The National Neonatal Audit Programme (NNAP)
Team members:

• Sam Oddie, Clinical Lead, Bradford General Infirmary Hospital
• Rachel Winch, Audit Manager
• Nick Longford, Audit Statistician
• Kayleigh Ougham, Analyst
• Melanie David-Feveck, Administrator
• Katie Hoare, Administrator
The NCAPOP project journey so far

- **A 3% improvement** from 58% in 2015 to 61% in 2016 in the rate of babies born at less than 32 weeks gestation who have a *temperature* recorded within a hour of admission *within the recommended range* of 36.5°C to 37.5°C.
- Continued improvement in the proportion of *parents documented as seen by a senior member of the team within 24 hours* of admission, from 68% in 2011 to 90% in 2016.
- **A 1% rise** from 2015 in the proportion of *preterm babies exposed to antenatal steroids before birth*, to 86% in 2016. Year on year improvement seen in this measure.
- **National Clinical Audit Benchmarking** project to improve CQC use of NNAP data
- Working with HQIP COP to improve public access to audit data on **NHS Choices**
- Becoming an **England, Wales and Scotland** wide audit in 2015
- **10 years of reporting**, commissioned for a further four years in April 2017
All Teach, All Learn

- **Quarterly progress reports** to units and networks: Review data completeness and performance throughout audit year
- Benchmarking through clear presentation of reported data at a local, regional and national level using **NNAP Online**
- **Your baby’s care and NNAP unit posters** – engage the MDT and families with local results and allow units to highlight their own achievements and improvements
- **Case studies** from participating neonatal units published in national report and online
- Measure specific, audience specific **recommendations**
- New measures closely align to **NHS priorities**, i.e. Minimising inappropriate separation of mother and baby
Insights from work and advice to peers

Parent representatives

• Proposal and development of measures important to families
• Developed Your baby’s care and the unit poster initiative alongside nurse representative - increased engagement with the audit within units, leading to closer scrutiny of audit data and results.

Engage with the multidisciplinary team

• MDT, particularly nurse, engagement is vital to the success of the NNAP. We work closely with the Neonatal Nurses Association and Scottish Neonatal Nurses Group.

Present data visually – Infographics!

• Infographics to communicate headline findings - simple, accessible and recognisable. Stakeholders can engage with the findings at different levels; understanding at a glance and delving further for more information.

Network support to improve data quality and completeness

• We introduced network level quarterly reports alongside unit quarterly reports. This means that networks can support units and have intelligence for network-wide QI initiatives.
We are keen to learn:

- How to best support units to achieve high levels of data completeness
- How to communicate information about statistical methods and data flow to a range of audiences
- How to make best use of longitudinal trend data for QI and to inform the future direction of the audit
- How to effectively deliver QI tools and support to units within resource constraints
Sharing effective and impactful ways of presenting data/recommendations

**NNAP Unit Poster**

### Your baby's care

**Measuring standards and improving neonatal care**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Local Average</th>
<th>National Average</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal steroids</td>
<td>94%</td>
<td>86%</td>
<td>8%</td>
</tr>
<tr>
<td>Temperature with in range</td>
<td>67%</td>
<td>61%</td>
<td>6%</td>
</tr>
<tr>
<td>Mothers who were given Magnesium Sulfate</td>
<td>65%</td>
<td>43%</td>
<td>22%</td>
</tr>
<tr>
<td>Consultation with parents</td>
<td>95%</td>
<td>90%</td>
<td>5%</td>
</tr>
<tr>
<td>Bronchopulmonary Dysplasia (BPD)</td>
<td>30%</td>
<td>31%</td>
<td>-1%</td>
</tr>
<tr>
<td>Screening for Retinopathy of Prematurity</td>
<td>98%</td>
<td>94%</td>
<td>4%</td>
</tr>
<tr>
<td>Mother's milk at time of discharge</td>
<td>61%</td>
<td>59%</td>
<td>2%</td>
</tr>
<tr>
<td>Clinical follow up at 2 years of age</td>
<td>88%</td>
<td>61%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Please see poster two for this unit's response to the results

**What we are doing in response to our NNAP results:**

Find out more

Please contact: [Type here]

To receive your neonatal unit results and take you through a copy of the NNAP summary report, please visit: [www.rcpch.ac.uk/nnap](http://www.rcpch.ac.uk/nnap)

**HQIP Healthcare Quality Improvement Partnership**
Sharing effective and impactful ways of presenting data/recommendations

Presenting a measure: Dip, swim, dive!

43% Mothers who were given Magnesium Sulphate

Magnesium sulphate was given to 43% of women who delivered at less than 30 weeks of gestation.
Sharing effective and impactful ways of presenting data/recommendations

Presenting a measure: Dip, swim, dive!

Key findings

- Forty-three percent (43%) of women who delivered at <30 weeks of gestation were given magnesium sulphate. (Table 2.1, Page 53)
- Magnesium sulphate was administered more commonly to mothers of babies born in maternity units associated with a NICU (48%) vs LNU (36%) and SCUs (23%). (Table 2.1, Page 53)
- Neonatal networks vary in how often magnesium sulphate was given, suggesting that implementation of NICE guidance is inconsistent. (Table 2.2, Page 54)
- Data were missing on whether magnesium sulphate was given in just 1 in 5 cases in 2016, the first year in which this new NNAP audit measure was introduced. (Table 2.1, Page 53)

Key recommendations

- **Neonatal units**, together with the lead obstetrician responsible for the implementation of the NICE guidance on preterm labour, should formally review records of babies born at <30 weeks admitted for neonatal care where magnesium sulphate was not given to the mother, in order to identify potential missed opportunities and themes as to why these were not given, and develop appropriate action plans.
- **Neonatal networks** should keep administration rates of magnesium sulphate in their units under regular review, identify any quality improvement opportunities and support units to achieve the best possible neonatal outcomes, for example by sharing best practice.
- **The NNAP** should investigate if an indication for antenatal magnesium sulphate administration could be added to the BadgerNet NNAP data quality checklist.
Sharing effective and impactful ways of presenting data/recommendations

Presenting a measure: Dip, swim, dive!
Next Steps

• With our stakeholders, evaluate the impact and effectiveness of:
  o NNAP Unit Poster
  o Your baby’s care – A guide to the NNAP annual report for parents and the public
  o NNAP Online – our interactive data reporting tool
• Use those findings to inform the direction of their development.

• Improve “real time” quality improvement tools for units, by working with Clevermed and BadgerNet

• Enhancing presentation of measures with risk adjustment

• Developing presentation of longitudinal trend data to include outlier analysis

• Expand the audit to include neonatal units in Northern Ireland.
How can HQIP help?

- Continue to facilitate dialogue with other audits that experience the same or similar challenges, identified through contract review meetings.

- Encourage sharing of best practice and toolkits for processes that are common to NCAPOP audits.

- Resources to deliver ambitious audit programmes.

- More opportunities to debate methodological aspects common to NCAPOP audits, i.e. risk adjustment, outlier identification and management.

- Advocate and facilitate high level data linkage, allowing audits to work together.