Terms of Reference

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 (subject to receiving consent from the families).

Background

This review follows a number of serious clinical incidents, beginning with a new born baby who sadly died in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. In subsequent years from 2009 until 2014 a number of further investigations and reviews (internal and external) were also undertaken to confirm whether:

- Appropriate investigations were conducted and
- The assurance processes relating to investigations in the maternity service were adequate.

In response to these previous reviews a comprehensive maternity service improvement action plan was put in place by the Trust. The progress of the implementation of the recommendations from these previous reviews has been monitored on a continual basis by the Trust Board. The action plan was devised with input from the parents of the baby who died in 2009. The parents have received ongoing communication in regard to the progress and implementation of actions identified within the plan.

Scope and purpose of this latest independent review

The independent review will be undertaken by a multidisciplinary REVIEW TEAM of independent external reviewers who will submit their findings to an INDEPENDENT REVIEW PANEL.

The REVIEW TEAM will comprise:

- Two midwives
- Two obstetricians
- Two neonatologists

The multidisciplinary REVIEW TEAM will undertake to:
• Review only those cases for which consent is granted to access the records pertaining to the case;
• Review the quality of the investigations and subsequent reports into the identified cohort of incidents;
• Identify whether the investigations appropriately addressed the relevant concerns and issues from those incidents;
• Establish if recommendations were accepted and appropriate actions implemented within the timescales identified in the associated action plan;
• Consider how the parents, patients and families of patients were engaged with during these investigations;
• Reserve the right to undertake a second-stage review of primary cases should the considerations above justify such action following agreement with the Executive Medical Director NHS Improvement and
• Present their findings of the review of each case to the REVIEW PANEL for challenge and quality assurance monitoring.

The INDEPENDENT REVIEW PANEL will undertake to:

Receive and quality assure the REVIEW TEAM’s findings in each case reviewed;
• Under the leadership of the chair, develop the report of the findings of the review and
• Actively engage and communicate with families relevant to the specified cases, where they have expressed a preference for such engagement, in particular around the review’s findings and recommendations.

In addition the INDEPENDENT REVIEW TEAM will assess the extent to which the Trust had appropriate arrangements in place for the oversight and governance of the incidents and the reporting mechanisms to the Trust Board.

The review process will comprise:
• A review of all the investigations in the cohort including but not limited to root cause analysis (RCAs), preliminary fact finding reviews, supervisory investigations and associated action plans from each incident investigation. All will be reviewed in relation to the then contemporaneous Trust policy and National Guidance;
• A review of the relevant / associated improvement plan and pace of improvement against the timelines identified in the plan and
• Contact with parents or relatives to establish their understanding of their involvement in previous investigations.
The **REVIEW TEAM** and **REVIEW PANEL** will be provided with direction in relation to the conduct of the review to ensure that there is consistency in the approach to reviewing each case. The **REVIEW TEAM** and **REVIEW PANEL** will give due consideration to the application of relevant policies and procedures that were in place both nationally and locally at the time of the incident, as well as during the subsequent investigation process.

If the **REVIEW TEAM** or **REVIEW PANEL** identifies any material concerns that need further immediate investigation or review, the NHS Improvement Executive Medical Director must be notified immediately.

The **REVIEW PANEL** will provide a report and recommendations of any actions required to Dr Kathy McLean, Executive Medical Director, NHS Improvement.

**The Review Panel**

The **REVIEW PANEL** will be chaired by an independent chair, appointed by NHS Improvement and supported by a panel of experienced clinicians and stakeholders with expertise in maternity services or governance and assurance processes.

The **REVIEW PANEL** will comprise:

- An NHS Improvement-appointed independent chair
- An NHS Improvement-appointed Director of Midwifery from outside the region
- A Senior Quality Manager from NHS Improvement
- An external independent midwife
- An external consultant obstetrician
- An external consultant paediatrician/neonatologist
- NHS England midwifery representative from outside the region.

**Key Principles**

The review will be expected to:

- Engage widely, openly and transparently with all relevant parties participating in the review process;
- Be respectful when dealing with individuals who have been impacted by the incidents being investigated;
- Adopt an evidence-based approach;
- Acknowledge the importance of inter-professional cooperation in achieving good outcomes for women and children;
- Consider links to the time relevant national policy and best practice in relation to midwifery and investigation management and
- Consider the implementation challenges of proposals including the workforce.

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

Directions to the REVIEW TEAM and REVIEW PANEL in relation to the conduct of the review:

1. 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?

2. Were incidents and investigations reported and conducted in line with the time relevant national and Trust policies?

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

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