

Witness Name: Graham Peter Urwin
Statement No: 1
Exhibits: 75
Dated: 14 February 2024

THIRLWALL INQUIRY

EXHIBIT GU/13

*Emails between NHS England's Director of Nursing for Specialised Commissioning (North)
and NHS West Cheshire CCG's Director of Quality and Safeguarding dated 5 July 2016*

Taylor Worth

From: Patel Lesley (NHS ENGLAND)
Sent: 05 July 2016 15:40
To: Wedd Paula (NHS WEST CHESHIRE CCG)
Cc: Bibby Andrew (NHS ENGLAND); McGorry Sue (NHS ENGLAND); Cornall Robert (NHS ENGLAND); Jones Roz (NHS ENGLAND); Prentice Mike (NHS ENGLAND); Murphy Kieran (NHS ENGLAND); Sedgwick Marie (NHS ENGLAND); Duggan Clare (NHS ENGLAND); Richards Hazel (NHS ENGLAND); Hales Gaynor (NHS IMPROVEMENT - T1520); Kitching Margaret (NHS ENGLAND); Cooper Lisa (NHS ENGLAND)
Subject: RE: Neonatal Services Serious Issues

Thanks Paula

We have looked on STEIS but weren't able to pick this up so thank you for clarifying, we may have a glitch.

To clarify I discussed the neonatal service with Alison a week last Monday as part of an assurance process and was given a fairly clean bill of health. It was only Friday that these new issues were discussed, we also have another incident which is outstanding which doesn't appear to have been reported which I raised with Alison. So likewise I think we were unaware.

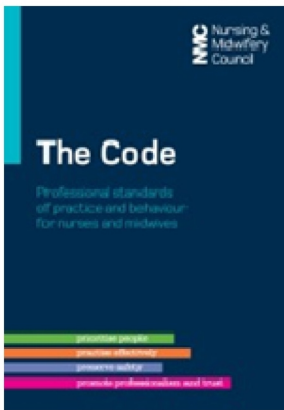
Thank you for your suggested approach which I would absolutely support

Lesley

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From: Wedd Paula (NHS WEST CHESHIRE CCG)

Sent: 05 July 2016 15:09

To: Patel Lesley (NHS ENGLAND)

Cc: Bibby Andrew (NHS ENGLAND); McGorry Sue (NHS ENGLAND); Cornall Robert (NHS ENGLAND); Jones Roz (NHS ENGLAND); Prentice Mike (NHS ENGLAND); Murphy Kieran (NHS ENGLAND); Sedgwick Marie (NHS ENGLAND); Duggan Clare (NHS ENGLAND); Richards Hazel (NHS ENGLAND); Hales Gaynor (NHS IMPROVEMENT - T1520); Kitching Margaret (NHS ENGLAND); Cooper Lisa (NHS ENGLAND)

Subject: RE: Neonatal Services Serious Issues

Thank you lesley for helpful summary position.

You note these current deaths are not reported on StEIS as of today but the incidents were actually reported on StEIS last week on Thursday 30th June so local NHSE should have had sight of these incidents. I have attached the information reported on STEIS as a table.

I have not been sighted on the wider context of earlier concerns at Countess in relation to the neonatal service as this had not been shared with me so I wasn't in a position to share these concerns with my local NHSE through my QSG report which is how I manage escalations.

To ensure we don't duplicate any effort I will focus on the point you make below "The Countess also has some work to do in order for the system to be assured regarding their internal governance within this speciality." This is of significant concern to me and where I will be directing my efforts.

My Serious Incident policy is clear in terms of what I expect to be reported to me but this will only work if the specialty is reporting internally to begin with.
So this internal failure must be my starting point.

Regards Paula

Paula Wedd

Director of Quality and Safeguarding

NHS West Cheshire Clinical Commissioning Group

Tel: 0161 **I&S**

From: Patel Lesley (NHS ENGLAND)

Sent: 05 July 2016 14:02

To: Prentice Mike (NHS ENGLAND); Kitching Margaret (NHS ENGLAND); Hales Gaynor (NHS IMPROVEMENT - T1520); Richards Hazel (NHS ENGLAND); Murphy Kieran (NHS ENGLAND); Duggan Clare (NHS ENGLAND); Sedgwick Marie (NHS ENGLAND); Wedd Paula (NHS WEST CHESHIRE CCG)
Cc: Bibby Andrew (NHS ENGLAND); McGorry Sue (NHS ENGLAND); Cornall Robert (NHS ENGLAND); Jones Roz (NHS ENGLAND)
Subject: Neonatal Services Serious Issues
Importance: High

Dear All

We have been made aware of some serious issues relating to the Countess of Chester Hospital Neonatal Services. I had a conversation with their Director of Nursing, Alison Kelly yesterday. A set of triplets were born at 34 weeks, well at birth, however two have now died and the third is currently in the care of the Liverpool Women's. These cases are with the coroner but are currently not on STEIS as of today.

The Unit was under some local scrutiny earlier in the year following an infection concern. A thematic review was undertaken 10 cases reviewed with no clinical issues identified. The Director of Nursing has confirmed that there are other issues coming to light now, that have not necessarily been reported, the recent deaths identify the Trust as an outlier.

The Trust were speaking with their CCG late yesterday and the network have met with the Trust to look at some immediate actions as follows:

- Downgrade unit to level 1: 34 weeks and above babies (3 cots less). An action plan is being developed by their clinicians
- External review of all aspects of the unit to include staff/ equipment/ pathways/ competency/ incidents reported

Whilst willing to support these steps temporarily this will put strain on an already pressured system in the Northwest. Spec comm Northwest are going to work with the network and other units to enable this bed reduction and the potential transfer issues that will arise. The Countess also has some work to do in order for the system to be assured regarding their internal governance within this speciality.

In the longer term Specialised Commissioning aim to accelerate a planned service review of Neonatal services in the Northwest to ensure a sustainable future.

I have discussed this with Margaret Kitching who has suggested that the DCO team coordinate an incident review meeting to look at the impact across Cheshire and Merseyside. I have spoken to NHSI Nurse Director Gaynor Hales as she has been informed that the COCH are to issue a media statement regarding the above actions. Gaynor has agreed to discuss the next steps with the DCO team this afternoon via Clare Duggan and will let us know the outcome.

Kind regards

Lesley

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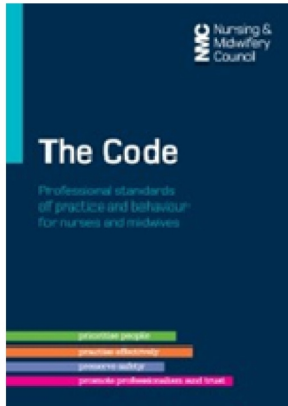
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