**EXTRA-ORDINARY BOARD OF DIRECTORS (PRIVATE)**

**MINUTES OF THE MEETING HELD ON THURSDAY, 14TH JULY 2016 at 12.30PM**
**BOARDROOM**
**SPC/CER FINAL VERSION**

| | | Attendance | |
|---|---|---|---|
| Chairman | Sir D Nichol | ☑ | |
| Non Executive Director | Mr A Higgins | | ☒ |
| Non Executive Director | Mr J Wilkie | ☑ | |
| Non Executive Director | Mr E Oliver | | ☒ |
| Non Executive Director | Mrs R Hopwood | ☑ | |
| Non Executive Director | Ms R Fallon | ☑ | |
| Chief Executive | Mr T Chambers | ☑ | |
| Medical Director | Mr I Harvey | ☑ | |
| Interim Chief Finance Officer | Mr S Holden | ☑ | |
| Director of Nursing & Quality | Mrs A Kelly | ☑ | |
| Director of People and Organisational Development | Mrs S Hodkinson | | ☒ |
| Director of Corporate & Legal Services | Mr S P Cross | ☑ | |
| Director of Operations | Ms L Burnett | ☑ | |

**In attendance**:
Mrs C Raggett – Secretary to the Board
Dr Steve Brearey, Consultant
Dr Ravi Jayaram, Consultant

***FORMAL BUSINESS***

1. **WELCOME AND APOLOGIES**

Apologies were received from Mrs Hodkinson, Mr Higgins and Mr Oliver.

2. **To review and consider the position with regard to the Neonatal Unit**

Mr Chambers reported that the Trust has noticed a change in mortality rates in the neonatal unit. This rise could not be explained and following on from concerns raised by the clinical team, the Trust is sufficiently motivated to do an in-depth review into the deaths. Mr Brearey, lead for the neonatal unit, had asked for a peer review from colleagues in Liverpool into the cases to see if anything had been



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difference from 2013 to 2014.
Mr Harvey stated that the staffing had been cross referenced however the staffing is post Francis so there is not a lot of back data. Mrs Kelly added that staffing is in-line with the Department of Health standard however it is more complicated in the neonatal unit as there is a specific measure and that comes with specialist training. The overarching view was that staffing compliance was reducing so the gap was wider.

Mr Harvey stated that there had been a more detailed review into each of the cases including those babies that were out of area. It has been identified that half of the patients in this cohort are from Wales. This carries through and in 2016 2 of the babies relate to triplets who had been under the Trust's care for the whole of their pregnancy. There seems to be an increase in patients from Wales that needs to be understood. Mr Harvey has met with the obstetricians and they are not aware of any issues. There is also a need to look into babies who have suddenly deteriorated.

Mr Harvey reported that the activity on the unit, staffing levels from June 2015 and cross referenced to the numbers on ITU, HDU and the specialist care babies. There are normally 14 cots with some flexibility between 3 classifications. From 2015, the unit has seen 17, 18 and at one point 19 cots in use against that some of the staffing levels did not match up as more at night than in the day.

Mr Harvey highlighted an issue around the rota allocation of medical and nursing staff on shifts before and when babies deteriorate. There are a number of staff who appear more frequently and one member of staff in particular. This member of staff is one of the unit's highest trained staff. The unit is working over and above, some babies are due to transfer but we are still taking babies but this is being managed. The Trust is in a position to take the next steps to ensure the unit is safe now and in the future.

Dr Jayaram stated that the nature of neonatal babies is that they are premature babies and by definition at higher risk. Within the context of that when things happen, they happen for a reason, so can see any trends. The concerns we had was not only the numbers of deaths rising but that these babies were not the ones we were expecting to die. These babies may have been premature but were stable, there was no reason to explain the collapse and then when they didn't respond to what was an entirely timely and correct intervention, this as well as the numbers made us worry. The data presented by Mr Harvey is helpful and backs what we say. The unit is busier and there is a strong strain on staffing and this is what we have been saying. This is not unusual across the region, neonatal cots are reducing, hard to recruit staff, lower staffing and higher intensity will lead to more risk, that said when look at these babies no direct effect on each patient.

Mr Harvey stated that Dr Jayaram was not referring to all babies. Dr Jayaram replied no, some baby deaths were anticipated as the babies were very poorly with abnormalities.



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Mr Brearey stated that even if abnormalities were the cause of death, babies were stable before collapse.

In some ways post mortems are not always helpful and added that everyone had done a lot of work on the data. The clinicians had not seen the data until yesterday and it had no input from neonatal specialist or context with workloads at COCH compared to other units in the network. The network report had been discussed yesterday and if one looked at the activity in HDU, ITU and Special Care with others this is comparable. If one looked at nursing standards, the average amount of time compliant is 50% compared to the national average which is 64%. Some units such as Warrington only have 20% compliance. There are strains in the system and as the neonatal lead, Mr Brearey could not see that any of the apparent changes in acuity, or staffing levels can account for the increased mortality.

Mr Harvey said that he was not saying this would be the end as there are factors to be considered.

Dr Jayaram stated that what he was to say next was confidential and not to be minuted.

Mr Chambers reported that the Trust has seen an increase in harm and acuity which is probably greater than originally thought. The Trust has seen pressures on staffing, there is a proportion of part time staff on the unit. This has been discussed with the clinicians. Mr Chambers sought assurance that the board felt the Trust are taking this seriously. The Board agreed that the Trust was taking these issues seriously and agreed that the proposed actions were proportionate.

Mr Chambers reported that supported practice and increased supervision would be discussed with staff and put in place. There will also be increased security arrangements not only access and egress but also CCTV. The Trust needs to understand the data more and this will start quickly whilst continuing the investigation. This is supported by Dr John Gibbs, Senior Paediatrician. There will be more investigation around still births and transfers. The terms of reference for the external review with the scale and scope will include an investigation of the competence of all staff.

Mr Chambers stated that the unanimous view from the clinicians is that the actions are proportionate and balanced and is the right course of action.

Mr Brearey referred to the competence and stated that 'MBRACE' data for 14 babies (perinatal review) showed that COCH was between 0-10; less than the national average, coding can vary across Trusts however the Trust was below the national average in these 14 cases. Neonatal nursing staff are highly trained outside of the Trust for their qualifications and there is a double checking procedure on the neonatal unit. There was a thematic review undertaken in February 2016 which noted deaths occurred between 12am and 4am and there was an action to go back and look at the proceeding 12 hour period of collapse and a secondary review was



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undertaken up to January 2016 but we could not identify any changes in observations, blood gas or blood results that would have indicated that we should have acted sooner. There is a high likelihood of being picked up by other staff ad this had not been the case so in terms of competence he felt there were no issues.

Dr Jayaram added that there was no wrong or right thing, the actions proposed are very much around safety. The unit has downgraded so the babies that are admitted are lower risk.

Dr Jayaram stated that the paediatricians think the actions are proportionate so far and felt that the holding measure to reduce risk as far as possible pending the investigations into the data and the external review. The worry is that at the end of the review there is no conclusion or idea as to what is going on. He knew this could not be answered until after the review but he felt that this could ultimately be a delay however he accepted that this needed to be explored further.

Mr Harvey said that there are too many uncertainties and that he has approached the Royal College of Paediatric and Child Health to undertake the external review. They are quickly pulling a team together and will start the review on the 18th August 2016. It they have any areas of concern they will highlight them straight away.

There will be 4 in the review team including a neonatal specialist, paediatrician, nurse lead for neonatal palliative care and lay member barrister, who has previously chaired the NMC Fitness to Practice Board. Mr Harvey felt this was a very good team. It is important that we ensure that the unit is safe now, explore the data and assess any other issues. This is not easy and is incredibly difficult. He said we haven't slept for a couple of weeks and we do need to check we are not setting someone up to fail and need to make sure not due to stress.

Mr Wilkie stated that he accepted that no evidence to say is due to an individual but there is no evidence to say the contrary, his question is what has been changed since the last conversations. He understands the stakes here and in previous discussion there was considerable disquiet about an individual. We are saying there is something wrong here as we are now supervising that person. Mr Wilkie stated that he wanted to better understand what are the critical issues that mean it is not appropriate to engage the police as he could see disquiet. Mr Brearey replied that this had been discussed after the last meeting with Mr Harvey, there is a considerable amount of discomfort regarding the member of staff, it was felt that this was dragging on and that this would not solve the problem. There is a fantastic team and morale is very low, they will see a member of staff being closely supervised for no apparent reason, people do have anxiety about that and there is definitely discomfort.

Mrs Fallon stated that there is a point in time where a change in data can be seen, and asked in terms of that member of staff, how long they have been on the unit. Mr Brearey stated there are nurses on the unit that have had concerns about clinical practice and that this staff member was off sick. There have been no clinical practice



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