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

This is now the 3rd Annual Report from the Network, reflecting their work and achievements over the last 12 months. Despite some very challenging circumstances, key personnel changes and uncertainty over their future, they have continued to make a valuable contribution to the development of and improvements in neonatal care across the region. They have also been engaging in some strategic discussions about the future shape of neonatal care to reflect changes within the NHS and many of the pressures that we all face on many levels and I have been taking an active interest in how these are developing. I know this will be of real importance to us all and it is crucial that we work together to re-design safe, sustainable, high quality neonatal services.

The Network has already started to adapt to the new NHS structures they find themselves in. More details of how they are doing this and all the other achievements, initiatives, projects and priorities they have collectively agreed and been busy addressing follow in this Report. I am sure once you read through it you will join me in agreeing that the Network have continued to provide value for money to the stakeholders who fund their work and a strong foundation for the priorities and targets they have set themselves this year. I am confident we will continue to benefit from their leadership and strong clinical expertise and I look forward to seeing them go from strength to strength with our collective input and engagement.

Foreword by the Northern Neonatal Network
Board Chair – Deborah Jenkins

It’s hard to believe that we’re reporting on another year of Network activity. Despite continuing change all around us, we seem to have found a bit more stability, with confirmation of our status and commitment of support from all our provider trusts and the specialist commissioners, at least for the time being. I’m delighted that the team can breathe a little easier after a worrying wait to hear whether their positions were secure. We all know how difficult it is to continue delivering high quality service when jobs are under threat, and I hope you will join me in congratulating Martyn and the team on managing a difficult year with aplomb.

Despite the uncertainty, we have moved forward to build our strategy for the future. The business case for the PIC/NIC transport proposal is shaping up well and we are hopeful that the commissioners will support our quest for parity with the arrangements in other regions. The annual conference was very well received, and I am looking forward to the next event on 20th September when I hope to meet many of you again. The various educational workshops have been a great success, and we plan to continue running them regularly – don’t forget to tell us if you have any ideas for new sessions. Our Network board days are popular, with excellent attendance both at the formal board meetings, and at the Forum sessions in the morning which address particular issues for groups of Network members. I am delighted that we have secured the Bliss Nurse post for the region, and
look forward to hearing how you all contribute ideas to the programme of activity for the post.

We are all grateful to Steve Byrne for the work he has put into the Network Clinical Lead post over the last three years, and congratulate him on his recent appointment as regional Lead to the national Neonatal Critical Care Clinical Reference Group (CRG) he has taken on. I would also like to thank Eileen Downs for the contribution she made as Network Educator during her time with us and wish her well from all Network members. We welcome Dr. Sundeep Harigopal who has taken over from Steve as Clinical Lead.

There is no question that the pace of change in the NHS is if anything accelerating, and plans for reconfiguration of services may put our relationships to the test. Let’s do our utmost to maintain and build on both professional relationships and our friendships as we move through the coming year. We have a huge amount to gain by working together to improve the services we can all offer to the children and families we serve, and I would like to think that we can get to know each other better as we do so.

Report from the Northern Neonatal Network Manager - Martyn Boyd

I think it is fair to say that the last 12 months since our previous Network Annual Report have been not only very quick in passing, but we have also seen some seismic changes across the NHS landscape that have redefined the way it operates and in particular the place of clinical networks, how they should perform and what their responsibilities are. Having said that, whilst the pace of change and passage of the last year has been swift, as networks we had to wait a long time for clarification from the Department of Health (DH) as to how we would be constituted and funded.

Last year I said that this was still a matter of speculation – and a significant amount of local work took place over 2012 led by Sir John Burn to try and forge a way of working that could be viable within the sort of boundaries the government were suggesting, by utilising a regional hub that could support the various networks we agreed needed it and local Chief Executives of the Trusts had indicated they could agree with helping to fund.

As it was, details finally emerged in late July from the DH that there would be two main types of clinical networks being designated, supported via different means (both structurally and financially) – "Strategic Clinical Networks (SCNs) and "Operational Delivery Networks" (ODNs). The former would be mandated, funded and hosted by the new NHS Commissioning Board and consist of networks, for cancer, cardiovascular, maternity & Children's and mental health.
When this announcement was made, further mention was made of the latter – that they would be supported and hosted by Trusts and consist of neonatal, critical care, trauma and burns networks. Unfortunately, further detail and clarification was not given until late on the last working day before Christmas, so the last 3 months of the financial year was occupied by networks frantically trying to agree host Trusts and operating budgets, which was a very difficult matter when the funding was suggested to be via a one-year transitional arrangement via CQUIN monies and then for the budgets to be absorbed within the tariff for each specialty.

Needless to say, this caused real problems for most of the existing neonatal networks that had evolved under various models but usually hosted by SHAs and PCTs, all of whom were being abolished as from 1st April. As it was, the Northern Neonatal Network (NNN) was one of only two such networks already hosted by a Foundation Trust (City Hospitals Sunderland FT) which meant the transition for us was relatively smooth and painless and we were able to agree our budget with the commissioners at an early stage.

However, lack of clarity as to the ongoing way that the networks will be funded in terms of budget and process is still creating problems for us when it comes to issues such as appointing staff, as without it, it is impossible to plan as we would like and need to in order to meet our remit, which remains focused on patient flows and pathways and ensuring the right baby gets the right treatment in the right Unit/hospital at the right time and as close to home as possible according to the care it requires.

The result of this lack of clarity across the country has been significant, with many other networks struggling to find a host Trust and agree budgets – and because staff were deemed “at risk” due to their previous employer being an SHA/PCT, many were lost to the wider reorganisation. This has had a detrimental knock-on effect and concerns remain as to the possible fragmentation and inequity across the county for neonatal networks, which goes against the very ethos at their heart and the DH 2009 Toolkit Principles.

We have been very fortunate to avoid this and it is appropriate to thank Peter Dixon, our lead specialised commissioner for helping to make it a problem-free and frankly quite easy process for us. I just hope that the potential uncertainty still surrounding the longer term funding is clarified in plenty of time before next years budgets are set as nationally this is now a real concern.

Against the backdrop of these wider organizational changes across the NHS, we as a Network have been focusing on our own priorities and issues. Much of the energy in the first half of 2012/13 centred on finally agreeing a long-term strategy for neonatal care across our region that would enable safe and sustainable services to be maintained, allowing us to continue giving the very highest quality care. This was drafted by Dr Steve Byrne, previous Clinical Lead and agreed and subsequently ratified by the Network Board in October 2012.

The main headline change suggested was to move to a 2-NICU model, with one Unit based in the North of the region in Newcastle and the other in the south, with a 3-NICU model as an interim measure, utilizing the existing facility in Sunderland. This is the vision amongst our clinicians and senior nurses/managers on the Board and is based upon sustainable levels of medical and nurse staffing that meet recommended national standards and acknowledge the potential impact of a national tariff related to activity that may struggle to sustain three, let alone four NICUs. It remains first and foremost a quality issue however; not a financial one and will, if accepted, take a great deal of consensus, agreement and planning amongst providers and buying in to this plan to implement it, but we as a Network are fully committed to it, as we feel it is the best way forward and will enable us to deliver the care we aspire to and that our local families deserve with the aim
of improving and maximizing their outcomes.

It is appropriate at this point having mentioned the Network Strategy to thanks Steve Byrne for his part in drafting that document, but also acting as Clinical Lead from October 2010 till the end of March 2013 when he stepped down. Steve has played a key role in some significant Network priorities over that time and helped chair some important clinical forums and help kick start our now regular and established clinical governance and case review meetings. He has been supersed ed by Dr Sundee Harigopal, with whom we look forward to working as we move into the next phase of our development as a Network. Sundee brings a different perspective, working as a consultant Neonatalogist at the RVI and is keen to help drive forward the Strategy that Steve drafted, so his leadership, energy and vision in helping make that happen is very welcome indeed.

There have been a few significant retirements of long-serving clinicians and nurses across the Network over the year, including Eileen Downs (nee Swinton), former Network Educator and who I pay tribute to in the Education and training section, but it is only right to make special mention of the sad passing of Dr Sam Richmond, who had worked for many years as a consultant at Sunderland Royal Hospital and been one of the original pioneers of neonatal care across the region, building up the NICU there almost single-handedly in the 1980s and 90s. His contribution to the field in general and the region in particular cannot be overstated, as well as his regular involvement with NLS (Newborn Life Support) courses and early championing of the whole networking method of providing neonatal care that saw us formally set up in 2010 and he is very much missed by all those who knew and worked with him. A very moving tribute was paid to Sam by his former consultant Neonatalogist colleague Dr Majd Abuharb in the spring edition of the quarterly Network Newsletter that I cannot add to really but I do want to put my own thanks on record for Sam’s life, career and achievements here too.

Despite the significant challenges (not least not even being sure of our own future in our current form for many months) that we have faced over the last 12 months during the “transition phase” of the NHS and our re-designation as an ODN, we have managed to make some significant progress against many of the targets we set ourselves. Some have proven impossible due to not having the services of a Network Educator and the way the reorganisation of the NHS took place, but I believe we have done some exceptional work as a Network. These are detailed in the rest of this Report and I hope you agree when you read it that this has been the case. Significantly, we managed to undertake some important new initiatives under the leadership of Dr Richard Hearn and Pat Dulson, who have both helped put simulation and developmental care on the map for us and we aim to continue building on the project work they did for the last few months of the year 2012/13 in the coming year. There are separate sections describing their work and also highlighting our main achievements during the last year in the Report that follows and I want to pay tribute to them for their hard work for us.

Some other areas we aimed to make progress on have proved more challenging for other reasons and we have had to rethink our approach to some of these and pledge to look again at them, such as NorBOS and some of the more difficult data reports, but we are already discussing how we can do that. We’ve made a good start on looking at Clinical Governance across the Network and also established our twice-yearly case review meetings as well as the clinical forums, which have enabled us to focus on some key clinical issues.

One challenge we now know we will face in the year ahead is trying to continue promoting training and education without the benefit we have had over the previous 2 years of any funding from the commissioners – this
previously amounted to £50k per annum and made a significant difference to the Network but we were told very recently that no funding will be available to us this year. Whilst this is very disappointing, we still hope to be able to deliver things like the Stabilisation Training Programme and other priority initiatives. We also have, as a Network, agreed to explore setting up a charitable arm in order to try and tap into sources of funding for education and training that might not otherwise be available to us and which would allow us to continue ensuring our workforce is equipped to provide the very best care possible.

One exciting development on the national scene is the recent establishment of Clinical Reference Groups (CRGs) for specialised services, including neonatal care. These were originally suggested as “assurance groups” but have more latterly been redefined as “the key mechanism for the development of specialised services contract products for 2013/14 and beyond.” They have been tasked with ensuring that service specifications and clinical commissioning policies are delivered on time and to a high quality standard. They are significant because they will have broad representation drawn from clinicians, commissioners, public health experts but crucially patient and carer representatives too. They have already been helping draft and revise national specifications that set out the standards and basis upon which services will be commissioned via Trusts and we already have such national specifications for neonatal care, neonatal transport and paediatric transport – all of which have implications for us to ensure that standards are met and which will help define the quality of services. We have, as we are going to press, been pleased to have confirmation that the northern representative on the national neonatal critical care CRG will be our very own former Clinical Lead, Dr Steve Byrne – and we look forward to working closely with him in his new role and benefitting via a strong 2-way relationship up to and down from the CRG itself.

Amidst all this change, we as a Network have “set our stall out” and agreed our main priorities for the coming year 2013/14. These will include, but not be limited to the following:

- Translating the agreed Network Strategy document into a firmed up plan for the delivery of neonatal care in the medium to long term across the region. We are aiming to use the 4th Annual Network Event as a Springboard for doing this and this will be a main priority area for Sundeep in his role as Clinical Lead.
- Work with our colleagues in paediatric intensive care to draft a suitable business case for a combined paediatric/neonatal transport services.
- Establish the common areas of clinical and practice development we can work together with our colleagues and counterparts in the new Maternity & Children’s SCN, seeking to minimise duplication but agreeing those areas that affect us together and enabling us to utilise our joint knowledge, expertise, talents and resources on key priorities.
- Clarify our role as an ODN in the new NHS architecture and work with the NHSCB as principal commissioners and our stakeholders to continue delivering first class neonatal care within the resources made available and an appropriate programme of care accordingly.
- Recruiting a second Board Parent Representative to help Gillian Baty with ensuring we have a strong parent voice in the major decisions we need to make. Gillian has effectively been on her own since Vicki Lynn stepped down last autumn and has done sterling work in her own time already. We have made this a top priority.
- Continuing to develop our key work streams along the lines we have used successfully over the last year – including our quarterly clinical forums focusing on key clinical issues. This has recently included data, where we agreed our new Network priorities that Mark Green describes in his section and also nutrition, which we hope to use as a springboard for a new group to help drive work on this area forwards with representation from all our Units, including agreeing and drafting suitable new Network guidelines.
- Appointing a new Network Educator who can take on the education and training priorities we have set ourselves, including taking stock of the post-registration university modules to assess how well the re-vamped system is working and equipping our nurses. We also aim to continue developing and rolling out the now established
Stabilisation Training Course to SCBUs and provide opportunities for more new workshops, study days and staff development.

- Working towards drafting a suitable strategy for the future of Advanced Neonatal Practitioners (ANNPs) as a key area of our workforce. This will include the future training up and ongoing support of nurses who wish to work as ANNPs and recognising that utilising them may be an option for maintaining neonatal services in SCBUs, particularly where medical staffing issues will be even more acute in the coming years. This will be the main priority for Lynne Paterson in her role's Network Nurse Lead in 2013/14 and we have already held some initial exploratory meetings with senior nurse director colleagues and university representatives to sound the viability of this out as a collective vision.

- Working with our colleagues across the specialties to agree a strategy for end of life/palliative care and for babies and children with life-limiting conditions. We aim to then draft a suitable Comfort Care Plan that can be used by all agencies in their care, including in the community.

If we can achieve these aims and continue to develop as a Network, I am convinced we can continue to demonstrate our worth and benefit to our stakeholders and remain both fit for purpose but more importantly the engine by which neonatal care is collectively delivered across the region and we can approach the future with confidence. In closing I would like to thank the Board and my colleagues in the core management team over the last 12 months for their help, support and hard work.

----------------------------------------------

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

As we produce the third Northern Neonatal Network Annual report, it is time to reflect on what the Network has achieved. Steve Byrne from whom I took over as Clinical lead has done an excellent job and we would like to thank him for all his input especially in setting up the Network Stabilisation Training course (SCAR1) and putting together a Network strategy document that now has clinical consensus.

The NHS England has outlined in their document 2013/14 NHS Standard Contract For Neonatal Critical Care that there is a growing body of evidence both nationally and internationally that suggests that caring for babies born before 27 weeks and those in other higher risk category groups should be concentrated in relatively few centres. This is to ensure that expert and experienced staff treat sufficient numbers of cases to maintain a safe, high quality service and move towards the national standards & maximise the use of scarce, expensive resources. To achieve this we need to move to a two unit NICU model but may need a three NICU unit model in the interim which is part of our Network strategy that now has clinical consensus. This will address the issues such a workload, staffing and capacity. Lack of capacity has resulted in transferring babies and the continuing shortage of middle grade staff has resulted in running inflexible rotas. We will be looking to work with maternity and child health networks as they find themselves in a similar situation. Therefore, there are challenging times ahead to implement the
strategy. I look forward to all the support we can get to make the Network strategy a reality.

There has now been some significant progress made on the transport service front. There is a clinical consensus to move towards a unified paediatric and neonatal transport service located in one centre. We are working along with our colleagues in paediatric intensive care (PIC) and hope to have a fully functional service by the end of 2014.

Although we were one of the last neonatal networks to be established officially, we have successfully addressed some education issues in the form of the stabilisation course, respiratory workshop and the simulation workshops which Dr Richard Hearn reports on elsewhere. Unfortunately due to the current financial situation, we do not have any further funding for Network education and training as we have in the past 2 years and the ongoing success of trying to maintain some of this will depend entirely on the goodwill of the already busy clinicians and nurses. Until now we have written various Network guidelines on topics including Therapeutic Cooling for hypoxic ischemic encephalopathy, Necrotising Enterocolitis, (NEC) Mouth Care, Lactation and Newborn blood spot screening. The Network has successfully run two annual respiratory workshops, and shared existing good practice via other sessions on developmental care, breast feeding and case discussions.

Lynne Paterson and Martyn Boyd have been in discussions with Northumbria and Teesside Universities and we hope to set up a neonatal nurse practitioner course which will provide an opportunity for nurses who wish to take this path and also address staffing issues.

I would like to take this opportunity to thank Eileen Swinton who was the Network Educator from 2010-2013 and who played a vital role in trying to establish the neonatal modules for nurses.

Finally, I would also like to thank my other Network colleagues Lynne Paterson, Martyn Boyd and Gillian Baty (our Network parent representative) for all their hard work and dedication.

Report from the Northern Neonatal Network
Nurse Lead – Lynne Paterson

It has been another busy year for the Network but perhaps for different reasons this year to last. We have had many changes implemented as a result of the new national organisation and we have also experienced some changes as mentioned elsewhere.

As to the role of the lead nurse and what I have spent time on this year. One of our biggest challenges has been the maintenance of neonatal nursing modules across the whole patch. With Eileen sadly retiring, there were some gaps to fill in terms of delivery and I would like to thank all of those Network personnel who stepped up to the plate to help out. There has also been much work going on behind the scenes making sure that neonatal modules were being delivered at both universities and as a result of many meetings, there are now modules which nurses can access from both Northumbria and also Teesside.

As most of you know Teesside did not run these for two years and this meant a lot of travel and difficulty with accreditation for the staff who had done their initial qualification at the Teesside end. We now have an intensive care module as well as a high/low dependency module for staff to access from both university areas. As a Network we will also be looking for some feedback on these in due course to make sure that both students as well as their managers feel that our QIS (Qualification in Speciality) training
continues to be fit for purpose and providing us in the service side with what we require in practice.

Also as part of training, I have helped out (as have many others) with the running of our stabilisation courses. These have been very well received and we have been able to deliver them to all of our special care areas and are currently revisiting these in the next year. Again, thanks to everyone who has been involved with these and especially to those who have done that in their own time.

A large part of my time has also been spent looking at the role of the Advanced Neonatal Nurse Practitioner (ANNP) in the region. I have put a paper together looking at what our needs may look like in the forthcoming years as junior trainee numbers are reduced and we experience more gaps in our junior medical cover. Martyn and I have also taken this paper to a regional meeting of Nurse Directors and continue to work on this so that we can move it forward to the LETB (local education and training board). This will detail our needs in terms of education for the future and how we can do this since currently there are very few training programmes for ANNP’s and these include Birmingham and Southampton, which incur additional travel and accommodation costs for our staff. We are presently liaising with others including university staff to map out the possibility of new ways of delivering this more locally; though obviously we also need to keep an eye on the costs.

I have been working with BLISS. Firstly in relation to the BLISS Family Care Nursing post for the Network and also applying for BLISS innovation monies.

The BLISS post was agreed with the Network and South Tees NHS Hospitals Foundation Trust and the job description developed with BLISS themselves. This post however is purely for local needs therefore the job description was based on some of those areas highlighted by the last PICKER survey so that we can really use this opportunity to specifically target some areas where we would like to raise our game. I am delighted to say that the post which we have now successfully recruited for will start by September once all the paperwork and associated details are in place. This will really be a boost for the whole region. Part of my role then will be to help induct Sue Thompson in this post together with Martyn and the other members of the Network and we will be coming around to visit all the units in the near future. I know that you will join me in welcoming her into this post in the Network.

An application was also placed for the BLISS innovation fund in relation to some work that Pat Dulson had suggested. Gillian Baty and I also sat together to develop this information further and to outline a parent’s booklet specifically for those babies who were born prematurely on what to expect with such issues as milestones etc. We also had ideas for apps which could be used by our parents. Unfortunately on this round we were not successful, but we will have more ideas in the future that I am happy to work up on the Networks behalf. So if anyone has any good ideas for innovations in the future and they want it worked up from a Network perspective, please get in touch and we can do this as a team. We will only stand a chance of being awarded funding if we repeatedly apply, so get your thinking caps on.

Speaking of Gillian, she came along to at least one of our managers meetings in the last year and was able to tell us some of the things which parents find difficult as they journey through our units and beyond into the community. One thing that was perceived as difficult was how the midwives and also the health visitors understand the needs of small and preterm infants. So, to this end I have been in touch with midwifery lecturers both at Northumbria University and also at Teesside University and Gillian and another member of her buddy group from Newcastle were kind enough to come along to a session for student midwives at Teesside University. There was a presentation done by both mums and then the students were able to ask questions and so a very interesting interactive session was had by all. I think that these are really valuable for our midwives of the future.

I had also put together a master class day aimed at Health Visitors and had started to identify if this would be something that would be of interest to them. This would be a whole day and would look at some specific issues which have been identified by Gillian and Vicky Lyn before her regarding growth, development and dealing with problems. I am still hopeful that I can pull this off with help from other staff within the Network before the end of this year.

Other things that we have started to unpick have taken a bit more time. We started to look at a consistent nasogastric tube feeding guideline and whilst this has not been completed yet, work has taken place and I will endeavour to revisit this in the near future.
Other work on guidelines and clinical governance continues and as always we rely on all staff to read and comment on drafts as they come through your emails.

Can I thank you for all your hard work in the last year and for all the work that still needs to be done so that we can continue to have high standards of care for our sick and preterm babies in the North East. As always, please let me know if there is anything that you want me to raise at the Network Board on behalf of nurses or anything that you would like us to work on in the forthcoming months and years.

Report from the Northern Neonatal Network
Data Manager – Mark Green

I have now been in post for 3 years and in that time there have been a lot of changes and developments in the data we collect on behalf of the Network and the reports we produce to monitor activity, occupancy and transport. A major change over the last year has been the need to switch to the new BadgerNet platform, which we aim to do in the next few months.

The quarterly report has also been modified and now includes a section on staffing numbers for each unit to complete.

The main on-going and new projects I have been involved with include:

1. The "Monthly Neonatal Dashboard"

The Dashboard has been the main reporting source for the last 3 years, and after a discussion with board members it has recently been modified to meet the need of the Network, and to include indicators and data that was useful to the units within the Network. These reports continue to be published quarterly and are available to download from the Network website.
We are always looking for suggestions and ideas on how to improve the dashboard and are happy to include any information that you feel is useful to collect and publish.

We now have three years’ worth of complete data to date, and we can start to identify trends, although no firm conclusions can yet be drawn, but it does give a very clear picture of the changes in activity across the Network over this period.

2. **Migration to the new BadgerNet Database**

As mentioned in last year’s report, each unit not currently using BadgerNet needs to migrate from V3 as soon as possible. This involves installing the client link on each desktop computer station within Units and other areas that access and input the data within the system. Apart from North Cumbria, who have been using BadgerNet for 2 years, two further units have successfully installed the Training and reporting clouds of BadgerNet, and we hope to have this installed on the remaining units by the end of the year.

Clevermed are constantly updating BadgerNet to meet the need of the Network with regard to dashboards, CQUINs and reporting, something that are no longer doing with V3.

The user interface is also very different, and the reporting tools more user friendly, and unit reports such as CQUINs can be generated very easily. Clevermed are offering full support but I will be helping users and Units with the migration if required, including Unit visits.

3. **Network Pathway Audits**

The 5 Network pathways have been analysed and the results are now available which includes 3 years’ worth of data. The Pathways aim to ensure the best care for mothers and babies throughout the whole Network and suggested monitoring to try and ensure that these agreed pathways are being followed with targets for Trusts to achieve. Each pathway also has a suggested audit metric that will be used to establish baselines for monitoring purposes.

4. **NorBOS (Northern Baby Outcome Survey)**

The aim of collating and analysing baby outcome data across the Network under the NorBOS banner remains a long-standing aim, but this has proved to be a significant challenge. Several factors have been influencing this and the national drive to look to improved patient outcomes means we need to move this back up the priority list, which is what we are planning for the year 2013-14.

5. **CQUINs**

Each NICU have signed up to an agreed number of CQUINs to be monitored on a quarterly basis and submitted to the North East Specialised Commissioning Hub. The 4 CQUINs are Timely Discharge, ROP, Breast Feeding and TPN. This data is available in the "Dashboards" section in BadgerNet.

6. **Staffing**

We first undertook the nurse staffing and cot occupancy project in 2010, with the results of 6 months’ worth of data showing that none of the 12 Units in the Northern Neonatal Network met the recommended minimum staffing levels at all times. We want to repeat this exercise on a quarterly basis to see if anything has changed in the 2 years since the first report was published.

Each unit have been kindly supplying me with the staffing levels on a daily basis for the last 6 months, and the aim is to match this up with the activity on each unit each day, and produce an in depth analysis on the staffing levels based on the activity levels per shift.

7. **NICE Quality Standards**

This remains a work in progress. We have managed to make some progress on quantifying a few of these Quality Standards, particularly in relation to recommended staffing levels (Statement 3). We are aiming to start Quarterly reporting on these in the new
financial year 2013-14 as we are getting the necessary staffing data from Units.

8. Transport

We now have a complete 2 years’ worth of data with regard to the transfers undertaken by the 2 transport teams within the Network. This is used to monitor the movement of babies throughout the Network, and any movement outside the Network. This information is being used as part of a business case for a stand-alone paediatric and neonatal transport service, which is the Network aim for the near future.

Future Data Projects and targets include:

Key Metrics

We are currently developing a "key metrics" quarterly report, which will include activity, pathways, NICE standards and CQUIN/NNAP indicators. The aim of this is to assist the units in meeting the CQUIN/NNAP targets, and to highlight any possible discrepancies/queries in the data, and will include a traffic light system based on agreed metrics. This may replace the current quarterly dashboard, depending on feedback received.

BadgerNet Migration

I am working with the units who are not currently using BadgerNet, to assist them with the migration from the old V3 Badger. BadgerNet is constantly being updated to meet the needs of the units with regards to CQUIN’s, dashboards, reporting, etc., something which is not happening in V3. I initially contacted each unit a couple of months ago, and everyone was happy for the switch to go ahead. We have successfully installed it at one unit and are hoping to install it in the remaining units as soon as possible.

Clevermed are currently developing an updated version of BadgerNet, which should have been released by now, however they can’t commit to a date when the update will be available, so I think it is necessary to go ahead with the installation of the current version and update to the new version when available. I will be contacting each unit to arrange suitable time to install BadgerNet, or you can go ahead with the installation if you are happy to do this. I am happy to assist in any way I can, however I can’t install the software and it is the responsibility of the local IT department, and it would be useful if each unit can arrange an IT contact in anticipation of the software installation. Once installed I will be happy to visit your unit if required and show you the basics of BadgerNet and what reports are available, and, of course, Clevermed are also available for any help or training requirements.

Routine Data Collection

The data collection and updating data systems is an on-going process, and we now have comprehensive data sets relating to all areas of Network activity. I am happy to answer any queries relating to Badger or Network activity and discuss bespoke reports as required – this has been happening with increasing regularity over the last year and is to be welcomed.
As noted in last year’s Annual Report, the NHS is undergoing significant organisational changes which will radically change commissioning responsibilities. Until 31 March 2013 Primary Care Trusts collaboratively commissioned specialised services via Specialised Commissioning Groups (SCG).

From 1 April 2013 NHS England assumed responsibility for direct commissioning of health care services, including specialised services. NHS England has four regions with 27 Area Teams, 10 of which commission specialised services on behalf of NHS England. Within the North of England, three Area Teams have been designated as specialised commissioners:

The key difference in specialised commissioning between PCTs and NHS England is that PCTs commissioned services on behalf of their populations and NHS England commissions services on behalf of all of England.

The direct specialised commissioning function of NHS England is supported by a devolved clinical leadership model. Clinical Reference Groups (CRGs) covering all prescribed specialised services, responsible for preparing national specialised service strategy and developing specialised service contract products such as specifications and policies. There are 74 CRGs are clustered around the five national Programmes of Care (PoC), which bring together services in functional groupings. One of the main CRG tasks is the production of national service specifications which will include specifications for Neonatal Intensive Care and Neonatal Retrieval Services. Each designated service will be assessed for compliance against the relevant service specification in the first half of 2013/14, with any non-compliance being addressed by an action plan to enable the service to achieve full compliance.
This last year has been so rewarding in terms of my involvement with the Network. There is so much to do and so much that I feel can make a real difference to the experience of parents who have a baby in a neonatal unit. My only struggle is trying to find the time to do the things I would like! For some time now I have been the only parent representative on the Network and as a result, I find myself being less pro-active than I would like and instead responding to issues, projects and requests that arise.

Parents' directory – This was initiated by Claire Campbell at the RVI as part of the family centred care initiative and Bliss audit. There are a number of families whose babies require care in more than one unit. Often they are unable to visit the unit their baby is going to and it is an obviously anxious time for them. We wanted to ensure that parents have easy access to information about the other units within the Network regarding size, cot capacity, staff, visiting arrangements, accommodation, car parking, etc. We have collated this information and it is available on the Network website. I would like to re-visit the format of this information and am exploring how other groups offer this information e.g.

Student midwife session – This was initiated and managed by Lynne Paterson. Lynne liaised with Margaret Bellamy, Senior Lecturer in Midwifery and Women’s Health at University of Teesside about speaking to a group of student midwives. Many mothers I have spoken to have had difficult experiences on the post-natal wards in terms of the midwives’ understanding of the issues faced by them after delivering a premature baby. Myself and another mum went along to a session and talked to the students about our experiences, including issues like helping mums to physically get to the neonatal unit and encouraging/supporting them to express breast milk. The students seemed really engaged and it was quite an emotive experience. We had very positive feedback from this session and hope to replicate it at Northumbria University.

I have also been involved in other projects that have required parental input. I am conscious that my view is that of one person so I always endeavour to gain a wide range of responses to any given issue. I met with Pat Dulson (Neonatal Physiotherapist) in relation to gaining parental views of the best ways of providing relevant information to them on how they can support their babies’ developmental needs while on the unit. I also recently met with Lynda Pittilla (Retrieval Coordinator, PICU) to talk to her about parents’ experiences of transfers between units and how that can be improved.

I am looking forward to working with the new Bliss nurse and possibly a new parent rep so that we can start to look at the issues facing parents and how we can work together to make things better.
A Report by Dr Richard Hearn

During the period from October 2012 – March 2013, I was tasked by the Northern Neonatal Network with the development of neonatal simulation and remunerated at 1PA per week. This was proposed as a way of increasing the educational utility of the Network’s 2 Laerdal SimNewB high fidelity simulators, originally purchased for the Network stabilisation course.

The RVI has from 2009 run regular resuscitation based multidisciplinary simulation sessions. These have been successful in improving clinical process and teamwork and communication. This is something increasingly reflected in the literature. The aim of funding simulation development for a period was to facilitate the development of this educational tool across the level 3 centres within the Network and then potentially on to the smaller centres.

The first step was to identify interested clinicians from the level 3 centres and form a simulation interest group. Dr’s Osama Hamud, Bernd Reichert and Steve Byrne and I are the consultants from the 4 units. In addition Dr’s Jill Spencer, Helen Chitty and Shalabh Garg, all HST trainees in the region have shown interest.

I have performed 2 site visits to Sunderland, 3 to North Tees and 1 to James Cook to deliver training on the setup and use of SimNewB. We have additionally run a training course in May 2013, taught by Laerdal, on the use of the SimNewB software and on the SimPad interface. As a result of these sessions all of the clinicians are now able to use the SimNewB to run both in-situ simulation sessions and as part of faculty for the stabilisation course. 6 core resuscitation scenarios have been written by myself and the HST’s and distributed to all of the clinicians in the group. The ethos from the start has very much been to share ideas across centres to develop this mode of teaching.

In addition to the aforementioned sessions I have used the Network SimNewB to deliver 3 simulation sessions in the special care unit in Ashington covering scenarios including, fetal haemorrhage, meconium aspiration, pneumothorax and the hypoxic ischaemic infant. These were all well received and illustrated for me the usefulness of this mode of teaching in areas where critical events are less likely to occur. I have also delivered, together with Dr Rob Tinnion, HST, a simulation session at the mini med school series of lectures in Newcastle University for prospective medical students.

The Network kindly funded my attendance at the Laerdal/ASPIH paediatric conference in Manchester in March 2013. This was a very useful exercise in terms of developing debrief and feedback which are vital components of simulation, probably more so than the high fidelity equipment, and in thinking about areas we could look at beyond neonatal resuscitation such as withdrawal of care and consent for procedures or post mortem.

Though the funding for further simulation development ceased in March 2013 work does continue - Bernd Reichert and I have attended the first North East paediatric simulation meeting at Northumbria University and together with Osama Hamud are collaborating in a training session at Northumbria University in July. This will hopefully be the first of many sessions and...
together with emergency/PICU/paediatric colleagues we hope to develop simulation and collaborate in the collection of qualitative and quantitative data.

I will be delivering a demonstration of simulation to staff from Durham and Darlington in July and continue delivering sessions both in the RVI and Wansbeck as well as providing support, and learning from the development of simulation, in the other level 3 centres. Two aims for the coming year are

- To entice staff from ANNP & nursing backgrounds to take part in developing and delivering simulation as the multidisciplinary nature of the scenarios benefits from the realism brought by the involvement of all the staff who deliver the clinical care.
- To continue to support the Network stabilisation course, we now have a larger faculty of individuals comfortable in the use of the Simulation kit.

Northern Neonatal Network Developmental Care Project – A Report by Pat Dulson

I was initially invited to discuss Developmental Care with the Unit Managers, early in 2012. The Network then proposed funding a project for a day a week over 6 months, this commenced in October 2012. My remit was to find out what was presently being delivered in terms of Family Centred Developmental Care across our region. Then identify the best and most efficient ways of supporting consistency of care, within present provision.

The overall development of premature infants can be affected by their early experiences whilst on Neonatal units. As staff involved in delivery of their care we need to strive to provide the most suitable environment and developmental experience for every infant and their family, from delivery onwards. The overall aim is to help to support their long term outcome and quality of care.


Survey of Family Centred Developmental Care across the Northern Neonatal Network, January 2013

Following review of the supporting literature, national reports and discussion with Parent representatives I designed an audit, in the form of a cross-sectional questionnaire. This was sent out to the lead nurse of all 12 units. The survey focused on 7 key areas of Developmental practise and delivery:-

1. Modifying the environment
2. Pain and comfort measures
3. Positioning support
4. Skin to skin (kangaroo care)
5. Feeding support
6. Family Centred care/support and information
7. Education and training of MDT.

The response rate was 100%. There were many positive areas which reflected a high level of commitment and agreement of approach to DC by staff within the Network. The survey also identified some key areas in which more consistency would be beneficial. Consistency is what parents tell us (Network feedback and POPPY) is really important to them, for e.g. support of skin to skin or tube feeding with skin to skin varying as they are transferred.
Key results

- 41% of units have feedback for sound levels. 8% had audited sound levels, as recommended in Bliss Baby Charter.
- All units offer parents guidance on Positive Touch and handling their baby from initial contact.
- Half of units use a pain scale and guideline. 50% of these were level 3 units.
- 83% of units have positioning nests. Half of positioning aids were funded by unit charities.
- 50% of units were able to provide gel head supports for infants.
- 100% of unit staff had staff with recognised training in developmental care (Neonatal Toolkit, NBAS, NIDCAP, Positive touch).
- 3 units presented regular teaching on DC for staff, (all level 3).
- 8.5% of all units had staff who had attended recognised DC training courses. - Toolkit for High Quality Neonatal Services: markers of good practice, principle 5. All staff should have training appropriate to their role, in assessing and providing developmental needs.
- DC workshops and Network website based information were voted most suitable for delivery of information across the large geographical area.
- Multi Disciplinary Team (MDT) - as a Network there is little provision of specialist MDT, as identified in the Neonatal Toolkit and other documents. NICE Quality standards for neonates 2010, Bliss Baby Charter.
- Therapies assessment and input is mainly in response to medical or nursing referrals, rather than being proactive and thus providing early intervention.
- Speech and Language – all but 2 units (level 3) can access.
- Occupational Therapy – 2 units can access Occupational Therapy.

- Physiotherapy – all units can access. Only one Specialised WTE across whole Network, funded by Tiny Lives Charity.

For the full survey result please contact pat.dulson@nuth.nhs.uk.

The findings from the project were fed back to the Unit Managers at a Network Forum meeting, early in 2013. This promoted discussion around Developmental Care, and ideas on how to continue to improve consistency of delivery. There was agreement that supporting staff, in clinical education, along with ‘pooling’ of information (skills, parent information leaflets, presentations), should be the first step. The importance of provision of developmental care education, early on in Neonatal Nurses Careers as part of their University modules was also suggested.

Project Outcomes

1. Developmental Leads identified all units – NICE 2010.

2. Professional Competence Education and training:

- Network Developmental Care study day/workshop 1/5/2013, Allergate House, Durham. This was fully subscribed with MDT and Developmental Lead Nursing staff from 11 units. Focusing on key areas identified in survey.
- The feedback was extremely positive; we managed to cover many DC topics, theory and practical over this collaborative day. Anne Wall, retiring Matron from the Friarage, Northallerton, generously shared her experience of NIDCAP training and skills and talked about how DC has changed over her career. Networking and sharing DC ideas between units was also well received.
- Neonatal Toolkit Course, – the need for all units developmental lead staff to be encouraged to attend this course was identified. Funding was then provided and places secured by the Network to send 6 Network staff on this nationally accredited Developmental Care Course. They did this at the end of April 2013. Planning to then cascade information to staff on their units.
• Educational posters and presentations were produced and shared with staff who attended the DC workshop, again to cascade on their units. These focused on key areas of Developmental care identified by survey: Tube feeding with KC, Skin to skin, Supportive positioning, Family Centred care support for parents, Preparation for discharge.
• Developmental supportive equipment and manuals were provided for each unit. In particular trying to improve the consistency of provision of Gel Head support between units.
• Environmental Audit Equipment was purchased by the Network. The plan is to share this across the units, with each unit aiming to audit sound and light levels and feed their results back to staff and parents, once the next year. This fulfils part of Bliss Baby Charter.
• Northumbria and Teesside University – High/Low Dependency module. Developmental care presentation/workshop to commence 23/10/2103.

3. Network Developmental Care Guidelines – draft for review
4. Improved consistency, quality and ongoing advancement of Family Centred Developmental Care across the Network.

Looking forward to 2013 -14 and working within present Clinical roles staff plan to continue to support Developmental Care:

• Network Developmental Care study day / workshops
• Feedback from the Environmental audit, which will be ongoing across units over the next 12 months.
• Networking and cascade of information between developmental care leads/groups.

Developmental Care - Where are we as a Network?

From the survey findings and discussions with staff and parent representatives we know there are many Network staff with skills, knowledge and a strong commitment to delivering age appropriate developmental care, on their units. There is a need however, to continue to raise awareness of the scope of developmental care, and the evidence behind it. This includes the sharing and evaluation of practise. The initial need is to have agreement of care in terms of the ‘Generic Model’, so guidelines, environmental audit and information and commitment, this is where we now.

‘The Individualised Model’, is the gold standard and is where we should be working towards for the future as a Network, Bliss Baby Charter. To enable this, key staff across disciplines would need to be supported in more advanced training, such as NIDCAP- who would then go on to provide leadership and advanced knowledge in developmental care.

There is only one unit with a WTE Therapist Specialising in Neonatal Care within the whole Network; this post is fully funded by charity (Tiny Lives). Developmental care practise, consistency and quality would be further improved by funded Therapy MDT posts. As recommended by several reports, Neonatal Toolkit, Bliss Baby Charter, NICE Quality Standards for Neonates 2010.

This project has been a real challenge, and is in reality ongoing. I was helped along the way, in particular with delivery of the study day by: Claire Marcroft, Clare Ellerby, Helen Smith and Anne Wall.

Pat Dulson
Clinical Specialist Physiotherapist in Neonates
RVI
Network Annual Data Report 2012-13

As a Network, we now have almost three full years' key data available to us. This is taken from a number of sources, but primarily the Badger database that contains all the baby episodic data relating to the birth, admission(s) and care during their inpatient episodes. We also continue to get a monthly Dashboard return from each Unit, centring on key metrics such as births, key infection rates and activity-based data such as in and ex-uterus patient flows in, around and out of the Network. This has enabled us to build up an increasingly rich source of data that we are increasingly able to look for trends developing. All the data for cot days is taken directly from the Badger. Births continue to be collated manually via the Monthly Dashboard. We are also now starting to look at nurse staffing levels and by receiving the daily numbers from each Unit, looking to provide reports that will allow them to see how they are meeting the minimum staffing levels recommended by BAPM and the DH Toolkit as well as the more recent NICE Quality Standards.

Once again, we have summarised in a comprehensive manner the main areas of activity that all 12 Units across the Network experienced over the last two years - 2011-12 and 2012-13. We have again concentrated on births, admissions and the "cot days" for each Unit and allowed a comparison to be made between the two years to allow an assessment to be made of relative performance. Although no firm conclusions can yet be drawn, it does give a very clear picture of the changes in activity across the Network over this period.

<table>
<thead>
<tr>
<th>Unit</th>
<th>Designated Care Level</th>
<th>Live Births</th>
<th>Unit Admissions</th>
<th>Intensive Care (IC) Days</th>
<th>High Dependency (HD) Days</th>
<th>Special Care (SC) Days</th>
<th>Total Cot Days</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11/12</td>
<td>12/13</td>
<td>% diff</td>
<td>11/12</td>
<td>12/13</td>
<td>% diff</td>
<td>11/12</td>
</tr>
<tr>
<td>RVI</td>
<td>3</td>
<td>6956</td>
<td>7403</td>
<td>6.4%</td>
<td>794</td>
<td>804</td>
<td>1.3%</td>
</tr>
<tr>
<td>Sunderland</td>
<td>3</td>
<td>3563</td>
<td>3263</td>
<td>-8.4%</td>
<td>393</td>
<td>339</td>
<td>-13.7%</td>
</tr>
<tr>
<td>North Tees</td>
<td>3</td>
<td>3571</td>
<td>3392</td>
<td>-5.0%</td>
<td>343</td>
<td>339</td>
<td>-1.2%</td>
</tr>
<tr>
<td>James Cook</td>
<td>3</td>
<td>4365</td>
<td>4414</td>
<td>1.1%</td>
<td>354</td>
<td>399</td>
<td>12.7%</td>
</tr>
<tr>
<td>Wansbeck</td>
<td>1</td>
<td>2851</td>
<td>2691</td>
<td>-5.6%</td>
<td>416</td>
<td>417</td>
<td>0.2%</td>
</tr>
<tr>
<td>Gateshead</td>
<td>1</td>
<td>1985</td>
<td>1859</td>
<td>-6.3%</td>
<td>230</td>
<td>240</td>
<td>4.3%</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>1</td>
<td>1521</td>
<td>1434</td>
<td>-5.7%</td>
<td>144</td>
<td>114</td>
<td>-20.8%</td>
</tr>
<tr>
<td>UHND</td>
<td>1</td>
<td>3256</td>
<td>3074</td>
<td>-5.6%</td>
<td>230</td>
<td>235</td>
<td>2.2%</td>
</tr>
<tr>
<td>Darlington</td>
<td>1</td>
<td>2669</td>
<td>2511</td>
<td>-5.9%</td>
<td>232</td>
<td>218</td>
<td>-6.0%</td>
</tr>
<tr>
<td>Carlisle</td>
<td>1</td>
<td>1804</td>
<td>1742</td>
<td>-3.4%</td>
<td>270</td>
<td>236</td>
<td>-12.6%</td>
</tr>
<tr>
<td>Whitehaven</td>
<td>1</td>
<td>1396</td>
<td>1387</td>
<td>-0.6%</td>
<td>212</td>
<td>212</td>
<td>0.0%</td>
</tr>
<tr>
<td>Friargate</td>
<td>1</td>
<td>1343</td>
<td>1293</td>
<td>-3.7%</td>
<td>174</td>
<td>134</td>
<td>-23.0%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>35280</td>
<td>34463</td>
<td>-2.3%</td>
<td>3792</td>
<td>3687</td>
<td>-2.8%</td>
<td>7783</td>
</tr>
</tbody>
</table>

Table 1 – Main Network Activity Summary for 2011/12 and 2012/13
It again needs to be noted that all the data relating to the two Units at JCUH and the Friarage has to be manually disaggregated, as Badger only records their data as one combined “South Tees” Trust total due to the way they enter their data as one “Trust” rather than the two separate Units they are. There is therefore a caveat that whilst every effort is made to ensure the accuracy of this data for both Units, it can only be held to be “approximate” with a potentially tiny margin of error; whereas for the other 10 Units, the data is as reliable and valid as can be expected where data entry on the system is correct.

As table 1 shows, there have in most cases been a slight decrease in activity across the Network. A slight decrease in births (down by 2.3% on the previous year) has seen a slight decrease in admissions to our Units (equating to -2.8%) and in terms of total activity as measured by cot days, there was a 7.2% decrease. The admissions to our NICUs were generally slightly lower, although there was a slight increase in admissions to the RVI and a significant increase in admissions to JCUH. However, the average occupancy rates for the RVI in particular remains consistently above the British Association of Perinatal Medicine (BAPM) recommended level of 80%. This reflects the fact that on many occasions, demand for cots at this Unit regularly outstripped supply, which is problematic with the need for regular referrals to Newcastle as the regional/Network centre for neonatal surgery and other specialist services that require non-cardiac investigations.

Table 2 opposite shows the total number of “cot days” that each of the four NICUs provided over the last year. As last year’s Report mentioned, the aim/aspiration was for the commissioning basis for neonatal care to change in two ways – firstly for all care to be commissioned by the new NHSCB (which has happened) and following on from that, for a national PBR (Payment By Results) tariff to come into operation by April 2013. Unfortunately, this has not occurred, which is understandable given the change to the new NHS landscape with the simultaneous removal of both SHAs and PCTs. This has meant that the previous system of “local” tariffs for NIC and HD has been rolled over, with most of the SCBUs agreeing block contracts not related to particular levels of activity. It remains to be seen if the proposed PBR tariff will be in place and operational by April 2014, which now is the aim, but that will, if it happens, bring a much greater degree of transparency and potentially eliminate marginal rate activity and each Unit would be paid according to the cot days they deliver. The impact of this on the Network has yet to be fully quantified, but it will be something we closely monitor and help Trusts understand.
Table 3 opposite shows the average occupancy levels of each of the Network’s 12 Units over the year 2012/13. The British Association of Perinatal Medicine (BAPM), DH Toolkit (2009) and NICE Quality Standards (2010) all recommend 80% occupancy as an average recommended safe operating limit and this also continues to be used in calculating the “standard” contracted activity rates for NIC/HD in the NICUs by NHSCB. Local flexibility means it is not unusually for Units, particularly the NICUs to operate above their “official” cot limit for short periods, but this can and should not be sustained as it can become potentially unsafe and have a negative impact on outcomes and the ability of the service to cope with unforeseen emergency admissions.

As can be seen, the RVI continues to regularly operate above this recommended 80% level – for all four quarters, the average Unit occupancy was above this. JCUH was regularly operating at or just under 80% average occupancy. Although detailed analysis of Network data shows that all Units are occasionally operating at or above this level even reaching capacity at times, the average occupancy rates, especially for the SCBUs.

As these two tables (4 and 5) opposite show, with 3 years worth of Network data, we can attempt to start monitoring such high level data for trends, but these would seem to suggest that there are no firm ones yet, although the live births at the RVI and JCUH have risen in the last year and the total admissions at the RVI remains higher than it was in the previous 2 years and continues to rise. Admissions at both the Friarage and South Tyneside have decreased in each successive year, the only SCBUs where this has happened.
By contrast, as table 6 opposite shows, the demand on available cots in terms of total activity as measured by "cot days" has been rather more fluctuating over the last 3 years. For example, after two years of successive rises, for the first time in 3 years, the total cot days at the RVI fell slightly during 2012/13 which is in contrast to slight increases in births and admissions. Other Units’ data is less consistent. It is worth noting however, that the total cot days at four of the Network SCBUs – Gateshead, UHND, the Friarage and South Tyneside has decreased slightly in successive years, although the table doesn’t suggest this for the latter in 2010/11, but we did not have any data for the first two months of that year, but it does remain the case. For both South Tyneside and the Friarage, this correlates to the reduction in admissions.

As has been pointed out, 3 years worth of data is not sufficient to start drawing firm conclusions about long-term trends, but come next years Report for 2-13/14, an additional full year of data for all these metrics will allow a more confident prediction to emerge as to whether medium-term trends can be established, or ad-hoc fluctuations are more consistent with the figures. It may certainly help the Network and individual Units and Trusts plan more effectively individual capacities and staffing levels, especially when mapped to patient flows.

Table 6 – Total cot days by Unit (3-years data)
Neonatal Transport

We now have, as a Network, collected two full years worth of transport data directly taken and coded from the transport record sheets used by the teams themselves. This has enabled us to standardise the way we collate the data and the reports we have been able to produce. Each team continues to use their own data for internal purposes and in the case of the RVI, this forms an integral part of the comprehensive Annual Report that is compiled and distributed by Alan Fenton. The aim has continued to be to focus on the key data fields that enable us to monitor the transport teams’ activity and summarise the main reasons babies are moved around the Network, including the crucial flows from Level 1 SCBU to Level 3 NICUs as these constitute the emergency or “time critical” transfers where babies require more intensive levels of care than are routinely provided at the referring Unit/hospital. Without a robust and reliable transport service, these patient flows would simply not happen in the agreed and necessary way and it continues to be testament to the hard work of the transport teams moving these babies that the service works so well and the needs of the babies and their families are met, with very, very few babies having to be transferred “out of region” – a record all our Units contribute towards with them and which we can be rightly very proud of.

During 2012-13, Neonatal transport services across the Network area continued to be provided by two teams - from the RVI, Newcastle (led by Dr Alan Fenton, Consultant Neonatologist and Sister Sue Gourlay, Lead Nurse for Transport) and JCUH, Middlesbrough (led by Dr Mithilesh Lal, Consultant Neonatologist and Sister Caroline Cleaver, Transport Co-ordinator) utilising the NEAS (North East Ambulance Services). This co-ordinated service enabled the teams to maintain a comprehensive regional service for babies needing urgent transfer for intensive care, surgical and cardiac treatment, repatriation or “back transfers”, as well as transfers of paediatric patients less than 6 months or 6kg in weight. The main activity for both teams continued to centre on transferring babies from Level 1 SCBUs to Level 3 NICUs postnatally when they require levels of care that cannot be provided locally, then the return journeys to their base Unit.

The regional neonatal transport service has operated on these principles for many years now, since the early 1990s – it was actually a pioneering service way ahead of its time and in recent years, other neonatal networks have commissioned stand-alone teams using staff dedicated to transport services alone. In the last 6 months, national specifications have detailed the service standards that should provide the basis on which commissioners seek to commission transport services. We know that our own services cannot meet some of these key specifications, particularly on staffing levels and a similar, indeed wider gap exists within paediatric intensive care transport regionally.

Recognising this and the need to plan for both transport services to meet these national specifications, exploratory discussions began last summer (2012) to try and establish potential options for how future services could best meet the needs of both babies and children needing transfers of all types around the joint Network area. The result of this has been in the last few weeks to agree a joint strategy that seeks to detail the options available to both services. The recommendation is to establish a combined, stand-alone, supernumerary dedicated transport service for both PIC (Paediatric Intensive Care) and NIC (Neonatal Intensive Care), so a joint project and stakeholder group has been set up to prepare a suitable business case for a “PIC/NIC” transport service. By combining our expertise and resources, we hope with our paediatric colleagues to create a transport service fit for purpose and “future-proofed”, that would compare and we hope surpass those now operating elsewhere across the country and provide first class care to babies, children and their families right across the north east and north Cumbria, helping to improve outcomes for all. Hopefully by the time of our next Annual Report in 2014, we can feature the progress we have made on the road to making this vision a reality.
The total transport activity for the last 12 months is down slightly on the previous year, from 710 in 2011/12 to 663 – equating to a fall of roughly 6.6%. However, it should be noted that last years Report suggested that a rise of 20.3% in transfer activity had occurred from 2010/11 (albeit using slightly different starting points across the calendar, which was substantial, so taken across the two years that Network data now exists for, this represents a rise of about 12.4%. Obviously with only the two years' worth of consistent transport data coded in the way we have, it is difficult to attempt to describe firm trends, but these figures, taken with historical data independently collated from both teams does suggest the trend remains firmly upwards over the last 10 years.

Table 8 therefore shows a 2-year comparison of activity for both NIC transport teams, quantifying this slight drop for the RVI and JCUH teams from last years figures.
Table 9 attempts to show the various reasons why babies were transferred into the four NICUs. This is for all types of transfer, including “back transfers”. “Surgery” is coded when a surgical procedure has been booked, rather than where babies merely require a surgical opinion and it also includes babies who were pre-booked for laser treatment for Retinopathy of Prematurity (ROP), which is performed at both the RVI and JCUH.

Transfer “urgency” can be a subjective assessment at times, as previous work done nationally by Alan Fenton has shown, but as with last year’s report, we have tried to apply consistent definitions across the Network when coding our transport sheets. This means we have been able to try and demonstrate the “types” of transfer into each of the four NICUs.

As can be seen from Table 10 opposite, this shows a marked difference for transfers to the RVI in particular – of the 219 during 2012/13, 186 (84.9%) were “unplanned”, meaning they would usually been deemed “urgent” in nature, where a baby required a cot for either NOCUY referral, or surgical or other specialist referral. The 18 “back transfers” into the RVI would usually refer to those babies who had to be moved out of the RVI when they have been full, as there would be few other reasons for any baby to be moved out. Unfortunately, this continues to be a regular occurrence.
Table 11 It is important for the Network to have a grasp and understanding of the patient flows that occur around the region, particularly with respect to the flows into the four NICUs and where the referrals come from. Table 11 opposite demonstrates this for the year 2012/13. Effectively, this shows where babies went to from each of the 8 SCBUs, but it also helpfully summarises those babies being transferred into the Freeman Hospital, typically for cardiac referrals. It would not usually include babies taken for ligation of patent ductus arteriosus (PDA) as these are usually taken to the theatre there by one of the teams from the RVI or JCUH, have their operation then taken straight back to the referring Unit without being “admitted” for ongoing treatment as this usually occurs back at the referring NICU.

This summary also shows that in the whole year, only 8 babies were transferred “out of area”, which remains the lowest rate in the country and also includes “back transfers” from our four NICUs where other regions (typically Yorkshire and occasionally Scotland) are full and need to use one of our NICU cots. This remains an outstanding achievement for the Network and means that very few babies have to be transferred large distances to other regions, with all the problems that creates for their families.

Finally, Table 12 opposite shows the number of transfers undertaken over the last 2 years by each team from the RVI and JCUH when split for NIC and PIC. This shows the general slight total reduction in activity between last year and this, but it also demonstrates a reduction in the number of transfers that our teams did for PIC babies. This may be partly explained by a comparatively “milder” (or at least less severe) winter, as the number of paediatric babies needing transfer for treatment of bronchiolitis tends to rise at such time. Factors like this are useful to consider for the planned combined PIC/NIC transport service.

Table 12 – Total PIC/NIC transfers by team (2-year comparison)
Northern Neonatal Network Education and Training

The last year has been a very challenging one for the Network in terms of its Education & Training strategy and associated aims and objectives. For most of the year we were without our Educator, who took early retirement at the end of March 2013 following extended sick leave. It is appropriate to start by putting on record for this Report a suitable acknowledgement of the work that Eileen Downs (formerly Swinton) did during her time in post with us.

Starting from scratch in March 2010 and whilst initially only in a half-time post for the first two years, Eileen helped get us up and running and has provided a very good foundation for our future in terms of the educational strategy and vision she drafted and formulated, as well as the hard work she put in with the University Modules and putting the Stabilisation Training for SCBUs together, which continues to be very popular and is reviewed later in this section.

At the time of writing this report, we are actively trying to recruit a suitable successor full-time Educator who can build on the firm foundation Eileen left us and take our vision to the next stage of our development as a Network. In the meantime we are very grateful to Eileen for her hard work for the Network and wish her a long, healthy and happy retirement.

In the absence of dedicated Educator input, we have still managed to focus on some key educational and training issues over the last year 2012-13 and formulate some further priority areas for us to consider over the next 12 months and beyond. We have also managed to put the second year's funding of £50k from the NESCG (North East Specialised Commissioning Group) to very good use. Two very high profile and specific examples of this are the project work that Dr Richard Hearn and Pat Dulson did for the Network and are fully outlined previously in this Report.

Of particular importance was the Network's aim of delivering the Stabilisation Training course to every SCBU across our area. We managed to do this over the course of the calendar year 2012, taking the course to five different Trusts and by combining this for two sets of staff at some of our Units, we made it a viable programme that managers could commit staff to and by utilising the backfill monies as agreed were helped to release staff to attend. This has included nurses of all bandings and doctors of all experience – from SHOs to consultants.

Last year's Report contained some detail as to this course and why we were so keen as a Network to support the staff in the Level 1 SCBU Units with the critical perinatal, pre-transfer period when babies needed to be transferred to a NICU for more intensive, specialised care, usually related to their prematurity or problems at birth if they are term.

The feedback from those who have attended the course has been very positive indeed and has also been useful in helping us to look at tweaking the content when we take it back on “Round two” in our attempt to enable all staff working in the Network SCBUs access to this in due course. Some of the feedback we have had includes comments like this;

"Very beneficial day. Relaxed and enjoyable."

"All neonatal staff should attend the workshop; it is a very good study day!"
“Excellent workshop”

“Very good study day to keep up these skills...”

It is therefore unfortunate that we heard very early on in the current new financial year that the funding we have been given for each of the last two years of £50k for this and other Network training and education has been stopped due to lack of funding availability with the new NHSCB, despite us making a strong case for continued need and how we could easily utilise such a recurring sum once more. This is very disappointing bearing in mind the benefits it has brought to the Network staff that we have highlighted here and in last year’s Report and the subsequent benefit this has on the care of the babies and their families, which is, of course, what we are all about.

It would seem that the prospect of future similar funding being forthcoming is slim in light of the anticipated NHS financial climate, but we as a Network are very keen to try and explore any other potential sources of funding which might allow us to continue supporting our priority initiatives and projects and these will be actively pursued as we believe them to be a crucial part of our education and training strategy.

Having said all this and illustrated the real challenges the Network has faced over the last year and on the horizon, it is very important that we highlight the real success stories on education and training and these are summarised as follows:

- As described in last year’s Report, we had been in discussion with the Universities at Teesside and Northumbria about revamping the post-registration modules for nurses, splitting them into a Low/High Dependency and a separate Intensive Care Module – this was in line with the work that Eileen had begun and aimed at preparing nurses for the work they encountered in their own Units. Both of these courses were delivered at both Universities for the first time and enabling students to decide where they wished to register and use the courses as a suitable pathway for both degree and master’s level qualifications. They are being repeated in the current year 2013-14 and during this period we as a Network are going to undertake a review of them to assess how well they are meeting hit needs of Units, students and the overall aim of making them reach Qualification in Speciality (QIS).

- As a key component of the Intensive Care Module has been the Respiratory Workshop the Network has run. This one-day course gives students a very thorough set of presentations and scenarios to help enhance their knowledge and practice in this key area. We hope to maintain this as an annual event.

- Nurses from both the transport teams at the RVI and JCUH were able to attend two update courses – the “PANSTAR” course held in Middlesbrough and also a 2-day course.

- The Network was able to help reduce a backlog in staff from across all Units needing to get their nurses through the NLS (Newborn Life Support) training required every 4 years by funding two full courses – including the very first in Newcastle, facilitated by Dr Rob Tinnion and Dr Richard Hearn.

- A team of ANNPs were able to attend a conference in London
along with the Network Nurse Lead Lynne Paterson, exploring their role in a developing NHS and enabling them to look to set up a Network ANNP Forum to help form a source of mutual support and discuss their own educational and training needs. This has meant the Network is now exploring a study day/workshop in the autumn of 2013.

- We funded places for nurses and support workers from across the Network on two study days looking at end of life/palliative care, held in Manchester and London. On the back of these and a further dedicated workshop that we facilitated and held in November at St Oswald’s Hospice in Newcastle, we have set up a project group to look at improving this key aspect of care and set about drafting a suitable Comfort Care Pathway that will hopefully eventually be used across the whole Network.

- The Network funded 6 places on a recognised 2-day course for Developmental Care as well as a workshop facilitated by Pat Dulson that has helped equip nurses from almost every Unit with key skills in this important and broad area of care. We also purchased a substantial amount of developmental care equipment for all 12 Units to improve the care babies get and their developmental outcomes through better positioning and other comfort measures when it is used.

In terms of our priorities for the year 2013-14 on the education and training front, as a Network we recognise that there are many significant challenges for us, but we are ready to rise to them. If we are able to recruit, as we hope, a Network Educator to aid us in this and take a lead on the priority areas we have already identified. Not least is the very real need to explore how we educate and train up the nursing and medical workforce of the future, which we anticipate will need to develop from the way it is currently shaped. The need for a course for training ANNPs is acute and we have already begun some exploratory discussions as to how this might best be facilitated – and where.

We also need to continue reviewing current post-registration educational provision and the further development of the modules and ensure our nursing workforce is equipped with the necessary knowledge and training – not just to be “QIS”, but so they can continue to deliver the very highest possible standards of nursing care. That also means working with our new partners in the LEBT (Local Education & Training Board) and the Academic Health Science Network – new organisations that we can tap in to make the most of the expertise available to us. If we manage to do all this and at the same time increase the range of support we give to all our Network Units and the various study days and workshops we facilitate and send nurses and doctors on where we are able to fund them, the future looks very bright indeed despite the challenges we face.
The Northern Neonatal Network – our details

Network Website – www.nornet.org.uk

Network Office – Northern Neonatal Network, Room 248, Trust HQ, Sunderland Royal Hospital, Kayll Road, Sunderland, SR4 7TP.
Tel (0191 541 0139)