Staffordshire, Shropshire & Black Country
Neonatal Operational Delivery Network

QUALITY AND IMPROVEMENT GROUP MEETING NOTES		
Monday 17th September 2018 at 14:30 pm		
Parent Education Room, First Floor Maternity Block, City Hospital, Dudley Road, Birmingham, B18 7QH.		
1.	**APOLOGIES:** Anand Mohite - Dudley Asha Shenvi - Stoke Karen Anderson - Dudley Lindsay Halpern - City Hospital Lisa Poston - Walsall Lynn Keilty-Woolcock - Stoke Melanie Sutcliffe – Royal Wolverhampton Hospitals Phil Velempini - City Hospital	
	PRESENT: Alison Moore – University Hospital of North Midlands Babu Kumararatne - SSBC Neonatal ODN (via conference call) Claire Cockburn – Russell's Hall Hospital, Dudley Lynsey Clarke - SSBC Neonatal ODN Penny Broggio – City Hospital, Birmingham Ruth Moore – SSBC Neonatal ODN Sagarika Ray – Princess Royal Hospital, Telford Shiva Shankar – Princess Royal Hospital, Telford Tamsin Lane – Walsall Manor Hospital	
2.	**MINUTES OF THE 16th MAY 2018** All agreed. Outstanding Actions: • **Deputy Chair – RM to ask Lynsey to take back to discuss with her team and to let us know if someone from City is willing to take this on** • **SC to request any documents units use to investigate the reason for term admissions, or state if no documents used. RM to provide name of Lead in each NNU for term admissions.** • **The notes of the Badger Champions Group to be put on the QI Group agenda.** • **BK to ask Danielle to attend the next QI Group meeting to discuss the WHEAT Pilot Trial.** • **SS to circulate individual dashboard for others to adopt.**	**Actions** **LH** **SC** **SC** **BK** **SS**
3.	**MATTERS ARISING** <u>Temperature on Admission</u> The Group noted this as an ongoing issue, it was decided that an audit was needed to understand what is impacting on the poor temperature on admission. There were two things that needed auditing the package of care provided to preterm infants to prevent loss of heat and term babies that are not being given skin to skin properly. **SS to contact KP to ask if this could be undertaken as a Network wide audit**. This would avoid term admissions for hypothermia. Each Trust could undertake the audit separately by a junior doctor and then these could be collated/compared across the Network. RM indicated that KP is already undertaking a Network wide breastfeeding audit. <u>Independent Peer Review</u> BK has got some volunteers for independent reviewNeed agreement on draft process to be undertaken. A small sub group will be convened to look at the draft process and finalise the practicalities of implementation. Write to each Trust to explain need for honorary contracts for these volunteers. AM agreed need Trust Board approval in order that it is included in individuals job plans. How much time is required has not been worked out (the more staff that volunteer will reduce the amount of time each person will need to do), however there are six Trusts in our Network and around 50	**SS**

	deaths per year therefore each Trust would need to commit to approximately eight days of either a consultant and senior nurses time per year. Term neonatal deaths will not be reviewed as covered in the national HSIB external reviews. <u>Vancomycin Audit Proposal and Proforma</u> The audit information has been sent out to all the units. **This can now be removed from the agenda for the Group.** <u>WM Neonatal Service Review</u> RM has drafted a proposal, using a document from Yorkshire and Humber ODN, **this will be discussed at a West Midlands meeting to be arranged with both neonatal and maternity representation and the draft document circulated beforehand.** The document encompasses information from.boththe BAPM TC framework. About TC as a level of care and not location. AM feels TC should be financially incentivized in order to encourage Trusts to keep babies with mum. <u>Workforce</u> Action completed. **RM has drafted the 2016/2017 Network Capacity and Demand Report and is part way through the 2017/18 Report which she aims to complete and circulate by the end of October** <u>Research Update</u> **SC to ask the Research Leads in each Trust what research their unit is currently undertaking. Wolverhampton's research lead is Tilly Pillay, Stoke's is Lee Abbott, Telford is Sanjeev Deshpande, Walsall is Raghu and Ashok, Dudley and City are to let SC know.** <u>LocSSIP</u> Telford has provided their forms. BK have adopted WHA checklist and modified for neonates. Formalises process and makes sure complying with Trust policies. AM arranging to meet with matron to go through this for umbilical lines. **SC to chase all units except Telford and share with the group what has been received.**	**SC** **RM** **RM** **SC** **Dudley and City** **SC**
4.	**NETWORK ACTIVITY AND QUALITY REPORT QUARTER 1 APRIL-JUNE** MS has given her apologies, RM presented on her behalf. <u>Admissions to NNU</u> Less than 27 weekers are on the whole born in Wolverhampton and Stoke, however this is not the case for Birmingham City who have a slightly higher number of admissions born at < 27 weeks. Their gestational threshold is 27 weeks the same as Telford and Dudley, however their pathway is into Birmingham NICUs where there is pressure. Birmingham City are able to ventilate for up to 7 days before contacting the NICU which is different to our pathway. The Network will be undertaking a refresh of care pathways to address the recommendations from the West Midlands Neonatal Service Review and ensure as many babies as possible<27 weeks are born in a hospital with a NICU, however we need to make sure there is NICU capacity for those babies to go to. Similarly with birthweight the majority of babies with low birthweight were born in Wolverhampton, not many in Stoke, City did have a few. There are high number of term admissions to City compared to the other units in the Network. The target for the National improving value scheme is 6%, West Midlands Specialised Commissioners are asking for units to aim for a stretch target of 3%, which units such as UHNM have achieved, though AM noted this was difficult to maintain. <u>Activity</u> On the whole all units are either slightly over performing or slightly under performing on their contracts, as it is only quarter 1. HD continues to be our area of pressure in all units, with both Stoke and Wolverhampton above 85% occupancy in IC as well. Overall close to 85% occupancy for all units except City. When units have accepted babies from outside of our Network, it has been exceedingly difficult to get them repatriated back to their Network. 98.2% of babies that should be cared for in our Network, did receive care. ***RM will find out what this % is for the SWMN ODN.*** <u>Outcomes</u> Cooling was eight this quarter, similar to previous. One laser treatment for ROP. Just under 80% of 2 year follow up assessments were undertaken, this is the highest it has been for a while. Mortality is 14, however this includes an extra unit to the previous year data, and the majority of deaths were in NICUs. <u>National Quality Dashboard</u> **All units to forward quarter 1 dashboard to SC once they have verified it as being correct.**	**RM** **All**

	NNAP NNAP antenatal steroids 83% is the lowest up to 100%, the majority are over 90%, just Dudley and Wolverhampton are between 83% and 85% with the standard being 85%. Dudley reassured the Group that this was only due to data collection inaccuracy. Admission Data Temperature taken within an hour of admission, four units have achieved this target, with the other two units just over and just under 90%. Mother's milk on discharge Dudley 25% and City were at just under 90%, Stoke are at 70%, Wolverhampton at 62%, Telford at 65% making it a very good quarter. Consultation within 24 hours, not good. Dudley have submitted an action plan to be put in place, as it is not acceptable. ROP screening 93% Dudley, 96% Wolverhampton and the rest 100%. Follow up City is the lowest at 55%, Walsall 60% however TL confirmed this was because they were behind with data entry, and Stoke at 100%. Magnesium sulphate with Stoke, Dudley and City all at 50%, Wolverhampton 60%, Walsall 66% and Telford at 75% which is all going up now we are surfacing the data and raising awareness. Rolling out PReCePT across maternity, **RM to circulate information about this to the network.** Exceptions IUT exceptions Wolverhampton did not have any, Stoke had 16 IUTs that went out due to the NNU being full, 3 had to go outside of the network as there were no NICU cots available. Telford had 6, 3 below the gestational threshold, two went to New Cross and one went to Coventry, and 3 because the unit was full. Dudley had 8, 4 below the gestational threshold for the unit. Walsall had 6, 4 below the gestational threshold. As a Network there were 37, 11 stayed in the network, 11 stayed in West Midlands, 14 went outside of the Network and one was unknown. 5 delivered, 13 did not deliver and 19 we do not know the outcome. Ex-Utero exceptions Telford got 9, Dudley 8, Walsall 3. There were 27 exceptions in the Badger monitoring report over half were attributed to City (14) which has a different ventilation threshold. Russell's Hall had 3 only one is a true exception, Walsall no exceptions, Telford 9 exceptions. 10 babies were born in LNUs below gestational threshold over half were at City, two at Telford are exceptions for Stoke as they went to other units, one is an exception for Wolverhampton as it went to another unit. Patient Safety Incident Report Q4 2017/18 Perforation transferred to Stoke from Walsall. Walsall have shared their new documentation and SOP which is going to feed into the Network Guidelines for the next edition. Getting the numbers of incidents and categories however need to work on sharing learning from RCAs as often there is a time lag from the report. Parent Experience Survey Results 133 parents responses and this is the first quarter all responses agreed or strongly agreed with all of the statements. **RM to speak to the unit managers about other forms of feedback and what units have done in response to feedback.** Staffing Quarter 1 This is not very good. % of shifts staffed to BAPM ratios: 3.3% at Wolverhampton and 12% at Stoke. The national average is 54%. Quarter 2 is looking better following recruitment of staff. **SC to circulate final report to Group.** Data Analyst We have funding between the two Networks for a data analyst. We are not in a position to recruit, as not sure of structure of Networks going forward, and previously had difficulty recruiting a Data Analyst on a fixed term contract. Approached East Midlands Neonatal ODN Data Analyst, Rachel Salloway, she has spare capacity that we could use therefore for a sixth month period October – end March we will have a SLA agreement with East Midlands ODN. Rachel will produce the reports and Mel would undertake the summary analysis of what the data shows. **RM will write a letter to all units in the West Midlands Trust, once Board approval on the 9 October, for units to give Rachel access to their Badger data.**	**RM** **RM** **SC** **RM**
5.	**MORTALITY REVIEW SUB GROUP** Shared Lessons Quarter 4 **RM to circulate quarter 1 shared lessons discussed in August.** Not necessary to clean the skin around the umbilical cord insertion. BK confirmed that in very	**RM**

	premature neonates causes burn the skin of the abdomen, consensus was that you just need to clean the cord and not the surrounding skin to prevent the risk of burns to the abdominal wall. Query as to whether not cleaning would cause a risk of infection. AM confirmed that the way that LGI were doing it was they were letting the cleaning solution dry and then washing it off with sterile non-saline solution to get rid of clorhexidene. **BK to circulate article with reference to the advice on not cleaning the chord.** Draft Process for External Reviewers in SSBC **All to circulate the draft process to colleagues and BK to set up a working group to take this forward.** Umbilical Line Incidents and RCA Actions AM updated that UHNM have had three incidents, firstly a baby had a UVC and then a UAC that resulted in the UVC being cut across resulting in the baby being transferred to a surgical centre to have the UVC removed, external review following which amended guidance around not cutting down on to the cord. Secondly, a UAC came out and the degree of blood loss meant we had to institute the massive hemorrhage protocol which worked really well. New guidance on insertion of lines, make sure trainees are trained. **AM to share new guidance with the QI Group**. RM suggested it be included in the update of the guidelines, **AM to share insertion of lines guidelines with Kathryn McCarron and Kate Palmer.** All agreed new learning needs to be included in the guidelines and shared with all units in the Network. Another cord leaked which had not been secured, this just needed educational supervision of that particular individual. AM stated that the new guidance advises to put the UAC in first and don't cut down on to a cord with a line already in situ. BK agreed that need a common guideline across all units.	**BK** **All and BK** **AM** **AM**
6.	**SERVICE DEVELOPMENTS** WM Neonatal Service Review **This to be removed from the agenda, as it is part of the work program of the Network,** including standardising TC criteria, reporting and recording, and developing effective community outreach services this is a CQUIN in the Black Country Trusts but not for Telford and Stoke . National Neonatal Transformation Programme The New Models of Care Group have had their three meetings and a draft report has been produced. Wider stakeholder engagement is taking place towards the end of October with selected individuals being invited to attend to give feedback from a variety of perspectives. Changes based on feedback received will be made and presentedto the NHS England Women and Children's Programme of Care Board in November for implementation. **RM will find out who has been invited from our Network.** QIL Work Programme – OPEL Pilot and Feedback ST and RM have met and looked at feedback. ST to invite representatives to a focus group meeting to look at proposed changes, and then it will be piloted for a longer period. Birmingham Children's with the NTS have developed an online system for recording cot status of units has been demonstrated at the TUG meeting. **RM to confirm that it will be demonstrated at our Board and Workforce Group meeting.** BAPM Quality Standards AM felt this could be used as a neonatal service quality indicators document. **The Group to recommend to the Board that all units benchmark themselves against the document, SC to put on Board agenda. SS has already done this for Telford and will send to RM to make into an excel template for units to complete.** RM agreed that this would be useful preparation for annual peer reviews. **The Group to bring the completed templates to the Group for comparison/review.** NIPE Quality Improvement Guidance This was circulated for information, and includes training of individuals.	**SC** **RM** **RM** **SC** **SS/RM** **All**
7.	**AUDIT UPDATE** Update from Audit Lead Attached for information. Draft Proposal Network Audit on Initiating Breastfeeding Proposal circulated to the QI Group for comments and approval. This was raised at the various Network Groups including the Badger Champions Group and following the	

	NNAP Report. BK should be equivalent to community breastfeeding rates at least. The group discussed populations and demographics. SS suggested a Network wide audit of chronic lung disease, how assessing babies? RM only a small proportion of babies have chronic lung disease whereas all babies need to be fed. Breastmilk at discharge, does it improve outcomes? We do have poor outcomes and we do have low breastfeeding rates on discharge, so it is one thing compared to others that we can improve. AM Audit Lead and Nutrional Lead at Trust has already done some work around this locally. Maternity and Neonatal Safety Collaborative Project is a priority for the Stoke unit**. SC to update Audit Lead distribution list with Zahid Saleem, as Fatima will be leaving.** AM suggested this could be nursing audit. **RM to suggest to KP that the proposal go to the Feeding and Nutrition Group to take forward.** This would allow another Network wide audit to take place with trainees. BK felt that we need to prioritise mortality and morbidity, and suggested writing to clinicians to get their views on what they want. **The Group to ask Kate Palmer to get suggestions for audits from across all the units in the Network in order for the Group to decide what the priorities are and the order in which we should do them.**	**SC** **RM** **SS**
8.	**RESEARCH UPDATE** **SC to add Siva Sivakumar to Audit Lead distribution as he is involved in research on the unit at City.**	**SC**
9.	**ANY OTHER BUSINESS** Two consultation documents for information. **SC to send to unit Leads to read and respond if they wish.** <u>Developmental Care Group</u> The Group have just done an evaluation of positioning aids and will be bringing recommendations for which aids all units should be using. LC is hoping to get a reduction in price from the suppliers and some training. SS suggested liaising with the Equipment Group, however LC confirmed that the Equipment Group only meets twice a year and due to the time element and needing to purchase before the end of the financial year that it needed to be taken forward. AM queried physio input. LC confirmed that the Group has involvement from a physio at Walsall, also SALT input and a physio at Dudley who is also involved in training and education. **Penny agreed to discuss with Lindsay and her colleagues at City one of them becoming the deputy chair of the QI group**	**SC** **PB**
10.	**DATE AND TIME OF MEETINGS IN 2018** The next meeting will be held on Monday 10 December at 2:30 pm in the NNU Resource Room at New Cross Hospital, Wolverhampton, WV10 0QP.	