Paper ref:	TB Public (09/23) 016

REPORT TITLE:	Neonatal Review Briefing Paper		
SPONSORING EXECUTIVE:	Melanie Roberts – Chief Nursing officer		
REPORT AUTHOR:	Helen Hurst – Director of Midwifery		
MEETING:	Public Trust Board	**DATE:**	13th September 2023

1. Suggested discussion points *[two or three issues you consider the Trust Board should focus on in discussion]*

The Trust Board is asked to receive this briefing, on the neonatal review: -

An external review of the neonatal service was commissioned following concerns raised around culture within the unit. This paper provides detail of the findings, the positive developments already commenced within the unit, as well as the work being undertaken by the team commissioned to support further improvements. The findings of the review can be grouped in to four key themes:

- Listening to families and workforce - improved two-way communication.
- Robust governance processes, escalation and learning from incidents
- Strong and correct leadership structures
- An improved safety culture built upon mutual respect and a no blame culture.

2. Alignment to our Vision *[indicate with an 'X' which Strategic Objective[s] this paper supports]*

OUR PATIENTS		OUR PEOPLE		OUR POPULATION	
To be good or outstanding in everything that we do	X	To cultivate and sustain happy, productive and engaged staff	X	To work seamlessly with our partners to improve lives	X

3. Previous consideration *[at which meeting[s] has this paper/matter been previously discussed?]*

None

4. Recommendation(s)

The Public Trust Board is asked to:

a.	**NOTE** the briefing of the neonatal review and the improvement work
b.	**ACKNOWLEDGE** the work already undertaken
c.	**SUPPORT** the ongoing plan to improve the safety culture within the neonatal unit.

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and, where shown, elaborate in the paper]*

Board Assurance Framework Risk 01	x	*Deliver safe, high-quality care.*
Board Assurance Framework Risk 02		*Make best strategic use of its resources*
Board Assurance Framework Risk 03		*Deliver the MMUH benefits case*
Board Assurance Framework Risk 04	x	*Recruit, retain, train, and develop an engaged and effective workforce*

Board Assurance Framework Risk 05		*Deliver on its ambitions as an integrated care organisation*					
Corporate Risk Register [Safeguard Risk Nos]							
Equality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N		If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM NHS TRUST

Report to the Public Trust Board on 13th September 2023

Neonatal Review Briefing Paper

1. Introduction

1.1 An external peer review was commissioned following concerns raised around culture within the neonatal unit. The review was undertaken by clinical neonatal experts and led by a health care consultant. It should be acknowledged this review happened over a two-day period and as such clear focus on the areas where improvements could support a change in culture.

1.2 The unit has a workforce of 115 members of the multi-professional team, including non-registered colleagues.

1.1 The unit is designated as a level 2 local neonatal unit, providing care for babies who:

- require continuous monitoring of their breathing or heart rate
- additional oxygen
- tube feeding
- phototherapy (neonatal jaundice)
- recovery and convalescence from other care.
- short term intensive care
- support following apnoeic attacks
- continuous positive airway pressure (CPAP)
- parenteral nutrition (tube feeding)

2. Findings of the Review

2.1 The review team found that the neonatal team were very aware of the issues and a passion to improve was evident. The reviews conclusion was that with changes in leadership structure, a review of policies and clearly defined processes for staff to be heard and supported then the change required could be initiated.

2.2 The high-level themes for improvement are:

- Listening to families and workforce improved two-way communication.
- Robust governance processes, escalation and learning from incidents.
- Strong and correct leadership structures
- An improved safety culture built upon teamwork, mutual respect and a no blame culture.

2.3 The unit has a higher level of term admissions, which the Trust is well sighted on and initiatives in place to support a reduction, however more work with maternity is required to reduce these rates further. A high factor in the term admission rates is Persistent pulmonary hypertension of the newborn (PPHN) and the unit have been working with the West Midlands Neonatal Operational Delivery Network to support improvement.

2.4 Workforce both nursing and medical met the requirements of the British Association of Perinatal Medicine (BAPM), however work was required to review workflow, equitable roster management, admission and discharge criteria and clarity of roles.

2.5 Ensuring pathways are embedded that ensure care is delivered in the most appropriate setting during pregnancy and the neonatal period. Ensuring that high quality holistic care is delivered not just the complexities of care associated with neonatal care.

2.6 The review team noted the impact the new matron had already had with improvements within the service as well as improvements with training compliance, sickness management and nurse leadership.

3. Quality Improvement Initiatives (QI)

3.1 There are several QI projects already in place within the unit to support continual improvement.

3.2 The QI project to reduce the term admissions to the unit include reducing hypothermia, increase delayed cord clamping and introduced the Kaiser Permanente Calculator to rationalise antibiotic administration. This is evidence of responsiveness of the team to the term admission data.

3.3 A back to basics refresh program has been introduced by the new matron, to ensure all aspects of care are of a high standard, ensuring we focus on all care and not just the technical aspects. This includes nasogastric tube competency, handling of babies, communication, feeding, documentation, preparation for admission etc. Audits post introduction of the program have also been undertaken and will continue as snapshot audits.

3.4 Badger neo , (the neonatal version of the maternity electronic patient record badgernet)is currently used as the record system, but the unit is imminently launching the additional system of the iPad app for easy information entry within the unit and Baby diary, this allows parents to view regular updates and photos of their baby in the unit includes a

parent's diary of care, which will also be a lasting memory for parents to have, following discharge from the unit.

3.5 Work has been undertaken with our psychologist to understand the key areas of stress for parents. The two highest impactors are new admissions to the unit and repatriation. The unit already has a support package in place at the time of admission, but a gap has been identified for those repatriated families. Work is underway to develop a booklet and undertaking a personalised care plan co-produced with parents could significantly reduce the stress of repatriation and grow relationships.

3.6 TRiM (trauma risk management) training for staff has been commissioned, in the form of train the trainer to enable this to be cascaded through all staff, this is to support identifying people in distress and the supporting in the right way. This will support both colleagues and families.

3.7 Work is underway with the head of patient experience to introduce a neonatal family's forum. This will be enhanced with the work across the Local Maternity and Neonatal (LMNS) system, to introduce a system wide forum. The community of support will be extended wider following a meeting with Birmingham and Solihull LMNS to look at a joint piece of work to support our neonatal families.

3.8 The Neonatal community Outreach Team (NCOT) are providing a quality service to enable care of babies at home, that would previously have required to have continued care in hospital, by supporting parents to deliver care in their homes. This is a nurse led service that works in co-production with the neonatal team.

3.9 Notable improvement within the less than 27-week pathway, supported by the LMNS preterm birth lead.

3.10 Freedom to speak up guardians undertake regular walkabouts within the neonatal unit as do the neonatal safety champions, this reports into the maternity and neonatal safety champion monthly meeting chaired by the Chief Medical Officer, with attendance also from the Chief Nursing Officer and Non-Executive Safety Champion.

4. Improvement Team Initiatives

4.1 The improvement team have developed specific terms of reference and plan with the Chief Nursing and Medical Officers to support the unit. They are working through the plan, with some initiatives already undertaken captured below.

4.2 Improving data collation and oversight with the development of a NNU specific dashboard in line with the National Neonatal Audit Programme (NNAP) criteria for care, which then can be monitored as part of the monthly governance meeting and will clearly identify at a glance areas for improvement as a topic of the week.

4.3 Right Baby Right Place document to support the daily huddles to ensure timely and appropriate transfer of babies.

4.4 Team away days have been planned supported by the psychologist from the Perinatal Network to look at culture and behaviours and support improvement.

4.5 Review of ongoing human resource (HR) cases and processes, including an invite for the HR team to the away days. This has included reviewing job descriptions, work plans and how they are reflected in what is being done.

5. Recommendations

5.1 The Public Trust Board is asked to:

a) **NOTE** briefing of the neonatal review and the improvement work.
b) **ACKNOWLEDGE** the work already undertaken.
c) **SUPPORT** the ongoing plan to improve the safety culture within the neonatal unit.

Helen Hurst
Director of Midwifery
1st September 2023