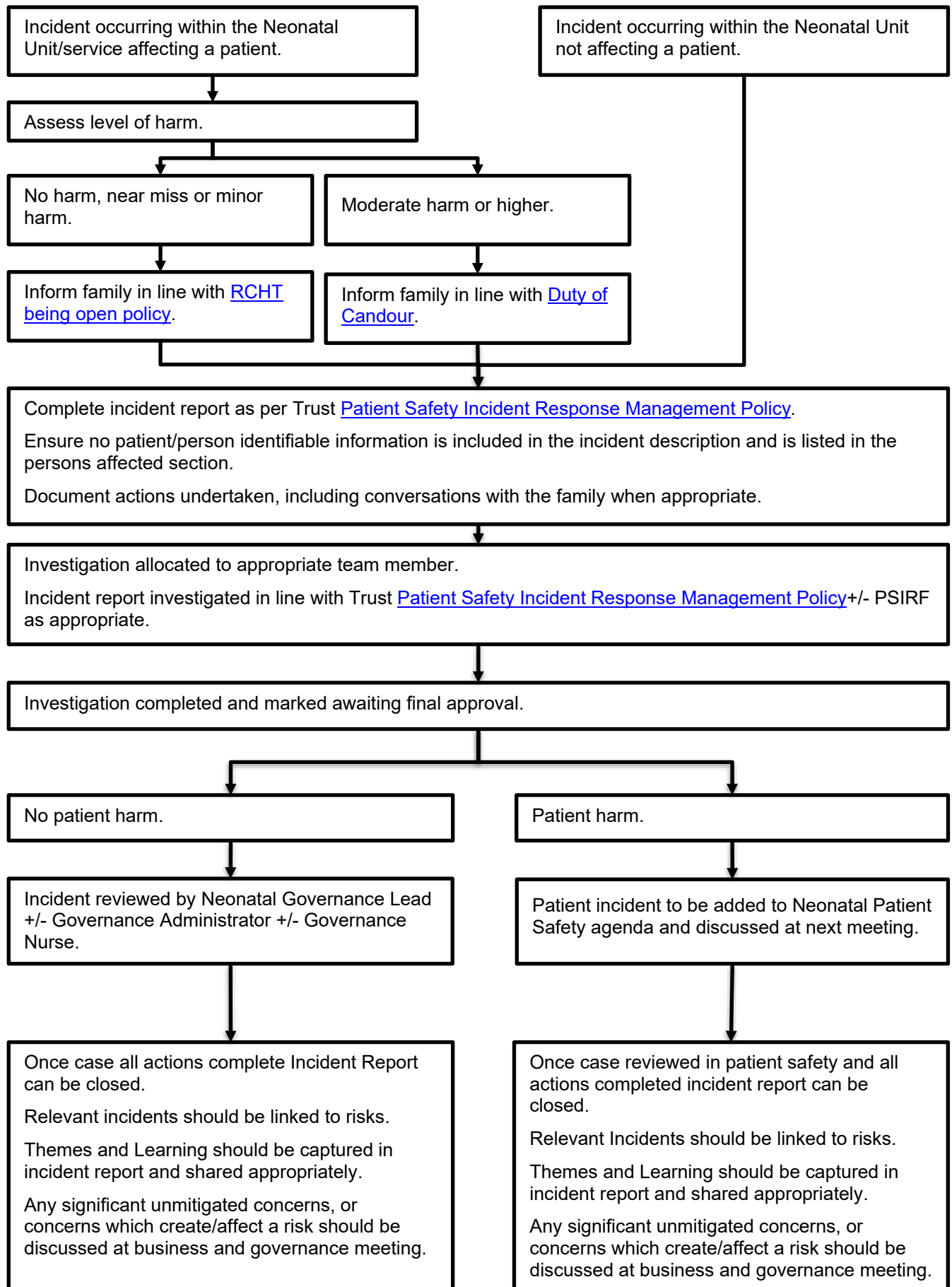


Neonatal Service Governance and Incident Investigation Structure

V1.0

October 2026

Summary



1. Aim/Purpose of this Guideline

This guideline outlines the process of incident review and management for the neonatal consultants, ward managers and matron.

Data Protection Legislation

The Trust must comply with the UK GDPR, Data Protection Act 2018, and Data (Use and Access) Act 2025 by ensuring all personal data is processed lawfully, fairly, transparently, and for a defined purpose.

Before processing personal data, an appropriate Article 6 UK GDPR lawful basis must be identified and recorded. Where special category data is involved, a relevant Article 9 condition must also be documented.

All staff, contractors, students, volunteers, agency workers, and third parties working on behalf of the Trust are responsible for complying with data protection legislation.

Further guidance is available in the Trust's Information Use Framework and Information Governance policies. Advice can also be obtained from the Information Governance Team.

2. The Guidance

2.1. The Routine Neonatal Service and Organisation

Daily review, acute incident management, incident report reporting and management of clinical issues remain the responsibility of the Neonatal Service Consultant and Nurse in Charge. Persistent or unmitigated issues should be escalated to either the Specialty Lead or Neonatal Matron/Head Of Nursing as appropriate.

2.2. Incident Reporting: Routine Reporting and Review

- 2.2.1. Patient and non-patient incidents should be reported in line with the [Patient Safety Incident Response Policy \(PSIRF\)](#).
- 2.2.2. All patient safety incidents should receive an appropriate assessment and grading of harm. All incidents which meet the threshold for harm should be highlighted to the ward managers, Matron and Neonatal Speciality Lead/Governance Lead for review and decision around investigation in line with PSIRF by the Governance Team.
- 2.2.3. In addition to patient/staff safety events there should be routine reporting of the below incidents, even when they do not result in harm to staff or patients.
 - 2.2.3.1. Operational escalation to OPEL4.
 - 2.2.3.2. Transfer out of a baby due to neonatal capacity.
 - 2.2.3.3. Estates issues which affect patient or family care.

2.2.3.4. Unplanned extubation. All unplanned extubations should trigger a PSIRF investigation and be included in the unplanned extubation audit.

2.2.3.5. Neonatal Death (see section 2.6).

- 2.2.4. Incident reports for nursing care and ward management should be investigated by an appropriate member of the senior nursing team (Band 7 or above).
- 2.2.5. Incident reports for medical care are allocated to a core neonatal Consultant on a rotational basis, unless they meet the threshold for further investigation under the PSIRF.
- 2.2.6. Incident Reports which meet the threshold for PSIRF should be discussed with the Neonatal Speciality or Governance Lead.
- 2.2.7. Incidents which, on review, require input from HR (Human Resources) or the Clinical Lead should be allocated to the appropriate member of the senior management team.
- 2.2.8. If an incident has been allocated to a member of staff, and it is felt that it should be reallocated to a different member of the team this should be discussed with the Neonatal Specialty Lead, Matron or Governance Lead prior to being reallocated.

2.3. Patient Safety Incidents

- 2.3.1. All incidents affecting patients should be reported.
- 2.3.2. These incidents should be reviewed by an appropriate member of the clinical team and an assessment of harm made.(trust guidance on levels of harm is at [Patient Safety | Intranet - Royal Cornwall Hospitals Trust](#)).
- 2.3.3. These incidents should be linked to relevant risks where appropriate.
- 2.3.4. Incidents involving patients and near misses.
 - 2.3.4.1. Patient incidents which reach the threshold for moderate harm or higher should be acted upon in line with the trust policy for Duty of Candour and moderate harm incidents.
 - 2.3.4.2. All incidents which, following review, meet the threshold for any level of patient harm or are near misses should be investigated by the relevant investigator and then discussed in the neonatal patient safety meeting, to identify themes or learning, which should then be capture in the incident report. Once actions are completed the Incident can be closed.

2.4. Incidents not involving patient harm

- 2.4.1. Patient incidents which do not result in patient harm should be investigated by an appropriate member of the team.
- 2.4.2. These incidents should be linked to relevant risks where appropriate.

- 2.4.3. These Incident Reports should be collated and reviewed by the Neonatal Governance Lead, and a Senior Nurse, to identify themes or learning, which should then be documented, and once actions completed the incident report closed.

2.5. Non-Patient Safety incidents

- 2.5.1. These incidents should be reviewed by an appropriate member of the clinical team.
- 2.5.2. These incidents should be linked to relevant risks where appropriate.
- 2.5.3. These incident reports should be collated and reviewed by the Neonatal Governance Lead, and a senior nurse, to identify themes or learning, which should then be capture in incident report, and once actions completed the incident report closed.

2.6. Mortality Review Process

See [Neonatal Death Clinical Guideline for Neonatal Staff](#).

2.7. Sharing of Learning

Learning will be disseminated via safety briefs, message of the week and safety huddles and/or newsletter. The route of dissemination should be identified at the time of closing the investigation completion.

2.8. Escalation and Oversight

- 2.8.1. Neonatal Business and Governance:
 - 2.8.1.1. A summary of risks and incidents is included in the governance report for Neonatal Business and Governance.
 - 2.8.1.2. Incidents which highlight new risks, significantly alter the risk profile of known risks, or which require escalation should be discussed at neonatal business and governance meeting.
- 2.8.2. Maternity and Neonatal Safety Champions:
 - 2.8.2.1. Incidents which represent a significant patient safety risk, that result in a patient death or significant harm, or which meet the threshold for escalation in line with the safety champions SOP should be highlighted to the Neonatal Safety Champion +/- Board Safety Champion and discussed at Safety Champions.
 - 2.8.2.2. Following escalation at Safety Champions actions are identified, assigned, and monitored via the Safety Champions Action Log.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Compliance with policy/key changes to practice.
Lead	Neonatal Guidelines Lead.
Tool	Adherence to guidelines will be monitored as part of the ongoing audit process on a Word or Excel template.
Frequency	As dictated by audit findings
Reporting arrangements	Neonatal Audit and Guidelines Group.
Acting on recommendations and Lead(s)	Ward Managers/Matron/Consultants/Clinical Directors.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within 3 months, immediately if required. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant staff/stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity and Inclusion Policy](#) or the [Equality and Diversity website](#).

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Neonatal Service Governance and Incident Investigation Structure V1.0
This document replaces (exact title of previous version):	New document
Date Issued/Approved:	October 2026
Date Valid From:	October 2026
Date Valid To:	October 2029
Directorate/Department responsible (author/owner):	Chris Bell, Neonatal Consultant
Contact details:	01872 252667
Brief summary of contents:	Guideline which outlines the process for neonatal incident review and governance of the neonatal patient safety meeting.
Suggested Keywords:	Neonatal governance.
Target Audience:	RCHT: Yes CFT: No CIOB ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Neonatal Audit and Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None required
Related Documents:	Patient Safety Incident Response Management Policy. Being Open and Duty of Candour Policy.
Training Need Identified?	No.

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/Neonatal

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
August 2026	V1.0	Initial issue	Chris Bell, Neonatal Consultant

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

[E11 QEIA Policy](#).

For guidance, please see the [QEIA Essentials – Quick Reference Guide](#) or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net.

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net.

Appendix 3. Meetings

N.B., the Chair is defined as the lead clinician for organising and routinely chair the meeting. This role can be deputised to another Neonatal Consultant or Neonatal Matron.

Critical Care Review	
Purpose	Forum for Consultant review of cases where babies required intensive care support for CPD and service development purposes. Any issues identified which represent a patient safety incident or where broader learning or service change is required should be discussed in the Patient Safety and Mortality meeting.
Roles	Chair: Neonatal Governance Lead. Quoracy: Two Neonatal Consultants.
Frequency	First Wednesday of every month, 14:00 to 16:00.

Audit and Guidelines Meeting	
Purpose	Review and sign off of guidelines for Neonatal and Newborn care area of documents library. Review of shared maternity guidelines as pertains to neonatal care. Presentation of neonatal audits and identification/dissemination of learning from these. Review of neonatal drug monographs.
Roles	Chair: Neonatal Audit and Guidelines Lead. Quoracy: Two Neonatal Consultants + Kernow Maternity and Neonatal Voices Partnership (KMNVP).
Frequency	Second Wednesday of every month 14:00 to 16:00.

Neonatal Patient Safety and Mortality	
Purpose	Review of incidents where there has been patient harm. Discussion of themes identified within routine Incident Report review or through routine practice. Review of incidents or themes identified in Critical Care Review. Review of Neonatal mortality action log, and new cases arising since previous meeting. Rolling review of Neonatal Risks (1 per meeting) to ensure that all risks are reviewed by a group of clinicians regularly. Incidents which require escalation go to Perinatal Patient Safety, Neonatal Business and Governance or Safety Champions as appropriate.

Neonatal Patient Safety and Mortality	
Roles	Chair: Neonatal Governance Lead. Quoracy: 2 Neonatal Consultants + Senior Nurse + KMNVP.
Frequency	Second and Fourth Wednesday of every month 13:00 to 14:00.

Business and Governance Meeting	
Purpose	Review and sign off of: • Clinical matters requiring escalation. • National, regional and local initiatives/drivers as pertains to neonatal care. • Trust and specialty finance. • Business cases, capital bids and service investment. • All other aspects of clinical governance which require escalation or group sign off. Items escalate from here to Divisional Board or Safety Champions as appropriate.
Roles	Chair: Neonatal Speciality Lead Quoracy: Two Neonatal Consultants + Senior Nurse + KMNVP.
Frequency	Third Wednesday of every month 14:00 to 15:30.

Perinatal Patient Safety	
Purpose	Monthly meeting to discuss perinatal patient safety issues, review shared perinatal projects (e.g. ATAIN (Avoiding Term Admissions Into Neonatal Units) and Peri Prem). Forum to discuss perinatal working, service development and service user feedback. Items escalate from here to Divisional Board or Safety Champions as appropriate.
Roles	Chair: Shared between Midwifery, Neonates and Obstetrics. Quoracy: Neonatal Consultant, Obstetric Consultant, Senior Midwife + KMNVP.
Frequency	Fourth Wednesday or every month 14:00 to 16:00.

Neonatal Operations meeting	
Purpose	Weekly review of: • Urgent neonatal actions.

Neonatal Operations meeting	
	• Neonatal action log. • Any expiring risks within the next 1 month. • CNST (Clinical Negligence Scheme for Trusts)/National and regional alerts/required action plans.
Roles	Chair: Specialty Lead. Quoracy: Neonatal Consultant, Neonatal Matron/Ward Manager, Group Manager for Child Health.
Frequency	Every Wednesday at 09:30.

Appendix 4. Datix Investigator Form Prompt

Completing Datix Forms Following Your Investigation:

Form Title in Left-hand Pane	Heading	Prompt – what to include/exclude/check/amend
Investigation description.		Check details are correct Ensure all personal identifying information is removed from the text (dialogue) boxes Check the location is correct. Ask the Governance team to reassign if you are the wrong person to investigate.
Investigation details. PLEASE SEE OVER FOR EXAMPLES of Contributory Factors, Lessons Learned and Actions.		Check accuracy of each box. In particular, the following headings:
	Investigator(s).	Enter your name. More than one person can investigate
	Contributory factors.	NOT what went wrong. List why things went wrong Do not repeat the incident description.
	Lessons Learned.	Specific safety issues that need addressing in relation to the incident Lessons listed must be backed up by a recorded Action (Action section found in left hand pane)
	What has the Trust learnt or changed as a result of this incident?	What changes have been or need to be implemented (recorded as an Action) in the unit and/or across the Trust
	Immediate result of the incident.	Choose from drop down menu. Actual harm, not potential harm
	Severity (including next 2 boxes).	Choose from drop down menu. Actual harm, not potential harm Follow link in green to help determine severity (scroll down the page) Harm above moderate requires Duty of Candour process- this must involve a consultant
	Next 9 drop down menus.	Answer as appropriate – note – some 'yes' answers in these sections will require further pages to answer and you will be prompted when you save each page of the form.
	Is the reporters assessment of whether this is a patient safety event correct?	Use the '?' link to help you decide whether it was correct to raise the Datix? If you disagree, you should select 'no' – this will open another form (LFPSE) you must complete. Training for the person who raised the Datix will be needed (and recorded in the Actions section).
		Complete the rest of the boxes on the form and SAVE .
Casual Factors.		Causal factors are the specific reasons or conditions that lead to the incident. They answer the question: "Why did this incident occur?" Use the drop-down menu to complete for Level 1 and level 2.
Actions.	Create a New Action.	Click on 'Create a new action' and complete the form. You may not be the owner of the action – so let them know if you have added an action for them. An action is usually required for every item listed in the Lessons Learned' section on the investigation form. POP or the safety brief should not be actions for thematic events or when the same reminders have been sent within the last 3 months- this should be a prompt to look at the process or system or address individual learning.
Linked records.		Click 'Link a record'.
	Module.	Select from drop down menu. Does this incident link to another incident? Does it link to a risk? Does it link to a complaint?
	Module Link ID.	If you are not sure of the linked record, please email: rcht.wcshgovernance@nhs.net .

Appendix 5. Examples of Contributory Factors, Lessons Learned and Actions

Incident	Contributory Factors		Lessons Learned		Actions
	Not Acceptable	Acceptable	Not Acceptable	Acceptable	
Needle stick injury while doing bloods for the patient.	Accidental. Human factors.	Staff had an awkward grip on baby as baby moving. Staff member was rushing.	More caution when taking bloods.	Staff member supported to find a better grip. Staff member to refresh training.	1. Staff to ask NIC or CSF Nurse to monitor next time they undertake blood sampling. 2. CSF to support with refresher training.
Unsafe staffing, couldn't have breaks.	Not enough staff. Not able to take adequate breaks.	Higher than expected acuity due to 2 admissions and frequent emergency bleeps. Escalation plan was not followed.	Ensure safer staffing levels.	Staff training needed in use of escalation tool. NIC training to help them how to manage shifts and breaks.	1. Ward manager to train staff member in use of OPEL tool during next shift. 2. Ward Manager to support NIC to identify gaps in knowledge and skills and implement training as needed. 3. Quality and Safety Nurse to provide training in raising Datix's to include sufficient detail.
Medication administered 3 times a day rather than every 6 hours. This was not noticed for 3 days.	Plan wasn't followed.	Staff did not follow plan because they didn't know it existed. Subsequent shifts followed previous dosage as handed over without checking the patient's notes, looking for a plan or discussing at ward round. Staff unaware of correct procedure for handover.	Ensure plan is followed.	Staff shown where to look for medication plans. Ward Manager to undertake audit to check staff look for medication plans for each patient in the patient notes and on Badger. Training for all band 5 nurses on handover skills and ward round involvement.	1. Ward Manager to show all B6 NIC where to find or check for medication plans and how to escalate if it is unclear. Band 6 NIC's to share knowledge with staff on their shift. 2. Ward Manager 7-day audit of staff, including evening shifts, to check they know to look for medication plans and where to find them by 31 July. 3. CSF Team plan and undertake training with all B5 nurses on handover protocols and skills and how to actively engage in ward round within 6 weeks.
Milk given to wrong baby.	Human Factors Staff did not check name prior to administration.	Staff member did not follow milk protocol because they felt under pressure to feed the baby. There was not another member of staff present to double check the milk.	Ensure milk is always double checked.	Staff complete reflection of importance of following guideline. Staff member recognised need to be better organised with feeds and eliminate feeling rushed.	1. Member of staff to complete reflection within 4 weeks and discussed with Ward Manager. 2. On next shift, member of staff to check every milk feed with NIC or Ward Manager.