THE MORECAMBE BAY INVESTIGATION

Chaired by Dr Bill Kirkup CBE

University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBT)

Maternity and Neonatal Services Investigation

Terms of Reference

Introduction

This paper sets out the scope and terms of reference for an independent investigation into the Maternity and Neonatal services of UHMBT and their governance and management, to be chaired by Dr Bill Kirkup CBE. The investigation will be known as the *'Morecambe Bay Maternity and Neonatal Services Investigation'.*

Background

UHMBT has been the subject of scrutiny since at least 2009. Initial concerns arose after several maternal and neonatal deaths. These have been the subject of on-going police investigation, the results of which are awaited. (A separate Memorandum of Understanding describing the relationship between the Investigation and Cumbria Constabulary will be drawn up).

The families of those who died under the care of the Trust have persistently sought a full and independent investigation into these services. The new management of the Trust itself proposed an external investigation. It has now been decided that the independent investigation is best commissioned by the Department of Health.

Terms of reference

Dr Bill Kirkup is appointed by the Secretary of State to chair an investigation into the management, delivery and outcomes of care provided by the Maternity and Neonatal services of UHMBT from January 2004 – June 2013. In particular:

1. To review the outcomes for mothers and babies that occurred during this time, including maternal and neonatal deaths that occurred in the Trust and in any other institutions to which patients were transferred;

2. To review the Trust Board's actions and governance procedures in response to untoward incidents such as the deaths of mothers and babies, including:

    a) The Board's processes for responding to serious untoward incidents (SUIs); and

    b) The relationship and communication between the Trust and
        - Patients and families
        - GPs and community ante-natal midwifery services
        - Commissioners, predominantly in the two local PCTs, Cumbria PCT and North Lancashire PCT, their predecessor PCTs, and successor CCGs
        - The North West Strategic Health Authority
        - Regulators – including Monitor, CQC, and the Healthcare Commission.
        - Public Health services
        - Other Trusts where mothers and babies were transferred
        - Any other relevant organisations.

    c) Relevant investigations published by the Parliamentary and Health Service Ombudsman.

3. To review the Trust Board's responses to, and any subsequent actions taken following receipt of, the following reports:

    - Monitor's review of the Trust's application for FT status (April 2010), October 2010
    - The Fielding Report, August 2010
    - Central Manchester University Hospital Diagnostic Review, December 2011
    - PWC Governance Review, February 2012
    - Gold Command Stocktake, April 2012
    - Care Quality Commission (CQC) Investigation Report, July 2012
    - Nursing and Midwifery Council (NMC) Review, July 2012;
    - The NHS Litigation Authority's Clinical Negligence Scheme for Trusts (CNST) reports

4. To make findings as to the adequacy of the actions taken at the time by the Trust to mitigate concerns over safety;

5. In light of this, to assess and make findings as to the Trust's ability to discharge its duties in delivering maternity services; and

6. To make recommendations on the lessons to be learned for both the Trust and the wider NHS to secure the delivery of high quality care.

Scope of the Investigation

The investigation should focus on the actions, systems and processes of the Trust. These should be considered within the context of the process of Foundation Trust authorisation (both Monitor and the Department of Health's role) and commissioning by the two former Primary Care Trusts (PCTs).

The investigation should consider the actions of regulators and commissioners insofar as they appertain directly to the safe provision of maternity and neonatal services.

Required output of the Investigation

The Investigation should prepare and publish a comprehensive written report covering areas 1 to 6, above, making clear recommendations for the Trust and the wider NHS.

The key audiences for the report are the families and the Trust. The report will also be sent to local clinical commissioning groups, NHS England, CQC, Monitor, the Department of Health and any other organisation for whom recommendations are forthcoming. The Department of Health would be expected to coordinate a response across the whole system, and each organisation would be expected to consider and respond constructively to relevant recommendations.

The written report is the responsibility of the investigation. The timing of the publication will be agreed with the Secretary of State and the families. Copies of the report will be received by the Secretary of State and the families 48 hours before publication.

Access to documents

All relevant NHS organisations, regulators and the Department of Health are required and expected to cooperate with this investigation as is normal, professional practice, including supplying documentation as and when requested by the Chairman.

Timescale

The Investigation should be undertaken with sufficient pace to enable resulting recommendations to be implemented as quickly and effectively as possible. It is expected, on the basis of current information, that the Investigation will make its best endeavours to complete work and produce its report in July 2014.

Resources

Resources for the investigation will be provided by the Department of Health. An independent secretariat will be appointed by the Chairman of the Investigation to support its work.

The hearings for the investigation will take place in the North West to assist the families in observing the investigation.