THE MORECAMBE BAY INVESTIGATION

Friday, 10 October 2014

Held at:

Trinity Enterprise Centre,
Ironworks Road,
Barrow in Furness,
LA14 2PN

Before:

Dr Bill Kirkup - Chairman of the Investigation
Mr Julian Brookes - Expert advisor on Governance
Ms Jacqui Featherstone - Expert advisor on Midwifery

GEORGE NASMYTH

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(At 10.05 a.m)

DR KIRKUP: Good morning.

MR NASMYTH: Good morning.

DR KIRKUP: Thank you for coming. Take a seat. I will just say for the record that my name's Bill Kirkup, and I'm chairing the Panel. We did meet when I came to visit the hospital – it seems like a while ago now. I'll ask my colleagues to introduce themselves.

MS FEATHERSTONE: Hello. I'm Jacqui Featherstone. I'm the Head of Midwifery and the Head of Nursing at an acute Trust in Essex.

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

DR KIRKUP: You will see that we are recording proceedings.

MR NASMYTH: Yes.

DR KIRKUP: We make an agreed record at the end.

MR NASMYTH: Yes.

DR KIRKUP: You will also know that we have family members in attendance as observers of the session and others will be able to listen to the recording if they want to do that.

MR NASMYTH: Yes.

DR KIRKUP: We have also asked you to hand over any mobile phones, laptops, tablets, recording devices just to stress the fact that nothing goes outside of the room until we are ready to produce a report and findings in context. Do you have any questions from me about the process?

MR NASMYTH: No.

DR KIRKUP: Okay. I am going to start you off with a very general question and then hand you over to colleagues, and my general question is can you tell us when you started at the trust and what you have done there?

MR NASMYTH: Right. I was appointed as a Consultant General Surgeon in Furness General Hospital in 1991. I gradually moved from being a very general surgeon to indulge my own special interest, which was colorectal surgery, and I also initially when it became a trust, because it wasn't a trust when I was appointed, became Chair of the Hospital Members Staff

1 Committee and then became Postgraduate Clinical Tutor and then an
2 Associate Dean in the Postgraduate Deanery in Manchester for the North
3 West Region.
4 DR KIRKUP: Yes.
5 MR NASMYTH: Then I was asked to be what was effectively Clinical Director for
6 Surgery as well by the incoming – that would have been 2006. That title has
7 changed slightly but the role didn't change very much in relation to a change
8 to a divisional structure, which happened over 2007 and then I was on the
9 verge of retiring in 2011 – I had reached the age of 60 – and I was going to
10 retire from clinical work in the trust by which time I was doing predominantly
11 emergency surgery only and working two days a week at the deanery – and I
12 felt that what that needed was for somebody new to come into that and I got
13 an agreement with the deanery that I would have a separate contract post-
14 retirement and worked for them two days a week but at that point I was asked
15 by Mr David Henshaw, who was the interim Chair, if I would stand in as interim
16 Medical Director. That morphed into a substantive appointment in the autumn
17 of two years ago, of 2012, and I have come to an agreement with the current
18 Chief Executive, Jackie Daniel, about the transition process. A successor has
19 been appointed who will start in January, but my departure will be, as it were,
20 phased so that he has a chance to work himself into that role with some
21 headroom, because as somebody carrying on the day-to-day job, whether I
22 will continue with the role within the trust after that will have to be determined
23 yet; I am not –
24 DR KIRKUP: Okay. Two small points of clarification, if I might. When you took over
25 a divisional responsibility in 2007, did that include any responsibility for
26 maternity?
27 MR NASMYTH: When the original structures were set up in 2007, the Surgery and
28 Critical Care Division also had responsibility for women's and children's and
29 paediatrics.
30 DR KIRKUP: Yes.
31 MR NASMYTH: That continued until 2009 when a separate division was created for
32 Women's and Children's Services.
33 DR KIRKUP: Okay, so I am picking up from that that you did have clinical director
34 responsibility originally?

1 MR NASMYTH: Yes.

2 DR KIRKUP: Okay, and the second thing is are you still involved at the postgraduate
3 deanery or has that come to an ending?

4 MR NASMYTH: No, I didn't think I was going to continue in this role, that I would
5 have time to do this and to work for the Deanery, so on the basis that I was
6 going to carry on at the hospital and carry on with this role, I resigned from the
7 deanery with effect from the end of March last year, 2013.

8 DR KIRKUP: Okay, thank you. That's helpful. Julian?

9 MR BROOKES: Thanks very much. Can I just pursue that a little bit? Your role at
10 the deanery – exactly, what was it?

11 MR NASMYTH: Associate Postgraduate Dean and predominantly I was involved in a
12 number of general things but I had responsibility for one acute trust which was
13 Blackpool, and all the mental health trusts, which were five, or are five, within
14 the north west deanery patch.

15 MR BROOKES: And the role itself was?

16 MR NASMYTH: I am sorry?

17 MR BROOKES: Well, what did you do?

18 MR NASMYTH: Okay. I worked with the trusts and with the specialities. It involved
19 making sure that they had proper educational processes in place with regard
20 to how they looked after the welfare of their trainees, that the educational
21 programme was robust, that the opportunities for learning and feedback were
22 robust. I think that is a reasonable synopsis of the main elements of it.

23 MR BROOKES: That's fine.

24 MR NASMYTH: We did provide some development opportunities for them but it was
25 mostly working with them and making sure that they were able to meet all the
26 requirements, they were aware of what they were, and certainly post-2007,
27 following Modernising Medical Careers, when we changed from the RITA
28 system of monitoring training progress to the current one, that involved annual
29 reviews of competence in the profession and certainly where there was any
30 question of a trainee not having met the required standards, the panel that met
31 to review that always had an associate dean on and that would take up ---

32 MR BROOKES: Right. I thought that's what it was but it's helpful just for
33 clarification. The reason I am asking is that some of the evidence has raised
34 concerns about issues about recruitment quality, getting high-quality staff to

come to Barrow, for example.

MR NASMYTH: Yes.

MR BROOKES: With your insight as an associate dean, could you just give me your views on what those issues were and how they were being tackled?

MR NASMYTH: Yes. On all the programmes in the deanery we would pay some respect to the choice of the trainee as to which programme they were on, but we also felt that out of fairness we could not do this completely, so where there was a particular problem for a trainee, they were travelling or they had a disability or something like that, that would be respected. Equally, if they had specific training needs which could not be met in a placement, that would be respected but otherwise we would, as it were, send people fairly on rotation to different parts of the region. There was fairly good fill of our training posts where there was high demand. So, in other words, if you take a speciality like my own, surgery, demand was high; the places in the programme were nearly always filled and therefore there was relatively little problem, particularly with the higher trainees, in filling the places on the programme and the same applied to medicine.

The programmes such as the mental health specialities, which I have responsibility for, that was much less so because the programmes tend to be underfilled. Psychiatry was not a popular choice of career, and we often found there were gaps in the programme and that try as we might we couldn't manage the gaps such that there did tend to be more gaps the further that you were.

MR BROOKES: What about obstetrics and paediatrics?

MR NASMYTH: Obstetrics and paediatrics? The fill rate for obstetrics was quite reasonable to my knowledge. I didn't work terribly closely with those specialities. Paediatrics, particularly since they have had a run-through programme – there were enough people who wanted to do it but, to take a contrast, in medicine if you were a poor trainee and you had not passed your MRCP at the end of two years, you would not be able to apply for higher training, and whilst you could go away and do your MRCP and re-apply, because of the competition your chances of getting back in, quite frankly, were quite slim, whereas in paediatrics if you hadn't passed the exams at the first attempt but the trainers were satisfied with your clinical progress, you would

1 be found a placement where you would work outside the training programme.
2 If you passed the exam, then you could reapply to enter the training
3 programme and usually for those trainees the chance of re-entering would be
4 quite high, but it did mean that there tended to be capacity in the programme;
5 not all slots were filled and the same applied to mental health.
6 MR BROOKES: But in terms of specifically Barrow, we have heard of constant
7 pressure to fill posts in obstetrics and paediatrics in terms of training places,
8 etc., and consultant posts, to a degree as well.
9 MR NASMYTH: Yes.
10 MR BROOKES: I am just trying to marry that up in my mind. So, what were the
11 specific problems there?
12 MR NASMYTH: The specific problems in Barrow would be, particularly around
13 obstetrics – I think the reports that I had were that the quality of the teaching
14 in the programme was quite high but the overall volume of the experience that
15 these trainees got was not meeting what most of them would expect in terms
16 of the number of deliveries and therefore the number of their exposure to
17 obstetric interventions, high-risk cases and so forth would not give them the
18 breadth of experience they were looking for in a relatively short space of time.
19 So, for that reason these posts were not necessarily the right posts for a lot of
20 the trainees. They were therefore much more difficult to fill.
21 MR BROOKES: And was there any solutions thought through, different ways of
22 working?
23 MR NASMYTH: First of all I think that that was less of a problem in Lancaster than it
24 was in Barrow.
25 MR BROOKES: Yes.
26 MR NASMYTH: In terms of different ways of working, I think the only thing which
27 cropped up, not infrequently, was discussion about whether or not maternity
28 services for Morecambe Bay should be centralised into a single unit.
29 MR BROOKES: So, there was no thought of different rotational patterns with linking
30 it across the Bay, for example?
31 MR NASMYTH: Those discussions may have taken place. I am not aware of them,
32 alas, and wasn't involved in them.
33 MR BROOKES: Okay, thank you. I would really like to get a feel, first of all, of
34 before you became Medical Director.

1 MR NASMYTH: Yes.

2 MR BROOKES: Can you give me just a summary of what your impressions were in
3 terms of the robustness or whatever of the governing systems in the
4 organisation you were working in as Clinical Director? Clinical governance –
5 how did that operate and were you satisfied with the systems that were in
6 place?

7 MR NASMYTH: Well, if I approach this from the perspective of looking back, I
8 cannot say, looking back, that I in any way could be satisfied with what was
9 there. If you then say to yourself why do I draw that perspective, what is it
10 that, as it were, was not driving this, if you look back and I have done at
11 minutes of both the divisional meetings and some of the Trust Management
12 Board meetings, they were very operationally-led. There was very little that
13 related to quality. There was something about performance indicators but it
14 often was a very small part of the agenda. Most of the agenda was operation.
15 Clearly, clinicians' concerns about the potential quality issues were discussed
16 but there was no outcome later; there were no hard facts; there was no
17 benchmarking of performance that would, as it were, guide how you wanted to
18 better the service, and that was leading that. I would have to say,
19 unfortunately, that when you look back in retrospect that was missing in a very
20 structured way from the time certainly that I became involved with the Trust
21 Management Board when I first became a Clinical Director. It wasn't
22 completely absent but it wasn't a high priority.

23 As divisional lead, again the minutes demonstrated a real focus on
24 operational performance. We did look at this and discuss how we might
25 address that as a division and for a while we tried having governance
26 meetings alternate months. The other alternative was to have two meetings a
27 month, one which was focusing on governance and one which was focusing
28 on key operational issues. We did not feel that we could draw out the clinical
29 time of people who were going to be attending those meetings to do that so
30 we tried to bag the two together. It was not based on provision of nearly such
31 high-quality data as it is at the moment. There were things happening in
32 different specialties, which I think many of the medical clinicians felt were
33 reflecting what they saw as the important elements of governance and to a
34 certain extent this was, I think, just what one might call historic attention to a

1 process without actually putting detailed structure, detailed data into it,
2 benchmarking it and being able to move on knowing that you were working
3 within a widespread, quality agenda.
4 So, my surgical experience has been that from the time when I first
5 started in surgery, every unit I worked in had regular morbidity and mortality
6 meetings. There was review of that and certainly in my speciality in this Trust
7 there were no exceptions to that. There were potentially criticisms of how it
8 was done. It was done differently in Lancaster to Barrow. We took the view
9 that it was right for us to alternate the Chair of those meetings and the Chair's
10 responsibility was to look at all the cases and to critically review those cases
11 with their colleagues whereas in some other departments there was each
12 colleague presenting their own information. But that was not assembling, if
13 you like, a cumulative pattern of performance which you could, in terms of
14 quality outcome statistics —
15 MR BROOKES: So, there was process in place?
16 MR NASMYTH: Yes.
17 MR BROOKES: But it was not necessarily getting to the root of the issue?
18 MR NASMYTH: No.
19 MR BROOKES: And you weren't comfortable or confident in some of the data that
20 you were being provided with as well?
21 MR NASMYTH: Yes.
22 MR BROOKES: Is that a fair summary?
23 MR NASMYTH: That would be a fair summary.
24 MR BROOKES: So, what was your involvement in serious untoward incidents?
25 MR NASMYTH: At that time, other than they would be discussed at divisional
26 meetings, if they came to divisional meetings, and there was one from time to
27 time, none, certainly not at trust level.
28 MR BROOKES: So, if there was a serious untoward incident which related to your
29 clinical division, you wouldn't have been involved in that?
30 MR NASMYTH: I might have been involved in it if the team responsible had brought
31 it to the divisional meeting, but I am not sure that I was getting that information
32 all the time.
33 MR BROOKES: So, what was your involvement with – let's get the timing, right,
34 sorry, but there were the five serious, untoward incidents relating to maternity

1 services while you were Clinical Director. Is that correct?
2 MR NASMYTH: Yes.
3 MR BROOKES: So, you were not involved in those at all?
4 MR NASMYTH: No.
5 MR BROOKES: Does that seem strange?
6 MR NASMYTH: Yes.
7 MR BROOKES: I am just trying to get to the bottom of why because that does seem
8 strange to me as well. Is that because the Clinical Director's role was not
9 seen as an important role in terms of the investigation of those kinds of
10 incidents or what were the reasons? Would the system have expected you to
11 have been involved first of all, or was the system designed not to include you
12 in that process?
13 MR NASMYTH: I had regular monthly meetings with the Medical Director and I
14 cannot recall conversations where these were fed back to me at those monthly
15 meetings or to the other divisional leads who often came to the same
16 meetings, that there was information-sharing about the serious cases at those
17 meetings. I had regular meetings with the speciality lead for obstetrics and
18 certainly in relation to one case it was apparent from what he told me about it
19 that the Chief Executive of the trust had become aware of the case before he
20 had.
21 MR BROOKES: Okay.
22 MR NASMYTH: So, what reporting mechanisms were involved in that I am not sure,
23 but they had bypassed both the lead for obstetrics and myself.
24 DR KIRKUP: Just for absolute clarity, can you identity who the speciality lead is that
25 you are referring to there?
26 MR NASMYTH: Yes, Ibrahim Hussein.
27 DR KIRKUP: Yes, thank you.
28 MR BROOKES: So, just to summarise that again, in terms of those incidents and in
29 general in terms of serious untoward incidents, the Clinical Director was not
30 involved in the process or you weren't involved in the process of assessment,
31 analysis and any action coming out of those?
32 MR NASMYTH: No, not unless we had some direct involvement and obviously if —
33 MR BROOKES: So, who would have ensured within your division that if there were
34 key things that needed to be changed, that they would be changed?

1 MR NASMYTH: We had a governance lead for the division. There was also a
2 governance lead within maternity, as far as I can reçall, and the reporting
3 mechanism that obviously we would have expected was through the divisional
4 meetings. Having looked through the minutes of those meetings going back to
5 2009 to see what reporting was there, I have been unable to find any that
6 detailed reporting within those minutes.
7 MR BROOKES: My understanding from previous evidence is that the system that
8 was in place at the time that we are talking about would have been through to
9 the established Clinical Governance and Safety Committee of the Board —
10 MR NASMYTH: Yes.
11 MR BROOKES: My understanding from that is that the representation to that group
12 would have been through the Divisional Clinical Directors and the Divisional
13 Manager would have gone to those to present issues around risk, etc.
14 MR NASMYTH: Yes.
15 MR BROOKES: From what I am understanding from what you are saying, it is that
16 there was no discussion at the division about those issues, so how could
17 those issues be brought to that committee?
18 MR NASMYTH: The governance lead for the division would be expected to attend
19 that but there was no detailed case discussion by leads within the divisional
20 meetings, certainly none that was minuted and I must admit I don't recall
21 detailed discussion about them either.
22 MR BROOKES: So, if there was an issue identified, if it had gone to the Clinical
23 Committee and Safety Committee, how would action actually be initiated?
24 Who would be required to take action?
25 MR NASMYTH: I would assume that if there was something arising from the output
26 of that committee, that would have been communicated back through the
27 appropriate people in the division.
28 MR BROOKES: And who were they? That's what I am trying to get to.
29 MR NASMYTH: Well, I would have expected that they would have come to me but I
30 can't recall ever —
31 MR BROOKES: You have pre-empted my next question.
32 MR NASMYTH: – receiving, as it were, regular feedback from that committee.
33 Certainly, as far as I know I was not expected and not asked to attend it.
34 MR BROOKES: So, you didn't attend the meeting?

1 MR NASMYTH: No.
2 MR BROOKES: So, the whole time that that structure was in place, the new
3 governance structure of the organisation, you were not expected – you were
4 never asked to attend that committee?
5 MR NASMYTH: No.
6 MR BROOKES: So, who went from your division? That would be governance would
7 it?
8 MR NASMYTH: We had governance for the division, yes.
9 MR BROOKES: Okay, thank you. Slightly different but still in that role, if an
10 individual clinician was to raise a concern with you, how would you have dealt
11 with those?
12 MR NASMYTH: I would have either asked somebody else within the division,
13 typically if it was nursing, to investigate it appropriately or I would have
14 instigated my own investigation to understand what the issues were and how
15 we took them forward, either in relation to an individual or into a service
16 procedure which was clearly identified as something that had risk to patients
17 or –
18 MR BROOKES: Okay. And how would that process link in with the governance
19 structure we have just been talking about? Would they be separate? Would
20 they link at a particular point? How would they –
21 MR NASMYTH: The linkage there would be either myself or other members of the
22 divisional team talking to divisional governance lead and obviously some of
23 these things would be discussed at divisional meetings.
24 MR BROOKES: And would you bring that to the attention of the Medical Director?
25 MR NASMYTH: I had regular meetings with the Medical Director. These were, if you
26 like, informal, unstructured meetings. I would usually take a list of things with
27 me that were concerning me and those would have been discussed with the
28 Medical Director if they were things that I felt we needed to talk about.
29 MR BROOKES: So, there was a route, basically, for a clinician who had a concern to
30 express that to you for a discussion with the Medical Director?
31 MR NASMYTH: Yes.
32 MR BROOKES: That in some ways was parallel to the system we were discussing
33 previously?
34 MR NASMYTH: Yes.

1 MR BROOKES: Okay, that's helpful. Are you aware of and can you recall any
2 particular incidents relating to maternity services or paediatric services which
3 were brought to your attention in that way?
4 MR NASMYTH: There had been discussions about the staffing of the neonatal unit
5 minuted at divisional meetings – I can't remember whether it was 2008 or
6 2009 – and options that might be developed there including what has now
7 happened, which was translocating the Special Care Baby Unit to a site within
8 the Maternity Unit at Furness General.
9 MR BROOKES: But that is the only thing that you can recall?
10 MR NASMYTH: That, yes, I can recall that one because that one is quite clearly
11 minuted.
12 MR BROOKES: Okay.
13 DR KIRKUP: I was going to raise this at a later stage, but it is absolutely the right
14 moment in that context. Can you recall a letter from Mr Misra in October
15 2008 that you were copied in on – it was written to Mr Hussein – about an
16 individual case? I don't want to talk about the details of an individual case –
17 that is not appropriate at the moment – but broadly speaking he identified
18 some quite serious failings of care. He said that it had happened before and
19 that unless something was done it was likely to happen again.
20 MR NASMYTH: Yes.
21 DR KIRKUP: Can you recall that?
22 MR NASMYTH: Yes.
23 DR KIRKUP: Okay, and your response to that was?
24 MR NASMYTH: I discussed that with Mr Hussein, who was the speciality lead whom
25 obviously that letter had been primarily addressed to.
26 DR KIRKUP: It was.
27 MR NASMYTH: And what actions – particularly in the sense of what dialogue – was
28 taking place between the clinicians and the midwives in respect of trying to
29 resolve those issues.
30 DR KIRKUP: Okay. So, what was the response to the letter?
31 MR NASMYTH: I can't recall whether I personally responded to it myself and I don't
32 know whether Mr Hussein responded to it.
33 DR KIRKUP: Okay. Would it surprise you to know that we can't find any record of a
34 response to it?

1 MR NASMYTH: I didn't know that but –

2 DR KIRKUP: It obviously has surprised you, okay. The outcome of the discussions
3 with Mr Hussein was that you – I don't want to put words too far into your
4 mouth so please tell me if I am wrong, but your understanding was that Mr
5 Hussein was going to take this up and investigate it?

6 MR NASMYTH: I don't think I would have had the knowledge of the working
7 relationships myself within that department.

8 DR KIRKUP: Yes.

9 MR NASMYTH: I felt that if there was a way in which this could be taken on further,
10 then he would advise me as to what it was and I would have expected him to
11 do that. By implication, I think there was a perceived difficulty between
12 medical staff in that unit, possibly in both obstetric units, and midwifery staff in
13 terms of working together in terms of having proper understandings and
14 appropriate relationships.

15 DR KIRKUP: Did you follow up afterwards with Mr Hussein? Did you say to him,
16 'Whatever happened about that? Has it improved?'

17 MR NASMYTH: I must admit I had regular conversations with him but I cannot recall
18 the detail of those conversations and whether we talked about that specific
19 thing or not, I can't remember.

20 DR KIRKUP: Okay. Sorry, Julian.

21 MR BROOKES: That is absolutely fine. I am focusing on the time before you
22 became Medical Director at the moment because quite a lot of the issues we
23 are looking into were while you were Clinical Director.

24 MR NASMYTH: Yes.

25 MR BROOKES: So, during your time you would have become aware of concerns
26 about maternity services?

27 MR NASMYTH: Yes.

28 MR BROOKES: How did you become aware of that?

29 MR NASMYTH: Mostly through the conversations that I had with Ibrahim Hussein
30 and also through the concerns that had triggered some of the paediatric
31 reviews, in particular the one carried out by Dr Mitchell. I'd met with Dr
32 Mitchell and he came and I talked through some of the issues with him.

33 MR BROOKES: And what was your response? As Clinical Director what were you
34 doing to tackle these issues?

1 MR NASMYTH: I have to say that at the time my concern was that I didn't actually
2 feel that I had the knowledge and the time to get sufficiently detailed
3 involvement with this that I could adequately pick them up myself and we, both
4 the Divisional General Manager at the time. Vanessa Harrison, and myself
5 had had conversations with – she had spoken with the Chief Operating
6 Officer, Stephen Bourne. I had certainly raised it with the Medical Director that
7 I felt that the detailed involvement with all surgical, anaesthetic services and
8 with paediatrics and obstetrics on the two sites did not have the insight in time
9 to become as involved as we should be and to fully understand what all the
10 issues were and we were probably too dependent on delegation of these two
11 other people, and whether that was one of the prime movers in setting up a
12 separate division for Women's and Children's Services in 2009 I don't know. I
13 haven't been involved directly in any decision-making which led to that but we
14 have raised concerns about it.
15 MR BROOKES: Okay. The question behind this is who was doing what and I am
16 clear that from your point of view you have a big division to deal with, you
17 don't feel you have the expertise to get involved directly in this, but who did
18 you think was doing something about it?
19 MR NASMYTH: My understanding was that the Head of Midwifery at the time and
20 the Clinical Lead for Obstetrics, Ibrahim Hussein – I think the Head of
21 Midwifery, if my memory is correct, was Angela Oxley and I would have been
22 very much dependent on advice coming into them. The Assistant Chief Nurse
23 for the division was Lynn Wyre and again feedback through her I assumed
24 would take place of the nursing issues and certainly we didn't get, or I couldn't
25 recall getting, any feedback from Lynn about that. Whether she got feedback
26 from Angela Oxley, I am not sure.
27 MR BROOKES: So, there was no discussion about it at the divisional meetings?
28 MR NASMYTH: No.
29 MR BROOKES: Okay.
30 MR NASMYTH: Well, certainly I can't find any that was minuted.
31 MR BROOKES: And you don't recall that? You don't recall being briefed and kept in
32 touch with what was happening?
33 MR NASMYTH: No.
34 MR BROOKES: Do you find that surprising as a clinical director not knowing

1 something serious – about serious clinical failings in your –

2 MR NASMYTH: When you look back and you see the magnitude and the
3 significance of the events that took place, yes. There was clearly a failure to
4 feed that information up, and if you like there was a failure on our part to act
5 upon it. Certainly, I would have expected, had there been an awareness of
6 this at Board level, that they would have come back to the division and spoken
7 to me about it, but I don't remember any conversations there either.

8 MR BROOKES: Okay. At the time, were you aware of the Fielding Report or when
9 did you become aware of the Fielding Report?

10 MR NASMYTH: I am trying to recall on that in time. If my recollection is correct, and
11 I will stand to be corrected by yourself, the Fielding Review or Report was
12 requested in 2009.

13 MR BROOKES: That's right.

14 MR NASMYTH: And my awareness of its content and what happened became
15 correlated more or less with the time at which Women's and Children's
16 Services became a separate division.

17 MR BROOKES: Yes, so wasn't necessarily within your –

18 MR NASMYTH: From my perspective the findings of the Fielding Report didn't
19 impinge on my radar in terms of things that I should be taking action on.

20 MR BROOKES: That is absolutely fine, thank you. Can I move to you taking on the
21 role as Medical Director?

22 MR NASMYTH: Yes.

23 MR BROOKES: It would be very helpful for us to understand your assessment of
24 what you found when you arrived into that role across the trust, but particularly
25 around responses to the concerns around Maternity Services.

26 MR NASMYTH: I think I was thrown into this and I had no formal handover so that in
27 a sense I was left with trying to pick as many pieces and run things
28 operationally on my own. The governance systems that were in place really
29 didn't seem to me to come together and one of the first things that I did was to
30 reorganise the divisional structures to make sure that these were clinically led,
31 and we then started building frameworks of a different way of doing things so
32 that we had a Quality Committee and each division was accountable to the
33 Quality Committee.

34 The new Chief Operating Officer, who started about the same time as I

1 did, initially as an interim, set up regular meetings which she had operationally
2 against performance outcomes with each of the divisions and the whole
3 executive team would attend those on a quarterly basis so that we were able
4 to ask questions and scrutinise what each division was doing. We also began
5 to look quite critically at a number of areas where we recognised that
6 performance was poor.

7 In relation to maternity in particular, this involved making sure that there
8 was a maternity dashboard in place and the metrics that were needed to just
9 really begin to understand what was happening and what needed to take
10 place. There was quite a bit of work done around staffing, around changing
11 the culture and making sure that there were proper governance systems within
12 each division that would then report upwards to the Quality Committee, or the
13 Performance Committee, which were sub-committees of the Board and
14 chaired by non-executive directors.

15 MR BROOKES: Okay, so you have changed roles; you have moved from Clinical
16 Director into the Medical Director's post.

17 MR NASMYTH: Yes.

18 MR BROOKES: It becomes clear to you when you are looking at it from a medical
19 director's perspective that there are significant worries about the governance.

20 MR NASMYTH: Yes.

21 MR BROOKES: I am just trying to understand why that was not visible to you as a
22 clinical director.

23 MR NASMYTH: I think it was visible to me as a clinical director. What I lacked was
24 good quality information. Streamed performance, really is reflected in having
25 the appropriate information and if you don't have that appropriate information
26 then it becomes quite difficult to understand where there are significant
27 failures in performance. There was data provided on those targets that the
28 Government had set, so we had data around referral to treatment times, we
29 had data around A&E performance and ambulance handovers, but we didn't
30 have data reflecting a wide range of metrics in each speciality which actually
31 indicate quality, so indication about hospital-acquired infections was not good.
32 We couldn't pin it down to a site, to a ward, and begin to put the things in
33 place that we would need to have, and also have accountability for this.
34 Really, accountability for this has to run through the organisation for it to be

1 effective and I don't think those accountability systems were there previously.
2 What we have tried to do since is to put those in place.
3 MR BROOKES: Okay, so you were aware as Clinical Director – it almost sounds like
4 saying you were not in a position to do anything about it?
5 MR NASMYTH: One almost felt there was a glass ceiling there. I could give you a
6 different example, which I found incredibly frustrating and actually led me to
7 have a discussion with the Postgraduate Dean, an offline discussion, as to
8 whether I could actually remain in my post as Clinical Director. I knew that we
9 were moving towards implementing the European Working Time Directive for
10 all our junior doctors – well, all doctors – in the North West Health Authority
11 area with effect from 2008 rather than the absolute deadline date of 2009. I
12 therefore put together a programme, a structured suggestion for what this
13 would mean for the division and what the staffing impact would be and how we
14 might begin to address it. That was sort of listened to nicely. I was told that it
15 would be very expensive and that this problem would go away and nobody
16 wanted to do anything about it.
17 MR BROOKES: So, who said that?
18 MR NASMYTH: This was fed back to me by different members of the executive at
19 the time.
20 MR BROOKES: Okay.
21 MR NASMYTH: I took it to the Trust Management Board in the autumn. I can't
22 remember exactly which month, but 2007, because I thought it was very
23 important that this plan, to have a chance of success, be implemented or we
24 began to implement it well before 2008 and it was only agreed that it should
25 be dusted off and we would attempt to implement it towards the end of May
26 2008, which was really far too late to look at advertising for all the additional
27 posts that we would need, particularly when everybody else would be in the
28 market for those posts.
29 MR BROOKES: I see.
30 MR NASMYTH: And as a consequence I think we had gaps and it did cost us much
31 more money in the long run than it would if we had implemented earlier and
32 had better and safer service.
33 MR BROOKES: You are using that as an example of a glass ceiling, so you clearly
34 think that there was a disconnect between the senior management and the

1 Board within the organisation, or am I putting words into your mouth? Is that
2 correct?
3 MR NASMYTH: Yes.
4 MR BROOKES: And that manifested itself in that particular example. How else did
5 that manifest itself?
6 MR NASMYTH: Quite frequently I would have conversations with the Medical
7 Director and ask him questions and the Medical Director couldn't clearly
8 answer to me.
9 MR BROOKES: But he was a member of the Board.
10 MR NASMYTH: Yes, and so I would have thought that he would have been able to
11 have, or would have had, conversations amongst themselves, and particularly
12 most of these related to workforce, and that answers in relation to workforce
13 would have been forthcoming but often they weren't.
14 MR BROOKES: Okay. I will pause at this stage, if that is okay.
15 DR KIRKUP: Okay, thank you.
16 MS FEATHERSTONE: I just want to pick up on some things that Julian said. What
17 regular formal meetings did you have with the obs, gynae and paediatric and
18 the management team during that time when you were Clinical Director?
19 MR NASMYTH: Formal meetings with – there was just the divisional meetings at
20 which they would be represented, both in terms of the Head of Midwifery and
21 the speciality lead for obstetrics and the speciality lead for paediatrics. I had
22 informal meetings with the speciality lead, Ibrahim Hussein. I had no formal or
23 informal meetings with the Head of Midwifery.
24 MS FEATHERSTONE: And that wasn't asked for and you didn't ask for that? That
25 wasn't expected of you?
26 MR NASMYTH: I certainly wasn't – it was never made clear to me that it was
27 expected of me. Clearly, with hindsight you recognise that this was something
28 that you should have done. I would rather have assumed that any necessary
29 conversations would have taken place between the Head of Midwifery and the
30 Associate Chief Nurse of the division, and that would have been
31 communicated back to me if there were issues that I should be aware of. I
32 don't know whether those conversations took place and I certainly cannot
33 recall any issues being brought back to me through that route.
34 MS FEATHERSTONE: And the divisional meetings were monthly meetings, were

1 they?

2 MR NASMYTH: They were.

3 MS FEATHERSTONE: And attended well by the obs and gynae and paediatric
4 staff?

5 MR NASMYTH: The expected attendance would have been the speciality leads for
6 paediatrics, for obstetrics and the Head of Midwifery. One or two other people
7 would come from time to time and I can't give you off the top of my head what
8 the attendance record is. The minutes do indicate who attended those
9 meetings.

10 MS FEATHERSTONE: When you were Clinical Director, that was across sites, was
11 it, across the Bay?

12 MR NASMYTH: Yes.

13 MS FEATHERSTONE: And how did you divide your time between the two sites, well
14 three sites?

15 MR NASMYTH: Because I was still working with the deanery and combining clinical
16 services at MGH, certainly until we appointed – the agreement had originally
17 been that I would do emergency work only in terms of general surgery and
18 that we would appoint somebody into a post that would allow me to drop my
19 elective surgery. We ran into difficulties with the trust in actually agreeing
20 funding for that to the point where it was not until 2009 that we were in a
21 position to make an appointment, which we did, and that enabled me to drop
22 all my elective surgery, which gave me much more time to do this but that
23 didn't really happen until the summer of 2009, so I was in fact taking on
24 responsibility for the division across all those sites.

25 I had both an elective and an emergency surgical work over at FGH and
26 I was also working two days a week for the deanery, ostensibly. In practice I
27 think the deanery were probably short-changed through much of that time but I
28 would come to meet with people, we would have some divisional meetings at
29 the other sites. I would attend the Trust Management Board, have meetings
30 with the Medical Director but my working offsite was constrained by those
31 difficulties and only really began to be resolved from the summer of 2009 by
32 which time I didn't have responsibility or continuing responsibility for Women's
33 and Children's Services.

34 MS FEATHERSTONE: So, in a week, you actually may not be at Barrow at all; you

1 might not have been at Lancaster?

2 MR NASMYTH: I would have been at Barrow. I would have been at Barrow most of
3 the time. The difficulty was getting to the other sites.

4 MS FEATHERSTONE: All right, and when you were Clinical Director, what would
5 you say the relationship between the obs and the paediatric – were you aware
6 of any issues with the relationship between the obs team and the paediatric
7 team?

8 MR NASMYTH: "No", I think would be the honest answer. I was aware of, shall we
9 say, operational difficulties in relation to each team and I was aware of
10 operational difficulties in relation to the midwifery staff and obstetricians. I was
11 not made aware of specific difficulties between the obstetric staff in terms of
12 either obstetricians or midwives and paediatricians.

13 MS FEATHERSTONE: Okay. In your role now as Medical Director and as the exec
14 team, are you visible on the clinical floor as an exec team?

15 MR NASMYTH: We try to be. We do regular ward rounds. I try to – my role
16 principally has to be engaging with medical staff and I make a point of doing
17 that but my presence on the wards is probably less than the Chief Nurse, and
18 the Chief Operating Officer also does that on one day a week too, so that
19 whilst I would visit wards on the hospital, there is usually a specific focus to
20 those visits rather than just as it were having a general chat with staff.

21 MS FEATHERSTONE: And does that go across sites now as well, then?

22 MR NASMYTH: Yes. For instance, yesterday I was on Ward 37 because I was
23 talking to the nursing staff and medical staff about resolving some issues we
24 had with developing an electronic in-patient prescribing model.

25 MS FEATHERSTONE: Okay, fine, thank you. That is all I have to ask.

26 DR KIRKUP: I want to ask you a couple of questions about Gold Command.

27 MR NASMYTH: Yes.

28 DR KIRKUP: How did it work from the trust's perspective?

29 MR NASMYTH: This was instituted, if I am talking about the right thing, in the
30 autumn of 2011 following the CQC issuing the trust with warning notices in
31 relation to Maternity Services and the outpatient incident which was escalated
32 through the Regional Health Authority and to monitor.

33 DR KIRKUP: Yes.

34 MR NASMYTH: At that time I was Clinical Director. I think my overwhelming feeling

1 at that time was that as a division we were very concerned that we didn't really
2 understand that anybody else was responding to those concerns about what
3 was happening to the appointments system. So, the review that was then put
4 in place by Helen Bellairs was, I thought, very helpful. Obviously, the
5 management of what occurred in outpatients was initially undertaken by the
6 Medical Director and the Division of Core Clinical Services, who were
7 responsible for outpatients. I took over the leadership of that and tied it off
8 once I took over as Medical Director in April 2011 – 2012, and then obviously I
9 became involved with the Gold Command meetings.
10 By that stage, most of the things that, as it were, needed to be done
11 immediately had been done and I think everybody was aware that the trust
12 was aware of the problems that had arisen and was moving towards putting
13 those right. Meetings were very transactional rather than, I suppose,
14 supportive but I would imagine to begin with that I would have expected them
15 to be supportive but I would not have been involved with meetings of Gold
16 Command much before April 2012.
17 DR KIRKUP: Okay.
18 MR NASMYTH: Does that begin to answer the question?
19 DR KIRKUP: Yes, and when you were involved in the meetings in April 2012, what
20 was the relationship like between the trust staff and the Gold Command
21 people?
22 MR NASMYTH: Cordial.
23 DR KIRKUP: Was it an effective working relationship?
24 MR NASMYTH: From my perspective it was, yes.
25 DR KIRKUP: Did they bring additional resources to the trust?
26 MR NASMYTH: I would have to say I would have to look back and know, if there
27 were any, what resources came through that particular process. I am not
28 sure.
29 DR KIRKUP: Okay. It wasn't visible to you in the role that you then had?
30 MR NASMYTH: No. A lot of things were done but my impression was that the trust
31 was paying for them.
32 DR KIRKUP: Okay. I think the other key resource there would be staff.
33 MR NASMYTH: Yes.
34 DR KIRKUP: Were you aware of any differences in staffing that resulted from Gold

1 Command?

2 MR NASMYTH: Obviously there had been huge pressure on the maternity staff and
3 one of the things that clearly needed to happen was to increase staffing in
4 maternity. Not being directly involved in that at the time, I am not sure where
5 the resources came from. I know that it was responded to.

6 DR KIRKUP: Okay. I have another set of questions to ask but I think probably you
7 want to come back on some of those?

8 MR BROOKES: Yes, that is okay. Part of our remit is looking for assurance about
9 what is happening now.

10 MR NASMYTH: Yes.

11 MR BROOKES: I would be very grateful for your assessment of the current
12 governance arrangements in the trust.

13 MR NASMYTH: Yes.

14 MR BROOKES: If you could do that, it would be very helpful.

15 MR NASMYTH: Right. It's a question of whether it's better to describe it, as it were,
16 bottom up or top down. I think I would start by trying to describe it, if you like,
17 as bottom up. We have put in place first of all incident reporting systems in
18 which we hope now that all of our staff have been trained in how to report
19 incidents. Unfortunately, there is a tendency for the medical staff to devolve
20 that responsibility to something else so proportionately you will see fewer
21 incidents reported by medical staff. Most of them get reported by nursing staff
22 but not exclusively, and that may be something that we need to look into. On
23 the other hand I am not aware at the moment that we are missing things and
24 certainly I could give you examples of a surgeon who recently self-reported an
25 incident of something that happened intra-operatively and we have put in
26 place some correct measures to try and avoid that again, but I don't think
27 there was – it was probably just an error of judgment at the time on his part
28 but it was one that anybody might have made. It wasn't deliberate and duty of
29 candour was fulfilled, so there are a lot of things there that I think are taking
30 place now which wouldn't have taken place before. So, in other words there is
31 reporting of incidents by people in the right place at the right time to a much
32 higher level.

33 I suppose within any organisation you don't know what you don't know
34 and obviously every time you do discover something that you don't know, you

look at it very carefully and say, 'How was that? What can we do about it to put it right?' One of the ways in which – again now talking from the bottom – having had discussions with the new Chief Nurse, actually before she came into post, we thought about how we might improve this and we established a patient safety summit, which takes place every Wednesday morning and we review – we either attend the meeting or we dial into it – but we get quite high attendance from all divisions including Women's and Children's – where all the incidents that have occurred in the past week are discussed and any significant complaints are brought to the table as well. Obviously, some of these will end up going to the Serious Incident Requiring Investigation Panel, the SIRI Panel, but even those that don't would all be followed up. There would be RCAs and there would be action plans available within the notes of those meetings so that we can be absolutely sure that that has taken place.

So, for instance, with prescribing incidents, those would be reported back to usually a junior doctor who had made them, but not exclusively – sometimes they are made by consultants – and certainly in the case of a junior doctor that would be fed back to their educational supervisor and the learning that would then be documented from that would be either an email from the educational supervisor or a trainee to say that this had been discussed and documented in their portfolio.

MR BROOKES: Okay.

MR NASMYTH: So, what we are trying to do is to ensure that learning from significant events takes place. Clearly, you then look at the themes that arise from that and so clearly one of the big themes would be things like falls, pressure ulcers, which are probably the single biggest cause of avoidable harm in any healthcare organisation and we are trying to make sure that the incidence of those declines. You can't necessarily reduce the incidence of falls but you can potentially reduce the harm that arises from those falls if you have done the appropriate assessments. So, for each one there was a look back to see whether the appropriate assessments have taken place, whether there was any failure of care which led to that.

There is, going beyond that, particularly in relation to maternity, a maternity dashboard. They have got their own divisional magazine, I suppose would be the best way to describe it, or news review, which they are now

1 publishing. That will include their dashboard. We noted the comments by the
2 CQC in relation to perceived high prevalence of Caesarean section rates,
3 particularly at Furness General. They have undertaken an initial audit. I am
4 not satisfied and I think that now they have looked at it they are not satisfied
5 either that that has properly addressed the question. Whilst no obvious
6 problems have been raised, I am meeting with them next week again to
7 discuss how this is appropriately re-audited. We have also done a selective
8 review of cases where I have taken all the Caesarean sections by case
9 number and submitted them to an obstetrician in another trust. They have
10 randomly selected four cases from each site of elective and four cases for
11 emergency section at each site which they are going to review for us and we
12 will send them copies of the case notes. So, another example of how that is
13 working at a divisional level.
14 MR BROOKES: So, governance is better? Is it better?
15 MR NASMYTH: I hope so. I hope so.
16 MR BROOKES: Yes, but do you know it is?
17 MR NASMYTH: I certainly feel that I am much more aware than I used to be.
18 MR BROOKES: Okay, and the knowing is absolute. You are absolutely right, if you
19 don't know, it's difficult. Where there are, for example, maternity issues, are
20 you confident that similar events would not occur again?
21 MR NASMYTH: Obviously one can never say 'never', but I would hope that the
22 measure that we are putting in place and have put in place would help. I think
23 the key issue here probably is having adequate staffing levels. I say that
24 because I come from a position where if you then look at everything else that
25 you may be should be doing but you don't do and you ask the question, 'Why
26 don't you do it? Why didn't it happen?', it is often because the staff have had
27 to make difficult decisions because they are too pressured and for me
28 probably the most seminal of the reviews that took place last year was that of
29 Berwick because what Berwick said was that actually when you plan how you
30 use your staff and the staffing levels that you need, you must take into account
31 the need for the staff as teams to meet and to work together and to have that
32 necessary resource of training and development factored into the number of
33 staff that you employ so that you are not only providing a safe net in terms of
34 having enough people there to deliver the service, but also you can maintain

1 that while at the same time you are taking some of your staff out to engage
2 with your team development. My concern would be that at present we haven't
3 got to that level, although it is certainly one that we are aspiring to.
4 DR KIRKUP: If your underlying problems include a fair element of knowledge,
5 behaviour, team working, inappropriate failure to escalate, one solution is to
6 have additional time so that you can have development and so on but are you
7 content that that is a sufficient solution?
8 MR NASMYTH: It is not enough on its own.
9 DR KIRKUP: Yes.
10 MR NASMYTH: You have to have adequate reporting systems. Performance has to
11 be informed by information. We are developing a variety of dashboards and
12 increased use of electronic systems, including the one that the trust is piloting,
13 Lorenzo, would enable us – is enabling us – to collate this information in a
14 real-time way and be able to meet very specific data needs of any clinical area
15 or team.
16 DR KIRKUP: Yes. If you have had a series of incidents in the past that have been
17 more or less clearly related to those kind of underlying factors, it seems
18 unnecessary to me that you have to wait for further incidents to come along to
19 demonstrate that those are the underlying problems, that there is an issue
20 about culture and dysfunctional relationships and team working underlying all
21 this that needs to be put right.
22 MR NASMYTH: Yes, I accept that. Again, that has taken place within that division
23 and specifically in terms of having people who have led events to attempt to
24 change the culture and to get people to work together and to be more
25 engaged with an appropriate team dynamic than was, I think, the case
26 previously.
27 DR KIRKUP: Okay. How will you know if that has been effective?
28 MR NASMYTH: I think there will be evidence from better working relationships
29 between different groups of people. To a certain extent that is what I describe
30 as soft intelligence. I would hope that if this was working properly, we would
31 also begin to see a reduction in the number of incidents reported and that we
32 would have greater confidence in the way that that was working.
33 DR KIRKUP: Okay. Sorry, Julian.
34 MR BROOKES: No, that is absolutely fine because that is really important. I want to

1 use a particular example. It is all about individuals here. Are you aware or do
2 you recall the issues that were raised with you about radiology?
3 MR NASMYTH: Currently?
4 MR BROOKES: In streaming.
5 MR NASMYTH: Yes, I have been informed of that.
6 MR BROOKES: Can you just go through how that has been approached, because it
7 is a current example and it would be useful to understand how it is different
8 now and how that has been approached by the trust.
9 MR NASMYTH: I think probably the key point to begin this is when a doctor came to
10 me with an audit in March, or well at least I had an email which he wanted to
11 discuss serious concerns with me. I met with her the following day. There
12 was an audit that she had carried out looking at interval cancers, that is
13 cancers that have occurred at the same site as the screening assessment in
14 the previous round, or previous rounds as was the case here because this
15 was from 2005 and it was 2011. Twenty-four cases had been identified and
16 the concern was that these were not evenly distributed amongst the
17 radiologists; there was one radiologist with a much higher proportion than the
18 others. I asked if I could see the methodology for the audit so that I could
19 understand it better. The individual concerned felt that she had often been
20 treated unfairly by the others although that had been investigated. There were
21 personal relationship problems which we had formally investigated with an
22 external investigator and no definite conclusions had been reached.
23 So, without that knowledge, I went to the Regional QA Director and put
24 this in front of him and said, 'I think we can investigate this internally. It would
25 not be right that we can't mark our own homework. I would be grateful if you
26 would look at it'. He gave us two radiologists, one from East Lancashire and
27 one from Liverpool who came in and reviewed all the films. They produced a
28 report which had a slightly different slant on it to the internal audit inasmuch as
29 they felt that 12 of the 24 interval cancers were not interval cancers. One was
30 quite an obvious decision because the case was not a breast cancer; it was a
31 lymphoma so that should not have been there anyway and the argument on
32 assessment was that these cancers were not at the same sites as the
33 problems that had been assessed but they did reach, if you like, the same
34 conclusion. They disagreed with the decisions that had been made in seven

1 of the remaining 12 cases and again there was a disproportionate number
2 attributable to one radiologist, although that was now very much smaller,
3 particularly given that this was a five-year period, and the conclusion of their
4 report at the time was that the trust had a low average or it was higher than
5 average incidence, below average performance in relation to interval cancers
6 in that period but was not a significant outline. No benchmarking data made
7 available that notes on what basis those conclusions had been reached.

8 I asked if we could have feedback directly. That was not supplied in the
9 way I had requested it in that I had had conversations as to whether they
10 could actually come back and explain on a case-by-case basis why they had
11 made those decisions and it was appropriate learning. That was not offered.
12 What was offered was just a simple list analysis and they didn't want to feed
13 that back in person. The radiologist who complained to me then complained
14 to Public Health England about that process. Obviously at this stage, that
15 problem was now out of my hands anyway. Public Health England engaged
16 with myself and it was agreed there would be further review and the theme of
17 that review would be to look at current breast screening services and establish
18 that the service was appropriate and safe. This was or is – we get, I am
19 hoping, the final feedback on that on Tuesday. The first round of films they
20 looked at – well, the first thing they did was they sent a questionnaire to all our
21 staff. They looked at that and then they came into the trust; they held
22 interviews with some of our staff and they looked at a raft of films that they had
23 pre-selected in terms of dates and people, radiologists, who had been
24 involved in the process, and then they came up with a list of
25 recommendations.

26 There were three patients who we were invited to recall. One was a
27 case where it revolved around documentation and that patient was not
28 recalled once the documentation was verified with the review team. The other
29 two patients were recalled and there were six other recommendations around
30 changes that should be made of which we have implemented five. The final
31 one about the new ultrasound machine – we are currently looking at all those
32 on the market and the manufacturers are bringing them in so that the choice is
33 made as to one which the staff find easiest to use, and I am hoping that that
34 will be a purchase that will be in place within a few weeks.

1 MR BROOKES: Okay, so in terms of the trust's response, do you feel that it was
2 appropriate and complete in terms of what you as an organisation should have
3 done?
4 MR NASMYTH: There were some other things that we have done in relation to
5 relationships within the department because in terms of previous reviews that
6 have taken place, I had –
7 MR BROOKES: I suppose what I am trying to get to is you have described a new
8 governance process. I am not clear how this has been fed into your overall
9 governance and quality assessment process. I can see what you have done
10 and I can understand why you did what you did.
11 MR NASMYTH: Yes.
12 MR BROOKES: It still feels separate from the mainstream governance of the
13 organisation.
14 MR NASMYTH: The original audit – although I must admit I was not made aware of
15 this by the department – but the original audit was registered with the audit
16 department. Whether the audit was then submitted to the audit department by
17 the radiologist, I don't know. In terms of where this needed to go, certainly I
18 have provided updates to the Board as to what we have been doing so that
19 the Board are aware of what has been going on.
20 MR BROOKES: Did it go to the Quality Committee?
21 MR NASMYTH: I can't remember if I have reported it back there in the sense that
22 because to date this has never been closed, I have given certainly summary
23 or verbal updates to the Board at regular intervals. I am not sure in terms of
24 what I perceived as needing to happen where else I should or could have put
25 it in. What we have done, I have asked that on all the cases that we
26 suggested there was a recall that we have a full RCA. Those RCAs have
27 started to go through our reporting system. One of them has already gone to
28 SIRI because there was an interval cancer.
29 MR BROOKES: Okay, thank you.
30 DR KIRKUP: The remaining questions that I have relate to a particular serious
31 untoward incident, which will involve clinical details, so I am going to ask for a
32 short pause while we ask the observers if they would step outside, please.
33
34 [*Pause for observers to leave*]

THE MORECAMBE BAY INVESTIGATION

Monday, 28 July 2014

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

Before:

Dr Bill Kirkup CBE – Chairman of the Investigation
Professor Jonathan Montgomery -- Expert advisor on Ethics
Professor Stewart Forsyth -- Expert advisor on Paediatrics

DAVID NICHOLSON

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

1 DR KIRKUP: Good afternoon. I will say
2 for the record I am Bill Kirkup I am
3 Chairing the Panel.
4 PROF FORSYTH: I am Stewart Forsyth.
5 I am a paediatrician and Medical Director
6 from Tayside and I Chair the Scottish
7 Government Committee on neo-natal services
8 in Scotland.
9 PROF MONTGOMERY: Jonathan Montgomery
10 here as Professor of Health at UCL and,
11 well, previously, PCT and SHA Chair. For
12 the record, previously Chair of the
13 Advisory Committee for the Nexus (?)
14 Awards, of which you were an ex officio
15 member, although the convention was they
16 did not actually attend.
17 SIR DAVID NICHOLSON: I am David Nicholson
18 retired.
19 DR KIRKUP: Thank you. You will notice
20 that we are recording proceedings and we
21 will produce an agreed record at the end.
22 We also have opened the proceedings to
23 family members, but as happens we do not
24 have any in attention today but they may
25 listen to the recording subsequently.

1 You will also know that we have
2 asked you to hand in any mobile
3 telephones, tablets, recording devices
4 just to reinforce the fact we don't intend
5 anything to go outside the room to they
6 produce a report with everything in
7 context.
8 Do you have any questions for
9 me?
10 SIR DAVID NICHOLSON: No, that is fine.
11 DR KIRKUP: I will start you off just
12 by asking, please, if you would --
13 obviously we are interviewing you as the
14 former CEO of the NHS. Can you confirm
15 the date of that for me, please?
16 SIR DAVID NICHOLSON: Yes, I was appointed
17 at the Chief Executive of the NHS in
18 August/September 2006 and I became the
19 chair executive of NHS England in
20 April 2013 and there was a period in the
21 middle where I was both.
22 DR KIRKUP: Okay and you retired ...
23 SIR DAVID NICHOLSON: March of this year.
24 DR KIRKUP: Thank you. That is very
25 helpful. I will pass you over to Jonathan

1 to start the questioning.
2 PROF MONTGOMERY: Thank you, Bill;
3 can we start by asking you just to give a
4 us a quick take on who is responsible for
5 quality within the system and the NHS
6 system as opposed to the post-2012 system,
7 so try to get a hand of what is the
8 relative responsibility of the Trust board
9 SHA commissioners and then we will get to
10 where the DH and NHS bits fit in.
11 SIR DAVID NICHOLSON: Well, of course,
12 over this period, between, you know, 2008
13 and now, 2015, there has been a whole
14 series of changes going on so some of this
15 has been shifting as we have been through
16 the process, but essentially, as Francis
17 pointed out in his original report on
18 Mid-Staffordshire, the responsibility for
19 the quality of the services in any
20 individual organisation is the
21 responsibility of the board of that
22 organisation, and that is fundamentally
23 the way in which this system is set up for
24 that board responsibility to be able to
25 deliver. The whole system stands or fails

1 on the back of that responsibility. So
2 the board and individual organisations.
3 Different boards will have
4 different ways of operationalising that in
5 their particular organisations. I have
6 you know, ran hospitals, I guess, others
7 have here. It can be run through the
8 Medical Director, through a clinical
9 governance quality Committee, there is a
10 whole range of ways in which people have
11 governance of the individual organisation
12 through all of that. And so that is the
13 fundamental building block of it.
14 The responsibility of ensuring
15 that, depending on how you describe it,
16 the minimum or essential standards of an
17 individual organisation, is that the
18 responsibility of monitoring that the
19 responsibility of the regulator, the
20 quality regulator, Healthcare Commission
21 then Care Quality Commission responsible
22 for that.
23 The commissioners are
24 responsible for both monitoring the
25 overall quality of the service for the

1 population, but also responsible for being
2 an agent to drive up that quality through
3 the commissioning process.
4 SHAs, depending on what kind of
5 organisations is in the system, so it
6 would be different, I guess, for a
7 Foundation Trust than it would be for an
8 non-foundation trust.
9 For a Foundation Trust that main
10 responsibility of the SHAs are delivered
11 through the commissioning process, so they
12 are on the back of that. In terms of
13 non-foundation trusts the SHA has a
14 responsibility for monitoring the quality
15 of the overall service, holding the ring
16 when things go wrong and ensuring that
17 action is taken to put things right. Then
18 the Department of Health is responsible
19 for making sure the whole system works.
20 PROF MONTGOMERY: Thank you very
21 much. Where does the what does the
22 department take to the politicians so,
23 what would flag something that was a
24 sufficiently serious quality concern that
25 you need to brief ministers or --

1 SIR DAVID NICHOLSON: Of course,
2 Ministers -- it would be wrong to see the
3 NHS Chief Executive as the kind of apex
4 and pinnacle of the whole set of reporting
5 systems; it does not actually work like
6 that.
7 Ministers, certainly up until
8 the most recent years, would have regional
9 ministers; so would have a minister with
10 the a regional responsibility who would
11 take a particular interest in that, they
12 would be briefed on quality problems, both
13 in terms of those that were of
14 significance in terms of the harm to
15 patients, and would also be briefed on the
16 quality problems that may have a media
17 interest or whatever and those briefings
18 would come up through the SHA system. The
19 SHA will have a briefing unit that will
20 have the department and the department
21 then will put forward things to ministers.
22 Some ministers will be more
23 active. They would meet with people from
24 the regions regularly to talk to them
25 about it; others would not.

1 PROF MONTGOMERY: Would those things
2 both flow through your office, if they
3 were of ministerial significance or would
4 they bypass you and ...
5 SIR DAVID NICHOLSON: I think if it was
6 serious harm to patients then they would
7 have gone through my office, although, my
8 guess would be that they much more likely
9 to be ones that have a systemic issue
10 attached to them rather than individual
11 reasons.
12 PROF MONTGOMERY: So a minister might
13 see something that you had, your office
14 had not necessarily seen?
15 SIR NICHOLSON: That is possible, it
16 is possible. Although I tried very hard
17 for it not to happen but it is still did
18 happen.
19 PROF MONTGOMERY: Thank you. We have
20 heard from one of the other interviewees
21 about National Quality Board, which I
22 think, you chaired. Was that right?
23 SIR DAVID NICHOLSON: One of the — without
24 kind of going, you know, boring everyone
25 with history of all of this, if you think

1 about the way that NHS operates. I was --
2 when Alan Langland was the Chief Executive
3 of the NHS which was my first recollection
4 or when I was first in involved at a
5 national level in all of that, there was
6 not a regulatory system. There was just
7 the NHS management system.
8 Of course, we know that the job
9 of Permanent Secretary and Chief Executive
10 were amalgamated with Nigel Crisp and a
11 more plural regulatory system was borne
12 out of that.
13 The job then was split again,
14 before I was appointed, and the
15 responsibility for regulations were the
16 responsibility of the Permanent Secretary
17 and the responsibility for the NHS
18 Management System were mine. So that is
19 the way, in a sense, that the system
20 operated.
21 What you had as far as running a
22 hospital was concerned, as I -- when I
23 look back on it, it did not seem that
24 simple but it was a hell of a lot more
25 simple than it was becoming. There were

1 now whole set of players on the quality
2 pitch. When we did the next stage review
3 — Ara Darzi lead the next stage review —
4 we were trying to work out how could we
5 make sure that, the way he described it
6 was 'making quality the organising
7 principle'.
8 When I pitched for the job in
9 2005/2006 part of my pitch was — and this
10 was a controversial at the time, and has
11 been, I think, since then — that between
12 2004 and 2006 the leadership of the NHS
13 sort of lost the reason it was there.
14 I was quite critical about it —
15 I was part of it, I am not saying I was
16 not — because what happen during that
17 period is that people got so excited, in
18 my view, about the changes, the reforms,
19 the Foundation Trusts, the payment by
20 results, all of those things that made the
21 Commissioning of Patients in the NHS, all
22 of the things that we lost sight of what
23 we were there for.
24 It was really important to me,
25 when I pitched for the job, to make the

1 argument for quality, Ara Darzi* came along

2 and described quality as the organising

3 principle. [* Ara Darzi identified 7 steps
1 – Standard setting
2- Measurement
3 – Publishing/transparency
4 – Raising standards/ Quality improvement
5 – Safeguarding – regulation
6 – Recognition and reward
7 – Stay ahead – research and development]
How do you make quality the

4 organising principle? There are various

5 things you need to do. One of the things

6 that we did — which I think is very

7 powerful, although, I guess, it is one of

8 those issues that, if you are not careful,

9 gets lost in all of this — is we defined

10 what quality was. As you know, everyone

11 is in favour of quality but everyone think

12 it looks slightly different.

13 So the idea that quality would

14 be effectiveness, safety and experience;

15 you could not have one them, you could not

16 have two of them, you had to have all

17 three in order to say that the service --

18 quality was an important part of it.

19 The idea of how you improve

20 quality through transparency, and

21 benchmarking and clinical teams, all of

22 that — putting emphasis on that — to do

23 all of that you need to organise the

24 national bodies. If they were all

1 significantly different ways, what chance
2 do you stand, at a hospital level, making
3 the difference for patients?
4 Therefore, the National Quality
5 Board was part of the response for that.
6 We did think about structural changes, you
7 know, should we change – and all of that
8 and, although I would say it is not been
9 one of my great successes as a Chief
10 Executive, I am a big sceptic about
11 organisation change solving problems. I
12 have not stopped very much of it but you
13 should have seen the stuff I did stop. I
14 mean, there would have been a lot more.
15 But any way, so we thought we
16 should have a forum which will have
17 quality as the organising principle, which
18 would seek to align all of the various
19 organisations in the NHS together, and so
20 that is what we did.
21 I chaired it. It was the first
22 time that we brought Monitor and CQC in
23 the same room, we had all the big national
24 bodies. We had a group of patients
25 representatives, patient experts, and we

1 had a group of people who had a particular
2 interest in quality. So we had a mixture
3 of the professional leaders of the system
4 and also some challenge, not quite
5 non-executive because they were members,
6 but challenge to the system. We set up
7 the National Quality Board. Its prime
8 responsibility was to align the various
9 things that we were all doing, to make
10 sense for the people who ran services.
11 PROF MONTGOMERY: There is an aspect
12 of that that will be helpful to hear more
13 about. You touched on it when you talked
14 about the Healthcare Commission and CQC
15 about providing assurance on minimum
16 standards.
17 I think one of the things we
18 want to try to understand is how around
19 that table, and how, if you were sitting
20 at trust board, reflecting on the
21 statements made by the regulators and,
22 indeed, if you were the families wondering
23 about whether to use the hospital, you
24 have these various ratings systems and
25 things that the Healthcare Commission and

1 CQC used, what do they really represent,
2 those assurance systems? Should we read
3 into them the fact you talk about minimal
4 standards, that they do not tell us very
5 much?
6 SIR DAVID NICHOLSON: Well, they tell you
7 what the — to make sense of the them you
8 need to understand what is in them. And,
9 I guess, part of the issues for
10 particularly patients, relatives and the
11 public is it can be fairly Byzantine, the
12 way they are constructed.
13 They are all very elegant and
14 they all fit together quite nicely, but
15 actually, they are quite difficult to
16 work out and that is why, in a sense, the
17 NHS focus so heavily on a star system,
18 they could get that, they can understand
19 that.
20 I guess that is one of the
21 reasons why the system that is currently
22 being implemented, it is clearer to people
23 in the system and outside how to make that
24 happen. But, you know, a chief executive
25 that I know who wanted to be a three star

1 Trust had 136 people in his organisation
2 that had the responsibility for tracking
3 one of the numbers in the rating system
4 and low and behold they became a thee star
5 organisation.
6 PROF MONTGOMERY: What did that tell
7 you about the organisation?
8 SIR DAVID NICHOLSON: That it was very
9 effective at doing what the Chief
10 Executive wanted it to do. I mean, which
11 is not a bad — you know, there are many
12 organisations with Chief Executives that
13 have fairly peripheral figures, I have to
14 say.
15 PROF MONTGOMERY: I understand that.
16 SIR NICHOLSON: But it did show that
17 their governance, they could do what they
18 said they wanted to do. But it does not,
19 in my view, give you an idea that was a
20 top quality organisation, although it
21 gives you an indication they could manage
22 their affairs.
23 PROF MONTGOMERY: One of the things
24 that we have heard and read is about
25 interpretations of what was meant when the

1 CQC gave a recognition of compliance, for
2 example, with standards.
3 SIR DAVID NICHOLSON: Yes.
4 PROF MONTGOMERY: Some questions we
5 are trying to get a handle on, would you
6 have expected the board to say, "this is a
7 signal that we are doing the right thing",
8 or is that a bit too strong, or is it "we
9 are not doing the wrong things", because
10 we are hearing comments about how those
11 sort of signals were being interpreted in
12 the system.
13 We need to understand, from the
14 top the NHS Chief Executive, would your
15 expectation be that the board would take
16 assurance from the fact they were
17 compliant with the CQC or should -- should
18 they have other clinical governance
19 systems in place?
20 SIR DAVID NICHOLSON: I mean, they are
21 minimal or essential standards. I mean,
22 no board — you would not want to say that
23 they were — it is worse than saying
24 "you're average", actually. It is not, I
25 think, what we would expect boards to do.

1 Why have a board in place unless

2 they are responsible? You know, they want

3 to take standards up. That would not be

4 the consequences of that. [To reinforce this point the board is the key body here. The system is built on boards that perform.]

5 What it does do to them though,

6 it does give them the freedom to get on

7 and do things. Part of the issue, I

8 guess, when you are in the in whatever

9 corner you want to describe it as, with a

10 poor rating or poor compliance, whatever,

11 you lose some autonomy over yourselves

12 because you have to respond continuously

13 to other people. I think which no board

14 worth its salt would want to do. It does

15 give you that but only that.

16 PROF MONTGOMERY: So if we take the

17 position that Morecambe Bay found itself

18 in where it had acceptable CNST

19 compliance, it had signed its self

20 declaration with CQC and that had been

21 approved by the CQC as compliant, you

22 would expect that just to be the starting

23 point you would expect to see.

24 SIR DAVID NICHOLSON: What the point of

25 the board be if, in those circumstances —

1 it has to be to take that forward. It
2 cannot be just getting minimum.
3 I would balk -- and I have I
4 have balked at boards who have told me,
5 "we are no worse than anybody else". I
6 said, "that seems to be a shocking thing
7 for people to say. There is no point in
8 having you, if you are not aspiring to be
9 the really good".
10 PROF MONTGOMERY: If that question
11 was in someone's mind about had the board
12 gone beyond that, or were they satisfied
13 with that, whose job in that system would
14 it be to test out whether the board was
15 really up to its job.
16 I am thinking particularly as we
17 move towards the FT authorisation process
18 in 2010 -- hopefully later on you can take
19 us through the various hurdles the Trust
20 have to do that, but I am thinking in my
21 mind, what if all the board was doing was
22 checking that they were complying with CQC
23 standards, that they are CNST? That
24 clearly would not be enough to reassure
25 you that they have their focus on quality.

1 SIR DAVID NICHOLSON: No, this is the
2 infamous comment that the Secretary of
3 State made about organisation "coasting",
4 I think. But, I think, in those
5 circumstances, of course, if you are an
6 FT, you have local accountability, you are
7 responsible to your local population.
8 You can expect the NHS as a
9 system to publish data and information
10 about your comparative position and the
11 rest of it but part of it is that the
12 local arrangements will drive that.
13 Commissioners, of course, should
14 be responsible for ensuring that we do not
15 just get next year what we got last year
16 but actually we should have continuous
17 improvement.
18 If you look at almost all of the
19 documents we have put out, if not all
20 because I have not been through them all
21 in detail. If you look at operating
22 frameworks we put out year on year, you
23 will see in those the issues of continuous
24 improvement. We expect people to be in
25 that position every year.

1 PROF MONTGOMERY: It will be the
2 board's responsibility to do it, the
3 governors, the local people, the FT would
4 express anxiety the commissioners should
5 be on the case. Pre-the FT —
6 SIR DAVID NICHOLSON: Yes, you would
7 expect — well, you would expect the SHA to
8 be in that particular position as part of
9 the way they would run things.
10 PROF MONTGOMERY: How would the SHA
11 get into the capability of the board
12 issue?
13 SIR DAVID NICHOLSON: I mean, this was a —
14 I mean one of the things that — when the
15 SHAs were set up — actually they were set
16 up originally in 2002, were they not?
17 When they went to 10, essentially, the
18 Chief Executives were appointed — I know I
19 was appointed in London at the time — you
20 were given a total amount of resources,
21 and a broad statement about what you were
22 expected to do and then it was a matter
23 for you about how you did it. You can see
24 around the country how different SHAs
25 started developing different kinds of ways

1 and, I guess, we will get to the North
2 West region, yes.
3 The question is what did degree
4 of differentiation was acceptable?
5 Because it is different. I mean, there is
6 no doubt in my mind it is different if you
7 are the SHA Chief Executive in London,
8 when you think about the complexity of the
9 organisation and the way they function, it
10 is different to somewhere like the
11 North-East.
12 It is a different culture,
13 different way of working, different
14 historic relationships, different
15 partnerships, local government is
16 different in the parts of the ...
17 We believed that there was too
18 much differentiation that, actually, we
19 needed much more common approach. So we
20 launched the, what we described as the
21 Strategic Health Authority Assurance
22 Framework, and we started off, we started
23 that, of course, as is very often in the
24 circumstances, we did one round, we did
25 some two rounds, and then they all got

1 abolished, so we did not see it through.

2 But that bought home this very issue.

3 So you have two types of SHA

4 really, you have the SHAs who essentially

5 ran their systems through the

6 commissioner; so in a sense they worked

7 with the providers through what the

8 commission is doing rather than directly

9 dealing with the providers themselves.

10 In a sense, if I say the most

11 extreme example of that on one hand would

12 have been somewhere like the east of

13 England who completely drove it through

14 the Commissioner's side, who did not

15 really have much engagement with providers

16 at all.

17 So you have that on the one had

18 not and you have probably have the

19 North-east on the other, where it works as

20 a slightly different -- I mean, there was

21 a more direct relationship between the SHA

22 and the providers.

23 PROF MONTGOMERY: We will not ask you

24 to incriminate anybody in the North-east.

25 SIR DAVID NICHOLSON: But

1 ....[simultaneous conversation]......

2 I think, at that point -- so we did not

3 think that was right, we did not think

4 that was the right way to do things, so we

5 implemented the strategic health assurance

6 process in order to bring some consistency

7 to all of that.

8 PROF MONTGOMERY: So what did that

9 tell you about the North West?

10 SIR DAVID NICHOLSON: The North West --

11 you will have seen this stuff, from the

12 North West -- the principle ideal was,

13 behind this, was that the best predictor

14 of performance was the health of the

15 organisation. In the sense we are talking

16 about the health of the health systems

17 that were operating. You can measure that

18 health. We did quite a lot of work, in

19 fact, the North East did quite a lot of

20 work before we even thought of this on all

21 of this.

22 We had a process, which involved

23 endless data coming in from the SHA to us,

24 a whole lot of visits, some we would go to

25 board meetings of SHAs, we would do all

1 that and we will do surveys of providers.
2 Then we would spent two days,
3 the whole of my team would spend two days
4 at in the health care system where we will
5 interview providers and commissioners and,
6 in a sense, we would start to create what
7 we describe as key line of enquiry that
8 when we would identify what we thought of
9 the organisation, we test that and then it
10 would culminate in a board to board
11 meeting between my board and the SHA, and
12 then we would write a letter and there
13 were an action plan and we would take that
14 forward.
15 This was all happening during
16 the period of all of this was happening.
17 So the north-west.
18 Well, I guess it was in the
19 letter. I have to say I have not been
20 able to find the action plan but I have
21 seen the letter.
22 Part of the issue, I think,
23 because of the way that the SHAs were
24 established, and the power that that gave
25 the individual SHA Chief Executives, some

1 SHAs Chief Executive find it very
2 difficult to separate out our assessment
3 of the SHA, with the assessment of those
4 individuals and it got quite complicated
5 in certain circumstances but nevertheless
6 it was an important thing to do.
7 So the North West. Well, I
8 think the way I would describe the North
9 West, it was on our in terms of the
10 spectrum of the strategic health
11 authorities. It was more strategic than
12 most. It was innovative. It had a whole
13 set of things, it was done particularly
14 around quality, and AQA, the improving
15 quality stuff, all of the things they did
16 which really did -- you know, they were
17 really leaders nationally in terms of
18 understanding and getting all of the stuff
19 together. Mike was a particular advocate
20 for improving quality.
21 They did try very hard to
22 operate, in the North West, as
23 collectively as they could in those
24 circumstances.
25 They were in the middle, I

1 think. Sometimes they operated through
2 commissioning, sometimes they operated
3 directly with providers. So there was a
4 slight variation there.
5 The comments we made about them
6 were two-fold overall. That was the
7 positive -- it was very positive, they
8 were. Even now, today, some of the stuff
9 they have done is still being driven very
10 impressively there.
11 One of them was dealing with big
12 problems, outliers, that we thought they
13 had some problems in all of that because
14 many of the things, when you were dealing
15 with an organisation, which is in serious,
16 serious trouble it is not like dealing
17 with organisations that have got some
18 problems. It is very different. We
19 raised that as one issue, we were
20 concerned about their ability to do that.
21 PROF MONTGOMERY: Were there
22 particular examples of organisations with
23 big problems —
24 SIR DAVID NICHOLSON: Well, for example,
25 they did quite some good work with

1 Trafford but, actually, they did it after
2 they were, you know, we had to push them
3 into doing it. Because the second
4 criticism was that they did not, they
5 sometimes struggled with really tough
6 decisions.
7 When it became really difficult
8 decisions, they did not want to stand by
9 them because they put a lot of store by
10 developing the relationships with
11 individual organisations and some of the
12 relationships were very productive.
13 They were the areas, I think, we
14 were concerned about. They put in place
15 new people to help them do it, but it was
16 not, I have to say, we did not use
17 Morecambe Bay as an example, or I cannot
18 find any evidence. I think I would have
19 remember it if we had we did not use
20 Morecambe Bay particularly as that.
21 To be honest, a lot of this
22 would have come from the providers
23 themselves because they would be saying,
24 "you know, so and so is getting away with
25 work, you know, rather unfortunate. But

1 bad things over here; they are not being

2 helped held to account et cetera". That

3 would be there. That would be, I think

4 ...

5 PROF MONTGOMERY: Can I ask you a bit

6 more about the "more strategic than most"

7 comment because, I think, one of the

8 things we have heard is the focus on the

9 quality framework and the gathering of

10 data. Clearly identifies issues around

11 Manchester as areas where there will be

12 health leads.

13 It is a massive region. It

14 makes a lot of sense for attention to be

15 focused on reconfigurations on sustainable

16 services there.

17 Did you have a sense that there

18 might not have been enough capacity in the

19 North West to pick up what could be seen

20 as strategic sustainability questions for,

21 particularly Furness where there is a

22 longstanding issue, we have heard from a

23 number of places around whether or not

24 there is enough money for the rural areas.

25 I know that everyone says there

1 is not enough money for their particular
2 configuration so I do not want to get
3 sucked into that one. I am trying to get
4 a sense of the consequences of being
5 strategic.
6 SIR NICHOLSON: Okay. Well, I
7 think, it is worth saying that — and I
8 will have, I mean, I think this is true, I
9 think this is true — that we did allocate
10 more money to the North West region and
11 London for their running costs because we
12 knew they had such a scale of a problem.
13 I certainly know we did for
14 London because I was in London at the
15 time, so I know we got it. I am pretty
16 sure that North West got some more as well
17 to do that. But isn't this is a broader
18 question?
19 I do not know whether it is a
20 question about NHS managers or people who
21 work in the NHS or whatever but most
22 people make their names and their careers
23 in the big cities. They don't make their
24 names and their careers running semi-rural
25 or rural systems. They don't have the

1 same cachet, they don't have all of those
2 sort of things.
3 I do not know if that makes any
4 sense but it just says to me, hence some
5 of the problems that people sometimes have
6 with them.
7 If you think about some of the
8 big cities, you know, you will see leading
9 NHS managers going through the big cities
10 on their journeys and other things or
11 whatever, and you will not necessarily see
12 people going through that. It is not, it
13 would be not be regarded as being a great
14 place to develop your career. I guess to
15 an extent that might be true in medicine,
16 some medicines as well --
17 DR KIRKUP: Exactly. I am absolutely
18 sure it is true in medicine too and I am
19 wondering, listening to that, which I
20 think is all absolutely right, whether
21 there is not another kind of inverse
22 care -- actually the places that most need
23 the best management are at least likely to
24 get it.
25 SIR DAVID NICHOLSON: Yes. Well, I mean,

1 without going over again the issues of
2 Mid-Staffordshire that is -- I mean, in a
3 sense, the Mid-Staffordshire hospital was
4 the kind of hospital -- and I guess
5 Morecambe Bay would not be -- where people
6 were appointed who might not have been at
7 the top of their profession, they are kind
8 of -- and particularly first appointments,
9 or first major appointments. You get a
10 lot of that in --
11 DR KIRKUP: More so in Furness than in
12 Lancaster.
13 SIR DAVID NICHOLSON: Yes.
14 PROF MONTGOMERY: I think there is a
15 whole thing around professional training
16 that also picks that up.
17 Can I take you then to the FT
18 pipeline process because, in a sense, that
19 was where you and your system would have
20 that the chance to ask that system as you
21 had to assess whether or not the Trust was
22 going to make it through.
23 I want, if can ask you to step
24 back to start with because we have heard
25 different things about this. We are

1 talking about the 2009/10 period, so
2 authorisation in October 2010; and a whole
3 team in April 2010 presumably working its
4 way through from early 2009.
5 How important was FT status to
6 the careers of the leaders in the Trust
7 and how important was it for the SHAs to
8 get people through that process and out
9 the other end?
10 SIR DAVID NICHOLSON: I mean, I have
11 responded to some of this before. There
12 is no doubt when I first started in this
13 job that the Prime Minister at the time
14 saw Foundation Trusts status or numbers of
15 Foundation Trusts as a measure of how
16 committed to reform the Department of
17 Health was.
18 If you think about it, the
19 Foundation Trusts process was taking
20 foundation Trusts out of the control of
21 the department so it was not a natural
22 thing for the Department of Health to want
23 to do to take to give all this
24 responsibility away. Particularly given
25 the same Government wanted all the

1 deliveries that they wanted.

2 When I got there that was seen

3 as a big -- I have to say that I was there

4 for the last year of Blair and then Brown

5 and it changed. I mean, it was not the

6 same for us. So I never agreed with any

7 of the SHAs Chief Executives (a) you have

8 got to do four by this date or five by

9 this date or whatever.

10 I genuinely -- I was never part

11 of it. I never got into the place with

12 SHA Chief Executives where I was saying,

13 'you are not doing enough'. I cannot

14 remember a time when I did that. Now that

15 is when you will find something but I

16 genuinely, I literally cannot. It was not

17 the way that I would have operated.

18 Having said that, there was

19 some -- even in the old way, in which the

20 Foundation Trusts process was being

21 delivered, it could be a very productive

22 way.

23 If you took a Foundation Trust

24 you had to be able to demonstrate that you

25 were both financially and clinically

1 sustainable. Which I not a bad thing for
2 a board to have to do. I think, overall
3 it was a positive thing.
4 What I would say to is that
5 amongst people who ran hospitals it really
6 was a badge of honour. I mean, at
7 Mid-Staffordshire, Martin Yates who much
8 maligned, quite rightly in some ways but
9 not in others, desperately wanted to be a
10 Foundation. He felt that was a
11 affirmation of him as a person, as him as
12 a leader. It showed he had arrived on the
13 management system.
14 I do not think we -- it
15 certainly was not played like that from
16 the blow I was looking at but certainly
17 for Chief Executives it was really, really
18 important, amongst their peer group and
19 all of us rest of it, to show they could
20 make their organisation clinically and
21 financially sustainable, to the extent
22 that they got very, very excited about it.
23 I mean, I do not mean that in they jumped
24 about cheering, I mean really quite
25 focused on this.

1 PROF MONTGOMERY: It would not be
2 surprising if the picture emerged that the
3 clinical staff and the front line staff
4 could get too overexcited about FT status.
5 The SHA was particularly pushing it but it
6 still was an organisational board level
7 objective with a lot of effort. That
8 would be a reasonable comment?
9 SIR DAVID NICHOLSON: Yes, it is. I mean,
10 I do not -- it is such, I mean, if I go
11 back myself to when I was -- I mean, one
12 of the defining moments for me as Chief
13 Executive was when Thatcher put together
14 the reforms for the NHS, working for
15 patients. We had to decide whether we
16 wanted to be a self-governing Trust and
17 part of that is we had to demonstrate a
18 clinical engagement, clinical buy in.
19 I was, at the time, running a
20 hospital in south Yorkshire which was not,
21 you might say, a place where Thatcherism
22 had really taken hold but I was determined
23 that we would become a Foundation Trust
24 for whole variety of reasons.
25 At the time -- you probably

1 remember this -- the staff side and the
2 doctors decided they were going to have a
3 vote on whether they wanted it or not. I
4 was horrified by this because I was the
5 Chief -- well, the General Manager of the
6 organisation.
7 I said all sorts of things
8 about, "Yes very interesting. We will
9 take note of it", all the rest of it but
10 heaven above did we work hard and we won
11 the vote. And that was quite a big --
12 completely changed my relationship with
13 the clinical staff anticipated all of the
14 rest of it, completely changed it.
15 So that process, in my view,
16 completely transformed the hospital and
17 the relationship between managers and
18 clinicians, and all of the rest of it.
19 If you could get by as a
20 Foundation Trust without having to be
21 tested in that way, I could perfectly see
22 how you could describe the way that you
23 did it.
24 Then the other side of it is
25 that some people wanted to be Foundation

1 Trusts and the whole organisations was
2 galvanised to do it and they tended to be
3 the earlier ones. As you got further down
4 it became less like that. Something you
5 had to do as opposed to something that you
6 wanted to do.
7 PROF MONTGOMERY: So can I move then
8 to the FT process and I am particularly
9 interested, obviously, in how it worked
10 for Morecambe Bay. So ideally that
11 process is going to distinguish between
12 the organisation that are galvanised in
13 the way that you describe and the ones
14 that are going through the motions.
15 So just take us through various
16 hoops an NHS Trust has to get through
17 before it gets to the Monitor side because
18 we will be able to ask them directly.
19 SIR NICHOLSON: Okay. Is this pre-
20 PROF MONTGOMERY: This is -- well --
21 SIR DAVID NICHOLSON: Morecambe Bay was
22 right in the middle of all of that really.
23 PROF MONTGOMERY: So, I guess -- I
24 think, Morecambe Bay probably starts off
25 early -- it got to Monitor, it got paused

1 in April 2010 and finally critical in
2 October 2010. I think, from things we
3 have seen, it is in the system from early
4 2009 as an aspirant so I guess we need to
5 know after that period.
6 SIR DAVID NICHOLSON: Yes, right. Well,
7 going right back to 2006/7, there was a
8 big piece of work done across the whole
9 country, setting out whether individual
10 organisations were ready to become
11 Foundation Trusts and what their pathway
12 to Foundation Trust would be.
13 So it would typically say, "this
14 organisation is not ready to become a
15 Foundation Trust yet because it needs to
16 do this, this and this", and the judgment
17 of the SHA was that would take two years,
18 three years, whatever, to do.
19 So the vast majority of Trusts
20 would have that kind of trajectory with
21 them and then they would be working
22 through that with their organisations to
23 make that happen.
24 It was predominantly something
25 driven by the organisations themselves.

1 So they knew what they had to do and they
2 were working through those processes.
3 The SHAs were responsible for
4 helping and supporting them do it. Some
5 did more than others but, nevertheless,
6 they were all responsible to help them
7 make it happen.
8 There would be a variety of
9 mechanisms so you would have board to
10 board with the SHA so that by the time
11 they got to coming to the department and
12 the department saying, "Yes, there were
13 the consideration by Monitor", they had
14 been through quite a process with the
15 SHAs.
16 So they come to the department.
17 There was a Committee which I cannot
18 remember the name of now. It was called
19 the something-Committee.
20 PROF MONTGOMERY: We will probably
21 find it.
22 SIR DAVID NICHOLSON: Anyway, a Committee
23 which was chaired by David Flory (?) --
24 actually, chaired by Andrew Cash, then
25 chaired by David Flory (?) and they would

1 consider each of the recommendations from
2 the SHAs and they would make an assessment
3 based on the work that they had already
4 been done.
5 There was very little that the
6 department then did, going back checking
7 all of that things or whatever. There was
8 not a big kind of further set of work done
9 after that and making a recommendation to
10 the minister. So that is how it worked.
11 PROF MONTGOMERY: So the department's
12 sort of working assumption was they could
13 take assurance than the SHAs had checked
14 whether what was in the documentation rang
15 true.
16 SIR DAVID NICHOLSON: Yes.
17 DR KIRKUP: So with Morecambe Bay we
18 have got approval in October 2010, we have
19 got the Fielding Report -- I want to come
20 back to that later on because a whole set
21 of questions about who should have known T
22 about it and when. But, for these
23 purposes, that seems to indicate that
24 there was not much clinical governance
25 structure and that certainly is still in

1 place when the CQC started looking at it,

2 later in the 2010.

3 SIR DAVID NICHOLSON: Yes.

4 PROF MONTGOMERY: I think you asked

5 yourself -- because we have seen the

6 documents -- 'how did it get through the

7 process given the things?'

8 SIR DAVID NICHOLSON: Yes.

9 PROF MONTGOMERY: So with the benefit

10 of what you know now about that process,

11 could it have been picked up that there

12 were not strong clinical governance

13 processes in that preparation process to

14 the FT? Should it have been picked up?

15 SIR DAVID NICHOLSON: I genuinely don't

16 know how you could have got under some of

17 this stuff because in a sense you are

18 going to be teasing out what the stuff was

19 that was underneath it --

20 PROF MONTGOMERY: And we are being

21 really careful about the problem of

22 hindsight.

23 SIR DAVID NICHOLSON: Yes. I don't, you

24 know, I -- so, for example, if you were to

25 say, "could that have teased out that

1 there were poor team work between", you
2 know, I think they probably would not have
3 been able to do. I do not think it would
4 have been. I cannot see how it would
5 have.
6 PROF MONTGOMERY: Let me put a few
7 things that you may have noticed. So the
8 Fielding Report does indicate poor team
9 work in the maternity departments and, if
10 that had been on the table of Mike Farrow
11 of the SHA as part of the process, would
12 that have been a red flag or would you
13 say, "that happens in lots of places. As
14 long as there is an action plan addressing
15 it, it would not stop us progressing".
16 I cannot get a sense of -- and I
17 want to come back to it later on, but
18 there are lots and lots of these reports
19 around the Trust and some people are
20 saying, 'well, if only we had known about
21 that it would have made all the
22 difference.' But it does not seem
23 necessarily the case that they had those
24 sort of status review. So I am trying to
25 understanding what counts as a flag.

1 SIR DAVID NICHOLSON: Yes. I think it is
2 really hard. I would like to say that, of
3 course, it would have done but I genuinely
4 cannot say that it would have done.
5 PROF MONTGOMERY: If we had found
6 that the board says, "we must be doing
7 fine because the CQC has signed off and
8 there is no more than that", would that be
9 a reason to think the board was not really
10 doing its job?
11 SIR DAVID NICHOLSON: Sorry?
12 PROF MONTGOMERY: We spoke earlier on
13 about what you could read and could not
14 read into the CQC statements and one of
15 the things that you said was that is the
16 minimum and you would expect a whole load
17 of others on top of that.
18 If a board says in the board to
19 board with the SHA, 'we were doing all
20 right because CQC has given us assurance
21 that we are me think the standards', or
22 the Chief Executive said that to the chair
23 --
24 SIR DAVID NICHOLSON: If -- okay, I do not
25 know whether that they actually said that

1 or not but that that would strike me as
2 being very odd. That -- as a
3 justification for giving people the
4 licence to run their own affairs, saying
5 that would not seem to me a very
6 appropriate --
7 PROF MONTGOMERY: Okay. Thank you.
8 Can I ask a bit about what did and did not
9 work its way through the system about
10 Morecambe Bay because we know, and we will
11 see later, as the pressure emerges you
12 yourself ask the question, 'how did it get
13 through?'
14 SIR DAVID NICHOLSON: Yes.
15 PROF MONTGOMERY: Can you tell us
16 when you had this on your radar as
17 something that did require your attention
18 and take us through that how --
19 SIR DAVID NICHOLSON: I have been unable
20 to work out when I first knew there was an
21 issue bigger than individual problems at
22 Morecambe Bay. The only bit of
23 documentation that I have seen, I guess,
24 is the stuff that you have seen and shown
25 me, that is when essentially the police

1 investigation was mooted and I went, 'hold
2 on a minute -- what is all this about?'
3 I cannot genuinely recall having
4 a conversation before that time. That is
5 not to say I have not, I genuinely cannot
6 recall.
7 PROF MONTGOMERY: So at that point,
8 when it becomes clear that you need to
9 know more than you would do in the routine
10 case --
11 SIR DAVID NICHOLSON: Yes.
12 PROF MONTGOMERY: Just take us
13 through how it progresses from there.
14 SIR DAVID NICHOLSON: Yes. Well, I mean,
15 always the issue for me in all of that is
16 'do we think it is okay now? What do we
17 know about what has happened here as we
18 get this information?'
19 Hence the work around that -- I
20 am going to get the chronology wrong now,
21 but -- I found out. So when was that
22 date? When was that -- when did we get
23 the police inquiry ...
24 I am trying to work at whether
25 it was the SHA or whether it would be the

1 cluster of the SHA and Iain Dalton and the

2 team that I would look to do it. I think

3 it would have been Iain Dalton and the

4 team, when we clustered the SHAs that is

5 all —[it would have helped me to have had access to a chronology I could have helped more if I had had one].

6 DR KIRKUP: September 2011, I think,

7 the police investigation was.

8 SIR DAVID NICHOLSON: Right. Yes.

9 DR KIRKUP: Is that post-cluster? I

10 can't remember now.

11 SIR DAVID NICHOLSON: I will have to look

12 at the chronology. I haven't got it here.

13 PROF MONTGOMERY: We can check that.

14 SIR DAVID NICHOLSON: Hence this -- I

15 mean, if you take the kind of Gold Command

16 stuff and all of that kind of intervention

17 that Jane Cummings and company led that

18 was all about making sure that it was

19 okay, you know, to mobilise the system, to

20 enable them to help their problem.

21 That was the first priority in

22 terms of having reconstructed the

23 organisations or do whatever is necessary,

24 that whole predominantly see Monitor as

25 being expensive.

1 PROF MONTGOMERY: Who drove the

2 decision to set up Gold Command? Do you

3 remember?

4 SIR DAVID NICHOLSON: Well, it would have

5 been – I can't remember whether it was

6 during Mike's time or whether it was Ian

7 Dalton. I am pretty sure it was Dalton's

8 time. It would have been the region who

9 would have driven that.

10 PROF MONTGOMERY: They would have had

11 to have called that because they were the

12 parties entitled to call that.

13 Did that feel like an unusual

14 step? The Gold-Command concept seems a

15 slightly odd one to deal with.

16 SIR DAVID NICHOLSON: It was relatively

17 unusual but in a sense, they, I think, it

18 was signalling to the whole system that

19 there was something serious that needed to

20 getting a grip of here. So I was not

21 happy that they did it but I thought it

22 was a reasonable thing to do. [Can I be clear here, I was not happy that they had to call it not that they did.]

23 PROF MONTGOMERY: Did it signal

24 failure and Trust management to you or did

25 it signal the SHA trying to get the Trust

1 back on its feet?

2 One of the questions is around

3 the competence of the Trust management

4 team through this and some of the

5 descriptions of Gold Command, the CQC has

6 used the phrase -- and in the document

7 that, I think, you have copied into --

8 'learnt helplessness from the staff in the

9 Trust'.

10 I am trying to get a feel for

11 whether this was thought to be a

12 struggling management team and what were

13 the problems, where the SHA sort of take

14 it over?

15 SIR DAVID NICHOLSON: It was a struggling

16 management team but dealing with very

17 difficult set of circumstances they find

18 themselves in.

19 PROF MONTGOMERY: Describe the way

20 they were difficult.

21 SIR DAVID NICHOLSON: Well, there was no

22 obvious end point to what was happening

23 that you had a whole series of operational

24 problems in the organisation, you had some

25 big strategic questions about what it was

1 there for, and why it existed even.
2 PROF MONTGOMERY: Are you talking
3 about the Trust or the SHA?
4 SIR DAVID NICHOLSON: The Trust, yes.
5 Okay, well, there was that going on as
6 well -- well, actually, they had already
7 decided by then they were going to get rid
8 of them.
9 PROF MONTGOMERY: So the Trust is
10 unclear about its mission?
11 SIR DAVID NICHOLSON: Yes. Yes, you know,
12 the question would be, in those
13 circumstances, whether just bringing in new
14 management team would be able to solve all
15 of that and, at the end of the day, that
16 would be a matter for Monitor to make a
17 judgment on.
18 PROF MONTGOMERY: Do you know whether
19 that question had been raised at any
20 earlier stage?
21 SIR DAVID NICHOLSON: I do not know, no.
22 PROF MONTGOMERY: Thank you. So you
23 have got Gold Command and one of the
24 questions we have been asking people
25 involved in that -- I will be interested

1 in your take on this in the general
2 oversight -- was what the end point of
3 Gold Command was.
4 We can understand how it is
5 generated to try to get the grip on
6 something that seems to have got out of
7 control. We are less clear what success
8 looks like in the Gold Command process. I
9 am guessing that is a question you may
10 well have asked somewhere or other.
11 SIR DAVID NICHOLSON: There was not an
12 answer to question.
13 PROF MONTGOMERY: What might have
14 been the answers that you would been --
15 what were they thinking about?
16 I know this is a little bit of
17 Balkans type question, 'what's the exit
18 strategy?'.
19 It does seem difficult to
20 understanding what it is thought that Gold
21 Command will achieve and, therefore, to
22 understand whether it was successful.
23 SIR DAVID NICHOLSON: Yes. At that stage,
24 I don't think that, if I am absolutely
25 clear, that people were really thinking

1 through what an exit strategy looked like.
2 Given that almost everybody in
3 involved in Gold Command at a regional
4 level were either applying for jobs, or
5 going somewhere else, or would not be able
6 to see it through or whatever structural
7 systems was there would not be there in
8 the future.
9 So, you know, I think that
10 people were trying to fix the problem in
11 the short-term. I don't then I they had
12 really worked through what the, as you
13 say, exit strategy was; we have not
14 either.
15 PROF MONTGOMERY: I wish I was
16 surprised by that answer. That is
17 understandable, in the context.
18 Except for the management of the
19 Trust, who presumably were in post at that
20 stage, Chief Executives seems to be
21 expected to hold on at that stage through
22 Gold Command, although he goes not that
23 long afterwards, not because of Gold
24 Command but because of the CQC.
25 SIR DAVID NICHOLSON: Yes.

1 PROF MONTGOMERY: Presumably, the
2 Trust management saw itself as part of the
3 future?
4 SIR DAVID NICHOLSON: I mean, this is
5 quite a long way away from where I was in
6 the sense of you have got Monitor between
7 me and them. So, making assessments and
8 judgments about management team of that
9 organisation, would not be something that
10 would we would be able to do or make a
11 judgment about.
12 PROF MONTGOMERY: Would you not have
13 wanted to be reassured that somebody was
14 making the judgment?
15 SIR DAVID NICHOLSON: Well, again, I think
16 they brought in David Henshaw --
17 PROF MONTGOMERY: Henshaw.
18 SIR DAVID NICHOLSON: -- Henshaw, who is
19 a competent manager leader and he would be
20 able to make -- he would have my
21 confidence to make a decent assessment
22 about what was required.
23 PROF MONTGOMERY: I think from what
24 said earlier it is Monitor's job first of
25 all, there is a strategy in terms of David

1 Henshaw going in, that gives you the
2 assurance that somebody is asking that
3 question that you would not ask in
4 general.
5 SIR DAVID NICHOLSON: Yes.
6 PROF MONTGOMERY: Okay. In terms of
7 the -- I want to go back to the FT because
8 there is questions we have got hanging
9 around to pick up. The CQC go in and they
10 do what's called a section 48
11 investigation; so this is the sort of
12 system review bit.
13 We would like to, I think, have
14 an understanding of how much that is a
15 collaborative discussion about the right
16 way to solve something and how much is the
17 CQC on part of the system and, obviously,
18 the responsibility of what to do sits with
19 them. Was that something your office was
20 played into in terms of what --
21 SIR DAVID NICHOLSON: Not in the detail,
22 we -- well, we had seen the SHA at the
23 being responsible to make sure that works.
24 We wouldn't --
25 PROF MONTGOMERY: Presumably that is

1 pretty high profile thing to happen.

2 SIR DAVID NICHOLSON: Yes.

3 PROF MONTGOMERY: So somebody needs

4 to brief the ministers of what is

5 happening. Would that go through your

6 office?

7 SIR DAVID NICHOLSON: Yes, it would. The

8 way it would work is that David Flory, my

9 deputy, who would deal with all that, he

10 would have done. I am sure that there

11 would be a submission somewhere that --

12 PROF MONTGOMERY: Sir Myles, (?) yes. [I am sorry I don't understand this reference]

13 SIR DAVID NICHOLSON: Yes.

14 PROF MONTGOMERY: Okay. Thank you.

15 Can I take us back to the bit of the

16 conversation about the FT application?

17 I am really interested to

18 understand what would now be called the

19 "duty of candour" issue post-Francis, but

20 I do not imagine that the idea that people

21 should be open and transparent in the FT

22 process is actually that new. I am sure

23 that was your expectation going through.

24 I want to tease at this question

25 around what weight we should be placing on

1 the disclosure and nondisclosure of the
2 Fielding Report.
3 I do not even know whether you
4 have seen the Fielding Report.
5 SIR DAVID NICHOLSON: Yes, I have seen it.
6 PROF MONTGOMERY: Okay. Therefore,
7 there were a number of other reports,
8 other than Fielding Report that had been
9 commissioned by the Trust and lead to
10 action plans and dealing with it.
11 So, I think that we would be
12 really interested in some help on how we
13 might distinguish between the reports that
14 should have been disclosed and
15 particularly would have been disclosed
16 under the new duty of candour system and
17 whether the feeling was so obviously a
18 report which should be disclosed as some
19 people are trying to suggest.
20 SIR DAVID NICHOLSON: But you see, I
21 think, I mean, we – I would argue we
22 strengthened the process after the first
23 Mid-Staffordshire Report. We got the
24 Medical Director involved [National Medical Director Sir Bruce Keogh], we did a whole
25 lot of stuff but, even then, I don't think

1 we ever said, 'you have to tell us
2 everything, open every file, show us
3 anything that you think might be material
4 about the way in which services are
5 delivered.'.
6 Even the improved about it has
7 not -- so, even up to today, that has that
8 is not the kind of -- there is not a
9 clause or, as far as I know, there is lot
10 a clause which says, 'open everything up
11 and in a sense it's your responsibility as
12 an organisation to proactively ensure that
13 everybody sees all of that.'
14 That is obviously, certainly
15 looking at it all, is a weakness in the
16 system that is probably there now.
17 PROF MONTGOMERY: Taking the Fielding
18 Report, would you have thought it was
19 obvious to people at the time they should
20 have disclosed that to the SHA initially
21 and Monitor as well?
22 SIR DAVID NICHOLSON: Well, given the
23 nature of the all of the stuff that was
24 going on with that organisation, you would
25 have thought that it would be sensible

1 because it is not -- it is hard to -- yes,

2 I would have thought they would give that

3 out and I am really surprised that they

4 did not or that somebody did not say.

5 PROF MONTGOMERY: Having read the

6 Fielding Report now, I do not know -- I am

7 guessing you did not write it at the time.

8 SIR DAVID NICHOLSON: No.

9 PROF MONTGOMERY: What do you think

10 it found? We are interested in this

11 because there are different versions

12 about -- there are different versions of

13 the report but, more importantly, there

14 are different takes on what we could learn

15 from it.

16 SIR DAVID NICHOLSON: It was odd -- the

17 way I read it, it was quite odd because it

18 seemed to me to point in two different

19 directions. [whilrst I was aware of the report and had read references to it in submissions I only read the whole report as part of preparing for this discussion]

20 It said early on that there was

21 not a connection, that this was not a

22 cluster of things, but then went on to

23 talk about 'there were some serious issues

24 around team work', which did connect or

25 did appear to connect a whole load of this

1 stuff together. That was the issue.

2 My guess would have been, at the

3 time, it would not have been the report

4 itself that I think would have created

5 something -- whether it would have stopped

6 it or not, I do not know, but it would

7 have created something. It was the fact

8 that it was on top of all of the other

9 things that was there.

10 DR KIRKUP: Can I just pick up a point

11 in relation to that because I am

12 struggling to remember now when I first

13 put this together. Was it obvious to you

14 on reading the Fielding Report that

15 Fielding and colleagues had not looked at

16 those indents themselves?

17 SIR DAVID NICHOLSON: No, it was not. It

18 was not because I could not work at when I

19 read it whether it was saying there is not

20 a cluster, because we have been told there

21 is not a cluster and it is accepted

22 knowledge that there is a cluster or

23 whether they have made a judgment that

24 there is not a cluster. That is what -- I

25 don't know whether -- that is what struck

1 me when I read it.

2 DR KIRKUP: That is exactly what I am

3 getting at. I know we are all now very

4 well aware that it was the former of the

5 two. They had been told it was not a

6 cluster but had no direct evidence because

7 their terms of reference excluded them

8 looking at it.

9 SIR DAVID NICHOLSON: Right.

10 PROF MONTGOMERY: If I read the

11 briefings that you and others got, they

12 almost you any formally seem to say,

13 'there is no connection between these

14 events', and many of them site Fielding as

15 evidence to support that.

16 So will it be right in saying

17 your understanding at the time was that

18 part of the assurance that there is no

19 cluster was you're the briefings you will

20 have received on the Fielding Report?

21 SIR DAVID NICHOLSON: Yes but I have to

22 say I have not read it myself. It was

23 only when I read it for this and I saw

24 that thing in the beginning where it kind

25 of -- I read it two or three times

1 actually to work out what it meant.

2 PROF MONTGOMERY: Yes. Would your

3 impression from the -- your impression

4 reading it, that they have done some case

5 reviews?

6 SIR DAVID NICHOLSON: Well, all I can say

7 is that my assumption was that they had.

8 PROF MONTGOMERY: Again, I think that

9 is something we now know is not quite what

10 happened.

11 SIR DAVID NICHOLSON: Okay.

12 PROF MONTGOMERY: But it has been

13 briefed up to you that.

14 SIR DAVID NICHOLSON: Okay.

15 PROF MONTGOMERY: As reasons to

16 believe it had been looked into.

17 I do not know whether you would

18 be able to help us with this but one of

19 the things we would like to do is

20 understand at which point that

21 interpretation of the Fielding Report

22 emerged. Where might we look to try to

23 find the source of the briefings?

24 SIR DAVID NICHOLSON: If you look at all

25 the bits of paper I have got it says they

1 are not connected. That would have -- the
2 source of that would have been the SHA
3 briefing section; they would have briefed
4 the system as a whole, all of us. They
5 would have made an assessment of all of us
6 at that level.
7 PROF MONTGOMERY: That is helpful.
8 One thing that has clearly happened is
9 that more weight has been put on that
10 interpretation of the Fielding Report,
11 than we were able to have at this stage.
12 Can I ask a bit about your
13 experience of reports? This is not a
14 question as Chief Executive of the NHS,
15 but you can answer as a very experienced
16 NHS leader. There are a few things that
17 feel a bit strange about the way the
18 Fielding Report was commissioned. We have
19 touched on a couple of them; is that it
20 seems to be the context where it looks, to
21 the outside world when they read it, as if
22 a question has been asked about the
23 connection and it looks as if there is a
24 review of the case notes and it has not
25 quite -- the terms of reference don't

1 actually quite lead you to do that. We
2 are assuming that there is quite a wide
3 range of reasons why a Chief Executive
4 might evoke an external review of things
5 and processes that they might go through.
6 We don't want to fall into the trap of
7 saying, well, it is obvious you should
8 have full public inquiry into these things
9 and anything less would not be an
10 appropriate thing to do.
11 SIR DAVID NICHOLSON: Yes.
12 PROF MONTGOMERY: Therefore, could
13 you give us a flavour of the range of ways
14 in which Chief Executives might get
15 assurance from independent investigations,
16 or is it too complicated and wide to ask
17 the question?
18 SIR DAVID NICHOLSON: I am not quite sure
19 where you are taking this?
20 PROF MONTGOMERY: Let me take you to
21 some questions about the Fielding Report
22 itself. We have touched on a couple,
23 which is why didn't it look at whether the
24 clusters were connected? Why didn't they
25 look at cases. It also had no follow up,

1 so it was never presented to the board;
2 there was never any request to come back
3 and see whether the recommendations had
4 been followed up. We would like a sense
5 of whether that was a surprising thing, or
6 whether actually the variety of ways in
7 which Chief Executives use external
8 assurance might have meant it was not that
9 uncommon to have that sort of look.
10 SIR DAVID NICHOLSON: Yes.
11 PROF MONTGOMERY: If we think of it
12 like a big public inquiry you would say,
13 of course, you will expect full
14 presentation to the board, action plan and
15 re-visit six months later.
16 SIR DAVID NICHOLSON: The first question
17 is -- the first question is why would you
18 do it? The reason why you would
19 commission something unless you wanted to
20 learn something from it and make something
21 different because of it. If that is what
22 you wanted to do there are certain things
23 you would do.
24 If you are saying that it is
25 a -- you are not quite saying this -- a PR

1 exercise, something we have got to do to
2 satisfy --
3 PROF MONTGOMERY: I would not want to
4 read in any interpretation. I mean, one
5 interpretation would be that the report
6 was not of sufficient good quality to be
7 useful for that, even if it was intended
8 to be like that. Another would be it was
9 a PR process. Another would be that there
10 is a pattern of things that they needed
11 assurance on; it was put into jigsaw
12 puzzle to get a complete picture.
13 SIR DAVID NICHOLSON: What I do not know
14 is that would -- having been the Chief
15 Executive of a hospital that had a
16 commissioner -- an external inquiry once
17 for it -- I mean, the first thing that you
18 need to make sure is that your
19 stakeholders, the people around you,
20 actually think that the terms of reference
21 are going to deliver what they want to
22 deliver because there is nothing worse
23 than setting up a report that gives you a
24 report and everyone says, "Very
25 interesting, but does not answer the

1 question we want to".

2 What I do not know is who agreed

3 the terms of reference of the Fielding

4 Report because you would normally expect

5 the Chief Executive pretty widely to talk

6 to people about that.

7 PROF MONTGOMERY: In a scenario where

8 someone in the SHA has helped them locate

9 the person to do it, you would expect

10 someone in the SHA also to have seen the

11 terms of reference and commented on

12 whether or not they would --

13 SIR DAVID NICHOLSON: It is always

14 dangerous, I think, for people -- you are

15 obviously the exception -- who are called

16 to do inquiries because there is a

17 double-edged sword. One year you are

18 bringing in the legitimacy, the

19 reputation, the experience, the integrity

20 of that individual; and, on the other

21 hand, you are drawing up a set of terms of

22 reference. You would expect, I think, the

23 interplay between the individual, the

24 terms of reference and the stakeholders,

25 to give you a decent say.

1 In these days -- I mean, even --
2 you know, certainly in my experience, in
3 the last 10 years -- no, eight years -- I
4 can think of very few reports of this
5 nature that were not published, you know,
6 in the environment that we have been
7 operating over the last few years. You
8 know, it goes along in the last two years
9 that actually the expectation would be
10 that, even if the report was not
11 published, an executive summary with an
12 action plan would go to a public board
13 meeting and all of that.
14 PROF MONTGOMERY: Would you have
15 expected the board to have been aware that
16 it was commissioned? Or would you expect
17 the terms of reference to be signed off at
18 board level.
19 SIR DAVID NICHOLSON: It is unimaginable
20 to me that they would not be, given the
21 nature of what was happening and all of
22 that.
23 PROF MONTGOMERY: We will not test
24 your imagination too much.
25 SIR DAVID NICHOLSON: I do not know

1 whether it was or not.

2 PROF MONTGOMERY: It does not appear

3 to have been, although we may just not

4 have found it so, yes, but, I mean, I

5 think that is really quite helpful in

6 terms of understanding the range of things

7 that were expected and whether it was out

8 of the ordinary or not.

9 I want to turn to the complaints

10 process. Can I start with a very open

11 question, which is what should families

12 expect from the NHS complaints system?

13 Albeit with some of the complexities and

14 how many aspects of it there are, but if

15 we were trying to capture, for the

16 families, in order to be able to answer

17 the question; did it deliver what they

18 should have had, the overall system, how

19 would we capture what it was supposed to

20 deliver for them?

21 SIR DAVID NICHOLSON: Well, the first

22 thing that it should deliver immediacy and

23 personal, i.e. that you should talk to

24 people locally about what happened and how

25 it happened and all the rest of it. I

1 mean, you know, the evidence shows that is
2 the way you deal with it. The likelihood
3 you can deal with most issues people have
4 got and you put them right or whatever in
5 those circumstances. Therefore personal
6 conversations with people to work all of
7 that through.
8 A slightly -- there is a part of
9 the way that sometimes the issue operates
10 is that people will say, yes, I know you
11 have got all these issues to deal with,
12 put it in writing, or be part of the
13 complaints procedure and then we will take
14 it over, sort of thing. That, again, is a
15 false dichotomy between what the
16 relationship of the individual would be
17 with the clinical team and the
18 organisation is and what should happen.
19 That should be done really up front. In a
20 sense, the effort and the time and process
21 needs to go in at that end to make it
22 happen.
23 Once you get beyond that, first
24 of all, a continuous dialogue with the
25 people. Certainly organisations I have

1 been responsible for have had people whose
2 job it was to ensure that that
3 relationship was good.
4 To keep people updated with what
5 is happening because sometimes,
6 inevitably, people have to be talked to
7 and issues have to be dealt with and it
8 takes a bit of time to make that happen.
9 Everyone needs to understand what all that
10 is right?
11 Then some kind of mechanism
12 whereby a more senior person -- the most
13 senior person or whoever the parents or
14 the relatives think are right, should
15 offer a meeting with them -- if they want
16 don't want a meeting to do -- but some
17 kind of culmination of it to bring it to
18 an end.
19 PROF MONTGOMERY: If that does not
20 work locally, take us through the options
21 families have where the ombudsman fits
22 in --
23 SIR DAVID NICHOLSON: The first thing is
24 the organisation needs a systematic way of
25 making sure it works. Sometimes they

1 don't have that and they don't know these
2 things are there and they are not dealing
3 with it. If the relatives are
4 dissatisfied with the conclusions that
5 they have come to, they have the ability
6 to get the ombudsman to look at their
7 complaint and make a judgment about it,
8 whether they will investigate it or not.
9 PROF MONTGOMERY: One of the issues,
10 I am sure you are aware of in this case,
11 was the ombudsman's decision not to
12 investigate at one stage. We are trying
13 to get an understanding of how things
14 worked when there was an overlap between
15 the systems. You have a change between
16 the Healthcare Commission and the CQC in
17 terms of the responsibilities in relation
18 to the complaints process. There is no
19 doubt the set of questions around what
20 should be done within the Trust, and the
21 SHA, may or may not, I do not know have a
22 sort of position in advising on whether
23 you should take assurance that this was
24 something that was being progressed
25 because the ombudsman would usually throw

1 things back to the Trust until they are
2 satisfied that a local resolution has been
3 successful. There is a complicated --
4 there is a potential for hand-offs and
5 things falling between the net. Was there
6 any sort of process for trying to make
7 sure that the bits of the jigsaw puzzle
8 were kept close enough together that there
9 were not gaps between, or was there not a
10 system for doing that?
11 SIR DAVID NICHOLSON: If there was a
12 system it was an informal one, not a real
13 one, in that sense.
14 PROF MONTGOMERY: Would you have
15 expected your office to be anywhere near
16 that or --
17 SIR DAVID NICHOLSON: No. I would
18 normally get involved with the ombudsman
19 when there was a particular complaint that
20 they dealt with that they were really
21 unhappy with, either the relationship they
22 had with the organisation that they were
23 trying to investigate; or the conclusions
24 of it had a wider implication. I did
25 not -- we certainly did not get involved

1 in that where people believed the
2 ombudsman should take up their complaints
3 and they were refusing to do so.
4 I have never come across that as
5 a issue. I have spent time with the
6 ombudsman; I have been out with their case
7 officers, you know, I had some
8 understanding about the way that they
9 operated. I have never personally been
10 involved or briefed or anything in
11 relation to that as an issue.
12 PROF MONTGOMERY: I think that is the
13 last question I was about to ask, which is
14 what knowledge, if any, the handling of
15 complaints in Morecambe Bay came to you
16 so -- that did not register.
17 SIR DAVID NICHOLSON: No, I didn't see any
18 of it.
19 PROF MONTGOMERY: Thank you very
20 much. I may have got to the end of my
21 list, but do you want to have --
22 DR KIRKUP: We will give Stewart a go
23 while you check.
24 PROF FORSYTH: Yes. Thank you.
25 The thing that strikes me about

1 the Morecambe Bay Trust is it is a very
2 small trust, relatively new to many of the
3 trusts. It is a small population, small
4 work force. A community hospital and two
5 rather low level hospitals. Yet, when
6 issues arose in the Trust, the whole
7 regulatory body of the NHS swung into
8 action. We have heard about the different
9 layers that had been involved in this.
10 Yet, five years later, the Trust
11 has gone into special measures because it
12 is not operating effectively. The
13 question I want to ask is: Do you think
14 this is a failure of all the systems
15 involved, in that they failed to turn this
16 around to provide an efficient quality
17 trust for the Morecambe Bay area; or other
18 circumstances that were touched upon very
19 briefly, in relation to trying to provide
20 and deliver healthcare in the geographical
21 and demographic situations.
22 SIR DAVID NICHOLSON: That is a small
23 question, but a massive -- I mean, that
24 is... You know, internationally that
25 question could apply to almost any

1 healthcare system that you want to look
2 at. How do you deal with organisations
3 and hospitals that get into trouble.
4 There are a variety of ways of doing it.
5 Are you asking me what I
6 personally think or what -- because --
7 PROF FORSYTH: I think what I want to
8 know, on reflection, what did happen; do
9 you feel it was being a success? If it
10 was not a success, how do you think, in
11 retrospect, you might have handled it
12 differently?
13 SIR DAVID NICHOLSON: I think that there
14 is -- there is an underpinning changes to
15 the NHS are a kind of an approach to how
16 healthcare systems operate, which is
17 seldom set out in the detail that it needs
18 to be, for a whole variety of reasons
19 because often politicians don't want to
20 talk about it in that kind of way. If you
21 think about a foundation trust, an
22 independent organisation, we have now
23 created a system of dealing with them when
24 they get into trouble, which is akin to
25 the way that the administrator might deal

1 with a private sector organisation that
2 gets into trouble. You can see, in
3 theory, that is how all this sort of stuff
4 should be able to work. But my contention
5 has been consistently that these
6 organisations are not like that.
7 That actually -- two things.
8 One, my experience shows me that
9 intervention early on is really important;
10 that the system we have created tends to
11 do interventions late-on, when
12 organisations have got themselves into a
13 place that they cannot get out of.
14 What is going to happen now, I
15 think, because it has been put in special
16 measures, a whole load of the resources of
17 the NHS are going to be put in. I do not
18 mean money -- although I am sure there
19 will be some money going in as well -- but
20 also expertise from other organisations,
21 people. There will be a focus on that in
22 a way that if we would have done that
23 earlier on, we would all been a better
24 place than we are now. Part of the issue
25 about the regulatory system as it is, is

1 that it can deal with failure; it cannot
2 deal with problems as they arise because
3 it is not a management system. It is
4 management that can get us out of this,
5 not regulation.
6 What will happen in the end,
7 someone will have to get hold of this, get
8 a grip of this, and make it work. It has
9 just taken too long for that to happen.
10 Does that make sense?
11 PROF FORSYTH: No -- I think, I agree
12 with what you are saying. I mean, it
13 seems to me that we are doing it back to
14 front. There is a local problem, let us
15 stand back and take a look at a grand
16 plan overall et cetera, and then when all
17 else fails let us go in and find out what
18 we know the problem is. What do you think
19 are the problems of, for example, an
20 example of Furness Hospital -- must be
21 Furness hospitals all over the United
22 Kingdom. How do you manage these?
23 SIR DAVID NICHOLSON: You see I, having
24 all I know about that particular hospital,
25 I have been to it and I have read the

1 stuff and all the rest of it, and you are
2 absolutely right, it is not unique,
3 although it has some slightly excessive
4 bits of it -- the geographical isolation
5 is slightly different, the kind of nature
6 of the population is slightly different to
7 others. But, nevertheless, I think it
8 is -- if you go back to when the Trust was
9 formed and there was some ambition around
10 that, but also there was -- so the
11 ambition was to stop organisations being
12 geographically isolated and to create
13 something, which would be greater than the
14 individual elements of all three, which
15 seems to be a good thing to do.
16 Of course, what happened in
17 those circumstances, when you do that, the
18 clinical organisation of the three
19 hospitals needed to change. That is when
20 it becomes much more difficult. There has
21 been a feeling, I think, that if you get
22 the organisation right, the clinical bits
23 will fall in. It does not work like that
24 at all. My experience is it does not work
25 like that. You have to get the basic

1 clinical strategy right before you can
2 decide what the organisation is. They did
3 not quite do it in there, but,
4 nevertheless, they had some kind of idea
5 about what they wanted to do.
6 Then the people who ran it went
7 off and did something else and a whole new
8 set of people come in and start to run it
9 and they have got their own ideas about
10 it. Therefore you never get that
11 consistency of purpose that you need to
12 make it happen.
13 Part of the issue there -- I
14 went there in March of last year -- is
15 about mindset. So, for me, it is
16 inconceivable, for example, that there
17 will not be some kind of maternity service
18 in Furness Hospital. Inconceivable. I
19 don't see how you can serve that
20 population without some kind. Yet it was
21 subject to some kind of major debate going
22 on about whether they would or they would
23 not, when everybody really knew that they
24 would have to. If your viewer is we have
25 got this service, so we have got to find

1 exciting, innovative ways of making it
2 happen, that is a different clinical focus
3 than; should it exist in the first place?
4 What drove me, you know, about
5 when I went there was how that was
6 still -- everything seemed to be up for
7 grabs everywhere. There was no nailing
8 things down in a way that I think would
9 help.
10 I think if you work on the basis
11 that you make some judgments early on
12 about what you are prepared to do, and
13 then mobilise the system to enable you to
14 do it, I think this is a better place than
15 literally leaving these problems up in the
16 air for years and years with people going
17 round and round them, 10 or 11 or 12
18 times.
19 PROF FORSYTH: I mean, around the
20 time where there was a significant number
21 of incidents, there was also a time when
22 they were progressing towards the FT
23 application. Also a time when
24 waiting-time limits were a very high
25 priority from a government perspective. I

1 mean, was it not inevitable that
2 specialities that were very much
3 acute-orientated specialities, such as
4 maternity services and paediatric services
5 and, as it turned out, A&E services,
6 tended to be a bit neglected and possibly
7 ignored at that time?
8 SIR DAVID NICHOLSON: I think it is when
9 you start to use the term "neglected".
10 You know, that is when it starts to become
11 difficult, doesn't it, because no-one
12 would say, you know, the policy is to
13 neglect maternity. What we were trying to
14 do --
15 PROF FORSYTH: Not deliberately.
16 SIR DAVID NICHOLSON: What is true -- you
17 have. I mean, the job I do is not a Chief
18 Executive job in the sense that you might
19 think one is. I didn't have a board, I
20 was accountable to a politician. You
21 know, there was no non-executive directors
22 or anything like that. There was a
23 politician. Typically those politicians
24 are in post for over a year. To begin
25 with they have not worked out -- very few

1 politicians, one notable exception, has
2 sat on the back benches saying, "I want to
3 be the Secretary of State for Health", you
4 know, they don't. So normally they do not
5 know very much about it. They come, they
6 have six months, they get very excited
7 about it then they have about nine months
8 to do everything they have ever wanted to
9 do, In a sense, part of my responsibility
10 was for the Government to implement
11 Government policy. As part of the
12 responsibility -- you know part of what
13 you are there for, for some ministers it
14 was the only reason you were there; for
15 some of them it was less so.
16 You could have 50 priorities, or
17 you can have 30 priorities, or you can
18 have four or five priorities. If you
19 really want to make change happen in that
20 short window of time that people have got,
21 the fewer priorities that you have the
22 better. That is not to say everything
23 else has to be neglected, but what it does
24 mean is that from the centre the messages
25 are very powerful. You know, they are

1 very powerful. For Chief Executives,
2 those messages can be, you know, very
3 powerful indeed for them.
4 This is, in a sense, part of the
5 dilemma we have always had because, in a
6 way, we have been able to deliver some of
7 the big priorities in that way, but there
8 is a downside to it. In the best places
9 people managed all of that and dealt with
10 it, but in some places they did not.
11 PROF FORSYTH: I am not going to put
12 words in your mouth, of course, but is one
13 of the problems of the big priorities that
14 they tend to be top-down priorities and
15 really where we are missing out -- and
16 Morecambe Bay could be an example of
17 this -- the bottom-up, speaking to
18 patients, speaking to the staff, and then
19 building up what we need to do to manage
20 the service. You know, I feel that, you
21 know, one of the most illuminating things
22 I have experienced in this investigation
23 so far, clearly the feelings of the
24 families, and because the process has gone
25 on and on and on -- this is five years of

1 torment for them -- but also the damage to
2 the staff who are there who recognise, you
3 know, the problem. They made mistakes or
4 could have done things differently, but
5 they themselves feel damaged in all of
6 this and it is five years down the road.
7 I feel has the system sort of let them
8 down as well as families?
9 SIR DAVID NICHOLSON: Yes, but there are
10 lots of other hospitals you can go to
11 where people are not dealt with like that.
12 You know, it is not a necessary
13 consequence of having a government that
14 wants four or five big things doing. It
15 is not -- it does not necessarily have to
16 be like that but there is always a risk
17 and that is part of the problem that we
18 have. I mean, I ran a hospital for 10
19 years and, you know, all right it was not
20 quite at the storm-end of all of this sort
21 of stuff, but on a day-to-day basis I was
22 not constantly thinking about what the
23 Department of Health, or the ministers
24 were doing. I had to run an organisation,
25 you know, with a very needy population,

1 who we had good -- you know. It is
2 perfectly possible to do all of this in
3 any hospital.
4 PROF FORSYTH: Do you think it is
5 fair to say that you could re-assure the
6 people of Barrow, for example, that they
7 can have a safe and sustainable health
8 service on their doorstep?
9 SIR DAVID NICHOLSON: Under what --
10 PROF FORSYTH: On their. Doorstep
11 local health service. Do you they feel
12 you can re-assure the people of
13 Barrow-in-Furness that their service is
14 possible to provide a safe and sustainable
15 service for them?
16 SIR NICHOLSON: That is what we are
17 there for.
18 PROF FORSYTH: I know.
19 SIR DAVID NICHOLSON: What other
20 responsibility would we have? Of course,
21 we need to have a conversation with them
22 about what safe, effective and decent
23 experience is and what that means, and how
24 we might work all that through. But that
25 is a conversation we would have with them,

1 not with politicians or somebody else. In
2 those circumstances, of course I am
3 confident that the NHS can respond to
4 those populations. Name me a healthcare
5 system better designed to do that --
6 PROF FORSYTH: They will probably
7 say --
8 SIR DAVID NICHOLSON: -- in the world.
9 PROF FORSYTH: -- why has it not
10 happened in the last five years?
11 SIR DAVID NICHOLSON: You know,
12 absolutely. I mean, presumably this is
13 what you are doing. You know, the
14 challenge has to be there. It is
15 absolutely, you know, for those parents it
16 is all words, isn't it? It is all kind of
17 structures, processes and whatever. The
18 simple humanity of relating to your local
19 population and nurturing and looking after
20 and supporting them, in some way, care has
21 been lost for those individuals. It is
22 tragic and if we can -- or if you can help
23 in all of that, it will be fantastic.
24 PROF FORSYTH: Okay. Thank you very
25 much.

1 DR KIRKUP: I am disappointed you did
2 not say Scotland was the answer to where
3 it could be done better. Shall I pick
4 up --
5 SIR DAVID NICHOLSON: Don't start me on
6 that.
7 DR KIRKUP: Shall I pick up a few of
8 the loose ends we have? I will do about
9 as a result of that; apologies for that.
10 Partly from what you said, partly from
11 what people have told us: One of the
12 things that you said that I was fascinated
13 by was the four to five priorities,
14 absolutely, and that does not mean the
15 other things are neglected. But is
16 quality one of the four to five priorities
17 there? You know, it briefly was when
18 Ara Darzi was around, but has that dropped
19 off the agenda now?
20 SIR DAVID NICHOLSON: Do you mean now? It
21 is an interesting question because I do
22 not think it has dropped off the agenda.
23 What happened is that bits of it have been
24 emphasised so, for example, there is a big
25 emphasis at the moment around safety,

1 beyond anything that we have ever had
2 before. So, different bits of it are
3 being emphasised, but I do not think it
4 has been lost in that sense. I think the
5 question for me is whether we have kind
6 of -- those three bits of quality, whether
7 they have all been taken forward and it is
8 properly the organising principle because
9 we have lost some of the other bits as we
10 have focused on the response.
11 DR KIRKUP: Do you think we ever treated
12 quality on an equal level with financial
13 achievement?
14 SIR DAVID NICHOLSON: When you -- it
15 is.... I guess the issue is that you use
16 the word "we" and I am just --
17 DR KIRKUP: The system in general.
18 SIR DAVID NICHOLSON: The healthcare
19 system in general?
20 DR KIRKUP: Yes. Have we ever taken
21 quality as seriously as it takes finance?
22 SIR DAVID NICHOLSON: Yes. Well, how
23 would you measure that? One of the things
24 that I would say is that if you look at
25 the time series around the staff survey,

1 and you look at the question we asked, "Do
2 you think your organisation has quality at
3 the top of its agenda", that has moved
4 from about mid-50s in 2005 to about
5 70-odd, which, all right, is not enough,
6 but actually shows that organisations are
7 thinking in those terms.
8 I would have said, well -- It
9 is quite -- I understand what you are
10 saying. I mean, the disappointment, I
11 guess, from us was one of the ways in
12 which we had said that we wanted to show
13 that quality was at least on a par with
14 finance was the development of quality
15 accounts because we said that was one way
16 in which you would show. For a variety of
17 reasons that has not worked. That has
18 been a -- I think that is... Part of that
19 is the consistency of purpose. You know,
20 one ministerial team sponsored it; the
21 next ministerial team is not interested in
22 it; the one after goes off to something
23 else so you kind of have that lack of
24 consistency of purpose in all of that.
25 DR KIRKUP: Sure.

1 SIR DAVID NICHOLSON: I am loathe to say
2 what... I think I would say the jury was
3 out on it.
4 DR KIRKUP: Okay. Thank you.
5 The system you described as not
6 being good at spotting things early.
7 Intervention early was much better than
8 intervention late, which I thoroughly
9 agree, but you said we have not set up a
10 good system to encourage early spotting of
11 problems and intervention. Where are the
12 intensives wrong to do that?
13 SIR DAVID NICHOLSON: Where are the?
14 DR KIRKUP: Where are the incentives
15 wrong? What has gone wrong with the
16 system that it does not encourage early
17 reporting of problems, early detection of
18 problems, early interventions to sort out
19 problems before they become more
20 significant?
21 SIR DAVID NICHOLSON: Right. Well, it was
22 one of the things that we looked at when
23 the mid-Staffordshire -- the original
24 mid-Staffordshire report came out and the
25 National Quality Board considered this as

1 a big issue. That was, in a sense, when
2 we set up the risk summits and the quality
3 surveillance groups because we thought, in
4 terms of surveillance, that was for us all
5 to share the information together, across
6 the health community, was a better way of
7 making sure that that happened?
8 The incentive before we did that
9 was individual organisations look after
10 their own data and their own information
11 and would not necessarily see the
12 importance of sharing it.
13 I think that is a good way in
14 which we can bring incentives into the
15 system to make it happen.
16 My general point is that we can
17 make almost any system you like work, but
18 you need to keep the systems going long
19 enough and not change all the people and
20 relationships every five minutes in order
21 to do it because this all depends -- and,
22 you know, I was in the Trent region for a
23 long time and we used to intervene early,
24 but it was based on the relationships and
25 trust and understanding that we had in the

1 healthcare system to enable it to happen.
2 If you are changing everybody every five
3 minutes that is very hard to do.
4 DR KIRKUP: What was the key
5 relationship there, was it between the
6 Trust and the commissioners, or the Trust
7 and the SHA?
8 SIR DAVID NICHOLSON: In Trent?
9 THE CHAIR: Yes.
10 SIR DAVID NICHOLSON: It was between the
11 Trust and the SHA -- I mean, it was
12 between the Trust and the region. In a
13 sense, part of when we did the SHA
14 assurance we were encouraging SHAs to
15 rediscover their relationships with the
16 providers because we did not -- it was...
17 The way it was said at the time was that
18 people had created what we describe as an
19 L-shaped relationship with providers,
20 which was SHA/commissioner/provider and
21 some had a triangle. We felt that the
22 most healthy was the triangle. That was
23 the best; that would be a better way of
24 making things happen.
25 DR KIRKUP: Yes. Just for clarity I

1 was taking "SHA" there as shorthand for
2 SHA regional office or whatever other
3 things are around --
4 SIR DAVID NICHOLSON: Yes.
5 DR KIRKUP: -- in that niche.
6 Another fascinating thing I
7 thought you said was that the answer is
8 "management not regulation". Part of the
9 problem here is potentially around how
10 communications work between management and
11 regulation. Can you expand a bit on how
12 you see how that ought to work?
13 SIR NICHOLSON: This maybe a point
14 in time, but my experience of when you set
15 up a new organisation, no matter what it
16 is, whether it is a CCG or a Foundation
17 Trust, or an SHA or a regulator, the first
18 thing that they do is they patrol their
19 boundaries. The first thing they do is
20 they create themselves as an organisation
21 and they emphasise their role and their
22 difference with everybody else. Over this
23 period I think you can see a set of
24 organisations who were setting up their
25 own unique selling point, their difference

1 and their unique bit of the system and
2 they were patrolling it quite heavily. I
3 mean, it is well-documented you can -- my
4 relationship with Bill Moyes was part of
5 this thing about guarding your boundaries
6 because, at the end of the day, the kind
7 of customer of all these boundaries are
8 patients and people, and really the most
9 important thing is to get that bit right.
10 That is why, you know, I would always
11 encourage SHAs to intervene and make
12 judgments and do things, even though
13 sometimes it created a whole load of waves
14 with other organisations to make that
15 happen.
16 During this period you have got
17 a set of organisations being set which all
18 wanted to create themselves as special
19 bodies. I think that -- if your first....
20 I mean, I have said this before, so it is
21 not something that I have not said before,
22 but I remember very well when the
23 mid-Staffordshire thing first happened, or
24 rather when the Healthcare Commission
25 report came out, we had the meeting in

1 Alan Johnson's office and I said what we
2 were going to do about intervening there
3 then and the response of Monitor was;
4 under what legal powers are you proposing
5 to make those points? That said it all,
6 you know, because if that is where we
7 are -- we are not there now, I have to
8 say, Monitor have changed a lot, that is
9 in a sense where we were in this day. I
10 think managers do not see the world like
11 that; they see the world in terms of
12 making things happen rather than the
13 other.
14 DR KIRKUP: Sure. How does that apply
15 to the relationship between CQC and the
16 SHA? How would you expect -- this is
17 pre-Mike Richards; how would you expect
18 that relationship to operate?
19 SIR DAVID NICHOLSON: Well, you would
20 expect it to be porous. You would expect
21 there to be a constant dialogue between
22 the CQC people on the ground, and the SHA,
23 about what is happening, what the
24 intelligence was, who was doing what to
25 who and in what order. All of those sorts

1 of things. You would expect, either
2 through the commissioning-side or
3 directly, for the SHA to play a part in
4 doing whatever was required to improve the
5 arrangements.
6 DR KIRKUP: Can I characterise that a
7 bit? I am keen to define this point. Are
8 you saying that there should have been
9 sharing of information, coming to a mutual
10 understanding about how a Trust fitted
11 into that?
12 SIR DAVID NICHOLSON: Yes --
13 DR KIRKUP: Okay.
14 SIR DAVID NICHOLSON: -- I am. I am,
15 which is quite -- I know that sometimes is
16 a problem for CQC, and I have seen that in
17 different places where that has happened.
18 It does put pressure on the CQC, you know,
19 because, I mean an example I might give
20 you is in London we had a problem over
21 maternity services with problems around
22 it. CQC's immediate response was: This
23 is unsafe; we need to close it; we need to
24 restrict it in some ways. The system
25 response is, hold on a minute, if you do

1 that, the consequences are this unit, this
2 unit, and this unit will fall over.
3 DR KIRKUP: Yes.
4 SIR DAVID NICHOLSON: Or can we modify
5 what you do? Or whatever.
6 That puts everybody in quite a
7 difficult -- that puts, certainly CQC, in
8 a very difficult position over all of
9 that. However, that conversation has to
10 happen; it cannot not happen because you
11 have got a regulator who was interested
12 in -- I exaggerate that point -- in
13 re-organisation, and then you have got the
14 SHA, or the commissioners responsible for
15 the population, not just the people in the
16 beds but people who are nine months down
17 then or whatever are going to be in the
18 beds, and there has to be a conversation
19 about all of that.
20 Part of the issue is: How
21 transparent that conversation is and how
22 alert we make people around all of that?
23 I am absolutely for making that as
24 transparent.
25 DR KIRKUP: Okay. That is kind of

1 about solutions, nonetheless important for
2 that. What about the kind of assessments
3 of how somebody is placed to deliver a
4 quality service in the first place?
5 Let me just reflect something
6 back to you that we have been told, more
7 than once, and that is that the SHA's view
8 was that it was for the CQC to report to
9 them on quality and if the CQC said
10 everything was okay, that was it. It was
11 the CQC's view that they would take
12 soundings from the SHA about whether this
13 was quality service. You have a sort of
14 mutual reassurance society, if you like,
15 you know, each party is telling the other
16 that everything is okay because they have
17 not heard any bad news.
18 SIR DAVID NICHOLSON: Yes.
19 DR KIRKUP: How is that relationship
20 supposed to work? I am sure it is not
21 like that.
22 SIR DAVID NICHOLSON: Yes -- indeed SHAs
23 are not organised and resourced to be able
24 to do all of that. They simply are not.
25 They did not have the resource because the

1 assumption was that a mixture of
2 independent organisations and regulators
3 would deal with the issue that you have
4 just described. Of course, we are in this
5 transition where there are bits of both
6 operating. It was one of the reasons why,
7 as part of the next stage review, we said
8 that every SHA should have a Medical
9 Director because, ironically, they did not
10 have them before that. When SHAs were set
11 up they did not have to have a Nurse
12 Director either; we insisted that they did
13 in order to give them the capacity to
14 enable those conversations to be had.
15 They were conversations that --
16 what we could not have, what we could not
17 afford and they were not set up is the
18 SHAs to have some big quality surveillance
19 systems that would give them real-time
20 feedback as to what the quality of the
21 service of the individual organisations
22 would be. They are simply not there. But
23 the ability to have the conversations with
24 CQC and in a constrictive way, and to be
25 able to have networks of people in those

1 organisations, in those healthcare
2 systems, that were capable of both
3 identifying issues and dealing with them,
4 was part of what we needed to do.
5 I think that in a -- the end
6 point was CQC and the regulators say to
7 the SHAs this is okay and we have got a
8 surveillance system to enable us to do
9 that and we have got monitor to do that.
10 But that is one thing. But we were not
11 there and so SHAs had to go into that
12 space. Had to.
13 DR KIRKUP: Okay. One of the ways SHAs
14 used to do that, or regional officers
15 certainly, maybe not SHAs I do not know,
16 was that they were monitoring the reports,
17 the serious indents reports that came
18 through, and could spot if there were
19 recurring patterns there that needed
20 further investigation.
21 SIR DAVID NICHOLSON: Yes.
22 DR KIRKUP: Is that something that the
23 SHAs were expected to continue with?
24 SIR DAVID NICHOLSON: They did and, as
25 part of the -- you will see in the

1 reassuring process, you know, that people
2 did it but some were better at it than
3 others.
4 DR KIRKUP: Yes. Okay.
5 This is picking up a specific
6 point that you made about when incidents
7 displayed "systemic elements", when they
8 were not just one-off incidents; there
9 were systemic elements to that. How do
10 you make the judgment? What are the sort
11 of things you expect people to look for
12 because there is a systemic issue?
13 SIR DAVID NICHOLSON: I am trying to think
14 of an example that would help.
15 First of all, more than one
16 organisation was involved.
17 Secondly, there was no consensus
18 between the commissioners and the
19 providers that there was either a problem
20 or a solution to the problem that was
21 there. If you saw those sorts of things,
22 they are the sorts of things that SHAs
23 knew they needed to intervene on.
24 DR KIRKUP: Okay. I was using
25 "systemic" in a slightly different way,

1 which is, you know --

2 SIR DAVID NICHOLSON: Sorry.

3 DR KIRKUP: It is fine, we have not got

4 precise definitions of these things.

5 SIR DAVID NICHOLSON: Yes.

6 DR KIRKUP: What I am thinking of is

7 where you have a cluster of incidents and

8 they only relate to a single Trust, they

9 only relate to the single unit in a single

10 Trust, but what are the things that an SHA

11 thinks to itself, "Hang on, this is not

12 just random fluctuation here; we may have

13 a problem in this unit that they are not

14 picking up and they are not dealing with"?

15 SIR DAVID NICHOLSON: Yes. Well, my

16 understanding in this particular example

17 is that people like the Director of Public

18 Health, they had a Medical Director, they

19 would look at these issues and make a

20 judgment about whether they thought they

21 were connected or not. Based on that

22 judgment, a whole series of other things

23 would apply.

24 DR KIRKUP: Yes. But at SHA level that

25 would be the Director of Public Health?

1 SIR DAVID NICHOLSON: Well, it would be
2 the Medical Director. I am saying that in
3 the North West region, because you have
4 got the Ruth Hussey, who was a particular
5 character, the Medical Director will take
6 a judgment about all of that.
7 DR KIRKUP: When you had a Medical
8 Director, yes.
9 SIR DAVID NICHOLSON: Yes. The Medical
10 Director should make a judgment about
11 that.
12 THE CHAIR: Okay. Sorry I am dotting
13 about a bit. Let me go back to the CQC
14 process. The CQC issued a warning notice
15 in relation to the maternity services in
16 Furness General. What would your
17 understanding be of how that process then
18 went on from there? What was supposed to
19 happen when the CQC issued a warning
20 notice?
21 SIR DAVID NICHOLSON: That the Trust and
22 the commissioners would take whatever
23 action they needed to, to have it taken
24 away.
25 DR KIRKUP: Yes, of course. Who would

1 make sure that happened and what would
2 they do if it had not?
3 SIR DAVID NICHOLSON: Well, in the first
4 instance the CQC would make a judgment
5 about whether it had been done or not. If
6 it had not been done, then the CQC would
7 then either respond to the Strategic
8 Health Authority for the commissioners
9 and/or Monitor for the provider.
10 DR KIRKUP: Yes. Okay. The
11 description that you were getting, and I
12 appreciate that you are entirely dependent
13 on the description that you are getting,
14 is that the warning notice was lifted,
15 which presumably you would have
16 interpreted as meaning that there had been
17 some sort of re-inspection or re-visit.
18 SIR DAVID NICHOLSON: Yes. That CQC were
19 satisfied that it was no longer required,
20 yes.
21 DR KIRKUP: The CQC are pretty clear
22 that is not the way it works. In fact,
23 they did not re-visit and they did not
24 re-investigate. You know, it is important
25 for you to tell me that was not your

1 understanding of how it worked.

2 SIR DAVID NICHOLSON: Yes, it was not. It

3 was not.

4 DR KIRKUP: Thank you.

5 On a related theme. What was

6 your understanding of the fact that the

7 ombudsman decided not to investigate

8 Mr. Titcombe's complaint?

9 SIR NICHOLSON: Do you mean --

10 DR KIRKUP: What did you

11 ....[simultaneous conversation]......

12 SIR DAVID NICHOLSON: Did I draw any

13 conclusions from it?

14 DR KIRKUP: Yes.

15 SIR DAVID NICHOLSON: I didn't draw any

16 conclusion from it. I mean, I cannot sit

17 here and say that I saw it and I drew no

18 conclusions, or I thought everything is

19 fine, or everything is not, because I know

20 that the way that the ombudsmen operate is

21 they do draw quite tightly the kind of

22 definitions that they use about whether

23 they are going to investigate something or

24 not. I will not draw a conclusion one way

25 or the other in relation to that.

1 DR KIRKUP: I appreciate I am asking
2 questions here about how the system
3 operated based on the evidence that you
4 are getting and that is putting you in a
5 slightly unfair position. I am.
6 SIR DAVID NICHOLSON: I am used to it.
7 DR KIRKUP: Aren't we all. I am not
8 suggesting that that makes that your
9 direct responsibility; to look at an
10 ombudsman's decision and draw a conclusion
11 from it.
12 SIR DAVID NICHOLSON: Yes.
13 DR KIRKUP: If the system is generating
14 a briefing that says the ombudsman decided
15 not to investigate, it clearly, in a
16 context, means that you should be
17 re-assured. Would you agree with that
18 interpretation of the briefing?
19 SIR DAVID NICHOLSON: All I can say is
20 that, myself, I would not have drawn that,
21 but I can see how others might have drawn
22 that conclusion. I can perfectly see how
23 that would be an example of someone saying
24 it is another tick to their --
25 DR KIRKUP: It is a --

1 SIR DAVID NICHOLSON: -- it is one less
2 problem.
3 DR KIRKUP: -- something crossed off
4 the problem?
5 SIR DAVID NICHOLSON: What I would say is
6 the opposite would also apply more so. So
7 if they would have decided to do the
8 investigation, that would have alerted you
9 to a bigger issue.
10 DR KIRKUP: Yes.
11 One of the reasons why the
12 Ombudsman might have decided not to
13 investigate is that it was not an isolated
14 incident and that there was this
15 "systemic" -- that the word again --
16 problem in the maternity services in
17 Furness.
18 SIR DAVID NICHOLSON: Yes.
19 DR KIRKUP: Therefore, she was going to
20 decline to investigate, pending something
21 else happening by somebody else, which
22 actually means it is more significant
23 rather than less.
24 SIR DAVID NICHOLSON: Okay. Right. Well,
25 no doubt we will learn from this.

1 DR KIRKUP: Yes. Yes.

2 I think that is me for the

3 moment at any rate. I will pass back to

4 Jonathan.

5 PROF MONTGOMERY: Thank you very

6 much. One area that I want to question

7 after that, I wanted to ask, because it

8 follows on from trying to understand your

9 understanding at the time based on what

10 you have been briefed. In the first half

11 of 2012 when the CQC -- there is a

12 discussion about whether the CQC should

13 announce its investigation in the

14 Christmas of 2011 and some discussion

15 around the disruption of making it public

16 at that point. I am really interested in

17 understanding whether the issues that the

18 CQC was concerned about were presented to

19 you as issues including maternity, or

20 whether they are issues about the urgent

21 care pathway; the general management of

22 the Trust.

23 SIR DAVID NICHOLSON: Yes. All I have got

24 is the bits of paper and they all talk

25 about the accident and emergency bit.

1 They do not talk about the maternity bit.
2 PROF MONTGOMERY: I think, if I have
3 understood the briefing that we have
4 looked at, it is not being pushed up to
5 you as being an issue in which maternity
6 is a significant part --
7 SIR DAVID NICHOLSON: No, because we have
8 already established it was not a set of
9 connected --
10 PROF MONTGOMERY: Thank you. I want
11 to make sure that I have understood that.
12 Then it is often said that you
13 could lose your job as a CEO or a chair if
14 you get the money wrong, but actually the
15 rest of it does not count in the same
16 status. A similar question to what Bill's
17 touching on. I wanted to give you an
18 opportunity to comment on whether that is
19 a myth or reality that, you know, people
20 focus on getting the money right because
21 that is where the job security sits and
22 the quality fades away in comparison.
23 SIR DAVID NICHOLSON: What I say to
24 people -- and it is not based on a
25 statistical analysis, but based on my

1 judgment on all of this -- is that there
2 are three ways in which chief executives
3 lose their jobs. The first two are
4 greater than the third. The first two
5 are: You have got a problem, you deny you
6 have got a problem, and as that problem
7 develops your denial turns into pretending
8 it never happened. That is the most -- in
9 my experience that is when most chief
10 executives go, in those circumstances.
11 You know, from Stanley Lloyd [Stanley Roydal Hospital]
12 there is a whole loads of examples. The
13 system is very, in my experience, very
14 tolerant about things going wrong,
15 probably too tolerant in some ways, but
16 intolerant about people who pretend, you
17 know, it did not happen or... That is
18 first one.
19 The second one is that they lose
20 the confidence of the medical staff.
21 The third one is the money.
22 That is my experience. I know it is --
23 you know, the people I have dealt with
24 over my career, that has been the issue, I
25 think.

1 PROF MONTGOMERY: At the moment – it
2 may become clear -- at the moment,
3 somewhat mysteriously -- Tony Halsall
4 disappears in the middle of the CQC visit;
5 which of the three categories do you think
6 he was in?
7 SIR DAVID NICHOLSON: I do not know. I do
8 not know. I genuinely -- I have to say
9 that I do not know the chap, I have never
10 really...
11 PROF MONTGOMERY: Thank you.
12 DR KIRKUP: Okay. Stewart, anything?
13 PROF FORSYTH: No.
14 DR KIRKUP: I am done too. Is there
15 anything else you would like to say to us?
16 SIR DAVID NICHOLSON: Other than thank you
17 for the opportunity to come and say my
18 piece in all of this. You know, the more
19 you see it, the more it gets to the heart
20 of what we are there for and, you know, it
21 is an absolute -- for the individuals it
22 is an absolute tragedy. I think that, you
23 know, having been to the hospital and met
24 the staff who were working there, it is a
25 big problem for them as well. If we can

1 shed some light on that individual, but
2 also get the learning for others, I think
3 it will be really worth doing.
4 Good luck with the rest of
5 your -- if you need me to come back and do
6 anything else, I am more than happy to
7 help in any way I can.
8 DR KIRKUP: Thank you. That is
9 appreciated. Thank you very much for
10 coming. That is end of the interview.
11 Thank you.
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