THE MORECAMBE BAY
MATERNITY AND NEONATAL SERVICES INVESTIGATION

Wednesday, 14 January 2015

Held at:
Park Hotel (Council Building)
East Cliff, Preston, PR1 3EA

Before:

Dr Bill Kirkup CBE – (Chair)
Mr Julian Brookes, Expert Advisor, Governance
Professor Jonathan Montgomery, Expert Advisor, Ethics

DAVID TANSLEY

Transcript produced by Ubiqus
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1 **(At 3.38 p.m.)**

2 THE CHAIR: Thank you for coming. My name is Bill Kirkup. I'm the Chair of the
3 Investigation Panel. I'll ask my colleagues to introduce themselves to you.

4 MR BROOKES: I'm Julian Brookes. I'm currently Deputy Chief Operating Officer for
5 Public Health England, but was previously Head of Clinical Quality at the Department
6 of Health.

7 PROF. MONTGOMERY: I'm Jonathan Montgomery. I'm Professor of Healthcare Law at
8 University College London and Chair of the Health Research Authority and, in the
9 past, I've chaired provider trusts, PCTs and an SHA.

10 THE CHAIR: As you'll see, we're recording, and we will produce and agreed record at the
11 end of the process. You may also know that family members are entitled to be here as
12 observers. As it happens, we don't have any. They may listen to the transcript
13 subsequently, and you'll also know that we've asked panel members and interviewees
14 to hand in mobile phones, recording devices and so on. That's just to emphasise that
15 we don't want anything to go outside the room till we produce the report with
16 everything in context. Do you have any questions for me about the process?

17 MR TANSLEY: No, thank you.

18 THE CHAIR: Okay. Thank you. Can I ask you just to start out by telling me what it is that
19 you do now and how long you've been in the Trust and what you've done?

20 MR TANSLEY: Okay, I'm currently Associate Director of Quality and Safety at East
21 Lancashire Hospitals NHS Trust. I've been with the Trust since January of 2014,
22 invited to join them through an interim consultancy function and was asked to join
23 them because of some significant concerns around where they are around quality,
24 governance and safety. At the time they were in special measures, and with the work
25 that we did the Chief Inspector of Hospitals visit that happened in June of last year
26 enabled us to demonstrate that things had significantly changed and, on the
27 publication of the Chief Inspector of Hospitals visit they were removed from special
28 measures.

29 THE CHAIR: Okay. Sorry, which Trust did you say that was? I missed it.

30 MR TANSLEY: East Lancashire Hospitals Trust.

31 THE CHAIR: East Lancs. Okay. Thank you, and where did you come from to go to that
32 post?

33 MR TANSLEY: Prior to that I was at Morecambe Bay. So I left Morecambe Bay in
34 December.

1 THE CHAIR: And when did you start at Morecambe Bay?

2 MR TANSLEY: I started in Morecambe Bay in January 2012 I think – yes, 2012.

3 MR BROOKES: Sorry, you said December. 2013 was that? 2014? You…

4 THE CHAIR: 2013.

5 MR BROOKES: You left 2013.

6 MR TANSLEY: December 2013, yes…

7 THE CHAIR: Okay. Did you work in Morecambe Bay before January 2012?

8 MR TANSLEY: No.

9 THE CHAIR: Where did you work before?

10 MR TANSLEY: I had a range of jobs and functions. I've been working with NHS Somerset,
11 with them ~~their~~ – in Yeovil. I'd moved to there from London and, specifically to go
12 and do a piece of work with them. They'd advertised an Interim Associate Director of
13 Nursing function, which was a year. That then stopped and I spoke to their Director of
14 Nursing about going into consultancy, and I did a number of pieces of work over that
15 –

16 [Cross-talk]

17 THE CHAIR: Okay, so is your background a nurse?

18 MR TANSLEY: Yes, I'm still a registered nurse, yes.

19 THE CHAIR: Right. Okay, thank you. Julian.

20 MR BROOKES: I think I should say I think we have probably met.

21 MR TANSLEY: Yes, I think we have.

22 MR BROOKES: Yes. I was working at NHS South West, so I don't recall when it was, but I
23 think your face looks familiar and we probably have met. Just for the record. So you
24 came in 2012. What was your – what was the job you came for?

25 MR TANSLEY: Okay, the piece of work that I was approached for was specifically around a
26 short term piece of work around about supporting the development and maturity of
27 risk registers within the Trust. Prior to arriving, risk registers were held in a number
28 of forms, either paper or in various electronic formats on remote computers, and I had
29 experience with Ulysses Safeguard and Datix~~ex~~ and my job was to support the
30 organisation to, effectively, make their risk register and electronic risk register in order
31 to support the appropriate recording and escalation and visibility of the risk register.

32 MR BROOKES: Who did you report to for that?

33 MR TANSLEY: In that first instance I reported to Mary Moore, who was also an interim,
34 who also then later joined as one of the Deputy Chief Nurses reporting to Jackie Holt.

1 MR BROOKES: Okay.
2 MR TANSLEY: Yes.
3 MR BROOKES: So you came for a specific task.
4 MR TANSLEY: I did.
5 MR BROOKES: And was that a [inaudible] post, or was that?
6 MR TANSLEY: The initial discussion and agreement was for a three month period.
7 MR BROOKES: Okay.
8 MR TANSLEY: Yes.
9 MR BROOKES: So I'd be really interested in your perceptions of the governance
10 arrangements of the organisation when you arrived.
11 MR TANSLEY: Okay. I was of the opinion that they – the risk register actually reflected the
12 governance arrangements in the organisation, in that historically it appeared that the
13 senior management team and board had, effectively, sort of pushed responsibility into
14 the divisions to own governance but there had then been, I suppose, a disconnect in
15 terms of, you know what, corporately was driven and what autonomies the divisions
16 then had. As a consequence, what appeared to me to happen was that there were
17 different governance arrangements within divisions, not standardised to a corporate
18 model and, as a consequence, there were also different roles, there were different
19 capabilities and, as a consequence, different maturities within various divisions.
20 MR BROOKES: You're not the only one who's used the word, 'Disconnect.' Could you just
21 explain that a little bit more, what you mean?
22 MR TANSLEY: What I mean – in terms of what I was seeing and the visibility of, you
23 know, after that first three months I was asked to support an understanding of what
24 their governance arrangements were and looked to support, to strengthen those. So
25 sort of moved to almost a post as sort of their senior risk officer, and my concern was
26 about actually what was visible to me, and the individuals and the systems weren't
27 making visible to me appropriately the risks that were being carried by division, and
28 what should the senior management team be sighted on.
29 MR BROOKES: Okay, and were you – there's obviously there's a virtual circle, a virtual
30 circle here, in terms of both identifying the risks and dealing with those risks. What
31 was your view in terms of the way in which the risks that had been identified were
32 being dealt with?
33 MR TANSLEY: There – there was a culture, I think, of shooting the messenger. Part of the
34 frustrations I had towards the end of my period with Morecambe Bay, and one of the

1 reasons I left Morecambe Bay, was I was key in a number of committees in terms of
2 setting up, running and supporting the SIRI panel, setting up and running the patient
3 safety and governance committee, which was a stressful period leading up to any of
4 those committees, and not a good day when, on that day, in presenting things to those
5 committees. It didn't feel a supportive environment in which you could articulate
6 without being shot as the messenger.

7 MR BROOKES: Okay. I'll come back to the shooting bit in a minute, because I'm quite
8 interested in that. But could you just describe to me the overall structure at the time,
9 and how it operated?

10 MR TANSLEY: Okay, so the board had – in terms of governance, the board had a specific
11 committee which was, I think, established as I arrived. Whether or not sort of the
12 membership and attendance of that committee needed revising, and being clear to the
13 senior managers within the divisions their responsibility to be there, and then their
14 responsibility to ensure that basics around, you know, the schedule of business was
15 published yearly, papers weren't being presented in a timely manner, the quality of
16 many of those papers was poor, and it felt that there was a disconnect in terms of they
17 didn't want or need to be there, and it was hard work bringing those people to that
18 committee.

19 Underneath that, the structure was that each of the divisions were to have their
20 own quality meeting, at which point, you know, so papers should go through to
21 division and then escalate up to the board level committee. But I couldn't get to those
22 to look at how those were operating, but in terms…

23 MR BROOKES: You didn't attend any of those?

24 MR TANSLEY: I did, in my first six months I did, as part of reviewing how those operated.

25 MR BROOKES: And how did you think they operated?

26 MR TANSLEY: Poorly. Again, things like establishing schedules of business. Many of the
27 meetings were gigantic in terms of those people sitting around the table, and they
28 struggled to effectively get through their business.

29 MR BROOKES: And were the right things going to the meeting?

30 MR TANSLEY: Yes, in principal, yes. Whether or not the right assurances were being
31 gathered through papers was questionable. Or not happening. Many of them were
32 talking about subjects rather than providing papers that provided assurance about how
33 those things were internally being managed.

34 MR BROOKES: Okay. During the period there was a review of divisional governance

1 structures. Is that something…
2 MR TANSLEY: PricewaterhouseCoopers?
3 MR BROOKES: No, internally.
4 MR TANSLEY: Yes, internally.
5 MR BROOKES: Internally?
6 MR TANSLEY: Yes.
7 MR BROOKES: Are you aware of that?
8 MR TANSLEY: Yes.
9 MR BROOKES: It highlights many of the things that you're saying. Was – including the
10 difference – different approaches that the different divisions were taking, was there
11 any attempt, that you were involved with, to address the issues that had been raised by
12 that report? I've seen the report. I've seen it acknowledged, but I haven't seen
13 anything to say what happened about that report.
14 MR TANSLEY: Yes. Again, I think it was part of that cultural thing about, 'This is
15 delegated to you, get on with it.' Without the, necessarily, the right advice and then
16 support for those divisions, you know. If you don't know what you don't know, how
17 do you move and migrate to something that actually strengthens governance from
18 ward ~~board~~ to board?
19 MR BROOKES: So how did the board keep – provide their own assurance themselves that
20 these issues, which had been identified, are being addressed?
21 MR TANSLEY: They designed their new system and trusted that that was working.
22 MR BROOKES: But there's evidence that that is perhaps the attitude that was there
23 previously…
24 MR TANSLEY: Previously.
25 MR BROOKES: When there was committee structure in place…
26 MR TANSLEY: Place.
27 MR BROOKES: But potentially weren't working.
28 MR TANSLEY: Weren't working, yes.
29 MR BROOKES: So what was different about this one?
30 MR TANSLEY: In terms of only board?
31 MR BROOKES: Well no, I mean in terms of in theory any of the previous structures, to
32 varying degrees, would have worked if every component had done what they were
33 meant to do, effectively.
34 MR TANSLEY: Yes.

1 MR BROOKES: So I'm just trying to understand why this one was different. If they
2 reorganise again, they've got the new structure in, what I'm just trying to understand
3 is how board be assured that the work that they've delegated to divisions was actually
4 happening?
5 MR TANSLEY: I – my – the mechanism would have been through – the had two
6 performance committees, which were not – they didn't report into the board level
7 committee on patient safety and governance but divisions, on a rotation, were invited
8 – not invited, scheduled, to come before the executive to report on their performance,
9 both financial and the quality arena. Sadly I was not part or invited to those meetings.
10 I understand that David Holden, when he joined the organisation for the short time he
11 was, was a key member of that.
12 MR BROOKES: Okay. So structurally you've got your division.
13 MR TANSLEY: Yes.
14 MR BROOKES: Who runs on a set of terms of reference and mode of operation which they
15 decide themselves. Is that correct?
16 MR TANSLEY: Well, I mean I can't remember them coming up for agreement at the board
17 level committee, which I would see as normal or standard practise, yes.
18 MR BROOKES: Certainly the indication from the report I referred to was – is that there was
19 various terms of reference...
20 MR TANSLEY: Yes, there were.
21 MR BROOKES: Various meeting, various mentorships in place.
22 MR TANSLEY: Yes.
23 MR BROOKES: So I'm making that inference...
24 MR TANSLEY: Yes. No, that's...
25 MR BROOKES: So you've got your divisional structure there.
26 MR TANSLEY: Yes.
27 MR BROOKES: Then the – you talked about disconnect. Was there a disconnect between
28 the divisional structure and the corporate structure?
29 MR TANSLEY: Yes. I mean there were a number of times where things were articulated to
30 me and so, for example, if we look at the Women and Childrens Division ~~Family~~
31 ~~Care Division~~, there was a heightened trigger list for serious incidents that we'd put in
32 place in agreement with the local area team and the CCG, and there was a constant
33 battle to, you know, have the senior management team provide the information that we
34 needed to assure, you know. So I'm not sure if it was a reaction to the change from

1 devolved responsibility to divisions, to moving to a stronger, centralised, corporate
2 oversight, but there seemed to be a tension there.
3 MR BROOKES: Okay. You mentioned about shooting the messenger.
4 MR TANSLEY: Yes.
5 MR BROOKES: How did that manifest itself?
6 MR TANSLEY: I will talk from personal experience. A number of papers that I may either
7 have supported the writing of or been the author of, in delivering the message to help
8 the board understand the picture, and what I could in terms of what actions were being
9 taken to attempt to address those. There was, I think, more than a robust challenge
10 and I routinely felt that the challenge was direct to me, rather than helping the board
11 understand how things are, to effectively support some change.
12 MR BROOKES: So you identified, potentially, an issue. Challenge of your view is totally –
13 entirely inappropriate…
14 MR TANSLEY: Absolutely, yes.
15 MR BROOKES: However there was no – did you feel that there was no acceptance that there
16 might be a need for change?
17 MR TANSLEY: No, no. There – I think they'd moved to a point where absolutely they
18 understood that, and I think there was a – clearly a frustration from a number of the
19 non-executives in terms of pace. But, you know, I mean my function in the
20 organisation was to help people understand how things are, do what I can to support
21 the management teams to identify how to, and what to change and demonstrate that
22 they're doing that. But, you know, repeatedly it was pointed in terms of – or my
23 perception was that I was responsible. I wasn't doing. Whereas actually my view is
24 that the board and senior management team needed to understand how things are to,
25 you know, was there a requirement for a different approach? Was there a requirement
26 for investment in areas to support those changes?
27 MR BROOKES: Okay.
28 MR TANSLEY: Yes.
29 MR BROOKES: During your period, or around your period was the Price Cooper's report,
30 which you mentioned.
31 MR TANSLEY: Yes.
32 MR BROOKES: How was that being tackled?
33 MR TANSLEY: It was published. I then met with a key individual from
34 PricewaterhouseCoopers to draw up, I suppose, a work plan, which I think was then

1 managed through their PMO, and then an officer from their PMO met with me on, I
2 think initially a weekly basis, to effect…
3 MR BROOKES: Sorry, when you say, 'Their PMO' do you mean Trust PMO?
4 MR TANSLEY: The Trust PMO, yes.
5 MR BROOKES: That's just a – it's a project management office?
6 MR TANSLEY: Yes. Project management office, yes.
7 MR BROOKES: Thank you.
8 MR TANSLEY: So I then met with an officer from Morecambe Bay's project management
9 office to, effectively, be called to account. To give evidence on how I was making
10 changes. What was the evidence, yes.
11 MR BROOKES: Okay, and were you given the support you needed in terms – because, as we
12 said, a lot of this is happening in divisional level. How did that operate? There's a
13 corporate plan, but it would require action from a variety of parts of the organisation.
14 What was your role and function in terms of assuring or ensuring that things happened
15 at divisional level and below?
16 MR TANSLEY: That was about being out there with the divisions, trying to effect those
17 changes and trying to improve and then report back on that.
18 MR BROOKES: Was there an acceptance of the findings as being an accurate representation
19 of the position of the Trust?
20 MR TANSLEY: Yes, ~~I—yes~~. I think there was, yes.
21 MR BROOKES: Okay.
22 MR TANSLEY: From memory.
23 MR BROOKES: Were you there during – I think it was an annual revisit by Price Coopers as
24 well, wasn't there?
25 MR TANSLEY: I saw a lot of PricewaterhouseCoopers for various reasons.
26 MR BROOKES: But they came back. They did their initial report and then, a stage later on,
27 I'm trying to remember when it was, was that – should be within your period of time.
28 They came back and did a follow up report.
29 MR TANSLEY: Follow up, yes.
30 MR BROOKES: Follow up report, and again it's – we've heard testimony to say that, while
31 there was progress in the right direction, that the organisation was still quite a way
32 from where it needed to be.
33 MR TANSLEY: Yes.
34 MR BROOKES: Would you agree with that assessment?

1 MR TANSLEY: Yes.

2 MR BROOKES: What were the key things it still needed to focus in on?

3 MR TANSLEY: I think the – that there was still, in my view, an issue about knowledge and
4 competencies within divisions. Divisions in terms – in terms of the divisional
5 governance arrangements. They effectively had sort of A N Individual who was
6 responsible. So they had a governance lead, and so you know anything with that
7 badge came to them, sat on their desk, was their responsibility. Rather than, you
8 know, governance is all of our business. Their job should be about supporting, should
9 be about coordinating, and so there wasn't the change, I don't believe, at a divisional
10 level, to enable that change - across the organisation that was the case. However,
11 within Women and Children's Services there was more resource, and they were
12 stronger than many of the other divisions.

13 MR BROOKES: Clinical governance is, in part, dependent on an open learning culture that
14 everybody buys into...

15 MR TANSLEY: Yes.

16 MR BROOKES: Would you describe that as the culture in the organisation?

17 MR TANSLEY: I think – I was talking outside of the room about where and what I'm doing
18 now. The changes that have happened where I'm working have been about clear and
19 visible leadership, and a visible change in culture in quite a short period of time. On
20 reflection, was that happening at Morecambe Bay in my time, with Morecambe Bay?
21 I would say I didn't feel it and I didn't see it.

22 MR BROOKES: What was the – I can't say strength. The clinical leadership within the
23 organisation?

24 MR TANSLEY: The clinical leadership.

25 MR BROOKES: So I'm thinking around clinical governance and the importance of associate
26 directors or clinical directors, medical director etc., nurse director and clinical groups
27 who really can lead and challenge in that change of culture. Was that visible while
28 you were there?

29 MR TANSLEY: I would say in part, yes. I spent a number of hours, days, looking to engage
30 at that level in maternity, obstetrics at that – when I was there. Because that seemed to
31 be the case. Some challenges I experienced were around the emergency care pathway
32 but, you know, with constant referral to issues around, you know, governance, being
33 seen, about bureaucracy and attending meetings when I need to get on with
34 clinical...yes.

MR BROOKES: That's very helpful. You mentioned that you set up the Serious Untowards Incidents Panel.

MR TANSLEY: Yes.

MR BROOKES: You set it up from what? What was there there before, and what was the purpose of the Panel?

MR TANSLEY: Okay, so Mary Moore had actually started ~~stopped~~ it, the piece of work. When I got there I worked to support and strengthen it in terms of its terms of reference etc. So effectively what we were looking to do was give broad oversight to serious incidents that required investigation, or the old language, Serious Untoward Incidents. The purpose of it was – there were a number of – a number of purposes. One, to help the board understand where, when incidents were happening of that nature, what was being undertaken to look to safeguard immediately that patient, or to learn to stop a replication of similar incidents. But also to be a forum in which the divisions and clinical staff could attend, again to learn from incidents as well.

MR BROOKES: What was your view on the quality of the recourse analysis undertaken?

MR TANSLEY: In the time I was there, it changed. We had an issue in terms of – and I suppose, again, sort of speaks volumes about how things had been devolved. So rather than a template, reports of various styles were coming through rather than, you know, this is how we want this information presented. So what we – what I looked to do is – so all incidents coming into the organisation and being reported had – were reviewed on a daily basis.

So the team I was managing, incidents were being reported on a central system, were held in an area. We then reviewed those. Our [inaudible] reported at the right level, yes or no. Did it need escalating or de-escalating? If it was of a serious enough nature then I would ask for a rapid review. The rapid review would be asked to be supplied back to us within 24 to 48 hours. The point of which was to then make the executive aware that that incident had happened and what steps we'd put in place immediately to manage any risk, including what work we might need to do with comms, to prepare them. Then the authors of – so we would then set up an investigation team. The reports would come through, and when I joined the organisation, one they were of a different…

MR BROOKES: Quality.

MR TANSLEY: Quality and, I have to say, within the time I was there, that had significantly changed. To the point where I felt confident enough to invite Linda Ward, who was, I

think, the Local Area Team, to come and participate and observe the SIRI panel and, in so doing I think that contributed to us effectively being able to move the ~~{~~Trust ~~inaudible}~~ reporting criteria within Women and Children's Services, back to the national agreed standard. - triggers

MR BROOKES: Just one more thing. You've mentioned on a couple of occasions, and described it quite well, I'm just interested in the use of the word, 'Devolved divisions.' I'm very conscious that it was a high emphasis, an important emphasis on frontline involvement in governance, but it sounds to me like you're saying it was a conscious decision to devolve that down and that they were the responsible components. Is that a misunderstanding?

MR TANSLEY: I – it's a perception. Because prior to arriving that felt as though – in terms of the behaviours when we were looking to support and strengthen a non-corporate function and direction, the resistance felt...

MR BROOKES: So a key – the key component part of the organisation was seen as the divisions in terms of governance?

MR TANSLEY: Yes.

MR BROOKES: Okay.

MR TANSLEY: Okay.

THE CHAIR: Okay, thanks Jonathan.

PROF MONTGOMERY: I think most of the areas have been covered. There are a few areas that you may or may not have had anything to do with, which I'd just like to find out. One was around the standing of the organisation with the CQC and whether that got entered in terms of it being a risk that would go through the register. So I'm thinking about conditions and all those sorts of things. Would that have been part of your remit?

MR TANSLEY: Part of my portfolio would, and was, about communication with the CQC, yes.

PROF MONTGOMERY: So when you arrived, January 2012, what was the status of the organisation with the CQC as it was – as you were briefed on it?

MR TANSLEY: Well, when I arrived that wasn't part of – so...

PROF MONTGOMERY: Okay.

MR TANSLEY: So there's a journey, in terms of my two years with the organisation. So when I arrived there was a specific piece of work that I was doing. That then was renegotiated as that first year happened, and so at that point I don't know what the...

1 PROF MONTGOMERY: There were various warning notices…
2 MR TANSLEY: Yes.
3 PROF MONTGOMERY: At the end of 2011 and going through the first few months of
4 2012…
5 MR TANSLEY: Right.
6 PROF MONTGOMERY: And we've been trying to understand what was in place and what
7 wasn't in place at particular times, so I wonder if…
8 MR TANSLEY: Right. No, I …
9 PROF MONTGOMERY: You can tell us anything that was said to you when you arrived?
10 MR TANSLEY: No, I wasn't tasked with any or sighted on any of that at that point.
11 PROF MONTGOMERY: Thanks, and what about Gold Command? Did that have any
12 impact on your work at that early stage? Also was running around the time.
13 MR TANSLEY: It was. I wasn't part of – that would have – I think that would have – that
14 would have been – I was reporting up through Jackie Holt. So…
15 PROF MONTGOMERY: And what was your impression of the impact of Gold Command on
16 the organisation and Jackie's availability to you and what it did to her work?
17 MR TANSLEY: It – it took up a lot of time, and it felt that people weren't visible because of
18 that.
19 PROF MONTGOMERY: And did you see any benefits to the Trust from Gold Command.
20 MR TANSLEY: Not palpable, no.
21 PROF MONTGOMERY: Okay, thank you, and I guess similar sort of questions really about
22 the Care Quality Commission Section 48 investigation, and what sort of impact that
23 had on the Trust and whether it helped you with your job or was a distraction?
24 MR TANSLEY: So Care Quality Commission Section 28…
25 PROF MONTGOMERY: 48…
26 MR TANSLEY: 48…
27 PROF MONTGOMERY: Okay, again did the – any – care pathway review – we're sort of
28 trying to understand how that had an impact on the Trust.
29 MR TANSLEY: Okay, and when – sorry, I don't know when that was in place.
30 PROF MONTGOMERY: 2012.
31 MR TANSLEY: 2012. No, I'm sorry, that's not something I was sighted on.
32 PROF MONTGOMERY: Okay, and I think the only other thing was I just wanted to make
33 sure that I've understood the shoot the messenger culture point. Because it could
34 mean quite a lot of different things. I think I've heard you describe that it wasn't that

1 you're saying they didn't want to hear bad news, it was that they were expecting you
2 to sort things out but really it was just your job to make sure they knew what's going
3 on. Is that what I've understood?
4 MR TANSLEY: Yes. Yes.
5 PROF MONTGOMERY: So you wouldn't want us to infer from that that at the time you left
6 in 2013 the board was refusing to accept there was a problem...
7 MR TANSLEY: No.
8 PROF MONTGOMERY: They did accept there was a problem, it was just that they were
9 expecting things to be...
10 MR TANSLEY: No, no absolutely not. I think there was a frustration about pace. Which
11 was often ...
12 MR BROOKES: That it was too slow?
13 MR TANSLEY: It was too slow. But I mean my concern about – about how that's delivered
14 is, you know, a number of people might, on that basis, reflect on what they say and
15 what they make available, you know, so I mean I'm of the opinion, you know, I felt
16 strong enough, yes, to be telling them but also still have an active registration with the
17 NMC and so have a professional responsibility to do that too.
18 MR BROOKES: Sure, thank you.
19 THE CHAIR: Okay, is there anything else that you want to say to us?
20 MR TANSLEY: No, thanks.
21 THE CHAIR: Okay, thank you very much for coming.
22 MR TANSLEY: Okay.
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THE MORECAMBE BAY INVESTIGATION

Monday, 22 September 2014

Held at:
Park Hotel
East Cliff
Preston
PR1 3EA

Before:

Julian Brookes – Expert Advisor on Governance and Chair of the interview
Dr Catherine Calderwood – Expert Advisor on Obstetrics
Dr Geraldine Walters – Expert Advisor on Nursing

DAVID TELFORD

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MR JULIAN BROOKES: Good afternoon. Can I, first of all, begin with an apology from Bill Kirkup who's chairing this investigation? Unfortunately, he can't be here this afternoon. I'm just going to go through some housekeeping things and ask the panel to introduce themselves and then if you could also, for the record, introduce yourself that would be really helpful. We'll start with that.

DR CALDERWOOD: Afternoon. I'm Catherine Calderwood; I'm an obstetrician in Edinburgh. I advise the Scottish Government and I'm also the National Clinical Director for Maternity and Women's Health for NHS England.

DR WALTERS: I'm Geraldine Walters and I'm Director of Nursing and Midwifery at King's College Hospital.

MR JULIAN BROOKES: And I'm Julian Brookes. I'm currently working for Public Health England, but I was previously head of clinical quality at the Department of Health. And for the record...

DR TELFORD: David Telford. I'm a consultant microbiologist at Morecambe Bay.

MR JULIAN BROOKES: Welcome. You'll see that we're mic'd up. All these sessions are being recorded for too many reasons. One is to ensure we get an accurate record of the discussions, but the other is as these sessions are open to the families, obviously there's nobody here this afternoon, but they have an opportunity at a later stage under controlled conditions to listen to a recording if they so wish, just to understand what was said in their absence. We'll have asked everybody coming into the room to hand in their mobile phones, etc. That's just to ensure confidentiality and to ensure that there's no recordings made of the proceedings, because we're very clear that we want to ensure that anything that's said here is taken in the context of the whole hearings we've held and rather than take them in isolation or/and leaked or whatever.

DR TELFORD: So we do get transcripts of our testimonies.

DR CALDERWOOD: You get to see them, yes.

MR JULIAN BROOKES: Yes, you will. And on that, as well as confidentiality, in some of these interviews we have just come to discussion about a particular case. If we do that, we will not do that in the open session, we will do that at the end in a closed session, because of the confidentiality around those cases. Okay. And just finally, we're not expecting a fire alarm, so if the fire alarm does go off we will leave the building.

DR TELFORD: Yes.

MR JULIAN BROOKES: Okay. So we'll start with some questions then.

DR WALTERS: Afternoon. Can you just tell us about your roles at the Trust from the time you were first there until now?

DR TELFORD: I was appointed as a Medical Director of Morecambe Bay Hospitals Trust at the end of 2001 and resigned in March 2006. Before that I'd been an associate Medical Director for the merged hospitals and before that I was a Medical Director of Kendal Trust when it was a separate institution. So I'd have thought it was about 10 years of corporate life or something like that.

DR WALTERS: Right. And from when the Trust was merged what were the sort of big issues over the years?

DR TELFORD: Finance, finance and finance I would say. The funding formulas didn't recognise split site working in multiple hospitals very well. We were always on the back foot, always running some degree of overspend and that tended to dominate the agenda for my years in corporate life.

The other issues – is it alright if I refer to notes? Thanks. It's a while ago and I'm not as au fait as I used to be with these things. The finance was a big issue; it was the main reason we steadily lost star ratings in the early noughties and one of the significant reasons why we didn't progress with Foundation Trust status in 2004/2005. Latterly it became much more aggravated by the impact of PBR where the funding formulas again didn't recognise rurality, so we tended to run very expensive against reference costs. We didn't do badly, but nonetheless it was a big struggle and, from the records, I'd forgotten that equal pay claims started to emerge as a very large potential issue. I don't think we were actually losing money on them at the time, but people were starting to hide money away against equal pay claims and that was looked to be a potential – another big financial hole that we were starting into.

Having said that, my own professional life in those years was the merger and the consequent rationalisations around that. Trying to overcome the competitive edge between two ~~[inaudible]~~ competing hospitals well, two and a bit. Trying to get the balance right between having critical mass against local delivery of services, which set some challenging agendas around what to do with Westmorland General Hospital and two smaller hospitals in Ulverston

and Morecambe as well, and what to do with that property stock as well. And trying to keep a close eye on – I was personally concerned that whilst a merger was inevitable and necessary around the critical mass sort of issues, the danger of that is you lose local focus and the more you concentrate on the big issues the less you're concentrating on small local issues. It's such a diverse area with very different social patterns, very different demographics, very different hospital cultures, very different risk profiles, I think we had to be careful about how far we tried to pursue a ~~homogenisation~~ I think I might have said 'harmonisation' sort of agenda. What was appropriate in Barrow wasn't necessarily appropriate in Lancaster and vice versa, so trying to keep that sort of balance, critical mass versus local service and local fairness.

DR WALTERS: The finance and the critical mass together, did that give you any clinical quality concerns, the combination of the two?

DR TELFORD: Over and above the quality concerns that you've always got in a big trust, at the time, not particularly. I'd watched the emergence of an increasingly Treasury-dominated cost-cutting agenda from the mid-90s onwards, something like that and, in some ways, saw the development of clinical governance as a way of trying to keep some balance and proportion in that. I'd been interested and enthusiastic about clinical governance and watched it develop before it was ever called that, from the introduction of audit in the mid-80s and then clinical risk management in the '90s, devolution of claims down to trusts. All of it, very encouragingly at the time, allowing more local focus on some of these issues and as the finance agenda gathered steam, I thought it was quite a useful way of keeping the balance proportionate. During my years, I think it's fair – I saw it coming, but I wasn't – it wasn't critical at the time and the trust, at the time, was very committed about quality issues. When we merged the trusts in '98, we had three separate departments of clinical audit, clinical risk, complaints. That was a substantial resource, three separate ones, rather better than many other similar-sized trusts would have and I thought that would be an invaluable resource for pursuing what was almost a personal interest at that stage and – if it wasn't going to get rationalised out of existence. Fortunately, with the new Trust board I found myself pushing at an open door.

DR WALTERS: When you say the 'new Trust board' what year are you in?

1 DR TELFORD: '98 onwards, '98, '99. And there was very little demand at the time
2 by way of financial contraction around the governance agenda and it was
3 going to be an interesting project to merge these three departments into a
4 robust governance department, because about that time the word
5 'governance' was starting to get used. So in the new trust I was given the title
6 of associate Medical Director with some responsibility for governance and
7 started to knit together those three discrete teams and get some corporate
8 sense of direction to them.
9 DR WALTERS: So when you became the Medical Director in 2004, what state was it
10 in then?
11 DR TELFORD: 2001.
12 DR WALTERS: 2001, sorry.
13 DR TELFORD: We've gone back a bit before your terms of reference here, but
14 there's some relevant history there.
15 DR WALTERS: Yes. So in 2001 to 2006, how would you sort of describe how it was
16 developing and working, the clinical governance system, in the organisation?
17 DR TELFORD: We'd got a team developed. We'd got, I believe, a reasonably robust
18 governance structure. Very early on we had a clinical governance committee
19 that exercised oversight. It had a very robust membership – looking back, it
20 might have been too big, we were kind of ~~driving~~ I think I would have said
21 'bringing' not 'driving' in rather too many people, but it was chaired by the chief
22 executive, it had two Non-executive Directors including the Chairman as
23 standing members. It took regular reports from the various governance
24 elements and was quite a sound platform, I think, at the time. It wouldn't pass
25 muster in a 2014 assessment, I don't think, but it was early days. I think we
26 were probably ahead of the game at the time.
27 DR WALTERS: What sort of influence did that committee have on the board? Did it
28 generate any real changes that the board wouldn't have made otherwise?
29 Can you think of any?
30 DR TELFORD: When I say yes, you're going to ask me for some examples and I
31 might have to go away and refer to my board minutes for that. Where I said I
32 would have to go away and refer to Board minutes to give examples of how
33 the Board was influenced by the Governance agenda. I could refer to my letter
34 to Julian Brookes after my interview where I identified the Board receiving and

adopting the Clinical Governance Strategy (2002); Clinical Risk Strategy and Clinical Incident Reporting Policy (2002) and, throughout my tenure, the CHKS clinical benchmarking data, at corporate and directorate level, were openly discussed and acted upon by the Board. Other examples of Board engagement would be our review of Bay wide paediatric surgery (January 2001); discontinuation of intrathecal chemotherapy in November 2001; discontinuation of caesarians and labour inductions of labour, for safety reasons, at Helme Chase in December 2001. But yes, it was taken seriously. There's no doubt about that. You'll have had access to the board minutes and the governance group minutes yourself, which is what I mainly have trawled through to refresh my memory on these years and it's clear, I think, from the documentary record that we didn't shirk difficult issues. Reports were regularly brought. My own personal style was to encourage the individual departmental heads to present the reports. I thought, firstly, it made for a more direct board to be part – you know, more direct connection with strategy and operations and whichever area it was. It certainly made the individual managers feel much more valued and appreciated and in a sort of logistic sense it allowed direct questions. If someone had a question, I always felt, at times when I was giving the report, I couldn't really answer it. You know, I'd have to nip into the room next door and come back with an answer or write around later. All the questions could be answered, but the individual who was in day-to-day charge of a department could answer those questions straight off the top and that made for a better dialogue between board and department as well. And also, without going through me, it impressed upon the claims manager, the governance lead, the complaints manager, litigation, whoever, what the trust board was interested in, concerned about and valued. And I think that ~~direction~~ direct connection was very useful to them, to the individuals working there. Also helped assure the board as well what was going on. I think it's always better when individuals turn up and give these reports than when they're transmitted through a third party Ulysses – our web-based reporting software, however well that third party's briefed.

DR WALTERS: What did you used to lose sleep over as medical director?

DR TELFORD: Medical staffing at all levels. Again, the record will show we were regularly on the back foot by way of consultant staffing. We had quite heavy

use of locums. The service was thin. Exactly the same applied to the Junior Doctors, trying to get the balance between their service commitment and their training commitment. We always did very well in the days when you'd call it inspections, but it was always a challenge. I well remember talking to colleagues in the medical ~~directing~~ directors network. When EWTD started to bite, we had some major issues. ~~[inaudible]~~ but in the teaching hospitals they only had to make a few minor adjustments and all these external agendas were getting very challenging. My own personal approach to that was developing empowered nurses and nurse prescribers. We'd seen several examples of that working extremely well in all sorts of other areas and I thought with the way junior staffing was going to having progressively less service commitment, the only way forward for rural trusts like ours was going to be with empowered nurses. And we were lucky in the early days of having some exceptional individuals who could, I think quite unusually, develop themselves into a role at the same time as the role was developing and so there weren't any clear goalposts for them. And I was quite proud with the way we started to introduce nurse specialists, nurse practitioners, empowered nurses at all sorts of levels in order to try and fill these gaps.

Yeah, it was probably medical staffing that caused me most worry and looking around in the privacy of my office meetings, the amount of stress that was causing some fellow consultants, especially the younger ones. The postgraduate training schemes were producing – still are – were producing individuals who were used to working in very large multidisciplinary teams with very high levels of specialisation and very high levels of personal support. In Barrow and, to a lesser degree, in Lancaster they didn't get that and some of them were seriously flaky. The senior registrar training programme just didn't equip them for a busy, multitasking life at a DGH level and there were quite a lot of stress absences and that sort of thing. That was a worry as well, the fitness for purpose of the people coming off the training programme. We set up a consultant mentoring scheme by buddying off new consultants with an older individual to try and give them somebody outside the appraisal network, someone they could develop a personal relationship with who would help them through the issue. None of them were insoluble, but we did see senior registrars who, one Friday morning – on a Friday afternoon in a time-protected

1 senior registrar training environment, any problems were sorted for them, because Monday morning they were in clinic, the phone was going, somebody had banged four extra patients onto the list, the SHO hadn't turned up and they simply didn't have a clue of how to adapt to it.

DR WALTERS: So did you start to see sort of incidents related to then perhaps having lots of temporary medical staff, any communication-based incidents or incidents or anything?

DR TELFORD: Not serious incidents. I would distinguish here between what have grown to be called SUIs. At the time we called them major critical incidents or something like that, if I remember rightly. They were the ones that resulted in death or harm. I was particularly interested in the emerging risk agenda – risk – yes, risk agenda, because it wasn't the serious incidents that were driving a lot of it. I think a serious incident, if someone replaces the wrong hip in a theatre, the chief executive knows about that before the patient's out of theatre. If someone is killed with an overdose of potassium or something, these things get escalated, always did, incredibly quickly. They can't be hidden. Of more interest was the lower-level stuff where you might be able to pick up trends and patterns, with a major incident at the end of it, but not in themselves major and where you need a much more sort of epidemiological approach and you're looking at grossing numbers up and trends and trying to spot patterns. And I saw quite a lot of those, yes, and through complaints as well, as someone under stress lost it at an inappropriate moment or something and we spent a lot of time working on that sort of thing, or people making the wrong call under stress. Again, nothing – no hideous consequences of that, just – and any professional would say, 'Yes, I shouldn't, yes, that was wrong' and they look at it and think about how they were going to manage that in future. So minor stuff, yes; major stuff, no.

DR WALTERS: So was it possible to send any of those trends about particular parts of the organisation which were more –

DR TELFORD: Early days, we had a paper-based system until Ulysses came in, I think, '05, '06, something like that, because we – I was encouraging minor incident reporting but it was paper-based, people had to take time to do it. It was a bit tedious. It was clear that some departments were doing it better than others; some wards were doing it better than others. Some people were

1 sending loads in and there was clearly some axe-grinding going on. Some
2 people weren't. There were a lot of teething problems around it, but I still think
3 it was worth doing. And then of course, you're in the situation with minor
4 incidents where you're in danger of drowning in them and how are you going
5 to get the balance in proportion to it or are you going to go down an electronic
6 system where you can start to get more automated data handling of your
7 complaints. I think it's fair to say by the time I'd stopped being medical director,
8 we'd got the complaint – the critical incident – the electronic, it was working.
9 We'd got some – a lot of the teething problems sorted out. There wasn't a
10 robust enough dataset to start looking at trends apart from, slips, trips and falls
11 where there was enough to start doing some analyses looking at areas,
12 starting to make recommendations about clinical practice, staffing levels and
13 this sort of thing. But there were a lot of slips, trips and falls, so you could
14 quite quickly build up a dataset for those; other stuff – medication errors – they
15 come through a bit more slowly.
16 DR WALTERS: Had anything to do with maternity in Barrow raised its head at the
17 point when you were...?
18 DR TELFORD: No. It wasn't really on the radar. There were one or two issues.
19 There were some personality issues around merging departments. There
20 were some issues about let's call it maturity or rather immaturity about one or
21 two consultants that didn't really need to be issues, that resolved by finding
22 mature enough people to be in charge, sitting down, having a few sessions
23 with them and getting some structure into their working lives.
24 In terms of risk, reports, complaints, litigation, a while before – the only
25 thing – a little while before 2004, they had seen about three shoulder
26 dystocias in Lancaster in a couple of years, which we thought was maybe
27 getting a bit too many. We had a look at it, talked to people, looked at the
28 incidents, couldn't find any pattern to it and it went away. We could only
29 conclude it was just an unfortunate cluster. But nothing – unlike one or two
30 other areas in medicine and surgery which, well, as you probably know
31 yourself as a corporate person, 1% of your staff occupy 90% of your time and
32 none of those were in maternity.
33 DR WALTERS: So, you've talked about the sort of small volume services, so you've
34 got essentially a small volume service with perhaps lower levels of staff on the

1 obstetric, paediatric and midwifery side. So there's an inbuilt risk there, isn't
2 there?
3 DR TELFORD: Yes.
4 DR WALTERS: Do you think – were the board aware of that or do you think it was a
5 case of, you know, there's nothing reactive coming out, so therefore it's alright?
6 DR TELFORD: Yes, we were always very explicit, because it fed into the financial
7 arguments, that running three of everything when we were budgeted for one of
8 everything made for thin cover or cost overruns or, if you're unlucky, both at
9 the same time. And so the issue about staffing levels was very central in
10 discussions about finance, yes.
11 DR WALTERS: Okay. Thank you.
12 DR CALDERWOOD: Thank you. I think you've covered some of my questions and I
13 was very interested – that I had on my list to ask you about medical staff
14 recruitment, because as you probably know, we've interviewed and gone
15 through a lot of case studies and so that, as a clinician, has jumped out as
16 being a problem both in the obstetrics side, but also in paediatrics. And I am
17 interested to hear about your bringing in the nurse specialists. That's the first
18 time I've heard that and I know we've only been looking at obstetrics,
19 obviously, and paediatrics, but I would be thinking, given that you were – it
20 was 10 years ago, I would have expected that if those were the solution they
21 would be there. And it's 10 years down the line; I am not aware that there are
22 nursing and midwifery specialists in obstetrics –
23 DR TELFORD: Oh, nursing and midwifery. Well, the midwives invented the
24 specialism really and always have been a very empowered set of nurses.
25 DR CALDERWOOD: But not at – what I'm meaning is the sort of level that they
26 would be taking some middle-grade duties, given that we know the problems
27 with the low –
28 DR TELFORD: ~~Yes, no, no~~ No, that wasn't happening, not during my tenure; I'm not
29 sure subsequently. I think if I'd stayed around we'd have got there, because
30 it's such an obvious solution, yes. And I was very impressed, I remember one
31 of the visits we did was to the John Radcliffe Hospital, looking at paediatrics
32 there, when if you took your sick child into the Radcliffe you didn't know
33 whether you were seeing an SHO or a nurse, you couldn't tell, except that

after they'd been doing it for three years you could, because the nurses were more experienced.

DR CALDERWOOD: That's very interesting, because that's an ethos that you're putting over which I agree as being a very good solution, but which then – obviously this is beyond your time now, but is –

DR TELFORD: I think possibly because I didn't perceive – again it's about maternity not being particularly on the radar as regards high-risk – the maternity staffing levels weren't that bad, actually, ~~[inaudible]~~ certainly not dangerous. The areas where we were looking, I think, quite dangerously exposed were in acute medicine, medical admissions, acute surgery, this sort of thing and that was a gap that desperately needed filling and so you go for those first.

DR CALDERWOOD: And again I appreciate it's a while ago and things may have changed, but do you have any thoughts about the level of skill or competence of staff because of the numbers or the volume? I'm thinking particularly of resuscitation or in emergency situations, which might happen very infrequently.

DR TELFORD: We were very concerned about that sort of thing – like I say, unusual events where you really have to be clued up when it happens, because you can't go away and read about it – and we put a lot of effort into issues like resuscitation. There was a separate resuscitation group and a separate paediatric element of that. And were concerned to build – I had some – a couple of very good resus officers who looked after that for us.

Other rarer stuff, in Barrow, if anything, because of relatively thin – and, well, Lancaster too, because of relatively thin levels of medical cover and talking to colleagues in similar hospitals around the country, the nurses, if anything, were more empowered than you would find in more robust established units, because they were – and the same with the junior doctors. A lot of junior doctors –a significant number, I would say, rather than a lot, found working in Barrow very good and very informative for their training, because they were expected to get on with it quite a lot more. You know, the level of consultant support for them was less than in other hospitals. There's a type of junior that revelled in that environment and they were obviously going to go on and do very well, because they learnt a huge amount from there. The same as when we had junior doctors in Kendal. Some of them simply couldn't cope with that and were seriously stressed as a result – different personalities,

1 horses for courses. Same with the nurses; they eased themselves into these
2 roles. One of the reasons I got involved with nurse prescribing in the first
3 place was a lot of the nurses – and that includes midwifery – were very
4 empowered on the intensive care unit in particular. I was worried that wasn't
5 recognised. There was no sort of governance around that and they were
6 drifting into areas where it was quite safe, but they were getting a long way
7 from what the nurses were traditionally being expected to do. I didn't have a
8 problem with that in principle, so long as the governance was sound, that it
9 was recognised and they were getting trained and they were well supported
10 and all that. It's why I encouraged it. Rather than stop it, which would have
11 been the safest thing to do, I thought it was better to develop a governance
12 system around it and recognise it and grasp the nettle.

13 DR CALDERWOOD: And obviously going back, because you were medical director
14 but you are still working in the trust, do you feel that the provision of service is
15 as good as it could be, weekend cover, bank holidays, back then and now?

16 DR TELFORD: Then and now.

17 DR CALDERWOOD: And I mean all, not emergency, diagnostics, and a senior
18 opinion on a bank holiday would be available?

19 DR TELFORD: Senior opinion, yes. It might be telephonic, but it's there. Senior
20 opinion where it matters, high-profile, acute physicians, obstetricians, I think, in
21 a lot of – we're getting out of my area now. I wouldn't like to – maybe better
22 not go there and make detailed comments about obstetric cover at the
23 moment. You need to ask someone else about that, I think. But I'm regularly
24 on call myself for my own discipline now. I'm regularly rung up by consultants
25 at all times, who clearly are getting involved with patients. So I think it's robust
26 enough. And from contact with obstetricians and gynaecologists out of hours,
27 I think it's robust, yes.

28 DR CALDERWOOD: And a willingness – if there is a problem that's either there or at
29 a level where it needed tertiary care, a willingness to move there and to
30 transport patients.

31 DR TELFORD: Oh absolutely, yes. I would think so, yes. Possibly over-cautious in
32 some of those respects, if anything, which is probably better than
33 under-cautious.

34 DR CALDERWOOD: And are you talking about now or in the past?

1 DR TELFORD: Certainly now. In the past, yes, I think so. Where we've found
2 instances – there were the odd couple of instances about slow ~~[inaudible]~~
3 response times or transfers, or cases where they could have got a consultant
4 in faster, this sort of thing, it looked like a wrong call made in good faith rather
5 than, you know, this is good, she's going to give birth, she's going to give birth
6 and, you know, you still see those regularly. I think one of the problems in
7 these critical incidents is trying to distinguish between is there a systematic
8 problem here or is it genuinely a wrong call made in good faith.
9 DR CALDERWOOD: And so would you have been aware in your time as medical
10 director of incidents like that?
11 DR TELFORD: I would have been, I would hope. I would certainly have been if it
12 had resulted in harm. I would have expected to find out eventually through the
13 reporting system if it hadn't resulted in harm. Did I? There was one instance
14 of a paediatric transfer, if I recall. I think I would rather go away and look at
15 the detail about that, if you want it, rather than saying off the top of my head.
16 DR CALDERWOOD: No, that's fine. I realise it's a while ago.
17 DR TELFORD: There were, yes, but there was no big pattern or trend or recurrent
18 behaviour to that effect.
19 DR CALDERWOOD: Thank you for the moment.
20 MR JULIAN BROOKES: Can I just ask you to describe how you would have
21 managed or been involved in a serious incident that happened in the trust?
22 DR TELFORD: 'Serious' in the sense of harm or death resulting.
23 MR JULIAN BROOKES: Yes.
24 DR TELFORD: That would have been escalated to the chief executive's office or me
25 very quickly. Who exactly picked it up would depend on who was around at
26 the time. We would then, firstly, make sure everything was being done to
27 render the situation safe. I'm thinking there of things like equipment failures,
28 get it out of action, do you need a replacement, the immediate sort of stuff in
29 order to make it safe and continue service. Then, at a more measured level,
30 convene a group to have a look at it. Again that would entirely depend on
31 exactly what the situation required. And then get some outcomes from it. The
32 reason for that is, certainly with the deaths, that is going to go to the coroner's
33 court and I firmly believed, not just for defensive reasons, because it's very
34 important to be publicly reassuring about these things, by the time the thing

1 came to inquest we should have the answers in place. And that set an
2 agenda for us as well. And also to be very open with the coroner as to what
3 had gone wrong and, therefore, with the public because this is a public
4 meeting. Be open about what had gone wrong, be open about failings,
5 weaknesses, lapses, whatever and be frank about what we'd done about it.
6 Does that sort of...?
7 MR JULIAN BROOKES: So was that set down in policy in terms of procedures?
8 DR TELFORD: Yes.
9 MR JULIAN BROOKES: Was it that everybody knew about it?
10 DR TELFORD: There was a critical incident policy. The last revision during my
11 tenure would have been autumn 2005 and that was largely – it didn't do much
12 – it did more work about defining what we thought were serious incidents, but
13 it was mainly around the electronic reporting system. We completely changed
14 the reporting system and that was the main driver to the 2005 revision of
15 procedures and policy.
16 MR JULIAN BROOKES: So you're a jobbing clinician on the ward, an incident
17 happens; would you automatically know there was a policy and procedure?
18 How would you – it's about if there's a difference between having a policy and
19 understanding what has to be done.
20 DR TELFORD: Well, I suppose that's why I started out saying earlier about the major
21 incidents not actually being a problem in this, because somebody thinks oh my
22 God, we've got to tell somebody about it. So the serious incidents get –
23 always did, before I was ever a medical director they were escalated very
24 quickly indeed, because any clinician really has to share that, they're not going
25 to try and hide it. And almost it didn't need a policy. It was sort of like hand
26 washing or something; it was something you used to expect of people. And
27 it's delivered; I don't think I've ever seen a situation where we had a serious
28 incident and we didn't know about it very quickly indeed. It was, like I say, that
29 almost didn't need a policy.
30 MR JULIAN BROOKES: But part of the patient safety was about – the whole
31 raison d'êre was about a systematic approach to this.
32 DR TELFORD: Yes, the systematic – I think what you do then and, very importantly,
33 no blame, supporting people, getting the right people together, encouraging
34 them to be frank, which means not being challenging with them about it, at

1 least in the early stages, they were certainly written into the policy how we
2 would react. I think because all the very serious incidents, they're almost
3 one-offs in the sense that you investigate them and think blimey, could that
4 happen again? Well, yes it could, but it won't because there was such an
5 unusual coincidence of events. And – so, no I don't. If they needed
6 investigating they got investigated.
7 MR JULIAN BROOKES: And in the same way, systematically?
8 DR TELFORD: Yes, systematically, yeah. Again, that's what I was going on to say,
9 sorry. The policy – any policy ~~[inaudible]~~, I firmly believe; instead of trying to
10 best guess exactly what the situation would be and lay down rigidly who was
11 going to get involved, you set down a set of – a checklist almost of these are
12 the issues you need to be considering in order to get the information quickly,
13 move on to a good outcome and rather than be very prescriptive in detail
14 about who would do what, leave that to the individual incident. So, most of the
15 policies one knows are about how to react to critical situations, be it outbreaks
16 or whatever, is more a checklist of things to be considered rather than an
17 absolute must do list of things.
18 MR JULIAN BROOKES: And was there an accountable person on the board
19 responsible for incident management? It's two ways: one, who was
20 accountable for that?
21 DR TELFORD: That would have been me. One person on the board would have
22 been me or the nursing director, depending on the precise mix of the incident.
23 If it was predominantly medical in nature –
24 MR JULIAN BROOKES: How were the board involved in your processes for clinical
25 governance?
26 DR TELFORD: We reported – the minutes of the governance group were sent up to
27 the trust board. Also, we did regular board reports through the various
28 elements – complaints, litigation, risk and so forth – again delivered by the
29 relevant professional. In the context of the investigation, it would have been
30 helpful if I'd added that the Maternity Clinical Risk Manager also delivered a
31 quarterly report to the Board in addition to complaints, risk etc If I recall, it was
32 about quarterly, I should think, something like that, four a year from each of
33 them. We didn't overwhelm the trust board; we staggered them, so one month
34 it would be risk, another month it would be litigation, another month it would be

1 complaints and so forth, another month it would audit. But they got regular
2 reports again with an opportunity to quiz the relevant professional about what
3 was going on.
4 MR JULIAN BROOKES: Okay, that's helpful.
5 DR TELFORD: And individual incidents, again there's a pretty good documentary
6 record. Serious incidents were discussed at board level and presented at
7 board level. Once we'd done that, non-executive directors invariably kept
8 wanting to know what was happening, so follow-ups were mandatory once
9 we'd told the trust board about it. And that was long before STEIS came along.
10 MR JULIAN BROOKES: So you've got – I think I'm reasonably clear on the way in
11 terms of risk incidents were handled, but alongside that you've got clinical
12 audit. How was that process handled? Was it – well, was there a programme
13 of audit, systematic and controlled by the organisation as opposed to
14 individual audits where people –
15 DR TELFORD: Both, yeah. We let people, especially the juniors if they want to
16 pursue an interest, we had a trust audit agenda and we also had a national
17 audit agenda to work to as well and the audit department – I was quite keen in
18 not letting it get overruled with any one of those three agendas. I think letting
19 people have their own sort of development ideas and pursue them is as valid
20 as jumping to the national tune as well, so yeah, we did all three.
21 MR JULIAN BROOKES: You mentioned about the three services coming together in
22 a group, specifically about the [inaudible]. Leave that to one side. In terms of
23 clinical services, did you see any pressure to amalgamate services from
24 having three of everything, as you said, into have one single service? What
25 were the drivers for that? Was it clinical quality or was it finance or was it both?
26 DR TELFORD: Clinical quality, critical mass, as I said right at the beginning really.
27 What did we do? We rationalised vascular surgery down to one site. We
28 rationalised the GI surgery on a ~~[inaudible]~~ Bay wide level to one ~~side~~ site.
29 Urology, we had a rather diverse approach; we had Bay-wide working. There
30 were no longer urologists appointed to any particular hospital. That was a
31 matter of spreading the resource more effectively, but the workload was such
32 that it was still perfectly sustainable on any site. Oncology, we appointed
33 oncologists right around the Bay and brought in other oncologists from the
34 regional centre or sub-regional centre, down in Preston, for some of the

1 slightly more esoteric stuff, but still built up two outpatients – no, at the time,
2 and inpatient chemotherapy units in Lancaster and Barrow. Where we could
3 see it was appropriate and where the critical mass driver was greater and you
4 can see from oncology I think that's where it was.
5 MR JULIAN BROOKES: I can see that, yes. Was there no discussion similarly
6 about maternity services?
7 DR TELFORD: Yes. Now, there was a midwifery review '04, '05,Our Maternity
8 Review was in fact in 2005. I referred to this in my letter to Julian Brookes and
9 attached a copy of the review something like that, which was – their reference
10 costs were relatively high. We were faced with having to look at that. We
11 didn't have a concern about quality, but we had to –
12 MR JULIAN BROOKES: You did or you didn't?
13 DR TELFORD: We didn't have a concern about quality. We got the department
14 essentially to review itself and present something towards a midwifery strategy
15 really. There was a conscious decision taken to continue with a consultant
16 unit in Barrow and Lancaster and a midwifery unit in ~~[inaudible]~~ WGH in
17 Kendal. So it was looked at. The outcome was no change. The decision was
18 to grasp the financial nettle.
19 MR JULIAN BROOKES: Was that the review that also looked at the grade mix?
20 Because I'm trying to remember exactly when it – around that time there was a
21 move to downgrade some of the midwife grades across the unit.
22 DR TELFORD: I think it might have done. I've got it in front of me if you want me to
23 check for you. Again I clarified this in my letter to Julian Brookes and stress
24 that the Maternity Review was not to do with midwife grading but expressly
25 addressed the issue of a £5 million reduction in the Trust's maternity income
26 as a result of the Payment by Results policy in 2005.
27 MR JULIAN BROOKES: It's okay. I'm just trying to balance what sounds a very
28 rational way of doing it with actually the consequence might have been – might
29 have been that, certainly in terms of the smaller unit, did you have staffing
30 levels which were appropriate?
31 DR TELFORD: They were – are about national norms, I think, which is – well, that's
32 the only benchmark you've got: what are other units doing. Staffing levels
33 there, I think they were less of a problem. At midwife level there was
34 reasonable staff stability. Consultant level, with the expanding governance

agenda, more time being required with patients, the issues that were emerging at the time about, you know, regular obstetric presence on the midwifery wards – the maternity wards and this sort of thing, we expanded our consultant numbers quite significantly between about 2002, 2005/6, something like that, mainly because of problems, I think, in guarantee middle-grade cover and junior doctor cover as well.

MR JULIAN BROOKES: Okay. Just one last question from me: were you aware of any tensions between obstetricians and paediatricians and anaesthetists?

DR TELFORD: Yeah. There are always – healthcare is riddled with inter-professional and interpersonal differences. By and large, I think that's a healthy thing. There's nothing wrong with having your values challenged overall. If it gets a bit bitchy and personal, there's still a medical director and a nursing director to knock heads together and ~~[inaudible]~~ deliver a lecture on professionalism, but by and large it's a healthy thing. I never found myself having to do that. Within that sort of qualification, I don't think relationships within maternity were egregious. We had one or two issues that were very low-grade and easily dealt with by asking the director of midwifery ~~[inaudible]~~ or medical director, whatever the title was, just to have a word with somebody. Nothing horrendous. I do recall colleagues in BAMM meetings having to have harsh words with people about inter-professional differences, but I never did.

DR WALTERS: Given what happened subsequently, are you surprised?

DR TELFORD: Sorry?

DR WALTERS: You know, what's happened with the maternity services and the reason for all this.

DR TELFORD: Yes. Am I surprised what happened subsequently, you mean?

DR WALTERS: Yes, given how you've described things when you were –

DR TELFORD: Yes. Yes, I was. I wasn't, obviously, closely acquainted with the detailed events that are under consideration here, but I was surprised that it had got to the state it had got to. Yes, I was surprised.

DR WALTERS: Do you think then anything had changed or do you think these were these things that just weren't visible previously?

DR TELFORD: Personally, and again because I'm wasn't close I don't know how much weight you'll want to give my views here, I think it's hubris. I think that in 2010 senior management decided they could deal with this problem and there

was undoubtedly a tragic death, they decided they could deal with it, it wasn't dealt with in any sort of the formal complaint mechanisms or ways of dealing with things and their eye wasn't on the ball and it just sort of grew from a tragedy to a disaster. Now, that's a personal view. Others might have far better informed views than me that would carry much more weight than that, but as an outsider by this point that's what occurred to me. I want to make it clear that I'm referring to the post Ian Cumming era; ie after Tony Halsall took over.

DR CALDERWOOD: Maybe this isn't a fair question, but you can say if you don't want to answer it. I suppose we're trying to get a feeling as complete outsiders. Do you see how things could be run differently now if you were medical director?

DR TELFORD: I've moved slightly closer to corporate affairs lately in the sense that there's been a more open attitude towards infection control.

DR CALDERWOOD: By 'more open attitude' you mean...?

DR TELFORD: More welcoming. In 2008, I was asked to stop being director of infection control by the previous administration, I'm pretty convinced because I was off-message, which might be as much my fault as theirs, I don't know. And infection control was ~~not marginally~~ marginalised, it became very target-driven and target-orientated; if you've no target you've got a problem. I lost a consultant colleague who had got rather fed up with that and changed trusts and I sense – no, more than sense, I know it's moving back to be a little more inclusive since Jackie Daniel's appointment. I got the impression, again from the shop floor, that we – there was load of clinicians out there in two of the big hospitals doing a reasonable job and there was a board of directors intent on doing something else and that else was mainly a very focused foundation trust campaign. I didn't like the ~~–~~ After 2008 there was a rather intimidatory sort of culture. In late 2008 We lost a senior infection control nurse under what I think were disgraceful circumstances, which was why my colleagues – we wrote quite a strong letter of complaint that got not even acknowledged, and disengaged. That's what I mean by exclude. It's is more inclusive now. I don't know still, reading the press, reading some of the emails, how much of that sort of mentality by directors wasn't an image of what was happening out in the NHS at large. I detected that that was going on as well

1 and I'm not sure that that's been corrected. Now, I know that broader NHS
2 issues are outside your remit, but ~~[inaudible]~~ still very relevant and so I think
3 the new corporate team gives the impression of trying a lot harder and they
4 are trying a lot harder. I don't know how much they're tied by wider NHS
5 culture. Sorry, did that answer your question?
6 DR CALDERWOOD: It did, I think so.
7 MR JULIAN BROOKES: Just to check one last thing. During your tenure as medical
8 director were any serious concerns raised to you, as medical director, of the
9 maternity services?
10 DR TELFORD: No. No, not in the form of critical incidents, not by people coming to
11 me saying, 'Oh my God, you've got to do something about this'. I did have
12 serious concerns from other areas. You can see the trust board minutes how
13 they were debated and discussed, but no, there was nothing on maternity.
14 There has been a little bit of I don't know whether it's trust gossip or what, you
15 know, that there were problems going on and they were covered up.
16 Somehow the midwives managed to keep all this away from the trust board. I
17 think I've set out and the record supports, I believe, that we did have robust
18 governance structures in place, we were taking them very seriously, we
19 weren't shirking difficult issues. I think to hide a serious problem for such an
20 extended period of time would be impossible. You might be able to fool some
21 of the people all the time, all the people some of the time, but you can't fool all
22 the people all of the time and I think over that period of time something would
23 have emerged. You know, a chink would have come from somewhere, there'd
24 have been a way in. If there was a conspiracy of silence, it was extremely well
25 maintained and you probably couldn't maintain it.
26 MR JULIAN BROOKES: Thank you, that's extremely helpful.
27 DR CALDERWOOD: Is there anything you would like to tell us that we haven't
28 extracted from you?
29 DR TELFORD: No, I think – I did make some notes, but I think I've covered
30 everything I wanted to. No, that's all. I've not denied there were problems.
31 I've tried to communicate that we had good robust governance systems in
32 place that were transparent, robust, that we didn't shirk difficult issues and
33 against that context we didn't really see maternity in Barrow or Lancaster or
34 out ~~to [inaudible]~~ at Kendal for that matter, we didn't identify that as a problem

1 area to be addressed, even as a low priority. There were certainly issues
2 where we said we've got to deal with this now and that can wait. Every Trust
3 board has to be prioritise things, but maternity wasn't even on the level of
4 something that's got to be sorted out, you know, when we'd dealt with some of
5 the bigger issues. It just wasn't there, not in the sense of clinical risk.
6 MR JULIAN BROOKES: Yes, I understand. Thank you very much. That's very
7 helpful.
8 DR TELFORD: Pleasure.
9 MR JULIAN BROOKES: Thank you very much for your time.

THE MORECAMBE BAY
MATERNITY AND NEONATAL SERVICES INVESTIGATION

Monday, 13 October 2014

Held at:
Westmorland General Hospital
Burton Road, Kendal, Cumbria, LA9 7RG

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Jonathan Montgomery – Expert Advisor on Ethics
Mr Julian Brookes – Expert Adviser on Governance
Professor Stewart Forsyth – Expert Adviser on Paediatrics

JACKIE DANIEL – Chief Executive
JOHN HUTTON – Interim Chair
PETER ARMER – NED
MELANIE WEEKS – NED
JACQUELINE PRATT – NED
MARY AUBREY – Director of Governance
DENIS LIDSTONE – NED
HELEN DENTON – NED
PROFESSOR ANNE GARDEN – NED
GEORGE NASMYTH – Medical Director
AARON CUMMINS – Director of Finance
DAVID WILKINSON – Director of HR and OD
SUE SMITH – Exec Chief Nurse

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1 **(The meeting resumed in full public session)**

2

3 THE CHAIR: I'll say again thank you for hosting us here. This is part of the Morecambe
4 Bay investigation process. It's also being borne in on me that I was so excited about
5 the differences between this and the usual interview sessions that we have that I forgot
6 to introduce myself and the Panel, so I'm Bill Kirkup, I'm chairing the Panel. And I'll
7 ask my colleagues to introduce themselves to you.

8 PROFESSOR FORSYTH: Good afternoon, my name's Stuart Forsyth, I'm a paediatrician
9 medical director from Dundee.

10 MR BROOKES: I'm Julian Brookes, I'm currently deputy chief operating officer for Public
11 Health England, but was previously head of clinical quality at the Department of
12 Health.

13 PROFESSOR MONTGOMERY: I'm Jonathan Montgomery, I'm Professor of healthcare law
14 at University College London, and chair of the Health Research Authority, and in the
15 past I've chaired provider trusts, an SHA and PCTs.

16 THE CHAIR: Okay. We have set this up as much like any other evidence session for the
17 investigation as we can, and that means that you will notice that we're recording
18 proceedings and we'll produce an agreed record at the end. We also have invited
19 family members to be present as observers. We have some family members present,
20 and others may listen to the recording subsequently. And you'll also know that we've
21 asked you to hand in any mobile telephones, recording devices, just to emphasise that
22 nothing goes outside the room until we're ready to produce a report that's got
23 everything in context.

24 Now, do the new arrivals have any questions for me about the process? Are
25 you content to proceed? Right. I think that you have asked for the opportunity to do a
26 brief presentation. You know that the themes that we're interested in for today's
27 sessions are how is the trust operating now, how is it different and what lessons have
28 been learned, so if the focus could be on that, and then we'll pick up a series of
29 questions afterwards. So over to you.

30 MS DANIEL: Thanks, Chairman, I'll keep this brief because I think the discussion is going
31 to be the important part of the meeting, but I did want to say a few words just to set
32 the context, and I'll try and be very clear in reference to maternity services.

33 First of all, I think I can speak on behalf of all my board colleagues. We
34 genuinely welcome the opportunity to be interviewed as part of the investigation. I

1 think we're all here knowing we came into the trust acknowledging the failings that
2 have happened in the past, and very much wanting to be part of the future; and that's
3 where we sit. I want to acknowledge again, on public record, the – I suppose bravery
4 of the families in raising these issues. I think we're a significantly better organisation
5 two years on, and still improving, so I want to put that on record.
6 I guess the challenge, certainly when I started in 2012 with many other
7 non-exec directors, some of the executive directors were around at that time, was not
8 what to change it was where to start. I think that the failings not just in maternity
9 services but across the trust were clear and were reported in lots of places. I think it's
10 important to say that those failures, certainly in my view, haven't happened overnight;
11 as a consequence of many years of a lack of investment, of poor relationships both
12 internally and externally, lack of clinical engagement certainly feature, and I think
13 importantly the board and members across the trust, members who have sat across the
14 trust not putting patients at the heart of what we were doing and every decision we
15 were taking.
16 So we began to describe the journey of improvement around three areas: of
17 stabilisation, transition and transformation. That's the language we use in the trust,
18 and I think recognising that it would take years, not a year or two years, and my sense
19 is that we're part way into that journey. I'm not sure we're even halfway into that
20 journey. Changing culture, which was a significant element of what I think this is
21 about, takes rather longer than a couple of years.
22 But turning to maternity services in particular, I'll just pull out a couple of
23 headlines in terms of the areas where I think the improvement is most visible.
24 Importantly, staffing; not just numbers. We've invested just short of £6 million in two
25 years in frontline staffing; a significant amount of that has been in maternity services.
26 And I think we're now following NICE guidelines; we've developed red rules to help
27 staff flag where staffing is inadequate, but that's taken a couple of years and we still
28 think at the last board meeting a further commitment to put another £2.5 million, so
29 we've still got further to go. But it's not just the numbers of staff; we have been
30 investing in specialist skills, particularly midwifery. So areas like clinical educators,
31 bereavement midwives, midwives with a focus on quality and safety. And more
32 recently, having developed values and a vision for the organisation, we are now in
33 pursuit of kind of valued base recruitment, so most trusts in the UK, not just the
34 North-West, are fishing in the same pond of recruits. For us it's important we get the

1 people with the right attitude, and that can live and breathe our values.
2 In terms of governance, we have completely overhauled the board governance
3 structures and processes, the board assurance framework, but particularly maternity. I
4 think they are leading the way in terms of a divisional approach to that. So I've talked
5 about the new skills and expertise in the governance team in midwifery, but also
6 around training and education. We put a lot of investment there, we safeguard our
7 system for instant reporting, but making sure, importantly, staff feel that they can
8 report incidents. And I think among North-West and national benchmarks we are now
9 considered to be a high reporter of incidents, and I think that's a good thing and needs
10 to continue to be encouraged.
11 We've put quite a lot of investment in information, so developing what we call
12 clinical dashboards to give staff a frontline visibility on not just clinical indicators but
13 staffing indicators, satisfaction indicators and those sorts of tools, I guess, to help us
14 improve further. I'm sure we'll talk about the serious incident reporting and incident
15 reporting in general. We've established what we call a SIRI Panel, a Serious Incident
16 Requiring Investigation Panel, which is chaired by a non-exec director. That's been in
17 place for over 18 months now. We've been on heightened reporting in maternity for a
18 number of years where we've reported every incident. More recently, I think, since
19 Sue's appointment, we now for those serious incidents we do get an external trust to
20 review our incident, just as a matter of course now, and that's certainly adding value.
21 And I've been really impressed by the safety summits, which is something
22 that's been in place since January this year, so almost a year, where the chief nurse
23 and medical director chair a weekly meeting which involves a lot of clinicians and
24 staff right across the trust. It happens over a period of an hour every Wednesday
25 morning. And so we review all incidents that have happened the week before, and can
26 begin the RCAs into those incidents, but also pick up the lessons learned along the
27 way.
28 I talked about culture, and that's perhaps one of the most difficult areas to
29 change, but again, the team in midwifery were quite keen to spend some resource on
30 getting external help with culture workshops. We're doing some of the organisation
31 and development that was necessary to bring teams together, not just – well teams
32 within multidisciplinary teams, or team members within MDTs, but importantly, try
33 and get some cross-way of working happening, which I'm pleased to say now,
34 certainly in this division, is working much, much better. Always a challenge where

1 you've got the drive from Lancaster to Barrow-in-Furness, but it is working well, and
2 we've now got midwives opting to work across the bay, which I think is healthy.
3 The communications are much, much better. Again, we've done a lot to
4 improve engagement. We've got quite a structured approach to weekly, monthly and
5 quarterly engagement across the trust using a variety of media, but also face-to-face
6 meetings. And I think that's paying off, but we've just about – in fact we've just
7 embarked on a programme called Listening into Action, which is something that many
8 trusts, 50 trusts had done before us, and I'm hearing quite remarkable things about
9 how that really does ignite the passion of frontline staff; puts them at the heart of the
10 changes that need to be made and gives them a real voice. So I'm certainly looking
11 forward to that.
12 Nearly done now. Leadership; we heard and we've picked up the messages,
13 and more recent messages in the CQC Hospital Inspection, which talks about the
14 importance of board leadership. We have now got a really robust walk-about
15 programme, of both very structured and formal clinically orientated walk-arounds, but
16 also less formal ad hoc walk-arounds, and the evidence from that is really
17 encouraging. I think the staff are finding that valuable, and we are investing a lot of
18 our time in that as a board.
19 In terms of next steps, again, I think we've still got a lot of way to go. If
20 you're asking where we are in the journey; less than halfway would be my judgment.
21 It's been important to think about the strategy for our services moving forward, so you
22 probably picked up, I don't know, but we're about to get sign-off for our clinical
23 strategy, which is called Better Care Together, which essentially will integrate
24 elements of primary community and acute care across the bay. It will retain services
25 on two main sites, but in order to do that we're very clear, we'll need to work with
26 other providers and partners, particularly in maternity services. It will mean us
27 recalibrating the money. We've talked about the levels of investment that we've put
28 into frontline staffing, and that will require us to lead some additional funding into the
29 economy over the next probably five to seven years in reality, and to think about how
30 we broker some capital investment. Furness is actually probably one of our better
31 units, but certainly Lancaster requires, we think, a considerable amount of capital over
32 the next few years to get services where they need to be.
33 So I hope that just in setting out some of that context I've given some of the
34 headlines, given a bit of a signpost for the future as well, and I'll stop there.

1 THE CHAIR: Okay, thanks for that. Recalibrating the money is a new one on us, but that
2 means you need more of it.
3 MS DANIEL: Yes, we need more of it from all sorts of different areas. Yes, we do.
4 THE CHAIR: Have you raised that issue already with commissioners or...
5 MS DANIEL: Absolutely.
6 THE CHAIR: ... is that an aspiration?
7 MS DANIEL: It's going to be a complex – I mean I use the word 'recalibrate' because it will
8 be a complex set of negotiations with NHS England and the Treasury; Monitor around
9 what we think is a very good case for modification of tariff. How you provide
10 services across the geography with challenge, and provide the right level, we think
11 needs further investment, so it's a sort of menu of options that we've got all the
12 partners engaged in.
13 THE CHAIR: Okay. I think we might come back to that one, shall we? I'll ask Stuart. I
14 think we've all got a series of questions that we'd like to ask; we'll just work along the
15 panel.
16 PROFESSOR FORSYTH: Thank you. Yes, you clearly set out any areas of improvement
17 and service delivery across the trust. Particularly in relation to maternity and neonatal
18 services, I just want to be somewhat reassured that you've got the service model right.
19 I mean clearly there's a lot of work going into improvements, but is the fundamental
20 service model the right one for you? I wondered in terms of your Better Together
21 strategy, or whether – how much you went into the clinical strategy for maternity and
22 neonatal services, looking at, particularly, clearly provision for safe service but also
23 sustainable service, and also an affordable service. And I just wondered if this had
24 come to your board and whether there was a strategy for maternity and neonatal
25 service which had addressed the fundamental issues of the past, what it proposes as the
26 model care for the future, and whether this is a practical, sustainable and financially
27 sound proposal.
28 MS DANIEL: Okay. Perhaps I can start. I can see the board members will want to come in.
29 I think – I certainly joined the board with no preconceived ideas about what that model
30 was going to be about. And in fact, casting my mind back to 2012 when we were
31 really struggling, the fragility of staffing, particularly at Furness was really troubling
32 us. And we'd still got that journey to go through. As you will probably know, the
33 commissioners, and this has been a very clinically and commissioning led review,
34 have made it clear that they think that consultant-led obstetrics at Royal Lancaster and

1 at Furness General Hospital is what we would want to retain. They acknowledge, though, in retaining that that we will need to partner with other organisations and really make sure that some of the areas like how do you keep an isolated, geographically isolated unit fresh? How do you keep skills up to the level, particularly in a unit where we know both of our units have only got half the numbers of births going through them than a kind of average trust?

7 So there are certain caveats, I think, underpinning that model. And I'll perhaps start, and I should invite those who are better qualified to comment on that, so George, do you want to say anything?

10 MR NASMYTH: Yes, I'm happy to do so. Obviously one of the key things that I think you were potentially driving at, which we had to consider, was whether it would be better to provide obstetric services out of a single unit, recognising that with the number of deliveries that we had we would still only be, as it were, the second smallest unit in the North-West area in terms of number of deliveries per annum, even if we had done that, as against continuing with the provision that we had. And one of the key dimensions is that certainly from the point of view of sustainability and from the point of view of following the sort of delivery of accepted metrics in terms of how you structure the services, that putting those services together onto a single site would be very attractive. But then we equally had to come to terms with the fact that we have quite significant deprivation of population in two centres that we serve, which are Lancaster and Morecambe, and Barrow-in-Furness, which are at least 45 miles apart, and trying to find a central location which would have rapid access and that would serve the needs of people, many of whom don't have independent transport, could not easily be served in an emergency by the ambulance service either was one of the big arguments that drives what both the population appeared to want, because we have engaged with the population and the people resident in these communities in reaching the decisions that have been arrived at jointly by ourselves and the CCGs.

28 And we think that if you take the interests of the population as the foremost driver for this, then we would have to consider how we might continue to provide those services on the current footprint, and to do so safely. And clearly that does mean that there would be, by comparison with many other units, an element of overstaffing. And it would certainly, from the point of view of paediatric services in Furness, be very much a consultant-based service rather than a consultant-led service, and we feel that in order to maintain the skills and to give oversight into things that

1 they would not see as commonly as they would in a bigger unit, we need to work
2 constructively, as Jackie has suggested, with another unit who can particularly oversee
3 our governance and give our staff a chance to see how things work differently in a
4 bigger centre, and perhaps have exposure to newer techniques and the reinforcement
5 of your own governance procedures and understanding in difficult situations.
6 PROFESSOR FORSYTH: Yes, I mean clearly there has to be some sort of integration,
7 because I think one of the issues in the past, it would appear that you had staff who
8 were a long time in one unit and therefore they were not being exposed to practices
9 elsewhere. I mean in terms of the consultant-led and the shape of the consultant-led
10 unit in Furness, I mean it doesn't have to – it's another consultant, it's not an all or
11 nothing really, is it? And you can actually have a consultant unit but actually maybe a
12 low risk unit.
13 MR NASMYTH: Yes.
14 PROFESSOR FORSYTH: And I just wondered whether, again, that that had been fed into
15 your planning. I mean, for example, we've just had a tour round the midwifery-led
16 unit here today, and it's serving local people, local mothers. But it's quite clear where
17 the cut off is, and they very much adhere to that. And I just wondered whether in
18 terms of the planning of the Furness unit, how you're going to manage that.
19 MR NASMYTH: We would clearly have to look at that in conjunction with safety, how we
20 operate particularly within the neonatal network.
21 PROFESSOR FORSYTH: Exactly.
22 MR NASMYTH: Which we have done to date. We only have a level one unit for supporting
23 babies within the Furness unit, and therefore there would be quite good arguments, I
24 think, for transferring out, whenever possible, those women who were likely to deliver
25 prematurely, either to Lancaster or to beyond, and to a certain extent that does happen
26 at the moment when possible.
27 MS SMITH: Can I add, I'm Sue Smith, I'm the chief nurse, and I was the SRI for a piece of
28 work that actually looked at the different options with our GP colleagues'
29 commissions. And when we actually looked at all three sites, the risks that we looked
30 at associated with different models, different ways of running the service included
31 patient safety, that was the first thing; patient experience was looked at; we looked at
32 the cost, the affordability; and we also looked at transport, which was a really serious
33 issue for us; and we also looked at the political implications not only of people
34 wanting their own unit nearer to their home, but also in a place like Barrow where you

1 have some very big employers, the ability for them to actually encourage people to
2 move to the area is often dependent on having these kind of services close to home.
3 So we actually looked at a wide range of different issues that would impact on – you
4 know, it wasn't – the one thing that everybody, the commissioners, all of our other
5 stakeholders agreed on was safety had to be the number one priority.
6 And the issue for us was the geography; getting somebody, if there was
7 an unexpected complication or – getting them from Furness to, for example, Kendal or
8 Lancaster would add a level of risk in itself. The other thing that we did look at was
9 whether or not we could have one super – you know, Westmorland General, what if
10 that became a women's centre? But that then fell out of the other end on the
11 affordability end of it. So we did look at all of these things through Better Care
12 Together, and the option that we came up with in terms of the safest and the most
13 effective and affordable was actually as it is at the moment, which is two
14 consultant-led units and a midwifery-led unit. And the consultant-led unit's with
15 co-located midwifery birthing services. So it was quite an inclusive piece of work that
16 included GPs as well as clinicians.
17 PROFESSOR FORSYTH: I fully appreciate all of that. Clearly part of our remit is to go
18 through all the case notes of many babies that are born across the trust, and clearly
19 we've got to try and reduce the risk. And the model of care shouldn't get in the way
20 of trying to reduce risk. I think you can have different models of care, but primarily
21 you've got to reduce risk, and this does – will take strong leadership, and we've just
22 been talking about that. But clearly I think that's what we would particularly be
23 saying, is that you do have a model of care which will reduce the risk.
24 MS SMITH: And one of the things that we looked at was, okay, if we have – you know, if we
25 continue this with the model that we've got, we've strengthened our leadership and
26 our governance in a number of ways. However, we were very – very aware that
27 perhaps one of the things that had happened before is that people – you can't always
28 see the wood for the trees, and if you're working in the same environment all the time
29 and there's no rotation and there's no opportunity to see things with fresh eyes, things
30 can become normalised. The abnormal can become normalised. And so we came up
31 with something called – at the time it was called stability partnership, now we're
32 calling it an improvement partnership, and we're just about at the point where we
33 should be able to announce any time who our improvement partner would be. And the
34 idea is that – and we've already started to send cases to them, and Jackie alluded to it a

1 little while ago. Where you have a case that seems to be more complex or we want an
2 external review on so that we've got those fresh eyes, this external organisation would
3 do that. So they'd look at cases totally independently for us, and we would do the
4 same for them so that you've got that objective review.

5 We would also look to share best practice, rotate staff across the
6 different units, and the partner that we're looking at, I can't tell you who it is at the
7 moment, but it's a tertiary centre, very good reputation, very, very keen to work with
8 us. We're just waiting to hear whether or not we've got the go ahead. But again, what
9 that would do is just give us that additional level of rigour and assurance that whatever
10 we're doing we're doing as well as we can and we're not missing anything.

11 THE CHAIR: The start of the process is people working to within a defined level of risk, and
12 you have Kendal, which sets a level like that, and by and large sticks to it. You have
13 Barrow, which is a bit higher, and you have Lancaster which is a bit higher than that,
14 and one of the things that's clearly gone wrong in the past is that Barrow hasn't stuck
15 to that level of risk. They know what they ought to have been accepting and dealing
16 with and they haven't. How do you address that?

17 MS SMITH: Well, that's exactly how. So by having a look – so there'll be an internal
18 review of every single case, but by getting the external review as well, and where
19 necessary it won't just go to one organisation, so we have got two cases at the
20 moment, but we have gone out to external review to ensure is there something that –
21 so we're not normalising the abnormal, to make sure that that tolerance is ...

22 THE CHAIR: It's retrospective though. You're saying you worked to an inappropriate risk
23 profile in that one in the past. How do you make sure that it's applied in the future?

24 MS SMITH: Well, we have – the weekly meeting that Jackie talked about enables us to pick
25 things up straightaway anyway, so within a week we've picked up whether or not
26 there's an incident. And we already have done the RCA, we've already been open
27 with family. We've got an audit trail to demonstrate that we've done that, so we will
28 pick up very, very quickly if anything was happening, so if those boundaries, if you
29 will, weren't being adhered to. And we would address that either through changing
30 something if necessary, but also by holding people to account, because now we're
31 very, very clear about accountability as well, and we do hold individuals to account
32 whether that's through educational supervision, whether it's through the medical
33 school, the School of Midwifery, local supervisor of midwives. We have very robust
34 processes. What you wouldn't do is allow something to go unchecked.

THE CHAIR: Okay, thank you.

MR BROOKES: I'll probably direct this to Aaron, if you can. I'll just preface this slightly. I've had the misfortune of being involved in discussions about renegotiating tariff in the past, particularly around orthopaedics and trauma services. And I know the only reason that that tariff was changed was because the overall envelope didn't change; they just changed the thresholds within it. So you've got – I'm just trying to understand the level of financial risk this organisation is, as in going forward, and whether or not there is – your clinical strategic plan is sustainable without the additional investment, and what happens if the additional investment doesn't come.

MR CUMMINS: Okay. Aaron Cummins, director of finance. Well, I'll just go through that in a couple of parts, if I can, Julian. I think what we've got here is a real evidence base for why national tariff actually doesn't work for all organisations or all local health economies. And it's one of the things I looked into before coming into the trust in January, about what's the – I'll call it the doability or the deliverability of a financial solution for this particular trust.

We're supported now that Monitor taking up the pricing policy and the responsibility for pricing has introduced a very clear regime for addressing exactly this kind of particular problem to the point where I think there's been 10 or 11 trusts now that have made an application thus far for what's known as a local price modification, where you have evidence that says, 'For average price and average tariff you need to demonstrate in a number of ways why you think that's not an affordable way of delivering services for the populations that we serve.' And we've spent the best part of seven months addressing that guidance, following that criteria and doing a significant piece of work with local partners to say, 'Okay, so how much of our deficit currently could we very clearly put in the basket of we're running essentially two and a half/three sites, two peripheral sites in addition for a population that would generally only need one large acute DGH to service?'

And we completed that back in June. That sets out a view that because of what we call stakes in the ground or commissioner requested services, particularly for emergency and maternity, you largely – and this will be grandmother sucking eggs – but you largely lock in what the rest of the hospital looks like once you start to have an undifferentiated takeover. You know, the profile of risk that we have with maternity. So of our deficit this year that's forecast to be around £25-27 million, at the moment we have demonstrated that between £21 million and £22 million of that is

1 down to that structural piece, the fact that we need three areas that were delivering
2 maternity. We've got two A&E services that need to be provided.
3 So there's a process now by which that's gone through the respective
4 CCG governing bodies for a formal request. We've followed the guidance. That
5 response came back positively from the governing bodies that said, 'Yes, we agree the
6 rationale, we understand the principle and the criteria followed. However, we do not
7 have the allocation or the resource to support the additional monies that have been
8 requested.' That's now been, as of last week, submitted as per the policy to Monitor's
9 pricing team for review, and we'll now follow their due process. So there's an
10 element that I think's really strong in terms of supporting additional investment.
11 We have asked the question of what happens if we don't get the local
12 price modification. The view at the moment is that because the trust is in receipt of
13 PDC to enable it to pay its bills as they fall due, that that will continue, and that the
14 position with regards local price modification would be addressed as part of the Better
15 Care Together strategy. So we've got an open dialogue now with the system, the local
16 price modifications with the regulator and there's some assurance that whilst we're
17 delivering the Better Care Together strategy, interim PDC would remain in terms of its
18 delivery.
19 Outside of the local price modification we still are inefficient, so by default you
20 can see that outside of our deficit now that can fall under that criteria there's still
21 somewhere in the order of £6/7 million worth of inefficiency today. And if we had
22 more time today I think we'd spend a little time running through our broader strategy,
23 which puts our workforce plan, the quality strategy, our estate strategy right at the
24 forefront of how we want to address the residual gap. I say this a lot, but the quality
25 and finance agendas are not mutually exclusive; they are inextricably linked. And if
26 you look at our current performance around the safety thermometer for infection
27 control, definite improvement; still a way to go. And I think part of our financial
28 strategy will be absolutely to nail consistently that quality delivery, because it will
29 release large parts of efficiency that we can currently see.
30 THE CHAIR: But typically there's a lag period before it releases the money.
31 MR CUMMINS: Absolutely.
32 THE CHAIR: And you need to support the investment to deliver that.
33 MR CUMMINS: Absolutely. So that's part of the ask that we've got to the system, and
34 people would be surprised if I didn't want to get up and draw a diagram at the

1 moment, but there's a...
2 THE CHAIR: Feel free.
3 MR CUMMINS: ...We start off with an issue that is partly structural and partly inefficiency,
4 and the Better Care Together programme seeks to start to address both. So although
5 we've got a very clear view through the policy that we could call upon this local price
6 modification, and if the commissioner requested services stayed as they were, it allows
7 an annual reflection. You could keep that local price modification at that level. What
8 the system has done is recognise that actually some of that structural issue in the way
9 we're delivering services also has an impact on the quality and the consistency of
10 delivery, and if we get it right with the out of hospital service provision and reduce the
11 inappropriate activity in the acute, it allows us to start to address some of that
12 structural issue, but improves on safety, quality and local provision for the populations
13 we serve. So you'll see an initial spike asking for the local price modification, and
14 some what I would call reasonably small pump-priming double running to get these
15 pilot and projects up and running. But it shows, as we start to see Better Care
16 Together delivering, a reduced reliance on this local price modification up to the point
17 where we address – I think there's a residual gap at the moment of maybe
18 £8-10 million at the end of five years on that structural piece.
19 MR BROOKES: How many of the people that are already – organisations that have already
20 applied for the price modification have been successful?
21 MR CUMMINS: So the process doesn't complete until the point at which the 15/16 tariff...
22 MR BROOKES: I wasn't aware of any, that's all. That's why I was...
23 MR CUMMINS: ...is complete, so there have been 17 applications. Five have been returned
24 very quickly; 10 have been held for review and then returned unsuccessful; one is
25 currently being reviewed with intent, for want of a better phrase. Ours is now being
26 reviewed under that same process, so as far as I'm aware there are two; us and one
27 other that are now in the formal review process.
28 MR BROOKES: Okay. What's your Plan B?
29 MR CUMMINS: Plan B, if the local price modification isn't successful, I don't think we
30 cannot progress and deliver with the Better Care Together strategy. What we'd need
31 to do is reprioritise in order of risk where we think we can reasonably deliver early,
32 and in particular where we've got pressures at the moment on the emergency pathways
33 and A&E attendance, which is where we're now talking as a local health economy,
34 that earliest intervention. I think all of the implementation that we've got is doable

1 over a period. I think from our ambitions, we'd want to do it as quickly as possible
2 because of the quality impact and the getting us back into a more financially viable
3 position as quickly as possible. If it isn't supported by upfront capital investment or
4 revenue, I still think the schemes are deliverable, but we'd have to do it over a longer
5 period, and that's the discussion we're having now with the system.
6 MS DANIEL: And I think, just to say, but I mean we are – last week we were having
7 conversations. We're trying to find the top of the house, which is quite difficult at the
8 moment.
9 MR BROOKES: Which house?
10 MS DANIEL: Yes. But we are – with Monitor and NHS England, I think being very clear,
11 you know, I think it's a time, and we've been talking about it as a goal this morning,
12 around actually we've been in this early regime, you know, for two and a half years,
13 and although we have had support with PDC, that's it. They haven't – you know,
14 there hasn't been anything – anything else on the table, and I think acknowledging
15 where we were and where we've got to, I'm saying – I'm being very clear as a trust
16 chief executive to say you don't really want to open that drawer that says 'Plan B'.
17 You know, this is the time now.
18 MR BROOKES: I understand that entirely, but we're in a situation where a lot of the
19 developments you are doing are actually within the current financing mechanism
20 unaffordable.
21 MS DANIEL: Yes, and that – well I would say – my straight answer to that, Julian, was
22 that's what got us into this mess in the first place. So unfortunately we're going to
23 have rethink the framework, and we are going to need to negotiate one way or another,
24 and it will be complex because I don't think the system's set up...
25 MR BROOKES: I agree.
26 MS DANIEL: ... to allow us to do it. But I think we've got to hold firm, because I don't
27 know that Plan B, from all – we have looked at many Plan Bs and Cs and Ds with the
28 commissioners, and I haven't seen any that are palatable, not just for us as a board, but
29 for the local economy or anybody else for that matter.
30 MR CUMMINS: If I could part of the process for Better Care Together, I mean there's been
31 a bit of sharp focus in the last six or seven months, but it's been probably 18 months to
32 two years in the planning with as many connotations as you could potentially look at
33 in terms of the way that the system is configured. What we've got now is a real clear
34 view that if something doesn't change, and the change can be pump-primed through

1 that support from the system, whether that's financial or through permissions and
2 authorities, the do nothing option at the moment with what we're seeing as a local
3 health economy, even in these first six months is quite stark. So with that upfront
4 investment and the improvement we can see over the five years, the alternative is that
5 we've got a system at the moment that is under real pressure, and if we don't make
6 those changes it's a really unpalatable Plan B.
7 Now Plan B, we could show you, I think, Plan A to Z of what's been
8 considered as part of the connotations that have been clinically led. And I think the
9 Better Care Together programme, I guess the analogy I would use, we had two or
10 three sessions over the course of eight or 10 weeks where we had between 130 and
11 150 clinical nurse, AHP and other leads from mental health and social care come
12 together across the patch to produce what they would see as being the best possible
13 plan for addressing what we're currently seeing. And the options that came out of that
14 was one, so that iterative approach, that was the clinical view over a period that said:
15 this is the system; we need to make sure that this is delivered, and that's the backing
16 that they got from the respective boards in the health economy at the moment.
17 THE CHAIR: I do recognise that there's a real tension in the system around Plan Bs
18 generally for trusts in that if you unveil for us a Plan B which isn't desperately
19 unpalatable, then everybody's going to say, 'Fine, get on and get on and do that.' So
20 we do recognise that position, but at the same time we do need to assure ourselves that
21 there's something, however unpalatable, that is workable behind all this if Plan A
22 doesn't deliver.
23 MS DANIEL: Well we've been given the mandate, I don't know if it helps in terms of the
24 investigation, but to have the plan on the table by the end of this month, so you know,
25 there will be an opportunity. And there's certainly a very detailed two-year delivery
26 plan within that as well to sort of talk about on the ground how we make some of the
27 changes. So that will be available.
28 THE CHAIR: Okay.
29 MR BROOKES: One other – it's a change of subject, one other question – if I could, Mary,
30 to you, this. I'm interested in your observations coming into post around the
31 governance arrangements in the organisation, and where you feel you are in the
32 journey. We've heard what Jackie said in terms of less than halfway. There was a
33 significant problem and a significant challenge facing you coming in. Where do you
34 think things are now and what are the big issues?

1 MS AUBREY: I mean, I've been in post for 12 months now. The journey that the Trust has
2 made has been absolutely phenomenal, from my point of view, from the teams, the
3 division of governance, we didn't have that in place properly. All those teams have
4 come together now and actually have integrated working and that was through
5 leadership direction and support and guidance and also now through supporting the
6 divisions in the – in each of the divisions we've got the governance leads and the
7 governance structure. That very closely now links in with the corporate governance
8 structure. Not only that, we've put many, many really robust systems in place which
9 weren't as robust before, such as the complaints process, I'm sure you're all aware,
10 where we had a backlog of complaints, we didn't have a robust process, they weren't
11 managed timely, the quality of the complaints weren't appropriate. And just as an
12 example, through that, now you can actually see the number of complaints that have
13 halved from the past previous year. We meet all the timescales now. We
14 acknowledge the –
15 MR BROOKES: Sorry, the number of complaints received or the number of complaints not
16 dealt with on time.
17 MS AUBREY: Both. So, basically, we've halved the number of complaints that come into
18 the organisation over the last 12 months. We've also – every single complaint, now
19 we respond 100% within three days of receipt of that letter. We have over 96%
20 compliance with a 35-day response rate. We've started reducing the number of
21 complaints that go to the Ombudsman, because the quality of the complaints has
22 improved with the divisional clinical input and that's really been important; that's
23 been the turnaround. And we've also now introduced the PALS system. Again, we
24 didn't have the PALS system in place before. So, again, we work with patients,
25 relatives, carers, so we address that complaint and the issue before it becomes a
26 complaint and the number of PALS issues that have increased is over – we've doubled
27 the number of PALS issues that have come through and then halved the number of
28 complaints.
29 We've also introduced the incident reporting system. Again, when I came in
30 post we had two incident reporting processes, one for clinical, one for non-clinical.
31 Again, it was a very bureaucratic system, so we've got one seamless process now and
32 we've actually improved the process now where as soon as the incident investigation
33 is closed, the incident reporter receives the full investigation, the recommendations,
34 the actions taken and lessons learned. And the lessons learned are now captured

1 through the divisions, through the assurance committees, through the patient safety
2 summit meeting, which is held weekly, through the SIRI panel meetings and then
3 through the governance meetings to look at organisational, divisional, ward,
4 departmental and individual learning.
5 We've also improved the policy document management system. We've got a
6 new policy in place. We've got a new system now we're piloting at the moment
7 where we've got an automated review system to make sure that policies are reviewed
8 before they come out of date. We're developing an e-learning package system and it
9 will be instead of emails being sent out to remind staff to update their policies, there'll
10 be a central folder where that individual person and the team will actually update those
11 policies.
12 Also, we've got audits and clinical effectiveness, NICE guidance, we've
13 improved that process and we've just established a clinical audit and effectiveness
14 committee where we've got clinical leadership and ownership of audits and making
15 sure we're compliant with NICE guidance. And for the first time, in the last quarter
16 we've been 100% compliant with the NICE guidance, so that just shows how we've
17 improved that process.
18 Health and safety, when I came into post we had five improvement notices and
19 again we've had excellent information from the Health and Safety Executive to show
20 that we're now working as one seamless process across the organisation.
21 MR BROOKES: Can I stop you there, because I hear the word 'process' a lot and when I've
22 looked at governance failures there's three broad categories: there's those who don't
23 have a process and components in place in the first place; there's those that do but
24 don't follow it; and there's those that do follow it but don't learn from the processes
25 and what those lessons are. And I think we would look at this organisation backwards
26 and see all three of those at different parts of it. I'm concerned more about the last bit
27 of those three at the moment. I can see a lot of process and systems being put in place.
28 It's the confidence and the evidence to give you that confidence that those processes
29 are delivering change, real change in clinical and services to improve patient safety.
30 MS SMITH: So how do we know that we are learning and things are changing? We know
31 that back in 2011 we had a really high mortality rate; I think it was about 127. What
32 we do know is that over the last couple of years that mortality has reduced and
33 reduced and, at the moment, out of our nine peer groups across the SHA, we have the
34 second lowest HSMR and the second lowest SHIMI across those nine peer groups.

1 That's a phenomenal improvement.

2 We're picking up themes from our weekly meetings, so we know earlier this
3 year that deterioration came up as a theme and what we can show is that when you
4 look at January versus August our cardiac arrests that are associated with deterioration
5 have reduced by 39%. So what we can show is that we're picking up the themes, that
6 we're doing something about it and then there's an improvement.

7 Stroke care, last year we were 22nd out of 22 trusts in the North West for the
8 quality of stroke care. This year we were third.

9 So again, what you can see is we are an organisation that's learning and I don't
10 think any one of us around this table would say that we've fixed everything, we
11 haven't, it's massive. But what we are able to do now is demonstrate that we are able
12 to pick up what our themes are – pressure sores, falls, these are all themes, still birth,
13 we've got the launch nationally on 27 October of something called the 'stillbirth
14 bundle'. We've actually been running the full bundle for some time and the rest of the
15 country will start on 27 October. We've done it because actually we can't afford ever
16 to let this happen again. We need to be at the front, not at the back and again that's
17 why we want this improvement partner.

18 MR BROOKES: There's a balance though between assurance being – or reassurance being
19 received from external factors or external benchmarking which, you could argue,
20 previously if you'd looked at a range of external benchmarks, would have said, well,
21 there's no problems with the services in maternity. I'm more interested in the internal
22 ways in which you know and the evidence from your internal systems in the
23 organisation which give you the assurance that you know what's going on.

24 MS SMITH: So, again, on Wednesday morning when George and I – when we chair this
25 meeting of all the most senior doctors and nurses, if something happens today in our
26 hospital and harm happens or even worse, by Wednesday morning then we know,
27 along with the rest of the senior team, we sit down and we discuss that. What we
28 actually do is we have an audit trail, so we can demonstrate all of the things that we
29 talk about, you know, what happened. So people tend to come with a rapid review
30 already undertaken, so they come with a story and what went wrong, if anything, that
31 we can immediately see. And whatever went wrong is immediately addressed by the
32 team there and that's followed up. So, for example, if a nurse didn't admit a
33 medication, we would want, next week, to see that something had happened to address
34 that issue and, if necessary, that that had gone through a holding somebody to account

1 as well. And the same with our junior doctors, so we would want to know, if it was a
2 junior doctor, that they'd been referred to their educational supervisor and something
3 had been done. We would want evidence of reflection to show that actually the
4 learning had taken place and then we would be monitoring whether or not that same
5 thing happened again, which is what we did with the deterioration, for example. So
6 what we can start to demonstrate with the deterioration is the cases, the learning and
7 embedded in our system now is the evidence to show that somebody was spoken to,
8 this was referred to the educational supervisor, that it went to the audit meeting, that
9 letters went out to all RMs from me saying, you know, 'you are accountable for your
10 acts or omissions, so your documentation'. So all that evidence is there for – and
11 embedded in, so we know, we can tell you what we found, we can tell you what we
12 did and we can tell you whether or not that's had an impact on our mortality or our
13 cardiac arrests or whatever measure. We're not perfect yet. We're still developing,
14 but we're in a much better place. I've worked in a number of organisations where
15 we've done something similar and this organisation has caught up really, really
16 quickly.
17 MS DANIEL: It would be good, Sue, to just allow – I'm just conscious this is quite an
18 executive-driven response.
19 MS SMITH: Sorry, yes.
20 MS DANIEL: It would be good to allow some of the NEDs that are sat closer to the quality
21 elements of assurance.
22 MS DENTON: I would just say that nothing goes off the SIRI panel agenda until it's been
23 proved, as it were. So we need feedback either from individuals or through a
24 demonstration of something or a report or whatever that something has happened. We
25 have external people who sit on our SIRI panel, our two CCGs are there and we have
26 to – you know, they have got the task to assure themselves by making sure that we
27 have demonstrated to them that whatever the change needed to happen has happened,
28 as it were. So we had a serious incident that we reviewed where a consultant was
29 carrying out a procedure which was a very specialised one and not many were done in
30 the country and we're a bit of a centre for them, and this procedure did not go
31 according to plan and through the root cause analysis, through discussion what we
32 determined was that we needed to ensure that we would always, in future, have two
33 consultants present. Because of the small numbers that were there, there had to be two
34 sets of eyes looking at what it was, because it was very easy to make mistakes. So that

1 will then become our formal policy in a range of different areas where we only
2 conduct a very small number of operations.
3 THE CHAIRMAN: That's an interesting example, if you don't mind me saying so. Was
4 there a process gone through to determine whether it was appropriate to do that
5 specialised procedure?
6 MS DENTON: Yeah, yeah, that's it, and that was commissioned by the SIRI panel.
7 THE CHAIRMAN: Yes, but before it was introduced. You're reacting again. If you
8 introduce a specialised service, then there ought to be some formal consideration of
9 whether that's the right thing to do, what are the risks associated with it, is this the
10 right place to be doing it.
11 MS DENTON: It isn't a formal specialised service, but as far as I'm aware, we just have two
12 consultants who have experience in that area and we receive referrals from across the
13 North West. Now, for whatever reason that has developed, but if it has developed we
14 need to make sure it's safe and having flagged up that something went wrong, then we
15 have to look at that risk, what can we do to mitigate it.
16 MR BROOKES: You're responding to a clinician's special interest there. Is that –
17 MS DANIEL: Well, I'm not sure we were. I'm not sure, without going into the detail of the
18 case –
19 MR BROOKES: Well, that's what it sounds like. Absolutely, it's about making sure that the
20 service is safe before you start doing it.
21 MS DANIEL: Of course.
22 MS DENTON: Yeah, absolutely, but the consequence of it was that we've then undertaken a
23 review of all of those areas where we may be called upon to do a very specialised
24 operation or we have been doing as a consequence of, you know, custom and practice
25 in the past, to say, 'Right, so let's have a review now of each of these and say whether
26 – is it safe and what should we do in the future?' And in some of those cases we need
27 to apply that same rule.
28 PROFESSOR MONTGOMERY: And how many have you stopped doing as a result of that?
29 MS DENTON: We're just in the process of considering it now; it comes back to my panel on
30 Wednesday. And of course I won't be making the decision, but it will then be handed
31 over to our clinical governance colleagues to make that decision about when it's safe
32 and how can we make it more safe.
33 PROFESSOR MONTGOMERY: It would be helpful, I think, to get some feedback about
34 how that goes through, to help us understand the process.

1 THE CHAIRMAN: That's right, yes. Before we hear from others, I would very much like to
2 come back to something that you said, Sue, which did alarm me slightly and that was
3 about the high mortality rate. My understanding about the high mortality rate was that
4 it was due to being an outlier on coding, particularly of palliative care and of
5 comorbidities and that what's changed since is really better coding of palliative care
6 and comorbidities, it's not clinical improvement.
7 MS SMITH: I think it's a mix of both. I mean, you know, you read all the research and it
8 tells you that clinical coding alone isn't going to reduce your mortality by that much.
9 We've come from 127. If you look at our latest mortality last month, just for the
10 month of August it was down to 79. Now, that's a massive reduction. On a 12-month
11 rolling it was 100.
12 THE CHAIRMAN: I disagree with you about the underlying cause. I'd say that changing
13 your coding is the only thing that can change it that fast.
14 MS SMITH: Isn't?
15 THE CHAIRMAN: No, it's the only thing that will change it.
16 MS SMITH: Oh. Well, I think it's a combination of both.
17 THE CHAIRMAN: Changes in practice aren't going to have an effect that rapidly.
18 MS SMITH: Well, I think there's an effect of both, because remember the Trust has been
19 changing over the last two years, not just since we brought in the Wednesday morning.
20 I think what that has done is focused people and accelerated change and it's got real
21 ownership at senior clinical level. So, you know, when you've got your clinical
22 directors and your senior nurses sat around a table talking about an individual incident
23 that happened in a lot of detail, it really does focus the mind and I think that's
24 probably, for me, been one of the biggest changes. I mean, you know, we could have
25 the debate on whether it's clinical coding or it's clinical care. I think it's a
26 combination of both.
27 THE CHAIRMAN: Right. Okay.
28 MR NASMYTH: I would agree with you that those changes in coding were actually what
29 made the big difference, but then you have to look at what the coders have to work
30 with and the improvement has actually been in the documentation that allows that
31 depth of coding to take place and that is a continuing theme. We now have mortality
32 reviews on both sides led by the associate medical directors and again one of the
33 themes that we've communicated out to the divisions on that is that we look to see
34 where there is potential avoidable mortality. And a lot of the time where we can't be

1 certain that that death was completely unavoidable, it comes down to documentation
2 still. So there is still a way to go and we can get a lot better about that and I think the
3 rigour of putting in place adequate documentation brings around that instant reflection,
4 which actually drives clinical quality.
5 THE CHAIRMAN: Okay.
6 MS SMITH: May I give you another example? So one of the other things that we found
7 earlier this year was that our pressure sore rates were very high and when we looked at
8 the root cause analysis the assessments weren't as robust as they should have been. So
9 again we did a lot of work around making sure that registered nurses understood their
10 accountabilities and that they would be judged by their acts and their omissions and if
11 harm happened because they hadn't done the assessment that was an avoidable harm,
12 no matter what comorbidities there were. And what we found was through the
13 Wednesday mornings we always say, 'Has every assessment been done at every
14 point?' and we have a root cause analysis that demonstrates whether that's the case.
15 And if not, we go back and a discussion is had with that individual nurse around the
16 harm that they could have caused to that patient. As a result, we've gone from being
17 well over the national mean all of the time to falling below it and we're sustaining that
18 picture and we're continuing to improve. The information that we've got is very
19 much more robust, we're sharing it with GPs, so we now have a level of grip that
20 enables us to share the story across the whole pathway. But, for me, it's a very good
21 example of actually doing the right thing and documenting it and maybe – for me,
22 doing the right thing is the first thing.
23 THE CHAIRMAN: I'm with you on that and I was happy with 90% of what you said. It was
24 just I wanted to check on that specific point about mortality.
25 MS SMITH: Are we up to 95% now?
26 THE CHAIRMAN: The needle's there. Does anybody else want to come back on any of that
27 or all I'll move on to Jonathan?
28 MS WEEKS: I'd just like to add about feedback, the board does get presented with a
29 patient's story at the start of every board meeting where we hear about the experience
30 of a patient or even a staff member and some weeks it can be a negative experience
31 that they've had and we hear about the lessons that have been learned and even
32 sometimes offer suggestions as to moving forward. And we hear about positive
33 feedback as well, so that is presented to the board at each meeting.
34 THE CHAIRMAN: Thank you. Jonathan.

1 PROFESSOR MONTGOMERY: Thank you. A number of my questions have been partially
2 answered already, so you'll have to bear with me a little bit on that. And the one in
3 this area, I had a general question really about my concerns looking back and
4 obviously what is now, but you could see lots of examples in the history of the
5 organisation – and I would say I see this pretty much everywhere I've been in the
6 NHS – of lots of monitoring of actions and not very much monitoring of whether
7 doing those actions delivered what it was hoped they would deliver. And I've just
8 heard, I think, you know, very helpfully, about mortality and I was wondering about
9 morbidity but you've just given me a nice example of that. You've given an example
10 of how whatever we should call it, an innovative procedure has triggered a set of
11 questions there. I wonder if there is also an example of how you've used the patient
12 and public feedback in the same sort of way, not just to solve the specific question, but
13 to learn from more broadly.
14 MS SMITH: Okay. Well, we now use IWantGreatCare as well and since January – between
15 January and August there have been 17,000 responses, which is a very large amount,
16 it's very successful. We also use – we do use duty of candour very – you know, it's
17 something that we do generally and not just for those areas that we're supposed to, but
18 actually for the lower grade harms as well. So we do use our patient feedback also
19 from the patient stories. Some examples would be one of the wards that I went on to a
20 couple of weeks ago, they have 'You said, we did' on the boards outside and a patient
21 with impaired vision had told them that the clear glasses were very hard to see, which
22 actually is quite obvious, but he'd told them, so they'd gone out and bought red,
23 orange and yellow glasses and asked him which one was the best and the red was, so
24 they then bought red glasses. And there are the little things and there are big things
25 that we do as well. So, for example, we had a baby, unfortunately, who died, Baby C,
26 earlier this year and his grandmother helped us to implement 'Every kick counts'. So
27 what we try and do now is where there's a tragedy or something goes wrong, whether
28 it's something that we've done or not done or not, we're trying very, very hard to
29 involve people. I think the one thing that I'm really sorry about is that we've never
30 been able to put anything right for any of the families that have been involved from
31 the past and that's something that we want to try and do something about in the future.
32 We've got bereavement midwives now and bereavement nurses. They also go out
33 when people have sudden unexpected deaths at home in Cumbria as well to offer
34 bereavement support. We kind of missed doing something very, very important as an

1 organisation when these babies and the families lost somebody and I think that's my
2 biggest regret.
3 MS DENTON: I think, if I'm not mistaken, there's also a patient – well, I say patient, a
4 service user reference group for women and children as well and there's an adolescent
5 group for young adults who are coming in this hospital or receiving services, the same
6 for children and the same for mothers as well and they've massively informed
7 developments and revamped areas and a whole series of different things.
8 PROFESSOR MONTGOMERY: So are you buying red glasses for the whole Trust then?
9 MS SMITH: We will be doing, yeah.
10 PROFESSOR MONTGOMERY: That's good to hear.
11 MS SMITH: Yeah.
12 PROFESSOR MONTGOMERY: Thank you. Can I go back to the plan B question and it's
13 something that you raised, Jackie, and it's about the commissioners' plan B and the
14 top of the house problem, because I mean an obvious plan B to go to commissioners
15 with is, 'Okay, if you can't give us the money, what do want us to stop doing that
16 enables us to get on, albeit at a different pace, going through?' and I think I took it
17 from the way you spoke about that, that something we might want to think about is
18 how easy is it to have that conversation in the current system of relatively small
19 CCGs, Monitor, NHS England having – so it would be helpful to understand what, if
20 any, you could – is there a hidden plan B for the commissioners as well that's being
21 worked on? Is it difficult to get people around the table to talk about it?
22 MS DANIEL: Not difficult at all. I feel like I spend more time with those people than I do
23 with my partner at home and, interesting, I think, being a trust under such intense
24 scrutiny over a period of time, it means that you've got all the top of the shop as well,
25 you know, in quick succession. So we're having parallel conversations with CCGs,
26 LACs, NHS England, Monitor, CQC around these plans and I do have to say, hand on
27 heart and having worked through some of those options that Aaron described, you
28 know, we did traverse around all of those options and looked clinically, financially,
29 whether they were deliverable even and did look at all of those. And I mean, you
30 know, the thought of a purpose built, brand spanking new DGH around about here
31 would have been lovely, completely unaffordable and probably not deliverable either
32 or not desirable certainly for many elements of our population. So I feel as though
33 we've been through a kind of real world conversation with all of those people that are
34 concerned with both finance and quality as well as, as Aaron said, had a lot of

conversation with local people, people in the community about the balance in terms of, you know, balance of access and quality and safety. So I really, really – I really cannot see a ready plan b.

PROFESSOR MONTGOMERY: And also it's not for want of looking at it, because one of my questions was whether you were saying to us that we could make a comment on the ability to get that conversation going, but you've said that's okay, although you did say it was in parallel with all those organisations, which makes me very nervous because I'd rather that they were converging at some point.

MS DANIEL: No, they have converged and at certain points they did converge and I think the options – I can't remember what the long list was; 16 and four variations on the 16 comes to my mind. So that's over an 18-month period we've kind of taken the options right through down to, you know, what look to be literally one, at the most two options on configuration.

THE CHAIRMAN: I think Aaron wanted to come in.

MR CUMMINS: It's a reflection on having spent two years at Mid Staffordshire and looking at the reconfiguration of the administrative process there and again having done due diligence before applying for this position, arrived in January. It is palpable the difference in the local health economy engagement and the system. It's sponsorship with a small 's', but a real recognition that there's a fighting chance of this local health economy coming up with a solution that whilst it doesn't answer everything quickly, has a very, very good chance, because of the way it's been configured and set up, of delivering something that's going to have real value at the end.

I think there is something about recognising the changes that are happening nationally and some of the instability or movement at the moment and, you are right, that does cause a bit of having to traverse through certain things. But we're definitely getting positive feedback from NHS England and Monitor on particularly referencing the 11 challenged local health economies, that they recognise this health economy, in particular, as being ahead of the curve on the solution that seems to have practical deliverability and the patient outcomes at its core. So it's positive feedback at the minute, notwithstanding the challenges on delivery as we progress, but I think at the moment that system ownership of what the plan looks like at the moment is quite positive.

PROFESSOR MONTGOMERY: Thank you.

PROFESSOR FORSYTH: In relation to that, apart from having a sense of déjà vu and people

1 talking about 'better together' and 'plan B', having just had two years north of the
2 border and, in fact, Alex Salmond refused to talk about a plan B, which probably is a
3 mistake. But actually, I think in terms of again looking at the health economy, you
4 need to look at probably the distribution of your resource. I mean, just as a one-off
5 example, we met with an anaesthetist and I asked her how many consultant
6 anaesthetists there were in Barrow and she said, 'Nine', 'And how many are in
7 Lancaster?' '23' Now, we need to know why is there such a discrepancy. I know
8 there are levels of care that are provided in Lancaster that are probably not provided in
9 Barrow, but really that's just one of many examples. In fact, if you look at the
10 medical staffing, the proportion in Lancaster is at least almost double that in Barrow,
11 yet, on the one hand, we're hearing that Barrow has one of the greatest health needs
12 and in Lancaster you've got other centres just 20 minutes down the road. So again,
13 there are ways of, you know, you need to look at actually what you're doing with the
14 Trust and can it be done more cost effectively elsewhere, for example.
15 MS DANIEL: I'm glad you've raised that, because that's certainly – just to assume that
16 everything stays the same under this strategy is false. So some of what we're calling
17 'stakes in the ground' about access to emergency care and maternity obstetrics are
18 stakes in the ground, but actually there's a lot of movement on services like surgical
19 day case work and some specialties that we think, you know, as you say, we need to
20 make sure that the resource is spread, the resource is in the right place. So there is
21 some room for manoeuvre there.
22 PROFESSOR FORSYTH: Yeah, I think so.
23 PROFESSOR MONTGOMERY: Thank you. There's a small number of things from your
24 very helpful brief to us in terms of the overall improvement that I'd like to hear a bit
25 more about and the first is the 150 leaders. I'm not sure whether it's called a
26 breakaway or whatever, but this way of getting people from across the Trust together
27 and a bit more about who they are and how it works would be really interesting.
28 MS DANIEL: Okay. So I've talked about the listening into action. We've done a number of
29 things over a couple of years to try and engage. So I've got something that I call my
30 leadership forum, which has been quite successful. We've got different interest
31 groups across the Trust.
32 PROFESSOR MONTGOMERY: I'm really interested to know which levels you've managed
33 together and things, so if you want to say a bit about your leadership form and who
34 comes and things, that would help flesh it out for us.

1 MS DANIEL: Okay. So it's always been up until now – and I've just come here to talk
2 about Listening into Action, which is really the big ticket item, I think, but until now
3 we've always sought volunteers to come forward. So my leadership group was people
4 from medical secretaries through to consultant neurologists and they've been working
5 together for over a year, 18 months now, with some external support, to look at things
6 that they felt were important, frankly. They've developed things like the staff charter,
7 they've been engaged in the bullying and harassment work that we're doing, they've
8 been pioneering some of that early cultural change work and been pretty successful for
9 a group of 30 staff across the geography.
10 Listening into Action just takes that into a whole different level. So through
11 my weekly sort of chief exec message, I asked for volunteers and we've had literally
12 close to 100. Our ambition is that we really want to get 200 leaders across a
13 workforce of about 5,000 and I think we'll do that working on their sponsors of
14 change, I guess, and they are at different levels, so again we have everybody from one
15 of our catering teams at Barrow through to – it's clinically biased and we did try and
16 engineer that. Thankfully, it's turned out, but it is clinically biased, so a lot of
17 clinically facing staff.
18 And we are working with Optimise, the national programme. There have been
19 50 trusts going through seven cohorts – the changes that they have been able to bring
20 about through getting involved in big conversations about what staff feel are important
21 to them. I hope and I think they will be aligned to the areas in our CQC improvement
22 plan. In fact the early indication is that the CQC were worried about where we are
23 with that. But I think the difference will be in how we go about that change. So, it
24 will be outwith the usual divisional up and down the hierarchical system. It will be
25 cross Bay; it will be cross-discipline and it will be big, so I think it will be powerful
26 and it will be quite a force. It is very, very structured and it is actually quite a
27 disciplined process we work through with Optimise and we will be pulse checking
28 opinion starting right now, so we are gathering that opinion now, and we'll do that
29 every month through the course of the next eight months.
30 PROFESSOR MONTGOMERY: So, do you already know who is going to be involved in
31 that?
32 MS DANIEL: Yes, we do.
33 PROFESSOR MONTGOMERY: Are there any – I have forgotten what the word is – any
34 gaps in engagement across the services in the trusts or are you pretty comfortable

1 around that?
2 MS DANIEL: No, I am confident that we've got all areas, all clinical areas or non-clinical
3 areas, all geographical areas covered, yes.
4 PROFESSOR MONTGOMERY: So, I guess just for the record, really, then, midwives,
5 obstetricians, paediatricians from Barrow are on that group?
6 MS DANIEL: Yes, they are.
7 PROFESSOR MONTGOMERY: Good, thank you. That is really helpful. The second thing
8 I wanted just to understand a bit better was the retention and recruitment pattern
9 particularly around the maternity services in Barrow. There are a couple of things just
10 for clarification, really. One is your sense of whether retention is a problem as well as
11 a gain – because most of the documentation I have seen comments on the fact that
12 retention is a strain, but if you have the wrong people, it's a problem – and a sense of
13 how you have thought that through. I am not entirely clear what the overall pattern is
14 around people that you have recruited in and how long they have stayed. So, you
15 mention that you had some short-term recruitments which, for understandable reasons
16 – I think I would like to understand that because understanding why none of them
17 were persuaded to apply for other jobs when you were recruiting would be helpful,
18 and when have the people that you have recruited in – and I am particularly thinking
19 of Barrow here, from outside, and I am particularly thinking midwives – stayed and
20 what you have learnt if people didn't stay, from exit interviews and the like. So, just
21 an understanding of that would be really helpful.
22 MR WILKINSON: David Wilkinson, Director of Workforce. Just to try to put that into
23 context, really, over the last two years the expansion or the investment in medical
24 staffing has been around 23 additional medics going in the budget and 28 actually in
25 post, and nurses and midwives: there are 86 people in budget, 61 nurses, 25 midwives,
26 with 80 in post. That just gives you a bit of a flavour, really, of some of that,
27 particularly when you look at our overall picture in terms of current vacancy rates:
28 round about 10 per cent for midwives, which is below average nationally, and around
29 about 5 per cent for nurses, again which is below average.
30 However, the aspirations are to move to full recruitment through successful
31 recruitment campaigns but I think your question focuses on retention, so okay,
32 bringing people in the pipeline, but you've got to turn the tap on at the other end.
33 PROFESSOR MONTGOMERY: I am particularly interested to know whether there is any
34 pattern of people coming in, finding that it is not the place they thought it was and

1 going away or going native, and I have another question about culture in a minute, but
2 it is a sense of understanding how you thought about that.
3 MR WILKINSON: Well, we have thought about that. We have listened and learnt from a lot
4 of staff. Part of the issue is around not just recruiting to Barrow as Barrow but
5 actually recruiting as a cross-Bay workforce, about moving the workforce about,
6 rotating round, and actually some of the feedback we have had from the most recent
7 recruitment has been that that has been a cause of turnover, actually, and some people
8 sometimes actually find that unpopular, so, particularly for preceptorship midwives
9 and that is something that is being looked at within the recent cohorts.
10 Focus around Barrow: a lot of work has been focused on the workforce there,
11 so we are looking to develop our own apprenticeship programme, which you may be
12 aware of – the first cohort signed in February this year – at both ends of the patch, but
13 primarily I think we all benefit and the focus will be at the Barrow end where we can
14 actually grow them through NVQ training, through professional qualification into a
15 long-term sustainable workforce.
16 We have also commissioned a piece of research through Lancaster University
17 looking at the medical students in terms of their retention because one of the things we
18 are not very good at, and I am sure that Anne can expand on this, is actually retaining
19 our undergraduate medical workforce. Now, we can put forward a whole lot of
20 anecdotes as to why that may happen, but we have actually commissioned a really
21 detailed piece of research which is due to report next month, isn't it, around some of
22 that?
23 PROFESSOR GARDEN: Next month, yes.
24 MR WILKINSON: I don't know if you want to ---
25 PROFESSOR GARDEN: Anne Garden, one of the non-execs. One of the big attractions in
26 setting up the Medical School here was that we hoped that we would grow our own
27 doctors; we'd feed into the health economy, and we were initially quite disappointed
28 when our first graduates – we had a lower number than we hoped taking up foundation
29 posts here and in a sense I am not worried about that because young folks go
30 elsewhere – as long as they come back here to do their training and stay at senior
31 levels I don't mind if they go out and see the big, wide world, but we felt that we
32 needed to understand what it was that was going on. As David says, we haven't seen
33 the full report yet but it does look as though the geography, just the fact that we are
34 where we are and we are away from Manchester, we're away from a lot of the places

1 where young people like to be is a major factor, but when we have the full report,
2 we'll look at that more closely and see what we can do to improve on that.
3 MS SMITH: Can I add as well that I think from the midwifery perspective – no, I don't
4 think; I know – we have been very successful in recruiting and the intention is very
5 good, but at times, and I am really expecting that once the media comes out, once you
6 report and the media comes out, that can affect the morale of our midwives and has
7 done significantly, so much so that I did receive a call not long ago, a couple of
8 months ago, from a midwife who had come to work with us from an external
9 organisation, had been incredibly impressed and pleased and happy but the first time
10 that an expected, not an unexpected complication arose, she became very panicky.
11 Because she was in Barrow she was afraid that her name would be on the front papers
12 and there is a paranoia for our midwives. There is no point in saying that there isn't.
13 There is a level of scrutiny associated with working in Barrow that does not happen
14 anywhere else. She was a very experienced midwife, who actually thought about
15 giving up practice on the back of that experience but she made herself come in. She
16 spoke to me, she spoke to our head of midwifery. She made herself come in and she
17 made herself get back into the job and she was okay, but she needed support, and I
18 think that the one thing – nobody can undo what's happened to the families – that's
19 inexcusable, but actually it does impact not only on those midwives that were here at
20 the time but our midwives that come in after when there is so much bad news, and
21 unfortunately the good news does not get printed very often because so much bad has
22 happened, and I think it would be very remiss of us not to mention that actually there
23 is a high level of – I think their emotional resilience is significant and I know today
24 where midwives across the country have been out striking, we have had striking
25 midwives at Lancaster, we've had striking midwives at Kendal, but in Furness they
26 did not, and then all the time they are very aware of the way that they are viewed by
27 the public and that that is not particularly a positive thing, and that needs to be said
28 because that is my one key concern about retention.
29 THE CHAIRMAN: I recognise what you are saying there and I want to come back to it when
30 I have some questions but I will let Jonathan continue.
31 MS DANIEL: Can I pick up another couple of areas – I am sorry, David, you've had your
32 chance now – on recruitment. I think there are a couple of areas just to point out. We
33 are trying to take a much more strategic overview of recruitment and trying to over-
34 recruit. All the evidence is that actually whilst you can recruit people with the right

1 skills and right value base, get them in and worry about – it's a worry we give Alan,
2 just to worry about where we get them in from, but it is paying off. We have been
3 quite successful internationally, particularly in Europe. The kind of delayed
4 gratification you get from recruitment like that is marked because you do have to put
5 in perception, but that is paying off.
6 So, I think the other thing, just to come back to and then I will shut up, but Best
7 Care Together – we are having some success with partnering with other community
8 and even primary care – even GP practices at the moment is one example where are
9 recruitment campaign is talking about working in the Bay and even working cross-
10 organisation and I think this is a big – I think this is an important area for the future.
11 We know that GPs are difficult to recruit. Midwives are a little less difficult to recruit.
12 I think the more we can work to make those jobs really attractive, we'll have to go that
13 extra mile, I think, definitely into the future, but that will be a feature.
14 MS SMITH: We have senior midwives and matrons on seven days a week now as well, so I
15 think that kind of adds rigour into the system.
16 THE CHAIRMAN: Okay. We'd better let you have a go then.
17 MR WILKINSON: I think that Jackie in her opening presentation talked about some of the
18 changes we had made around values. One of the things we have done is values based
19 inductions, so we now have a requirement where for about 90 per cent of our staff,
20 their first day at work is a values based induction, a full day led by exec directors and
21 others who teach them what we expect of them as an employee of Morecambe Bay
22 and what we expect in terms of how they approach and treat patient-serve issues as
23 other members of staff.
24 As part of that exercise we seek their feedback in terms of their experience on
25 their employment journey, for those that have been in post a while or their pre-
26 employment journey and we do a 90-day follow-up with every single employee now,
27 which we have started doing since April. So, for every employee what we have been
28 doing since April – 90 days into their employment – is we follow-up with them and
29 say, 'How has it been for you? What can we learn from that? What can we do
30 differently?' and we are constantly refining and feeding back as managers about the
31 issues and things that come out of that, which tend to be around local welcome, being
32 made to feel welcome on the local wards and departments. So, there is lots of learning
33 processes in play where we can demonstrate the changes that we have made.
34 PROFESSOR MONTGOMERY: There is a piece of information from that which I think

1 would be quite good to pin down in response later on and that is that there is some
2 ambiguous information in various things I have read about whether the people you
3 have recruited into midwifery have stayed or not and actually just a note explaining
4 who was recruited in, whether or not people left or not and anything learnt, if they did
5 leave, from exit interviews would be really helpful to just bottom that out.

6 But I wonder if I could use that to bridge into the other thing I wanted to ask
7 about, about the detailed things. It is really about culture. If I could put it starkly, the
8 'grow your own' works if your culture is fundamentally sound. It could just
9 perpetuate your problem if your culture is the problem. So, I am sure that you have
10 thought carefully about that, because what I have seen is a lot of work on creating a
11 culture for the organisation and losing three sites. I have not seen very much about
12 your assessment about whether you have cultural problems to address, that things
13 were poor and you had to change it, or whether it was just that it wasn't integrated.
14 So, I would like to hear a bit about the thinking about that because I can see the work
15 that you have done to reduce a culture for the trust. I am not quite sure what your
16 assessment of the problem was in the first place, and I am thinking again, obviously,
17 about maternity services in the questions that have been asked. So, you must have
18 asked yourself that question to design the response.

19 MS DANIEL: Yes, it is a really central one and I think certainly when I came into post I saw
20 a lot of really committed and enthusiastic staff. Morale was pretty low, though. I
21 think it is not surprising given the circumstances they were working in but alongside
22 there was staff who were committed and wanting to improve. There were also pockets
23 of staff that had grown complacent, that quite liked – I call it 'the victim swamp' but
24 quite liked wallowing in that. I think they had probably lost sight of what we would
25 normally see as good discipline around governance, process and practice
26 improvement, and were too inward looking. I am particularly thinking about
27 maternity at Barrow and Furness when I talk about this.

28 I talked right at the beginning of the conversation here about three phases,
29 about stabilisation, transition and transformation. It is quite difficult when you are
30 fixing things and there are so many things to fix, to get into a real discussion about
31 culture, which is why I say with real sincerity that I think we are less than halfway
32 because I think we are only just beginning, in the last 12 months, to get into that
33 territory. We can talk about things that we have put in place in terms of structures and
34 process which hopefully help with that but I really think, hand on heart, we have

1 another few years on that journey. People are getting it. I think they are beginning to.
2 I think we absolutely know where, if there are remaining pockets where we have
3 really poor behaviour and culture, we are on it. I think we are now actually taking
4 action and that's given some really good visible signs to the rest of the organisation
5 that we are serious about that, but I think it is a journey and getting the strategy set,
6 underpinning that with a good quality improvement plan, which actually talks about
7 things we are doing in year but the aspiration that we have for three and five years, a
8 'Daltonesque' look on quality improvement, which arguably has taken them 10 years,
9 and we have put in the right intervention.
10 So, I think the leadership and the cultural work that we have done in Women
11 and Children's to date has been really helpful, but we are going to need to continue
12 with that as part of overall OD strategy. Investing in leaders at every level is really
13 important and we began that with appointing clinical directors over two years ago
14 within divisional teams and that definitely tipped the clinical focus and put the patient
15 at the heart of decisions. The work that, Sue, you have led with matrons and at ward
16 level has been really key. I think we have other corporate but non-clinically facing
17 areas that make a real difference to the patients.
18 We still have areas to tackle. So, the quality improvement plan with Listening
19 Into Action and with the establishment of what we call an improvement hub where we
20 are pulling together all our improvement resources, working with organisations like
21 AquA and buddying with people at Salford who have a track record, will really help
22 us shift up a gear. But I think we are still in that transition phase.
23 PROFESSOR MONTGOMERY: If I can reflect back on what I think I have heard then, you
24 talked about stabilisation, transition and transformation. I think what you were saying
25 is that the cultural issues you had to stabilise before you could really get started on
26 that.
27 MS DANIEL: Yes.
28 PROFESSOR MONTGOMERY: Is that right?
29 MS DANIEL: Yes.
30 PROFESSOR MONTGOMERY: And so you have now started on it with the transition and
31 then the real gains will come.
32 MS DANIEL: Yes.
33 MR HUTTON: Just reflecting back on our discussion earlier this afternoon, Johnathan, I
34 think one of the things which gave the non-executive some reassurance in this area is

1 if you look around the table and you see where the executive directors have come
2 from, these are people who have worked in some of the top organisations in the
3 country and who know what good looks like, and when you say that the danger of
4 growing your own is that if your local culture is wrong they are going to grow up
5 crooked, well, the culture is being driven from the top; it is not necessarily coming
6 from the bottom, so I think we should avoid that one, although given our previous
7 discussion again about the cascading down the organisation we do have to be
8 constantly aware that the message is getting through properly to the right levels.
9 PROFESSOR MONTGOMERY: I am acutely aware of how difficult, I think, the task is.
10 My next question really is linked to that, which is it would be really helpful just to
11 hear your sense of which of these various issues you are dealing with manifest
12 differently in a maternity context and which of them are common across the whole
13 trust, because what I read from the document is a programme for the whole trust trying
14 to pull everything up and because of that, you lose what it would look like if all you
15 were talking about was the response to this when our terms of reference are – so, I
16 would just like to make sure I don't lose the sense while you are here of the
17 assessment of that, because I can fully understand why you need a programme for the
18 trust but it would be helpful to just have your thinking on to what extent there are any
19 fundamentally different issues either of nature or are they just more acute, and you
20 described a bit of that when I asked about the culture, that there was a particular set of
21 problems at Barrow maternity and I just wanted an opportunity, really, if you could
22 reflect for us on that question head on, what is common to it and what is particular,
23 which is very much our terms of reference.
24 MS SMITH: I am probably best placed to pick that up and I think when you say there are
25 some cultural issues at Barrow, especially in midwifery, I wouldn't say that that is
26 necessarily the case today.
27 PROFESSOR MONTGOMERY: I was only reflecting part of the answer.
28 MS SMITH: Yes, so I think there have been and there remain pockets in different places, but
29 coming in as an experienced chief nurse, who has led nursing, midwifery and HPs in
30 another organisation before here, I think once I started taking the nurses and midwives
31 away together for development days to start to develop us as a team, some of them,
32 some of our senior nurses across the Bay, hadn't met each other before, and certainly a
33 number of them didn't know who their previous chief nurse was; lots of work to do
34 around them recognising that actually a chief nurse is not somebody who sits

1 somewhere out of the way. They were surprised when I was in a uniform. I had been
2 out working next to them and I expect all senior nurses to do the same. Unless we are
3 role modelling and set an example, then nothing else is going to change.

4 Now, in terms of the culture, what did I find? I found a lot of nurses and
5 midwives in an organisation who wanted to do the right thing, who did the right thing
6 within the resources that they had but had been working within a system and with
7 resources that were inadequate to do what they needed to do. This is my opinion. I
8 felt that the staffing was not where it should have been in a number of areas despite
9 significant investment having been put in place before I got there in order to start to
10 get them to where I needed to be. I even had the kind of discussion with one ward
11 manager that went along the lines of me saying, 'You haven't got enough registered
12 staff'. 'It's okay, I can manage'. 'No, you can't manage. You can't deliver. I can't
13 be sure you can deliver safe care'. 'But I'm saving the trust money', and it was that
14 kind of a culture that had been embedded and for me one of the most difficult things is
15 to say, 'Actually, no, you cannot. You have a duty of care', and that's the first thing.
16 I have had to remind some people about their NMC responsibilities, about
17 accountability, about patients first, about the need to escalate if they are unhappy, if
18 they see something that is not right, or they feel it is not right, it probably isn't. But,
19 do you know, once you start to do that, they actually catch on really, really quickly
20 and now I have people who tell me all the time, 'This doesn't feel right and here's
21 what I've done about it and here is who I have escalated it to', but I've also got a
22 board who are listening and who will put in that investment where it is required so
23 long as I have done my homework and have shown them that that case is absolutely
24 solid.

25 That is a very different organisation than they have had before and I do feel
26 that a lot of the health care professionals that I am accountable for have felt dumbed
27 down, if I'm honest. So, changing that kind of culture is quite difficult, and
28 empowering people. It is not that they haven't wanted to do the right thing but they
29 haven't always been in an organisation that has enabled them to do that and I do think
30 that that is one of the big things that we as a team have been trying to change and it is
31 quite surprising.

32 MR NASMYTH: I would echo quite a lot of that in relation to the medical staff. I don't
33 think, in answer to your question, that the obstetric or paediatric staff are specifically,
34 as it were, lagging behind any other groups. If you look at them as groups you will

1 find that there are people there that are keen to do things and I think that they will
2 begin, and are beginning, to take the bull by the horns and begin to change the culture.
3 One of the real issues has been a lack of adequate performance data which people
4 need to reflect on themselves and to look at so that they understand their own
5 performance and that has not been routinely available to them in the past.
6 The notion that they have to avail themselves of this, they have to reflect on it
7 and they have to demonstrate how they are improving is, shall we say, proving more
8 difficult for some than others, but this is not peculiar, I don't think, to obstetrics or
9 paediatrics as compared with any other departments and in fact within most there are
10 people who are leading the way and are very good and there are also people who are
11 going to have to be dragged along by their bootstraps and if they don't come we have
12 to question whether they should stay but I think that process is there.
13 PROFESSOR MONTGOMERY: One last question from me then, Bill. I would just like to
14 give you an opportunity to counteract what feels as though it is an unfair impression
15 from the document that you sent through, which you sent through in PDF that was
16 searchable, which was great. So, I searched the section of how has the trust changed
17 for maternity, for 'midwi', so that I got 'midwifery' or 'midwives' and for 'obstetri' so
18 I got 'obstetrics' and 'obstetricians' and it had nothing in it that dealt with that
19 separately. The only references to midwives were "senior clinical leaders, nurses and
20 midwives". The only reference to maternity was the friends and family test locked in
21 with the impressively high response rate, and I must say that is really good, or CQC
22 comments. You did not set out what you would say about how maternity services in
23 Barrow had changed. So, it would be just great to give you an opportunity to offset
24 that impression, which is obviously consistent with what I have just asked about,
25 which is how far are they different questions and how far are they common, but it
26 would be really helpful to have a sense of, if you were just narrowing it down, and I
27 understand from our conversations why we need to deal with it on the trust, what
28 would you say?
29 MS SMITH: I would say how things have changed in maternity in Barrow. They have
30 changed significantly. We have different leadership; we have really robust processes
31 that everybody understands; they have got training. Supervision is very good. We've
32 got preceptorship now that is as good as any in the country if not better. We are
33 leading the way in a number of things, so we introduced GAP early last year, which
34 makes us an early implementer, if you like. In terms of the stillbirth care bundle,

which I mentioned earlier on, we have been running that since last year and we are actually achieving every single element of that. Stillbirths are down. We have been using Fresh Eyes for nearly two years. Fresh Eyes is where an independent midwife will come in every two hours and read somebody's CGTs so again you have that independent – We were one of the pilot sites, well, one of the first organisations to implement Safety Thermometer for maternity. We have been filmed over this month because our improvements on Safety Thermometer and Fresh Eyes have been so significant that we are being used for the national launch site, you know, Morecambe Bay with all that awful media coverage is being used as a national pilot site to show how well this works.

We do share what we have been learning, both what we have done wrong and what we have learned from it nationally, and only last week Sacha and I were in Bristol sharing some of that learning. It is important that we share that. So, I think that a lot of the stuff that we have done with some of our families more recently again involving them in designing and developing our services – 15 Steps has been implemented with families.

How has the service changed? It is not recognisable. If you look at our service today compared to the service that you have been looking at in the past, it is a very different service. Is it where we want it to be? No, because actually the improvement part that is going to help us take things to another level maybe a level at the moment of people where we'll be first. We've got really committed staff and, as I say, their emotional resilience has astounded me because I have been here 11 months now and I have to say at times my emotional resilience gets really low. The impact of the negative media is very significant, but they come to work and our retention is good in Barrow and we are recruiting people into Barrow. So, our reputation in terms of the job and the work and the unit nationally seems to be much better than that that the media is portraying and I am glad that there is a recognition that we are making progress on maternity national, but it does not seem to get away from the media – we don't seem to make progress with the media or with some of, I would say, the national regulators, the paranoia.

MS DANIEL: I think the truth is now we've got to – I have made my personal views clear about where we are on that journey. We are a people-orientated business and the trust and relationship we've still got to rebuild with families, with the population, with our partners. There is a lot to be done, so I can see the outcomes that Sue is describing on

1 a day-to-day basis, but it is about just being really open to the possibilities of where
2 we have been, what that has meant and everything from the way that we prepare for
3 inquests and we work with our midwives is really, really important. It was done in a
4 very legalistic, very kind of binary way. We are a people business with patients at the
5 heart of what we do and I think if we hang on to that as we build trust going forward,
6 we will improve even further.
7 MS SMITH: The last two coroner's inquests that we had, on one of them the coroner did find
8 that our discharge documentation was not very good but he commented on the
9 learning from it and what we have done. He also commented on how open and honest
10 we had been from the beginning, and the second one, the last inquest that we had, a
11 different corner also commented on how open and honest we had been with the family
12 and he commented on the relationship with the family in the break when the midwives
13 and the family all came together and sat and talked. That is a very different unit to the
14 unit that some of these families had experience of. So, it is different, and as Jackie
15 said, there is a lot of work to do to try and reinstall that trust with those that we have
16 worked with before.
17 PROFESSOR MONTGOMERY: Okay. I am glad that I asked that question ---
18 MS SMITH: I'm not!
19 PROFESSOR MONTGOMERY: – to come back on what you said.
20 THE CHAIRMAN: Okay. I've got a couple of points that I want to make. A bit of
21 background, first of all, and then a little bit of feedback and I will ask you to respond
22 to it. The background is that you are clearly very keen to tell us about all the positive
23 things that you have done and that is right, that is what you want to do and what you
24 want to emphasise, and we are keen to see you succeed in all of those things. There is
25 a pretty important point, though, that we don't kind of collude in a slightly cosier,
26 'Well, everything's all right in here' because you have been here before – not you
27 individually but the trust as an organisation has been here before – and I've lost count
28 of the number of times that the trust has said, 'It's all right now', and other people
29 have said, 'Yes, you're right it is', and it hasn't been and it comes back and bites
30 everybody if that is the case. So, we need to keep a healthy scepticism here.
31 I take your point entirely that is (a) fundamentally rooted in organisational
32 culture in some of these units, and (b), that that is driven from the top but that it takes
33 a long time to change and that you are on a journey and you might be slightly less than
34 halfway through. I am concerned that there might be some parts of the organisation

1 that have not actually taken the first step off and the reason they haven't taken the first
2 step is because they are still in denial about this. You referred a couple of times to
3 paranoia and the effect of the scrutiny and all the rest of it. One defence mechanism to
4 that is this siege mentality where you say, 'Actually, it wasn't us. This is all unfair.
5 It's all viewed from outside', and I have to say I could give you various examples but
6 it wouldn't be appropriate of things that we have heard that suggest there are places in
7 your organisation that still are in denial and refuse to acknowledge those kind of
8 serious failings. It is only fair to reflect that back to you. I will give you one very,
9 very tangible example of that, actually, in your own documentation where you talk
10 about the reports in the past and you have repeated this bull and canard about five
11 unconnected serious incidents – unconnected? They are clinically different because
12 the final thing that went wrong clinically was different but they are all rooted in the
13 same failings of knowledge, attitude, behaviour, teamwork, multidisciplinary working.
14 They are not unconnected at all.
15 MS DANIEL: I completely agree.
16 THE CHAIRMAN: I am concerned that until that is generally acknowledged and generally
17 recognised, and that is just one example of it, that there are some bits that haven't
18 taken that first step.
19 MS DANIEL: I would acknowledge that from my perspective. I don't think when you have
20 a workforce the size of ours you can ever deny that, that there will always be those
21 people that are in denial. Our job, really, I think, is to steadfastly try and work
22 through that and, as George said, you get to the point where either the people will
23 change or you have to change the people. We have done quite a lot of that over two
24 years. We've probably got more of that still to do.
25 THE CHAIRMAN: Yes, okay. I am glad to hear the acknowledgment of that. That is
26 helpful. Okay. Is there anything else any of my colleagues want to ask? I have
27 another question that I would like to ask you but it relates to a clinical incident and I
28 am going to have to ask for a brief pause while we ask for ---
29 PROFESSOR FORSYTH: Can I ask about one thing in particular? You mentioned about the
30 Medical School. Was that Lancaster?
31 MS SMITH: Yes.
32 PROFESSOR FORSYTH: I wondered what your relationship was with the Medical School
33 and are any of your non-execs from the Medical School?
34 PROFESSOR GARDEN: I am the head of the Medical School.

1 PROFESSOR FORSYTH: Are you the Medical School representative?
2 PROFESSOR GARDEN: I am the head of the Medical School.
3 PROFESSOR FORSYTH: That is what I wanted to clarify.
4 PROFESSOR GARDEN: Yes.
5 PROFESSOR FORSYTH: Because clearly again it seems to me that that would be a very
6 strong partner to have working closely with the organisation, particularly as a potential
7 teaching resource or certainly for medical students.
8 PROFESSOR GARDEN: Yes.
9 PROFESSOR FORSYTH: And when you are talking about trying to encourage medical
10 graduates then to come back here at a later stage, what they remember is that
11 informative time when they were students and that for them is the attraction of
12 bringing them back. So, the linkage with all this is that if you are going to have to
13 employ more consultants than you do require for the day to day work because they
14 cover the out of hours, then that's a great resource for teaching and that is a positive, I
15 think, for many people in the job if they have an opportunity to teach. And if you are
16 then going to improve their performance, actually it's good for them to think, 'Gosh,
17 I'm teaching them this. I'd better read up about it', and so I think there are a number
18 of benefits from having a good working relationship with the Medical School.
19 PROFESSOR GARDEN: Yes, and I think the relationship between the Medical School and
20 the trust is a particularly good and particularly strong one. Because we are a very
21 small medical school, we have had to develop a different structure and a different way
22 of working from some of the medical schools that you might be more aware of, and
23 that method of working is a much more integrated way where members of staff from
24 the trust have roles in the Medical School in terms of leadership and development that
25 they wouldn't have in a more traditional medical school. So, I agree entirely and I
26 certainly see the Medical School as part of the developing future of this trust.
27 PROFESSOR FORSYTH: I was particularly thinking of, again, the Barrow end of the trust –
28 PROFESSOR GARDEN: Absolutely.
29 PROFESSOR FORSYTH: – where you are going to have a lot of clinical material and
30 opportunities for learning.
31 PROFESSOR GARDEN: Yes, absolutely, and there are people at the Barrow end of the trust
32 who are involved in the leadership of the clinical teaching of the Medical School.
33 PROFESSOR FORSYTH: Okay.
34 THE CHAIRMAN: Is there anything that you want to say to us in this contact meeting that

1 you have not had the chance to say? [Pause] It is not compulsory. Okay, can we
2 have a brief pause then?
3
4 **(Pause for members of the public to leave the meeting)**

THE MORECAMBE BAY
MATERNITY AND NEONATAL SERVICES INVESTIGATION

Monday, 13 October 2014

Held at:
Westmorland General Hospital
Burton Road, Kendal, Cumbria, LA9 7RG

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Jonathan Montgomery – Expert Advisor on Ethics
Mr Julian Brookes – Expert Adviser on Governance
Professor Stewart Forsyth – Expert Adviser on Paediatrics

JOHN HUTTON – Interim Chair
PETER ARMER – NED
MELANIE WEEKS – NED
JACQUELINE PRATT – NED
DENIS LIDSTONE – NED
HELEN DENTON – NED
PROFESSOR ANNE GARDEN – NED

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1 THE CHAIR: Thank you for inviting us here. This is a part of the Morecambe Bay
2 investigation process. We're going to run it as far as possible to the usual systems that
3 we apply for the Morecambe Bay investigation process, which is to say that we are
4 recording proceedings, that we will make an agreed record of proceedings at the end,
5 that we have extended an invitation to family members to be present, and there are
6 some, and that others may listen to the transcript subsequently. And we've asked you
7 to not bring along any mobile telephones, laptops or other recording devices to
8 emphasise that we don't want anything to leave the room until we are ready to
9 produce a report that has all of the findings considered in context.
10 The nature of this session is in relation to our last two terms of reference,
11 which are about the services now and about the lessons learned by the trust from
12 what's happened subsequently, so we're grateful to you for coming along and
13 allowing us to talk to you sort of semi-corporately at the moment, and then in a full
14 session of the trust board subsequently.
15 We also want to split it into two parts; one where we talk about most of the
16 issues, and the second briefly following a pause where we'll ask people to leave the
17 room, where we raise some issues that are related to confidential matters. Do you
18 have any questions for me about the process that we're following?
19 *[General agreement there are no questions]*
20 THE CHAIR: Okay, thank you. In that case I'll ask Jonathan if he'll start out with some
21 general questions, please.
22 PROFESSOR MONTGOMERY: Thanks very much, Bill. And most of all, I wanted to ask, I
23 think it would be more appropriate to ask when we're in the full board, but I
24 particularly wanted to ask – well, we've just had you as non-executives – around your
25 induction, because you're all relatively new to the trust, and we just wanted to know
26 where the issues that are within terms of reference is about maternity services featured
27 in your induction, whether it is a big part of it or a small part. I don't know who wants
28 to start.
29 MR HUTTON: I think it may seem not long ago, but in other ways it seems quite a long
30 time. I took the typical one-day new staff member induction, and as I recall there was
31 no specific mention of any issues to do with maternity in that general induction
32 programme.
33 PROFESSOR MONTGOMERY: And that's for all staff, not for board members particularly,
34 but for all trust staff? So that's understandable.

1 MR HUTTON: No, we didn't have a specific individual board member induction programme
2 at that time.
3 PROFESSOR MONTGOMERY: And did you have a briefing pack of historical documents
4 that were thought to be important background or anything of that sort?
5 MR HUTTON: No, we had a general introduction from the then acting Chair, who was
6 appointed by Monitor, of all the issues that he felt had to be dealt with by the board.
7 PROFESSOR MONTGOMERY: And did our work – I don't mean the work of the
8 investigation, but did the maternity issues that have led to that, was that part of
9 that briefing specifically, or did it come later that you discussed that?
10 MR HUTTON: No, that was clearly on the agenda at the time, yes.
11 PROFESSOR MONTGOMERY: Okay. And what about getting to know the sites and
12 visiting the places, did you have a visiting programme as part of your induction?
13 MR HUTTON: We each did that individually in the course of the work that we do, given the
14 constraints on the time of a non-executive director. We fitted that in alongside other
15 meeting and so on at each particular site.
16 PROFESSOR MONTGOMERY: So does that mean you've all been to Barrow now?
17 *[General agreement]*
18 PROFESSOR MONTGOMERY: That's a relief.
19 MR ARMER: Our board meetings are actually rotated around the major sites.
20 PROFESSOR MONTGOMERY: Okay.
21 MR LIDSTONE: Yes, actually I live in Barrow, so any spare time I've got I spend at Furness
22 General. I normally go on visits with one of the governors, one of the staff governors,
23 and that's just ad hoc, that's just wandering round and talking, but that's in addition to
24 the formal review of each site.
25 PROFESSOR MONTGOMERY: Okay. And so what opportunities has that given you to
26 meet and talk to staff in the maternity unit in Barrow? Some of these visits are a bit
27 like Royal Progress, and you're accompanied by someone and you get to see the place.
28 Other times, you know, you just spend time talking to people just to get a flavour of
29 how you're able to get direct contact with the staff.
30 MR HUTTON: I think if we can get away from this idea of an induction and talk about the
31 normal work of the NEDs, I think it might be more helpful, because we are part of the
32 regular programme of walk-arounds, which the chief nurse has instituted across the
33 trust, which includes maternity. And we also do the 15 Steps programme, which I
34 recently took part in the women and children's departments on all three sites. And my

1 colleagues have taken part in similar walk-arounds, not necessarily in maternity, but
2 across the three sites.
3 PROFESSOR MONTGOMERY: So has that given you chance to talk directly to midwives
4 and other maternity care without an executive director there, or…
5 MR HUTTON: Yes.
6 *[General agreement]*
7 PROFESSOR MONTGOMERY: And what's the feedback from them about where we are
8 now?
9 MS DENTON: I chair the SIRI Panel, and I could say that I've met probably quite a
10 significant number of the maternity staff because we had enhanced reporting for a
11 while where everything was reported, and so consequently whoever is reporting comes
12 to the SIRI Panel, and I've had opportunity to speak to staff beforehand, during and
13 after really, and to ask them how they felt, and to explore cases with them that we
14 were looking at as part of the SIRI Panel. And that's been clinicians through to just
15 normal staff on the wards.
16 PROFESSOR MONTGOMERY: And what have they told you about how they felt?
17 MS DENTON: I'll be very honest and say that they have felt initially, I think, when we first
18 started looking at cases they felt very under siege, if you like, morale was very low. I
19 think more latterly they feel that they are still under very intense scrutiny. They feel
20 that they are, if you like – they report back to the minutest detail being very
21 over-cautious, I think, probably, which I'm sure is a natural reaction. But I think that I
22 would say that from having talked to some of them 18 months ago, for some of them
23 as they come and talk now, I think they are getting more confident than they perhaps
24 would have been 18 months ago.
25 PROFESSOR MONTGOMERY: Okay. What do you pick up about the relationships
26 between the – particularly the obstetricians and the midwives, the paediatricians and
27 the midwives, because obviously that's been a feature in some of the documents that
28 we've read. And we can track through some of the metrics and have these sort of
29 processes, but your sense of how they feel about it would be really helpful.
30 MS DENTON: Again, from about 18 months ago, I think, perhaps there felt to be a bit of a
31 gulf. I think that there have been some new clinicians who have been brought into the
32 trust. I can think of one, [Alison Sandbrook?], who – the impression that you get all
33 the time, and you see in the documentation, is team working then. So I think that there
34 has been some new blood that's come in, if I can put it that way, in terms of new

1 clinical staff who have a different way of working. And I think you can see that
2 certainly, and they have taken the initiative to put some things in place, for example,
3 to make sure that they provide us with good RCAs, because the quality of them when I
4 first came and first started chairing the SIRI Panel was not good. And having sent
5 them back and talked through what we needed, and the governance lead having done
6 the same, the quality of them has improved significantly, and the detail, the relevant
7 detail. And certainly the women and children's division have paid particular attention
8 to that in terms of that minutiae of examining things in detail. And we have asked for
9 independent people to look at things as part of the SIRI, where we weren't satisfied,
10 but again, women and children's, with having that very close scrutiny of what they
11 have been doing themselves have sometimes pre-empted that by having had that done
12 already, which was a very positive sign from my point of view.
13 PROFESSOR MONTGOMERY: There's one other I had, although it might be it's more
14 appropriate for the full board, but it might be resolved quite quickly. I mean I've
15 looked at your last couple of sets of board papers, and one of the things that struck me
16 was that you had reported for July, so the August meeting, a drop of qualified nursing
17 and midwifery staff against the April complement of 5.6 whole time equivalents in
18 July, and then it went up to 10 point something in August, so you seem to have had
19 quite an attrition of – and this is at Furness specifically. So your headline figures are
20 fairly stable, but that leapt out as very different from the others. I wondered what
21 discussion you had at the board about that.
22 MS DENTON: If I can recollect, I think that was around we increase the staffing
23 complement, so consequently if we'd have matched it against what it was the previous
24 month it probably would have been perfectly fine, but we'd taken quite a lot of
25 decisions as the board to significantly increase the nursing and midwifery staffing
26 levels. So then you have to build...
27 PROFESSOR MONTGOMERY: So what attrition...
28 MS DENTON: So we've moved the baseline up, I think is the – because we did have a
29 discussion about that in a board meeting. Because we all went, 'Oh, you know, that
30 doesn't look right,' and – but we hadn't built in the fact that we had agreed to – we
31 originally agreed to overstaff because we felt that we needed to be in that position.
32 But then when the new guidance came out we'd already agreed to overstaff, but then
33 we needed to up it again, and we were reviewing that decision.
34 PROFESSOR MONTGOMERY: Why did that happen at Barrow but not at RLI?

1 MS DENTON: I think you'll find that we've increased staffing right across the board, but
2 there were particular issues around Furness in terms of...
3 PROFESSOR MONTGOMERY: Because staffing increased at RLI, but it decreased at
4 Barrow on these figures. So if the...
5 MS DENTON: Yes.
6 PROFESSOR MONTGOMERY: ...upping had happened across the board you'd expect
7 there to be a consistent pattern.
8 MS DENTON: I think you've got to see where your baseline is. I've you've got a significant
9 number of vacancies already, and then you put in place something which ups your
10 baseline, then it is going to look worse, isn't it? And in terms of RLI, our staffing was
11 reasonable, but it was worse at FGH, so it needed to be increased.
12 PROFESSOR MONTGOMERY: Thank you. Julian?
13 MR BROOKES: Do you think as this is collective, anyone can pitch in if you can, I'm just
14 interested on your responsibilities as board members and how you fulfil those. You
15 need good information to do that, and I'd just like your views on whether or not you
16 feel that as board members you receive the level of information and the quality of
17 information in order to make proper decisions as a board.
18 MR HUTTON: Perhaps I should start on that one. I think the answer would generally be yes,
19 but you're always looking for more and better. I think in connection with maternity,
20 where I've had a closer interest as part of the intensive support programme we put in
21 for the women and children's division, particularly when we had licensing conditions
22 with regard to maternity services imposed on us, and that group was particularly
23 charged with overseeing the action plan to correct the deficiencies identified on that
24 occasion, one of which was around the quality of information. And it was quite
25 revealing in that process that in switching from one information system to another we
26 did identify discrepancies in the way that the information came up on the new
27 programme as opposed to the old one, which obviously set alarm bells ringing. And
28 we bottomed that one out before proceeding further obviously, because if what the
29 new system was telling us about previous information had been correct, it meant we'd
30 been dealing with incorrect information. And it turned out to be a little bit of one, a
31 little bit of the other, but as a result of that, particularly with regard to the maternity
32 dashboard information, we're now much more confident that we've actually got
33 accurate information on which subsequent decisions are made, and that lesson learned
34 is being transferred to other divisions as we develop our information systems at the

1 moment.

2 My colleagues can speak for themselves, but I can't think of an instance where
3 we have not made a decision because we didn't think we had adequate information at
4 the board to make that decision. And that of course reflects the level of scrutiny that
5 goes on with proposals below board level before it gets to that level for final decision,
6 I think, rather than, you know, the fact that the board is making decisions on the spur
7 of the moment on the basis of a paper put in front of them on a Wednesday morning.

8 MR BROOKES: I would be interested in other people's views.

9 MS PRATT: I think there's still a way to go would be my perspective. I've been with the
10 trust six months, and from my perspective, you don't always get the comparative data
11 with other trusts that's sometimes helpful to be able to position yourself in terms of
12 performance. And I think we're just sort of unpicking things at workforce committee
13 that's recently been established. You start to sort of like dig into some of the detail,
14 like mandatory training, for example, and then sort of, well, are the right people
15 getting the right level of training, and sort of starting from that basis before you can
16 then get reasonable data from that. So I think there's definitely work going on, but my
17 assessment would be we're not where we want to be at the moment, but we are trying
18 to sort of get there along the way.

19 MR ARMER: I think my point is I think – I mean I'm a non-exec, I'm a chartered accountant
20 as well, so information is quite important to me, especially numbers. I sit on the
21 finance committee and I chair the audit committee. The thing I would observe is not
22 about the quality of the data, it's about the reaction of management if further data is
23 asked for, or further information asked for. And I've always found the management
24 team to be extremely responsive. It has been a journey, as Jacqui said, and I've been
25 in the trust a bit longer, I've been here just over two years, and I've found the quality
26 of the data presented to us has improved. And as we've demanded it's improved
27 we've found a fairly positive response – a very positive response actually from
28 management.

29 MR LIDSTONE: I chair the quality committee, and I think, again, I've seen an improvement
30 in the quality of information. So during the early stages we were challenging a lot of
31 the information coming to us, and that was going back. It's a lot better; we've got
32 some very good dashboards now, but even up to quite recently, when we were looking
33 at the CQC responses; okay, we may meet a target, but then there's an ongoing as that
34 target improves over months, so we've gone back again and challenged to say, 'Let's

1 have proof to make sure that the quality of information we're basing that delivery on
2 is good information,' so there's action currently with the executives to go away and
3 just double-check. I know that's going on in a number of areas; I mean a crucial one
4 which we talked about recently was availability of patient notes. A system, electronic
5 system is telling us one thing, but I know for a fact they're cross-checking that using a
6 sort of paper approach, but nevertheless, I know there's work going on just to quantify
7 or qualify the value of the information we're getting. Is it quality information that
8 we're basing a lot of our future on delivering key targets?
9 MS DENTON: I would just reflect back. I chair the safeguarding board as well, and we now
10 have a safeguarding dashboard where I can double – cross-check, as it were, with
11 colleagues – that's attended by colleagues from Cumbria and from Lancashire, and we
12 can cross-reference the numbers of referrals and things like – just to check that we are
13 – we're keeping abreast of how many referrals we're making, what sort of referrals
14 they are, those sorts of things. But also, I'll go back to what I said before; the
15 information that was presented to the SIRI Panel when I first started chairing it was
16 poor. I'll be very fair, it was poor, and over the last 18 months we worked very hard
17 to not accept anything that we didn't feel gave us the information that we needed to
18 know from a governance point of view, which is then backed up by people attending
19 the SIRI Panel, and for there to be a discussion with other clinical colleagues around
20 the room as to what might have happened or what might be missing.
21 And the use of information wasn't – the use of information to identify themes
22 and trends wasn't good either. So we were getting a lot of pressure ulcers, a lot of
23 falls, and it was only through, I suppose, questioning and demanding in terms of my
24 background, to look at – to have somebody do pieces of work to identify themes and
25 trends to be able to say, 'Right, so what do we need to do differently to get it right first
26 time?' But having pushed and pushed on those things, they now happen as a matter of
27 course, and there's a free from harm group which actually does regularly and routinely
28 now from establishing it, and there's a whole series of things that have changed as a
29 consequence of it.
30 THE CHAIR: On the poor reports, the poor SIRI reports, was that a reflection of poor report
31 writing or was that a reflection of inadequate investigations?
32 MS DENTON: I think once people were in the room they could talk very ably about what
33 they had thought, what they'd looked at, but they certainly weren't recording it that
34 way. But I wouldn't say that – I think it was probably a mixture of both. I would say

1 now it's quite different, and we obviously tell people when it isn't a good RCA, and
2 we would send it back and we'd send it to the governance leads and say, 'It's not
3 acceptable; we would require this. Why didn't you get an external view on this
4 because we would want one?' But then we have others where now we're getting some
5 really good quality with very good analysis and detailing, and quite often produced
6 from a whole team looking and reviewing at the same time, including clinicians, to
7 say, 'Right, so what could we have done differently?'

8 To some extent we're identifying a lot of things that weren't relevant to the
9 outcome, as it were, but are still learning points. So we're into that process of trying
10 to look for every single learning point, but then when we get a number of them
11 coming up in the same way, we have to say, 'Right, that's a theme or a trend.' And
12 we also take those themes and trends, where appropriate, through to the quality
13 committee and report them there, so we've made some significant progress, I think, in
14 terms of upping the quality, and…

15 THE CHAIR: You say including clinicians there almost as if it was a surprise, but surely that
16 should be absolutely fundamental.

17 MS DENTON: Well, absolutely, but to start off with when – again, 18 months ago or so, they
18 were largely nurse-led presentations and RCAs, which we said, 'No, absolutely not.'
19 And we now have both of the deputy chief medical officers who attend the SIRI Panel,
20 so there's significant cross-profession representation that comes to do that, and that
21 looks at the cases.

22 THE CHAIR: Okay, that's fine. Stuart?

23 PROFESSOR FORSYTH: Yes, if I can just go back to maternity services, and of course
24 neonatal services are part of our remit as well, and I'm a paediatrician so I'm
25 particularly interested in that. But what I wanted to know from yourselves just now is
26 do you feel that you have gathered or gained a good understanding of what the
27 fundamental issues were with maternity services, or are with maternity services and
28 neonatal services? And do you feel that the management are going forward with a
29 clinical strategy which will address these fundamental issues to prevent further
30 episodes occurring?

31 MR HUTTON: Again, I will start. It would be presumptuous of us as non-clinicians to say
32 we've got a total understanding of the issues, I think. But in our role as
33 non-executives, I think we know what we need to be looking at to make sure, as far as
34 humanly possible, these things don't happen again. There's clearly an issue around

1 staffing and staff skill levels and training; the big issues around the culture of the
2 service, particularly with regard to lack of communication between the three parts of
3 the service, and also relationships between different professional groups within the
4 service. And I think there are also some issues of communication both within the
5 department and the relationship between patients and staff, or should I say service
6 users and staff in connection with maternity services, to be more appropriate.
7 As we've been discussing earlier, the staffing issue we have spent a lot of time
8 trying to address, although as you'll be aware, recruitment of suitably qualified
9 individuals, it's not easy both nationally, and particularly locally, for a variety of
10 reasons. We have, however, committed the resources to do this in spite of the
11 financial difficulties that the trust finds itself in at the moment, and we see this as
12 something that we cannot afford to fail on, and we will take other measures to try and
13 redress the financial situation, which we're actively doing.
14 So I think we've addressed a lot of the – you could say internal managerial and
15 relationship issues within the departments, and we've opened up communication both
16 within the trust and outside the trust, and sought support from larger and more
17 experienced units with more specialised staff, which we see as the only way we can
18 continue to provide a good quality service in the future. Given the volume of work
19 that goes through our service, the fact that it's split between locations, but also the fact
20 that our commissioners have decided that they want the service provided pretty much
21 as it is at the moment, and therefore we are planning around that for the future. So I
22 think everybody's up to speed on the strategic context in which the service must be
23 developed and the need for appropriate levels of staffing and skill mix. We're trying
24 our best to make it attractive to recruit people and looking at manpower strategies
25 which have a bit more imagination in them than perhaps they had previously, to do
26 that. But it's still high on our risk register and our broad assurance framework of
27 major concerns, and it will always be there simply because I think we're being asked
28 to provide a service in a particular context, which is never going to be stable given
29 even the maximum financial resources which this trust can see being made available
30 to us over the foreseeable future.
31 PROFESSOR FORSYTH: So you obviously emphasised the point that the commissioners
32 are very keen for the same service model to continue, but the trust – I get a feeling that
33 you feel that this is a service model which is clearly difficult to deliver, and I just
34 wonder about what the trust arguments were to the commissioners on this particular

1 point.

2 MR HUTTON: Well through the Better Care Together structure, which I think you are
3 familiar with from other sessions, quite detailed discussions obviously took place
4 about this. And if you start from a purely clinical perspective, the optimal size of unit,
5 throughput, staffing and skill mix, it is difficult to justify a two-site service for our
6 population within the current tariff. However, given the geography and the difficulties
7 of accessing service across our locality, the commissioners decided we definitely did
8 not want to go down the route of trying to centralise and take on board all the other
9 difficulties that that would presume; and the palpable reduction in accessibility of all
10 the associated risks with that as well. The evidence on the impact on effectiveness of
11 services in that context is not so strong, but certainly there's a supposition that there
12 could be bigger risks in certain sections of our population if we did that.

13 So ultimately it is a trade-off between providing a service and a volume and
14 throughput, which medical experts consider not to be the safest way to do it, and to
15 draw in experience from outside and to give staff experience of working in other units
16 so they can keep their skills up as far as possible is the route that we are going to have
17 to go down in order to meet the commissioners' demands. And to be fair, I think we
18 recognise that that is what the preference of the local population is. It's not just the
19 commissioners who are saying that, and we are here to provide a service as
20 appropriate as possible for the population.

21 PROFESSOR FORSYTH: Okay.

22 THE CHAIR: Okay, I have a couple of questions for the second brief part of the session, so
23 I'll just have a pause while I ask if people could withdraw, please.

24

25 **(Pause for members of the public to leave the meeting)**

THE MORECAMBE BAY INVESTIGATION

Thursday, 2 October 2014

Held at:
Park Hotel,
East Cliff,
Preston.

Before:

Mr Julian Brookes -- Expert Advisor on Governance
Ms Jacqui Featherstone -- Expert Advisor on Midwifery
Professor Geraldine Walters -- Expert Advisor on Nursing

STEVEN VAUGHAN

Transcript from the Stenographic notes of Ubiqus,
Clifford's Inn, Fetter Lane, London. EC4A 1LD.

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INTERVIEW OF STEPHEN VAUGHAN 1

1 MR BROOKES: Good morning. Welcome. Can I start,
2 first of all, by an apology from Bill Kirkup, who is
3 chairing the investigation. Unfortunately he's not
4 able to be here today, so he has asked me to chair this
5 particular session.
6 I am Julian Brookes; I am one of the Panel Members
7 and I am currently Deputy Chief Operating Officer for
8 Public Health England; I was previously Head of
9 Clinical Quality at the Department of Health.
10 PROFESSOR WALTERS: Geraldine Walters. Director of
11 Nursing at King's College Hospital.
12 MS FEATHERSTONE: Jackie Featherstone, Head of
13 Midwifery and Head of Nursing at a district general
14 hospital in Essex.
15 MR BROOKES: If I can go through the administration
16 arrangements first, that will be useful. As you can
17 see we are mic-ed. This is for recording purposes
18 only; it does not help us in terms of talking. It is
19 quite echoy in here, so we will try to keep our voices
20 at a relatively high level. The purposes is two-fold
21 for this. One is to ensure that we gain an accurate
22 record of the discussion today. The second is that
23 these sessions are open to the families. We do not

24 have any family members attending today, but they have

25 the opportunity, if they wish under controlled

1 circumstances, to listen to what was said at a later
2 stage. It performs that function as well.
3 We will have asked you to hand in your telephone,
4 any other recording equipment, or equipment that could
5 be used for recording. That is very much to allow us
6 to have the sessions kept confidential and what we say
7 within here stays in here. That is because we want to
8 ensure that we take all the evidence that we receive,
9 both in writing and through the sessions, and look at
10 the bigger picture in terms of what we conclude in
11 terms of the investigation. We do not want elements of
12 it to be used out of context.
13 If we get into any discussion around individual
14 patients we will stop at that stage and we may feel
15 there is a need to have a private session at the end.
16 I don't believe that will be the case today, but it is
17 something that we say to all people, so be aware of
18 that. We try to keep this very much around the
19 generalities. If we need to get into individuals we
20 have the facility to do that, but we do that in
21 confidence at the end.
22 MR VAUGHAN: That is fine.
23 MR BROOKES: If I start with an initial question. If

24 you could say for the record who you are and what your

25 role at the Trust was?

1 MR VAUGHAN: I am Stephen Vaughan. I was a Director of Operations
2 and Performance at the
3 Trust from October 2007 to December 2011.
4 MR BROOKES: Thank you.
5 PROFESSOR WALTERS: Hi, Stephen, did you report
6 directly to the Chief Executive?
7 MR VAUGHAN: Yes, I did.
8 PROFESSOR WALTERS: From 2007, say for about the next
9 two or three years, what were the really big issues at
10 the Trust.
11 MR VAUGHAN: The big issues at the Trust -- there were
12 a range of things. There was -- the primary objective
13 was for the organisation to improve its delivery of
14 care across a range of aspects and to be more
15 consistent in that delivery. There were a range of
16 indicators that historically the Trust had struggled to
17 achieve. There was a period of stabilising and
18 changing operational management systems around
19 delivery, you know in over-arching terms to enhance
20 and, as I say, to get more consistent delivery of
21 services. Also to understand how some of the processes
22 and systems worked behind that to enable that
23 consistency. The idea was not to take a sledgehammer

24 to the system to try to change it.

25 Most of those key operational indicators sat more

1 within the general performance remit of -- or target,
2 if you like, of the NHS at the time -- rather than
3 issues around maternity, I would say so.
4 Specifically there was a lot of focus around A&E
5 and 18 weeks RTT and cancer, those sorts of things.
6 Clearly there was -- I should have said at the
7 beginning this is not in any particular order --
8 clearly there was an objective of the Board regarding
9 becoming a Foundation Trust. That was a process that
10 had already begun before I started. I remember the
11 first week that I was there attending a sort of a
12 workshop that was multi-disciplinary in terms of
13 clinical staff as well as managerial teams regarding
14 how the strategy was being formulated. That was
15 already in process before I started but, clearly, going
16 through those next two or three years, to 2010, that
17 was very clearly on the Board's agenda in terms of
18 delivery.
19 Some of the other key priorities were around our
20 relationships, around some of the governance
21 structures, which supported all of that delivery.
22 In terms of how did we develop and sorry -- what
23 is the word I am looking for? In terms of how we

24 develop a reporting structure, but also a structure

25 that picked up the qualitative agenda as well as the

1 quantitative agenda because, at the time, it would be
2 very easy to feel that the numbers were driving
3 everything in terms of performance standards.
4 There was -- I recall us having some specific
5 discussions and also, in terms of how we worked with
6 our management teams in terms of how we developed a
7 three-pronged, we were trying to develop a
8 three-pronged performance approach, which was focused
9 around quality and quality was all encompassing of
10 qualitative standards in a broader clinical quality
11 agenda perspective, as well as a quantitative agenda,
12 as well as the way that our people and our finances
13 came together. We focused around all three. We were
14 trying not to allow the target-driven culture, that we
15 might have talked about, to overview and drive the
16 whole agenda.
17 Although I could understand if people who sat in
18 this chair previously would suggest that there was a
19 focus around the targets, because the agendas that we
20 were working in there was a lot of pressure from
21 multiple avenues regarding targets, in particular the
22 headline targets around cancer and A&E -- sorry, cancer
23 RTT and A&E -- it would be very easy to think that

24 those were the only things that we were focusing on.

25 PROFESSOR WALTERS: You said you brought about some

1 changes to improve consistency. What were those
2 changes?
3 MR VAUGHAN: There were some changes in management
4 structure and also some changes in the way that we
5 tried to operate.
6 In terms of divisional and directorate structures
7 there were changes in personnel, there were changes in
8 structure. Issues, when issues were highlighted, so
9 clearly we put a focus around women's and children's
10 and separated that out at one point, a point in time, I
11 can't remember whether that was 2009 or 10; there was a
12 change in that structure to deliver that.
13 We brought more clinical directors into the fold,
14 in terms of discussion, but we did not really ever get
15 to have a clinically-led organisation. It was still
16 very much -- it still would have felt and practically
17 would have felt more like a managerially-driven
18 management structure and accountabilities, if that
19 makes sense?
20 We used independent review to try to assist in
21 developing in terms of operational systems. I utilised
22 the intensive support teams, particularly around our
23 elective and non-elective care pathways in terms of

24 advising and supporting about best practice that we

25 could utilise and opportunities and things that we

1 could copy in and also try to influence change of
2 practice.
3 There were areas within the Trust where some of
4 the practice was recognised by the IST, for example,
5 around emergency medical practice -- or our emergency
6 pathway for medicine where the way that some of our
7 physicians would operate needed some review. We bought
8 experts in to try and influence that because of that
9 work -- the internal clinical champions for that at
10 that time.
11 PROFESSOR WALTERS: What did you do specifically to
12 improve quality?
13 MR VAUGHAN: Me personally or as a --
14 PROFESSOR WALTERS: As an organisation.
15 MR VAUGHAN: I mean, in terms of the way that we were
16 structured, as an executive team there was very much a
17 triumvirate approach with regard to the quality and the
18 performance matrix. My role, if you like, as a
19 Director of Ops' was I picked up the day-to-day
20 management responsibilities for the teams. I was
21 working very closely with the Director of Nursing and
22 the Medical Director in terms of the development of the
23 quality agenda. In terms of -- I was part of a team

24 that we went on a journey; whether the journey was far

25 enough or fast enough is a different discussion

1 point -- but to change the way that we looked at
2 quality, to improve the regular reporting in terms of
3 the escalation, to try to incorporate it within our
4 performance processes. As I say, the level of
5 successes is a different debate.
6 Actually, that was the approach that was trying to
7 be taken. So, you know, hindsight and all of that is a
8 great thing, but actually how we should have pushed
9 that further and to drive it deeper into the
10 organisation, within the divisional structure, and how
11 that then cross-referenced across to the Clinical
12 Quality and Safety Committee, and the accountabilities
13 from board-to-board, going the other way round, as
14 opposed to the way we tend to discuss it and describe
15 it, I think that there was more that we should have
16 done and could have done but at the time it is one of
17 those things that you tended not to notice.
18 PROFESSOR WALTERS: Were the Board and executive team
19 worried about any particular quality issues at the
20 time? Was there anything that was sort of rising above
21 the parapet more than anything else?
22 MR VAUGHAN: Well, things rose above the quality
23 parapet at different times around different subjects.

24 Clearly if we go back to the end of 2008/early 2009 the

25 issues that happened in maternity became -- the Board

1 were aware as a Board; we were aware in terms of
2 executives and non-executives as to where we were. It
3 drove a range of actions that were taken either by
4 individuals or by the Board in terms of the Fielding
5 Report and actions associated with that.
6 There were a range of other -- right back to the
7 end just before I -- post-Lorenzo implementation --
8 there was the issue with out-patients that became a big
9 ticket item that was picked up and the Board were aware
10 of that and we discussed. There were a range of things
11 that came up and were discussed at periods of time
12 across the sort of several years.
13 PROFESSOR WALTERS: Maternity only really arose about
14 2008 --
15 MR VAUGHAN: Well, I cannot recall back to where we
16 were when I first started, back end of 2007, but I
17 cannot recall having significant discussion about
18 maternity services prior to the issues that cropped up
19 at the end of 2008. I recall that there was a serious
20 untoward incident involving gynaecology at Barrow that
21 was dealt with under the relevant policy earlier in the
22 time. But in terms of was it -- were we singling
23 maternity services out as a problem area; I don't

24 recall having specific discussions that would indicate

25 that we needed to make investment or make change or

1 that there were underlying clinical observational
2 issues.
3 PROFESSOR WALTERS: What sort of feedback would you get
4 from individual managers about what was happening in
5 divisions, from a quality point of view? Or was that
6 sort of not really on the agenda to talk about?
7 MR VAUGHAN: Yes. Well, I was -- what I was going to
8 say was, in terms of because what could be argued what
9 would now, when we look at it, would suggest is a
10 weakness of our governance structures, then I would
11 agree that, you know, there was not probably the formal
12 feedback that and that process working formally, as we
13 might have expected. In terms of issues around
14 day-to-day operational issues, or day-to-day clinical
15 issues, that were needing to be picked up we were
16 having conversations about those. If we required, you
17 know, if we were needed staffing issues or there were
18 particular issues between clinical professionals that
19 needed conversations, they would be escalated and dealt
20 with.
21 However, what we were not doing was retreading
22 that line necessarily and formalising them. Were we
23 capturing them as incidents? Were we reporting them

24 through the system? With hindsight, no, we probably

25 were not doing that as effectively as we could have

1 been.

2 PROFESSOR WALTERS: Lots of places were not as well.

3 Then going on to the Fielding Report. What do you

4 remember as being the sort of scenario around that and

5 how it was taken forward?

6 MR VAUGHAN: My recollections around the Fielding

7 Report were that we had had some investigations or

8 investigators -- as I said earlier we had used

9 independent advice around some of our core operational

10 targets and we had used clinical assessment around a

11 couple of things previously. It was paediatrics and

12 there is one other, which I can't remember; I have a

13 feeling it was cardiology --

14 MR BROOKES: Surgery --

15 MR VAUGHAN: -- that came afterwards. That was later.

16 I think it was something about cardiology at the time.

17 Certainly we had paediatrics, we had some people to

18 come in, some other organisations and experts coming

19 in. As I understand it, or as I recall it rather not

20 "as I understand it", as I recall we used that

21 principle for the Fielding Report to commission. So

22 the Fielding Report was commissioned at the back end of

23 2009, I think.

24 PROFESSOR WALTERS: Was that a Trust decision to

25 commission it, or was it an SHA decision?

1 MR VAUGHAN: I do not know. I think it was a Trust
2 decision but I was not -- I cannot recall being part of
3 the discussion that made the decision. That does not
4 necessarily mean I was not at the meeting where it was
5 discussed, but I do not recall being part of the formal
6 decision-making process. I understand, or I recall,
7 that we dealt with -- it was dealt with via the Board
8 and I assume the Chief Executive and the Chair made the
9 calls and the commissioning.
10 PROFESSOR WALTERS: Was it because the Board were
11 worried about something particular?
12 MR VAUGHAN: Well, obviously during 2009 there had been
13 a cluster of incidents, or what was perceived to be a
14 cluster of incidents, and there was ongoing dialogue
15 between the Chief Executive and [redacted] across the
16 period. Therefore, in response to these issues, that
17 was, you know, clearly there was something that we
18 needed to try and take some assurance from as to
19 whether or not there was an inherent -- what's word I
20 am looking for -- unrecognised problem that needed to
21 be dealt with.
22 PROFESSOR WALTERS: So the view of it was that you
23 might have a real problem here; or was the view of it

24 actually we think they are not connected but we need to

25 do some assurance particularly for [redacted]?

1 MR VAUGHAN: Well, I cannot speak for the Chief
2 Executive who made that call. From my perspective we
3 had --
4 PROFESSOR WALTERS: But the Board --
5 MR VAUGHAN: -- we had had some discussions about a
6 range of is incidents. As I recall, at the time our
7 mortality rates for maternity are not exceptional, so,
8 therefore, the independent indicators, if you like,
9 would suggest that there is not a problem but that does
10 not necessarily mean we should not be looking at the
11 fact that we have a cluster of, or what could be
12 described as a cluster of incidents that needed to be
13 looked at. On the basis that there are a cluster of
14 incidents, as you know, as a Board member, it is
15 important that we understand what is going on; why;
16 and, you know, whether there are underlying issues that
17 have or have not been addressed.
18 PROFESSOR WALTERS: Okay. The report was done then.
19 Then what happened afterwards?
20 MR VAUGHAN: Do you mean -- sorry, in terms of are you
21 talking about time line from when the report was
22 written through -- through 2009 and the CQC and --
23 PROFESSOR WALTERS: Not quite. I suppose, as you have

24 said, you have a cluster of incidents and there is a

25 spectrum of concern, is there not, which would be true

1 anywhere. Either this is probably just a bit unlucky;
2 or this is probably something really awful. A good way
3 forward is to get somebody else to come and have a look
4 at it.
5 MR VAUGHAN: Yes.
6 PROFESSOR WALTERS: In terms then of the report that
7 was done, the report that was done -- I suppose the
8 next logical thing is that everybody will be quite
9 interest in where that report is actually pitching it
10 on that spectrum. I wondered what the interpretation
11 of it was.
12 MR VAUGHAN: In terms of outcomes, if I summarise the
13 outcomes is that there was -- in terms of the cluster
14 there was a view, in fact I recall that it was even put
15 in inverted commas "cluster"; it was incidental rather
16 than a technical cluster; that there was progress
17 against the actions that we were already taking; but
18 actually there were a range of things that we still
19 needed to pursue. It was recognised, at that point,
20 that the family -- that by creating the Women's and
21 Children's Division that was the right thing to do but
22 actually it was not embedded and we needed to move that
23 further faster, particularly around the quality

24 governance agenda as would be the specific -- one of

25 the specific points which I think is probably what you

1 are getting at in terms of what came from that report.
2 There were a range of actions that were then
3 incorporated within an action plan for progression by
4 the Trust.
5 In terms of how and what did we do with that. Did
6 I take the lead on any of that? No, not really, would
7 be the answer. It was very much, as I said earlier, it
8 was a lot of the quality agenda was driven by the
9 medical and nursing directors so if we were a
10 triumvirate doing it there were three concentric
11 circles with a slight overlap in the middle and
12 actually, with hindsight, that should have been a much
13 bigger overlap in the middle.
14 Actually, in terms of, you know, my agenda was
15 very much focused on dealing with the day-to-day
16 operational challenges around the Trust in terms of the
17 tactical and operational development of maternity
18 services, on the back of Fielding, whilst the
19 divisional team work to me -- actually they were really
20 being managed outside of my office.
21 PROFESSOR WALTERS: Okay. As a member of the Board
22 were you assured that the actions were being delivered?
23 MR VAUGHAN: As a member of the Board I received

24 reports that said we were delivering against the action

25 plans. I think I attended a meeting with Monitor, at

1 some point, and, I think, in 2010 or 11 -- must have
2 been 2011 actually -- where they described our
3 assurances systems as providing with reassurance rather
4 than assurance. I think that possibly with
5 hindsight -- well, definitely with hindsight -- that is
6 where some of the challenge and some of the failings
7 have probably occurred because actually our systems
8 provided "reassurance" that things were taking place,
9 as opposed to "assurance" that things were taking
10 place.
11 PROFESSOR WALTERS: Okay. I have finished for a minute.
12 MS FEATHERSTONE: When you talked about part of your
13 roll is changing the quality agenda, did you have
14 clinical engagement when that was happening?
15 MR VAUGHAN: I would suggest that the clinical
16 engagement was not as -- it was not as detailed as it
17 should have been though at the time it did not feel
18 like it was not. It is one of those things that
19 afterwards you think, yes, I should have done it that
20 way, but actually there was some clinical engagement
21 but we largely drove it centrally in terms of the
22 agenda that was coming from the Medical and Nursing
23 Directors' offices. The way that we were driving that

24 to martial and understand what was going on in the

25 observation, the quality perspective, to fit with our

1 CQSC agenda. There probably was not enough, would be
2 the short answer.
3 MS FEATHERSTONE: Did you feel that it was sort of
4 coming from the shop floor, or just generally it was
5 not happening at all?
6 MR VAUGHAN: I think in terms of did it come from the
7 shop floor, I think that there are always people within
8 organisations who want to engage and want to discuss so
9 there was always feedback from the shop floor. Barrow
10 specifically, not necessarily around maternity, but in
11 terms of trying to work review and change some of the
12 pathways with it being a very different hospital, is
13 that I used to meet with a team of people, a group of
14 clinicians, on a regular basis to how we developed the
15 site. In terms of some of the pathways through that,
16 particularly from the front door, from A&E, through
17 into other areas and there was a lot of engagement from
18 people within A&E and from across the pathways.
19 Did we formalise that and drive that into the
20 quality agenda? No, I did not at the time. Would I do
21 it if I was there again? Would I do it differently?
22 Yes, I would. I think to answer your question, there
23 was not as much engagement in general terms as there

24 could be. In terms of how were we developing the

25 quality matrix around maternity? I think until Sasha

1 came into post as Head of Midwifery, I think there was
2 a little bit of inertia -- or a lot of inertia -- in
3 that agenda and that was possibly, you know, a problem
4 in terms of that evolution of our quality agenda and
5 development really.
6 MS FEATHERSTONE: You talked about "assurance" to the
7 Board that things were happening. Where was it coming
8 from? Was it coming from Board meetings and somebody
9 from the division -- irrespective of which -- would
10 come to the Board and assure? Or would it just be on
11 paper?
12 MR VAUGHAN: It would be on paper. We rarely had
13 divisional clinical and management leads to the Board
14 meetings to discuss operational details -- although
15 operational workings of their divisions they would
16 attend some of the Board development sessions and we
17 would have discussions, but rarely would we have a
18 detailed discussion either at the Board or at the
19 Clinical Quality Committee directly with Directorates
20 or Division about their matrix, if you like, around
21 quality.
22 MS FEATHERSTONE: You talked about separating womens
23 and children. Which division did -- where did you put

24 them?

25 MR VAUGHAN: Where did we put them?

1 MS FEATHERSTONE: Did you separate them and just left
2 them --
3 MR VAUGHAN: We created -- so they had been merged with
4 surgery when I started.
5 MS FEATHERSTONE: Both of them?
6 MR VAUGHAN: It was entirely surgery and womens and
7 children, so we created -- I can't remember the title
8 now, but it was, I think it was either called Family
9 Services, but it combined women's and children's
10 together as one division.
11 MS FEATHERSTONE: Sorry. Yes, I misunderstood.
12 MR VAUGHAN: We appointed a specific manager just to
13 handle that.
14 MS FEATHERSTONE: Sorry. You did not separate women at
15 one point and then children, you kept them in the
16 division. That is fine.
17 MR VAUGHAN: Yes. Sorry.
18 MS FEATHERSTONE: They were my main questions. Thank
19 you.
20 MR BROOKES: I am interested on your insight on
21 assurance verses reassurance. Can you expand on that
22 for me?
23 MR VAUGHAN: As Board members we get a report that says

24 that everything is green. If we are assuming that that

25 is okay, we are reassured that we are delivering.

1 Actually, if the information that underpins that green
2 is wrong, we are not assured that it is green. The
3 example that I have used many, many times since I left
4 Morecambe Bay is about clinical incident reporting
5 systems. Clinical incident reporting there was a
6 specific item where there had been a level of, if I
7 call them colours rather than numbers, but red, amber
8 green. The number of reds and ambers was at a level
9 and the total was another number. The total number and
10 the number of red and ambers started to track down so
11 indicating an improvement. So that was providing, in
12 the way the system worked that is providing assurance,
13 but in reality was providing reassurance because what
14 had happened was that people had stopped filling the
15 forms in. That would be how I would, you know --
16 MR BROOKES: Do you think that the Board was only
17 seeking reassurance and not assurance?
18 MR VAUGHAN: Not always. I think it is difficult
19 because when the CQC produced a report that says that
20 the maternity at Barrow is okay, in theory we ought to
21 be able to take that as assurance. I would suggest
22 that we were not only seeking -- only receiving
23 reassurance; I would suggest that some of the

24 underpinning systems in the assurance framework that

25 supports our Board reporting had some weaknesses that

1 may have missed things.
2 MR BROOKES: That is with the benefit of hindsight.
3 How did you feel at the time?
4 MR VAUGHAN: At the time it felt like we were being
5 assured, in a way. As I say particularly around
6 maternity there had been a series of issues we had
7 taken some action, we had -- the outcome of the
8 Fielding Report was that there was some progress.
9 There was still things to do, but there was progress.
10 CQC had given us the over-arching Trust assurance --
11 quality sign-off had been provided. We were doing a
12 specific review about maternity, that said it was,
13 again, said it was okay.
14 It felt like things were tracking in the right
15 direction, particularly, you know, from a personal
16 perspective where I was to say that I was standing
17 slightly away from it because a lot of my role was
18 concentrating on the rest of the hospital because that
19 needed to be run as well. You know, there were a lot
20 of challenges in running that three-site split
21 configuration on a day-to-day basis in terms of just
22 patient -- you know, managing the patient's journeys
23 through the hospital and ensuring that they get

24 appropriate care and that we do --

25 MR BROOKES: I accept that, but you also have a role as

1 a member of the Board --

2 MR VAUGHAN: I do.

3 MR BROOKES: Do you believe that the Board was

4 challenging enough in terms of the information that it

5 received?

6 MR VAUGHAN: No, and I would be guilty of that as well.

7 MR BROOKES: Can I go back to the Fielding Report for a

8 minute? We have struggled a little bit to understand

9 precisely how it interacted with the Board. I have not

10 been able to find any information or have anyone

11 enlighten me about precisely whether or not the Board

12 was informed when the Fielding Report was commissioned.

13 Did that go to the Board? We have not found any

14 evidence that it did. Also --

15 MR VAUGHAN: I can't remember; I do not know.

16 MR BROOKES: -- also we struggled to find any evidence

17 of it going back to the Board, although there is a

18 reference to it in one of the closed-sessions of the

19 minutes at a later stage.

20 As a member of the Board do you recall what the

21 debate was around the Fielding Report, which I would

22 have expected to have been quite significant because it

23 is an independent investigation, or review, into

24 services in your organisation.

25 MR VAUGHAN: And I have been struggling to remember

1 that over the last few days, in terms of trying to
2 think of my own time line. We used to have a series
3 of -- obviously there is Part II meetings as well as
4 Part I meetings. There was also a series of Board
5 development workshops that we would have regularly,
6 where we would talk about things off-line in a sort of
7 a non-minuted arrangement. I do not remember, either
8 as a Board commissioning the report, or receiving the
9 report. That does not mean we did not, but I cannot
10 remember it and I have not had an opportunity of -- you
11 will have searched the minutes, and been clear that we
12 have not so I would not have found anything
13 different --
14 MR BROOKES: Does that surprise you?
15 MR VAUGHAN: With hindsight it does, yes.
16 MR BROOKES: We talked about --
17 MR VAUGHAN: I would say at the time, in terms of the
18 final Fielding Report, it came after some of the other
19 things had taken place with the CQC, and, I think,
20 there is something about that time line and how does it
21 all fit together --
22 MR BROOKES: Yes, it is complicated; we understand
23 that.

24 MR VAUGHAN: -- and I could - but, no, the answer to

25 your question is; we should have done, yes.

1 MR BROOKES: You mentioned about an "incidental
2 cluster" as well. The cases were an incidental cluster
3 rather than a clinical cluster. Where do you recall
4 that conclusion being reached?
5 MR VAUGHAN: That is stated in the Fielding Report.
6 MR BROOKES: There is an assumption in the Fielding
7 Report that it is based on information provided to --
8 MR VAUGHAN: Yes --
9 MR BROOKES: -- Dame Fielding.
10 MR VAUGHAN: -- in terms of what I have said, I do not
11 have any statistical or empirical evidence that
12 suggested either way.
13 MR BROOKES: Was that the conclusion that was reached
14 within the Trust, is what I am trying to understand.
15 MR VAUGHAN: Based upon -- yes. I guess, in short,
16 yes, because that was what we were being told by our
17 independent reviewers. Whether that was right or not
18 is a different debate.
19 MR BROOKES: Can I turn to the FT application? What
20 was your involvement in the FT application?
21 MR VAUGHAN: Obviously as a Board we were all involved
22 to various different extents. So, in terms of the
23 detail, if you like, in terms of the paperwork, I do

24 very little of the paperwork. We all took chapters and

25 bits of the process and led on them, so I have a

1 particular section that I wrote and supported in terms
2 of the estate strategy around that part.
3 Obviously in terms of the operational and
4 performance matrix, there was a lot of engagement in
5 that, so in terms of the detail of what was being
6 written. It was, it meant -- I think though in terms
7 of a lot of the other development around the FT
8 strategy, my involvement was more around the strategic
9 intent and some of the discussions at the early part in
10 terms of the strategy settings. I was quite new into
11 the Trust at that point, but in terms of that whole
12 discussion, in terms of some of the developments that
13 came from that.
14 Also, as part of the Board, we had a substantial
15 series of Board development informal as well as
16 semi-formal sessions either individually or with
17 outside advisers and reports that were written that
18 were to support the process. So there was an
19 engagement with that.
20 Then there is the general supporting of the
21 process --
22 MR BROOKES: That is all.
23 Obviously part of the integrated business plan and

24 strategy. Did you have any involvement in the

25 assurance processes around governance, for example?

1 MR VAUGHAN: I had limited involvement in that part of
2 the process. In reality, it is one of those things I
3 probably should have had more.
4 MR BROOKES: So there was a memorandum of clinical
5 quality, basically a self-assessment tool undertaken by
6 the Board. Were you at the meeting that signed that
7 off?
8 MR VAUGHAN: I think I was.
9 MR BROOKES: Do you recall whether or not there was any
10 challenge about the statements made in that?
11 MR VAUGHAN: In the original application?
12 MR BROOKES: This is the restarted application.
13 MR VAUGHAN: Yes, so in 2010.
14 MR BROOKES: Yes.
15 MR VAUGHAN: I can't remember.
16 MR BROOKES: Okay, that is understandable. I am trying
17 to -- you know, that was a key element or component of
18 the FT application. 18-months later, this is your
19 leaving this, PriceWaterhouseCoopers are brought in to
20 do a governance review, which shows extreme
21 vulnerability in the overall governance arrangements.
22 I cannot square how the Board could assess itself as
23 being good at 18-months previously when there was such

24 fundamental issues at a later stage.

25 Were you aware of governance deficiencies in the

1 organisation around the time of the FT application?
2 MR VAUGHAN: Again, as part of the process, there were
3 external reviews that were taking place --
4 MR BROOKES: The fundamental document is a
5 self-assessment by the Board --
6 MR VAUGHAN: Yes, I know.
7 MR BROOKES: -- in terms of its internal systems --
8 MR VAUGHAN: So, as a Board member, I probably was not
9 as well-cited or as considered the detail as may be as
10 I should have done with hindsight.
11 MR BROOKES: Because you're the Director of Operations,
12 you are out there all time, you understand how the
13 organisation works in reality, as opposed to how
14 information flows through; would you have had any
15 concerns in terms of the governance arrangements around
16 the organisation?
17 MR VAUGHAN: I think this is where there is some
18 interesting view on this because actually, from an
19 over-arching governance -- incorporate everything.
20 From an operational governance perspective, if there
21 were challenges and problems actually there was a clear
22 line of sight in terms of what we were doing. Actually
23 how we cross-referenced that and integrated it with the

24 quality governance agenda, and how that came about,

25 until we got a problem in A&E -- we know we have got a

1 problem in A&E, we know what it is and we have got a
2 reactive system that deals with that. Actually, if we
3 have got some underlying behavioural issues taking
4 place between groups of multi-disciplinary
5 professionals in an area, actually that is not linked
6 into that system. That is where, I think, with the
7 benefit of hindsight, that is where the problem was and
8 actually, as a Board member, I should have been more
9 aware of that in terms of my own linking it together
10 and I did not.
11 MR BROOKES: So I understand what you are saying there
12 is that if a clinical issue had been raised by the
13 staff, you would not necessarily have been made aware
14 of it.
15 MR VAUGHAN: No, no. I am not saying that. I am
16 saying that the over-arching governance process might
17 not have necessarily have knitted the two bits
18 together. The clinical governance -- the reporting
19 processes of issues, there was a process that was
20 followed and they were assessed and dealt with
21 through... We almost had a clinical governance pathway
22 and an operational governance pathway instead of them
23 coming together. They are sort of tied together at the

24 top, at the Clinical Quality and Safety Committee,

25 whereas actually they should have pushed together

1 further down the organisation, is what I am saying. I
2 am not saying that I was not unaware that there were
3 issues and concerns being raised; that is not what I am
4 saying.
5 MR BROOKES: Let us take two examples of things that we
6 have had discussed with us about concerns being raised
7 in a particular part of the organisation, up through
8 both the managerial and clinical networks. The
9 perception was nothing happened about it; no feedback.
10 Does that surprise you?
11 MR VAUGHAN: It surprises me that there is no feedback
12 on anything -- that does surprise me, yes -- from
13 either side. But that maybe that there is a -- yes,
14 yes. I would need to know the specific examples, but
15 it does surprise me that there is no feedback; that
16 certainly would not have -- that would not have been my
17 approach, so if I did it wrong then --
18 MR BROOKES: I understand.
19 MR VAUGHAN: -- I would not have planned to do it that
20 way.
21 MR BROOKES: A final question from myself. When you
22 arrived at the organisation how would you describe the
23 culture of the organisation? Similarly, as you

24 departed, how would you describe the culture of the

25 organisation?

1 MR VAUGHAN: When I arrived I would say that the
2 culture of the organisation was changing. I think that
3 there was an air of expectation and there was an air of
4 engagement. If I cross all clinical and managerial
5 operational teams -- I mentioned the workshops that,
6 first week I was there, it was standing room only in
7 room. There was a lot of engagement; people were
8 excited about the prospects for the future and where we
9 were going. I think there was then a period where it
10 went up and then, I think, as I left I would suggest
11 that the culture of the organisation had reverted
12 probably to prior to my -- to where it had been several
13 years before in terms of some disconnection (a lot of
14 disconnection) between the clinical teams, the
15 operational teams and the view, certainly from some of
16 the senior clinicians about the Board.
17 MR BROOKES: Why do you think that happened?
18 MR VAUGHAN: I think it is a range of issues really in
19 terms of there was some specific issues that changing
20 the IT systems did not help. There were issues about
21 the way that we, as execs, worked within the
22 organisation and the visibility of executives. Whilst
23 I tried to spend time at all three sites all the time,

24 I failed miserably and it just does not work.

25 Actually, we were not all -- we did not do that. We

1 were not necessarily engaged with the clinicians as
2 closely as we should. Whilst I had some good personal
3 relationships with some of the key clinicians across
4 the organisation, it was not everywhere.
5 I think that there were then challenges, for us as
6 an executive team, and our relationship and I think
7 those are sitting in as the key issues, I suspect --
8 not "I suspect", I think.
9 I think that actually as we went through 2010 and
10 into 2011 -- or 2011 actually -- the clinicians became
11 more, I think they may have been aware that there were
12 underlying clinical governance issues, but actually
13 they had not really engaged with that agenda and
14 actually they started to become more concerned about it
15 and more vocal about it.
16 In terms of actually wanting things to happen to
17 change it was the right thing, but actually what we did
18 not do was engage with that agenda to get the change
19 that should have happened.
20 MR BROOKES: Thank you.
21 PROFESSOR WALTERS: Just tell us a little bit about
22 when the HSMR results came out in 2010; how that was
23 dealt with and interpreted by the Board?

24 MR VAUGHAN: Is that the year they went up?

25 PROFESSOR WALTERS: That is when you were there

1 first --

2 MR VAUGHAN: They went up and then came down. In 2010

3 when HSMR came out that was reported to the Board and

4 discussed and we incorporated HSMR into the broad

5 performance path. Whether we had done it before 2010

6 or after I cannot remember, but it did become

7 incorporated. It was one of the quality indicators

8 that we did start to measure, even if it was measured

9 later.

10 The Board did discuss it. There was some work.

11 We were already engaged with CHKS at the time. Peter

12 was very much leading on it in terms of explaining what

13 was being done. There was a series of reports, which

14 you will have seen and read and no doubt discussed

15 previously.

16 Did we -- I guess what you are getting at is did

17 we have a massive level of concern that made us go and

18 do something different? I think, yes. The answer is,

19 yes, there was a level of concern. What we received

20 was information that suggested that things were

21 tracking back and actually in 2011 it did track back.

22 But actually did the Board take a proactive

23 decision to change what was already taking place at

24 that point of time? There was a little bit of

25 challenge, I recall, in some of the conversations, but

1 actually the processes that had been put in place
2 through the governance team, at that point in time,
3 were not really challenged and did not really change,
4 if I recall correctly.
5 PROFESSOR WALTERS: So was it all a data issue? How
6 was it discussed and described and how did you explain
7 it coming back down again?
8 MR VAUGHAN: I think that there is always an element of
9 trying to blame data. Actually I don't think that we
10 just blamed data. There was an analysis; there were
11 mortality groups; and reviews set up. You know, there
12 is an M&M structure – it might not have been set up
13 until after that in a formal way, but actually, you
14 know, the organisation did take mortality seriously in
15 terms of dealing with it. Whether it was coding or
16 whether it was real, I do not know.
17 PROFESSOR WALTERS: I suppose as a Board member you
18 would want to know why did it suddenly go that high and
19 why did it drop down that low. What did the
20 organisation do.
21 MR VAUGHAN: There were discussions about data and, in
22 particular, around palliative care. That is the point
23 that all organisations with mortality discussed because

24 it has a significant impact on your risk of mortality.

25 There were discussions about that at the time.

1 PROFESSOR WALTERS: What processes were put in to
2 capture that more --
3 MR VAUGHAN: In terms of the processes, again it was
4 very much led by the Medical Director's office, as
5 opposed to my office. Again, I was part of taking the
6 reports from the Board at the time as part of the
7 Board.
8 In my role did I have time to go and get more
9 actively engaged in it? No, I felt like I was
10 constantly fighting a fire. If I was doing it again
11 would I do it differently? Yes, I would. I cannot,
12 you know, I cannot go back and say, actually, I should
13 have been engaged in that because we cannot -- I cannot
14 go back and change it. Actually, there is something
15 about the learning from this is, you know, it is how do
16 you get a more integrated operational quality assurance
17 processes; that is very clear. What is happening
18 around M&M and how does M&M actually feed into our
19 operational management processes as well as our
20 clinical processes. There is very much a -- there was
21 very much a culture, if you like, I suppose it kind of
22 crosses back to your previous question, of the
23 clinicians being a clinical group; managers being a

24 managerial group; and that is -- we talked earlier

25 about earlier we did not have a clinically-led

1 organisation and that is part of that problem. We end
2 up with mortality being focused on by the doctors, as
3 opposed to, in terms of where it is -- as opposed to
4 being seen as a clinical operational function.
5 PROFESSOR WALTERS: I am not suggesting that you should
6 have been responsible for it. It was just to get a
7 view from you about what was going on at the time.
8 MR VAUGHAN: Yes.
9 PROFESSOR WALTERS: Something you probably were a bit
10 more responsible for was the out-patient follow up.
11 Can you take us through that?
12 MR VAUGHAN: In essence, I mean the solution is really
13 simple as to what we should have done as opposed to
14 what we did do, is that out-patients became a
15 challenge, it historically has been a challenge, it has
16 been historically been a challenge in many
17 organisations. Actually when we migrated the data over
18 what we ended up with, through the data, was we were
19 actually able to count how many patients should have
20 been treated by when, which actually was not the case
21 previously because the system did not allow it and is
22 not the case in many other Trusts today.
23 When we migrated the system over it gave us some

24 information. Using the data quality report, in terms

25 of the building backlog, actually we could monitor it.

1 What we did not do was drive the delivery agenda to
2 clear that off quickly enough and say, actually, what
3 we should have done, with hindsight, is gone: "That is
4 a problem, this is what we are going to do".
5 There were all sorts of other things going on in
6 terms of political, managerial, local agenda so
7 actually the commissioners did not want us to treat any
8 more follow-ups because we were already over our
9 ratios, so there is financial penalties associated to
10 that. I am not saying that should not have got in the
11 way, with hindsight, but it did because that was where
12 we were sitting as an organisation; if I need to do
13 10,00 follow ups, it is going to cost a fortune and I
14 am not going to be paid for them. That is where we
15 were sitting in that continuum.
16 In theory, we should have identified those who
17 were at clinical risk and should have been identified,
18 so it would have been the ones the 12-month cardiology
19 follow up that should have a red card and go back to
20 their GP if they feel they have got some issues because
21 12 months should be less of a problem. We should have
22 had a better handle on the eye patients. We should
23 have had a better handle in terms of the way the cancer

24 pathways work. That is why how it should have worked.

25 Fundamentally what we did not do was say we have

1 got 14,000 records here that need to be dealt with and
2 just deal with them, which is ultimately what did
3 happen but it took getting to a crisis point for that
4 to be able to take place.
5 PROFESSOR WALTERS: The original thing was you have got
6 to reduce your follow-ups because we are paying for
7 them, which we have all been there. Then, from a
8 clinician's point of view, how was that handled with
9 them? Clearly, you know, probably a lot of these
10 people probably did not need to be followed up --
11 MR VAUGHAN: Actually in terms of a lot of the
12 follow-up patient activity, in terms of the principles
13 there was quite good clinical engagement. I remember
14 we had a couple of sessions where we had three GPs and
15 consultants in a room for specialities and they sat
16 there and went through a series of scenarios and made
17 decisions and agreed -- setting a ratio on paeds was
18 like one to 0.8, or whatever it was they wanted was,
19 you know, was not going to work and actually we should
20 ignore that and carry on the follow-up process that we
21 had got. Actually there was some engagement around
22 that. Actually what happened, what we had was we had
23 inherent or an underlying backlog, which we had not

24 been reporting, if you like, from the way that the old

25 system had worked. We then was brought into stark

1 contrast when Lorenzo went live and every patient had a
2 guaranteed access date. You know, what we did not do
3 was respond quickly enough to that.
4 PROFESSOR WALTERS: So then when the clinicians were
5 thinking here is a patient who probably does not need
6 following up, but might do, you know, in the old days
7 you might have followed them up. If they wrote
8 something like, "To be followed up at a later date",
9 where did the clinicians think that record was going?
10 Did they think that somebody else was going to look at
11 it?
12 MR VAUGHAN: Most patients had -- unless they were
13 clearly discharged they were given a date. Actually
14 the good thing about the guaranteed date was it told us
15 when patients needed to be treated, which was new and
16 actually which we had not planned through. You know,
17 if only I could go back to 2009 and change the way I
18 planned it to go live for out-patients I really would,
19 but I cannot because actually our whole set of pathways
20 and the inter-relationship with our commissioners had
21 not stimulated that conversation. The whole ethos of
22 where we were going with out-patient care was that we
23 needed to do less of it and that was what was

24 singularly driving it. We were not having an

25 integrated qualitative discussion as well as a

1 quantitative discussion with our commissioners about
2 that not from either side. Fundamentally we had got
3 ourselves to how do we shrink out-patients, not expand
4 it, so, therefore, we were doing more out-patients than
5 we had done anyway and we still had a backlog actually.
6 The bit that is missing is that we had not
7 risk-stratified it properly and taken out and
8 identified the patients at higher levels of clinical
9 risk. That was where we went wrong.
10 PROFESSOR WALTERS: Were the clinicians not helping you
11 about that? Were they not pointing that out?
12 MR VAUGHAN: The clinicians were engaged with the fact
13 that there was a problem. Were the clinicians engaged
14 in finding a solution? No, not all of them. Some of
15 them were but, in general, no.
16 PROFESSOR WALTERS: Okay. Thank you.
17 MR BROOKES: I have got nothing else.
18 Any questions you would like to ask us or anything
19 you want to bring to our attention?
20 MR VAUGHAN: I think that is great. Thank you very
21 much.
22 MR BROOKES: Thank you very much for your time.
23

THE MORECAMBE BAY INVESTIGATION

Thursday, 24 July 2014

Held at:
Park Hotel
East Cliff,
Preston
, PR1 3EA

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Stewart Forsyth – Expert Adviser on Paediatrics
Ms Jacqui Featherstone – Expert Adviser on Midwifery
Professor James Walker – Expert Adviser on Obstetrics

SARAH VAUSE
KAREN CONNOLLY

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DR KIRKUP: Hello. Thanks for coming. My name is Bill Kirkup. I'm the Chair of the Panel. I'll ask my colleagues to introduce themselves to you.

PROF FORSYTH: Good morning. Stewart Forsyth, paediatrician and medical director from Dundee.

MS FEATHERSTONE: I'm Jacqui Featherstone. I'm the head of midwifery and head of nursing at a district general hospital in Essex.

PROF WALKER: I'm Jimmy Walker. I'm an obstetrician and I'm the new professor in Leeds. I also have a background in clinical governance with the National Patient Safety Agency and CMACE.

DR KIRKUP: And as you are a double act would you mind just saying which is which?

DR VAUSE: I'm Sarah Vause. I'm an obstetrician at Saint Mary's Hospital in Manchester and the ~~c~~Clinical ~~d~~Director for obstetrics there.

MS CONNOLLY: I'm Karen Connolly. I'm the ~~d~~Director of Saint Mary's Hospital. My background is midwifery.

DR KIRKUP: Okay. Thanks. You'll have seen that we're recording proceedings and we'll produce an agreed record. You'll also be aware, I think, that there are family members present as observers of the session and that others may listen to the recording in due course, and we have asked you to hand over mobile telephones, laptops, recording devices. That's just to underline the importance that nothing goes outside the room until we're ready to produce a report with everything considered in context. Do you have any questions for me about the process?

DR VAUSE: No. That's fine.

DR KIRKUP: Okay. In that case I'll just ask a general question, which is when were you first aware of Furness General and what was your first involvement with it?

DR VAUSE: Well, I think it had been in the press and then we were approached by Monitor, ~~by~~ via the Trust, and asked, with two other colleagues, to inform the review team.

MS CONNOLLY: So Monitor approached our chief nurse to see whether we would be supportive of undertaking the review, and that was in 2011.

DR KIRKUP: 2011.

MS CONNOLLY: Yeah.

DR KIRKUP: Okay, that's great. Thank you. I'll hand you over to Jimmy.

1 PROF WALKER: Thanks. Good morning. When you were first given this remit by
2 whatever method, in what – what were your first set of impressions of why you
3 were doing it?
4 MS CONNOLLY: I think for me my impression was that there'd been some untoward
5 incidents. There had been some external reviews of the obstetric and
6 paediatric services and therefore a number of risks, potentially, had been
7 identified, and so we were asked then to have a look at those risks and to see
8 what immediate things could be done to improve the safety of the service
9 across neonates and obstetrics.
10 PROF WALKER: Did you have any preconceived ideas before you took on the –
11 MS CONNOLLY: No, I didn't. Dr Vause I didn't.
12 PROF WALKER: Okay. Now, when you were given – the remit you were given
13 includes things like producing a review risk log. Did you actually do that?
14 DR VAUSE: Yes.
15 MS CONNOLLY: Yes.
16 PROF WALKER: Because I don't have in front of me – one of the copies I've got –
17 we've got a copy of that, this log.
18 DR VAUSE: Yes, we did.
19 PROF WALKER: Okay, so you've got a copy there?
20 DR VAUSE: Yes.
21 PROF WALKER: And did you – when you were reviewing it, were you actually
22 reviewing the processes that – in response to the problems that occurred, or
23 were you actually reviewing the problems as well? I mean by that were you
24 going back to review the incidents or just the responses to the incidents?
25 DR VAUSE: We didn't review the individual incidents. What we did look at were the
26 previous investigations that had been done and the previous reports that had
27 been produced. And we'd been asked to produce a comprehensive risk log,
28 so we looked at the risks that had been identified by previous investigations
29 but also included risks that we identified ourselves when we visited the Trust.
30 PROF WALKER: Okay. So the – did you make any assessment of the previous
31 reviews or did you take these reviews as being accurate and good?
32 MS CONNOLLY: Well, we took the reviews and I wouldn't say we made an
33 assessment of whether they were accurate and good but we took them on
34 face value, and then looked to see how we could triangulate that when we

1 went to the unit and to see then what we would find. So we went through
2 things like the Fielding Report, went through CQC, NMC reports, and then we
3 identified where they had picked up risks and then we went and assessed for
4 ourselves what we thought the risks were, through observation and interviews.
5 PROF WALKER: Looking at the, sort of, global view then, you've got some to some
6 extent incidents and maybe reports of incidents, you've got these reviews and
7 so on. Did you fit it all – did you think it all fitted together, or did you find that
8 you didn't quite understand whether the reviews came to their conclusions
9 compared with another review or the incidents themselves?
10 MS CONNOLLY: We did think, for example I think it was some of the work from the
11 CQC and NMC, where they'd actually reported positively that we didn't find it
12 to be as good as that when we went to the Trust, but we didn't know in
13 advance. We took the reports as they were.
14 PROF WALKER: And when you went to the Trust who did you actually interview?
15 What sort of level of people?
16 MS CONNOLLY: We interviewed the chief executive, the chief nurse. We
17 interviewed clinical directors. We interviewed directors in training, senior
18 midwives, midwives on the ground, ward clerks, support workers.
19 PROF WALKER: And again, when you interviewed the senior staff, the clinical
20 director for instance or the medical director, were you – what were you
21 wanting from them? Were you wanting their opinion of the reports, what
22 changes they'd made? What was the purpose of interviewing?
23 MS CONNOLLY: I think we were trying to establish whether there was a level of
24 assurance at Trust board level of what was happening actually in the clinical
25 area, and we used the opportunity when we were interviewing the chief
26 executive, chief nurse etc, to say what things we had found. And we were
27 then trying to triangulate whether we thought there was bBoard assurance in
28 place.
29 PROF WALKER: So you started, therefore, with a certain opinion gained from
30 previous reports of what the state of the hospital was during a certain time
31 period leading up to the year or so before you went in and then what you were
32 doing to see where they'd got to from there to overcome the problems that
33 these reports highlighted. Would that be –

1 MS CONNOLLY: Yes, but we looked at things like guidelines, governance structures
2 in place, how reports went from, you know, as we all know, ward to ~~b~~Board, to
3 see whether there was a pathway, to see what the contents of reports or
4 minutes of meetings were, to actually – if you like, for us to provide a level of
5 assurance or otherwise as to whether what the ~~b~~Board thought was actually
6 what was happening in practice.
7 PROF WALKER: And you feel that you also interviewed people on the shop floor, so
8 did you feel that they – that what the minutes of various meetings and the
9 processes that were being described, which were then handed up to the
10 ~~b~~Board, did you feel that they were accurate as far as what the people on the
11 shop floor felt was happening?
12 MS CONNOLLY: I think there was a disconnect because the quality of the papers at
13 the ~~d~~Divisional level were not robust. So for the ~~b~~Board to have any
14 assurance of what was going on at divisional level it would have been very
15 difficult.
16 PROF WALKER: Okay. So if the paperwork at divisional level wasn't robust, does
17 that mean the work that was actually being done on the shop floor was not
18 being properly audited or looked at?
19 MS CONNOLLY: Yeah, that – yeah, yeah. Yeah.
20 PROF WALKER: Okay. So how could you be sure that the practice was safe after
21 this report?
22 DR VAUSE: I think our report highlighted that we didn't feel it was.
23 PROF WALKER: So did you feel that it had not been safe and nothing had changed,
24 or did you feel that it wasn't safe previously but there was no evidence of
25 change, or – which –
26 DR VAUSE: Some of the risks that we – that had been identified in previous reports
27 had been addressed, and in the risk log we've rated those as green because
28 we saw evidence that those risks had been addressed. And we looked for
29 various evidence to assure ourselves that those risks had been addressed, but
30 there were other things that were still not addressed and were still ongoing
31 risks, and those were the things that we've graded as red within the risk log.
32 And then from that we made various recommendations as to what we felt
33 should be done going forward to address them.

1 PROF WALKER: In the report, and I have copies of two reports that you've done, a
2 lot of the findings the recommendations are at a fairly high level, sort of
3 managerial level and of reporting back and making sure that there's a
4 comprehensive workforce plan and there's a – etc, but what about the practice
5 actually by midwives and doctors in the unit itself?
6 DR VAUSE: I think some of the immediate recommendations, which are towards the
7 very end of the report, are much more shop floor level. So one of the things
8 that we identified on the shop floor was that junior doctors didn't know where
9 the resuscitation trolley was, and so that was one that we felt needed to be
10 actioned immediately because that was an immediate risk to patients. There
11 were other risks that were picked up on that we flagged up at the time. So for
12 example, the eclampsia guidelines on the intranet were different from the
13 printed guideline, which was in the folder on the labour ward, and that was
14 again different on the two sites, and it was different from the guideline that was
15 on the front of the eclampsia box. And the ampoules, the size of the ampoules
16 in the box didn't correspond with what was written in the guideline, and again
17 we felt that that was something that needed to be sorted out straight away so
18 we made recommendations there.
19 PROF WALKER: Okay. So you've got two situations then where guidelines and also
20 the implementation of something was just open to error, you know, the next
21 time it occurred. One of the things that we picked up in interviews is the
22 problems over theatre access, both during the day but particularly at night.
23 Was that something you picked up as well as a problem?
24 MS CONNOLLY: It had improved from when it had been assessed previously by the
25 CQC, so the problem was with the finesse, the journey to theatre and going
26 across the public corridor. So they had already taken steps that the – they
27 would take the patients then through the medical assessment unit, there were
28 curtains on the corridor, and they would go straight to theatre. So that had
29 happened when we went. It wasn't ideal but it had happened.
30 PROF WALKER: So it was better than it was but it still wasn't probably what it
31 should be?
32 MS CONNOLLY: No, it wasn't adequate. Yeah.
33 PROF WALKER: Was that something again you highlighted to – that should be
34 looked at and –

1 MS CONNOLLY: Well, they'd done an option appraisal on the estate to see whether
2 they should actually build another theatre but it actually stopped. So the
3 process had got so far and then it had stopped, so we had highlighted that. I
4 think in the risk log – we gave the risk log to the Trust so they had the detail
5 that goes behind the report of every risk and where we'd assessed it was up to.
6 So they – I know the Trust was intending to use that as their action plan.
7 PROF WALKER: Okay. So again you'd be highlighting these risks to the Trust along
8 with various other recommendations that you've got here. Did you feel that
9 the Trust – well, this was Monitor who actually asked you to do this. Did
10 Monitor give you the impression that they were concerned about the hospital's
11 practice or they wanted to make sure that the hospital had responded to the
12 concerns?
13 MS CONNOLLY: I got the impression they were concerned about the practice, but
14 they needed us to give that independent view I think.
15 PROF WALKER: But your remit wasn't to review the practice. Your remit was to
16 review response to the problems and see whether the – what had changed.
17 DR VAUSE: The remit for the first visit was to develop a comprehensive risk log, and
18 then the revisit was really to look at progress against that.
19 PROF WALKER: But I got the impression the risk log that you produced the first time
20 was based on – largely on previous reports that picked up these risks, plus
21 more things you might have picked up, but you didn't go into any in depth
22 investigation of practice or incidents.
23 MS CONNOLLY: Well, we didn't do individual's practice, but we did review things
24 that informed practice. So we reviewed, as Sarah said, about guidelines. We
25 reviewed records to see whether they correlated with practice. So for example
26 when they did the fresh eyes approach to CTG monitoring they had a clear –
27 they'd had training, they had information in the clinical area about fresh eyes,
28 but when we reviewed that in practice it wasn't being delivered in practice as it
29 had been portrayed with the training packages etc. So people weren't
30 buddying CTGs, they had – they were reviewing them hourly but they didn't
31 have a buddy to review them unless there was an abnormality and then it
32 would be a medical – an obstetrician that would review the trace, but they
33 weren't routinely buddying.

1 PROF WALKER: And what about when a – did you check to see that when a doctor did review the trace did they make a note of that and then put in a plan or –

3 MS CONNOLLY: Yes.

4 PROF WALKER: They did, or –

5 MS CONNOLLY: We reviewed the records and we could see where there had been plans and we could see what the decision making had been. I think the other side of that is that if there was nothing in the record then we didn't know what the next stage had been. So we didn't interview, if you like, clinicians on particular cases.

10 PROF WALKER: No, but the fact that if they had been called and there was nothing in the notes then –

12 MS CONNOLLY: Then we would have picked that us, yes.

13 PROF WALKER: Then there's no plan being put in place.

14 MS CONNOLLY: Yeah, yeah.

15 PROF WALKER: What about things like mandatory training of staff? I understand they now have a record of whether they're up to date with mandatory training. Did you review that?

18 MS CONNOLLY: Yes.

19 PROF WALKER: And were you happy with the degree of that being completed?

20 MS CONNOLLY: No. So the first review that we undertook the records were not good. There were records but none of – I think the majority of obstetricians had not undertaken their mandatory training. I think there were three, if I recollect, that had participated in that training. But the next time we visited that training had been undertaken and the systems for monitoring the training were more robust.

26 PROF WALKER: So your first visit then, the 2011 report, although it was about developing a risk register, that it also seemed to emphasise that despite all previous reports and the incidents nothing appears to be have been done to change that, or am I surmising wrongly?

30 DR VAUSE: Very little. Very little had been done.

31 PROF WALKER: Very little?

32 DR VAUSE: Yes.

33 PROF WALKER: So the fact that the – despite the Fielding report and the CQC report and the incidents and the inquest and those sort of things, all the

1 recommendations or anything coming out of these, they had not been applied
2 at all or just a very little?
3 DR VAUSE: A small number had been implemented, but not the majority.
4 PROF WALKER: Okay. So you then highlighted presumably these things and what
5 was missing, and then you gave them the list of things and you came back
6 again two years later, or maybe a year or two –
7 MS CONNOLLY: Just over a year.
8 PROF WALKER: And what did you find then?
9 MS CONNOLLY: Again, there'd been some improvements but I think the concern I
10 had was the level of robust detail as to them again getting their assurances.
11 So there was a new team in place, so there was a new exec team in place,
12 and they'd set up a programme management office to gather the evidence as
13 to whether they'd delivered on the action plan. But when we actually again
14 looked at the evidence there were still things that were, for us, not robust. So
15 again the quality of minutes at a divisional level and how that informed the
16 bBoard. The bBoard were engaged and the non-exec team were very
17 engaged and the non-execs definitely wanted to make a difference, but I think
18 at dDivisional level it still wasn't robust enough to provide that bBoard
19 assurance.
20 PROF WALKER: So the main problem then was between the shop floor and
21 divisional level you feel?
22 MS CONNOLLY: Yes, yes. There was a – it was a question of leadership. So the
23 first visit the leadership throughout was not at the level you would expect. On
24 the second visit there was a stronger team leading from an exec level, but it
25 hadn't yet really translated into a divisional level.
26 PROF WALKER: Okay. Now, did you at any time – did you report to the bBoard?
27 Do you actually present your report to the board?
28 MS CONNOLLY: Yes. The bBoard came to Manchester. The whole bBoard came
29 to Manchester and we presented the findings of the second review to the
30 bBoard.
31 PROF WALKER: And what was their response to that?
32 MS CONNOLLY: I think some of the response – they disputed some of the findings
33 that we found. Some of it that they acknowledged that they still were not
34 where they wanted to be, and they'd had a lot of change in the 12 months

1 since us doing the first and second review, but we felt confident in our findings
2 and what we'd put forward for the second report.
3 PROF WALKER: In either of these reports were the ~~b~~Board or the hospital given a
4 draft of your report to verify factual things, or did they –
5 MS CONNOLLY: Yes.
6 PROF WALKER: Yes. So when they came to Manchester to get the information
7 they'd already reviewed the information, so – but they still could question
8 some of the facts?
9 MS CONNOLLY: Yes. Well, they – with some of the presentation of feedback they
10 said, 'We know all of that'. They didn't want us to continue, in part, giving the
11 continued presentation, but we did.
12 PROF WALKER: Right. How did you feel about that? Did you feel they were trying
13 to dismiss that problem or they didn't want to be told again or –
14 MS CONNOLLY: I think it was they didn't want to be told again, because they were a
15 new team and I think they felt that they understood and they wanted to move
16 forward.
17 PROF WALKER: Okay.
18 MS CONNOLLY: But it was important for me to able to give a clear picture of where
19 – of what we'd found.
20 PROF WALKER: And is there any plan for you to follow up again?
21 MS CONNOLLY: We've not been asked to.
22 PROF WALKER: No. So do you feel now, you've been through three years, or two
23 years and then it's been another year since then, that – do you feel that you've
24 got any confidence that the hospital or the Trust has moved from the first day
25 you walked into the place.
26 DR VAUSE: It had moved forward, but there was still a long way to go when we went
27 for the second visit.
28 PROF WALKER: Well, had they moved forward half way to where they had to go or
29 quarter of the way?
30 DR VAUSE: A third of the way?
31 MS CONNOLLY: Third of the way.
32 DR VAUSE: Third of the way.
33 PROF WALKER: Third of the way, okay. And you feel that that's at the top level
34 rather than actually at the bottom.

1 DR VAUSE: Yes, ~~yeah.~~
2 PROF WALKER: When you first went in and interviewed people, did you get the
3 feeling that the staff that you talked to were concerned about the safety of the
4 unit?
5 DR VAUSE: Some were, yes.
6 PROF WALKER: So some meaning less than a half or the majority?
7 DR VAUSE: I think some were actually concerned about safety – and correct me if
8 it's not the same impression – and I think that that was actually a small
9 number. There were – I think the majority of them felt that they were providing
10 good care, and I think some of them had reached the point of feeling that
11 they'd been inspected to death and were very demoralised.
12 PROF WALKER: Yes, but did they have any understanding of why they'd been
13 inspected to death?
14 DR VAUSE: I don't think there was full insight, no.
15 PROF WALKER: So the people, they'd gone through these things, they'd been
16 inspected, they'd had incidents, there'd been inquests, but did they lack insight
17 into the problems that the hospital had?
18 MS CONNOLLY: I – I'm sorry.
19 DR VAUSE: I feel a lot of them couldn't see the bigger picture and they couldn't see
20 – this was from junior staff to really quite senior staff that they couldn't see the
21 bigger picture. They couldn't learn from the incidents that had happened and
22 the processes weren't in place to support that learning. I think they felt on an
23 individual patient basis they were giving very good care to individual patients,
24 but they weren't moving the service forward and there was no strategic
25 planning and learning across the organisation.
26 PROF WALKER: Did they see the difference between giving all the care that they
27 could and wanted to give to an individual and the ability to then escalate care
28 when something starts going wrong? Did they understand the lack of
29 response to abnormality that appears to occur?
30 DR VAUSE: I'm not sure they were recognising the –
31 MS CONNOLLY: No, I think there was a lack of knowledge. I think there was a lack
32 of understanding that if you had some of these processes in place and they
33 were implemented robustly they would have actually have improved the

1 service and made the service better for everybody, themselves included. I
2 don't think they knew what they didn't know.
3 PROF WALKER: Okay. And when you went back for a re-review, I mean, I presume
4 you didn't interview all the same people again, but did you feel that there was
5 – that they actually did know more what they need to know?
6 MS CONNOLLY: They did know more but I think they – and the leadership was
7 definitely better, but I think they needed different expertise in the unit to
8 support them to know how to take these things forward.
9 PROF WALKER: Within your remit did you feel that there was any place for you to
10 make a decision of what sort of case should be looked after in what sort of
11 place, and risk categorisation and feeling that certain people shouldn't be
12 delivered in certain environments?
13 DR VAUSE: It wasn't something we were asked to look at within the remit of the visit.
14 PROF WALKER: And was that something you felt as a – in the report that you could
15 have or should have or put in to it as a suggestion of a way forward?
16 MS CONNOLLY: We weren't invited – I mean, we know that they were having
17 conversations around what the model looked like going forward, and they were
18 discussing the clinical model, particularly on the second visit. I think from our
19 position we didn't get involved in that directly at all but we could appreciate the
20 difficulty with the geography and understanding that, you know, if there was
21 one obstetric unit for the whole of the region then that would have been quite
22 challenging.
23 PROF WALKER: Did you feel that your remit was too limited for what you felt – once
24 you'd got there and started working there did you feel that you wold have liked
25 to have had a wider remit to look at the practice in a broader way?
26 DR VAUSE: I think it was big enough at the time to – yes, I think it would have
27 become very unfocussed if we'd tried to look at individual's practice. I felt the
28 remit was big enough.
29 PROF WALKER: Well, not necessarily individual's practice but, sort of, more about –
30 MS CONNOLLY: You could have spent a lot longer there.
31 PROF WALKER: And looking back on what you did, would you have done
32 something different then , knowing what you know now and knowing what the
33 second report found?

1 MS CONNOLLY: I think we were very clear with the team as to where the gaps were
2 and what needed to happen, and I think we gave a lot of detail of what was
3 behind the report, so I'm not sure we would have done anything differently for
4 the remit that we had.
5 PROF WALKER: Okay. And do you feel that this effort, considerable effort you've
6 put in, has actually done any good?
7 MS CONNOLLY: It's made small changes. I think it could have – a lot more could
8 have happened, for definite.
9 PROF WALKER: Okay. Right, thank you.
10 DR KIRKUP: Thanks. Stewart?
11 DR VAUSE: We did wonder whether perhaps we should have made a
12 recommendation about an external clinical leader being put in place on one or
13 both sites to provide some external expertise and leadership and guidance,
14 and to help things be embedded more successfully.
15 PROF WALKER: So that was a way of getting round the problem of this shop floor to
16 divisional gap?
17 DR VAUSE: Yeah, and I think in retrospect that might have been something that
18 would have been useful, but at the time it wasn't something that we suggested.
19 So I think if we'd done anything differently perhaps that would have been –
20 MS CONNOLLY: Because at the time they were working with Liverpool Women's, so
21 we knew they had a partnership arrangement for Liverpool to provide some
22 mentorship style work, some governance support, but at – like Sarah said,
23 reflecting afterwards I actually think that the – if somebody who is used to
24 working, I think, at a tertiary level had gone in and provided clinical leadership
25 that would have enabled the unit to move forward at a quicker pace.
26 DR KIRKUP: Can I just pick up the point about Liverpool Women's? Did you explore
27 the nature of the relationship that they had with Liverpool Women's? What did
28 it mean in practice?
29 MS CONNOLLY: We didn't meet with Liverpool Women's, no. We looked at some of
30 the dialogue and communication that had taken place between the two, but we
31 didn't actually speak to Liverpool Women's, no.
32 DR VAUSE: It also didn't seem to be clinical –
33 MS CONNOLLY: No, it was more governance.

1 DR VAUSE: – but it was more of a governance input. And I think it may have been
2 that it would have engaged the clinicians more and helped them take
3 ownership of the problems better if it had been a clinical leader rather than a
4 governance advisor.
5 DR KIRKUP: It seems to have been at quite a high level and, sort of, being
6 conducted remotely. It doesn't seem to have involved meetings or –
7 MS CONNOLLY: No.
8 DR KIRKUP: Okay. I just wanted to check –
9 MS CONNOLLY: And it was high level, but I don't think the person involved was
10 necessarily at a high level.
11 DR KIRKUP: Okay, thanks for that clarification. Stewart?
12 PROF FORSYTH: So this was a Trust wide review. I just wondered when you
13 undertook the review if there were specific issues related to each of the three
14 centres which were involved within the Trust?
15 DR VAUSE: I think the first time we went we felt that the Furness site was the one
16 where there was least clinical leadership. And I felt that we got the impression
17 that that was the one where one very newly appointed consultant had actually
18 been delegated jobs of being the tutor, the labour ward lead, she was – people
19 told her she was the CNST lead but it transpired that she wasn't [inaudible] or
20 the governance lead. And so I think when we first went there were – we felt
21 there were more problems on the Furness site. There was very little senior
22 presence there from the exec team and yet it was the site where the problems
23 had perhaps been identified mainly on. I think when we went back for the
24 second visit in some ways on the Lancaster site there seemed to be more
25 disagreements between the clinicians there, and there certainly seemed to be
26 more problems on the Lancaster site when we revisited than the Furness site.
27 PROF FORSYTH: Well, you succeeded in shifting the problem from Furness to
28 Lancaster.
29 DR VAUSE: And again I think it was to some extent lack of ownership of the
30 governance structure and an unwillingness to take and engage in leadership
31 roles there. And there was a very heated argument going on about whether
32 guidelines should be called guidelines or protocols, which seemed to be
33 consuming a huge amount of energy, rather than looking at actually how they
34 took practice forward. And it seemed to be causing big divisions amongst the

1 consultant body there and a lot of, sort of, disparity in practice. There were
2 also issues around the use of the theatres in Lancaster when we went back for
3 the second visit.
4 PROF FORSYTH: What were these issues?
5 DR VAUSE: There was poor access to a second obstetric theatre. There was a very
6 small obstetric theatre which really didn't provide good facilities for the patients.
7 There was poor privacy and certainly potential for lack of dignity for women
8 that were taken to that theatre. At times the general surgeons were using the
9 theatres, the theatre space, and so there were problems accessing a second
10 obstetric theatre, so that was one of the issues at Lancaster at that point. I
11 think there was also an issue about people's leadership or governance roles
12 not being recognised within job plans, and in some ways almost giving the
13 message that those roles weren't being valued within the Trust as a whole. So
14 the person that had taken on a governance role didn't have any recognition of
15 that within a job plan and was actually having to do a lot of the administrative
16 support, typing guidelines etc, in their own time, and that could have been
17 supported in a much more efficient way and taken forward.
18 PROF FORSYTH: Were there issues around area wide clinical leadership?
19 DR VAUSE: Around?
20 PROF FORSYTH: Area-wide clinical leadership, or was the leadership –
21 DR VAUSE: Across both Trusts?
22 PROF FORSYTH: Yes.
23 DR VAUSE: When we went back for the second visit then at that point the divisions
24 had been reconfigured. So Women's and Children's had been made into a
25 separate division and at that point David Burch had been appointed as the
26 clinical director for both sites, and actually he had time within his job plan for
27 that, and –
28 PROF FORSYTH: So how was that working?
29 DR VAUSE: Well, he was visiting both sites and I think certainly the team at Furness
30 recognised that he – they were getting more input from that. Also the
31 executive nurse – I've got the right title?
32 MS CONNOLLY: Yes.
33 DR VAUSE: – was based, had an office on the Furness General site as well, and so
34 she was more visible on that site, and again that did seem to be happening

1 and people knew that she was there. And from a paediatric perspective the
2 lead paediatrician was also working across both sites. That had changed in
3 the year between the two visits.
4 PROF FORSYTH: I notice in your report you very much recommended the
5 Department of Health toolkit for neonatal services. I wondered what your
6 views were regarding the neonatal services in both Furness and in Lancaster.
7 DR VAUSE: I mean, certainly neonatal staffing was a major problem on the Furness
8 side, particularly if – well, for both nurses and paediatricians.
9 PROF FORSYTH: In where?
10 DR VAUSE: On the Furness side.
11 PROF FORSYTH: Furness, yes.
12 DR VAUSE: That had improved to some extent between the two visits and some of
13 the neonatal nurses were being rotated to Furness.
14 MS CONNOLLY: They were, but since then had escalated so –
15 PROF FORSYTH: Furness unit's a level one unit.
16 DR VAUSE: Yes.
17 PROF FORSYTH: And were you aware or did you feel that the information regarding
18 the levels of care they were attempting to provide there –
19 DR VAUSE: They were attempting to provide – initially attempting to provide care for
20 babies from 32 weeks onwards and then that changed to 34 weeks, above 34
21 weeks' gestation. They appeared to be managing to staff the rota, although
22 the majority were often not getting any breaks and it meant that sometimes
23 there was only one nurse rather than the recommended two nurses available
24 there. But equally, I can't remember which visit, there'd been a three month
25 gap when they hadn't had any babies within the neonatal unit at all and yet
26 staffing had had to be provided for those three months. So it certainly was a
27 problem. One of the other things that we identified was that on the Helme
28 Chase, the Westmorland General site, a lot of the midwives there had training
29 for the examination of the new born and were able to provide that, and those
30 midwives, the vast majority of them were trained in that. And yet actually if the
31 midwives on the Furness site had received that training then they would have
32 been better able to support the junior doctor rota for paediatrics or neonates.
33 And it felt as though perhaps if there was a shift in the training, or if the training

1 was reassessed things could perhaps have been done somewhat differently.
2 I'm not a neonatologist, so if I get the details slightly wrong –
3 PROF FORSYTH: No, I know that. I appreciate that. And also regarding, well,
4 transport arrangements for high risk mother or high risk babies, did you look
5 into that and arrangements for that and were they sustainable and safe?
6 MS CONNOLLY: We didn't look into that.
7 PROF FORSYTH: You didn't?
8 MS CONNOLLY: No.
9 DR KIRKUP: Thanks. Jacqui?
10 MS FEATHERSTONE: When you visited the first time to do the interviews were the
11 staff aware you were coming and the remit of your report?
12 MS CONNOLLY: Yes, they were aware that we were coming.
13 MS FEATHERSTONE: Fully aware and so – and did you go out to the wards to visit?
14 MS CONNOLLY: Yes.
15 MS FEATHERSTONE: So you worked within a ward environment?
16 MS CONNOLLY: Yes.
17 MS FEATHERSTONE: And were they prepared interviews or were you who was on
18 duty at that time?
19 DR VAUSE: A mixture. So we did some prepared interviews, and those staff had
20 been arranged to meet with us and knew why we were there, but we also went
21 out on to the wards. And for example we went to the morning handover on the
22 labour ward and just observed both the midwifery handover and the medical
23 handover and then went out onto the post-natal wards. A colleague who is a
24 neonatologist went to the neonatal unit and spoke to staff there, but staff were
25 aware we were coming but some were planned and some weren't.
26 MS FEATHERSTONE: And was the response good? Were they willing to talk to you?
27 DR VAUSE: Yes. Everyone was willing to talk. Some people were actually very
28 keen to talk and to give us their views on what had happened, what they felt
29 should happen, what their concerns were. Some people that we interviewed
30 as a planned interview then came back to us over the course of the two or
31 three days with further information or said, 'I forgot to tell you this' or 'I'd like to
32 discuss that with you'.
33 MS FEATHERSTONE: And then when you went back you interviewed again, the
34 second visit you went back, and was it apparent that the staff had read or seen

1 or knew about the report if they weren't the same people? You know, did you
2 get the feeling that they knew?
3 DR VAUSE: It depended on the level of staff, and obviously some had had more
4 involvement with it than others. So the more senior staff had obviously read
5 the report and been involved in implementing the changes. The more junior
6 staff less so, and certainly junior medical staff had rotated and –
7 MS CONNOLLY: [inaudible], you know, when we'd – one of the recommendations
8 was multidisciplinary ward rounds. So the staff on the ground were monitoring
9 that that took place, so things like the practical things like that they could talk
10 to us about, and they knew why it had happened.
11 MS FEATHERSTONE: And when you formulated your risk log, was part of it looking
12 at the investigations, and with the recommendations about the sharing of the
13 learning, was that apparent that that that was happening?
14 MS CONNOLLY: I think when we did the second review there was a greater level of
15 – or there was more evidence around shared learning from incidents. I think it
16 was less so when we went the first time.
17 MS FEATHERSTONE: And would you right down to – you know, you said you'd
18 interviewed healthcare assistants, were they aware of things that were
19 happening?
20 MS CONNOLLY: To a degree, yes.
21 MS FEATHERSTONE: You talked about that record keeping and obstetrician record.
22 Was record keeping an issue when you were looking through notes, or with
23 anything you were doing did you feel that record keeping was an issue the first
24 time that you went at all?
25 MS CONNOLLY: I can't recall.
26 DR VAUSE: Certainly the buddying of the CTGs –
27 MS CONNOLLY: Yeah.
28 DR VAUSE: – was an issue, wasn't it?
29 MS CONNOLLY: We picked that up on the second time we went.
30 DR VAUSE: Sometimes when we looked at decisions for caesarean sections and
31 the record keeping and the documentation of the decision for caesarean
32 section was sometimes poor. Sometimes it was the midwife that had actually
33 documented decision for caesarean section rather than the doctor actually
34 writing something in the notes.

1 MS FEATHERSTONE: So was there evidence of any audits or anything that had
2 followed up from you doing the first?
3 MS CONNOLLY: There were. There were documentation audits but they weren't – I
4 can't quite remember the whole detail but I... There were lots of matron
5 records for record keeping audits, but the quality of the audit and what they
6 were learning from the audit was poor.
7 MS FEATHERSTONE: Okay. And then – so generally, sort of, sharing, it did
8 happen but not to a great – you know –
9 MS CONNOLLY: It's almost like they were doing the actions bout not really fully
10 appreciating why and what the benefit of that action was. So it was that next
11 step of either reviewing a piece of work and saying, 'So okay, what do we
12 need to do on this?' It became task focussed rather than underpinning
13 everything that they did.
14 DR VAUSE: And we very much felt that <u>from</u> our first report, they'd taken the risk log
15 and addressed the particular issues that we'd highlighted ~~rather –~~ and ticked
16 the box and provided evidence for it, some of which was the evidence that
17 we'd already seen, rather than actually looking at 'What are the themes
18 coming through this, what does it mean for the service, what do we need to
19 put in place to actually change the quality of care that we're providing?' And,
20 as Karen was saying, it seemed to be at the wrong level. It was, 'Oh, another
21 report that we've got to tick the boxes for' rather than, 'What's this saying
22 about our service and how do we put things in place to really improve the
23 quality of care we've been giving'.
24 MS FEATHERSTONE: And so when you went back the next time, sort of, just how
25 they dealt with serious incidents, had that changed a lot? You know, was
26 there more multidisciplinary input into it and a shared – of actually doing the
27 investigation and doing the root cause analysis, was that evidenced at all?
28 DR VAUSE: There was more multidisciplinary input, but one of the concerns we had
29 on the second visit was that a lot of the incidents ~~all~~ seemed to have been
30 signed off on the same day with no further action required, and it did make us
31 wonder how rigorously the incidents were being reviewed. And it was
32 surprising that out of – I can't remember – it was about 30 incidents that were
33 reviewed on one day, not a single one needed any further action, and it, sort
34 of, suggested that perhaps learning wasn't happening.

MS FEATHERSTONE: Had they been escalated? Had it been the PCT though? Were they escalated some of those? Was it evidenced they'd been escalated outside of the Trust then?

MS CONNOLLY: There were some, weren't there, some [inaudible] reported ones but not everything.

MS FEATHERSTONE: Okay. Thank you.

DR KIRKUP: Just one point I want to pick up, in the follow up report you said that the culture within the division had clearly changed and there was a more cohesive workforce. I just wondered what the evidence was that you based that conclusion on.

DR VAUSE: I think that was particularly at Furness wasn't it –

MS CONNOLLY: Yes, yeah.

DR VAUSE: – that there the midwives were working more collaboratively with the consultants and that was something ~~—~~that was working much better than it had been previously.

DR KIRKUP: Were you able to see that in practice or was that what they were telling you?

MS CONNOLLY: No, it felt different, which I know is not hard evidence, but it did feel different. I think when we did the ward round in the morning they first of all went to start the ward round even though everybody wasn't there and the consultants said, 'No, we'll wait until the' – I think it was the shift coordinator was there. So you felt it was more joined up, whereas I think previously that would have just gone ahead. And there was an acknowledgment – and I think we were received, by some midwives, in a more positive way. So before I think they were suspicious, naturally.

DR KIRKUP: Yeah.

DR VAUSE: And I think various meetings had more medical input to them. ~~and~~ ~~t~~The incidents reviews had ~~—there was~~ more medical input than – previously, when the midwives in isolation had reviewed the incidents~~,~~. ~~whereas~~ ~~w~~When we went back the second time there was medical input and multidisciplinary input into those.

DR KIRKUP: Sure, okay. Any follow ups from anybody? Is there anything else that you would like to tell us?

DR VAUSE: No

1 MS CONNOLLY: No, I don't think so.

2 DR KIRKUP: Anything we haven't covered? No. Okay. Well, thank you for coming.

3 It's appreciated. That's the end of the meeting.

4 [End of Interview]