Thames Valley & Wessex Neonatal ODN Mortality Overview

Terms of Reference

1.0 Context

The Thames Valley & Wessex (TV & W) Neonatal Operational Delivery Network (ODN) supports the commissioning and provision of high quality, effective and affordable clinical care with equity of access across a managed clinical network.

The Thames Valley & Wessex Neonatal ODN Network Managers Governance process for neonatal mortality overview will provide oversight and shared learning from neonatal mortality for the 14 units within the Thames Valley and Wessex Neonatal ODN through the TV & W Network Clinical Forums, for services and perinatal systems across Thames Valley & Wessex and to include networked services in Milton Keynes, South Wiltshire, Dorset and West Sussex.

Thames Valley		
TRUST	**Hospital**	**Designation**
Oxford University Hospitals NHS Foundation Trust	- John Radcliffe Hospital, Oxford	NICU
Buckinghamshire Healthcare NHS Trust	- Stoke Mandeville Hospital, Aylesbury	LNU
Frimley Health NHS Foundation Trust	- Wexham Park Hospital, Slough	LNU
Milton Keynes University Hospital NHS Foundation Trust	- Milton Keynes General Hospital	LNU
Royal Berkshire NHS Foundation Trust	- Reading	LNU

Wessex		
TRUST	**Hospital**	**Designation**
University Hospital Southampton NHS Foundation Trust	- Princess Anne Hospital	NICU
Portsmouth Hospitals University NHS Trust	- Queen Alexandra Hospital	NICU
University Hospitals Dorset NHS Foundation Trust	- Poole Hospital	LNU
Salisbury NHS Foundation Trust	- Salisbury District Hospital	LNU
Hampshire Hospitals NHS Foundation Trust	- Basingstoke and North Hampshire Hospital	SCU (Temporary designation)
Hampshire Hospitals NHS Foundation Trust	- Royal Hampshire County Hospital, Winchester	SCU (Temporary designation)
Dorset County Hospital NHS Foundation Trust	- Dorset County Hospital, Dorchester	SCU
Isle of Wight NHS Trust	- St Mary's Hospital	SCU

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The Thames Valley & Wessex Neonatal ODN acts as a facilitator within a collaborative model where the commissioners remain accountable for commissioning of neonatal services and providers for the delivery of neonatal services. The Thames Valley & Wessex Neonatal ODN will provide assurance of a process of neonatal mortality oversight and review.

The Thames Valley & Wessex Neonatal ODN reports directly to the NHSE South East Regional Specialised Commissioning and the SE Regional Maternity and Neonatal Programme Board and ICB through the Local Maternity and Neonatal Systems (LMNS). The ODN will report any areas of concern for units sitting outside the SE to relevant regional boards.

2.0 Objectives of the Thames Valley & Wessex Neonatal ODN Death Overview

2.1 To evidence a process of oversight, with transparent review and shared learning, and escalation of highlighted patient safety concerns as part of the NHS Patient Safety Incident Response Framework (PSIRF).

3.0 Process of the Thames Valley & Wessex Neonatal ODN Death oversight and governance

3.1 The Thames Valley & Wessex Neonatal ODN Management team will review all reported neonatal deaths (all deaths on NNU recorded on BadgerNet system) including those on labour ward, all other deaths with neonatal team involvement ie transfers for hospice care, transfers to non-network unit neonatal services, all deaths that meet PMRT criteria for review ie: deaths following neonatal care prior to discharge home.

3.2 All units will complete and submit the Thames Valley & Wessex Neonatal ODN standard neonatal death proforma or share completed Perinatal Mortality Review Tool (PMRT) review for Neonatal Mortality review. Any immediate care concerns, shared learning should be shared quarterly at the Network Governance meeting by the provider Trusts / Network Management team. Updates on progress on outstanding death reviews should be shared by provider Trusts. Shared learning will be circulated and shared with all provider units, including Trust & LMNS governance representatives at the ODN Governance meeting.

3.3 All neonatal death reviews should have external representation at Trust level mortality PMRT /CDRM reviews.

3.4 Annual review of ODN Mortality, all Trusts will come together to share local themes, shared learning from local death reviews at a joint TV & W Neonatal ODN mortality and morbidity meeting using the TV & Wessex Mortality review overview template. The agenda will include TV & W overview on NNAP mortality data, MBRRACE, PMRT and any other relevant national reports on mortality.

3.5 TV& Wessex ODN will escalate any patient safety concerns related to neonatal death highlighted by local review processes to the relevant LMNS Perinatal Quality Safety Forums (PQSF) and the SE Regional maternity and neonatal safety concerns group.

3.6 The responsibility for engagement with Child Death Overview Panels (CDOP) sits with the provider units, any shared learning from the CDOP annual reports should be shared at ODN governance meetings via the provider units or local CDOP panel leads.

4.0 Thames Valley & Wessex Neonatal ODN Death Overview Membership

Membership should include perinatal representation from all Neonatal Units (NNUs) and Local Maternity and Neonatal Systems within the Thames Valley & Wessex Neonatal ODN footprint. NNU representation from governance / safety champion leads with nursing and medical representation. Quoracy of the meeting requires representation from the ODN Core management team and Neonatal Clinical Leadership from provider units.

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- Operational Delivery Network Manager
- TV & W Clinical Forum
- Unit governance / safety leads / safety champions
- TV & W Clinical Lead and Safety Quality Lead
- TV & W Lead Nurses & Practice Educators
- Network Care Coordinators
- TV & W Parent & Family Engagement Lead (Parent representative)
- Network Data Analyst
- Network Manager
- SONeT Neonatal Transport Team
- CDOP Leads
- LMNS Quality and safety leads

<u>References & Links</u>

TV & Wessex Neonatal Death SOP
Child Death SOP - Neonatal Network South East (neonatalnetworkssoutheast.nhs.uk)

Child Death Review Statutory and Operational Guidance 2018

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK
MBRRACE-UK

Perinatal Mortality Review Tool
PMRT

NHS England Saving babies' lives version three; a care bundle for reducing perinatal mortality May 2023
Saving Babies' lives Version Three
NHS England December 2020 Perinatal Quality Surveillance Model
Implementing a revised perinatal quality surveillance model

NHSR Maternity Incentive Scheme

NHS England Three year delivery plan for maternity and neonatal services March 2023
Three year delivery plan for maternity and neonatal services delivery plan

NHS England Medical Examiner system
The national medical examiner system

National Child Mortality Database

Working Together to Safeguard Children 2023

NHS England Patient Safety Incident Response Framework (PSIRF)
NHS England » Patient Safety Incident Response Framework

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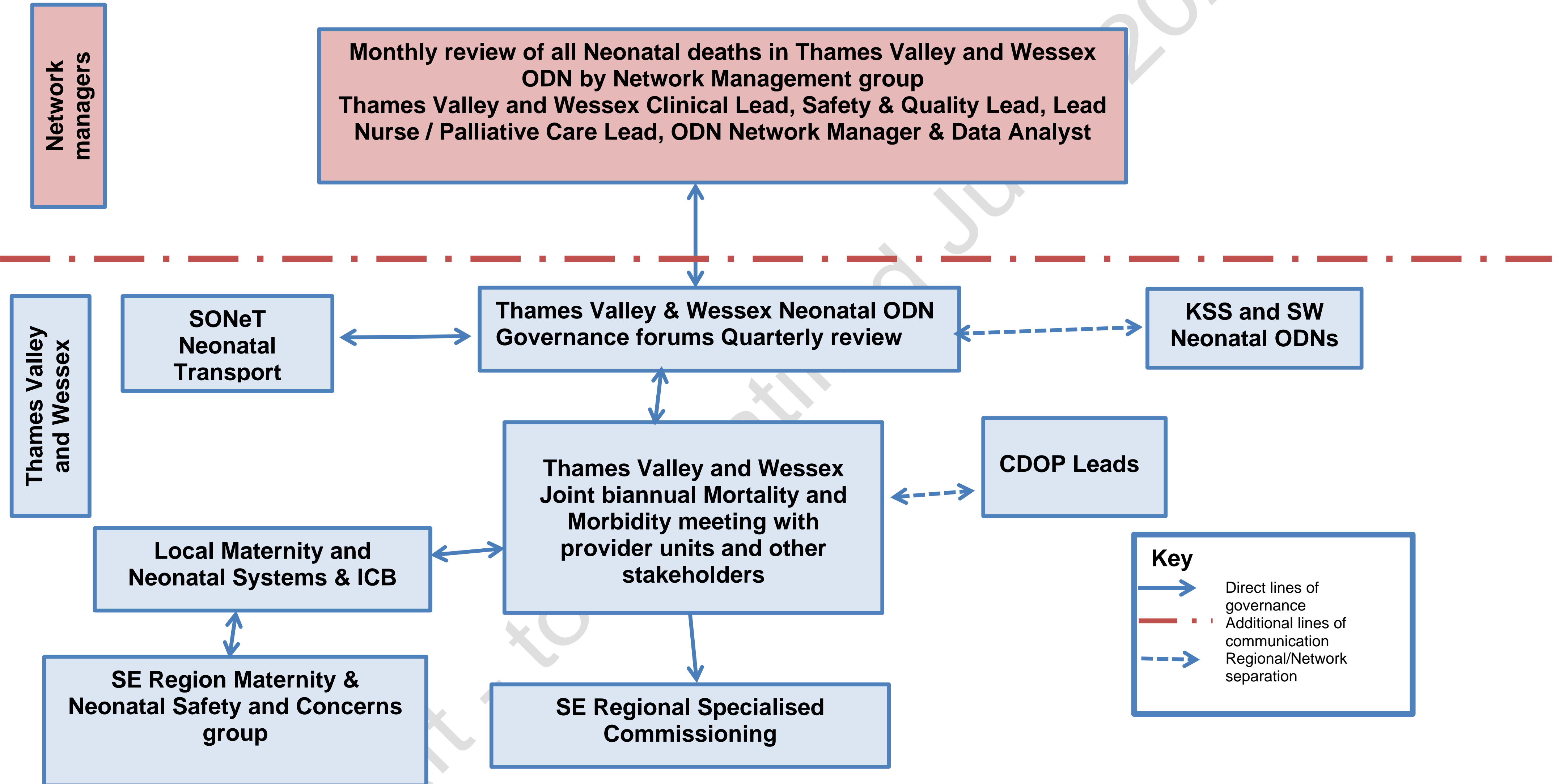
Thames Valley and Wessex Neonatal ODN Mortality Oversight Process



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Version Control:

Version	Date	Details	Author(s)	Comments
1	17.08.2018	Final Version	GO	Ratified September 2018
2	23.08.22	Reviewed and updated	GO	
3	22.01.24	Reviewed and updated	VP, GO, LL	Comments received March 24
4	24.04.24	Amended following comments received.	VP, GO, LL	For ratification in June 2024
Ratified by:				
Review date:				

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