THE MORECAMBE BAY INVESTIGATION

Tuesday, 11 November 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
PROF Stewart Forsyth - Expert Adviser on Paediatrics
Mr Julian Brooks - Expert Adviser on Governance

CHRISTINE BEASLEY

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(At 11.17 a.m.)

DR KIRKUP: Hello. Thank you for coming.

DAME CHRISTINE BEASLEY: That's alright.

DR KIRKUP: It would be nice to see you but perhaps not under the current circumstances.

DAME CHRISTINE BEASLEY: Yes. No, that's alright.

DR KIRKUP: I will say for the record that I am Bill Kirkup and I am chairing the Investigation Panel. I will also declare that we have been colleagues for a while at Richmond House. I will ask my fellow panel members to introduce themselves.

PROF FORSYTH: Good morning. My name is Stewart Forsyth. I am paediatrician and I am formally a medical director in Tayside, Scotland.

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

DR KIRKUP: You will see that we are recording proceedings. We will produce an agreed record at the end. You may also know that family members are invited to be present as observers. As it happens we do not have any but they may listen to the recording subsequently. And you will also know we have asked you to hand in any mobile telephones or recording devices, just to emphasise we do not want anything to go out of the room until we produce the report. Any questions for me about the process?

DAME CHRISTINE BEASLEY: No. That's fine.

DR KIRKUP: Okay. I will just ask a very general question then I will take even more of a back seat than usual in view of our previous connection. But the general question is just we are talking to you in the context of your position as Chief Nursing Officer, can you just remind us of when you started and when you moved on?

DAME CHRISTINE BEASLEY: Yes. I started in October 2004. I finished in June 2012, but actually I retired in 2011 and then came back part-time to assist David with the work running up to the new Health and Social Care Act. That last year was slightly different to the others. So really 2004 to 2011 and then more part-time job from 2011 to 2012.

DR KIRKUP: Okay. Thank you.

DAME CHRISTINE BEASLEY: No problem.

DR KIRKUP: Stewart?

PROF FORSYTH: Thank you. Can you begin by telling me when you first became aware of issues in the Morecambe Bay Trust?

DAME CHRISTINE BEASLEY: Yes, I know. I sort of fear I will not be able to help you too much about it all. Really, I can't – I do remember it. When was it? Likely to have been earlier or middle in my time as CNO rather than later. I have had a little look at my archived records, which were at the department, just in case there was anything of any – that sort of jogged my memory and there isn't really anything there at all. So it is probably around then although my memory around dates in that sense is not clear around it. And I think that is partly because although I knew about it I didn't know about it in a lot of vast detail.

So I guess in terms of if you want me to go into how I knew about it then that is sort of explained. Obviously, as you know, in those days we had regional SHAs, whatever you call would call them then, and my recollection of hearing about it is that Jane Cummings was the Regional Nurse Director and the Director of Performance in the Northwest and when I met with all of them on a regular basis they would, as well as discussing bigger things, would also bring up and say some of these things are happening in the patch. That is my recollection of when I first heard about Morecambe Bay, with Jane saying, "We have got a problem with midwifery and issues at Morecambe Bay." Sadly, it wasn't the only place in the country. Other people were bringing up other things. So that is my best recollection, I think, of when I heard about it and probably how I heard about it.

PROF FORSYTH: And did it reach your office again in a sort of more high profile –?

DAME CHRISTINE BEASLEY: Really, I mean I have even looked to see if I was copied in stuff. Yes, I had further conversations with Jane. But if you sort of compared, for example, it with Staffs where it reached in all sorts of ways and there was lots of documents and all that sort of thing as far as Morecambe is concerned, no. It was a more a question of a continuing conversation with Jane as far as I was concerned.

PROF FORSYTH: And did any of the reports and reviews, in particular [inaudible reviews, again across your desk?

DAME CHRISTINE BEASLEY: They didn't.

PROF FORSYTH: So was there a time when some issues that were probably related to Morecambe Bay Trust came to your attention? I was thinking regarding, in particular, the regulation of midwives.

DAME CHRISTINE BEASLEY: Yes. So I think, certainly, wider discussion I can remember took place at one of our regular meetings that I had with regional nurses. Because several of them had problems. Several of them had organisations that had issues with midwifery, so whether it Northwick Park in London or Barking and Havering – There were quite a few organisations. They were different issues, but certainly we had discussions, for example, around staffing levels of midwives and where people were going with that, the role of the LSA, were we sure that was working well, how that linked to the NMC. Were there other things we could be doing that we weren't doing as a group of nurses? So my recollection that was the discussion that was – It was a broader which people shared, whether it Morecambe Bay or Northwick Park or whatever.

PROF FORSYTH: Had there been issues coming up in others – you have touched upon other similar issues in different parts, but did some issues, in particular around the LSA, was that sort of seeming from your perspective as a national issue that needed to be addressed?

DAME CHRISTINE BEASLEY: Yes. I mean not in a way related to Morecambe Bay. Perhaps early on – Every time there were any changes to the structure, which as we know are frequent in health, then there would nearly always be a discussion about do we need the LSA role? What is it? We don't like it. I don't mean from us. I mean a wider group of people looking and saying, "What should be in a health authority? What should be in a PCT?" or wherever it was.

And so there was always – I think every time there was a need, I think, to be clear with colleagues around what the LSA role was. First of all, you just couldn't get rid of it even if you wished to. But there was quite a long discussion often about where it should be placed. Where would be the best place for it to be? For a while there was a view, well, couldn't it just be at the NMC? And so, personally, and certainly with my colleagues, we felt very

strongly that it needed to be at that health authority level because it needed to be working across that sort of an area.

So there were discussions about that. Are we going to have the role at all? Where should it be placed? And therefore what its relationship would be with somebody like, in the case of Morecambe Bay, the region as in the case of Jane and, indeed, the Health Authority. So a real discussion about the independent nature of what the LSA does.

And then I guess the other bit of it was always about how those LSA officers operate their role when there is only one of them, usually, across quite a big area. And what is practical about that and how did that work? And, certainly, my recollection around some of those discussions, as you would expect across the whole country, was that of course people were variables. Some were better at the jobs than others. And I think part of the issue is trying to make sure that they really kept focus on things that they were there to do rather than – Many wished to sort of expand their role into big areas, midwifery, which they may well have had the competence to do or had the capacity to do it. So those were some of the discussions that we had around the LSA.

PROF FORSYTH: I mean it is quite remarkable that the LSA does still exist. I know it is set out in statute, and if it wasn't statute do you think you think would have got rid of it, to put it bluntly?

DAME CHRISTINE BEASLEY: Well, I do not know whether I – You like to think you would never do these things. But I think other people would have done, yes. I think, interestingly, now the world of revalidation and the changes in regulation have come round then I think, actually, in a general way there much greater understanding of the power of that supervisory role. Because I think when it works well it can be very helpful: helpful to the individual midwife, helpful to the service and helpful to how you maintain standards in a slightly independent way, not completely independent but slightly independent. Absolutely, if it wasn't it statute it would have gone. Even in statute it was hard to keep it because sometimes people would, you know, want to make the patches so bit it was not worth having them. So it was still difficult even with statute.

PROF FORSYTH: It predates our understanding of clinical governance.

DAME CHRISTINE BEASLEY: Certainly, yes.

PROF FORSYTH: From looking at the Morecambe Bay situation, in fact, it did get in the way of properly managing these issues more effectively because there was obviously clashes with LSA and with management, clashes with LSA and the families, clashes with LSA and midwives as well, I presume. It just seems to me that certainly that in this area was not fit for purpose.

DAME CHRISTINE BEASLEY: And I think that is the issue. When it doesn't work – I said it was variable across the piece about understanding what that role is. It is not an easy role for individuals to occupy because they are – So what they bring is some independence. Sometime that is uncomfortable for people who don't wish to be told, actually, you haven't got enough midwives, or training isn't right or something else isn't right. On the other hand, and this is the nature of midwifery, it's a sort of generalised rule really, but midwives are – your virtue is often your vice, isn't it? So midwives are often very, very independent practitioners ready to stand up for what they believe is right, I think very genuinely, for the women and babies in their care. The other side of it is they can take up very polarised positions and go – That is the downside of it. Now, if you get an LSA officer that is much more into that role of it all then I think you are in difficulties with it. But I think the purpose of it if it works really well, and we have had some good examples across the country, we have had really good people doing it, then it is a very valuable resource.

PROF FORSYTH: I mean could justify it for all different fields of nursing, for example, or medical?

DAME CHRISTINE BEASLEY: You could do it for all professions. Of course you could.

PROF FORSYTH: It would become unsustainable, wouldn't it?

DAME CHRISTINE BEASLEY: Yes. It may be as you look to the future that is not the right model as you go forward. It is like a lot of things, isn't it? Nevertheless, I think before one throws it all out it is worth just thinking, "So how will some of this work?" because like most things in life there are some good things about the things, even if they don't work very well, and when you get rid of them you can often have unintended consequences around how it works.

PROF FORSYTH: Can I move on to ask you a bit about models of care from maternity and neonatal services, particularly those relating to a geographical area such as Morecambe Bay Trust, and whether in your role of Chief Nursing Officer there was discussions about sustainability of maternity and neonatal services?

DAME CHRISTINE BEASLEY: Yes. There were often discussions around – I mean there were often wider discussions of which I was part, not just myself and myself. It was wider executive team. It is that very difficult balance, isn't it, between insuring quality and safety, often against access or not against access but taking into account access, particularly in some of the areas of the country. So there were quite a lot of discussions around the shape of organisations, particular not just about becoming an FT but how things shaped in areas as to what the midwifery and what the neonatal and obstetric offer was, really, for people. And I think we discussed through all those well-tried roots, from midwifery led services and how that worked, and how near or not they didn't need to be and those things. So as part of quite a few of the discussions around there, there were discussions around models and what that looks like. And different regions were working with – I don't mean they were doing things differently but they were working, local areas, around that. So we certainly had discussions around it.

PROF FORSTYTH: And do you think there has been any progress in resolving some of the issues around models of care, particularly those that are out with major urban neighbourhoods.

DAME CHRISTINE BEASLEY: Well, I still think in the end we are still struggling with those models of care, not actually just in midwifery and obstetrics but in other areas, particularly when you look at rural areas it is a real struggle. So at the moment I am a non-executive on the NTDA and, of course, we are looking at – obviously in a non-exec role – supporting trusts to FT. And when you get to some of the organisations that are now coming forward some of them in some parts of the country it is the huge challenge about not event just the money but how do you get clinical staff able to work in those areas. Even you had all the money in the world to throw at it how do you get them there and how do you keep them competent. It is still challenge.

I don't think there as a magic answer to it. I think that was is important is that people having the real discussions and really coming to so how is this going to work for patients, and also involving, I think, the local communities and people in that discussion to try and get them to have some sort of understanding of what some of that means. I think some of the models have been more refined and I think people have worked at, but I don't think there is a magic answer. I still think it leaves real difficult questions to answer in some of the areas, really difficult.

So we have just had the discussion at the TTA around the break up of Mid Staffs and one of the big issues is the obstetric services – I mean it is in the public domain -- which are not sustainable on the Mid Staffs site. In fact, they are clinically very frail and they need to go to North Staffs, but it is it a journey and people locally understand they are going. And we have almost rehearsed the same arguments again about what is a clinically viable service and how do work. I think that we are better at having the discussion but there is still no magic bullet at the end of it.

PROF FORSYTH: Do you think some of it relates to how we train doctors and nurses? We are training them in a way for the more there specialist centres whereas are not actually train them for the other 80 percent of the country?

DAME CHRISTINE BEASLEY: I think that is definitely true in all sorts of areas of healthcare. We are in some ways still are training model and pathway, which is not the way the world is now in all sorts of areas. Obviously, it takes some time to break into some of those training models but you can do some things. I think you can do some things with the training and education, I think you absolutely can. I think it still leaves you in some degree of difficulty still, I think, with how you manage some of these services. You can manage them better. You can get people. And I think peoples career pathways, particularly in medicine, and the pathway that takes you where you go needs redefining because we have pathways that people naturally want to be on to get wherever they want to be, and actually spending their life buried in Lincoln somewhere is often not part of it because we haven't go the pathway right. I think we can do something about that and that would be helpful.

PROF FORSYTH: One of the issues, particularly in Barrow-in-Furness, is that you have an obstetric led unit but you have a neonatal unit sub- level one, which

is really midwife or neonatal nurse led unit with a small about of paediatric in. And that clearly, I think, from the evidence we have has been an issue, an issue in terms of working relationships between consultants and paediatricians. And just, again, the model is not helping those situations and mothers and babies are at risk as a result of it.

DAME CHRISTINE BEASLEY: I think some of those things can absolutely be changed by looking at a different path of services. Absolutely, they can.

PROF FORSYTH: And what about further development of maternity and neonatal networks? It seems to be it a bit sort of ad hoc as far as I can see, particularly around this area, and the parents do not recognise that they are part of a joined up service. And the idea of, for example, Barrow being a separate service and therefore – and certainly in other areas – In Scotland we have developed some maternity and neonatal networks in which parents then can travel considerable distances but it is planned. The whole idea is it is meant to be planned and safe. I just wonder how much work have you been involved in or been aware of developments in that area?

DAME CHRISTINE BEASLEY: Well, again, I think that was part of all the discussions around the models and how you might get to it. I think there are definitely some advantages around that and I think – So some of that, as I said, was broad discussion around maternity services and how it was shaped and what that looked like and how it all fitted with the rest of it. And as I think, as ever, it is the challenge of really being able to engage local populations in both their contribution and understanding so that they feel that that is safe for them, because I think that is the difficulty.

So a very different example, and I live in London, in London about four or five years ago – probably longer now – the London Health Authority did a whole lot of work on stroke and centralised stroke onto four or five big centres. Well, I live in Ealing, so Ealing Hospital is a sort of DGH, rapidly going towards day surgery, I think, and all of that sort of thing. So the people just marched in the streets every weekend, and I used to come out of the tube and people would give you leaflets saying you will die. I would like to say if you have a stroke you will probably die anyway and Charing Cross is a mile and half up the road. You know are not talking –

And sort of getting into that conversation is very important. But, however, to be fair they did in London. I am not saying it wasn't done without some bloodshed. But it did work and the outcomes have been very impressive. I think the effort you have got to put into those sorts of things is very important with populations. And maybe it is both more difficult and easier in more isolated populations because at least you can sort of corral the population. In a big city the population is a bit fluid. But on the other hand, people have very definite views and definite views about where they live. So I think all of that work – So some of that was done. Some of it was done by the regions. And the Northwest, I think they did do some work around those areas. So we had some general big policy discussion about it but the practical outworkings of it were often discussed then in the regions around what it meant for the Northwest as opposed to the Southwest.

PROF FORSYTH: Okay. Thank you. I will stop there.

DR KIRKUP: Thanks Stewart. Julian?

MR BROOKES: Can I just follow on a couple of – I am interested in the models side of things before we go into some other things, and I remember the stroke work very well. I did it in the Southwest with Damian Jenkins. And we got to the stage where we said, "No. You do not stop at this hospital because it is not safe." I was also involved in the A&E service reconfigurations in Bristol. So it is difficult. But you have got Barrow is very isolated, very geographically isolated, and I do think that makes it more difficult.

And I just would be interested in your views because I there was some work done, because I was involved with it, around the Darzi Review time around isolated services and maternity services was quite prominent in that. And there were ways of fixing the money. It took some will to do so, but you could look at different models, a revisiting of the tariff, an acceptance of running at a lost which is cost subsidised by other services. There are a number of potential ways forward. But it was the staffing side of things, which is what Stewart has already mentioned, which caused the issues. And do you have any views about how those kinds of issues could be resolves going forward, because we are still in the same situation ten years later?

And it is still a challenge speaking to the Trust at the moment in terms of how they want to move forward. They are talking to TDA and others, and

Monitor about trying to get an exemption on the tariff, but at the moment they are running millions of pounds in deficit on an on-going basis to meet the quality standards that are required. And this dichotomy between not being able to afford a service which meets the quality standards seems too often to lead to services closing rather than potential other ways of looking at how you support a local isolated service. And I would just be interested in your views on that.

DAME CHRISTINE BEASLEY: Yes. If I knew the answer to all of that I would be probably running Monitor, but I have no desire to do that. So yes, I think there are. Sometimes it is almost back to the conversation we have just had about the training of medical staff or clinical staff, generally, that there comes a point that no matter how much you work the current system to the best of its ability it still isn't the answer. You might do the best you possibly can and everybody works the best way. So I think there's definitely some merits around relooking at tariff and saying given you have still got people living in somewhere like Barrow you have got people there that will need access to these services. How is an organisation going to do that without either spending so much money that they are going to be out or actually getting into trouble with the quality of it?

So I think there are some things which says, right, that isn't going to work in that bit so if we are going to do it differently how might we do that rather than keep flogging a dead horse. So I think there were some sort of glimmers around it but of course people didn't really do it. Because every time you had a conversation about tariff with the department people would say you can do it locally. You can do what you like locally. Sort of in theory, but in practice not really. So there is something about, I think – There are some things I think you can do that would mean we look at it differently. I think we have got to look more imaginatively around some of the – And it is back to the staffing pathways because, again, how do you get people to work in these areas and stay competent because of the sorts of work that they are doing? So what is the deal for, in this case, a midwife or a neonatologist or an obstetrician? What is the deal which says how do we do it?

So this is just a small example because I have been involved with it in London, not to do obstetrics but with A&E. So in East London, you will

probably be aware, Barking, Havering and Redbridge, which has been a struggling trust forever and a day, has had a couple of – about a year ago had 45 percent vacancy in A&E and its medical staff no matter what the Trust did. They didn't know what to do with it. Because up the road you have got Bart's Health with the ambulance, the helicopter, and a big, swinging new hospital. So where are you going to go if you are a doctor? Do you go? I think not.

Now, actually, because we have got quite a good academic health science network running out of that part of the world what they did with us and one or two other people involved we sort of got together some of these doctors and said, "Alright. What would it take for you to go and work in Barking, Havering and Redbridge? What would it take?" And like most things in life it wasn't money, although we could have given them some more money, what they wanted was something badged under the UCL badge that gave them fellows and something else and something else, which actually was relatively easy to do and we could do it. So I am not saying it is magic but it started to say, "Alright then, under those circumstances I will work their for six months" and we can get some rota and all of that going.

So I think some of it is about talking to some groups of people, good people, and saying what would it take for you to work here now, because if we change the educational pathway now it's going to be quite a long way down the thing before it hits. I think we have got to do some of that with some of those things, get people together and say, "What would it take?" And then you have got to get some of the decision makes together, whether they are the professional ones, the GMC, all the rest of it. Some of it was money. So for us in that part of the world it included NHS included, the TDA, Health Education England because of some money around that, all coming together and saying, "How do we support that model? And then let's have a look at it and see if it works." So we are in the middle of looking to see if it works. So I am not saying that is the answer to everything but I think some of it has to be that in the short term.

MR BROOKES: I think it is very interesting because it's understanding who and where in the current system are the leaders.

DAME CHRISTINE BEASLEY: Yes, exactly.

MR BROOKES: And it does feel very fragmented.

DAME CHRISTINE BEASLEY: It is.

MR BROOKES: And if you were to talk – One of the things we have found is – you call it learned helplessness or something. There is a feeling of helplessness where "We couldn't do that because we didn't feel we had the authority or the power to do that, or we thought we would be countermanded by the next layer of the organisation" etc. And you can do that. You have got a good understanding of how the systems work and who the key players are. But I am trying to get to feel is this something that should be happening locally? Is this something that should be – In which case it is down to the quality of the local people and their ability to work together to come to solutions. Is there anything that should be done at national level? Or is there something in between? Where does it sit, this kind of management of the bigger questions?

DAME CHRISTINE BEASLEY: Of the system? Yes. Well, I guess some of the long-term solution has to sit nationally because some of the long term solution means talking to Royal Colleges and saying, "You know what, we need –" However brilliantly you might be locally to have this person going it is not going to work. So some of it needs to happen. There needs to be, I think, a vision of sort of where we are going and what will that look like. And so some of it needs to happen nationally.

And then I do agree part of – good, bad or indifferent as health authorities were, they were the place that pulled together all the players and they sort of had a system leadership role and that is what now missing in the current set up. And so I think there is something which says how do we, given that it is probably not going to change too dramatically too soon, somehow charge the main players to have a responsibility for coming together with a system? Now, we have done it in a way around – So we have done it a bit around whenever there is a big problem there is a quality summit where everybody is required to come, whether it is the CQC or the TDA, together and say, "How do we solve that?"

So I think it is possible to generate in people that this is your responsibility to come together around some of those areas. But I think it is much harder – I mean we were lucky because what [inaudible] for us,

because it was one of the early ones at UCL and there is marvellous guy called David Fish who runs it, who everybody loves, and what that really is is a provider network. So they bring together medical directors, nurse directors and all the chief executives in the patch so when there is a problem we can mobilise them. We can say and they will come to the table because they are part of this what they call UCL partnership.

So somehow there is something which says – I don't know whether you want one size fits all or whether there is a charge which says in each area you need to be able to demonstrate how you can mobilise people around issues. You come up with so that you don't end up with somebody saying, "We don't work like that here in the Northwest", but you come up with a model which says how you do because you do need to do that. In my view, there isn't a way you are going to get out because we wouldn't have even begun to solve Barking, Havering and Redbridge without everybody around the table.

MR BROOKES: And somebody holding the ring on that discussion.

DAME CHRISTINE BEASLEY: And it was quick. Yes. Well, the person who held the ring, you see, was David Fish, who is a doctor, very well respected, but understood and he really – Actually, he didn't instigate it. Several people were saying, "We don't know what to do." And they said, "Well, let's go and ask the people." And he turned up and because he was slightly on the outside he became the person that sort of held the ring. It won't work in every part of the area, but I guess one of the downsides and upsides of this sort of local devolved thing is that it is going to be a bit messy and what you can charge people with is that they have got to have a model. How they do it is sort of up to them but I have got to have a model to deal with it.

MR BROOKES: That's quite helpful. Changing the subject slightly, again something Stewart mentioned about LSAs and their relationship to strategic health authorities at the time. It seems that that was variable around the country. You would accept that that is a fair assessment?

DAME CHRISTINE BEASLEY: Yes. That's true.

MR BROOKES: Do you have any view of how it worked within this particular area?

DAME CHRISTINE BEASLEY: My sort of recollection – It was variable. It was variable in the people. And it was also, to be fair to the LSA officers, it was

variable about how their regions involved them. So some were very on the sort of over there as a slight irritant and others were pulled in more to the how can we make the best of you to help us do all that. So I think it was variable. And my recollection of the Northwest was this wasn't one of the better models of the LSA model. I think –

MR BROOKES: In what was it more isolated?

DAME CHRISTINE BEASLEY: Well, my recollection – and I wouldn't stand up in a court of law and swear to it – was that the individuals who were LSAs officers were a much more sort of independent mind, as it were, and I don't think were as knitted into the Health Authority as they might have been. And it is that whole issue of independence that people spend hours overdoing. The good areas had got that cracked, managed to sort of work that together. I don't think the Northwest had got it as well, has sort it out as well.

MR BROOKES: So in a situation where there had been local advice to a Trust from the LSA about improvements required, and not seeing improvements, and they brought that to the attention of the Health Authority what would be your expectations on the SHA's role in terms of that? Would you expect them to become involved at that stage?

DAME CHRISTINE BEASLEY: Yes, I would. I mean even for an FT, which I only understand the issues around that, I think if an LSA officer was saying "I am very bothered about the standards of whatever, and this is why I am bothered and here is the evidence" and more than just a – Well, sometimes it is helpful to have somebody to say, "I can't really prove it but I am anxious." I think that should mean let's investigate further and just see. But if you got some then I would expect somebody to say, "We need to be talking to –" I mean I think practically the discussion would have been – So if anything of that nature – that wouldn't have come to me in the department – but a bigger issue, if it had come to me, a professional issue in the department, my first response would have been to think about it, talk to David Nicholson and say – that's my boss – "I have got a real concern about this. This is what I think I want to do about it. But I want to tell you so that I am not going to –" And then you would agree what you're going to do. So I would expect that to happen in the SHA. But to go in – And sometimes, you see, the advantage of the professional route is you can go in when a general management route

is more difficult, particularly with an FT. You can go in and say, "I want to understand what is happening here, I am really bothered about it."

MR BROOKES: You mentioned FTs. Probably, I think, this is a short answer, but what was your involvement at the department in terms of the assessment of FTs?

DAME CHRISTINE BEASLEY: Certainly right at the beginning there was no involvement from any clinical side. It was only when, post-Mid Staffs, Bruce Keogh, who is the Medical Director, started and then I did – I would do a little bit. If there was some clinical issues that needed wider [inaudible] then I would work with Bruce. But it was very latter days of my role their because it didn't come out of that unit, really.

MR BROOKES: What was your involvement in quality at the department?

DAME CHRISTINE BEASLEY: So in all the years I was there I obviously too the professional leadership role and then for quite a while I was responsible for reducing healthcare associated infection, so that – I mean in the sense that quality sort of fits around there. I clearly had quite – It wasn't my lead responsibility, but obviously I was involved in quite a lot of the workforce issues, so numbers and particularly on the nursing and midwifery side, growing and not growing. So I was absolutely involved in that. And then, really, those were the areas, so some of the safety work, some of the workforce areas, that sort of area. And, of course, that grew as the importance of those areas became much more –

MR BROOKES: So take Mid Staffs to one side for a moment, but if there had been a significant clinical quality concern or safety concern which had escalated to a stage where it had been made aware to you at the department where would it sit within the department at the time? Who would take the lead and the responsibility?

DAME CHRISTINE BEASLEY: Yes. Good question, isn't it? I think, you see, it could have come in in several routes because there wasn't a "you come in through this route". So I suppose it got more organised as time went on, if I think from 2004 to 2012 because, obviously, Mid Staffs was quite early. But even before Mid Staffs we had things like Maidstone and Tonbridge Wells. We had other areas. And I guess this the issue about it didn't come in in that way. So sometimes it came in through the clinical route. It might come in

through the CMO route. It could have come in through my route if it was really nursing and midwifery. It certainly would have come in my route for quite a long time if it was healthcare associated infections. I would have come in.

So it didn't come in to somebody who says "I am the Director of – and it comes to me." And so I think it is fair to say that because it could come in in those different ways you are very reliant on the person to whom it comes in to, not only to maybe to clock it is important but also to think, "I need to talk to these other people". And sometimes it is easy in hindsight to look at it and go, "We should have done this and that." But when in the busy fit of the day it comes in and sometimes things look big and they're not, and other things come in and they look like nothing and then, suddenly, they blow up in your face. And I guess that is the bit about having a proper system, which I think is much better now, where people absolutely know how to look at it all.

MR BROOKES: I think we would agree with you. There is evidence of elements of knowing little bits of the picture. It is where it is brought together and how that would then be dealt with.

DAME CHRISTINE BEASLEY: And I think where it did work and when it was brought together was when somebody did say we have got a problem with whatever it was, and then there were times when we discussed either as an executive team and then agreeing who was going to take the lead or the executive team and the SHA directors as well, some of those bigger areas. Certainly, that's what began to evolve in David's time, 2007, 2008, 2009. That began to be a much more systematic way, I think, of looking at failures or concerns. But before then that wasn't how it worked when I started in 2004.

MR BROOKES: Were you involved at all with CQC or anything, any other sort of external moderators of service investigating long-term etc.?

DAME CHRISTINE BEASLEY: Not really. No. I mean –

MR BROOKES: So who did that report through to?

DAME CHRISTINE BEASLEY: Well, in my early days it was CHI and that – Do you remember CHI Yes, exactly. So some of that reported into – CHI reported to Liam. I can't remember. Yes, I think it did just going but in the mists of my mind. So things often reported into there or, as things went on, different

directors. So I think at one stage Una O'Brien at one stage before she was permanent secretary she was the director of something strategy that took responsibility for setting up what came after CHI.

MR BROOKES: The Healthcare Commission.

DAME CHRISTINE BEASLEY: That is it. So she was the lead director that was responsible for that and it came in that way. That is partly, I think, because it was setting up a new organisation. So different people took different lead roles. Yes.

MR BROOKES: So there wasn't, again, a bringing together, necessarily, of the intelligence from those? It was a more an organisational, responsive relationship.

DAME CHRISTINE BEASLEY: No. When all of that – I think if I am really honest about it all of that started of the Mid Staffs. So the work then that came out of the West Midlands, so then after that there was the incomings and Peter [Blythe?] and [Joe Leonard?] and [inaudible] worked with a whole range of us that used to then come together, looking at how you did some of the legacy handover bits, how you really looked at quality. And that, I think, was the first time it started to come together so that everybody had some input into it, but it was post Mid Staffs.

MR BROOKES: Is it fair to say that at that time there would be an expectation that the strategic health authorities had a better handle on the quality of service that is being provided in those areas?

DAME CHRISTINE BEASLEY: Yes. I think that the view was that the department had a role in absolutely looking at both the policy implications and some of those wider things, so whether it was workforce. Those sorts of things. And that, actually, the operationalization of it happened at Health Authority through level. Except that every so often, as always happens with ministers, they would have a view about something. So that is how I got healthcare associated infections and then had an operational hand, really. I mean I exercised it through the SHAs because you can't do it from sitting centrally doing it. But there were things like that that minsters then suddenly said, "This is important so you had better do it." Mixed sex accommodation was another thing that they just said, "You do it." But in general terms – But even

then that is the only way you could do it. You didn't really have any other levers to do it.

MR BROOKES: Because in effect they were the operational arms for you.

DAME CHRISTINE BEASLEY: They were.

MR BROOKES: I understand. So that is the service and system I knew well. Where does those responsibilities lie now, in my view?

DAME CHRISTINE BEASLEY: I left two or three years – Well, this talks to the fragmentation of where we are at doesn't it, really? Because love or hate, as I say, there was a sort of line of sight, as much as it didn't work but there was a line of sight. If I want to be very honest about it I think somebody like the current Secretary of State searches around for levers that he doesn't have anymore because of the Health and Social Care Act. There are few levers to really sort of operate whether you wanted to or not from Whitehall. And I think it therefore depends on people coming – To be fair, I think they are. So NHS England, the TDA, Monitor, in the person of Simon Stevens, David Flory and David Bennett, come together as a sort of we need to try and work collegiately together so the system, so the people that we are working with, does not get 5000 different mixed messages and we need to – there is quality issue, we all come together. Obviously, that includes the CQC as well in that area. So I think that is where it sits. But the levers are very different for all those different organisations and you have got to sit down and work out how you are going to work it together. And to be fair that is what they are trying to do because they see that on their own it is not sensible. But it is a bit of a muddy picture.

MR BROOKES: It is. Just a final one from me, I might argue that those are responsive and reactive services. They tend to come together when there is a failure and already a failure has happened and it is an opportunity to try to bring them together to say – I don't see that proactive element.

DAME CHRISTINE BEASLEY: No. Although I think – I am obviously a bit biased because I am on the TDA. I am obviously a bit biased about, despite what [inaudible] says about it. But I do think what they are trying to do now in some of the areas is to start to do that look forwards. So certainly the discussions around where we are with the money, what that implication has for services and how we pull that together, what that looks like for the shape

of it. So we have had discussions and they have had discussions with Monitor and NHS England about as you look forward at the shape services where are the ones that with a following wind we think that will go pretty well, where are the ones that need a lot of input and what does that look like, and where are the ones where we haven't got an answer to it and we should be working very hard around. What does that look like in terms of the shape? And then what is the link to workforce and education?

So I think they have started those discussions but they are very embryonic and partly because, too, they have also had to wait for Simon Stevens to arrive and sort of, whoever it was, in the case Simon Stevens, for NHS England to be part of that bit, because in my personal view the commissioning side is still very week. Not surprisingly it is not to do with individuals, it is how it is. So that side is very week and without that it can turn into a reactive thing because you tend to deal with what is happening in front of you today rather than doing the where does this shape, where do we go forward with it. So I think they are starting to do that but it is early days. And I think the department it is not set up to do that anymore. It has neither got the capacity or, indeed, the competence, not because the people are incompetent but because a lot of that what I might call NHS competence went out when they said that's not what the department does anymore. So they're I think in a much more different place.

MR BROOKES: That's very helpful. And just to summarise what I think I have heard is that as far as your involvement in Morecambe Bay very little came across and you were aware of some conversations, mainly through Jane Cummings and your links as regional nurses, but very little came that way. You have also described, certainly at the beginning of your time, a more fragmented approach or not a joined up approach within the department with different people responsible for different elements and that slowly coming together with the catalyst for that being very much around Mid Staffs.

DAME CHRISTINE BEASLEY: Yes, absolutely.

MR BROOKES: Okay. You have described a particular kind of role for the strategic health authorities, a more doing bit in helping you implement, and being aware and seeing what happened in those localities and managing the market in those localities, which was one of the duties and responsibilities.

And I think I would agree with you about the current commissioning. The commissioning wasn't really strong beforehand either.

DAME CHRISTINE BEASLEY: No. Not at all. I mean it is not surprising because we have never invested as much. I don't just mean money but in development of it. So it is not surprising that there are notable exceptions. It is a much weaker part of our service and we have still got if you look at the big and able people, whoever they are, they tend not to be in commissioning. They tend still to be in the provider side of the business. And so it is a bit of a journey and it is not a criticism of the particular GPs doing commission, it is commission itself it a fiendishly difficult thing to do in something like a national health service, I think.

MR BROOKES: Just when it means you might have to close services.

DAME CHRISTINE BEASLEY: It is not easy, like you say.

DR KIRKUP: Just a couple of specific points from me. I was interested in what you were saying about what would it take for professionals to go and work in the hospital down the road as opposed to the big centre. You talked about badging And I think you can see in another of different places they have tried to that. For example, in this case it is University Hospital of Morecambe Bay. That is an attempt to do that.

DAME CHRISTINE BEASLEY: I know.

DR KIRKUP: The problem seems to me to be that it sort of devalues the currency because nearly everywhere is in a University Hospital now, isn't it?

DAME CHRISTINE BEASLEY: Yes.

DR KIRKUP: Is there way around that or are we just stuck with that?

DAME CHRISTINE BEASLEY: Yes, I agree with that. Well, I think it has got to be real, hasn't it? If it's not real then people suss it out. Probably – I know some or the Northwest but it is more the Manchester side of it – the University of Morecambe Bay is not going to be in the same league as some of the other universities and people know that. So just calling it that makes people look foolish, really. I mean it doesn't do it. I think the important thing is what actually happens and how that links, particularly if you are talking about medical staff and lots of clinical staff. How does that help me get the experience I want, move on in my career, do the things I am interested in?

Not, necessarily, because I want to be the most stunning obstetrician in the world, but I want to do things I am interested in. So that has to be real.

And in a sense whether you are badged under a university at all doesn't really matter. I think it is what actually happens. Here am I on my pathway, how is this going to help me? And that is what I think has got to be real rather than the – And then you might want to badge it with something else. And the reason it works in that bit of London is because UCL is – so UCL has got a big reputation so therefore you are happier to have that as your badge.

DR KIRKUP: Absolutely. That takes me on to the second half of that question which it is takes two to tango. If you are going to link up with somebody, having Barrow linked up to Lancaster, which is supposed to bring to some of those candidate – It is not exactly UCL but it was a step in the right directing – what they seem to have met with is a lot of resentment from Lancaster. Lancaster regarded them as not in the same league as themselves. How did you overcome in the case of the UCL example?

DAME CHRISTINE BEASLEY: Yes. Well, as I say, I think because there were some significant players sitting around the table, so David Fish from UCL, the Medical Director from Barts. As it happens, and sort of serendipitously, the person who works – The reason I know quite a lot about it, not just the NTDA, because I share a [inaudible] and the person who was the [Letherby?], managing director they were called, as it happened had been a doctor at Barts previously and so also knew enough people. So I think you have got to get some of the key medical players for this bit. It doesn't always have to be. It depends what you are trying to solve. That was where you got people so that it became a real experience. I mean it is still early days so I wouldn't overegg it with it has all been marvellous because it has only been going a while. But I think that is what you have got to get.

I am not saying this but if the Medical Director at Lancaster thinks, "It's all rubbish down there and they are all rubbish, I am never going to talk to them" you are doomed to start with, really. Somehow you have got to start to say, "Well, that isn't the way we are going to work here." And then you are back to who is the system has that conversation, now, with people. So what is it in for Lancaster to go and help. What is in it for us? It is not because

you are just nasty about it. It is just because the system rewards you in certain ways, doesn't it?

And the thing is when people want you to do things – So you'll know because Jerry is on your panel. So Kings in London has taken over the PRUH, which is in Bromley, which was a struggling organisation. So while it is all happening everyone is agreeing it and it is marvellous, you are marvellous, and it is all lovely. You'll get on with it and it is all lovely. Now the money is going south a bit and Monitor are going [inaudible] you suddenly think, "Why did I ever do that? Why did we ever take that on?" Because it is difficult.

I think there is something about how you – It is back to some of those culture behaviour, which are just as an important a change as a sort of caring and compassionate nursing end of it and there is some of the cultures about how we work together, which I think has been lost a bit by some of the whole market FT stuff.

DR KIRKUP: Okay. Thank you. Last subject area from me. One of the things that really shapes the kind of public response when there is a serious service failure like the ones we are talking about is how the communications around that are handled. And I want to ask you what was your view of how the department got involved in that? What were the messages that the department were giving in this situation?

DAME CHRISTINE BEASLEY: Yes. Again, I think over the time – I don't think this was linked to Mid Staffs in particular – I think over time the way the department dealt with comms got better, I think, in some ways in terms of how it worked, how it set up its networks with SHAs and began to get some of that going. I don't think that always worked like that. And I also think that the department was sometimes caught between looking up to number ten and that responsibility around comms as well as looking out and thinking, "How do we get a joined up communication?" And sometimes I think SHAs were not good themselves in having those sort of conversations. So, again, I think it could be a fragmented type of service, which I think got better but was fairly fragmented, I think.

DR KIRKUP: How did you reconcile the demands of looking up to number ten in terms of dealing with the SHAs and other organisations that were managing this on the ground?

DAME CHRISTINE BEASLEY: And certainly I was very involved in that around HCIs because in a way that was [inaudible] week, practically. I mean I think it is all that practical stuff. You have got to have someone in number ten who understands what you are trying to do. And also that you have got a bit of an eye on what that means for number ten. So some of that is just practical stuff about when you make announcements and how you do it rather than just inadvertently –

In my day it required close links to the spads around the ministers. That's what it required so that you could sit down and so that you could be a bit of a voice for the SHA to say, "They can't do that" or "If you get them to do that this is what will happen." So when it sort of went wrong, which I was involved with, which was before was Mid Staffs, it was when it was Maidstone and Tunbridge Wells and that was all around – I won't bore you with the story. Alan Johnson had just come in as Secretary of State. He had come from Education. He had brought his spads with him and it was August. You can always write the story, can't you?

And I kept saying to the spad, who was very reluctant to talk to me, that this was going to be a big story. His view was, because they had come from education where, actually, if something was wrong with a school unless something dreadful it was all local, and I kept saying, "This isn't how it works with health. This is all going to blow up." So they absolutely and completely sort of set their face against me, really. David Nicholson was sort of just in and he said, "Yes. There probably will but you know." Anyway, then it all blew up. It didn't give me any consolation because then I had to come back from a holiday, because when they found out it all blew up they then said, "Where is Chris Beasley? She is on holiday. Come back now."

And then I think it was a big learning thing for them about how in health you have got to stack up of comms things. So sometimes it doesn't work however hard you try. I think it is better now because they have got a much better understanding. But you do have you to stack up Number 10, the spads and the comms.

DR KIRKUP: What you're describing there, I think, let me play this back to you and you can disagree if you want to. What you are describing now, I think, is the process of managing expectations on both sides, is that right? Is that fair?

DAME CHRISTINE BEASLEY: Yes, I think that's right.

DR KIRKUP: Were you ever involved in any situations where people were instructed to manage news stories to make them go away?

DAME CHRISTINE BEASLEY: To go away? To be absolutely fair I don't think I ever was. I think there were – I mean I personally wasn't. I suspect some of the people in the comms department might have had a more robust conversation with number ten. I think the conversations that I ever had were much more about when you made the announcement, not that you didn't but when. You know, "The Prime Minister is about to do so and so. You can't do it on Monday." Even if it was a bit tricky. So it was more that than, "No, you can't do it. No, you can't say." We had tricky times around the HCI bit. But that was about counting, really, counting the numbers. And there was many ways to count them as you can think. So some of that was more about trying to keep – And my line – Well, not my line. But my belief then was to say it took me a while to get microbiologists on board for all sorts of reasons around this, not least because I was a woman and a nurse. So it took me a long time to get them to say we could to better on this. And I sort of said, "If you try and muck this about for me you will lose them because they are already very suspicious. If you try and put numbers out that don't stack up for them professionally they will just go." So those of things. But it was more that, not we don't want the story at all.

DR KIRKUP: Okay. So robust conversations about timing, robust conversations about whether you are counting things in the most appropriate and useful way and all of that, but not about making the story go away.

DAME CHRISTINE BEASLEY: Nobody ever said to me – No. Nobody said that to me.

DR KIRKUP: Did that change it the run up to an election?

DAME CHRISTINE BEASLEY: Yes. I suppose. Nobody ever said to me, "Don't print a story." But there is never any doubt that people don't want bad stories as you run up to an election. But to be fair I think it was more about, "So do we think there are going to be bad stories? What are they? And what can

we now do about it to stop them being a bad story?" Rather than, "Don't let's do it." So if A&E is going wrong will money help? Rather than just sort of pretend it isn't happening. Those were more the conversations rather than anything else.

DR KIRKUP: Do you have any examples of "Let's pretend it's not happening"?

DAME CHRISTINE BEASLEY: No. For me, personally, I never got involved in that. None of them ever said that to me. No.

DR KIRKUP: Okay. Any –

PROF FORSYTH: To go back to the issue around models of care but just as a different aspect of it, it seems to me in medicine we have very much been over many years now evidence based medicine. But we don't we don't to have quite grasped the importance of evidence based care. Again, from you perspective leading up a multi-million pound organisation, how much funding goes into researching this? It seems to me that we are clearly quite badly concerned about actually delivering care to the patient is really important in terms of their health. But, actually, probably a lot of poor healthcare arises from the models of healthcare, not having the patients treated in the rate place at the right time by the right person etc. Again, bringing it back to Morecambe Bay, this is an area where everyone has said to us it is really difficult. It is really difficult to know how deliver maternity and neonatal services here. If it is a problem why are we not researching it and actually finding the solution?

DAME CHRISTINE BEASLEY: I think that is valid. I think there is research and investigation into some of those things. And there is some of that happening, but probably not enough. So I think there are some things – As I said at the beginning, you've got to look at it differently, you have got to look around and see what is out there in other systems and have we got things to learn form some of those?

But I also think that it is also important to say there is quite a lot that we do know that we should get on with. So if I got back to the HCI bit, so Bruce Keogh, my medical director, used to say – So when HCI working started, which was reducing MRSA, Bruce was a heart surgeon in Birmingham and then UCLH, so he didn't know me and I didn't really know him, and he said, "I can still remember reading about this and thinking 'Who is this silly woman

who is meant to be – It is a mark of modern medicine.'" It's what you usually said. And we are good friends now so it is alright.

But what he use to say when he and I used to share platforms when we started to work together, "Look there is a lot of evidence around. We as clinicians did nothing about it. It took a politician, it took John Reed, a robust Glaswegian, who came in and said it is not good enough. You have got to do better." So the evidence was there. We did do better. It is a very different world now in HCI work. But, actually, it wasn't the clinicians who drove it, it was a politician. So sometimes when I used to talk about things, I don't do so much, I used to say there are some good things about politicians as well as bad things. They sometimes say things that are not comfortable. So I always hold that in my mind because I think there is a lot there that we know about that we don't do.

So, actually, Lancaster should be helping Morecambe Bay and we should be thinking, "How do we get them to do it?" So there is something about upstream stuff, absolutely there is otherwise we wouldn't be getting anywhere. And some of the models, I think it's absolute right. But there is an awful lot about what we know now that we need to get on with in my view and get it done.

PROF FORSYTH: Again, it does seem to be very fragmented that approach, isn't? There is a group about to start looking at the configuration in Cumbria and you just wonder where they are coming from and have we got a wider strategic approach which is evidence based, we have [inaudible], we have got evidence of how to actually take us forward. I wonder if it might be – You have got to take time to do this. You can't sort of suddenly close hospitals overnight, which is fairly obvious. I just wonder, and this is just one area where – I am sure there are several examples elsewhere across the country – and it would in relative resources that go into healthcare within England it wouldn't take a huge amount of that to maybe sort out some of these issues and actually provide funding into Barrow which would be a centre of some of this research and actually attract people to go there.

DAME CHRISTINE BEASLEY: Yes, exactly. So you need to do both, don't you? Yes.

PROF FORSYTH: You wouldn't give the funding to Lancaster.

DAME CHRISTINE BEASLEY: Exactly. You are back to some of the levers. What are some of the levers you could use that could make it easier for other people to play, to support them, really?

MR BROOKES: Again, I find the system – there are barriers in the way to pulling those levers.

DAME CHRISTINE BEASLEY: Yes, there are.

PROF FORSYTH: Who is going to focus the attention on doing that? It might come up with some recommendations from a report or something, but who is going to do that? How does the local community come into that kind of situation and have the ability and the way of pulling those levers? There is just one last question I wanted to ask you which is if you take the example hospital acquired infections and the work and the way in which you operated across the system, a totally system approach, how would that happen now would be my question? And I am not sure.

DAME CHRISTINE BEASLEY: No. I think it would be very difficult. I mean it is even more dependent now upon relationships. Relationships always matter, but it is even more dependent now on personal relationships, I think, to get that going. I think it is very hard. I don't know how it'd work. Because even if the department said, "I am going to do it" or Public Health England said they were going to do it where you would reached into – You can't reach into all the CCGs. You can't do that. It is not possible. And, I suppose, when you get back to it that is sort of slightly what we lost with these changes was that system, poor though it might have been in some ways, leadership. It what other countries envy of us because we have a system. It is what faces the States. They can't do that because they haven't got that sort of system. That's the sort of way we are here in many ways.

PROF FORSYTH: Thank you.

DR KIRKUP: Is there anything else you would like to say to us?

DAME CHRISTINE BEASLEY: No. Good luck, I think, is what I want to say. Thank you very much. Nice to see you again. Bye.

DR KIRKUP: Thank you. It is appreciated and thanks very much for coming.

THE MORECAMBE BAY INVESTIGATION

Wednesday, 8 October 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Professor Jonathan Montgomery – Expert Adviser on Ethics
Ms Jacqui Featherstone – Expert Adviser on Midwifery
Professor James Walker – Expert Adviser on Obstetrics

DAVID BEHAN

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(At 12.35 p.m.)

DR KIRKUP: Apologies for the late start, some of which we've contributed to.

MR BEHAN: That's okay.

DR KIRKUP: I'll say for the record I'm Bill Kirkup, we have met previously, and I'm chairing the investigation panel. I'll ask my colleagues to introduce themselves to you.

MS FEATHERSTONE: I'm Jacqui Featherstone, and I'm Head of Midwifery and Head of Nursing in an Acute Trust in Essex.

PROF MONTGOMERY: Jonathan Montgomery, Professor of Healthcare Law at University College London, and Chair of the Health Research Authority, and for the record, we have met in liaison between the Health Research Authority and the CQC.

MR BEHAN: I do remember, yes.

PROF WALKER: I'm Jimmy Walker, I'm Professor of Obstetrics and Gynaecology in Leeds, and have previously worked within the National Patient Safety Agency.

DR KIRKUP: We are, as you know, recording the proceedings and will produce an agreed record at the end of the process. We also have opened proceedings to family members, although as it happens there are none present today, but they may be able to listen to the recording subsequently.

MR BEHAN: Yes.

DR KIRKUP: We have asked you to hand in any mobile telephones, recording devices, etc. So do we, by the way, that's just to underline the fact that...

MR BEHAN: Yes, I know, they've all been taken, yes.

DR KIRKUP: Yes. We don't want anything to go out of the room until we're ready to produce a report with findings in context. Do you have any questions for me about the process?

MR BEHAN: No, I'm fine, yes.

DR KIRKUP: Okay. I'll start with a very general question, then I'll hand you over to Jonathan initially. My general question is will you just remind us of exactly when you started at CQC?

MR BEHAN: Yes, I started on 13 July 2012 on secondment from the Department of Health. I think people were keen to get me there as quickly as possible, and I formally started – my contract started on – I think it's probably Monday, 29 July, if that's a Monday.

DR KIRKUP: Yes.

MR BEHAN: And – yes, so that's when I started.

DR KIRKUP: And that was as Chief Executive, which is your current position.

MR BEHAN: Yes, I began as Chief Executive. I think my predecessor left on the Friday before 29 July, so it was continuity. I think that's what the then Chair wanted, is continuity of accounting officer role from Cynthia leaving and me starting, so that's what that was choreographed around. So my letter of appointment is from the 29th. As I say, I was in there from – I think it was the 13th, off the top of my head, which was a Monday.

DR KIRKUP: Thank you.

PROF MONTGOMERY: Thank you very much. As you know, a number of members of staff who worked with the CQC at the times when those decisions were taken talked to us about what's gone on. I think what we'd really like to hear from you is what the CQC has learned from the Morecambe Bay experience, and how you've changed things in order to remedy what you might think are the learning points and how you think things will go now if the same sort of set of circumstances unfolded.

MR BEHAN: Okay, thank you. So I think there were a number of things happened from the creation of the CQC to the publication of our strategy, draft strategy, in the September of 2012 that actually contributed to some of the changes; Morecambe Bay is one, the concerns around Morecambe Bay, but the reports of the Health Select Committee, the reports of the National Audit Office, the comment from the Public Accounts Committee, the Department of Health's own capability review.

There were then numerous complaints, of which James Titcombe's case was one where people made feedback in relation to the effectiveness of CQC, and I think there is consistency between the Select Committee, the NAO, Public Accounts Committee and the Capability Review about the robustness of the methodologies that were actually being used to inspect and regulate health and care services. I think it's important that I stress that actually as a regulator we're responsible for regulating a range of services of which acute healthcare is but just one. And some of the feedback in relation to the robustness of the methodology wasn't just focused on acute healthcare at Morecambe Bay.

So there were a range of avenues of feedback, and if I distilled those comments it was about the robustness and resilience of the methodologies that were being used. Do ~~T~~they get under the skin of how effective health and care services were being – how effectively they were being delivered?~~.~~ The strategy that we worked on, that we published in the autumn of 2012 really set out the direction of some changes that we would make. So they asked a number of key questions in relation to the development of services, and there was a pretty extensive consultation programme that took place during the late autumn/early winter of 2012 into 2013. ~~They~~ We published a revised strategy in early 2013.

There were two or three other things going on at the time, Jonathan. Firstly there was – Robert Francis was coming to his conclusions, and if you can go back to that period of time it was when will this be published? We thought it was going to be published earlier in 2012; it ended up going back a bit, so landing and finalising the strategy was something that we needed to be mindful that we'd need to accommodate Robert Francis's recommendations; also aware that the Government would respond to Robert Francis's recommendations, which indeed they did. And in September 2012 I was aware that there would be a new Chair for CQC, I just didn't know when. I don't think Jo had resigned at that point, it was later in the autumn that she resigned, but I knew that that was something that she was considering, and the issue wasn't "if", it was "when", and that that would then trigger anew.

So what did we say in the strategy? We talked about having a differentiated approach to inspection. That translated on discussion into a move from generic inspections, an approach which actually had as its basis that how you inspect an international teaching hospital and a three-bedded care home for people with autism was effectively the same, and that inspectors could be generic, that you could inspect a three-bedded care home and an international teaching hospital, and the skills that were required were generic. It was the skill of regulation.

And I had all kinds of problems with both of those concepts of both generic inspections and generic inspectors, and we teased those out in the consultation. And they were effectively at the heart of the changes that we'd made, so from generic to specialist was one of the ~~minutes~~ changes;

inspections being a single pursuit of an inspector that would attend on site, maybe with one or two other inspectors, to being a team pursuit. Our inspections now of acute hospitals would involve inspectors who will know regulation, know how to take evidence, be able to take witness statements, but would also comprise of specialists, clinicians, governance experts, people that have managed in acute healthcare services, and experts by experience, people who have used services and will have a contribution to make from the perspective of either caring for some of the acute services or the fact that they've used services. So they were some of the changes we ~~took~~ made. Effectively it was about getting under the skin of an organisation.

We also changed, in a sense, the model. We moved from an approach to regulation, which was built on compliance, a simple pass or a fail approach. You either meet these standards or you don't meet these standards to one where we used judgment, and that would be clinical and professional judgment about the quality of services. So in moving from a regulatory framework which effectively saw a measurement of compliance with a number of standards to one where we were going to give a judgement about the effectiveness of services, ~~s~~So we designed the approach to regulation to answer five key questions: Are services safe? Are services effective? Are services caring? Are services responsive? And are services well led? The reason we went for those five questions was the first three are based on Darzi's definition of quality and high quality care for all. We did not want to change the envelope within which the discussion about quality took place; that was pretty much embedded. And you can go back to the 60s and Donabedian, and build on those definitions of quality that go from that time, and that's we were consciously setting out to do.

How services will respond to their local population. The hospital that serves Newham, where I think there's 140 languages spoken in primary schools is going to have to meet a diverse population in a different way, without getting into dreadful stereotypes, ~~and~~ then something in Northumberland, just by definition. So responsive wasn't just do you meet waiting times, etc., but was about do you meet the needs of your population?

And then how well led were organisations, and this was really borne out – Morecambe Bay played a role in this, but also largely borne out of Francis's

recommendations in relation to Mid Staffs about the culture of organisations, and how the leadership from the board through the executive team set the culture in an organisation. What is it that's important in organisations? What do the senior leadership signal as being important, and how does that signal become adopted by the people that work in an organisation? So if the important thing around here is money and financial balance; that will be signalled in a way. If ~~T~~the important thing around here is clinical quality, and that will be signalled and people will behave accordingly.

The literature of people like Michael West on culture and leadership, the literature around engagement and culture and leadership influenced the way that we designed that fifth question, and I think was one of the changes from our previous methodologies where we ~~were~~ are looking at the culture of an organisation, not just a compliance with standards, so a pretty significant root and branch change from a model of compliance and genericism to a model of judgment based on professionals and regulators working in combined teams.

We also wanted to have a more intensive process where any approach to regulation combined intelligence, and by intelligence I mean data, hard and soft. And a key development of the work that we've taken forward since 2012 is what we called intelligent monitoring. One of the key questions I was effectively set by a number of different people when I took the job is, 'Could you predict another Mid Staffordshire?' You could ask, 'Could you predict another Morecambe Bay?' And – well, I would answer that, 'With precision, no.' But it is possible to actually look at a range of data, quantitative and qualitative data that will act as a smoke alarm, so it is not definitive, but it can identify where there's risk in services, risk to quality and safety in services. And we did a lot of work over a 12-month period to develop what we've called our intelligent monitoring, so we've now published three iterations of this, which against 150 metrics, quantitative and qualitative metrics, so things like 30-day readmissions would be a hard quantitative measure. Qualitative measures would be junior doctor surveys.

PROF MONTGOMERY: Has it identified anything yet that you've then followed up with an inspection?

MR BEHAN: Yes, yes. Yes, so we've published this, as I said, on three separate occasions. We band trusts from band 1 to 6, and we'll select for inspection

high risk trusts based on that data. We'll also use other intelligence in relation to concerns in relation to a trust. So if you take the picture of Morecambe Bay and the concerns which were being flagged during early 2009 into 2010 with serious untoward incidents, etc., etc., they would now be captured in the intelligent monitoring tool, and they would drive the approach to inspection. The purpose of the intelligent monitoring tool is to flag risk, to ask questions: are these being dealt with? And it might be sufficient to say, 'This is flagging; what are you doing about this?' Trusts will respond to the inspector that's linked to that trust, and that might be – that answer might be sufficient. There might be other places where we'll commission a responsive inspection and we'll go in and inspect specifically to look at the issues. And since we began this system in the summer of 2013, and Mike Richards' takeing up his post in 2013, we've used the intelligent monitoring to select when we inspect and what we inspect. Indeed in the first wave, Wave 1 of our inspections, we looked at 18 trusts. Six were low risk, six were medium, six were high risk, the public source reports, and we continued to use intelligent monitoring to direct our approach. The intelligent monitoring plus the intelligence of conversations we get, the feedback we get from local Healthwatch, conversations with clinical commissioning groups plus our inspections will then drive our rating, and we will publish ratings on all of our hospital inspections.

PROF MONTGOMERY: So have you retrospectively tested that with something like Morecambe Bay to see whether if you ran through the data that you held in 2009 through your model it would have flagged up?

MR BEHAN: Yes, and it's not just Morecambe Bay, I think, in relation to this, Jonathan. And it's absolutely appropriate that we do this. Yes, we have done that; yes, it would have flagged differently. Benefit of hindsight, I mean the trickiness of coming here and preparing for this is the benefit of hindsight. I wasn't – I wasn't there; everything I know about what happened in 2009, 2010 and 2011 and the early part of 2012 is what I've read and what people have told me, not what I experienced.

PROF MONTGOMERY: Okay. How would that model address one of the questions that's come out of a number of points, which is whether or not incidents have any connections between them? So one of the things that we've seen in a number of briefings is an idea that had emerged that the incidents in the

maternity on the context of Morecambe Bay were unconnected? Would your model enable you to ask that question? Would it flag up the five incidents that had been assessed, not to raise common themes, but you know, if we look in hindsight, I mean that I think an assessment certainly needs to be examined more closely.

MR BEHAN: Well, certainly the design of the model is to look for patterns and trends, and actually a sequence of things that look disconnected at the time, and people might have been absolutely convinced they were disconnected at the time that we're looking at them, and that was seen with the connections. I think what we've designed is even if there was a sequence of events, what does this tell us about the culture of learning in this organisation? Do they investigate incidents that occur, and actually that incident and that incident might not be connected, but actually the way that they investigate incidents and the way they then take their learning from those incidents, and the way they as an organisation put those things together, is that saying something about the culture of learning in an organisation?

PROF MONTGOMERY: And how would you capture that?

MR BEHAN: Well I think what we'd do is we'd do that, and this goes right to my point about why we ask five questions, and one of the questions is how well led is this organisation, and what we're trying to get at in that is what's the culture? What's the culture of learning? Is there a robust system of responding to concerns, investigating complaints, carrying out investigations? And it's not, 'Do you do that? How many have you had and what did you do with them?' but it's 'How many have you had? What did you do with them? What have you learned from them and what are you doing differently?' And I think it's – that's the point that I'd like to think that is different from the methodologies that applied in 2009, 2010 and 2011 and into 2012, and the methodologies that we've got now. And I can think of numerous cases that we've dealt with over the past – well, few weeks, quite frankly, where the issue that we've been addressing is, 'What is the culture in this organisation of learning?' And if you want me to talk about those, I'm happy to do that.

PROF MONTGOMERY: So how does that work? Is it a documentary process? Is it the inspector going in and talking to people? I mean one of the things that is clear about Morecambe Bay is that there are plenty of action plans, it's just not

very clear whether any action was actually taken as a result. So I'd like to understand a bit how that process gets to the nub of what really happens and enables you to assess the culture of leadership as opposed to the paperwork.

MR BEHAN: There's two separate things, isn't there, there? Because I think our job is to identify the issues around quality and safety in an organisation. And having identified them, our job is to encourage improvement. That's what the Act, the 2008 Act says our job is. Our job is not to do that improvement, so we are an agent of improvement; we are not an improvement agency. In the system we're now working in, not the system that applied in 2010/2011 and the early part of 2012. The system we're now working in, the responsibility for driving those improvements in trusts sits with the trusts and the board of the trust, and with Monitor and the TDA.

We have a range of tools to drive that action; enforcement tools that we can take. Monitor and the TDA have a range of tools as well that are available to them that they can take. What we can do, and we'll do this through the Chief Inspector of Hospitals, through ~~markers[?]~~ Mike's team we can place something in special measures. That's indeed what we have done in relation to Morecambe Bay now. And we will then inspect to see whether the improvements that were identified and flagged have indeed taken place. I think one of the key differences to speak, I think, to your question, and come back to me if I don't do this fully enough, is following each of our inspections there will be a quality summit. The purpose of that quality summit is to bring the commissioners, Monitor and/or the TDA, depending on whether it's an FT or a non-FT, and ourselves together with the hospital, with the trust to identify what needs to happen to drive improvements in the way that the services are provided within a trust. And that will result in an action plan, and it's that action plan that I would expect to be delivered, and if that action plan now isn't being delivered, I'd expect us to identify that at an inspection, and flag that it's not improved for a hospital that's in special measures. As a consequence of the 2012 Care Act, that may well trigger something going into, effectively, the insolvency regime. This is what's happened in Mid Staffs, and the consequences of that is hospitals may well be taken over, so the hospital may not close, but the organisation, the trust itself may be dissolved and taken over. That's what's happened in Mid Staffs, and indeed in South London.

So that's how it should work. Why did those group of people come together? Why are the commissioners in there? Well it may well be that some of the things are about the way that the system operates. It's not just within the gift of the organisation itself, so flows into A&E, for example, might be a systemic issue that needs to be addressed. Junior doctors saying they can't get a senior consultant on Saturday evening for advice when they need it is not a systemic issue; that's something that that hospital need to sort out. And the solution to that will rest with the hospital and the trust to sort that out, so there is a mixture of systemic issues which will need others to help with, and organisation issues which is for the trust to sort out.

PROF MONTGOMERY: And whose responsibility is it to hold the ring on that? I wanted to ask you about the responsiveness to local populations, and there's a similar question, I think, about the well led, about the relationship between your role and the commissioner's role, about responsiveness that led to your role in the development agency, and Monitor's role about quality of leadership. So I guess one of my questions is you have to be confident that somebody does pick up the responsibility and it doesn't fall between the net, and that they don't overlap and get confused by two people trying to drive it forward.

MR BEHAN: Yes – no, and I think hugely important. So I think there's two things here. I think the first is in terms of the architecture and the way that that's described and written down. And then the second thing is, is everybody working in the system? Are they operating that and implementing it and delivering it? So I think as a result of the Care Act, I think it is reasonably clear what the role of commissioners is, what the role of CQC is, TDA and Monitor.

So CQC's role is to – we are the quality regulator for the health and care system. Our job is to register, and then inspect, if necessary take action, and then rate the quality and safety of health and care services. It's our role then to take any follow up action which is required. That could be criminal or a civil action, and we've set all of this out. We also rate services, and we've now been rating all the hospital trusts on a four point rating scale: inadequate, requires improvement, good and outstanding.

For services which we've rated as inadequate, and those that require improvement, there will be action plans, and we will follow up our inspections by further inspections to assess whether those actions have been taken.

PROF MONTGOMERY: So if I can pick up...

MR BEHAN: So our job is to identify and assess. We diagnose, if you wish, whether there's an issue around quality and safety, and we make that transparent. We shine a light on that.

PROF MONTGOMERY: So if your assessment is that the service in somewhere like Morecambe Bay is not able to respond appropriately to population needs, and that the commissioners – and the organisation says, 'Our commissioners are not helping us do that,' how will that work its way through the system? There are a number of versions of the story that we're hearing now. One of them is it's an intractable commissioning problem because of the geography of the area around maternity services, so...

MR BEHAN: What, Morecambe Bay is?

PROF MONTGOMERY: Yes. I'm not saying that we accept that story, but it's one of the stories that floats around, and I'm trying to work out if you hear that story, what's the role of the CQC in making sure it's addressed, if any? So it could be it's a commissioning failure as much as a provider failure, I guess, is the challenge that we kind of...

MR BEHAN: So, our job is to judge the quality and safety of services, not apart from if you're a "back to the sea hospital."

PROF MONTGOMERY: Okay, so...

MR BEHAN: Are you with me? So I just think this is a fundamental issue here about – it's not, 'We'll do you like it this because you're in London and you're an international teaching hospital, but we're going to do you in a different way because you're in a remote isolated community,' otherwise we'd just go around the whole edge of England saying, 'Actually, this isn't good enough, but it's tough out in these extreme – Scarborough, Morecambe Bay, Royal Cornwall.' So you could actually just go round the coast and say, 'Actually this is tough.' So, no, what we've said is that there are some standards of quality and safety that are set out in regulations where there's evidence that supports the development of those standards, and our job is to assess that those services are meeting those.

There will be times, Jonathan, where there are commissioning issues, there are issues beyond the hospital around patient flows where people can go to, and they have, and are, taken into account, and there's been some

pretty fierce debates over the past three or four years about reconfigurations, about services merging, about what is clinically safe, what's the critical mass of clinical safety. How many procedures need to be done in a particular place to get that critical mass, etc., etc. And, you know, there's been some pretty high profile examples of this; a reorganisation of stroke services in London; I would quote as an example of where the debate about how many stroke centres there are going to be in London was largely worked out on what's the critical mass that you need to provide safe stroke care to people. And...

PROF MONTGOMERY: But that's what I'm...

MR BEHAN: These are deeply emotive issues.

PROF MONTGOMERY: But I'm trying to understand whether your regulatory sanctions are [inaudible]. So if you felt that despite having been in special measures, the University Hospital of Morecambe Bay cannot meet the safety standards, is it realistic to deregister?

MR BEHAN: It's theoretically possible to do that.

PROF MONTGOMERY: Realistically? I'm trying to get the – I mean you raised the valid point earlier on, there's one thing about how the system is designed to work, and then are there some types or problem or types of problem which is really hard to make work effectively? So can you contemplate however bad an organisation got that it's sat in the sort of geography that we see in Furness, you could exercise those regulatory powers?

MR BEHAN: So I think this is a really important question. I think it depends on the service and the set of circumstances. So there've been a number of occasions where there's been active consideration about whether we should close maternity services, and active considerations about whether some A&E services what we've had to regulate over the past couple of years we should close. The consequences of closing something is you just send 3,000 women into the next place that means they've got twice as many and they were struggling anyway. I'm not sure that's a solution.

Our job is to encourage improvement, so there is an issue, I think, about the resilience and robustness and of our methodology. So the earlier points about where you need improvement, who is responsible for those improvements? My answer was Monitor, the TDA. I think the Royal Colleges have a role to play in this, if I'm being honest. I think NHS England do have a

role to play in this about how they can actually contribute what additional responsibility they get. NHIQ is currently – and NHS England, they spend £30 million a year on improvement. It could be directed at these services to provide additional capacity for these hospitals. We think hospitals that we rate as inadequate need help. They might not think they need help, but we think they need help because they're not capable of actually the improvements that they need to make by themselves.

PROF MONTGOMERY: Would you contemplate using your regulatory powers as a lever on the TDA or NHS England if you felt that they were not helping the hospitals sufficiently?

MR BEHAN: I don't understand what you mean.

PROF MONTGOMERY: So if your assessment of a – I mean we've heard a number of things about Gold Command; we don't know whether you'll have been briefed about the Gold Command.

MR BEHAN: Yes, yes, yes.

PROF MONTGOMERY: And what that seemed to do was to bring in a lot of interest from the SHA and PCTs that didn't seem to have been deployed on the problem previously, and we may have views on them, and it's a sensible way of doing it and an effective way of doing it. But one of the things that seems to have been going on is that – I wasn't quite sure who was taking responsibility for really sorting the problem out.

MR BEHAN: I agree. No, I do agree with that.

PROF MONTGOMERY: And I'm trying to understand if there were no longer any SHAs, how would the system respond to that sort of question that says, 'Okay, we all know from our various measures that it's not being solved.' How would we make sure that it would be solved in the future? Because you might say...

MR BEHAN: No, no, no, very good.

PROF MONTGOMERY: ... that we're going to deregister...

MR BEHAN: No, no, I'm with you.

PROF MONTGOMERY: ... the hospital because it can't be done.

MR BEHAN: So, East London, we were concerned about A&E. Could we shut an A&E? Well theoretically we should, we could. If that just pushed a whole bunch of people either in – further into Central London and further out, certainly the services in our view further...

PROF MONTGOMERY: But London is easier.

MR BEHAN: No, no, I'll come back to your question. I'm not going to be evasive. But we could put conditions on how many people we could have who are going into that A&E, and how many beds we could – now that isn't something historically and traditionally that CQC has done by using our powers to put conditions on registration. So it's not quite shutting something down, but it is intervening in quite a direct way, saying actually this is not acceptable. We don't think this is safe, you need to do something about the number of people coming through here given the number of staff that you've got to provide that care.

On Friday I met with my counterparts in Monitor and NHS England to express concern about another hospital where we were concerned about the pace of improvement that's taking place. It's a hospital we just inspected. We've put that hospital into special measures, and the purpose was to put more pace and energy into the improvements that need to take place. What did we do to do that? I picked up the phone and spoke to my colleagues and said, 'Actually we're worried this isn't going quickly enough, and whilst it isn't going quickly enough there~~'s~~ are people continuing to receive, in our view, suboptimal care.' So that's an example.

PROF MONTGOMERY: Yes.

MR BEHAN: I think coming now to Morecambe Bay, to the specifics, ~~so~~ of your investigation. I think if you look at what is happening now, Morecambe Bay went into special measures earlier this summer. There's been a range of meetings which have involved the local area team, CQC and Monitor in relation to the action which is being taken by both the board and the executive of Morecambe Bay. And we've had – I think Ann Ford spoke to you a couple of weeks ago, and she would have taken you through, I'm sure, the events over the summer and into September in relation to what we've been doing in conversations with the people at Morecambe Bay to get more energy and pace into the changes which are taking place, especially given there have been more untoward incidents.

PROF MONTGOMERY: Do you have a sense of that, as to whether or not – and again, there are various versions of this we hear, but one of them is it's never been right, and we have the same problems now as we had in 2009, and the

system has not yet found a way to address it. Is that what it feels like, that you are uncovering the same problems now as were partly uncovered and partly not uncovered by your predecessors, and just haven't found a way of solving it, or do you think the situation has changed?

MR BEHAN: A bit of both, if I'm not sitting on the fence in relation to this. I don't think previous...

PROF MONTGOMERY: So can you tell us which bits? That's what my question is.

MR BEHAN: Yes, I will. I will, I will, and if I don't, come back to me and I'm quite happy to pursue this until you feel you've got to the bottom of it. So the previous methodologies didn't get under the skin of these organisations, and I mentioned earlier, so I'll not repeat that.

PROF MONTGOMERY: And I think we understand that.

MR BEHAN: Yes. I think the new one does. And why do I think that? Because that's what chairs and chief executives of trusts tell us. So is this a better, more robust resilient methodology? Yes, it is. Let's just put on one side whether you agree that regulation is a way to do this. I do, I wouldn't be sat here doing this job otherwise. Not everybody has that view. I do; I think there is a reason for having regulation in health and care. I can go through that if you want. But actually you cannot regulate quality and safety into healthcare. The only thing you can do is actually hold a mirror up and describe what that quality and safety is. The people that will put quality and safety into health and care are the people that provide those services, the professionals that work in ~~it~~ then. I do think there is a personal~~,~~ and professional responsibility around quality, particularly for registered professionals.

I think regulators have a role: systems regulators~~,~~ Monitor; quality and safety regulators, CQC; but also the professional regulators as well. But actually the people that put quality into services are those that provide ~~it~~ care and the professionals that work in it. Commissioning does have a role in the way that they specify services and the way that they then ensure that services are being delivered to that specification. I think they've got a fiduciary responsibility about how public money is spent, and is it being spent and having the impact that it was intended. When Parliament votes for £120 billion to go into the health and care system it's got some idea what it wants it to do. It needs to be satisfied it's getting something back for that, so it needs to know

about that. So I've said in other places at other times I think there are five influences on quality: what commissioners do; what providers do; and I'm in Robert Francis's space on this, by providers I mean the board and the executive team, so senior leadership in organisations, what professionals do, what regulators do; and fifthly, the voice of people that use services. They all have an impact on the quality and safety of services, but you cannot regulate quality into services. We can only flag whether that quality is in those services.

But flagging it and then describing it as it is, making it transparent, and then publishing what we find I think is a hugely important part of the role that we've got to play. The improvement has got to be by the trust itself, and the people that work in the trust. There's got to be ownership. One of the issues, we'll publish in – next week, I think it is – the State of Care Report for 2012/13 – no, 13/14, and one of the issues that we flag up, coming to this issue about pace, is when we carry out an inspection, a new inspection this is, and publish our report, where does the energy go from that organisation? Does the energy go into arguing with us about the fine detail of it, or does it go into saying, 'This is really helpful, let's take this away and work out how we're going to use this to improve'? And certainly we've experienced both extremes since we started our new methodologies, and the organisations which give us confidence that they will improve are the ones that say, 'Thank you, we're going to take this and we're going to work at this and improve.' And I think there are some organisations that are in denial about this.

PROF MONTGOMERY: So they don't recognise the reflection...

MR BEHAN: Yes, and I would use an example of an organisation which we think was in difficult water; George Eliot, who have taken it, used it, sought help, a buddying arrangement with a UHB, used that energy, used Monitor and the TDA and those other resources, engaged their clinicians and have driven real improvements, so much so – and they were part of the ~~KO14[?]~~ Keogh 14, the original ~~KO14~~ Keogh 14, and we went back in we thought they'd made real improvements, genuine improvements in the way that they were performing. Now that was another hospital where we'd had concerns on an ongoing basis, so comparing George Eliot with Morecambe Bay, yes, I do think it's possible for organisations to improve. An example of that would be George Eliot.

The issue then, I think, which is also implicit in your question is really about timescales. If you've got a deep cultural malaise, and I think some of the issues in Morecambe Bay we flagged in the earlier reports, investigation report in particular about an absence of clinical engagement still running. That trust has been three separate entities where there wasn't a sense of this is one organisation. Then if you've got that kind of cultural malaise, a feeling of separateness, and there are more organisations which have been brought into the current configurations in trusts where the energy that should have gone into forming a one organisation culture and actually really working at that has not been demonstrated. You can see that, we can see that in other places, and that will contribute to difficulties in creating a one organisational culture. So in some places if there are cultural issues, it is going to take more than six/nine/12 months, and if we put ~~in~~ a hospital into special measures we'll go back and inspect within 12 months is what we say. I think some of the issues, though, this comes to your point about will you ever close something; if one of the issues in our assessment is there's a real cultural issue in this particular establishment, at what point do you arrive at that judgment you're going to close something? And that's what we've got to do. We've got to arrive at that judgment, and it's a tough judgment, and it's not a simple and straightforward judgement.

Would we do it? I'd like to think we do. It might be easier to shut something in a mental health trust, for instance, where we actually know that people who are being inappropriately cared for, people with say challenging behaviour, learning disabilities, and actually we feel people are being abused. One way to deal with that might be to close it. That might be the right way to deal with those eight people that are in that place, by removing <u>them</u> from it and just making sure it doesn't happen again. That's <u>of</u> a different order than closing an A&E when people would have to travel 60 miles to get to another A&E. So there are judgments in here about contacts, impacts, etc., that need to be taken as well, which is why <u>in</u> a lot of the improvement work, it's hugely important to be clear about what needs to improve. Our challenge in our reports where we've found concerns is to be absolutely clear about what we've found ~~that's~~ <u>what is</u> not acceptable, and what it is that needs to improve to put that right. And when we go back, that's what we're testing; that's what we're

checking. We identified this needed to improve; what have you done to improve this?

PROF MONTGOMERY: One of the challenges I can see is that it's going to be easier to change a few people at the top than it is to change the whole of the frontline professional staff. Now one possible interpretation of Morecambe Bay is that you've got a frontline cultural problem, which serial groups of leadership has failed to actually get a movement – get to move, and we're seeing quite a lot of change at the top level. I'm not so sure whether we've seen evidence that that's achieved the cultural change at the frontline. Do you have any experience of that sort of type of challenge and how you can change the frontline culture? Because there's a sort of sense in which people look for scalps and scapegoats, and if the problem is really deeply rooted in the organisation that may never get us the grip that we need.

MR BEHAN: Well you've just played back to me the dilemma that I've just given to you.

PROF MONTGOMERY: Yes, I know.

MR BEHAN: So – so am I fatalistic about it might be another way of going at this.

PROF MONTGOMERY: I think I'm more hoping that we might have some examples where you can say...

MR BEHAN: Yes, I can.

PROF MONTGOMERY: ... experiences where it can be done.

MR BEHAN: No, I can, I'd quote George Eliot. But in a sense, the senior leadership have got to – you know, the investigation, Section 48 Investigation Report in July 2012 flagged this issue about the disconnect between clinicians and the leadership in that organisation. That would give you a clue that what – something that needs fixing there is to engage the clinicians in the organisation about what's happening. The case I referred to earlier, the meeting on Friday was about Medway. That's another example of where the clinicians are completely disconnected. And actually we think that's a real risk in Medway to those improvements taking place., sSo Professor David Walker's been appointed as a medical director, he's going in, he's got a big job to do. That decision to put David in, who I do know from both of our previous incarnations, my sense is David will give it a real go.

But the hypothesis, and this comes to my point on denial, people have got to understand what the diagnosis is, and the model of change needs to be one which is built on this diagnosis. The problem here is engagement, so what do we need to do? We need to get engagement. I would argue going into CQC in 2012 I had a problem with engagement of staff. I've got people giving whistle-blowing disclosures to a public inquiry. That tells me something about I've got people that were disengaged. I've put a lot of effort into engaging frontline staff in the CQC. So I do think you can do it; it's tough, it takes time and it doesn't come easily, but it's got to be part of the hypothesis you've got about what's wrong here. And having formulated the hypothesis as a leader, you've then got to set about developing a strategy which is about engagement, about creating a single organisational culture. The difficulty is if your model of change is you change the senior leadership, if that's the model of change, then that won't work. And I think this is why – or a well led domain, and this is why we got Michael West to do the kind of academic advice, if you wish, based on his research and the literature that now exists around the relationship between engagement and outcomes for people, a whole bunch of stuff being done at King's College in relation to nursing about engaged nurses and the correlation is ~~we'll engage~~ with satisfied patients, ~~.~~ ~~D~~disengaged nurses~~;~~ lead to dissatisfied patients. Tesco, and they might not be the best example at the minute, but those places understand how you engage. Very often people are paid at the minimum wage to give good customer care. So it is possible to do this, and there's a number of places we could point to.

We awarded an outstanding rating to Frimley Park just a couple of weeks ago. I didn't do that inspection, ~~my – I was~~ we were absolutely clear about the quality of what was seen at Frimley Park, and what was right at the centre of it was the engagement of staff.

PROF MONTGOMERY: Not about commissioners then [inaudible].

MR BEHAN: Okay, well lots of people will bask in – but I think one of the interesting issues though about this, Jonathan, going back to your question as formula, and I don't mean this is a cheap strapline. But churn is not change. Changing stuff – changing people doesn't mean you're changing cultures and the way that organisations operate, and I would argue that what we've had a lot of is churn not change. I think there's now a group of people coming together in

Morecambe Bay in their leadership from the Chair through to the new Medical Director, new Director of Nursing. September also saw a new Transformation Director coming up from Portsmouth to replace Adam Cayley ~~Kaye[?]~~, who's been from Monitor, and also carrying that out, so I think there's now a team being put together, and they need to reach into the organisation, they need to reach into the middle and frontline management. Leadership in an organisation is not just what the chief exec and the Chair of the board do, it's actually – I think there's three bits to leadership in organisations. There's organisational leadership, there's service leadership and there's practice leadership, and you need an alignment between your organisational, your service and your practice leadership. Your ward sisters will be doing your practice leadership, but your service directors will be doing your service leadership. So actually the failures in A&E and maternity at Morecambe Bay are not just with the chief execs and the previous chief execs of the board, but actually who's the service directors who are the ward leaders that are actually responsible for some of those, and actually successful organisations are about teams, so it's no surprise that Dalton has been at Salford for 13/14 years. Frimley Park, he's been there for 25 years. These are organisations that have developed cultures of 'This is the way we do things around here,' not that they make a mistake and they're off.

PROF MONTGOMERY: Thank you.

PROF WALKER: Thank you. There's several things I want to pick up. One thing, you talk about systemic issues that – and I'm still not sure that even with the new investigations that you have that they're necessarily going to pick up systemic issues. They're going to pick up a lot of aspects of care quality and various other things. But you mentioned just the specific thing about disengagement of staff to – frontline staff to management. Now that will be picked up in the investigation, but the problem is that that's true in many organisations now as in the health service, and this disengagement between the management structure and what here has been given at the bottom at the end. Now why has that not been looked at? Why has it not been looked at why disengagements occur? What's happened in our health service in the last 10/15 years that we have so many unions now, but there's total disengagement because management always appear not to think about the

frontline; they're more process orientated, target driven, etc., etc. I mean is that something that the CQC should not be looking at, why this has occurred?

MR BEHAN: So I went to CQC in 2012 where everybody told me what we should be doing. And we had more variations of what we should be doing and what our role was than you could shake a stick at ~~out~~, quite frankly. So the whole bit about developing a strategy was to settle ~~up~~ this issue about what our purpose is. So Jonathan quite correctly pursued the issue of what role do we play and how does that role relate to others, absolutely correctly. Because if you go back to the Health Select Committee, the Public Accounts Committee, they were critical that CQC wasn't clear about why it was there and what it was there to do.

So our role, to come back to that bigger question, is to look at the quality and safety of the services that are delivered. We can look at the system, the broader system, and we've got the power under Section 48 of the Act to actually carry out investigations or reviews. That was used in Morecambe Bay, you have the chronology of all of that. One of the things that we did – when I inherited this it was just about being commissioned when I went in 2012, was to get Deloitte's in to do a review of the way that CQC had used Section 48 powers. I think my predecessors had largely used Section 48 powers to carry out a piece of systemic work, had largely used Section 48 as an escalator. We do these inspections; if the inspections don't work what can we do next? So it wasn't we'll take enforcement action; what we'll do is we'll do another review, and it will be a Section 48.

Deloitte's quite properly said, 'Actually this is a strategic tool; it isn't a day-to-day operational tool.' I think that was absolutely right, that was presented to the board, the board accepted that as a position. So I think we will undertake systemic reviews, but we've not been set up to do systemic reviews, going back to the purpose. We've been set up to register and inspect health and care services. We have the power to do systemic reviews, but our main business is as a regulator. This is why we're not an inspectorate. So we're not like HMRC or those other inspectorates. Not like Ofsted in relation to schools, because we register services. You cannot operate and provide health and care services in this country unless you're registered with us; ~~but~~ we issue a licence to operate.

Ofsted doesn't issue a licence to schools. Her Majesty's Inspectorate Constabulary don't issue a licence to police forces. They will inspect them against standards, but we do occupy a particular role within the system. We've been given the power to carry out systemic reviews under Section 48, and we will use those powers, and indeed we published – I'm losing track now – have we published it? – a report on dementia. Yes, we did. We put this in, and we had published our forward plan where we will carry out the Section 48 systemic reviews, and that forward plan is published for the period until April 2015/March 2015.

I've already mentioned, Jimmy, that next week we'll publish the State of Care Report, and the key message in that report will be about variation. So you – I think implicit in your question is why do we not say something about disengagement? Well, we will, but actually I've already used in part of my examples, you can go into hospitals like Royal Salford, Frimley Park, and actually see how they engage staff. How they engage staff working constructively, they're engaged, they're delivering the purpose. And there's no evidence that they get any more money than anybody else.

PROF WALKER: I think you're quite right, I don't think it's – maybe more money helps on occasions, but it's not a [inaudible] money issue. But what I'm saying is, is that in a clinical setting, and you're looking at Morecambe Bay from the incidents they have, one of the things they've said was that we've got five incidents but they're not related, and one of the problems we have is that we said, 'Yes, they are related because in fact there was a lot of similarities in the way the problems occurred.' Now in some ways at your level, you're going round hospitals and seeing that this hospital has got its problems and it's disengaged, and this hospital's got problems and disengaging, but not actually looking if there's actually a relationship here, you know, there's a common theme within not all hospitals, because some hospitals are very good, but there's a common theme around disengagement seems to have occurred. And I was just wondering why that has occurred and how that can be stopped from occurring or generically solved, because we seem to be going round each individual hospital when it's flagged up, then going and trying to do the same cure.

MR BEHAN: I think this is a really important issue. So I don't know if there was any conversation going on about engagement with frontline staff before Francis published his report. So if you look at the literature, the *Health Service Journal*, the lecture circuit, the places that people were, I think there was *sotto voce* some stuff going in one or two places about the relationship between leadership, culture and engagement. I'm not sure ~~this~~ there was a debate in the way that we've had it since Robert Francis published his report. Certainly, one of the things, in answer to Jonathan's question to me at the beginning, "what's different about our previous inspections and the inspections we're doing now?", - we're consciously looking at leadership and culture because of this relationship between leadership and culture. So I think it's something that we're at– the beginning of understanding about the nature of the relationship between ~~this~~ these two.

And if you look more broadly, you know, there's examples from America which have been talked about pretty much by the Secretary of State, hospitals in Seattle were – hospitals which were seen to be struggling to deliver clinical quality a decade ago through the way they've ~~ved~~ engaged their clinicians are now highly performing, world renowned organisations, and they've done that through engagement. They've got more numbers and targets than you can shake a stick at. The issue is that they're numbers and they're targets that they've worked out that they're going to deliver. But they've got a highly engaged workforce. Some of those hospitals in the States are not measuring patient satisfaction anymore. What they're measuring is ~~they're measuring~~ staff engagement, and it's through those measurements that they are driving quality.

I would argue that that wasn't the debate we've been having in this country until really we got to this point around the publication of Francis's report, ~~and~~ wWhat do we do about this? We'll re – it's too early to say just at the minute. I think we've done 65 trusts out of the 164 that we I ~~are acute hospital trusts~~, so we're not quite at halfway on our new inspection methodology, but we will be able to, to come your points, when we get to the end of that and answer ~~well~~, "what do we know about leadership in acute healthcare?" We can look through the evidence we have collected. We'll have a fantastic database when we complete the first wave and then go in to the

second wave, ~~and~~ wWe can ask ~~say~~, 'What do we know?', 'What, of our outstanding organisations, what are the characteristics that have made those outstanding?' We've published a definition of outstanding. We've published our handbooks and the background information on this, following an extensive consultation over the summer. Just last week we set out what we think the description of, 'Good', 'Outstanding', 'Requires Improvement', 'Inadequate' is, and once we've completed the programme I think we'll have a rich database. And going back to your point, I don't think there's any inspectorate or regulator in the world doing some of the things that we're doing – combining the data and intelligence with turning up and ~~seeking~~ 'seeing' alongside the information we receive from others. So I think we will be able to make a contribution to this, but one of the things I will say, within CQC, to my teams, is we're not a polemic organisation. We're a regulator. I'm flattered when people ask me for my opinion, but it can only be my opinion. I think when we speak about our reports and present a report to parliament in the discharge of our statutory responsibilities, we've got to set out what we've found and what is the evidence of what we've found and, as I say, are not engaged in polemic. So I might have a view about X, Y, and Z. What we've got to demonstrate in our reports though is what did we find through our work. So, that's what we'll attempt to do.

PROF WALKER: Do you think that that position that you have is unfortunate or good? I mean, would you like to be in a situation with all the knowledge or have all the investigation you've had, to be able to feed into an opinion and a changing environment.

MR BEHAN: Well, I think these are – I don't think they're either/ors, if I may. Do we have a role to actually describe what we've found, and for that then to inform both at the local level and at the national level what happens and how improvements could be made? Yes, ~~or~~ dDid I come to the job wanting to make a contribution to improving the quality and health and care services? Yes, I did, ~~a~~And do I think we can do that? Yes I do. Are we developing methodologies that allow us to do that? Yes we are. So, I see – I take to heart our job is to encourage improvement.

PROF WALKER: Because I think the – one of the problems at the moment is that trusts are being told that they're failing in certain areas. I'm not sure they're

told how they can make it better, and it may be able to do that by buddying with another hospital that does the job better, but it would be helpful, I think, if the – not only are they criticising something, but there's some information or somewhere they can go where they can see how things can improve, and I'm being – the signal to my left here – right here –

CHAIR[?]: Just checking the time, Jimmy.

MR BEHAN: Well – and I think this comes – this – I want to stay with this, if I may, because I think this is hugely important about role we've been asked to play, and it goes back to the questions that Jonathan was asking me about what is our role and what role do others play, and the debate about this – if CQC was an improvement agency, not a regulator, it would identify what the problem is and then go in and say, 'And this is what you need to do, to sort it'. I think that would then completely compromise our ability to go in and check whether those improvements have taken place. We'd have a vested interest in saying, 'That worked'.

PROF WALKER: I would not disagree with that, but is something missing –

MR BEHAN: No, no, no, well, this comes, I think – so we then went to, 'Well what happens then?' and in the current role, Monitor and the TDA, their role is to support improvements to take place after we've identified there are failures or are concerns around the quality and safety of services. It's for Monitor and the TDA's to go in to do that. Now they may draw on a range of resources, of which the royal colleges will be part, the trust – NHS Confederation, through to the NHS IQ through to commissions, to pick up on your systemic point. I think there is an issue, and this was why a report that was also commissioned around the time of Robert Francis from IHI, - ~~and~~ Don Berwick's report, ~~and~~ Don Berwick referred to the 'science of improvement'. It's a really important phrase I think. My personal view is I think we're at the beginning of a journey of understanding what the science of improvement is, and for that being rolled out on a broad base across the NHS and the social care system. So people talk authoritatively about improvement, but I think that we're at the beginning of it, and I think your questions about 'How do you deal with resistance? Is it the front line, is it the middle-management, is it the senior?' all speak to this point about, 'What is the model of ~~employment~~ improvement that we're using in England?' where we've identified concerns about services that is being used.

And is there a model? Is there a science that you in your clinical role, you would draw on that body of knowledge, that science, and use that and apply that? Is there a similar science in relation to how you improve large, complicated organisations?

And I think we're reaching for that rather than we've got it, if I'm being brutally honest. Some of the conversations that I've been having with my senior colleagues in Monitor and the TDA, and some of the conversations we've had on the CQC board, and we've had a number of bilateral board-to-board meetings with Monitor, exec-to-exec-team meetings with the TDA. I've gone through exactly this point about what is the science, because we're now in a place, if we go back ~~– so, organisations that Mike said needed to go~~ in to special measures, ~~when they've gone~~, and if we go back in and say, 'This hospital –' or 'This Trust has not improved', what are we judging? Are we judging the hospital hasn't improved or are we judging that Monitor or the TDA haven't got an effective change programme, so we're now beginning to expose these kind of issues, and I think it goes right to the heart of, 'What is the model of improvement?' ~~and so I don't think it's what the BHSAs do.~~

If I may say, I think the key question is, I think, what you're digging in to, it is what's our model of improvement and how is that being applied, and do we know enough about that science to apply it? Because that science is a mixture of organisational design~~,~~ and development, organisational psychology, motivational psychology – a whole bunch of stuff that's in there about how you effect change. I think what I do feel more confident about, though: if you've got disconnected clinicians from managers, whatever the reason, whether the managers are chasing targets and the clinicians ~~and the clinicians~~ are saying, 'These are not our targets', or, 'I'm not bothered about all that. I just want to operate', or whatever that transaction is, you're not going to get an effective organisation.

PROF MONTGOMERY: I know we've got to move on. David, can I just check? My impression of the powers that Monitor and TDA have is that they address the churn rather than the change issue, as you put it – that's to say they have a lot of powers to change boards and put people in. Their powers are constructed on a different model of change that the one you've identified. I don't need a long answer, I just want to know if I'm [inaudible].

MR BEHAN: Well, no, I think that is interesting and important point, but we shouldn't underestimate the influence we've got.

PROF MONTGOMERY: That's a fair point.

MR BEHAN: 'I don't buy the Health Service Journal, but I'm the seventh most powerful in this that or the other.' I think it's all froth, quite frankly.

PROF MONTGOMERY: You still remember the number, though.

MR BEHAN: Well, 007's the better number, yeah, yeah, yeah. But, no, the serious point from this is we shouldn't underestimate the impact of reputation. Actually, we said to UCLH, 'Your accident and emergency is not any good', and within two weeks –

PROF MONTGOMERY: They weren't very pleased with it.

MR BEHAN: – they'd demolished the wall and they'd started changing the physical environment in A&E. What was that about? That wasn't about statutory powers. That was about reputation. UCLH: the cap did not fit that somebody like us said, 'You're not good enough', because they're benchmarking themselves against world leading hospitals, and all of a sudden we went in and said, 'Sorry, this, that, and that, is absolutely fantastic, and we agree with you is world leading, but your A&E is not serving your population well enough and, furthermore, your staff are telling you it isn't as well, which is coming back to the –' so it doesn't mean that UCLH are not engaging their clinicians. They're doing some fantastic working there, but it means that service wasn't good – that's a variation point – you'll have variation. So I – reputation is a driver and I think we've got influence by what we say as well Jonathan, not just by our legal powers. So between Monitor, the TDA and CQC, if you combine Monitor's ability to change senior people, and our ability to issue warning notices, change regulation, take civil and sometimes criminal action at times – and again, some of the new powers coming in that are not yet there – things like the duty of candour – are going to change the way that organisations like Morecambe Bay are going to have to report untoward incidents.

DR KIRKUP: Okay, Jacqui?

MS FEATHERSTONE: Very, very brief. You talked about planning expectation –

MR BEHAN: Sorry, say that again. Planning, yeah?

MS FEATHERSTONE: You talked about planning the inspections and the importance of having the expertise there. Do you know have the expertise

there every single visit, because obviously if you don't, then – and you're in a particular service then that can make a difference. So, from your inspections from the new way that you're working, is there always the expertise there of the services that you're looking at.

MR BEHAN: Yeah, I think so. I think the issue – the challenge for us Jacqui is – not been, 'Can we get people in?' We've been inundated, if I'm being brutally honest, with people that want to make a contribution to this, an inspection. I think the issue is getting repeat visits. I think there's been a whole bunch of clinicians that want to find out how it works and then they can go back to their own place, and that's good, because I've spoken to lots of people that have said, 'This has been really helpful. I've learnt a lot and I'm going to go back to my place and we're going to do this, this and this, because this is a really good idea'. There have been others who've been there to find out how it works, and then when we inspect them, they know what to expect. Well, that's fine. The very first media interview I did when I got his job, I said I'd like everybody in health and social care to spend some of their career in CQC, so people that come in, learn about what we do, and go out again, and maybe come back at a later time. It will enrich us and it will enrich the service, and we can stop this, 'Them and us' kind of issue around quality and safety. The challenge is: do we get repeat visits? The other challenges is: how can we ensure the quality of people? I have no doubt some people are released because people are quite happy to let them go, and there are others that people aren't happy to let go, perhaps we need. But examples of this: there have been huge issues around paediatric cardiac surgery. We've not gone to look at paediatric cardiac surgery without having a leading paediatric cardiac clinician ~~—cardio-clinician.~~ So they're examples of where, based on, the answer to some of Jonathan's questions about the intelligent monitoring. The fact that we're looking at those risks then flags what were the issues in a particular place and they can help us contribute to what were the experts that we need on those teams. So ~~I did a—~~the last inspection I did was Norfolk Community Healthcare Trust. I spent the day going out with people looking at children's services and the Director of Nursing for NHS England in the south was a health visitor by her own background. She was on the team.

MS FEATHERSTONE: Thank you, yeah.

DR KIRKUP: Okay. I'm sorry, time is getting on, but I do have one question that I want to ask you. You've talked about the difference between how you regulate now and how you regulated then, and you've given us a very persuasive account about having designed a better smoke alarm. There is a view which I need to put to you that, in fact, there was so much stuff coming to CQC in 2009 and 2010 and generated within CQC that the smoke alarm was going off – it wasn't a question of needing a more sensitive alarm. The difficulty was they were overriding the alarms that they'd got. Do you recognise that picture and how do you respond?

MR BEHAN: I do recognise it. So some of issues about the previous – and just preparing to come along to this session, Bill, and going through the chronology from 2009 – March 2009 when they applied for FT status – what is it? – I counted on the train on the way up, 13 inspections, ~~f~~Fielding, PwC, KPMG, one investigation, a follow on. Actually the issue is judgement. It's not stuff. One of the interesting things – I began my career working in children's social care services, and working in child protection, one of the risks in child protection is you don't know what to do, so you have another conference, and I have to say there's a lot of resonance with, 'We don't know what to do so let's have another inspection'. And so I think we began this interview with me ~~with me~~ is 'So what, then, what do you do when you find something that's not good enough? How does that drive improvement?' I think your questions as well, Jimmy, were absolutely apposite and to the point. The issue is can we not identify where things are going wrong? I think we are doing that but I hope I've not been too persuasive. I want to be quite humble about this.

This is very, very difficult work, and I've got a big job to do to transform CQC and I'm not underestimating the job that we've got to do, so we talked about a three-year strategy. That strategy began in 2013, ~~so we are literally~~ to 16 – so we are literally half way through. I am pleased with where we've got to. I'm delighted with the people we've been able to attract at a senior level to come and do the jobs. I think we've got some really talented individuals. Well, actually, the question around the front line and the middle line is: I know I'm going to be judged on what an inspector's doing today in Northumberland, in Norwich and Newquay, not by what I'm saying here or when I go to a select committee, wherever I go. And so we're spending a huge amount of time

investing in management, reaching out to our staff, engaging with our staff, to make sure that we can be confident we can deliver this. This isn't – I've said on numerous occasions, this isn't about we say, this is about what we do, and we're on a three-year journey. We've also said we'll learn by doing. We've looked at what they do in Australia, in America, New Zealand, Canada, and I don't know anybody who's got this cracked.

DR KIRKUP: Okay.

MR BEHAN: Everybody's worried about quality and safety, and the context I think that you were getting to of money, and morale and disconnection. These are international issues and we do listen, we do learn, and David Prior – I wasn't in work that day; I needed to be at a funeral – met the Chair of the Australian Commission. You know, we are reaching out to actually look at what can be learned from others. So we'll be quite humble about what we're doing and why. If we try something and it doesn't work then we'll stop doing that and we'll reach for something else. So the learning-by-doing and having a three-year strategy is really where we are, but you're right, it's about judgment and it's about risk and we assess judgment and risk.

DR KIRKUP: Okay, that's very helpful, thank you. Is there anything else that you want to say to us? It's not compulsory, but if there is anything?

MR BEHAN: No, if you want anything else of us, I think you've seen eight or nine people from CQC, and – but the approach we wanted to take, though, is to support the enquiry, the investigation. David and myself, after we published the Grant Thornton Report, went up and met a group of families and spoke directly with the families about their issues and their concerns, so I think I understand the concerns of families and the issues that you're grappling with. We've tried, since 2012, to listen to the feedback that we've got, not just from public accounts committees and house select committees, but from families as well. I've personally met a large number of complainants and whistle blowers, as has David Prior and as has Mike Richards so that we can actually learn from that feedback and take that on, so the way that we're responding and planning to move forward. We'd want to support the investigation and if you need any more from us, we can give you that, and we want you to feel that we've been helpful and supportive so that you can do that job at you're there to do, and –

DR KIRKUP: Yes, indeed.

MR BEHAN: – so that's the most important thing. I could rattle on, but there's no point.

DR KIRKUP: Thank you. That's been really helpful. Thank you very much. Thanks for coming. Sorry to keep you waiting.

MR BEHAN: No, no, no, thank you.

(The meeting concluded at 1.55 p.m.)

THE MORECAMBE BAY INVESTIGATION

Friday, 28 November 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert Adviser on Governance
Dr Geraldine Walters – Expert Adviser on Nursing

DR DAVID BENNETT

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(At 11.22 a.m.)

DR KIRKUP: Hello, thank you for coming. My name's Bill Kirkup, I'm chairing the investigation. I will ask my two colleagues to introduce themselves to you.

DR WALTERS: Geraldine Walters, Kings College Hospital.

DR BENNETT: Hi.

DR KIRKUP: And.

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

DR KIRKUP: As you see, we are recording proceedings; we will make an agreed record at the end.

MR BROOKES: We've also invited family members to be present as observers of interviews; as it happens there are none this morning, but they may listen to the recording subsequently. And you also know that we've asked you not to make any recordings or transcripts of the proceedings itself; just to emphasise that we don't want anything to go outside of this process until we are ready to produce the report; any questions for me about the process?

DR BENNETT: No.

DR KIRKUP: Okay, well, I will start off just by asking if you could outline for record please when you started at Monitor and what your role has been there.

DR BENNETT: Yes, well, I started at Monitor on ~~21~~ 4 ~~4~~ March 2010, and I've had a rather chequered set of roles over that period, so I first ~~when~~ went in as interim Chief Executive; it's worth probably as context to explain that prior to my going there the first Chief Executive was also chair, so he was executive chair Bill ~~Morris~~Moyes.

DR KIRKUP: Yes.

DR BENNETT: And when Bill's term of office expired, the ~~department~~ Department of Health decided they wanted to split the roles, but at the point of Bill's departure they didn't have replacements, so I agreed to go in as interim Chief Executive, and the ~~acting~~ Deputy Chair stepped up as acting Chair. So that was March 2010, we had a general election, you may recall, in May 2010. The incoming government – well, just as the government arrived a new Chair was appointed, a man called Steve Bundred, and so I remained as interim Chief Executive, but about six months into his appointment, Steve Bundred decided to step down, basically, as I'm sure you know, the incoming Government, specifically Andrew Lansley, had big plans for Monitor, major change, and frankly I just think he wanted his Chair in there.

DR KIRKUP: Yes.

DR BENNETT: And so Steve stepped down and a process was run to appoint a Chair. I was still interim Chief Executive; my intention at this point had been, as I was doing before I took the role on, actually to have a portfolio of interests, and so I thought well, being a part time Chair would be quite a good fit with my longer term plans. So, I applied for, and became, DR KIRKUP, non-executive Chair, at which point we set out to find a replacement Chief Executive, but this was just as Andrew Lansley's Bill was getting into some difficulty, and there was a lot of uncertainty about what Monitor would look like.

And we frankly struggled to know what sort of Chief Executive to appoint, so in the end we put it on hold; the Bill took a long while to go through Parliament in the end, but at the end of that long process, when it was finally passed, we knew exactly what our role was to be; just as we were about to look again for a Chief Executive, we knew what sort of Chief Executive we needed, I was asked by various people, including the board, my ~~board~~ fellow executives and the Department of Health if I wouldn't actually stay on as Chief Executive, because I'd continued as interim Chief Executive throughout this period.

DR KIRKUP: Yes.

DR BENNETT: And allowed me to find another Chair instead. I think the reasoning was it might be easier to find another Chair than to find another Chief Executive.

DR KIRKUP: Sure.

DR BENNETT: I had been doing it for a while as well, so I agreed to do that; so I am now just Chief Executive and we have a Chair.

DR KIRKUP: Okay that's very helpful, thank you. When you started in March 2010, can you just outline for us the application process for new Foundation Trusts, how was it operating at that stage?

DR BENNETT: So, this of course, is a process that had been put in place by my predecessor. The core of the process – when the Foundation Trust policy was first established, which of course was long before my time; I think the principle was that – was first of all that we wanted – the government wanted to give NHS provider ~~or~~ organisations, a greater degree of autonomy and independence. But in order to do that they needed to demonstrate that they were sufficiently well governed in order to be given that independence.

So, at the time the HCC, the Health Care Commission was looking at, in

particular, at the quality side of provider organisations, ~~monitor~~ Monitor ~~the~~ was set up to look at the overall governance of the organisations, and also to make sure that they were financially sound.

So, the assessment process, when I arrived, had started in that position; but since those early beginnings there had been the problems with Mid Staffs, where it became clear that frankly we had finished up authorising a Trust which was not providing sufficiently good quality care. So, Monitor was in the process of making some changes to its assessment process to increase its focus on quality aspects as well.

So, it was still the case that the presumption would be that the primary test of whether or not a Trust was providing good quality care would be the quality regulator, and this, —just as I joined ~~it~~ had become, – well, I think possibly a year before I joined it had become - the Care Quality Commission when the HCC was merged with various other bodies. But the principle was still the same, it was their job primarily to establish that good quality care was being provided, but we had started to look at things that we could do to support that process, in the light of lessons learned from Mid Staffs, so that was just beginning to happen.

DR KIRKUP: Did that involve an independent assessment of quality, or did that rely on close liaison with CQC?

DR BENNETT: Well, the latter, except that I would say of course fundamentally the CQC should, whilst providing an independent assessment of quality. SENSE?

DR KIRKUP: Yes I'm sorry, so I should have said a separate assessment from the CQC?

DR BENNETT: No.

DR KIRKUP: You used the CQC as the tool to provide an assessment of quality.

DR BENNETT: Exactly, yes.

DR KIRKUP: And where were Morecambe Bay, at that point, can you recall?

DR BENNETT: Yes, Morecambe Bay had, as I expect you know, had begun the process of being assessed for authorisation as a Foundation Trust almost exactly a year earlier, it started in March 2009. But just a couple of months into that, the process had been stopped, and it had been stopped because the assessment team had said there seemed to be some concerning – a concerning pattern - of quite a number of serious and untoward incidents over a relatively short timescale, ~~, there~~ There were 12 and 5 of them were in maternity. So, they had said this looks concerning, they stopped the assessment and they asked the CQC to look at it. So, the point I arrived the CQC

was just completing both – it had just completed the registration of all provider organisations, which it was doing as part of it setting its new regime up. And they had also specifically looked at these maternity issues that we asked them to look at in Morecambe Bay. So, we, having got from that process, an indication that Morecambe Bay was fine; we re-started the assessment of Morecambe Bay in our process in April, so just a month after I arrived.

DR KIRKUP: Okay and that was a restart of the previous process that had been suspended in 2009?

DR BENNETT: That's right.

DR KIRKUP: What difference would it have made if it hadn't been deferred in 2009, rather than suspended?

DR BENNETT: I am not sure very much difference, because it hadn't been done all that much, and given the 12 month interval we had to restart a lot of the examination anyway, so I don't think a huge difference.

DR KIRKUP: One difference that it would have needed further re-approval by the Secretary of State.

DR BENNETT: ~~Yes – technically~~ Technically no, not if we deferred it, only if we had rejected it, if we'd sent it back.

DR KIRKUP: Okay, I've got the terminology wrong.

DR BENNETT: Yes, technical points.

DR KIRKUP: Okay.

DR BENNETT: So in fact we – if we have a Trust where some issue comes up and we think they need more time to sort things out, if we think that that can be done in a period of around about 12 months, then we defer, which puts things on hold, rather than sending them back again, which means not only do they need the Secretary of State again to resubmit them, but all sorts of things happen to them regarding their membership, which they've put in place in anticipation of becoming a Foundation Trust and so on.

So, in order to avoid that happening, which then requires a lot more work to be repeated, if we think they can sort themselves out in a relatively limited period of time we will defer. So, in practice, if we deferred them it would have looked to be essentially the same.

DR KIRKUP: Okay would you then, for a suspended application like this one, would you then carry out any conversations with the Department of Health, or would you say

that they had already had their input into this, we don't do that now?

DR BENNETT: The primary focus, once they are in that process, will be discussions with the CQC; in those days with the Strategic Health Authority as both the people commissioning from the Trust but also effectively the line managers of the Trust, until they become a Foundation Trust, and all of the other stakeholders; that's our focus. Once the Secretary of State has said yes, we think they are ready to be looked at.

DR KIRKUP: Okay. The level of concern that was expressed in 2009, did you have a chance to see the level of concern when you took the post, you weren't there in 2009. There was a fair amount of significant concern in 2009 from the CQC?

DR BENNETT: From the CQC, well, initially not, when the Trust was first presented to us, the CQC had indicated that they had only minor concerns; they were rating them as green.

DR KIRKUP: Yes indeed.

DR BENNETT: When we then said, 'Well actually we have got some concerns. We are at least wondering if these ~~series~~ SUIs aren't telling of something'.

DR KIRKUP: Exactly so.

DR BENNETT: They then, after some discussions between us and them, they then looked again and then they said, 'Yes, we're going to have to investigate more closely.' They, as I understand it, they briefly, for about a month, rated ~~it~~ the Trust as red in their ~~mentorship~~ ratings. I think that was essentially a holding position, whilst they began their investigation. A month later they downgraded it to amber; and then it stayed at amber during the period when they were looking, doing further investigations and requiring some changes until eventually, when we restarted the assessment they moved it back to green.

DR KIRKUP: Are you aware whether that was the regional part of the CQC that was expressing those views or the central part of the CQC. I guess you mostly dealt with the central?

DR BENNETT: Well, of course all of this was going on pretty well, ~~because this went on~~ before I arrived.

DR KIRKUP: Yes.

DR BENNETT: So I wasn't directly involved at all. All of – yes, it would be true to say that all of my interactions with the CQC when I arrived was with the senior leadership in the centre. But of course, the teams ~~monitor~~ Monitor would be dealing with were the

regional people as well.

DR KIRKUP: Yes, sure. The point that I wanted to work round to was that that fairly significant level of concern, certainly at the regional end of the CQC, involved their view that there was a pretty deep level of systemic failure around those services, and more generally than the Trust. And I just wondered what your reaction was to the fact that they had gone from that position to giving them a green light within a very few months.

DR BENNETT: Now, this may be – what I'm about to say may simply be a reflection of the fact this was all going on before I arrived.

DR KIRKUP: Yes.

DR BENNETT: But, on the basis of what I have seen, and what I have looked at, after I arrived, about what had gone on before I arrived, I didn't see any expression of that degree of concern, a deep seated systemic failure.

DR KIRKUP: Right.

DR BENNETT: Because had I seen that I would have been wondering how the Trust could have fixed it.

DR KIRKUP: Within that timescale?

DR BENNETT: Within that timescale.

DR KIRKUP: Yes, as are we; that's right.

DR BENNETT: And I think, in retrospect, we now know that they didn't.

DR KIRKUP: Yes, okay. How would the assessment process be different now? What would happen to Morecambe Bay if it was happening this year rather than then?

DR BENNETT: The single biggest difference, and it is an enormous difference, is the difference that you see in the CQC regime. So, one of the things that happened with Morecambe Bay once I was there, we had authorised the Trust in October of 2010 and then around the middle of the following year things started to come to light that suggested there were still problems at the Trust. I think much of it kicked off by the Coroner's report on Joshua Titcombe.

There was then a period of further CQC investigation and so forth; the result of which was I was left feeling that we didn't have sufficient clarity about really what was going on in this maternity area. And I then asked for an in-depth review by real maternity experts, because at that time the CQC approach was not to use experts in their reviews.

DR KIRKUP: This was the Manchester review.

DR BENNETT: And that was the – we asked central Manchester to go and do that. That absolutely convinced me that where we have these sorts of situations where there are lights flashing, suggesting there may be problems at an organisation, under the old CQC regime we had to send real experts in, and I agreed with the CQC at that time that if anything like that were to happen again, that's what we would do.

As it happens, of course, that principle, that actually you need real experts spending real time on the ground, possibly quite a number of them, to understand what is going on in the Trust, was picked up when Bruce Keogh did his review of 14 Trusts, and has now been factored into Mike Richard's approach to all his inspections.

DR KIRKUP: Right.

DR BENNETT: So, if you ask how would Morecambe Bay be dealt with differently now, as compared with back then, that is the most important difference.

DR KIRKUP: Yes.

DR BENNETT: And of course, fairly recently, Morecambe Bay was subject to one of Mike Richard's in depth reviews and it did indeed reveal the sorts of issues that we had also thrown up in the central Manchester Review, and subsequently. But of course ideally we would have – those would have been issues would have been discovered at the original assessment.

DR KIRKUP: Right, okay thank you, that's very helpful; talk me through then, how the concerns came to light that led to the sort of review that you're talking about, the Manchester review.

DR BENNETT: Yes, before I do that ~~I can~~ can I just say that there would be other things that would be different about the assessment.

DR KIRKUP: Okay, please.

DR BENNETT: Shall I just –

DR KIRKUP: Yes, please tell me about that and then we'll go back to it.

DR BENNETT: So, another important – let me get my notes here, just so I cover all the key points, another important point is coming out of the Mid Staffs work, we decided that when we looked at governance, how well led an organisation, provider organisation, was, we needed to do a lot more around quality governance. So we created a quality governance review process, which is quite in depth and quite detailed. As it happens Morecambe Bay did get a very quick look, because it was being authorised just at the point at which we were introducing the quality governance reviews. Although

because it had more or less completed, we had more or less completed the authorisation before we were ready to do them, it was only a fairly quick look, which in retrospect, was very unfortunate; it might have been the one thing that threw these things up back in October, later in 2010.

So, the quality governance review now is firmly ~~imbedded~~ embedded and it is also firmly linked to the ~~work that the~~ new work that the CQC does, so we work very closely together on that, and they have actually adapted, adopted and adapted quite a lot of our quality governance review in their own review process, but we make sure they focus, as they say, from the ward up to the board, and Monitor now focuses on the board down to the ward, and we've made sure that it does.

We also looked much more explicitly at the impact of Trust plans on their ability to sustain quality of care. That was an issue particularly coming out of the Mid Staffs review, one of the things that, in retrospect, was clear ~~that~~ in Mid Staffs, was that in their efforts to make their finances look sound, they had cut corners on things like staffing levels with inevitable quality consequences, so we looked much more explicitly at that.

I won't say that we're working more strongly or more closely with CQC~~,~~ now. ~~we~~ We do work extremely closely with CQC but I think ~~we've~~ we had fixed that at the time of Morecambe Bay~~,~~. I don't think that was an issue when we reviewed Morecambe Bay.

DR KIRKUP: No.

DR BENNETT: I think there are lots of more detailed points, but I think those are the main differences about what would happen. But as I say, if there's one thing that ~~was~~ I would have hoped would have identified the problems that we now know about, it is that~~,~~ a deep inspection that every Trust has to go through before we will authorise them by Mike Richards and his team at the CQC.

DR KIRKUP: Yes.

DR BENNETT: Sorry, you –

DR KIRKUP: Yes, I moved you on prematurely. I was going to ask about how you monitor the established Foundation Trusts and what gives rise to alarm that prompts the sort of action that you took in 2011, back in 2011.

DR BENNETT: 2011 yes~~,~~ s. So once a Trust becomes a Foundation Trust we monitor its performance. The whole principle is that we should have a relatively light touch monitoring regime, unless we start to see things going wrong, so that monitoring

regime is through a mixture of ongoing dialogue with ~~a~~ the quality regulator, who of course are monitoring quality performance; at the time the CQC had their quality risk profile and they have now got a different version of that, but it brings in lots of soft intelligence and harder metrics,

So we remain in close contact with CQC throughout. We continue to monitor some soft intelligence, if you like, ourselves, which includes things like, from just reading the media, the local press; (you can learn an awful lot from reading the local press,) staying in touch with local MPs, staying in touch with commissioners; (that's very important,) through to looking at staff surveys, patient surveys and so on.

DR KIRKUP: Okay.

DR BENNETT: We also monitor some rather more concrete measures of how a Trust is doing, and in particular we look at things like whether they are meeting the targets the government sets them on things like hospital acquired infections, access targets and A&E waiting times and for elective care and so on.

So, we monitor all of that and have fairly regular, but if they're doing fine, informal conversations with the Trust. And then, once a year, we ask them to submit a three year plan. And we are actually required by Parliament to do that, although Parliament didn't tell us what to do with it. What we do is try to analyse those plans and see if there's anything in the plans that suggest, even where we think, on current performance, and current intelligence, there are no problems, whether there are indications of potential problems coming down the line.

And we look at that from an operational point of view and, to a limited extent, from a quality point of view, I say to a limited extent, because the real quality experts, of course, remain the CQC and they too, of course, are looking for that.

DR KIRKUP: That's still a fairly detailed level of analysis that you have to subject; how many Foundation Trusts at the moment, several hundred?

DR BENNETT: 149.

DR KIRKUP: Yes, okay.

DR BENNETT: Yes, so –

DR KIRKUP: That's a fairly challenging task.

DR BENNETT: It is, it is and so we have a sort of sequential process where we essentially try and triage first time around, and hopefully find that the majority of the Trusts aren't indicating anything that we should be alarmed about and then a small number where there may be issues, some of which will already be in our, what we call our

enforcement regime, where we're dealing with those issues and then there's the group in the middle, where we will dig deeper, not in the form of a formal investigation, but simply saying there are things in your plans and what's going on in your health system which gives us some cause for concern, so we want to dig more deeply but this is, at this stage, not a formal investigation. And that's the way we try and deal with numbers.

Back in 2011, when we started seeing some indications of issues at Morecambe Bay, we were, if I remember correctly, we were in the low teens in terms of the number of Trusts that came out of that process that we thought needed a bit more work. Of course the system is more under pressure today than it was back then.

DR KIRKUP: Yes, just before we move onto Morecambe Bay specifically, do you look at incident reporting as part of that process? You talk about monitoring levels of HCII and so on, do incidents come into that or not?

DR BENNETT: The primary use of incident reporting is through the CQC.

DR KIRKUP: Yes.

DR BENNETT: So primarily we will look at any indications of outliers, but we will rely on the CQC in the main, to collect incident reporting information and factor that into its assessment.

DR KIRKUP: Yes, okay. And in fact, in terms of overall numbers it's actually probably better to be a higher reporter than a lower reporter of course.

DR BENNETT: This is one of the problems isn't it, with this whole issue of incident reporting, that it's very difficult to get the right incentives because what you really do want is that people identify issues and deal with them to avoid the risk of it happening again.

DR KIRKUP: So higher reporting, but not repeat reports.

DR BENNETT: Exactly,

DR KIRKUP: It's not the same thing coming through again and again.

MR BROOKES: So what one has to avoid is any kneejerk reaction, if you see an organisation of higher reported incidents, to assume that there are problems. It could be the exact opposite.

DR KIRKUP: Yes, absolutely.

MR BROOKES: Just one more question about the system you are talking about there.

DR BENNETT: Yes.

MR BROOKES: The system relies on a triangulation of different sets of – and from different organisations.

DR BENNETT: Yes.

MR BROOKES: Were you have a situation where there is a dissonance between those different systems, how are those resolved? So, for example, you've got concerns from your metrics, CQC hasn't or vice versa, how were those kind of things discussed, resolved; how do you make sure that you've got the right way forward?

DR BENNETT: Fundamentally the approach is either/-or~~,~~ , s~~S~~o, if we've got concerns in our own right, or the CQC has got concerns in their own right, either is sufficient for us to decide there are concerns. So, if CQC came along and said, 'You may think this Trust is fine, but we've got concerns' ~~and~~-then as far as we're concerned that means we've got concerns as well.

So, I can't really think of any situation where they've said 'We've got, —the CQC has got, concerns and we've said, 'No, you shouldn't have' indeed, they are the experts on the quality front~~, so~~. ~~of~~ Of course we have asked questions about why they have concerns, what's led them to have those concerns, and quite detailed discussions about what you should do about it. We would automatically assume that if the CQCs got concerns then we have to start investigating ourselves.

MR BROOKES: And can I ask this, if you take the local commissioners or the local intelligence as concerned, but how do you weight that kind of – or is it again it's a concern and therefore you go -

DR BENNETT: Absolutely~~, so~~. As you will know that what will happen if any of the key bodies ~~raising~~ raises concerns quite often is the establishment of a quality risk summit and then we all sit around the table, and we are there with everybody else, and we will talk it through and I think it's very unusual that there isn't a consensus emerging out of that about what's the nature of the concern and what needs to be done – and then we'll take away, if things need to be done about it.

DR KIRKUP: Okay, so in the specific case of Morecambe Bay.

DR BENNETT: Yes.

DR KIRKUP: Some concerns arose during the course of 2011 if you remember.

DR BENNETT: Yes, that's right.

DR KIRKUP: Can you tell us what nature of them and where they came from?

DR BENNETT: So, in very simple terms, I think it would be true to say it was mixture of increasing concerns at the CQC, and also our own annual plan review, which raised

some concerns. So, ours ~~was~~ were the more straightforward ones~~, so~~. ~~we~~ We do our review, the annual plans arrive around June time, and ~~so~~, over the next couple of months we do this analysis to identify which ones we think are worrying and so should be subject to some sort of what we call 'stage 2' and Morecambe Bay in 2011, confirmed that category, partly because there were still some indications of quality issues, but also frankly there were some financial issues, some lights flashing on that front.

So, they were subject to one of our stage 2 reviews, which was completed in September of 2011 and that said, there were some medium to high risks around the finances, which was essentially saying, like every organisation in the NHS these days, they had to make productivity improvements and there were concerns about whether they were going to deliver on those, and we said there were medium to low risks around some ~~indications~~ indicators around quality governance, ~~what~~ which seemed to be medium to low on the basis of that review.

However, in parallel, I think this is the right sequence, ~~so~~ when the Coroner's inquest on Joshua Titcombe's death was going on in – this was spring, early summer of 2011~~, -~~ one of the things that came to light, ~~because~~ I am pretty sure that this is right because the report that was given to the Coroner, was that there was this report ~~given to~~by Elaine Fielding, into the maternity unit. Now, the fact is that this was available in August 2010 to the Trust~~,~~. ~~I~~indeed, there had been two drafts of it available months before that.

DR KIRKUP: Yes.

DR BENNETT: Neither we, nor the CQC, were made aware of that at the time, and indeed one of the other things that we've now changed in our assessment process is that we have a longer list of things that we require a Trust to ~~say they must~~share. ~~information~~ Information they must share with us at the point of assessment. And we require them to sign something that says they have given us everything, and there is a catch~~-~~ all in there, which is 'and anything else that you think might be relevant'. So, we rather trusted or expected that a Trust would do that, ~~would~~ but have now introduced an explicit statement that they have to sign.

MR BROOKES: So, it wasn't explicit at the time that they would have needed to share; I absolutely agree that it was expected of them to.

DR BENNETT: It wasn't explicit. No, of course, it's difficult to say you must – to tell them what it is they should give you, if you don't know what it is they've got that they

should give you. So, we rather expected that they would tell us but now, as I say, we require them to sign it. We've extended the list so certainly, if something like the Fielding report were to exist today they absolutely would be clear they need to give it to us, but there's this catch- all as well. But we do find that simply requiring the board to sign something focuses their attention.

DR KIRKUP: Yes, indeed.

DR BENNETT: So, I think the thing that ~~sort of~~ resulted in increased attention was partly the fact that the Fielding report's existence came to light ~~because~~ and I think it was, if I recall correctly, because of the Coroner's inquest.

DR KIRKUP: Yes.

DR BENNETT: The CQC also did a planned inspection of The Royal Lancaster in the April, I think they became aware of the Fielding report in the May and then, in the June the Coroner's inquest concluded with the issuing of a Rule 43 letter, which not only talked about the circumstances at the time, of Joshua's death, which I think was 2008 if I remember correctly.

DR KIRKUP: Yes. Yes it was.

DR BENNETT: But also said there were concerns that seemed still to be – there, ~~were issues~~ Issues that still seemed to be ongoing. So, now there were a whole series of pieces of evidence that led the CQC to decide that they needed to do a more thorough review of what was going on, particularly in maternity. They did another review in June and then an even deeper review in July; and this culminated in them issuing a warning notice in August.

So, back to how things looked from our point of view, ~~we~~ We were aware, of course, of what was going on, and very anxious to see what the CQC would conclude. And in August we got their conclusion, which was a pretty severe issue leading to this warning notice. And then, in September we got the result of our own review, which also said that there were some ~~governance quality~~ quality governance issues, or at least some indication of potential quality governance issues; so that was the point at which we brought the Trust in to what we called in those days, an escalation meeting.

~~The purpose of which we~~ We would have the board of ~~Trustees~~ the Trust and the purpose of these meetings was to really understand a lot of work would have gone on around them as well, with our teams gathering information and interviewing various members of the Trust, but this would ~~not~~ be effectively an interview with the

whole board.

DR KIRKUP: Sure.

DR BENNETT: For them to explain to us how they could – their explanation of what was going on and what they were doing about it and that was what led us in the following month, in October, to put the Trust in significant breach of its terms of authorisation, which is a major step, and reflected our view that there were serious issues that needed to be dealt with.

DR KIRKUP: Okay.

DR BENNETT: And enabled us to start issuing directions for them to get things sorted out, and one of those directions was to accept this review from central Manchester.

DR KIRKUP: Okay, just before we get onto that, I just want to pick up two points in relation to the Fielding Report.

DR BENNETT: Yes.

DR KIRKUP: The first one is was the significance of the Fielding report the contents or the fact that they hadn't disclosed it previously, or was it both?

DR BENNETT: I think the most important point was the content, because it indicated that there were more deep-seated issues in maternity, all of which – the moment you see evidence of governance processes not working properly, and potentially cultural issues then you know you've got a big, and potentially quite lengthy job on your hands to get it sorted out. And my recollection was that the Fielding report gave indications of these sorts of more deep-seated issues.

Of course the fact that they didn't, the Trust, didn't make it available to CQC when they were concluding their review was presumably one of the reasons why the CQC didn't, at the time, discover that there were these more deep-seated problems

DR KIRKUP: Yes, now that takes me directly onto the second question, which is were you able to form a view as a result of the discussions that you had with the Trust about the Fielding Report, whether their non-disclosure of it was an oversight because they didn't think that it was explicitly required of them, or was there something more to it than that?

DR BENNETT: Well, what they told us was they didn't think it was relevant. I think that is an inappropriate interpretation of our rules as they existed at the time, even before we had this longer list and so on. They should have shown it to us.

DR KIRKUP: Yes.

DR BENNETT: But of course, ~~that~~ at this point~~, and~~ we were much more focussed on how

do we get problems solved than how did we get here, but it was significant.

DR WALTERS: So, did that come out at the escalation?

DR BENNETT: Yes.

DR WALTERS: So you had the escalation meeting and then put them into breach?

DR BENNETT: That's right.

DR WALTERS: Give us a flavour of the escalation meetings.

DR BENNETT: Well, so to some extent this is casting my mind back rather than anything that was written down.

DR KIRKUP: Sure.

DR BENNETT: To be honest I thought they gave a quite credible account of themselves, both – yes there was this issue that they didn't give us the Fielding report, but okay, my view is that they should have done, but they sounded convincing in explaining to us that they didn't realise they needed to in terms of the things that they were doing, already doing to address the issues raised in the Fielding review, and subsequently in the CQC reviews which had happened more recently; they were fairly convincing about being in control.

And I recall, after the escalation meeting, talking to the senior ~~compliance officer~~ relationship manager at the time for the Trust, who, in fairness to her, and she was an experienced NHS manager, I am very used to dealing with boards of organisations, but not in the NHS. She was more sceptical and then, over the course of the next few weeks, I started hearing about various – there were never the follow on questions, i.e. information that we asked for at the escalation meeting, and as the answer to those came back I became increasingly unconvinced that it was true, that this board was really on top of what was going on.

And that was what led me on to say what I need is an in-depth review here, by real experts, reporting directly to us; because of course the Fielding report was done for the Trust, not for us, and hence the decision to send Central Manchester in, so over the period of between the escalation meeting and I guess it was about a month to the board meeting at which we agreed to put the Trust in significant breach, I had gone from feeling that this was a Trust that was on top of the issues, to feeling there were serious question marks here.

DR KIRKUP: Okay, so you received the Central Manchester report.

DR BENNETT: Yes.

DR KIRKUP: What happened next?

DR BENNETT: Well, the Central Manchester report, of course, absolutely confirmed that there were really quite serious issues, they had 118 risks identified.

DR KIRKUP: Yes.

DR BENNETT: And it also became clear that many of these were systemic problems that a) therefore had been around for quite some time, and b) would require quite significant change to get sorted out. So, we required plans ~~in~~ to be put in place by the Trust to address all of the issues raised. I don't think there was anything inconsistent at all with what the Coroner had said, what the Fielding report had said, what the CQC had said; but now we had a really in depth report that brought it all together.

So, we asked for a plan that would address all of that, we had also, as part of putting them in significant breach of their terms of authorisation, asked for an in depth review of governance, which was done by PWC.

DR KIRKUP: PWC, yes.

DR BENNETT: So, we got the draft of that – so we got the Central Manchester review pretty quickly, in I think within a month of us asking for it; the governance review took longer, but we got the draft of that in the February of the following year; that also identified a whole set of issues. Even before we got that the ~~DR KIRKUP man of~~Chair of the Trust resigned and we put in an interim chair who we asked to sort this thing out, and as you will know, shortly after that there were a whole series of executive departures as well.

DR KIRKUP: Was the Trust chair resigning something that you encouraged to happen?

DR BENNETT: It needed to happen.

DR KIRKUP: Yes.

DR BENNETT: And we have powers to make it happen, if necessary.

DR KIRKUP: Yes okay that's very clear, thank you. What about the Chief Executive?

DR BENNETT: Well, our general approach, and particularly in those days, was say what we need is high quality, reliable Chair in these Trusts, and then it's their job, with their fellow non-execs, to make sure they have a strong executive team. So we put in an experienced Chair, David Henshaw, and he very quickly came to an agreement with the Chief Executive, who then I think he'd left on secondment initially, but left the Trust very quickly.

DR KIRKUP: Yes sure, okay. Right, so we are now in early 2012.

DR BENNETT: That's right, yes.

DR KIRKUP: We have a largely new team in place; or interim team leading to –

DR BENNETT: The emergence of a new team.

DR KIRKUP: Yes precisely so and we have plans to improve what had gone wrong.

DR BENNETT: Yes.

DR KIRKUP: What happened after that?

DR BENNETT: Well, so then a period of the plans being implemented and both Central Manchester, on the maternity issues, PWC and of course, to some extent, the CQC as well, going in to the Trust to check on the implementation of plans. In practice, although there was evidence of progress being made on the implementation of those plans, new issues emerged over this period, so we had another set of CQC warning notices in the early part of that year, around things like mixed sex accommodation, clinical monitoring of patients, they were concerned about emergency medicine in the Trust.

So, of course, what was becoming clear was that not only were the issues around governance and the quality of care quite deep-seated in maternity, but they were much broader than maternity as well, So of course, this meant that the set of things that the Trust needed to tackle was growing.

The other thing that became clear was that this was a Trust that really had some sustainability issues. And I would say it is a very, unfortunately good example of what has become a clear pattern over the last few years. And it's a pattern of small, isolated Trusts struggling to provide good quality care and to do so within the financial resources available to them.

So, one of the things that Bruce Keogh said, when he looked at the 14 Trusts that he looked at, a common characteristic, he didn't look at Morecambe Bay, but common characteristic of small, isolated organisations, who partly because they were small, but also because they were disconnected from the rest of the NHS, were just not following good practices. And I think Morecambe Bay absolutely fits this characterisation of course.

Morecambe Bay has about – the Trust as a whole, has about – its catchment is about 85% of the average of an NHS provider, a hospital Trust, which is not a long way from the average. It's geography is 2.2 times the average, so this is – it's essentially two or three small isolated organisations, so it absolutely embodies that, so also in the course of 2012, as they were struggling to deal with an ever growing list of issues, it was becoming clear that part of their problem was just the geography, the size of the Trust and so on.

So, one of the things that we did in early 2013 was first of all require a whole set of further actions to be taken, some further actions in maternity, but some in emergency care, because of stuff that had come up where further actions in finance, sorry further actions in governance. We also asked them, or required them to take some actions to try and get on top of some of those aspects of their finances that they could reasonably be expected to deal with. But we also commissioned a review of their long term sustainability, both clinically and financially; and because, as I say, the whole set of things that both this Trust and other things that were going on across the NHS, made it clear that this was a Trust where there were likely to be questions about that sustainability.

DR KIRKUP: Yes, what was the outcome of that?

DR BENNETT: So, ~~we'd~~ we've just received the draft report, and these things do take a long while, they essentially need to be led by commissioners, it is commissioners after all that have to decide what services they want in any health economy. They - another lesson we've learnt, particularly from Mid Staffs is that it's no good trying to solve these problems within the boundaries of individual organisations; you've got to find a solution for the whole health economy. But of course that makes it more complex.

DR KIRKUP: Sure.

DR BENNETT: Lots of stakeholders, lots of organisations, so they take – we've just got the results of that in draft form, so this is not finalised. So one of the things they've said, and I don't even know whether this is in the public domain but I don't think it will be a huge surprise to anybody, is that unlike some other situations where we have this, the answer isn't consolidate services, so we do find situations where you've got sub-scale maternity services, particularly obstetric services, or sub-scale A&E, where there is the option of consolidation to provide better quality care on a sustainable basis.

That's not an option here, because of the geography, so they've confirmed that. They have a number of ideas about however strengthening primary community care in the health system can help support these Trusts, which are otherwise, or really the sites, which are otherwise a bit too small. They've identified something which was also becoming increasingly clear over this period, which is that part of the Trust's problem is that even as a single Trust it has not been making best use of what it has got. It has been operating on a very isolated basis across its different sites.

So, there is a very strong further recommendations; I understand, around

getting much better working across the sites. They are also saying, however, we do need to establish a relationship with another Trust. We know that because of the geography there will be limits to the extent for which, for example, they can share consultants share rotas and so on, which is sometimes what we are able to do.

DR KIRKUP: Sure.

DR BENNETT: But nevertheless, just having the sort of buddy or partner who they have a professional relationship with, we think can help on appointments. ~~Appointment can – attracting~~ Attracting high quality people to these Trusts can be a problem, because of their size and their isolation, so it can help on appointments. It can help, we think also, in trying to drive more good best practice into the Trust, so that's, I think, a strong proposal. So those are some of the core elements I think, of this emerging proposal.

DR KIRKUP: Okay thank you for sharing that with us, I appreciate that you are not in position to and don't want to go into any more details about that; but can we just talk, for a moment, about the kind of principles; I'm particularly interested in this buddying relationship. Presumably, to get the benefit of that it a) needs to be a kind of major centre which is, you know, has the university links and the prestige, and all of that, because of the recruitment, and b) it needs to be not too far away.

DR BENNETT: Well, I would say yes to both ideally.

DR KIRKUP: Right.

DR BENNETT: But there also has to be some pragmatism, just on the basis of who is interested in doing it, who is available and so on.

DR KIRKUP: Right, okay.

DR BENNETT: So, I – that's still the discussion; and one of the things that we will need to do, and we have had to do in a number of cases recently, is we will, I think need to intervene, there are some proposals now, but we can talk to potential buddies, because many of the candidates will already be Foundation Trusts, so we can see whether we can't encourage an attractive partner to step up.

DR KIRKUP: And is that at the whole hospital or whole institution level? It's not serviced by services?

DR BENNETT: I think the focus here actually is on maternity, but that's a question I've got, is that the right way to do it, or would it not be better to do it on a whole organisational basis. I would have thought the latter myself.

DR KIRKUP: Yes I think that would strongly occur to us as well, on the basis of what we've

heard.

DR BENNETT: Yes.

DR KIRKUP: One of the suggestions that has been made, and I don't know how to public this is, again, but I mean the name has been mentioned of Coventry in relation to maternity services, which doesn't seem to me to fit either of the two.

DR BENNETT: Yes, I have heard this name as well; I don't want to leap to judgement because I have not had time to look at this in detail but there may be some very good reason why Coventry is a good choice, but it does seem rather a long way away doesn't it.

DR KIRKUP: Yes.

MR BROOKES: Sorry can I just ask a point of information as well, is there any requirement on Foundation Trusts to engage in these kinds of arrangements, supporting other organisations. The thing I'm thinking of is for Foundation schools, it's actually a requirement as part of the Foundation status, that if they failing in the area that they work with them, that they have a responsibility to support the overall system. And I was just wondering if there was a similar arrangement, or whether that was something that was being considered.

DR BENNETT: No, it's a very good point, but no there is no requirement. Now, that said, I have not had a conversation yet which hasn't been entirely positive and constructive. But that's not to say that all the conversations I have produce the outcome that I would initially have hoped for; but that's because, let me give you one example, I am not going to name names, but another failing or a seriously failing organisation that needs a strong partner, there seemed to be a strong partner not too far away, a big teaching hospital, and they are going to help.

But they are not going to do quite as much as I wanted, but in fairness to them they are quite, —they are a good organisation, but they are quite different to the one that needs help, so that – they sort of convinced me that they're not a perfect match. Secondly ~~they're~~ their strategy, what they want to do is to strengthen themselves as an organisation, is focus on what they do as a teaching hospital, specialist hospital, research centred hospital. And frankly, trying to help rescue a struggling, medium sized district general hospital doesn't fit with that.

DR KIRKUP: It's a distraction.

DR BENNETT: So you've got to find the right balance of course, between helping, enabling the good organisation to continue to be good and where ~~you~~ they can, get better, and

providing the support. I think this is going to be an increasing challenge for us.

DR KIRKUP: Right, so where would you say Morecambe Bay was now?

DR BENNETT: Well, so of course we've just had the report from the CQC. I suppose the good news is that they say there ~~had~~ has been progress in the maternity area, but they have got a long way to go. And I think, in terms of the leadership the – I hope the changes that are still – there's a sort of second wave of changes happening, and I hope the result of this second wave will put them in a strong position. So as you may know we had an interim Chair, David Henshaw, and then the governors appointed John Cowdell. He has stepped down now.

DR KIRKUP: Yes.

DR BENNETT: And I think that's to his credit, he's acknowledged that he probably wasn't the right person to sort out the nature of the problems they've got. We've a new Chair in place, who looks like a very strong Chair. We've got a new medical director, just about to arrive, who looks to be a strong medical director, so I think – I'm hoping that we've now, in this second wave of appointments, going to have a strong team there.

But I think they will, on their own, not be able to sort this out; we've got to get both the other things in the health economy, the support from primary and community care, and an arrangement with another Trust in place if the conditions are going to be there for them to really sort out these deep-seated problems. But I think we have to acknowledge that some of the sort of cultural issues that we see ~~in~~ and some of the governance problems can take quite a while to work through.

DR KIRKUP: Yes, and they take their lead from the top of the organisation but it will probably take some time to filter down.

DR BENNETT: That's right.

DR KIRKUP: And if some of the deep-seated problems are amongst some of those clinicians in paediatrics, in midwifery and obstetrics, then that's quite hard to change too.

DR BENNETT: Well that's why I think the appointment of a strong medical director is one of the most important things to do in these sorts of situations.

DR KIRKUP: I guess it's fair to say you'll be keeping a close eye on them.

DR BENNETT: You bet. Yes absolutely, well they are in special measures; this is a very small number of Trusts, Foundation Trusts and non-Foundation Trusts in special measures. And amongst other things, what ~~the~~ that means is that we have one of our people - someone acting on our behalf on the ground, and a very experienced person,

Fiona Wise has just taken over this for us, so a very experienced NHS Chief Executive, spending significant amounts of time on the ground, partly there to offer advice and support to the board, but above all, as our eyes and ears, so they are getting exceptional levels of attention from us.

DR KIRKUP: Yes, okay thank you. Who would like to come go next, Geraldine?

DR WALTERS: Just a few reflections I think because this is obviously before your time, but when we started this process we spoke to the families and heard their reflections, and what they thought and to them before they authorised the Foundation Trust Monitor involved and the CQC were involved, and the Ombudsman was involved; so what they can't quite understand is how they ever became a Foundation Trust. And I know that was before your time, so do feel free to give your reflections to help us explain that.

DR BENNETT: No, it's an absolutely fair question, because they should not have been. We shouldn't have authorised them as a Foundation Trust, and that is – although much of what happened, happened before I arrived, I was there when they were authorised. So how can that be; well of course it was exactly the same question at Mid Staffs as well. And frankly I think the failings there were more evident and it was even less clear how they, those failings were missed and they were authorised. I think, bluntly, it's a personal view because much of this at Morecambe Bay, and probably well all of Mid Staffs happened before I got involved~~.~~

~~B~~but collectively those responsible for overseeing the quality of care delivered by these organisations weren't doing what was needed were they~~;~~? ~~how~~ How else could you not only have specific incidents of poor care, which in fairness, of course, can happen, ~~as~~ at any organisation from time to time, but how could you have a pattern of that and then, when you finally do the in-depth investigations, discover that there are deep-seated reasons for it~~.~~? If that happens and isn't picked up for years, then something is not working the way it should be is it.

MR BROOKES: And to be clear, who is on that list, in your mind?

DR BENNETT: It's sort of everybody isn't it. ~~What – w~~Where I think the focus should be~~,~~ ~~though~~ and it is difficult to argue ~~this~~ otherwise, is the regulator responsible for looking at the quality of care; and therefore that's why I answered your question "What's different", with the answer, the changes at the CQC are what's different. Now, I don't want to, per se, criticise the old CQC regime; they were operating within a set of statutory conditions, with a certain level of resources. But it wasn't

revealing what was needed. I have no doubt the current CQC approach will evolve over time but I think this switch to an ~~expert~~ expert-based, in depth review, with significant numbers of people having their feet on the ground at the Trust, talking to a lot of people in the Trust, is the sort of process you need to get under the skin of what's going on in these organisations.

DR WALTERS: And do you think this really disperses responsibility for quality is something that's going to continue long into the future?

DR BENNETT: Well.

DR WALTERS: Because it's difficult to articulate to the public isn't it, because really they want the people responsible –

DR BENNETT: Well, it's difficult to articulate the reality I think, and so my view of what happened in Mid Staffs was in part there were so many people with a responsibility ~~to~~ for quality, ~~but~~ that nobody really felt the buck stopped with them. Now, people will say, rightly, that of course it was the board of the Trust where the buck stopped, and that is always true. But we know that doesn't always work. So there's got to be at least one other body that is looking at the organisation and asking is this board doing what it should be doing.

And the problem, I think, in part in the old system was there were too many bodies doing that and therefore nobody absolutely felt that if it turns out there's bad quality care ~~of~~ at this organisation, yes the board's at fault, but so are we.

I am absolutely clear that is the CQC's job and I think the CQC is clear about that now. Yes, there are other people who have some involvement, but in terms of establishing whether or not the quality of care is good enough, first of all its borne with the Trust, and then it's the CQC, in my view, in the new world.

Now, that said, if there are problems, and it's a Foundation Trust, it's our job to make sure that they get sorted out, so they have a role and we do a little bit of belt and braces as well, both at authorising new Trusts and overseeing existing Trusts. The commissioners still care, of course, about the quality of care, so they have a role and then we have organisations like the Health Ombudsman and so forth. So I can see how this still doesn't look very clear to members of the public. I think the more we can be absolutely clear that fundamentally it's the job of the CQC to make sure, after the board of the Trust, the quality of care is at the requisite standard, whoever else is responsible for making sure it's sorted out if there are problems; whoever else you can complain to if you want to complain, I think if we can get that clear then

hopefully we've made a big step forward.

DR WALTERS: The sort of quality cost axis is quite difficult, isn't it?

DR BENNETT: Yes.

DR WALTERS: And I suppose, looking at the list of monitoring criteria.

DR BENNETT: Yes.

DR WALTERS: And we've looked at the data on all of this, I think, from the Trust point of you if you put yourself back in 2009, there were no big flashing lights about maternity; we can see them now.

DR BENNETT: Yes.

DR WALTERS: You couldn't see them then, but there probably were flashing lights about where this organisation was, where its funding was, and just how the services were dispersed, and I'm wondering if it's more to do with the type of organisations where the risk is, and not what the metrics has shown.

DR BENNETT: Well, I think, as I was saying earlier, the answer is yes, that a combination of things like Bruce's review of his 14 Trusts and increasing experience with struggling organisations ourselves, what Mike Richards says and so on, all of that is pointing exactly to this point; a small and isolated Trust is in trouble. I think what's changed over the last few years is frankly that as the system has been asked to find significant productivity improvements, which I think across the system it can find, although that's not to say that it's easy, but I think you can.

But as that has been asked of the system, those organisations who are, if you like, in a structurally difficult position, that structural difficulty has been exposed. I think that's what, in part, what happened in Morecambe Bay, it's in part what's happened at a number of other organisations.

DR WALTERS: Thank you.

DR KIRKUP: We almost touched on the subject, just before I hand back to Julian; I just wanted to ask you explicitly, should there be a separate quality regulator in Trust.

MR BROOKES: Exactly.

DR BENNETT: Oh, this trade off of quality and cost issue and whether you look at them together?

DR KIRKUP: Should you combine the two organisations?

DR BENNETT: Yes, which of course Robert Francis said he thought they should, others have as well. So, I think there are two issues here, let me start with sort of the practicalities of running this organisation. Is there a trade-off between cost and

quality, certainly not a straightforward trade off; there's lots of evidence, and frankly not just limited to health care, ~~but~~ that well run organisations are both – will deliver good quality services, whatever those services happen to be, and are likely to be run as efficiently as you can run an organisation of that sort.

So there's no necessary trade off, but what doesn't mean to say that aspects of quality don't cost money, of course they do, so if part of what you want to do to improve quality is just have more staff, 24 by 7 say, there must be a cost associated to that, it would be foolish to pretend otherwise.

So, as we think about what quality standards we should set, there obviously can be cost implications of doing that ultimately. So, if you say as part of a cost quality requirement we want 24/7 consultant cover; you need more doctors. It's going to cost money; there's no good pretending otherwise. Now, very few health systems make that trade off explicitly. They evolve onwards with whole lots of smallish, sometimes smallish decisions that sort of move forwards.

Of course, in one area the UK has really tried to put itself ahead of the field in this and with the establishment of NICE, and asking NICE to look very explicitly at aspects of trade-off between cost and ultimately the quality of care, and make decisions. But in lots of other areas we don't do it explicitly, and as far as I'm aware, very few, if any, other health systems do either.

So, it's a constant process of adjustment. Now, you could make that, both that adjustment and the review of how the organisations are doing, against wherever you are in that balance within a single organisation, I can see arguments for doing that which would effectively mean that aspects of what Monitor does will be moved into CQC.

That's not to say all of what Monitor does with Foundation Trusts; we both look at the performance in terms of general corporate governance and, amongst other things, financial performance. So that's a sort of inspection type of activity; but then we also are responsible for getting things fixed when they're broken. You could move the inspection bits across to CQC and still leave the getting it fixed when it needs to be fixed, in Monitor.

There is, however, I think some merit in keeping the looking at the financial aspects separate from the quality aspects. And I think this is quite a powerful argument, which is that having the quality regulator unencumbered with having to worry about the financial aspects gives you an absolute focus on is this care good

enough.

Now, at a policy level we do, from time to time, have to ask ourselves the question, is the standard that the CQC is setting is affordable. But the notion that on a day to day basis they are not asking that question, they are not making a trade-off between the quality that organisations deliver and whether it's affordable is a good thing. And then it's our job, with the Trust board, to sort out how you make sure it's affordable. I think there's a lot of merit in that.

DR KIRKUP: I can see that, but are you also saying that if CQC was saddled with the responsibility for the financial performance as well, that their judgement might be seen as tainted; that they're saying that some level of quality is acceptable but in the back of their minds, because they think that's the only level of support?

DR BENNETT: Well, there's both the perception and the reality isn't there, so there might be a perception issue.

DR KIRKUP: Yes.

DR BENNETT: People might, even if not true, they might ~~thing~~ think well, they've said it's okay, but only because they know if they can't – yeah? And then there's reality, there's a reality that if Mike Richards' team is doing an inspection and they say 'We're not really happy with the staffing levels here, but this Trust is on the edge financially, and if we demand more staff we'll tip it over, so we mustn't demand more staff' then I think that's difficult. An advantage of having the two separate is that you've got a much more transparent and explicit dialogue about the affordability aspect.

The CQC can say 'This is what we think is necessary from the quality point of view', we then say, 'Can that be made to be affordable in this setting and we must do work with the Trust board to make sure everything possible is done to make it affordable'. But if that's still not possible then we look at other things.

In the short term we look at things like sharing costs and sharing rotas and so on, we can even look at the question about whether the Trust should be entitled to some sort of subsidy if you like, because you know, if you're just too small and you can't help it because of the geography you're in, then maybe you deserve some uplift that regulations allow for that as a possibility.

But also it means that we are worrying about the longer term trade off. If we find a situation where the quality of care that the providers have been asked to provide by CQC is not achievable with the amount of money the systems got, even if

the providers were all operating as efficiently as possible, then we can say 'This isn't adding up, if you want to maintain this quality then some more money will be needed' and I did this two weeks ago and three weeks ago, with the full review.

MR BROOKES: Yes, it's like your view in terms of Morecambe Bay; what is your view on that?

DR BENNETT: Morecambe Bay, well that's what we need to finish off as part of this sustainability report. All I would say is that prima facie, they are the sort of Trust that will struggle to provide adequately good care in the long run, on a financially sustainable basis without something else being done because the points about geography and so on.

MR BROOKES: And there is a view that the improvements that they have put in, in the maternity services at the moment are non-recurrent and are potentially unsustainable within their resources.

DR BENNETT: And that's what we have to look at and fix, if it's true.

MR BROOKES: And how do you fix that?

DR BENNETT: Well, so step one you've got to make sure our organisation is running itself as efficiently as it can; step two, we have to look at ways in which it can share costs, so it is more difficult because of the geography but it may not be impossible, there may be things it could do to share some of this cost with a neighbouring Trust.

And then, when we've done those two things, the third step is, is this an organisation which deserves some form of top up to its normal tariff income because of its geography.

MR BROOKES: And that isn't available at all to that -

DR BENNETT: Absolutely.

MR BROOKES: Okay. I'm interested in this; I did some work around the Darnell review on the impact of rurality.

DR BENNETT: Yes?

MR BROOKES: Maternity wasn't specifically, well it is, but most were coping with these kinds of issues of small services such as this, by cross-subsidisation from those where they make maybe a little bit more money on the side, but that's not always an ability available to all organisations. So, a flexibility, well they were talking at that time about rurality impact, or rurality in terms of the overall tariff mechanism.

I'm also aware of the stuff you did around trauma services, where they readjusted the tariff within its overall envelope, to take into account in that case, the

impacts on trauma centres.

DR BENNETT: Yes.

MR BROOKES: But there are ways and means, but it isn't just going to be Morecambe Bay is it, is this done on a case by case basis, or is there some kind of thinking around the impact on similar kinds of organisations across the country?

DR BENNETT: Absolutely, so the way we define how we look at this is to say 'We will ask the question is a provider organisation at a structural disadvantage?' Now, that might be a rurality issue, but there could be other things at stake. But the point being there's nothing this Trust can do about it; it has costs which are higher than the average, which is how the tariff is calculated, there's costs which are higher than the average, for structural reasons about which they can't do anything, and if that's the case then they are entitled to a subsidy.

MR BROOKES: Sorry I have some slightly other questions, different questions, I am quite interested I that though, as you can understand; if we go back to the time of authorisation of the Trust.

DR BENNETT: Yes. Yes.

MR BROOKES: And I absolutely understand what you're saying in terms of the primary responsibility of the CQC around the quality end of it.

DR BENNETT: Yes.

MR BROOKES: But again, we talked earlier about triangulation.

DR BENNETT: Yes.

MR BROOKES: So there were other key players around at the moment, and I'm just interested in your views on the kinds of input that they were putting into those decisions because there's the Strategic Health Authority, there's the local commissioners, we are aware that there are issues being raised with the Ombudsman at the moment in time.

DR BENNETT: Yes.

MR BROOKES: First of all, in terms of generalities, how were those kinds of things failing; and I'm interested in the waiting on those as well or was it, as you said before, concern of one is the concerns of everybody?

DR BENNETT: Broadly it was sort of a significant concern of one is a concern for everybody, so the SHA, after the CQC I think in the structure as it was at that time, the SHA would be the next place we would look to say 'Are you comfortable with the quality of care being delivered by this Trust?' And they had raised, I'm on the

wrong page here, they had raised some issues around the time of our first assessment, which we of course stopped quite quickly, but then over the period – so that was early 2009, over the period of then and early 2010, when we restarted, they had downgraded their concerns to a point where they had rated the Trust green light. So, if you see, they were saying they basically had no concerns and we have formal communications from them saying that they didn't have concerns. The PCT were spoken to as well, and they too weren't raising major concerns.

MR BROOKES: I'm interested now, because from a number of sources and from both relevant PCTs, we've been told that they did have concerns and that they raised them formally with Monitor about the leadership of the organisation, certain clinical services, the affordability of their business plans, the lack of communication with them over the planning and strategies put forward as part of the management process.

DR BENNETT: Was this in 2009 or in 2010?

MR BROOKES: I believe it was 2009.

DR KIRKUP: Yes.

DR BENNETT: Okay so that –

Mr BROOKES: So, it was part of the original bit before the pause.

DR BENNETT: So this is before my time and I am not familiar with the details of any discussions with PCT.

MR BROOKES: Sorry, I don't think the PCT then were subsequently re-asked whether or not, in their opinion, as part of the –

DR BENNETT: Well that's what I'm wondering, is –

MR BROOKES: Yes, I don't think they were.

DR BENNETT: Now I know the Strategic Health Authority was.

MR BROOKES: Yes.

DR BENNETT: But I don't know whether the PCT was. But that's an issue. *NOTE corrected per email Monitor to Investigation of 09/12/2014.

MR BROOKES: Because that's why I'm asking – that's why I'm wondering, in terms of this triangulation because we've been clearly told that.

DR BENNETT: Yes.

MR BROOKES: I understand the description you've given in terms of the SHA.

DR BENNETT: Yes.

MR BROOKES: But, there was noise in the system which potentially would have been picked up.

DR BENNETT: Yes. No, in fairness people in Monitor, of course, were doing this, of course the PCT reported to the SHA.

MR BROOKES: Indeed.

DR BENNETT: There sort of comes a point where you hope that – if you talk to the senior body it would pick up any issues at other levels.

MR BROOKES: And again, I assume there was expectations placed on partner organisations that if they were holding information which they felt was relevant to you, in terms of your Foundation Trusts, that they would be expected to provide those?

DR BENNETT: It wouldn't be as formal as it is with the Trust itself.

MR BROOKES: So, if the SHA knew about the Fielding report, for example, would you have expected them to have provided that information?

DR BENNETT: I would have expected them to yes, but there was no formal arrangement to do that.

MR BROOKES: Okay. Again back to the different strands of where the responsibilities lie; I understand, and we've talked a lot about CQC and the quality elements of this; but my understanding, in terms of both then and now, there was quite a lot of focus from Monitor itself, on both the financial plans of the perspective organisation, but also the sort of the corporate governance, the way in which it ran, the board's responsibilities, the board's competence to take on what is a very different role in a lot of cases.

DR BENNETT: Yes.

MR BROOKES: So, what was the assessment from Monitor on those particular strengths and weaknesses of the organisation in those areas?

DR BENNETT: Well, in terms of, let me just remind myself; you have the document which went to the board which summarised the overall position; so, just looking down here, everything is colour coded amber, traffic lights, red, amber and green. So everything green until I get to quality governance. Now remember, we only did a very light touch quality governance review, because we were just in the process of introducing it.

Quality governance, well I think it was amber, green, so it was at that point where we say 'Is this okay or not?' Now perversely, because this was a Trust where we'd already asked questions about quality of care, and we'd got specific reassurance, I think that's what tipped us over to say, well, this was only the very first ever, and it was only a very quick look at quality governance, there's been lots

of people asking very – in significant detail, about whether the quality's okay here, and they said it's okay. So, we went ahead, in retrospect perhaps it was signalling something which the others had missed.

MR BROOKES: Because, yes with the benefit of hindsight you've got an organisation whose board may not have been of the required standard.

DR BENNETT: Yes.

MR BROOKES: They did their own self-assessment of the governance arrangements, which was clearly inaccurate.

DR BENNETT: Yes.

MR BROOKES: There were ...potential concerns about the systems in the organisation at time.

DR BENNETT: Yes.

MR BROOKES: Commissioners are raising issues about the financial viability of their plans and are not necessarily signed up to it.

DR BENNETT: Yes.

MR BROOKES: So, I am drawing out areas which potentially could have raised concerns in the bit that Monitor was responsible for.

DR BENNETT: Absolutely, so one of the things I did when, in late 2011 it became clear that things had been missed; was a commission a review from our auditors of how we had conducted the review and why we had missed things and what lessons we could learn. One of the things they said was that there were a number of slightly concerning issues which individually didn't tip over, but if we'd looked at it in the round we might have said, 'Aren't there just too many mildly flashing amber lights here?'

And so, we've introduced a scorecard which essentially looks at everything we look at and sort of rag rates it all and then the teams now explicitly step back from that and say, 'Even if, in some numerical sense, it all adds up to a pass, are there enough amber lights on there that we really ought to go back and look again'. So you're right, with the benefit of hindsight, there were a number of things that, if you look at them in the round, you ~~night~~ might have said, 'Isn't this just a bit too worrying to simply go ahead?'

MR BROOKES: I assume you were not involved with the boards; that would be before your time was it?

DR BENNETT: That's correct, yes.

MR BROOKES: Because that's obviously a way of testing the quality of the board, the quality at the top of the organisation.

DR BENNETT: It is. Now, just to be clear though, I wasn't involved in the first board to board, that was before my time, The second board to board happened when I was there; now the system, and remember I was interim Chief Executive at this time; the system I inherited, I think in part, in reflection of the fact that Bill ~~Morris~~ Moyes was executive Chair, both Chief Executive and Chair, was that the board to boards were chaired by a non-executive with a second non-executive present and then members of the assessment team as well. So, the board to board did happen whilst I was there, but two of Monitor's non-execs did that with the deputy Chair of the Monitor board, chairing the board to board.

But yes, that is one of the things that the board to boards can help us do. It – just as that sort of overall scorecard is an attempt to get a feel for the organisation based on lots of individual points of information, the board to board is another opportunity to get a feel for an organisation and for senior members of Monitor, who haven't directly been involved in the day to day work on the assessment, to get that feel.

Now, as it happens I've changed the system now, so I do Chair the board to boards, and I have just one other member of the board – a non-executive member of the board, there, because I still think it's useful to have someone outside the executive involved, but I wasn't at the one for Morecambe Bay.

MR BROOKES: Okay, thank you.

DR KIRKUP: Anything else, Geraldine?

DR WALTERS: No thank you.

DR KIRKUP: Okay, is there anything else that you would like to say to us?

DR BENNETT: Are there any other questions? Well, what are you – what aspects of this are you most feeling you haven't understood? Is – what I'm trying to ask is, is there anything else I can tell you?

DR KIRKUP: I think that all of the concerns that we have are really around communications with other organisations.

DR BENNETT: Yes.

DR KIRKUP: I don't think that, as far as Monitor is concerned, we have particular concerns that we want to explore any further, but I think where there are real questions, and you may not be able to help us with are how are communications operated with other

organisations, especially the CQC for example.

DR BENNETT: Between the Trust and other organisations?

DR KIRKUP: And between yourselves and the CQC and the SHA.

DR BENNETT: Yes, so for what I suppose is only a personal view, but certainly in the second and the final assessment I don't think there were any issues about the communications between us and CQC; not only do I think, but CQC at the time also agreed that they'd obviously missed something, and they agree with me that part of the reason for that was that they didn't do the in-depth reviews that are now being done and we got done by Central Manchester.

DR KIRKUP: Yes.

DR BENNETT: Communications between us and the SHA, the health authority, I couldn't so much speak to, I personally used to speak to Cynthia Bower at least once a week.

DR KIRKUP: Yes.

DR BENNETT: And there were other communications, not least because one of the criticisms of the review of what happened at Mid Staffs was that Monitor was not talking to, first the HCC and then the CQC enough, and so I – when I arrived, one of the things that I set as an immediate goal was to establish better relationships with everybody, and above all with the CQC. So, I think that communication was when in fact – and I can't directly speak to the SHA because I wasn't involved in that.

In terms of the Trust communications with various bodies, well, we did just briefly touch on this. I do think it was a Trust whose public presentation was not as transparent as I would have liked.

DR WALTERS: I think, from my point of view, thinking about what happens in the future, because I think, even with the aid of the 'retrospect scope', if Monitor hadn't authorised anyone that had flashing lights they wouldn't have authorised anybody.

DR BENNETT: Well, you could argue that; the only thing I would really would say about this, because I do think people miss the point, that care was bad, irrespective of whether we'd been looking at it for FT status or not. So yes, it was another opportunity to spot it and fix it that was missed.

DR KIRKUP: Yes that's right.

DR BENNETT: But if, for example, they had not been authorised, that care would still have been bad.

DR KIRKUP: Yes.

MR BROOKES: So, the big question from me is currently, today, if Morecambe Bay came

along.

DR BENNETT: Yes.

MR BROOKES: Would we have the mechanisms in place, generally, irrespective of it's going as a Foundation Trust or other, to spot these underlying issues?

DR BENNETT: Yes, and my answer is I think there's been a huge change – I've said this before and I'm going to say it again, because I think it's so important, there's been a huge change, which I think is the reason we should be more confident, and it's the new CQC regime. So, if it's a Trust that happens to be at a stage in its life where it's coming to Monitor to be authorised as an FT, it must have a full CQC inspection, and an appropriate bill of clean health from CQC before we would authorise it.

But of course, the CQC is not waiting until they get ready to come to us, it's got it's intelligent risk monitoring, and is going in and looking at Trusts long before they come to us, but that, I think, is the basis on which we should be hopeful that these sorts of problems are now being surfaced, and won't continue. I didn't actually answer your question Geraldine, did I.

DR WALTERS: I can't remember what it was now; I was just thinking that you know, if you can be very, very risk conscious.

DR BENNETT: Yes.

DR WALTERS: And you know, as a few people have said to us, a lot of heat started to rise in about 2010.

DR BENNETT: Yes.

DR WALTERS: Before that everybody's review had been fine, but someone said, "And as soon as there was a problem there was a complete, broad fast, so that everybody that comes in says they're terrible", and I think this is the nature of quality interests and that you've got to be looking at the right things.

DR BENNETT: Yes.

DR WALTERS: And if you think everything is alright there is a tendency for everybody to collude towards it being okay, so it's just whether we're looking at the right variables and the new CQC presumably they have got more people around.

DR BENNETT: You see I think that that is the answer because first of all, of course you're right, that – well you know better than I do, no organisation doing as something as difficult and as complex as what hospitals do is never going to have problems; that's, I'm afraid, unavoidable isn't it.

But nevertheless, organisations, with problems as severe as they now turn out

to have been at Morecambe Bay, we should find out about and fix. What I think is so beneficial about Mike Richards' new regime is that he goes in with lots of experts and they talk to junior doctors and nurses and people like that. So, even if there's been some accidental sort of conspiracy, not conspiracy but group ~~thing~~ thinking I suppose is the – that everything's alright when it isn't.

Even if you've got a Trust where the board is frankly not being as transparent as it should be, hopefully that Mike Richards' process, where they are in there, talking to the junior doctors and so on, will get closer to the reality of what's happening, I'm absolutely sure that if CQCs current regime had inspected Morecambe Bay back in 2010, or even 2009, they would have identified the problems and they wouldn't have come close to authorisation and we'd have been a couple of years earlier starting to sort them out.

DR KIRKUP: Yes, I can't resist asking this, but the Trust board would have been able to do a sort of Mike Richards like process in 2008 or 2009.

MR BROOKES: Absolutely.

DR KIRKUP: Wouldn't it?

DR BENNETT: It could have done.

DR KIRKUP: Yes, it didn't have to wait for the external people to come in.

DR BENNETT: No, but isn't this all the way back, in a way, to the point about reporting incidents? If you've got a Trust board that welcomes the reporting of incidents, sees, especially in the early stages, a lot of incidents being reported, as a positive sign and then had good processes to make sure that they work out what the root causes are and get them fixed, then that's a good Trust board.

DR KIRKUP: Yes.

DR BENNETT: They are not all as good as they might be.

DR KIRKUP: Absolutely.

MR BROOKES: That's very helpful.

DR KIRKUP: Are we all done? Thank you very much for coming, we do appreciate you giving up your ~~tie~~ time to come and talk to us.

DR BENNETT: Not at all.

DR KIRKUP: Thank you.

DR BENNETT: Thank you.

MR BROOKES: Thank you.

DR BENNETT: Thank you very much.

1
2 **(The hearing concluded at 12.55 p.m.)**

THE MORECAMBE BAY INVESTIGATION

Monday, 22 September 2014

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

Before:

Julian Brookes – Expert Adviser on Governance (in the Chair)
Dr Catherine Calderwood – Expert Adviser on Obstetrics
Dr Geraldine Walters – Expert Adviser on Nursing

TIM BENNETT

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MR BROOKES: Good afternoon. My name is Julian Brookes. Bill Kirkup unfortunately is not available today so he's asked me to chair this session for him. I'm just going to go through some housekeeping things. Feel free to use those, etc. Just we'll introduce who we are, ask you for the record to introduce you. I'll just do a little bit of in-context stuff, and then we'll get into [inaudible], okay?

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

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

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

MR BENNETT: Yes, I'm Tim Bennett, I am currently Finance Director at Blackpool Teaching Hospitals Foundation Trust.

MR BROOKES: Welcome. As you'll know we are on microphone, and these sessions are recorded for two main purposes. One is to ensure we get an accurate recording, record of the discussion, but also these sessions are open to the family if they wish to attend. There's nobody attending today, but they do have an opportunity at a later stage to listen under controlled circumstances to the discussions if they so wish, so that's the reasons for that. We've asked you to hand your phone in. That really is about ensuring that what's said in here is for the Panel and for the discussions. It's very much about ensuring that we take everything in here in context, and elements that are about it are not taken out of context.

And all these sessions will be taken as part of the overall consideration in that case, which we do for the final report. There is a confidentiality issue, just so you're aware, as well. If – and we probably won't in this session, but if we get into particular cases, I'll stop at that stage, and if we need to have a conversation in private session at the end of the discussion.

MR BENNETT: Okay.

MR BROOKES: If that's okay?

MR BENNETT: No, that's fine.

MR BROOKES: Okay, and as I've said to everyone, so I will for you as well, we're not expecting a fire alarm, so if the alarms go we will vacate the building.

DR WALTERS: So tell us about your history at Morecambe Bay Hospital.

MR BENNETT: I joined at the University Hospital Morecambe Bay in April 2005, and I was there until November of last year, 2013, in the capacity of Director of Finance and Information. Prior to joining the trust, University Hospital Morecambe Bay, I worked for the primary care trust as a commissioner, a direct finance commissioning organisation.

DR WALTERS: And what's the sort of history of the organisation over that time? What were the big issues from when you first arrived as the years went on?

MR BENNETT: Well, I think from my perspective as Finance Director, when I arrived the organisation was in some financial difficulty. It had – and also some difficulty with achievements of various targets and standards at that time. Prior to my arrival in 2005 it had actually put itself forward as a first wave foundation trust. But under the old star rating system, at that time you needed to be a three-start organisation to progress to FT, and it went from three star, I think, to one star before 2005, so there was a lot of focus on why that was the case, and also there was a lot of financial problems when I arrived in 2005.

DR WALTERS: Were they mainly easily resolvable? Sorry, a silly question.

MR BENNETT: On the face of it, yes, but when you dug a little bit deeper into what was driving some of the issues, then no. So the Trust had first come to get merged in 1998, the three separate hospital trusts, and I think it had come together at that point with a view that it would be one organisation essentially spanning quite a big geographical patch from the three main hospital sites. When I joined it, it was very clear that they were still pretty much distinct separate hospitals and there was very little integration other than at the senior level; and probably more locally where it really came together. There was very little when I arrived, and I don't think it had changed a great deal, but very little sort of cross-cover or arrangements between the different sites. I think initially they intended when the Trust was merged in 1998 that that would be the case, you know, essentially look towards merging lots and lots of things and to provide cross-cover across the three sites, but that was pretty evident in 2005 that that wasn't the case.

And I think in part that was sort of enhancing the financial problems because things were relegated on a multi-site basis, and obviously there's economies of scale, and they were a factor as well.

DR WALTERS: How informed were the board generally, and engaged in what the real problems in the trust were?

MR BENNETT: In 2005 are we talking about?

DR WALTERS: Mmm.

MR BENNETT: Gosh. I mean I don't think that they were aware of some of the financial issues that they currently had. And perhaps we can talk more about that, because that's my particular area of focus and accountability. But they were not aware of some of the underlying financial problems they had. There was no finance or performance sub-committee of the board. All the sort of financial business was transacted through the main board meeting, which meant it was – you know, there wasn't a great deal of time and discussion on those issues. And I don't think the board particularly drilled down into trying to understand what the underlying position was around what was driving and what was causing it and what could be done about it at that point.

MR BROOKES: Sorry, I was going to ask later, but I'd quite like to understand a little bit what those underlying problems were.

MR BENNETT: Well some of it was just economies of scale, so I just mention that in the early 2000s the NHS introduced the payment by results system. As you know, that runs activity at the time based upon average cost – cost to the NHS, and within the organisation it was – you'd also have to struggle to provide these sort of services in an average type business, and the geographical dispersal issue mostly because of the economies of scale. So that's one of the factors.

When I arrived I also discovered that there was something called the Consultant Expansion Programme in place, and I never really got to the bottom of what led to that in the first place. For all three there was no business case that you would recognise that would sit behind that and actually substantiate why we were doing it, what the benefits were, what the cost and financial implications of that would be, it just seemed a little bit like it was a free for all and we'd be able to expand and to grow the trust in a number of different areas.

DR WALTERS: What about quality of governance and those sorts of activities? What sort of profile would they have at the board?

MR BENNETT: In 2005? Well I think certainly in terms of quality governance, I think that's probably a relatively unheard of term back in those days. I think the things that they tended to get on the board agenda would be the things that were measured around

and that were reported on, something like the performance statistics or waiting times, we obviously had counts on waiting times, but very little in terms of what you'd recognise as quality governance or some of the underlying stuff perhaps around quality at that point in time.

DR WALTERS: And when did that start to emerge?

MR BENNETT: Well I think during the – probably 2007/8/9 period, I think there was starting to be a progression towards more thoughts on quality alone. Again, by comparison to how things are now in most NHS Trusts, I still think it was pretty under-developed and lacked a little bit of focus.

DR WALTERS: Just say something about the FT process. When did it start? And then particularly the issues around when Monitor sort of pressed the pause button.

MR BENNETT: Well, as I say, it's interesting, because I'm not sure that people recognise, but the trust actually started the FT process around – I think it was about 2003 or 2004, and it was stalled to stay it was because a star, two stars and a star rating across was the first step. But in terms of re-engaging with it properly, I think that started again round about 2008 when we were devolved, and non-FTs at that point in time were required to agree a trajectory and a timeline to become a foundation trust with the strategic health authorities. I recall from around about that time we agreed what that would be. We did, we went through – at that stage the FT process required that you went through an SHA type of process before you went to the Secretary of State for approval to be forwarded into the Monitor stage properly.

So from memory, it was round about early 2009 that we received the Secretary of State's approval to proceed with the formal Monitor process. But arguably we were in Monitor, we were in the FT application process before that and going through SHA and then getting to Secretary of State approval. Then it started in 2009, and then obviously, you know, the other part of 2009 we had a historic due diligence review which was undertaken by an external firm of accountants, and they covered things such as financial management and governance arrangements as part of that historic due diligence. And that culminated in an application and a board to board meeting with Monitor in the spring of 2009. I think it was April – I don't know the exact date of these, but it was around about that stage.

And so we had the protocol where the trust board met with the Monitor Board; we were challenged on various issues within our integrated business plan. And then we were expecting that the decision would be taken by the Monitor Board in May

2009, and – but it didn't – well, I can tell you the timeline from my perspective. I was away on holiday, I was up in Scotland at the time, and I got a phone call from the Chief Executive, Tony Halsall, to say, 'You'll never believe this.' I thought it's going to be something serious if they phone me up on holiday. He said, 'Monitor have decided not to progress with the decision on whether to authorise us as an FT.' And I think this was just the day before even. You know, decisions usually take [inaudible]. And he explained to me that it was due to conversations or something that had been flagged by CQC with Monitor. He didn't really sort of extrapolate or sort of explain too much about that time or subsequently my direct concerns around a number of services in maternity, but I think at the time the telephone call took place it was really just to say there were concerns raised by CQC, and that Monitor had decided not to proceed with considering our application, which was sort of unusual because it affected – it was put on hold, you know, the decision to defer or not to authorise, it was just essentially – well it was actually at that time put on hold.

So that was say in the May time. I think then a whole series of conversations then, and meetings took place with the CQC, or [inaudible], largely the Chief Executive and the Chair meeting the Regional Director at the CQC to try and understand what is useful and what needed to be done to address those at that point in time. Obviously then at that point, probably like most board members, I became more aware of the five cases in particular, and some of the details behind those. But that sort of progressed through the rest of 2009, where essentially the trust was on hold for the Monitor process, and the discussions were taking place at senior level with the CQC about what needed to be done to sort of re-enact that process.

DR WALTERS: And what approach did the trust take towards these five incidents?

MR BENNETT: They were obviously being treated as serious untoward incidents, so they were investigated, and presumably it was due process. I wasn't party to those, I mean, so I won't be able to tell you anything about that.

DR WALTERS: Did they report to the board what it was all about?

MR BENNETT: It was a bit blurred in terms of when things were reported, but I certainly recall there being Part II board papers that referred to those cases, and a number of other cases as well, but I can't recall whether or not they were reported prior to the FT process being put on hold, or whether that was post that. But I'm sure that will be within the board minutes though.

DR WALTERS: And then was it after that then that the Dame Pauline Fielding Report was initiated by the FHLA? Was that the sequence of events?

MR BENNETT: Well again, without wishing to sound [inaudible], I wasn't too aware of the Fielding Report. I knew that somebody had been asked to come in and to review some of the issues around maternity services, but I didn't – I've never seen the terms of reference of that particular review, it was only when…

MR BROOKES: So the terms of reference never came to the board?

MR BENNETT: I don't recall seeing them. I'm not saying they didn't, but I certainly don't recall seeing them.

DR WALTERS: So were you aware of the progress of that review and the report sort of pointing to …

MR BENNETT: Well only kind of informally, not – as I understood it, I think there were a number of drafts of the Fielding Report. I didn't get to see it until it came as a final version that went to the board. I can't remember the exact date that it did go to the board, but I'm sure, you know, part of the documentary record, there's evidence somewhere, but I don't recall seeing it until it came to the final version to the board because it was being dealt with as a draft by the sort of Chief Executive and Medical Director, etc., at that point in time. So in a way, although it's kind of – I suppose arguably if there'd been a financing external audit report, it would still have been finalised and reviewed and quality checked, and it wouldn't be reported until it was finalised.

DR WALTERS: So I suppose if you could sort of help us with this, because it seems like these five incidents actually stopped your FT progress, and so the report was put in place. But then nobody seems too interested in the findings of it or how serious the findings might be or what the actions should be following it. Is that the wrong impression, or was it not like that in reality?

MR BENNETT: Well I think probably up until the point at which the FT process was put on hold, I think they would have been seen as being not necessarily connected into sort of [inaudible] same services and same locality, but they'd been seen in the same way that a serious untoward incident would be seen. It's something that needs to be investigated and properly reviewed and understood so those lessons can be learned and actions can be taken. But I don't think it was connected together in any way up until the point at which, as I say, these concerns were raised, presumably by the CQC

with Monitor, and then that kind of heightened everybody's sort of awareness and concern around this.

DR WALTERS: And what happened to get the FT back on track again?

MR BENNETT: Well from my perspective, we – CQC changed their focus, and I think during 2010, all organisations were required to register with the CQC. I think up until that point, I don't think – you know, they'd done inspections, but I don't think formal registration was required up until that point.

When formal registration came in the trust obviously had to apply for registration, and I understand it was registered about conditions at that point. I'm not sure that that's – well, I think it was registered without conditions, but what I can say is that we received a call, the trust received a call from Monitor to say, 'We've now seen that you've registered without conditions essentially. We'd now like to re-enact or get your FT application process going again.' There was an issue then because we had done most of the work for the FT and the assessment under the old FT assessment regime, and they wanted to come in, in the intervening period, so there was sort of conversations between ourselves and Monitor about how much of the new regime we had to comply with and how much they could rely upon what had gone before. But there were some things that were definitely new, so we had to – in the intervening period there was a quality governance framework that had been introduced, and that wasn't part of the original FT assessment.

MR BROOKES: We understand you were the first organisation to use that, is that correct?

MR BENNETT: That's correct, yes. I remember at the time that we were – it was that sort of thing while you were – there's nowhere else to go to, to sort of check our CV sort of, how they'd answered some of it with questions within that. So we got the call round about the sort of May time sent by Monitor to say that they wanted to restart the FT assessment process. I think they were also pretty keen, they'd done some fast track process. Certainly that's the impression that we got. You know, if you were asking me to point to the evidence to say here's a letter saying they want us to go through quickly, but it felt that way. I suppose as one of the key directors responsible for engaging with Monitor, it felt very much like they wanted it to progress quite quickly at that point in time.

DR WALTERS: Were you surprised about that?

MR BENNETT: About them wanting to do it quickly?

DR WALTERS: Mmm.

MR BENNETT: No.

DR WALTERS: From an external point of view.

MR BENNETT: Well, we were not surprised. I think – I mean I suppose it was – it's a good question. I'm just trying to think whether I was surprised at the time, but I think I was – I think we were sort of concerned about being frank about if we were going to move through it quite quickly, whether or not we could actually comply, whether we had the capacity to be able to do that. So there was a degree of kind of nervousness about whether or not we would be able to go through the Monitor process as quickly as seemed to be intended.

DR WALTERS: Was everybody – were all the other stakeholders supportive?

MR BENNETT: Of the FT process? I think there were some concerns raised by our commissioners, who had some issues. And another Monitor, you know, we've obviously spoken to them and met with them during the assessment process.

DR WALTERS: What were they concerned about?

MR BENNETT: Well I don't know if it's – it weren't made privy to all of those involved.

DR WALTERS: Right, okay.

MR BENNETT: The conversations were between the PCTs and the board and Monitor. I mean part of – one of the issues is that as part of the FT process, Monitor gathers a lot of evidence and information relating to the Trust, so normally reveals part of it to the trust. And so to some extent you piece it together, pieces of information, trying to understand and so forth. So we did a very – yes, we did a very detailed financial assessment of the organisation, which runs to multiple pages, it's quite a lengthy document, but I think you get to see about two pages of that, which are very much a sort of high level summary on risk assessment.

DR WALTERS: So presumably then the board must have been quite confident that there weren't any problems with maternity services.

MR BENNETT: I think they were confident that there'd be sufficient external reviews and views taken of both maternity and sort of the clinical governance framework around that at that time. So obviously CQC had sort of registered. We'd also been through the quality governance framework with Monitor and various kind of reviews Monitor had undertaken, and assessments around that. I think not so much that there were no concerns around it, I think that would be stretching it too far. But I think the view would be that probably at the time – I don't think the board ever answered this question, but if you were to look at [inaudible] it was always perceived to be a

challenging organisation, partly because of its geography and so on, and then that wasn't going to change as a result of FT status. So I don't think there was a bit of a view that the foundation trust would actually resolve all the problems.

DR WALTERS: So in spite of the Fielding Report, and having some sort of fairly challenging actions attached, the board were ensured by the fact that Monitor and the SHA were prepared for them to be fast-tracked with the process.

MR BENNETT: Essentially.

DR WALTERS: Okay.

MR BENNETT: Well that's certainly one of the views that shareholders and the board would take.

DR WALTERS: That's it from me, thank you.

DR CALDERWOOD: Thank you. We've heard over time about problems with staffing and a lot of locum use, and we've heard some concern about the staff on the on-call rotas for the theatres. Would you say that those presented a big issue from your point of view? And financial pressures obviously, as you're concerned, but also that the [inaudible] were concerned, particularly – well lots start with medical staff and then recruitment and retention and use of locums.

MR BENNETT: I mean that was certainly a concern of the board for a number of reasons if they're reliant on agency locum staff. Because I think at that point there'd been a report undertaken of Mid Staffordshire Hospitals, which at least implied that there were risks associated with heavy use of agency and locum staff. There was obviously issues such as unfamiliarity and so on, all those kinds of things that come in. There's also concerns around – there's a whole raft of concerns around the finances of that, the costs. It's quite an expensive way to run a service when you're reliant on locum staff, with implications then for recruitment and retention of other staff for training and so on and so forth. So I think the board were concerned about agency use, but I think that was across the whole organisation, not just concentrated in obstetric services. I think that was in a number of different areas, I think, the reliance on agency staff as a concern for the board.

DR CALDERWOOD: This may be not a fair question to you because it's not your area, but did they try to discuss solutions for that, or was it just, 'Oh, there's a problem. We recognise these are problems'?

MR BENNETT: No, there were conversations about solutions and trying to understand whether or not – so there were things such as what could be done to make it a more

attractive place to want to come and work. What could be done to retain staff? There were things such as within the process of appointing staff were we somehow tardy or slow in, you know, one person leaving and then being replaced in terms of the HR process that could be improved.

I do remember at one point that we'd had an agency clinical haematologist in post for something like two years, and it was largely because the relevant consultants in the rest of the service couldn't agree the job description, so the time commitment of who was going to be appointed. It was kind of – so there were some real kind of issues that I think could – they were addressed in terms of some internal processes. And sometimes it was – emergency medicine, even some there was a national shortage, or certainly a shortage within the North-West, and the solution there wasn't necessarily around proving it, it was also [inaudible], it required something a bit more fundamental about how the service was constructed and whether or not we could do different things rather than just sort of rely on [inaudible].

DR CALDERWOOD: We have the Fielding Report that subsequently flagged up one of the risks in terms of maternity services was the lack of a formal on-call for theatre staff, so the theatre staff were phoned at home if there was an emergency requirement for them. Was that based on financial concerns or was that perhaps just not a realisation that you needed such a thing in order to run a safe, reliable service?

MR BENNETT: I think it was the latter. I mean I certainly – I cannot recall in all the time that I worked in the trust until the point at which we had the Central Manchester Review of maternity services – sorry the CQC findings and the Manchester Review, the need to put in place a dedicated theatre team ever being raised as being a financial pressure that needed to be addressed. I just can't recall that position, so I think it was more customer practice and the history, that's how it had always been and I don't think anybody had – certainly not to the best of my knowledge, had ever raised that as an issue of concern.

DR CALDERWOOD: And you're obviously describing these different reports and the reviews that happened. What was your feeling at the time about the board as to how these were being dealt with? Were they taken on one at a time, and an action plan and altering the actions? There was a period when – I think in fact one followed from another one.

MR BENNETT: Yes, I think if you go back prior to 2011, there was no programme management office in place in the trust. That all came in late 2011/2012, so every

action plan up until that point resulting from a review would have been dealt in isolation and wouldn't have been sort of coordinated, and the board would have been relying upon those, the responsible director in that area, to provide some level of assurance about the action plans being delivered on time. I mean late 2011/2012, we set up a programme management essentially to give a slightly more impartial view rather than we were delivering the actions that were required. And that was partly to provide that sort of assurance, but also because by that stage it had become self-evident that there was that much to be done in such a short period of time, that without putting a proper programme structure in place we were just getting the report, but not getting [inaudible] from anything.

DR CALDERWOOD: And did you feel then that that solved that, or that seemed to make a difference, that programme management board?

MR BENNETT: Well, it probably in the first instance just highlighted even more the scale of what needed to be done across a whole raft of services. I mean not just maternity, but across prompting outpatients, prompting medical records, so across a whole range of different things it sort of highlighted the scale of what was required. And I think probably up until that point that probably hadn't been properly appreciated, the scale of change and [inaudible] that needed to be dealt with. So what the PML does, in the first instance it highlights exactly what's the scale of the problem and what we need to do to address that. And we were a bit kind of alarmed, so in the first instance it's not unusual to have a slightly adverse reaction to that. It's almost like laying bare the scale of issues; the scale of the problem.

But then in terms of getting leadership for the dedicated support, project support to – really from a practical perspective, to make sure that things were kept on track was really important at that point, just given the scale of what was being addressed.

DR CALDERWOOD: And was that separately budgeted for, that? There was no people brought in to – or was that squeezed in amongst everything else that everyone was doing?

MR BENNETT: Well, I think the point at which the organisation was placed into breach in terms of authorisation by Monitor, I think you could probably see at that point that certainly for a period of time that financial management and financial control – basically if something needed to be done and it was done, and I remember at the time that we, within financing, we were just keeping separate accounts of everything that

we felt was being done around that. Certainly we were – not for any particular reason other than we recognised that we would be need for external financial support for the trust, and we wanted to be evidence what that was being spent on.

So to answer your question, it wasn't budgeted for at the time. The trust incurred a deficit by setting up all these new processes and so on. And we then had discussions with our commissioners, and ultimately with Monitor and the Department of Health and external financing did some of that.

DR CALDERWOOD: Okay, thank you.

MR BROOKES: I'm just reflecting on that. That implies that you looked at is as an additional expenditure rather than as needing to recast your financial strategy dealings and business strategy.

MR BENNETT: Well no, at Monitor's request we produced two recovery plans. The first of the recovery plans was essentially outlining all the services that the trust had problems with, and then the needs to address the problems in those areas and the supporting structure included in the PML, and that was done – that was submitted in June 2012. What that did, that highlighted – it was June 2011 or 2012 there was a recovery plan submitted to Monitor, and that highlighted that the trust would have a very significant deficit over and above what it had budgeted for. It also said that the trust needed to produce a financial strategy to do that. That would take longer to put together because we had to have discussions with the commissioners and the Department of Health about where the sources and the financing of this would come from. And there was another recovery plan, Recovery Plan Part II, which was in October 2012 from memory, that dealt [inaudible] our financial strategy.

MR BROOKES: That's helpful. Thinking of your role as a board member rather than as the Director of Finance, what was the, through your [tenant?] time, what was the kind of discussion that there was around quality of service rather than just on the metrics, the performance targets, the finance. Where did that fit, and what was the sort of balance of that kind of discussion on the board? Was it 5%? Was it 100%? How did that feel during that period? It will have probably changed as well.

MR BENNETT: Well, it almost certainly did. So certainly post-2011, it was very significant at that point.

MR BROOKES: So up to 2011.

MR BENNETT: Up to 2011 I would say that, certainly by today's standards, very little focus was given to the quality of service.

MR BROOKES: There were no standing items?

MR BENNETT: I can't recall standing. There will have been reports from the Quality Committee, and notes from that, feedback from the Quality Committee, but nothing on a sort of routine basis.

MR BROOKES: And then, as you say, a change in 2011.

MR BENNETT: Yes.

MR BROOKES: And what was it like then, after 2011?

MR BENNETT: I mean I think the – obviously a lot of focus on – in the first instance a lot of focus on the services where there were problems, so maternity and outpatient services. There was a lot of focus on mortality rates, focus on adequate records from the areas where there'd been problems and where there'd been known issues. That then expanded to cover a range of other services and quality metrics associated with that, but I think the trust did a lot of work to think through its whole approach to risk and to quality governance during that time, following 2011. I'm not sure that it ended up, in inverted commas, to the point where I was fully satisfied that it dealt with all of those, because that's one of thing it did, it decided to set up a board risk sub-committee, which – so it was only put in place for about 12 months, but it was to make sure the board were fully appraised of all the clinical quality and governance risks in the organisation. It was only put in as a sort of 12-month interim arrangement whilst the whole governance structure was reviewed at that point in time.

MR BROOKES: Going back to the Fielding Report, I know it's only one report and it's tiny in terms of the FT processes, but it's quite interesting. Were you aware that the report was never shared with Monitor or CQC?

MR BENNETT: I wasn't aware that it hadn't been shared, but nor can I recall ever asking the question, 'Has this been shared?' In my opinion I was not aware of any decision or – not to share it, you know, the conscious decision that this would not be disclosed in some way or other. I'm not saying that people didn't consciously decide not to do things, but...

MR BROOKES: I understand.

MR BENNETT: ... but never discussed with me formally or informally, 'We don't want so-and-so to see that because that...' you know.

MR BROOKES: You can understand why it looks a bit strange, because your FT process gets stalled, which relates around these five issues, serious untoward incidents, which relate to maternity services.

MR BENNETT: Yes.

MR BROOKES: An independent report is done into that, and yet that doesn't seem to have been fed back into the process. I understand what you're saying about CQC acting as a trigger for it in the process to start again, but it seems rather surprising that the report which is the outcome of those concerns in many ways is then not shared back to the organisations, the regulators who have concerns about maternity services in the first place.

MR BENNETT: Well, and I think with the benefit of hindsight [inaudible].

MR BROOKES: Then there's internally with the report there's an action plan that you might have – there might have been expectation in at least the review of its consequences in terms of whether or not it had any impact on the strategic plans and the financial plans which were part of your FT indication. Do you know if that ever happened, that there was actually an assessment about the implications that this might have, because as we know now, there are minimal staff, there are all kinds of potential issues in terms of affordability, and the overall case being very [inaudible].

MR BENNETT: I mean the answer is, as far as I'm aware, there was no assessment done of the financial implications of that. But go back, you know, the status, it's a report that – I was aware that a review had been undertaken by somebody in the field. And essentially, that was being finalised and being checked for factual accuracy etc. prior to coming to the board. With the benefit of hindsight I think [inaudible] which partners have seen the draft and so on, and understand the financial and other consequences of that, the indications of that, but that didn't happen.

MR BROOKES: Because we both know that if there was – and taking your own example of a financial report being going through it, that clearing process. If there were fundamental problems or risks being raised in those, even in the earlier drafts, that's something which you'd be working on and being aware of irrespective of the fact that the report hadn't quite been finished at that stage. So I'm not seeing a similar kind of process here around the Fielding Report.

MR BENNETT: No, I think it was dealt with by a relatively small number of people. And given the significance and the implications of that, I think it should have come to the board sooner, it should have been discussed and analysed, and given a sort of [inaudible] come to the board and said, 'Those are the issues we need to concern ourselves with,' and so on. But that didn't happen, and as I say, with the benefit of

hindsight, that was clearly wrong. In my view that was not good practice; should not have happened, but you know, it did.

MR BROOKES: Okay. Just one last thing, slightly different. During your time on the board, what's your recollection of both the frequency and type of discussion that was had around serious untoward incidents?

MR BENNETT: We dealt with Part II [inaudible] as you'd expect. My recollection of them, they were dealt with as separate incidents. I think all of these things have to go where you take personal learning as well as whatever comes out in our investigation. But the thing for me was that I don't think the SUIs were connected together within the scope of a pattern, even though looking back now that everything has happened, that's self-evident, but it wasn't at the time. It didn't come across that way, certainly to me anyway.

MR BROOKES: So what then would be ...

MR BENNETT: So it would be basically important to, if there has been an incident relating to X, this is what happened, this is what's the next steps in the process would be, and then concluding perhaps with recommendations to follow up on that. And then maybe five months later there may be another report on a service.

MR BROOKES: [inaudible].

MR BENNETT: Yes, but more [inaudible] connected, see whether there was any connection between those.

MR BROOKES: Did the board sign off the actions? So when would you receive confirmation that the action plans had been completed?

MR BENNETT: Mmm.

MR BROOKES: Okay, thank you. That's very helpful.

DR WALTERS: Sorry to keep going back to the Fielding Report, but just in terms of what we will need to put in the final report to try and explain that, and I know this is only asking for an opinion, but I suppose if you were somebody looking in from the outside you'd have to think, well, it wasn't read because either somebody didn't want it to be given that profile because they didn't like what it said, or it just wasn't seen as being anything really significant, or that you just sort of forgot about it. I can't think of any other reason why, other than those three, why it wouldn't have been seen?

MR BENNETT: Well, I mean from my perspective, I think it was an assumption, maybe a false assumption that it was being dealt with elsewhere, it was being managed elsewhere, and that at the time I had confidence in the individuals who would be

dealing with that, and assumed that they were dealing with it properly, thoroughly and that any immediate issues were being addressed and, you know, that what was – the reason why it was delayed coming back to the board was simply because there were some issues with factual accuracy or they needed to be corrected before the report would see the light of day.

But saying that, with the benefit of hindsight now looking back, that's obviously what we would do now. But at the time I just assumed it had been dealt with elsewhere within the trust.

DR WALTERS: So it wasn't something that the board thought needed to go to them?

MR BENNETT: Well I think the board would say – I mean I can't speak for the entire board, I'm giving my view, but I think my expectation would be that it would be important that – if you ask me – no, I think that's a report that I would have expected would have gone to the board when the report was related to go to the board, not the first draft or anything. For all I know it may have had grossly inaccurate points in there. I hadn't seen it, I wasn't in a position to be able to say that. As far as I knew there was being a review undertaken by Fielding that had come up with a number of issues, they were being addressed. There were some issues of factual accuracy which needed to be resolved in terms of the finalising of the report and then it would come back to the board. And I think as far as I understand there were in actual fact several iterations of the report that eventually emerged.

DR WALTERS: Yes, well I don't think it's something that couldn't happen in a lot of places, but obviously on this occasion [inaudible]. Just going back to pre a lot of these issues really coming up. What do you think the attention – what was the level of attention in the CIP programme to cost reduction and implications for quality?

MR BENNETT: Well I think if you go back to, certainly prior to about 2008/2009, I don't think there was any formal process for assessing the impact on quality of CIP programmes. I think there was a reliance upon individual managers and clinicians in their area to shout out, to say if they were not happy with something that was going to mean adverse effects on safety or quality at that point in time, but there was no formal process in place.

In 2008 we engaged a team from Ernst & Young to do a piece of work, doing some benchmarking to help us regarding our CIP programme in subsequent years, and one of the elements of that was to look at each service and to try and identify whether or not – well try and answer a number of different questions, try to do some

benchmarking about whether or not it was [inaudible] efficient or inefficient, but also whether this was a service that the trust could provide, whether it could be provided by others, so there was a whole series of questions that people went through at that point. But that was probably the first time there'd been a systematic process to go through.

And then in terms of quality impact assessments, like CIPs, that really didn't sort of come about until we started to engage with Monitor on the FT assessment process, and that got stepped up a level once the quality governance framework was published by Monitor. At that point then, I think from then onwards I think the kind of detailed and quite clear quality impact process that required signing off by senior clinicians before any scheme can go ahead. But prior to that I think it was largely reliant upon the individuals speaking out.

DR WALTERS: How much did you rely on benchmarking information to indicate whether – you know, in terms of staffing, that CIPs were actually realistic?

MR BENNETT: Well we didn't – certainly from about 2008 onwards we relied very heavily on staff. And I think up until that point we had done some work, so there'd been an audit commission who were our external auditors, done a review of nurse staffing levels on their external orders, and that had suggested that overall the staffing levels across the trust were broadly comparable to what would be expected in other hospitals, but with some pluses and minuses in individual areas. And the overall benchmark was set, and it looks about what we'd expect trust-wide [inaudible].

Then in 2008, as we say, we engaged in something and we did a lot more detailed analysis, and really drove down into – much more sort of clinical pathways and how they were constructing the working to try and help identify what we've achieved here as a workforce. So one of the things, for example, they did was [inaudible] and we did benchmarks in comparisons for particular HRGCS, but what we're also particularly keen on is the variation between particular consultants, because that seemed to be a quite high variation between individual consultants with the same HRGC and they were apparently treating the same condition.

MR BROOKES: So the purpose was to save money?

MR BENNETT: Well I think it was – I mean certainly we engaged in the first instance for identifying cost savings and efficiencies, but I think in terms of the engagement with clinicians and others, I think it wasn't just about saving money, it was trying to understand whether there were material differences, and why were there differences. You know, they may have been entirely justifiable and actually appropriate, but you

know, just trying to sort of unpick that [inaudible]. But the starting point for it was engage with them to help us to develop a CIP programme.

DR WALTERS: Okay.

MR BROOKES: I think that's it. Have you anything we should ask you that we haven't? Anything you'd like to share with us?

MR BENNETT: No, I don't think so. As I say, I think the – my apologies if some of the data is not correct. It's not deliberate, and I'm sure they're a matter of record.

MR BROOKES: It's very common.

DR WALTERS: Yes.

MR BENNETT: Yes, lots of things happen over a long period of time.

MR BROOKES: Okay, thank you very much.

THE MORECAMBE BAY INVESTIGATION

Thursday, 17 July 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Dr Geraldine Walters – Expert Adviser on Nursing
Professor Stewart Forsyth – Expert Adviser on Paediatrics
Professor Jonathan Montgomery – Expert Adviser on Ethics

DR MIKE BEWICK
DR NEELA SHABDE
PETER CLARKE

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DR KIRKUP: I ought to say, for the sake of the full record, I'm Bill Kirkup and I'm the Chair of the Panel. I think most of you will know that. I'll get my colleagues to introduce themselves, please.

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

PROF FORSYTH: I'm Stewart Forsyth, Paediatrician and Medical Director from Dundee.

PROF MONTGOMERY: I'm Jonathan Montgomery, Professor of Healthcare Law, University College London and Chair of the Health Research Authority, but previously Chair of an SHA and a couple of PCTs when they clustered and some provider trusts.

DR KIRKUP: Thanks for coming. You'll have spotted that we're wired for sound and we are making a recording of proceedings. We produce an agreed record at the end of the process. We open the proceedings to family members as observers. As it happens, we're not being observed this morning. However, they can listen to the recording on a subsequent date if they want to.

You'll also know that we've asked you to hand over mobile phones, tablets and so on – as have the Panel and everybody else present. That is just to stress the importance of nothing going out of the room until we are ready to produce a report that takes all the perspectives into account. Do you have any questions for me about the process before we start?

DR BEWICK: Do we have to press this to speak?

DR KIRKUP: I think it is on permanently. It is on permanently, yes. Okay. I am going to ask a very general question of all of you, but I perhaps ought to say we thought it would be most effective to talk to all three of you together, but we

might want to ask individual questions or you might want to come and tell us individual things at the end – and we will discuss that when we get to the end of the interview.

So, my general question to each of you in turn is just if you could set out your associations with the area and what you've done over the period. I don't know – shall we start with Neela?

DR SHABDE: Yes. My name is Neela Shabde and I'm a Paediatrician by background. I've worked in the North East for a number of years when I was invited by Sue Page, then the Chief Executive of the PCT to come to Cumbria to help with moving children's services forward. I was in a full-time job there, so it took me a year to kind of take an early retirement and moved to the PCT in Cumbria on 1 January 2011. And I was appointed as Medical Director for Children in ~~with~~ the PCT, along with the other medical colleagues there. My role was to influence the agenda within Cumbria for children and young people and move it ~~to come~~ up the agenda so that more ~~kind of~~ notice was taken of children and young people. I was aware that the services for children were very fragmented, all the sort of issues that you probably kind of know about it.

DR KIRKUP: We might get into some of that.

DR SHABDE: Yeah, in detail. So, I took up that role ~~and then I was employed, obviously, by both trusts~~ the first thing I did was to make contact with the provider Organisations (3 Trusts) in Cumbria trying to make relationships with the medical colleagues as well as the senior management teams, really influencing them and using ~~to bring~~ my leadership to impress upon them why we needed to take the children's agenda forward.

DR KIRKUP: Thank you. Mr Bewick...

DR BEWICK: I'll try and be brief. My name's Mike Bewick. My role in Cumbria was initially as a GP. I came there in 1987/88, having been in Dundee before that in oncology. I was a GP who got an interest in assessment and ran the Royal College of GPs exam for about seven years.

As a consequence of that, Sue Page asked me if I'd be interested in coming and doing some work around, basically, primary care, but looking at moving services from the secondary sector to primary care and community sector. That's since been a recurring thing for the past 10 years, hasn't it?

But in terms of the detailed job that I was initially asked to do, which was Director of Primary Care and Medical Director for Primary Care, essentially, now that took a little bit of a change in about 2009 when the Executive Medical Director fell foul of the GMC and lost his job as a consequence. I then became the Executive Medical Director some time in 2009. To be honest, I still can't find that accurate date, but it's around that time and, therefore, my role broadened in that year and I became a board member.

It was during that time we were really pushing the 'Closer to Home' agenda and one of the big areas that we had concerns about – and I'm sure you're going to talk about later the Mitchell review and finding out... Andy Mitchell's report, Andy being a paediatrician in Guildford and now Regional Medical Director in London, was about the fragmentation of services and we wanted to look at that in more detail.

Allied to that was the fact that although Cumbria has a relatively normal to low perinatal mortality rate, we were concerned around the stillbirths and the antenatal deaths that had occurred, as well as the maternal deaths that

had occurred. I guess the crux of this came later on when we started to notice what we thought was an increased frequency, but we wanted a better measure of that, so we went for the Centre for Maternal and Child Enquiries, which, as you know, took a bit of time to get going, because of the internal governance ~~government~~ of that organisation, not because of our request to have it.

We subsequently went into the realms of regulation because of the CQC report, which we'll no doubt come to later, and I had a pivotal role in running the Gold Command that was set up by the SHA but delegated ~~given~~ to Cumbria PCT – which ~~and~~ I chaired that for... approximately ~~Well, although it was about~~ eight months in Gold standing, in terms of what happened afterwards it was considerably longer. And my right-hand man will speak next.

DR KIRKUP: Okay.

MR CLARKE: I'm Peter Clarke; I'm a retired gentleman, but with a career largely in mental-health services and in senior management roles. Found myself in Cumbria PCT with a role which was mainly about public engagement and communication, but by virtue of kind of being a slightly spare senior manager found myself with a assorted tasks and roles at various times as it was required. And one of those was to be the incident director for the Gold process, in which role I did my best to support Mike in his leadership role and provide support to the functioning of Gold it's doubtless we'll talk about.

DR KIRKUP: Thank you.

DR BEWICK: May I add just one thing? Subsequent to that role at the PCT as Medical Director, I was then appointed during the process of the change following the Health and Social Care Act, as Regional Medical Director in the

new world, but there was an overlap, where I acted partly as Regional Medical Director in the SHA. [Stephen Singleton ~~Ian Singleton?~~], who I believe is going to be interviewed later, became the Chief Executive of the interim organisation ~~that~~ and therefore I got involved with Morecambe Bay on one more occasion when there was a threat to closing the maternity unit at that point, so I just want that on record.

DR KIRKUP: Okay, thank you. I'll hand you over to Jonathan.

PROF MONTGOMERY: Thank you. I think there are a number of areas where we are hoping to get your wisdom from as we go through. And Gold Command, obviously, is a big chunk of that, but we'd quite like to understand how we got to Gold Command and there are two things – it may turn out that they branch [inaudible] which it'd be particularly helpful to pick up. One is just the sort of commissioning perspective, because the PCT is the lead commissioner for the trust. And you've begun to open up some of those questions. And then there's also the SUI management process which moved from the SHA to the PCT in 2009, which we'd also like to have a decent understanding of.

So, if I could just start with the general commissioning role and what the priorities were. You've outlined some specific things, but it'd be good to have a sense of where paediatrics and the maternity issues sat in the commissioning agenda in the PCT around the trust.

DR BEWICK: It is always difficult to talk about a Trust in isolation when you ask such questions, because Cumbria's a very unusual county. It's a landmass with a population surrounding it that are distant, generally, from anywhere that has true tertiary centre facilities – and therefore the maintenance of its maternity services is not as determined by numbers of births as it would be in other

areas. And so all the units in Cumbria and North Lancashire [inaudible] because of Morecambe Bay would not pass the test of the minimum number of births per year. And that's just a fact of life.

So, there was always – in the policies that were originally consulted on in the north of the county but never really on the south of the county – a move to try and preserve maternity services, because we felt we could not run DGHs without them at that time in a safe way. And that was always a reassurance the population received and I think whether we... We would all like to follow the Royal College of Obstetricians and Gynaecologists' guidance, but that's not always possible in very peripheral areas and one must come up with other ways of running it.

On top of that, there was the responsibility of running the associated ~~therefore the~~ neonatal service, ~~that you have~~ as well as ~~And~~ the associated paediatric service on site was also an issue, where you had to supply a minimum number of neonatal beds to do that. And that was as true for Barrow as it was for Whitehaven. And they're both very similar in their isolation and in their particular problems.

Just to clarify, I worked at Whitehaven Hospital before, but never Barrow. I was born and bred in Workington, so I was born in that hospital, so I understand from a lifelong association with it what it's like to deliver services there.

Our policy, however, was I think modified dramatically when we concerned not necessarily about paediatric and neonatal deaths at that time, but the fact that the children's agenda was not high up on the commissioner's

agenda and hadn't been in the past. And I have to say that was a national issue, not just a local issue. In the north of the county –

PROF MONTGOMERY: When are we talking? Are we talking 2008, when you started, or...?

DR BEWICK: This was 2008. And I think Sue Page at that time recognised that we needed – how were we going to support child services more fully in the community? Because children had a long way to go for anything that was out of the ordinary, either Newcastle or to Manchester from the south of the county.

And we commissioned Andy Mitchell to do a short review of the paediatric services, which I think reported in February 2009. And I think the two things that came out of that more than anything else was the lack of strategic leadership on children and family services. And that was a county-wide issue. And the second was the fragmentation of services and the lack of coordination of the services.

At that time we were becoming a very clinically-led organisation. We had recruited six senior GPs to run the localities and this pre-empted the days of CCGs. There were four Medical Directors by the time Neela came, later on, and three at the start: myself, John Ashton, who was public health, as you know, and – Irving Cobden ~~the name's gone.~~

DR SHABDE: ~~[Owen Gibson?]~~ Dr Irving Cobden

DR BEWICK: Dr Irving Cobden ~~Owen Gibson~~, who was for adult care and acute care. So, she put a lot of emphasis on that clinical input and we were pleased about that because we all, as GPs in the county, felt that the Cinderella areas – elderly care, mental health and family and children – were neglected. And we had a lot of input externally into what would be a good system and what

would make... And Dr Gibson took over the role of looking at the strategic direction of this and forming a more coherent, sensible community-led service.

Now, in Barrow at that time we had dreadful difficulties in the community. The community service was... If you asked GPs – and we did; we visited every practice in the county – to try and find out where they perceived their problems were, interestingly in Barrow it wasn't neonatal and maternity that they highlighted; it was community paediatrics, cardiology and some other aspects of elective care.

But because we recognised the deficit that was there and there were some SUIs by that time coming through, your question around when this transferred across... I think one of the key points of this is that – I was trying to think of a better word than 'ambiguity', but I think it's a bit of uncertainty. When you hand over a system to a new organisation, but yet you still have a relationship with that organisation as an SHA and PCT did, some of those you wish to continue it to the end of those incidents and some you wish to hand over, because they're early. And at times we didn't know the full numbers in the early days. I think it was the end of November 2008, from memory, that SUIs were handed over officially, but there was a transition whereby the SHA and ourselves had that. Peter might correct me on dates, but that's my memory of it.

I think at that point in time we were uneasy, so we set up a specific incident group. And our aims of that incident group – because the three areas that we were particularly concerned around were the usual things which would never happen, the never event-type issues, but the SUIs surrounding mental health, children and maternity were higher on our list.

And we tried to get a more cohesive serious untoward incident format and we developed protocols about how they would be looked at; we formed an executive group for those incidents and we invited the trusts to an initial open day to discuss how we would manage that type of business and, then, subsequently, three or four times a year, to go through all their incidents and ask them how they were updated that and what they done to change the systems.

Now, for Morecambe Bay, Peter Dyer was the Medical Director by this time and Peter was very easy to get on with. Peter was a very straightforward person. He wanted this to improve. The rate of reporting of incidents climbed rapidly. In fact, they were one of the highest reporters. Of course, when you take that on board, it looks like there are more problems, but what it means is you've got more admitted problems and therefore you've got a fighting chance of doing something about it.

So, we had to explain that in the terms, that this was a good, transparent system. Now, I applaud Peter and Jackie Holt at that time for making that available.

DR WALTERS: What year are we talking about?

DR BEWICK: I'm sorry; I'm probably transgressing here. This was evolving over about an 18-month period from the beginning of 2009 following the Mitchell report, but it wasn't just due to the Mitchell report; it was to the very question at the beginning. So, we go through into 2010.

And we had had ~~get~~ a very good relationship at that time, but that didn't stop certain events happening. And the conflation of events when we had these sort of constellation of issues come in, which were two maternal deaths,

two further paediatric neonatal deaths. And then there was the family referring their death via Section 43 to the police and the initial police inquiry.

And then, after what can only be described as a complete *volte-face* on behalf of the CQC, having found a competent and, in Peter Dyer's words, exemplary maternity unit not long over a year before, it then found great problems in the maternity unit. And this was backed up by the Nursing and Midwifery Council's visit.

And it was at that point, when we looked at our own evidence, which we were concerned about, and we'd had discussions in the June of 2011 with CQC, but mainly with the SHA again reviewing these, that we felt things needed to change. And during that period, June to October, there was a great deal of information coming in and a great deal of involvement of ourselves with the SHA, particularly Angela Brown, who was leading on it for the SHA at that time, to make sure that we were looking at this more critically and it was something we were doing.

Now, I think Neela had joined before that and we had quite frequent meetings, including one with Mr Titcombe. And I've brought the letter with me in case – for Neil more than... Just reminders. But we had a very frank conversation with Mr Titcombe, because his case, when I joined the PCT, I didn't know about. I found out about Mr Titcombe's case through Mr Titcombe's own tenancity and reporting ~~own way of doing it~~. And I thank him for doing so. And we had a very frank discussion with him at that time, realising there were certain things that had not been done well. And we promised him we would take that forward. And he wrote –

PROF MONTGOMERY: And what time was that?

DR BEWICK: That – can I just refer to that, because it's...?

DR SHABDE: I think that was October/November 2011.

PROF MONTGOMERY: 2011, yeah, it was...

DR SHABDE: 2011, yeah.

DR BEWICK: So, it was – the right thing to have done was to have looked at it in more detail, we felt, and in fact the PCT pushed the SHA. I have to say that. There was a reluctance at first to form an incident, but we felt because of that constellation of events and the number of occurrences of maternal deaths – there were 14 maternal deaths nationally in that year and three of them were in Morecambe Bay, so we felt we had to do something that would, one, put support into the trust, but, mainly, there was public distrust arising. There was a *Daily Express*, I think, or *Sunday Express* article calling it the death hospital, which meant that we had – they were going to have a reputational issue.

So, I think my summary would be that the PCT was proactive in trying to get the children's agenda higher up, that we demonstrated that by getting an external review and then acting upon it by appointing a Medical Director for Children and Families and we attempted, with the trust, to keep to account in terms of how they managing their incidents and what they did in response to that.

I have a whole host of views of why that probably too difficult, but I think that's perhaps for later.

PROF MONTGOMERY: Okay, that's really helpful. I'm afraid we'll need to go back to the beginning and tease out some of the things... So, are you okay for me to go on?

DR KIRKUP: Yes, go on.

PROF MONTGOMERY: Can I first of all go back to the sort of emerging commissioning strategy? I think I understood that the Mitchell review was initiated not because of adverse events; it was because the problem was identified as something you needed to get into and then you began to realise there were adverse events as well. Have I understood that part...?

DR BEWICK: [*Indicates affirmatively*]

PROF MONTGOMERY: Alright, can I ask about the maternity-side strategy bit? I think you said that there was some consultation in the north of the county; there wasn't consultation in the south. I think the trust itself had looked at some options around that time and looked at the fact that it was inevitable they had to keep the services in Furness. And one of the questions is the funding of those services.

So, you talked about the College guidelines on numbers of births and how it was not going to get there. There's also a whole load of issues around staffing levels and we have a tariff system that relates the funding of the unit to the number of births going through, so that creates a financial question of maternity services. Was that a PCT problem or just a trust problem?

DR BEWICK: Well, I can't do an isolated question, because the reason we did the consultation in the north wasn't just about maternity; it was about closer-to-home policy. And that was because when Sue arrived in the county people were marching on the streets to keep their community hospitals open and we needed a different – and that just happened to be one of the issues people in the west in the county were worried about, the maternity going north and the paediatric going north and acute services going north.

So, that's why that was – so, there was necessity in the south to do that, but we wanted... In terms of the trust, of course, it was going through its FT application at the time and Monitor was not as concerned about their financial situation at that time and neither were we, so it wasn't a financial discussion at the time; it was more a viability one.

And my memory of that at the time wasn't that it because there was difficulty in staffing it at that time. Now, I think that came later when the reputational issues came on and it was difficult to recruit nursing staff in general but particularly midwives. I don't think that was a problem and certainly it wasn't a problem when Monitor accepted them for FT in 2010 – otherwise I guess they would not have got through Monitor's methodologies process.

PROF MONTGOMERY: So, the viability/sustainability issue – I'm trying to work out whether there's a financial pressure on maternity and paediatric services, because if you have a funding stream that comes in related to the number of births and you have to have a set of staffing levels that's set at higher than that, you have a question about whether you need to cross-subsidise. I'm wondering whether the trust came to the PCT, saying, 'There's a funding issue that, as commissioner, you should be giving us' – I'm speaking as a former PCT chair; I know our trusts were saying that to us.

DR BEWICK: I have never known a trust that didn't ask for more money, but I'll... I think there was no specific ask for that, but there was a recognition that it couldn't wash its face in terms of funding itself. And, of course, there's no PBR around those services anyway, so it is a... So, we recognised that it

would be a cost-plus part of the contract. Now, I didn't negotiate that contract, so I'd have to defer to the Director of Commissioning at that point.

PROF MONTGOMERY: And so there isn't a maternity strategy the PCT has particularly that we need to see, then.

DR BEWICK: Well, the maternity strategy it was unwise and not acceptable to shut a maternity unit. I think there were numerous discussions about whether you could centralise that maternity unit, but it would have taken it away from Furness, which has the highest problems in terms of perinatal and neonatal care, so there's both a practical aspect to it, in the sense that the most difficult births are probably going to be there, and, secondly, there's obviously a political one, removing services from more deprived populations was never going to win an election. Sorry to say it that way, but there's always that in the background.

PROF MONTGOMERY: You talked about staffing issues in relation to nursing and midwifery. What about obstetrics and paediatrics staff?

DR BEWICK: I think I've indicated the community staffing – and, of course, there was cross-covering in terms of community. It became much more difficult to get junior staff and senior staff to cover that. And maybe Neela wants to comment on this in more detail, because it's more her area of concern.

But it became more difficult and, especially, one of the biggest problems we had was getting cross-cover from the two sides. And that was true of many specialties, not just obstetrics and paediatrics. I remember going to a meeting with the paediatricians in Lancaster and – this was early on before we'd looked at alternative ways of providing services – I have to say

there was a cultural difference between the two sides. Barrow is much seen as down the road – you don't want to go there.

Whereas – and that wasn't just true of paediatric; it was true of other specialties as well. And getting people to staff that at weekend was becoming more and more difficult. And, as a commissioner, that's very difficult, because you're talking to a trust, not to two hospitals. And, especially, you've got two sets of commissioners here and we have to have that sort of combined view that we have to keep the Barrow end safe. And that became very difficult at times.

PROF MONTGOMERY: And who were you talking to in the trust about this? Was it Chief Executive to Chief Executive, Medical Director to Medical Director?

DR BEWICK: Well, there were numerous conversations, but it was mainly chief exec to chief exec in terms of the capacity. Later on, when we starting getting into difficulties around real concerns following the maternal deaths, Peter was often meeting myself or eventually Neela and of course we had nursing colleagues and ourselves meeting the Director of Nursing and Head of Midwifery. So, they – but I have to say most of that was at the sort of chief-exec-to-chief-exec level in terms of the conversations about the concerns.

PROF MONTGOMERY: And was your impression that when those conversations between the chief executives happened, if you met the Medical Director, the Medical Director would know about them or were there some...? I know there were cases where the chief executives would do deals and it would be completely unknown to the clinical staff.

DR BEWICK: I certainly knew and I'm pretty sure Peter would know as well. Peter had... I think the only problem Peter had was getting that changed cultural

process in terms of handling incidents into board-type discussions about how you will manage that hospital. I don't think that was a strange issue at that time for many trusts. And it's only since the Francis report and all the reviews have taught me that boards have become latter-day converts to the knowledge that if you understand your incidents and do it well and do it transparently, you actually improve services. So, I'm fairly sure Peter would have heard that as well.

PROF MONTGOMERY: Do you want to add anything?

DR SHABDE: Yes, I think paediatric staffing's always been an issue in Barrow, long before I came here. Because being in Newcastle I knew that a lot of trainees didn't want to go to Barrow. They would go as far as Carlisle/Whitehaven, but it kind of suffered from some reputation issues. And I wasn't really aware at that time, but a lot of trainees I used to have, you know, Barrow ~~[inaudible]~~, I think it was very remote and they felt when you didn't get a job anywhere else you would end up in Barrow.

But, having said that, some people made a positive choice, because they for lifestyle issues would go to Barrow, so I think Barrow ended up with paediatricians who had been doing long-term locums and then eventually settled in Barrow, so the quality of services would be much different than if you had substantive kind of really enthusiastic committed people who really enjoyed what they did.

So, I think, when they didn't have the right people in place, others were not persuaded to go to Barrow, so I think that was an issue always for whatever reason, so that made it very difficult. RLI in Lancaster was much better off because they had trainees – and Barrow didn't, because nobody

wanted to go as far as Barrow, because of the low volume workload as well. So, how do you keep your skills up when you see a pre-term baby once in three years or whatever with so many consultants etc?

So, there's obviously that issue. People felt if you go to Barrow there wasn't much work. And I know – I've spoken to some potential consultants wanting to work there. They said, 'I wouldn't be interested.' Somebody joined and then left, because they said, 'What will I do? I joined paediatrics to make a difference and enjoy work. I will be completely wasted there.'

Against that background – and I think the culture issues are really quite pertinent, because midwives didn't get on with obstetricians and didn't get on with paediatricians, so there were three kind of silos that worked on their own, which was quite striking, because I came from a trust where everybody was kind of raring to go, wanting to make a difference, clinical leadership was developed and

PROF MONTGOMERY: Can I ask a bit more about these silos?

DR SHABDE: Silos, yeah.

PROF MONTGOMERY: How did that become apparent to you?

DR SHABDE: Because my first few months was to get to know people, find out what the issues were, so meet a lot of colleagues as well as the Medical Director, Director of Nursing – people in kind of leadership/managerial roles, so the divisional manager for children and families. So, I wanted to kind of make that rapport, so they know where I'm coming from; I'm not a commissioning manager, because that was my first exposure to commissioning. I was coming as a clinician to support commissioning, raise the profile of children's issues etc.

So, I met with a lot of people. And at that time it became quite evident. I also asked the question about perinatal mortality reviews. I said, 'Who attends and how often do you have – what kind of...? Do you have the minutes of meetings that I can have a look at? What lessons have been learned etc?'

And, really, it was non-existent, really, to start with. Paediatricians would do their own perinatal mortality and that was – you know, one consultant would present a couple of cases to paediatric colleagues, but I said I wanted to see the attendance sheet. Who was there? And not always the key people were there, so how were lessons learned and taken forward? Your guess is as good as mine, really. Clearly, that wasn't taken forward, you know.

Obstetricians didn't attend perinatal mortality meetings; midwives sometimes did those, but they were talking amongst themselves. So, that became apparent and, through SUI, because I was involved in SUI group right from really sort of April time after I joined, because I needed three months to get a picture of child health in Cumbria and, I mean, acute paediatrics [inaudible] because I worked in an integrated child health system, so I knew what good looks like without commissioners telling me what good looks like. I knew that, so I became involved with the SUI group and I was then asked to look at the paediatric SUIs, including safeguarding.

PROF MONTGOMERY: Asked by who, by –

DR SHABDE: The PCT – part of the PCT Serious Incident Performance Management Group, as we called it. So, I was able to bring my expertise as a clinician and as well a wealth of experience, really.

PROF MONTGOMERY: So you go in to take stock for part of your induction and it becomes obvious to you that the different professional groups are not talking to each other.

DR SHABDE: Yes.

PROF MONTGOMERY: Did the trust know that?

DR SHABDE: I think they probably knew, but there was a disconnect between senior management and the staff on the ground. I think I'll give you one example if I may, but I also met with the non-executive director on the board who was responsible for children.

PROF MONTGOMERY: Do you remember who that is?

DR SHABDE: She was a health visitor by background, but I think the name escapes me. I'm usually good with names. It might come back to me, but... My question was, 'How many incidents are reported from children's division?' and she said, 'None.' I said, 'That can't be right.' Having been a clinical director in the provider organisations, I knew how many – and governance meetings – we knew how many R1s, R2s, complaints, serious untoward incidents, you know. I said, 'Are you sure?' and she said, 'No, we don't have any problems in paediatrics.'

I think when you delve into it further, it was quite clear that incident reporting was seen as failure on the part of the services, rather than seen as – if you report minor incidents you would probably prevent some of the serious incidents, because you get the system right. Often it's a systems issue.

So, I was very surprised. And I think I also met with the chief executive, who was probably more aware of these ~~paediatric~~ kind of issues, but felt that they could sort it out themselves. I was concerned about the paediatric kind of

culture and behaviours and issues and I wanted to undertake a review of paediatric services, particularly after the CQC declared the trust was in breach of compliance etc.

And there was much resistance in terms of getting that review agreed by the Trust. The review – as I said, it would be supported, so that we could make sure whatever issues, these ~~there are~~ can be addressed, where commissioners need to get more involved or there's [inaudible] issue, we can look at it, but at the moment it's my perception, impression, of what's going on – not really an independent, kind of objective review of what was going on.

And we were just looking at Furness. Furness was quite a particular issue, because of the issue I just mentioned, but it looked at the whole trust with particular emphasis on Furness General.

PROF MONTGOMERY: Can I try and tease out if people knew about the disconnect between professions at the frontline but the board didn't know? Where did the blockage come, do you think? Would Peter Dyer have known about what you knew about?

DR SHABDE: I think I can only offer my observations and view. I think clinical leadership was non-existent. They felt quite disengaged from the whole process. And it's not unusual, because all my career I've come across colleagues saying, 'Oh, them and us.' And I say, 'No, it's not about them and us; we have to be working together, hand in glove' – you know, that kind of approach.

So, they felt, 'It's up to management to do whatever. I'll do my clinical bit,' so there was a disconnect.

PROF MONTGOMERY: So, would it be fair to say that you knew more the culture than the Medical Director or Nursing Director did?

DR SHABDE: Possibly, but I think we were talking about it and I think Peter Dyer, who I've mentioned here, was very easy to get on with, really wanted... I was very impressed by him, because he was a holistic surgeon, I call him, because surgeons normally are very narrow and very kind of focused on what they do, but he could look at wider holistic issues about child health. You know, I think he had also done dental, public health, you know, roles.

But I think he found it really difficult to really crack the issues, as it were. So, when it came to individuals, challenging them and saying, 'Right, we need to move on. You may have personal views about it, but this is what the organisation needs to do in the best interests of children.' What I think I felt within the PCT – and certainly my whole kind of life approach has been, what do we do in the best interests of children? How would I like my child to be treated? Or my mother or my...?

PROF MONTGOMERY: Did the trust have a strategy for children's services or was it a joint commissioning strategy emerging?

DR SHABDE: I think... I think it wasn't clear to me what strategy they had and I think they were keen to work together to kind of develop their strategy and I think as time went on we do have good relationship with both maternity and children's services. We had joint commissioner provider meetings, because I felt you can't write a commissioning strategy in a darkened room because you've got money and you tell people what to do.

It's about clinical engagement and doing it right from the word go, so there is complete commitment to what we're delivering and, also, there's

expertise on both sides on how we do that within the context of the resources we have. How do we work differently? How do we use resources smartly? Where there is duplication, how do we address that?

PROF MONTGOMERY: Did that come from to fruition? Did it –

DR SHABDE: Yes, it did. I think we made progress. I think I would have liked a faster pace of progress, because of the number of issues and changes in senior management a couple of times. I think it does take things back and that is, I think, the nature of the beast we are dealing with.

PROF MONTGOMERY: I think the thing we need to get our heads round is whether the series of incidents and review of the incidents and Gold Command distracted from the process of developing a sustainable system or were they helpful and triggers to do that? Do you want to come in on that?

MR CLARKE: I was wanting to come in, if I may, just before you do that, just to go back to the point you were asking Neela about, whether she knew what – more than Peter Dyer or others knew and it's a personal observation. I should have said at the beginning by way of introduction that another of my involvements was that I was the PCT-nominated foundation trust governor, so I saw a bit from that time. And my observation would be that it's not so much whether they knew, but how they calibrated the significance of what they knew. And it was almost a kind of, 'It's the way it is,' and a weariness about tackling it.

PROF MONTGOMERY: So, what wasn't appreciated is it wasn't like that everywhere, as opposed to –

MR CLARKE: I think that's right – or that it wasn't changeable. So, it wasn't the knowledge per se; it was the interpretation. But, sorry, that was going back a step.

PROF MONTGOMERY: Can I shift back to some of the – this is all back to [inaudible] for different things. But I want to ask about the Fielding Report and when you knew about the Fielding Report and I want to ask about the CQC and the relationships a bit later on, because there are things that you both picked up, things going on. So, was the PCT involved in the commissioning of the Fielding Report?

MR BERWICK: It's a Rumsfeld moment this, isn't it? It's an unknown unknown that suddenly became known. We had no idea that it'd been commissioned. And learned about it when we held the risk summit in Manchester I think it was. Tony Halsall at that point alluded to it. We'd never heard of it before that date. I think that was around the first week in October 2011. And subsequently I remember being at the Oversight and Scrutiny Committee for Cumbria and North Lancashire and pointing out that it would have been useful to have known that.

Being honest, it just pre-empted what the NMC found later on, so I suppose we found out eventually, but it would have been better that that had been shared. So, that's when I personally found out about it and I know no other colleague in the PCT had seen it before when we asked.

PROF MONTGOMERY: So, there was no contact with the commissioners when the team came in to look at the service.

DR BEWICK: No. Sorry – none that I'm aware of, sorry. But, yeah, subsequently nobody refuted...

PROF MONTGOMERY: And one of the things that's becoming apparent to us is that there were an awful lot of external reviews, reports at different levels of, shall we say, complexity, rigour, methodologies. I mean, some are just quick and

dirty views; some are visits. Were you aware of a pattern of reports like that or were they mostly internal and off the radar?

DR BEWICK: Until we had the initial CQC report, I don't think I had personally seen a report from the trust, no. There was, also, due diligence going on in terms of their FT application and, for instance, Gateway were interviewing people. I remember taking a phone call from Gateway around the FT application, but, to be honest, it was the only time before we set up the ~~sort of~~ SUI group and subsequent executive group when within Cumbria PCT. ~~we were coming to Cumberland[?]...~~

I have to say my view is that it was isolated from us as a senior executive team. However, if you talk to the GPs – and of course we were trying to disseminate clinical leadership at the time – [Jeff Jollife ~~Jelley?~~] would tell you he had regular conversations with the trust about services, but I don't think maternity and paediatric services were top of their list. It was more particularly around cardiology at the time. There was a big issue with cardiology, elective cardiology. So, it would vary who you asked in terms of locality.

DR KIRKUP: Would you expect the PCT to have been told about the report?

DR BEWICK: The Fielding Report...?

DR KIRKUP: Yes.

DR BEWICK: Yes, especially as we were – it was during that FT process and there had been two maternal deaths. ~~too much adult deaths.~~

PROF MONTGOMERY: At the time that was commissioned you were already trying to set up your way of understanding the clinical issues, I think it was described –

DR BEWICK: I think what –

PROF MONTGOMERY: You had already identified this was a Cinderella area that needed a look.

DR BEWICK: I think what had happened was what John Ashton, who you know has the international reputation in terms of looking at public health issues, was concerned partly with the maternal deaths, but also that we were probably underestimating in some areas the perinatal and neonatal deaths, because overall Cumbria had a good figure, but, actually, we were missing something. And he was particularly exercised at that time, I remember, about Still births ~~Silberts~~[?]. And that's when we decided we would need an external review of the 40 – and it became 40 deaths in the end, because of overlapping we ~~overlapped~~ years.

But, yes, there was an interest in that. And it was partly a concern and, to be honest, partly an academic interest into looking into more detail into how you evaluate in small numbers in small-number maternity units what is and what isn't a benchmark. And that is – as it came to follow – an exceedingly difficult thing to do. But you can look at trends and you can look at preventable factors and the RCAs that occurred in all of those did find preventable factors, whether it impacted on death is a different matter, of course.

PROF MONTGOMERY: By the time the Fielding Report was commissioned, there was a sense that the incidents were unconnected and the Fielding Report was asked to do work on the assumption that they are connected incidents. What was your assessment of whether there was a pattern here or whether they were connected?

DR BEWICK: I think it was one of sceptical inquiry and I didn't know enough to say it was safe, so we should be doing something to look at whether it is safe. And that was, I think, the sort of hypothesis: we have to prove that there's safety in the system. And that's why we wanted an external review, but, obviously, other things accelerated after that and that became more obvious to us – that we needed that level of review.

DR WALTERS: Which review was that? Which external review is that?

DR BEWICK: This is the one that we commissioned by the Centre for Maternal and Child Enquiries – and it took two years to get going because at the time there was a lack of funding of some of their enquiries, for about a year, and it delayed it and we couldn't get other funding to do it at that time, so it was done a year later than we had hoped for – and that studied 40 perinatal deaths over a three-year period, I think it was, in the end.

PROF MONTGOMERY: When did you receive that report?

DR BEWICK: I'd have to look back at records for that, but it was after Gold, from memory. Yeah, it was after we'd established Gold.

DR SHABDE: Yeah –

DR BEWICK: It definitely was after Gold.

MR SHARPE: Yes, it was, definitely.

PROF MONTGOMERY: We have also seen some statistical analysis that was sourced to try and see whether the patterns of deaths were statistical – and they looked not dissimilar to what we have tried to get to the bottom of. Do you remember who commissioned those and when you had them?

DR BEWICK: I don't remember who commissioned them, but it's likely to have been Professor Ashton, just because he would have –

DR SHABDE: Are you talking about perinatal –

DR BEWICK: Yes.

DR SHABDE: Yes, it is Professor John Ashton, yes. And I was involved in that, part of the steering group, which I could only attend a few meetings of because I didn't work on Fridays, but I did, whenever I could, by telephone conference. But I have looked at the report in detail, because it was Rebecca Wagstaff who was involved as a public health consultant and then handed over to the commissioner saying, 'How do you take forward the recommendations from that report with both organisations, Cumbria and Morecambe Bay?' And we now have got an action plan and I'm involved in overseeing that, because children's commissioning teams were being asked to look at the maternity commissioning as well in the last year or so or six months, I think. So, that's why I'm involved.

But it was very interesting, that report, because also – if I may just mention a couple of things, although the overall figure was better than the national figure, there was a clear message coming in that one third of cases there were potential avoidable factors and those were in terms of how do you stop ~~promote~~ maternal smoking sessions, better foetal growth mentioning, CTG interpretation? You know, the training etc... So, we could do better – so Cumbria could have even better mortality figures.

PROF MONTGOMERY: And when – I mean these things are easy with hindsight, but at what point could that have been picked up? Was that in the root-cause analyses? It's easy with hindsight to say we can see a pattern; it's harder to tell when that could have been apparent.

DR SHABDE: Yeah, absolutely, hindsight's a wonderful thing, isn't it? But hindsight, in my opinion, is to learn lessons. Once you've developed that, it's to prevent those. And you need the right system, so people are all engaged and committed, to prevent those things.

I think the SUIs – I think we had managed to get commitment from the trust to report stillbirths, which is not [STEIS ~~Stice~~-reported?], but that was the commitment the trust made, both organisations. So, that's how we could get a picture of stillbirths, because some of those, are ~~they're~~ intrapartum deaths, the woman comes in, there is a heartbeat and then, you know, the baby's delivered dead – and the most upsetting thing. As a paediatrician, I know how painful it is for everybody involved. So, I was particularly interested in what goes wrong out there and how that could work better.

So, yes, we were aware of some of the stillbirth reporting coming through, that that needed to be addressed. And I think that's why, when the new head of midwifery was appointed, Moira Angel, who was Executive Director of Nursing, and myself had regular meetings with her on what's been happening, what they were ~~you're~~ doing about it, because the Fielding Report became kind of known to us.

We wanted to know the recommendations within that report, how they had addressed those. For example, you know, from theatre, the labour ward distance was quite a long way. They had to go through a public corridor. And we were really quite...

DR KIRKUP: And, sorry, just because you go on to that, because I don't want to lose the thought, there was an initiative to look at never events that I think was

prompted by North Lancashire rather than Cumbria. Were you involved in that at all? You didn't come across that one...

DR SHABDE: I can't remember. I'm sorry. I can't recollect. If you – what date was it? Maybe that time I wasn't involved in maternity.

DR KIRKUP: It would have been around about 2008.

DR SHABDE: '08 – no, I was far away from Cumbria then. I was in Newcastle, because I only joined Cumbria in 2011.

DR KIRKUP: I am interested to get your reaction to it anyway. I think they implemented the first year of it, but in the second year, if they'd been able to implement it, they were going to include intrapartum stillbirths as a never event. Is that something that you would support or would have supported?

DR SHABDE: I would have supported it. I think every incident needs to be looked into in detail. I would want the RCA to say, 'What can we learn from here? Was it preventable or not?' And whilst I have paediatric ~~kind of~~ background expertise, but wherever I needed obstetric midwife expertise, I have no problems ringing my expert colleagues round the country if I needed to, so that I'm not just making assumptions on my own.

DR KIRKUP: Last one from me, before I apologise again and hand back to Jonathan. But did you pick up a pattern of intrapartum stillbirths?

DR SHABDE: I think I remember with a colleague in public health we did – review of perinatal ~~[inaudible]~~ mortality was addressing all this, we did a quick and dirty analysis of that. I think the issues then, from memory, were about foetal-heart monitoring, interpretation of CTG and all –

DR KIRKUP: And failure to monitor at all in high-risk pregnancies.

DR SHABDE: Yes, yes.

DR KIRKUP: Okay. Sorry, Jon.

DR WALTERS: But when, then, was that? When was all this happening?

DR SHABDE: I think it was probably end of 2011/2012, really.

PROF MONTGOMERY: There are a couple of things about the Fielding Report that I wanted to pick up. And we wanted to go back to 2010, so before your time, the CQC *volte-face* [inaudible] understand. You were just talking about the theatre issue and the fact that you had to go through public corridors. And I wondered how urgent an issue that appeared to you and it appeared to the trust.

DR SHABDE: I think once it was flagged up... And, again, it was a year after ~~later~~ the Fielding Report was received by the trust. And we actually walked the ~~kind of~~ corridor and it would have been really important for a woman, maybe not in a dignified position, being wheeled through the corridor.

So, they managed to find a shortcut through the medical assessment unit and then go across the corridor to the theatre. And one of my questions was – there was a lot of equipment cluttered around. I said, 'How do you make sure that your journeys are as smooth and it can get though? If there's equipment, who clears it? So, you need a better kind of solution. Whilst it is okay for immediate kind of mitigation of that particular issue, but in the long run it needs to be addressed better.'

So, the journey was shortened just across the corridor.

PROF MONTGOMERY: So, you're saying it appears [inaudible] for immediate mitigation, but the visit was in early 2010; the report was in August 2010; and this is in 2011 when you get there.

DR SHABDE: Yeah, so there was probably a delayed –

PROF MONTGOMERY: And we understand when the CQC went round a few weeks ago they couldn't find the key for eight minutes – still the same problem. I'm trying to get a sense of whether this is a big clinical safety issue and you would have expected the trust to have sorted it overnight or whether or not it's not a safety issues so much as a dignity and... What's your sense on it? It's not just [inaudible].

DR BEWICK: My sense of that was it was both of those –

DR SHABDE: Yeah.

DR BEWICK: because the distance involved was long, but it was – the NMC did this as well. They were really concerned about the dignity aspect more than anything else. In terms of the other parts of the Fielding Report, I think they were more worrying to me, because they showed to me the communication problems that there were between the different aspects of clinical staff – sorry.

DR SHABDE: I think there were safety issues as well, the dedicated needs that is for labour ward, you know, all those kinds of things, how quickly you can get into theatre, can you get the –

PROF MONTGOMERY: I'll just let Stewart come in.

PROF FORSYTH: Actually, was it not a commissioning issue?

DR SHABDE: Sorry?

PROF FORSYTH: Was the theatre issue not a commissioning issue?

DR SHABDE: I'm sure –

PROF FORSYTH: The solution was funding.

DR SHABDE: Yeah, I think –

PROF FORSYTH: If you were going to try and have a –

DR SHABDE: I think somebody did say, 'Give us £5 million and we will sort it out.'

PROF FORSYTH: Yeah, that's – okay.

DR SHABDE: Obviously, if they said to me, I would have –

PROF FORSYTH: But the point I was going to make is in normal practice would you have a co-located theatre if you're going to have an active labour suite?

DR BEWICK: Can I just say one thing about that?

PROF FORSYTH: It seems to me this was clearly at least a commissioning issue for consideration. And, if you were not able to provide a suitable resolution to that from a financial perspective, you then need to have a satisfactory clinical solution.

DR BEWICK: In terms of the finance, when this became known, in the Fielding Report and in the NMC report, at the time that Gold was established, we agreed with our financial colleagues, both north and south, that there would be a need for investment. And part of it was to invest in Gold itself, because there were a lot of costs that were going to come with that and we negotiated with the SHA about where that landed, but we accepted that. But we also accepted that there were some other local funding issues that were required. And I can't quite remember verbatim on this, but I'm fairly sure it included the relocation of certain parts of the system, which would have seemed likely.

PROF MONTGOMERY: So, I'm just wondering –

DR BEWICK: In fairness to Tony Halsall, I think when that was pointed out to him as being a major risk, he made it a priority. I guess it should have been a priority a year before, if they knew that information.

PROF MONTGOMERY: And I guess if you've asked for the commissioning support you can't have the discussion that's there. I mean, we can ask about that with –

DR BEWICK: I think there was... Once we set up an incident – one of the first things we wrote down was, 'This is a supportive arrangement to them.' And we recognised there would be funding issues within that. The scale of it was very difficult to predict, because it became, as you'll probably ask later – there were more things, we established, going on than just the two things that we'd set it up for.

PROF MONTGOMERY: Can I stick with the Fielding Report for a few more minutes? And one of the things that seems to have happened in the Fielding Report is a number of recommendations were found to be not applicable and these were actually traced through the action plan. There were things that were there that were sort of not appropriate for the area. Did you see – you'll have seen the action plan, no doubt, now, but you didn't see it at the time.

DR BEWICK: I didn't see it at the time.

PROF MONTGOMERY: Are you surprised by the things that were not actioned at all?

DR BEWICK: I think you'll find that when we did the incident and then set up our own, already a lot of those things were put into action, so the answer is yes.

PROF MONTGOMERY: Are you aware of when the action planning around the Fielding Report began to happen? Because we're trying to see – we can see an end-of-process audit; we can see when it became accessible to people like yourselves externally, but we can't quite tell whether it was a process that was seen all the way through but invisibly or whether it didn't really get anywhere.

DR BEWICK: I don't think I can answer that question; I just don't know.

DR SHABDE: Maybe I can offer something. I think when the subgroup of maternity and paediatric was set up under Gold, I think that was the time when we did have sight of the Fielding Report and the action plan.

PROF MONTGOMERY: Was your sense, when you saw it, that the action plan was something from the past that was more or less closed down?

DR SHABDE: Yeah. And I think there were so many activities happening they had set up a programme office within the trust. Monitor was coming from their perspective. There were lots of actions happening. People were doing action plans and, what I kind of felt – that they're not all joined up. Somebody's doing action planning here, action planning there – and that wasn't cohesive, well, kind of coherent, really.

PROF MONTGOMERY: And whose job might it have been to join it up?

DR SHABDE: I would have thought the trust, really, the executive – this is my opinion; I may be completely wrong – the Executive Director of Nursing and Medical Director, really, to take issues on board and say, like, 'How do we crack it?'

PROF MONTGOMERY: And did you have any sense of them playing that role, that they were trying to pull together these various things?

DR SHABDE: I think they were trying, but I think they were being pulled in all different directions. And I didn't get the sense that it was a co-ordinated approach. The trust was fully aware of what needed to be done and they knew what the issues were.

PROF MONTGOMERY: You talked about the Executive Director and Medical Director. Was the Chief Executive involved in that? I'm trying to get a sense of how this is brought together.

DR BEWICK: Peter, I mean – I'll come back.

PROF MONTGOMERY: Indeed. And did the governors know?

MR CLARKE: I'm trying in my own mind to sort out the time sequence and struggling a bit, but certainly one of the things that was a major initiative by the interim arrangements that were brought in was to create the programme office and its programme-management function.

And that was explicitly a recognition of the fact that that they had kind of drowned under action plans which were produced not interconnected and not necessarily followed through. So, the fact that they did that means that there was an awareness they had got themselves there, but what I can't track back in my mind at this moment is at what point that awareness started to be explicit.

DR WALTERS: So in 2011, the PCT, or yourselves, did a briefing which states that the Trust commissioned the Fielding Report, which found that the incidents were coincidental, and that the action plan had been implemented. So, who was sort of responsible for tracking it around that time?

MR CLARKE: That's... sorry, that's quoted from one of the briefings from Gold, is it?

DR WALTERS: I don't know. It's a briefing from the PCT.

PROF MONTGOMERY: It's headed 'Risk Summit Briefing.' It's the end of September '11.

MR CLARKE: Headed 'Risk Summit Briefing', did you say?

DR WALTERS: No, mine isn't. Mine is just 'Briefing'.

PROF MONTGOMERY: The email that it is attached to... or is that the earlier

one? I think it's the earlier one. It's the earlier one, in which case that's headed 'Maternity incident updated'.

MR CLARKE: It may sound slightly illogical, but if it is a briefing which we produced after each Gold Command meeting, then I ought to be able to answer your question. If it's a briefing for the risk summit, then I can't answer it, because I wasn't involved in the preparation for it.

DR SHABDE: What date is it, please?

DR WALTERS: I don't think Gold was set up then. It's September 2011.

MR CLARKE: This will be when...

DR SHABDE: Pre-Gold, yes.

MR CLARKE: Yes, this would be pre-Gold.

DR SHABDE: There was the summit before that, wasn't there?

MR CLARKE: I'm afraid I simply don't know who produced that or where that information would have been derived from.

DR BEWICK: I think that would have been produced by a mixture of people, the commissioning side, SHA side and perhaps Clare, just from our own side. I imagine it's a... the way I've read that, it feels like a composite document rather than just a PCT document.

DR WALTERS: I think it's SHA.

DR BEWICK: It would have been one of these things that would have been labelled by authorship.

DR WALTERS: And Mark Graham?

DR BEWICK: Mark Graham was the head of comms at the PCT, so it would be a risk summit preparation document.

DR WALTERS: There was a belief then about the PCT that the trust had

implemented the action plan.

DR BEWICK: I don't know whether it's a belief. It's a statement in a press release, but I guess we found out they hadn't. I think, if I could go back to one of Jonathan's questions around the relationship between senior management and senior clinicians in the Trust, I guess like a lot of managers people believe that they're carrying their clinicians with them, ad that they are supporting certain aspects, which seems to demonstrate that, but actually I think that there was a complete disconnect between a clinical strategy for the hospital, which we were trying to work with them to do, and that of the financial and organisational and operational model.

PROF MONTGOMERY: That would not be unusual.

DR BEWICK: No, it was not unusual. And the other thing, remember, at that time there was a push to FTs, and it was regarded as a status symbol to get your FT badge. And there was a certain, I have to say, change in culture in terms of the drawbridge coming, being drawn up, as soon you got that FT status. Now, I'm not saying that's everywhere, but that's certainly what t felt like.

PROF MONTGOMERY: It's certainly elsewhere as well, isn't it?

DR BEWICK: Just to give you an example, Neela ~~Neil~~ and I, we discovered an incident. This was post Gold starting, and this was early on, and there was an incident happened, and we requested to go down and see the clinicians there, and we were refused entry. We were halfway there, driving through ~~down~~ Cumbria, and we were told to turn back, that we wouldn't be welcome until they'd looked at it themselves. Now,

we thought we were building a relationship then, and there was still a mistrust around. I guess that if you are branded as an FT and you feel that you've got over that hurdle, and the reputation is there, there is a tendency to push out things that are good and not a tendency to discuss, and it took a time. I think we thought we'd already done it, because there'd been some pretty explicit conversations, but the answer to your question is I don't believe that they were really as joined up at board level as they should have been, in what was becoming an escalating problem for them. And there were difficult discussions about who they sent to Gold, for instance, at the beginning. They sent at times relatively junior people in the organisation, for what was a major incident, and we had to criticise for that, but that did change, I have to say, as time went on and we got high-level representation, and the [inaudible] has also put a lot of its own resources into the programme office, etc, and recruit from outside to give, you know, fresh eyes and fresh perspective.

PROF MONTGOMERY: Can I just ask you to clarify a bit? You talk about an escalating problem for them. Are you saying that the clinical issues were getting more concerning, or are you saying that they were seeing, not necessarily a change in the clinical risk but it was becoming reputationally more serious?

DR BEWICK: I think both of those. I think certainly the reputational risk, I mean I don't particularly want to swear in front of you, I think, but I remember Tony Halsall, because, in fairness to him, there were so many people looking at Morecambe Bay at that particular time, and I

think the SHA had been one day, and he said 'How many times do we have to be beaten up and told we're crap? Surely once or twice is enough, and we'll do something about it.' So there was a sense of drowning in the number of people coming in and criticising them, and what we hoped Gold would do was actually to minimise, well, to bring it together for them, so that they were just clear about what the actions they needed to do to make sure that there was transformation.

DR KIRKUP: Do you think they actually accepted that they were 'crap', at least in some aspects? It's one thing saying 'You can stop now, because we've accepted the problem,' and another saying 'We've been told this so many times but we still don't believe it.'

DR BEWICK: No.

DR KIRKUP: Sorry, no to which?

DR BEWICK: I think it got better as new people came in, but it's very easy to have [inaudible] insight and comment on other people's problems rather than your own.

DR KIRKUP: Sure.

DR BEWICK: And the relationships did improve. That's not to say there weren't people there who were desperately trying to improve the relationships, and I believe the Chief Executive was trying to improve relationships. It was the how of it that was difficult, and I guess that they were... They just struggled with that, and I think the Board, my view and I think that Monitor's view at that time was that the Board did not support this enough, and there was a governance issue about how to run a hospital, and therefore the evidence was that they didn't

achieve that.

DR KIRKUP: Sure. Thank you.

DR SHABDE: Can I just add a comment? I think they were in denial, really. I think they were trying so hard to be successful as an FT that they were in denial, that they weren't doing as well as they ought to have done. And I think the out-patients side, I mean, that was just incredible, you know, the kind of numbers who were lost to follow-up, just beggars belief really. I think they probably then did admit that things were not quite right, but they were in a state of denial, I think, yes.

PROF MONTGOMERY: Can I move to the CQCs, does anyone else want...?

PROF FORSYTH: I'll be coming back with quite a few questions in relation to the services.

DR KIRKUP: That's okay. I think we'll do it in separate chunks.

PROF FORSYTH: That's fine.

PROF MONTGOMERY: One of the things we're trying to understand is what might lie behind the lack of recognition of the issues that you're picking up, and you used the phrase, Mike, about the CQC's *volte-face* in 2010, and we've heard from other people we've seen about mixed messages in 2010, and particularly the CQC appearing to give them a clean bill of health, and then that changing. It'd be really helpful to have a sense of what, from the perspective of the health economy, you thought the CQC was telling people in Cumbria about the quality of services. Because what the CQC thinks it's doing and what is understood from reports is not necessarily the same thing. So, why did you use the word '*volte-face*', I think?

DR BEWICK: I think that at that time the inspection regime, the culture of the inspection regime, was very unlikely to be enquiring enough to pick up problems. I think this was an issue around the leadership of that organisation, the recruitment that took place, and the people who were sent in to look at complex clinical systems not having, in my view, enough experience in looking at complex clinical environments. And so there was a relative scepticism about, as time went on – and I think this is one accepted now ~~of the, around that~~ - ~~I think~~ that ~~when~~ they were reactive to issues. ~~,~~ So a problem arose, and they would go in, say ~~so~~, a never event would have occurred, two never events in the hospital, and they would go in; there would always be a report they'd found a problem. If it was a routine one and, it was often routinely found that things seemed good. And this was in all three trusts that we had, don't forget; there was a very sizeable foundation trust, mental health trust, as well, at that time.

So I suppose in my relatively new role at that time, I was used to inspecting primary care and going in with data, but I never based my opinion on the data. The data supported my opinion or it didn't, you know? You had to find reasons why, and it struck me they didn't do that, and so there was, I think, a scepticism. And there was also, another problem, a relatively hands-off approach until something happened. I don't feel we had a particularly good relationship in the sense of regular check-ups with that organisation until the summer of 2011. Of course, CQC had a duty, because until fairly near that time we still had a provider arm, so PCTs were always viewed ~~in that~~

differently,~~,~~ ~~and~~ We ~~we~~ delayed moving our provider arm because we wanted for a different process (than TCS) ~~reason~~ to transform it to something else, so there was always a little bit of edginess in the sense that 'They'll be inspecting you next week as well, as a provider.'

Now, Sue always tried to keep that arm's length with the provider arm, but inevitably, because the staff are the same and you are responsible for them as an employer, that was difficult. I have to say once the difficulties had arisen we started to get a much more mature involvement, and consistent involvement, by someone, who was had ~~certainly with~~ a good nursing background could look at this, she would escalate appropriately, so I think it did improve, but in those earlier years, when CQC went through that sort of transformation in the relationship, I did some work for CQC. I did part of the enquiry of the death in Cambridgeshire, of the GP, the Ubani inquiry. It was at that time that they altered their clinical input, and I think that was one of the last investigations where they used senior clinicians to look into it, and they then went to a more centralised approach in the way it was done, and they recruited then but there were generally less clinicians involved in all of that. The organisation did change at that point, and then of course it's now done the reverse transformation and changed into a much more clinically-led organisation.

PROF MONTGOMERY: Can I ask you a bit more about the second half of 2011 on that, when CQC issues a warning notice? That warning notice runs until November. Did you get a sense that the Trust did anything to remedy the defects the warning notice related to? So, it's particularly

about maternity, the warning notice.

DR BEWICK: I think if your major regulator – and don't forget they were put in breach as well as well, as a governing body – puts that in front of you, there is a real impetus to change. I think what they still were struggling with in those first few months was realising that you will only change that if you do that with your commissioners and not independently, and it took a little bit of time, I think, for that to evolve. Once that did evolve, and we started to look at both the interim measures you are going to have to do now to make it safe, and they put that programme office in, and we had leadership in that programme office that could make changes operationally, I believe that they started to make a difference. But of course CQC then had other visits, and they did spot visits in Lancaster which had issues around acute care there, so one of the problems with a small trust, and especially on three sites, is you've got a problem there, it's like a waterbed: you push it down there and it's coming up over there again because you've taken your eye off that ball, and really they had a capacity issue initially, in operationally keeping a lid on all of these problems, and that was compounded again when the Royal College of Physicians sent their visitors and found stroke care was very poor, especially at Lancaster.

PROF MONTGOMERY: Was it only a capacity issue, or was it a capability issue as well, do you think?

DR BEWICK: Well, I think it... There was definitely a capacity issue, because there just weren't enough people there to run the issues. I think that some people who were appointed to relatively senior roles had not got

the experience to do this effectively, and therefore they needed substantial external help to come in and help with that.

MR CLARKE: And I'd link that with a cultural issue, because, again, there's a sense that for years they had felt themselves to be battered for one thing or another, and had developed a coping mechanism which was about sort of batting that off rather than getting down underneath it. And as a governor during that period, there was no sense that the governors were being presented with anything other than the... I would almost say it was seen as a kind of irritation, as opposed to the fact that there was something significant in it.

PROF MONTGOMERY: So there was a sense that all these external things identified a set of issues that had to be dealt with, but they weren't really symptoms of anything deep; they were specific situations.

MR CLARKE: And we expect outside people to criticise us.

PROF MONTGOMERY: and the CQC warning notice gave a, as they have to, quite limited period.

DR BEWICK: Three months, I think it was, yes.

PROF MONTGOMERY: And at the end of that three months, had they made much progress on their targets?

DR BEWICK: I think they made quite a bit of progress in terms of reorganisation of maternity, and the maternity rota and cover. I think our major worry was about sustainability, because, as I say, you can quickly direct resources to that area but then it falls over if you can't put it into perpetuity. But they did take of course take external help, from both Manchester and Liverpool at that time in terms of support for

maternity, to try and get a better model that would work, so I think one of the I guess advantages we got through CQC's findings was they engaged with external units to demonstrate what could be done.

MR CLARKE: And that was the point they brought in a new head of maternity too, wasn't it?

DR BEWICK: Yes.

MR CLARKE: Who was a significant influence.

DR SHABDE: Yes.

PROF MONTGOMERY: So was your sense that the CQC was... Because the warning expired in November, December, at the end of the three months, and was your sense that the CQC felt the warning had done its job? It didn't seem to be renewed; we were slightly perplexed.

DR BEWICK: Well, there may have been a view... I can't second-guess CQC at the time, of course, but with the incident being called, you've got another modus operandi to make sure that that was going to be fulfilled, and they were still very much involved in Gold Command. They were an intimate member of that, and when we had the stock takes each time there was a review of where each part of the system had got to, so I guess they'd got some reassurance by what was going on by commissioners with the trust at that time, through the incidents.

PROF MONTGOMERY: So was your sense that the warning was lifted at the end of December and expired?

DR BEWICK: To be honest with you, it just seemed like it was becoming as near a normal business in the sense that we were demonstrating there was cooperation between commissioners and provider to radically

change what they were doing, and they'd already put in quite a bit, particularly around the safety aspects round maternity at that time, so I don't think if they'd said to us 'Do you think we should have lifted it?' I wouldn't have opposed that, because we had another modus operandi to make sure that the Trust...

PROF MONTGOMERY: And in terms of patient safety, you'd say that the scrutiny was still on, and that you were doing something that was aiming to deal with that.

DR BEWICK: Yes. And don't forget, throughout the whole of this the police inquiry was going on into many of these deaths, and, you know, there was a little bit f a phony war going on, in a way, because we couldn't, of course... John Ashton was the information person between the two, but that was only giving us the sense of where the police were, not that... Because we had to do this as separate, and in fact one of the big problems we had the beginning of setting this up was whether you can legitimately set up an enquiry while there was such a major police investigation going on, and we decided that there were too many patient safety issues for that not to happen, so we agreed with the commissioner of police that we would do that.

PROF MONTGOMERY: One other CQC question, and that's the Section 48 investigation. You did one of those for the Ubani one, it's one of half a dozen we understand they'd done. We are trying to understand the scope of that, so there was a warning notice about maternity services and a lot of concerns continuing, but it wasn't part of the Section 48 terms of reference. Was that something that was discussed with you at

any point?

DR BEWICK: It wasn't discussed with me, I don't know whether you...

DR SHABDE: No. Would you mind, Section 48? I'm sorry.

PROF MONTGOMERY: When the CQC went in in 2012 and they did a system review, they picked emergency care as the thing to have a look at. They'd done a similar status enquiry in Barking and Havering, where they'd looked at maternity outcomes.

DR SHABDE: That is Section 48, is it? Right, thank you.

PROF MONTGOMERY: So that is the method, and obviously you'd have to sort out what the scope of that is, and we haven't quite understood why maternity wasn't part of the scope of that. I just wondered whether there was any discussion with...

DR BEWICK: No, there wasn't. There wasn't.

PROF MONTGOMERY: And were you surprised when you discovered it wasn't part of the scope?

DR BEWICK: No. I still think there were issues with the way CQC performed at that time, and I think subsequently there were...

PROF MONTGOMERY: You weren't surprised, but you thought it might, you would have expected it to have been.

DR BEWICK: There were several things that we learned afterwards that CQC had done without contacting us. Eventually, when they were starting to do their uninvited, sort of spontaneous visits, they were, they did give us warning, and I remember we had a difficult conversation with them once about what they wanted to do on a Friday afternoon, and we said 'You can't do this on a Friday afternoon, because the weekend's

coming up and it will cause mayhem.'

PROF MONTGOMERY: It was Christmas as well.

MR CLARKE: It was Christmas.

DR SHABDE: Yes, Christmas as well.

MR CLARKE: The Section 48 one wasn't Christmas.

PROF MONTGOMERY: It wasn't a Section 48 one – it was a time they were discussing that.

DR BEWICK: And we said, you know, you'll have the roads crammed out of the county, and I remember I was [redacted] in Brighton [redacted] It was about an hour's conversation. It was a very difficult conversation.

DR SHABDE: Any services at Lancaster, I think.

PROF MONTGOMERY: Would it have been helpful, do you think, if that Section 48, thanks for telling us that, had included maternity, or would that have been unhelpful, because you were doing the incident, the Gold Command at that stage?

DR BEWICK: I have to be honest, I don't think it would have made any difference.

PROF MONTGOMERY: Thank you. There's lot of Gold Command in a minute.

DR KIRKUP: Do you want to come in on Gold Command, or do you want to wait and we'll have a section for you and see it?

DR WALTERS: Yes, we'll have a section on Gold Command, I think.

DR KIRKUP: Okay, you go on then.

PROF MONTGOMERY: I was going to go to Gold Command for my bit next.

DR KIRKUP: That's right, and we'll take everybody else in turn.

PROF MONTGOMERY: So, I think I've got a bit of a picture, but I'd just like to understand a little bit more about what you hoped Gold Command would achieve, so you've described the context in which you pulled it together; what were you aiming to achieve, and how would you tell whether it succeeded or not, and then we can take through and understand it.

DR BEWICK: We felt that there was a lack of control, and a lack of direction, and that things were being done in a haphazard way. People were putting their finger in the dyke rather than looking at the cause of the flood.

PROF MONTGOMERY: Are you talking about the system as a whole?

DR BEWICK: The system as a whole. The system as a whole. Cumbria at that time had a lot going on: we had a very financially challenged Trust in the north, which had been financially challenged for well over 20 years by that time, but it was coming to the fore. We had concerns over the mental health trust in terms of the running of that organisation, and particularly around deaths when under treatment, and we had new information coming from Morecambe Bay. And some of the relationships about Morecambe Bay and children's would of course interact with the Cumbria partnership trust, because they'd taken on the provider arm and therefore the children's services side, so there was a great concern that we were just losing control of this as commissioners. We wanted to bring some order and some effective planning in place. When we got the further information from CQC about their second visit

and their concerns, we felt the only way to do this was to actually declare it as a major incident, and of course we couldn't declare this a major incident. It has to be the SHA, especially as it crossed two (PCT) boundaries, and of course the definition of why you called Gold incidents includes that threat to the wider economies, and so we felt we had a very substantial case for doing so, and that in itself would bring in a supportive mechanism to the Trust, who we felt were in the headlights a bit, and trying to persuade themselves it was only a bit that was going wrong, when in fact there were things that we were really concerned were more widespread, and our view was the SUIs and things like this were demonstrating it wasn't just one part of the Trust that had a problem but others. And so the first one was how can we support this to improve it. The second was, to be honest, to call a halt; just to say 'This is a moment in time when we are taking stock and looking critically at the whole Trust and its environment around it. And thirdly, we realised at the time that the reputation of the Trust was just being destroyed, either externally ~~extremely~~ by the media or with ~~because the~~ staffing, we just couldn't get people to go and work there, and they were struggling with it, so there was a whole host of things that we were concerned about, that the Trust would just carry on going downwards, and we had to try and help them get back on a route that was at least stabilising at first, and then improving. So we – John Ashton and myself – actually at that time said to Sue Page that we thought the best way of doing this was to call an incident. Cumbria at the time had a good experience of calling incidents, we've had

shootings and floods and rail crashes and various other things, and it struck us as being an unusual way of doing it, perhaps, but a good way in the sense that it would bring everybody to the table, and you got a much greater honesty when that happened. And using the National Quality Board's mechanisms through – they've changed since then, but, you know, the risk summit process was a very good way of doing that. And the SHA led that with Jane Cummings and Mike Cheshire at the time, they were the two senior clinicians.

PROF MONTGOMERY: Did the SHA take much persuading that this was a good step to take?

DR BEWICK: Yes.

PROF MONTGOMERY: So what were their concerns?

DR BEWICK: When we got clinician contact, it was fine, but initially I think that they felt that we should be able to do it through other ways, through Monitor, obviously, and CQC, and I think it was only when, as we're doing today to you, we gave all the evidence that was accumulating that we felt, especially as the police were now involved, etc, as well, that this would be an appropriate thing to do. And at that point, I think, Mike Cheshire certainly became very, very supportive of... I was in the office in Manchester with them, and others were telephoning ~~videoing~~ into it at times when we were initially having the discussions, and we were able to make a good case to do that, because they knew there would be, obviously, a resource issue behind this, not least our time, because this became, certainly for me, it became 50%, 60% of my workload for the next eight months, and so there was a... And as

Cumbria had most of the input, if you like, into this, it was agreed that although we deal jointly with North Lancashire, Cumbria would have the lead on it, and it was at that point that Sue appointed me, I think, as the Chair of that Gold Command.

PROF MONTGOMERY: And how much of the human resource from the SHA was involved in Gold Command? Did they push it back to you, basically, to run, or were they closely involved in it? You couldn't call it without them, but you could run it without them, presumably.

DR BEWICK: We had high level support, and we had some practical support as well, through Angela Brown, who had a lot more expertise than we had in such things, in terms of the particular problems around midwifery and paediatrics. But I think it's fair to say that we were left to go it alone. That was the idea, and there'd be regular reporting back through Gold, not just to SHA but obviously further up to national and the Ministers.

PROF MONTGOMERY: And how did Tony Halsall take the idea?

DR BEWICK: Through gritted teeth, I think, would be a fair way of saying it. He was very disappointed to have come to this, and he must I suppose have felt that it was a level of personal failure, to have come to this. He was... I think it took him a little, a few weeks to acclimatise, because he had so many investigations recently, and inputs and negativity that I think he found this as a negative event rather than what I was trying, and I met him several times to persuade him-

PROF MONTGOMERY: So he saw it as one more thing, as opposed to...

DR BEWICK: Yes, that's when he said about 'how many times do we have to

be told we're crap?'

MR CLARKE: I think that would be true of his senior team too; they saw it as an added burden, and an unwelcome added burden, as opposed to an assistance or support or benefit. Initially.

PROF MONTGOMERY: And once it got up and running, how do you think the senior team saw it?

MR CLARKE: My personal judgement – and I don't think I've any evidence to support this – is that they acclimatised to it rather than ever seeing it as something that was really beneficial. But they ceased to see it as really negative. 'Okay, it's what we've got to do.'

DR KIRKUP: I think we get the flavour of that.

PROF MONTGOMERY: One of the things I'm trying to get my head around is whether it slowed down anything that they might have been doing internally. We had a phrase said to us about the degree of helplessness from the senior management, that somehow they felt that the power to do things was taken away. They were only responsible to the CQC or to Monitor, or to Gold Command. Does that ring any bells as a picture?

MR CLARKE: I don't think I rate Gold's influence as being very great in that. As I say, it was almost just kind of something they had to do, so I am not sure. I think that some of them might well have felt that it slowed them down in that they had to produce another report or attend another meeting, but I don't think it was the helplessness bit from Gold, would be my view.

PROF MONTGOMERY: Because from outside it could look like taking the

authority away from the Trust Board, sticking it in the Gold Command for the *n* months or so that they were there. Would that be a -

MR CLARKE: I think we tried to be very clear and fairly consistent that the emergence of Gold didn't change any of the accountabilities or routes, and I don't think I was aware of that being played through, 'Oh it's moved to Gold.'

DR BEWICK: No, I think...

PROF MONTGOMERY: And with all...

DR BEWICK: I guess that their initial response was one of, 'We are trying our best, why did we need another set of committees to persuade us what to do?' As opposed to, 'We can maybe get more resources, put you in touch with people that will help you.' That just wasn't what they initially thought, and I guess I wouldn't have thought that in their situation right away. I don't think it did, because they had to bring new people in to do quite a lot of this anyway, and remember there was going to be something had to happen, because Monitor had put them in breach. They weren't going to be left alone. This was just one of the methods. Had other things not been there, Monitor finding them in breach of their FT status, they would have had to have brought in an external consultancy to look at that management team and probably replace it, so to some extent we might have been a buffer. It could be perceived that we were a buffer against that.

PROF MONTGOMERY: How did you try and manage the risk that you might be adding unnecessarily to the burden? There was the governance review, the Monitor's requirements; there was a whole series of things

going on, and I could see if they felt they were doing a lot of new reports all around the same the thing that the burden of it would be quite obvious. How did you make sure that what you did pulled together those strands, because that's what you've described, the principal problems?

DR BEWICK: Well I think the thing is that we set it up, and it was quite explicit that it was in two areas that we were looking at, and we would not duplicate the governance review that Monitor were doing. Now, events subsequently meant that we had to look at other systems, but again we tried to purely concentrate on those two areas that we felt were high risk at the time, and the reasons why we set it up. So we were trying not to interfere with other organisations' ability to change things that they'd recognise were a problem, but recognising that for CQC that was the whole point, you know, they were doing the same work.

PROF MONTGOMERY: And did you have all your conversations you thought were doing those things were doing it to Gold Command, so you were getting the information from them and they were knowing what you were doing?

DR BEWICK: Absolutely explicitly.

DR SHABDE: And can I just add to that? I think several clinicians actually felt that things were moving forward, so there was almost a sense of, kind of relief that things are out in the open, and they're going to be addressed. So some clinicians actually felt better, but at the same time we'd highlighted that there was no cross-site working, that Lancaster thought Lancaster was the only thing within the Trust, Furness was the

poor relative, and Westmoreland Gen in the middle, you know? I don't know how they felt.

PROF MONTGOMERY: If I can push back a bit on that sort of issue, you didn't need Gold Command to tell you that. Report after report had identified that. So, what was the added value of Gold Command?

DR SHABDE: Because that was just one element.

PROF MONTGOMERY: Exactly.

DR SHABDE: Yes, because there were other issues.

PROF MONTGOMERY: No, I can see it more easily in some of the others, but there was something around... Perhaps we should step back. How long did you think you set it up you'd have Gold Command in place?

DR BEWICK: I thought we'd be through by Christmas. Yes, I thought that was realistic.

MR CLARKE: We could deliver that.

DR BEWICK: And I think I said to them it'll be at least three months, and should that sort of back ~~buck~~ CQC's position in a way, yes, at that time, and it was only when we realised particularly the complexity around the out-patient issues ~~one~~, which took ages to do. I mean, to be honest I was always looking for an excuse to stand Gold Command down, don't get me wrong. I didn't want to make my days longer by this. You know, you were trying to find positive reasons to stop it, and we had to, but there were certain things that happened because of the organisations finding other problems, so it would have seemed very strange to the public when new problems were arising that you would

have stopped prematurely. And in truth we got into a way of working together that I think became almost normal business for them, in altering the operations of the three hospitals.

PROF MONTGOMERY: That is interesting, and I'd be interested in hearing a little bit more about it, because I can see that you end up with something which is a bit more like a commissioning relationship with a struggling hospital. They try to make what is a shared problem and work it through, but you start with quite a specific crisis type model. What would have enabled you to stand down earlier? What were the things that you were hoping to have achieved that would have let you stand it down after three or four months?

DR BEWICK: Well, in terms of the maternity side, and children's side, I think that probably could have been stood down slightly earlier, because they had put a lot of things in place earlier. I still think we had issues over the staffing, and so I think if we'd got more security around the staffing levels I guess we would have done that. But the outpatients notes one, because we then brought in an external consultant, a medical director from Cheshire, to come in to look at some of the cases, because we were trying to describe whether harm had occurred by delays, and we rated those, the levels of harm. That took more time, and in fact the system that they were using that they were depending on was a relatively new system, in terms of the IT system, and that wasn't working. And we were discovering that people who were making appointments had absolutely no input into what those clinics were like, and so we had to develop a whole different system,

called the Hub, at the time, which probably had some wider... We all like to think that whatever we learned in these incidents has wider application, but actually this did. You know, there were certain things that we learned from that that were useful.

PROF MONTGOMERY: But that feels like core Trust business, doesn't it? Core commissioning business, as opposed to managing incidents.

DR BEWICK: Yes, but if we hadn't had issues around the A&E and the acute services, the acute stroke services, as well, then anyone could be... it could be argued that you could have dropped that one off earlier. But there was a certain reservation about whether the Trust initially had the capacity to do the investigation into the 12,000 notes. The expertise that North Lancashire brought in at that time, because they were leading on that particular problem ~~GBR~~ and they did that for the group, was highly complex, and I don't think we could have honestly ended it before we had some assurance that that system had been resolved.

MR CLARKE: For your point earlier, about how we were perceived in ending it, was of relevance too, both locally and further up the system, and there was a kind of reading of the context. Another strand which I think was into play at this was that the standing down goal was about returning to normal business. And one of the things we were very conscious of at that time was the capacity of ordinary business to deal with things, because we were beginning to enter the phase of organisational change, and all the uncertainties that went with it. And so there was a judgement about how strong the system is, how strong the relationships are, and how it would be read.

PROF MONTGOMERY: I'm almost done on my bits, I think. In terms of the upwards management, one of the functions of Gold Command at the stock take is to make sure the Secretary of State can be briefed on what's going on. How close was the interest you were receiving demanded by the SHA? I mean, how detailed were the reports on what was going on upwards, or were you more or less left to sort the problem?

DR BEWICK: We produced pretty detailed reports on a weekly basis.

MR CLARKE: After every meeting there was a briefing went up. I haven't a clue where it went.

PROF MONTGOMERY: And that went up as well as sideways, right. Okay.

DR BEWICK: I know it was read...

MR CLARKE: It was designed for up.

DR BEWICK: I know it was read, because whenever I met people in the SHA, they'd read it, so it was a straightforward as that.

PROF MONTGOMERY: They'd read it, and we've seen evidence that it went up.

DR BEWICK: And that wasn't infrequent, and I know local MPs, for instance, were getting briefings at that time. I did brief MPs occasionally, but it mainly was others that were doing so.

PROF MONTGOMERY: Now, from outside there's an obvious question about leadership in the Trust for capability, for capacity. Tony Halsall leaves a little bit later, near the end of Gold Command, but quite soon after that. Is that something that was discussed around the table, or discussed on the back of what you were learning at Gold Command

with the SHA?

DR BEWICK: Well, firstly it was never discussed during the process of Gold Command.

PROF MONTGOMERY: No.

DR BEWICK: At all. And in fact, I don't think I ever had a conversation about Tony's leadership with anybody from the SHA. Sue may have, off the record, I don't know. You'd have to ask her. I had private conversations with him about what we were doing actually to try and get him on board more, and, you know, till not that long before he went, and I was sad that he went, because he desperately was trying hard to do things, you know? But I think the reason that that decision was made was that he probably didn't get out of denial that this was as big a problem as it was. And his rather glib comments do beg the question of whether you understand when your organisation is struggling, and I guess he didn't fully understand that. I think that he... but certainly it was never a discussion, Peter, you might, at Board level? I can't remember that. It was not for us, it was for Monitor, and I think that was the basis I entered it. I was working with the people I was working with, and it was not in my jurisdiction to say whether they were... I suppose if I discovered a clinician there who'd been negligent in his duties, that would be different. There's another regulator for that, but in terms of his position I think that he was worn by continued attrition that was put under question, rather than an event.

PROF MONTGOMERY: Thank you.

MR CLARKE: There was some sort of expectation in some quarters that

Gold's emergence meant potential regime change and things, and I remember that's another thing that we were very clear about, that that wasn't a Gold function.

PROF MONTGOMERY: And that wasn't discussed by the ?governors ~~governance~~ for that reason.

MR CLARKE: Basically, about the governors ~~governance~~, in shorthand my perception was that the governors were a very dysfunctional group in a dysfunctional relationship with the Trust, and as I recall it, it was only on the resignation of Eddie Kane as Chair that there began to be any kind of emerging discussion about the nature of leadership.

DR BEWICK: That was very precipitous, wasn't it?

MR CLARKE: Yes.

DR BEWICK: That was completely out of the blue, and very, very quick, that he left.

DR KIRKUP: Sure. Geraldine.

DR WALTERS: So, you've said that Gold Command was set up to support the Trust and support the Executive. What tangible support did you give?

DR BEWICK: Well, firstly we through Angela Brown, Director of Nursing, and the medical director, we contacted senior obstetricians, senior midwifery, both from Manchester and Liverpool, to lend practical support.

DR WALTERS: What did they actually do, these people?

DR BEWICK: Oh, Manchester did a site visit, and gave them immediate help. I think they come up within a week to do that. A senior consultant obstetrician and midwives came. Liverpool, they were trying to develop

a more long-term relationship in terms of supporting particularly the midwifery and recruitment around that, and we also tried to mobilise improved recruitment at that time, which as you know has not been easy, because certainly England, I'm not sure about Scotland at the moment, but in terms of peripheral hospitals attracting them.

DR WALTERS: Did those things work? How many extra staff?

DR BEWICK: Well, they took time to work, but yes, I mean I think they got a new way of looking at how they might staff their services, including consultant-led on core paediatrics, where one of the issues that was highlighted, I think in one particular case, was that the level of clinical input at that time wasn't senior, and also that it wasn't consistent, and the assessments weren't consistent, and I think they put some clinical rigour into that at the time. So they were very practical ways. The second one was to support them in how they would respond to CQC's findings, and, you know, I've said before, there was recognition that there would be a resource issue here, and commissioners would commit to that at both SHA and the two PCT levels.

DR WALTERS: So how much did it cost you as a commissioner, I mean long-term?

DR BEWICK: In retrospect?

DR WALTERS: Well, sort of in terms of additional commissioning.

DR BEWICK: Well, I think the Gold Command itself, and the support we have to put in, cost around £2 million

DR WALTERS: Yes, and so was there any additional, would you say, commissioner support to underpin the service, long-term?

DR BEWICK: Well, one of the things we set up during and after Gold was a strategic group from both North Lancashire, and this was becoming CCGs, this was April/May 2012, as we were getting into the fledgling CCG position, so we were very keen to, not just ourselves as PCTs who were obviously declining in our governance role, and the increasing role of CCGs, in this to make sure that we had everyone together. And I remember a very icy night in Kendal, the first meeting we had with the fledgling CCG in North Lancashire, and ourselves in Cumbria, which was a whole CCG at that time, together to put in longer term support as well as an interim about how you're going to maintain and sustain that service. And I have to say that proved incredibly difficult. Not the meeting, and getting people together, and with the right people in the room to do it, but actually, some of the problems just don't go away. Staffing, when you've got a damaged Trust, even if you've got the best commissioning will and talk to your providers explicitly, which we did in those days, it's still not going to get staff to come without actually being really competitive in the market and getting that staffing. We still found that difficult.

So, I suppose to answer your initial question, there was a short term support, but we recognised from the beginning there would need to be a longer-term strategy that described how that Trust was supported in the wider community of children and families especially, and the provision of acute care. ~~And we went,~~ we did as much as we could, I think, to get expertise externally coming in, to put people of our own staff in with them to help with the review around paediatrics, and

maybe Neela'll tell you more about that from the maternity and children's side of this. But it was always like, we felt, we recognised that people would think that it was an intrusion, but we also did our best to communicate that we were there to support and not always to criticise, although there will be criticism within what we had to do.

MR CLARKE: I realise the focus here is particularly on the maternity end, but the out-patients element of Gold, it was directly through Gold that very practical, hands-on validators, as they were called, were recruited on a secondment basis from the neighbouring parts of the health community.

DR BEWICK: True.

DR WALTERS: To go through these thousands of cases.

MR CLARKE: To go through the thousands of cases and to do weekend shifts doing them and such like, and that was a very practical outcome from Gold.

DR SHABDE: Can I just add that clinicians were really quite pleased that there was support coming, and they were showing commitment to work with commissioners. Suddenly I was really welcomed into the organisation, both in maternity and in paediatrics. We were looking, you know, looked at the job descriptions; I was on their interview panel to appoint consultant paediatricians. They saw ~~really~~ that relationships as very important, not just to get the people they required but also within the organisation that they could push forward the agenda regarding paediatrics. And also, I think, their relationship with the Cumbria Partnership Trust was strained, because Ccommunity

paediatricians were employed, and are employed, by the community mental health trust (CPFT), so I think they needed to be working with community paediatricians in a more integrated way. So I think I was able to offer that kind of support to get them to work together, so I don't know how you'd cost it, but I think it was in terms of working very closely, and understanding both sides, you know?

The other thing I also raised with the Trust was that whenever new consultants are appointed what support are they getting., Ppeople think once you appoint a consultant everything is sorting out. The new consultants don't have that measure of experience; they need mentorship, you know, and who did they have on a mentorship programme with within the organisation. Quite often I would get that information from the medical director, saying yes they would put that in place, but six months down the line, there wasn't that support, so if you don't ~~you wouldn't~~ invest into your workforce in terms of leadership and mentoring and support how will the consultants deliver?~~ing~~. It's really quite important. That was beginning to happen, but that was non-existent initially.

DR WALTERS: What gave the assurance to close the Gold down?

DR BEWICK: I think it was, well, firstly it took time. We did a stock take, I think it was in the February, and we had positive things going around maternity staffing, around the flow of patients coming in being very good and orderly; good paediatric cover; the notes issue resolved; and there was some improvement in the organisation at the Lancaster end around stroke care and acute care at that time. And it was coming

together, but there were still issues around the police and the investigation there, and there were still issues around the governance of the organisation and not yet getting in place, because there'd been a lot of staff changes by that time, and we felt it was better to probably prolong it by another two months, and relatively low key. We went from sort of weekly meetings to two-weekly and things like this, to emphasise it was going away, but we felt that if we just stopped at that point, they may have slipped back. We were determined that all partners and stakeholders of that group, including local authority, which we included from the beginning, were in a position to feel confident that what we came to address had been addressed, and that there were sustainable systems put in place. And there were still concerns about the Trust that never went away. We put this ICG in place which was to continue to monitor it as commissioners, just for, I think, our own reassurance, and especially as we were going into a completely new commissioning world at that time, and the CCGs were very keen that we kept some hold on it. Of course, the mechanism is that we would recommend to SHA whether the Gold could be stepped down, and they had to be assured that we had fulfilled that purpose, and one back to near as normal business as we could.

MR CLARKE: I think that was an important point, because it was about the 'It has reduced to a level that's more manageable under normal mechanisms, rather than everything is solved or sorted. So it was 'Is Gold added element still required?' rather than 'Is the problem solved?'

DR WALTERS: Just looking at some of the themes for shortage of staff and

staff capacity, clinical disengagement, long-term recruitment and retention difficulties; not very good risk assessments; low volume activity. I mean, I appreciate, because I've been involved in similar things myself, that getting everybody together round the table, trying to locate and pull people in, and also generating lots and lots of action plans and emails, which is sort of what we can see, is something that you do, but do you really think that that exercise was going to address these very root cause, cultural issues in action plan format, and if it's not, were you satisfied to keep commissioning the service afterwards?

DR BEWICK: Firstly, I think we set an environment that changed, in the sense that all of the things that you've listed just there were commonly known and shared by both commissioners and the provider, and they knew they would have to work differently. And at that point I remember Stephen Singleton, who was still the SHA regional director, came in to give some extra input into that, and of course as he's changed he's maintained an interest in that. So I think there was nothing further that Gold would have added by continuing, but we had set an environment where – the CCGs especially by then - we were trying to make it their core business to sit down with your provider and make rational decisions about how you do this. To be honest, I don't think the PCTs ever did. And there was more credibility, because there would be six or eight GPs in a room and not six or eight managers. Now, our PCT was unusual: we had recruited a lot of GPs and a lot of hospital doctors to lead on things, but that wasn't the case in all PCTs at the time, so the Trusts had a suspicion that the management would do what

management does. But I think with a fair wind they were in a better place to improve services.

MR CLARKE: I think we'd also seen the significant changes within not just the personnel but the mechanisms within the Trust, and Gold had presentations from the programme office people which gave a lot of assurance that there was a framework for ensuring that the necessary tasks were being taken forward, and there was a very strong momentum given by Sir David Henshaw when he came in as the interim chair to a sense of getting on with the task and moving from the culture I was describing earlier. We needed to shift away from that sense of we're back to, 'we just cope with it' to 'We can change this.'

DR WALTERS: Yes, I think some of those aren't tasks, though, are they? I think we have seen a little bit of something in an action plan which looks like a cultural objective and then it's got 'met' in the right hand column.

MR CLARKE: Absolutely. But it feels as though Gold's presence was to with art rather than science, and it was about whether there's a feeling that this organisation is managing what it's faced with or not, and there was both specific actions and organisational processes and the kind of relationship and attitude that had begun to shift in a way that gave more confidence that the more long-term agenda that it was needing to address with those themes was being tackled.

DR BEWICK: Can I give you an example? At the end of all this, we were just starting to talk about transparency agendas and duty of candour ~~[inaudible]~~, and I remember a really quite enlightening conversation

towards the end of Gold and into the next phase about how the Trust would manage that now, and how their Board would ensure it. Now, that would never have occurred six months ~~previously~~, or eight months previously, and to be honest there were people in the room who understood what it meant, as opposed to saying the words, and that was... as you say, the art of this is perceiving that you've got confidence in people to do something different, and certainly by the end of it I think there were people sitting in the room who were not defensive anymore, who were quite proud of what they'd done, and were looking forward to what they were going to do, and that was different than being defensive and critical of external scrutiny.

DR SHABDE: I can think of one example also, I think programme office had completely missed about safeguarding, not because they wanted to miss but I think once that ~~that~~ was pointed out to them and they readily accepted and put it right on the top of the list, and I think they were much more willing to take on board and didn't see it as a criticism, but their attitude was 'Right, how do we work together to move things forward?' ~~But~~ If I could just mention another example, that the maternity and paediatric sub-group wanted to continue in some form or shape after Gold was stood down, because they felt that that was the right way to take the agenda forward, the strategy, you know 'We can all kind of work together,' but Trust at that time had embarked on a clinical strategy development, and there was another issue, because David Henshaw was in Chair, and I think the CCG kind of got involved; that (clinical strategy development) had to, obviously, change, because

the way that was going wasn't progressing, and it changed it's tack ~~attack~~. But I think people were really looking forward to getting into the discussions about the strategy of improving services, and you could see a real commitment coming out. People really wanted to make things better, as most people go to work to do, to make a difference and to do a good job. So that was beginning to emerge.

DR WALTERS: I think it's important that these things are said, really, because otherwise, if you're the man on the Clapham omnibus you could say, actually, all this – meetings, action plans - all happen when everything has gone terribly wrong, with the dogged determination of one individual to keep it on the agenda. So, with hindsight, do you think your scrutiny prior to all this should have been any different?

DR BEWICK: It would be impossible to say no to that question, because hindsight, picking up threads-

DR WALTERS: What might have been possible?

DR BEWICK: I think that, I wish I'd had the conversation with James the month after his child died, not several years later. I found, bizarrely, that conversation quite energising in the fact that you had to do something different. And much as we had set up Gold and there was lots going on in terms of the questioning, it was that that galvanised me into knowing that actually there should have been a different mechanism in place to listen to that type of complaint, rather than it going through ombudsman, coroner, a whole heap of other people who were so far removed from the workplace that nothing will happen.

DR KIRKUP: Doesn't it go to the clinicians who were responsible for the care

in the first place, though?

DR BEWICK: Sorry, I didn't catch you.

DR KIRKUP: Isn't the initial point of contact with the clinicians who are responsible for the care in the first place?

DR BEWICK: Yes. I accept that, but as a commissioner, as a doctor in that position, I just wish that sort of conversation had happened earlier, because there is no way you could explain that away without looking at the system around the decision making that was there, and I guess the SUI system, and learning a lot about that at the time, led us to question whether they were changing things, but I suppose, if I was being critical of myself – I'll leave colleagues to do that themselves – there should have been an open door to patients to come and see us earlier, and that, I think, would have probably given us more insight into what was going on.

DR KIRKUP: Thank you.

DR WALTERS: Okay.

DR KIRKUP: Right, I am conscious that we've going for nearly two and a half hours. Are we likely to be through in the next half hour? Because to be honest if we're not I'm going to suggest that we take a break, otherwise we'll be accused of cruel and unusual punishment.

PROF FORSYTH: I am not going to take that long, but my colleagues haven't spoke yet.

DR KIRKUP: That's fine. Go on, Stuart, the floor's yours.

DR BEWICK: I am happy going on.

PROF FORSYTH: I was actually going to pick up on what Geraldine has just

touched upon. I'll let you refill.

DR BEWICK: Water deprivation would not be good.

PROF FORSYTH: I have found this morning very interesting. There've been a huge number of agencies, individuals, manpower, womanpower work, cost, gone into this. To go back to the original root of the problem, you've got a small hospital with a small maternity unit providing about a thousand deliveries, or just around that, a year, and with some issues, and it seems remarkable that that was not managed at the time, and we've sort of catapulted into all these issues. Now just, again, really picking up from what you've just been answering from Geraldine, retrospectively looking back, what were the critical issues, the critical times when actually something should be done, and why not? Part of our remit is what are the learning points from this, and clearly you've said that discussion, and fairly personal conversation took place at an early stage, but are there other things that you feel from your perspective, and taking into account other people's perspectives on this, could have been done back in 2008 which would have reduced the suffering of the families, the staff as well, and many other people associated with this?

DR BEWICK: I think commissioners have very little effect on maternity units, and I still think this is true. I think the way maternity units are run, they're pretty autonomous, they're not funded in the same way, so they happen, enough people are recruited to do, and there is less scrutiny of how they work than other parts of the system. I don't think that's correct. We have internal enquiries, we have all the usual things that

have been put in place in terms of all this, and I think that the solution to maternity is not found in a Trust or a trust and a commissioner. It's found in a network. Having done this now and various other peer reviews and CQC reviews, it strikes me that we have an opportunity to describe a networked solution to a service, rather than automatically people thinking you're coalescing trusts together. Now, we do this for cancer services, effectively; we do it for trauma services now effectively; but we don't, in my opinion, do it for maternity services, and the reason we don't do it like this is because of what you were saying. If you've got a paediatrician who doesn't have enough experience, they're not going to stay. It's not interesting enough. But if you can cycle those around, it's almost like National Service that you go to these trusts to run it, because all you've got to say that we will put a different type of service in, which doesn't have everything, and it requires more people to transfer. I suppose if you took Aberdeen, where you bring people from the Islands in and put them in a situation where they're having planned maternity care towards the end of it, you'll still have tragedies, because of premature birth and things, but we have to think differently.

And I don't think a trust can be expected on its own to do that, so I think, getting back to your point, I think we should have had, and I think we tried to do that following the Mitchell Report and then bringing other expertise in to have a maternity, a children and families policy. Now if you look at the national children and families work, years ago when we had it for diabetes, for the elderly, there was one for children,

and very little was done, and because I don't think – and I'm probably speaking completely to the converted – that there is enough, in commissioner's eyes, or in governance eyes, on those services until things go wrong, like safeguarding has gone wrong in particular parts of the country, or you notice that your cancer deaths are higher, or your early intervention cancer isn't high enough in children. So we tend to be reactive for this group, as opposed to being proactive, and I think that we attempted to be proactive but realised that there is no support across a wider system. And by 'a wider system', I mean that it should be Newcastle's business, if they're training those obstetricians and midwives, say, to come across the north, or Manchester's in the south, to have... it's as much their business, the staffing of Furness General, to make sure it's safe, or to at least to describe what would be safer and explain to the population that you need to do something different. So I suppose my long-winded answer is, we should have had a more robust maternity and children's commissioning policy at that time. I think when we discovered we needed one, we acted upon it to try and do it, but I think we were not atypical.

MR CLARKE: Not by way of defence for not having it at that time, but just an added dimension for me is the scale of the Cumbria agenda, and the fact that with the benefit of hindsight, perhaps wrongly, but nonetheless at the time for very good reason there was enormous focus on the north Cumbrian issues. And it feels to me as though had the organisation been able to be looking both north and south more consistently, then some of the avenues for spotting the problem and

some of the strength of the relationships for solving the problem might have been different.

PROF FORSYTH: You can increase your critical mass then as well, in terms of patient numbers, and delivery numbers.

MR CLARKE: Yes.

DR SHABDE: Can I just come in? I think commissioning was so different, and I've worked in the Health Service for 30 years plus, and I think in those days, in the early 1990s and later people talked about commissioning but that wasn't refined at all, or sophisticated at all. And I think over the years, you know, with the world-class commissioning things are talking more about specifications and how that should be monitored, but I think the commissioners' general view is that they lacked clinical input and expertise, so I think that the commissioners that were commissioning services were really quite different in terms of, you know, finding solutions. I think, as Mike says, I do believe that there isn't a solution for places like Morecambe Bay for the individual trust to come up with an answer. If there was a solution, it would have happened 20 years ago, so I think that a networked solution, it has to have a collective responsibility of preventing these kinds of situations, and I do strongly believe that network is the way forward, and how we do that obviously needs a lot more further discussion. So I think that commissioners, the commissioning responsibilities and the way they performance manage now is very different. Often the contracting process was the way to see whether they were delivering the numbers. The quality came in quite late, really, in the last few years, that people are becoming more about

quality and harm-free care and all the rest of it. So yes, I think that hindsight, yes, things could be very different and as we learn we need to look at more radical and different solutions.

DR BEWICK: Can I make one other point, and that is generally we're becoming a more metropolitan society? People want to stay nearer their points of initial training. They tend to have relationships with people and want to stay in those places, and as much as maternity and children's services is, you know, I could take you now in any part of peripheral England and describe to you general practice that cannot recruit, acute medicine that cannot recruit, emergency departments that cannot recruit, because this is fundamentally about recruitment now, of who comes in as clinicians, and where they come from. There is no ownership now, socially, of the problems that you're having to deal with, and people tend to stick with their own. I have said it in print before, but I do think we have got to look at the points ~~pints~~ of entry into medical school - and particularly that's the bit I know about; I'm sure nursing's the same – and the actual reasons people are going into it and what they want to achieve out of it, because we are losing that local society view of it. And Barrow has supported its hospital throughout this. James Titcombe and others got hate mail because they were saying things about the hospital, and threats at times, and the same happened, we know, in Mid Staffs. Communities are very strongly around keeping their services open, and we have to understand that and respond to it rather than just saying it's a problem for them.

PROF FORSYTH: But that can be done. You keep services open, but just make sure that the level of care they provide is appropriate, and that's where I take it on to what I think is probably still a current issue, but certainly an issue back in 2008 and around there, of what you have in Barrow, which is a relatively high level obstetrics service, but a level one neonatal unit. And I think a number of the issues arose because – and I mean, you can expand on this - obstetricians are clearly wanting to look after some high-risk women but there was not the neonatal support for when the baby was delivered. Do you think that is a fair comment?

DR SHABDE: Yes it is, because their paediatric recruitment was always a problem. They couldn't get paediatricians of high calibre, you know. In fact, the paediatricians didn't even have dedicated neonatal sessions, and I think that was mentioned in one of the reports, that they needed ~~had~~ to have a lead for neonatal services within their organisation. Because there were not enough people, how many lead roles can you give to different people? And people are reluctant to take that on, because they are disempowered, dysfunctional, disaffected, and the culture is of a 'can't do' approach, rather than can do. Given all that, it is very difficult for an organisation that was concentrating on other services to really take on board those kinds of issues. It can be done, but I think you need to have staff, isn't it?

PROF FORSYTH: Yes. And so thus you need to modify the service there. It doesn't mean to say you're closing the service or moving the service or anything like that. You need to modify it. In terms of paediatric

services, what was your view on paediatrics' relationships with obstetrics and with midwives? Have they been difficult?

DR SHABDE: I think they were kind of distant, and not really working together. I think they would do things when they were called, but there wasn't any proactive approach to say 'Right, okay, how can you look at developing this service?', or 'This thing didn't go very well, can we learn from this?' and have better relationships and better culture, really, within how we can work together. More a multi-disciplinary approach than just paediatrics doing their bit and midwives doing their bit, and obstetricians doing that bit. I didn't feel that there was enough dialogue, enough conversations happening. It's like having a staffroom where midwives, obstetricians and paediatricians went to have a cup of tea. You have much better rapport and much better conversations, and that didn't happen. I know midwives didn't even have a proper staffroom to go and have a break or something. It's changed since then, because I have been to see that, you know.

PROF FORSYTH: Yes, there were some disciplinary issues around paediatrics as well. Are you aware of these?

DR SHABDE: Yes I think it took a long time for some of the issues, that it's something in the way the consultant contracts run and they can have legal representation and, you know, the whole process can take very long, but I think two paediatricians were not allowed to do clinical work, but they were allowed to come to the office and do audit and things like that, so clearly that impacted upon the capacity.

PROF FORSYTH: What is the current decision regarding paediatrics in terms

of paediatrician numbers who are actually working?

DR SHABDE: I think the numbers on the face of it, they are going to go for advert, because one of the paediatricians who had the disciplinary issue has kind of accepted that he would be allowed to go, not going to be allowed to continue with the clinical practice, and the other one is getting some further training, etc. They still need to get to the consultant-delivered service. They need a minimum of eight consultants, and I think-

PROF FORSYTH: Eight consultants.

DR SHABDE: Yes. Yes.

PROF FORSYTH: That is just for Barrow.

DR SHABDE: That's for Barrow. And Alan Craft ~~Croft~~ did the review of paediatric services and he said if you want to really get the proper consultant on-call system, you will need at least 10 to 11. And you're not going to get 10 to 11, realistically, because you won't have enough clinical workload, unless we have a system - because RLI is still part of Morecambe Bay, and their activity's not great but it's slightly more than Barrow – a system where they can really rotate and get involved wider, if you go wider than that, as part of a clinical network, so they can all get their special interests going and feel good about some specialty interests that they can do. We won't get the right calibre of people going through Barrow.

PROF FORSYTH: So what's your timescale for getting a complete resolution to obstetric, maternity and paediatric services?

DR SHABDE: I am sure you've heard about the Better Care Together

strategy, it's being driven in the south by both local area teams and CCGs and the Trusts, so within the context of that they're looking at the paediatric models as well as maternity, and all services, because you can't just look at these services outwith the rest of the services, because paediatrics will have an impact on A&E and obstetrics and everything else. So that strategy is continuing, the clinical strategy group is continuing that work, and I think the timescale, sometimes the timescales keep being pushed, you know.

PROF FORSYTH: If we were publishing our report in December, say, and Bill was chairing the press release, and the first question was 'are the services safe in your area?', what would the answer be?

DR SHABDE: They could be safer. I mean, they could be.

DR KIRKUP: It is not going to be a winner with John Humphreys.

DR SHABDE: I think I said before, at the moment the way the rota is running they are, I can't say definitely with hand on my heart that there won't be any safety issues or safeguarding issues, you know.

PROF FORSYTH: To go back here, this has now been going on for about six years. 2008 was when things began to really surface, and here we are in 2014. It's going to be difficult to say that despite the huge input from a huge number of organisations, healthcare organisations, expensive organisations, that we cannot say that these services have been reorganised, they are now safe and sustainable.

DR BEWICK: Can I just say, I don't think it's, to be honest, your job to do anything but tell the truth. If you think that they could still be improved, and you recognise within the running of this inquiry that there are things

that need to be done now, you'll presumably act upon them.

DR KIRKUP: Absolutely.

DR BEWICK: So I think what's more important – to me it's more important – is are the building blocks in place, that the right people are making decisions about improving services? And I think that what you're describing is – and I'm away from this now, locally, but keeping an eye on it nationally – it seems to me the right people are there. Whether the resources are in the right places yet, and whether you've got the adequate staff in there, I think is something that they're still troubled by.

DR SHABDE: Yes, I mean, there are issues that you can obviously improve, for example with the Joshua Titcombe case, that midwives did not know that not maintaining your temperature, you know, low temperature could be a sign of infection. They kept putting Joshua in the cot where they could, so a heated cot if you like, and all the midwives actually said that they were not aware that unstable temperature or low temperature in neonates should be of concern, so you can improve in terms of their education, in terms of audits, in terms of guidelines-

DR KIRKUP: And if we are putting I think my slightly flippant response to one side, the key thing is, are you satisfied that they are safe enough to continue commissioning services from, because you're in the CCG?

DR SHABDE: I think I would say that a lot of improvements have been made. I know that they have got better policies and procedures, and they are doing audits, and I couldn't say that there won't be any untoward incidents, as I couldn't say it anywhere else in the country.

DR KIRKUP: But that depends on how you define safety. Safety isn't a complete absence of untoward incidents, because if so there isn't a safe service in the world.

DR SHABDE: Yes.

DR KIRKUP: We have to be careful about what we mean by the term. What I'm saying to you is, it seems to me that you are regarding the service as safe enough at the moment to continue commissioning services from it.

DR SHABDE: I think it's important that all the systems are in place to make sure that the right services are offered by the rightly trained people at the right time, so that the outcomes can be as good as, in those particular clinical cases.

DR KIRKUP: Yes.

DR SHABDE: I don't think anybody can give guarantees that there won't be any kind of untoward incidents.

DR KIRKUP: No, I accept that, but we're saying that's not included in the definition of safety.

MR CLARKE: It seems to me -

DR KIRKUP: But mechanisms to look when things go wrong, and to learn from them and ensure that the systems are improved as part of a safe service, do you think that those are in place now?

DR SHABDE: I think there are much better systems in place ~~pace~~ now, in terms of ~~whether~~ sustainability, is an issue, whether they could remain sustainable.

DR KIRKUP: Did you look historically at how they'd investigated incidents and

dealt with them? Did you look at them, or were you concerned?

DR SHABDE: I think historically the Trust would admit as well, the RCA training of the people who were looking into incidents wasn't really as good as it can be. In fact, there were no incidents being reported, so I think since they've got better systems in terms of ~~they've allowed~~ reporting incidents so that they can learn from them early on, rather than waiting for a serious incident to happen. So yes, from that perspective things are changing. Patient experience and patient feedback is being taken on board, in terms of 'I want great care,' etc, so, yes I think a lot of progress has been made, but I'm concerned about the sustainability of services as well.

MR CLARKE: That's the point I was going to make, because I was going to say it seems to me from a lay impression that an awful lot has been done about mitigating risks in the world as it is. The sustainability question has not been answered, and as a south Lakes resident I can't sit here and not say that I think it's taken an extraordinarily long time for any kind of clinical strategy to emerge, and that it is very difficult to justify the length of time that that's taken. That's not necessarily the CCG's fault, or the Trust's fault, but it's a fact of the system, and it's going to be a long time, as I understand it, before we see that product actually emerge in terms of a change of services which are potentially sustainable.

DR WALTERS: I think it is hard for the general public to see. I mean, we heard yesterday that the Trust back in 2005 had looked at the cost of services, and that running the Furness unit, they had to cross-subsidise

it, but Furness unit had to stay without any additional finding to support that. But they said the unit is too small, and they didn't have theatre access very quickly in the middle of the night, but everybody was happy for that to continue, so that, I think, pushes the responsibility now to the Trust, and actually it should have been a clinician responsibility.

DR SHABDE: Yes, I could comment on that because I know there were six PCTs in Cumbria at that time?

DR BEWICK: Not quite.

DR SHABDE: Or three, four, I don't quite remember, but there were too many commissioning organisations, so I think sometimes the real issue.

MR CLARKE: There was one commissioning org for that part of south Cumbria. Morecambe Bay PCT.

DR WALTERS: The challenge with commissioning, really, is commissioners have got to say 'This is not a safe service to commission,' because otherwise we all collude in it, don't we?

DR SHABDE: ~~No,~~ I agree. I agree with you.

DR BEWICK: And in fairness that's what we did, in fairness, but it took time.

DR KIRKUP: Okay, we don't want to go too far into a debate about what the issues are.

DR BEWICK: Can I just say, in terms of... it's been a while since I've been involved at this kind of micro level, but one of the things I can say is if you look at the reporting of serious untoward incidents and what happened because of them, there was a transformation of that in that two-to-three year period. So there were some processes put in that

have been repeated that have shown that they deal with these in a more grown-up way now, and they act upon them.

DR KIRKUP: That is what I am looking for, and I wanted to know whether you were aware of how poor it had been.

DR BEWICK: Rather than saying that every service every time will be perfect, it's not the case, obviously.

DR KIRKUP: Yes, exactly. Exactly. That's why I was pushing you a bit on whether you realised quite how rudimentary the reporting and the investigation of incidents had been in the past.

DR SHABDE: I was, yes, and I think I was quite-

DR BEWICK: You were very disappointed in the quality of reporting when you came in.

DR SHABDE: Yes. Certain things should not happen in the 21st century, and the practice was still happening like that.

DR KIRKUP: Sorry, Stuart. Are you finished? Anybody else want any?

PROF MONTGOMERY: I was going to ask a question along the lines you were suggesting. There were two particular cultural issues that came up in the discussion, and I'd really like to ask whether you think there's evidence that they've changed. One is about cultural denial, and the second is about these professional relationships and the silos between the midwives, obstetricians and paediatricians. Is there any evidence that those things have changed?

DR BEWICK: Can I answer the first one and ask Neela to answer the second? I think certainly at the end of my tenure in Cumbria and in the north, I saw definite evidence of the former on that. I think when not

just the Gold Command being stood down but when we got past the stage of more detailed monitoring, I think they were bringing things to us; we weren't asking for them, and that's how I would demonstrate it. But in terms of the relationships between the departments, Neela...?

DR SHABDE: I think my observation is that they are improving, but a lot needs to happen to continue that improvement. I wouldn't say they are absolutely brilliant, you know.

PROF MONTGOMERY: And is it your sense that the Trust is working to improve that, and who's taking responsibility for improving that?

DR SHABDE: I think, I think the clinical director for the family division is a paediatrician, who is doing his best, but I think the Trust being on three sites does provide a major problem in terms of one person having to kind of be present in all three places, and I think they are looking at developing clinical leads, so that there is a better kind of support and working within the local units as well. So, for example, Furness General, if you have a clinical lead who people can see and go and talk to them, you know, you've got an open door policy, rather than the clinical director being present in all three places, so they're looking at that, yes.

PROF MONTGOMERY: So if I went into Furness General and there now is a space where the midwives and obstetricians and paediatricians can have refreshments, would the midwives be in one corner and the paediatricians in another, and the obstetricians in two corners not talking to each other, or what? Because I take it from that the answer to my question on the Trust accepting there's a problem that has to be

grappled with is that there's good evidence that they are now on the case, as it were.

DR BEWICK: I think that's a Board thing, isn't it?

PROF MONTGOMERY: I take from your response that we don't really know whether it's any better.

DR SHABDE: I don't know for sure, but I think I'd like to go and have a cup of coffee there.

PROF MONTGOMERY: Thank you.

DR SHABDE: And find out.

DR KIRKUP: I say this with slight trepidation, but is there anything else you'd like to say to us for the recording?

DR BEWICK: No.

DR KIRKUP: Alright. Thank you, thanks very much. If any of you would like to come and see us, do feel free.

DR SHABDE: So if I did think about two weeks later if I wanted to come and talk to you, would that help?

DR KIRKUP: Please do get in touch, yes. You have ...

DR SHABDE: Right, fine.

DR BEWICK: Thanks for your time and patience.

[End of Interview]

THE MORECAMBE BAY INVESTIGATION

Monday 1 December 2014

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

Before:

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

LINDSEY BIGGS

Transcript produced by Ubiqus
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(At 11.56 a.m.)

DR KIRKUP: Thanks for coming. My name's Bill Kirkup. I'm DR KIRKUP of the Investigation panel and I'll ask my two colleagues to introduce themselves to you.

PROFESSOR FORSYTH: Good morning, my name's Stewart Forsyth and I'm a paediatrician and a Medical Director from Dundee.

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

MS BIGGS: Okay.

DR KIRKUP: You'll see we're recording proceedings, and we'll produce an agreed record at the end. You will also know that family members have been invited to be present, as observers, but as it happens, we don't have any this morning. They may listen to the first part of the recording – I say the first part, because we will signal that we're moving into a second part of the session and we can talk about any clinically confidential details and that part of the transcript isn't available to anybody.

MS BIGGS: Right.

DR KIRKUP: You'll also know that we've asked you to hand in any mobile telephones, laptops, anything else that might be a recording device; that's just to emphasise we don't want anything to go outside the room here until we can produce the report with all the findings in context. Do you have any questions for me about the process?

MS BIGGS: No, I don't think so.

DR KIRKUP: Okay. Thank you. I'm going to start off with a very general question, which is, could you just outline for us the – when you started at the Trust and what you've done since then?

MS BIGGS: I started at the Trust as an employee of the Trust, in April of 2002 as a staff nurse. I very quickly then commenced my midwifery training in the August of 2002 and completed that in the March of 2004. I then – because of the job situation at Morecombe Bay, I then went and spent 12 months as preceptorship midwife at the University Hospitals of Central Lancaster – Lancashire, sorry, here in Preston. And I then got a midwife job at Morecambe Bay at Barrow-in-Furness in the April of 2005. And I've worked

as a staff midwife since that time. I also have spent 15 months acting up as a band 7 midwife during that time and I've recently become part of clinical governance team as education midwife.

DR KIRKUP: Okay. Just on one aspect of that, you said in 2004, because of the job situation, you went and worked here in Preston for 12 months, does that mean there were no posts...?

MS BIGGS: There were no jobs – there were not posts, no. Myself and another midwife – because we only had two students at the time, because we were post registration, midwifery students, there was no direct entry at that time, and there were no jobs for us at all.

DR KIRKUP: Okay. Thanks for clarifying that.

MS BIGGS: Okay.

DR KIRKUP: Okay. I'll ask Stewart to carry on with questions.

PROFESSOR FORSYTH: Thank you. So when you first started in April 2005, as a staff midwife, where were most of your duties at that time?

MS BIGGS: Most of my duties at that time were on the – well, between the postnatal ward and the labour ward. Yeah. I didn't do – I didn't work in the community, I didn't work in clinic, I was basically just in hospital on those two wards. But time is probably equally split between those two areas.

PROFESSOR FORSYTH: And has that changed since then, or is it exactly in your job description?

MS BIGGS: No, that hasn't changed. I mean, obviously, when I was acting up as a band 7, I was a labour ward coordinator, so all my time was spent coordinating the labour ward. And then I've just – went back into the band 6 role and...

PROFESSOR FORSYTH: So when did you go up to band 7?

MS BIGGS: It must – was it December of 2010? I think, yes. December 2010.

PROFESSOR FORSYTH: So you went up to seven about 2010 and then you were – sort of re-grading at that time – after that?

MS BIGGS: No, it was just a temporary post...

PROFESSOR FORSYTH: So that was a temporary post?

MS BIGGS: Yeah, it was a temporary post due to – there was a lot of sickness and there was some band 7 – there was a band 7 midwife on long – on maternity leave and things – so they were temporary posts.

PROFESSOR FORSYTH: And so went back to band 6?

MS BIGGS: To a band 6 post.

PROFESSOR FORSYTH: When was that?

MS BIGGS: That was February of 2012, I think. Yes, it was 2012, February.

PROFESSOR FORSYTH: So tell me, when you first started there, has – back in 2005, has the sort of – the unit changed during that – during the period of time until now?

MS BIGGS: It's...

PROFESSOR FORSYTH: In the way it –

MS BIGGS: Yeah, it's unrecognisable, really. In my view, it's unrecognisable as to what it was, back in 2005. Yeah, in...

PROFESSOR FORSYTH: So do you think the big differences you've seen?

MS BIGGS: I think – one of the main differences is that we now have a more robust clinical governance structure which we never had before. Which has allowed more education, you know, people are being released for study days which never happened, you know, we used to have in-house study days only, and – we now have more staff because it was recognised that we were grossly understaffed than – we have more bodies on the ward, a lot of them are agency midwives because we do have difficulty recruiting, and I think that's probably the main difference really.

PROFESSOR FORSYTH: So the – so in terms of supporting the establishment, the midwives, do they continue to do a lot of agency work or bank work on top of their normal allocation of hours?

MS BIGGS: No. I think – what happened in the past was, because we didn't have a bank, we didn't have a midwifery bank at all, really, we didn't have agency midwives, so we – we either covered the extra shifts, or the shifts were left short, and that was just the way it was and then we – we were given agency midwives, so therefore people could have the amount of time off that they needed, you know, they were only needing to work their contracted hours. There are some midwives that do work over, but that is purely their choice. If they want to earn extra money, then they can do that, because it is still cheaper than employing an agency midwife, but they are not – they don't feel like they are forced to do that, because the shifts won't be short, if they choose not to. So it's – it's entirely on a personal, whether they want to or not, really.

PROFESSOR FORSYTH: So you touched upon key governance changes that have

taken place; and when did they begin to take – to come into effect?

MS BIGGS: I think it was following the appointment of the new head of midwifery, Sascha Wells. I think she – when she came to the unit, I think she clearly saw that we had one risk midwife who concentrated on sort of the patient quality aspect, but all the other areas were missing from – all the tiers of governance were missing. And I think she started that ball rolling and getting people into post and you know, we'd never had any – there was no formal audit, you know, there was no research midwife. There were no education midwives, we – we relied solely on in-house midwives that happened to be also instructors, to teach us our – to do our skills drills with us every six months and that was what we were relying on.

PROFESSOR FORSYTH: So looking back, where do you think the weaknesses were in the practice in the day to day care of [inaudible]?

MS BIGGS: I think, looking back, I think that we didn't realise how much trouble we were in at that time. I think – I think geographically, we're very isolated and I think it's very difficult to employ people from outside, to bring their ideas and what's going on in other units. I think, at the time as well, with – with the state of the finances of the Trust, services were being cut, and by services, I mean like actual staff on the shop floor were being cut, equipment wasn't being upgraded. We weren't – we were given our mandatory training, which was – like I said, it was in-house on a six monthly basis and we were relying on our own staff to teach us and you only know as much as what the person teaching you knows, don't you? And I think that was a big problem. And I think it just had a snowball effect really. All these different components put together, meant that the service was failing. And over time, it just got worse and worse and worse.

PROFESSOR FORSYTH: And did you – you're back at work, been off work for a while, is that right?

MS BIGGS: Yeah.

PROFESSOR FORSYTH: I just want to know about how the unit felt today actually, does the unit feel much more informed and confident, or is there still issues as you see it?

MS BIGGS: I think there's still issues; I think the issues that are there now are ones of fear.

PROFESSOR FORSYTH: Fear?

MS BIGGS: Yeah. I think – practice is very defensive, I think the section rate has gone up because everybody is fearful of what could happen, really.

PROFESSOR FORSYTH: So, that's your main thought about it. Is there anything else around that that you feel would be helpful for us to know?

MS BIGGS: At – well, just – there were – just little things really, there's still the use of agency staff and things like – you know, when you haven't got your own staff and sometimes we have a lot of agency midwives that have worked with us for a number of years now and they feel like part of our team, but then sometimes, you do get new agency staff and it's – it's just tiring because, you know, you've different faces on different shifts and having to go through everything with them all the time; I mean they're competent midwives, they can look after women, it's just the – the peripheral things that just are a little bit time consuming, really.

PROFESSOR FORSYTH: What about your relationships with obstetricians, do you feel that that has changed over the period of time as well?

MS BIGGS: I think – I think it has; I think the – I think previously – I've always had a very good relationship with the doctors that I work with, I've always had a very respectful relationship with them. I think there were a couple of consultants there while I was – obviously while I was training, they've been there a very long time, and I felt they were unapproachable, but that's my own opinion of that and I think that's just because I – you know, I – they'd been there such a long time, I didn't feel like I could approach them about anything. Whereas the other doctors were very approachable, you know, the registrars and things were very approachable, and I did have a good relationship with those. I think now, because we have some new consultants, that have come into post since I've been working there, they are approachable, and I think when they first arrived, they're new consultants that have come from – you know, they've been working in other places as registrars, so they've kind of inject a sort of new bit of life into their post really, and I think, yeah, so I think the working relationship is better, but I'm not saying that it – for me, it's better, but because, obviously, I felt the other two were – the previous two consultants were untouchable really, and I didn't feel personally that I could discuss anything with them.

PROFESSOR FORSYTH: Is there ever any intention about women being maybe delivered in Barrow who might have been better to have been transferred to a larger centre or specialist centre, or is there any – or is it fairly straightforward, is it sort of general consensus as to which women are high risk and which women are low risk?

MS BIGGS: Yeah, I think the women that we – the women that we care for, and I think this has always been the case, the women we care for is set by our paediatric staff, I think, because – because of the – the facilities we have, on our special care unit, it has a knock on effect of the women that we care for. If our SCBU can't handle the gestation, then these women need to go, if it is safe, and we have had cases where women who should have delivered elsewhere, however, have come into our unit in established labour, and it has been unsafe to send them, because geographically, they're not going to get to another unit within 20 minutes, you know, it's at least 45 minutes to Lancaster, if you have a clear run, you know, these are the things that we have to think about. It's not just, 'Can we look after this woman?' you know, is it 'Actually safe to transfer her at this time?'

PROFESSOR FORSYTH: Does that then present difficulties when the baby's then born about decisions about transferring the baby out – them mother out at that time?

MS BIGGS: I don't know that, because it – that would then be in hands of the paediatric staff really. I mean, the paediatricians and the obstetricians work – have – I mean, I have overheard discussions on the unit, you know, 'We can't possibly send this woman out because she's in established labour and she might deliver in ambulance', and when you've already got a compromised baby anyway, or your perceive to have a compromised baby, you do not want them being born in the back of an ambulance where you've no facilities. Is it safer to deliver the baby at Barrow, where at least you have some facilities, and call the transfer team in to them transfer the baby out to another unit? Those are decisions – well, they're above my pay-grade really, I'm not – I wouldn't be involved in that really.

PROFESSOR FORSYTH: And do you think that, from your experience of attending these deliveries and seeing what goes on in terms of resuscitation, do you think that the resuscitation skills in Barrow have been satisfactory over the

years?

MS BIGGS: I think that's – as a group of midwives, every six months we are taught neonatal resuscitation, basic neonatal resuscitation, i.e. if a baby is born with poor Apgars, one of the first things is to – you would fast bleep, or you would crash bleep a paediatrician; in my view, that would be one of the first things we did. Because the sooner they are there, the better chance that baby has. You know, I mean, I can wrap and I can dry a baby and I can commence initial kind of – well, rescue breaths, inflation breaths and things like that, but that's just the initial one or two minutes and...

PROFESSOR FORSYTH: So a paediatrician's able to get there promptly?

MS BIGGS: Yeah, if we crash – if we put out a 222 call, which is done with a baby with poor Apgars, yeah. I mean, we do sometimes phone them, if we – you know, we would have them lurking around on the labour ward if we had a baby that had thick meconium, that was – you know, about to deliver, or if there was any instrumental delivery or something, we would call them so they were there for the delivery, but if it was a baby that was sort of unexpectedly born with poor Apgars then they would get crash bleeped...

PROFESSOR FORSYTH: I mean has the availability of the paediatricians changed again over the period of time from 2005 when you were –?

MS BIGGS: Has the what, sorry?

PROFESSOR FORSYTH: Well, has the availability of the paediatrician...

MS BIGGS: Yeah.

PROFESSOR FORSYTH: Improved?

MS BIGGS: Yeah. Yes.

PROFESSOR FORSYTH: Over what period of time do you think things have got better?

MS BIGGS: I think since about two – I'd say within the last maybe three or four years, yeah. It's much easier now, getting a paediatrician to come to the labour ward. If I phone – previously, when you phoned, if you just bleeped them and said, 'We've – you know, baby, instrumental delivery, we've had some decelerations, can you attend?', 'Well what's this, what's this' – you know, 'Can you just attend?', because, you know – well, that doesn't happen now, 'Yeah, yeah, that's fine, I'll be there as soon as I can', and usually that's within the minute really, it's much better, much, much better.

PROFESSOR FORSYTH: I just wondered how much involved you felt from – look at the midwifery staff, [inaudible] in terms of the various incidents that took place, and how you felt you had been able to engage with management of the Trust?

MS BIGGS: All management or are you on about a particular tier of management?

PROFESSOR FORSYTH: Well, go up the tiers –

MS BIGGS: Right, okay. I think – in 2008, I think the head of midwifery was very visible on the unit, following all the incidents, she was very visible on the unit, there was a lot that was going on, she was at Barrow probably more than she was anywhere else, in my opinion. Trying to sort things out, trying to get things going, trying – you know; as for the other tiers of management, I – I don't think they were any help or support, really. There was no engagement really, I don't think. Well, certainly not from my view.

PROFESSOR FORSYTH: Were you aware of some of the reviews of the service that were done?

MS BIGGS: No. There were – I know there were people brought in to investigate different things, I knew that – yes, like you say, there were reviews but I only knew about them after the fact. Considering that I was a midwife involved in a case that happened in 2008, nobody has ever asked me what happened, nobody. Apart from my head of midwifery who phoned me at home to ask, 'Can you tell me what happened on your shift?', and I did. But nobody else has every asked me.

PROFESSOR FORSYTH: Okay. Okay, I'll stop there.

DR KIRKUP: Okay, thanks, Stewart.

MR BROOKES: Thanks. Well – I just want to pursue a little bit about the governance arrangements. You referred to improvements in the governance and particularly around your roles [inaudible] the team. If you were to describe the governance arrangements in 2005, 2006, how would you describe them, what was in place and what was missing?

MS BIGGS: We had a risk midwife and that was all I was aware of. We had a midwife that was appointed to look at clinical incidents that had happened and to take those forward and investigate those and also she would look at the policies and guidelines that we had, and to my knowledge that was what her role was. If she did anything else, I wasn't aware of that. If there was anyone else in the background doing anything, then I wasn't aware of that either. It

was just the risk midwife.

MR BROOKES: So if something happens, who would you report it to?

MS BIGGS: I would report it to the risk midwife.

MR BROOKES: Okay. But you've no idea what happened to that, after then, in terms of –?

MS BIGGS: No, I don't know about the investigation and what she would do. Then ever – was it every month, or every three months? There would be like a – the unit would produce a, 'This is what happened and this is what we've done', 'This is what happened and this is what we've done, and as a result of this, this has changed'. But I don't know who produced this document, I don't know how this document ever – I don't know who was involved in writing it or –

MR BROOKES: So if there was an incident which – not an incident, so, but you have a concern, you've observed something on the ward, you've seen something, how would you deal with that? Who would you go to, to get that rectified? Was it clear who to go to?

MS BIGGS: No, at the time, I would have probably gone to one of the labour ward sisters or the risk manager. I would – you know, it would be an informal, 'Oh, I've – this particular event has happened', or, 'I think that this possibly could happen'. There was no kind of electronic way of highlighting what was going on.

MR BROOKES: It doesn't need to be electronic, it's just about having some...

MS BIGGS: Yeah, yeah, well, I'm saying electronic now...

MR BROOKES: Being clear...

MS BIGGS: Because that's what we have. But – I mean, we used to have like – what did they call them? Like the big forms, I can't remember what they were called now. But they were used for things like people falling over and – I mean, we didn't realise at the time, but we could have used those as well for things like near misses and things, but with – we just didn't use them that way.

MR BROOKES: So was there any routine training about how you should be dealing with issues which were of great concern about the quality of care?

MS BIGGS: No. We had – in the six monthly mandatory training days that we used to do, there was always a little slot for the risk midwife, but usually that was just to tell us any updates or tell us – or, 'Remember such and such an incident, well, this is what we've done about it and this is what we're going to

change', there was never like a session on, 'If you see this, then I want you to do this about it and this is what you should be doing', and there was no kind of information about how the process runs, there was just like the final kind of outcome really.

MR BROOKES: And you've described a route around midwifery; if, for example, you'd seen something that concerned you about the clinical practice of a doctor, how would you – who would you have taken that to?

MS BIGGS: Well, depending on the doctor –

MR BROOKES: And would you have been reluctant to do it, or –?

MS BIGGS: No, I wouldn't be reluctant to do it, no.

MR BROOKES: So who would you go to for – to raise those concerns?

MS BIGGS: I would go to – I would probably go to one of the consultants and I would also go to the – well, our head of governance, and I would – yeah, I would address it on the risk reporting as well. That would be one of my things.

MR BROOKES: Okay.

MS BIGGS: I mean obviously, you'd have to anonymise that.

MR BROOKES: I may be wrong, I'm getting a sort of hesitancy that it probably isn't clear to you, you're thinking what you would do is – would it be clear to your colleagues, would your colleagues have followed the same process?

MS BIGGS: Yeah. I mean, there have been instances where somebody's seen something and – we use the risk reporting system and that's what we do.

MR BROOKES: Okay. And has it changed now. Is that now – I just want to be clear?

MS BIGGS: No, we use the – we use risk reporting.

MR BROOKES: Okay.

MS BIGGS: If it's something – the reason I would probably go and speak to somebody face to face, rather than just using the risk reporting system is because – depending on who gets a copy of this, you don't want it to be full of people's names – you see what I mean? So, it would be – this would be anonymised, whereas if you went to see somebody, you could just say, 'I have witnessed this'.

MR BROOKES: Yes, I suppose I – I'm trying to understand if things have changed...

MS BIGGS: Yes.

MR BROOKE: And I know they've changed in terms of now having access to

electronic reporting but in terms of the way, and your awareness and how you're trained, to identify risks and deal with risks, has that changed from when – from 2005, 2006 onwards...?

MS BIGGS: Yes.

MR BROOKES: To now? And if so, how has it changed?

MS BIGGS: Yes. Well, we report more risks now, because we – there is a – we have a list within the clinical areas, 'These things must be reported'. You know, if there's a low Apgars of below a certain point, third and fourth degree test – there is a – there's a comprehensive list, all these things have to be reported. If there's something that you're not sure about, then you still report it, you know, don't – if you're not sure, report it anyway, because if it's – if it can be addressed simply, then that's fine, but it might not be, it might need to be looked at in further detail.

MR BROOKES: Okay, that's helpful.

MS BIGGS: So, whereas previously, we didn't have the list, we just had the kind of...

MR BROOKES: So it would be down to an individual's [inaudible] for what they thought was concerning?

MS BIGGS: Yes.

MR BROOKES: Can you just briefly describe to me the organisational structure in which midwifery sits now within the Trust? What division is it in, how does that report through – is that something that's clear to you?

MS BIGGS: We're in the women and children's division. We were – we were in women's health – originally, we were just women's, we weren't – we weren't in with children, then there was a bit of a re-jig a little while ago and we were put in with elective services, such as surgery. So we were actually women's health and surgery, and then they realised that didn't actually work, so then they put us in with the children's directory as well, which actually is much better because we work so closely together, it make much more sense us being together.

MR BROOKES: So do you feel that you're part of one division or part of service based at Barrow?

MS BIGGS: I feel I'm part of service based at Barrow, personally. I think they are trying very hard to get us to feel as part of one big team and I think they've done the right thing in making jobs that are cross bay ~~crossed based~~, or that

people get to see different faces. I think our – well, I know, all our study days now are cross Bay ~~based~~, or we get to work with other people from the other units. I just think geographically, it's going to be very difficult to – well, it's a problem that needs – they're never going to be able to be addressed, I don't think.

MR BROOKES: Is there any simple things they can do to help improve that situation?

MS BIGGS: I think – I can't think of anything, I think that – you know, what they're trying to do is right, you know, I can see they're trying to make us one big division that can work seamlessly throughout the three units and – well, with the paediatric staff within our two units, I just think geographically, it's just very difficult.

MR BROOKES: And is that an improvement on what it was like previously round then?

MS BIGGS: Yes.

MR BROOKES: Okay, in what way?

MS BIGGS: Well, we were on our own. We were Furness General Maternity Services. We were part of the Trust, but we – the only people we saw really, from the other units were head of midwifery and possibly a couple of the modern matrons, that came through because they needed to on a – or there was a meeting, or whatever; we didn't really see anybody else.

MR BROOKES: Okay. Just one final question. You said you did your preceptorship in Preston, is that correct?

MS BIGGS: I did.

MR BROOKES: Coming from there, into the unit at Barrow, were you surprised by the practice, and the way in which the operated or was it very similar to what you had been used to?

MS BIGGS: Well, because I'd trained at Barrow, I was kind of used to it...

MR BROOKES: Well, I'm specifically thinking the difference between Preston and Barrow.

MS BIGGS: Oh, so when I went to Preston you mean? I – it was just such a big unit, you know, I spent a lot of my time on the delivery suite, and there are massive differences, not just in the volume of women that are on the unit, but there is – they've got a neonatal unit rather than a special care unit, so you're dealing

with women – high risk women, more high risk than I'd ever encountered at Barrow. They had their own theatre, just through the double doors, 'There's your theatre', wonderful, so – whereas I'd been used to women going to theatre, quite early on, decisions were made, 'Right, we need to take this woman to theatre because we can't allow this woman to labour any longer due to the length of time it took to get theatre' – because we never had – it used to be an on-call system. So, due to the length of time getting a woman to theatre, whereas at Preston, it was much more, 'Oh, let's wait and see, let's try and achieve a normal delivery, let's used foetal blood ~~plug~~ sampling, let's have some vaginal breach deliveries, because we know that this woman can be in theatre in a very short space of time', whereas, that was early [inaudible] coming from Barrow.

MR BROOKES: And going back, did you find the practice was as good as it could be, under the circumstances?

MS BIGGS: Going back – going back was – it was as it was when I left, you see, and I can't really remember, to be honest. I think because instead of looking after three labouring women, I was possibly looking after one a shift, it was that kind of – personally, I felt I was able to be more of a midwife to the women in Barrow because I wasn't being pulled to do lots of different jobs for lots of other different women because it was a much quieter unit, and that was, I felt, very good, you know, I could give one to one care to this woman, but then over time, that changed, because over time, the midwife numbers depleted and we were short staffed and things like that and it – it was such a long time ago that that's only – the only thing I can really – that really sticks in my mind, you know, we would never have had high risk babies on the maternity ward at Barrow, but I was used to caring for them at Preston, but then I come back and there isn't any because they're all cared for on special care and then slowly, over time, the inclusion criteria for special care changes, and they then take – they're not going to take anybody that's less than – you know, these babies that can now go onto the ward. All these babies that would once have been on special care can now be cared for on the maternity ward.

MR BROOKES: So you were caring for high-risk babies on the maternity ward, than you were at the beginning of your time at Barrow? Is that –?

MS BIGGS: Well, what I'm saying is, babies that I would care – that I was caring for

at Preston were babies that were of a low birth weight. They were deemed high risk; we used to have phototherapy on the maternity ward and things – on the postnatal ward and then I came back to Barrow, and nothing like that happened, because all these babies were cared for on special care. And then a year or two later, the special care decided, for whatever reason, it was probably – you know – I don't know, I can't even – I wouldn't know how to think of that, but what happened was, they changed their inclusion criteria, so babies that were once cared for on the special care unit, now, were being sent to the maternity ward with their mothers. Babies that were less – well, we never used to have babies that were less than 36 weeks, but now babies less than 36 weeks were coming onto the maternity ward. Babies using BiliBeds, babies that were – you know, these kind of things, they just – it was – and it kind of happened slowly, over a course of – one, you know, there might be one baby and then next week, there might be a couple of babies, and slowly over time, you don't realise it's happening until suddenly, you've got a lot of babies that are needing a lot of extra care, but you've got a lot of midwives that've not actually been shown how to care for these babies because it's happened – it's like they've trickled onto the maternity ward.

MR BROOKES: So – that might help me with something with – I'm not finished[?], so if you – we hear how busy the unit at Barrow is and yet the numbers you're talking about, comparing it with larger units, and the numbers you'd be doing, wouldn't indicate that it's as busy. So, so why was it so busy?

MS BIGGS: It was busy – it's – the volume of women is different than a big unit, but so is the number of staff and whereas at Preston, we'd have up to 17 ~~70~~ midwives on a shift, at Barrow, you would have four. You'd have four midwives on a late shift and if you couldn't cover one of those midwives, that they went off sick, you would be down to three midwives. Now those three midwives have to cover the maternity ward, they also have to cover the labour ward. So if you get one midwife caring for a labouring woman, on that labour ward, that leaves you with – so she's now busy, you've got one midwife on each of the wards and they've got to care for everybody else that's there. You know, you need another – you can't leave one midwife on the labour ward when there's a labourer, in case there's an emergency, there has to be another midwife...

MR BROOKES: Thank you, that's helpful...

MS BIGGS: So then you've got one midwife caring for who – however many women it might happen to be, on the maternity ward. Not just the women, but she's got to care for the babies as well. And that was – that was quite common, you know, especially prior to sort of when we started getting the agency midwives and things in, you know, three midwives, because of the level of sickness, and sometimes we'd have three midwives on a night shift as well, the only differences at that time, we had an on-call system, so if it was busy, we could at least call somebody in. It wasn't perfect, the on-call system, because some of our midwives live nearer to Lancaster than they do live nearer to Barrow and if you need somebody at that moment and the other midwife happened to live in Hest Bank, then, you know, it's pointless calling her in. And another thing that used to happen as well, was at the – the labour ward sister, the band 7 coordinator, personally, again this is again my own personal feeling, I think that they used to feel that they'd failed if they had to call somebody in. It was seen as a, 'I can't cope, that's why I've called somebody in', and I think that people should have been called in a lot more than they were. In my personal opinion.

MR BROOKES: And was it clear when they should be called in, were there protocols in place?

MS BIGGS: No, it was just on – at the discretion of the band 7.

MR BROOKES: Okay, thank you.

DR KIRKUP: Okay, thanks. Just one point that I wanted to pick up with you in this part of the interview. Where did the unit in Barrow in general, and you in particular, stand in relation to normalising childbirth?

MS BIGGS: I – can you kind of – what do you mean?

DR KIRKUP: How was that – it's a very worthwhile agenda, [inaudible] but how's it been implemented in Barrow and perhaps you could compare that with how it was being implemented in Preston, for example?

MS BIGGS: Oh, I see what you mean. Right, okay.

DR KIRKUP: That would give us a comparison.

MS BIGGS: Yeah, I think – I think at the time, there was – I don't really want – I think – at the time in Barrow, there was a culture – or should I say more like a group, it wasn't a culture, because it wasn't everybody, there were a group of

midwives who thought that normal childbirth was the – the be all and end all and at all – at any cost – does that sound awful? Yeah, it does sound awful, but I think it's true. You have a normal delivery at any cost and I think that's – yeah, I mean I didn't agree with that. I think that in Preston, due to the amount of – well, due to the fact that you had doctors on the unit at all times, due to the fact that you had equipment that was available if you should need it, modern up to date equipment which would give you accurate kind of readings, or accurate results on what was happening with both the mother and the baby, I think you could achieve a nice – you could achieve nice, normal deliveries. That woman might be incredibly high risk but we had the equipment to ensure that she was safe and her baby was safe and she could achieve a normal delivery, and even if she ended up with an instrumental delivery, you could allow her to – well, you could empower her to know that, 'That is the best outcome for you and well done', you know, and I think that's – at Barrow it was more difficult to achieve that, because obviously, we didn't have the equipment, we didn't have a theatre on the unit, we didn't have all this. However, there was still the, 'We can achieve a normal delivery'.

DR KIRKUP: Okay. I absolutely get the point about theatre not being available and being an on-call system and all that, but what was the equipment that was lacking at Barrow that impacted on that. What are we talking about?

MS BIGGS: We had old CTG machines, we had very old CTG machines that had very old and complicated foetus scalp electrode systems. Now they're much better, it's very easy to attach and to de-attach and things, so you weren't always getting accurate readings, so, you know, if you needed to use a foetal scalp electrode because of an – you know, sometimes you'd come to a monitor and the – things would be missing, you'd have to scrabble around and things and it – so in that – in that sort of an incidence, if you're not being able to monitor a baby's heart rate appropriately, in a woman that you need to monitor, then what do you do? You know, you have to get that baby out and you have to get that baby out now, because if you don't know what's going on, you can't just leave her to labour, and that's – these are the kind of problems that we encountered at Barrow.

DR KIRKUP: Yes, I understand that. So are you saying that as a result of that, people weren't monitored electronically when they would have benefited from

being monitored electronically?

MS BIGGS: I don't know that but I – I don't know that. I can't...

DR KIRKUP: But you are clear that the equipment was poor and the [inaudible] weren't always available?

MS BIGGS: Yes. If people weren't monitored when they should have been monitored, they– that's something I don't know.

DR KIRKUP: That didn't happen in your direct experience?

MS BIGGS: That's not something I witnessed, I'm not saying...

DR KIRKUP: That's what I'm...

MS BIGGS: No, it's not something I witnessed. It's not something I have any knowledge of, really. Like I say, one of the reasons our section rate was high was because women – because we had a lack of monitoring equipment and because we had an old foetal blood sampling machine that would never work properly, so therefore, if you take foetal blood samples, and you can't get a reading, you've took them for a reason and you took them because you're concerned about the baby, and if you can't get the result you need, you know, off she goes to theatre and it was that kind of – it was – yeah.

DR KIRKUP: I'm sorry to be a little picky about this, but you're saying two slightly different things there and I need to be clear which we're talking about. You started out by answering the question about normal childbirth very helpfully and very clearly. And I said, 'What was one of the factors that impacted on your view that people were too keen to achieve normal childbirth, lack of adequate equipment?'. Now you're saying that the lack of adequate equipment meant lots of operative and section deliveries.

MS BIGGS: Yeah, and I think – I think...

DR KIRKUP: Do you see the difficulty? I'm just not clear whether it's –?

MS BIGGS: Let me try and get this clear. I think in – because there was lack of equipment and because there was a lack of – and because knowing that – because we couldn't use this particular – or we could use it, however, if it wasn't working as well as could be expected, we would end up in theatre, then – 'Do we need to use this, can we, you know, can we not just do something else, so –?' and I think there were some midwives that would do that, because ultimately, if I need to do this particular procedure and I can't do it, then this lady's going to end up with a section, whereas if I don't do it, we can just

maybe carry on and achieve a normal delivery, and I think – and I think that happened; I wasn't witness to that, but I think that happened.

DR KIRKUP: That's fine, that's really clear and helpful, thank you, I appreciate that. There will be more questions in the private session. I'd like to record that we want to move now into the part of the interview where we talk about clinical confident details, and we'll have a short pause while we ask people to leave the room please.

[*The remainder of the interview was held in private*]