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N.B This governance framework supersedes the previous guideline “NWNODN Guideline for exception and mortality reporting” and STR-ODN-01 North West Neonatal Operational Delivery Network Risk Management Strategy.
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Introduction:
The North West Neonatal Operational Delivery Network (NWNODN) encompasses three localities: Greater Manchester, Cheshire and Merseyside and Lancashire and South Cumbria. Across the North West there are 22 neonatal care providers including 7 Neonatal Intensive Care Units (NICU), 1 Neonatal Surgical Unit (NNSU), 12 Local Neonatal Units (LNU) and 2 Special Care Units (SCU). In addition there is one neonatal transport provider, Connect North West (CNW), which provides safe transfer of premature and sick infants across the North West. The guiding principle of all providers within the NWNODN is to provide safe, effective care of the highest standard to babies and families.

In order for the NWNODN to achieve its four key success factors:
- improved access to and egress to/from services at the right time
- improved operating consistency
- improved outcomes
- increased productivity
A clear governance structure is in place to support its function.

Purpose:
This document will describe all elements of the NWNODN governance offer, providing detail of the governance structure within the NWNODN team as well as the governance support offered across the North West (NW) to neonatal providers. This document aims to provide assurance to those involved in the provision of neonatal services across the NW that the NWNODN supports and monitors areas of neonatal care which may affect patient flows, adherence to national service specification and have an impact on the patients and family experiencing neonatal care.

NWNODN Governance Structure:
The NWNODN is a mature network commissioned by NHS England and the governance structure within the NWNODN reflects this maturity. The structure set out in Figure 1 demonstrates how all work is overseen at the highest level by the NWNODN Board but the layers underneath this lead to a well-managed local and network wide service ensuring exceptions escalated to Board have been both locally reviewed and network level reviewed by the senior management team before the Board is required to act.
Quarterly governance reports are produced with a summary of all governance activity across the NWNODN described. These reports are shared with providers via Neonatal Steering Groups (NSG), reviewed by the wider network team at Senior Management Team (SMT) meetings and are available for information to the NWNODN Board ensuring any areas of concerns are highlighted and any shared learning is recorded and disseminated.

Clinical Effectiveness Groups (CEG):

The clinical effectiveness groups are held across the three localities on a quarterly basis. Attendees include the lead nurse and medical representative for governance from each of the neonatal providers in that locality. The meetings are chaired by the ODN Clinical Lead for that locality and supported by the NWNODN governance lead nurse. There are terms of reference available for each locality meeting and these describe providers’ responsibilities and attendance requirements. Attendance is supported within the network Memorandum of Understanding for all providers and there are high levels of engagement demonstrated.

The meetings require the submission of provider reports of their local risk management issues including the number of reported incidents and a description of any of those which were identified as high risk. High risk incidents are discussed with a focus on any learning identified. The sharing of this learning ensures high level risks are identified and the potential for a reduction in the risk of a repeat incident is reduced not only to the local provider but across multiple providers.

Providers are also required to submit mortality reviews of all infants that die within their service. Local mortality reviews are peer reviewed at CEG meetings with a focus on any
learning identified to be shared across the other providers. Further detail of the NWNODN role in mortality reviews is described in the governance reviews section of this document.

Whilst providers submit reports into the NWNODN CEG meetings the responsibility of the management of clinical incidents and mortality reviews remains with the provider organisation. The role of the NWNODN is oversight of these reviews in order to share learning and identify themes which may lead to further work to support improvement.

In addition to provider reports CEG focuses on identifying and supporting other areas of quality improvement identified through themes, such as the creation of guidelines or the support of audits. National and local alerts are shared via these meetings and actions discussed as a locality rather than individual provider responses ensuring services can support each other. Support is offered by the NWNODN with the implementation of national frameworks for practice or new governance initiatives by sharing information and disseminating latest news regarding initiatives to keep all providers up to date.

A meeting log is maintained for each CEG meeting ensuring the learning and decisions made within a meeting are captured. Attendees are reminded that the learning page of the log is to be shared locally at their governance meetings to disseminate learning wider than those that attend CEG. Locality lead educators are encouraged to access the CEG learning log to support locality wide education priorities.

The benefit of the NWNODN governance lead nurse supporting all three locality CEG meetings is that learning is shared not only across the locality but across the North West.

**Governance reviews:**
There are a number of mechanisms the NWNODN offer to support governance reviews, all of which are supported by a separate process document describing the identification of a case for review and actions required to support the review process.

**Mortality:**
For further detail of the process behind these reviews please see document PD-ODN-05 mortality process.

All mortalities occurring on neonatal units across the NW are tracked by the NWNODN. These mortalities should all be reviewed locally utilising the Perinatal Mortality Review Tool (PMRT) or if out with this criteria via a local review process. Following local review mortalities are then shared at CEG and those with learning identified are discussed in more detail at the meeting to ensure all learning has been identified and any additional clinical
practice points are raised. At this time the grade of care is agreed by those present at CEG and the case is closed on the NWNODN mortality tracker.

The NWNODN mortality tracker maintains a record of some key aspects of each death and is able to pull data and themes in more detail from the deaths across the North West, supporting learning and quality improvement.

The NWNODN links to the majority of Child Death Overview Panels (CDOP) across the North West. The CDOP leads have observed the additional layer of peer review the CEG meetings offer and request that the NWNODN CEG mortality submissions be shared with CDOP. In addition to the deaths identified through the Badgernet system, by linking with the CDOP we are able to identify deaths on delivery suite, deaths in hospice when transferred from the neonatal unit and deaths on Paediatric Intensive Care Unit (PICU) at Alder Hey where an infant was cared for in the neonatal unit and transferred to PICU for continuing care or for surgery. This triangulation of deaths from different sources enhances the overview the NWNODN have of deaths associated with a neonatal journey across the NW.

If on review of any death at CEG the group feels the case requires additional review either because of issues identified or a complex case with multiple providers involved either an independent review or multi-provider review can be requested. The case remains open to CEG and any learning following the more in-depth review is then shared when complete.

**Independent Reviews:**
For further detail of the process behind these reviews please see document PD-ODN-01 Independent review.

The NWNODN Independent Review process offers providers support with an independent review of a case occurring within their unit. This may be case resulting in a death or just a clinical case where care provided requires review and learning to be identified in a supportive setting. The NWNODN co-ordinates the review, identifying appropriate members of a review panel, pulling together a report with details of the case and then facilitating the review meeting to ensure the case is discussed and learning identified. A report of the independent review is then compiled by the NWNODN and this details learning and actions for both the individual provider and for the NWNODN.

Learning and actions from the review report are then shared as part of the NWNODN quarterly governance reports and feedback through CEG.
Multi-Provider Reviews:
For further detail of the process behind these reviews please see document PD-ODN-02 Multi-Provider review.

Due to the nature of neonatal care many babies require transfer between different providers during their neonatal journey. It may be the case that a baby requires more than one transfer and may receive care from multiple different level neonatal units and the transport team. In such cases where there may be elements of the journey where learning is identified a multi-provider review may be requested by any provider involved in the care or if the case results in deaths when the case is peer reviewed at CEG.

The NWNODN supports the multi-provider reviews in the same way as the independent review and writes up a report containing learning and actions for all providers involved and potentially the NWNODN.

Learning and actions from the review report are then shared as part of the NWNODN quarterly governance reports and feedback through CEG.

Reporting:
Such is the level of engagement the NWNODN team have with the providers across the NW, lead medical and nursing colleagues are aware they are able to discuss any local issues or concerns with the lead nurse for their locality and support will be offered. Formal reporting via the NWNODN is also available in the following areas.

Incident reporting:
For further detail of the process behind this reporting mechanism please see document PD-ODN-03 Clinical Incident reporting.

A mechanism exists within the NWNODN to facilitate the reporting of clinical incidents which may occur in one neonatal provider but be identified by another provider caring for the baby. These incidents can include failure to communicate, failure to adhere to agreed pathways, delays in transfer and clinical care issues. By facilitating the reporting of these incidents from one provider to another via the NWNODN the provider can enhance their local risk management by receiving information and acting on issues highlighted by another provider. It also allows the NWNODN to have a view of these incidents and to identify themes and learning, particularly around the adherence to pathways and any blocks to transfer. These incident themes can then influence any quality improvement work the NWNODN may choose to undertake as well allow the NWNODN to support local learning.
All clinical incidents that come via the NWNODN are tracked and learning and themes are reported through the quarterly governance reports.

**Exception Reporting:**
For further detail of the guideline describing the exception reporting mechanism please see document GL-ODN-01 Exception reporting.

The Neonatal Service Specification provides clear guidance regarding the care to be provided in all levels of neonatal units. Care provided within LNUs and SCUs outside of that described within the service specification is exception reported on a weekly basis. This process is managed within the NWNODN and exception report requests are sent to local providers to respond to any exceptions to service specification identified within their service in the previous week. The exception form response is then reviewed by the locality lead nurse to confirm this was an exception and what the local review has found. If necessary the lead nurse may escalate to the locality clinical lead to ensure appropriate management was offered.

All exceptions are tracked by the NWNODN and locality quarterly exception summaries are shared at the NSG meetings with learning identified. An exceptions summary is included within the NWNODN quarterly governance reports.

Cases of infants <27/40 born outside of an NICU are also shared with nominated maternity colleagues within the LNU/SCU setting. Reviews of these exceptions are then carried out by both maternity and neonatal services and learning shared. This information is then shared via the maternity systems in the three localities.

Exception reporting allows the NWNODN to track adherence to service specification for all units and explain any areas of care offered outside of this. This offers assurance to the NWNODN Board and specialised commissioning that the right level of care is occurring in the right place.

**Escalation:**
For further detail of the guideline describing the escalation process within the NWNODN please see document GL-ODN-04 Escalation Guideline.

Part of the NWNODN function is to ensure capacity and flow of patients is managed to allow neonatal care to be offered to families within the NW region. The escalation guideline offers clear guidance on what should be escalated to the NWNODN relating to impact on neonatal care provision. This includes infection prevention outbreaks, estates issues and
staffing concerns. The NWNODN are made aware when the capacity in any unit is impacted and then has a responsibility to respond to this by understanding capacity across the region. Local provider adherence to this escalation guideline supports the continued high standards of care being offered to NW families.

Escalation of any clinical incident to a serious incident (SI) within a provider trust leading to a StEIS report being entered to the CCG requires notification to the NWNODN. StEIS reports are viewed by commissioners and the NWNODN are then required to provide assurance to commissioners regarding the incident and the safety of the neonatal service. Escalation of StEIS reportable incidents can be escalated to the NWNODN via email to the lead nurses.

**Risk Register:**
The NWNODN risk register is maintained on the NWNODN’s host trust risk system and contains risks associated with the NWNODN team, funding and work programme.

Changes to the NWNODN risk register are highlighted within the quarterly governance report.

High level risks associated with the Connect North West transport service are documented within the quarterly governance report and discussed at transport steering group with the host trust of CNW, the NWNODN and specialised commissioning present.

Any high level risks from either the NWNODN or CNW requiring action to mitigate are highlighted to the NWNODN Board and appropriate action requested.