Parent involvement

4.4.28 The unit has an excellent relationship with families of current and past patients, although the 'Friends and Family' test has not yet been rolled out to the unit. The neonatal unit participates in the FAB network based in Arrowe Park which supports early discharge and provides 'gold standard care at home'

Parents seemed to have accepted the change of status of the unit and there were reported to be no real difficulties with the arrangements for antenatal transfers.

4.5 Does the unit have a positive relationship with the neonatal network and transport service?

Yes, links are good but the transport service and arrangements at LWH are significantly under resourced. This delays transfers and increases the risks for infants and the anxiety of clinical staff. There are a number of ways the service could work better for minimal investment. Although there are strategic plans being developed for reconfiguration of neonatal services across Mersey and Wirral in the longer term these did not adversely affect current relationships or individual or corporate behaviours,

4.5.1 All those the Review team spoke to told us that there are significant capacity pressures on the Cheshire and Merseyside Neonatal Transfer service, which contribute to delays in transferring infants out promptly. Advice available from the tertiary units was sound and easy to access, but out of hours the transport team has no central administrator and calls are directed straight to the clinicians on call who may be undertaking a transfer at the time. In effect there cot bureau service operate office hours only which appears to be in breach of the service level agreement which states

CMNNTS will provide a dedicated medical and nursing transport team 24 hours a day, 7 days a week. A co-located perinatal cot bureau will operate 24 hours a day, 7 days a week in order to identify a cot within the Cheshire & Merseyside Region.

4.5.2 There were several reports that the doctors will wait too long before escalating concerns about an infant, both from junior to consultant and also to the network and when they do seek tertiary level advice, the transport team is not informed sufficiently early to be on `standby`. Consequently when a decision to transfer is made, there may be further delay as the transport crew and an appropriate vehicle are mobilised If the team is on another retrieval or undertaking a `park and ride` [14] surgical engagement then either the transfer must wait or another team mobilised from elsewhere in the network. With the Cheshire and Mersey transport team having no out of hours' administrator to manage the cot bureau function it is incumbent on the referring clinician to identify and mobilise an alternative team. Since the re designation of the unit there were reports that the consultants can spend up to 4 hours trying to find an available cot

[14] this refers to a custom in which the transfer team supports a neonate whilst undergoing surgery – this can tie the team up for up to 7 hours., Following the surgical review this arrangements is being overhauled.

and retrieval team due to the increased demand for transfers. This is an unacceptable waste of senior medical time, and should be raised as an incident on DATIX. Other services in the UK create a `conference call` so those giving advice and those on the transport team are aware of the status of infants which may require transfer.

Recommendation: Ensure tertiary advice calls include an `early warning` or conference call to the transport team to enable better planning and deployment of the crews

Recommendation: Arrange for central monitoring and management of transport team enquiries out of hours across the network

4.5.3 Following the case review of a neonatal death in 2014 several changes were made to the transport staffing arrangements. The service now deploys Tier 2 registrars with consultant oversight during weekday daytime, with registrars and ANNPs from LWH covering the service out of hours. There are serious gaps in cover anticipated as Tier 2 rotas become increasingly hard to fill, general trainees have been withdrawn due to inadequate training opportunities, and there are no grid trainees and Clinical Fellows cover the service.

4.5.4 Quarterly reports indicated that no infants were transferred by other teams during 2015-6, but in only 77% of urgent requests in Q4 was the team mobilised within one hour (target 95%). However the target of 3.5 hours to bedside was easily met with over 90% achieved. The transport team uses the NW Ambulance service to provide the emergency vehicle and there is within their protocols for emergency the consideration that an infant in hospital is in a `place of safety` and may therefore not be prioritised at busy times.

4.5.5 An exception report is apparently prepared on infants whose care has not met the criteria for transport and response time, due to availability either of personnel or vehicle. This data supported a proposal submitted to NHS England in 2015 to combine the three ambulance services and 4 hosts (including the paediatric retrieval service, NEWTS) into one service with two host units and network-agreed guidance and protocols in order to meet the national specification for such services. Further evidence for improving transport availability and streamlining pathways emerged from the neonatal surgical peer review in April 2016. The business case is likely to have been consolidated within the STP and no decision has yet been made.

Recommendation: The NHSE/Network should expedite the decision on the whole-network transport service and centralise the administration out of hours in the interim

Antenatal transfers

4.5.5 Antenatal in-utero transfers out of COCH are usually arranged by midwives, who identify a cot (either through the cot bureau or directly) and work with the consultants to