North West Neonatal Operational Delivery Network
Mortality Reporting Process

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The North West Neonatal Network (NWNODN) consists of 3 locality neonatal networks, Cheshire and Merseyside (CM) Lancashire and South Cumbria (LSC) and Greater Manchester (GM). This document has been agreed by locality Clinical Effective Groups (CEG) and can be adapted for local use. Please acknowledge source if this document is adapted for local use.

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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.

As part of the NWNODN governance framework the tracking and reviewing of neonatal deaths across the region provides support for providers and assurance to commissioners regarding the review process in place of neonatal deaths across the NW. Local providers remain responsible for the reporting of and local review of neonatal deaths. There are a number of national reporting requirements for all neonatal deaths and whilst the NWNODN offer support and guidance to providers regarding their responsibilities it is up to them to adhere to national requirements. In addition to these reports the NWNODN Clinical Effectiveness group meetings (CEG) offer a peer review of some local mortality reviews to aid the sharing of learning.

Purpose

This document aims to describe and illustrate a process for mortality reporting across the NWNODN. This will include the NWNODN monitoring and tracking responsibilities and an understanding of how themes and learning will be identified and disseminated.

National Requirements

There are a number of national neonatal mortality reporting requirements for all providers to 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

- 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 that resulted in early neonatal death: when the baby died within the first week of life (i.e. days 0–6) of any cause.

NHS-R – NHS Resolution

- 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) of any cause.

CDOP – Child Death Overview panel

- All deaths occurring within your own neonatal service.

All trusts should ensure reporting is carried out in line with national requirements and access support if they require any additional information regarding this.

Any review carried out at NWNODN level should take account of where other national reviews are up to and where possible the NWNODN would encourage the sharing of reports received from HSIB and action plans generated from the PMRT as part of the CEG review submission.

NWNODN Identification of deaths for CEG review:

Neonatal unit deaths

All deaths occurring on any neonatal unit within the NWNODN should be captured via the Badgernet system. The NWNODN data analyst provides a report of all deaths within neonatal services across the NWNODN monthly. Details of the badger ID in these cases will be sent to the provider where the death occurred requesting a CEG review proforma be completed (see appendix 1).

If the baby has been cared for within another NW neonatal service within its life the unit involved will be requested to provide background mortality review on a CEG proforma (see appendix 2). In an event where CNW are either in attendance and the transfer deemed not to be in the baby's best interest or a death has occurred within 6 hours post transfer CNW will also provide a mortality background in accordance with CNW processes. All reports will then be sent through for review by the requested date.

Delivery Suite Deaths

Liveborn but not admitted deaths occurring on delivery suite down to, and including 22 weeks gestation prior to admission having a neonatal presence or received neonatal resuscitation should be entered on Badgernet utilising the Badgernet short admission form as per NNAP 2023 (see appendix 3). The NWNODN data analyst will send through details of these cases on a monthly basis and reviews will be requested by providers in the same way as neonatal unit deaths with requests to complete a delivery suite death proforma for CEG (See appendix 4).

PICU Deaths

Deaths occurring at Alder Hey PICU where the baby has been transferred directly from a neonatal unit and never discharged to a paediatric ward or home may benefit a CEG review. The NWNODN governance lead nurse will liaise with the PICU mortality lead to identify eligible cases. Mortality background requests will be sent to all neonatal providers involved in the infant's neonatal journey. Both background details and PICU mortality meeting details will be reviewed together for CEG.

Hospice Deaths

There is a national drive to improve end of life care and to offer families choice regarding place of death. When a baby is transferred directly from a neonatal unit to a hospice for EOL care, any lessons learnt from the case should be shared. These cases will be identified through the NWNODN data analyst within the monthly data report and a mortality background request form will be requested from the neonatal provider involved. Only cases where death occurs 1 week following transfer will be reviewed and only the care at the neonatal providers will be considered. The NWNODN links with CDOP across the NW and on occasions mortality may be identified through this process, where this is identified these cases will be CEG reviewed.

Process for Mortality Review

A flow chart to describe the NWNODN mortality review process is illustrated in appendix 5.

Following receipt of all mortality submissions as described above, the NWNODN administration team upload the PMRT reports to the locality teams channel. This offers CEG group members a pre-meet preview of the reports and an opportunity to raise any issues with any of the cases at the meeting. Further to this, the Clinical lead and the governance lead nurse will collaborate and highlight any cases for discussion, these will be presented by the providers focussing on the learning. Those cases where no learning is identified are shared via the teams channel but will not be discussed within CEG, unless, there has been no external neonatal reviewer present at the local PMRT meeting. Providers will be asked in the first instance if there are specific cases they feel require a more detailed review at CEG due to locally identified issues. Those cases not further discussed at CEG will be tracked on the NWNODN mortality tracker and closed.

Deaths further discussed at CEG will be documented on the CEG meeting log with comments regarding discussion and learning identified. These deaths will also be tracked on the NWNODN mortality tracker and closed when all reviews are complete and a grading of care is agreed by CEG members.

Issues identified by the local provider or by other members of the CEG meeting where a further review is recommended, such as a NWNODN multi-provider review (MPR) or a NWNODN independent review (IR), will be documented as such on the meeting log. The death shall be left open on the mortality tracker until the additional review is complete.

Following the completion of either an MPR or IR a report is collated with action. This report will be shared with CEG for learning. For further details of the MPR or IR process see NWNODN documents PD-ODN-01 and PD-ODN-02.

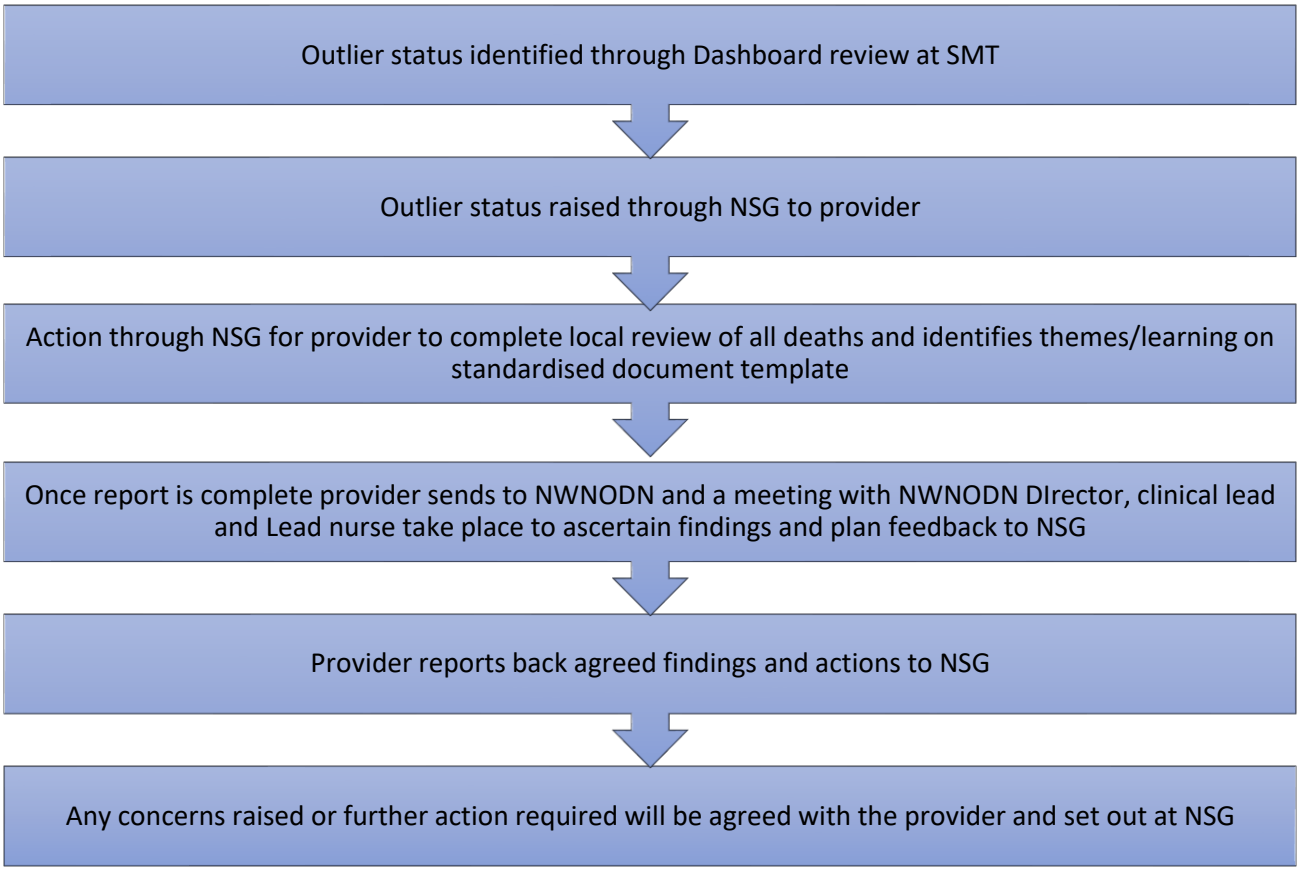
All CEG mortality reviews completed will then be shared with CDOP as requested. The CDOP administrators send through details of all deaths involving neonatal care to the NWNODN governance Lead Nurse and through non-identifiable details the deaths are cross matched to the NWNODN mortality tracker. Once the CEG review is complete the report with comments from the CEG meeting are sent over to the CDOP team and are included in papers for CDOP meetings.

Monitoring

A quarterly mortality summary is presented to NSG with details of any themes or learning identified through CEG and any areas of quality improvement identified will be supported by CEG and the wider NWNODN team.

The NWNODN review mortality figures through the dashboard at both Senior Management Team meetings and Neonatal Steering Group (NSG) meetings. Mortality data from both the dashboard and via CEG is included in the quarterly governance reports shared via NWNODN Board and locality steering groups.

Flag identified as per the **Flags Support Document 202223 Final.pdf** for neonatal mortality within a provider will be escalated via NSG to the provider. A local review and report back to NSG will then be requested to understand any learning or local requirement for further investigation. A guide for reporting back local review will be shared with a provider with local data when identified as an outlier and a copy of this structure is available in Appendix 6.


Outlier status identified through Dashboard review at SMT
Outlier status raised through NSG to provider
Action through NSG for provider to complete local review of all deaths and identifies themes/learning on standardised document template
Once report is complete provider sends to NWNODN and a meeting with NWNODN DIrector, clinical lead and Lead nurse take place to ascertain findings and plan feedback to NSG
Provider reports back agreed findings and actions to NSG
Any concerns raised or further action required will be agreed with the provider and set out at NSG

Appendix 1: CEG Mortality Reporting Form

Badger ID			**ODN Ref**				**Hospital**		
Gestation			**Birth Weight**				**Age at Death**		
Has this case been accepted for coroners inquest?	**Yes**	**No**	**If yes is the date set?**	**Yes**	**No**	**Date set:**	**Case referred to HSIB?**	**Yes**	**No**
Has a local PMRT been completed?	**Yes**	**No**	**Has baby had a PM?**	**Yes**	**No**	**Was a PM offered?**			

Cause of death on death certificate:	
Death at less than 28 days	**Death at more than 28 days**
a. **b.** **c.** **d.** **e.**	**Ia.** **Ib.** **Ic.** **II.**

Did baby receive delayed cord clamping?		**Admission Temperature:**		**Comments:**	

Golden Hour elements achieved within an hour of birth:	**Tick if achieved:**	**Comments:**
Temperature within range:		
IV Access and fluids running:		
IV Antibiotics administered:		
Blood glucose checked:		

Did baby have a positive blood/CSF culture anytime during admission?	**YES**	**NO**	**If yes give detail of organism and if this was identified as a contaminant.**	
Was baby colonised with any alert organism during their admission:	**Yes**	**No**	**If yes please give detail of organism and if baby cleared this during their stay?**	

Please provide brief highlights of the baby's journey noted from local review:

Please supply a brief summary of lessons learnt locally and those to be shared across the NWNODN.

Please provide details of any excellence noted within this case you would like to share to support learning across the NWNODN:

Grading of care of the baby from birth up to the death of the baby (PMRT).		
Grade A		**No issues with care identified from birth up to the point the baby died.**
Grade B		**Care issues identified which would have made no difference to the outcome for the baby.**
Grade C		**Care issues identified which may have made a difference to the outcome for the**

Appendix 2: CEG Background Mortality Review Form

Badger ID		**ODN Ref**		**Hospital**	
Gestation		**Birth Weight**		**Age at Transfer**	

Please provide brief relevant antenatal and delivery room care details:					
Did baby receive delayed cord clamping?		**If yes for how long?**		**Admission Temperature:**	

Golden Hour elements achieved within an hour of birth:			**Tick if achieved:**	**Comments:**
Temperature within range:				
IV Access and fluids running:				
IV Antibiotics administered:				
Blood glucose checked:				
Did baby have a positive blood/CSF culture anytime during admission?	**YES**	**NO**	**If yes give detail of organism and if this was deemed a contaminant.**	
Was baby colonised with any alert organism during their admission:	**Yes**	**No**	**If yes please give detail of organism and if baby cleared this during their stay?**	

Please provide brief highlights of the baby's journey at your hospital noted from local review:
Please supply a brief summary of lessons learnt locally and those to be shared across the NWNODN.
Please provide details of any excellence noted within this case you would like to share to support learning across the NWNODN:

Grading of care of the baby from birth up to the discharge from your hospital:		
Grade A		**No issues with care identified from birth up to the point the baby died.**
Grade B		**Care issues identified which would have made no difference to the outcome for the baby.**
Grade C		**Care issues identified which may have made a difference to the outcome for the baby.**
Grade D		**Care issues identified which were likely to have made a difference to the outcome for the baby.**
If PMRT review meeting complete please document grading of care (A-D) within the following area		
	Grading of care of the mother and baby up to the point of birth of the baby.	

Appendix 3: Entering a Delivery Suite Death onto Badger

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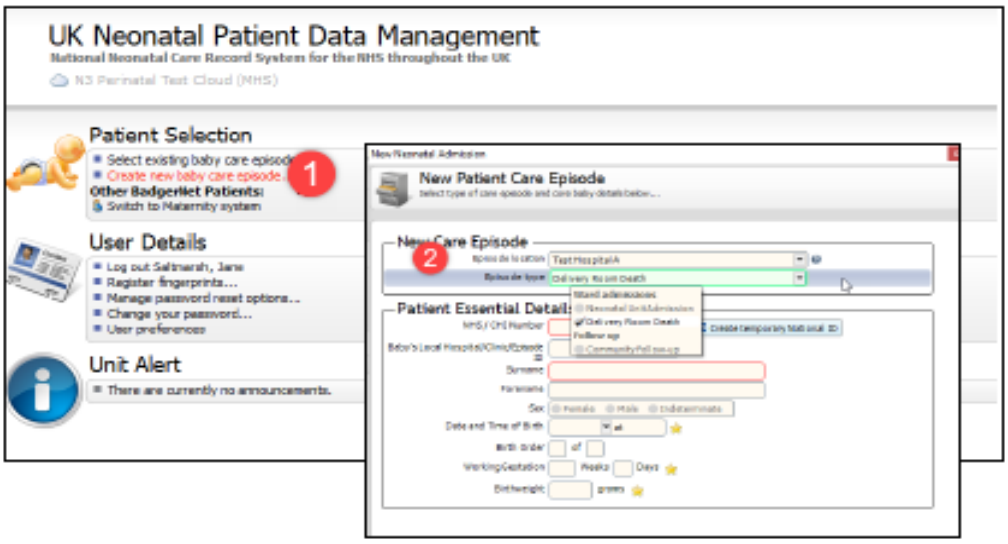
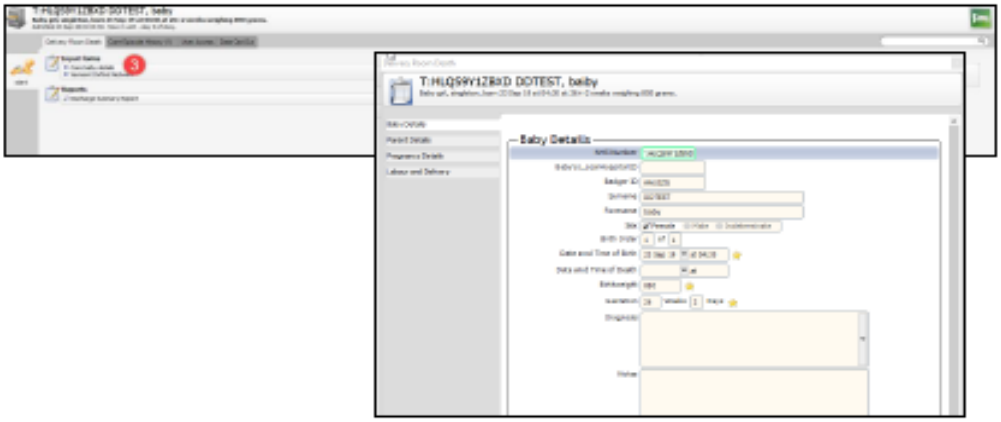
How to record Delivery Room Deaths in the Neonatal BadgerNet System

1. **Select 'Create new baby care episode'**
2. **In 'Episode type' select 'Delivery Room Death' and complete the fields below, Save & Close**



3. **Complete the 'Core baby details' form**



Appendix 4: CEG Delivery Suite Death Review Form

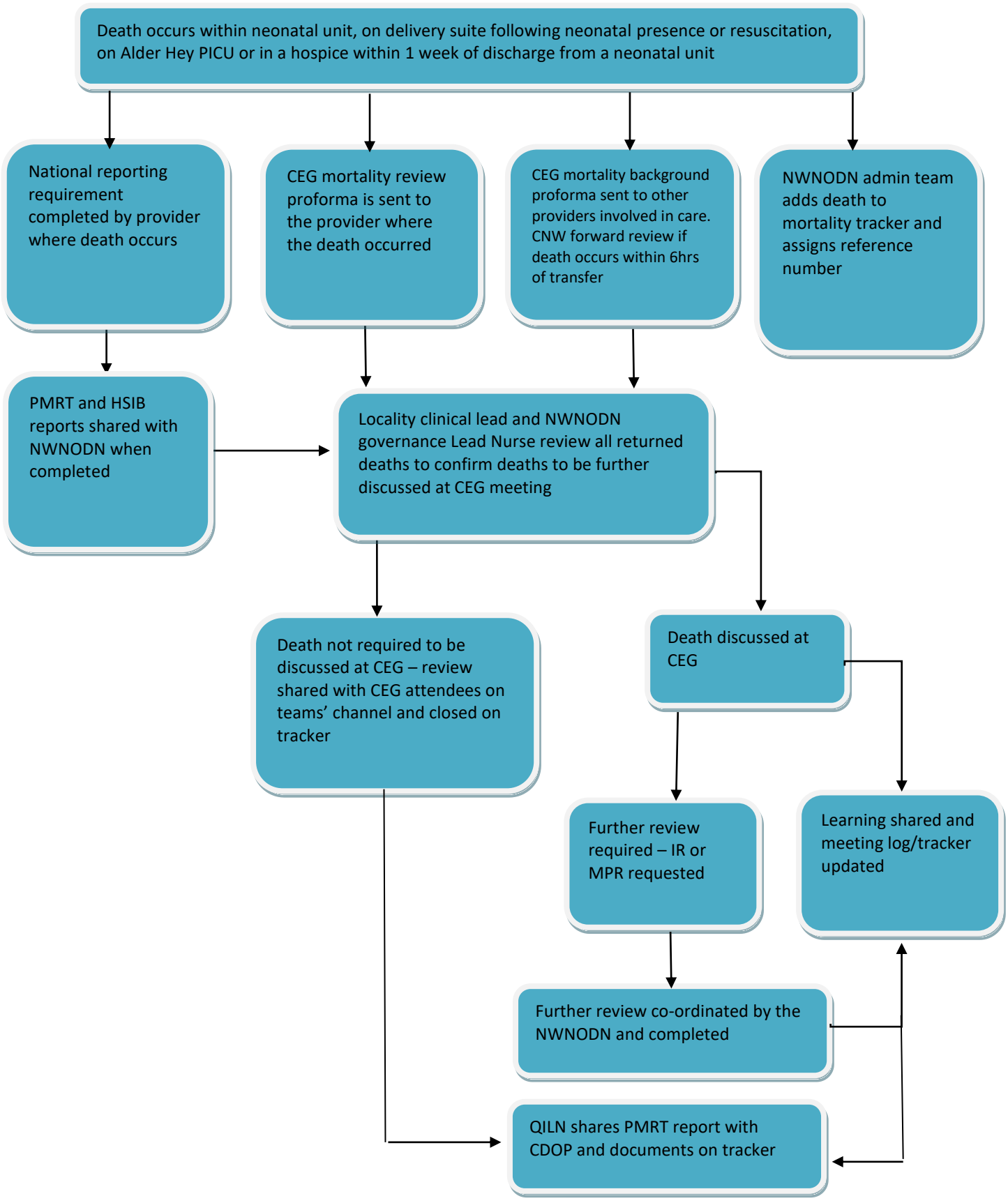
Badger ID			**ODN Ref:**				**Hospital**			
Gestation			**Birth Weight**				**Age at Death**			
Has this case been accepted for coroners inquest?	**Yes**	**No**	**If yes is the date set?**	**Yes**	**No**	**Date set?**	**Has this case been referred to HSIB?**	**Yes**	**No**	
Has a local PMRT been completed?	**Yes**	**No**	**Has baby had a PM?**	**Yes**	**No**	**If no was PM offered but declined?**				

Cause of death on death certificate:
Death at less than 28 days
a. **b.** **c.** **d.** **e.**
Please provide brief details of the management by the neonatal team:
Please supply a brief summary of lessons learnt locally and those to be shared across the NWNODN.
Please provide details of any excellence noted within this case you would like to share to support learning across the NWNODN:

Grading of care of the baby from birth up to the death of the baby (PMRT).		
Grade A		**No issues with care identified from birth up to the point the baby died.**
Grade B		**Care issues identified which would have made no difference to the outcome for the baby.**
Grade C		**Care issues identified which may have made a difference to the outcome for the baby.**
Grade D		**Care issues identified which were likely to have made a difference to the outcome for the baby.**

If PMRT review meeting complete please document grading of care (A-D) within the following 2 areas.	
	Grading of care of the mother and baby up to the point of birth of the baby.
	Grading of bereavement care offered to mother following death.

Appendix 5: Mortality Reporting Process



Appendix 6: Structure for Mortality Outlier response

1. Purpose

The purpose of this document it to support the local provider in responding to a flag raised around mortality by providing a standardised proforma for reporting back through locality Neonatal Steering Group (NSG) findings of the requested local review.

2. Background

Mortality is reviewed in the North West Neonatal Operational Delivery Network (NWNODN) via the Neonatal Dashboard and through the Locality Clinical Effectiveness Groups (CEG).

The Dashboard Flags document https://www.neonatalnetwork.co.uk/nwnodn//wp-content/uploads/2021/08/Flags-Support-Document-2122-Revised-July-21.pdf sets out when a flag will be identified. The NWNODN Mortality reporting process sets out process for monitoring flags and actions required

3. Expectations

When a unit has been identified as an outlier for mortality there is a requirement for a local review of all mortalities to be undertaken.

This review must ensure that a robust local review with external neonatal input and MDT representation has been undertaken in line with PMRT standards.

Any themes identified within the learning from each case should be summarised in section 6.

Any areas of concern identified from this local review should be set out clearly within section 7.

If following local review there is a need identified for further external/independent review to be supported by the NWNODN this should be set out clearly within section 8.

There is an expectation that outlier status and the detail of this review is signed off at directorate level.

Once this report is completed it should be returned to the NWNODN and a meeting set up to discuss the findings with the NWNODN Director, Locality Clinical Lead and Locality lead nurse. This meeting will set out actions for reporting back through NSG.

4. Data

5. Local Review Findings

Please break down local review findings per case using the template table:

Badger ID	Gestation	Birth Weight	Cause of Death	Age at Death	Local review complete	Grade assigned following PMRT	External neonatal representation at local review	Learning identified

Add any narrative relevant to this section here:

6. Themes Identified through Local Review

7. Concerns Identified

8. Next Steps