Response to consultation document on behalf of Northern Neonatal Transport Service (NNeTS)

Q1) How would you expect patterns of retrieval to change in light of the above proposals (providing any historical activity levels as appropriate)?

For both of the two proposals outlined NNeTS would expect to continue to provide retrieval and repatriation to the SRH site in line with what is agreed across the region and accepted practice nationally.

I would expect that because SRH has a NICU and is *already* the first port of call for babies needing ITU care from STGH, there may be a small reduction in number of ITU uplifts required in total as these babies (if there is correct identification antenatally) would be born in-house at SRH. Similarly, the post-NICU care repatriations our team performs might be expected to reduce as a number of these are currently from SRH back to STGH. If the SCBU capacity from STGH is absorbed into SRH, then the ITU graduates will be looked after at SRH (in SCBU) rather than need repatriation to STGH.

In terms of increased workload at SRH, the quoted bed numbers/cot days (in the report) for ITU plus SCBU tallies closely with the number of cots funded by the network at SRH, and it also suggests that if staffed to 6 cots, there is a potential for 'spare' capacity of SCBU cots at STGH:

STGH:

Quoted cot number (SCBU): 6

Cot days/days: 1,100/365= approx. 3 cots occupied per annum

SRH:

Quoted cot number (funded+Trust): ITU 7+1; SCBU 7+9

Cot days/days: ITU:2100/365 = approx. 5.75 cots per annum

SCBU: 3100/365 = approx. 8.5 cots per annum

Based on the crude calculations above, assuming the funding moves from STGH SCBU to help support the extra 9 cots at SRH SCBU, I would not expect that there would be an in-house excess generated from maternity at SRH that suddenly necessitated SRH becoming an increased exporter of babies to the rest of the network, on average. This calculation depends on adequate staffing, obviously, which is harder to predict.

Therefore, I would anticipate that the impact from the SRH/STGH catchment area out to the rest of the network might be a very small net reduction in use of the NNeTS service with respect to ITU uplifts and repatriations.

It is important to note that if a MLU is left in place at STGH, the Trust and Team at SRH would be responsible for arranging suitable pathways to move mothers and babies who needed unexpectedly higher levels of care to the SRH site. NNeTS does **not**, anywhere in the region, retrieve babies from MLUs and would **not** provide a retrieval service to an MLU at STGH. Commonly, arrangements are in place that if a baby is born unwell at an MLU the local midwifery staff present give appropriate NLS based care in the interim and a 999 ambulance is called to move the baby as an emergency to the

nearest, higher level care centre. Examples of this exist as precedent in the region in the Northumbria and South Tees Trust.

Q2) What, if any, risks, do you foresee from the proposals, particularly in relation to the neonatal transport team and associated neonatology clinical outcomes, in terms of staffing, activity, performance and quality?

I do not think that these proposals *as listed* would, in theory, present any additional risks on NNeTS in terms of activity as long as amalgamation of the SRH/STGH services maintain the current net level of service provision as exists across the catchment area currently. If the amalgamated service was *not* able to maintain the existing capacity it would have two impacts on NNeTS in terms of potentially increased work load by either (1) increased numbers of ex-utero transfers from the Sunderland site of babies to other centres (described as 'uplifts for capacity reasons') or (2) if the current capacity was reduced and limited to only meet the demand from inborn SRH babies, then babies born in other centres within the network may face a longer journey to place of definitive care if they cannot be accepted at NICU SRH as currently happens within the network. Any increase in duration of transport or imposed need for transport which is otherwise avoidable may contribute to adverse neonatal outcomes for any given baby as Transport itself is a physiologically hostile experience.

Anecdotally, in my own experience, closure of a SCBU and relocation to a different site does not always happen with full retention of nursing staff, especially if the SCBU nursing workforce are expected to upskill to NICU standards of practice. I would worry most that the likeliest reason for actual reduction of capacity in an amalgamated site would be attrition of the STGH staff from the nursing pool. There have also been recent instances of NICU closure to admissions at SRH on safety ground due to staffing levels. Thus, there is potential if the plans as listed are implemented to lead to have a period of time where cot availability might be impacted across the catchment area and the two situations impacting on neonatal care occur as described in the paragraph above.

In terms of performance and quality of service provided by NNeTS, I would not anticipate any changes from the proposed reconfiguration.

Q3) What positive impacts would you foresee from the proposals?

A single site with increased delivery rates and neonatal care capacity has potential to improve care standards by increasing staff experience/unit time with the sickest babies (principle of centralisation of services). From a NNeTS perspective we would expect the babies we moved out of a single SRH site, therefore, to be cared for by a workforce dealing with the sickest babies more frequently and thus be better prepared for moving. With the current set up of care, the STGH team do not have as much exposure to sick babies by virtue of numbers of deliveries per annum and so have less opportunity to keep up their stabilisation skills for the sickest babies compared to their potential level of exposure if they were absorbed into single site working with the SRH NICU population.

Q4) What, if any, further considerations would you encourage South Tyneside and Sunderland FTs to make prior to any final decision being made on the proposed service changes?

I would encourage the Trust to engage with the Northern Neonatal Network vis-a-vis the NHS England report written by Prof Field and his team. This report identified a final network

configuration with SRH looking after babies of 26 weeks gestation upwards and if reconfiguration is being mooted, it would be sensible to consider whether this strongly recommended endpoint is taken into account and planned for now. I would also encourage the FTs to approach other FTs which have completed this sort of move (South Tees NHSFT and Northumbria NHSFT) to draw on their experience and reflections on impact on service, especially around retention of staff from the SCBU service which is absorbed.

RT 5/5/17