Message

From: Kelly Alison (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [alison.kelly9@ I&S
Sent: 30/06/2016 5:08:48 PM
To: Ford, Ann [ann.ford@ I&S
CC: Chambers Tony (COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST) [tony.chambers@ I&S ; Lees, Bridget [bridget.lees I&S]; Lindley, Deborah [deborah.lindley@ I&S
Subject: Neonatal Unit - Update (CoCH)

Importance: High
Sensitivity: Company Confidential

Dear Ann,

Following our telephone conversation earlier today, as requested, please see below overview of issues and actions being taken:

Context
The Trust has identified an increase in the number of deaths of new born babies (differing levels of prematurity) on our Neonatal Unit in 2015-16 and now in 2016 -17 compared to previous years. An in depth thematic medical review of the individual cases was undertaken internally followed by a subsequent Peer Review (by a Consultant from Liverpool Women's Trust), however the reviews have failed to identify any cause or common theme for this increase – (these reviews were submitted as part of our recent CQC inspection data pack).

For this reason we have commissioned an independent review of the unit from the RCPCH, we anticipate this will be commenced in the next 4 weeks. Over the past 48 hours a number of meetings have been undertaken between the executive team and relevant clinicians and our actions are as follows:

- Proposal being developed to 'close' the unit, to only accept Level 1 babies – clinicians have been tasked with developing a clinical plan by tomorrow of what the model of care will be and numbers involved
- Once confirmed, liaison to be undertaken with the Neonatal network re operationalising the plan and requesting support to do this (recognising the impact on other trusts), internal management resource being identified to support this process
- RCPCH review terms of reference being developed via our Medical Director
- Review of incident reporting data
- Deep dive into staff rotas (of all disciplines) clinical and non-clinical regarding staff on duty at time of neonatal deaths (to be completed in the next week)
- Review of environmental issues – microbiology review and equipment
- Detailed review of security and access to the Unit
- Review of any staff competency/performance issues, appraisal rates etc.
- Review of PALS/Complaints data
- Review of Coroners referrals
- External stakeholder list developed regrading who requires notification of our plans
- Robust Comms plan being drafted re: internal re our staff, external stakeholders, parents of babies currently on the unit in addition to those families of babies who have died
- Plan being drafted to address potential public concern once external comms agreed ie Helpline
- Staff support in place via our Occupational Health team for all concerned – a debrief on the unit took place end of last week

In respect of a couple of specific questions you asked Ann:

Nos of sets of triplets born in our Trust – these are as follows:

2012: IVF triplets, born at 29 weeks, 1 triplet died in early neonatal period, complication of prematurity – remaining 2 discharged alive and well
2014: IVF triplets elective section, discharged, all babies alive and well
2015: IVF triplets at 30+3 weeks, discharged, all babies alive and well
2016 (last week), Spontaneous triplet pregnancy, born at 34 weeks, transferred to NNU but were stable

The two incidents from last week were being entered on STEiS today, this now triggers a Level 2 investigation (and as per our usual process, a family liaison link will be identified for the family). I believe the clinicians spoke with the family early this week but I need to confirm this including what they were told

I hope this provides you with sufficient detail but please do not hesitate to contact me if you require any further clarification

Regards, Alison

Alison Kelly
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