Name of the meeting	North West Neonatal Operational Delivery Network Board Meeting
Date of the meeting	12TH September 2016
Agenda item number	
Title of paper for consideration	Neonatal Mortality at Countess of Chester Hospital (COCH)
Decision required please tick	
Level 1: For information	✓
Level 2: Decision required and individual members are expected to action the outcome through individual organisations	
Level 3: Decision is required binding all members and uses the governance arrangements of the Operational Delivery Network	
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Neonatal Mortality at Countess of Chester Hospital (COCH)

Background

The NW ODN Management Team was alerted by one provider unit, COCH, regarding concerns about the relatively large numbers of neonatal deaths in 2015/16. All neonatal deaths at COCH are the subject of detailed internal reviews in line with the Trust's local governance procedures. The C&M Clinical Lead had previously acted as an external 'reviewer' to provide some oversight of the findings of these mortality reviews conducted in 2015. Although no major deficiencies in care or recurring themes were identified, it was noted that it had not been possible to assign a clear cause of death in some cases despite a post-mortem examination being performed.

Actions

1. COCH has asked the RCPCH to perform an external review of neonatal deaths at the Trust (scheduled for 2/3rd September 2016). The NW ODN will be represented at the review by JM and network data has been offered to the review panel.

2. The ODN Management Team has reviewed mortality rates at COCH and benchmarked them against other ODN local neonatal units (appendix 1). These data show a greater than expected mortality rate at COCH which is approximately 1.5 to 2-fold higher than comparable units. Furthermore, the mortality rate at COCH appears to be rising (appendix 2).

3. Review of nationally collected data from MBRRACE-UK in 2013 and 2014 has not identified COCH as an outlier for neonatal mortality. Data from 2015 will not be available routinely until next year. ODN/locality mortality rates are reviewed annually against published national data from MBRRACE-UK and NDAU.

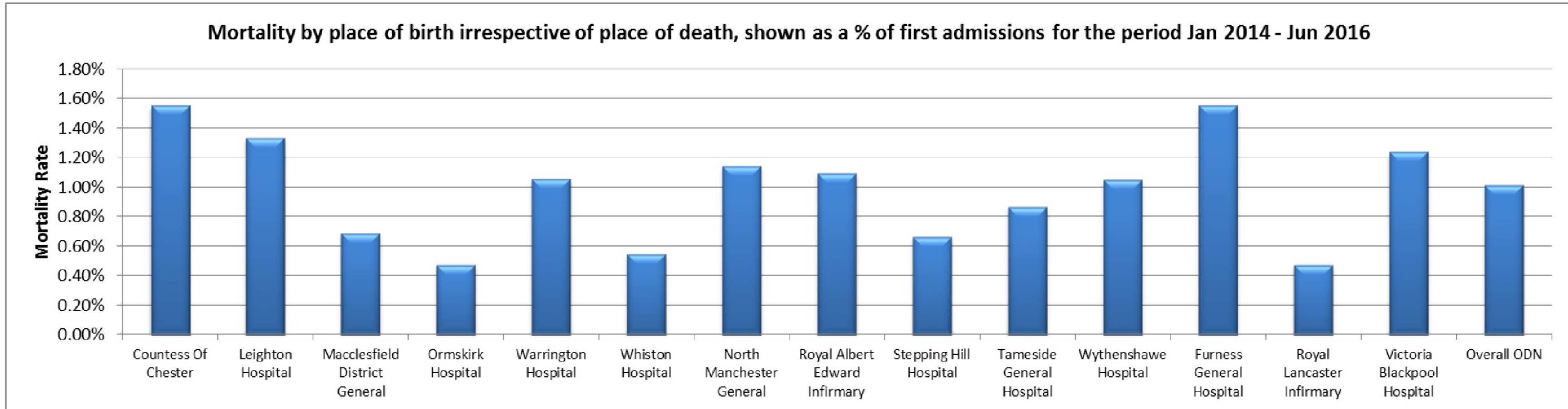
4. The C&M Clinical Effectiveness Group meets bi-monthly and has a process for ensuring neonatal deaths in the locality are reviewed locally by each provider and that lessons learnt are shared with other providers. This includes local Trust assessment of the care provided using a CESDI grading system. However, this process is currently 'work in progress' and needs to be strengthened and made more robust. There is also a national initiative led by BAPM and others to try and standardise the methodology used for reviewing all perinatal deaths.

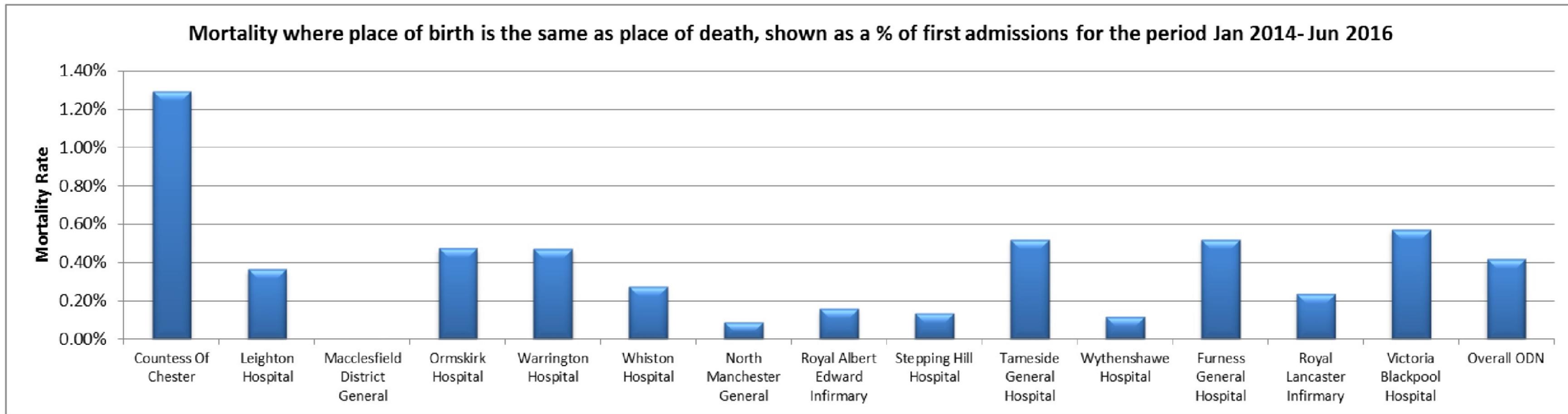
5. The ODN data group is currently developing a monthly activity and outcomes' dashboard. Neonatal mortality at ODN and locality levels is one of the data items which will be collected and monitored monthly. Mortality data is also presented in the quarterly reports received by the three locality Steering Groups.

Recommendation

The ODN board is asked to accept and approve the actions described above and support the ODN team's current approach to reviewing neonatal deaths pending the findings of the RCPCH-led external review.

Appendix 1





Appendix 2