TERMS OF REFERENCE

Independently led thematic review of incidents relating to maternity care at the Nottingham University Hospitals NHS Trust (the Review)

Introduction

1. In response to concerns regarding the quality of maternity services at Nottingham University Hospitals NHS Trust (the Trust), enhanced oversight and surveillance processes were put in place by NHS England and NHS Improvement (NHSE/I) and the NHS Nottingham and Nottinghamshire Clinical Commissioning Group (CCG) during Autumn 2020.

2. A system oversight framework was established, monitoring progress of both immediate safety concerns and the Transformation & Change Programme; this aims to provide oversight and support for the NUH Maternity Improvement Programme. Partners from the Nottingham and Nottinghamshire Local Maternity & Neonatal System (LMNS) put increased scrutiny processes in place of untoward events and serious incidents at the Trust, whilst also working with the Trust to retrospectively review a number of maternity incidents.

3. This enhanced oversight identified a failure to learn from incidents and investigations, and also the potential for a number of incidents, complaints and concerns in relation to maternity care that may not have been appropriately identified, reviewed or escalated.

4. NHSE/I and the CCG recognise that the maternity care provided by the Trust has not been of the quality required, and that issues remain ongoing. NHSE/I and the CCG are committed to improving the quality and safety of the services that women, people who require medical terminations, people who give birth and their families receive from the Trust.

5. NHSE/I and the CCG will therefore commission an independently led review of maternity services at the Trust. The review will be known as the *'Independent thematic review of incidents relating to maternity care at the Nottingham University Hospitals'* ('the Review') and will be undertaken by an independent Review Team ('the Review Team').

6. NHSE/I and the CCG recognise that significant work has already been undertaken nationally in relation to commissioned maternity reviews. This includes the learning and recommendations made most recently in the form of immediate and essential actions arising from the Ockenden Review of maternity services at the Shrewsbury and Telford NHS Hospital Trust (2020)[1] . It was acknowledged in those findings '*that there must be an end to investigations, reviews and reports that do not lead to lasting meaningful change'.*

7. NHSE/I and the CCG will therefore seek to trial a new approach to maternity review, that captures local themes, trends and learning in order to inform specific and measurable actions for rapid improvement. This Review will examine both current and

[1] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

recent concerns with maternity services at the Trust, in order to explore correlating trends, causation and connections, recognising that concerns may have previously been seen as isolated or individual events.

8. While the Review will consider the significant body of evidence already available, it will also identify additional evidence required from the Trust, NHSE/I, the CCG and wider system, in order to gain insights into current and recent maternity practice, culture and processes. The Review will also work with women, people who give birth and families to ensure the Review learning and recommendations reflect people's lived experience.

9. Throughout the period of the Review, NHSE/I and the CCG will continue to work closely with the Trust to ensure rapid improvements are made, providing capacity to support, as well as continuing to provide scrutiny and challenge to the Trust's maternity improvement plans. The Review will ensure key areas of learning are fed into that process and that this informs the NUH Maternity Improvement Programme.

10. This Review does not replace the statutory processes that exist around the response to individual cases, the duty of candour, notification of incidents, concerns relating to individual practitioners or other obligations relating to the provision of care by the Trust, either retrospectively or prospectively.

11. **In order to deliver a thematic Review, the Review Team will consider the detail of individual cases. However, it is recognised that the Review Team may identify individual cases which require further action or investigation; such as retrospective significant events, complaints or concerns, and/or where professional referrals are required.**

12. **An Independent Investigation Team (IIT) will therefore be established in order to undertake these investigations. This Independent Investigation Team will only complete individual investigations identified as being required by the Review Team, and this will be completed in line with national guidance, policy and best practice.**

13. **The IIT process will ensure that individual, retrospective case investigations are not tied to the Review timescales. The process will ensure that specific answers or outcomes are provided where possible to women, people who require medical terminations, people who give birth and families affected. While the IIT process will run separately to the Review, it will be overseen by the Review's independent Programme Director to ensure that actions from these investigations are reported back to inform maternity improvement at LMNS and Trust level.**

14. **Terms of Reference for the IIT will be devised by the Programme Director and independent Clinical Leads upon commencement of the Review.**

15. In the future, serious incidents, significant events, cases, complaints, concerns or professional referrals will be subject to a strengthened process, overseen by the LMNS, as recommended by the Ockenden Report. To facilitate this, the Nottingham and Nottinghamshire LMNS Perinatal Surveillance Quality Group have established a Serious Incident Shared Governance Group, which includes external clinical specialist opinion from outside the Trust.

16. It is recognised that ongoing support will be required for families affected by their experience of maternity services at the Trust. While separate to the Review, the CCG

and NHSE/I (as joint commissioners of the Review) will work with the Trust to ensure that there are appropriate and robust support services in place.

Purpose of the Review

17. The Review will provide an independently led assessment of what has happened with the Trust's maternity services and identify lessons and conclusions, including but not limited to the following:

    a. Determining if the systems and processes adopted by the Trust to identify and report serious incidents and harm are in line with national guidance, fit-for-purpose and effective;
    b. Identify any areas to support future recognition of concerns to allow earlier intervention;
    c. Identifying any service related themes/wider issues or links that are apparent from this Review;
    d. Evaluating the Trust's approach to risk management and implementing lessons learnt from HSIB and other internal investigations;
    e. Assessing the Trust's governance arrangements and making recommendations to address any identified gaps from Board to ward;
    f. Reviewing all identified themes against the Trust's current quality improvement work.

18. The Review will draw conclusions as to the adequacy of the actions taken at the time by the Trust and organisations surrounding the Trust, including the CQC, NHSE/I and the CCG. Taking account of improvements and changes made, the Review will aim to provide lessons helpful to the Trust in ensuring appropriate actions are taken to improve maternity services.

19. NHSE/I, the CCG and the Trust will act upon the findings of the Review and ensure the learning and recommendations are incorporated into the maternity improvement programme. The Trust will be expected to implement the recommendations from the Review.

Scope of the Review

20. The Review will consist of four component areas:

    A. **Data & Analytics:** a review of data, trends and management information at the Trust since its inception in 2006, in order to assess patterns of incidents over time, correlating themes or trends, and potential causal factors.
    B. **Detailed Review & Key Lines of Enquiry:** examining current and recent concerns with maternity services at the Trust and investigating specific themes and trends, in order to gain insights into practice, culture and processes.
    C. **Listening to Women, People Who Require Medical Terminations, People Who Give Birth and Families:** ensuring that the Review incorporates the learning and experience of those with lived experience of maternity services at the Trust
    D. **Review of the Governance & Oversight of Maternity Services at the Trust:** looking at the levels of assurance to ensure the safety and quality of service provision

A. Data & Analytics

21. The Review will examine data, trends and management information at the Trust since its inception in 2006, in order to assess patterns of incidents over time, correlating themes or trends, and potential causal factors. This will support the identification of any strategic issues or events within the Trust that may have had a bearing on the way that maternity services were run.

22. It is acknowledged that themes and trends may pre-date 2006. However, as 2006 represents the inception of the Trust, it is not possible to obtain or extract data and information prior to this date.

23. The Review will examine a number of information and data sources to support the identification of themes and trends. These will not be considered in isolation and, where possible, will be correlated in order to identify any interconnecting themes, issues or trends. Information and data sources will include (but not be limited to) the reporting of:

    a. Serious incidents (including, but not limited to fetal medicine, intrapartum stillbirths, neonatal deaths, maternal deaths and babies with severe injuries) – numbers, themes and trends
    b. Healthcare Safety Investigation Branch (HSIB) referrals and recommendations made
    c. Incidents which have been internally recorded by the Trust (including incidents recorded as low or no harm) – numbers, themes and trends
    d. Near misses - numbers, themes and trends
    e. All coronial cases held and, where relevant, resultant Prevent Future Death reports
    f. Number and types of litigation proceedings issued in relation to maternity care
    g. Concerns and/or complaints that have been lodged to or from any source about maternity care at the Trust – numbers, themes and trends
    h. Cases of maternal admission to ITU following delivery
    i. Maternity cases resulting in a referral to the General Medical Council (GMC) / Nursing and Midwifery Council (NMC) / Health and Care Professions Council (HCPC)
    j. Professionals referred to the General Medical Council (GMC) / Nursing and Midwifery Council (NMC) / Health and Care Professions Council (HCPC)
    k. Staffing vacancies, turnover and professional supervision within maternity and the wider trust
    l. Findings of staff surveys in relation to the Trust's culture, in particular the prevalence and effectiveness of the patient safety culture
    m. Staff complaints, whistleblowing and Freedom to Speak Up (FTSU) concerns– numbers, themes and trends
    n. Staff training and compliance
    o. Data and information collated within the Trust for the purposes of assurance and monitoring.
    p. Data shared with the Trust's regulators and commissioners in relation to quality, activity, assurance and monitoring

B. Detailed Review & Key Lines of Enquiry

24. The Review will examine current and recent concerns with maternity services at the Trust and investigating specific themes and trends, in order to gain insights into practice, culture and processes. The Review will expedite and examine themes and

Key Lines of Enquiry (KLOEs) identified using a clear methodology, as well as learning from the review of data and management information.

25. This detailed element of the Review will consider a number of Key Lines of Enquiry and use the appropriate evidence to do so. While a number of KLOEs will emerge as the Review progresses, the following areas may be included:

    a. Improvement & Improvement Culture: Where internal reviews or regulatory / externally commissioned reviews into the Trust's maternity services have taken place in the past:
        i. Has the learning been implemented?
        ii. Have all required changes to practice been sustainably embedded in the Trust?
        iii. How were the recommendations and actions assured?
        iv. Were the actions specific, measurable and/or adequate?
        v. Are staff able to articulate the actions that were implemented, or the impact of actions implemented?

    b. How, in the individual cases which were referred to the coroner and to HSIB, did the Trust respond and seek to learn lessons? Did the Trust provide appropriate support and compassionate care to families after these referrals?

    c. Communication:
        i. How far are women, people who require medical terminations, people who give birth and their families listened to, and communicated with, in an open, honest and transparent way?
        ii. How far do women, people who require medical terminations, people who give birth and their families feel informed about their health and care, or the health and care of their child?
        iii. How far do women, people who require medical terminations, people who give birth and their families feel engaged in decision-making?

    d. How robustly do the Trust share information with families following an early termination, neonatal death, maternal injury or other high-harm event?

    e. Does the Trust provide compassionate, respectful and culturally-sensitive care?
        i. Is sensitive care provided to families affected by early termination, neonatal death, maternal deaths and babies with severe injuries?

    f. Following early termination, neonatal death, maternal injury or other high-harm event, does the Trust have robust, practical arrangements in place to support women, people who require medical terminations, people who give birth and their families?
        i. Are there processes and procedures in place that are followed?

    g. Is there documented evidence of a timely verbal and written apology to women or people who give birth, as a part of the duty of candour process?
        i. Does the Trust do this now?
        ii. Are staff trained in, and confident around, the duty of candour process?
        iii. The Review will quantify both the volume and themes of incidents, complaints, concerns and Freedom to Speak Up (FTSU) concerns in relation to maternity care within the Trust and will include an examination of Trust policies and procedures directly applicable to the Review.

h. How robust are the Trust's maternity triage processes?

i. How robust are the Trust's systems in relation to post-mortem and pathology following neonatal or maternal incident?

j. What infrastructure, training and resources are in place to ensure that Trust effectively supports pregnant women and pregnant people who have pre-existing mental health needs?
    i. What infrastructure, training and resources are in place to ensure that the Trust effectively supports women and people who give birth who develop post-natal mental health conditions?

k. How robust are the Trust's current processes around record-keeping and information sharing?
    i. What processes are in place to ensure that accurate, timely medical information is shared between maternity units?
    ii. Does the Trust have a robust process in place for securely sharing medical notes with women, people who give birth and their families?
    iii. Are these processes routinely followed?

l. Did the Trust's Quality Assurance Framework ensure the effective reporting, investigation and monitoring of serious incidents in line with the NHS Serious Incident Framework and Trust policies?

m. Where individual cases have been identified through any source, were these recognised appropriately? Are there any gaps in the identification and investigation of individual cases?

n. How did the Trust respond to complaints and concerns raised with them by women, people who require medical terminations, people who give birth and their families in relation to the maternity services?
    i. How did the Trust seek to engage and learn from these?

o. How did the Trust respond to whistleblowing or Freedom to Speak Up (FTSU) concerns raised by staff in relation to the maternity services?
    i. How did they seek to engage and learn from these?

p. For maternity staff departing the Trust, have exit interviews been completed? How has the feedback informed service improvement, staff experience and workforce development?

q. Does the Trust have a maternity service that is culturally-competent? How far do services provide differential care to women, people who require medical terminations, people who give birth and their families from underrepresented groups?

r. How far does the maternity workforce represent the demographics of the people it cares for?

s. How does the Trust assure itself that it is following national guidelines and appropriately updating internal policies in line with this, across all aspects of fetal medicine, maternity care and neonatal care?

C. Family Group

26. The Review Team will work independently with women, people who require medical terminations, people who give birth and their families to establish a Family Group. The purpose of the Family Group is to ensure that women, people who require medical terminations, people who give birth and their families can share their experiences of the Trust's maternity services with the Review Team, in order to inform learning, themes and recommendations.

27. The Family Group will be led by an independent Chair or representative from the Group (the "Chair"). The Chair will support the work of the Review Team and act as an independent advocate, to ensure that the voice of those with lived experience is effectively captured. In supporting the Review Team, the Chair will not have access to any patient-identifiable information.

28. The Family Group will be publicised using a variety of communication methods, in order to be as open and accessible as possible. Families can join the Family Group at any stage throughout the Review process.

29. The Review Team will ensure that members of the Family Group receive regular progress updates on Review activity. The Review Team will ensure that updates and communications are accessible and are shared via a range of methods.

30. The Review Team and Chair of the Family Group will seek to ensure that the Family Group is representative of the population served by the Trust's Maternity Services. This will ensure that the Family Group has appropriate representation from: Black, Asian and minority ethnic (BAME) families; lesbian, gay, bisexual, transgender and queer (LGBTQ+) communities; Gypsy, Roma and Traveller (GRT) communities; and other underrepresented groups.

D. Review of the Governance & Oversight of Maternity Services at the Trust

31. The Review Team will consider whether the Trust has had, and continues to have, governance and oversight arrangements in place to ensure appropriate identification and actions related to themes emerging from incidents, complaints and concerns at all levels.

Review Timescales

32. The Review will update NHSE/I, the CCG, the Trust, the LMNS Board and the Trust's Quality Assurance Framework Group at regular intervals throughout the Review to ensure that learning can support the active maternity improvement journey underway within the Trust.

33. The Review set-up, including the recruitment of staff and ratification of the Terms of Reference, will take place in October 2021. Clinical Reviews will commence from November 2021.

34. The Review will aim to complete and share the final report with NHSE/I, the CCG Governing Body (or other relevant statutory body), the Trust Board, the LNMS and Quality Assurance Groups within 12 calendar months of commencement.

35. The findings of the Review will be made publically available through public facing LMNS Board and Integrated Care Board papers.

Protocol

The final protocol and methodology will be jointly agreed by the Review Lead, NHSE/I and the CCG in line with the principles outlined here.

Principles Underpinning the Review

- Women, people who require medical terminations, people who give birth and families involved in the Review will be treated with compassion and kindness, and appropriate support will be provided for all those who are engaged in the Review
- Women, people who require medical terminations, people who give birth and families who share their story as part of the Review will be provided with appropriate and robust support services, should they require ongoing support
- The Review will accept the experiences and stories of women, people who require medical terminations, people who give birth and families as truth
- The Review will be led by an independent Programme Director, supported by a strong project management office (PMO) structure to support timely delivery against objectives and adopting an evidence-based approach
- The Review Lead, expert clinical panels, investigators and specialist advisors will be independently appointed and have no association or connection to the Trust
- In order to remunerate members of the Review Team, CCG business mechanisms may need to be used. In doing so, this will not mean that members of the Review Team are “employees” of the CCG
- There will be a clear Scheme of Delegation and Review Programme Plan in place, to ensure that the Review remains independent and cannot be curtained by NHSE/I or the CCG
- The Trust will cooperate with the Review, including supplying documentation, as and when requested
- The Review Team will develop an independent Communication and Engagement Strategy, to ensure that all families and stakeholders who wish to receive updates and communications do so
- There will be a clear, consistent methodology used to undertake the review which will be determined by the Review Lead, NHSE/I and the CCG
- All personal and special category data accessed for the Review will be accessed and stored in accordance with the Data Protection Act (2018), the UK General Data Protection Regulation (GDPR), CCG and NHSE/I policies
- At no point in the Review will cases, incidents, concerns or complaints be considered “historic”, in recognition that harm and loss is not historic for the families affected
- This Review does not replace the statutory processes that exist around the response to individual cases, the duty of candour, notification of incidents or other obligations relating to the provision of care by the Trust either retrospectively or prospectively
- The Review will look in detail only at those individual cases for which consent is granted to access the records pertaining to the case
- The Review conclusions will be shared with the wider system via the Trust's Maternity Quality Oversight Group and other ICSs and NHSE/I quality oversight and assurance routes