AJW/KAD
13th March 2012
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Mrs Christine Chapman AM
Chair
Children & Young People Committee
National Assembly for Wales
Cardiff Bay
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Dear Mrs Chapman

Re: Children and Young People Committee – Neonatal Services

Please find below a briefing in response to the areas highlighted in your letter dated the 21st February 2012, in relation to the above services within Cwm Taf Health Board.

1. A copy of current local neonatal action plan, including information about the mechanisms in place to monitor and evaluate the implementation of the key actions within these plans and timescales.

   The current local neonatal action plan is attached with relevant timescales for action. Monthly meetings at Directorate level ensure ongoing action is undertaken and the action plan is monitored via the Chief Operating Officer at monthly operational team meetings, this enables review of progress and escalation of issues or timescale challenges.

2. A copy of the latest annual report on quality of care (as set out in standard 6.8 of the All Wales neonatal standards), alongside information on the number of instances when patient safety has been compromised.

   The expectation was that this would be available via the badgernet system held by the network, this has not been forthcoming to date. In order to address this the Health Board are in the process of linking into the National neonatal Audit programme which will in future assist in producing an annual report.

3. An outline of any action taken and any plans for investing into neonatal services in the short, medium and longer term to ensure all services in your area are fully compliant with the Standards.

   As identified within the enclosed action plan a full review of neonatal and children's nursing services is being undertaken and a workforce plan is under development. This will require some re-investment into neonatal nursing in the future to achieve compliance with BAPM Standards. Medium and longer term investment plans are being explored within the network programme.

4. The costs associated with cross border transfers, including the amount paid to English PCTs for the transfer of neonates as well as the income generated for Welsh providers.

   There have been no costs related to cross border transfers.

5. Whether you have had any discussions with WHSSC and neighbouring LHB about the overall increase in cots needed and any joint planning as to where they are located and at what level of intensity.

   Monthly meetings are held between Cardiff and Vale UHB and Cwm Taf HB to review all areas of the Neonatal Standards, these meetings have proved beneficial and have assisted in the following areas:

   Improved communication
   Improved transfer arrangements (reducing delays)
   Development of a rotational programme for staff
   Alignment of clinical practice

6. Whether any work has been undertaken with neighbouring Boards or the Welsh Government via WHSSC, on workforce planning to address what impact changes to junior doctor recruitment and the number of training places in the future will have on services in the coming years.

   The Health Board has plans in place to meet the shortfall in junior doctor's recruitment in the short term and is fully engaged in the ongoing regional work which is being undertaken.

Yours sincerely

Mrs Allison Williams
Chief Executive/Prif Weithredydd

		Compliance Dec 2011	comments	Action Planned	Timescale for Action
OBJECTIVE 1: ACCESS TO NEONATAL CARE **Rationale: All newborn babies who require over and above the normal birth pathway have equitable access to the appropriate level of care in a timely manner.**					
1.1	Neonatal care is commissioned to meet the local and national population need.		Local services in the main are able to provide care to level 2 babies, however accessing IC support is often problematic and may result in IC babies remaining within the unit for longer periods than would be expected. This may also result in high risk maternity cases being delivered locally when they require IC services as transfer of mother is deemed to be unsafe	To continue to work with the network to increase IC availability by enabling transfer of HDU and SC babies back to level 2 units	Ongoing
1.2	Neonatal care is available at all levels as close to home as possible as part of a MCN. Each MCN has defined Level III unit(s).		Although all levels of care are provided locally (within network) these services are not always available when required		

1.3	There is a clear referral pathway to and from all levels of care. These pathways include: feto-maternal assessment transfer of the mother antenatally (including from home to specialist centre for high risk management) neonatal transfer access for step up from level I to II and subsequent step down access for step up from level II to III and subsequent step down access to other specialist services i.e. surgery, cardiology, neurology and ECMO.		Relevant pathways are clear and there are local guidelines and risk assessments in place to ensure transfers are both safe and timely and are led by Consultant staff.	There is a need to develop monitoring systems within Cwm Taf to identify when IC care is being provided and when the network are contacted for support to monitor occasions when IC support is not available	End February
1.4	Effective communication mechanisms are in place for access to and discharge from level I, II and III services.			Develop Monitoring systems to identify delays in discharge/transfer between hospitals and home	End Feb
OBJECTIVE 2: STAFFING OF NEONATAL SERVICES **Rationale: Neonatal Services are staffed with appropriately trained, multi-disciplinary professional teams, according to the level of service they provide.**					
2.1	All units involved in the care of babies have established arrangements for the prompt, safe and effective resuscitation and stabilisation of babies.			Monitor any clinical incidents	In place
2.2	Staff trained in neonatal resuscitation are available at every birth. When delivery of a baby at <30 weeks gestational age is anticipated, a consultant or career grade/training grade doctor with neonatal training and experience should also be present.			Monitor training records	In place

2.3	All staff involved in the delivery of high- risk pregnancies are trained to recognise and manage neonatal and obstetric emergencies.			Monitor training	In place
2.4	When a delivery is planned at <28 completed weeks, arrangements are in place for the baby to be delivered at a level lll centre.		Transfer documentation and risk assessments are in place for safe transfer. Issue arise when there are lengthy transfers required due to lack of IC capacity within the region	Monitor transfer destinations	In place
2.5	All neonatal units have a designated neonatal nurse with protected time dedicated to providing teaching and education of the neonatal team.		Cwm Taf are not entirely compliant and this is being reviewed.	Establishment review to be undertaken	End Feb 2012
2.6	All MCNs should have in place a MCN with a clinical Chair who has time dedicated to the role.		Network	N/A	
LEVEL I Care in Level III Unit Neonatal Intensive Care					
2.7	A nursing ratio of 1:1 is provided for babies requiring Neonatal Intensive Care. The named nurse has post registration qualification in Neonatal Intensive Care.				
2.8	The unit can provide evidence that the establishment is correct for the number of Neonatal Intensive Care cots commissioned.				
2.9	Level III unit consultants have their principal duties to the Neonatal Intensive Care Unit. There is a neonatal consultant on-call rota.				
2.10	All consultants appointed to Trusts with Level III units have CCST in Paediatrics, Neonatal Medicine or equivalent training.				
2.11	A Level III unit has a separate middle grade staff rota.				

2.12	A Level III unit has SHO/SHO equivalent dedicated to the neonatal service.				
2.13	Clerical and support staff are in place in all units to provide discharge support, e.g. specialist nurse, liaison health visitor. This is in addition to the clinical establishment.			Will form part of establishment review	Feb 2012
2.14	Follow up support near the baby's home is provided by the local community children's nursing team in liaison with a specialist neonatal nurse.		There is no dedicated neonatal liaison nurse however neonatal staff support discharges	Will form part of establishment review	Feb 2012
2.15	Every level lll unit should have a designated senior nurse manager who is supernumerary to the staff establishment. An element of this role will be to manage the Level lll unit and its relationship with Level l and ll units in its network.				
LEVEL II Care in Level II Unit Neonatal High Dependency Care					
2.16	A nursing ratio of 1:2 is provided for babies requiring High Dependency care. The named nurse has training in neonatal care.		Substantive staffing levels are below BAPM standards at present, however bank staff (that are neonatal trained and known to the unit) are utilised and maintain staffing levels at BAPM standards on a day to day basis.	Will form part of establishment review	Feb 2012

2.17	The unit can provide evidence that the establishment is correct for the number of High Dependency cots commissioned.		Substantive staffing levels are below BAPM standards at present, however bank staff (that are neonatal trained and known to the unit) are utilised and maintain staffing levels at BAPM standards on a day to day basis.	Will form part of establishment review	Feb 2012
2.18	A Level II unit has one consultant who is responsible for the direction and management of the unit including the monitoring of clinical policies, practice and standards.			In place	
2.19	A Level II unit has 24-hour availability of a consultant or non consultant career grade doctor with neonatal training. This consultant can evidence up to date CME in neonatology and new developments.			In place	
2.20	A Level II unit has trained and experienced middle grade staff readily available to resuscitate and stabilise babies unexpectedly requiring short term intensive care.			In place	
2.21	A Level II unit has SHOs/ANNPs dedicated to the neonatal service.		In place in RGH not dedicated SHO in PCH		
LEVEL III Care in Level I Unit Neonatal Special Care					
2.22	A nursing ratio of 1:4 is provided for babies requiring Special Care.		Substantive staffing levels are below BAPM standards at present, however bank staff (that are neonatal trained and known to the unit) are utilised and maintain staffing levels at BAPM standards on a day to day basis.	Will form part of establishment review	Feb 2012

2.23	The unit can provide evidence that the establishment is correct for the number of Special Care cots commissioned.		Substantive staffing levels are below BAPM standards at present, however bank staff (that are neonatal trained and known to the unit) are utilised and maintain staffing levels at BAPM standards on a day to day basis.	Will form part of establishment review	Feb 2012
2.24	A Level I unit has a designated consultant paediatrician responsible for the clinical standards of care of the newborn babies.			In place	
OBJECTIVE 3: FACILITIES FOR NEONATAL SERVICES, INCLUDING EQUIPMENT **Rationale: Appropriate, up to date and safe equipment and facilities are available to care for babies with neonatal care needs and their families.**					
3.1	Neonatal facilities are commissioned based on population need, taking into account local differences.		Neonatal Capacity review undertaken in December 2012 identifies that there are a lack of SC cots within RGH which affects our ability to maintain HDU capacity	Action plan to reduce SC admissions and expedite SC discharges/ transitional care is under development	Action plan to be completed by March 2012
3.2	Neonatal facilities are adjacent to labour suites.			In place	
3.3	All units within a MCN have in place an IT infrastructure that allows consistent information to be collected and collated across the network.			In place	
3.4	All neonatal units are able to transfer clinical details of a baby electronically when a baby is transferred.			In place	

3.5	Support services are readily available. These include: Pharmacy Dietetics Therapy Screening Genetics Physiotherapy Social Work Speech and Language Therapy These include staff with expertise in the care of neonates.			In place	
3.6	An agreed appropriate budget is available to purchase and maintain equipment for neonatal care to meet these standards.			In place	
3.7	Joint working arrangements are in place with the local Medical Technical Department responsible for equipment safety and maintenance including the blood-gas analyser.			In place	
3.8	24-hour laboratory services are available which are orientated to neonatal needs.			In place	
3.9	Each cot on a Neonatal Intensive Care Unit or High Dependency Unit has the following equipment: a. Incubator or unit with radiant heating b. Ventilator* and NCPAP driver with humidifier c. Syringe/infusion Pumps d. Facilities for monitoring the following variables: i. Respiration ii. Heart rate iii. Intra-vascular blood pressure iv. Transcutaneous or intra-arterial oxygen tension v. Oxygen saturation vi. Ambient Oxygen. * Intensive Care Cot only			In place	

3.10	Each Neonatal Intensive Care or High Dependency Unit has access to the following equipment: a. Resuscitation b. Blood gas analysis (on the neonatal unit by unit staff) c. Phototherapy d. Non-invasive blood pressure measurement e. Transillumination by cold light f. Portable x-rays g. Ultrasound scanning h. Expression of breast milk i. Transport equipment (including mechanical ventilation) j. Instant photographs (consent based).			In place	
OBJECTIVE 4: CARE OF THE BABY AND FAMILY/PATIENT EXPERIENCE **Rationale: The baby and the family receive holistic child and family centred care as close to home as possible, with ease of access to specialist centres when this care is required.**					
4.1	Breast feeding is actively encouraged in the unit.			In place	
4.2	Breast feeding is facilitated by the provision of breast pumps, an area for expressing and for storing expressed milk.			In place	

4.3	Access to the following support services are available: Social Worker Spiritual Adviser Bereavement Counsellor Breastfeeding support staff Psychological/Psychiatric Advice Multi-ethnic health advocates and translators.			In place	
4.4	Post discharge care is provided for all babies by appropriate staff with specialist training.			In place	
4.5	Resources are available to support parent training.			In place	
4.6	Information is available at all antenatal facilities about post natal service provision.			In place	
OBJECTIVE 5: TRANSPORTATION **Rationale: A transport service, staffed by trained personnel is in place 24/7 for all areas of Wales, to provide rapid and timely transport for neonates to and from appropriate service across the network and country boundaries.**					
5.1	Transport services are planned and commissioned on an all Wales basis with working arrangements in place for each network and across the border with England. All units accepting and/or referring neonates have, or have access to, an appropriately staffed and equipped transport service.		CHANT service available 12 hours a day outside of this time transfers are reliant on WAST, on occasions transfers are made via WAST during day time hours when appropriate	Monitor transfer issues	In place
5.2	Arrangements are in place in partnership between maternity and neonatal units for the timely transfer of the mother (in-utero transfer) when a high-risk situation is anticipated. Written arrangements are in place for the transfer of the neonate who requires care at a level not available at the place of birth.			In place	

5.3	Written arrangements are in place for: the transfer of a mother with a high risk pregnancy across the network. the transfer of mother and baby together when moving back to a unit near home.		Written guideline for transfer and risk assessment of in utero transfer in place No written guideline for transfer of mother and baby in place at present	Develop appropriate guideline for mother and baby transfer	End March 2012
5.4	Staff responsible for transfers are in addition to those of the clinical inpatient team.		Staff are made available in addition to the clinical teams when transfers arranged		
5.5	Each unit keeps a detailed log of all transfers including unmet requests with the reasons. This information should be included as part of the MCN annual audit process.		Log of transfers kept unmet need issues not always recorded	Develop system to monitor all requests and escalate issues	Feb 2012
OBJECTIVE 6: CLINICAL PATHWAYS, PROTOCOLS AND GUIDELINES/CLINICAL GOVERNANCE **Rationale: Care will be delivered based on the best available evidence. Pathways and guidelines circulated widely and agreed nationally will ensure that the child receives high**					
6.1	Clinical pathways, guidelines and protocols are in place and audited within the MCN. These include as a minimum, hand washing, use of alcohol gel and the care and management of babies requiring: Antenatal steroid administration Surfactant therapy Ventilatory support Fluid management Inotropic support Inhaled nitric oxide ECMO		Partially met	To ensure all local areas identified are met	March 2012
6.2	An agreed protocol is in place for the resuscitation and management of the extremely preterm infant.			In place	

6.3	Protocols are in place to ensure babies are transferred between units within the network according to clinical need. Arrangements are in place with neighbouring networks to ensure a seamless service when babies need to be transferred across in Wales or across the border to England.			Network	
6.4	Protocols are in place for: a. Cerebral Ultrasound examination of the brain b. Screening and treatment for retinopathy of prematurity c. Screening for hearing loss d. Screening of hip abnormalities e. Post mortem examination procedures. f. Infection control (including HIV and Hepatitis B)			In place	
6.5	Every unit must submit detailed reports on morbidity to the MCN. The MCN will produce an annual report that assesses morbidity.		In process of development with MCN		
6.6	All babies with an identified neurodevelopmental condition should be referred to a local child development team.			In place	
6.7	Systems are in place to feed into National Databases - CARIS and CESDI.			In Place	

6.8	It is essential that each designated specialist centre:- • identifies a named individual who is responsible to the Trust clinical governance lead for the comprehensive capture of information on all neonatal cases admitted to the designated specialist centre; • produce an annual report for the Trust on quality of care; • participate in the all Wales audit programme co-ordinated through the MCN; • participate in national neonatal audit programmes coordinated through the BAPM - set up a clinical audit group; • to consider the audit report produced by the lead clinician and to recommend improvements within the Trust; • audit the service against these standards and report the outcome to the Trust clinical governance committee on an annual basis; • ensure exception reporting to the Trust Board occurs when patient safety is compromised; • ensure systems are in place for reporting, investigating and learning from adverse incidents.		There are named lead individuals in each unit. The health Board are linking with the national neonatal Audit Programme to ensure an annual report is available for 2012/2013. The Health Board has implemented Badgernet . There are robust governance arrangements in place with incident reporting of all untoward incidents.		
OBJECTIVE 7: EDUCATION AND TRAINING/CLINICAL GOVERNANCE **Rationale: All members of the multi-professional team are trained to the required standard to deliver a high quality service safely.**					
7.1	Staff attending home births, including paramedics are trained in Newborn Life Support (NLS).			In place	
7.2	All doctors and nurses caring for critically ill neonates have initial access to and a rolling revalidation programme for Newborn Life Support (NLS).			In place	
7.3	Post registration neonatal education is readily available based on a competency framework.			In place	
7.4	All staff involved in feeding babies receive training on supporting the family unit for successful breastfeeding.			In place	

7.5	Research into neonatal care is a core component of the service.			In place	