




The Countess of Chester Health Park  
 Liverpool Road  
 Chester CH2 1UL

Telephone: 01   
 Fax: 01   
 E-Mail: tony.chambers@ 

6<sup>th</sup> February 2017

Dear Colleagues

You will recall in July last year we took the decision to change admission arrangements for neonatal facilities. The unit stopped providing intensive care. Any women expected to deliver earlier than 32 weeks were transferred to a neighbouring facility. This change was implemented while we invited The Royal College of Paediatrics and Child Health and the Royal College of Nursing to carry out an independent review of the unit. This has now been completed and the report will be published this week (Wednesday, 9 February at 12 noon) for sharing with our staff, partner organisations and those families who have lost a baby and asked to be kept updated on the outcome.

We asked for this review. It was not imposed on us. While I encourage colleagues and healthcare partners to read the full report, let us not forget the complexity of neonatal services and mortality rates. This is a unit that provides care for poorly and vulnerable babies, often born many weeks before their due date.

There is no single cause or factor identified as a means of explaining the increase we have seen in our mortality numbers. The review makes a total of 24 recommendations across a range of areas including compliance with standards, staffing, competencies, leadership, team working and safety culture. We are already working to implement these recommendations. They reaffirm we were right in our decision to change the admission arrangements last July, and for now these will remain in place. Since we made these changes there have been no neonatal deaths on the unit. The report references our staff feel calmer and more confident, morale has improved, the pressure has reduced and the service is operating more in-line with national neonatal standards.

One specific recommendation included conducting a further thorough independent review of each neonatal death between January 2015 and 2016 to determine any factors which could have changed the outcomes including obstetric, pathology, post mortem indicators, nursing care and pharmacy input. While this has now been completed as a matter of priority, it has led to the review taking longer than originally anticipated. We have carried out a total of 13 individual external case note reviews as advised by the Royal College. This has been a detailed exercise, concluded within the last two weeks. This means that when we speak with parents we can now share full and accurate information, on an individual basis.

Following publication of the review, we may face criticism and questions that we still cannot answer at this time. Now is not the time for 'knee-jerk' responses but rather the opportunity to reflect and an opportunity to learn and improve. Working in the NHS we get used to 'coping' every day. This means that when we are busy our response is to work harder. However, our good intentions and desire to care for our patients to the best of our ability is why it is important to stop and take stock, which this review has enabled us to do.



Chairman Sir Duncan Nichol CBE

Chief Executive Tony Chambers





I would like to take this opportunity to thank the 52 healthcare professionals and patient representatives from neonatal services and paediatric care for the time they spent with the review team providing information and contributing towards the recommendations. I know this has been a difficult few months for everyone. In all of this we have never lost sight of the fact that behind these mortality numbers, there have been families left bereaved by the loss of their baby. At the same time there is a dedicated team of doctors and nurses who have felt the devastation of not being able to do enough to save a life and left questioning if there is anything we could have done differently. We talk a lot about courage in the NHS and these colleagues have demonstrated this attribute throughout the review process in voicing concerns, reflecting on working practices and seeking to learn. As we now work our way through the findings, this service will undoubtedly continue to be in the spotlight. I want our neonatal team to know they have the support and respect of colleagues throughout the Trust.

Yours sincerely

PD

**Tony Chambers**  
Chief Executive



Chairman Sir Duncan Nichol CBE

Chief Executive Tony Chambers

