Quality Surveillance Team

National Peer Review Report:

Neonatal Critical Care Services 2017/8

An overview of the findings from the 2017/8 National Peer Review of Neonatal Critical Care Services in England

Acknowledgements

The Quality Surveillance Team, as part of a national peer review programme gratefully acknowledges the support of the reviewers, and where relevant, of their employing organisation. Reviewers willingly give their time before, during and after each visit and without them the process could not take place.

The Quality Surveillance Team would also like to thank the Neonatal Critical Care Services for their hard work, preparing for this round of peer reviews. Their openness, healthy debate and hospitality during the reviews is recognised and sincerely appreciated.

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1. Introduction

This report summarises the findings of the national comprehensive round of external Quality Surveillance Team (QST) peer review visits to all Neonatal Critical Care Services within England from October 2017 to March 2018.

The scope of the peer review examined three types of neonatal units (NNU); special care units (SCU), local neonatal units (LNU) and neonatal intensive care units (NICU). The structure and process, including engagement with the operational delivery networks (ODN), family experience and clinical outcomes was included within these reviews.

The report principally summarises the numerical data contained within the Quality Surveillance Information System (QSIS) that records the level of compliance by individual services against the neonatal critical care quality indicators. These were based on the National Service Specification E08/S/a, The British Association of Perinatal Medicine (BAPM), Service Standards for Hospitals Providing Neonatal Care (3rd edition), 2010, The BAPM Categories of Care 2011, The National Neonatal Audit Programme (NNAP) 2015 Annual Report on 2014 data, The NHSE special commissioners' Neonatal Quality Dashboard, Toolkit for High Quality Neonatal Services - NHS & Department of Health, October 2009 and NICE Neonatal Specialist Care Quality Standard QS4 2010. Additionally representatives from Bliss were involved in the development of the quality indicators providing consistency against the Bliss baby charter.

Specific comments and narrative from the peer reviewers' is referenced regarding the qualitative information gathered from the peer review visits. The identification of good practice for dissemination and recommendations is an important and positive component of the peer review process. This report highlights examples of good practice that have been identified during this peer review cycle. It should also be noted that the peer review programme used clinical lines of enquiry against clinical outcomes data from NNAP, EMBRRACE and SSQD datasets when reviewing a service.

2. Neonatal Critical Care Service Summary

There are 157 neonatal critical care units within England where a peer review was undertaken. Eight of these units were reviewed alongside another unit within the same Trust with the same clinical lead following the same guidelines, pathways and policies. Therefore 149 reports were produced. All of these services were assessed against the quality indicators. Details of the quality indicators can be seen on the Quality Surveillance Information System (QSIS) at https://www.qst.england.nhs.uk .

There was a range of compliance between 19% and 88% against the quality indicators, with no service assessed as 100% compliant. Compliance has not been broken down to represent compliance against the three levels of unit.

Out of the 157 units two immediate risks were identified through the peer review. A further 98 serious concerns were raised with some units having more than one serious concern raised.

3. Neonatal Critical Care Units

3.1 Compliance with Quality Indicators

Neonatal Critical Care Unit Quality Indicators

The highest level of compliance was 88%. This was achieved by:

- Chelsea And Westminster Hospital NHS Foundation Trust
- Guy's And St Thomas' NHS Foundation Trust
- North Middlesex University Hospital NHS Trust
- Milton Keynes University Hospital NHS Foundation Trust
- Colchester Hospital University NHS Foundation Trust
- West Suffolk NHS Foundation Trust
- Oxford University Hospitals NHS Foundation Trust
- Western Sussex Hospitals NHS Foundation Trust

38 units (26%) achieved ≥ 80% compliance and 11 units (7%) achieved ≤ 40%. The mean average of compliance was 65%.

Table one shows compliance at regional levels.

Table one; quality indicator compliance

	London	Midlands and East	North	South	National
Lowest % compliance	18%	31%	25%	44%	18%
Highest % compliance	88%	88%	81%	88%	88%
Mean average compliance	59%	70%	57%	71%	65%

An overall percentage compliance against each of the quality indicators is provided at both National and Regional level within Appendix 1. There was high compliance Nationally for units being part of a Network and sending representatives to Network governance meetings. A National compliance of 43% was achieved against the quality indicator for named lead roles. A number of the units who did not meet compliance for this indicator were due to there not being defined roles and/or dedicated time for the named lead to undertake the role. Support for a unit from a team of allied health professionals was low at 20%. There were varied levels of support across units at different levels. This was identified as a serious concern in seven units and in numerous units as an area for improvement. There was a lack of a person providing psycho-social support preventing compliance with this indicator.

Nurse staffing compliance was at 24%. If a unit did not meet BAPM standards to meet the indicator, this did not automatically raise a serious concern. There were 13 serious concerns raised against nurse staffing where there were risks or concerns in addition to not meeting BAPM staffing standards. These concerns included the availability of flexing the staffing to meet the needs of acuity requirements of the unit or the layout of the unit. Compliance against the indicator was not met in a number of level 2 and 3 units due to no supernumerary nurse co-ordinator. This was risk assessed and not raised as a serious concern for not meeting BAPM requirements unless there was a concern about the practices. Training for non-medical staff was 55% compliant but this was recognised as an area of growing challenges for units due to the reduction of continuing professional development (CPD) monies for staff to undertake a qualification in speciality (QiS) recognised course. A comprehensive induction programme has been implemented by one ODN which could be developed further to plug this gap. Medical staffing was 64% compliant with 16 serious concerns raised. A serious concern was raised where there was a significant risk or concern and not just that staffing did not meet the requirements of the toolkit. This would include the availability of a medic to attend an emergency while having additional responsibilities or the supervision of junior medics to assess competency.

Compliance of Network agreed pathways at 51% is due to some of the ODNs not having developed all the pathways within the indicator. Despite there not being Network agreed pathways the majority of units were following locally developed pathways.

Facilities for families were 26% compliant. There is a requirement to provide a number of facilities within this indicator. A unit not meeting one of these requirements deems the indicator as non-compliant. It was noted that there was a variation in size of the parents' room and the number of overnight accommodation rooms for parents. Some units were unable to meet this indicator as there were not designated spaces and spaces were multi-functional. Numerous units were unable to provide parents with free car parking facilities and only some able to provide reduced car parking.

3.2 Good Practice Identified at Visits

Numerous examples of good practice or significant achievements were identified in all the units during the visits. These relate to the delivery of the service and can be either innovative or common practice and related to:

- Parent leaflet - A day in the life of… which includes photographs of the unit including equipment
- 24 simulation sessions per year
- Development of the Breast Milk DVD aimed at high risk antenatal women whose unborn infants are at an increased risk of hypoglycaemia immediately following birth.
- Information Boards prepared by student nurses on placement on the unit.
- Second eyes project

- Jaundice screening service to reduce readmission rate and waits within Accident and emergency.
- The induction and career progression training packages available for all levels of nursing staff which is comprehensive and goes beyond developing the competencies of new starters and is a good retention tool for staff career progression.
- Availability of a daily rapid access clinic where parents can bring babies in for assessment if experiencing difficulties therefore reducing hospital re-admission rates and improving patient experience.
- Addressing medication error root cause analysis, specific governance forum led by pharmacist.
- Network induction programme for nurses.
- The involvement of a play specialist across both sites.
- Cot side card/diaries for communication between parents and nurses.
- Noah's Star charity; led by ex-parents/carers of babies cared for by the unit provide tea trolley round giving support to families on the unit.
- Good links with the local hospice and established palliative care pathway.
- Neonatal newsletter for parents.
- Governance/incident feedback newsletter to staff.
- ODN meeting feedback sheet within a page.
- Baby hat colours, identifying different condition/treatment.

3.3 Immediate Risks and Serious Concerns identified at visits

Immediate Risks

An immediate risk is an issue that is likely to result in significant harm to patients or staff or have a direct serious adverse impact on clinical outcomes and therefore requires immediate action.

Two centres, had one immediate risk raised, this is detailed below:

The milk storage room where ready feed milk is stored has temperature issues. Ready feed milk should be stored between 5 and 25 degrees Celsius to maintain stability of the product as per manufacturer's instructions however, on the day of the peer review visit, the room temperature was reported at above 25 degrees Celsius despite the door propped open to allow cool air to circulate. Products stored above the recommended temperature can potentially degenerate in nutritional value which would have a direct adverse impact on the health and development of babies and clinical outcomes.

The units where the immediate risk was raised was aware there was a temperature issue within the storage room and had the risk on the Trust risk register. When identified by the reviewers this was rectified immediately by the team. The unit

relocated the ready feed milk to a temporary storage area until the room was made to maintain a suitable temperature.

Serious Concerns

A serious concern is an issue that, whilst not presenting an immediate risk to patient or staff safety, is likely to seriously compromise the quality of patient care, and therefore requires urgent action to resolve.

The 98 serious concerns raised were categorised and related to;

- Medical staffing (16 serious concerns)
- Nurse staffing (13 serious concerns)
- Facilities and parental support (8 serious concerns)
- Capacity (7 serious concerns)
- Cot space (7 serious concerns)
- Allied health/pharmacy provision (7 serious concerns)
- Infection prevention (6 serious concerns)
- Data (5 serious concerns)
- Clinical guidelines (5 serious concerns)
- Clinical governance (5 serious concerns)
- Equipment (3 serious concerns)
- Outreach service (2 serious concerns)
- Leadership (2 serious concerns)
- Admission hypothermia management (2 serious concerns)
- Health and safety (2 serious concerns)
- Readmission rates (1 serious concern)
- Information governance (1 serious concern)
- Two year follow up (1 serious concern)
- Diagnostic testing availability (1 serious concern)
- Security issues (1 serious concern)
- Working outside of clinical guidelines (1 serious concern)
- Compliance with service specification (1 serious concern)
- Patient information (1 serious concern)
- Out of date nursing resources on intranet (1 serious concern)

The relevant Trusts have responded detailing how the immediate risks and serious concerns will be addressed. The plans have been formally handed over to the relevant local specialised commissioning hub to monitor progress with the implementation of these plans.

Table 2; Regional overview of immediate risks and serious concerns

Region	Number of	Number of	Number of	Ratio / % of

	immediate risks	serious concerns	regional reviews	risk/concerns raised
South	**0**	**11**	**39**	**11:39 (28%)**
London	**1**	**9**	**26**	**5:13 (39%)**
Midlands	**0**	**36**	**43**	**36:43 (84%)**
North	**1**	**42**	**49**	**43:49 (88%)**

Areas for Improvement

Areas for improvement are issues that affect the delivery or quality of the service that does not require immediate action but can be addressed through the work programmes of the services. Centres had concerns raised with concerns relating to;

- Medical staffing
- Nurse staffing
- Allied health and pharmacy support
- Robust attendance records at
- Less than 70% of registered nursing staff holding qualification in speciality (QiS)
- Limited access to accredited NLS training for medical and nursing staff
- Lack of robust feedback from parents and implementation of development following feedback
- Lack of written information relating to financial support and support services
- Lack of free car parking
- Dedicated facilities for breast feeding
- Secure storage for parents
- Data collection
- Cot capacity
- Lack of supernumerary shift coordinator in LNU and SCU
- Lack of psycho-social provision

There was a noted variation in the provision for storage of expressed breast milk (EBM). This may be due to a lack of formal guidance for units on best practice considering the conflicting demands of safety against parents' ability to access to their own EBM.

4.0 Future Neonatal Critical Care Compliance and Reviews

On an annual basis the QSIS portal provides the facility for the initiation of the annual service specification compliance process with provider self-declaration. The portal will enable the service provider to upload their annual declaration and commissioners, including service specialists, lead nurses and supplier managers along with the QST to review and update the status of services. The outcome of these discussions should

be recorded on the quality portal and will determine regional priorities for peer review visits in the following year as well as actions for regional teams in terms of on-going monitoring and surveillance. This also allows for a national service specification compliance process and annual assessment to identify areas / services where outcome are at risk of not being achieved.

Equality Statement

"Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

• Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;

• Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities."

Appendix 1: Overall percentage compliance quality indicators

Quality Indicator and Short Description		National % Compliance	London	Midlands and East	North	South
E08-17-001	The NNU is part of the ODN network governance group	97%	85%	100%	100%	100%
E08-17-002	The NNU is represented at network governance group meetings	91%	81%	98%	86%	98%
E08-17-003	There are named personnel for lead roles	43%	44%	53%	22%	62%
E08-17-004	There is a multidisciplinary team of specialist AHPs	20%	22%	25%	18%	17%
E08-17-005	The NNU meets the requirements for medical staffing	64%	89%	77%	47%	55%
E08-17-006	There is 24/7 consultant neonatologist advice	97%	85%	100%	100%	100%
E08-17-007	The NNU meets the requirement for nurse staffing	24%	22%	35%	8%	33%
E08-17-008	There is training for registered and non-registered nursing staff	55%	52%	45%	57%	63%
E08-17-009	There are integrated community support/ outreach services	71%	78%	70%	67%	74%
E08-17-010	There are network agreed pathways in place	51%	33%	83%	25%	63%
E08-17-011	There are clinical guidelines for the care of babies on the unit	88%	70%	98%	81%	93%
E08-17-012	There is a clinical governance process in place	86%	85%	80%	84%	98%
E08-17-201	Parent/Carer feedback is reflected in service development	80%	70%	90%	75%	85%
E08-17-202	There is information for parents and carers	63%	41%	65%	59%	81%
08-17-203	There are facilities for families	26%	22%	23%	14%	50%
E08-17-204	The NNU undertakes an audit of family centred care	74%	37%	85%	78%	81%