Staffordshire, Shropshire & Black Country
Neonatal Operational Delivery Network

QUALITY AND IMPROVEMENT GROUP MEETING NOTES		
Monday 10th December 2018 at 2:30 pm		
Resource Room, New Cross Hospital, Wolverhampton, WV10 0QP.		
1.	**APOLOGIES:** Anand Mohite - Russell's Hall Hospital, Dudley Asha Shenvi - University Hospital of North Midlands Claire Cockburn – Russell's Hall Hospital, Dudley Jo Cookson – SSBC Neonatal ODN Karen Anderson - Russell's Hall Hospital, Dudley Kate Palmer – University Hospital of North Midlands Patricia Cowley – Princess Royal Hospital, Telford Rachel Salloway – SSBC Neonatal ODN Robin McMahon – Royal Wolverhampton Hospital Sanjeev Deshpande – Princess Royal Hospital, Telford Wendy Tyler – Princess Royal Hospital, Telford	
	PRESENT: Alison Moore – University Hospital of North Midlands Babu Kumararatne - SSBCN ODN Jyoti Kapur – University Hospital of North Midlands Lindsay Halpern - City Hospital Lynsey Clarke - SSBC Neonatal ODN Ruth Moore (Acting Chair) – SSBCN ODN Sarah Tranter – SWMN ODN Girish – Walsall Manor Hospital Penny Broggio – City Hospital	**ACTIONS**
2.	**MINUTES OF THE 17th SEPTEMBER 2018** All agreed.	
3.	**MATTERS ARISING** <u>Deputy Chair of Group</u> Penny Broggio at City Hospital is nominated as Deputy Chair. All agreed. <u>Chair of the Group</u> Shiva has resigned as Chair. Volunteers were requested and JK has come forward. No further nominations have come forward. All agreed JK as the Chair of the Group. **SC to arrange future dates for meetings with JK and Penny.** <u>Cardiology Lead Role</u> Kalyan Gurusamy has volunteered. **JK to do a report on her experience having undertaken the role and how it should go forward.** The main parts of the role are: • BCH require attendance at a minimum of five clinics a year. • Arranging the West Midlands Regional Cardiology Study Day • Network Peer Review Meetings All congratulated JK on the successful Study Day that she organized. <u>LocSSIP</u> AM confirmed Stoke's was similar to Walsall however there was information about the guide wire being removed following learning from an event. BK has sent a checklist. **SC to circulate additional documents. All units to look at examples and make any local changes.** All agreed that the guide wire was removed as soon as line was inserted and did not wait for confirmation of line position by radiography before removing guide wire. <u>Term Admissions</u> Each unit completed a template around term admissions across both Networks that identified the neonatal, obstetric and midwife leads, the top five reasons for term admissions, what they had done to reduce the term admissions and any plans to reduce term admissions further. RM and ST have written to units thanking them for	**SC** **JK**

	their completed templates and identifying gaps/questions. Sagarika Ray's response has been circulated. Walsall has also sent a response. RM congratulated units on reducing term admissions. AM highlighted that there was a financial disincentive from Commissioners to reduce term admissions. The ATAIN national target is 5% and our Network is well below this at between 2% and 4% depending on the unit. It is only avoidable term admissions, such as hypothermia. JK has identified babies that could have gone to TC but TC was full or there was not the staff on the neonatal unit therefore had to close TC in order to staff cots on the unit, staffing issues have now been addressed and improved TC capacity.	
4.	**NETWORK ACTIVITY AND QUALITY REPORT QUARTER 1 APRIL-JUNE** <u>Network Benchmark Report for Quarter 2 2018/19</u> RM apologized that a report was not circulated prior to the meeting. This is the first quarter that Rachel Salloway, Data Analyst in East Midlands ODN has collated the activity. RM informed the Group that as well as the Network data there was also individual unit level data for each Trust in the Network. There are two reports; activity and workload, and quality report reflecting the NNAP measures. Unfortunately not got City's unit level data as Siva had only just managed to get sign off from the Trust Caldicott Guardian. **RM and MS presented the data to the Group which will be circulated with the notes.** <u>Activity and Workload</u> RM confirmed that the national pricing work stream is currently looking at applying a tariff to HRG5 in the future, implementation in 2021/22. This will also address the imbalances and variations across the Country. **RM confirmed that the occupancy levels were not correct and needed amending, RM to take forward with Rachel when she returns from annual leave**. Care out of Network is higher than it should be as it includes City which is not part of our Network care pathway, **RM will make Rachel aware of our care pathways.** It is still less than 5%. AM congratulated Rachel on the graphs. RM agreed that Rachel had managed to summarise the data in far fewer graphs. BK felt that this was the value of having a proper Data Analyst. RM stated that this also allowed benchmarking not only across the WM but also East Midlands, using direct comparison. It was highlighted that RWH was undertaking over 100 days care for units outside of the Network. BK identified the units as Hereford and Worcester. Stoke and Telford were the opposite sending babies out for care. Stoke identified that families were not happy to travel to Telford and therefore send babies to Leighton for step down care. RM confirmed that care should be provided as close to home as possible and that if Leighton is closer to families' home then that is appropriate. Telford almost 100 critical care days had gone out of the Network, RM queried which units babies were being transferred to if not Stoke and Wolverhampton. **All to identify any significant anomalies (other than occupancy) on units individual reports to RM, for discussion with Rachel in order to get accurate information for each unit.** <u>Quality</u> These are each of the NNAP measures. Antenatal steroids compliance as a Network last year was 90%, so far this year the Network is at 85.7% which is below where we were last year. **RM asked units to identify any data that might be missing and to liaise with Obstetric colleagues to make sure steroids are given.** MgSO4 has improved, from last year 49%, however short of the target of 85%. **All to liaise with Obstetric colleagues to make sure Magnesium Sulphate is given.** Walsall are part of the trial. The group discussed whether it was a case of poor recording, ST stated that have to make the assumption that if it is not recorded, it is not happening. Stoke, City and Telford are less than 27%, whereas New Cross and Dudley are above 75% and Walsall is 83%. Jyoti is working with the Governance Lead at Stoke to improve the figures. AM suggested raising Datix where should have been given in order for investigation to take place. All agreed quarterly figures help to identify issues before the end of the year. **All to identify any errors or inaccuracies with their unit level data in order for these to be corrected prior to the Board.** The Badger Champion Group looks at whether the issue is data capture or practice that needs to be changed and the **minutes of the Badger Champion Group come to this Group.** RM reported the term admission rates as a % of all term live births. JK educate midwives in order to reduce term admissions with the ATAIN module included in the student midwife training at Keele, and they have taken this on board	**SC** **RM** **RM** **All/RM** **All** **All** **All** **SC**

	with skin to skin initiated as soon after birth in theatres as possible in order to maintain a stable temperature. PB agreed almost half of all term admissions to unit are cold and will be presenting an audit shortly. RM agreed that reducing term admissions helps with capacity issues. **RM is waiting for clinical incidents data from units, SC to chase.** RM work needs to be done with the PPI Group in order to capture more parent feedback. Looking at moving to a single WM wide parent app. ST working with Badger to develop an app. Exceptions to care pathway, IUT exceptions in quarter 2 were much lower, of the 16 half were because the neonatal unit was full, with 7 then going outside of the Network to Sheffield, Cardiff, Wirral, Bolton and Chester. ST the OPEL policy will identify where cots are available. All agreed that even if the NICU is full that the transport service ring if a baby requires a cot as part of the normal care pathway to make sure that cot space cannot be made available. ST agreed that as long as a unit has the staff they can possibly move babies around on the unit to make space. Ex-Utero exceptions, **Telford's data is missing**. Over half of the exceptions were at City, however of those 18 only 9 were actual exceptions to City's care pathway. City's care pathway has not been updated in line with the national service specification. An exercise needs to take place across the whole of the West Midlands in order to review the current care pathways. ST has recently updated SWMN ODN care pathways and is waiting for Vish to review these. If a baby is transferred out at less than 24 hours of age, it does not appear on the Badger exception report. All agreed that capacity needs to be increased elsewhere in the Networks before City's care pathways can be changed. Q1 nurse staffing was difficult, improves in Q2. New Cross, Stoke and City have all got successful Business Cases and are actively recruiting. All agreed that staffing had contributed to capacity issues. <u>Capacity and Demand Reports</u> **RM is still completing 2017/18 and will circulate as soon as it is available.** City will not be included as it was not part of the SSBCN ODN during this period.	**SC/All** **Telford** **RM**
5.	**MORTALITY REVIEW SUB GROUP** <u>Independent Peer Reviewer Process</u> BK attended a BAPM meeting as well as CDOP National Lead presented at the Mortality Review meeting. There will be independent review under CDOPs, they are going to start the process in April 2019 and roll out across the country in three years' time. The plan is for quarterly neonatal review and CDOPs with externality from other units than those being discussed. A huge amount of guidance has come out but it will take time for the CDOP process to be rolled out. There is currently a Black Country CDOP (Walsall and Wolverhampton), and are trying to incorporate Dudley and City. There will be separate CDOPs for Shropshire and Staffordshire. There is a national framework and guideline. They will be looking at deaths from 22 weeks onwards. The CDOPs will use the information in the Trusts PMRT to complete the review with input from external neonatal colleagues, as they will not have the case notes. ST stated that some of the CDOPs had already got separate neonatal review panels already set up, others it is done within the existing children's panel with the police, education, etc. The Network proposal for an external person to attend the existing individual Trust neonatal review is still required. There are approximately 50 deaths in our Network with the majority of the deaths in the level 3 units and City. Propose that an external neonatal consultant and if possible, nurse, attends the Trust review meetings. Vish has tried to start this process in the SWMN ODN. In the SSBCN ODN the Mortality Group has already been meeting for six years to review deaths and instead of continuing this process, the Group have agreed to instead use this time to provide externality at individual Trust instead. All units would still supply the summary of their case review with the Lead Clinical, Lead Nurse and/or Clinical Effectiveness/Audit Lead identifying shared learning points for circulation across the Network. BK realistically cannot review all 50 deaths, if starting doing some of the deaths, it is a start. Need to practically start the process using the PMRT form. All agreed that it is part of clinical governance and DCC activity. PB suggested that need to pick and choose the cases where externality would be of most benefit to the Trust, for example serious untoward incidents and disagreements on care provided on the unit.	

6.	**SERVICE DEVELOPMENTS** WM OPEL Policy ST: Policy complete following a workshop. Made some additional changes. Hoping to start in January, but Alex has asked to postpone until February. Sent out to all units re online tools. Email to Clinical Leads and unit managers would have had email, asking if want to use Cot locator system on Badger or nOR system. Commissioners want to know our preference. This has gone to SWM and Stakeholders for Commissioners to make a decision on which system is used. Only 5 responses so far. A request was made for responses to be given prior to the Programme Board Meeting to be held on 18th December. WM Neonatal Service Review Standardising criteria in Neonatal Services Briefing Paper. Around standardising transitional care criteria. Yorks and Humber document discussed with the group. (Refer to documents prepared for this meeting). Tariffs are affected by additional care given. E.g. tubing. There are queries surrounding tariffs for readmissions and the criteria for additional funding. Is it Commissioning which has led to change in practice, or capacity? Normal practice should be, if baby has been discharged 'fit' then if readmitted, should come in via Paediatrics. . 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 presented to 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 –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 SATH have assessed selves and document to be sent by Siva but has left so Sanjeev to do. Would be helpful to see how SATH did it. **.**	
7.	**Audit Update:** Audit update: Kate sent apologies so no update available. Will be circulated when available.	
8.	**ANY OTHER BUSINESS** Initiative on Breastfeeding: somebody is prepared to lead on this and it has been started. There is a set of minutes from previous QI group, terms of ref say this is the group to initiate audits. Sanjeev has identified breastfeeding as an issue for the Network. Badger Champions group has met and outcome is with papers. Precept update: Walsall and City have responded in the positive. Need responses	

	from others in the Network. Precept is rolling out in January, those participating get more resources. Subaru: Research information has been sent and will see if any actions are required . Highlight report: Attached. Stakeholder Report (Draft): Attached. 22 recommendations. Neil Marlow is 'tweaking' the report. Final Report due at the end of December. Comments being collated for final report, which if approved will then come out ? January. Audit and QI: March. Date to be confirmed. Perinatal Mortality Morbidity Event: Date 11th October 2019 in Walsall. West Midlands ODNs: Sue Eaton has written out for comments for proposal to this. Responses by 12th December. Single WM ODN.	
9.	**DATE AND TIME OF NEXT MEETING:** 3 April 2019: 10:00-12:00 Resource Room, Maternity Building, Ground Floor, D2, Royal Wolverhampton Hospital, New Cross. .	