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Department of Health & Social Care

Guidance

Independent review into maternity and neonatal services at Leeds Teaching Hospitals NHS Trust: terms of reference

Published 28 September 2026

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Purpose

On 20 October 2025, the then-Secretary of State announced the decision to commission an independent review (the 'review') into maternity and neonatal services at Leeds Teaching Hospitals NHS Trust (LTHT). This was due to:

- LTHT having one of the highest extended perinatal mortality rates
- hearing families' experiences
- the 'inadequate' rating in the latest Care Quality Commission (CQC) report

The purpose is to review the care women, babies and families received in a maternity and neonatal context, identify any failings and recommend actions for improvement. For clarity and consistency, references to 'women' throughout this document are intended to include women and all birthing people, including those who do not identify as women.

During the defined time period, the governance and leadership of the trust and the extent to which the regulators were aware of issues will be reviewed to determine if the regulatory response was sufficient.

Objectives

The objectives of the review are to:

- identify areas of concern within maternity and neonatal care, including clarity on lines of accountability and responsible individuals within decision making at LTHT and associated regulatory oversight
- provide timely learning and communicate recommended actions to help improve the safety, quality and equity of maternity and neonatal care at

LTHT

- enable accountability and provide clear answers to families. This will be achieved by reviewing individual cases through a team of multidisciplinary clinicians and providing personalised feedback following publication of the report
- assess the effectiveness of LTHT governance and leadership, establish the extent of regulatory knowledge of the issues, and evaluate the adequacy and effectiveness of the regulatory response during the review period
- assess the handling of concerns at LTHT when they are raised by women and/or their families and staff members

Governance

The review has been commissioned by the Department of Health and Social Care (DHSC). The DHSC sponsor, and the senior responsible officer (SRO), is the director of maternity policy. The review will be led by an independent chair, Donna Ockenden (the ‘chair’), who is responsible for the delivery of the review as outlined in these terms of reference.

The chair will be supported by:

- a core administration and programme management team
- a multidisciplinary team of clinical and governance experts
- engagement experts
- independent legal advisers
- experts in research and evidence
- experts in local community engagement across the LTHT catchment such as voluntary, community and social enterprise organisations

The chair will meet with the DHSC SRO on a monthly basis to discuss:

- progress against key performance indicators and agreed milestones
- risks and issues
- budget and expenditure

The chair will also formally share key findings with DHSC, LTHT and NHS England regional and national teams on a bi-monthly basis through a ‘learning and improvement’ process. Further information on this process is available in the ‘Emerging findings’ section below.

DHSC will agree a budget and financial plan with the chair that will ensure appropriate resourcing.

The chair will consult DHSC prior to the review team putting in place any contractual arrangements. This will ensure value for money and that all contractual arrangements are compliant with the DHSC procurement framework.

All current and former NHS staff, relevant NHS organisations and regulators are expected to co-operate with the review as is normal, professional practice, including supplying documentation, as and when requested by the review team. Public officials and public authorities are expected to engage with the review as though the duty of candour and assistance set out in clause 2(1) of the Public Office (Accountability) Bill as at the date of these terms of reference applies. Upon the enactment of the Public Office (Accountability) Bill and commencement of the relevant provisions, public officials and authorities will be expected to comply with the duty of candour and assistance as it applies to them by law. If the chair has any significant issues regarding non-co-operation that cannot be resolved, this will be escalated to the DHSC sponsor team.

If the review team identifies areas of concern relating to current patient safety in LTHT maternity and neonatal services, the chair will:

- escalate to LTHT and, where appropriate, to the relevant body (for example, CQC, the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC)) through an agreed process to allow action to be taken to address issues
- notify the DHSC sponsor team in parallel

Time frame

Engagement with families and LTHT commenced from 1 April 2026. Family meetings began in July 2026 and case reviews will begin in November 2026.

Learning and recommended actions will be shared with LTHT, DHSC and NHS England as they become apparent throughout the review to allow rapid action to improve the safety and quality of maternity and neonatal care.

The final report will be presented to the families, LTHT and DHSC (as the commissioners of the review) and will be published on or before 31 March 2029. No extensions to this date are expected.

Contact with families for final feedback and other work to close down the review will be completed within 6 months of the publication of the report (September 2029).

Scope

The review will consider maternity and neonatal care from 1 January 2011 up to and including 31 March 2028, where mothers and babies have suffered severe harm or death while under the care of LTHT. The period 1 January 2011 to 31 December 2014 will be on an ‘opt-in’ basis, and from 1 January 2015 will be ‘opt out’.

The review may be contacted by families who will not have their case reviewed as they do not meet the criteria. To allow for the consideration of a wide range of experience of perinatal care, these will be recorded as ‘maternity experiences’ in a standalone chapter of the final report.

The 8 categories of severe harm or death that the review will look at are:

- stillbirths from 24 weeks’ gestation
- neonatal deaths from 22 weeks’ gestation on the neonatal unit, and babies who are discharged who die within 28 days of birth. The review team will conduct a comprehensive review of babies’ neonatal never events (https://www.england.nhs.uk/patient-safety/patient-safety-insight/revised-never-events-policy-and-framework/2024-consultation-findings/), high-level serious incidents and consideration of patient safety incident response framework (PSIRF) or Perinatal Mortality Review Tool (PMRT) documentation. This relates to all babies cared for at LTHT regardless of whether the baby was born at LTHT or not
- babies diagnosed with hypoxic ischaemic encephalopathy (grade 2 and 3) who were cared for on the neonatal unit, after consideration of existing reports or investigations, which will be referenced as a starting point for further review
- babies admitted to the neonatal unit with significant hypoglycaemia
- babies admitted to the neonatal unit with kernicterus
- maternal death while pregnant or within 42 days (6 weeks) of the end of pregnancy, from any cause related to or aggravated by the pregnancy or its management, excluding accidental or incidental causes
- maternal death by suicide while pregnant or within one year of the end of the pregnancy
- severe maternal harm, including cases such as:
  - all unexpected admissions to critical care

- major obstetric haemorrhage, where blood loss exceeds 2.0 litres or requires a blood transfusion
- unplanned peripartum hysterectomy and other major surgical procedures arising from the maternity episode
- eclampsia
- sepsis
- pulmonary embolus
- fourth degree tears
- admission of women for causes related to mental health to a psychiatric unit while pregnant or within 42 days of the end of pregnancy

The review will consider whether LTHT 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 and neonatal care. This includes post-death care of mothers and babies in the mortuary and associated after-death care services in all settings in the trust. This will include:

- listening to women and families
- accuracy, transparency and effectiveness of incident reporting, investigation and response to families
- leadership and organisational culture, including staff voices (current and former) and staff wellbeing, responses to staff whistleblowing, and consideration of local workforce race equality standards (WRES) and other workforce data
- the commissioning and oversight of maternity and neonatal services and any actions taken to improve the safety of maternity services
- considering if there is a failure to escalate and refer concerns, including consideration of issues such as hierarchy, culture and prioritisation of normal birth

The chair will take into consideration national-level ongoing actions when making recommendations.

Methodology

Opt-out approach

The inclusion of individual cases in the review will be based on an ‘opt-out’ methodology from 1 January 2015. From 1 January 2011 to 31 December 2014, there will be a process of families actively opting in. This will be supported by wide community and media engagement across the catchment area of LTHT.

From January 2015 onwards, the ‘opt-out’ approach means that the care received by every family who meets the criteria of the review (see ‘Scope’ above) will be included within the review unless the family requests otherwise. The review team will write to all families with instructions on how to opt out and the time frame within which they need to respond, should the family wish to do so.

If families do not opt out, they will automatically be included in the review. Explicit consent will not be sought from the families for their information to be shared by LTHT with the review team.

Where families have chosen to opt out of the process (and they may decide to do so while the review is underway), their information will not be included in the review. In limited circumstances and where it is in the public interest, a minimal amount of information may be considered where this is already contained within LTHT corporate documents.

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.

Review process

The review will listen to and undertake engagement with:

- women and families who have received maternity and neonatal care at LTHT, including those from diverse backgrounds who are representative of the local population
- current and former staff from a wide range of cultural and professional backgrounds and students on placement across maternity and neonatal services at LTHT

- local, regional (including regional chief midwife, regional lead obstetrician and neonatal operational delivery networks) and national stakeholders
- professional regulators (including CQC, GMC and NMC) and bodies responsible for carrying out relevant investigations (including Maternity and Newborn Safety Investigations (MNSI), Medical Examiner, PMRT, HM Coroner, child death reviews relating to neonatal deaths and NHS Resolution)

The review will consider:

- the latest clinical practice in relation to NHS maternity and neonatal care
- available local and national guidance to identify areas of learning for LTHT going forwards
- all previous internal and external reviews of LTHT maternity and neonatal services, relevant to the time frame of this review, actions or recommendations and the progress made in the implementation of these

Care will be considered with reference to the relevant local and national policies and guidance in place at the time of the incident or case.

The review will also consider the actions taken by professional regulators in relation to the specific cases being considered, to ascertain if their actions were sufficient to support:

- accountability
- any regulatory action
- the identification of potential learnings

Emerging findings

The review will formally share key findings with DHSC, LTHT and NHS England on a bi-monthly basis. This will support LTHT to continuously learn and improve the safety and quality of maternity care (enhancing the trust's current improvement plan where appropriate). It will also ensure that the findings from this review are contemporaneously considered and shared alongside wider national work on maternity and neonatal care.

A learning and improvement group will be established to facilitate this. It will meet on a bi-monthly basis and be chaired by the DHSC director general responsible for maternity and neonatal care, who is also the Chief Nursing Officer for England. Membership of this group will also include LTHT, NHS England and any other relevant organisations considered appropriate by the chair of the group (such as national investigatory bodies).

During the course of the review, if issues are identified that require referral to an appropriate professional body, the review team should refer the matter directly to the professional body (regulator) in line with the process identified with the professional body. In those instances, the regulator will ensure that the provider is made aware of this referral. The review team should maintain a record of all referrals made. The number and themes arising should be shared with the DHSC SRO and sponsorship team at agreed intervals.

Grading of cases

Clinical care of mothers, babies and families will use a system that was developed by a previous Confidential Enquiry into Stillbirths and Death in Infancy (CESDI). This helps to understand the ways in which care may have impacted on outcomes for the families involved. The system is outlined in table 1.

A grading of care score does not provide a standalone basis for determining clinical negligence. Families should be made aware of this point to avoid confusion.

Existing processes including, but not limited to, coronial inquests and investigations by the Healthcare Services Safety Investigations Body (HSSIB) (formerly the Healthcare Safety Investigation Branch) or MNSI may draw different conclusions from those reached by the review team. The review team will ensure families are aware of this.

Table 1: grading definitions

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

Grade	Summary description of care	Detailed description of care
		to have made a difference to the outcome

Care provided by organisations other than LTHT

Where cases are included in the review and elements of care have been provided by different organisations other than LTHT, the review team may feel it necessary to consider the care carried out by the other organisation or organisations as part of the review process and may therefore request relevant case notes from these organisations where this is the case.

The care delivered by these organisations will not be graded by the review team. However, to ensure learning is shared and improvements made where needed, any themes or concerns identified by the review team about care provided by organisations other than LTHT will be reported by the chair to the chief nurse and medical director of the organisation, the regional chief nurse, and the review's SRO at DHSC.

This will allow the organisation to address the issues, including contacting the family in line with duty of candour obligations. Oversight will be with the regional chief nurse who will report to the SRO on appropriate and timely action taken.

Family feedback for the neonatal care at LTHT will be delivered in the same way as all other cases included in the review.

As the review is focused on the care provided by LTHT, any such themes or concerns identified that relate to the care provided by other organisations other than LTHT may form part of the review report. However, those organisations will not be identified.

Support

Family support

In recognition of the traumatic experiences of families, DHSC has commissioned a culturally appropriate and trauma-informed specialist psychological support service for families engaging with the review. The service will be available for the full duration of the review, including the family feedback and closedown phases. Where further psychological support is needed, the commissioned specialist psychological service will support families to transition into mainstream services, which will be responsible for providing ongoing care.

Staff support

The review team will be responsible for managing liaison with members of LTHT staff, both current and former, regardless of their roles. LTHT will provide the review team with information to ensure they can signpost or direct current and former LTHT staff to appropriate and available support mechanisms. These will be in place to encourage staff members to voice their perspectives and experiences freely and without fear.

Publication of findings

The review team will notify individuals and organisations who are referred to in the final report and provide them with the opportunity to respond to any significant criticism of them that is proposed for inclusion in the final report. The precise process, known as Maxwellisation, and timings to be used, will be agreed between the DHSC SRO and the chair of the review following appropriate professional advice. Prior to publication of the final report, families and staff will have opportunity to see and feedback on pseudonymised ‘vignettes’ or excerpts from interviews regarding their cases. Where families or staff decline inclusion of ‘their’ excerpt, this will be respected.

Publication of the final report (including an easy read summary) will be preceded by disclosure to families, DHSC and LTHT at a timescale to be agreed, so that they are aware of the content of the report to be published. The report will be publicly available on GOV.UK.

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