

ACTION PLAN

Bradford Royal Infirmary

Date of Visit: 16th February 2022

Ref	IDENTIFIED ISSUE/AREA TO BE ADDRESSED	DETAILS OF ACTIONS TO BE TAKEN
3.8/ 3.10/ 4.2-4.3	Capacity and Activity: IC was at the NCCR threshold in the datapack but has since reduced somewhat, in part, due to significant nurse shortages which are currently being addressed. Occupancy is at or near 80% for all cot types.	The borderline IC activity should also take account of excellent respiratory practice reducing IC LOS. In addition, the high-risk preterm population is in the upper quartile compared with other NICUs and there is a higher proportion of IUGR preterm infants. This unit needs to remain a NICU to support the high numbers of local/regional high-risk infants. There is also some activity which is unmet, likely due to staffing difficulties and IC activity is likely to increase as staffing is resolved. Network are analysing unmet need. Please continue to work with the network to monitor activity and capacity and support nurse staffing increases to increase activity and reduce any unmet need
4.5	ROP service will be less robust with imminent retirement of ROP ophthalmologist	Current service is excellent. The trust is actively seeking a replacement ophthalmologist but personnel with relevant skills can be difficult to find. To work with network on solutions to make the service more resilient. These may include training of alternative staff in acquiring images using a retinal imaging system at surrounding units, additional training for existing ophthalmologists and/or networked regional ophthalmology cross-cover arrangements.
4.7	There is insufficient access to Tc bilirubinometers in the community.	This has been NICE guidance since 2010 and many hospitals were able to acquire additional Tc bilirubinometers during the pandemic. All services should have access to sufficient Tc bilirubinometers to provide safe screening (particularly for darker skin tones where jaundice is more difficult to identify) and to minimise painful procedures. To review requirements and develop business case to resolve this issue.
4.8	Transfer pathway to children's services could be improved.	There are good pathways into paediatric community services, but the team are aware that pathways to children's services and paediatric critical care are more challenging and could be optimised further. This is a current workstream. Please work with children's service to review the pathway and improve discharge processes for those babies requiring transfer.

5.8	Culture positive sepsis rates and CLABSI rates are higher than most NICUs for babies <32 weeks	This is a current QI with active involvement of IPC team. and several care bundles have been put in place to try to address this. Rates may be higher due to the higher numbers of extremely preterm infants who are higher risk. Nurse staffing shortages are also thought to be a factor. The unit have consulted with other units with lower infection rates. To continue to work on improving early and sustained breastmilk (see action below). Antimicrobial stewardship may also be an important factor and is strongly recommended (see below). Please continue to do root cause analysis for all positive cultures and initiate any further measures suggested from the outcome of these reviews.
5.9	There is not a regular weekly meeting with microbiology/ID to discuss antimicrobial stewardship.	This service is present in 65% NICUs. There should be a regular focussed review at least once a week (2-3x per week is preferable) regarding antibiotic choice/use to ensure reduced likelihood of emergence of resistant organisms. This is particularly important given the higher incidence of infection, the higher incidence of resistant organisms in the community and the higher rates of NEC. The trust has had difficulties appointing appropriate staff for this role. Please consider alternative models to provide this service including networked solutions and or specialist pharmacist roles.
5.9	There is currently no EPR record used for electronic prescribing.	Cerner is being rolled out across the trust. Please ensure there is appropriate time and support built in for neonatal prescribing requirements which are additional to paediatric requirements.
5.11	The NEC rate is in the upper decile (back to average in 2019). Enteral feeding rates have dropped since the data in this pack.	Review of cases to ensure cases do meet the NNAP definitions and to look for modifiable factors. Increasing early and sustained breastmilk is important for NEC prevention. Neonatal infant feeding lead is about to be recruited who will also focus on Unicef Neonatal BFI reaccréditation (well done for being the first NICU accredited). This is an important focus for the unit – please ensure sufficient time, and resource is allocated and also consider AHP (particularly SALT) input into this important project.
5.15	HIE rates requiring cooling are in upper decile	This was an isolated occurrence across a single year and has been investigated with no specific actions required. There have been no concerns flagged since this period.
7.1-7.2	Parents Some facilities are insufficient or of poor quality.	There has been additional parent dining facility added but the current facilities are not fit for purpose. There is a new parent accommodation extension planned (circa £3M) which is supported by the trust and is the main focus of the charitable fund-raising team. Please work with the network care co-ordinator in the build plans for the new extension.

7	Parents: Family Care Development and BLISS Baby Charter accreditation – this has stalled somewhat due to covid-19.	Work on BLISS Baby Charter accreditation should be resumed which encompasses both facilities and FiCare. BLISS BC and Unicef BFI are mutually supportive for FiCare. Nurse, medical, and AHP staffing time to support neurodevelopmentally focused Family Care is a current project within the unit and GIRFT supports appropriate protected time allocation for leads to develop these QI initiatives.
8.2	The unit does not meet BAPM consultant staffing standards during the week or at weekends	There is now a full complement of Tier 3 staff, and the unit is compliant with BAPM standards in the week but not the weekend. This is being kept under review, but the unit feel there are higher priority areas for support than extension of tier 3 hours at weekends and current arrangements are not felt to impact on clinical care.
8.7/8.8	Nurse staffing is well below the BAPM standard for numbers in establishment and QIS. This position has worsened since the data collection period.	The trust is aware of this issue and there has been a successful recruitment drive which is reducing the recruitment gap. There is a recognition that retention and increasing QIS numbers requires support, and more nurse practice development time has been allocated and there are plans for career development and QIS progression in progress. Neonatal nurse staffing is an independent risk factor for mortality and morbidity in the preterm population and has therefore been given a very high level of focus in the National Neonatal Transformation Review. Please ensure additional LTP funding is used to increase the nursing establishment. Well done on progress so far and continue to review QIS and staffing numbers 2x yearly against the new NNA/CRG neonatal nurse staffing workforce calculator. This needs ongoing close monitoring by trust and network please.
8.8	Not all nurse quality roles have protected time.	To review nurse quality roles with support from network nursing lead and ensure appropriate protected time is built into the establishment (particular focus on FiCare, Infant Feeding Leads, and Bereavement support were highlighted at the visit)
8.10-8.20	There are gaps in pharmacy, psychology and AHP workforce against recommended standards.	There have been significant improvements in AHP and psychology support since the datapack was developed – well done. Please continue to review requirements against recommended standards as these posts become embedded. For Pharmacy, continue to develop and implement business case for additional support (SATO).
9	Reference cost activity data is not allocated to the correct location code and the activity is incorrect when compared to badgernet activity. Relative cost allocation is not as suggested in National Casemix office/ PLICS guidance	To ensure activity data is accurate and allocated to the correct location within reference costs. To review relative cost allocation between neonatal HRGs before next data submission.

NOTABLE GOOD PRACTISE

There is a strong clinical governance and QI mindset with data examined and used actively to develop successful QI. There was a high level of engagement with the GIRFT data information and many of the identified issues are already being very actively addressed.
Transitional care facilities and pathways between TC, SC and PNW are very well developed. ATAIN results are in best quartile for a NICU and there are well developed neonatal outreach services available 7 days/week.
The units have embraced routine pulse oximetry screening which reduces morbidity and mortality for critical congenital heart disease as well as supporting earlier pickup for respiratory conditions and PPHN
Extensive perinatal involvement in improving optimal start metrics with particularly good improvement in delayed cord clamping.
This unit follows NICE preterm respiratory guidance in relation to use of non-invasive ventilation, LISA for surfactant administration, volume targeted ventilation and lower use of morphine and there is continuing QI work to improve performance against these measures
The unit has low rates of ventilation and BPD.
There is an active QI project to improve early milk /colostrum intake and a new neonatal feeding advisor is about to be appointed. The unit were the first to achieve full Unicef BFI accreditation and are about to embark of work on reaccreditation. The unit uses probiotics, has standardised feeding guidelines and access to donor breast milk (all associated with NEC prevention).
The paediatric radiology and radiography service provision is good.
Bereavement services are well developed, and the team are currently looking to support a perinatal palliative care co-ordinator role.
There are well developed workforce plans to reduce reliance on medical staff in training and development of ANNPs
There have been significant improvements in nursing, AHP, and psychology provision recently – well done and keep going!