Ms Joanne Andrews
Area Coroner
West Sussex, Brighton and Hove
Record Office
Orchard Street
Chichester
PO19 1DD

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

24 October 2024

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Felix Burton Hartley who died on 19 February 2023.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 30 August 2024 concerning the death of Felix Burton Hartley on 19 February 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Felix's parents and family in these very sad circumstances. NHS England are keen to assure the family and the Coroner that the concerns raised about Felix's care have been listened to and reflected upon.

Your Report raises concerns over the availability of on-call Neonatology Consultants over the weekend period and overnight and, specifically, the arrangements for on-call Consultant cover at University Hospitals Sussex NHS Foundation Trust, which covers two hospital sites. Relevant to NHS England's remit, you have raised that there is no national guidance as to the time that an on-call Neonatology Consultant should be expected to attend hospital in the event of an emergency, and whether multiple sites can be covered by one on-call Consultant.

All neonatal critical care units (including neonatal intensive care units) adhere to the national standards set out in the neonatal critical care service specification. The service specification references the following British Association of Perinatal Medicine (BAPM) standards for staffing for all levels of neonatal critical care units, for both neonatal intensive care units ('NICUs') and Local Neonatal Units (LNUs) and Special Care Units (SCUs). I note that you have also addressed your Report to the BAPM. To assist the Coroner and family, I have summarised the main guidance on staffing from the relevant BAPM standards:

- NICUs with more than 2500 intensive care days per annum should double tier 2 cover at night by adding a second experienced junior doctor or appropriately trained specialty doctor or an advanced neonatal nurse practitioner (ANNP). A consultant present and immediately available on NICU in addition to tier 2 staff would be an alternative.
- NICUs undertaking more than 4000 intensive care days per annum with onerous on call duties should consider having a consultant present in addition to tier 2 staff and immediately available 24 hours per day.

- It is recommended that all NICUs implement consultant presence on the unit for at least 12 hours per day or more, as resources allow and depending on patient numbers and intensity.
- LNUs providing either more than 2000 respiratory care days or more than 750 intensive care days annually should provide a separate Tier 3 Consultant rota for the neonatal unit.
- All LNUs should ensure that all consultants on-call for the unit also have regular weekday commitments to the neonatal service. This is best delivered by a 'consultant of the week' system, and no consultant should undertake less than 4 'consultant of the week' service weeks annually.
- In SCUs, there should be a Lead Consultant for the neonatal service.

Trusts with more than one neonatal unit should have separate cover at each level of all levels of staffing during office hours and out of hours.

NHS Trusts exercise their own policies for out of hours, on call response times. This is linked to the Terms and Conditions for all NHS Consultants. My colleagues in the South East have been asked to engage with University Hospitals Sussex NHS Foundation Trust and Sussex Health and Care Integrated Care Board on the concerns raised in your Report for assurance purposes. NHS England will also consider the Trust's responses to your Report carefully in due course.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Felix, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director