TERMS OF REFERENCE

Independent Investigation into East Kent Maternity Services

Introduction

1. Following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHS E/I) have commissioned Dr Bill Kirkup CBE to undertake an independent review into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust (the Trust). The Review will be known as the *'Independent Investigation into East Kent Maternity Services'* (the Independent Investigation).

2. This is to set out the Terms of Reference for the Independent Investigation, including its scope and the arrangements that are to be put in place to support its functions, detailed in an accompanying Protocol.

3. Dr Bill Kirkup is appointed by NHS E/I to chair the Independent Investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at East Kent University Hospitals NHS Foundation Trust during the period since 2009 (when the Trust came into being) drawing upon the methodology followed in the Morecambe Bay investigation.

4. The Independent Investigation was also confirmed in Parliament on 13 February 2020 by Nadine Dorries, Minister of State for Patient Safety, Mental Health and Suicide Prevention. At the same time the Minister announced that the Chief Midwifery Officer, Jacqueline Dunkley-Bent, had sent an independent clinical support team to the Trust to provide assurances that all possible measures were being taken.

Scope

5. The Independent Investigation will examine maternity and neonatal services in East Kent, in the period since 2009, by looking in particular at the following four layers:

    i. What happened at the time, in individual cases, independently assessed by the investigation.

    ii. In any medical setting, as elsewhere, from time to time, things do go wrong. How, in the individual cases, did the Trust respond and seek to learn lessons?

    iii. How did the Trust respond to signals that there were problems with maternity services more generally, including in external reports?

    iv. The Trust's engagement with regulators including the CQC. How did the Trust engage with the bodies involved and seek to apply the relevant messages? And what were the actions and responses of the regulators and commissioners?

Purpose

6. The Independent Investigation will provide an independent assessment of what has happened with East Kent Maternity and Neonatal Services and identify lessons and conclusions. This includes:

A. Determining the systems and processes adopted by the Trust to monitor compliance and deliver quality improvement within the maternity and neonatal care pathway.

B. Evaluating the Trust's approach to risk management and implementing lessons learnt.

C. Assessing the governance arrangements to oversee the delivery of these services from ward to Board.

7. The Independent Investigation will draw conclusions as to the adequacy of the actions taken at the time by the Trust and the wider system. Taking account of improvements and changes made, the Independent Investigation will aim to provide lessons helpful to East Kent but also to share nationally to improve maternity services across the country.

8. The Independent Investigation will focus on the experience of the families affected and the actions, systems and processes of the Trust, (with reference to clinical standards for maternity and neonatal care during the period). The Independent Investigation will listen to the concerns of the affected families, use their experience to shape the key lines of enquiry and provide an opportunity for them to be heard. The Investigation should also consider the processes, actions and the responses of regulators, commissioners and the wider system as they are relevant to the provision of maternity and neonatal services at the Trust.

9. The Independent Investigation will produce a report to be disclosed first to the affected families and then to NHS E/I as the commissioning organisation and to the Department of Health and Social Care prior to publication. The Report will be published and presented to Parliament.

10. The Investigation will agree with NHS E/I steps it might take at the completion of its work to help ensure that the lessons identified are understood and acted upon. These steps might include presentations to NHS groups.

Timescale

11. The Independent Investigation will aim to complete its Terms of Reference by Autumn 2022.

Protocol

Access to documents

- All relevant NHS organisations, regulators and the Department of Health and Social Care are required and expected to cooperate with the Independent Investigation as is normal, professional practice, including supplying documentation, as and when requested by the Investigation.

Contact with families and the public

- The Independent Investigation team will be responsible for managing liaison with families whose cases are relevant to the Independent Investigation

Methodology and case review

- The Independent Investigation will decide how best to deliver its Terms of Reference including by drawing upon:

    a) the experiences of families affected by maternity services in East Kent and the impact on those families looking as widely as necessary to understand the whole of that experience and impact;

    b) the medical records of patients;

    c) the corporate records showing how the Trust discharged its responsibilities for maternity services, how it communicated and engaged with patients, their families and representatives and with regulators and others over concerns with maternity services;

    d) interviews with those whose work involved maternity services;

    e) interviews with regulators, NHS England and Improvement, HSIB and others;

    f) its assessment of what went wrong in individual cases and lessons aimed at ensuring improvements which should be made to maternity services in East Kent and elsewhere.

- In applying its methodology, the Independent Investigation will consider individual cases where there was:

    i. a preventable or avoidable death;

    ii. concern that the death may have been preventable or avoidable;

    iii. a damaging outcome for the baby or mother;

iv. reason to believe that the circumstances shed light on how maternity services were provided or managed or how the Trust responded when things went wrong.

- The Independent Investigation will take account of other relevant work including the following but will be responsible for reaching its own assessment, findings and conclusions:

  - HSIB Reviews
  - The invited review by the RCOG in 2015/16
  - The invited RCPCH review in 2015
  - Perinatal Mortality Review Tool data and reports
  - Intelligence from the CQC/associated reports/recommendations
  - Letters and findings from HM Coroners
  - Each Baby Counts reviews (the Royal College of Obstetricians and Gynaecologists national quality improvement programme)

Resources and governance

- Resources for the Independent Investigation will be provided by NHS England and NHS Improvement. The Independent Investigation will establish with these resources a team with sufficient expertise and capacity to carry out the work

- The Chair will appoint those with appropriate experience in order to help deliver these terms of reference, including:

  - An expert panel and specialist advisers
  - Secretariat functions
  - Clinical input
  - Legal advice
  - Communication functions
  - Engagement with and support for families
  - Engagement with relevant staff from the Trust
  - Information governance and management

- The Independent Investigation team will keep in regular contact with NHS England and NHS Improvement via the SRO and their team but will not provide a running commentary on the Investigation's findings. Through this contact, NHS England and NHS Improvement will keep in touch with progress of the Independent Investigation, ensure that sufficient resources are available and are being deployed appropriately.

- If the Independent Investigation identifies areas of concern with current patient safety in East Kent Maternity Services, it will contact the Chief Midwifery Officer, Jacqueline Dunkley-Bent in her role described by the Minister in the House of Commons on 13 February 2020[1].

[1] The trust was placed on the Maternity Safety Support Programme which involves improvement advisors supporting the trust with maternity improvement.

Consent and information governance

- Specific consent will be sought from the families for their information to be shared with the Independent Investigation team, if initial contact has been via NHS England/ Improvement, or the Trust. The Independent Investigation will secure suitable consent from families for their information to be used as part of the investigation.

- The Independent Investigation will have an information handling and privacy policy that will set out the approach the Investigation takes to handling information appropriately and complying with information legislation.

Fact checking and opportunity to comment

- The Independent Investigation will notify individuals and organisations who are referred to in the investigation's conclusions and provide them with an opportunity to respond to any significant criticism proposed for inclusion in its Report.

Disclosure

- The arrangements will include disclosure first to the families and to NHS England, NHS Improvement and the DHSC so that they are aware of the content of the Report to be published.