



The Northern Neonatal Network

An Operational Delivery Network

Annual Report 2015-16



The Northern Neonatal Network. Our year 2015-16 at a glance

- Following the publication of its Invited Review Report in August 2015 by an independent external Panel from the Royal College of Paediatrics & Child Health (RCPCH), the Network has worked with the main stakeholders involved across the four Trusts involved and NHS England to bring about implementing its recommendations – this process is now well under way with appropriate and inclusive working groups to verse it.
- In late September, the Network drafted and submitted a business case to NHS England for a standalone, newly funded neonatal transport team, to be hosted at Newcastle upon Tyne Hospitals NHSFT but provide a Network-wide service. We were delighted that this was accepted in the Spring of 2016 by the commissioners and funding has been agreed with recruitment to the new posts starting in the summer. To be titled "NNETs" (Northern Neonatal Transfer Service) this will be based on a new model with Advanced Neonatal Nurse Practitioners (ANNPs) delivering the care with teams of nurses supporting them under the leadership of a new Neonatal Transport Consultant.
- A significant amount of work was put in during the year by the Network in conjunction with Health Education North East (HENE) to create a local course for the training of Advanced Neonatal Nurse Practitioners (ANNPs) with a suitable local university. It was originally hoped that this could be in place for the Autumn of 2015, but uncertainty about the budget for HENE meant this could not be confirmed. At the time of going to press, an open tendering process is under way to choose a Higher Education Institution (HEI) to provide this with the first cohort to start their studies in September or October.
- The new Educational Lead role that we created in late 2014 has continued with the recent appointment of Dr Richard Hearn in January 2016. We are looking forward to him working alongside key professionals from across the Network to build on our existing training and educational priorities as well as looking at new and innovate ways to equip all our staff to maintain and develop their clinical knowledge and skills.
- We started a new Network-wide Parent Survey to gain feedback on key aspects of their baby's care and their ability to get involved in this. This will be an ongoing piece of work and is designed to highlight areas of good practice that can be shared and also where improvements can be made.
- The Network has continued to promote family-centred care with the support of its BLISS Nurse, who has worked to help Units undertake the BLISS Baby Friendly Accreditation Scheme (BFFAS) audit. It is hoped one or more will gain full accreditation next year
- The Network supported over 200 of its staff by fully funding their places so they could attend a wide range of locally-facilitated and funded courses, conferences and workshops, as well as key national events.
- We have continued to facilitate our quarterly clinical forums and meetings to focus on key issues in a proactive way and agree appropriate collaborative solutions and also refined our quarterly reports to look at new data metrics, highlighting any potential issues and areas that may need further analysis and discussion to enable improvements to care to be made.

Introduction by the Northern Neonatal Network **Host Sponsor Chief Executive – Ken Bremner**



As I highlighted in my introduction to last year's introduction, the publication of the Invited Panel from the Royal College of Paediatrics and Child Health (RCPCH) following their review of neonatal intensive care services across the Network was always going to be an important milestone. It has been clear for some time that the current configuration across the north east is not going to be sustainable in the long run and it was very clear that the College had a vision for how that could be addressed. The details of their recommendations and how the Network is responding can be found elsewhere in this Annual Report, but as a community of Chief Executives in the Foundation Trusts, we are committed to working with them in order to bring about the changes necessary to ensure the very highest quality neonatal care is available to all families across the north east and north Cumbria.

The sort of issues that the Network is grappling with are mirrored elsewhere across the NHS amidst a backdrop of unparalleled challenges and it is certain that the NHS needs to further develop and change in

response to these, which is why we are starting to look at closer collaboration and strategic partnerships with other providers to try and address this. Very recently we have created an alliance with South Tyneside NHS FT and set up the South Tyneside and Sunderland Healthcare Group to look at jointly providing some clinical services. I think this is going to be the sort of approach other providers will start to take across the region and the Network can help to support such initiatives as we plan together for the future.

It was very pleasing to see that NHS England positively received the business case that the Network made for a new neonatal transport service, which was in response to another of the RCPCH recommendations and which they have committed to fully fund. Once the service is up and running this will ensure the movement of babies and their families across the region works in their best interests and provides a first class service at critical times for them.

This Report also contains a useful summary of the other priority areas and work streams that the Network has been busy delivering on over the last 12 months and it is certain this will continue as they set about delivering on their Work Plan for this year too. It has recently been announced that NHS England are planning to undertake a National Review of neonatal services and once completed, this will need to be duly considered in conjunction with the Maternity Review that was published earlier this year in order to ensure the appropriate planning of services which are co-dependent and it is again here that the Network can play a pivotal role.

Finally, it has again been encouraging to see the response to the second annual Sam Richmond Nursing Scholarship that the Network launched successfully last year and I was delighted that the winner was Emily Nelson, one of the sisters on the neonatal unit here at Sunderland. Her success is also featured separately in this Report. I am sure that there will be another excellent series of applications when this year's Award is opened up and I wish this ongoing venture well and look forward to meeting the next winner in due course.

Foreword by the Northern Neonatal Network Board
Chair – Deborah Jenkins



As pressure mounts on NHS services across the country, the work of the clinical networks seems increasingly important. Although reconfiguration decisions remain political, we can continue to promote mature and supportive relationships between clinicians which go beyond the interests of the organisations that pay their salaries. In our own case, the driving concern is to provide the best possible care for premature babies and their families across the North East and North Cumbria, and in the last year we have seen many examples of sharing, learning, debating and imagination between professionals working in very different units, each of which is facing its own problems.

For some the main challenges are to do with capacity and finding enough money to meet demand. For others the key issues are finding staff to keep a remote service safe. All of us struggle with work-force problems, and none of us have as much funding as we think we need. The commissioning environment remains unclear. The ambitious central plans for reconfiguration driven by increasing financial desperation thunder around the skies above us in a sort of NHS Valhalla, and it is easy to feel completely disconnected from the levers of influence.

Nevertheless, we must remain true to our purpose, which is to do everything within our power to improve the services we deliver, no matter what obstacles may be in our way. We can continue to deliver interesting and relevant training courses to all our units. We can continue to share technical problems and work out the best solutions. We can continue to put the clinical case for better collaboration or modest funding increases, provided we can demonstrate that we are genuinely driving out waste in every aspect of our work. Above all, we have it in our power to work together as colleagues and friends across our region in a common pursuit of excellence to the benefit of babies and their families.

We have been disappointed by the failure to create a strong local course for ANNPs despite three years of effort, but will return to the charge and ensure that we find a better outcome next year, now that the funding has been awarded.

We are proud of the increasingly strong links between the clinicians on Teesside which are building a better integrated service in the wake of difficult reconfiguration decisions.

We are grateful to all those who have contributed during the year to a programme of events, courses and conferences to increase the skills and knowledge of our clinicians, nurses, managers and AHPs across the patch.

On a personal note, I would like to thank the Network team, and in particular Martyn, who has continued to maintain a national profile for us through his leadership of the national neonatal ODN Manager's Forum and his role on the Bliss charity Board, in addition to piloting us all through a year of complication and uncertainty. We have all been working at such pace that we have often made his job more difficult by our failure to respond.

The Network is a valuable asset to all of us, and I hope that in the coming year we will all contribute to its success as a vessel of stability in an increasingly unstable world.

Report from the Northern Neonatal Network **Manager - Martyn Boyd**



I think it is fair to say that the past 12 months have been amongst the most challenging we have faced during our time as a formal Network. The Report from the RCPCH did not cut any corners and was very clear and stark in highlighting not only the main recommendations for the reconfiguration of neonatal intensive care services, but also in other areas the Invited Review Panel felt we could and should make changes, some of them urgent. We already knew about many of these and it was a case of their Report simply highlighting this from an independent perspective, but it has also prompted some serious focus on other areas where we could improve things and we were grateful to the College for their work.

The main 3 areas the RCPCH concentrated their Report on were as follows;

1. Reconfiguration of NNN NICU services
2. Neonatal Transport
3. The role of the Network itself

To summarize each of these in turn, the main reason for the Invited Review followed a Network attempt to move forward with a strategy for the sustainable provision of safe, high-quality, cost effective neonatal intensive care services that takes account of the major challenges that the NHS and our specialty in particular are facing. Previous Annual Reports have highlighted these and indeed, last year's anticipated the RCPCH report that followed and

outlined the background to them being invited to undertake an independent review in the first place. After a series of site visits and extensive consultation and discussions with staff across all four sites currently providing intensive care (Newcastle, Sunderland, North Tees and Middlesbrough), the Panel published very clear recommendations, along with the rationale behind them suggesting a model that would address the needs of the populations we serve and also the challenges being faced now and in the future.

The main headline from this recommendation was that they agreed that four NICUs was not sustainable in the long run and suggested that there should be just one serving the Tees, based at James Cook University Hospital (JCUH) in Middlesbrough, with North Tees continuing to provide neonatal care, but as a Special Care Unit (SCU). They also recommended a new approach in the north of the region, with changes to patient pathways at Sunderland that would seem them continuing to provide intensive care to babies over 26 weeks gestation, but concentrating the care of the very smallest babies below this in Newcastle. They also suggested that there should be closer collaboration and co-operation across the northern and southern "hubs" between the staff.

This was felt to be quite a radical approach, although much of the RCPCH "solution" was not unlike what the Network itself had concluded in the summer of 2014, although at that point no specific sites had been suggested for the changes needed, despite all stakeholder agreeing with the conclusion that continuing to provide intensive care on four separate sites simply was not sustainable for all the reasons previously highlighted and discussed and being faced elsewhere across the NHS – the challenges are not unique to either neonatal care nor our region.

Translating this into action has not been easy however and naturally people are concerned about the impact of such changes on the local populations affected, so there are quite detailed consultation processes to go through which is now happening. However, the bottom line remains that any changes have to be primarily in the best interests of the babies and their families and about ensuring the highest possible quality of safe, sustainable care. Collectively we are committed to this and many people are now working hard across organizational boundaries to implement the required changes, acknowledging the size of the task and challenges involved, but accepting that further unnecessary delays may start affecting patient care and safety, which must be avoided at all costs as the RCPCH were very clear to highlight in their Report.

The second area that the Report highlighted as one needing urgent change was neonatal transport services. This was actually an area we had been addressing as a Network priority anyway and previous Annual Reports have detailed the work we have undertaken, including the unsuccessful attempt to have a combined paediatric/neonatal (“PIC/NIC”) service commissioned by NHS England. In the aftermath of that decision, we had already started working, as we were requested, on a new business case for a fully-funded, stand-alone neonatal transport service. This resulted in a submission to the Commissioners in late September 2015, which was duly considered and as reported elsewhere by the lead NHSE Commissioner, accepted at the end of the financial year, so work is now fully under way to recruit the staff needed to run the service.

After discussion with the current teams, it was felt that the most sustainable model to provide a high-quality service should be based at the RVI on an Advanced Neonatal Nurse Practitioner (ANNP) led solution, with oversight and leadership from a new Transport Consultant and delivery by 2 teams of transport nurses with support from new call handlers to enable a new and consistent way of responding to requests for the transfer of babies around the Network and beyond.

I think it is only right to highlight the excellent service that has been provided for over 20 years by the two transport teams currently based at the RVI and JCUH in Middlesbrough. This has never been a “fully-funded” service in the sense that the staffing has not always been separate to the clinical teams where they are based (particularly at JCUH) and this has increasingly put a strain on the cover available there when transport has been needed and doctors and nurses have left to provide this. The fact that despite these pressures we have had such a good local service underlines how well the teams have worked under increasingly challenging circumstances so it needs to be acknowledged accordingly. This was an aspect that the RCPCH were especially concerned about and why they flagged the need for urgent action to create a new service as such a priority. This mirrored our own work to seek a solution and helped the case we made. Recruitment to the key posts is now well under way with the first trainee ANNPs expected to start their course this September. As they complete their training the current two-team service will gradually transition until a full service is provided by the new team in a few years time.

The final part of the RCPCH recommendations highlighted some areas where the Network itself needed to focus and change. Although it was not the primary remit to look at the Network itself, it was helpful to get some feedback from an external independent panel on how we could further improve our functionality and governance and we had already started this and will make further changes as we agree and are able to allow us to collectively better meet the needs of our stakeholders. This also applies to the commissioners as was also picked up and we have committed to bring this about in the coming months and years, although much of what we needed to start addressing necessarily needed us to have a better understanding of how reconfiguration would look and need to be undertaken in order for other associated aspects of our work to then flow from that. I think it is fair to say that the Network was subject to a high degree of scrutiny that other neonatal networks have not been and it was reassuring to have areas of good practice reflected and acknowledged but at the same time having that independent light shone to enable us to prioritise our response in a better way. As a Network we thank the RCPCH Panel for their Report and recommendations and the way it has given us focus and direction for the future priority areas we need to address.



As you will see from the various updates in this Report, the Network has had a very busy year and whilst there have been some challenges and changes with some personnel, we have managed to deliver on our key priority areas for last year and are already making significant progress with this year's too. We have recently seen Dr Richard Hearn take over the mantle of Educational Lead from Dr Osama Hamud and we look forward to his input in the future. Richard has already provided a significant amount of support in the past to the Network's education and training programme and he has some ideas for further development that we are very keen to undertake, including delivering more clinical discussions and case reviews across the SCUs. He has outlined some of this in his own update in this report and the separate section at the end.

As well as the successes and progress we have made in our key priority areas, there have also been some disappointments, most significantly and very recently when we discovered that all our plans and work to create a local course for training ANNPs in conjunction with one of the local universities had been unsuccessful. This has been particularly frustrating as we have been working towards this since October 2013 and as last year's Report highlighted, with the support of Health Education North East (HENE) following their decision to support a course with funding, very hopeful that a suitable local solution could be created. Unfortunately, we recently discovered that no local university tendered to run the course. This is very disappointing indeed as the priority to train ANNPs for a variety of clinical service needs has been evident for many years, hence our work in this area.

The inability to create a suitable local course to address this is problematic, but at the time of going to press, it seems we have an interim solution with the option of HENE funding places at Sheffield for this coming academic year and possibly beyond. Whilst not ideal, it does mean that we can train enough ANNPs for the priority areas that have identified them and also aim to explore possible future options to see if there is still any potential to create a local course once we better understand the reasons and contributing factors that led to no tenders being submitted. This may lead to us being able to revisit the process for future years.

At the national level, one of the main developments during the last year was the publication in March of the "Better Births: Improving outcomes of maternity services in England. A Five Year Forward View for maternity care" Report following a national maternity review overseen by Baroness Cumberlege.

There were specific references to neonatal care on the report, many referencing the need to ensure we work closely with maternity to ensure care is provided as, when and where needed, but interestingly, there was acknowledgement that the scope of the maternity review could not also include a detailed review of neonatal services and that therefore a separate national neonatal review should be undertaken.

As a result, NHS England has started the process for such a national review and I am part of the core steering group that will be involved in this. I am very keen to ensure we grasp the opportunity being afforded to us in "getting this right" to enable a final report with suitable, appropriate but also *deliverable* recommendations to be made in order to focus on how we provide neonatal services in England for many years to come. We know the size of the challenge, but we cannot ignore the current strains on the NHS in general and neonatal services in particular, so need to be both frank and realistic in acknowledging these and also the possible options to address them. I am hopeful this Review will provide that.



Once again, it is frustrating to report that as things stand, no long term funding mechanism for Operational Delivery Networks (ODNs) has been agreed beyond April 2017. A "review" of ODNs and their funding, including some potential options for the future was undertaken in the spring time, but we are yet to hear how the results will translate into firm recommendations, which

obviously creates ongoing uncertainty. After so many years of just not knowing and rolling over “transitional arrangements” that were only originally supposed to last a year, it would be nice to have clarity and hopefully that will come in the next few months, finally allowing us to make longer term strategic plans than we have been able to so far.

On a more positive note, it has been both very pleasing and encouraging seeing some of our own neonatal staff being recognized for their work on the national stage. As well as the ongoing research projects that many of our Units are not just involved in but actually leading on through the leadership of senior medical staff, there have been some notable individual successes during the year too. In November, Claire Campbell (Sister, Ward 35 NICU, RVI) was shortlisted as one of the final 8 in the prestigious Nursing Times “Nurse of the Year” Award. Although Claire was unfortunately not the eventual winner, it was a significant achievement and huge honour to reach the final 8 in recognition of her work on the Unit. Then the following month, Jo Chubb, (Sister, NICU at James Cook Middlesbrough) was awarded a Florence Nightingale Foundation travel scholarship that will enable her to explore how neonatal transport services are provided across the UK and Australia too, which is excellent news. Also, as this Report is being drafted, Claire Ellerby (Sister, Ward 35 NICU, RVI) has been shortlisted as a finalist for the RCNi Child Health Award category for work introducing a new method that promotes bonding on the NICU. Well done to all these nurses and we celebrate their success and excellent achievements!

In summary, I feel the Network has once again achieved much to be proud of over the last 12 months and we have continued to deliver our main aims and objectives according to the priorities we agreed and set in our Annual Work Plan. We know we face unprecedented challenges across the NHS in the coming years and are faced with some very difficult decisions and choices ahead in our ongoing mission to provide the very highest quality neonatal care. The people working in all of our Units do an amazing job in often difficult circumstances and we know from the feedback we collect it is truly appreciated by the parents and families of the babies cared for on them. I would like to close by once again paying tribute to each and every one of them and the dedication they show every single day of the year as well as my colleagues across the network itself for the support they give in trying to ensure we help to underpin that work, both to myself and the Units themselves.

Report from the Northern Neonatal Network **Clinical Lead – Dr. Sundeep Harigopal**



As I write the report for the sixth Northern Neonatal Network Annual report, I am pleased to say that we have made significant progress towards the aims that the Network had set itself. The last year has been particularly busy but also productive towards achieving some of the goals. We need to continue to build on the momentum to ensure that we continue to deliver equitable, high quality neonatal services in these changing times.

The RCPCH external review was commissioned by NHS England (NHSE) following recommendation from the Northern Neonatal Network. The report published in August 2015 made the following recommendations:

- 1) Independent 24 hour neonatal transport service
- 2) Configuration - RVI to be a quaternary service, Sunderland to deliver intensive service for babies at 26 weeks gestation and above, Teesside to have one neonatal intensive care unit at James Cook University hospital and a SCBU at North Tees.

Following consultations between the regional Oversight and Scrutiny committee, N Tees trust, NHSE, Better Health Programme and the Network it

has been agreed to develop a Teesside neonatal service with intensive care for all babies delivered at James Cook neonatal unit and N Tees will continue to care for babies from 27 weeks onwards as an initial step in view of the wider reconfiguration of acute service across Teesside (Better Health programme). The Network and NHSE would review this position if there was unacceptable delay with Better Health Programme.

We have calculated that that Network would need to expand by another by another 7 cots to carry out the recommendations. This is only for NICUs and work is under way for SCBUs. There is recognition that there needs to be expansion at RVI to achieve reconfiguration and we have received support from trusts providing intensive care regarding cot capacity to carry out the recommendations as mentioned above and await NHSE reply.

I am pleased to inform you that recent meetings with James Cook and North Tees have been very encouraging towards reconfiguration across Teesside. Work is already underway to achieve this and significant progress is expected in the next 12 months.

Another major achievement has been towards transport. The Network has secured funding from NHSE for an independent neonatal service that will be hosted by Newcastle trust. Northern Neonatal Transfer Service (NNeTS) will be an ANNP delivered service. There has a rapid development over the last few months with appointments being made for NNeTS to include ANNPs, trainee ANNPs, transport nurses and a dedicated transport consultant. As this is a new model of delivery it will be a few years before it is fully functional in its intended form.

The Network has also secured funding from Health Education North East for training ANNPs. This will have a significant impact delivering high quality neonatal care at time of shortage of medical workforce. We have developed links with Sheffield University for our nurses to undertake ANNP training and I would like congratulate Lynne Patterson and Martyn Boyd for this.

The Network has always had education as high priority from its inception. We continue to make significant progress in the field. We have recently appointed Dr Richard Hearn to the post of education lead who supports the delivery of regular stabilisation courses and simulation workshops to train and maintain

skills in stabilisation and resuscitation. The guideline group has successfully developed a repository of guidelines and continue to build on this. There have several other initiatives to improve governance structures. This includes case discussion sessions at SCBUs. There are clear pathways for care for NICUs and SBCUs. The Network continues to facilitates discussions been nursing managers, clinicians to discuss ways of improving care. We are in the process of developing an inter-unit peer review process to discuss neonatal deaths. The Network has successfully run two NNN Research days that has received excellent feedback will now become a regular event like the annual conference.

Although the last 12 months has being challenging at times with difficult negotiations, I would like to say that we come some way achieving agreement in the direction of travel for the model for care we would like to deliver whether it is transport or reconfiguration. However I believe that it is vital that we have the full support of NHSE and provider trusts achieve it.

Finally I would like to thank all my Network colleagues and special thanks the Network officers – Martyn Boyd, Lynne Paterson, Sue Thompson and Richard Hearn for their hard work and dedication.



Report from the Northern Neonatal Network **Nurse Lead – Lynne Paterson**



Another year over and I'm not sure where the time has gone. The Network and region has been a busy place in the past twelve months.

We have had another worthy winner of the Sam Richmond Nursing Scholarship, Emily Cameron, Sister on the Neonatal Unit at Sunderland who I know will do good work looking at bereavement support for neonatal nurses. However can I also say that the standard of the nominations this year was very high and so we are keen for staff to get their thinking caps on again for the next year so feel free to apply and remember that we are here at the Network Board to help you with your application ideas, so please just ask.

Much of my time in the last year has been spent attempting to get a local Advanced Neonatal Nurse Practitioner Programme up and running in the north east for our staff. The sad news is that this will not happen at the moment closer to home, but the good news is that Health Education North East (HENE) has agreed to fund the programme for our staff for the first three years elsewhere. We have therefore agreed with the University of Sheffield that our students will attend there for their training. HENE will fund the first two years of a postgraduate programme, with the third year for a Master's degree being funded locally by individual Trusts, since thus is the standard we expect. We are therefore looking forward to getting some of our local staff

sent off to undertake this programme including the first of the trainees who will make up our neonatal transport team in the future at Newcastle. So things are moving forward in a positive direction.

We have also been trying to work on the new Qualification in Specialty (QIS) standards for our local neonatal training modules but this has been hampered by the University tenders that have gone out again from HENE. Many of you will know that there have been standards published for England last year that we now need to incorporate into our neonatal nurse training. This is quite structured and includes anatomy and physiology and a much more in-depth programme of theory and clinical competencies. We will be moving forward with this and the Networks responsibility to deliver a foundation training programme for new and junior staff, so keep looking on the website for this to be advertised.

I am also pleased to say that I have been involved with several other network staff in trying to get a nurse, midwife and allied health professional (NMAHP) neonatal research group up and running. This is the second year of a Neonatal Network research meeting but this year we were trying to put more emphasis on this particular group of staff. There has been good interest in this but we are also looking to grow and increase this group with the objective being that we provide some local teaching and support for those interested in developing some future research. We therefore hope to have some tangible outputs from the group that will lead to improvements / advancements in care; so this is really exciting. It is not too late to join this group and we will be having a follow up meeting later in the year or early 2017. Dates will be published on the website.

Over the next year I hope to further develop the QIS and foundation programme as well as the research group and look forward to including you in this. I also hope to be addressing nurse staffing levels and to look in a bit more detail at a manpower strategy. Within this we have over the last year been discussing the use of health care assistants and how we can share and spread some of the staffing models such as these that we use in some parts of the region, but not all in order to improve our resources. Once again I look forward to working with you all in order to achieve this and continue to develop our Network.

Report from the Northern Neonatal Network **Educational Lead – Dr. Richard Hearn**



I took up the position of Network Education Lead in February of 2016 having been involved in delivering some of the Network's educational commitment in the form of the Stabilisation course over the preceding 2 years.

The first priority on taking up the post was to run the respiratory study day, a few weeks later. This has been part of the nursing intensive care model for 4' years now. It was a challenge putting together a faculty at short notice but the day was well supported by Dr's Imran Ahmed, Jans Janakiraman & Prashant Mallya and of course the organisational skills of our manager Martyn Boyd. Having had the opportunity to see how the day runs, there is the opportunity to revise a significant amount of the existing teaching material should the day run again. This is very dependent on the structure of future intensive care modules.

Subsequent to the respiratory day the two main threads of work have been continuing the stabilisation course and setting up case reviews in the regional Special Care Units (SCUs).

The stabilisation course has run in Cumbria this year and has Durham/Darlington dates in the autumn with dates to be arranged for Northumbria and South Tyneside/Gateshead subsequently. The date delivered ran well and looking forward to the rest of the dates the biggest challenge is finding dates which suit both the faculty, candidates and the availability of venue.

Sadly two of the courses have been cancelled this year due to difficulty in releasing staff from their clinical posts. Should this be a recurring problem it will make it more difficult to run the course in the current format and will require consideration at Network Board level.

There have been two case review afternoons delivered, one each in Northumbria & Cumbria with further dates in the autumn. These have again been well received and the Cumbria date made very good use of their telemedicine service allowing input from both Cumbrian services. My hope is that this format will allow more discussion about the complex cases we move around the region and strengthen the clinical governance around the new transport service as it develops. I am particularly keen to make use of any telemedicine resources available within the region and see this as a method of increasing our ability to deliver and participate in educational opportunities.

There is a wealth of experience in our medical, nursing and allied professions within the region and I would be keen to hear of any suggestions for future educational sessions and would encourage anyone to make contact with myself or Martyn Boyd with suggestions.



Report from the Northern Neonatal Network **Data Manager – Mark Green**



Work undertaken in the last year

A large piece of work that was undertaken in the last year was the modelling work to support the reconfiguration recommendations as outlined in the RCPCH report that was published in August 2015. This modeled patient flows based on a number of different scenarios, and looked at the impact of activity, staffing and cot capacity based on these patient flows. This work is currently ongoing.

The quarterly report has been redesigned into a more readable and shorter format, but has more data included, and more relevant information; NNAP indicators, term admissions, average length of stay and transitional care have been added to the activity and transport data that have always been included in the report. There is now a full years' worth of the new report on the network website.

A new unit report has been recently developed; this is an individual report for each of the SCBU's in the network. The reason we decided to do this report was in the hope that it helps the units with data quality, data completeness and to give a snapshot each quarter of their own activity, rather than a network report. This is sent to each unit and there has been some positive feedback. This report is still under development and will be modified over time to fulfil

the needs of the units and to report on what they feel is important for them. As always feedback and suggestions are welcome.

The parent survey has been active now for 10 months and the first 3 reports have been produced and sent to the units. This report highlights the views of the parents, and the good and bad experiences they have had whilst on the units. This work is ongoing.

The data manager's forum takes place in London twice a year. This is an opportunity for the data managers of all the neonatal networks, as well as NNAP, NDAU and Clevermed to meet and discuss current data issues and what other networks are reporting and what is happening in other parts of the country with regards work is being undertaken, and any research projects that are currently being done.

Continuing to support the units in BadgerNet, keeping the units informed of any developments and changes to the BadgerNet system, and distributing any correspondence as appropriate.

Routine data collection and ad-hoc requests.

Future and ongoing work

Support and equip units/trusts to move towards National Specifications and recommended minimum staffing levels by providing timely, accurate and validated quarterly NNN staffing reports for each unit. To provide annual network summary and performance report based on units meeting of BAPM recommended staffing levels for each unit.

Monitor agreed network patient pathways to ensure appropriate care is provided according to unit level of care. Provide regular annual reports, by unit, highlighting patient pathway compliance and incidences of variation.

Review and revise regular unit & network level reports highlighting quality indicators, focusing on trend analysis and performance monitoring indicators. Develop and publish ongoing quarterly reports at unit and network level utilising new key performance metrics and unit compliance with identified audit measures. Explore potential use of collated Badgernet dashboard data to

create dedicated simplified reports.

Collaborate with maternity SCN to equip obstetric colleagues with data highlighting appropriate maternity care metrics that influence neonatal outcomes. Utilise existing national quality reporting stream from annual NNAP report to provide detailed, timely feedback to maternity SCN leads highlighting Trust level performance on key indicators affecting neonatal outcomes.

Provide units with timely reports allowing identification of babies due 2-year follow-up assessments and reporting of 2-year outcome data according to national specification requirements and NNN NorBOS aspirations. Quarterly reports to be summarised and sent to unit lead clinicians highlighting forthcoming due 2-year assessments, and identifying babies due and subsequent entry onto Badgernet.

Provide supportive role to individual units for Badger data entry and reporting enhancements to increase familiarity with systems and maximise potential. To provide support for Badger users across the network. Assist data leads with requirements to enable compilation of annual reports.

Support commissioner activity data requirements. Produce quarterly summary of unit activity levels across HRG/care levels according to NHSE requirements, supplied to CSU for anonymising, then distributing to Trusts for validation/checking.

Support transport teams with audit/reporting of activity and responses utilising quarterly network reports.

Oversee completion of required information for app templates ensuring system in place for parent feedback and network liaison to enable new reporting at unit/network level.

Report from the Northern Neonatal Network **BLISS Nurse – Sue Thompson**



This is my third report for the Network and finds me coming towards the end of my role as a 'Bliss' funded family support nurse in the Network. Once again I would like to thank all 11 of our units for their support and participation in the various areas of improving family centred care across the Network.

The following areas are where we have developed as a Network in the last 12 months.

Bliss Baby Charter Audit and Bliss Family Friendly Accreditation Scheme (BFFAS)

All 11 units have completed the audit and submitted it to Bliss, with several units successfully applying for £10,000 from the grant fund to improve facilities for families on their units. Units have improved parent accommodation, both day/waiting areas and bedrooms, applied for developmental care aids and used the money towards building new parent/sibling areas. Grants are no longer available, but the improvements to all units are continuous throughout the Network.

Bliss acknowledged the Network's commitment to improving family centred care through promotion of the audit and we continue to be one of two pilot sites for BFFAS. I hope that some of our units will be amongst the first to achieve the BFFAS mark of commitment to family centred care. We currently have one unit in the process of accreditation and several others ready to start.

Northern Neonatal Network App

The Network continues to fund an app for 3 years to help ensure parents have the most up to date information about all 11 units, access to accurate information about caring for their baby in a neonatal unit and the ability to give feedback about the services they received from the units in the Network.

Thank you to all the staff who ensure the information within the app is updated and relevant. We have added extra information this year into the section 'Help for Parents' as various charities have approached us to be included. Publicity information and individual parent cards are available on every unit, however the success of the app depends on all staff in the Network ensuring families are aware of it and how to access it; this is a fantastic tool for families and staff.

Network Parent Satisfaction Survey

A single parent survey is now in use across all units in the Network, with a quarterly report generated for unit managers to share with staff and families. The aim of this survey is to evaluate and share good practice and allow units to benchmark within the Northern Neonatal Network. This survey is given to all parents prior to discharge home, with the aim of completion before leaving the unit to maximize completion.

Parent Representatives

As a Network we are currently reviewing the role of parent representatives, we currently have 3 parents who have been interviewed by Bliss and can support the Network. It continues to prove difficult to engage parents in this voluntary role, and also difficult for them to attend Network meetings. As such we are planning a day later this year where we actively invite parents from all units to attend and share their experiences with us. We will facilitate this day with an external company who can also deliver a report of parental experiences in the Network.

Family Support Groups

I am pleased to report that all four level 3 units now offer support to parents after discharge from the unit in the form of a well-attended family group. A fifth and sixth group has also been established to cover the families from University Hospital of North Durham and South Tyneside, with more groups in the planning stage.

Bliss Volunteers

As part of the new Bliss strategy the role of volunteers will be increased to cover all areas of the country. Bliss are currently reviewing the training programme for volunteers and hope to be able to start recruiting new volunteers from September.

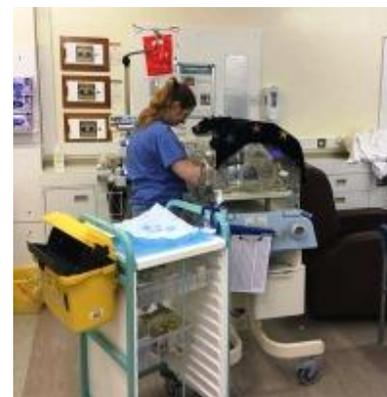
Parents Mental Health Support

The support for parents across the Network remains variable when needing to access external mental health services for families. Improving Access to Psychological Therapies (IAPT) programme remains the only universal service for parents across the Network. IAPT can be accessed via GP referral or self-referral and local services can be found on NHS Choices website by searching IAPT. Unfortunately it still means many parents accessing the service in a different location to their baby as it is funded via commissioners and influenced by postcode.

Reading to Babies in NICU/SCBU

Following successful evaluation of the promotion of reading in NICU 'BookTrust' book bags can be acquired for all units via the BookTrust lead in local libraries.

With everyone's help I feel we can continue to raise the profile of families during their neonatal journey both locally and nationally, it is small changes which will make a big difference. I cannot achieve this alone and I am grateful for the support I receive from all staff, families and volunteers on the units.



Report from NHS England Specialised Commissioner – Peter Dixon



Financial constraints continue to limit the ability of NHS England to invest in services, but neonatal services continue to be amongst NHS England's highest commissioning priorities, and particular emphasis is being placed on:

Service reconfiguration

The Independent Review of Neonatal Intensive Care Units recommended that the number of centres should be reduced from four to three, with cots currently located in Stockton being transferred to Middlesbrough, with Stockton continuing to provide Special Care Baby Unit facilities.

The Review's recommendations were accepted by NHS England and referred to the North East Regional Joint Scrutiny Committee which requested that the recommendation should be included in the Better Health public consultation. The consultation is likely to commence in November 2016

NIC transport/retrieval

The Royal College of Paediatrics and Child Health's (RCPCH) review stated that the NIC transport service "... must be re-commissioned as a stand alone service.

The current service represents a very significant and on-going risk to patient safety."

Discussions commenced during the year, and NHS England has agreed to fund a stand alone NIC transport service to be located at the Royal Victoria Infirmary, although it should be emphasised that it is a regional transport service, and not a Newcastle service.

Staff recruitment has commenced and it is anticipated that the service should be fully operational within 12 months.

Cot Capacity and Staffing

The RCPCH confirmed that the capacity of Intensive and High Dependency cots should be reviewed by the Network, and initial findings suggest that the Network has a shortfall of seven cots.

Discussions have commenced between NHS England and the NIC Trusts, and these are expected to continue during 2016/17.

Staffing levels continue to fall short of BAPM standards, and this will impact on any expansion of cot capacity. Nevertheless NHS England will continue to work with the Network and Trusts to ensure a safe and sustainable service.



Northern Neonatal Network Sam Richmond Nursing Scholarship – Winner for 2015, Emily Cameron



As we announced in last year's Report, a new initiative we were particularly proud of as a Network was the launch of an annual Nursing Scholarship, named in memory of the late Dr Sam Richmond, who had worked as a Consultant Neonatologist in Sunderland for many years, pioneering neonatal care there. The main aim in that was and remains to try and foster a spirit of innovation amongst the nursing staff across the Network and support them in developing new ideas as to how neonatal nursing care can be improved.

Working with permission from Sam's widow Liz, the Scholarship was formally launched in late 2014 and our first winners announced in early 2015. Due to the success of the initiative, we agreed that this should definitely continue so the 2015 Award was opened up for applications at the end of the year.

The Scholarship comprises two separate aspects - a prize of £1000 that the winner can use towards their proposal and also a trophy that Liz has specially commissioned by the Sunderland Glass Centre. This gets engraved with the winners name and year on and they get to keep it for 12 months until the next Scholarship is awarded.

Once again, the standard of submissions for consideration was extremely high indeed, making the judging panel's task of picking a winning entry very difficult. Eventually though, it was agreed that the winning entry and the Sam Richmond Scholarship for 2015 should go to Emily Cameron, who works as a Sister on the NICU at Sunderland Royal Hospital. Her submission was titled "Debriefing after Neonatal Death". The aim of the project is to set up a structured approach to facilitate a team debriefing following a baby's death on the Unit.

We know from research and conversations around our own Network when we have been working on the Neonatal Comfort Care Bundle (NCCB) that this is a very challenging area that staff often struggle to cope with. This is often compounded by the comparative infrequency of babies dying on the neonatal unit, especially the SCUs, where it is quite rare, so exposure to dealing with it could be something some staff may not see for months or even years. Any process that can help support staff when they do confront these situations would obviously be a welcome development and it is hoped that Emily's work will help provide that in a way that can be rolled out to our Network units and hopefully beyond too. We wish her well and look forward to hearing of her progress in due course.



Emily Cameron receiving her Award and trophy from (L-R) Lynne Paterson, Liz Richmond, Ken Bremner, Dr Majd Abu-Harb and Martyn Boyd

Network Annual Data Report 2014-15

The Northern Neonatal Network now has a full 6 year history as a formal managed clinical network and we placed a high priority on the data side of our functionality right from the first day. As a result, we end the year 2015-16 with a full 5 years' worth of general activity data and a full 4 years' worth of transport data. We include another mix of data, reports and charts in this year's Report to hopefully provide an interesting and useful mix of this with the aim of giving some helpful information to our stakeholders to enable a better picture to be built up of how we are performing in key areas and also with an emphasis on the trends we are now beginning to see over a medium timescale. The hope and aim of this has always been to better inform us collectively and assist with the planning and subsequent delivery of neonatal services both within individual Units and also across the Network.

This has been demonstrated in a very full way within the last 12 months in the context of the modelling work that has been carried out by Mark Green in order to use historical data in order to try and assess the potential impact of reconfiguration of NICU services according to the RCPCH Report previously described. Without access to the historical data we needed, it would have been an impossible task. It was actually in the end a very complex task, but would simply not have been possible at all without this and we are grateful that the BadgerNet system all Units use whilst not perfect does allow for such work to be undertaken, as well as the regular quarterly reports that have always formed the main output for our Units and as a Network. These continue to be revised and evolve with feedback and input and we are grateful to Dr Imran Ahmed for his valuable work in this respect, allowing some new report templates to be used over the year. He also very kindly worked with Mark on the data section that follows and provided most of the narrative and analysis that accompany the various charts and tables to give some context and background to the data themselves.

For the first time since we started collecting data in 2010, we have seen a rise in both the aggregate live birth rate and also unit admissions across the whole Network. We had been bucking a national trend for many years that elsewhere in the UK had seen a rise in both these key metrics, sometimes significantly so. It will be fascinating to see if this continues as if, as this may now be the case, the birth and admission rates start to rise, this will have implications for the future capacity needs of our Units across the Network. We will be monitoring and reporting on this very closely in the coming years.

Unit	Live Births								
	Financial Year					3 Year Average			
	11/12	12/13	13/14	14/15	15/16	11-14	12-15	13-16	% diff
RVI	6956	7403	7387	7339	6969	7249	7376	7232	-2.0%
Sunderland	3563	3263	3267	2998	3097	3364	3176	3121	-1.7%
North Tees	3571	3392	3259	3099	3092	3407	3250	3150	-3.1%
JCUH*	5708	5707	5383	4987	4740	4314	4323	4431	2.5%
Cramlington	2851	2691	2425	2127	3068	2656	2414	2540	5.2%
QE Gateshead	1985	1859	1748	1844	1820	1864	1817	1804	-0.7%
South Tyneside	1521	1434	1397	1311	1330	1451	1381	1346	-2.5%
UHND	3256	3074	3004	3193	3087	3111	3090	3095	0.1%
Darlington	2669	2511	2249	2192	2201	2476	2317	2214	-4.5%
Cumberland	1804	1742	1696	1729	1731	1747	1722	1719	-0.2%
Whitehaven	1396	1387	1292	1239	1177	1358	1306	1236	-5.4%
Network	33937	33170	31886	31463	32312	32998	32173	31887	-0.9%

Table 1 – Live births by year plus rolling 3-year averages

Unit	Unit Admissions								
	Financial Year					3 Year Average			
	11/12	12/13	13/14	14/15	15/16	11-14	12-15	13-16	% diff
RVI	794	804	761	787	728	786	784	759	-3.2%
Sunderland	393	339	363	336	330	365	346	343	-0.9%
North Tees	343	339	331	334	376	338	335	347	3.7%
JCUH*	528	533	452	486	441	358	379	393	3.7%
Cramlington	416	417	337	295	310	390	350	314	-10.2%
QE Gateshead	230	240	220	252	248	230	237	240	1.1%
South Tyneside	144	114	96	92	98	118	101	95	-5.3%
UHND	230	235	251	253	233	239	246	246	-0.3%
Darlington	232	218	232	187	229	227	212	216	1.7%
Cumberland	270	236	233	207	225	246	225	222	-1.6%
Whitehaven	212	212	173	140	174	199	175	162	-7.2%
Network	3618	3553	3317	3302	3392	3496	3391	3337	-1.6%

Table 2 – Unit admissions by year plus rolling 3-year averages

Unit	Intensive Care (IC) Days (BAPM 2011)								
	Financial Year					3 Year Average			
	11/12	12/13	13/14	14/15	15/16	11-14	12-15	13-16	% diff
RVI	2581	2613	2787	2683	2262	2660	2694	2577	-4.3%
Sunderland	822	891	856	883	1066	856	877	935	6.7%
North Tees	1122	709	1057	992	1126	963	919	1058	15.1%
JCUH	1203	1159	1381	1301	1401	1248	1280	1361	6.3%
Cramlington	19	26	32	71	37	26	43	47	8.5%
QE Gateshead	23	13	16	21	22	17	17	20	18.0%
South Tyneside	11	15	5	8	13	10	9	9	-7.1%
UHND	28	29	34	56	51	30	40	47	18.5%
Darlington	20	52	44	29	44	39	42	39	-6.4%
Cumberland	25	22	28	20	32	25	23	27	14.3%
Whitehaven	31	26	27	23	20	28	25	23	-7.9%
Network	5885	5555	6267	6087	6074	5902	5970	6143	2.9%

Table 3 – IC care days by year plus rolling 3-year averages

Unit	High Dependency (HD) Days (BAPM 2011)								
	Financial Year					3 Year Average			
	11/12	12/13	13/14	14/15	15/16	11-14	12-15	13-16	% diff
RVI	3436	3077	3385	3187	3139	3299	3216	3237	0.6%
Sunderland	1008	1046	1168	1437	1041	1074	1217	1215	-0.1%
North Tees	862	900	972	1003	1204	911	958	1060	10.6%
JCUH	1302	1547	1633	1557	1632	1494	1579	1607	1.8%
Cramlington	145	110	124	141	124	126	125	130	3.7%
QE Gateshead	87	101	121	101	55	103	108	92	-14.2%
South Tyneside	42	55	29	29	49	42	38	36	-5.3%
UHND	119	152	173	227	230	148	184	210	14.1%
Darlington	136	217	216	151	184	190	195	184	-5.7%
Cumberland	161	74	115	122	111	117	104	116	11.9%
Whitehaven	115	82	65	84	73	87	77	74	-3.9%
Network	7413	7361	8001	8039	7842	7592	7800	7961	2.1%

Table 4 – HD care days by year plus rolling 3-year averages

Unit	Special Care (SC) Days (BAPM 2011)								
	Financial Year					3 Year Average			
	11/12	12/13	13/14	14/15	15/16	11-14	12-15	13-16	% diff
RVI	5940	5455	5695	4878	4534	5697	5343	5036	-5.7%
Sunderland	3579	3416	3042	2870	3173	3346	3109	3028	-2.6%
North Tees	3197	3342	2949	2829	3219	3163	3040	2999	-1.3%
JCUH*	5041	5503	4382	4981	3921	4975	4955	4428	-10.6%
Cramlington	2304	1766	2002	1881	1982	2024	1883	1955	3.8%
QE Gateshead	2265	2224	2148	2415	2141	2212	2262	2235	-1.2%
South Tyneside	1725	1118	997	864	941	1280	993	934	-5.9%
UHND	2285	2011	2380	2060	2245	2225	2150	2228	3.6%
Darlington	2239	2103	2239	1935	2077	2194	2092	2084	-0.4%
Cumberland	2112	1456	2082	1648	1621	1883	1729	1784	3.2%
Whitehaven	2109	1714	1756	1378	1522	1860	1616	1552	-4.0%
Network	32796	30108	29672	27739	27376	30859	29173	28262	-3.1%

Table 5 – SC care days by year plus rolling 3-year averages
*Includes Friarage up until 15-16

Unit	Total Care Days								
	Financial Year					3 Year Average			
	11/12	12/13	13/14	14/15	15/16	11-14	12-15	13-16	% diff
RVI	11957	11145	11867	10748	9935	11656	11253	10850	-3.6%
Sunderland	5409	5353	5066	5190	5280	5276	5203	5179	-0.5%
North Tees	5181	4951	4978	4824	5549	5037	4918	5117	4.1%
JCUH	7546	8209	7396	7839	6954	7717	7815	7396	-5.4%
Cramlington	2468	1902	2158	2093	2143	2176	2051	2131	3.9%
QE Gateshead	2375	2338	2285	2537	2218	2333	2387	2347	-1.7%
South Tyneside	1778	1188	1031	901	1003	1332	1040	978	-5.9%
UHND	2432	2192	2587	2343	2526	2404	2374	2485	4.7%
Darlington	2395	2372	2499	2115	2305	2422	2329	2306	-1.0%
Cumberland	2298	1552	2225	1790	1764	2025	1856	1926	3.8%
Whitehaven	2255	1822	1848	1485	1615	1975	1718	1649	-4.0%
Network Totals	46094	43024	43940	41865	41292	44353	42943	42366	-1.3%

Table 6 – Total cot days by year plus rolling 3-year averages

Workload: a rolling review

Network Annual reports are now in their 6th year since 2010-11. This year we started reporting data based on the BAPM 2011 standards and this meant we had to revise the previous years in line with these standards to show the differences in activity. There have also been a few changes with units - JCUH show combined activity with the Friarage Hospital, Northallerton up until October 2014 when the SCU There closed and all activity was transferred to JCUH. The SCU at Wansbeck Hospital, Ashington transferred to a new facility at the Northumbria Emergency Specialist Care Hospital, Cramlington in June 2015. To make the tables and data reporting easier, the retrospective change to BAPM 2011 therefore reads "JCUH" and "Cramlington" respectively.

3 year averaged live births across the Network show a slight drop by 0.9% and the admission activity in the same period shows a drop of 1.6% in line with this change in births. We hope that the separated data presented for each of the 11 units gives a comprehensive overview over the years and an opportunity to reflect on types of care provided by each individual unit.

The 3-year aggregate data also shows network activity for Intensive care (IC) increase by 2.9%, high dependency (HD) increase by 2.1% and a decline in special care (SC) activity by 3.1%. This is depicted by the bar charts shown below both as yearly activity and 3-year averages.

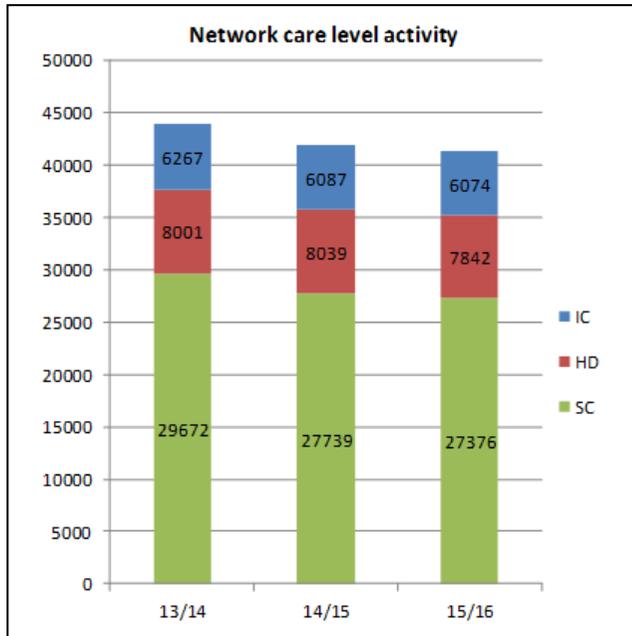


Table 7 – Network yearly network activity at each care level

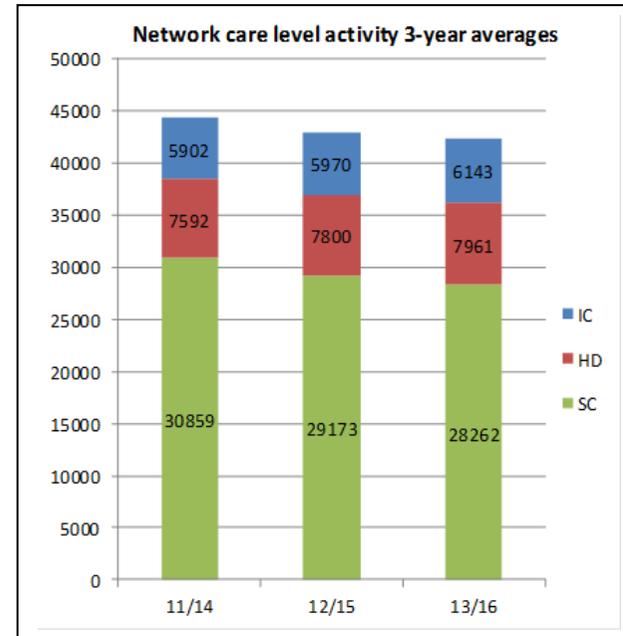


Table 8 – Network rolling 3 year averaged activity at each care level

This financial year we have included average funded cot occupancy separately for IC/HD and SC reflecting the specific demand for different types of care cots in the region. The RVI continues to show activity above this level, whilst North Tees is a significant outlier due to commissioned cots being lesser than the declared cots by the trust. JCUH and Sunderland show small increase in activity above the recommendations in some quarters.

The first table below (table 9) shows the activity levels of the 4 NICU's and shows the total number of cot days (BAPM 2011).

The second table below (table 10) shows the IC/HD funded activity for each NICU summarised by each quarter highlighted against the 80% occupancy recommendations (BAPM & DH 2009 Toolkit).

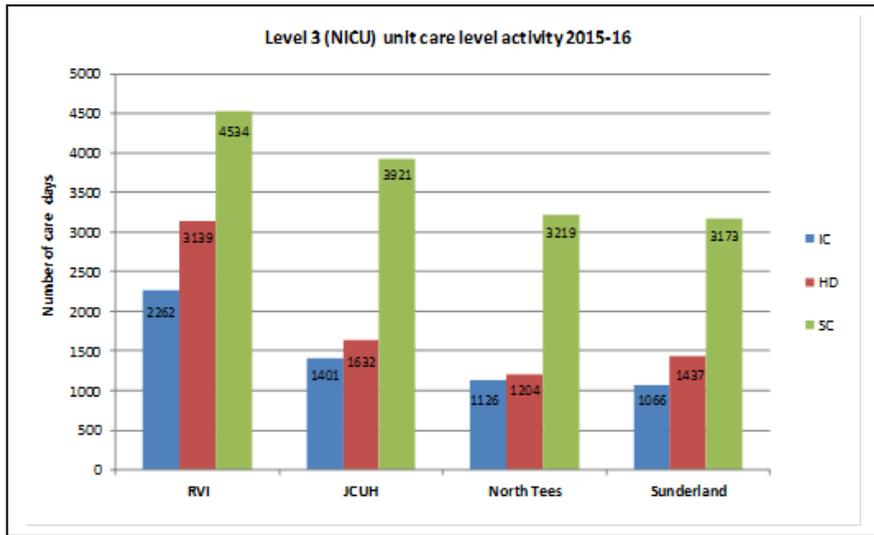


Table 9 – Total cot days by care level for each NICU

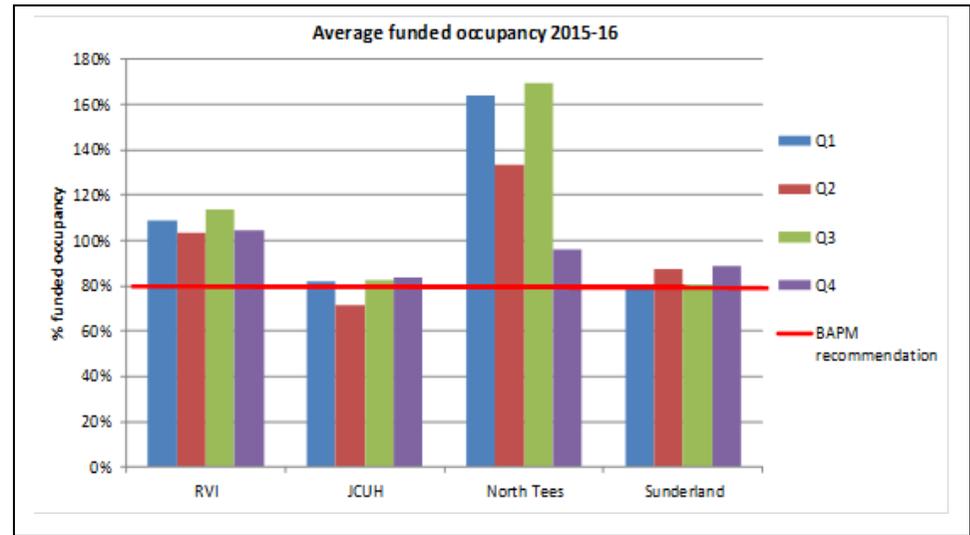


Table 10 – Average occupancy level for “funded” NIC/HD cots

Table 11 opposite shows the average activity by occupancy level for each of the Network’s seven Special Care Units (SCUs) by each quarter. These are mapped by using the declared total cots available from each Unit and the total numbers of babies by total cot days, to give an average percentage. Obviously there are times when the actual occupancy levels are significantly higher and also lower than these and at times of peak activity the SCUs can be over-capacity, although this is typically less frequent than the NICUs and a change in the number of available cots can have a significant impact, as can be seen from the South Tyneside chart. During the year their cot capacity was sharply reduced from 7 to 4 and then as this was increased following staffing changes, the occupancy levels fluctuated accordingly.

The Network plans to introduce a similar graph for the NICU’s separating the special care activity in future reports.

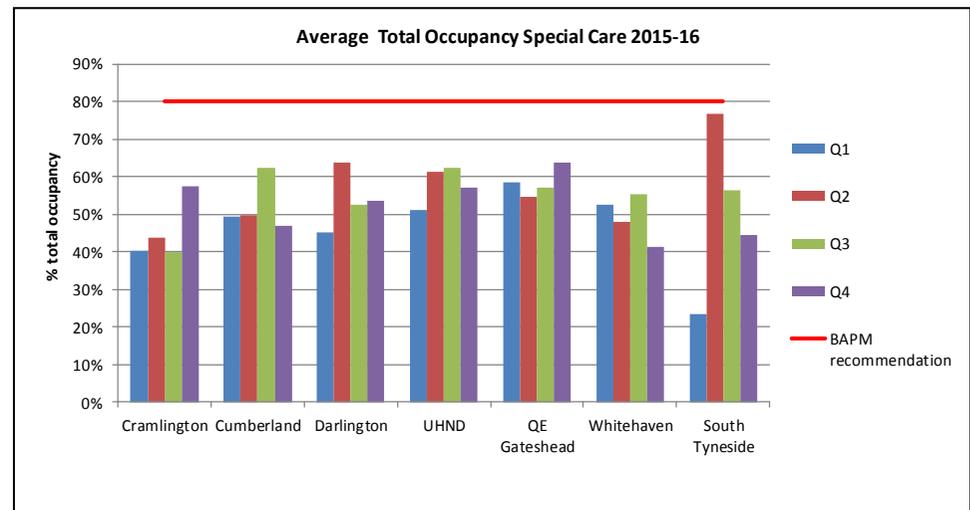


Table 11 – Average SCU occupancy levels by Unit for 2015-16

Also this year sees us start reporting key performance indicators, which we hope will allow us to focus on specific areas for the whole Network. The focus could be merely improving how we record data to improving outcomes.

The focus on outcomes especially in the last few years on term admissions has seen us not only successfully reducing admissions but remain well under Network targets for 5 consecutive years as shown in the table 12 opposite, although we know from more detailed analysis by Unit that there are variations within this with some admitting above the network average target. We will continue analysing this and working on reducing this variation in the coming months and there is also national work under way to address similar issues that we will be aiming to tap into to assist in this.

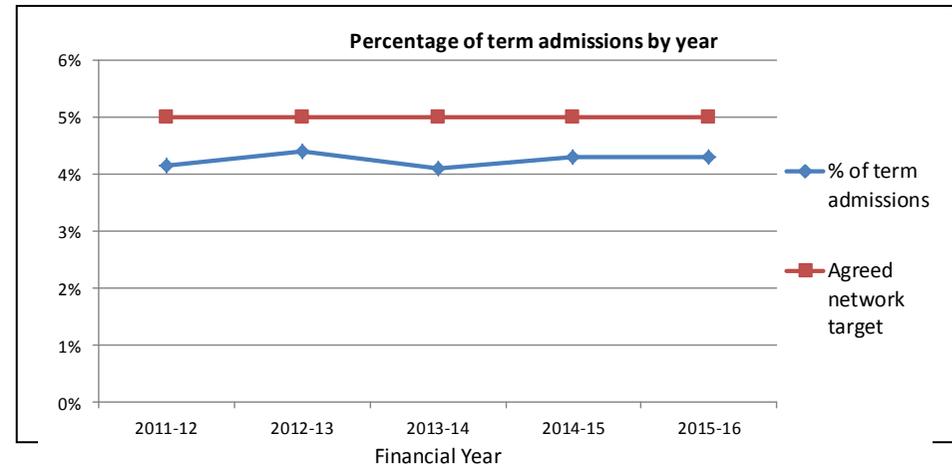


Table 12 – Average term admission rates across the Network

NNAP Audit indicators

We have chosen the well-accepted NNAP (National Neonatal Audit Programme) data obtained from BadgerNet and available nationally to highlight specific areas where we have excelled and others where improvement is required.

One such area that is evident from the tables opposite and below is data input. Table 17 on 2 year follow up illustrates this very well; we have made significant progress in data entry year on year going from 45% of follow ups with no data entered at 2 years to 37% in 2 years.

There is clearly room for improvement and we hope that this continues to improve in the next annual report.

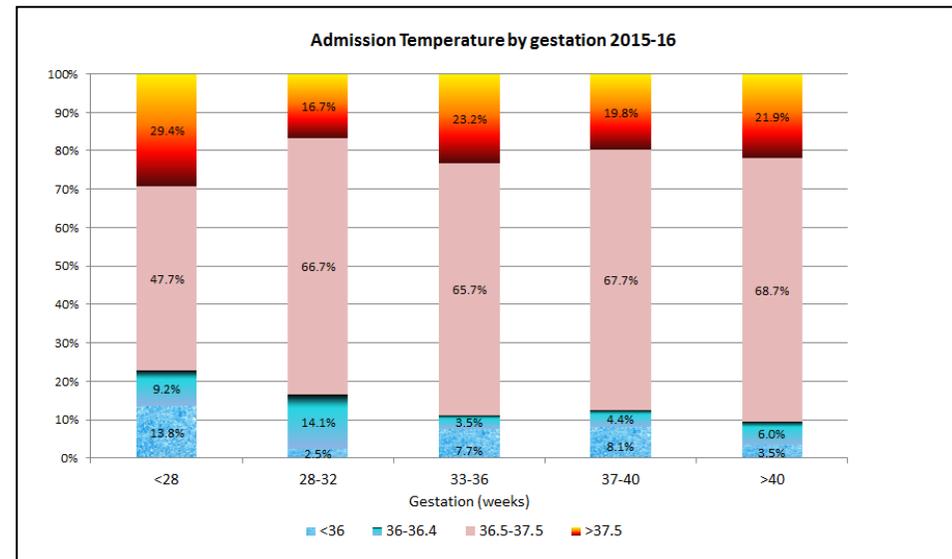


Table 13 – Network admission temperatures by gestation (NNAP measure)

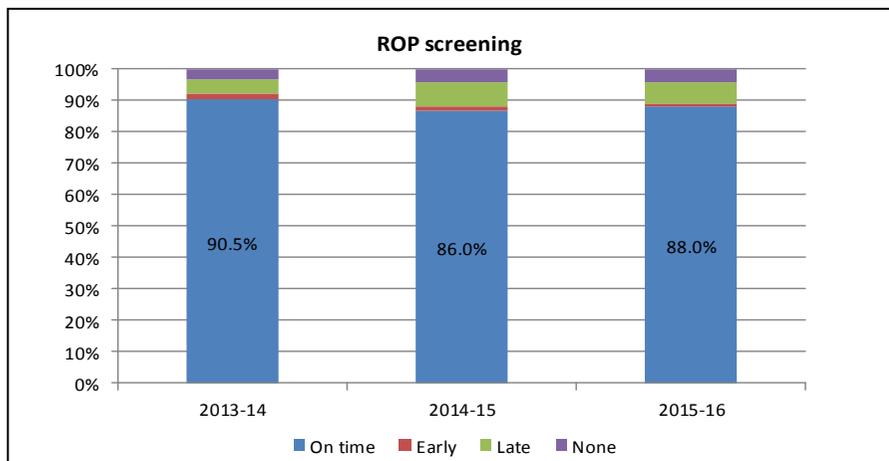


Table 14 – Network ROP screening rates (NNAP measure)

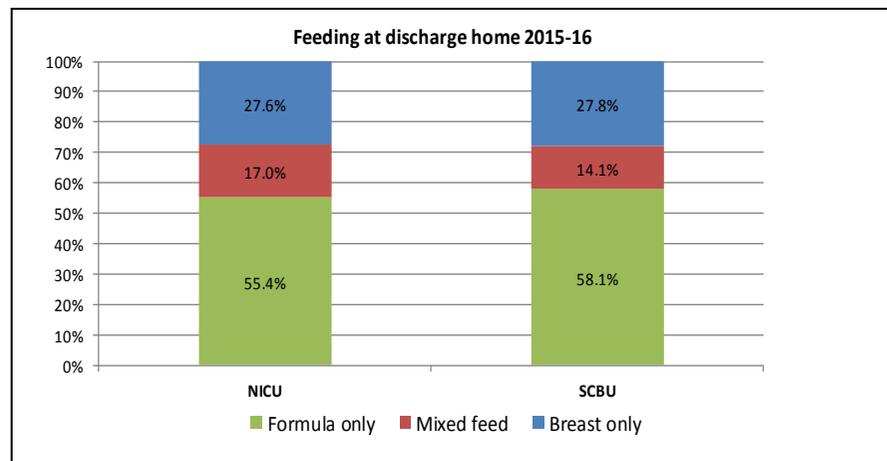


Table 15 – Network feeding method at discharge (NNAP measure)

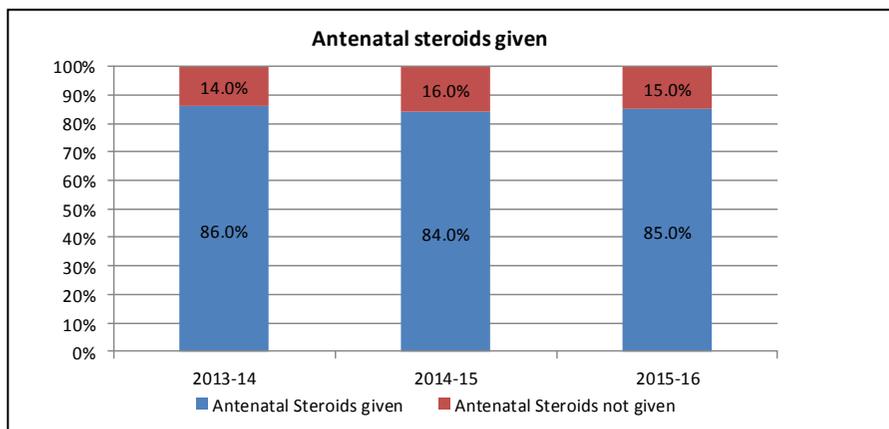


Table 16 – Network Antenatal steroid administration (NNAP measure)

Tables 14-16 are taken from the NNAP Report for 2014, which is the most recently published. All the data is taken directly from BadgerNet by NNAP and then used for the key indicators that they report on. The tables on this page highlight how the Network performs on some of these.

Significantly more detail is available in the full NNAP Report available via their website, including performance on an individual Trust/Unit basis and also benchmarking against other comparable Units (NICU with NICU, SCU with SCU etc.). NNAP also performance report on some of their measures, identifying outliers and this is then used to bring about improvements where necessary. The Network compares favourably with other neonatal networks and some of our Units have already used the NNAP data to plan service improvements. We have also started to incorporate NNAP measures in our key quarterly Network reports in a more timely manner than NNAP as their full reports are only issued annually in retrospect, delaying responses to them significantly.

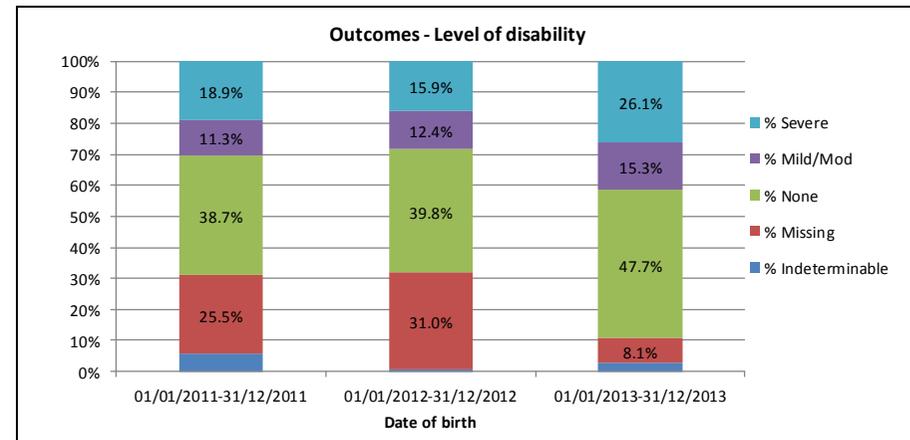
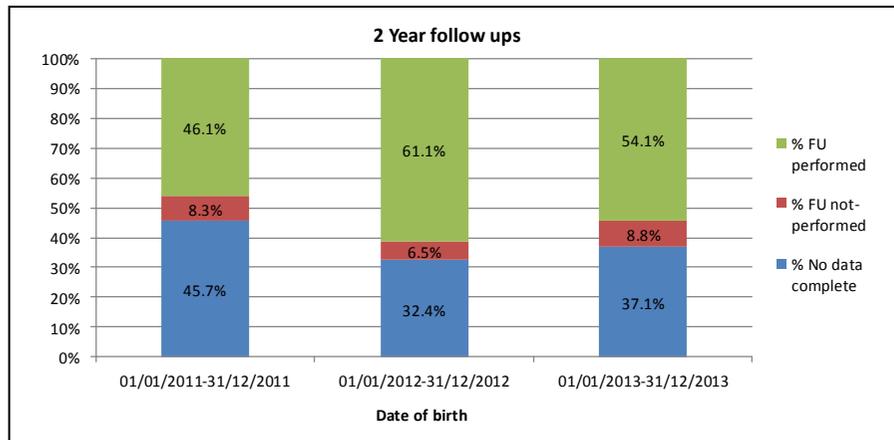


Table 17 – Network 2-year follow-up rates on BadgerNet (NNAP measure) Table 18 – Network 2-year outcomes on BadgerNet (NNAP measure)

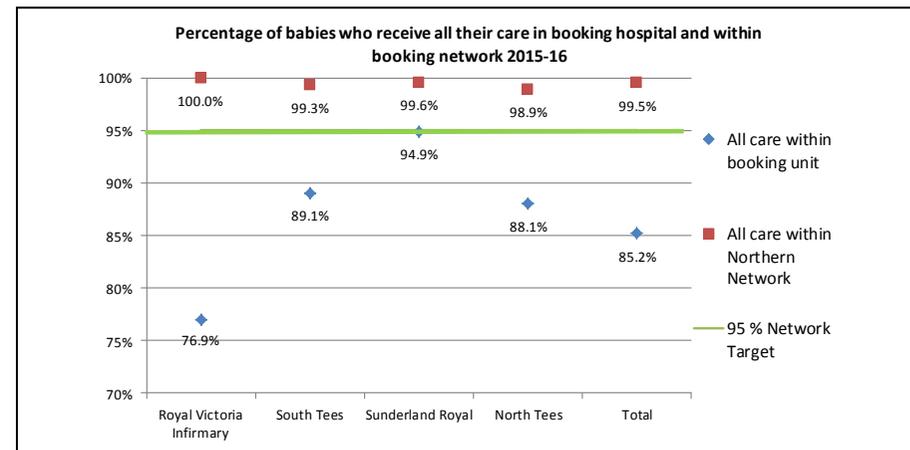
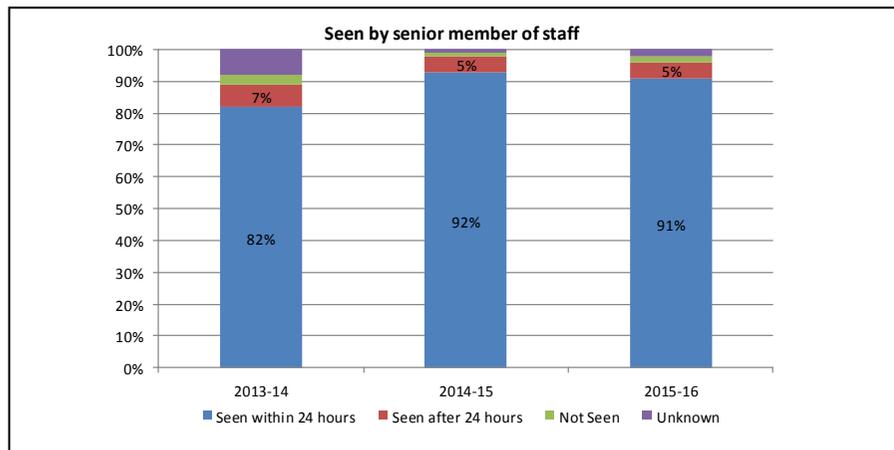


Table 19 – Babies seen by senior member of staff (NNAP measure)

Table 20 – % of babies receiving their care in Network (NNAP measure)

Table 20 above illustrates very well Network performance in managing the workload within the region with negligible transfers out of Network and it remains the lowest in the UK. This is a testament to the hard work and commitment from all the units in the region. However it is to be noted that this is at the expense of the NICU's performing above the expected 80% occupancy (BAPM & Toolkit 2009 recommendations). This is unsustainable in the longer term and is out with the recommended guidance nationally. The other tables illustrate how the Network performs on other key NNAP measures as reported nationally via BadgerNet.

Neonatal Transport

This has been a year of significant development for our neonatal transport services. As reported in the last Annual Report, following the failure to have a combined paediatric-neonatal transport service ("NECTAR - North East Children's Transport And Retrieval) commissioned as originally hoped and planned, the Network was asked to draft and submit a suitable business case for a separate neonatal service. This was duly undertaken and sent to NHS England via the proposed host Trust (Newcastle) at the end of September 2015. This made the case for a fully funded, standalone and supernumerary neonatal transport service based on the primary delivery of the service by ANNPs working under the leadership of a neonatal transport consultant and 2 teams of nurses to cover all transfers across the Network, including repatriations. This should then enable the key national standards and specifications to be met that are currently not.

Following submission, the case was given due consideration by NHSE and subsequent discussions took place between the Trust, commissioners and Network with further negotiation before it finally being accepted in the spring of 2016. Once funding was agreed and this became available in April 2016, recruitment could begin to the new team, which has now been named "NNeTS" (Northern Neonatal Transfer Service). This will be ongoing for many months but once complete will have created a team capable of delivering a service across the whole Network 24/7, 365 days per year that will include all types of transfer. It will also mean a tier of call handlers acting as the front line for referrals to smooth, speed up and improve communication and allow the clinicians and nurses more time to focus on the clinical aspect of retrievals.

Due to the new service being based on an ANNPs leading and delivering it, and because it requires them to be first recruited and the trained, it will take some time for the new NNeTS service to be fully operational, so in the meantime there will be a transitional period as the two current teams based at the RVI and James Cook in Middlesbrough continue to operate. However, as the newly recruited staff come on board, the pressures that the existing teams are facing should also begin to decrease. This was one aspect the RCPCH Panel had expressed particular concerns about when the transport

teams have to undertake retrievals, as it leaves the rest of the Unit with less staff and this has been an ongoing issue at JCUH for some time, so this will be one aspect of ongoing improvements that the new service will deliver, as well as the ability to better co-ordinate and respond to repatriations across the Network, freeing up crucial resources in all Units, but especially in the NICUs, where the timely transfer of babies back is vital to minimise the cot blocking that sometimes currently occurs. However, it remains true that the Network has the lowest export rate of babies out of area for non-clinical reasons, with just 5 babies needing to be moved for this during the year when a suitable cot could not be found in our own area.

As a Network I am sure we can look to the future with confidence as the new NNeTS service takes on the responsibility for all transfers and the next Annual Report will reflect the developments that will occur over the next 12 months and feature a contribution from the Transport Consultant following their expected recruitment and appointment in the autumn of 2016



In the meantime, the current neonatal transport service based at the RVI and JCUH continues to operate and what follows relates to the teams' activity for the last year 2015-16. As always, they have continued to provide an excellent

service under increasingly challenging circumstances. In total there were 676 transfers undertaken over the year by both teams, which equated to 477 for the RVI and 199 for JCUH, effectively a 70:30% split respectively, mirroring previous years. The total number of transfers is down slightly from 2014-15, but this was to be expected as the number of paediatric transfers that the teams have undertaken has dropped to almost negligible numbers as the NECTAR service has begun to assume responsibility for all paediatric/non-neonatal transfers. However, there were also 30 “non-acute” transfers of babies undertaken by Units themselves and not by the two teams – usually for investigations or occasionally repatriations when the teams were not able to respond as timely as needed, so the total number of “baby transfers” was actually at *least* 706 and because the Network is not always informed of every non-acute, we expect this figure is even higher so it will certainly provide a significant workload for the new service to undertake and the consensus is this will continue to grow.

The charts and data that follows is a summary of the main activity

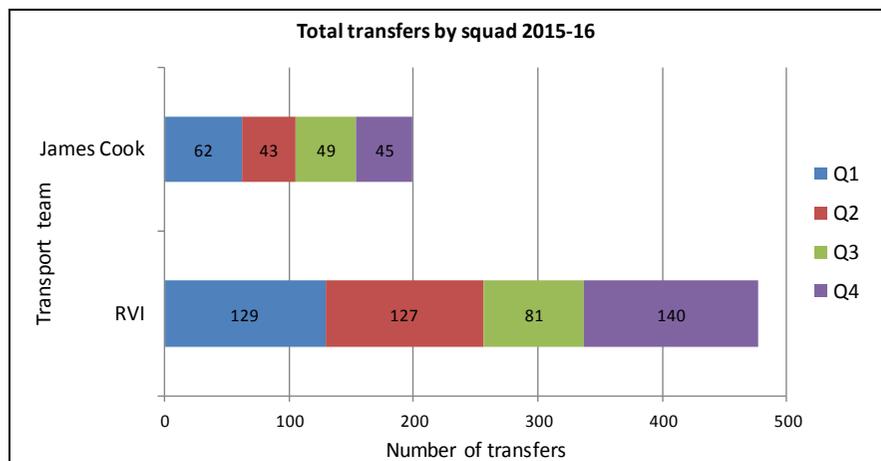


Table 21 – Total transfers by each team during 2015-16

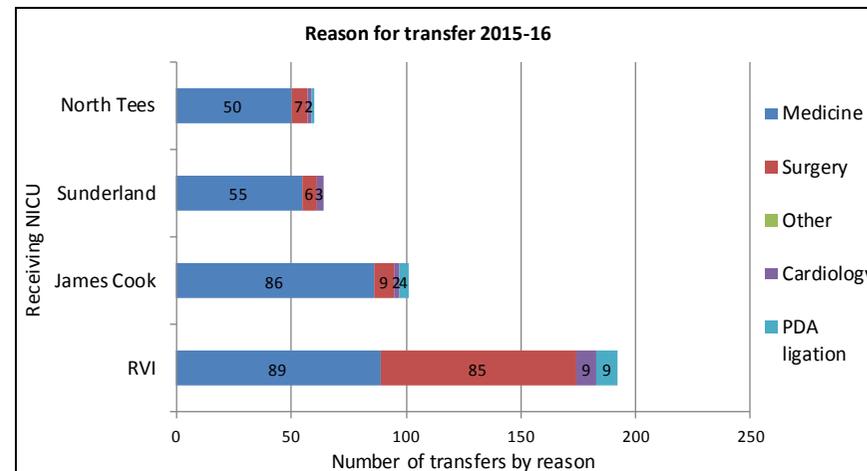


Table 22 – Reasons for transfer by NICU 2015-16

The two tables here summarise the main transfer activity undertaken by the two transport teams over the year by quarter (table 12) and then the indicated clinical reason for transfer broken down by receiving NICU (table 13). This demonstrates that the split of the transfers continues to be roughly 2:1 between the RVI and JCUH and that most of the transfers for non-medical reasons (PDA ligation, surgery, cardiology etc.) go to the RVI, although JCUH continue to provide laser surgery for the treatment of ROP (Retinopathy Of Prematurity).

As highlighted previously, we continue to rely on manual coding of the infant transfer record sheets completed by the transport teams as the main method of compiling, collating and analysing this activity and it is occasionally unclear or relying on subjective assessment as to the “urgency” of the transfer or the main category/reason, but we have been applying consistent methodology to this process since April 2011 so the Annual Reports reflect this. It is anticipated however that as we move to the proposed single team, they will take on the coding, auditing and reporting of their activity on behalf of the Network.

Referring Hospital	Receiving Hospital			
	RVI	James Cook	Sunderland	North Tees
Carlisle	8	4	2	4
Cramlington	15	3	2	3
Darlington	7	21	0	6
Freeman	18	8	4	4
Friarage	0	1	0	0
Gateshead	15	4	4	3
RVI	0	33	24	23
James Cook	49	0	4	8
North Durham	20	9	7	3
North Tees	15	7	0	0
Out of Area	3	0	1	0
South Tyneside	4	2	10	0
Wansbeck	5	1	4	1
West Cumberland	10	7	3	2
Sunderland	23	1	0	2
Grand Total	192	101	65	59

Table 23 – Transfer summary 2015-16, referring Unit, receiving NICU

Table 23 above illustrates the movement of babies around the Network over the year in terms of the referrals into the four NICUs. This helps to demonstrate the comparative activity for babies that have been transferred from a SCBU to a NICU postnatally for ongoing intensive, high dependency care or other appropriate reasons. In the case of the RVI, this obviously includes the inward referrals for surgical assessment and/or treatment as well as the more complex medical and cardiac cases they may onward refer to the Freeman. This chart continues to be helpful in summarising the main patient flows around the Network to allow better service planning as these pathways change under reconfiguration as discussed elsewhere in the Report.

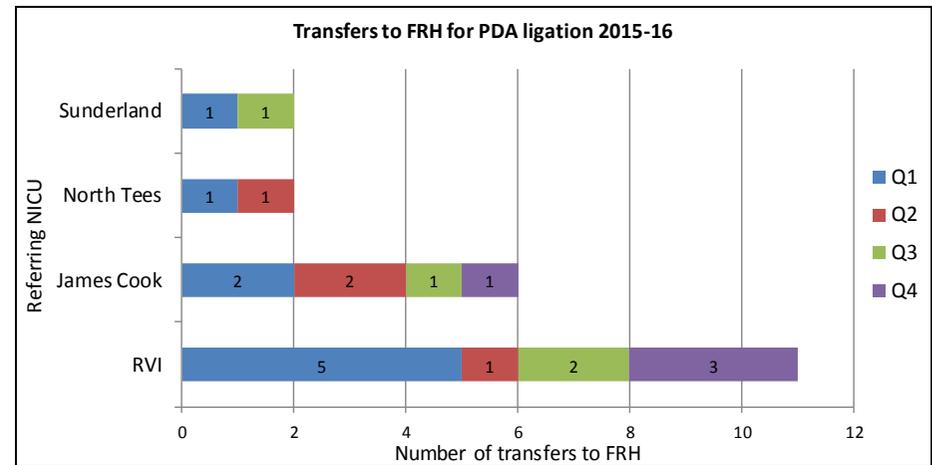


Table 24 – Transfers to Freeman Hospital for PDA ligation

Table 24 above summarises the number of transfers that were undertaken to the Freeman Road Hospital for ligation of Patent Ductus Arteriosus (PDA). These are usually booked electively in advance, involving close coordination with the cardiac surgical teams but also relying on the transport teams transferring the baby to the operating theatre and then once recovery is completed, taking over the care before transfer back to the base Unit.

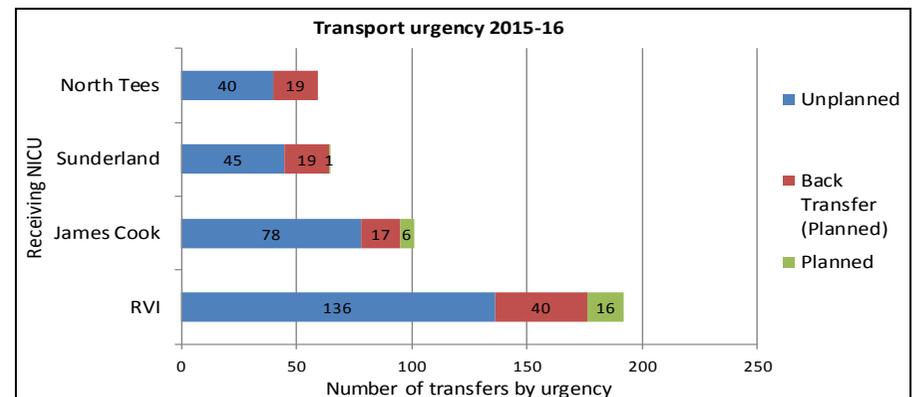


Table 25 – Transfer urgency for 2015-15 by receiving NICU

Transport – 5 year summaries

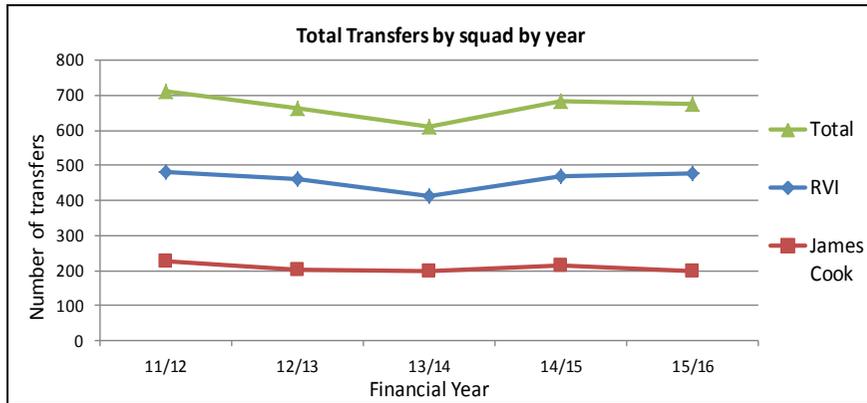


Table 26 – Total transfers by year for each transport team

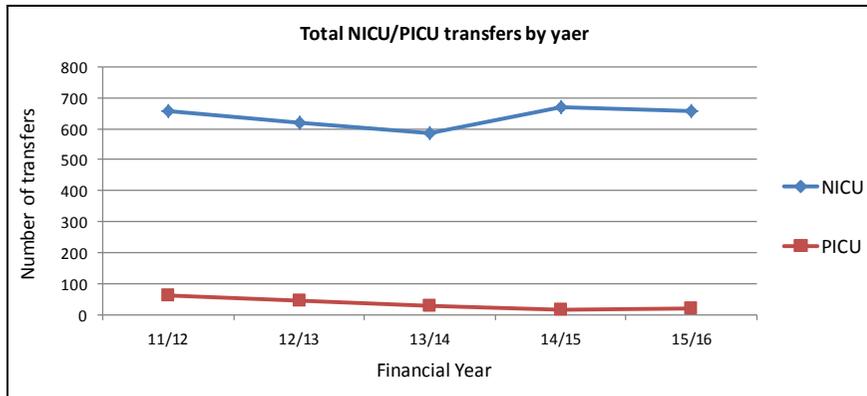


Table 27 – Total transfers for NIC/PIC care by year

These charts show the 5-year summaries of the total and individual numbers of transfers undertaken by each team (table 26) as well as the split between Neonatal and Paediatric transfers (table 27), confirming the steady fall in the later over recent years. Table 28 below shows the back transfers each of the two teams undertook as a percentage of their total activity.



Table 28 – Back transfers as a percentage of activity by team

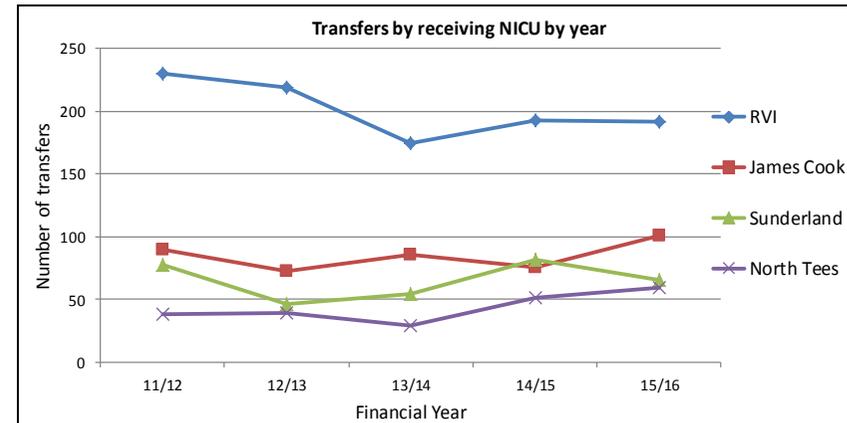


Table 29 – Transfers to each NICU

Table 29 shows the changes in activity across the four NICUs by reception of referrals. This shows a continuing trend highlighting the fall in the number of babies transferred to the RVI over the 5-year period, and the corresponding changes at North Tees, Sunderland and JCUH. These remained fairly consistent but there have been changes in the last year, all of which reflect the RVI's high occupancy levels necessitating transfers to the other NICUs.

Northern Neonatal Network Education & Training



The Network continues to place a very high priority on its remit for education and training. It has been at the heart of what we are seeking to do in supporting and equipping our staff to provide them with the knowledge and skills to give the very highest possible quality of care.

To help facilitate this as a priority, in the previous year, we moved from a full time Network Educator to an Educational Lead, with one of the Consultant Neonatologists having the brief to be a focal point for this on a sessional basis. Unfortunately, we have had two changes in personnel in this role in just under 18 months which has challenged the aims we had somewhat. We started the year with Dr Jans Sundaram from North Tees in the role, but when he stepped down, Dr Osama Hamud took over, but when he moved away in early 2016, the position was taken on by Dr Richard Hearn from the RVI, Newcastle.

However, Richard has been very supportive of the education and training for some time pre-dating his formal appointment as he led on the well-established Network stabilisation training programme, so we look forward to his leadership as he takes this on. He has written a piece elsewhere in this Report highlighting his work to date in a short space of time and also some early plans

for other initiatives, which we are very supportive of.

It wasn't just the changes in personnel that provided some challenges to our training and education programme and aims and objectives however. Ongoing uncertainty about the funding of post-registration modules and courses at local Higher Education Institutions (HEIs) meant our plans to work with the University leads at Teesside and Northumbria to revise the current "QIS" (Qualification in Specialty) training courses. As reported last year, the hope had been to collaborate to re-design a suitable course that reflected the new national standards and could be provided on both sites for our nursing staff. Unfortunately however, the funding situation was not clarified until into the start of the new financial year 2016-17 and this not only affected the plans we had for the QIS modules, but also the impact on our proposals to set up a local course to train ANNPs as reported elsewhere in this Report.

The net effect of these delays has been to prevent us putting anything in place for the academic year 2016-17 which is due to start very soon, so we have had little choice but to continue for at least one more year with the current "old" programme with two QIS modules at both universities in the autumn and spring, with the Network again delivering one common "core" day for the students from both coming together, equating to a Family Centred Care day that Network's BLISS Nurse, Sue Thompson facilitated in November, then the Respiratory Workshop in March which is opened up to other Network staff too. In 2016, this saw a total of 36 staff attending, including 24 students undertaking the Intensive Care QIS module. We are now already in early discussions with both universities about what we can collectively work on in time for 2017-18 and progress on this will be detailed in next year's Report.

The Stabilisation training programme that the Network first developed in 2012 continues to go from strength to strength and once again in 2015-16, we were able to facilitate four separate courses that enabled staff from all seven SCUs to attend. It continues to evolve and be revised, especially in response to some of the very useful feedback we get from attendees. This consistently evaluates as our most popular training course/event and we are committed to continue providing it, making it free at the point of delivery to those attend and within their own hospitals, usually at educational centre type facilities. By doing this and ensuring that those who come work together using equipment they are familiar with and in their own teams, we can maximise the learning opportunities in a better and more "realistic" environment. Richard and the

team of consultants, trainees and ANNPs who give up their time to deliver this training feel the benefits of attending are obvious and always enjoy the day, although they are not often without the odd logistical challenge to keep us busy! The main issue for the Units themselves is being able to release the staff to attend the days at all and we know from the recent cancellation of two courses that this is an increasing problem, so we hope that Trust management can provide better support for them to facilitate attendance as the benefits of it are not in doubt, but we need that ongoing commitment if they are to continue doing what we hope and equipping SCU staff with skills that may not be called on to be used often, but when they are, are vital.



The Network continues to invest in suitable equipment to support its training and education programme and this year we were able to purchase a new “low fidelity” preterm manikin to support this aim. Whilst not as “complicated” as the “SMART Preterm manikins” we bought last year, this model does allow intubation practice, which is very helpful in a preterm setting as SCU staff may not see and have the opportunity to practice this essential skill often. We have already used this on Stabilisation courses and it was felt to be very beneficial by those who have already used it, this adding to the benefits of the day itself.

One new initiative that we are currently looking into as a Network that may well have exciting potential for educational and training opportunities is telemedicine and some new technology that is already being trialled with much success and positive feedback in Dublin, Ireland. This relies on some new and very innovative “smart glasses” which when worn allow the user to connect what he/she is viewing to a 3rd party connection which can then be streamed live or recorded using the appropriate proprietary software. This can then potentially be used in a whole host of different settings and scenarios.



In terms of education and training, it has already been successfully used by Dr Eugene Dempsey in Dublin to create a suite of training videos that have been compiled into an App. We are actively discussing the potential for us to have a look at this new technology for our own Network purposes and are already wanting to explore the possible use of them in live streaming telemedicine links, as this may allow a user in one location to actually view live video of what a colleague in another, possible remote location is seeing and offers incredible possibilities to assist and support in the diagnosis of problems and also offer the option of giving more detailed advice based on viewing babies rather than relying on phone conversations as happens now. This could be particularly helpful for babies that may need referral and eventual transfer to other Units. We will give updates on any developments and progress as they are made, but this is certainly a real possibility for the future, whilst acknowledging the challenges of IT systems across different organisations.



As a Network, we know that the current plans for reconfiguration would see the need for new investment in additional capacity and that in its most practical sense, this would require additional staff. Add into that equation the impact of the NNeTS teams (as “new” staff above and beyond the current establishments and the move to an ANNP-led service to shift the balance to different roles) as it comes on line as well as any further improvement in staffing as Trusts try to meet the recommended BAPM staffing levels and it is clear that there are both new opportunities for different career pathways for staff, as well as a great number of jobs that we can expect to be available in the coming years.

This whilst very welcome presents individual Units (particularly the RVI where expansion is most urgently needed) with real logistical challenges in terms of the recruitment, training and then retention of staff. Unfortunately, this is further complicated by the demographical make-up of the existing workforce, as we know from work we have undertaken that a significant proportion are likely to retire in the next 5 years. It is one of the main factors that led us to identify the need for creating a suitable local course for ANNPs, as the number who will be retiring is going to severely adversely impact some Units and needs urgent attention.

For that reason, we are already looking at how we can best support Units and their Trusts with their staffing and as part of that, their education and training. In the current year 2016-17 and on the back of the RCPCH recognising the need for it anyway, the Network will be drafting a workforce strategy that seeks to address these issues and offer a way forward, so that using a collaborative approach, we can deliver what is needed to equip our workforce of the future. As Lynne Paterson reports, part of this will also focus on aiming to create a suitable Network Foundation Training Course, which will hopefully enable newly qualified and recruited nurses to have a suitable “grounding” in neonatal care in addition to their own Units’ induction and preceptorship periods. We look forward to working with the managers and lead to bring this about and being able to update the Network in next year’s Report on this too.

Now that Richard is in place, we are also looking to maximise training and education in other ways too, including case review meetings that are hosted locally by the SCUs as well as creating on-off study days and workshops in addition to the well-established days that we have been facilitating. We are always open to suggestions for new ways to do this and have already set up one day in the current year focussing on loss and bereavement and will explore other opportunities, as well as the possibility for supporting staff to attend relevant/appropriate courses, conferences and training days elsewhere in the UK.

One way we have been doing this in a more structured way is through the quarterly “Network days” we have. These have been well established for some time in that the afternoons have always included the Network Board meetings at the end of the day, but we have tried to use the mornings in a constructive way to discuss clinical issues and topics of interest and/or timely relevance with the aim of agreeing any required action in terms of changes to practice. During the course of 2015-16, these clinical forum meetings included outlining and promoting further developments and changes to the Neonatal Comfort Care Bundle to equip staff with some tools for the care of babies with terminal or life-limiting problems. We also on a 6-monthly basis have case discussion meetings, where clinicians present a recent case of interest and then it is discussed widely by the attendees, allowing an excellent opportunity for learning outcomes. These meetings are an ideal opportunity for any Network staff to come along and take part and enhance their knowledge and understanding of neonatal care and we will be hoping to develop these further in the coming year too.

As well as these ongoing key priority areas for our Education and Training strategy, we have continued to focus on providing other opportunities for our staff to develop. As a result, over the last 12 months, the Network has been able to facilitate and/or sponsor attendance at the following;

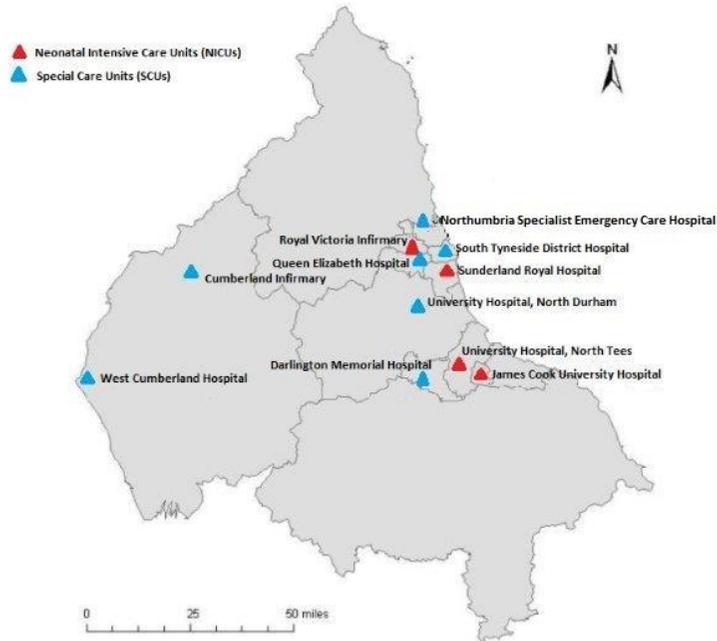
- In May, the Network facilitated a one-day “Transfusion Matters for Neonates” Symposium. With support from colleagues in the NHS Blood Service, this focussed on all aspects of the administration of blood and blood components to neonates. Feedback was excellent and attendance was nearly 40 delegates from across the Network.
- In June, the Network facilitated another Level 1 “Foundation Toolkit Course in Developmental Care” in Durham. This is provided by recognised expert Inga Warren and her team, accredited by BLISS and enabled almost 40 staff from all but one of our Units to attend. This is a very popular and well-received course and the Network remains committed to providing more in future years as demand continues to allow
- In July, the Network hosted a full afternoon session dedicated to local research initiatives. A series of presentations and updates from consultants and trainees overseeing these were given to almost 30 doctors and nurses. It was agreed in the discussion that concluded the day that this should be an annual event and the Network is fully supportive of this suggestion.
- Building on the success of past Foundation Toolkit courses, the Network funded a follow-up “Level 2 FINE Practical Skills course” in early September for 8 nurses across the four NICUs who have shown an interest in this area and wish to take a more involved role. This was a significantly more challenging course and equips the attendees with the knowledge and tools to take developmental care to the next level in their own practice as well as being able to support their own colleagues too.

- The Network hosted its sixth Annual Conference in late September. The programme included a mix of local and national guest speakers on a range of current topics of interest within neonatology. It was again attended by nearly 60 delegates and was rated very highly by the attendees that gave feedback.
- In November, the Network funded places for 6 nurses on 2 separate courses - four on the national transport meeting in Brighton and then 2 on a course exploring transitional care. Both evaluated very well from those attending them.
- Following the pattern of previous years, the Network was able to support places for Network staff on two NLS courses in Newcastle and North Tees to provide places for a total of 26 staff.

We continue to believe that by creating, providing and facilitating these various training and educational opportunities for Network staff, we are continuing to deliver our priority aim of developing health professionals at all levels and disciplines right across the Network. Indeed we have funded and made places for various MDT staff on our courses, including doctors, nurses, physiotherapists, speech & language therapists, pharmacists and others. In doing so, we are enabling them to remain and keep as up to and enable them to keep as up to date as possible as well as learning new skills. This is essential now that revalidation is embedded in medical and nursing registration legislation so it is simply not an option for us as a Network not to prioritise this accordingly.

By continuing to support funded places on key external workshops and conferences as well as developing our own “in-house” Network ones we feel we are continuing to equipping and enabling all our staff to provide the best evidenced-based care possible. This is an ongoing commitment to our staff and one we hope that our stakeholders recognise the benefits of and continue to support in an increasingly challenging environment when they themselves are struggling to achieve this.

The Northern Neonatal Network – our details



NICU (Neonatal Intensive Care Units)

Royal Victoria Infirmary, Newcastle
Sunderland Royal Hospital
University Hospital of North Tees, Stockton-on-Tees
James Cook University Hospital, Middlesbrough

SCBU (Special Care Baby Units)

Northumbria Specialist Emergency Care Hospital, Cramlington
South Tyneside Hospital, South Shields
Queen Elizabeth Hospital, Gateshead
University of Durham Hospital
Darlington Memorial Hospital
Cumberland Infirmary, Carlisle
West Cumberland Hospital, Whitehaven

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