



AGENDA ITEM

6.2.1

QUALITY & SAFETY COMMITTEE

PRINCE CHARLES HOSPITAL (PCH) NEONATAL DEEP DIVE REVIEW UPDATE

Date of meeting	19/07/2022
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Leanne Richards Lead Nurse, Neonatal Improvement Programme Shelina Jetha MNIP Programme Manager
Presented by	Miss Sallie Davies, Deputy Medical Director and SRO
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)

Committee/Group/Individuals	Date	Outcome
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS

IMSOP	Independent Maternity Services Oversight Panel
CTMUHB	Cwm Taf Morgannwg University Health Board
MNAF	Maternity and Neonates Assurance Framework
GMC	General Medical Council

NMC	Nursing and Midwifery Council
AMaT	Clinical Assurance Audit Technology
PID	Project Initiation Document
RCOG	Royal College of Obstetricians and Gynaecologists
PCH	Prince Charles Hospital
ATAIN	Avoiding Term Admissions into Neonatal Units

1. SITUATION/BACKGROUND

- 1.1 The purpose of this report is to update the committee following the IMSOP Neonatal Deep Dive Review of Neonatal Services at Prince Charles Hospital which was published on the 10th February 2022. It will demonstrate the progress made to date in key themes outlined below but predominantly in the **'Immediate actions' to be submitted to IMSOP by 31st July 2022.**

In 2020 the Health Board requested an external review of its Neonatal services at Prince Charles Hospital (PCH) as part of the assurance processes being undertaken by IMSOP for Maternity services.

The committee will recall that part way through the Deep Dive review, IMSOP escalated a number of immediate concerns in August 2021. These were the subject of a previous paper to the committee, however, these concerns are also contained within the final Neonatal Deep Dive report.

- 1.2 The Neonatal Deep Dive review was published in February 2022 with an overall 56 which include 42 recommendations of which 5 are immediate plus a further 14 escalations, grouped into the following seven key themes:

- Family engagement and support
- Governance, Assurance and Accountability
- Neonatal Service Workforce
- Reporting
- Neonatal Unit Functionality
- Neonatal Unit Safety
- Clinical Case Assessments

1.3 IMSOP had also identified 5 immediate actions and 14 escalations to be completed by 31/7/2022 and their delivery time table is demonstrated in the section below.

1.4 Assurance process

The process for submitting evidence to IMSOP is as follow:

- Gather evidence
- Submit to work stream lead for approval
- Submit to MNIB Huddle for Health Board (HB) assurance, require $\geq 75\%$
- Final sign off by Programme Leads: Leanne R/Steve S (*note: in the event $\leq 75\%$ assurance*)
- Submit recommendations to MNIB membership – HB assurance (*note: to prevent delays, this stage likely to be after submission to IMSOP*)
- Final submission to IMSOP i.e. upload to Objective connect
- Update Immediate actions project log

1.5 Immediate actions

The following table provides a summary on the immediate actions and progress being made:

RAG key:

Verified	✓
submitted to IMSOP but un-verified – to provide further evidence	∞
Not submitted (working on evidence/MNIB assurance) – on-track	
Submitted to IMSOP awaiting verification	submitted

Notes:

- All submissions are HB assured by the workstream leads and MNIB membership
- Also, several of the recommendations from IMSOP are linked and identified below

No.	Immediate action no.	Brief description	Date of submission	RAG status @23.6.22
Neonatal Service Workforce - Lead: Interim Head of Children Young People & CAMHS				
1	ESC 3	Consultant cover for the neonatal service is safe and effective	1/4/22	✓
2	3.2 (<i>links to above</i>)	Extra consultant time	1/4/22	✓



3	3.9	Clinical pharmacist resource dedicated to the neonatal service	1/4/22	✓
4	ESC 1 (links to 3.9 and 7.3 - medium term)	Make safes to support safe prescribing in practice	1/4/22	✓
5	7.6	Documentation standards must be improved in line with GMC/NMC requirements and there must be senior medical oversight of discharge summaries.	1/4/22	✓
Neonatal service workforce				
6	ESC. 13 (links to 3.3 - short-term)	The Health Board improvement hub and clinical teams must work together to understand the common goal of a safer service.	1/4/22 - re-submission on-track for HB - MNIB assurance	∞
Wales & National Reporting				
7	5.1	Completeness and accuracy of Neonatal Unit data	1/4/22	∞
Clinical case assessments				
8	7.1	Communication with families	1/4/22	∞
9	ESC. 4 (links to 7.2 - long-term)	Expert clinical decision making for the sickest and most vulnerable patients in the service	1/4/22	∞
Neonatal Unit functionality				
10	ESC. 2 (links to 6.3 - short-term)	The Health Board must continue to show an improvement in the working relationship with maternity services in numerous areas.	tbc	
11	ESC. 8 (links to 6.3 - short-term)	The Health Board continue to progress a robust mechanism for reviewing all term admissions to the neonatal unit alongside obstetric and maternity colleagues.	16/6/22	submitted
12	ESC. 12	The Health Board must improve the staff culture on the unit to ensure all staff feel valued and listened to.	On-track - to review safety culture survey	
Family engagement and support				
13	ESC. 11 (links to 1.1 -1.5 - medium/short-term)	The Health Board should consider actions to support working with families to understand the impact of the listening exercise and improving family involvement in the service.	On-track for HB - MNIB assurance by 30/6/22	
Governance, assurance and accountability				
14	ESC. 14 (links to 2.3 & 2.4 - medium term)	The Health Board must introduce a clear audit structure to monitor improvement and evidence the effectiveness of the service.	On-track for HB - MNIB assurance by 30/6/22	
Clinical Case Assessment				

15	ESC. 5 (links to 7.4 - medium term)	The Health Board must review its cooling practice in line with national frameworks and ensure local practice meets this standard.	24/6/22	submitted
16	ESC. 6 (links to 7.8 - short-term)	The Health Board should immediately review all cases of unplanned extubating occurring in the service.	17/6/22	submitted
17	ESC. 9 (links to 7.5 - medium term)	The Health Board should review current formal radiology reporting mechanisms and request an external review by Paediatric Radiologist with neonatal experience to highlight areas of concern.	Under review	
18	ESC. 10 (links to 7.6 - immediate)	The Health Board must undertake an immediate documentation review and introduce supportive documents to assist in improving documentation standards.	On-track for evidence	
19	ESC. 7 (links to 7.9 - short term)	The Health Board must ensure clinical incident reviews, SI reviews and PMRT/Mortality reviews are carried out as an MDT with external support from colleagues within the local NICU to provide clinical expertise and questioning.	On-track for evidence	

1.6 Other recommendations.

Following the deep dive by IMSOP in February 2022, apart from the above immediate recommendations a further 42 were made as follows:

Rag status:

On-track
To be commenced
completed

The following tables provide details on our plans for the delivery of the 'other' recommendations with each action linked to a recommendation from the IMSOP deep dive report:

1.0 Family engagement - Lead: Interim Senior Nurse, Neonatal Services/ Neonatal Governance Nurse			
IMSOP recommendation	Rec. no.	Completion date	Status @23.6.22
Neonatal PREMS Questionnaire design & finalise	1.1/6.4	12 August 2022	
Establish PREMS process for collection and analysis	1.1/6.4	12 August 2022	
Establish mechanisms/processes (CSG assurance)	1.1/6.4	12 August 2022	



PREMS to be added to electronic system (CIVICA)	1.1/6.4	23 December 2022	
MMMW Neonatal sessions as part of maternity group	1.3	23 December 2022	
Re-establish parent and baby group (face to face)	1.3	26 August 2022	
Introduction of peer support to the unit to improve family experience. Veteran parents to become champions.(BLISS)	1.3	30 September 2022	
Review and organise family feedback into themes and a useable review format.	1.1/6.4	30 September 2022	
Infant Feeding lead for Neonates (protected time for role) - Work force business case	1.2	01 July 2022	
Infant feeding lead for Neonates JD - work force paper add line below	1.2	01 July 2022	
Psychologist support role sustainability (workforce business case)	1.4	24 June 2022	
Family Integrated care (FIC) plan	1.5	05 August 2022	
Establish FIC working group	1.5	05 August 2022	
Appoint FIC medical & nursing lead	1.5	05 August 2022	
AHP post business case submission	1.5	05 August 2022	
Video's of unit for transfer of baby into unit from other units.	1.5	30 September 2022	
Network parent passport	1.5	29 July 2022	
Appoint Engagement Lead	1.1	15 April 2022	
Psychologist support for staff/families	1.4	05 November 2021	

2.0 Governance, Assurance & Accountability - Lead: Clinical Service Group Manager - Women and Children			
IMSOP recommendation	Rec. no.	Completion date	Status @23.6.22
Process for audit outcome, shared learning by Q+S committee meeting ToR/agendas/actions. Outcomes of items discussed/did they facilitate improvement -	2.3/2.4	05 August 2022	
Agree metrics with clinicians e.g. term admissions, <32 week admissions, unplanned extubations, drug prescription audit and cooling. - Document to show the local report of required metrics	2.1	05 August 2022	
Review metrics to see if there has been improvement	2.1	05 August 2022	
Continued quality of SI's with DU support	2.2	05 August 2022	



Improvements with Si review structure of reporting	2.2	05 August 2022	
SI Tool Kit	4.1	05 August 2022	
Robust process for sharing learning from Si outcome (Joint)	2.2/4.1	05 August 2022	
Reflective practice tools	4.3	02 September 2022	
Set up working group	4.3	02 September 2022	
Joint Neonatal / maternity Audit Plan complete	2.4	01 April 2022	
AMAT Programme	2.4	01 April 2022	

3.0 Neonatal Service Workforce - Lead: Interim Head of Children Young People & CAMHS			
IMSOP recommendation	Rec. no.	Completion date	Status @23.6.22
Ensure clinician NLS training up to date	3.11	26 November 2021	
Review need for Shift Co-ordinator role and case	3.7	17 December 2021	
CTM Maternity and Neonatal Reflection Model	4.3	29 July 2022	
Identify MDT Training Need (statutory and non-statutory)	3.12	08 July 2022	
Develop MDT Training Plan	3.12	08 July 2022	
workforce paper (with consultation with health board)	3.1 /3.6/3.7/3.8	26 August 2022	
Business case for next 5 years	3.1 & 3.4	26 August 2022	
Acuity tool used based on BAPM guidelines	3.1	26 August 2022	
Datix completed for inadequate staffing levels medical/nursing	3.1	26 August 2022	
"Nurse in charge role must be supernumerary. Clear description of the roles and responsibilities should be available.		26 August 2022	
Mandatory training compliance needs to improve across all staff groups. This needs to be facilitated within working hours.	3.10	29 July 2022	
Nursing, midwifery and medical Newborn Life Support (NLS) instructors need to be identified within the Health Board to support robustness in NLS local training and simulation training.	3.11	29 July 2022	
Clinical Supervision groups to be established formal and informal	3.13	29 July 2022	
Joint Staff engagement sessions	4.3	11 March 2022	
Ensure Nursing NLS training up to date	3.11	10 December 2021	



Rollout Maternity (inc TALK) debrief tool	4.3	27 May 2022	
QI LIFE training commences again	4.3	27 May 2022	
Explore financial remuneration to support staff rotation	3.5	05 November 2021	
Develop long term plan for ANNP role	3.4	05 November 2021	
MDT maternity/neonatal SIMS/skills drills with staff of all levels across the two disciplines.	3.14/3.15? Network	01 April 2022	

4.0 Neonatal Unit Safety - Lead: Lead Neonatal Nurse			
IMSOP recommendation	Rec. no.	Completion date	Status @23.6.22
Safety Culture Survey design	4.2	03 June 2022	
Safety Culture Survey on CIVICA system and promote use by staff	4.2	02 September 2022	
Extract data analysis and review outcomes and improve safety culture	4.2	02 September 2022	
Rollout Maternity (inc TALK) debrief tool	4.3	27 May 2022	
QI LIFE training commences again	4.3	27 May 2022	

5.0 Wales & National Reporting - Lead: Consultant Paediatrician			
IMSOP recommendation	Rec. no.	Completion date	Status @23.6.22
Dashboard part of quality and safety	5.2	07 January 2022	
Include metrics in Quality and safety committee report	5.2	07 January 2022	
Maternity/Neonatal Joint data showcase.(e.g. how data is used to manage the service)	5.2	17 June 2022	

6.0 Neonatal Unit Functionality - Lead: Lead Neonatal Nurse			
IMSOP recommendation	Rec. no.	Completion date	Status @23.6.22
Transitional Care - Data	6.1	03 June 2022	
Joint Forums/Meetings with Maternity	6.3	19 August 2022	
Joint educational SIMs with Maternity	6.3	29/ July 2022	
QI Project on Thermoregulation		12 November 2021	
Admission temperature for all babies		05 November 2021	
Joint NN/Maternity safety metrics (check joint workstream)	6.1/6.2	05 November 2021	
PID developed for joint work stream	6.2	05 November 2021	
Blood Gas Monitor insitu on post-natal ward to aid reducing Hypoglycemia	6.1	05 November 2021	
Implement Hypoglycemia Pathway	6.1	05 November 2021	
May - commence transitional care working group	6.1	06 May 2022	

7.0 Clinical Case Assessments - Lead: Consultant Paediatrician			
IMSOP recommendation	Rec. no.	Completion date	Status @23.6.22
Neonatal Learning from the weekly recorded DRUGle	7.3	25 March 2022	
Audit system to identify issues and learning for good prescribing	7.3	25 March 2022	
Datix Trigger List	7.7	15 October 2021	
Datix report audit of utilisation of trigger list (audit 10 medical notes)	7.7	15 October 2021	
Recognise existing national tool kit	7.8	15 October 2021	

1.7 Health Board Response

The Health Board accepts the findings of the Deep Dive report and in the process of expanding the existing improvement plan to incorporate improvement to cover the full extent of the recommendations within the report.

We continue to work with IMSOP to clearly define and jointly agree the meaning of each of the 42 recommendations from the Deep Dive report. Prior experience with the RCOG recommendations has confirmed the importance of this step. This has been strengthened with the health board working with the Neonatal assurance officer in Welsh Government.

Leads have been identified for each of the seven themes outlined above, and PIDS, outlining the improvement work, plans, governance and improvement measures are being developed.

It should be noted that whilst the Deep Dive review focused on our Neonatal Unit at PCH, the Programme of improvements has included Neonatal Colleagues and teams at our POW Unit as well who have actively engaged with the process. We aim to ensure that we have equitable approaches that reflect Neonatal standards on both of our Units

1.8 Conclusion

Overall the immediate actions are on-track for submission to IMSOP by 31/7/2022 with queries on some items that require a consideration by IMSOP. The items under query are as follows:

- Following the deep dive review, the IMSOP recommendations were further reviewed by the HB and a 'revision' was submitted to IMSOP 13/6/22 and response awaited
- ESC. 9 (links to 7.5 - medium term) - 'The Health Board should review current formal radiology reporting mechanisms and request an external review by a Paediatric radiologist with neonatal experience to highlight areas of concern.'
- ESC. 12 – 'The Health Board must improve the staff culture on the unit to ensure all staff feel valued and listened to.'

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

- 2.1 IMSOP considers that current services are regarded as viable and improvements are able to be made
- 2.2 IMSOP has recognised the progress of the improvement journey to date
- 2.3 IMSOP recognised the adverse impact of Covid on the service and improvement plans.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

- 3.1 The committee are asked to note this report, the themes for the Deep Dive report, progress the Health Board has already made and the plans in place and being developed to address the recommendations of the report. Regular reporting of progress and risks with mitigating actions will happen through the existing Maternity and Neonatal Programme Highlight report, which the committee receives regularly.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	See above
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:



Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Not required for this update report
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	Yes (Include further detail below)
	Investment will need to be continued into the Neonatal Improvement Team and service to ensure continued progress. Business Cases will be submitted as needed.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality and Safety Committee are asked to **NOTE** the report.