House of Commons

Committee of Public Accounts

Caring for Vulnerable Babies: The reorganisation of neonatal services in England

Twenty–sixth Report of Session 2007–08

Report, together with formal minutes, oral and written evidence

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Report

Summary

Neonatal services provide care to babies born prematurely or with an illness or condition which requires specialist care. Over the last 20 years, neonatal services have undergone substantial organisational and technological changes whilst remaining a challenging and innovative area of medicine. Following a 2003 review of neonatal services, the 180 neonatal units based in the English National Health Service and Foundation Trusts were organised into 23 geographical, managed clinical networks.[1] Demand for neonatal care has risen year on year. In 200–07, around 60,000 babies (roughly one in ten births) were admitted to neonatal units, at a cost to the NHS of some £420 million.

Whilst there was widespread support for neonatal services to be delivered through clinical networks, these networks have developed at different rates and two areas have yet to establish a formal managed network. Networks have helped improve communication and co-ordination between units and have made progress in reducing the number of times babies have to be transferred long distance to obtain the necessary level of care, but there has been less progress on a key review recommendation for networks to re-designate units to ensure that the supply of intensive, intermediate and special care matches demand.

The NHS still has limited data on patient outcomes, other than mortality rates which show unexplained variations between networks. While these variations may be due to the demographics of the population covered by the network, such as high and low maternal age, obesity and smoking, other factors, such as access to care during pregnancy and speed of access to the right level of neonatal care, may also have an influence.

Constraints in capacity mean that the Department of Health (the Department) is still struggling to meet the demand for neonatal services, and problems over recruiting, retaining and training the staff required to deliver the service remains a major challenge. Financial management at the unit level needs to be improved. Neonatal units have a poor understanding of the costs of running their unit and there are differences in how units' determine their charge for a cot day with wide variations in charges between similar types of unit.

On the basis of a Report by the Comptroller and Auditor General (C&AG),[2] we examined the quality and effectiveness of neonatal services in caring for these most vulnerable members of our society. We looked at the ability of the system to meet increased demand for neonatal services, the benefits of networking neonatal units, recruitment and training of staff and the impact on health inequalities. We took evidence from witnesses from the Department of Health and the NHS.

1 *Neonatal Intensive Care Review: Strategy for Improvement*, Department of Health, 2003

2 C&AG's Report, *Caring for Vulnerable Babies: The reorganisation of neonatal services in England*, HC (Session 2007-08) 101

Conclusions and Recommendations

1. **The decision to establish a Neonatal Task Force is an important development, with the potential to improve the care for vulnerable babies.** The Department should set the Task Force clear objectives and associated milestones for improving services, and monitor achievements against these milestones to ensure delivery of the objectives by the end of 2008–09.

2. **The reorganisation of neonatal services into clinical networks has had limited impact in reducing geographic variations in mortality rates.** Prematurity and illness in newborn babies are associated with a complex range of factors, including social deprivation, ethnicity and maternal age. Primary Care Trusts need to improve their understanding of the changing demographics of their local population and model the impact on demand for neonatal services to target intervention and prevention strategies on key high risk groups.

3. **Whilst three-quarters of neonatal units have reviewed the types and intensity of care a unit should be able to provide safely, the resultant re-designation has yet to be implemented in full.** All networks should work with their relevant Primary Care Trusts to use the information from local strategic needs assessment to inform the designation of neonatal units, taking into account the standards recommended by the relevant professional groups. Primary Care Trusts should base their commissioning of neonatal services on units being able to demonstrate that they have the right levels of suitably qualified and experienced staff to provide the designated levels of care.

4. **There are currently no formal arrangements for performance managing neonatal networks.** In return for continued funding of networks, Strategic Health Authorities should agree a set of performance measures and review networks' performance against these objectives. Strategic Health Authorities should also require the two areas without a formal managed network to establish them as a priority.

5. **There are wide variations and mismatches in costs and charges between neonatal units for the different levels of care provided, and units' understanding of costs is generally poor.** Improving understanding of cost drivers is essential if the Department's plan to introduce a 'Payments by Results' tariff is to be effective. In setting tariffs for neonatal care, the Department should ensure that the full costs, including the costs of meeting professional staffing standards and providing transport services, are taken into account.

6. **There are serious shortages in the numbers of neonatal nurses with an average of nearly three vacancies per unit for nurses qualified in neonatal care.** Strategic Health Authorities and the new Neonatal Task Force should develop a national action plan to address neonatal nurse shortages, including developing recruitment and retention initiatives based on good practice. In the meantime, Strategic Health Authorities should increase the number of neonatal training courses.

7. **Only half of networks provide specialist neonatal transport services 24 hours a day, seven days a week.** Some 73% of units experienced delays in transporting babies and 44% believed that care had been compromised as a result. Strategic Health Authorities working with networks need to develop local partnering arrangements so that all neonatal units have 24 hour access to appropriately staffed transport services.

8. **On average, in 2006–07, each neonatal unit had to close to new admissions once a week due to a lack of baby cots.** A third of neonatal units operated above the recommended occupancy rate of 70% and three of the 178 units operated above 100%. High occupancy rates could have major implications for patient safety due to increased risk of infection or inadequate staffing levels. The functionality of the National Cot Locator needs to be improved so that it identifies occupancy levels in order to meet the needs of networks and units wishing to transfer babies.

1 Demand for neonatal services and the impact of health inequalities on prematurity and neonatal mortality

1. Most babies are born healthy requiring little or no medical intervention. Every year, however, around 10% of babies are born prematurely or suffer from an illness or condition which requires specialist care. There are three levels of progressively more complex specialist care; a local special care baby unit; a high dependency unit, and a highly specialised neonatal intensive care department. A baby needing neonatal care can move between these three levels of care as his or her condition changes.[3]

2. The overall birthrate in England has been rising since 2001 and the Department, using Office for National Statistics projections, acknowledges that this rising trend is likely to continue.[4] The trend in low birth weight babies and other risk factors associated with prematurity (such as maternal obesity, high and low maternal age, ethnic origin, deprivation and assisted conception) are also increasing, and the number of newborn babies needing specialist care rose by 5% between 2005–06 and 2006–07 to 62,471.[5]

3. Survival rates for premature or low birth weight babies have improved significantly. In 1975 half of babies born prematurely with a birth weight of 1,500 grams or less died and many others were stillborn. By 1985 a quarter died and by 1995 only a sixth of very small premature babies died. Improved survival rates have led to increased expectations that very small babies will survive. Infant mortality as a whole has fallen from 7.3 deaths per 1,000 live births in 1991 to five deaths in 2005. The neonatal period has one of the highest mortality rates of any period of life, with some 70% of infant mortality occurring in the first 28 days of life. Although prematurity and low birth weights are most closely associated with infant mortality, other factors such as congenital abnormalities also have a significant impact.[6] Of all babies who die before their first birthday, two thirds die because they are premature. There is also a correlation between high neonatal death rates and lower socio-economic groups.[7]

4. In 2002, the Department set an overall Public Service Agreement target to reduce by at least 10% the gap in infant mortality between the 'routine and manual' group and the population as a whole by 2010.[8] By 2007, although infant mortality rates in the 'routine and manual' group were improving, the gap between this group and the population as a whole had widened. The Department is still working to meet the target, but acknowledges that the

3 C&AG's Report, paras 1,1.14; Figures 1, 4

4 Q 3

5 C&AG's Report, Key Facts, page 4

6 C&AG's Report, Key Facts, page 5, para 1.18

7 C&AG's Report, para 1.18

8 In 2001 a new National Statistics Socio-economic classification was agreed by the National Statistician; it is an occupationally based classification. The Routine and manual groups covers the lowest three of eight bandings, and includes lower supervisory and technical, semi-routine and routine occupations (similar to the previous classification of social classes IV and V).

target is challenging and may not be met by 2010. The Department is redoubling its efforts including issuing a practical guide for Primary Care Trusts and health communities, and is also reviewing its health inequalities strategy.[9]

5. England's neonatal mortality rate of an average 3.4 deaths per 1,000 is below that of Northern Ireland but above those of Scotland and Wales. It is also lower than neonatal mortality rates in the USA and Canada but above those in Australia and Sweden. The Department consider that part of the reason for an apparently better performance in Scotland and Wales is that, as smaller countries, they have smaller numbers of births (about a tenth of the number in England). More detailed statistical analysis indicates that rates in Scotland and England are broadly the same, but there does appear to be a difference in Wales, possibly because Wales has fewer low birth weight babies. When the incidence of low birth weight is taken into account England compares well internationally.[10]

6. There are wide variations in mortality at network level (**Figure 1**) with Midlands South having the highest mortality (4.8 deaths per 1,000 live births compared to 1.8 in Surrey and Sussex and Essex).[11] Identifying the reasons for such variations is made difficult because of a lack of data on neonatal mortality rates at neonatal unit level. Analysing variations in neonatal mortality would require a sophisticated risk adjustment to reflect the complex combination of factors that occur at the local level.[12] As neonatal networks were expected to reduce many of the local differences in mortality rates, a review of network neonatal mortality rates could provide an indication of the quality of care provided.[13]

7. The Department is unable to confirm whether variations in outcomes were due to socio-economic or other factors affecting the population, or related to the quality of neonatal service delivery.[14] The Healthcare Commission's National Neonatal Audit being undertaken in 2007–08 should provide better comparative data on outcomes, including outcomes of babies at two years.[15]

8. Early intervention can improve neonatal mortality rates. Good communication and education can help by encouraging pregnant women to book early to see their midwife or General Practitioner. But there is also a need for interventions that help mitigate risk factors, such as smoking during pregnancy.[16] The Department is exploring the impact of premature labour on premature births and the actions that might help avoid premature births.[17]

9 Qq 31–34, 50; C&AG's Report, para 1.17

10 Q 23; C&AG's Report, para 1.21

11 Qq 8, 36, 51, 86; C&AG's Report, paras 1.19–1.22; Figure 6

12 C&AG's Report, para 1.18

13 Qq 8, 76-77; C&AG's Report, para 8

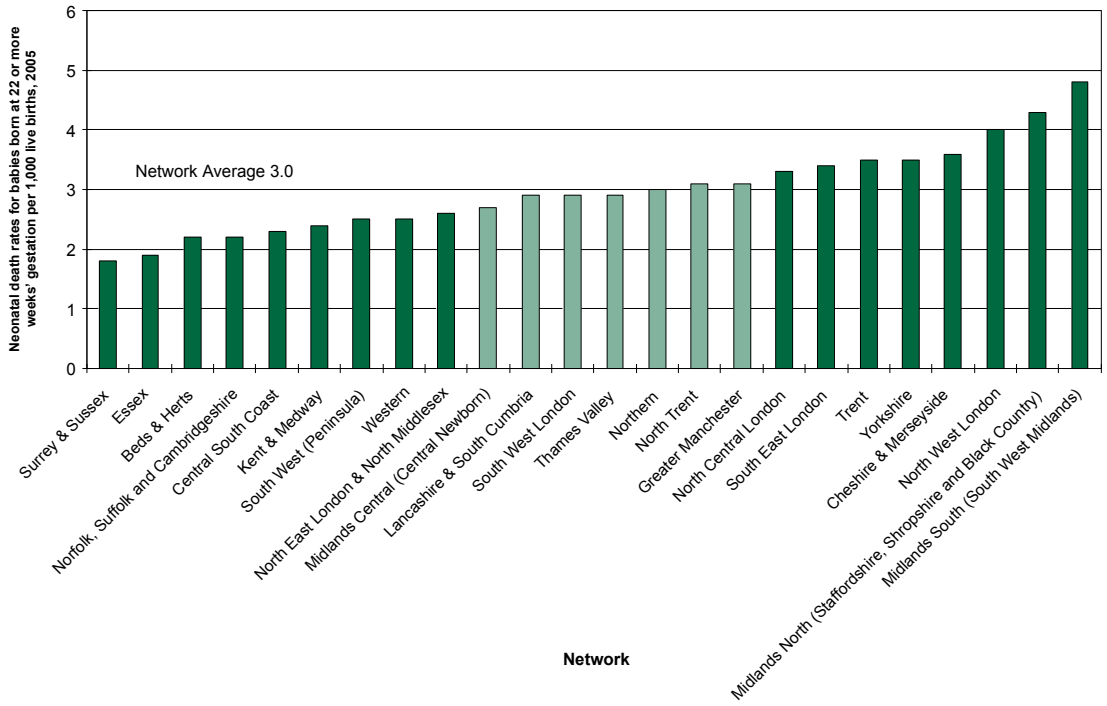
14 Qq 51–53, 55

15 Qq 22, 54, 67

16 Qq 35–37, 65

17 Qq 77–87; Ev 17

Figure 1: Network neonatal mortality rates (for babies born at 22 or more weeks gestation), 2005.



Key: Dark shading indicates those networks whose neonatal mortality rates are significantly different from the average.

Source: C&AG's Report, Figure 6

2 Progress in networking neonatal services and its impact on capacity.

9. The year on year increases in birth rates since 2001 and improvements in survival rates have placed increasing pressure on the capacity of neonatal services and in some instances led to babies being transferred long distances to receive appropriate care. A 2003 review of neonatal intensive care services commissioned by the Department found that neonatal care was provided in a widely dispersed manner with limited capacity in the larger units providing care for the most ill babies. There was also a lack of national data on outcomes, major challenges in nursing recruitment and a need for agreed national standards of care. The report proposed the re-organisation of neonatal services into managed clinical networks so that units in each network would provide virtually all the care required by mothers and babies without the need for long distance transfers.[18]

10. Most of the 180 neonatal units organised themselves into 23 formal geographical networks (**Figure 2**). The Department consider that the concept of a network is a fluid one and should reflect local needs and circumstances and it is important therefore that local organisations determine the structure, role, responsibilities and budgetary arrangements for their network. As a result, the pace of implementation has varied widely. A typical network comprises a group of neonatal units linked by a supervisory management structure. It includes a designated lead clinician and a funded manager, with at least one unit capable of providing the whole range of neonatal care, including the highest level, intensive care, and the remainder providing special and high dependency care.[19]

11. In April 2003, alongside publishing the report on the review of neonatal services, the Department announced that it was allocating an additional £72 million over three years to Strategic Health Authorities to support the establishment of neonatal networks. It is not clear, however, whether this money was spent as intended. The Department agrees that it is not been easy to pin point how this money was used due to the 2006 re-organisation of Strategic Health Authorities and Primary Care Trusts[20] but that around an extra £150 million has been spent on neonatal care.[21]

12. Not all units have the skills and expertise to provide ongoing intensive or high dependency care although they should be able to stabilise a baby prior to transfer to a more suitable unit. Networks have largely achieved the objective set by the 2003 Review of treating the majority of babies within a network, but the remainder of the Review's objectives have only been partly achieved. As a result, networks have yet to realise their full potential in the provision of effective neonatal care.[22]

18 C&AG's Report, paras 1.2–1.3

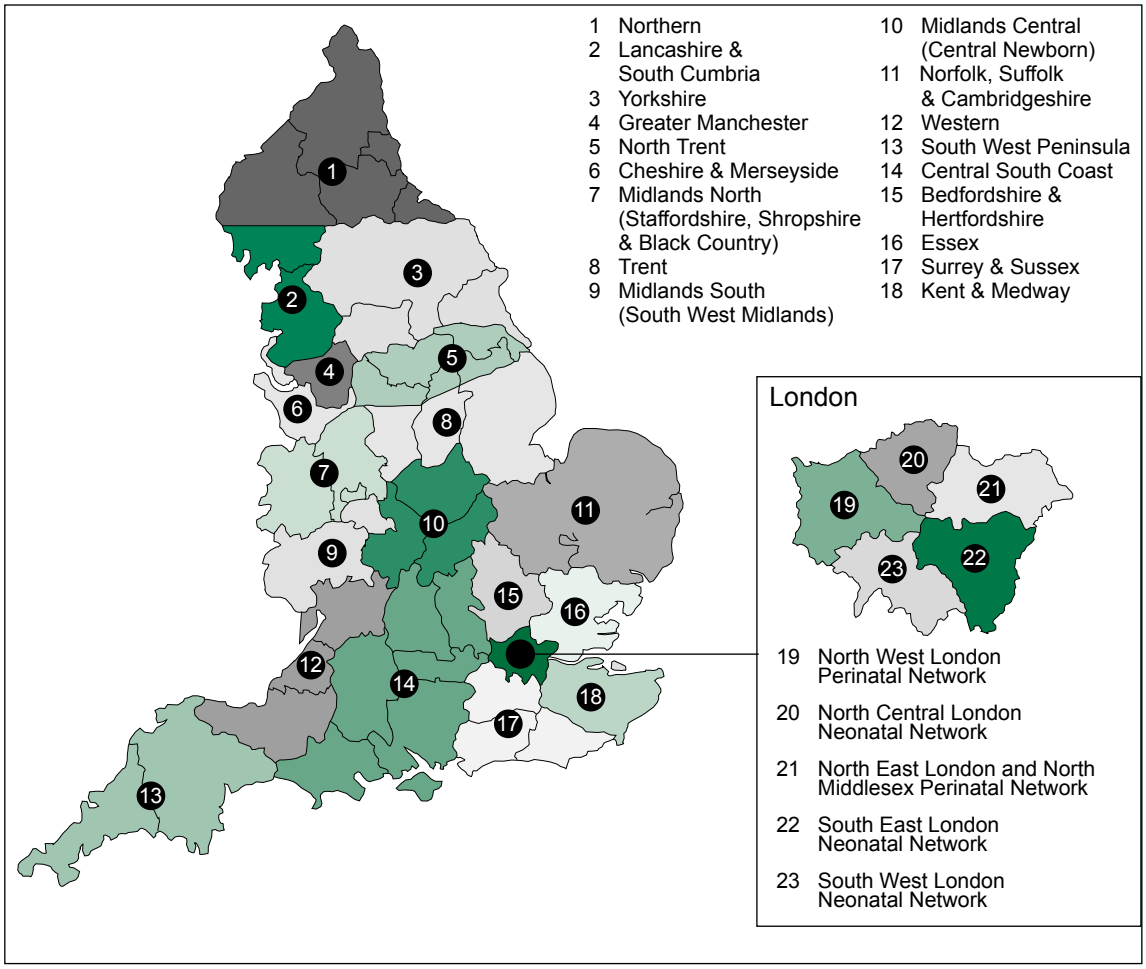
19 Q 58; C&AG's Report, paras1.5–1.9, Figures 3, 4, 5

20 In July 2006 as part of the NHS Reform agenda, the 28 Strategic Health Authorities were reduced to 10, and in October 2006 the 303 Primary Care Trusts were reconfigured and reduced to 150.

21 Qq 16, 45

22 Qq 68–69 ; C&AG's Report, Figure 2

Figure 2: The location of networks in England



Source: C&AG's Report, Figure 3

13. Two networks, Essex and the Northern network, have yet to establish a formal network. The Northern network is not structured as a formal network, although it has been delivering care in a co-ordinated fashion since 1983. The Essex network has no manager and is not functioning as a network due to a lack of agreement as to which unit should provide intensive care and take the lead role in the network. The Department is committed to establishing formal networks across all of England.[23]

14. One area of the Review which has not yet been achieved is the key process of re-designating units.[24] Three-quarters of networks have reviewed the designations of all or most of their units, but re-designation has not been implemented in full, largely due to vigorous debate about which units should take which roles. Without meaningful

23 Qq 15, 38–39; C&AG's Report, para 1.12

24 A key role envisioned for network management teams was that they would lead work to categorise, and if necessary re-designate, all the units in their region according to the amount and type of neonatal care each one could provide safely (for example recommended nurse to baby ratios of 1:4 for special care; 1:2 for high dependency and 1:1 for intensive care. The expectation was that each network should have one or more level 3 units (including a lead centre) and a number of level 2 and level 1 units.

re-designation processes, networks may find it difficult to provide appropriate capacity to meet demand safely.[25]

15. A further complication is the blurring of some designations. Twelve units across nine networks described their designation as '2 plus', meaning they are officially designated as level 2 units but often provide intensive care (level 3). Where this is being done, it is in most cases a pragmatic way of maintaining skills and capacity across networks.[26] It is important to maintain clinical excellence across all levels of the service and the Department does not envisage a significant rise in level 3 units at the expense of level 2 units but intends to examine the relationships between level 2 plus and level 3 units.[27]

16. One of the key objectives set by the 2003 Review was the establishment of specialist transport services. The Department has, however, made limited progress in achieving this and performance is variable across England. Currently, around half of the 23 networks can provide a service on a 24 hour, seven days a week basis, and a further three have access to such a service. Three of the other eight networks are not meeting the objective, although a further five networks are planning to introduce this service shortly.[28] The Department is committed to improving transport services through its new Task Force.[29]

17. The Department established a National Cot Locator in order to ensure that cots were allocated to babies on an efficient basis, but, only 20 out of 23 networks actually use this facility. In addition, networks have made progress in reducing the number of babies needing to transfer across the country, meaning that there is less of a need for a centralised service. The Department is now planning to review the use of the National Cot Locator.[30]

18. Five years after the introduction of neonatal networks, some of the problems identified in 2003 have yet to be fully addressed.[31] The Department explained that this was because changing any kind of clinical service is complex and can take a number of years. The Department believes that neonatal networks have saved lives but acknowledged that there is more to do. It intends that its new Task Force will assist the NHS in addressing all of the problems still facing the neonatal service.[32]

25 Qq 4, 5, 83, 101; C&AG's Report, paras 1.14–1.16

26 C&AG's Report, para 1.16

27 Qq 86–87

28 Q 12

29 Q 24–25

30 Qq 13–14

31 Q 68 ; C&AG's Report, para 1.5, Figure 2

32 Q 68

3 Recruiting, retaining and training the staff required to deliver an effective service

19. Providing care for the most vulnerable members of society can be extremely pressurised and emotionally demanding. Compounding these pressures are capacity and staffing problems, which can lead to some neonatal units regularly exceeding 100% cot occupancy and high numbers of closures to new admissions; on average, one closure per week.[33]

20. Care in neonatal units is underpinned by guidelines from the British Association of Perinatal Medicine (BAPM), the professional body providing clinical leadership. BAPM has recommended that the nurse to baby ratio for babies requiring intensive care is one-to-one. Only 24% of neonatal units stated that they met this ratio. Of these, only four level 3 units, the type which provide the most intensive care, stated they met the standard.[34] The Department neither endorses independent staffing guidelines such as BAPM, nor sets its own minimum standards as it considers that staffing requirements are best determined locally, based on clinical needs.[35] An example of this is the West Midlands, which covers three networks. These networks undertook a joint review and increased funding in order to employ five advanced neonatal nurse practitioners across their level 3 units.[36]

21. Notwithstanding the limited ability of neonatal units to provide one-to-one nursing, each unit had, on average, three vacancies against their current establishment for nurses qualified in neonatal care. The number of vacancies increased as the intensity of care provided by the units increased (**Figure 3**).[37] In total there were 459 nursing vacancies against current establishment in England in 2007.[38] Even if the current establishment was at full strength, previous research has shown that the shortfall in meeting the BAPM nursing guidelines was 2,285 nurses across the UK in 2006.[39]

33 Qq 2, 7

34 Qq 5, 42; C&AG's Report, para 3.13

35 Qq 5–6

36 Q 9

37 Q 4; C&AG's Report, para 3.14, Figure 9

38 C&AG's Report, para 3.14

39 Q 2; C&AG's Report, para 3.15, reference 31

Figure 3: The average number of nurse vacancies increases as the intensity of care provided by the units' increases

LEVEL OF UNIT	AVERAGE QUALIFIED NURSE VACANCIES
1	1.3
2	1.8
3	4.7
3 PLUS SURGERY	8.3
AVERAGE ACROSS TOTAL	2.9

Source: C&AG's Report, Figure 9

22. Recruiting neonatal staff has always been a challenge but this is compounded by the lack of reliable data on how many neonatal nurses are currently practising. The Department now intends to maintain data on neonatal nurses nationally through the new electronic staff record.[40] The Department is also responding to the increased birthrate by asking health organisations to look in detail at both their maternity and neonatal staffing and develop plans to increase staff numbers.[41] The aim is to address nursing shortages, including the problem of the ageing workforce, in a concerted way across the whole of the NHS.[42]

23. There are challenges in ensuring nurses are properly trained and that their skills are up to date as neonatal nursing is a post registration specialty, requiring a specialist training course. There are, however, insufficient specialist post-registration training programmes and staff can find it difficult to find time to attend training, a problem exacerbated by existing staff shortages.[43] On the job training, for example competency based training, and developing relationships between NHS trusts and local universities, are crucial to delivering training in flexible ways.[44]

24. The implementation of the European Working Time Directive will impact on neonatal services. There is currently an interim 56-hour maximum working week, with a final deadline of August 2009 for implementation of the 48-hour working week.[45] The Department accepts that, whilst this Directive will impact most on medical staff, there will be a knock-on effect for nursing staff, particularly in areas like neonatal services where they work so closely together. To mitigate this risk, the Department has asked all Primary Care Trusts to examine the likely effects of the European Working Time Directive on their neonatal unit staffing.[46]

40 Q 4; C&AG's Report, para 3.20

41 Q 3

42 Q 11

43 Q 10; C&AG's Report, para 3.18

44 Qq 9–10

45 C&AG's Report, para 3.12

46 Qq 89–90

4 Improving the understanding of costs and the financial management of neonatal services

25. One way of improving the management of neonatal services is through effective commissioning and financial management of services. Commissioning of neonatal services is complicated and not yet sufficiently integrated. The three types of neonatal care are planned and commissioned separately. Primary Care Trusts commission neonatal special care and the ten Specialised Commissioning Groups commission high dependency and intensive care.[47] The three types of care are, however, mutually inter-dependent as a baby's condition can improve or deteriorate very rapidly and most babies move between the different levels of care as their condition changes. Furthermore, although maternity services are a key determinant of demand for neonatal services, there is no formal link between them for commissioning and planning purposes.[48] In one region, the Kent and Medway network, all three types of neonatal care are commissioned together to improve the planning of the care pathway.[49]

26. Effective commissioning is constrained by Primary Care Trusts, Acute and Foundation Trusts not understanding the costs of providing neonatal services, which is partly explained by inconsistency in calculating such costs.[50] **Figure 4** shows the variations in the costs per cot for each type of neonatal unit.[51]

Figure 4: The average cost of running a cot increased as the level of unit increased but also shows wide variations between the maximum and minimum for each level of care

Designation of Unit	Annual Cost per Cot (2006–07)	
	Minimum	Maximum
Level 1	£43,672	£205,740
Level 2	£46,310	£180,718
Level 3	£61,218	£246,339
Level 3 plus surgery	£96,583	£256,248

Source: C&AG's Report, Figure 10

27. Daily charges for neonatal care vary across all levels of care, with little consensus on the basis on which these charges were determined (**Figure 5**). In 41% of units, charges were based on historic costs adjusted for inflation. Foundation Trusts' average charges were lower than NHS trusts and in a third of units charges did not cover their costs. These

47 For specialist services, such as neonatal intensive care services, that are provided by a small number of specialist providers, the Department has convened Specialised Commissioning Groups, in which one Primary Care Trust commissions services on behalf of the others in the same Strategic Health Authority.

48 C&AG's Report, para 4.16, Figure 13

49 C&AG's Report, para 4.17, Case Example 5

50 Q 70–73, 102 ; C&AG's Report, paras 4.7–4.15

51 C&AG's Report, para 4.10, Figure 10

charges form the basis of contracts with commissioners which are a fundamental component of how the service is run.[52]

Figure 5: The charges for cot days in 2006–07 varied across all types of care.

	Special Care Cot day (n=109)	High Dependency Care Cot day (n=95)	Intensive Care Cot day (n=95)
Minimum	£126	£165	£173
Maximum	£1421	£1680	£2384
Median	£406	£635	£945
Range	£1295	£1515	£2211
Average	£426	£714	£976

Source: C&AG's Report, Figure 11

28. No common method exists for tracking and allocating the costs of each neonatal unit, with nursing salaries and equipment consumables the only common features in the units' cost estimates. The estimates of running costs did not reconcile with the estimates of income received. On average income exceeded expenditure by £559,000. All of these discrepancies point to a fundamental lack of understanding in Trusts of the cost of providing neonatal care. While some improvements in financial management have been achieved, further progress is needed, both in the way financial information is collected and the way costs are apportioned. In the medium term the Department expects staffing cost data to be more accurate and transparent, but information on pharmaceuticals, for example, will not be available until the Department's electronic prescribing is fully implemented, which is not expected for several years.[53]

29. The NHS expects the introduction of Payment by Results and the development of a national tariff for neonatal services to help promote better financial planning in the way it relates costs to actual levels of patient activity.[54] There is currently some confusion however on how this will be done in practice for neonatal care.[55]

30. The NHS has not yet introduced Payment by Results for neonatal care, largely due to the inherent difficulties in developing a robust tariff for such complex services. Units have concerns about the practicalities of implementing Payment by Results and there is uncertainty as to how the development of a tariff is being taken forward. There are also concerns about the extent to which a tariff would recognise transport costs.[56]

31. The Department expects that in the next couple of years they should have a national tariff for neonatal services. For 2008–09, each of the specialist commissioning groups, which have overall responsibility for securing adequate levels of health provision, is

52 C&AG's Report, para 4.10, Figure 11

53 Qq 92–93; C&AG's Report, paras 4.7–4.13, Figure 10

54 Payment by Results links income to work actually performed in order to reward efficiency and encourage innovation. It is based on a prospective payment system whereby the price of a given unit of activity is set in advance (national tariff) and income is based on multiplying the tariff by the amount of activity or numbers of episodes of care delivered.

55 C&AG's Report, paras 4.20, 4.23

56 C&AG's Report, paras 4.19–4.21

providing a baseline and setting out clearly what the costs and expectations are against the amount of money it intends to spend.[57]

57 Qq 9, 17, 70–74; Ev 13–14

Formal Minutes

Monday 12 May 2008

Members present:

Mr Edward Leigh, in the Chair

Mr David Curry
Dr John Pugh
Mr Don Touhig

Draft Report (*Caring for Vulnerable Babies: The reorganisation of neonatal services in England)*, proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 31 read and agreed to.

Resolved, That the Report be the Twenty-sixth Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

[Adjourned till Wednesday 14 May at 3.30 pm.

Witnesses

Wednesday 27 February 2008

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Oral evidence

Taken before the Committee of Public Accounts

on Wednesday 27 February 2008

Members present

Mr Edward Leigh, in the Chair

Angela Browning
Mr Philip Dunne
Nigel Griffiths
Mr Austin Mitchell
Dr John Pugh
Mr Alan Williams
Phil Wilson

Mr Tim Burr, Comptroller and Auditor General, and **Ms Karen Taylor**, Director, National Audit Office, were in attendance and gave oral evidence.

Mr Maruis Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, was in attendance.

REPORT BY THE NATIONAL AUDIT OFFICE

CARING FOR VULNERABLE BABIES: THE REORGANISATION OF NEONATAL SERVICES IN ENGLAND

Witnesses: **Mr David Nicholson CBE,** Chief Executive and Accounting Officer, **Dr Sheila Shribman,** National Clinical Director for Children, Young People and Maternity Services, **Professor Christine Beasley,** Chief Nursing Officer for England, and **Professor Sir Bruce Keogh,** Medical Director, National Health Service, gave evidence.

Q1 Chairman: Welcome to the Committee of Public Accounts which today is considering the Report of the Comptroller and Auditor General C*aring for Vulnerable Babies: the Reorganisation of Neonatal Services in England*. We welcome back to the Committee David Nicholson, Chief Executive and Accounting Officer of the National Health Service. Perhaps you would like to introduce your team.
Mr Nicholson: I have with me Professor Christine Beasley, Chief Nursing Officer for England, Dr Sheila Shribman, National Clinical Director for Children, Young People and Maternity Services, and Professor Sir Bruce Keogh, Medical Director for the NHS.

Q2 Chairman: I should like to welcome to our hearing a delegation from Uganda including members of its Committee of Public Accounts and the Auditor General. I think some Members of this Committee will be talking to them after this session. Mr Nicholson, yesterday some of us had a most instructive visit to Homerton Hospital. All of us felt it to be a moving experience and we should like to pay tribute to your staff. The expression: "the most vulnerable members of our society" is perhaps overused but when you look at a 24 week-old baby and see the amount of care provided it is very humbling, and we should all be grateful for what your staff do. But there are some questions I wish to ask you which relate to the pressure placed on staff. It is quite obvious that this is an extremely pressurised job and is often emotionally demanding. Capacity and staffing problems are dealt with beginning on page 24 and it goes on to paragraph 3.15 to which I wish to refer. That tells us that there is a shortfall of nearly 2,300 neonatal nurses. Do you think that is acceptable, and what are you doing to address the problem?
Mr Nicholson: Obviously, staffing levels in neonatal services are extremely important and quite a lot of work has been done in that regard over the past few years. A set of guidelines, the BAPM (British Association of Perinatal Medicine) guidelines, has been published. As a matter of principle the Department of Health does not support or pass out particular guidelines for particular services nor does it endorse them, largely because, first, it believes that is much better done by local decision-making based on clinical need, and, second, in other parts of the world where people have tried to do this in a national way it simply has not worked. Therefore, as a matter of principle we do not do that. I believe the figure of 2,300 comes from using the BAPM guidelines and multiplying them by the number of cots we have. We do not do staffing levels for cots anyway; we do them for babies.

Q3 Chairman: But do you accept there is a real problem? We have just been briefed by BLISS, the premature baby charity. They tell us that there has been a 5% increase in demand and a 2% increase in staffing. We cannot deny that the birth rate is increasing and the number of premature babies increasing and so there is very severe pressure on this part of the NHS. The fact that there is pressure is not your fault, but your responsibility is how responsive your service is to that increasing pressure.
Mr Nicholson: I understand that and I shall ask Christine Beasley to say a little about the detail of nurse staffing in particular which is where the pressure point is. There is no doubt that if you look

at the trends of rising birth rate they are significant. Right up until October the Office for National Statistics said that the birth rate looking forward would be relatively flat. It has now revised those figures and said there will be an increase. That is one of the reasons why we have asked all health systems to look in detail at both their maternity staffing—hence the announcement on Monday by the Secretary of State about the potential for 4,000 more midwives—and the operating framework sent out to the NHS before Christmas which asked every health organisation to look at the staffing of neonatal teams and come up with some plans to increase the numbers and explain how they might do it.

Q4 Chairman: Look at figure 9 on the page to which I have just referred. It explains to us that on average the number of vacancies increases as the intensity of care provided by the units increases. Therefore, it appears from this that as the problem gets worse the shortage also gets worse, which is very worrying, is it not?
Professor Christine Beasley: There is no doubt that it is a highly pressurised service. In my experience over many years, recruiting staff to neonatal units has always been a challenge because it is such a pressurised area. I absolutely agree that we always have to work on how to get more staff into these areas. In terms of the chart in the Report to which you refer, it goes back to the BAPM guidelines. Because the 2,300 relates to the BAPM guidelines, which for intensive care are one to one, that is why looking at that as the denominator it appears that the vacancies are higher. When one talks to clinical staff they are very clear that at that high level of intensive care there is variability around babies. Some very sick babies may need two nurses to one baby and others in the same intensive care may need half a nurse, so the ratio is one to two and one will get a different picture if one looks at that. Although we collect data only on paediatric nurses in terms of the increase as a national figure we shall try to collect it for neonatal nurses when we get the electronic staff system. We have had a big increase of paediatric nurses over the past 10 years and each of the regions is doing an awful lot not only to recruit nurses to neonatal care but to provide the sort of training that is often work-based. One of the real problems is being able to release people to go away.

Q5 Chairman: Do you think it is fair or just that adults have the right to one-to-one intensive care and in paediatrics it is the same but with this most vulnerable group, where everybody accepts that what is done in the early days is absolutely vital, the health service does not give babies the right to that level of care?
Professor Christine Beasley: Put in that bald way, it is not just, but the guidelines for adult and paediatric intensive care are just that—guidelines—like the BAPM guidelines.

Q6 Chairman: Which according to our briefing are met in large part but not here?
Professor Christine Beasley: My understanding is that they are met in the same way that the neonatal guidelines are met. It is down to the condition of the patient and what seems to be the best care, and that applies also to adult intensive care.

Q7 Chairman: Let us look now at bed occupancy. If we look at paragraph 3.4 we see that many units find themselves operating at over 70% cot occupancy, some at over 100%, and most close to new admissions on average once a week. We saw one example yesterday of a very ill baby that had been referred from Whipps Cross to Homerton, had been sent to Medway, then to St George's and back to Homerton and could not get back to Whipps Cross. If you were the parent the stress of that would be appalling, would it not?
Mr Nicholson: Absolutely. I do not defend that position at all, but it seems to me that the most important thing is to make sure that the child is in the place best fitted to deal with the particular condition it has, and inevitably in those circumstances it will be necessary sometimes to move a child. Increasingly, we try to move the mother rather than the child to make sure the birth is in the right place, but some kinds of movements are inevitable. The key issue for me is the way in which the network operates. We have had some significant progress in terms of treating individual babies within networks, but sometimes—the case you cite is an example—it does not work. In all those cases it is incumbent on the NHS to do an absolutely root cause analysis as to what happened in the individual case and feed that back to the network to ensure action is taken to avoid it in future. We have increased the number of cots over the past three years by about 167 and developed tools such as the cot locator scheme and capacity planning tools to help people identify the number of cots they need to provide services for patients, and we continue to take that seriously.

Q8 Chairman: You talked about networks which are dealt with briefly in paragraph 1.17. Your department declared that the introduction of neonatal networks would help reduce variations in infant mortality rates within different social groups and save 200 to 300 lives a year. Has it achieved a reduction in variation between social groups in terms of mortality? Has it saved up to 300 lives a year?
Mr Nicholson: I shall ask Sir Bruce to talk a little about different social groups, but the general point I make here is that the figure of between 200 and 300 was based on an analysis of information from California on the one hand and Sheffield and the rest of the UK on the other. That was how the figure came about. The work we have done in identifying the expected level shows that in the three years up to the end of 2006 we have saved 310 lives.

Q9 Phil Wilson: Having read the Report, since 2003 things have improved in some areas. Parents seem to be content with the kind of services their babies get in these care units. We all know the stress and strain

for parents and nurses as well, but I understand there are some problems concerned with staffing, financial management and even transport. As far as concerns the recruitment of neonatal staff and nurses in particular, what mechanisms do you have in place to recruit more staff to this particular field?

Professor Christine Beasley: There are some very good examples of networks. Three networks cover the West Midlands and together they have increased funding and are putting over £½ million into the employment of about five very advanced neonatal practitioners working almost always in level 3 units. They have also put in more resources this year to appoint another 29 or 30 nurses to neonatal services, so in every area they are putting money into it. At the same time, although money and resources are an issue, there is the question of people having training and still staffing the unit. In the West Midlands there are other examples. They are doing competency-based training on the job and, critically, putting in some work for nurses at preregistration level. They get experience in neonatal services and so it is an area to which they want to return, because nurses are often frightened of going into that area if they have never had any experience of it. There are examples across the country where people have a package of measures to improve staffing.

Q10 Phil Wilson: Are there any difficulties concerned with on-the-job training of nurses, for want of a better expression, to keep up to date with techniques? Is there any shortfall in that? How do you train them and basically re-educate them in new techniques?

Professor Christine Beasley: Clearly, it is a range of areas in which people are trained. For on-the-job training there is a link between the local university and the hospital itself and there will be competency-based training on all the things one would do. For advanced neonatal practitioners right at the very top end that is commonly a year's course, some of it spent in the academic world and some in practical courses. Both clinicians and practitioners teach as well as people who have academic underpinning.

Q11 Phil Wilson: In paragraph 10 on page 9 it is said that: "each network had closed to new admissions an average of 52 times during 2006–07 due mainly to either lack of cots or shortages of nursing staff". To me, that is a pretty significant figure. I also understand that of the neonatal nurses who work in that area 30% come up for retirement in the next few years. Does that not exacerbate your problem?

Professor Christine Beasley: The whole of the nursing workforce is aging—I sit before you as one example—and we are doing all we can to increase the appeal of nursing across the piece, including neonatal nursing, not just for young people but older people. There is a whole range of mechanisms. There are nurses who want to retire when they are 55 but will often come back to do one day a week. Perhaps they do not want to do a whole week. We are trying to address a whole range of things to make sure we keep very skilled people particularly in the area of neonatal nursing.

Mr Nicholson: It is true that in the past we have not necessarily put a national overlay onto this to ensure it happens. Essentially, we have left it to local organisations to take it forward. This year we have changed that. In the operating framework we have said that every strategic health authority should come together to set out exactly how it will deal with the very issues you have described in a concerted way across the whole of the health system.

Q12 Phil Wilson: To turn to transport, why do only 50% of networks offer specialist transport 24/7?

Mr Nicholson: Networks have been working quite hard over the past three years to get the transport system properly set up because in the past that was certainly identified as a serious difficulty. All units are capable of stabilising a baby and looking after it in the initial period, so you can be reassured that that is the case in all units. As far as concerns transport, currently 12 of the networks have a 24/7 service and three have access to such a service. For example, parts of the east of England use the London one out of hours. Five of the networks plan to introduce 24/7 this year[1] which leaves us with three. We shall pursue each of those three to make sure that next year we can get 24/7 transport across the whole country.

Q13 Phil Wilson: The national cot locator also did not get a very good write up in the Report. What is the point of it when 20 out of 23 networks do not use it?

Dr Shribman: We introduced the cot locator to enable people by one phone call to move a baby if they had to move from their existing unit. What we know from the NAO Report is that we are maintaining babies within networks a large proportion of the time and we have certainly decreased the number of transfers across the country. The cot locator is a help to people and we encourage them to use it. They can contact people more easily to find a cot. Therefore, it was designed to assist with that, but we plan to review progress with it this year and see how well it is doing.

Q14 Phil Wilson: If 20 out of 23 are not using it perhaps you should be looking at what they are doing and build on that. Is that what you intend to do?

Dr Shribman: Indeed we do. It was certainly something that people wanted, which was why we developed it. People welcomed it and it was launched with enthusiasm, but as with everything we do we need to review whether it is really doing the job. When people work closely together in networks sometimes it is the phone call to the department which they know is the speedy way to get the baby to the right place at the right time, but this was designed to back up the system so that people would have access to advice and not have to make quite so many phone calls as they had to do previously to get the baby to the right place at the right time.

[1] *Note by witness*: This year, or next year.

Q15 Phil Wilson: The northern region which is an area very close to my heart—I represent one of its constituencies—does not have a network which apparently clinicians would like. Is there any particular reason why that is so?
Dr Shribman: My understanding is that before we established formal networks clinicians in the northern region were already working very closely together in a networked way, so at first perhaps they did not feel the need for a formal management structure with a network manager, clinical lead and so on. There is no reason why a network should not be developed and I am sure that is something we can look at as part of the way forward because it is the ideal way to go.
Mr Nicholson: The northern region will have one.

Q16 Phil Wilson: I have a couple of questions on finance. I refer to the £72 million additional money that was not ring-fenced. According to the Report it is not known where £25 million of that sum is, or it has been spent on something else. There are indications that it has been siphoned off into other areas of the NHS to do whatever. Is that the case? Has £72 million of additional money been put into neonatal services or is it £25 million less than that?
Mr Nicholson: You are absolutely right that the money was not ring-fenced. We identified it nationally and it went out to the NHS. £20 million of that was a recurring sum every year and the rest was pump priming. I know that the NAO did a sterling job to find out where it had been spent and on what. There is no doubt that this is slightly exacerbated by the fact that during the period we went through one of our regular processes of reorganisation in the NHS whereby we moved round all our organisations. It has been quite difficult to pin down some of it because most of the organisations holding it have disappeared. What we can say is that when we looked at our programme budgeting information we calculated that about £150 million extra had been spent on neonatal care, so we do not believe that in overall terms there has been a siphoning off of the money, although we cannot pin down all of that in the way the NAO tried and you have described.

Q17 Phil Wilson: I want to ask about revenue income and expenditure. Some of the income from the units exceeds the cost and yet they do not seem to get the money to spend on those units; it goes somewhere else. Is there a reason for that? Is that normal practice within the NHS? Is this not money that could be reinvested in neonatal services?
Mr Nicholson: What is true is that we are on a journey in terms of financial management of the NHS and understanding what our costs are and controlling and organising them properly. We are significantly better than we were two or three years ago. Nevertheless there are areas where we could do better. If you look at the total amount of income that a particular hospital receives, for some specialties the income against expenditure shows surpluses and for some there will be deficits. Our view at the moment is that it is up to the hospital to organise itself appropriately so it can make sure it uses that money to best effect. There are occasions when one specialty subsidises another, but it seems to me that that is perfectly okay when regard is had to the hospital as a whole. We need to be much better both at the way we collect information and the way we apportion cost. Our experience is that once you start to design the tariff, which is exactly what we are trying to do for neonatal services at the moment, the discipline becomes much better and more transparent.

Q18 Angela Browning: Mr Nicholson, why is it that neonatal units are not formally inspected by the Healthcare Commission?
Mr Nicholson: All healthcare organisations are inspected by the Healthcare Commission. I do not know why the Commission has not at this particular moment chosen to specialise in neonatal services. I think you will have to talk to the Commission.

Q19 Angela Browning: We are told in the NAO Report that they are not. I have just been involved in the committee stage of the Health and Social Care Bill. I was rather astonished to read this because the point certainly was not raised in committee on the Bill, which is rather relevant to that. As the NAO has picked this up in its Report I wondered if there was a reason for it. It read as an exemption.
Mr Nicholson: It is certainly not an exemption.
Professor Sir Bruce Keogh: As a former Commissioner of the Healthcare Commission, its philosophy is to reduce the burden of inspection and ensure that inspections are focused. It has tried to base its inspections on intelligent information that comes in which indicates an inspection may be required and, where appropriate, that is coupled with random inspections. I do not know why it has not focused specifically on the neonatal units.

Q20 Angela Browning: I assume that the department had sight of this Report from the NAO before it was published. Can the NAO confirm that?
Ms Taylor: Yes.

Q21 Angela Browning: In that case, having read that in the Report is that not something you would have raised prior to publication if it had not been accurate?
Mr Nicholson: It is accurate. Neonatal services are not exempt from the activities of the Healthcare Commission. The Commission operates in a particular way around self-audit looking at information and data from the system and then decides itself where to focus its attention. As an example yesterday I visited a neonatal unit which had called in the Healthcare Commission to do an inspection because it was worried about some of the numbers in it, but it is certainly not exempt.

Q22 Angela Browning: Perhaps I can ask the NAO if it can throw some light on the reference to that in the Report.

Ms Taylor: As Sir Bruce says, the Healthcare Commission's focus is on the annual health check in terms of its overall view of the quality of care being provided across the health service. It uses a risk-based approach based on data and to date it has not highlighted that neonatal units are things on which they want to focus. The main point is that they are not looking at quality and consistency of care; nobody is. We found nobody that was auditing or inspecting neonatal units. The Healthcare Commission has recently launched a clinical audit of neonatal units which will provide the first data, but until now no one has looked at neonatal units.
Mr Nicholson: They are doing that because we asked them to do it.

Q23 Angela Browning: That sets the context. It looked as though a very important part of the health service was just falling through the net in terms of a body inspecting and monitoring it. On page 17 in paragraph 1.21 there are comparison of the results as far as concerns England. There is also reference to Scotland. We know from the BLISS report[2] that Scotland does rather better than England. Could you throw some light on whether the department seeks to learn some lessons from the Scottish experience?
Mr Nicholson: Sir Bruce can talk in more detail about the statistical base. The work we have done on this indicates that particularly when one talks of Scotland and Wales these are relatively small numbers compared with England as a whole; they represent one tenth of England. Therefore, one gets significant changes on a year-to-year basis. The statistical analysis we have done looking back at this particular issue seems to indicate that Scotland and England are broadly the same, so we do not believe there is a big difference between Scotland and England. There does however appear to be a difference in Wales; there is, if you like, a better record. We have looked at that issue in some detail and from the analysis we have carried out it appears that in Wales they do not have as many low weight babies.
Professor Sir Bruce Keogh: As you rightly say, there appears to be some difference between different regions of the United Kingdom. The neonatal mortality rate for 2005 in England was 3.5%; in Wales it was 3%, for the reasons to which Mr Nicholson has alluded, and Northern Ireland was 4.7%. Therefore, the average across that group is 3.5% which I believe compares very well with places like the United States at 4.5%. We know that the neonatal mortality rate is affected by a number of variables. If we go along the lines outlined by the International Federation of Gynaecology and Obstetrics and we exclude very, very tiny babies—less than 500 grams—the neonatal mortality rate for England is 2.8% versus Scotland at 3%. If we exclude some of the other major malformations which are a major cause of death and are not influenced by neonatal intensive care and babies under 1,500 grams we see again that England and Scotland are neck and neck at 0.9% and 1%. I suspect that the initial figures are relatively superficial and bear further scrutiny.

Q24 Angela Browning: In one of his opening questions the Chairman made reference to transporting babies. Homerton Hospital is in an urban network and therefore the distances are perhaps not as great as they would be in some of the more rural regional networks. In my own area of the South West I believe that babies in Devon and Cornwall go to Bristol which is quite a journey for sick babies. From the report we have had from BLISS, it appears that Scotland has gone ahead in terms of what it provides for transporting sick babies. I refer not just to the structure it has put in place but its investment and training in nurses, paramedics and medical staff. It seems to have made a lot of progress. I just wonder whether you agree, given the fact there has to be transportation within these networks, that investment in that sort of structure and level of trained staff for the transportation of babies would make a difference.
Mr Nicholson: You are absolutely right. The Report draws attention to this particular area in a significant way. Having reflected on the Report, we decided to set up a small task force nationally to move the thing forward, not to think up lots of new policies because we know what needs to be done; the issue is just getting it done. That is why I have tasked Sir Bruce to lead a task force to do that. One of the first things that task force will do is get into the whole issue of transport. I said earlier that we certainly have plans for all but three of the networks to have 24/7 transport in the way you describe with proper training and staffing underneath it. We are not sure about the other three and we shall pursue them as a matter of course. We need to move on that and it is a priority for us next year.

Q25 Angela Browning: That is very encouraging. Perhaps I may ask you to think outside the box. One matter that struck me yesterday at the Homerton Hospital was how difficult it was for parents to be with their babies. Obviously, there are practical problems; there are other children to look after and so on. There is also the cost of transport for a mother who has just given birth, may not have her own transport and is perhaps reliant on a rather difficult public transport system. I know there are schemes to help people who cannot afford regular hospital visits, but in this case it seems to me that though it may not necessarily be your departmental brief while you are looking at it you may want to consider how to assist parents, particularly those who cannot afford transport costs, to gain easier access to transport so they can be with their babies. I may be wrong, but one of the things that struck me yesterday was that I saw only one mother.
Mr Nicholson: We have a responsibility to the parents as well as the baby, so we will take up your suggestions and let the task force look at it to see what we can do.

[2] Ev 15–16

Chairman: There is now a division in the House—there may be two—so we must take a short break. We shall return as soon as we can.
The Committee suspended from 4.15 pm to 4.34 pm for divisions in the House

Q26 Angela Browning: I realise that PCTs manage their own budgets and so on, but one of the things that came to light at the Homerton—I suspect it would apply in many of the urban-based neonatal units in particular—was the difficulty experienced by hospitals in communicating with the parents of some of these babies for whom English is not their first language. We saw in one case yesterday that the parents had no English at all. I know that this comes from within the overall budget and it would apply to all levels of patient care, but given the extensive conversations that need to be had not just about sick babies but ensuring that parents fully understand what is required when the baby goes home I ask you to take a look at that. Clearly, it is quite a stretch for the hospital's resources particularly if it is within an area where there is a very large ethnic community and such translation services are needed quite frequently.
Professor Christine Beasley: I agree that it is a very important service for all relatives but particularly for mothers, fathers and families in these circumstances. Certainly, many neonatal units that have that sort of community seek to provide appropriate interpretation facilities and we would expect to see that as part of the package of support for parents. Obviously, it varies from hospital to hospital. I have seen some very good examples around the country of people using proper local interpretation services to help mothers understand what is a very difficult, complex matter even when English is one's first language. You are absolutely right to say that that is a service we would expect to see to support mothers in that very vulnerable position.

Q27 Angela Browning: It is not just a matter of providing the service; it is the impact it has on the rest of the budget because clearly it is something that is part of the general hospital budget and is not related just to this unit.
Professor Christine Beasley: That is absolutely right and it needs to be seen in the round because clearly hospitals which have that issue in their neonatal units have it across the piece; it is rarely in one area and is part of a whole interpretation service, not just a specific one.

Q28 Chairman: The Chief Executive of Homerton mentioned this particular point to us yesterday. She was saying that it was not taken into account in her funding.
Professor Christine Beasley: For neonatal services?

Q29 Chairman: The difficulty in dealing with translation and that sort of thing.
Professor Christine Beasley: These are very useful things that we can pick up as we begin to look at what next we need to do in the task force areas. I think we will pick that up.

Q30 Angela Browning: If you are sending home a baby that will be on oxygen a level of expertise is required for the staff to feel confident that the parents have fully understood what is required and what to do and what not to do and there is a cost associated with that.
Professor Christine Beasley: There is. This goes wider than just the interpretation service. Many units now broaden their staff mix so they have different sorts of staff who can go out and help support people in the community to assist them in this very area. There are nursery nurses and other support staff who can help people when they are first at home.

Q31 Mr Mitchell: I see that the department's public service agreement target for infant mortality was to reduce by at least 10% the gap in mortality between the routine, which is a manual group, and the population as a whole. When was that target set? I want to get the timescale because you have not met it, have you? The department considered that implementing the recommendation of the 2003 review might have had an impact on the infant mortality gap through the reduction of deaths due to immaturity-related conditions, but by 2007 that gap had widened to 18%.
Professor Sir Bruce Keogh: One of the things we know about the gap is that it is due to a lot of factors which influence the parents prior even to the conception or birth of the child. There had been a positive trend in that in the three years between 2002 to 2004 it was 19%; in the next three-year period it went down to 18%; and in the next three years, 2004 to 2006, it had dropped to 17%. I was not aware that it had crept up to 18%, but the general trend has been good.

Q32 Mr Mitchell: But why has it widened in this particular instance? When the reforms were implemented it was hoped that the gap would be reduced and it has not been. Why?
Mr Nicholson: There has been progress in relation to those particular socio-economic groups. The point is that the improvement in the other socio-economic groups has been even greater and faster, so that is the reason. We have placed a huge amount of emphasis on getting this right, but the rest of the population has got significantly better.
Dr Shribman: I have just referred to my documents. It was in 2002 that the target was set to be achieved by 2010. Mindful of the trend in the data to which Sir Bruce has referred, the department reviewed how we were progressing with infant mortality last year and has recently issued a practical guide for local PCTs and health communities to tackle it.

Q33 Mr Mitchell: If it has widened it figures that you will not meet your target which is to narrow the gap by 10% by 2010?
Dr Shribman: The review was to try to accelerate progress towards it. We are not there but you are right that it is a worrying trend.

Q34 Mr Mitchell: But the prospect is that it will not be met?
Dr Shribman: I believe that is correct, yes.

Q35 Mr Mitchell: How far is this an issue of class or ethnicity in the sense that people do not speak English, are not integrated into the system or they hope that things will be all right and do not get plugged into the maternity services? Is it the case that they tend to produce these kinds of problems?
Professor Sir Bruce Keogh: Yes. There are a number of socio-economic and demographic influences. For example, between the top and bottom of the socio-economic scale there is a two-fold increase in neonatal mortality, and there are also some differences between ethnic groups.

Q36 Mr Mitchell: Is class and ethnicity an explanation of the differences shown in table 6 on page 18? If I live in Surrey or Sussex, which I always think of as upper-class areas, or indeed in Essex which is not a high-class county, the neonatal death rate is much lower than if I live in the south west Midlands. Is that mainly a factor of class?
Professor Sir Bruce Keogh: I think there are class, lifestyle, genetic and economic factors. Those kinds of patterns spread into other areas of healthcare as well.

Q37 Mr Mitchell: Part of the answer is education and getting people into the system?
Professor Sir Bruce Keogh: Indeed.
Dr Shribman: You are absolutely right that these are key factors, but improving access to services is also very important which is why in maternity services we are particularly keen to encourage people to book early and have set in train measures to ensure that they book by the twelfth week of pregnancy so there is the maximum opportunity for these services to give them the benefit of help to tackle some of the problems with which they may present. For example, one thinks of smoking in pregnancy or access to services where they are more vulnerable. Therefore, helping people to access the system early is an important part of our strategy to tackle health inequalities.

Q38 Mr Mitchell: As I understand it, the North—Yorkshire and Humberside—does not have a network. Is that correct?
Professor Christine Beasley: It is only the northern region that has a less well established formal network given the absence of a structure, manager and so on.

Q39 Mr Mitchell: But you are happy with the structures that are there?
Professor Christine Beasley: They network together but we want them to have a formal network and they want to have one.

Q40 Mr Mitchell: How about Yorkshire?
Professor Christine Beasley: It already has a network.

Q41 Mr Mitchell: It must be the case—Grimsby is not affected by this because I understand it is plugged into north Nottinghamshire, which seems a bit haphazard given the fact that we are part of Yorkshire for strategic purposes—that the formation of a network gives an impetus to the whole system, must it not? If the North does not have a network it loses out to some extent?
Dr Shribman: You are absolutely right that networks are extremely important. That was why in the 2003 review we were particularly keen to see the establishment of networks and the NAO Report indicates that we have them fairly well established, but there is more to do. You are right that there are a lot of benefits of networks, and certainly they are seen by parents, parent organisations, clinical professionals, managers and others within the system as having led to significant steps forward in the sharing of common guidelines and working together on audit and the patterns of care for babies. Therefore, not to have a network is a bad idea.

Q42 Mr Mitchell: I turn to paragraph 3.13. It seems to me absolutely appalling that only half of the units met the standard for high dependency care and 24% met the standard for intensive care. This is very low. I understand from BLISS that only 12 units in the UK operate at the minimum recommended staffing levels.
Mr Nicholson: The department does not issue recommended staffing levels or guidance on staffing levels.

Q43 Mr Mitchell: Should you?
Mr Nicholson: No. We believe that it is better for local decision based on clinical need. When you look around the world at those places that try to do it because services are so different in the way they operate most have had to move away from it in a relatively straightforward way.

Q44 Mr Mitchell: These services are not all that different; they are all doing the same thing.
Mr Nicholson: But our expectation is that where clinically a child requires one-to-one nursing it should have it; and certainly our experience is that that is the case. As I said before, we do not staff cots but babies.

Q45 Mr Mitchell: I wonder about that because earlier we dealt with the provision of £72 million in funding of which £25 million went walk about and you said that the organisations holding the money disappeared. Did the money disappear with them? This is fairly extraordinary, is it not? We allocate this sum of money and £25 million does not get there.
Mr Nicholson: What I said was that based on the programme budgeting information we identified that an increase in funding for neonatal services of £150 million happened during that period. There was a particular bit of money, £72 million, given to strategic health authorities and the NAO did a sterling job to try to find exactly what happened to every penny of that sum. It could not do so. I am sure

that part of the explanation is that the records and the organisations that administered the resource have disappeared.

Q46 Mr Mitchell: Therefore, you do not think it went to the intended purpose; it just disappeared?
Mr Nicholson: I think the vast majority of it went to the intended purpose. I happen to know because of my own experience in being in one of those strategic health authorities that some of the money did go to other places, but that is part of the tension, if you like, around not ring-fencing money.

Q47 Mr Mitchell: That is the next question. In view of the importance of this service, its understaffing and the costs of training should you not have designated ring-fenced funding for it to indicate the importance you attach to it and improve it?
Mr Nicholson: Our records show that we spent double the amount, £150 million and not £70 million, on improving neonatal services across the service in that period.

Q48 Mr Mitchell: We hear horror stories of staff shortages and too much pressure on nurses so they cannot talk to parents in the way they need to and carry them along which should not be happening in such a crucial area.
Mr Nicholson: We did what we said we would do. We said that we would save between 200 and 300 lives and we did; we said we would set up networks and we did; we said we would set up transport services and we did. We said we would increase the number of cots and we increased them by 167. We have increased the number of staff. If you are asking me whether that is enough quite patently it is not. We know that with the rising birth rate and technical changes that are going on in our ability to look after very small babies there is pressure on the system and that is why we have asked each part of the country at the moment to look at the staffing of their neonatal teams to make sure we have plans going forward to address the very important issues you have described.

Q49 Mr Mitchell: But you have a situation where closure is happening all the time; the service just closes down and is not available to people coming in for maternity services. That is extraordinary. It must cause an enormous amount of waste of time with people ringing round to find cots for kids in other areas.
Mr Nicholson: The other thing we want to do is make sure we can look after all of our children within the networks, and we have got to the position where 95% are looked after within network. I believe that is a significant step forward. You are absolutely right. Occasionally things happen and we need to find ways to avoid them, but the services do not close down. A particular unit may not be able to admit a particular patient but we have always found another unit somewhere else and appropriate transport for that patient.

Q50 Mr Mitchell: It is a continuous process of improvisation?
Mr Nicholson: The vast majority of children are treated exactly where their mothers give birth or in the most appropriate clinical area. Perhaps I may make one point on the question of health inequalities. I have not given up on the target of delivery. I know that it is very difficult and there are very few places in the world that have managed to tackle the issue of health inequalities and narrow that particular gap. That was why at the end of December we published new guidance to add impetus to it and the secretary of state announced a review of the health inequalities strategy to make sure we do not give up on this particular issue—I do not think we should—but redouble our efforts to make it happen.

Q51 Dr Pugh: Perhaps I may pick up where Mr Mitchell started which is figure 6 on page 18. I think my question is directed largely to Sir Bruce. It quite clearly shows a wide variation in neonatal deaths. You have said that socio-economic factors are an element in that and we would expect highly urbanised areas possibly to have a worse profile than leafy rural and suburban areas, but presumably you can factor that into the analysis. Although it would appear that Midlands South is the worst and Surrey & Sussex are the best if you factored in socio-economic factors—clearly you can—you would have a different profile or list, would you not?
Professor Sir Bruce Keogh: Yes, you would.

Q52 Dr Pugh: You would have a list of those networks that performed better and those that performed worse?
Professor Sir Bruce Keogh: Yes. The graph to which you have alluded takes no account of the nature of the babies that appear at the front door of the neonatal intensive care unit. There is a variety of factors that influence how those babies are likely to do. One would be the socio-economic group which for a variety of reasons will be relatively powerful and the others would be things like the size, weight and gestational state of the baby and so on.

Q53 Dr Pugh: There are many factors, but it is possible for you to have a private list in a sense of those networks that perform really well given the circumstances and those that do not perform at all well. Looking at this list of networks, are there any that give you cause for concern; in other words, allowing for all socio-economic factors, they are not doing at all well?
Professor Sir Bruce Keogh: We have not made that analysis.

Q54 Dr Pugh: You do not know which networks should give cause for alarm?
Professor Sir Bruce Keogh: We have not done that level of analysis. This is all very superficial.
Mr Nicholson: Progress here has been fraught by a lack of national data with which we can work. One matter that will help significantly is the Healthcare Commission's national audit which will give us

much better comparative data. At the moment it may be possible to say by network what is the expected death rate in neonatal, but we are reluctant to do that because of real worries about some of the data. When we have that data we shall be in a much better position to do exactly what you describe.

Q55 Dr Pugh: In terms of accountability, I am looking at Cheshire & Merseyside which is my area. Apparently they are one of the four worst in terms of neonatal deaths. Allowing for all sociological factors, they may be performing relatively well; on the other hand, they may not. I simply cannot tell.
Mr Nicholson: The figures map remarkably well on infant mortality generally. We know from infant mortality generally that socio-economic factors are very critical in that. In none of the networks is it going in the opposite direction.

Q56 Dr Pugh: All networks are progressing, however good they might be?
Mr Nicholson: It is the same pattern, but if we are to identify a league table in the way you describe of what is expected we need to be cautious until we have some really good data to make sure we can take it forward.

Q57 Dr Pugh: Are there any networks currently on that list that give you cause for concern?
Mr Nicholson: On the basis of the data we have, no.

Q58 Dr Pugh: It says in paragraph 1.9 on page 13 that the concept of a network is a fairly fluid one. We have had discussions so far about formal and informal networks. I understand that it is a very unpredictable field and you cannot plan for births turning out wrong because you simply do not know where and when that will happen. Obviously, there are trends but they are very rough and in broad terms. What is important is that you have a clinical path where the right people can deal with the problems in the right place and within a reasonable range to assure an equal outcome. What is the difference between a formal and informal network? What features does a formal network have that an informal network lacks? You said that the North had an informal network.
Dr Shribman: The key difference is in structure. A formal network will have a designated lead clinician and a funded manager and it will have more structure around it. As to an informal network, one can say that at one end it is just a loose group of clinical staff who get together from time to time to share information and discuss best ways forward. If you formalise it you develop a much clearer structure of sharing to develop guidelines and clear protocols and policies about transfer and so on.

Q59 Dr Pugh: Let us look at the map on page 14 where the networks are laid out. I have the misfortune in a sense of having a constituency that is right on the peak of network 6 which is the Cheshire & Merseyside network. When I looked at it further I thought it was not a very coherent network in many respects. It goes along old health authority lines, but if you are devising a network you will know that most people in Cheshire will look to Manchester rather than parts of Merseyside. The river is a barrier right through that network. In a sense ought not networks be designed on the lines on which people travel rather than existing health authority structures?
Dr Shribman: My understanding is that when the networks were first developed they were based on care pathways and referral patterns. There could be tension between administrative boundaries and patient flows, but we also expect the networks to liaise and work together.

Q60 Dr Pugh: Therefore, patients in Cheshire are likely to go north rather than towards the Manchester region where there is an ample supply of very experienced and good hospitals?
Dr Shribman: No. Patients need to go where they are clinically most appropriately cared for. Patients cross boundaries and therefore people need to work together where that is required. A typical example of moving across networks would be perhaps neonatal surgery where, in the case of the North West, you may need to access the services at either Alder Hey in Liverpool, if that is the specific clinical need, or Manchester. It depends on the baby. We need to see clear referral pathways across the networks and network managers get together to discuss any issues there may be about those.

Q61 Dr Pugh: My constituency is Southport. There is no maternity hospital in Southport. There is a trust there but it involves the transfer of people to Ormskirk. They live in network 6 but when they go to hospital they are in network 2. Does that create any problems for them?
Mr Nicholson: Sadly, my knowledge of that particular part of the country is not as good as it might be.

Q62 Dr Pugh: But you can see the difficulty in designing a network?
Mr Nicholson: Wherever you draw the lines I am afraid these issues will arise. In those circumstances I would expect the admission and transfer protocols to be consistent between one network and another.

Q63 Dr Pugh: Supra-network protocols?
Mr Nicholson: Absolutely, because that reflects the reality of the clinical and patient experience and relationships.

Q64 Dr Pugh: Referring to page 36 and the situation in Cheshire & Merseyside, it says that there is no level 3 unit (plus surgery). Alder Hey is within that network, is it not? Does it not provide surgery?
Mr Nicholson: I am sure it does.

Q65 Alan Williams: What about the other end of the story? What are the associated risk factors? What is being done to avoid premature birth? Paragraph 4 identifies causes. Having identified the risk groups, is there any initiative taking place to try to prevent those groups suffering this misfortune?

Mr Nicholson: Absolutely.
Dr Shribman: You touch on an extremely important point. If we were able to reduce premature births and tackle low birth weight it would help enormously. We have already this afternoon talked about a number of factors in terms of vulnerable women and pregnancies, but with about 43,000 babies being born prematurely every year it is clear that research in this area is very important. There is much that we do not understand about this. I understand that about £4 million a year has been devoted to this area, but there are four new research projects to do with premature birth costing over £1 million due to start shortly. There is a call for further research over the next five years, so it is a very important area that we need to tackle in terms of a clearer understanding.

Q66 Alan Williams: I can understand that it is very nebulous. Is it possible to analyse and take effective action earlier? Would that be a high cost?
Dr Shribman: It would certainly be very cost-effective for the country if we were able to reduce these deliveries. In terms of factors that we now know are important, I referred to people accessing services early. We encourage mothers to book early with their midwife or GP, which is very important. We can then offer interventions to help them with other risk factors such as smoking cessation because we know that smoking and pregnancy has adverse effects. We can tackle the things we already know, but we do not yet know all of the answers. I certainly wish we did.

Q67 Alan Williams: I can understand the incredible complexity and difficulty and that prompts further investigation. It has been said that you use the mortality rate as a guiding statistic. How far do you through clinical audit and so on use predisposition to such things as disabilities, either physical or mental, for premature births?
Dr Shribman: Obviously, that is a very important factor in terms of outcome because we need to look at outcome more widely than mortality, and morbidity, particularly disability, is important as you draw to our attention. It is for that reason that the neonatal audit commissioned through the Healthcare Commission not only looks at a number of parameters but towards the end of this year will collect data on the outcome of these babies at two years. That is a very important factor that needs to be taken into account in terms of looking at how well we are doing in the broader picture and in terms of individual units.

Q68 Alan Williams: I gather that most of the recommendations of the 2003 review have been achieved only in part. Why is that five years on?
Mr Nicholson: Changing any kind of clinical service is complex; it is not a straightforward journey where one tells people what to do and they do it. One must work with clinical staff and organisations to take things forward and identify when one can fund particular priorities and do things. We have seen that over the past few years. Whilst I agree with you that we have not done absolutely everything we set out to do we have set up and staffed the networks and increased the number of cots. We have increased the number of staff and completely reorganised the transport services. We are well on the way to getting better data about the system. We now understand better our costs. We believe that demonstrably we have saved lives, but there is more to do. I have come to the conclusion that if we just left it to the system to operate in the way it is we would not get to the end of the strategy soon enough. That is why we have decided to set up the task force under Sir Bruce which is not there to develop a whole set of new policies and clever ideas; it is about ensuring we do what we know works. That must be the national focus to take forward over the next 12 months or so. We need real action to finish off the strategy.

Q69 Alan Williams: Sir Bruce, have you identified the key reasons why certain elements of the recommendations have not been fulfilled, or is it too early to say?
Professor Sir Bruce Keogh: It is too premature at this stage, but we shall be looking at them very closely.

Q70 Alan Williams: PCTs are expected to Commission neonatal services and yet there is no common way to calculate the cost of running them, so how do the purchasers know which unit represents the best use of public money?
Mr Nicholson: Absolutely. It is true that we are on a journey of understanding all of this and we are getting our financial situation in the right shape. We plan to have a national tariff for neonatal services.

Q71 Alan Williams: How soon?
Mr Nicholson: We estimate that it will be within the next couple of years.[3]

Q72 Alan Williams: Will it take that long?
Mr Nicholson: It will take that long because it is an incredibly complicated thing to do on a national basis because of all the potential local arrangements one has. For the year starting 2008–09 each of the specialist Commissioning groups which have overall responsibility for making all of this happen is currently baselining and setting out clearly what the costs and expectations are against the amount of money it invests in 2008-09, which will be a much narrower band than we have seen in the past and will show significant progress.

Q73 Alan Williams: You prioritise things for maximum gain?
Mr Nicholson: Yes.

Q74 Alan Williams: Would it be asking too much to request a more detailed note so it can go into our Report?
Mr Nicholson: You mean a note about the neonatal tariff and how it is operating?[4]

[3] *Note by witness*: On further consideration, however, I do not think that that a tariff for neonatal critical care within a couple of years is likely.
[4] Ev 16–17

Q75 Alan Williams: Yes.
Mr Nicholson: Yes.

Q76 Mr Dunne: From your responses to this Committee and the Report can I take it that one of the primary objectives in establishing networks was to reduce mortality from premature birth?
Mr Nicholson: Yes.

Q77 Mr Dunne: Dr Shribman, is it the case as I presume that all premature births stem from a premature labour?
Dr Shribman: Yes.

Q78 Mr Dunne: Approximately what proportion of premature labours results in premature birth?
Dr Shribman: In terms of labours that then proceed to a delivery? Some people go into labour and then do not deliver, so I cannot give you that data now.[5]

Q79 Mr Dunne: But do you have a rough rule of thumb? Can any of your colleagues help you?
Dr Shribman: The majority of premature labours result in a premature birth.

Q80 Mr Dunne: The majority? My discussions with obstetricians suggest that the majority of premature labours do not result in a premature birth and many mothers who exhibit signs of premature labour do not go on to the delivery phase and may or may not subsequently deliver prematurely.
Dr Shribman: Certainly, for anybody who looked as though they might be going into labour at a pre-term stage—I am not an obstetrician but am familiar with the background to it—you would do what you could to stop that proceeding if there were steps you could take in each individual clinical case because, as we have heard, a premature delivery is undesirable in general because of the risks associated with prematurity and low birth weight. Sometimes it is desirable to deliver a baby early because the risks of the baby remaining in the womb are too great and therefore one chooses to deliver a baby early for clinical reasons.

Q81 Mr Dunne: Indeed, but it would be most desirable for both the mother and the health of the baby not to have a premature birth if it can be avoided?
Dr Shribman: Yes.

Q82 Mr Dunne: The anecdotal evidence from those to whom I have spoken suggests that in my area of Shropshire approximately one in five women who present with premature labour end up having a premature delivery. Is that something you would dispute? If there are any statistics on this it may be helpful to have them.
Dr Shribman: I can certainly go back to the experts and provide more detail on those obstetric issues. I guess the question here is: what is true labour? When a woman presents she may have symptoms that are believed to be labour but turn out not to be. I think a critical issue is whether a woman is truly going into labour or has some symptoms that it is believed indicate that is the case.

Q83 Mr Dunne: I believe this is very important. My understanding is that one of the consequences of focusing on level 3 intensive centres of excellence is pressure on staffing and beds as we have heard from other Members earlier. If we drive the population of women who present with the possibility of premature birth, which is very small, into these intensive centres and a large proportion of them—I am told it is the majority, but you will come back to us and say whether or not it is true—do not require intensive care at that point those costs are being absorbed unnecessarily in many cases by those centres.
Dr Shribman: We need to be very clear about the definition. Technically, the definition of prematurity is before 36 weeks of gestation, that is, any baby born earlier than four weeks early. It is only the very small pre-term babies that we would look to have born in level 3 units.

Q84 Mr Dunne: I think that we are talking only about level 3 under 28 weeks. That is the information to which I am referring.
Dr Shribman: Indeed, but the definition of premature labour would include prematurity under 36 weeks, so it is a question of which population we are covering. The vast numbers arise in that larger group and we would not seek to transfer those.

Q85 Mr Dunne: To avoid confusion, I am not talking about any babies over 28 weeks.
Dr Shribman: You are talking about premature labour below 28 weeks, not the technical definition of it.

Q86 Mr Dunne: Mr Nicholson, I do not know whether or not you want to comment on this, but it seems to be very important in providing the appropriate level of care in appropriate places that there is some clarity about the clinical need for intensive services in the way the networks are being established at the moment. I come to this from a parochial perspective. Having looked at the NAO Report with some care, I have gone back to my area which you know well. Unfortunately, as is clear from table 6 on page 18 to which Dr Pugh referred the area I represent and where I live, Midlands South, is the second worst in terms of mortality. But these figures mask some good performance and some less good performance. If one turns to the appendix on page 40 there is a little more clarity. For example, if we take Midlands North—it is one I know well—it is the second worst performer in terms of mortality and the worst performer in terms of babies transferred out of the network for clinical reasons, yet we have lower than average vacancies for nursing and so it is not a staffing issue that causes it but something else. If one goes to the CMEC website, in particular the West Midlands neonatal register, it is clear that the mortality rate in the acute hospitals that provide level 2 services at the moment,

[5] Ev 17

the Royal Shrewsbury Hospital and the Princess Royal Hospital Telford, have a 93% survival rate for both 2005 and 2006 based on a very similar number of cases to the two level 3 facilities at Stoke and Wolverhampton which have between a 59% and 72% survival rate for both 2005 and 2006. The populations are broadly comparable. If we are trying to improve mortality rates across the country should we compel the better performing and smaller level 2 units which have better staffing capacity, professional expertise and outcomes to be conjoined with a network where performance is much less good?

Mr Nicholson: That raises a whole series of issues. In a sense you put your finger on a dilemma that is identified in the document itself which talks about some places commissioning level 2 and 3 separately from other bits of the service and the argument is that all of the service should be commissioned together. The danger of doing that is, as you say, that you shift acuity right up the system so you end up using more level 3 than perhaps you would expect. That is a danger in the system and why the protocols have to be absolutely right throughout the system. We have seen the development of what other people describe as level 2-plus, that is, those places that have a really good record and have worked really hard at it and can take babies that perhaps in the past might have been seen as level 3 because of the experience, knowledge and understanding of their staff and the way they have developed. I believe that is something the task force should take on board to consider the issue between what might be described as level 2-plus and level 3. That is absolutely right.

Q87 Mr Dunne: I am encouraged to hear you say that. If that is an outcome of this inquiry then we will have made great progress. Having delved into the numbers, I am fearful that we are at risk of dumbing down as a result of trying to create a network that is convenient from an administrative point of view. We do not want to lose clinical excellence where we have it. One of the concerns of practitioners is that because of the infrastructure being established nationally there is a risk to funding of level 2-plus facilities. Can you comment on whether if you to pursue this line of inquiry internally you will also consider maintaining resources for level 2-plus facilities?

Mr Nicholson: This is part of the discussion about the tariff in addition to what you pay and how you pay it.

Dr Shribman: To comment on the clinical issues, not specifically the tariff, we strive for clinical excellence at all levels. I could not agree more that that is absolutely essential. There is a very large amount of work to do at the level 2 end of the spectrum because there are a large number of babies in the 28-week-plus category, not to mention the ill term babies who require full care as well. It is not simply an issue of the under 28-weekers who are very important; there are other issues as well. We want our level 2 units to perform very well in their own right.

Mr Nicholson: We do not envisage one outcome of this being a massive increase in level 3 at the expense of levels 1 and 2. That would be a perverse way of working. We are very keen to make sure that does not happen.

Q88 Mr Dunne: The question of distance has been raised by a number of colleagues. If one looks at the map on page 14, three sections of the United Kingdom that are not included: Wales and Scotland and Northern Ireland. Many of the mothers who require neonatal care in Shropshire come from Mid-Wales. I do not know whether I can claim that is a greater distance than would apply around Merseyside or the South West but it is very considerable and the stress on parents having to travel potentially large distances to go in this case to Wolverhampton and Stoke right on the eastern extremity from Mid-Wales where there is effectively no public transport is very considerable. If you have outstanding level 2-plus capacity I think that is another argument for maintaining some of it round the region. Do you share that concern?

Mr Nicholson: I think we have to take all of this on board and the issue of distance is vital.

Q89 Mr Dunne: Can you comment on the impact next year of the EU Working Time Directive in exacerbating existing staffing problems you have within nursing provision?

Mr Nicholson: Particularly on nursing or in general?

Q90 Mr Dunne: You have an apparent shortage of permanent staff in servicing these networks and it will get worse when the directive comes in, will it not?

Professor Christine Beasley: Inevitably, when the directive comes into force it will tend to impact on medical rather than nursing staff, but, as you rightly say, it has a knock-on effect on nursing staff. That is one reason, not the only one, we have asked PCTs in terms of the operating framework to look at both their services and their workforce for a range of reasons. They will need to take into account also the new Working Time Directive in terms of how they staff units. It hits mainly on the medical staff but it has a knock-on effect particularly between doctors and nurses who work so closely together.

Q91 Nigel Griffiths: Do you accept that the financial management of the unit level needs to be improved?

Mr Nicholson: Yes.

Q92 Nigel Griffiths: Why have they got into a position where some PCTs include pharmaceuticals in their costs and others do not?

Mr Nicholson: We are continually trying to improve the way in which we allocate costs and understand the way those costs shift in the NHS—I have to say from a very low base—over the past few years. It just takes time to get organisations in place. If it does not matter to them and they get funded no matter how their costs are organised the chances are that they will not take as much care over it as they need to. Now that they know the tariff will be established and real money will move round the system based on the

analysis they are making people are paying much more care and attention to this particular area. For most parts of the country up to two or three years ago essentially there was a big block of money given for these services and that did not vary depending on activity, but it will do so in future. I think we can be assured that people are paying attention to make it happen, but I acknowledge that we are not there yet.

Q93 Nigel Griffiths: Will you be able to look at data at, say, spending on pharmaceuticals across the 180 neonatal units and then decide whether pharmaceuticals might be making a difference? I see in paragraph 4.8 that a number of the items are included in some but not others. How on earth do you get to grips with what of all the elements makes for good care, apart from the obvious one of caring doctors, specialists and nurses?
Mr Nicholson: I guess we will focus on the big issues in relation to the inputs here. We will have good data on the staffing element, that is, the number of doctors and nurses. I guess that in the medium term the detail around pharmaceuticals, until we have got electronic prescribing up and running across the NHS, will not be a major issue in the way we benchmark, but it is only a relatively small amount of the expenditure.

Q94 Nigel Griffiths: You mentioned nurses. Nurses' salaries are included in all the estimates and one would expect that to be picked up, but medical salaries are not.
Mr Nicholson: Medical staff should be and the electronic staff record will enable us to do that in a much clearer way.

Q95 Nigel Griffiths: Does that mean you will be able to pick that up for the 180 units?
Mr Nicholson: There is benchmark information that we will be able to pick up.

Q96 Nigel Griffiths: Do your guidelines or whatever instructions you communicate to the financial directors or those responsible reflect this?
Mr Nicholson: Yes; it is in the accounting manual we send out.

Q97 Nigel Griffiths: Does it mean that when the NAO found that 9% of units had to operate above 100% levels that would be picked up by the system and addressed?
Mr Nicholson: It is picked up now. The issue is whether it is addressed is the role of the network. Very often it is a short-term issue that has moved it in this particular direction. It may be that the balance between levels 1, 2 and 3 is not right or that transport is not working appropriately. Part of our job is to strengthen the networks because we now know that it is action which is the important thing.

Q98 Nigel Griffiths: How do you intervene to assist them with this at the moment, or how do you intend to do so?
Mr Nicholson: The task force has already started its work. It will look essentially at each network to see what arrangements are in place both to deal with this but also to deal with the consequences of it. Nationally we shall be monitoring quite closely the out-of-network transfers that take place and take action through the normal performance management system.

Q99 Nigel Griffiths: What happens now to the almost one in 10 units that operate above the 100% occupancy rate? What do you do? Does anyone care?
Mr Nicholson: Of course people care but that does not always mean there are more children on the unit for which it has physical capacity.

Q100 Nigel Griffiths: I have your explanation for that. I am just interested to know whether in Whitehall alarm bells ring when that is seen and a dialogue takes place as to whether or not it needs to be addressed.
Mr Nicholson: Our expectation is that the alarm bells ring at local level because it is at that level that people can take action. If it is sustainable and is a pattern then, through the work of the task force, I would expect us to be much clearer about what we should do.

Q101 Nigel Griffiths: How do you calculate the proportions of levels 1, 2 and 3? Do you have a model that affects urban and rural areas?
Dr Shribman: When the networks were established there was a clear look at which units should be designated to deliver which levels of care, but we have heard this afternoon that though we developed a modelling tool for capacity at that stage times have now moved on and there is a need to review capacity, and a number of networks need to look again at their particular patterns. Certainly, those that we have visited recently have seen an increase in birth rates and need to look again at designation.

Q102 Nigel Griffiths: To return to my previous point, I am concerned to know that the inability identified by the National Audit Office to give an average or definite cost per cot—in your case, per baby—hampers forward planning and, I imagine, the adoption of best practice where networks exist. Do you have an active strategy to address that?
Mr Nicholson: Yes. I described the development of a national tariff which is exactly the point you try to make. That will be based on an absolute analysis of cost across the system and the way in which patient activity relates to it. I have already said that we shall give the Committee detail about how we are taking it forward.[6]

Q103 Nigel Griffiths: You referred to the importance of encouraging mothers to book early. What steps are you taking to reach that group of mothers who are least responsive to that message?

[6] Ev 16–17

Dr Shribman: First, we have set the challenge to the system that this should be by 12 weeks, so we expect everyone within the health system to work towards that. Clearly, as we roll out our *Maternity Matters* strategy locally people have been looking at how to reach the very communities to which you refer. One has to design this individually for the particular population. One might be looking at travelling families and take a particular approach perhaps with liaison staff; one might be looking at a particular community with language challenges. To work closely with those individual communities is the way forward to ensure that the services are designed around their particular needs and they can access them in a way they find easy and successful. That is the challenge to which we are working.

Q104 Nigel Griffiths: Has that started? Are there any shining examples about which you can talk?
Dr Shribman: Our *Maternity Matters* policy has in particular emphasised the importance of access and choice in reaching the more disadvantaged communities. There has been a series of regional workshops to look at how to implement that. In the process of Lord Darzi's review of next steps for the NHS, *Our NHS Our Future*, there is a specific work stream on maternity and the new born. I am aware from discussions with people leading those groups that they are particularly prioritising the delivery of *Maternity Matters* but also health inequalities and the new born. Therefore, people are actively looking in their SHA groups at how they might do this in new and innovative ways, because in the past we have not reached these groups as effectively as we need to. Lots of initiatives are being looked at. One might make mention of particular towns. For example, Bradford has particular challenges and it is tackling them in innovative ways.

Q105 Nigel Griffiths: We look forward to hearing the outcome.
Mr Nicholson: One of the things we said in terms of our own planning was that 2007–08 was a year in which people were to plan this and 2008–09 was the year in which they delivered it, so we expect action in 2008–09.
Chairman: Mr Nicholson, we thank you and your colleagues. That concludes our hearing. This is a multi-faceted Committee because of the sheer range of its work. On Monday we talked about nuclear decommissioning and today we are talking about helping premature babies. I for one find it very interesting and once again I pay tribute to what your staff achieve. We hope that by our report we can put the spotlight on the shortage of nurses and ensure that mothers when most in need get the services they require and expect.

Memorandum submitted by the Neonatal Nurses Association

The Neonatal Nurses Association, as a professional organisation representing neonatal nurses, very much welcomes the Report by the National Audit Office. The Report highlights a situation that we recognise and endorse, and feel largely relieved that these issues have now been exposed so that sensible and collective discussion can take place that will finally initiate some resolution.

Those problems in particular, that have been identified around the staffing of neonatal units with appropriate nurses is a chronic problem that has hindered units for a long time. For the first time we have a current national profile that simplistically quantifies the extent of the problem. It is however, a wide and far reaching problem that poses many challenges as it does not lend itself to an overnight quick fix programme. What is needed is an examination of the career structure and the professional, social, and economic issues affecting neonatal nurses specifically, rather than nursing in general.

Much of this and our overall perspective has been elaborated upon by BLISS in their evidence to the Committee of Public Accounts. We have worked closely with them as colleagues and their support and concern about the current situation and the impact it has on babies and their families is reflected in their comments and recent report, *Too little, too late?* Although we appreciate that there are many and increasing demands for health care, we hope that the proposals made by BLISS and the recommendations from the National Audit Office will be considered as a priority for the benefit of the babies and families we aim to serve.

Executive Committee
Neonatal Nurses Association

February 2008

Memorandum submitted by BLISS

"WHY ARE OUR MOST VULNERABLE BABIES NOT BEING GIVEN THE ONE TO ONE NURSING CARE THAT CLINICIANS SAY THEY NEED?"

Executive Summary

— The National Audit Office Report shows that the demand for neonatal care is outstripping supply and there is a lack of strategic planning in place to meet this increasing demand.

— The national shortage of specialist neonatal nurses means that the clinical standards are not being met.

— Units are often unable to provide the level of care that babies need and are forced to turn babies away.

The care that our most vulnerable babies receive in their first days and weeks may affect their health for the rest of their lives. It is unacceptable that babies do not receive the equivalent level of critical nursing care that children and adults do. If we do not ensure the best start for these babies, we are failing them, their families and the professionals who treat them both in terms of health outcomes and the associated cost to the NHS.

Background

In 2003, the Department of Health (DH) published a strategy for the improvement of neonatal care. It recommended that hospitals coordinate the care of the sickest babies in a series of clinically managed networks. The Government made an extra £72 million available to neonatal services over three years to implement the recommendations. The NAO Report has found a shortfall of £25 million in terms of how this money was spent.

Nursing

The BLISS report *Too little, too late?*[1] found that from 2005 to 2006, nursing numbers increased by 2%. It also found that the number of days of care they provided increased by over 5%. The NAO Report confirmed this figure. Demand is outstripping supply. Neonatal units have told BLISS that their ability to meet minimum nursing levels has got worse. Our data shows that the shortfall of specialist neonatal nurses in England currently stands at about 2,200.

What's more, the scale of the problem is masked because nurses and doctors work beyond agreed capacity. Professionals faced with too many babies and too few staff often prefer to cope with the situation as best they can rather than highlight the shortage and refuse to take on more work. This has knock-on effects on the level of care they are able to provide and the amount of time they can spend with parents. It also has an impact on their ability to keep their skills and knowledge up to date in this rapidly evolving field of medicine.

Standards

In 2001 the British Association of Perinatal Medicine produced a set of clinical standards on the operating practices that neonatal units should follow to ensure that babies receive the best level of care.

One key point was that neonatal intensive care should be provided on a **one baby to one nurse** basis "**as a minimum standard**". The RAND survey, *The provision of neonatal services* which was conducted to inform the NAO Report, cites examples of where this one to one nursing recommendation is also in place in other countries. These standards were endorsed by the Department of Health External Working Group in their report on Neonatal Intensive Care and are included in the Children's and Maternity National Services Framework. In 2007, only 10 units across England told BLISS that they comply with this minimum standard.

A study published in 2007 found that increasing the number of specialist neonatal nurses to the recommended one to one ratio was associated with a decrease in the risk-adjusted mortality of the smallest babies of 48%.

[1] Information provided, not printed.

Capacity

The RAND survey also found that 78% of neonatal units in the UK had to turn babies away in 2006—this is 8% higher than in 2005. A BLISS survey in 2007 found that units were forced to close their doors to new admissions for an average total of two weeks in six months.

When this happens, it is usually either due to a shortage of staffed cots or the lack of specialist transport teams. This can leave parents facing an agonising wait while staff phone round different hospitals trying to find somewhere that can provide the care their baby so urgently needs.

Networks

The organisation of neonatal care into networks, as recommended by the 2003 review, has achieved notable improvements. These include better transport of babies; improvements in the way parents are involved in the care of their babies; and in general better coordination to ensure that our sickest babies receive the right level of care at the right time.

Networks are still a long way from achieving their full potential, however, and they now have to compete for funding alongside PCTs' other priorities. Some networks have managed to secure further funds. Others have not and this naturally contributes to instability, particularly over the funding of staff posts.

Payment by Results

The Payment by Results (PbR) system of funding, if carefully implemented, may help to improve the funding of neonatal care. The DH consultation document on PbR points out that it can be used to encourage a particular standard or norm. If the payment "tariffs" are set according to the standards set by the British Association of Perinatal Medicine, PbR would provide a financial incentive for healthcare providers to focus on the care of sick and premature babies. However, if the standards are not taken into account, PbR will only serve to compound the historic under-funding of neonatal care in England.

The NAO Report points out that under the existing arrangements, 27% of units examined would have to operate above the recommended 70% occupancy to cover their costs—while 9% of units would have to operate at 100%. The tariff is therefore not viable and needs changing.

14 February 2008

Supplementary memorandum submitted by the Department of Health

Questions 74 and 102 (Mr Alan Williams, Nigel Griffiths): *Neonatal tariff and how it will operate*

The building blocks are in place for the NHS to start collecting the relevant information for neonatal critical care services from April 2008, and this could lead to production of a tariff in 2011–12.

The Department of Health will receive the first data in Summer 2009, but it is optimistic to believe that a national tariff based on the first year's collection of new information will be able to be implemented. Until confidence in the underlying data is robust, setting a price would be a gamble.

The Department needs to ensure that clinical, financial and operational issues are resolved initially so that the cost implications of these issues are not transferred into a price that reflects a suboptimal service and, in such a sensitive area, puts services at risk.

A thorough evaluation and impact of any proposed currencies and price levels will be undertaken. The results of that evaluation and impact assessment will help determine whether a Payment by Results tariff is the best funding mechanism for delivery of neonatal critical care services, and when any tariffs might be implemented.

The building blocks that are required are: patient level data (a minimum dataset) and a unit of activity (healthcare resource group), that can be costed (through reference costs) and paid for (either a local or national tariff).

Patient level data

All the patient data collection systems in the NHS need to be modified to implement new information requirements. The processes to do this are in place: Dataset Change Notices (DSCNs) were issued in August 2006 informing the NHS and the systems suppliers that local clinical data collection systems need to be changed to allow the collection of this data from 1 April 2007.

The NHS has been informed it needs to collect the minimum dataset (ie, it is mandated or mandatory for collection) from 1 April 2008.

Healthcare Resource Groups (HRGs)

The HRGs have been developed and are in place for use from 1 April 2008, in line with the minimum dataset.

Costing information

The first reference cost data collection using the new data will be 2008–09. This will be received by the Department in Summer 2009. It is anticipated that reference costs collected in Summer 2009 will be used to determine Payment by Results tariffs in 2011–12. Depending on the quality of the data and the impact assessment and evaluation, the Department will consider whether Payment by Results should be extended to include neonatal critical care services in 2011–12.

Question 78 (Mr Philip Dunne): *What proportion of premature labours result in premature births*

It is not possible to answer this request from officially collected data.

The Information Centre collect Hospital Episode Statistics data for England and although these record NHS episodes of false labour these data are not collected by gestational age so it is not possible to link these episodes with subsequent preterm births.

Evidence suggests that more than one-half of women diagnosed as being in early preterm labour will continue their pregnancy to full term.[2, 3] Preterm labour can lead not only to preterm birth, resulting in an increased risk of mortality and disability, but also cots being reserved for babies that are subsequently not born at that time. It is therefore important to minimise the risk of preterm labour and birth.

Some of these risk factors are known, for example, lifestyle influences such as smoking and recreational drug use, etc, and are conveyed in public health advice to pregnant women. Also, through the "Better Care for All" PSAs announced in October 2007, we have developed a new maternity indicator aimed at ensuring that women have early access to maternity care, so that they have seen a midwife or a maternity healthcare professional for a health and social care assessment of needs, risk and choices by 12 completed weeks of pregnancy. This will enable those women who can be identified as being at increased risk of having a preterm baby to be identified at an early stage and the progress of the pregnancy to be closely monitored.

Other causes of preterm labour and birth have still to be identified. The Department of Health's Policy Research Programme funds a five-year programme of research at the National Perinatal Epidemiology Unit (NPEU), which includes workstreams on the compromised fetus and baby, care of the healthy woman and baby and maternal morbidity. Within this framework, the NPEU undertakes a range of studies, including work on pre-term birth.

The Department has recently commissioned the NPEU to take forward a programme of systematic reviews of the research evidence to identify and promote the key interventions that are most likely to contribute to meeting the 2010 infant mortality target and, in the longer term, to improving maternal and child health and a sustainable reduction in health inequalities. The review topics are likely to include the major medical causes of infant mortality, including preterm birth, as well as generic public health interventions.

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2 Vendetti F, Mamelle N, Munoz F, Janky E. Transvaginal ultrasonography of the uterine cervix in hospitalized women with preterm labour. Internat J Gynecol Obstet 2001;72:117–125.

3 Peaceman A M, Andrews W W, Thorp J M *et al*. Fetal fibronectin as a predictor of preterm birth in patients with symptoms: a multicenter trial. Am J Obstet Gynecol 1997;177:13–18.

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