agreed policies.	Yes	▪ Trust has standardization of infusion group
The unit has a policy for training and updating of clinical staff in the use of equipment and evidence of staff being trained and updated in accordance with this policy.	Yes	▪ Cascade training

The unit should has a funded, rolling programme for purchasing, maintenance, replacement and upgrading of equipment for neonatal care.	Yes	▪ Directorate equipment group ▪ Trust Medical Equipment Strategy Group for items over £5k

4. Please indicate in the table below the training/competence of staff in the neonatal unit.

Neonatal Staff Training/Competence	Yes / No	Supporting Information /Comments
Each new member of staff undertakes a period of induction and orientation.	Yes	▪ Trust and local induction
All staff have an annual appraisal resulting in an agreed personal development plan. For professional staff, this includes a programme of Continuing Professional Development.	Yes	▪ Quarterly report on number of appraisals ▪ Working toward Agenda for Change – Knowledge and Skills
All nurses providing intensive or high dependency care are registered nurses or midwives assessed as competent to care for neonates needing intensive or high dependency care.	Yes	▪ Through Specialist Practitioner degree ▪ Stand alone '405' module ▪ Unit competency based training
A nurse with up to date NLS or equivalent training in neonatal resuscitation is immediately available to the neonatal and maternity units at all times.	Yes	▪ Unit has own NLS based course ▪ Midwives are trained in NLS
At least one member of the neonatal unit medical or ANNP staff with up to date NLS or equivalent training in neonatal resuscitation is immediately available to the neonatal and maternity units at all times.	Yes	▪ All consultants and ANNPs are NLS providers, as are a number of nurses ▪ 2 NICU Consultants and 1 ANNP are NLS instructors ▪ A number of other staff from NICU and Maternity Unit are awaiting for places trainers course
The unit has a senior nurse with neonatal experience who has managerial responsibility for the unit, including: • Monitoring of clinical policies, practice and standards • Ensuring further education and training of nursing and health care support staff.	Yes	▪ Acting manager in post – no interest from 2 previous adverts ▪ Use benchmarking – Essence of care ▪ Training programme available from 2 local Universiities and in house training programmes
A nominated consultant is responsible for: • The direction and management of the unit • Monitoring of clinical policies, practice and standards	Yes	
The unit has links with the university for training and research	Yes	▪ Keele University and Staffordshire University

5. Please describe below any established or planned links/meetings between the neonatal unit and the maternity services within the Trust and /or external to the Trust

Link/Meeting	Purpose	Established/ Planned And Frequency
Low Apgar Meetings	Discuss risk issues, lessons to be learnt	monthly
Term audit meetings	To discuss all term admissions to the	Weekly

	NICU	
Perinatal Mortality Meetings	Discuss risk issues and lessons to be learnt	Monthly
Perinatal team meeting	Discuss potiential future admissions and co-ordinate antental counseling also discuss unexpected term admission to NICU	weekly

6. Please describe below any established links/meetings between the neonatal unit and other neonatal units

Link/Meeting	**Purpose**	**Established / Planned And Frequency**
Stafford	1 consultant working 1 day a week in Stafford	
Stafford	Commencement of a rotational program for nursing staff	Monthly
North West Benchmarking group	To share best practice between units	As required – however fees increased therefore will not be continuing membership
Educators group	To share educational issues and network information	Quarterly

7. Please indicate in the table below the support for families available in the maternity services

Maternity Service – Support for Families	**Yes/No**	**Supporting Information/ Comments**
Support services are available, including: • Social worker • Religious advisers • Bereavement support • Psychological / psychiatric advice • Multi-ethnic health advocates and interpreters	 Yes Yes Yes yes Yes	 ▪ Hospital Social Worker for Staffordshire Social Services ▪ 24hr Chaplin support service – all denominations ▪ Link personnel in place ▪ Limited bereavement support ▪ Use of language line and local interpreter provision
The maternity unit has: • Overnight accommodation for families • A bereavement suite	 Yes yes	 ▪ May stay in off-site accommodation ▪ Forget me not rooms
There is a policy on financial support which is communicated to families.	yes	

8. Please indicate in the table below the staffing arrangements for the Maternity Services

Maternity Services – Staffing	**Yes / No**	**Supporting Information /Comments**
There is a nominated lead consultant obstetrician for the labour ward with responsibility for clinical standards of care	Yes	▪ Mrs G Masson

There is a feto-maternal medicine service available on the same hospital site as the neonatal unit.	Yes	▪ Partial service in place referrals made to Birmingham & Nottingham
There is a minimum of 40 hours consultant cover per week on the labour ward available. These consultants have responsibility for supervision of practice and training of medical staff and do not have responsibilities or commitments elsewhere that prevent their availability to the labour ward.	Yes	
There is an experienced Specialist Registrar (or equivalent) who has satisfactorily completed at least three years of higher specialist training available for the labour ward at all times who does not have responsibilities or commitments elsewhere.	No	
There is a Specialist Registrar (or equivalent) available for the labour ward at all times and who does not have responsibilities or commitments elsewhere that prevent availability to the labour ward.	Yes	▪ Covers Gynae however Labour Ward priority
There is an SHO (or equivalent doctor) present on the labour ward at all times.	No	▪ From 12 midnight no SHO Monday-Friday
There is a doctor with appropriate training in obstetrics to ensure competence to assess and respond to all obstetric emergencies available to the maternity unit at all times.	Yes	▪ Always in place
There is a consultant obstetric anaesthetist available to the labour ward at all times who does not have responsibilities or commitments elsewhere.	No	▪ Day time only. Night time always access to Consultant if necessary
There is an obstetric anaesthetist available to the labour ward at all times who does not have responsibilities or commitments elsewhere. If not at consultant, this anaesthetist is supported by a nominated on-call consultant.	Yes	
A 24 hour spinal epidural service is available.	Yes	
The unit has undertaken the *Birthrate Plus* (or equivalent) analysis of midwifery staffing.	Yes	
The unit has a plan, agreed with commissioners, for achieving the midwifery staffing levels recommended by the *Birthrate Plus* (or equivalent analysis).	Yes	▪ Staffing establishment achieved. Looking at new model of care.
Midwifery staffing is at the level recommended by *Birthrate Plus* or above.	Yes	
All labour ward staff who supervise deliveries have up to date NLS (or equivalent) training in neonatal resuscitation.	Yes	
All staff are compliant with the CNST mandatory training requirements.	yes	
Maternity units have: • Access to the hospital cardiac arrest team • At least one member of the medical or midwifery staff with up to date ALS (or equivalent) training on duty at all times.	Yes	

9. Please indicate below the facilities and equipment in the maternity services.

Maternity Service – Facilities and Equipment	Yes / No	Supporting Information /Comments
There are two dedicated obstetric operating theatres, staffed and equipped to allow an emergency caesarean section to be performed close to the labour ward **OR see below**	Yes	
Or There is at least one dedicated obstetric operating theatre and one other facility in which emergency obstetric operations under anaesthesia can be performed close to the labour ward		
The labour ward has the facility to provide high dependency care	Yes	
The labour ward has: • High quality ultrasound equipment • Adequate numbers of electronic fetal monitors • Appropriate devices for accurate control of intravenous infusions • Blood gas analyser capable of measuring pH, pO_2,pCO_2,and base deficit • Adequate resuscitation equipment for both mothers and babies	 Yes Yes Yes yes	▪ Access to high resolution equipment within maternity department. ▪ New equipment recently purchased.

10. Please indicate in the table below the support services available to the Maternity Service.

Maternity Service – Support Services	Yes / No	Supporting Information /Comments
High dependency and intensive care unit facilities are available on the same hospital site.	Yes	
Specialist advice is available to the unit from at least: • Renal medicine • Diabetes medicine • Endocrinology • Cardiology • Haematology	Yes	▪ Mrs G Masson Lead Obstetrician for Diabetic patients. ▪ Looking at setting up medical disorders clinic good links with listed specialties.
24 hour laboratory support is available from: • Haematology • Biochemistry • Microbiology	Yes	
Two units of O negative blood are available within five minutes and fully cross-matched blood is available within 30 minutes of the laboratory receiving the sample.	Yes	
The maternity unit has access to: • ready availability of fetal assessment (growth and biophysical assessment) • invasive diagnostic services such as amniocentesis and cordocentesis • clinical genetics	 Yes Yes No Yes	 ▪ Amniocentesis (yes) ▪ Cordocentesis (no) ▪ 2 genetic Nurses in post

Date:Fri, 15 Jul 2005 13:17:46 +0100
From:"Williams, Les" <Les.Williams@dgoh.nhs.uk>Save address | This is Spam
Subject:FW: Neonatal response
To:"'ruth.moore2@nhs.net'" <ruth.moore2@nhs.net>
Cc: "'Sarah.Carnwell@uhns.nhs.uk'" <Sarah.Carnwell@uhns.nhs.uk>, "O'Connor, Yvonne" <Yvonne.O'Connor@dgoh.nhs.uk>, "Mohite, Anand" <Anand.Mohite@dgoh.nhs.uk>, "Sharma, A" <A.Sharma@dgoh.nhs.uk>, "Meer, Lorna" <Lorna.Meer@dgoh.nhs.uk>, "Mansell, Steph" <Steph.Mansell@dgoh.nhs.uk>, "Quammie, Doreen" <Doreen.Quammie@dgoh.nhs.uk>

Dear Ruth,
Following the visit that you and Andy made to Dudley, please find attached our comments and our suggested changes to the information used in the review.

Best wishes,
Les

Les Williams
Director of Corporate Development

DUDLEY GROUP OF HOSPITALS – NHS TRUST
NNU Network
Response to Review of Service

Following our meeting on 7th July 2005 with Dr Andy Spencer and Mrs Ruth Moore to discuss the Neonatal Designation of Units our comments are as follows

- There is a need to ensure that the assessment process is fair, unbiased and applied in the same manner to all units. The membership of the assessment team should in our opinion been comprised of external advisors only or representatives from all 5 Trusts. In the event the assessment team had representation from 2 of the 5 Trusts involved. This approach does not inspire Trusts with confidence that the process is fair and assessment applied consistently. It should have been possible to invite the remaining 3 Trusts to nominate an individual to be part of the assessment team. We confirmed at our meeting that there was no intent to suggest that individuals were biased or influenced the process unfairly, however to ensure total confidence in the process, future reviews of service should take the opportunity to learn from this experience and avoid criticism that the processes could be perceived as unfair.

- The absence of a robust assessment tool to assess the quality of the information submitted allows the process to be manipulated by Trusts eager to impress assessors and fails to provide a level playing field for the assessment of all 5 Trusts. The use of a subjective approach to elements of the assessment fails to instil confidence in the process.
  The criterion for assessment should have included, alongside the standard statements what evidence was required to support the information supplied by Trusts. Trusts are well used to formal assessments and the need to provide strong evidence to support information submitted. Following our meeting it was confirmed that the assessment process was subjective and there was no consistent methodology used for the application of the scores. We would suggest for the future, assessment of services should either use a process of scoring with a robust system that provides a consistent and logical assessment of score or uses a softer subjective approach. Where the latter is used this would require the assessment team to be seen to be objective and representative of all Trusts involved.

- The use of a scoring system out of 10 again emphasises the use of subjective assessment without clear guidance on how assessment of each of the standards is verified or how scoring was weighted

- It is disappointing that the assessment process did not utilise current robust assessment processes such as CNST. Such assessments provide evidence of Trusts meeting predetermined standards and some of the information required could have been verified using the CNST assessments

- The assessment of the Dudley Group of Hospitals service was carried out primarily on the Wordsley site, despite the planned transfer of services to a new purpose built unit in January 2005 at Russells Hall. Although a visit of the new unit was organised this only included one member of the assessment team. Given the provision of the new build services at Russells Hall it is inappropriate to ignore how these services could best be utilised for the local population. There was no recognition of the new hospital build.

- It was disappointing to learn that the assessment team decided against placing any priority on the clinical outcomes and success of service provision. To parents, the public and clinicians (nurses, midwives and doctors) the standard of care provided by any service will always be the most important aspect.

- There were real concerns around aspects of information published. Many units vocalised that information was incorrect or outdated. It is of vital importance that this information is corrected. At the meeting it was agreed that the information for Dudley would be corrected and a review of the score undertaken to reflect the assessment of the unit in light of the new information

- The neonatal capacity planning tool appears to be a robust tool that allows it to be fairly applied to different units. It is however worrying that the there is only a theoretical assessment of the impact of the tool on the real provision of service

- When comparing the assessment document for the 5 different units it is evident that different issues were assessed for all of the standards. There is no consistency on what was assessed at each unit. There is no detail available to confirm what were the main issues for consideration within each standard. Following our meeting we were informed that the important elements of the assessment were around the geography and location of the units, the medical staffing levels and the costs associated with bringing units up to the assessed standard. This information could have been collected using hard data, allowing a more robust comparison against very specific requirements.
  We would suggest that future assessments identify and focus on the priority issues. In this scenario had these parameters been focused on they could have been assessed using an approach based on hard data allowing robust comparisons that would likely have confirmed the same decision. However such an approach would have allowed Trusts to understand the reasons underlying the decisions.

- The Trust raised concerns regarding the different criteria applied for the two units designated to provide level 2 care. Staff recalled at the last meeting that there had been agreement to set the gestational age in excess of 27 weeks for babies receiving care at units designated to provide level 2 care. This it was agreed would help to maintain the expertise of staff in caring for high risk babies who could not be transferred because of inevitable capacity problems, ensuring a high standard of skilled care was still available. During discussion at the meeting it was suggested that in practice the decisions around transfer of babies would and should be based around a clinical Risk Assessment. This approach is accepted by the Trust as the most appropriate way of addressing this issue. Following further discussion it was agreed that the criteria detailed for units providing level 2 care should be exactly the same. We agreed that level 2 units would retain babies born in excess of 27 weeks gestation, unless a clinical Risk Assessment suggested that transfer to a level 1 unit would be beneficial for the baby. We would want this information included in the agreed criteria for both level 2 units.

- At the meeting the Trust was asked to comment on concerns raised that the paediatric unit 'frequently' closes and children have to be transferred to other units. We were able to confirm that whilst this was a difficulty experienced when paediatric services were on split sites and the bed complement was limited, since moving to the new unit at Russells Hall in January 2005, this was no longer a problem. The paediatric service now has all services on one site with increased capacity, resulting in no paediatric service closures, an increase in paediatric activity and a notable ability to help by accommodating paediatric admissions from Sandwell

- The Trust was also asked to comment on the concern that the recently appointed Consultant Paediatrician did not have a specialist interest or experience in neonatology. We were able to confirm that this was not true and that the Royal College of Paediatricians representative who was part of the interviewing panel had confirmed the experience of the candidate within Neonatology.

Y O'Connor 13/07/2005

Appendix 4

Unit Evaluations

Capacity and quality of unit: Dudley Group of Hospitals NHS Trust

Number of births July 03 – June 04: 3891

Aspect	Comments	Dudley amended information
Good facilities and support should be available for parents and families.	The unit has most of the facilities expected but does not have a day room for parents. There is a flat were parents can stay which has a kitchen – but this is not available to parents who are not staying overnight.	There needs to be recognition of the superb new services provided in the new hospital build. This facility still has the provision of 2 flats for parents to stay. These facilities are available during the day for those parents spending a considerable amount of time within the unit
Maternity services should have the capacity to care for the expected numbers and care required, including: • Obstetrician and midwifery staffing • Training and expertise of obstetricians and midwives, in particular, expertise in feto-maternal medicine for level 3 units. • Facilities and equipment	The expected staffing and facilities are available, with the exception of: • There is not a Specialist Registrar available to the delivery suite at all times. • Midwife staffing is not yet at the level expected by Birthrate Plus and there is no plan, agreed with commissioners, for achieving this level of staffing. • There is not always someone with skills in neonatal resuscitation available to support all deliveries although this should be achieved later this year. • Feto-maternal medicine expertise is limited and there is not a feto-maternal medicine unit within the maternity service.	• There is a Specialist Registrar available for the delivery suite at all times • There has been an increase in the midwifery staffing establishment from 104.78 wte @31.03.04 to 107.70 wte @31.03.05 • There is always someone with skills in neonatal resuscitation available to support all deliveries • There is a Consultant Obstetrician with feto-maternal expertise
Neonatal services should have the capacity to care for the expected numbers and care required, including: • Medical and nurse staffing • Training and expertise of staff on the neonatal unit • Facilities and equipment	Medical staffing meets the standards expected for a level 1 unit. There is a separate SHO/ANNP rota for the neonatal unit during the daytime but not at nights. In relation to level 3 - the middle grade rota is not separate from general paediatrics and there is not a separate rota of consultant neonatologists. There is currently one paediatrician with an interest in neonatology. In the near future, this is expected to rise to two. There will also be a joint neonatologist appointment with Wolverhampton. The nurse staffing establishment is 19% below the level recommended for the current designation of cots and there are 9% vacancies. The expected facilities and equipment are available with the exception of a second spare ventilator in case of emergencies. We need to review this	• There is a separate middle grade for the neonatal unit in the daytime as well as an SHO. • The second consultant with neonatal interest has been appointed and starts in August. • The nursing establishment for providing neonatal intensive care and high dependency care does meet the BAPM requirements. There is currently no vacancy in neonatal nursing staffing levels • There are available within the unit 4 ventilators. Drager Babylog 8000, plus the ventilator on the Transport Incubator.
Relevant support services should be available, including imaging and anaesthesia.	• All services are available.	
Other relevant services should be located close to the neonatal unit.	• All relevant services are 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.	• A range of meetings take place within Dudley. Staff from the unit participate in network meetings but there is no evidence of other links or collaboration with different levels of neonatal unit. The joint appointment with Wolverhampton should help collaboration.	• Consultants from New Cross and Russells Hall hospitals have participated in joint ward rounds. • There have been joint nursing meetings with New Cross staff. • Joint teaching meetings have been held with Walsall. • The ANNP's within the West Midlands meet two monthly
Level 3 units should have university links for training and research.	• There are links for nurse and ANNP training but not for research.	

Level	Score (out of 10)	Reason for score
1	9	The unit meets nearly all of the requirements for a level 1 unit. Day facilities for parents are not available.
2	5.5	The SHO / ANNP rota is not separate from general paediatrics at nights. Day facilities for parents are not available. Nurse staffing is low.
		DUDLEY COMMENT The facilities in the new hospital build place the Children's ward, the Neonatal unit and the Maternity service in very close proximity, maximising the availability of all grades of paediatric medical staff
3	-	Scoring against the criteria for level 3 units was not considered appropriate. Medical staffing in obstetrics and neonatology are a long way from the expected levels and the unit does not therefore have the expertise needed to care for very small and very sick babies or mothers who need to be transferred. Travel times to the unit at Wolverhampton are not long.

-----Original Message-----
From: Mcmillan Elizabeth (RBK) WHT
Sent: 13 July 2005 17:14
To: Carnwell, Sarah
Cc: James Sue (RBK) WHT; Balachandar Mrs C (RBK) Walsall Hospitals NHS Trust; Drew D Dr (RBK) Walsall Hospitals NHS Trust; Head Mr A (RBK) Walsall Hospitals NHS Trust; Fallon Eileen (RBK) WHT; Walsallhospitals (RBK)* Medical Director
Subject: Neonatal Network Unit Designation Report

This is The Interim Trust Response from Walsall Manor Hospital to the above report.

Miss E McMillan has made the response on the trusts behalf as instructed by the Chief Executive.

We are unhappy with the process of designation because the maternity services were not represented fully and this designation has far reaching effects for maternity services as a whole.

We are unhappy with the process because the type of population served by each unit in terms of high risk obstetrics, preterm delivery rates, deprivation scores, car ownership were not taken into account. National average figures for preterm labour rates have been used.

Information was not verified and every unit has complained about accuracy of information. Our new information will be made available for the visit on 27th July as will a more detailed response to the report.

It has been presumed that we will have no in-patient paediatric services in Walsall and a decision has not been taken regarding this. There are a range of outcomes that are possible including retention of paediatric services in Walsall.

It has been presumed that we will be a merged trust and this has yet to undergo a consultation process.

The network is pre-empting the outcome of The Black Country Review and this is unhelpful.

A more detailed response will be made available to the visiting team on 27th July.

Miss E. McMillan
Consultant Obstetrician and Gynaecologist

Name of Trust: Royal Wolverhampton Hospitals Trust

Name & designation of person completing the form: Mark Edwards – Divisional Manager, Women & Children's Services

Date:14th July 2005

Please list the names & designations of who the report has been circulated to within your Trust.

Name	**Designation**
David Loughton	Chief Executive
Penny Venables	Chief Operating Officer
Janet Anderson	Clinical Director/Consultant Paediatrician
Deepak Kalra	Divisional Director/Consultant Paediatrician
Babu Kumararatne	Lead Consultant Neonatologist
David Churchill	Lead Consultant Obstetrician
Pek-Wan Lee	Consultant Neonatologist
Skinner Alyson	Consultant Neonatologist
Chrisantha Halahakoon	Consultant Neonatologist
Andrew Browning	Clinical Director/Consultant Gynaecologist
Sandra Reading	Head of Nursing & Midwifery
Clare Steggle (Price)	Head Nurse – Neonatal Unit
Clare Beards	Divisional Accountant
Mark Edwards	Divisional Manager

Please list the names & designations of all the people who have participated in the Trust's response

Name	**Designation**
David Loughton	Chief Executive
Penny Venables	Chief Operating Officer
Janet Anderson	Clinical Director/Consultant Paediatrician
Deepak Kalra	Divisional Director/Consultant Paediatrician
Babu Kumararatne	Lead Consultant Neonatologist
David Churchill	Lead Consultant Obstetrician
Pek-Wan Lee	Consultant Neonatologist
Skinner Alyson	Consultant Neonatologist
Chrisantha Halahakoon	Consultant Neonatologist
Andrew Browning	Clinical Director/Consultant Gynaecologist
Sandra Reading	Head of Nursing & Midwifery
Clare Steggle (Price)	Head Nurse – Neonatal Unit
Mark Edwards	Divisional Manager

PV/LNR/RMNEONATAL

Ms R Moore
Network Manager
Staffordshire, Shropshire & Black Country Neonatal Network
Room M038, NSPD
City General Site
University Hospital of North Staffordshire
Newcastle Road
Stoke on Trent
ST4 6QG

15 July 2005

Dear Ruth

RE: STAFFORDSHIRE, SHROPSHIRE AND BLACK COUNTRY NEONATAL NETWORK UNIT DESIGNATION WORKSHOP 29TH JUNE 2005 - DRAFT DESIGNATION REPORT

Further to your letter dated 4th July 2005, please find enclosed our Trust response and the details of the Trust personnel who have contributed to the discussion, following the outcome of the Designation Workshop.

The report was widely distributed and discussed in the organisation, with the outcome that we would view our Unit designation at Level 3 status very positively. We felt that the report fairly reflected our current level of service and that, as an organisation, we are confident we can continue to expand the service to meet the capacity requirements as set out by the Network.

Dr Anderson has noted only one correction to the report in that we are staffed separately from paediatrics at Middle Grade level during the week day and not out of hours; otherwise the report was accurate from our perspective.

As we move forward towards agreeing final designations within the Network we will need to set out a resource position that meets the level of service as specified in the report and will work comprehensively with the Network to achieve that position.

In collating the views of colleagues who have participated in the process and workshops to date, the Trust position in relation to the Unit designation is that we are satisfied that the process was open, well researched and that the outcome is acceptable to us in moving forward with this designation status for the Network.

Kind Regards

Yours sincerely

Mrs Penny Venables
CHIEF OPERATING OFFICER

cc Mr M Edwards
Mrs C Steggle
Dr J Anderson
Dr B Kumararatne
Dr D S Kalra

The Shrewsbury and Telford Hospital NHS
NHS Trust

Royal Shrewsbury Hospital
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Ruth Moore
Network Manager
Staffordshire, Shropshire & Black Country Neonatal Network
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City General Site
University Hospital of North Staffordshire
Newcastle Road
Stoke on Trent
ST4 6QG

18.07.05

Dear Ruth

Re. Designation of Units Response

Thank you for your emailed letter dated 4th July 2005 asking for a response to the draft Designation of Units Report, with a deadline of 18th July suggested. Such a deadline is not feasible due to

- The previously planned annual leave of our lead Neonatologist (either side of the deadline date) preventing his ability to make an appropriately considered response
- Our Trust has an Interim Chief Executive, Mr Graham Smith, pending the start of Mr Tom Taylor, Chief Executive as from 1st August 2005

This Trust is committed to the Network designation process and wishes to be able to participate fully and appropriately. We have many comments to make upon the Designation Report, and we are pleased to see that the Report acknowledges the lack of agreement with the process, information used and conclusions drawn.

We are surprised though that the concerns raised at the Designation Workshop on 29th June by the Chairman of the Network, Mr John Crockett, are not made reference to in Section 20 (his opinion, non verbatim being "… given the significant concerns raised with regard to the process and information used, that I cannot accept the proposed designation outcome").

We are delighted that the Network has already made plans to organise a meeting with our Trust, and that the persons visiting will include Prof. Neil Marlow, Tracey Woodall, Lead Nurse, and Laura Burt, Bliss Representative. The date proposed for this meeting however coincides with the annual leave of Dr Sanjeev Deshpande, Neonatal Lead Clinician, and Dr Martyn Rees, Clinical Director. Unfortunately the meeting date was not arranged in person with the clinicians (despite their secretaries informing the network administrator that the doctors would be on leave). We note no attempts were made to involve the Obstetricians in this meeting, and assume this was an oversight on the Network's part. The Network administrator, Sarah Carnwell, had suggested that deputies be sent, but the issues for discussion are of such paramount importance that such a request is clearly inappropriate.

We would expect to be in a position to make a response to the Designation report by end of August, and be in a position to receive the Network team from 22nd August.

We would be grateful to receive confirmation receipt of this letter, and for the Network's response at the earliest opportunity to allow necessary arrangements to be made for the Network visit.

Yours sincerely

Dr Martyn Rees
Clinical Director Children's Division

Signed copy to follow by post

Mr Graham Smith, Interim Chief Executive
Shrewsbury and Telford Hospital NHS Trust

-----Original Message-----
From: Ridout Vanessa (5MN) [mailto:Vanessa.Ridout@sws-pct.nhs.uk] **On Behalf Of** Fisher Susan (5MN)
Sent: 27 July 2005 16:28
To: Carnwell, Sarah
Subject: FW: Neonatal Network Unit Designation Report

-----Original Message-----
From: Pearce Helen (5MN) **On Behalf Of** Warren Jan (5MN)
Sent: 25 July 2005 09:02
To: Price William (5MN)
Cc: Iqbal Zafar (5MN); Fisher Susan (5MN)
Subject: RE: Neonatal Network Unit Designation Report

ON BEHALF OF JAN WARREN

Neonatal intensive care is a highly specialist activity where the appropriate level of staffing, both numbers and expertise is crucial to achieving good outcomes.

The report has modelled the scenarios and I have no objections to the conclusions they have reached.

The only additional comments I would make are:

- Have they factored in inuterotransfers as well as post partum ones fully?
- Support services have to be specialised, e.g. for paediatrics/neonates specialist anaesthetistics are required.
- The report does make the connectivity between neonatal and paediatric units, but this may need more emphasis.

Jan

-----Original Message-----
From: Price William (5MN)
Sent: 18 July 2005 10:52
To: Iqbal Zafar (5MN); Warren Jan (5MN); Fisher Susan (5MN)
Cc: Thomas Jennie (5MN)
Subject: FW: Neonatal Network Unit Designation Report

This is asking for views on preferred designation of each of the neo-natal units. Is any-one well placed to look, otherwise can you all form a view please.

Ta Wm.

Note 25 July response date required