10/6/2012

SAVE THE MID

New Neonatal Unit Antrim is too small by RQIA standards

Fears are already sparked before the provision of a new neonatal unit at Antrim Hospital, The Northern Health & Social Care Trust board have passed a new neonatal care unit that will be too small in regards to RQIA standards.

The NHSCT and the historical legacy Trusts that governed the Mid Ulster and Antrim Hospital failed to make extra provisions at Antrim Area Hospital post the stripping down of services at Mid Ulster despite health chiefs being warned in 2005 that without development the biggest risk they could undertake was shutting Mid Ulster maternity. The new business case specifically states that the ward had not been developed since 1994, this revelation is worrying enough considering that Mid Ulster lost all of these services in 2006.

The business case, (see attachment) was approved by the board without question on the 24th May 2012, despite the warning that the unit size will only have 13 square meters around the cots instead of the RQIA recommended 15 square meters for infection control.

Save The Mid responded to this business case at the Northern Health & Social Care Boards monthly meeting on the 24th May, Chairman Hugh McCloy cited that the board had passed a A&E unit which is the same size of the current one, a new mental health ward which is to small according to projected attendances and now the neonatal unit that does not meet RQIA standards, the board did not answer to this question.

The last 2 years have seen a total of 92 recommendation's into maternity services in Northern Ireland, what assurances have we got that 32 recommendations from 2012 will be implemented while we are still waiting from the rest to happen.. See below for all recommendations.

Since 1999, the Northern Health and Social Care Trust area has seen a 37% drop in the average amount of maternity inpatient beds, there was no extra development when the Route was closed or Mid Ulster maternity was closed (see attachment average beds available).

This was a high risk moved as identified in 2005 in a risk assessment so in fact since the inception of the trust in 2007 they have been fully aware that mothers entering into their hospital do so at the risk of Antrim or Causeway not having enough room to admit them.

This was later proved by RQIA in 2010 when it stated that within the NHSCT there were 4,493 births within the NHSCT; however 1,813 mothers within the trust boundaries gave birth in another health trust. Potentially there could have been 6,306 births in the NHSCT. Serious doubts would have to be considered if the NHSCT would have the capacity for these deliveries.

http://savethemid.weebly.com/
TEL: 07871503189
EMAIL: hughmccloy@googlemail.com

10/6/2012

Background reference to Maternity and neonatal services in Northern Ireland since 2010:

In the wake of the pseudomonas outbreak Health Minister Edwin Poots (link)announced that all recommendations contained within a review of neonatal care would be implemented, however this does not seem to apply to the NHSCT.

The Independent Review of Incidents of *Pseudomonas aeruginosa* Infection in Neonatal Units in Northern Ireland 2012 flagged up several weaknesses in the NHSCT, the report stated:

> **"Antrim Area Hospital**
> One baby was found to be colonised with a unique strain of *Pseudomonas aeruginosa* in January 2012, in Antrim Neonatal Unit, following the introduction of screening. This strain has not been linked to any other human or environmental strains associated with these incidents. Two sinks and water samples from two taps in Antrim neonatal unit were found to be positive for *Pseudomonas aeruginosa* when environmental sampling was carried out.

Summary of Recommendations from Phase Two **2012**

1. All trusts should develop a communications plan for incidents including arrangements for engaging with families. The plans should ensure that clinical staff are provided with sufficient support to allow them to concentrate on clinical matters, with other roles taken on by non-clinical staff.
2. Trusts should establish arrangements for independent validation of their self-assessment processes for water management compliance with statutory requirements and guidance.
3. Trusts should maintain an evidence file of compliance with L8 and HTM 04-01.
4. Trusts should maintain up to date registers of all those with named responsibilities under Approved Code of Practice L8 and that each is provided with written authorisation to carry out their statutory functions in water management.
5. Trusts should ensure that their written schemes for water management are kept up to date to reflect changes in procedures and facilities.
6. Trust should review the training needs of staff with prescribed functions in water management and ensure appropriate accredited training is provided when required.
7. Trusts should develop Water Safety Plans for Legionella, Pseudomonads and other opportunistic water pathogens as recommended in Annex A (2) of the DHSSPS Circular HSS (MD) 16/2012 issued on 30 April 2012.
8. Trusts should develop an annual action plan for water management which should be submitted to Trust Board for approval.
9. Trusts should review their governance arrangements for infection prevention and control in accordance with the NICE Quality Improvement Guide: "Prevention and Control of Healthcare Associated Infections".
10. The Public Health Agency should establish a weekly health protection alert bulletin for health protection professionals across Northern Ireland.
11. All HSC organisations should review their systems to ensure that any unusual incidents or intelligence related to infectious diseases are promptly shared with the PHA duty room.
12. All organisations should review their arrangements for sharing and documenting information received in relation to infectious disease incidents.
13. A joint plan across relevant organisations for the regional response to the management of outbreaks, affecting more than one organisation, should be developed, which clearly identifies the roles of each organisation.
14. The review team recommends that trusts should ensure that high impact interventions related to key clinical procedures are implemented and assured using a standardised common approach across all neonatal units

15. Guidelines should be developed for the organisation of, and participation in, regional teleconferences for future incidents.
16. All organisations should review their arrangements for supporting staff during incidents including outbreaks and ensure that incident plans include provision for support for staff both during and after incidents.
17. The recommendation on using sterile water in the interim report should be kept under review in relation to babies in Level III neonatal units (Special Care Baby Units) as new evidence emerges.

Recommendations of Interim Report published on 4 April 2012
1 The current interim guidance that sterile water should be used when washing all babies in neonatal care (Levels 1, 2 and 3) should be continued pending early consideration of the Department of Health (England) guidance issued on 30 March 2012.
2 Tap water should not be used in maternity and neonatal units during the process of defrosting frozen breast milk.
3 The current arrangements for testing water in neonatal units in Northern Ireland for pseudomonas should be continued pending early consideration of the Department of Health (England) guidance issued on 30 March 2012. This guidance sets out recommendations for water testing for all augmented care units including neonatal care.
4 The presentation of test results of water samples should be standardised across the laboratories which undertake this for HSC organisations.
5 The review team recommends that guidance on cleaning sinks should be reviewed so that practice is standardised across all clinical areas.
6 Regional guidance on the cleaning of incubators and other specialist equipment for neonatal care should be produced.
7 Independent validation of hand hygiene audits should be carried out on a regular basis, supported by robust action plans where issues of non-compliance are identified.
8 The intensive care accommodation in the neonatal unit at Antrim Area Hospital should be expanded to allow more circulation space around cots.
9 *Pseudomonas aeruginosa* should be identified as an alert organism for neonatal intensive and high dependency care. When identified from a sample from a baby, taps and sinks should be tested in rooms which had been occupied by that baby since birth.
10 Surveillance arrangements should be established for *Pseudomonas aeruginosa* for augmented care settings including neonatal care.
11 All relevant organisations should work to an agreed regional protocol for the declaration of outbreaks.
12 Arrangements for the typing of strains of *Pseudomonas aeruginosa* should be established in Northern Ireland.
13 A regional neonatal network should be formally established in Northern Ireland.
14 The hours of availability for the regional transfer service for neonates should be expanded with plans put in place to move to a 24 hour service.
15 The development of the new Regional Neonatal Intensive Care Unit at Royal Jubilee Maternity Service should be expedited as soon as possible. In the interim period, improved accommodation for the purposes of isolation and for the cleaning of equipment should be made available for the current unit. Steps to improve the space around each cot should be considered.

In September 2011 again more recommendations were submitted to maternity and neonatal care and welcomed by Health Minister Edwin Poots,

RECOMMENDATIONS

Recommendation 1: The PHA should ensure all women and girls of childbearing age are advised about emerging public health messages including the impact of obesity, smoking, alcohol and substance use on pregnancy.

Recommendation 2: Women of childbearing age who have long term conditions, even those not planning a pregnancy, who are on regular medication or who have other risk factors should be proactively given tailored advice by their GP and specialists about pregnancy as part of their general management. This should include the effect of their condition or medication on pregnancy and the baby.

Recommendation 3: When a woman becomes pregnant she should be facilitated to make early direct contact with a midwife.

Recommendation 4: Each Trust must ensure it provides appropriate access to confirmation of pregnancy scans and NIMATS in community settings.

Recommendation 5: For women with straightforward pregnancies antenatal care will be provided primarily by the midwife in the community

Recommendation 6: Women with complex obstetric conditions will have care led by a consultant obstetrician.

Recommendation 7: Women should be encouraged to contact their midwife if a problem develops to ensure only women who require to be seen by an obstetrician are referred to the Day Obstetric Unit.

Recommendation 8: Trusts must put in place and encourage involvement in antenatal education, which must be women centred and developed to ensure all women and their partners receive the advice they require to prepare them for parenthood as well as birth.

Recommendation 9: Women should be supported to make an informed decision about place of birth. Women with straightforward pregnancies should be encouraged to consider Midwife Led Units or home births.

Recommendation 10: Each Trust should provide at least one Consultant Led Unit which should have a Midwife Led Unit on the same site.

Recommendation 11: Freestanding Midwifery Led Units should be developed and maintained where there is an assessed need and the service contributes to sustainable maternity services.

Recommendation 12: All Trusts must reduce inappropriate variability in practice by rigorously examining all intervention rates and benchmark against comparable units across Northern Ireland, the rest of the UK and Ireland.

Recommendation 13: Postnatal care in the community should offer a home visiting schedule which is responsive to need for a period of not less than 10 days and include visiting by midwives and maternity support workers

Recommendation 14: Woman should be advised and encouraged to attend their 6 week postnatal appointment with the appropriate clinician.

Recommendation 15: **Each** Trust should ensure its maternity service shows good clinical leadership and communication including the use of the hand held records, Labour Ward Forum and other multidisciplinary groups.

Recommendation 16: Work should progress to agree minimum data sets, definitions and contributing data to a regional dashboard in order to promote quality improvement and influence choice.

Recommendation 17: The NIMATS system should be reviewed and updated to ensure coordinated regional data collection

http://savethemid.weebly.com/
TEL: 07871503189
EMAIL: hughmccloy@googlemail.com

In September 2011 again more recommendations were submitted to maternity and neonatal care and welcomed by Health Minister Edwin Poots, IN 2010 (http://www.rqia.org.uk/cms_resources/Northern%20Report%20Published%20Version%2011%20May%2010.pdf) when RQIA published its results for maternity, the NHSCT were heavily cited for recommendations receiving the most of any health trust in Northern Ireland:

- From the report it showed 4,493 births were inside the NSHCT page 10, however 1,813 mothers within the trust boundaries gave birth in another health trust (page11). Potentially there could have been 6,306 births in the NHSCT. Serious doubts would have to be considered if the NHSCT would have the capacity for these deliveries

The report cited several staffing issues (page 22-29) which have again been reiterated in 2012, these staffing problems were cited in the removal of services from mid Ulster Hospital in 2006
Recommendations from RQIA to Health Trusts 2010:

Recommendations for Maternity Services across Northern Ireland
1. The Northern Ireland Maternity Services Information System (NIMATS) should be implemented in all maternity units across Northern Ireland.
2. All trusts should prepare an annual programme of audit activity in relation to maternity services and publish an annual report on the audit results which should be disseminated to members of the maternity team.
3. All trusts should ensure the harmonisation of policies and guidelines from those used by their legacy trusts and ensure that there are effective mechanisms to disseminate them to staff.
4. All trusts should review their structures and processes for the reporting and analysis of incidents and near misses in maternity services and ensure there is effective and timely feedback on a multidisciplinary basis.
5. All trusts should consolidate induction, training and practice in respect of written and electronic record keeping across all disciplines involved in providing maternity services and carry out regular audits of records.
6. Each trust should ensure that the terms of reference of its labour ward forums are clearly defined and that there are mechanisms for user involvement. Where there is more than one labour ward forum in a particular trust, steps should be taken to ensure regular communication between them.
7. The HSC Board and trusts should consider the adoption of a single assessment tool for midwifery staffing across Northern Ireland and the frequency with which it should be applied.
8. All trusts should review their senior and junior medical staffing for maternity units in relation to the Safer Childbirth Standards in conjunction with the HSC Board, DHSSPS and Northern Ireland Medical and Dental Training Agency (NIMDTA).
9. DHSSPS should develop a specific policy on the development of the role of consultant midwives across Northern Ireland, in line with its policy on the introduction of midwifery-led units.
10. All trusts should aim to have a consultant present for a physical ward round as appropriate and at least twice a day during Saturdays, Sundays and public holidays.
11. All trusts should have formalised written agreements in place with the Northern Ireland Ambulance Service on attendance at emergencies or when transfer is required.
12. Trusts who do not have dedicated 24 hour anaesthetic services should review their cover arrangements to ensure that there will be no delay in carrying out an emergency caesarean section.
13. All trusts must work to achieving an appropriate balance between managing rotas and providing protected time for training opportunities, for medical staff.
14. All trusts must ensure records of staffs' attendance at mandatory and other training sessions are regularly reviewed and that line managers are made aware of the reasons for non-attendance at mandatory training.

15. All trusts should establish a skills inventory for midwifery staff.
16. The proposed plan for the new maternity unit at the Royal Jubilee site should be revisited to take account of increased throughput and of the potential for further increases in activity as a consequence of the plans to re-profile maternity services on the Lagan Valley Hospital site, which may impact on referrals to the Belfast Trust.
17. All Trusts should explore further innovative ways to harness the views of service users and to utilise feedback from service users to bring about improvements in the birthing environment.
18. All trusts should review their information needs for maternity services to ensure that they have systems to provide the data set out in the Safer Childbirth Standards and that this information is effectively shared with staff.
19. The DHSSPS, Business Services Organisation (BSO) and trusts should work together to develop the capabilities of the NIMATS system and ensure that appropriate information is readily available on clinical outcomes as set out in the Safer Childbirth Standards.
20. DHSSPS should consider the development of a strategy for the future development of maternity services in Northern Ireland reflecting increasing birth rate trends, changes in working patterns and developments in obstetric and midwifery practice.

Belfast Health and Social Care Trust
1. There should be a clinical audit lead to direct multidisciplinary audit.
2. The trust in conjunction with the HSC Board should consider a future model for provision of maternity services at the Mater Hospital based on the document entitled 'The Future of Small Maternity Units', Royal College of Obstetricians and Gynaecology. This paper provides solutions for small obstetric units like the Mater, where service can be provided without the presence of doctors in training.
3. The trust should appoint a labour ward manager in the Mater Hospital.
4. The trust should ensure, through clinical support and supervision, that medical staff are fully supported and adequately prepared for the work undertaken in the birth setting.
5. The trust should continue to improve the birthing environment giving priority to the provision of piped gas and air facilities in the rooms at the Mater. They should also harness the view of service users to look at ways of making the environment in the Royal Jubilee less clinical and more homely where possible.

Northern Health and Social Care Trust
1. The trust should explore ways to strengthen the onsite midwifery leadership at night and reduce the need for the band 6 midwives to call the band 7 midwives for advice on patient management.
2. The trust should ensure that all midwifery staff have regular rotation, around all areas of practice, and that there is a system of rotation on and off night duty.
3. To help achieve appropriate levels of consultant presence on labour ward, the trust should review clinic provision with a view to implementing a phased reduction of peripheral clinics.
4. The trust should continue to pursue the establishment of an early assessment unit and a midwifery led care model at Antrim Hospital.
5. The trust should identify a lead obstetric anaesthetist for anaesthetic services at Causeway Hospital.
6. The trust should consider developing a high dependency care facility close to the labour ward in Antrim.
7. The trust must ensure they have robust procedures to ensure consultant obstetricians are available within 30 minutes and that this is reviewed on a regular basis.
8. The trust should take into the account the requirement for a bereavement room when developing their plans to provide a close monitoring room / high dependency area at Antrim Hospital.

Southern Health and Social Care Trust

1. The trust should develop a specific risk management policy for obstetrics ensuring that this includes a clearly defined trigger list for incident reporting.
2. The trust should consider the appointment of a designated risk management midwife to strengthen and build upon existing arrangements and assist in the development of a rolling programme of audit.
3. The trust should review provision of anaesthetic cover in the Craigavon and Daisy Hill hospitals given the nature of the case mix in both units.

South Eastern Health and Social Care Trust

1. The trust should consider the viability of having a reception room for those women who require elective caesarean section or induction of labour.

Western Health and Social Care Trust

1. The trust should implement the new arrangements for quarterly risk management meetings without delay; staff from across the trust should be facilitated to attend these meetings.
2. The trust should ensure a documented procedure is in place for the dating, archiving and central storage of past guidelines.
3. The trust should develop a policy for the wearing of identification badges.
4. The trust should develop appropriate procedures to ensure staff have an appropriate level of competency in English.
5. The trust should identify a lead obstetric anaesthetist for anaesthetic services at the Erne Hospital.
6. The trust should take into account the requirement for a bereavement room when developing their services at the Erne Hospital.

http://savethemid.weebly.com/
TEL: 07871503189
EMAIL: hughmccloy@googlemail.com