NHS
Countess of Chester Hospital
NHS Foundation Trust

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Dear Richard, Graham, Michael, James, Andrew, Chris and Rowan,

Re: Restoration to LNU level 2 Designation

I am delighted to enclose a document setting out the assurances relating to the standards necessary for the Countess of Chester to recommence delivery of a level 2 LNU service.

Based on the evidence included in the document plus the full support of the North West Neonatal ODN and the National Clinical Director for Children and Young People, Professor Simon Kenny. We are requesting restoration of level 2 status as per the roadmap in Appendix 1 of the document.

Some nine years after the events that led to the Trust requesting a temporary redesignation to a level 1 LNU and the extensive work undertaken by the team, it is time that the population of Cheshire West and North Wales have access to a local service.

The document may generate further questions and to this end we should like to set up a meeting in the next few weeks to discuss.

Yours sincerely,

PD

Jane Tomkinson OBE
Chief Executive Officer

Countess of Chester Hospital NHS
NHS Foundation Trust

Appendix 1: Roadmap for LNU admission criteria and acuity

Stage	Change to admission criteria or capacity	Comments	Commencement
1	**Increase HD cots to 3.**	Allowed for better utilisation of the current nursing skill mix.	18th Dec 2017
	Allow some procedures currently classified as intensive care. Examples include: Short term use of UVC in babes with difficult iv access. Peripheral long line and high flow oxygen. Intubation, surfactant and extubation (INSURE).	Babies should be treated according to their need and what is considered best practice. A discussion would then be expected with a NICU consultant whether transfer is needed or the baby can stay in CoCH.	18th Dec 2017
2	**Reduce gestation criteria for admission to ≥30 weeks.**	A move to 30 weeks would not lead to a significant increase in intensity of care required for the majority of these babies. Very few would require intensive care or transfer from the unit. **Staffing – nil additional required**	6th May 2024
3	**Admission to ≥30 weeks with short term intensive care (<48hrs).**	1 IC cot space for ≥30 weeks gestation **Staffing - nil additional required**	+6 months*
4	**1 IC cot space:** • **Gestation criteria for admission to ≥28 weeks.** • **Short-term (<48 hrs) intensive care**	Babies would be more likely to require short-term (<48 hrs) intensive care. Pull in NCOT (no business case – as pilot) – so would require 1 additional band 6 WTE	+6 months*
5	**2 cot IC spaces** • **Gestation criteria for admission to ≥27 weeks.** • **Short-term (<48 hrs) intensive care**	1 IC cot could be added at a time, dependent on nursing staffing levels and network approval.	+6 months*
6	**Review activity and demand data to assess appropriate total cot numbers required**		

*Dependent on satisfactory audit, outcome data and appropriate nursing staffing levels

CHILD DEATH GUIDELINE

Table of Contents

INTRODUCTION

The death of a child is a devastating loss that profoundly affects bereaved parents as well as siblings, extended family, friends and professionals who were involved in caring for the child in any capacity. Families experiencing such a tragedy should be met with empathy and compassion and need clear and sensitive communication. They also need to

understand what happened to their child and know that people will learn from what happened. Mementoes, memories and kindness last a life time.

PURPOSE AND SCOPE

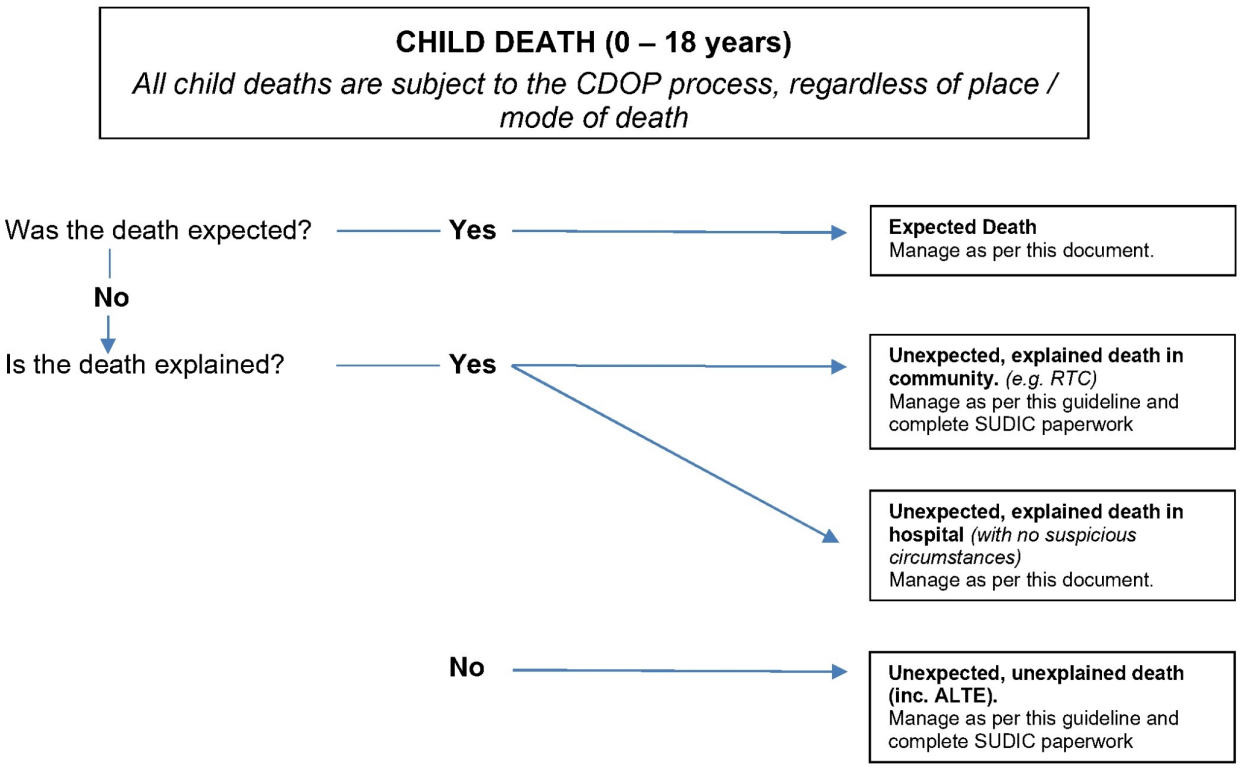
This guideline aims to ensure that all appropriate processes are followed after the death of a child. It covers immediate care of the body, support for the family as well as the statutory processes that need to be followed. Any death that occurs before an individual's 18th birthday is covered by this guideline.

RESPONSIBILITY

All staff working with children will be required to follow these guidelines in the event of the death of a child.

GUIDELINES

Flowchart



If in doubt follow SUDIC pathway in addition to this document.

In ALTE cases presenting in extremis who are successfully resuscitated and admitted to PICU/HDU but are expected to die or suffer significant harm, and the cause remains unexplained/suspicious, follow SUDIC pathway in addition to this document.

ADDITIONAL CONSIDERATIONS

Neonates.

All deaths of babies less than 28 days old are subject to additional reporting requirements (MBRRACE, PMRT, MNSI, NHS-R and EBC). Initial management should follow this document and an 'immediate decisions proforma' needs to be completed as well as a e-CDOP referral. Babies born with signs of life before 22+0 weeks are not subject to the PMRT process but are still reviewed by CDOP.

All neonatal deaths of Welsh babies (including those who are born and die in England before discharge home) need a PRUDIC discussion with Welsh Police, even if there are no suspicious circumstances.

Stillbirths.

All unattended stillbirths (defined as baby born without signs of life after 24 weeks gestation) need reporting to CDOP and should trigger a joint agency response. The management of these patients is outside the scope of this document.

Late fetal losses and attended stillbirths do not need to be managed as per this document.

Deaths on Labour Ward with No Paediatric Involvement.

It is important to be aware that a **baby born with signs of life at <u>any</u> gestation** who subsequently does not is subject to the same reporting requirements as any paediatric death, whether or not resuscitation was attempted. Evident signs of life after birth would include one or more of the following: easily visible heartbeat seen through the chest wall, visible pulsation of the cord after it has been clamped, breathing, crying or sustained gasps, definite movement of the arms and legs. Fleeting reflex activity including transient gasps, brief visible pulsation of the chest wall or brief twitches or involuntary muscle movement can be observed in babies that have died shortly before birth we recommend that such fleeting reflex activity observed only in the first minute after birth does not warrant classification as signs of life.

Initial management of these deaths should be as per this guideline focused on the '0-4 hours post death- sections of the Lead Health Professional and Lead Nurse checklists. Lesley Roe (Bereavement Midwife) and Katherine Davis (Paediatric Consultant and Child Death Review Lead) are happy to be contacted for advice. For urgent out of hours advice the on call paediatric consultant can be contacted via switchboard.

Cases where there is a live birth after a planned termination of pregnancy carried out within the law are not subject to a CDOP reporting (although should be notified to the coroner).