

1. Apologies were received from Mr Higgins.
2. Mr Harvey gave an overview ^{of the paper.} and stated that the COCH team had highlighted issues which was an increased mortality rate over a period of time. They had been unable to come a view despite reviews, however there seemed to be a common link to a member of staff. This had ultimately led ~~to~~ ^{to a detailed} a review by the Royal College of Paediatric and Child Health. The review team made a number of recommendations although nothing immediate. One recommendation was for an in-depth review to be commissioned ~~into a small number of babies. This does~~ have implications in terms of inquests. This ~~in~~ in-depth review (not yet circulated) says that post mortem results should be reviewed in a small number of babies. This does have implications in terms of inquests. In one of the cases the cause of death is unascertained, which is not uncommon. Alderney will undertake a review into the causes of death however he did not feel that this will substantially change the findings. Mr Harvey is loathed by the depths of reviews undertaken to draw a line however we are close to having everything. The case reviews very much reinforce what is in the review, it comes down to issues of leadership, escalation, timely intervention and does not highlight any single individual.

Mr Chambers stated that once we have the final 4 reviews from Alderley, we can draw a line under this first part, the review itself. Following the clinicians raising concerns about the increase in mortality, the Board decision was to first commission an ^{independent} review by the RCPCH, the ~~2~~ second decision was to down grade the admission criteria to the unit. The unit has been monitored on a daily basis to assess the impact on both our own maternity unit and the wider neonatal network. ~~The Trust has seen some unintended consequences~~ There was an unsubstantiated explanation that there was a causal link to an individual, this is not the case and the issues were around leadership and timely clinical interventions.

Mr Chambers said that the admission criteria for the unit was changed and there are consequences to the changes around the people. The report highlights leadership, team communications and the implications for the individual. The ~~also~~ individual has raised a grievance and the evidence and outcomes from that mean there are actions we need to deliver on. The outcome of the grievance has not been shared as felt not appropriate but there are some things from the grievance that Mrs Hodgkinson can outline.

Mrs Kelly gave details of the consequences of

changing the admission criteria to the unit which did put a spot light on the unit. Mrs Kelly and Ms Burnett were on a daily basis monitoring admissions in and transfers out of the unit. ~~This~~ Discussions were held with the network in terms of the impact. The staffing levels on the unit are much improved and the acuity level has reduced. The staff found the whole process difficult but they felt more in control. The clinical decisions were all monitored. This was all formally reviewed at the weekly execs meeting along with a tracker report. There have been no significant incidents. Any transfers of babies have also been tracked. Work has been undertaken with obstetric colleagues in making sure there is the same understanding of transfer from maternity to the neonatal unit internally and also when transferring out.

Ms Burnett stated that when first started the review, we did intervened a lot and ^{we must do} ~~there is~~ still need oversight there is a better ^{relationship} ~~for~~ with obstetrics and neonates. Discussions continue with the network and they do not feel there is undue pressure on other units, however last week there was level 3 pressure across the region. Work is going on at the network strategically as to how neonates will look across the region and they are working with us on that.

Mr Chambers stated that the Trust's ambition was to maintain safety for mums and babies and the Trust had successfully achieved that. The impact has been beneath the radar is no impact at all, which is surprising as at the start of the conversation we were told that we would need to transfer 17 mums out. Mrs Kelly reported that only a small number of mums had needed to be transferred.

Mr Chambers reported that there had been no undue pressure on other maternity or neonatal units as a result of the changes. There is another strategic review as part of the Cheshire and Mersey vanguard work and it makes sense to look at the changes as described in the report as some investment would be needed if did change.

Sir Duncan referred to the admission criteria being mums over 39 weeks gestation and asked ^{about the 1 and/or baby} if mums under 39 weeks gestation being transferred and if there ~~was~~ were high numbers. Mrs Kelly replied that there had only been a small number of transfers out of the unit.

Mrs Hopwood asked if ambulance with a mum under 39 weeks would go straight to Arrowe Park. Ms Burnett replied that the clinicians had advised that if a mum goes into labour prior to 39 weeks it is very quick so they would still come to COCH.

Mr Harvey said that when thinking back to actually one alarm bell was how many cots the unit had over their allocation, the number of low birth weight and gestation babies and this strengthens the case that it was due to the intensity of the babies.

Sir Duncan asked if this information would be of interest to the network. Mr Harvey replied that we do have the figures however the scrutiny has been from the CCG, NHS England CQC and the network, who all want a copy of the review.

Mrs Hopwood said that she was hearing that the issues were due to staffing ~~and~~ pressures. Mr Harvey ~~say~~ replied that this was one factor in what was a multifactorial case.

Mr Chambers added that the Trust saw an increase in mortality but not a change in other data. The daily monitoring on the unit provides data which has not previously been captured.

Mrs Hopwood stated that the report clearly talks about staffing shortages however this was not coming through on ~~the~~ staffing indicators at OSPEC or Board. Mrs Kelly had undertaken a separate nursing review as there had been no significant issues at the time. We knew were under the standard but we were not the only Trust doing this in England. We discussed

6
This with NHS England about not meeting the standard, staff were happy and raised no issues.

Mr Wylie said Mrs Kelly had also answered his question as nobody was meeting the standards, we had professional advice so this was appropriate but that he could not then understand why ~~became~~ staffing became an issue during the review.

Mrs Hopwood asked ^{about} ~~what had been~~ the consultant ~~was old~~ ^{staffing} ~~ASPEC~~. Mr Harvey replied that the Royal College has brought in new standards for paediatrics and following the ~~se~~ approval of a couple of business cases a 9th consultant ~~is~~ has just been appointed ~~to~~ and interviews are scheduled for a 10th consultant, which once filled ~~with~~ will fulfil requirements from the College. Trainees will always be an issue as HENL have training posts empty.

Mrs Hopwood said that at ASPEC, we receive a verbal update ~~in terms~~ about vacancies, and a safe staffing 6 monthly report goes to Board for nursing. She asked if there was anything similar for the ~~to~~ consultants. Mrs Hodgkinson replied that at the fortnightly medical pay board, vacancies are reviewed, it is also included within the performance report and any issues are highlighted.

~~St Dunce~~

(7)

Mr Chambers stated that this was a good debate, and that in terms of the recommendations and actions going forward we need to reflect on and lighten up on tracking and realtime information.

Mr Chambers stated that there is an important set of consequences for people and for one individual. There is an unsubstantiated claim that the issue was down to one individual's actions and behaviours. We did explore supervised practice for the individual but this was not supported by clinical colleagues. The individual submitted a grievance and has subsequently written a statement of how this has affected her.

Mrs Hodgkinson read out the statement from the individual which was in the individual's own words. Mrs Rees, Head of Nursing - Urgent Care would also read out this statement to the consultants in the near future.

- Mr Chambers and Mrs Kelly have met with the individual and their family. Mr Chambers said that the motivation for the decisions we
- ~~the decision maker~~ have made, as we probably knew was a sub optimal decision but was made for the right reasons, The reasons were not motivated by reputational issues, the motivation was safety.

We wanted to make sure no harm to babies and we needed to have the team with us. The team were very strong in their views that this would not be possible if we did not redeploy the individual. The reason we redeployed the individual was that they would have been put in an intolerable position and potentially it could have been a self fulfilling prophecy of harm to the individual and babies. The Board took the decision in the best interests of the family patients and staff. When Mr Chambers felt it went wrong was that we were not as honest with the individual as we could have been. Mrs Kelly has apprised over this as well, we were not transparent in the first instance ~~as~~ as we were trying to protect the individual in some ways, as our feelings were that if we really believed that the individual was the ~~causal~~ causal factor in the change of survival rates on the unit, we would have called the police. However, we did not feel this was the case and we have explained this to the individual and their family.

Mr Chambers has said to the individual and their family that we will manage as best we can a safe transition back to unit but you see from her statement this maybe tricky. It may not be possible in the end but we will do everything we can. The recommendations from the grievance and some of the unprofessional behaviour from the consultant will mean that we are seeking an apology

from the consultants for their behaviour and verbal statements which border on victimisation, this is deeply uncomfortable. As a Board, we did not do anything wrong, this is a tricky situation and the next steps will be critical.

Mrs Hodgkinson stated that there is an apology and also a request for mediation with Dr Brearey and Dr Jayaram. Mrs Rees has been assigned as a mentor for the individual, with Mrs Hodgkinson, Mrs Kelly, Mrs Rees and Miss Cooper to support the individual and their continued professional development.

Mr Oliver said that we are where we are, we took the decision for the right reasons. The next stage is crucial not just for the reputation of the Trust but also for the unit and the individual.

Mr Duxie agreed with Mr Oliver's comments.

Mr Chambers stated that the Board had been given the unredacted version of the report, however the RCPCH had made some comments about some of the HR issues and not appropriate to be shared. Mr Harvey has discussed the issuing of 2 reports with RCPCH and may be content to do so. Mr Chambers added that the redacted report still answers the questions raised. Mr Cross

Mrs Fallon referred to members of staff hearing comments and that from the Board's perspective



● This is unacceptable behaviour from the consultants. We sat as a Board and made a decision that night at that time. In hindsight we may have managed this differently, not changed the decision but may have done in a different way.

Mr Wulcie felt the decision was right but the behaviours were not.

● Mr Chambers stated that the outcomes from the grievance will address the behaviours and we will go ahead with the recommendations from the grievance.

● Mrs Hodgkinson reported that Dr Green did the investigation into the grievance and this was then heard by an independent chair. It is clear that we acted appropriately given the issues. Mrs Kelly has discussed this with the individual and said that we should have been upfront from the start, but that it was to protect them but they do not see as fair and that we could have done differently.

● Sir Duncan stated that the Board is comfortable with the process and notes there are lessons to be learnt. The Trust will seek to implement the recommendations from the review. There is the issue of communication of the report. There is no ~~requirement~~ requirement to go above a level 2 unit at this stage, as that decision lies outside the Trust with the network and would require investment. There is a need to engage with the

the consultants and the individuals return.

Mrs Hopwood ^{asked} ~~asking~~ are we having formal communications with the individual to say that we have reflected as a Board and we stand by our decision but acknowledge we could have managed this differently.

Mr Chambers replied that the individual's family want assurance that the bad behaviour will be dealt with and any re-occurrence would be dealt with. We have given that commitment and will support the individual back to the unit. The individual is not looking for any further redress and the grievance exonerates her.

Mrs Hopwood ask where the individual's statement would be going. Mrs Hodgkinson replied that it was being shared with the doctors.

Mr Burke asked if the consultants accept the recommendations from the report. Mr Hanley stated that the draft report had been shared in a controlled way with Dr Brearey and Dr Jayaram for comments. The areas that need to be brought together are the feedback from the review and the recommendations from the grievance. We need to be clear on the message from the Board and also the consequences for stepping over the line.

Sir Duncan stated that in terms of communication the public know that we did this for the right



reasons, we have issues around the 2 reports, we need to handle the communication carefully. We did talk about leadership, escalation and staffing levels at peak times, there is no single cause and no collective issue. The words are really important and people will choose ^{what} to believe. The Trust will be making a statement once we have met with the consultants.

Mrs Hopwood asked that there are assurances that the report will not be leaked to the press. Mr Chambers replied that this would form part of the conversation with clinicians where we will be very clear about the expectations.

Mr Wylie asked if the issues around behaviour was accurate. Mrs Kelly replied that it was accurate. Mr Chambers added that there was a lot of substantiation around the behaviours.

Sir Duncan stated that the Board accepted the report and support the implementation subject to the strategic review, ~~and~~ supported the individual going back on the unit and that the admission criteria should not be changed.

Sir Duncan suggested that a further meeting be held once these actions are completed and that the Board spend some time considering the communications statement before it is released.



We can also revisit the strategic decision from the network and the investment needed around the level of the unit.

Mrs Hopwood stated that ~~the~~ the assurance she has gained is that as a Board we will approach the strategic discussions from the best interests of patients and the local area.