Classification: Official

Publication reference: PR1985

NHS England

# Terms of reference: Independent maternity review – Nottingham University Hospitals NHS Trust

13 September 2022

## Background

This Review has been established in light of significant concerns raised regarding the quality and safety of maternity services at Nottingham University Hospitals NHS Trust (NUH) and concerns of local families. This Review replaces a previous regionally-led review after some families expressed concerns and made representations to the Secretary of State for Health and Social Care.

This nationally-commissioned Review will focus on identifying areas of concern within maternity care at NUH and will provide information and recommend actions to help improve the safety and quality of maternity care and the handling of concerns at NUH when they are raised by women and/or their families.

The recent Care Quality Commission report[1] which highlights the inadequacy of the current maternity services provided to the local community is noted in supporting the need for a review at this point.

## Governance

The Review has been commissioned by the NHS England national team, and its sponsor and senior responsible officer (SRO) is the chief operating officer (COO), who will receive periodic updates from the review chair. This Review replaces the regionally-commissioned Review, the work of which ended on 10 June 2022.

---

[1] https://cqc-newsroom.prgloo.com/resources/ins2-11385749621-rx1ra-queen-s-medical-centre-2022-05-20-002
https://cqc-newsroom.prgloo.com/resources/ins2-11385749621-rx1cc-nottingham-city-hospital-2022-05-20-002

The Review will be led by an independent chair, Donna Ockenden, and will be supported by a wider review team including:

a) an administration team

b) a multidisciplinary team of clinical and governance experts

c) independent legal advice sourced through the NHS Procurement Framework.

On a day-to-day basis the Review will liaise with the NHS England COO's directorate.

## Timeframe and duration

The Review began on 1 September 2022 following preparatory work including the development of these Terms of Reference (ToR) and early engagement with families and NUH from June 2022, and is expected to last 18 months.

Learning and recommendations will be shared with NUH as they become apparent to allow rapid action to improve the safety of maternity care. The only and final report will be published and presented to NUH and NHS England (as the Review's commissioners) within 18 months (estimated March 2024).

This timeframe is subject to review. Any requested extension to this time period will be considered and may be granted following discussion and agreement between the NHS England SRO (the COO) and the Chair of the Independent Review, Donna Ockenden.

Clinical care in cases considered by the Review will be graded using an established grading of care scoring system (see table below) developed by the Confidential Enquiry into Stillbirths and Deaths in Infancy (CESDI).

Targeted and specific family feedback will be provided to those families who wish to receive it and where the opinion of the review team is that improved care would reasonably be expected to have made a difference to the outcome (graded 3 on the 0-3 scale set out in the below table).

The purpose of the review remains to ensure timely learning, action and improvements in the safety and quality of the maternity care provided. A grading of care score does not provide a standalone basis for determining clinical negligence.

Existing processes including, but not limited to, coronial inquests and investigations by the Healthcare Safety Investigation Branch (HSIB) may draw different conclusions from those reached by the Independent Review Team.

| GRADE | SUMMARY DESCRIPTION OF CARE | DETAILED DESCRIPTION OF CARE |
|---|---|---|
| 0 | Appropriate | Appropriate care in line with best practice at the time |
| 1 | Minor concerns | Care could have been improved, but different management would have made no difference to the outcome |
| 2 | Significant concerns | Suboptimal care in which different management might have made a difference to the outcome |
| 3 | Major concerns | Suboptimal care in which different management would reasonably be expected to have made a difference to the outcome |

Family feedback is anticipated to be completed within three months of publication of the report. Closedown of the review will follow completion of family feedback.

## Scope

The Review will consider cases from 1 April 2012 to a time anticipated to be three months before publication of the final report. This will enable the Review team to advise NHS England and NUH as to the safety and quality of maternity services immediately prior to completion of this Independent Review. In an exceptional case, where the chair of the Review believes the consideration of a case from 1 April 2006 to 31 March 2012 may add significantly to the Review's findings, such a case may be accepted into this Review.

Cases in the scope of the Review will include clinical incidents where mothers and / or babies have suffered severe harm[2] or death. The Review will clearly and concisely set out to NUH an understanding of the elements of maternity care that have failed over the period of the Review relating to:

- clinical care
- governance and incident reporting and investigation and response to families
- leadership and organisational culture including staff voices and staff wellbeing, including responses to staff whistleblowing
- consideration of the commissioning and oversight of maternity services and any actions taken to improve the safety of maternity services by the then-primary care trust (PCT)/clinical commissioning group (CCG) or other external bodies.

The Review will consider whether NUH has had, and continues to have, robust governance and oversight arrangements in place to ensure appropriate identification, learning and action related to themes emerging from incidents, complaints, and concerns regarding maternity care at all levels in the trust from patients, families, and staff (current or former).

---

[2] The term 'severe harm' will be defined and agreed

## Methodology

The approach to the identification of cases will be based on the ‘open book’ approach as used in the review of maternity services at Shrewsbury and Telford Hospital NHS Trust, in the following five categories:

- Term and intrapartum stillbirths.
- Neonatal deaths from 24 weeks gestation that occur up to 28 days of life; the Review team will also consider neonatal serious incident reports and neonatal never events.
- Babies diagnosed with hypoxic ischemic encephalopathy (Grade 2 & 3) and other significant hypoxic injury.
- Maternal death up to 42 days post-partum.
- Severe maternal harm to include cases such as: all unexpected admission to ITU requiring ventilation; major obstetric haemorrhage e.g. cases where blood loss exceeds 3.5L; peripartum hysterectomy and other major surgical procedures arising from the maternity episode; cases of eclampsia; and clinically significant cases of pulmonary embolus requiring further treatment.

The Review will consider the governance and learning from cases by:

- listening to the experiences of families and identifying common themes
- considering the learning for current clinical practice along with any relationship to common themes in families’ experiences and the clinical care provided
- ensuring that the cases considered are appropriate and reflective of local demographics to ensure that lessons and learnings for NUH reflect the experience of families, staff and all sections of local Nottingham communities.

The Review will undertake engagement with:

- families
- current and former staff
- local, regional and national stakeholders
- professional regulators.

The Review will consider the latest clinical practice in relation to NHS maternity care and available local and national guidance to identify areas of learning for NUH going forwards.

During the course of the Review, if issues are identified that require referral to an appropriate professional body, NHS England, as the commissioner of the Review, will work with the Review team, the relevant professional body/bodies and the affected families to agree an appropriate process for any such referrals. Once confirmed, the process will be issued as an addendum to these Terms of Reference.

The Review will share key findings with NUH and NHS England on a quarterly basis. This will support NUH to continuously learn and improve the safety and quality of maternity care (enhancing the trust's current improvement plan where appropriate).

### Engaging with families who joined the previous review

To help reduce additional distress to families who have already taken part in the previous Review and where they have had a 'listening session', these can be provided to the Ockenden Review team with the consent of the families.

Alternatively, families may wish to speak to Donna Ockenden's team afresh or may not wish to participate in this Independent Review. The decision of individual families will be respected. Donna Ockenden and her team will make every effort to reach out to and engage with families who participated in the previous review.

### Family support

The local NHS will ensure specialist psychological support continues to be available to families who are part of this Review for its duration and throughout the family feedback and closedown processes, and that where necessary, they are subsequently transitioned into mainstream services who will be responsible for providing ongoing support.

### Staff support

The Review team will be responsible for managing liaison with members of NUH staff, both current and former, who will be provided with appropriate support by the trust.

## Ways of working

### Resources

The Review will agree a financial plan for the duration of the Review with NHS England based on a formal agreement set out in writing between NHS England and the chair regarding resourcing.

The Review chair will consult NHS England prior to the Review putting in place any contractual arrangements. All contractual arrangements will need to have been deemed compliant with the NHS Procurement Framework by NHS England.

### Information sharing and governance

The Review will keep in regular contact with NHS England via its sponsor and their team. Should the Independent Review team identify areas of concern relating to current patient

safety in NUH maternity services, it will contact the sponsor's team at the earliest opportunity to allow action to be taken to address issues.

All relevant NHS organisations and regulators are expected to cooperate with the Review as is normal, professional practice, including supplying documentation, as and when requested by the Review team. If the chair of the Review has any significant issues regarding non-co-operation which cannot be resolved, this will be escalated to the sponsor's team.

Specific consent will be sought from the families for their information to be shared with the Independent Review team. Initial contact will be made via NHS England (where families have already provided that consent) or the Trust following the open book exercise. The Review will gain consent from families for their information to be included within the Review.

All records and data relating to the Review will be processed according to the agreed information sharing agreements. The Review will have information management and privacy policies that will set out the approach the Review takes to managing information that complies with information legislation. The policies will include the approach to managing information upon completion of the Review.

NHS England and the Review team will work together to agree a governance process to cover the end period of the Review and data transfer requirements. This governance process is anticipated to be completed by the end of December 2022.

## Publication of findings

The Review team will notify individuals and organisations who are referred to in the final report and provide them with a timely opportunity to respond to any significant criticism proposed for inclusion in the final report. The precise process, known as Maxwellisation, and timings to be used, will be agreed between the NHS England SRO and the chair of the Independent Review following appropriate professional advice.

Publication of the final report will include disclosure jointly to families and NHS England so that they are aware of the content of the report to be published.