Countess of Chester Hospital NHS
NHS Foundation Trust

**Overarching Executive Lead : Ian Harvey, Medical Director**

| NEONATAL EXTERNAL REVIEW – ACTION PLAN<br>February 2017 | | | | | |
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| **Recommendations** | **Actions Required** | **Executive Lead** | **Clinical/Operational Lead** | **Date for Completion** | **Completed Y/N Exception/Evidence/Comments** |
| (a). Ensure there are clear, swift and equitable processes for investigating allegations or concerns which are followed by everyone. | Continue work on raising awareness of the importance of escalating concerns<br><br>Daily and weekly reporting of clinical incidents to Executive team to continue for foreseeable future<br><br>Plan to invite Director of Nursing & Quality and Head of Nursing (Urgent Care) to input into nurses training sessions regarding raising concerns<br><br>General awareness required regarding 'Speak Out Safely' agenda to ensure all staff are aware of Trust processes | Medical Director/ Director of Nursing | Neonatal Lead (Medical ) and NNU Nurse Manager | Ongoing<br><br><br><br><br><br><br><br>Ongoing as part of training and team facilitation | <br><br><br><br>**Completed** & ongoing<br><br><br><br>**Completed** |

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| (b). Conduct a thorough external, independent review of each unexpected neonatal death between Jan 2015 – July 2016 to determine any factors which could have changed the outcomes (Include obstetric & pathology/post-mortem indicators, nursing care and pharmacy input | Independent review commissioned for review of clinical cases<br><br>Liaise with the Coroner regarding pathology input<br><br>NNU team meeting with medical Director and Neonatal network clinical lead to review outcomes<br><br>Communicate to parents regarding review of each case – meetings to be arranged where appropriate<br><br>Following clinical case review, small number of cases require a further forensic review prior to discussion with parents | Medical Director | Lead Clinician (Children's services & Neonatal Clinical Lead) | Dec 2016<br><br>Dec 2016<br><br>Feb & Mar 2017<br><br>Feb & Mar 2017<br><br>April 2017 | **Completed**<br><br>**Completed**<br><br>**Completed**<br><br>**Completed**<br><br>Further communication required with parents re planned meetings |
| (c). All unfilled rota gaps and transport problems should be recorded through Datix and risk assessed at a senior committee such as the Divisional Governance Committee | Develop a Standing Operating Procedure to ensure consistency of approach<br><br>Maintain focus on Datix reporting to highlight concerns supported by Patient Safety & Risk Lead<br><br>Standing item on monthly W&C governance agenda<br><br>Further escalation to Urgent Care Divisional Board where necessary | Medical Director | Lead clinician for children's services | June 2017 | |

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| (d). Strengthen the response to neonatal death/near miss investigations to:<br>- Normalise the reporting culture<br>- Include risk & governance staff<br>- Involve a wider group inc maternity & external scrutiny<br>- demonstrate completion of actions<br>- clarify senior management oversight | Develop a collaborative process of review of neonatal deaths/near miss in partnership with obstetric team that is aligned to corporate risk management processes<br><br>Identify clear routes of communication and escalation to the Serious Incident Review Group regarding incidents<br><br>Develop a clear process of sharing learning and communicating to the wider team and across specialties<br><br>Discuss a process of 'External Scrutiny' with the Neonatal Network team | Director of Nursing & Quality/ Medical Director | Lead clinician for children's services & Obstetric Risk Lead | June 2017 | |
| (e). The obstetric and paediatric incident review processes should follow similar systematic methods as set out above. | Actions/learning from joint meeting to be shared at relevant governance boards<br><br>Risk & Safety lead to be part of the above meetings to provide corporate oversight to feed into executive led SI panel<br><br>As above develop a collaborative process of review | Director of Nursing & Quality & Medical Director | Lead clinician for children's services & Obstetric Risk Lead | June 2017 | |

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| (f). Strengthen procedures for involvement of more senior advice and develop guidelines for consultant availability to the Neonatal unit | Develop an escalation process for escalation to seniors when Consultants are not available (ie when attending an emergency) | Medical Director | Lead clinician for children's services/Neonatal Clinical Lead | July 2017 | |
| (g). The 2 additional Consultant appointments must be in place before any consideration can be given to possible re designation as a level 2 unit | Recruit 2 Consultant posts | Medical Director | Lead clinician for children's services | September 2017 | Partially Completed<br>1 Consultant recruited and in post<br><br>2nd post – interviews 15 May 2017 |
| (h). Ensure maintenance of skills of neonatal nursing and medical team to ensure that return to level 2 can be safely managed. Rotation of staff to level 3 units should be explored | Develop a plan to address maintenance of skills to support Level 2 status for all clinical staff<br><br>Access to Liverpool Womens Hospital re Neonatal Induction Course<br><br>Access to Neonatal ITU course<br>Nurse Rotation to be developed<br>Continue ongoing educational support from the NNU Practice development post holder<br><br>Repeat nursing workforce review<br><br>Access to Advanced Practitioner | Medical Director & Director of Nursing & Quality | Neonatal Clinical lead/Neonatal Nurse Manager | May 2017<br><br>Ongoing<br><br>June 2017<br><br>March 2017<br><br>Feb 2017 | Already underway but medical and nursing requirements need to be articulated in one plan<br><br>Some staff already completed, others planned<br><br>3 staff currently on this course<br>Planning in place with Wirral University Teaching Hospital<br><br>**Completed**<br><br>**Completed** |

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| (i) Develop a strategic plan for sustainable recruitment to the Tier 2 rotas through development of nurse practitioner or other roles and review the protocol for locum assessment | programme<br><br>Refresher training in-house for medical staff on neonatal resuscitation, intubation and principles of ventilation<br><br>Discuss with the Neonatal Network lead re exploring a medical staff rotation to other units<br><br>Review protocol for Locum Assessment | | Neonatal Clinical Lead/Medical Staffing Manager | July 2017<br><br>July 2017<br><br>May 2017 | One advanced practitioner for NNU approved via health Education England submission |
| (k). Establish a short term group to examine nurse involvement in decision making, guideline development and transport liaison | Develop a multi-professional forum to develop joint protocols and guidance to support NNU practice and procedures | Medical Director & Director of Nursing & Quality | Neonatal Clinical lead/medical Staffing Manager | June 2017 | |
| (l). There should be a Children's Champion on the Board. One of the executive directors should have a specific remit to support neonatal nursing & medical team until the enquiry and subsequent management of the action plan is completed | Identify an Non Executive lead that will Champion the ongoing work and profile of the Neonatal unit | Director of Legal & Corporate Governance & CEO | N/A | March 2017 | **Completed**<br>Individual identified (Awaiting confirmation)<br><br>Medical Director & Director of Nursing & Quality to support from an executive perspective until actions completed |

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| (m). An annual report should be prepared for the unit which is disseminated to the Board and Network stakeholders | Identify what would be required in an Annual Report – clinical and executive team to work together on clarifying this.<br><br>Report to presented to the Women's & Children's Governance Board then up to the Board of Directors | Medical Director & Director of Nursing & Quality | Neonatal Lead clinician and NNU ward manager | March 2018 | |
| (n). Include a unit-wide debrief for neonatal deaths on the unit to include all grades of clinical staff who cared for the infant | Develop an SOP with timescales and clarity on who, when where etc<br><br>Share the learning from the ED team re debriefing methodology to NNU for support<br><br>Formalise a handover safety brief/huddle between NNU nursing and maternity team.<br>Explore inclusion of medical inclusion in the future | Medical Director & Director of Nursing & Quality | Paediatric lead/ Neonatal Clinical lead & NNU Nurse Lead | May 2017<br><br>May 2017<br><br>In place | NNU safety briefs in place as per Maternity safety briefs<br>Safety huddle is currently being piloted (supporting NHSi Maternity/neonatal safety collaborative) |
| (o). Agree a mechanism for data recording, management and reporting across the IT systems including noting M&M case review reports and CDOP notifications | SOP to be develop regarding reporting responsibilities<br><br>Explore how the Datix system may support reporting and data | Medical Director & Director of Nursing & Quality | Paediatric lead/ Neonatal Clinical Lead & NNU Nurse Lead | May 2017 | Partially completed<br>CDOP process internally formalised with the Designated Doctor for CDOP linking into the SI process |

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| should be devised and implemented systematically | collection<br><br>Formalise reporting of relevant deaths into CDOP process | | | | |
| (p). All neonatal guidelines should be developed in conjunction with the network and tertiary service for consistency of care in emergencies | Check all relevant guidelines to ensure consistency | Medical Director & Director of Operations | Neonatal Clinical lead & NNU Nurse Lead | July 2017 | |

| **ACTIONS FOR EXTERNAL STAKEHOLDERS** | | | | | |
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| **Recommendation** | **Action Required** | **External Stakeholder** | **Clinical/Operational Lead** | **Date for Completion** | **Completed Y/N Exception/Evidence** |
| (q). Arrange for central monitoring and management of transport team enquiries out of hours across the network | Neonatal network operational Director has met with CoCH Director of operations – awaiting response to actions | Cheshire & Merseyside Transport Team | Neonatal Network Director of Operations | TBC | |
| (r). Ensure tertiary advice calls include an 'early warning' or conference calls to the transport team to enable better planning and deployment of the crews. | Neonatal network operational Director has met with CoCH Director of operations – awaiting response to actions | Cheshire & Merseyside Transport Team | Neonatal Network Director of Operations | TBC | |
| (s). NHSE/Neonatal Network to expedite the decision on the whole network transport service and | Neonatal network operational Director has met with CoCH Director of operations – | Cheshire & Merseyside Neonatal | Neonatal Network Director of Operations | TBC | |

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| centralise the administration out of hours in the interim | awaiting response to actions | Network | | | |
| (t). The CDOP (Child Death Overview Panel) should consider whether its processes could have detected the cluster of deaths and initiated external review more swiftly | Share report with CDOP Chair & LSCB Chair for action<br><br>Director for Nursing & LSCB Chair to meet to discuss | Cheshire West & Chester Local Authority | CDOP Chair/Designated Doctor CDOP | | **Completed**<br><br>**Completed**<br><br>External Review report has been shared with LSCB chair and CDOP Chair (including Wales CDOP) – awaiting response re actions from CDOP Chair re next steps to strengthen processes and audit |
| (u). Clarify between network and commissioners the arrangements for multi-site investigations and timely implementation of actions | Neonatal network operational Director has met with CoCH Director of operations – awaiting response to actions | Cheshire & Merseyside Neonatal Network | Neonatal Network Director of Operations | TBC | |
| (v). The network should develop a policy for temporary closure of a unit to admissions due to capacity concerns | Neonatal network operational Director has met with CoCH Director of operations – awaiting response to actions | Cheshire & Merseyside Neonatal Network | Neonatal Network Director of Operations | TBC | |

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