Title:	North West Neonatal Operational Delivery Network Independent Review Process
Reference number	PD-0DN-01
Main Author (s)	Kelly Harvey
Target Audience	All Local Neonatal Units within the North West Neonatal Operational Delivery Network
Ratified by:	SMT
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North West Neonatal Operational Delivery Network

Independent Review Process

1. Introduction
   The North West Neonatal Operational Delivery Network (NWNODN) encompasses three localities: Greater Manchester, Cheshire and Mersey and Lancashire and South Cumbria. The guiding principle of all providers within the NWNODN is to provide safe, effective care of the highest standard to babies and families.

   Governance processes within the NWNODN require all neonatal high-level incidents and mortalities to be internally reviewed by individual providers. Following this review the provider reports high level incidents and mortality summaries to their locality Clinical Effectiveness Group (CEG), sharing lessons learnt. If an incident or mortality is identified as resulting in avoidable harm and the internal review has not produced appropriate actions or lessons learnt the CEG members, the locality clinical lead or the NWNODN may request an independent review.

2. Purpose
   Describe and illustrate a process for independent review of clinical cases within the NWNODN.

3. Scope
   Applies to all providers of neonatal care in the North West Neonatal Operational Delivery Network.

4. Responsibilities
   4.1. Providers:
   - To engage with NWNODN governance process and highlight any incidents/mortalities that would benefit from an independent review.
   - Fully engage with the process of the independent review
   - On request of the NWNODN form part of an independent review panel.
   - Provide requested information within set timeframes for the independent review.

   4.2. Connect North West (CNW):
   - To engage with NWNODN governance process and highlight any incidents/mortalities that would benefit from Independent review.
   - Fully engage with the process of the independent review if CNW were a part of that infant's neonatal journey.
   - On request of the NWNODN participate as part of the independent review panel.
   - Provide transport expertise as part of an independent review if another transport service was involved in a case for review.

   4.3. NWNODN Team:
   - Support individual providers to contribute to the NWNODN governance process.
   - Engage with providers outside the NW if involved in the care of a baby to involve them in the review.
   - Facilitate and manage the independent review process when requested by an individual provider or by clinical lead via CEG.
   - Document independent review and share lessons learnt across the NWNODN.

5. Independent Review Criteria:
    - Any incident/mortality identified by an individual provider as requiring an independent review. No specific criteria has been set however if within internal review a requirement for further review is identified, any individual provider can request NWNODN support with an independent review of a case.
    - Any incident/mortality identified by locality clinical lead via CEG as requiring an independent review.
    - Any incident/mortality identified by NWNODN or NHSE as requiring an independent review.

6. Information required for independent review:
    - PMRT report if available.
    - Internal governance/mortality review paperwork including timeline where applicable from each provider involved in the neonate's journey including transport services.
    - CEG submissions.
    - Confirmation of additional reporting undertaken (StEIS, MHRA, NPSA).
    - Details of any RCA/SUI undertaken locally.
    - Case notes will only be reviewed if the required information cannot be obtained from internal reviews submitted.

7. Members of independent review panel and their responsibilities:

The independent review panel would be expected to consist of the following:

Member	Role	Responsibilities
NWNODN	Network Director. Not required at all reviews.	Oversee review process and report to NHSE.
NWNODN QILN	Governance QILN	Information gathering, process monitoring, report writing.
Clinical Lead	Clinical lead should be from alternative locality to that where care took place within the case. If care has taken place within all 3 localities an external clinical lead will be identified from a neighboring ODN.	To provide overall medical expertise on the case.
Lead Nurse	From NICU and/or LNU dependent on providers involved in case.	To provide nursing expertise and review nursing involvement in the case.
Transport	External (Embrace clinical lead) if CNW were part of care provision within the case or CNW if NWTs were part of the care provision.	Provide transport expertise on the case.
Providers	All providers involved in the clinical care of the infant.	To provide additional information required by the independent reviewers. To have the opportunity to contribute to the discussion regarding lessons learnt.

8. Independent review process:

- Flow chart to describe process in Appendix 1.
- NWNODN informed of requirement for independent review.
- Information requested from all parties involved in neonate's care by K. Harvey (Governance QILN for NWNODN).
- Members of independent review panel contacted for availability.
- Meeting date set when all documentation received (minimum 6 weeks' notice).
- Review takes place with all parties present, lessons learnt and recommendations/action point identified.
- NWNODN compile report and identify lessons learnt, recommendations and wider learning.
- Report shared at subsequent locality CEG.
- Report shared with commissioners if reported on the Strategic Executive Information System (StEIS).
- Action points followed up according to timeline by NWNODN and reported back to review panel.
- Any serious concerns identified within an independent review will be escalated appropriately within the organization where issue identified and with commissioners if necessary.

9. References

- NHS England. (2012). Serious Incident Framework: Supporting learning to prevent recurrence: https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

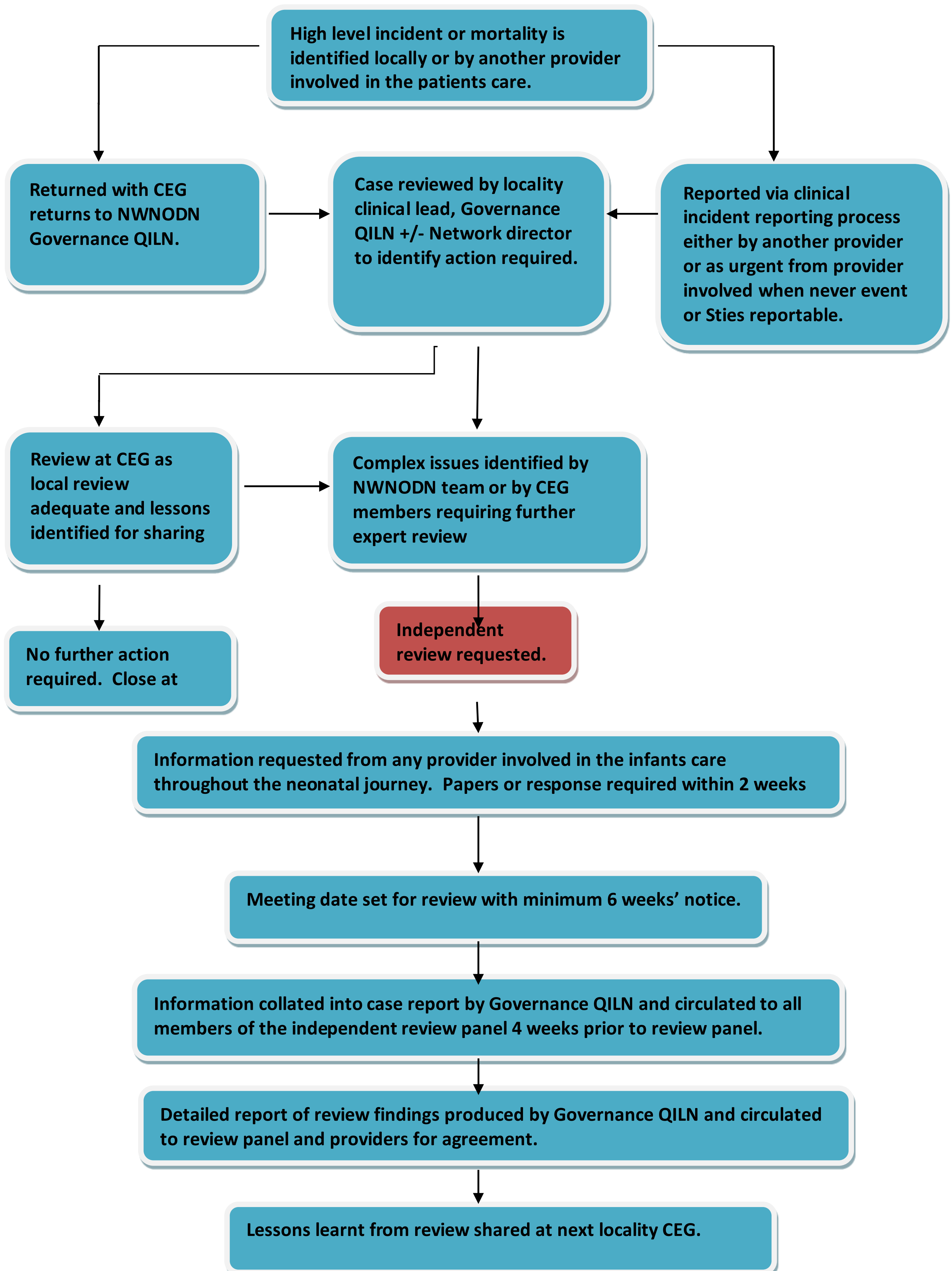
10. Monitoring Systems Monitoring and or Audit

Monitoring and Audit	Frequency	By Whom	Reported to
	Annually	NWNODN Team	SMT & NSGs

11. Equality and Diversity Assessment Box

Equality and Diversity Assessment	**18/05/2018 & 30.9.21**
Impact Assessment Completed by	**K. Harvey**
Date completed	
Relevance Shown	**none**
Action plan completed	
Nominated Lead for Action Plan	
Completed Assessments held by	**North West Operational Delivery Network**

Appendix 1: Independent Review Process.



12. Appendix 2

Proforma for panel member feedback:

Independent
Reviewer Feedback P

13. Appendix 3

Proforma for review meeting/report:

Independent review
report proforma V1.d