East Midlands
Neonatal Operational Delivery Network

Terms of Reference

East Midlands Neonatal Operational Delivery Network (EMNODN) Mortality Oversight Group

The EMNODN governance framework includes a responsibility to have oversight of the neonatal deaths within the region. The EMNODN aims to provide support to the providers and to give assurance to commissioning teams around the review process which is in place for all neonatal deaths across the East Midlands.

Local providers remain responsible for the review and reporting of the care provided to babies who have died and for giving assurance to the Trust Boards about their neonatal mortality rates. There are a number of national reporting requirements for all neonatal deaths and whilst the EMNODN offer support and guidance to providers regarding their responsibilities, it is up to them to adhere to all national requirements. In addition to any recommendations that may arise from national reporting, the EMNODN produces a Mortality Learning Bulletin which is distributed across the Network.

Purpose
This document aims to describe and illustrate the process for mortality reporting and review across the EMNODN. This will include the EMNODN Mortality Oversight Group meeting Terms of Reference, monitoring and tracking responsibilities, and an understanding of how themes and learning will be identified and disseminated.

Membership and Scope of the EMNODN Mortality Oversight Group

Core Membership of the EMNODN Mortality Oversight Group
The membership of the group incorporates the following:

1) Chair – Network Clinical Lead
2) Mortality lead (or nominated deputy) from all units within EMNODN (neonatal)
3) Obstetric or midwifery representation from each Trust
4) Representative from the Midlands Perinatal Network
5) Network Management Team representation
6) CenTre Neonatal Transport Service representative
7) CDOP representation from each aligned CDOP
8) LMNS representation from each Integrated Care System

The membership of the group is not exclusive, and other members may be co-opted to join as required.

The Chair
The Chair of the group will be one of the EMNODN Clinical Leads.

The role of the Chair is to:

1. Ensure engagement of the Trust representatives at Mortality Oversight Group meetings
2. Coordinate discussions and promote an open dialogue
3. Ensure group clarity regarding discussions and any resulting actions
4. To identify key learning points for dissemination to the wider Network group

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

Interested Parties for whom attendance is welcomed:
1. Obstetric/midwifery representation from East Midlands Perinatal team
2. Risk managers
3. Medical Examiners

In order to ensure externality, the meeting shall be quorate if there is:
1. Representation from at least one tertiary service if the chair is not an employee of the same tertiary service
2. Representation from 60% of Trusts within the EMNODN
3. LMNS representation from at least 1 LMNS
4. Obstetric/midwifery representation from at least 1 Trust (this should be different from the LMNS representation)
5. CDOP representation from at least 1 CDOP
6. A member of the EMNODN Senior Management Team

Membership Responsibility
The responsibilities of the Oversight Group members will be –

1. To engage with Oversight Group representatives within the other Trusts to facilitate information gathering from services that were previously involved in the care of the neonate i.e., where transfer between units has occurred.
2. Anonymised information sharing and case presentations on the day at the Mortality Oversight Group meetings.
3. The Trust representative will feedback into the Trust processes to ensure that learning is disseminated.
4. Scrutiny of all cases shared including those which are not proposed for wider discussion. Where individuals have questions about cases not proposed for discussion at the MOG meeting, they should contact the Network Clinical Leads to propose that they be considered for inclusion.
5. To identify and convey learning points internally within their own Trusts, to the appropriate Networks, and to the local CDOPs and LMNSs.
6. It is beyond the remit of this group to review the maternal aspects of care in detail, but any concerns, learning or excellence highlighted, will be fed back to individual trusts, LMNS's and the Midlands Perinatal Network for further investigation and dissemination.

Meeting Frequency
Bimonthly meetings

Provider Trust Mortality Reporting Responsibilities

National Requirements
There are a number of national neonatal mortality reporting requirements which all providers must adhere to:

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

• Early neonatal death:
  A live born baby (born at 20+ 0weeks gestational age, or later, or with a birthweight of 400g or more, where an accurate estimate of gestation is not available), who died before 7 completed days after birth.
• Late neonatal death:
  A live born baby (born at 20+0weeks gestational age or later, or with a birthweight of 400g or more, where an accurate estimate of gestation is not available), who died from 7 completed days after birth, but before 28 completed days after birth.

PMRT *- Perinatal Mortality Review Tool*
Supports standardised perinatal mortality reviews across maternity and neonatal units ensuring a systematic, multidisciplinary, high-quality review of the circumstances and care leading up to and surrounding the neonatal death.

Mortality Outlier Response
• All perinatal deaths from 22+0 days gestation, until 28 days after birth excluding termination of pregnancy and those with a birth weight >500g if the gestation at birth is not known.

HSIB *- Healthcare Safety Investigation Branch*
• Term deliveries (≥37+0 completed weeks of gestation) following labour which resulted in early neonatal death: when the baby died within the first week of life (i.e., days 0–6) due to any cause.

NHS-R *– NHS Resolution*
• Term deliveries (≥37+0 completed weeks of gestation) following labour which resulted in early neonatal death: when the baby died within the first week of life (i.e., days 0–6) due to any cause.

EBC *– Each Baby Counts*
• Term deliveries (≥37+0 completed weeks of gestation), following labour that resulted in early neonatal death: when the baby died within the first week of life (i.e., days 0–6) due to any cause.

CDOP *– Child Death Overview panel*
• All deaths occurring within the Trusts own neonatal service. All trusts should ensure reporting is carried out in line with national requirements and should access support if they require any additional information regarding this.

EMNODN Identification of Deaths for Mortality Oversight Group:

Neonatal unit deaths or where death occurs on a transfer between units.
All deaths occurring on any neonatal unit or after transfer between units within the EMNODN should be captured via the Badgernet system, and the outcome should be coded accordingly. The EMNODN data analyst records all deaths on a tracker spreadsheet. The

details of deaths are provided to Trust neonatal mortality leads one month prior to the Mortality Oversight Group (MOG) meeting date.

The Badger ID in these cases will be sent to the Provider Trust where the death occurred requesting a copy of the anonymised completed. If the baby has been cared for within another neonatal service during its life or has been transferred by the CenTre Transport Service to another unit within 24 hours preceding the death, those services will also be asked to provide anonymised background PMRT data. All reports will then be sent through for review by the EMNODN clinical team by the requested date.

Delivery Suite Deaths

Deaths occurring on the delivery suite prior to admission to the neonatal unit but having received neonatal resuscitation should be entered on the Badgernet system utilising the Badgernet short admission form. The EMNODN data analyst will send through details of these cases a month prior to the MOG meeting date. Badger ID will be sent to the provider as above and reviews will be requested by providers in the same way as the neonatal unit deaths, with requests to provide anonymised PMRT data.

PICU Deaths

Deaths occurring where the baby has been transferred directly from a neonatal unit to a PICU service and never discharged to a paediatric ward or to their home address will be reviewed through the EMNODN mortality process. Paediatric services should inform the neonatal unit of the death and the final neonatal outcome on BadgerNet should be updated to reflect this. Mortality background requests will be sent to all neonatal providers involved in the infant's neonatal journey. Anonymised PICU discharge summaries will be requested by the referring neonatal unit for completion of the anonymised PMRT data as in previous scenarios.

Hospice Deaths

There is a national drive to improve end of life care, and to offer families choice regarding place of death. It may be that occasionally a baby is discharged from a neonatal service to a hospice or to the home with home care support at this difficult time. This does not mean lessons regarding the care of the infant on the neonatal unit should not be reviewed and shared. The EMNODN data analyst will pick up cases of deaths at a hospice or with the home care team where the final outcome is recorded as death on the BadgerNet system. Only the care at the neonatal provider shall be reviewed by the MOG.

Process for Mortality Oversight Group Review

A flow chart to describe the EMNODN mortality review process is illustrated below.

Following receipt of all MOG proforma submissions as described above, the EMNODN data analyst and EMNODN deputy lead nurse for QI/EMNODN lead nurse will collate the reviews and share them with the EMNODN Clinical leads. Providers will be asked in the first instance if there are specific cases that they feel require more detailed review at MOG due to locally identified issues. Prior to the MOG meeting the EMNODN Clinical leads and the EMNODN deputy lead nurse/EMNODN lead nurse will meet to review each case. Any cases deemed necessary to discuss at the MOG meeting will be presented by the providers and discussed to share learning for the wider Network teams. Those cases where no learning is identified will be shared with the agenda but will not be discussed in the meeting. Instead, all MOG attendees will have the opportunity to see a copy of anonymised PMRT reports prior to the meeting and can take the opportunity to raise any issues with any of the cases. All cases not requiring further discussion at MOG will be tracked on the EMNODN mortality tracker and closed.

For deaths that do require presenting at MOG, discussion comments will be documented, and learning identified. These deaths will also be tracked on the EMNODN mortality tracker and closed when all reviews are complete, and a grading of care has been agreed by MOG members. Any cases where issues are identified by the local provider, or by other members of the MOG during the meeting, and where a further review is recommended, will have the discussion documented. The case will remain open on the tracker until further information is provided and/or an additional review is complete, and the MOG members are satisfied that all learning has been identified. All learning from completed MOG reviews will then be shared with the Group and wider Network members via the Mortality Learning Bulletin. Any outstanding actions will be documented on an action log and reviewed at each meeting until complete.

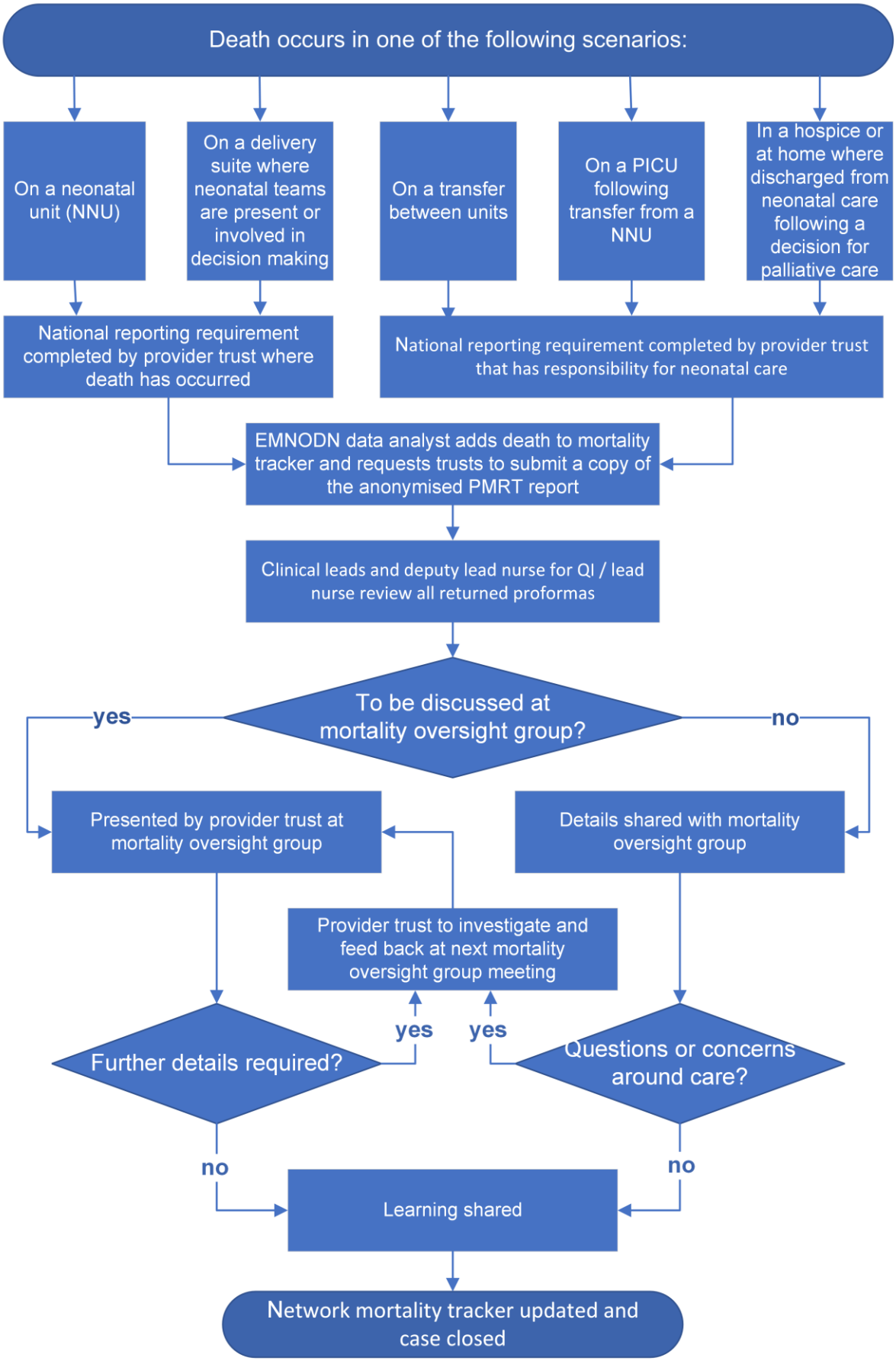
Monitoring

A quarterly mortality summary is presented to the EMNODN Clinical Governance Group with details of any themes or learning which has been identified through MOG. Any areas of quality improvement which are identified will be supported by MOG and the wider EMNODN team.

The EMNODN review Network mortality figures via the dashboard at both Senior Management Team meetings, and LMNS Neonatal Steering Group (NSG) meetings. Mortality data from both the dashboard and via MOG is included in the quarterly governance reports and shared with the EMNODN Board. Where neonatal mortality data is either flagged as an outlier through MBRRACE, or a negative trend is identified within a particular provider Trust, i.e, through MOG or through the EMNODN Senior Management Team, this will be escalated to the provider Trust and a local review and report may be requested to understand any learning or any local requirements for further investigation.

Date ratified: December 2023

Date to be reviewed: December 2025


Death occurs in one of the following scenarios:
On a neonatal unit (NNU)
On a delivery suite where neonatal teams are present or involved in decision making
On a transfer between units
On a PICU following transfer from a NNU
In a hospice or at home where discharged from neonatal care following a decision for palliative care
National reporting requirement completed by provider trust where death has occurred
National reporting requirement completed by provider trust that has responsibility for neonatal care
EMNODN data analyst adds death to mortality tracker and requests trusts to submit a copy of the anonymised PMRT report
Clinical leads and deputy lead nurse for QI / lead nurse review all returned proformas
To be discussed at mortality oversight group?
yes
no
Presented by provider trust at mortality oversight group
Details shared with mortality oversight group
Provider trust to investigate and feed back at next mortality oversight group meeting
Further details required?
Questions or concerns around care?
yes
yes
no
no
Learning shared
Network mortality tracker updated and case closed