East Midlands Neonatal
Operational Delivery Network

Terms of Reference

East Midlands Neonatal Operational Delivery Network (EMNODN)
North/South Hub Mortality Oversight Group

Aims

To review and understand neonatal and infant mortality within East Midlands Neonatal Operational Delivery Network (EMNODN) and share learning.

Scope

1) Maintain list of Badger identifiers for labour ward deaths with neonatal involvement and neonatal unit deaths and monitor cases presented against the list of Badger identifiers to ensure that all babies are discussed
2) Review the learning from all deaths which occur following a live birth at ≥22+0 weeks gestation on the labour wards and neonatal units within the North or South Hub (as applicable) of EMNODN
3) Review neonatal care of babies that die within 1st year of life who have had a neonatal stay >7 days as identified by CDOP
4) Review the yearly reports from NNAP and MBRRACE and support action as required
5) Be available to assist in reviewing more complex deaths as required
6) Share learning across the Network
7) Report to the EMNODN Board and Clinical Governance Group
8) Work with the local Child Death Overview Panels (CDOP's) and Local Maternity & Neonatal Systems (LMNS's) to share wider learning
9) Feedback from the LMNS's to understand still birth rates
10) Review of deaths that are being investigated by the Coroner will not usually be discussed until the coronial process is complete.
11) To utilise the panel to organise multicentre perinatal death review using the perinatal mortality review tool (PMRT) where babies have been cared for in multiple centres within the EMNODN

Core Membership

The membership of the group is not exclusive and may include representatives of members where required.

1) Chair – Network Clinical Lead (or representative)
2) Medical and nursing representation from all units within EMNODN (neonatal)
3) Obstetric leads for each centre
4) Network management representation
5) CenTre Neonatal Transport Service (will be invited to attend on an adhoc basis where relevant)
6) EMCHD mortality lead (if the infant has been transferred to Glenfield and subsequently died)
7) Local CDOP representation

Interested Parties for whom attendance is welcomed

1) Obstetric/midwifery representation from East Midlands Clinical Network
2) Risk managers
3) Bereavement lead (neonatal or midwifery)

Parent representation to be considered at a later stage.

The meeting shall be quorate (only required when formal recommendations are required in the meeting) if there is single representation from all units within EMNODN and the chair.

Membership Responsibility

The responsibilities of the Oversight Group members will be –

1) To coordinate the completion of the required documentation for timely submission to the Oversight Group.
2) To engage with other disciplines within their Trust to ensure a holistic understanding of the neonate's pathway
3) To engage with Oversight Group representatives within other Trusts to facilitate information gathering from services that were previously involved in the neonates care i.e. where transfer between units has occurred.
4) To notify the Network of the status of case review on request and/or at the point of appropriate milestones.
5) Anonymised information sharing and case presentations on the day at the Oversight Group meetings.
6) The Trust representative will feedback into the Trust processes to ensure that learning is disseminated
7) To feed through to the Network issues and revisions to the adopted process
8) To identify and convey learning points internally within their own Trusts, to the appropriate Networks and to the local CDOP's.

Meetings

Quarterly meetings

Reporting Process and Schedules

EMNODN Data Analyst will send list of Badger identifiers to each neonatal unit one month in advance of the meeting. The identifiers will be for all hospitals within the hub where care was delivered, not just the hospital at which the baby died.

Each unit is expected to bring Perinatal Mortality Review Group (PMRT) findings to the meeting so that learning can be collated with the Badger identifier.

		To be discussed at:	
Quarter	**Months**	**North Hub meeting**	**South Hub meeting**
Q4	Oct, Nov, Dec (previous year)	March	April
Q1	Jan, Feb, Mar	June	July
Q2	April, May, June	September	October
Q3	July, Aug, Sept	December	January

Where an infant has died within 48 hours of transfer the badger identifiers will also be sent to CenTre Neonatal Transport so that the transport episode can be reviewed and discussed at the meeting.

Occasionally following discussion of the case at the EMNODN mortality Oversight Group it will be decided that a further round table case review meeting is required involving CenTre Neonatal Transport – the findings of this will feed back into the EMNDON Clinical Governance Group and future Mortality Oversight Group meetings.

Information Sharing

The Oversight Group members will not disclose data regarding the neonates under discussion that is personally identifiable.

Should any points arise from discussion that requires feedback to parents, this will be undertaken by the appropriate clinician in the Trust in which the baby was cared for. Equally, parents requesting feedback should receive it from the same source.

For babies who move across the region, between hubs or out of network, a formal round table meeting should be arranged to enable review of the whole care episode, if concerns are raised through the mortality review process.

The Chair

The Chair of the group will be EMNODN Clinical Lead (north or south hub respectively)

Role of the Chair is to -

1) Ensure engagement of Trust representatives at Oversight Group meetings
2) Coordinate discussions and promote an open dialogue
3) Ensure group clarity regarding discussions and any resulting actions

In the absence of the chair, a nominated deputy may take that role

It is not the role of the chair to feedback to parents.

Outputs

1) A quarterly report of neonatal deaths within EMNODN to be presented to the Network Clinical Governance Group
2) A quarterly report of learning distributed to all units in the form of a bulletin
3) Form an understanding from national reports of our comparison across other networks and support investigation as required
4) An overarching report of recurrent themes will be produced every 2 years

Date ratified: January 2021

Date to be reviewed: January 2023