systematic review of staffing on duty at the time of the deaths and the shift before but this only includes clinical staff, not cleaners and others with access.

4.4.9 The RCPCH review team recommends that the death / near miss reviews process requires further strengthening to involve the risk management team systematically and follow corporate process. All deaths should be raised as an SI, the case reviewed promptly by paediatrician, risk midwife, neonatal nurse and obstetrician and then either stood down or investigated formally. Investigation could be internally or with external input if there are serious concerns. There should be a clear forum for ensuring recommendations are actioned. The decision to stand down a case should also be formally reviewed at the Women's and Children's Governance Board or Quality and Safety and Patient Experience Committee, and a mechanism for informing the CCG of all deaths (perhaps linked to the obstetric reporting) should be identified. This process including the involvement of an external adviser is in line with the recommendations of the RCOG`s `Each Baby Counts` report[10].

Recommendation: Strengthen the response to neonatal death/near miss investigations to normalise the reporting culture, include risk and governance staff, involve a wider group including maternity and external scrutiny demonstrate completion of actions and clarify senior management oversight

4.4.10 The paediatric and neonatal team has worked hard to build and review a large number of practice and system guidelines. They appear to be systematically updated by the consultants, sometimes as a result of situations and incidents with a process monitored by the Divisional Governance meeting, Many of the clinical guidelines reflect NICE guidance, reference APH or Alder Hey or are developed from policies in place at LWH and this should be explicitly encouraged with those relating to stabilisation and transfer clarifying network liaison and governance responsibilities to minimise risk of confusion at handover particularly in an emergency situation. There was some uncertainly over the engagement of nursing staff with guideline development, although joint authorship was noted on some.

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Recommendation: All neonatal guidelines should be developed in conjunction with the network and tertiary service for consistency of care in emergencies.

Data, Activity and risk monitoring

4.4.11 Nurses complete a daily summary on Badger but use paper notes until discharge. Concerns were expressed that the different systems for care, incident and death reporting do not communicate and data differs between them. The Badger neonatal system and the Medictech hospital system appear to have different arrangements for recording and reporting details about term admissions, discharges and infant deaths, and the MBRRACE study requires different data again. This has caused some tension between neonatal and audit/clinical governance staff which needs to be resolved.

[10] See https://www.rcog.org.uk/eachbabycounts