SOUTHAMPTON OXFORD
NEONATAL TRANSPORT

CLINICAL GOVERNANCE & QUALITY ASSURANCE FRAMEWORK

Background
A robust clinical governance and quality assurance framework is an integral requirement for nationally commissioned neonatal transport services. The key elements of this are outlined below:

- **Incident Reporting Process**
  Any incident causing concern is reported through the OUH Datix system/UHS Safeguard system categorised under a specific neonatal transport-reporting field so incidents may be grouped separately to NICU service. The clinical incident reporting form details specific items, which should be reported through the system. Incidents will be reviewed through the OUH or UHS governance framework with governance leadership provided through the clinical governance structure for OUH Children's Directorate Quality Committee and UHS Women & Newborn Directorate. Incidents are discussed and reviewed at the monthly neonatal clinical governance meetings at each trust. Lessons learnt from this are sent out to all transport staff across both hubs in a monthly "at a glance" bulletin. Where incidents cross boundaries with different organisations, the transport lead consultant at the relevant hub will report these to the neonatal network and work with the relevant trusts and the neonatal network to support the governance processes and disseminate wider learning where appropriate

- **Review of Transfers**
  All transfers will be reviewed by the relevant transport co-ordinator and consultant lead at each hub. Selected cases will be presented at clinical governance meetings within the individual trust and shared at transport study days to facilitate wider learning. Any issues identified will be addressed as appropriate, and feedback given through the monthly "at a glance" where wider learning is indicated

- **Reporting**
  Data is collated primarily through the SEND Badgernet Transport Database and the SONeT control centre database. This data is used along with service improvement and development information to provide monthly, quarterly and annual report for stakeholders, commissioners and the neonatal network. Data for the Transport National Dataset are collated and reported nationally giving comparative data on key performance indicators. This is reported through both internal governance structures (OUH Children's Directorate Quality Committee and UHS Women & Newborn Directorate) and shared with stakeholders.

- **Transport Study Days**
  The transport study days run twice yearly and include case reviews, a summary of incidents and actions, equipment updates, guideline review, audits and other quality improvement processes

- **Feedback**
  Feedback is sought from referring and receiving units and from families. The service maintains a stakeholder group which includes clinical personnel from the network hospitals, the ambulance service, parents and commissioners. Meetings are held twice a year. The service operates a secure NHS.net account to facilitate confidential correspondence and reporting

- **Training and Education**
  There is an induction programme for nurses, ANNPs, doctors and ambulance drivers aswell as an ongoing education programme. There is a competency assessment framework which allows for progressive learning. Staff are encouraged to attend multidisciplinary educational opportunities hosted both locally and nationally.