

Message

**From:** Harvey Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [i.harvey@ I&S]  
**Sent:** 12/02/2016 10:27:42  
**To:** KELLY, Alison (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [alison.kelly9@ I&S]  
**Subject:** FW: MBRRACE  
**Attachments:** exec summary PN mortality 2013 ammendum.doc; maternal deaths 2011 to 2013 exec summary.doc; maternal deaths 2010-12 action plan.docx; NND and SB review 2015 - final.docx

FYI

Where are we up to with the central CTG monitoring, do you know?

*ian*

Ian Harvey  
Medical Director  
Countess of Chester Hospital NHS FT  
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**From:** Davies Joanne (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)  
**Sent:** 25 January 2016 11:22  
**To:** Harvey Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)  
**Subject:** RE: MBRRACE

Dear ian

Please see attached exec summaries

There have been 4 reports 2015 –

1. Perinatal mortality for all deaths 2013 – the report shows trust specific data and COCH are up to 10% lower than than the average for both stillbirth and neonatal deaths
2. Maternal deaths 2010-2012 – no trust specific data – action plan produced from exec summary and after dissemination and discussion at RHD
3. Maternal deaths 2011 – 2013 – see exec summary – only published Dec so not disseminated yet and working on rest of actions
4. Conf enquiry into stillbirths 2013 – still working on action plan which will be based on reports exec summary - hoping to complete today

Main issues

Stillbirth is related to unrecognised growth retardation – we are trying to implement customised growth charts and scanning (GROW package), this is also on the quality schedule. However there is not enough ultrasound capacity to implement fully. This has been placed on the risk register. Radiology will be submitting a business case

We have had an increase in stillbirth and neonatal death for 2015. Therefore additional review was undertaken – see attached report. 2 cases were found where care had affected outcome - these had already been identified and reviewed at level 1. Main issues with both are CTG interpretation -

CTG interpretation education remains a priority - we have put lots of things in place over the years but mistakes still happen – new group recently set up to relook at

Hope this is what you were after

jo

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**From:** Harvey Ian (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)  
**Sent:** 25 January 2016 8:01 AM  
**To:** Davies Joanne (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST)  
**Subject:** MBRRACE

Dear Jo

With the CQC due in less than one month, is there anything that I need a heads up about relating to the most recent audit report. Are there any significant concerns, outliers or actions outstanding?

Thanks

**PD**  
Ian Harvey  
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