RCPCH Invited Reviews Programme

Service Review

Countess of Chester Hospital NHS Foundation Trust

September 2016

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Royal College of
Paediatrics and Child Health
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3.6 The Cheshire and Mersey transport team is combined with the cot bureau and is run as a separate service out of LWH. It uses Tier 2 doctors and Advanced Neonatal Nurse Practitioners (ANNPs) rostered from the Liverpool rotation with consultant advice and support during working hours. In 2014 tThe ODN developed ~~in 2014~~ a business case to combine the three transport services into one centralised, dedicated team based at Liverpool or Manchester, and a decision is awaited on this from NHS England Specialist Commissioners.

Concerns raised

3.7 Since June 2015 the paediatric consultants have become concerned about a higher than usual number of neonatal deaths on the unit, several of them being apparently `unexplained` and `unexpected`. These are set out in Appendix 3. Most of these infants had post-mortem examinations; all cases had been reviewed by the mortality and morbidity meeting, one had undergone a Root Cause Analysis review, with some also being examined by obstetric secondary review. In January 2015 a ~~short (~~half day~~)~~ `high level` thematic review of nine of the cases took place with the involvement of the Neonatal Network clinical lead. A summary review of the nursing observations, staffing and junior doctors rotas for the12 hours before the deaths was then conducted. No definite causal ~~, with still no~~ correlation ~~found~~was identified, between the various cases, however, ~~but~~ a number of recommendations (such as new UVC guidance) resulted from the high level review.

3.8 Further analysis by the neonatal lead had examined activity and acuity between June and December 2015. This included admissions per month, time between deaths, total care days per month, IT care days per month, ITU&HD, birthweight, prematurity. This was not a systematic review but concluded that there was higher activity and lower admission birthweight than average during the period corresponding to the increase in mortality ~~but~~ however this was not ~~significant~~ .felt to have been significant enough to explain ~~definitively~~ the increase in mortality.

3.9 The MBRRACE-UK report[3] published in May 2016 provides historical analysis of neonatal mortality and morbidity for births during 2014 and does not show the Trust as an outlier for that period, which makes the recent prevalence more curious. Similarly the evidence from the National Neonatal Audit Programme (NNAP)[4] for 2014 indicates the unit is performing well against those of similar size.

3.10 The Review team ~~concurred~~ agreed that there were no obvious factors which ~~predicated~~ linked the deaths and that ~~were not present at any one time in equivalent units within the network/UK.~~circumstances in the unit were not materially different

[3] https://www.npeu.ox.ac.uk/mbrrace-uk/reports
[4] http://www.rcpch.ac.uk/improving-child-health/quality-improvement-and-clinical-audit/national-neonatal-audit-programme-nnap

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The Urgent Care Governance Board[9] also covers neonatal services but does not explore issues in depth.

4.4.2 The unit is proud of its safety arrangements, citing the '4 'P's checks before intubation and the implementation of actions following the enquiry into a neonatal death in March 2014. The twice-daily handovers were described as being `comprehensive` although the handover information was not seen by the Review team. There is a daily 'Safety Huddle' with the shift leader. The neonatal lead emails a monthly `Neonatal Incidents` one-page briefing to all staff in the unit detailing any incidents, learning and updates. This was mentioned by several staff as being very useful and informative.

Incident reporting

4.4.3 If an incident meets criteria a Serious Incident panel is established within two days chaired by the Medical Director and Director of Nursing. An SBAR report is prepared and the recommendations from the panel are reviewed at the Governance Board and Divisional meetings.

4.4.4 Those incidents not meeting the criteria for SI should be noted on the DATIX system. All deaths should be recorded (should they?) and those deaths and near misses which are not SI are reviewed at the perinatal Mortality and Morbidity (M&M) panel which meets around 5 times a year. The M&M report template has been updated since February 2016 following the neonatal death review and includes brief findings and actions/learning arising from the incidents. Minutes from the M&M are circulated to all the paediatric consultants and senior nurses on the neonatal unit for dissemination.

Commented [dm9]: Depends on local decisions – we could make it a recommendation

All deaths should be raised as an SI, the case reviewed promptly by paediatrician, midwife and obstetrician and than either stood down or investigated formally. Either investigated internally or external if there are serious concerns
The decision to step down should also be reviewed at the Trust risk /incident meeting presumably chaired by another clinical service director

Unexpected deaths must be referred to CDOP SPOC Named Doctor for Death and should have a Rapid Response Meeting within 5 working days
If cause of death s not clear than no Death Certificate can be written and the case must be referred to the coroner

What is the role of the CCG in responding to provider SI deaths?

Five times a year is too infrequent for lessons to be learned

[9] From January 2016. Until November 2015 this was the Urgent Care Divisional Board

The ODN could have an annual death meting (if not already)

4.4.5 There is a formal system of Root Cause Analysis for internal Trust reviews run by the Risk Manager for the Horton but this is relatively new and was used in only one of the index cases.

4.4.6 The deaths are also reviewed, using case notes, separately by the neonatal lead, senior nurse and the quality facilitator and a report regarding any learning and actions required is completed. A condensed version of this report is then circulated to the network clinical effectiveness group. This process in the network only started in August 15 and it was not clear which forum checks formally that agreed actions have been completed.

4.4.7 There is no Risk Midwife, fetal medicine consultant or external adviser present at the M&M – the Risk Midwife is pivotal to the governance and should attend every meeting and an external adviser is recommended in the RCOG`s `Each Baby Matters` report.

Recommendation: Review the composition and approach to M&M investigations to include a wider group, external scrutiny and a clear process for monitoring completion of actions.

Commented [dm10]: + Datix all deaths

Practice example: *Significant cases and deaths are discussed in a meeting of risk midwife, senior midwife not involved in the case, neonatal paediatrician not involved in the case, and Perinatal pathologist if there was a post mortem. Risk midwife produces a draft summary and recommendations for all to consider. The summary is presented and discussed at unit perinatal mortality meeting. A flat management structure across one level two and two level three units means that risk midwife can approach people from out with the unit.*

4.4.8 Whilst some findings are added to the Risk Register the Review team did not see a formal `owner` responsible for of following up and ensuring completion of the recommendations. The Risk Register / M&M report seen by the Review team indicated an assessment of 'Green- low risk of harm' to neonatal deaths which seemed curious..

4.4.9 The review of deaths carried out by the (neonatal lead) consultants that triggered the unit`s reconfiguration in July 2016 did not use a recognised RCA process nor did it involve the governance lead/risk manager. The staffing grid in particular was not validated. The Risk Manager has conducted a more systematic review of staffing on duty at the time of the deaths and the shift before but this only includes clinical staff, not cleaners and others with access.