# INDEPENDENT INVESTIGATION OF PATIENT SAFETY INCIDENTS AND DEATHS AT LIVERPOOL COMMUNITY HEALTH NHS TRUST

## TERMS OF REFERENCE

### Background and Powers:

1. Community health services are rarely at the forefront when the NHS is being considered or discussed, and often seem to be low on the list of NHS priorities. Yet these services are vital to the care of patients, particularly the growing number who have longer-term health problems and they are essential to the proper functioning of hospitals general practice and mental health services. They deserve more attention.

2. In February 2014, Rosie Cooper MP raised questions about the management of the Liverpool Community Health NHS Trust (the 'Trust') with the Secretary of State for Health and with the Prime Minister. This followed whistleblowing concerns from staff at the Trust. Rosie Cooper MP had also witnessed staff under significant pressure trying to provide appropriate patient care when her own father was a patient in an intermediate care ward run by the Trust.

3. An Independent Review chaired by Dr Bill Kirkup CBE was established. The Review Report, published on 8 February 2018, found significant failings in the Trust from November 2010 to December 2014, the period covered by the Review's terms of reference. The Review Report may be accessed here.

4.The Secretary of State noted that the Review Report described how over-ambitious cost improvement programmes as part of a bid for foundation trust status placed patient safety at risk, leading to serious lapses in care and widespread harm to patients. A culture of bullying meant that staff were afraid to speak up and safety incidents were ignored or went unrecognised.

5. Stakeholders were contacted, and their responses were taken into consideration when framing these terms of reference.] The Secretary of State has therefore appointed Dr Kirkup to chair an Independent Investigation of historic patient safety incidents and deaths at the Trust.

6. The Independent Investigation is:

- established under the general duties and powers of the Secretary of State for Health and Social Care in Parts 1 and 2 of the NHS Act 2006;
- founded on the principle that the public interest demands that the failings uncovered at the Trust should never be repeated;
- and:

- is designed to recommend measures that will protect the public against seriously improper conduct.

7. Accordingly, the Independent Investigation will be required to obtain and review evidence from all relevant organisations and individuals. t is therefore incumbent on organisations and individuals to assist by providing information including documents, written and oral evidence including, where relevant, personal data, in order that the Investigation can deliver these Terms of Reference.

**Remit of the Independent Investigation**

8. The Independent Investigation will be conducted over three stages. Stages 1 and 2 will identify individual serious patient safety incidents that had not been reported or adequately investigated by the Trust and undertake a series of historic, mortality reviews.

9. Stage 3 will fully investigate those individual serious patient safety incidents identified from the previous stages to determine the scale of deaths and patient harm and identify local and national learning.

10. The Independent Investigation will also advise regulators where, in the opinion of the panel, the systems, processes and senior leadership within the Trust may have adversely contributed to the safe delivery of patient care. It will identify any themes, trends or issues that may require further investigation.

a) establish the nature and scale of deaths and patient harm at the Liverpool Community Health Trust between 2010 and 2014 and the action taken at the time by the Trust and other organisations;

b) determine the lessons, both local and national, which need to be understood and followed in order to reduce the risk of similar deaths and patient harm in future;

11. The Independent Investigation will produce and submit to the Secretary of State for Health and Social Care and to the Minister of State for Health and Social Care a report, with recommendations, which will be published in Parliament.

12. If information is obtained in the course of the Independent Investigation, it will report any instances of apparent collusion or other conduct of concern (including conduct that indicates the potential commission of criminal or disciplinary offences) to the relevant employer(s), professional or quality regulator(s), and/or the police for their consideration. The Investigation does not have the power to impose disciplinary sanctions or make findings as to criminal or civil liability.

13. The Independent Investigation will aim to submit its Report in Winter 2021.

**Work of the Independent Investigation:**

14. The Chair will appoint expert members and a staff team (Secretariat) with appropriate experience in order to help deliver these Terms of Reference.

15. The Independent Investigation will engage with former patients, families and staff to understand their concerns and take written and oral evidence as deemed necessary.

16. The Independent Investigation will put in place confidentiality agreements with individuals and organisations in order to facilitate sharing of information with the Investigation. The Independent Investigation will also agree with individuals and organisations where their information is considered for publication; and will, before publication, notify individuals and provide them with an opportunity to respond to any significant criticism proposed for inclusion in its Report.

1st July 2020