Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust

Chaired by Donna Ockenden

Revised Terms of Reference - November 2019

1. This document sets out the revised Terms of Reference for the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which was commissioned in 2017 by the Secretary of State for Health. These updated Terms of Reference reflect changes to the scope of the review.

2. The original Terms of Reference set out an 'independent review of the quality of investigations and implementation of their recommendations, relating to a number of alleged avoidable neonatal and maternal deaths, and cases of avoidable maternity and new born harm at Shrewsbury and Telford Hospitals (the Trust). The review will be led by NHS Improvement and will cover incidents raised with the Secretary of State in a letter dated 6 December 2016 requesting an independent inquiry.' Terms of Reference, May 2017.

3. Following the original launch of the review, more families have come forward with concerns about the care they received at the Trust. NHS Improvement commissioned an Open Book review of Trust records which also identified additional cases for review. These two factors have led to an extension to the scope of the original independent review as outlined in the original Terms of Reference.

Background

4. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:
   a. appropriate investigations were conducted; and
   b. the assurance processes relating to investigations in the maternity service were adequate.

Governance

5. The review was commissioned by the Secretary of State for Health.

6. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who will periodically update the Department of Health and Social Care on progress.

7. The review will continue to be led by independent Chair, Donna Ockenden and the final report will be presented to the Department of Health and Social Care.

8. The Chair will be supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

Revised scope

9. The review will now include all cases which have been identified since the original review was established. Cases where families have contacted various bodies with concerns regarding their own experiences since the commencement of the original review will also have oversight from the clinical review team undertaking the Secretary of State commissioned review. This is in addition to cases identified in the 'Open Book' review. Any reports from previously commissioned reviews will also be submitted to the Chair of the review to ensure consistency and record any recommendations and lessons learnt for sharing more widely. The processes applied to the Trust case review and the associated governance process will also be reviewed by the maternity review team to ensure rigour and application of good practice.

Review approach

10. The multidisciplinary Review Team will:
    a. Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
    b. Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
    c. Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
    d. Consider how the parents, patients and families of patients were engaged with during these investigations;
    e. Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the National Medical Director of NHS Improvement and NHS England; and
    f. The review team will present cases internally, and on an as required basis seek further external advice

11. If the Review Team identifies any material concerns that need further immediate investigation or review, the National Medical Director of NHS Improvement and NHS England must be notified immediately.

12. All relevant case notes and other information will be passed by the Trust to the Chair and the Review Team and will be treated confidentially by them. Every effort will be made to contact families to let them know whether their case forms part of the review and to ask how they wish to be engaged, if at all. In the interests of conducting a comprehensive review and maximising the clinical learning, it is necessary for the Chair and Review Team to consider all cases within the scope of the review but no patient or family member will be identified by name in the final published report unless they have consented to this.

13. Directions to the Review Team:
    a. Did the Trust have in place, at the time of each incident, mechanisms for the governance and oversight of maternity incidents? Does the Trust have this now?

    b. Were incidents and investigations reported and conducted in line with national and Trust policies, that were relevant at the time?

    c. Is there any evidence of learning from any of the identified incidents and the subsequent investigations?

d. Were families involved in the investigation in an appropriate and sympathetic way?

Key Principles

14. The review will be expected to:
    a. Engage widely, openly and transparently with all relevant parties participating in the review process;
    b. Be respectful when dealing with individuals who have been impacted by the incidents being investigated;
    c. Adopt an evidence-based approach;
    d. Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and babies;
    e. Consider links to national policy and best practice in relation to midwifery, maternity, neonatal and obstetric care and investigation management that were relevant at the time; and
    f. Consider the challenge of implementing proposals, including the workforce.
    g. Handle data and information with care and in accordance with good information governance practice

15. For families who have contacted the Chair of the Secretary of State commissioned Independent Review directly, and whose cases were originally investigated by the Trust, the investigations of these cases will be reviewed. The review process will consider the investigations and associated action plans from each incident investigation to ensure these appropriately addressed the relevant concerns and were implemented by the Trust at the time.

16. All cases will be reviewed in relation to Trust policy and national guidance that was relevant at the time.

17. In 2018 NHS Improvement commissioned an 'Open Book' review of Trust records. Shrewsbury and Telford Hospital NHS Trust was requested to 'open its books' in relation to specific maternity data held by the organisation from 1 January 1998, when national incident reporting on the Strategic Executive Information System (STEIS) began, to 27 September 2018. The scope included patients from England and Wales (Powys).

18. The purpose of the review was to determine as far as reasonably practical with the available data, the number of cases and associated incident reporting and investigation practices over the time period in relation to:
    a. Maternal deaths
    b. Stillbirths
    c. Neonatal deaths
    d. Babies diagnosed with Hypoxic Ischemic Encephalopathy (Grade 2 & 3)

19. This has identified over 300 cases which don't appear to overlap with many other cases known to the review team. The independent review will now consider how to incorporate these cases, and any others which arise through the investigation, into its scope to assess whether their outcomes were the result of failings.

Resources

20. Resource requirements will be agreed between the Chair of the review, NHS Improvement and NHS England and the Department of Health and Social Care to ensure the review is adequately supported.

Timeframe

21. The overall timeline will be agreed between the Chair of the review, NHS Improvement and NHS England and Department of Health and Social Care, in light of the extended scope of the review.

22. The final review report and proposals should be available within one month of the review being completed.