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 advisor on Governance
Dr Geraldine Walters – Expert advisor on Nursing

UNA O'BRIEN

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(At 2.02p.m.)

DR KIRKUP: Thank you very much for coming. We do appreciate it. I will say for the record that my name's Bill Kirkup and I'm chairing the investigation panel, although I'll also say for the record that we have worked in the same department in the past. I'll ask my colleagues to introduce themselves to you.

DR WALTERS: I'm Geraldine Walters and I'm Director of Nursing 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 was previously Head of Clinical Quality at the Department of Health.

DR KIRKUP: You'll see that we're recording proceedings. We'll produce an agreed record with you afterwards. You may also know that members of families affected by this are entitled to be observers. As it happens, we haven't got any here this afternoon, but they may listen to the recording subsequently. You'll also know that we've asked you to leave behind any mobile telephones or recording devices. Our intention is that nothing goes outside the room until we produce the report with everything in context. Any questions from you about the process?

MS O'BRIEN: No.

DR KIRKUP: I will start with a very general – and again it's for the record – question, which is could you just outline briefly what your position is and where you have come from to get to that?

MS O'BRIEN: Well, thank you very much, Bill. I'm Una O'Brien. I'm the Permanent Secretary at the Department of Health. I've been in that post since November 2010, and I am a professional civil servant. I've been based in the Department, one way or another, since 1990, but I've also ~~spent~~ had two major secondments – one to University College Hospital, where ~~is~~ I was the Director of Clinical Governance, and I was also the Secretary to a public inquiry into the Bristol heart surgery scandal.

That's broadly my background, and I'm here today to support your investigation in whatever way I can because, if I might just say initially by way of introduction, it's profoundly important to the families concerned, to the NHS and to the Department of Health that we get to the bottom of all of these

matters and, once and for all, can honestly address all of the remaining questions that the families have. It's a source of deep personal grievance to me that we haven't been able to do that. I feel greatly for what they have gone through and what they're still going through and I would like to do whatever I can to help your investigation personally, but also to provide any further materials or support you require from my organisation will be at your disposal.

DR KIRKUP: Thank you; that's extremely helpful and much appreciated. I'll pass you over to Julian to do the bulk of the questions, although Geraldine and I will come in with any follow-ups after that.

MR BROOKES: Thanks very much. I guess some of this is just for the record. We're just trying to understand the role the Department of Health played at different points in time. I'd also be interested in the roles you've played within the kind of timescales of our terms of reference, in terms of the Department. If we could start with that that would be extremely helpful, because I know you've spent some time, as you say, with the inquiry, some time out at the Trust. It would be just helpful to understand the times you were at the Department and the kind of roles you played.

MS O'BRIEN: Okay, would you like me to go through those?

MR BROOKES: Yes, please.

MS O'BRIEN: I ran the Bristol inquiry between 1998 and 2001. Between 2002 and the late autumn of 2005, I was at UCLH, then I returned to the Department in 2005 to be a director in ~~a~~ the ~~policy~~ Policy and ~~strategy~~ Strategy ~~group~~Group, where I had responsibility for reform of providers. In April 2007, I became the Acting Director General of Policy and Strategy. I applied for that post and was confirmed in it in autumn 2007.

MR BROOKES: Excellent, thank you. Did you have specific role around any relationships to CQC or any of the other bodies involved in monitoring of the quality systems in the NHS?

MS O'BRIEN: Yes. Between 2007 and 2010, I was responsible for the legislation that established the CQC and also for the initial arrangements to get the organisation set up.

MR BROOKES: In terms of their oversight, there would obviously be a leading sponsor branch. Do they report to you?

MS O'BRIEN: Sorry, can you ask me that question again?

MR BROOKES: Sponsor branch, was the sponsor branch part of your directorate?

MS O'BRIEN: Yes, they were, although they weren't a sponsor branch in the way we do it today. I wouldn't want to confuse the two approaches.

MR BROOKES: Could you just, for the record, describe what it was like then and what it's like now?

MS O'BRIEN: I would say the principal difference between the sponsorship then and now, and I'm generalising to make the point, is that sponsorship was conducted at a relatively low level and the approach within the Department up to about 2011 would have been one that very much handed the responsibility over to the arm's length body, and very much said, 'There are your powers. That is your budget. You are the leaders of that organisation and it is your job to do that work.' It would have been a time when there was a sense in which we were almost parallel bodies, rather than what we have today, which is, partly through my own experience of having been through that, I have to say, that I have led and instituted within the Department a much more systematic, rigorous setting of objectives for our arm's length bodies, whether they be a ~~Next Steps~~next steps agency, an NDPB or a regulator, and then ensuring that there's a proper professional holding to account of those organisations, including setting ~~in the way that we set~~ standards for the civil servants who ~~were~~ are doing that work.

I wouldn't want to suggest that there wasn't a dialogue and a relationship between us – well, obviously it goes back to CHI and the Healthcare Commission, and the CQC – there certainly was. I think that we have improved the systematic approach, the consistency and the holding to account of what you might call our arm's length bodies, in this more recent ~~area~~ era.~~, which~~ This means there's a much ~~more~~ sharper focus on does the organisation perform, is it doing its job? If not, what are we doing to put that right?

MR BROOKES: That's very helpful, thank you. One of the things we've been grappling with in the picture is the different parts of the Department, which have different particular interests in the quality agenda in terms of the NHS. We're obviously aware of the Quality Board and its role, and David Nicholson's chairing of that. We're aware of the rule that Bruce Keogh got.

What we're not quite sure is where it all came together. Also I'd be quite interested, in terms of the role of Permanent Secretary, what your role is in that establishment of quality in the responsibilities the Department has.

MS O'BRIEN: I think in order to help your enquiries, if I may, I'd like to describe how the accountabilities worked before the implementation of the reforms ~~worked~~ in April 2013 and how they work now at the top of the organisation. Forgive if I'm slightly vague about the pre-2007 arrangement but, essentially, the story goes as follows.

Between 2000 and 2006, Sir Nigel Crisp was both the Permanent Secretary and the Chief Executive of the NHS, which was the first and probably the only time that we've had an explicit combination of those two roles since the point at which an NHS Chief Executive role was established in the late 1980s/early 1990s. When Sir Nigel Crisp stepped down, there were a number of issues about the governance and running of the Department that were raised by the fact that ministers wanted a replacement as NHS Chief Executive. They felt very strongly that it needed to be separated out from the role of Permanent Secretary because, to put it bluntly, the good running of the Department had been a low priority.

In order to put that into effect for the two individuals who were then in those respective roles, there was a memorandum of understanding as to their respective accountabilities. This also linked, if I might say, to the accountability for the money. That memorandum of understanding could be available; if you don't already have it, we can make it available to you but, essentially, the practice was Sir David – he later became Sir David Nicholson – was appointed as the NHS Chief Executive. I think it was the autumn of 2006. It was around about the time that Hugh Taylor became the Permanent Secretary. This memorandum was essentially a division of responsibility and accountability where, to my understanding as a more junior person in the organisation at that time, there were effectively parallel Permanent Secretaries, with David Nicholson being responsible at the apex of the NHS infrastructure, looking to the people in the SHAs and the PCTs. He chaired the management board of the SHA chief executives, and Hugh Taylor had responsibility for the running of the Department, public health and the social care advice.

It wasn't perfect. There's always an imperfection in the governance of something that's so huge, but it made it manageable. There were lots of points of intersection. For example, Hugh Taylor sat on the management board and, indeed, as someone who was responsible for policy and reform of the NHS and the surrounding system, I also had a seat on that management board. There was a clear distinction in between, in operational terms, where the responsibility lay. Not to oversimplify – it was very complex – you could say that policy, strategy, managing change and legislation rested with Hugh Taylor and the people who reported to him. The in-year ~~delivering~~ delivery, dealing with events, handling issues rested with David Nicholson. That really was the division of responsibility then.

If we fast forward to 2010, when I took over at the beginning of November that year, effectively, David Nicholson and I agreed it made sense to maintain this division because, at that point, we already knew that the Government wanted to change that infrastructure and change those rules and responsibilities. We were in effect, at that point, planning for a transition in 2012. In reality, it turned out to take a year longer, so it made no sense to address that, because we were already taking that system apart. Indeed, we both agreed that it was extremely important that we did retain that clarity of responsibility between us during that transition, for what turned out to be two years. I'm sorry if that's slightly a long answer, but I hope that –

MR BROOKES: It's extremely helpful. I obviously recognise that I was before Nigel Crisp as well, and there was that split before there as well, so it's something I recognise. The reason we're asking is to understand, if an issue like Morecambe Bay came up, how it enters into the system. Does this division create problems or added challenges, in terms of how it's managed within the organisation?

MS O'BRIEN: I'm not sure if the division itself did, although I think – and no doubt we'll come on to them – the shortcomings and weaknesses that were in the system at every level... I don't want to take away from the position of your question at all, but my observation of being in the Department in the 1990s is we had a number of clinical failures. Indeed, we had the failures at Bristol itself, where there were shortcomings in local supervision and an inadequate system around that local supervision to pick up those failings.

If we stand right back, what have the last 15-20 years been about? It's been about an attempt to address that (ie shortcomings in clinical supervision), once you get problems at the point of the board of the organisation, ~~the external supervision~~ endeavours have been made consistently to strengthen ~~it~~ external supervision. When it's been strengthened, too many assumptions have been made that it's improved. We then find that it hasn't and move to the next stage. I don't think you can say it was solely an issue of the adequacy of that division of responsibilities in the Department.

MR BROOKES: I'm not saying solely. I'm just trying to understand.

MS O'BRIEN: As regards an in-year event and management issue, certainly my experience was, in 2007 ~~in~~ to 2010, that would come up into the arena of David Nicholson's grouping. That's where the NHS relationships were with Strategic Health Authority Chief Executives. Those were the people who met together who dealt with these matters. Where there were policy implications arising from them, that's when they would come across into wider consideration as to how we're going to address this in a policy way or a legislative way or changing the regulations. People work together; they would be aware of the issues. They would support each other. There wasn't really the physical divide. We weren't in different buildings and so on. People would know each other.

MR BROOKES: CQC is shorthand for CHI.

MS O'BRIEN: Yes.

MR BROOKES: The sponsor responsibility was within your element of the Service.

MS O'BRIEN: Yes, well what happened was – how shall I put it? – the development of and the support of ministers for the legislation was handled by the group that I joined in 2005. When I took over from Bill McCarthy in the spring of 2007, I continued that, because there was the build-up to the legislation and then the Act itself going through Parliament. It was logical that I then took a much deeper interest in it and worked with the team, worked with the ministers of the day, to give them what they wanted to see that legislation through Parliament.

As we got into 2008-09, it became clear to me that there were shortcomings in the way in which that legislation was going to be

implemented. I wasn't satisfied with that. I went to see Hugh Taylor and I said, 'I think one of us needs to be more involved in getting this organised.' It wasn't necessarily in my responsibility to do it, but I could see that it wasn't working so I, if you like, inserted myself into that process, with Barbara Young, who was then Chair designate, and Cynthia Bower to bring to the ~~service~~ surface practical matters about how the implementation was being planned. These were largely to do with things such as buildings, the transfer of staff, those sorts of matters, and to make sure that there was a proper organisation of that and that what was being done at the time was improved.

MR BROOKES: I understand the roles there. Would it be in your bit of the organisation, for example, if there were concerns by a board member of CQC, for example, wanting to raise concerns to the Department? Would that come through yourself?

MS O'BRIEN: Yes. Well, it would have come insofar as we had a visible sponsor team at the time. To be honest with you, if I may just in parenthesis say for the moment, clearly Kay Sheldon did raise issues in the autumn of 2011. When I investigated those issues as we did – we've always taken matters raised extremely seriously – it was very clear to me that, at quite a junior level, because most of this started to come to light after the Winterbourne View report in the spring of ~~2010~~ 2011, that there had been knowledge at a junior level in the Department that things at CQC were not as they should be from around about that point; once that became clear to me through the capability review we undertook through the late autumn of 2011, going into 2012, that was the moment when I decided, in my new role, that the approach to sponsorship needed to change very significantly. Prior to that, I think we had had generally weak systems to hear from non-executive directors in the Department.

We've done other things since then, including ~~requiring~~ recommending a senior independent director to be nominated on each board. We've done a lot – I maybe can give you a separate note on that if you're interested – to address these issues.

MR BROOKES: That was an initial useful description of that. What I'm interested in is, having recognised those weaknesses, how they've been addressed so

that, if there is similar intelligence in the DH at the moment, how that would be happening.

MS O'BRIEN: If I may understand your questions in two different ways, one is the generic question of if non-executive directors raise issues about their ALB and, secondly, concerns about an individual organisation. On the first one, just to reinforce the points that I've made, we've done three principal things. First of all, we have, by a significant factor, increased the professional nature of sponsorship. There is a high-level named individual who has, as a fundamental part of their objectives, to understand the board, understand the issues of their ALB, to know those people personally and to be available to them. That's the first thing, and backed up with a professional sponsor team, which is held to account against a set of agreed standards. I have an assurance group within the Department who check and validate that.

The second thing that we've done is that we've made clear, in the appointment of non-executive directors, what their routes are should they wish to raise concerns, which I do not think was clear in any part of Government really, before Kay rightly raised these issues with us.

Thirdly, we have ~~required~~ recommended a senior independent director on each of those boards so that, if a non-executive director has concerns about ~~The~~ the Chair of a board, they can go to somebody and know that their concerns will be listened to.

Specifically about matters to do with clinical failures, the truth is that information about clinical failures comes into the top of the system in many different routes. I do not expect a person who is probably quite traumatised and upset, having gone through an experience like this either personally or with a member of their family, to somehow automatically know all of those routes. It's quite reasonable that, sometimes, people write to the Department of Health. We do not, however, have a complaints investigation system within the Department. With that said, since the matters to do with the Mid Staffs inquiry were set out by Robert Francis in his public inquiry – in fact, before that, when I first came into the job, I had a fundamental review of how complaints correspondence was handled. We handle over ~~30~~ 50,000 items a year, and why should a member of the public know that the Department of Health doesn't deal with complaints? I don't expect them to.

What we've introduced is a system whereby we triage the letters that we get. If anything looks like an un-dealt-with complaint, a first-order complaint or even, more seriously, a whistleblowing matter, we now have – and I'm happy to supply you with a note – a proper protocol whereby those letters are dealt with, forwarded to the right organisation and then we follow up with that organisation to satisfy ourselves that they didn't just go into a drawer, but that they were properly dealt with.

MR BROOKES: That's really helpful, because we were trying to get a feel. We know there was a significant number of officials around this organisation. I say 'significant'; it sounds a lot to us, over 400. The question is we're not sure whether that is a lot for an organisation. Clearly, one thing is key triggers in terms of the seriousness of a letter. The volume tells you something: there are consistent things that, on their own, they trigger that may be examples of systemic issues within an organisation. Could that be picked up then? Is it stronger now?

MS O'BRIEN: I don't think that was the approach at the time. If I may, because I have spoken publicly about the situation within Mid Staffs, in my first week in the job, I asked to see the letters that came to the Department about Mid Staffs. What was really shocking to me was that, quite unusually, they were reports from third parties. This is something that, having been a Director of Clinical Governance, I immediately spotted as unusual. To have people writing and saying, 'I was a visitor on that ward and I saw the following,' to me was obvious that that was something that people don't make up. Unfortunately, the vast majority of those letters, going into the mid-2000s, were not forwarded to the place they should have been and they were ~~no~~ not really addressed in any degree of substance. That's why I instituted the root-and-branch review of how we deal with our correspondence.

We do have a routine assessment of when we have tried – because obviously people write about all sorts of things. ~~We get~~ There have been times when we've had ~~more letters about car parking~~, to be honest, than virtually anything else. We do get the team to produce a report every month – in fact, I've only seen one recently – trying to draw out and identify any patterns. It's difficult, because we don't know what size of a subset we are getting, so we mustn't try to regard ourselves as somehow being omniscient.

What we've got to do is make sure that those letters that find their way to us get to the right organisation and are dealt with by that organisation, the organisation that has the fuller picture. For all of its troubles, I am now seeing a much stronger, more systematic and professional approach from CQC, now that we have the ~~e~~Chief ~~i~~Inspectors there able to deal with that intelligence that's coming in, whether it's a letter into an MP forwarded to the Department or a letter written from a member of the public to the Department of Health.

I will never want to sit here though and claim that that is a ~~full~~ fool-proof system that I've got at all. We have plans to have regular internal auditors going in to validate for me that my triaging approach is being properly implemented. It has to be; we're dealing with so many pieces of correspondence we have to have methods of checking and assuring, and that's the way that I can satisfy myself that the letters that do come to us – sometimes it's the first time that a complainant has written – do go to the appropriate place to be dealt with. One thing we cannot be – we're a Government Department; we cannot be the investigator. We don't have the skills and we don't have the ~~board~~ broad base that we now expect of CQC to be able to follow up those matters.

MR BROOKES: I understand that. Do you think you have the processes in place that would allow you potentially to spot a pattern? My experience of it often is that people are doing so many that they're deal with that one; that's got to go to so-and-so. It gets done; it gets processed. It's the stepping back slightly.

MS O'BRIEN: We do definitely draw out, on a monthly basis, and we're able to see, 'My goodness, we've now had X number of letters about this issue in this same Trust that are finding their way to us,' but that would only alert us even further in this current time to be saying to CQC, 'Are you dealing with this?' I think it's very unlikely, however, that the only place now a pattern would emerge would be within the Department of Health, because it's hard to estimate. Sometimes we're on the receiving end of a campaign. Sometimes we're on the receiving end of letters where people just don't know what to do, and they think, 'I need to write to the Government about this.' To be able to

say whether something is a pattern or not is very, very difficult for us to draw that out.

MR BROOKES: I understand that. It's just that I'm thinking about some of the questions that have been raised with us about, 'Well, the Department knew all about this.'

MS O'BRIEN: Actually, I know we've supplied a lot of evidence to the investigation, and I'm happy to let you have anything that I may refer to today that is not in your pack, but my understanding is that, certainly as far as maternity services were concerned, we did not have much, if any, correspondence at all on this matter. Certainly what I've been able to find, there wasn't something there that... In a way, it's been very interesting going back with Mid Staffs. There were many letters that you can see with hindsight were raising a flag. I don't see a similar body of correspondence about this service in this Trust.

DR KIRKUP: There was one very persistent correspondent, James Titcombe. If you set him aside for the moment, there wasn't much other than that.

MS O'BRIEN: I will double-check after today, because it's very important that I give you a full, fair and honest answer but, in the material that I have looked at, I do not see any correspondence categorised as raising maternity as the main issue, before James Titcombe's first letter to the Department. All the material is there, to the extent that we have analysed it. That's the best answer that I can give you.

DR KIRKUP: That's helpful, thank you.

MR BROOKES: That's what we would agree, so that's the pattern to us as well. Just to move on, when you were first aware of issues being raised around Morecambe Bay?

MS O'BRIEN: I can't truly recall it as a standout issue for me personally until, let me think, really... There are two different things. One, have I ~~see~~ seen things that refer to it? Probably yes, but when did I really sit up and recognise that there was something that was not being sorted out here? It would have been when matters around CQC's attitude and approach towards this in the spring of 2012. That was when I really thought – although I do believe that I was probably aware that there were some issues with maternity that were being investigated prior to that. With these things, you can't quite remember when was the first thing you knew about the thing itself and when was the first time

you knew that there were unhappinesses about something not being sorted out.

MR BROOKES: Do you recall what made you sit up? What was it?

MS O'BRIEN: Well, made me really pay attention were the issues being raised at CQC about the CQC itself going back over its conduct in relation to that, and then David Behan going in there as the new Chief Executive and him letting me know – I think it was in the June or July of 2012 – that he had commissioned the Grant Thornton report.

MR BROOKES: I'm just going to recall when Kay Sheldon raised her concerns.

MS O'BRIEN: ~~Simultaneously with that.~~Earlier than that [in the Spring].

MR BROOKES: It was about that time, wasn't it? Clearly that was potentially a trigger as well.

MS O'BRIEN: Of course, what I was looking for, if I go back to my role, what I was seeking to do, I had a particular focus on improvement and addressing the bad governance at CQC. I had been tracking this from the point of the capability review in the autumn of 2011. Don't forget my capability review was published ~~on~~ in January 2012. On the same day, the Chief Executive resigned, then I was obviously very focused on getting a new Chief Executive and sorting out the leadership of that organisation. Of course, I was very alive to hearing a further matter that was not properly dealt with and, certainly, it hadn't come up during the capability review, which again made me concerned that something significant was coming across my desk that had not been raised. We spoke to lots of staff in that organisation when we did that capability review and there were six of us doing it – it wasn't just me on my own – so it was a bit of a jolt to discover there was another matter that was potentially improper that we had not uncovered in our review.

MR BROOKES: Relating to your review, did you feel that it was reticence from people to actually come forward or was it that they genuinely didn't know that it was as bad as it was?

MS O'BRIEN: I don't know. I think that's a really hard thing to judge. What we've now learned is obviously there are some deeper cultural issues in that organisation, where people felt unsafe to raise issues within the organisation. I don't think we fully could see that or understand it when we did the capability review. I think we were very, very focused on getting on with it,

dealing with the issues of governance, tackling the matters on the board. I felt, until we'd got that right, we weren't going to get anything right and that was the one thing that I could make happen that other people couldn't, so I was very focused on that. It would have been too big a thing to bite off to try to take on how the organisation needs to be reformed, because what I needed to do was to get the people in there who knew how to do that.

MR BROOKES: There are a number of other organisations that have interests into Morecambe Bay, but also interests in NHS organisations, in terms of quality, directly or indirectly. There's Monitor, obviously. Where did Monitor feed into the Department? The reason we're asking that, so you can help the answer, is just were you picking up any information about the relationship between Monitor and CQC at that time?

MS O'BRIEN: Certainly you have to chunk this up into different phases. I think that, as CQC came into being in 2009, colleagues Barbara Young, the chair at CQC; Bill Moyes, the chair at Monitor. I was not in this job ~~as~~ I was a DG at the point. The relationships between them personally were not good. I learned some lessons during that time that I've tried – whether I'm ~~not~~ succeeding or not, others will judge, but I felt very unhappy about that personally and have made it part of my own journey to be very intolerant of poor relations between top people in these organisations. I think it casts a very long shadow. More people can see it than the individuals often imagine can be seen. These things are very bad when they happen and they shouldn't happen.

It was particularly evident to me because one job I was given was to work on the document about who does what to clarify responsibilities in the new system, which we published in 2010, the year after the first Mid Staffs inquiry. Obviously we need good, capable, driven people to come forward to chair organisations. Each ~~in their own right~~ of those individuals in their own right, I would say, was an outstanding leader and it was incomprehensible to me that they couldn't get on or that they had disagreements between them that couldn't be resolved. Probably you will have to ask them personally what their reasons were for that. I suspect, knowing that they were highly motivated public servants, they probably had different views about how to do

the right thing. Unfortunately, that difference wasn't contained and it was sometimes having an effect on how the organisations worked together.

There was also, I think, a degree of confusion as to Monitor's role on quality, which I think, in that particular era, led to uncertainties, whereas now we've got a very clear hierarchy of who determines whether the service is of a right and proper quality.

MR BROOKES: Is that balance right? It's interesting there were other suggested ways of bringing Monitor and CQC closer together, for instance.

MS O'BRIEN: Yes, absolutely. I could do a PhD thesis on it. I know there is no right way to organise this. It's a very complex system. If I just stand back for a moment, part of what's been going on in the last 15 years has been a movement, if you like, from a hierarchically managed system, which is perhaps the way things used to be, up until the 1990s, where hospitals reported to area health authorities that reported to some other authority and some other authority, to actually saying that doesn't work. We had the purchaser/provider split in the 1990s and an anxiety emerging around the financial governance and the quality governance of provider organisations.

There are two different and parallel attempts to sort that out. One was to strengthen management, so you see the strengthening of the role of the NHS Chief Executive, the SHAs; but in parallel, and governments were – I don't ~~quite understand the rationale of~~ know whether we really understood we were doing two parallel things at the ~~same~~ time – the emergence of regulation of providers. It was a historic step to create the Commission for Health Improvement. There'd been no prior ~~– I'm sure you know this –~~ inspection of providers. There'd been no external-facing governance, no test of those organisations in the whole history of the NHS. Having created that organisation, immediately its imperfections and the imperfection of the legislation became evident. There were two successive attempts, through the Healthcare Commission and then the CQC, to strengthen what it is, and even subsequent to that, the creation of the chief inspectors.

There has, in a sense, been this attempt to understand this~~.~~: ~~How~~ how do we get a grip on the external supervision and challenge of providers? Do we do it through management, a sort of line management approach and performance management? Or do we do it through a strong external

presence that can question, challenge and have rights of entry? I think, to some degree, we've still got a bit of both.

MR BROOKES: You probably need both as well.

MS O'BRIEN: You probably do. The crucial thing is there needs to be clarity about role and responsibility between those two different components.

MR BROOKES: I'd be interested in your view on one of the things that has come through relatively strongly in some of the discussions, which was the impact of organisational change and continuity between organisations. Quite a lot of these things were happening at the time of significant organisational change in the structures. It seems to have certainly been a contributing factor, but of what strength we're not sure. Did you, in terms of any of the work you've done, see any of this – as organisations morphed into others – some of the issues that that might raise.

MS O'BRIEN: Yes, I think I did. The first thing I might comment on is you asked me earlier about the creation of CQC. I think, for a number of reasons, that organisation began in a very, very difficult context. If you look at how it came about, the people who took over running that in April 2009 had one very difficult uphill climb. Here are some of the reasons why, in my own judgment, having looked back on it and having looked through it. The first thing we need to reflect on was the way in which the decision was made to create it in the first place. That decision was made with no prior discussion.

I can understand the legitimate reasons behind it. At the time, there was an endeavour to look at various inspectorates for different parts of the public sector, whether it was the justice system or the education system to say these are growing like Topsy we need to combine them. There was a decision announced in the run-up to the 2005 general election to create four inspectorates for the whole of the public service, which then required the merger of the Healthcare Commission and CSCI, which regulated social care, and the Mental Health Act Commission. That arrived as a pronouncement.

There then followed what I believe created a very, very difficult environment for the change to be enacted, which was a period of concern and, in some cases, outright opposition from senior leaders to that merger. My own judgment is that that created a very difficult platform for when the

merger did actually happen, because all the staff in the organisations had lived through this, had observed it and were aware of it.

The other thing of course is that, unlike in the non-public sector/private sector, when mergers happen they get done very fast, because of all these cultural and behavioural elements that are unleashed when there is change. People worry about their jobs; they have unclear direction. They take their eye off the ball. The reason things get done quickly in the private sector is because leaders know that those dynamics kick in. Unfortunately, in our case, from that announcement in 2005 to it actually happening, that's four years and that's virtually the entire life of the Healthcare Commission. It was ~~held~~ holed below the water line, before it was really even able to get going and I think it left a very difficult legacy then, with the degree of discussion and argument there'd been about that, for the CQC as they began.

My own view is that structural reorganisation is best done rarely, if at all, and that what we need to focus on is using the structures that we have got, working with them and improving them, and moving away from a belief that, somehow, if you change the titles and legal powers, move people to new offices and put new logos on things, that that will really change things. Some really big lessons were learned from that CQC experience and certainly I tried my very best.

When we planned the transition for 2012-13, ~~Dave~~ David Nicholson and I ~~both~~ talked a lot about how we were going to try to address some of these dynamics. Certain things we did, which I think were better on the whole although not necessarily everywhere~~, we~~. We were very, very clear with staff ~~across that whole change~~ of SHAs and PCTs across that whole change, 'If you're not happy with this, you need to go now.' We can't have people in the organisations not working on business as usual or helping to plan for the future. 'If you think you see yourself as somebody who can help to manage the transition but you don't want to be part of it in the long run we will accept that,'. ~~this~~ This was the message we conveyed to leaders across the system~~,~~ ~~'we will accept that~~. If you see yourself as part of that future, let us know, because we want to know if you've got the energy to help to create a new organisation.' I really applauded David for this in the summer of 2010. He got out there and had those conversations with every organisation affected

by the change very early on, so that we didn't get this internal campaigning for change not to happen, which is very toxic.

The other thing we did, which I think was done better, was a proper, structured closedown and handover of material. Don't forget here we're dealing with hundreds and thousands of documents. I'm not going to sit here and claim that everything was done perfectly, because I'm sure that, in something of that scale, there will be shortcomings. Having said that, I am confident that we structured a proper system for closedown of organisations. We created a proper legacy management team in the Department that could deal with any matters that were left unresolved by an SHA or a PCT, and we've been absolutely thorough in chasing down every single unresolved matter. In fact, I haven't yet quite closed down that legacy management team. All of those were lessons that I personally learned from the CQC experience that I felt we needed to do better.

MR BROOKES: Thank you. That's very helpful. Just one last area, if we could. We are now in a different situation. You've described some of the things that have happened to strengthen the system. I'd just be interested in if we now have all the right components, with the right powers and responsibilities in place, and is the system clear in terms of if something like this were to happen in the future. Are we confident now that we have an infrastructure that would enable us to make early identification of this and to resolve the issues?

MS O'BRIEN: If we go back to, first and foremost, my assessment of this situation is that weak clinical governance and weak leadership and management, ~~or~~ where they are insufficient within the Trust itself, ~~were~~ this the first ~~damn~~ dam that was breached. It is of fundamental importance that we continue to grow, nurture and improve those quality systems that exist within providers. The first line of defence has got to be within the organisation itself. We cannot externalise that. It goes back to the very professionalism of the individuals involved, their relationship with patients and the public, the transparency with which an organisation deals with matters where there is a serious incident, a clinical failing.

On that level, then what we have done, the work we have done following Robert Francis's report on candour and the need for, both at an

individual level and an organisational level, more candour with the patients and the public has been a major step forward. What we haven't yet seen is that fully implemented and the impact of that. I think that's crucially important and an improvement, although I hesitate ever to say that everything is perfect.

The second thing I'd just like to comment on is I've been very struck by the confusion there was around the supervision and regulation of midwives and where that fitted into all of this. I certainly credit the PHSO, Dame Julie Mellor, for the report that she published last year on this. We know the King's Fund is currently working on the next steps. Certainly I am looking to the NMC, under their new Chair. They are an independent organisation; they're not under my line management, so to speak, but I do expect them to really progress this issue and to resolve what I think is still a confusion. We do need to have a clearer distinction between the regulation and the supervision of midwives. I think that that got in the way in progressing the resolution of the investigations that were undertaken.

The next matter then is transparency, where we are moving towards, I think, a revolution in transparency about clinical quality in this country. We will be ahead of what anywhere else is doing and that's a very much needed – if I even go back to Bristol. If there had been transparency about the data, those matters would have come to light and been solved much sooner. It takes everybody to come to the table. I do appreciate that, for clinicians, this is hard, because clinicians go to work to do a really, really good job. I know it's personally heartbreaking for them when things go wrong, so ~~finding~~ we are finding ways to ensure that this transparency can be consistent with good professional practice, as opposed to it being seen as a threat or an attempt to deprive someone of their livelihood. We want the best of transparency, but we also want an understanding ~~of~~ on the part of the public about some of the complexities of modern medicine. It's not like having your car fixed. It's not mechanistic processes. Some of the decisions that people are making are right at the frontiers of science, and they do mean that things will not always go well. Having said that, I do think we are seeing progress. It's too slow for my liking, but I'm definitely seeing things moving in the right direction.

The third thing is ~~if~~ whether the external supervision system of the organisation is adequate. It's a big step to have introduced the chief inspector regime. The much easier codification about the quality of the organisation into the four categories to give the clarity that the Secretary of State has required is a really good thing. I'm concerned about whether we can sustain the inspectorate approach and, if we rely too heavily on it, we will come to be disappointed, because this has to be achieved every day in every clinical setting, not just the moment when the inspector goes in. Getting the culture about quality fully embedded within that relationship with patients and the public inside each provider is profoundly important.

The final thing I would ask is: is the Department of Health itself changing? We've had some very serious criticisms of our performance, I think, which we have really tried to lean into and accept to change our practice. I will never claim that we're going to be perfect, but we do understand what's at stake now if our ALB organisations are poor or not performing adequately. One of the things that we have done, which I'm very, very keen to sustain, regardless of what further pressures Government departments are put under in the future, is the programme that we've established, whereby the staff in the Department of Health are required – the senior staff – to do between 15 and 20 days a year outside of the organisation, on the ground, in touch with the realities that are facing clinical staff, patients and the public, including also being a member of inspection teams. I think it will help us, alongside the data that we have about how ALBs are performing, the feedback from non-executives and the soft intelligence we get from how things are working on the ground, that will help us to ask really good questions in our accountability meetings.

Things are changing. They are changing in the right direction. I wouldn't claim to ever say that it is enough, but I do think we are seeing some breakthrough potential in these changes.

DR WALTERS: These are just reflections really on the tension between having to provide a service in an area when, geographically, it's very difficult. Services are very small. For example, some people we've interviewed have said, 'Well, we knew that this service was too low on obstetricians and too low on neonatologists, but we have to provide a service in this area.' It's not funded

according to the tariff in order to do that. It sort of seems there's a collusion around that, which is where the political imperatives come in. I just wondered, in your position, what your observation was around that.

MS O'BRIEN: I know it's not going to help to say this, but every health care system in the world has to live within the resources that it's got and it has to do the best possible quality job within those resources. I don't think there is or should be a trade-off between money and quality, and we saw what goes wrong when you've got that, in Mid Staffs. That was a very extreme version of that. It's the moral duty of clinical teams and management teams in the NHS to care about resources, because misused resources are depriving other patients or other parts of the country of that resource. At a general level, I don't think any healthcare system ever escapes this difficult triangle between quality, performance, access and good use of resources. I won't accept an easy trade-off between those, because the job of any clinical team and any management team, and the job of a group of civil servants, is to find the best combination of those for the areas of the country and for the services that we're trying to provide.

That's my general approach to the relationship between resources and quality. I want more transparency. I think that we should be open where there are choices that are being made. With the introduction of Clinical Commissioning Groups and Health and Wellbeing Boards, we're trying to both bring a greater clinical questioning to bear on that. Linking clinicians to the deployment of resources is as close as you can possibly get to making those judgments well, but also ensuring that we have, if you like, a more democratic oversight locally about what those choices and trade-offs are going to be.

There are genuine challenges in all rural areas, particularly maternity and A&E. This isn't the only part of the country where those things exist. Putting those choices back out to the public to say, 'These are the consequences of fragmenting a service over multiple different sites,' no country in the world ~~to~~ can afford ~~the~~ significant amounts of, if I might call it, redundant capacity that's simply not utilised in order to sustain very small services, in any specialist area. That's just not tenable, so we have to find ways and search for ways to make services safe.

Actually, I think people are being far too reticent in talking more openly about what those choices are. We need to be talking to the public in different localities. What is the type of service that you want? What are the risks that we're prepared to manage in our community in order to deliver that service? It's very interesting because, back in the early 1990s, I was actually involved in a review of GP-led maternity services – can you believe it? – and midwife-led maternity services in Cumbria. There was a big debate at this point, it's farther north from this area, I appreciate that, as to what it was that people actually wanted. There was a suggestion that all the local midwife-led maternity units at that point were going to be closed down. Our review demonstrated how, in and around Kendal, in that area north of the Lake District, how it would be possible to sustain midwife-led units if proper clinical protocols were followed. I think that actually that approach has been adopted in many parts of the country now, quite successfully.

Of course, I'm a cautious sort of person and I prefer midwife-led units to be next door to consultant-led units, where help is there if it's needed, but that doesn't work for every part of the country. We just need to be open about these things. I think the public is very willing to engage around these discussions. What I don't like is the way that things are smoothed over and people are given the impression that everything is perfect, when choices are being made.

DR WALTERS: I wasn't suggesting that we should throw money at small services. We've talked a lot in this room about how, in Scotland, people expect to be taken from the Outer Hebrides quite long distances, but we don't always bite the bullet if we think that services might not be satisfactory.

MS O'BRIEN: I agree with you. One of the things I do want to say though, which I think is incredibly important I put on the record, is that unsafe services should never be tolerated. Certainly clinicians shouldn't be put in a position where they're required to provide an unsafe service, nor should they tolerate it but, equally, that would be a quite wrong thing to offer to the public under the veneer that somehow it was okay. Let's be honest about this; our concept of what constitutes a service that's of an appropriate and improving quality does change all the time. 30-40 years ago, it was regarded as of a good quality if you get the GP, as well as the midwife, to come to a home birth, when most

births were at home. I mean, our idea of what constitutes quality in maternity services has changed dramatically over the years, and I'm sure it will continue to change.

DR WALTERS: What was your involvement in the authorisation of the Foundation Trust process? Were you sort of overseeing just the mechanics within the Department? I was wondering what insight you had into that when Morecambe Bay was going through.

MS O'BRIEN: If you go back to my description earlier on because I was working on the policy around Foundation Trusts, ~~while~~ I probably was~~, because I was working on the policy around Foundation Trusts,~~ copied into a flow of papers about every FT thing that came through. The responsibility for that process..., there were very clear decision points within the Department that rested with David Nicholson and one of the DGs in that group. I think it was Andrew Cash at one point. His predecessor and successor would chair a group that looked at the submissions on the Department's clearance before they went to individual ministers prior to being handed over to Monitor, so I was aware of what that system was, but I wasn't part of the decision-making process, because it was very much seen as an operational delivery element of the work, as opposed to the sorts of things I was working on at the time, which were whether we were going to extend Foundation Trust status to community trusts. I recall that as one of the big projects that I worked on in 2008-09.

The other thing I was working on was where we were going to go with Foundation Trusts. Were we going to accelerate people moving to that status, or were we going to have a different timetable, given that we clearly got some of the higher performing better organisations through earlier on in the programme, but the timetable was stalling round about this time?

DR WALTERS: I appreciate from what you're saying how this is sort of like an operational arm, which went through to David, and you were more a sort of policy arm. Do you think then, which was obviously very different to the way it is now, that actually getting Trusts to Foundation status was seen as a bit more as an escalator that everybody was on? It was sort of a fairly step-by-step process to get them there and it wasn't perceived that there'd been much to knock them off course in terms of quality issues, or was it

always, 'This is a big hurdle, and some Trusts are going to make it and some aren't'?

MS O'BRIEN: Inevitably, the hurdle became... More and more Trusts found it difficult to meet their standards. That's why in a way the pipeline started gradually to dry up, because the standard was and still is high. I think perhaps the question might be looked in another way, which is did quality play sufficient part in that process and, as more and more Trusts came ~~though~~ through that had variable quality, were the systems for assessing quality strong enough? The early organisations that got through, assumptions were made about them having good quality, which in fact were not evidenced really. Some were of a good quality. It was very interesting my experience, because I was at University College Hospital when it applied for and became a Foundation Trust. Of course it had great quality, but it also had some areas that were not of great quality. In that first wave of Foundation Trusts that never really featured.

DR WALTERS: They were the usual suspects, weren't they?

MS O'BRIEN: It didn't feature. As you go through the decade, what actually happens is that Monitor starts to take more of an interest in quality as the less well performing Trusts are coming through. There starts to emerge, you can see then, a pattern with problems with internal governance, finance and quality, which causes them to take a greater interest in quality, although, it turns out, probably a fault in the design of its process was that it was never formally part of what it was required to do. We only really changed that after the first Mid Staffs report. That was a big wake-up call, because how had that organisation got through when this was such a feature of the organisation? How could that be really? How could it be judged to have good enough governance and yet have those sorts of things going on?

MR BROOKES: That hurdle was part of it, not necessarily the right hurdle.

MS O'BRIEN: I think that's right. Assumptions were made about the governance tests. I don't think people were even looking at quality.

MR BROOKES: It was a self-assessment process.

MS O'BRIEN: It wasn't visible to people. All these issues about poor and variable quality have come to light at a scale more than was actually thought to be there. I would say, if I look back on the last 10 or 15 years, we've moved

from a position of perhaps thinking we have isolated incidents to realising that every organisation was struggling with some form of quality problem, one way or the other. That is the realisation that we have collectively confronted, when I look back now on the journey of the last couple of years in my current job. To claim that the NHS was the best in the world was, in a sense, closing our eyes to the fact that we had got quality shortcomings. They've probably always been there. What's different now is that they started to be much more visible.

DR KIRKUP: The two things aren't necessarily incompatible though, are they?

MS O'BRIEN: Exactly, I agree.

DR KIRKUP: You can still be the best health organisation in the world, because every developed healthcare system has got those kinds of problems in it.

MS O'BRIEN: Maybe our shortcoming as a society is that we just haven't been able to talk about them.

DR KIRKUP: Can I pick up a slightly different aspect of the Foundation Trust process? It's been put to us a number of times that there was pressure on organisations to become Foundation Trusts and on management teams in organisations to become Foundation Trusts, and that that affected their capacity to deal with the day-to-day issues. Do you have any view on that? Is that something that you have had said to you?

MS O'BRIEN: I'm sure that it was experienced like that in a number of places. It's interesting because it went from a sense in which organisations were stepping forward to wanting to do it, which was there with the very first wave ~~forward~~. It's like anything; once it gets turned into a programme and then there's a set of goals, objectives and delivery objectives, people start saying to the people below them, 'Where's your list?' and then another group of people start saying, 'We've got to get people on the list' and then other people say, 'You must get on the list,' and folks in that organisation are going, 'Well, we never even thought we would do that. Why would we want to do that?' You move from a position of having the early adopters and the enthusiasts to people having it put on their table who actually don't even think it's going to make much difference to where they are and what they want to achieve. I'm sure that did happen.

There were various deadlines that were set, if you go back through the 2000s. I certainly recall, in 2006, there being a stated deadline that all Trusts would become FTs by 2008. There are new thoughts now about looking into the next decade about whether that form of governance is right for us in the next decade. At the same time, I don't think it was a bad thing to want Trusts to be Foundation Trust. I just think sometimes the way it was gone about led to an overly pressurised top-down 'You're next; why haven't you done it?' type of conversation, which wasn't really in the spirit of what the legislation wanted. If you strip it all the way back, what was it about? It was about saying, 'Let's have providers take more responsibility. Let's have the people who sit on boards really feel something serious about what they're responsible for. Let's connect providers more certainly to the people they serve and the community they serve.' If you go back to the original 'What was the point of it?' that was the point of it, rather than what we had before, which was boards that really took virtually not much responsibility and passed the problem up to the group above them.

It wasn't an ill founded policy. It just got turned into a sort of bureaucratic pipeline, and the purpose and principle of doing it was smothered in the process of that. It was never, ever meant to be something that... We had an aspiration that everybody could achieve it, that they could be that flourishing organisation with a board of people who cared profoundly about what went on and linked into a community. That's what was wanted, not that they should all just have those two words after their name.

MR BROOKES: Sorry, I was just going to say that it may have been felt, as a Chief Exec or an aspiring Chief Executive to move to the next role, that having FT was a critical element of your CV and your portfolio.

MS O'BRIEN: I've not heard before, but I wouldn't be surprised ~~how~~ to hear that the message got translated down into that. I've not heard that specifically, but I'm interested to hear that and it wouldn't necessarily surprise me, given what we now know about the way the pressures got applied. A request for 'Have you got any more FT candidates?' that might have been made at a national level often got translated into, 'What are you doing and why aren't you on the list?' at a local level.

MR BROOKES: Having been in that system at that time, I'm fully aware that mistranslation happened, because it certainly felt that there were clear messages coming down the system that there was a real onus on getting people into the FT pipeline. It wasn't that it's an aspiration; it was a must-do. I'm just interested on where that translation or mistranslation...

MS O'BRIEN: I think at some point a switch in perception took place, but you can't quite put your finger on when or why, from 'Wouldn't it be great if all organisations were this good' to 'We just need more of them.' I don't think anyone ever sat down at the centre and said, 'We just want the number,' but it goes back to the missing thing, which was the leadership, commitment and explanation of what it was all really about. That message just got completely muted and there was no longer a link between the purpose of a policy and the doing of it. I think that that's really where we started to... If you look at some of the marginal decisions that were made in that era, 2009, 2008, Morecambe Bay, Mid Staffordshire – another one that I know very well, which was a really difficult one for other reasons, was Peterborough, where it wasn't so much a quality issue, but a marginal decision about the affordability of a PFI. It could and should have been a much more visible element on that decision-making process. The way in which the process got tightened up subsequently, in the following two years, would probably mean that none of those organisations would have got anywhere close. We sort of lost the explanation of what the overall purpose of that was.

DR KIRKUP: There does come a point, doesn't there, when you have to say the systems are only capable of tolerating non-FTs, so you have to find another way to deal with them? If the other way to deal with them is to wind them up and merge them with other people, there's a pretty powerful organisational incentive to avoid that, isn't there?

MS O'BRIEN: There's a whole set of wider questions now about the future of providers. In a way, we're turning into a different sort of future. The past decade's policies are really being questioned now across a whole range of different thinkers, think tanks and others, as to whether they help us with the problems that we face. NHS England's ~~five-year forward view~~Five-Year Forward View, which is being welcomed by ministers in the Department of Health, sets out a different approach to the aggregation of services under

providers. It's quite a rich policy terrain at the moment. I think it's less about the so-called status and more about helping organisations to be able to do the right thing for patients and the public, and not create mis-incentives, which I think the current provider landscape does cause to happen. That's the issue that now really needs to be addressed. It's no longer about independence or not independence; it's all about being able to organise clinical services in a way that's best for what people need. I think everybody recognises there are shortcomings in the current infrastructure for that.

DR KIRKUP: Can I stick with a couple of general policy questions? There are clearly strengths and weaknesses to the model that has quality monitoring and assurance separate, at regulatory level, from Foundation Trust finances and general performance. Where do you stand on the balance between the two?

MS O'BRIEN: Well, I think we have now required and we do expect CQC to look at the entirety of the organisation. That must be the case. They are completely different inspectorates; they must tell the truth without fear or favour, and they must do a highly professional job in what they do. I don't think that's the same job as the job we've asked Monitor to do, which is to be the in-year, in-month engager around how you're managing your finances, and the bridge back to the Department of Health where people need cash help or ~~a~~ public dividend capital. That's a "managing the money" issue, which we don't want the independent regulator to do. I think it would be a complete confusion of roles to put that inside CQC. I just simply can't see it happening.

What we do need to do is to further strengthen the help that is given to providers to sort themselves out, whether it's dealing with quality problems or very much increasingly on my agenda is better utilisation of resources inside the organisation, so for example stock control, inventories, best practice on rostering. ~~All~~ On all of these running ~~other~~ complex hospitals issues, there are big variations between organisations and there needs to be more availability of benchmarking and best practice data nationally that people can go to to help them do those jobs well. The helping and the challenging about performance is not the same, in my book, ~~to~~ as an independent inspection that goes in, holds up a mirror, undertakes surveillance and can publish reports without fear or favour.

DR KIRKUP: That's very clear, thank you. The other related point on that would be that one of the spinoffs from the abolition of the Healthcare Commission and its incorporation into CQC was the change in complaints procedure, where the PHSO went from being the third-tier backstop into the second tier. What's your view on the strengths and weaknesses of that?

MS O'BRIEN: It's very difficult this one. If I may, I'll just go back to when I was at UCLH. When I was there, I was responsible for the complaints department and, at that point, we obviously did the first-level complaints but also, when someone wasn't happy, it was my job to convene a panel to do the second-tier investigation. That would usually be a non-executive director of the Trust. Depending on the nature of the complaint, it could be somebody from another Trust or whomever. All of those reports, my recollection is, in our case would be brought to our clinical governance committee, where it was a second-tier complaint. We'd see it in much more detail than just monitoring data on first-tier complaints.

I wasn't involved in the policy decision to aggregate and nationalise that second tier, when it was done, to the Healthcare Commission. I can see one of the arguments for it was that people felt that there was too much potential conflict of interest for a Trust managing its own second tier. Certainly quite rightly, by then there was no confidence in the clinical governance. Although I'd like to think we were improving, and I think we were, at UCLH at the time our clinical governance, what I've now come to understand is that a lot of other Trusts were a long way behind that in understanding what clinical governance was and the comprehensive way in which you have to go about it, including a review of complaints. I can understand why ~~the decision that,~~ through a lack of confidence and a fear of conflict of interest, that <u>decision</u> was somehow taken from the Trust, but my own personal view is that it was taken too far away. I know that the Healthcare Commission tried to do their best, but they struggled to do it.

Then the decision was ~~made~~ faced: <u></u>was it right to leave it with CQC when it was created or moved to the PHSO. There was a lot of debate about the right thing. We were trying to de-layer the process and make it easier for people not to go through multiple layers, 'Now I've got to go to the third tier.' Insofar as we were going to keep a national view, it made sense to take one

of the layers out. I do agree with that. We had a position where, arguably, too few matters were then being investigated, because the bar for investigation by an ombudsman – ombudsman is like a high-end quasi-legal statutory organisation. My goodness, the expectation was perhaps too high, given the status of an ombudsman, that they should be that... You know, what proportion of complaints would we expect to be investigated a second time? Probably 15-20% maybe, particularly the more complex cases where people feel either all matters haven't been looked into. Hopefully we are now improving the quality of complaints systems in Trusts. There's been some failing in that respect.

I do think that the decision that's been made to widen the number of investigations has been a good one. I'd like to feel that we could think of a way that didn't have to nationalise it myself. To try to do that once for a population of over 50 million people seems to me to be at a level of aggregation that takes things a long way from where they actually happened. I think views are genuinely divided on this and for very good reason.

On the other hand, there is a huge benefit in having them done once nationally, because you get a standard approach and you have a sense of comparability. Also, it enables something that I think is definitely a strength of the system, a very compelling annual readout from the PHSO as to what the issues are that are coming through the second tier. I really do think there are advantages in that and I'd be loathe to lose them. Furthermore, what the current PHSO has shown is that she is very willing to take some of these issues, the supervision of midwives being one of them, and then write a subsequent report. I think that that's a good thing.

Maybe keep the best of what we've got, make it more timely and more accessible, and include some greater engagement of locality in that complaint handling. I think that would be a good thing. I'm not in favour of any reorganisation of it though, because I just don't think it would result in any... Well, it might result in some changes, but whether they'd be marked improvements would be highly questionable. I am very much, on all of these matters, coming from the perspective that we should make the systems that we've got work.

MR BROOKES: Isn't the key in that strengthening local resolution of complaints?

MS O'BRIEN: Absolutely, and I am pleased now that there is a clearer direction to Trusts, when they're first dealing with a complaint, to not having it handled by some well meaning junior official in the complaints department, which could happen all too often in the past. Genuinely hardworking though those people have always been, and very committed in my experience, a high level of judgment is needed as to the nature of the complaint and to inject an independent element and an external element in the first investigation, first pass, rather than do it poorly and pass it up the line. I completely agree with you. We need HealthWatch particularly to be working with and challenging provider organisations on the quality of their ~~complaint~~ complaints systems.

DR KIRKUP: A couple of points about the operation of the CQC: you referred to the previous organisation, the first year or two of the CQC's existence, as being characterised as a rather heavy-handed internal style. I think that was the phrase or maybe that was my interpretation of it. People didn't feel that they were able to speak out. One of the clear features of this is that there was a large element of concern about Morecambe Bay within CQC in the middle of 2009. They were talking about serious systemic failures and a red risk rating, all of which seemed to evaporate over the course of about six or seven months, and they ended up with only minor concerns and a green risk rating. Given that some of those concerns were about pretty deep-seated cultural issues within the organisation that surprised a lot of people. How can those things be expected to turn around in six or seven months? From your perspective, do you think that the internal management style of CQC that you alluded to might have played a part in that?

MS O'BRIEN: Well, this is certainly a matter that I hope your investigation can get to the root of. You've pointed to a particular question that I still don't think is resolved, which is how did those concerns evaporate. When you try to strip it all away, it's necessary not only to look at what was happening in the offices in London, because there were different layers of people and different sorts of relationships going on in the immediate locality and in relation to the SHA, which I think confused and confounded who was really dealing with what. It's very difficult to point to one single instance.

Furthermore, it's trying to get to – and I hope you will look into this – what exactly was going on in 2007-08, in relation to the Healthcare

Commission. What did they actually know? Many of these staff are the same people. I don't know if they were, but in many parts of the country they were. Looking into what was happening through that transition, in terms of the flow of knowledge such as it was between the Trust and the local inspectorate and so on, I find it hard myself. I'm looking really more to yourselves, with access to all of this information, to be able to help us to address that question.

DR KIRKUP: I guess what I'm wondering is, in your dealings with the CQC, you formed a view that they had that particular management style. I wondered if you'd come across any other instances where you thought that might have been a factor that might have been comparable to Morecambe Bay.

MS O'BRIEN: I still would go back to what I was saying. If you think about it, really it wasn't much of a top team at the beginning of 2009. I think they had a very, very difficult inheritance, because they weren't actually allowed much access to the organisation before April 2009, going back to the matter I described to you earlier, which was a proper and profoundly held view on the part of the previous management that they had a job to do and they would do that job up until the end of March 2009, and then the staff would somehow be morphed into this other organisation. I don't think that transition between the new leaders and the old leaders was what it could have been and should have been. I'm only looking at it, if you like, from one end of the telescope.

What I don't fully understand is what that felt like if you were working for the Healthcare Commission in this locality. Did it have any impact on you at all? Working at a national level, you can sometimes overstate and exaggerate the impact of what you see is going on, where you don't know how that translates down locally. I think your insights into how that was experienced locally could be very helpful to us, were we to manage further transitions. I simply don't know the degree to which you handed down, I mean that was felt down inside the organisation, or the degree to which some of these cultural issues – the reticence to raise concerns – was actually switched on in April 2009. To what extent was that actually there prior to that? I think that needs to be opened up and understood.

DR KIRKUP: You mentioned the concerns that were raised by Kay Sheldon, who was the non-exec of CQC. We've heard an account from her, which makes it

clear that she doesn't think that the response to the concerns that she was raising was ideal, from her point of view. Can you give us your perspective on that?

MS O'BRIEN: You're talking abut Morecambe Bay, I take it.

DR KIRKUP: She raised general concerns, and then I think subsequently used Morecambe Bay as a particular example of that.

MS O'BRIEN: Well, I would say as regards my perspective on the failings in that organisation in general, if I may address that first, were first raised much earlier than when we heard from Kay Sheldon and that was when the Winterbourne View *Panorama* happened. There was no doubt about it in the Department; that was the first time we said, 'There's something going on here that we don't know about.' We were already concerned about the running of that organisation in the late spring of 2011.

Subsequently, the Health Select Committee undertook its review and it reported in the summer. That was the point at which we said – it's the only time we've ever actually done this; it demonstrates the degree of concern – I proposed to ministers and they agreed that I lead a capability review of the organisation. We then assembled a team, including non-executive directors from the Department, and we started that review in September.

Maybe we should have done it faster. Now I look back on it, I think, 'My goodness, we should have done it the very same day.' We were in there, inside the organisation, and also the National Audit Office was also undertaking an investigation at that time. I think, 'Did I have concerns? Did the senior leadership of the Department and ministers have concerns about the CQC by September 2011?' Yes, we did. We were already doing... I mean, we didn't have the knowledge that we now have, but we were concerned enough to do something that was completely unusual, which was to send in a team to question and investigate the leadership of that organisation, of which of course Kay was herself a part, as were others.

Further matters, although they were all matters that we were aware of, were ~~part~~ put on the table with the Mid Staffs inquiry. What was different when we come to the spring of 2012 was something very, very specific about Morecambe Bay. I was quite clear that this was going to have to be something that the new Chief Executive dealt with. Shortly after that, I had a

meeting with David Behan, where he satisfied me that he had set up an external investigation into it. Should I then have been investigating it myself? My judgment was no. Was that the right judgment? Only history can really tell. Had he gone in there, as a new Chief Executive? Was he somebody who I had confidence in, having worked with him for four years? I knew the calibre of the person ~~who~~ he was. Did I think, did I have confidence that he would leave no stone unturned and get to the bottom of it? Yes, I did. The fact that he set up an independent review gave me that confidence. I didn't see the need for a subsequent review or a parallel review to be undertaken by the Department.

DR KIRKUP: That's very clear, thank you. She alleges, I think, that there was an attempt to remove her as a non-executive. Can you shed any light on that?

MS O'BRIEN: This is not related to Morecambe Bay at all, but this has all been thoroughly documented. I can give you my own personal experience of it. Following the hearing at the Mid Staffs inquiry in 2011, ~~DR KIRKUP~~ Dame Jo Williams, Chair of the CQC wrote to the Secretary of State asking for Kay to be removed as a non-executive director. The decision that the then Secretary of State Andrew Lansley made was to not act quickly. He'd had a request; we didn't have the full information at that time. We knew that we had the NAO report going on. We had the capability report going on. The judgment that he took was, actually, to step right back and to ask himself, 'I've got completely different views here,' one from a Chair that he'd not that long since appointed to the role, and from a non-executive director. The view he took was, 'I need more information and I need information from outside the Department to help me with this,' which is why he asked an independent person, who'd previously been director of HR in the Cabinet Office, to investigate it for him. That investigation was undertaken.

The report of that was then shared with both Jo Williams and with Kay Sheldon, in final draft. In fact, he had meetings with each of them separately. He has been very open on a number of occasions in Parliament that he was considering removing, because he was asked to consider, but he took all the advice and evidence that was put to him, including further representations from Kay herself. He reached the conclusion that he would keep her on the board. What actually happened subsequently was that all

the other non-executives ~~left or were removed~~ stepped down, and a new Chair was put in place in the autumn of 2012. Kay Sheldon's own term of office has been extended.

DR KIRKUP: Absolutely, and there was some question of a medical report. Was that something that you were aware of?

MS O'BRIEN: Yes. I have explained this. By the way, in saying this to you, I do want ~~o~~ to let you know that this is a matter on which I have written, in full detail, an account to Kay herself and to the Public Accounts Committee, who've questioned me on it. Therefore, all the information I'm giving you has already been shared with Kay. I wouldn't want to be discussing such a matter without her having previously known this information.

My own role in it was really very minor, if anything. At some point in the January of 2012, as I recall, Jo Williams came to me and said that Kay had put a number of requests to her about having an assessment, under the recent disability legislation, of her needs to enable her to fully participate on the board, and did I know who did these assessments. I said, 'I didn't, but were I faced with a similar request from within the Department or from any other ALB, I would refer them to my occupational health service,' which is an organisation called Medigold. I said, 'I don't know if you've got an occupational health service yourself but, if you need to use the one from the Department, I'm sure that that could be arranged if that would help in getting this assessment for Kay.' Always in my mind was that an assessment is done with and alongside ~~with~~ the person themselves. That's really where I left it.

It was only later that, through a sequence of events, it came to my attention that, for some inexplicable reason that I do not think was at all acceptable, a report was written by or about Kay that talked about clinical matters, which were completely inappropriate.

DR KIRKUP: Yes, on the basis of a telephone conversation.

MS O'BRIEN: I think that that has been raised in Parliament. It has been explained. I personally have written to Kay to say that I think it was wrong and that I'm very sorry that it happened at all. It should not have happened and it was wrong. It did not get instituted by the Department of Health and we would never have instituted any such thing.

DR KIRKUP: Okay, that's really helpful, thank you. It is slightly tangential to the purpose of the investigation.

MS O'BRIEN: It's important that you should ask about it.

DR KIRKUP: The final area, you'll be glad to hear, that I wanted to touch on was some of the critical decisions that were made around Morecambe Bay were in the run-up to the 2010 general election. I wondered if you could just reflect for us on whether that timing and people's perceptions about bad news in that sort of period may have played any part.

MS O'BRIEN: I think what I see of people in political office is that they are desperate to do a good job for the public. That's what I observe. How they interpret that varies from one person to another. I wasn't really that close to ministers. If you think about that period from the summer of 2009 to the summer of 2010, my role, as Director General of Policy and Strategy, was absolutely focused on preparing for the spending review and for what would come after the election. I wasn't engaged with ministers on a day-to-day basis. I do know that there was a desire for CQC to get on with it and to do their job. That was very evident at the time, but I have never, to my recollection, sat in a room where someone said, 'Let's have all the bad news after the election rather than before.' I just have no recollection of any such thing happening and I certainly don't see it happening now. We're only weeks away from an election.

If anything, what you see is people in political office generally wanting to get on and do a lot of stuff, because they worry that they won't be there afterwards. I haven't got any personal experience of that or evidence of that.

DR KIRKUP: Thank you. That's very clear and very helpful. Let me just ask whether there are any final follow-ups. No? Is there anything else that you would like to say to us while you have the opportunity? You don't have to, but if you would like to.

MS O'BRIEN: I have had the opportunity to meet only one of the families who has been affected by this series of very difficult circumstances, and my heart absolutely goes out to all of them. Through my experience on the Bristol inquiry, I know the longstanding impact that this has on a family. To lose a member of your family is hard enough, but to think that the services that were there to help you may have been part of that or that the systems around them

to scrutinise them were short of what they should have been only adds to the pain that people have to deal with.

For all of that, I am extremely sorry. I will continue, in the role that I have, to do everything in my power to address those shortcomings and I'm really pleased that we've got this inquiry. I'm very appreciative ~~for~~ of you and the rest of the panel members for giving your efforts and attention to it, and I'm really open to the recommendations that you make in your report, such as they fall to me, to do something about how we can strengthen the systems.

DR KIRKUP: Thank you very much. That's much appreciated, and thanks for coming. Thanks for your help.

(The meeting concluded at 3.48 p.m.)

THE MORECAMBE BAY
MATERNITY AND NEONATAL SERVICES INVESTIGATION

Friday, 9 January 2015

Held at:
Trinity Enterprise Centre, Barrow in Furness
LA14 2PN

Before:

Prof. James Stewart Forsyth – Chairing the interview and expert advisor on paediatrics
Ms Jacqui Featherstone – Expert advisor on midwifery
Dr Catherine Calderwood – Expert advisor on obstetrics

DR MOHAMED ANAS OLABI

Transcript produced by Ubiqus
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(At 4.07 p.m.)

THE CHAIR: Thank you for coming along Dr Olabi, and I'm pleased we were able to find a mutually acceptable time for this interview. My name is Stuart Forsyth. I'm a paediatrician and Medical Director from Tayside. I'm Chairing this interview because Bill Kirkup, the Chair of the Panel, is not available today and not able to come. I'll introduce my other two members of the Panel.

DR CALDERWOOD: Hello, I'm Catherine Calderwood. I'm an obstetrician in Edinburgh and I'm the Deputy Chief Medical Officer for Scotland and the National Clinical Director for Maternity and Women's Health for NHS England.

MS FEATHERSTONE: I'm Jacqui Featherstone, I'm Head of Midwifery and Head of Nursing at an acute trust in Essex.

THE CHAIR: Some housekeeping notes to begin with. You'll be aware that we are doing recording the proceedings, and there will be an agreed production of that recording available thereafter. You also see that these panel meetings there are family members are invited, and today we do have a family member here today. Welcome to you.

The – as I said, the interviews are recorded, and there are transcripts made of these recordings, and these are available to other family members who have not been able to attend the panel meetings, so be aware of that. We've just discussed about the mobile phones, and there are no other recording devices are allowed during the interview, and really the objective is that information that is passed at the interview remains confidential.

The interview's really in two parts. One will be other general questions which we will just ask you, and then the second part, when the family members will then be asked to leave the interview, we will ask you some questions regarding some of the more confidential aspects of patient care. Quite clear about proceedings? Are there any questions you wish to ask?

DR OLABI: No, I'm fine, thank you.

THE CHAIR: Okay. I'll just begin by asking you a few questions, then I'll pass on to my fellow Panel members. Just for the record, your current position within the Trust is what?

DR OLABI: Consultant Paediatrician in Furness Hospital and some duties in Lancaster as well.

THE CHAIR: When did you start?

DR OLABI: Long time ago. '96, '97.

THE CHAIR: '96.
DR OLABI: Around that time.
THE CHAIR: Right, and prior to that, where had you received your clinical training?
DR OLABI: I had done training as Glasgow, in Scotland, and overseas before that.
THE CHAIR: Sorry, before that?
DR OLABI: Overseas.
THE CHAIR: Overseas. Where?
DR OLABI: In Syria.
THE CHAIR: In Syria. So you're [inaudible] Paediatrician, Furness General Hospital. Your day to day clinical responsibilities, what are the sort of range of duties you have?
DR OLABI: Over the last few years I've taken up interest in paediatric neurology and epilepsy, so that's my practice at the moment. The day to work is general paediatrics, [inaudible], and of course acute paediatrics in chronic conditions and safeguarding cases, and specialist clinics in epilepsy and plus allergy. Focusing more towards the neuro and epilepsy in the last couple of years.
THE CHAIR: So how do you, looking back on the length of time you've been in Furness General, how do you see your contribution to the service and how do you feel – you, personally – feel that the service has been managed?
DR OLABI: It's a very big, open question. My contribution to the service, I always wanted to be in the middle of the decision making groups and teams, and I've shown interest and different experience in this area. Currently I'm the lead clinician in Furness Site.
THE CHAIR: How long have you been the lead clinician for?
DR OLABI: Officially, over the last possibly couple of years.
THE CHAIR: How many?
DR OLABI: Two years.
THE CHAIR: Two years. Right.
DR OLABI: Previously I'd been the most senior person here, with expected responsibility of being - managing the local service. Of course, this wasn't official, and I think the previous management system was clinical director across the Bay, but sometime they have a locum person who will do the day to day fire-fightings and management and it should have that.
THE CHAIR: So the sort of the wider question of how you personally feel the service has managed over these years. Do you think it's been...
DR OLABI: Well it's starting from a very sort of limited number of clinicians when I joined

the service. We were, I think three only consultants and about two or three juniors. And this is a goal over time. Main difficulties in Furness is the geography isolations and recruitment of staff and their retaining of staff as well. So this might been challenging area over the years, so the turnover of locums and short term appointment has been quite high, and this has affected the service – the development and continuity of team work and so on. Things have improved lately, of course, but this is going back ten years of course.

THE CHAIR: Yes. So why do you think – well, the medical staff, for example, or paediatric staff were reluctant to come and work in Barrow?

DR OLABI: I don't know. I myself came here and to stay for a year or two, because it's perceived as remote and isolated unit. But I loved it and stayed here for this amount of time. My kids love the local school and they're flourishing now, they've developed quite well. So I think the perception that your question why people are not coming is perception of the isolation and the geography.

Some other factors, of course: the number of medical staff and the supporting structure for the medical staff also contribute to people being reluctant. Historic element; place used to have small number of middle grade staff, as you said the paediatrician, you know, in terms of be just always being like a three tier service; junior, middle tier and consultant, but I think in Furness area why it's not attracted more people is because the difficulty of maintaining the middle grade tier. So the support for the consultant is rather small and limited, and this maybe scare people off, basically.

THE CHAIR: So why is – why were the difficulty in maintaining middle grade doctors in Barrow?

DR OLABI: I think, going back again to there wasn't middle grade training rotations from the [inaudible] you like. We used to have only non-training middle grade post, which basically gone now. Disappeared. And the size of the Unit...

THE CHAIR: Do you think – sorry – do you not think there was training opportunities for...

DR OLABI: Oh there are...

THE CHAIR: Middle grade doctors to come for a period of time to work in Furness?

DR OLABI: I think we had, through the College of Paediatrics, about 5, 6 years ago we had an ST1, ST2 trainees in paediatrics, mainly in general and community paediatrics, which – and there are plenty of learning opportunities from it. But we had our certificate is in recruiting community paediatricians at one stage. Which is well-

known facts which weakened the training potential for the trainings.

THE CHAIR: Do you think this question of isolation – that you describe as isolation – the jobs vacant is addressed by greater working, better working with Lancaster?

DR OLABI: I would think is - is certainly is the case now. Because, again, going back the Trust was three separate trust: Kendal, Lancaster and Barrow, and when the Trust merged there's been more working across the Bay if you like. More travelling across the Bay and more working across the Bay. It had it's advantage and had disadvantage as well, of course. But the – this isolation has been lessened in the last few years due to the networking with Lancaster, and also networking with the regional centres Manchester, Liverpool as well.

THE CHAIR: Why did it take so long to actually develop better networking between the two centres?

DR OLABI: I think it's – if you flip into the history of Morecambe Bay again, there's been lots of changes of management, few Chief Executives came and gone. I do remember about four or five of them over the space of possibly ten years. So there's been, from the senior management, probably there's been quite a few changes because possibly...

THE CHAIR: Well what about the relationship between the paediatricians in Furness and paediatricians in Lancaster?

DR OLABI: Normal relationship like any other colleagues. Professional relationships. Talking about myself, I do run clinics regularly in Lancaster, and I found it normal relationships. If you're talking about managers or clinical director type things, the way they approach things etc., they – everybody has different styles and different approaches, and that can be either helpful or unhelpful sometimes.

THE CHAIR: Well presumably I mean there were some difficulties, weren't there, with clinical directors and clinical leaders trying to have the two Units working well together? I mean, why was that?

DR OLABI: I'm sorry, I didn't catch the first...

THE CHAIR: Well the clinical – there were clinical directors who tried to improve the working between paediatricians in Furness and paediatricians in Lancaster, but they had great difficulty, and I just wondered why?

DR OLABI: I think the two Units are different units, in terms of resources. For example, Lancaster Unit the working patterns for a consultant there is completely different from the working patterns of consultant at Furness. They have a full middle grade team in Lancaster and they're fully supported. There's no kind of [inaudible] consultants time

back in Furness.

So you try to get two Units to work together, I mean the geography was a very challenging. Because if you are closer we get all these consultants to participate in a rota and cover the two units closely. But at 50 miles distance make it absolutely challenging to get any sort of more closer working, or cross-cover if you like, between the two units being practical or possible. To travel to Lancaster and go back to Barrow you need two hours, for example. So that's gone out of your working days. If there's no slow moving vehicles on the A590 or accidents etc. So the road is very treacherous as well. So all these factor makes it – you know, if you're talking about Central London, Manchester, etc., you have 5, 10, 15 miles units next to each other, that makes sense to amalgamate and etc., but the geography here is very challenging, I feel.

THE CHAIR: You know there are [inaudible] the geography is part of it. The relationship between the two units is really important as well, isn't it? To provide a good, high quality, sustainable service across the Trust catchment area.

DR OLABI: I mean that's the aim, and I think each individual clinicians is providing, to their abilities and expertise, a high quality service. It depends what you mean by working together. As I said, I do run specialist clinics in Lancaster, go to the patients.

THE CHAIR: So when did you start doing these?

DR OLABI: It was quite – quite a few years now. The allergy – the paediatric allergy clinics we added those special expertise about seven, eight, nine years ago. I've started to do clinics there, [inaudible] at least five, six years ago, and this is developed and become like – it's set up like a tertiary paediatric allergy for Manchester [inaudible] I join them and we see patient together from across the Bay.

So this – this particular development has been very positive, and that's improved the relationship between the clinician and the staff and you exchange information and become less isolated as well. So that piece of [inaudible] has worked out quite well according to the feedback, I'm aware of.

THE CHAIR: What about the relationships between the paediatricians themselves, in Furness? Have you always got on well with – have they all worked together as a team?

DR OLABI: They've changed over the year again. Depends on what year you're talking about.

THE CHAIR: Well this review is from 2004 to June 2013.

DR OLABI: Yes, I mean each unit they have their own challenges. From my point of view, as personal experience, I did have some – not difficulties, but different of opinion, if you like, which is more or less reflects the individual experience and training and approaches and so on. But as a Unit we have worked together for the best interest for patient populations.

THE CHAIR: Can you honestly say that? Do you think that the relationships have not been sufficiently bad to, in fact, affect your clinical care?

DR OLABI: Definitely I can say that. I'm not aware that due to differences of opinions that the patients received less quality care, if you like. Because at the end of the day, regardless of how your relationship with your colleagues, you've got your patients to deal with and you get your full attentions and skill to that particular patient and families.

On the other hand, you might have issues with your colleagues or – I think this is not something specific to Furness Unit, because if you go up and down the country, overseas, each unit and each different teams, they function differently and the dynamics of the team depends on the members of the team and so on. So I don't think in Furness particularly it was a big issue in terms of colleagues' relationship.

THE CHAIR: Well, I think some people might disagree with you on that...

DR OLABI: I'm sure...

THE CHAIR: Who are not necessarily... both from within your own paediatric group, I mean there are some who have described the relationship as – as very poor. And even worse than that.

DR OLABI: It depends on these people. I'm sure the people you're referring to either have left or retired, and they have their own views about how things worked out, you know, I can go to specific example if you have anything in mind.

THE CHAIR: Well, I think that what I wanted to try and get a feel for is what you – you're obviously, as a senior paediatrician throughout this time period, latterly as a clinical lead, and I'm trying to work out why relationships were poor. Why actions were not taken to improve that, particularly because of the potential risks to the care of children within Furness.

DR OLABI: I don't agree with this statement, the last one you mentioned, that the relationship was poor between the clinicians, which affected patient care. I think the relationship was less ideal, if you like, between the clinicians and the management.

THE CHAIR: And when you say, 'Management', who are you referring to there?

DR OLABI: Well, the middle management, the clinical director, for example. Not the current one, previous one if you like. There's been – I think due to the style of the management of a particular person there's been lots of tensions?

THE CHAIR: Why were there tensions?

DR OLABI: Well, because I think first of all, as I said, Furness unit were trying to get some sort of equity to Lancaster unit. I don't think we'd been listened to over the years in terms of having a good support for the medical team. Again, going back to the juniors and middle grade establishment. So that's affected the kind of relation between...

THE CHAIR: Well can you give me an example where you put forward a proposal that was going to address these issues, and that it was not addressed?

DR OLABI: I mean plenty of time we have – we used to have – we still have senior meetings and discuss with the management our concerns, and put proposal forward to improve and strengthen the medical team. They have tried, at certain stages but again, due to the difficulties of retaining and keeping the staff in the Unit things have not – for example, currently we advertised for a consultant paediatrician, because we're not full complement yet, and we advertise a few times and there's been no applicants. I will keep re-advertising, despite the current clinical need person is very much liked by the staff and by the team and we work very well together, very closely, who's a different person from previous management. So what I'm trying to say, the relationship and management did not affect the recruitment and things. There's so many other factors which play a role in this.

THE CHAIR: Some of your colleagues, I think some have just recently retired or retiring, have had conditions placed on their medical practise. Can you tell me about how that was – how that came to light and are you, as sort of senior paediatrician, involved in that?

DR OLABI: These particular colleagues has been investigated by the Trust. I was not part of the investigation, but I was aware about the reasons for the investigations. I was completely not a part of that process, and I'm made aware of the outcome of that investigations. This particular person again – there must be enough ground found by the investigation body to put conditions on his registrations, which I'm suspect they are temporarily and they will be lifted in due course etc.

THE CHAIR: What I'm trying to get at is if you're working closely together how – and do you have processes of picking that up? Do you have joint meetings to discussing cases? Do you do joint ward rounds? How do you know that you're colleagues are

actually performing adequately or not? Or how do they know you're performing adequately or not?

DR OLABI: I mean as a colleagues of course we meet every day and we have got a system of handover. We actually, at Furness, is very interesting Unit because it's a consultant delivered service at the moment. So in 24 hours you could have three or four consultant rounds and handovers. We certainly have one at 9 in the morning. We have another one about 4.30, 5 in the evening. A third one we have it at 9.00 p.m., so it's 24 hours fairly close working relationships, and the current – we do have, of course, system of governance, a system of the incident reporting and PSIs...

THE CHAIR: When was that – when did that really begin to develop?

DR OLABI: I think few years now.

THE CHAIR: But not back in 2004 or around that?

DR OLABI: I don't think in 2004 we had this system. No, I cannot recall that. Yes. But this particular person, the one you mentioned, found that he – there was question mark about managing few cases, and I think, at one stage also there was a safeguarding case which tipped off the whole process and was suspended, and then into three years or something? Or investigation without any clinical work. Of course, this person I feel felt very bitter about the Trust and the Department, that he ended up in such situation, and he possibly might reflect or might say things which can be true or can be untrue as well.

THE CHAIR: And who reviews all the complaints for paediatrics to you? As a lead clinician do you look at the complaints that come in?

DR OLABI: I look at complaints with the current system of medical staff. We had a modern matron person who – and we have a clinical governance team as well. There's quite a few people recruited in the last few years to look into the PSIs...

THE CHAIR: But that wasn't there previously then?

DR OLABI: There was no such a system previously. I think this is all developed in the last three, four years possibly. So we have a designated now person look into PSIs, clinical guidelines up to date, make sure people are practising up to date and compliant with the Nice and so on. We have a very active system in the last few years, into these areas.

THE CHAIR: Okay, well I'll stop just now. I've got some other questions I want to ask you, but I'll first of all hand over to Catherine and she'll ask you some questions.

DR CALDERWOOD: Thank you. I suppose we've already explored relationships within

paediatrics. What about your friends, the obstetricians? How does the relationship with obstetrics...

DR OLABI: Excellent, I would say. I've – I like all my colleagues in obstetric. The previous and current ones. Of course, things change over time. Maybe there was no such strong system of governance and meeting in Furness [inaudible] section previously but certainly over period of last five years or so things are becoming far more structured and discussions always take place.

We have a system also of a foetal alert they call it. So any concern from the obstetricians about any foetal issues communicated to the paediatrician and then we have a named person who will act on this alert forms put like provision in hand and pass it onto the other paediatricians to be aware. So there's been lots of improvement in the last few years, in terms of working together with the obstetric staff.

Midwives are – sorry I'm not going to say this now, but in relationship from my perspective have always been – it depends on the person investment, you know, in the relation, and depends on how strong you believe that this is for the best interest of the service and care. But if you compare the Furness unit to like a Great Ormond Street unit or to [inaudible] unit there will be lots of different areas of practise. It depends on the support and the resources these units receive. Which comes, I think, naturally. I'm not saying that we should accept less standard, but I think the support and the structure for these units are different.

DR CALDERWOOD: So I'm reassured to hear that there are perinatal [inaudible] and a foetal alert system. You've said that that's relatively recently...

DR OLABI: We're talking about few years now. Talking about three, four years.

DR CALDERWOOD: When we were looking back over case notes from previous to the four or five years ago, it would appear that there was – there didn't seem to be any perhaps recognition of a need for that sort of level of communication. So there's obviously been – you've used the word, 'Improvement'.

Did you think that there were relationships at that time previously that prevented good communication, where there have been obstetricians wanting to look after cases where the paediatricians said, 'Well this isn't appropriate for a level one unit...' Might there have been – or the other way round, where the paediatricians were wanting to look after higher risk cases and the obstetricians didn't agree?

DR OLABI: We used to be level two units. We downgraded to level one recommended by the network....

THE CHAIR: What was the date of that? Do you know?

DR OLABI: You're talking about a good six years or something, yes.

THE CHAIR: About six years?

DR OLABI: Yes. I see your point. I mean I worked very closely, for example, with the previous Clinical Director for Obs & Gynae. I don't know if I'm allowed to give names or not. He would come to certain paediatrician if you like, saying about this case, I need to look after this one, going to deliver this case here, happy. Should be kind of standard, but some paediatrician are more keen to agree and accept than others, and this reflect, in my view, the experience and the skills and the confidence of the person. This is still the case. If we have somebody saying, 'Got this case, what do you think?' Again, it's such an individualised kind of approach...

DR CALDERWOOD: Although a 24 hour seven rota. So the individual's making a decision about something that is not going to be their responsibility all the time.

DR OLABI: Yes, I see. But again we're not talking about really quite complex cases here. You're talking about somebody who's – I mean currently the standard for – or the guidelines for the Unit, level one, is that not to deliver anything less than 32 weeks. Not to leave babies on CPAM more than six hours, four hours. I'll give you one example, recently baby born about 31 six days. Just about – just under 32 weeks by one day, was kept in the unit and we did about CPAM few hours.

We discussed with the network and we felt it's in the best interests of the child and family, and the child done quite well. So there are these areas of practise variations, you need to look into the circumstances of the case. I – at one stage they wanted to take all 34 weekers and less transferred to deliver in Lancaster, and we felt that this is not really in the best interests of the families around here, because they have got huge amount of travel and disruptions, and the staff here would be completely deskilled. So we discussed this area here, and now we agree on 32 and below to be transferred. So there is lots of discussion currently with the two teams. There are new people, new faces in the – in the team, and I think things have improved.

DR CALDERWOOD: So you – I don't want to put words in your mouth, but you perceived that previously this level of discussion with individual cases could not go on to the extent that it does now? That perhaps new faces have brought in better communication, better agreement?

DR OLABI: Yes. I mean there are more people as well, I mean before there was possibly

two or three, and now you're talking about five people.

DR CALDERWOOD: And again then, in the past and then now, what I'm hearing is that there are still individuals who are able to agree about keeping a certain cases. Are there not protocols, or criteria, where...

DR OLABI: As I say, protocol is this gestational aim.

DR CALDERWOOD: Yes, fairly blunt though.

DR OLABI: Very blunt. Yes.

DR CALDERWOOD: So there's a bit of wriggle room if somebody's – in somebody's opinion, then there would be a...

DR OLABI: Yes. I mean I give you example of one case, and I think, as a clinician, your best interest of the child is really – is your paramount responsibility. If you just blindly follow numbers and figures and protocols that can affect the patient adversely. But if you deviate from these figures, you have to explain properly why you've done it. Document it, and make sure it's plausible. If not, you just follow protocol. I mean, my concern that the new doctor, new generation are, you know, guidelines followers basically. And you need to look into the patient as a whole, not just figures and so on. So it's my personal opinion, really.

DR CALDERWOOD: But it's a very – and it's a small unit. It's got four cots. I don't imagine it's very often full? All four? How do you ensure, then - that there aren't any neonatology trained among you, with a special interest - how do you ensure that those decisions that you are making are based on people who are competent and have – have maintained the skills? It's not – this is a – it's not – you're a small unit, this is a small unit problem and what if your 31 and 6 days baby goes off? How do you know that the person that's on call in the middle of the night will be able to intubate that baby and deal with that baby appropriately? That the drug doses are very complicated, that you don't need me to tell you that. You've got nursing staff that are equally then spread over more shifts than the doctors. How do you ensure then, as a Unit, that that decision made by one person who believes that when they were on call – perhaps it was you – 31 and 6 all day every day – that it is – that there's a whole team of varying standard, of varying competencies, who need to be – to be working to the standard? Which is why the guidelines exist. So how does the Unit overcome the fact that any one case will not be seen very often?

DR OLABI: When – I'm not saying I deviate from the guidelines, or treating babies who not supposed to be left in Furness. I've never say that.

DR CALDERWOOD: Would you have a baby ventilated with a diaphragmatic hernia, for example?

DR OLABI: No, no...

DR CALDERWOOD: In the past?

DR OLABI: These cases should be dealt with antenatally.

DR CALDERWOOD: In the past?

DR OLABI: If not - any babies who have diaphragmatic hernia must be transferred.

DR CALDERWOOD: In the past?

DR OLABI: Even in the past.

DR CALDERWOOD: So there hasn't been a baby kept?

DR OLABI: No. No.

DR CALDERWOOD: Okay.

DR OLABI: We kept babies only waiting for transfer team to arrive. But we never, ever leave a baby with a chronic hernia in Furness or even Lancaster. These babies should go to tertiary centres straight away. I'm very surprised about, you know, this idea. So that's never, and should not happen, to leave a baby with this condition in the level two, let alone level one unit.

DR CALDERWOOD: Quite.

DR OLABI: So basically you saying that how could you keep a baby 31, 6?

DR CALDERWOOD: Well you gave me that example...

DR OLABI: Yes...

DR CALDERWOOD: And [inaudible]...

DR OLABI: Yes, and all your consultant colleagues are fully qualified consultant paediatricians in the unit have experience. So I would expect for all of them to be able to intubate a baby on the intubations. If not, and if this is highlighted, this is a serious, you know...

DR CALDERWOOD: But how do you ensure that they are, so you're neonatal...

DR OLABI: All the consultants are done [M&S?] courses and updated regularly. [ABS?] courses updated regularly. If we keep a baby, say of 31, 6 in the Unit we would have a word with the network in Preston.

DR CALDERWOOD: Okay.

DR OLABI: And we'll discuss with them the case and make sure we get their agreement. This is what we've done in this baby who needed some CPAM more than six hours. [Inaudible] got 12 hours and he kept in the Unit. But this was done in collaboration

and discussion with the network – in the network in Preston, and this is normal practise, nobody will deviate from this practise.

DR CALDERWOOD: So it's not and – you're telling me, I'm wanting, that it's not an – down to an individual then to decide where – where they then are sharing responsibility across.

DR OLABI: Yes.

DR CALDERWOOD: So – and the people who are working at the moment would all – would all agree? Or would there be cases where that you would be saying, 'Well, I'm not comfortable with that baby being kept in Furness'?

DR OLABI: I think if you have a guidance about gestation, for example, all these cases should be transferred out. The only exception is that you only have one day and there's no complications and you discuss with the network you keep that baby in for the best interest of that babies and family.

DR CALDERWOOD: Yes.

DR OLABI: But I think all the team aware about the existence of protocols and guidelines, and the network connections. They all discuss cases with the network if need be, and it's not like a matter of individual decisions, to make it on behalf of the rest of the team.

DR CALDERWOOD: Alright, and that is – could there have been situations where - you're saying that there has been improvement and improved perinatal meetings, etc. Because we are covering a long time period in – when did all that sort of recognition, really, of needing to have agreement and needing to have network support – how long has that been in place?

DR OLABI: I think this is when the network was established, there was lots of reconfigurations about six, seven years ago of all neonatal networks in the country, and this is where all these protocol guidelines, gestation contact then it was about 6 years ago or so, roughly.

DR CALDERWOOD: Okay.

DR OLABI: And from then, and after all these Morecambe Bay investigations if you like, and cases and so on, people are more aware of complying with all these systems.

DR CALDERWOOD: And prior to that?

DR OLABI: Prior to that we did have a system, but possibly it – I mean things change over time, definitely. Practise ten years ago, standard of practise ten years ago, acceptable standard of practise ten years ago, is different from acceptable standards of practise

today. The amount of tests, and the amount of investigations etc. are different all the time. I wouldn't say that previously we had failed our patients. We have been given a MUMs award in our [inaudible] unit before the network established, and the MUMs award is a national award for unit who have the lowest – for neonatal mortality meeting – for neonatal mortality rate, and we actually amongst the lowest of national neonatal mortality rate, if you like, and this is documented as well, and there is a placard on the outside of the Unit.

DR CALDERWOOD: And what year was that?

DR OLABI: Just checking my memories now. I think possibly '04, '05?

DR CALDERWOOD: And if then, for example let's take the criteria for a baby who would need to be cooled after the Toby trial was published, what would – what would it – what would happen currently, in Furness?

DR OLABI: What would happen...

DR CALDERWOOD: So the babies are assessed once they're born. And you obviously have sometimes got some prior knowledge that the baby may not be in good condition, and you would hope that your good relationship with the obstetrician will mean that you're pre-warned. But what would happen then if that baby was assessed and found to meet the criteria?

DR OLABI: We will be straight away, within the six hours time, within, you know, quite limited amount of hours, contact the network again...

DR CALDERWOOD: So within...

DR OLABI: Arrange for transferring this baby as soon as possible.

DR CALDERWOOD: And that's – there's a 24/7 transfer service?

DR OLABI: There – there is a two transport team. One is called STaR team, which is Preston network, and one is the Manchester Saint Mary's team. And this service is 24 hours. I think the STaR one is – I think it's working hours only.

DR CALDERWOOD: It's 9 till 7.

DR OLABI: Yes. 9 till 7.

DR CALDERWOOD: How do I know that and you don't?

DR OLABI: Well I do know that they are not 24 hours.

DR CALDERWOOD: They're 9 till 7.

DR OLABI: Working hours, 9 till 5, 9 till 7, yes. The Manchester team is 24 hour service.

DR CALDERWOOD: So from...

DR OLABI: But it's not always...

DR CALDERWOOD: Let me just be clear. So if a baby have met the criteria to be cooled in Furness, 24 hours a day that baby would be transferred within the minimum time possible to a unit where the baby could be cooled? There would be no question of having to wait for the transport to kick off the next morning?

DR OLABI: Of course not.

DR CALDERWOOD: And what would your – what would you feel your normal transfer time to have the baby to be where it should be, what would that – how long would that take?

DR OLABI: This depends on lots of factors, I mean depends on the transport team. If they are busy or not. They sometimes can be retrieving babies from other areas in the network. But by and large, my experience that if we have a baby need cooling the response was quite good, and the transfer happened within the – the agreed timescale.

DR CALDERWOOD: And an awareness of, from yourself and all of your colleagues, of those criteria so that a service would be contacted within a very short time of the baby being born?

DR OLABI: Absolutely. We never hesitate in the Unit, you know, about cooling criterias, clinically and biomechanically if you like, [inaudible] and so on. So all these criterias are very clear and you do it – also your teaching sessions from time to time. We have any need to educate a person as well, two of them who go through all these clinical teaching scenarios from time to time.

DR CALDERWOOD: Okay, so you feel confident that that would always happen?

DR OLABI: I think this is my information, that all my colleagues aware of these criterias, and take it very seriously and discuss with the network if you have clinical indication.

DR CALDERWOOD: Okay, thank you.

MS FEATHERSTONE: Couple of things I'd just like to ask. One, you talked about the – you've had a good governance structure. Could you just expand on what you mean by what is your governance structure now, and what was it like before?

DR OLABI: The governing structure now that we – we have designated people who have a different titles in terms of processes and information gathering and the PSIs – patient safety incidents reporting - depends on the actual reporting itself. Is it like medical or nursing or non-clinical and so on, and they are distribute into different people, so I look after the medical ones with the clinical director as well. The modern matron's been through the nursing ones, and then they are repeated sort of like – they spread this information regularly to the member of the team.

MS FEATHERSTONE: How do they do that?

DR OLABI: The newsletters and external communications about PSIs outcomes and learning lessons from them.

MS FEATHERSTONE: And what would have happened in 2004 onwards?

DR OLABI: 2004 I think this system wasn't very clear. I'm sure PSI system wasn't established then, at least electronic one. If you have concern you discuss it with a manager or the senior...

MS FEATHERSTONE: Or paper – you should have paper probably copies then, it used to be a paper incident form so...

DR OLABI: Yes, yes, and part of the governance also keep the guidelines, clinical guidelines up to date and present audits in the Department very regularly.

MS FEATHERSTONE: And are they multi-disciplinary audits?

DR OLABI: They are multi-disciplinary audits, yes. We have a different topics for the audits. We have currently over six meetings of a year of for this and guidelines and all team activities [inaudible] during these days. They are called KITS, there is aware nursing, doctors, midwifery also been invited, you know, attend if there's issues to do with the neonatal audit activities, and this KITS are audit and guidelines there is – are well attended, and the lessons is spread among the whole team basically, and this is cross-Bay activity as well, and clinics are cancelled during these days, so people are given the chance to come and attend these activities, to keep up to date and make sure the governance issues is also.

MS FEATHERSTONE: And how long have they been happening for?

DR OLABI: They've been happening now for possibly three years or so. There's a person, there's a colleague of mine who's actually giving session to organise it as well, so there's a clinical guidelines lead person.

MS FEATHERSTONE: So prior to three years ago, how would your – you and your staff, your colleagues, rather – know that, if there had been an incident, how would they know about lessons learned then?

DR OLABI: It discussed occasionally in the senior meeting. We have a senior meeting on weekly, fortnightly basis in the past and currently. So all these incident cases are discussed in these senior meeting and the team made aware of...

MS FEATHERSTONE: A formal basis? So if somebody wasn't at the meeting they could...

DR OLABI: They would be documented and minuted.

MS FEATHERSTONE: Okay. We talked about relationships with obstetrician and

paediatrician, so what about with the midwives? Because that needs to be quite a close relationship.

DR OLABI: Certainly, yes. I mean my experience with the midwives is always been excellent relationship. I understand I have no problem with the midwife relationship.

MS FEATHERSTONE: So now and previously?

DR OLABI: Previously and now. I'm not aware of any conflict of interest or relationship issues. We work together, we know our first name and respect each other and I'm not aware of any major issues with them.

THE CHAIR: Can I just follow that up? I mean that's your view. You're obviously – that's your view. Do you feel that's a view shared by other colleagues? Other paediatric colleagues? That relationships that they have with obstetricians is just wonderful, the relationships they have with midwives is also excellent? Is that universal? Or is that just your opinion?

DR OLABI: No I think universally, by and large, we work together with the obstetric unit and midwifery units. You just above the issues – sometimes, of course, if you've got new juniors and [inaudible] and they call you – the midwife they call them for attend deliver the session, sometimes they complain, 'What's the indication, etc.' so you need to clarify it for them and make sure they do follow the guidelines, if you like.

But I'm not aware – I think there was one incident where one of the middle grade had some – a little bit of challenge in relation the midwife but following discussions and explanations things calmed down. Senior staff, I'm not aware of anybody has anything with the midwife. I mean you might disagree, or you might have different opinion, or – but that, you should move on and, you know, you look after a child and a mother. That should not be held as stigma to affect your work.

THE CHAIR: Correct.

DR OLABI: So my experience, and my colleagues' experience usually is that we had a good relationship.

THE CHAIR: You mentioned earlier about how the course of practise has changed, to a certain extent, over the time period of this review, but actually a lot of the basis care has not changed. As you'll also be aware we've reviewed quite a number of case noes over that period of time and there are certainly examples of basic care that does raise some concern.

I mean basic – such as, I mean an important one is around assessment of risk and, from an obstetric point of view, that information being passed on to

paediatricians, and yet – or maybe a [inaudible] example where the information doesn't seem to [inaudible] to paediatricians so a baby is born in poor condition, the most junior member of staff is there, deputies are resuscitating, unable to intubate, eventually a paediatric consultant coming, several minutes, eight minutes, ten minutes later. Do you – I mean is that a – do you recognise that?

DR OLABI: That could have been a scene I recognise years and years ago, where the consultant is not resident, and you had a junior doctors or middle grade doctors who find difficulties in managing a sick neonate for example. There's been few cases in the – if you're talking about ten years ago or so – if example consultant living in [inaudible] for example, you got about a good half an hour distance to get there, and you always say that communication should address these issues, you need to be aware and be prepared, not to wait for the last minute. On number of occasions you go and wait for the baby to deliver, basically. But now, I think, the whole issues now is that you have a consultant resident 24/7, 365 days a year, and the service is safe.

THE CHAIR: Can I give you another example? Baby born, moderately, severely asphyxiated, pH 6.9. Would that baby be cared for in your level one unit? Would that not be a baby that would be transferred out immediately? Out of that...

DR OLABI: That possibly – I mean that – we talk about criteria for cooling and, you know...neuro protection.

THE CHAIR: But this – for example, obviously before even the peak cooling era, you know, that baby would have been managed more aggressively, but there was very much the sort of coming over a number of cases, 'Oh we'll wait and see'. Do you think that is again – do you recognise that, 'Well, we'll see how the baby does over the next few hours, or days?'

DR OLABI: Well I mean if you have a compromised babies nobody will wait and see...

THE CHAIR: Well we've got examples of that.

DR OLABI: Yes. If you have a compromised babies, you know, it's a 6-9 or, you know, this is a serious clinical scenario.

THE CHAIR: But there are examples of that, and failure to really manage effectively – obviously the hypoxia and metabolic acid was...

DR OLABI: I mean there must be some odd cases over the years, which can happen here, and can happen in any other units. But how you address them and how you manage them should be extremely aggressive and – because the first few hours can dictate the consequences of that baby's future. So I hope that this did not happen, you know, out

of negligence but if you have a baby who is such a sick babies, and clinically also – of course, you sometimes have [inaudible] foetal distress, and you can have a degree of abnormal gases, but you need to monitor the scenario very closely, make sure things are stabilised.

THE CHAIR: Do you think that the input was appropriate, certainly at that time period we're talking about, 2006, 2007, 2008. Do you think – you've said that the relationship with the obstetricians was excellent. Do you think that that was excellent? Do you think the communication was sufficiently good that the consultant paediatricians were made aware of potential women who were high risk and whose babies may be unwell at birth and really needed to have the most skilled paediatric staff there?

DR OLABI: I mean, this is a general kind of comment. But I'm sure if there's such a high risk delivery, or lady whose baby potentially needs intensive care and help, that should be communicated very effectively as I say previously.

THE CHAIR: But even during labour, you know, maybe the woman was not initially seen as high risk, but I mean do you think that – I mean obviously as you're well aware the risk appears during labour. Do you think, again, the communication was sufficient between obstetrician and paediatrician to make sure that all the right skills were there for the baby to be received and for the immediate action to be taken appropriately?

DR OLABI: I mean...

THE CHAIR: I mean the paediatrician had been [inaudible] with that, relatively junior doctor otherwise.

DR OLABI: Yes. But again it's difficult to generalise comments, really. Comments can dictate that all these cases should be actively pursued and discussed and best case delivered...

THE CHAIR: Do you recognise examples of cases, looking back? Do you...

DR OLABI: Possibly yes, yes. But things becoming more critical now that I think documentation is a big issues as well. People might do things for babies and womens and so on, but not document things, and if it's not document, it's not happened, and I think people are taking more serious issues that they document every single care they provide...

THE CHAIR: Okay, before we go...

DR OLABI: [Inaudible] something...

THE CHAIR: No, no, it's [inaudible]...

DR OLABI: Upset the lady.

THE CHAIR: That's okay, we'll carry on. Before we move onto the next part of the interview, do you have any other comments you want to make in this part?

DR CALDERWOOD: I've got a – I think you've reassured me about your staff training, and to try and maintain competencies. How else does the Unit assure itself that your outcomes are as good as they could be?

DR OLABI: I mean, again, the outcome have this regular [inaudible] mortality morbidity meetings, looking at outcome and statistics and so on…

DR CALDERWOOD: Do you look at your lower [inaudible 57:34] scores in comparison – in relation to other units of a similar size?

DR OLABI: I haven't looked at this myself honestly, but it would be very useful exercise to do. We do have a consultant currently, who is a neonatal lead, who has been given that title because of his interest, and I'm expecting from that person to look into all these areas of, you know, statistic, standard, matching other units, and put a plan for improvements.

So, and I think previously also they put in neonatal meetings being just like – it's not – don't – I betting there's quite a few in Glasgow got in maternity hospital, in [inaudible] you remember the place, and they done in a very structured and comprehensive way. Here they used to be done very, very, very superficially. Things have improved. They can still be better, and I think having the neonatal lead person to look into all these statistics in comparing will be extremely useful.

DR CALDERWOOD: Has the Unit had the PROMPT training which the Royal College of Obstetricians offer. It's a multi-disciplinary emergency training.

DR OLABI: I'm not aware that it's covered the [inaudible]…

DR CALDERWOOD: Again, it's very structured and there's been very good evidence that it improves…

DR OLABI: [Inaudible]…

DR CALDERWOOD: …Outcomes, and particularly…

DR OLABI: I mean we ran these – is it called the Bell scenarios? Or the drums? What…so we'd – we run from time to time. Midwife is in charge of that system currently. Again this is something introduced in the last couple of years or so. Out of something you just call for a scenario, and each one will take their role in dealing with that scenario, and then get feedback to the team as a whole and to the individual people as a whole. So that these simulations are happening, and I think that will improve team working and experience.

DR CALDERWOOD: And any difference since you moved the Resuscitaires into the labouring rooms?

DR OLABI: You're aware of that as well? Yes. I mean that should be the case a while ago.

DR CALDERWOOD: So you think that's a good thing?

DR OLABI: It is very good things, yes.

DR CALDERWOOD: And been supported by everyone?

DR OLABI: To my knowledge, yes.

DR CALDERWOOD: Nobody worried about resuscitating babies in front of the parents?

DR OLABI: No, I think that should be the – that should be the norm, if the parent – I mean sometime people worried about parents emotion and you know, seeing the bloods everywhere etc., etc., but I guess things have changed and moved on, and the practise now is different from practise before. But I think this Resus inside the delivery unit is certainly a big plus.

DR CALDERWOOD: And you new site of your neonatal unit on the post-natal ward?

DR OLABI: Now, yes. I don't know if you've seen the Unit, but there's some – I mean having clinics on the post-natal ward is positive, in terms of working together between midwives, nurses and support in transition care and so on. I don't know about there might be some more plan to try to re-juggle the whole things, and they have their own theatre, if you like. Or – because still there's issues of labour ward and theatre is still a problem, so they're talking maybe get the labour ward to a – the current existing paediatric ward and back door to theatre, so the ladies can go directly from the back to there. But certainly, having the transitional unit on post-natal ward is very – even if you move the thing, you need to maintain this development which is quite positive.

DR CALDERWOOD: Good, thank you.

THE CHAIR: Okay, anything more...

DR CALDERWOOD: No, I've got not more questions.

THE CHAIR: Okay, we're going to now move on to the second part of the interview, and the families have left.

THE MORECAMBE BAY INVESTIGATION

Wednesday, 9 July 2014

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

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert advisor on Governance
Professor Stewart Forsyth – Expert advisor on Paediatrics
Professor James Walker – Expert advisor on Obstetrics

ANGELA OXLEY

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DR KIRKUP: Okay. Thank you for coming. My name's Bill Kirkup. I'll ask the other members of the panel to introduce themselves.

PROF FORSYTH: Good morning, my name's Stewart Forsyth. I'm a paediatrician and, latterly, a medical director from Tayside in Scotland.

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

PROF WALKER: I'm Jimmy Walker, I'm an obstetrician and university professor in Leeds. I was involved in CMACE and the National Patient Safety Agency.

DR KIRKUP: You'll have noticed that we're wired for sound. And the intention is that we make a recording of the proceedings and then we'll produce an agreed record of that at the end. You also know that we've asked you to hand in any potential recording devices and I would just reinforce the fact that what happens in this room stays within the room, until we are in a position to release the report at the end, when we can put all the information into context. And as you'll also be aware, we have some family members in attendance. There will be a brief second phase to the interview where we talk about any individual clinical cases that might raise issues of patient confidentiality, where will not be attended. Do you have any questions about the process or...?

MRS OXLEY: No, not at the moment, thank you.

DR KIRKUP: You are content with it. Okay. I'd just like to get things started by asking you if you could tell us briefly what your involvement with the Trust has been. What have you done at different times? When did it start?

MRS OXLEY: From the beginning of my career?

DR KIRKUP: Briefly.

MRS OXLEY: Briefly, yeah. I worked at Morecambe Bay for about 30 years, with a four-year break during when I had my own children. I was maternity – I worked in Kendal for quite a lot of that time. I was the midwifery manager in Kendal up until 2007, for about a seven-year period. After that, I was displaced from my job and applied for and got the head of midwifery post. Eighteen months later, I was displaced from that job and was given the service manager for gynaecology, inpatients and outpatients, and head of midwifery. And 12 months after that I was displaced from my job again, as part of further reorganisation, and was given the lead for obstetrics, lead manager for obstetrics and gynaecology. Still had the service manager, head of midwifery, and I was then asked to take on governance.

DR KIRKUP: Okay. And is that the position you're in now?

MRS OXLEY: No.

DR KIRKUP: Go on.

MRS OXLEY: Twelve months after that, I left.

DR KIRKUP: Right.

MRS OXLEY: I actually did a two-year posting abroad, a voluntary post.

DR KIRKUP: Can I just clarify when it was that you left?

MRS OXLEY: I left in February 2011.

DR KIRKUP: Okay. You did two years abroad and then...?

MRS OXLEY: I did two years abroad, working clinically, and when I came back – it was a career break, but when I came back I didn't go back to Morecambe Bay. I went back to North Cumbria Trust as a clinical midwife.

DR KIRKUP: Right, in Carlisle.

MRS OXLEY: Carlisle Penrith.

DR KIRKUP: Okay.

MRS OXLEY: And that's where I work at the moment.

DR KIRKUP: Okay. That's helpful, thank you. If I can hand you over to Jimmy.

PROF WALKER: So I'm slightly confused about all that, but in principle you've had a head of midwifery role from 2007 really up to 2011, but you were given extra duties over and above that.

MRS OXLEY: Yes.

PROF WALKER: And when you said you were displaced from your post, it was because of reorganisation.

MRS OXLEY: Yes.

PROF WALKER: And you had to then reapply for these positions. Or were you placed in these new positions?

MRS OXLEY: I was placed.

PROF WALKER: Okay, so there was no... It was reorganisation and you got really just given more roles to do.

MRS OXLEY: Yes.

PROF WALKER: So over that period of time – over what, four years – how well do you think you could function in each of the bits? You know, head of midwifery you were focused on and then you got more and more added to it. How did that affect the way you worked?

MRS OXLEY: The head midwifery role, it was a new role for me so it was a steep learning curve, with lots of challenges, but I felt confident that I could do that

role. I had prepared for that role; I had done a Masters in midwifery in preparing for that role. The service manager for gynaecology, it was – as I know you'll remember – it was a very political time, when government was saying, you know, if there happened to be any breaches of two-week waits, cancer waits, patients being seen... That was a very steep learning curve for me, but I felt I did the role reasonably. I reorganised the whole system within that. What I felt was there was an awful lot of work to do in the midwifery. I'd got a strategy plan, which I hadn't embedded by the time I got the service manager role, so I was continuing to do that but also concentrating on the service manager role. Again, with the service management role we got a completely new way of working, which wasn't embedded when I got the next role, the lead. And it was when I got the lead, at my interview that I had for the lead, about the lead – as I say, I didn't apply for it; I was given it – I raised the issue of capacity. I just felt that I didn't have the capacity either myself or within my staff to do this role. At the end of that interview, I was asked to add governance to the job description. It wasn't in the job description when we were discussing it earlier. And what I was informed was that as support, I would have a buddy system to help me move into that role and work in that role. That was the solution to my capacity issues / concerns.

PROF WALKER: When was that last bit? I can't remember. When was that?

MRS OXLEY: I think it was January 2010.

PROF WALKER: So really over the last two years of where –

MRS OXLEY: One year. The last year.

PROF WALKER: Okay. And you left at the end of that year. Was that a personal

decision to leave?

MRS OXLEY: Yes. It was something I'd wanted to do. I was unhappy in the role by that stage, that I was trying to do. Yeah, and it fit it personally with other things.

PROF WALKER: From the point of view of... Let's take the head of midwifery part of your job. As you went on from 2007 through 2011, did you feel that you just gave less and less time to it because of the other commitments? Did you feel you lost touch with what was going on, or lost the handle on what was going on?

MRS OXLEY: During the last year, I was working about 60-odd hours a week, trying to do all the roles. I obviously had to rely a lot more and delegated down to the matrons. Unfortunately, the matrons – there was eight matrons when I was first displaced; that went down to five and then it went down to four. So their roles were –

MR BROOKES: Across the three sites.

MRS OXLEY: Across the three sites, yeah, across the total number. I found it was a very difficult job. It was two different PCTs, three different hospitals. I found it quite –

PROF WALKER: So you were in a situation where you were spending less time, inevitably, being head of midwifery.

MRS OXLEY: Yes.

PROF WALKER: And then the matrons that you were relying on, got less of them as well.

MRS OXLEY: Yes.

PROF WALKER: Okay. I was going to ask, you know, who you reported to. You probably, as the years went on, you kept reporting to yourself.

MRS OXLEY: It kept changing. It kept changing. I started off in the Women's Health Directorate. It then became the Surgery and Critical Care Directorate. It then became the Core Clinical and Family Services Directorate. There was one point I was told that I had to report to the divisional nurse, who was the surgical lead. That was kind of a two-month hiccup because I was really unhappy with that. I was reporting within the directorate, but I also, particularly later on, was also reporting, the head of midwifery part, direct to the executive nurse.

PROF WALKER: You suggested – at your last interview, you highlighted the fact that you felt this job was impossible as a role. Did you report that constantly[?] to who your line manager would be, or whoever was meant to be supporting you or mentoring you or who you reported to?

MRS OXLEY: It was a divisional manager. Yes, I did. At one point, when I got one of the roles, I showed the job description to the executive nurse and said, 'It doesn't include the head of midwifery. This job description does not have head of midwifery.' And then she said, 'You've got to add it. You must add some points from your previous job description into that.' So, you know, I said how difficult it was and she said, 'You have to go back to your division,' but the divisional manager had given me that post.

PROF WALKER: What do you think the driver was for these changes? Was this to make everything more efficient or was it to –

MRS OXLEY: It was financial.

PROF WALKER: To save money.

MRS OXLEY: Yeah. When I was in the middle of my three-and-a-bit years there, the lead for obs and gyny was off with stress, so coming back and going off again. But when he left, it was his role that was added on.

PROF WALKER: He was a doctor, was he?

MRS OXLEY: No, sorry. It was business lead.

PROF WALKER: Business lead, okay. So this was a merging of jobs, basically.

MRS OXLEY: Yeah. So his pay was a saving.

PROF WALKER: By giving you his job.

MRS OXLEY: Yeah. His role was divided between myself and he also had a bit for children's as well, and that was given to ~~something~~ someone else.

PROF WALKER: Okay. Let's look at the way downwards then. As far as head of midwifery is concerned, you had originally eight matrons and then it went to five.

MRS OXLEY: Yes.

PROF WALKER: How were they distributed?

MRS OXLEY: It did keep changing. There was a matron on... Well, it went down to four eventually. There was a matron based on each site and then one matron who was covering community in Furness and Lancaster area.

PROF WALKER: So towards the end of the time, you had really one matron. Were they acting as sort of lead midwife for that unit at the time?

MRS OXLEY: Yeah.

PROF WALKER: How well could they cope with that? Because originally there had been three matrons doing that, I think, in the sites.

MRS OXLEY: Yeah. Well, the other thing that we did was we looked at the band 7 roles, the role below the matron, and looked at... We actually reduced the band 7s but the band 7s that we were left with had much more specific managerial roles to take on some of the work of the matrons.

PROF WALKER: Now, how well did you think the matrons had control over their environment within the hospital?

MRS OXLEY: Along with the obstetricians.

PROF WALKER: Did they, for instance, act as mini head of midwifery for that unit, or was it more picking up things –

MRS OXLEY: Clinically, I had to rely on them to tell me what was going on, to feed back to... We obviously had regular meetings.

PROF WALKER: And what sort of personal input did you have into the hospitals concerned? I mean, how often would you visit say the labour ward in Furness?

MRS OXLEY: It changed. Over the first year, I used to visit once a week. My base was Westmorland but most of the divisional meetings were at Lancaster. But I always made sure I visited at least once a week, met with the matrons and helped with business at Furness General. In the second year, because of the serious incidents, I went twice a week because obviously various action plans and obviously there was a lot more work there. In the third year, I would say it was probably back to once a week.

PROF WALKER: Okay, so you went there presumably to support the matrons and also, you said, trying to look at changes that were coming in or being brought in. Were you seen by the hospital as someone who was integrated into their system or someone who was coming from outside to change them or assess

them?

MRS OXLEY: By Furness General Hospital?

PROF WALKER: Yes.

MRS OXLEY: I was probably more of an outsider to Furness General Hospital than I was to Lancaster or Westmorland, at least when I first came. I did try very hard and always when I was there I went round the wards and said just 'Hello' and 'How's things?' to the midwives who were on duty, just to make myself seen. In the first year in particular they really saw me as somebody who had come to change things, very much so. One of the issues that I had at the time was that we'd discuss things, we'd decide on changes across the Bay, and the lead clinician, the lead obstetrician at Furness would come to me and say, 'The band 7s are not happy. They're not happy that you want to change things,' which I was very, very annoyed about. And I had to do a lot of work saying, 'You do not go...' You know, when we as midwives are trying to improve things, trying to bring things up to national standards, trying to implement these changes, you do not go and have a meeting with the obstetrician and say, 'We don't do it like that at Barrow and we're not happy.' By the second year, I felt that that was a lot more solid. It was a lot more... They knew if they had any gripes about changes, they came to me and we discussed them.

PROF WALKER: And what were the matrons saying at that time? Did they not give you that feedback as well, that the band 7s were unhappy?

MRS OXLEY: They would. They would tell me when things weren't right, but it was... There were three times and I did sit down and discuss it with the lead obstetrician as well. I said, 'This is just not... I can't manage if every time I

want to implement something, they go to you.'

PROF WALKER: I was just wondering why the matron has been kept out of the loop.

MRS OXLEY: But that's the way Barrow had run for years and years and years.

PROF WALKER: So do you feel that the matrons didn't appear to have the authority or the position within the –

MRS OXLEY: Yeah. Originally there was three matrons and it reduced to one matron. And she needed support, which was why I did put in... The matron that worked, she was based at Lancaster doing community and she was a real good, strong change agent and it was her that I put in, covering community across the Bay. And she worked very closely with the matron that was in Barrow, as the change agent.

PROF WALKER: So she was helping to make changes within the hospital and not just within the community?

MRS OXLEY: Yes, she did. Yeah.

PROF WALKER: What changes were you trying to bring in for the band 7s?

MRS OXLEY: The band...?

PROF WALKER: You said you were making changes to the band 7s and you were unhappy –

MRS OXLEY: Yes. In the final year, there was a lot of band 7 midwives, many of whom were not taking the responsibility of a band 7. They were saying, 'I've been a midwife for 15 years, therefore I deserve a band 7.' They weren't doing the band 7 role, I felt, so across the Bay we rewrote all the job descriptions for the band 7s and displaced the band 7s and put... They all had to interview for

their jobs. The number of band 7's on the labour ward did not reduce with the re organisation of band 7's – I think it actually increased by 1 wte – the reductions were mainly on community & AN clinic.

PROF WALKER: What happened to the ones who didn't make the band 7?

MRS OXLEY: They were downgraded to a 6.

PROF WALKER: That's going to produce a certain degree of unhappiness, I would think.

MRS OXLEY: Yes.

PROF WALKER: Did that affect the way the –

MRS OXLEY: Well, that was quite near the end of my time there. What I did feel was that we then had some vibrant, positive band 7s who would make changes and would carry things forward. But that was quite close to the end of my time, by the time we got them in. And they have very, very specific job roles, and quite far reaching. Yeah.

MR BROOKES: Within the delivery suite itself, how many midwives would be on the delivery suite at any given time, say during the day?

MRS OXLEY: I can't remember exactly, but I think four or five.

PROF WALKER: And would there be a coordinator of that group?

MRS OXLEY: One of those would be a band 7 coordinator.

PROF WALKER: And would they take a case load? Or would they be supernumerary?

MRS OXLEY: They would if they had to, but they were the lead.

PROF WALKER: Were the numbers calculated to try and make it in the majority of the time they would be supernumerary.

MRS OXLEY: Yeah. I mean, there was 900 births at the time, in Furness, so it's quite difficult to put somebody on who is just management. You know, in a big unit that's what you would do, always. When there's 900 births, you know, the labour ward could be empty or there could be one, you know... But that was the idea, that they remained managerial and outside, unless they had to take a case.

PROF WALKER: You were saying there were some midwives who had been there for a certain length of time and expected to be band 7s. Did they work independently within the labour ward or would they work as a team? Would they relate up to the coordinator or to the matron? You know, how did the system work?

MRS OXLEY: There was always at least one band 7 on and a lot of the others would be band 6. You know, often there'd be a second band 7, but that second band 7 wouldn't be the labour ward coordinator for that day. You know, the labour ward coordinator should know what's going on in every room, with every case.

PROF WALKER: And when things went wrong in the labour ward, if something happened that was a concern, what was the process of escalation?

MRS OXLEY: At the time of...?

PROF WALKER: You can tell me what changed, but what was it like at the beginning? When problems started arising, what was highlighted and what changes did you bring in?

MRS OXLEY: So on a clinical basis, right, the midwife looking after that case would inform the lead and inform the – they weren't registrars; they were staff grades

– that there was a problem that needed reviewing and then either of those would refer up to the consultant.

PROF WALKER: Okay. How smooth was that escalation?

MRS OXLEY: I would say it seemed to be fairly smooth. It wasn't reported to me as a...

PROF WALKER: So there's no sort of feedback through your matrons or whatever that there were problems getting medical staff or problems that things were being missed, other than any incidents that were occurring.

MRS OXLEY: There was issues which came to light after some of the incidents. The way the staff grades, sometimes registrars, were working was not how I'd seen them working in the Lancaster labour ward, in that they didn't seem to take ownership of the higher risk cases. We put things in place to improve that and changed the system at that point.

PROF WALKER: And who decided who was high risk? Who risk assessed?

MRS OXLEY: The midwives did a risk assessment, with somebody in labour. But it would be done very early on, you know, antenatally. Any higher risk women would be referred through the consultant clinics antenatally.

PROF WALKER: As you know, risk changes, and particularly as they come into the labour ward.

MRS OXLEY: Absolutely.

PROF WALKER: You mentioned that the doctors weren't taking ownership of higher risks. Is that because the midwives who referred them would say, 'Look, we want you to monitor this patient or look after this patient' and they didn't do it? Or that they weren't told about it? What was the problem of lack

of ownership? Did it occur?

MRS OXLEY: There seemed to be an issue that any women that come in will be looked at by just the midwife, even if it was a consultant referral for an induction or a specific thing, unless the midwife specifically called them. There wasn't an ownership. There wasn't a, 'Who have we got in today? These are all high risk and they're medical cases.' And we put steps in to change that. That was one of the –

PROF WALKER: So when you're saying that there was medical staff that didn't take ownership, it was more about that the midwives didn't necessarily escalate –

MRS OXLEY: No, they knew women were in. They knew women with diabetes were in being induced, but they wouldn't... You know, I'd expect the medical staff to be on the ball with that, knowing that 'She's been induced. We need to keep an eye on her. Every couple of hours we need see what's going on. We need to...' But at that time it seemed to be, 'Oh well, the midwives are doing it.'

PROF WALKER: So you feel that from the medical staff, that they decided, 'We'll leave it with the midwives until they call us,' –

MRS OXLEY: Yes.

PROF WALKER: – rather than actually the midwives taking these patients and not telling the doctors? It was about more the doctors –

MRS OXLEY: Yeah.

PROF WALKER: Was there a handover ward round in the morning in the labour ward?

MRS OXLEY: I can't remember if there was early on. There certainly was later on because we had baton handovers and...

PROF WALKER: Is that something you implemented?

MRS OXLEY: It might have been there, but we made it more clear and documented that it had taken place.

PROF WALKER: So that was done first thing in the morning, was it? Or were there other ones during the day? Can you remember?

MRS OXLEY: When we implemented it, it was done at each shift handover of the doctors.

PROF WALKER: Okay. Can you remember what shifts the doctors worked? Did they work 12-hour shifts, or 24-hour shifts?

MRS OXLEY: I think they were 12-hour. I cannot remember the details of medical staffing.

PROF WALKER: Twelve-hour shifts, okay. You mentioned it was staff grades that were the main middle grade that worked there. Did they have other duties they were doing at the same time as labour ward?

MRS OXLEY: No, I don't think they... No, they were on for the labour ward and the maternity ward. I don't think they had... You know, they wouldn't be running a clinic or –

PROF WALKER: So they were around the labour ward most of the time.

MRS OXLEY: Yeah.

PROF WALKER: So there's no problem getting hold of them if they were required.

MRS OXLEY: They should ~~not~~ have been around the labour ward.

PROF WALKER: How about the response to an emergency, like acute bradycardia? How would the midwifery staff respond to that? What would be the process?

MRS OXLEY: Yeah. They would immediately beep the registrar.

PROF WALKER: Who would? The midwife with the patient or...?

MRS OXLEY: Registrar or a staff grade.

PROF WALKER: No, no. Who would page the registrar or staff grade? Would it be the midwife with the woman herself? Would she get hold of the coordinator?

MRS OXLEY: You know, if it was very acute, she'd pull the emergency buzzer. Whoever came in first probably. It wouldn't necessarily be the lead midwife. She would be saying to whichever midwife put her head in first, 'Call the registrar.'

PROF WALKER: Was there any problem getting medical staff there at the time? Would they attend quite quickly?

MRS OXLEY: There were some issues about, 'Where were they?' at the time. Are they supposed to be in the unit? Are they supposed to be...? Especially at night time, there were ~~annual~~ occasional issues.

PROF WALKER: Okay. So there's some delay sometimes getting a doctor there. Once a doctor was there and say they made a decision to manage things in a certain way, what's the midwife's role? If the midwife wasn't happy with the doctor, would they escalate that to –

MRS OXLEY: They should go to the consultant.

PROF WALKER: To the consultant. Did that happen very often, do you know?

MRS OXLEY: I know it happened, in certain circumstances. How often, it's difficult to say. As I say, there's only 900 births.

PROF WALKER: If a decision is made to go to theatre, how long would it take to go from that decision to the delivery?

MRS OXLEY: An awful long time.

PROF WALKER: And why was that?

MRS OXLEY: Because they... First they had to call in the registrar. And then they called in... There was like nobody there; everybody was called in, particularly at night. It was an issue that I raised a number of times.

PROF WALKER: Did you have some sort of idea of the decision [in the interval?]?

MRS OXLEY: The anaesthetist on call was called in from home. The theatre team were called in from home. Everybody was called in from home – the consultant, obviously. And then the other issue which I had major issues with was that the theatre wasn't in the labour ward; it was an awful long way away. You know, I'd been used to the theatre being in the labour ward and basically if you shouted out of the door, the theatre could hear you and start getting things ready, you know, all other systems failing. But there, it was an awful long way along a corridor. And I flagged that up.

PROF WALKER: Okay, so obviously the ability to deliver within 30 minutes would be probably unlikely in most cases, especially at night. I mean, that's obviously something you realised and flagged up, but what did you actually do about it? Who was that reported to?

MRS OXLEY: I reported it to my divisional managers and to my executive nurse. I actually did, myself and the matron, we did a report – that was just one of the points, but we did a report on the state of the labour ward. I didn't feel it was fit for purpose in the 21st century. – It was also reported through the risk register

PROF WALKER: When would that be?

MRS OXLEY: That was fairly early on. 2009? And I took it to – I can't remember

which meetings I took it to, but what I was asked to do was to hand it over to the architects and to the estates team for them to look at it. They then did another report which was similar – much more glossy and photographs, et cetera – which they took to their division and it went up their pathway. We later had architects coming around, looking at the place, but we were basically told there was no money, there was no funding. The other... What I wanted was the whole maternity unit on one site, with the theatre as well, because it was so small. I felt that in an emergency on the labour ward, you should be calling all the midwives you've got, because at night you've only got four, and not have them at the other side of a corridor, you know, looking after two women, low risk but you couldn't leave them because you couldn't come across the corridor, kind of issue. That was flagged up quite a lot and was moving slowly along. It also involved the neonatal unit, pull in the neonatal unit. Because it was a very, very tiny, quiet neonatal unit, but there would be one or two members of staff on that unit, sitting with one baby. And I felt that staffing wise it should all be consolidated in one area and the staff could work wherever they were needed at the time, much more flexibly.

PROF WALKER: Were the paediatric staff in the neonatal unit, the nursing staff, were they midwifery trained as well?

MRS OXLEY: The paediatric staff?

PROF WALKER: The paediatric nursing staff.

MRS OXLEY: Some were; some weren't. They used to have, for example, at night they'd have one trained neonatal nurse and an assistant who has usually done child healthcare kind of qualification, which would be very beneficial on the

ward as well as in the unit, but she couldn't go because it was down the corridor again. They were all separate areas.

PROF WALKER: So if you wanted someone there to help resuscitate a baby, would that be done by a trained midwife on labour ward or would someone come from the natal unit?

MRS OXLEY: Both. Likely, if it was very acute, the midwife would start the resuscitation and call the neonatal nurse across.

PROF WALKER: Can I ask you about how the serious untoward incidents were coped with and reported? So if you had an event that occurred say in your labour ward, who flagged that up as an incident?

MRS OXLEY: It was expected that any clinical person could flag it up as an incident. Anybody who was involved –

PROF WALKER: But was there any system to make sure that was done? If it's dependent on the individual involved, they may not flag it up.

MRS OXLEY: The risk management midwife used to look in the register and, you know, make sure that it got... You know, if there was a major PPH registered in the register, she'd double-check that she'd got an incident report.

PROF WALKER: Were there various trigger things, like a term baby admitted to neonatal unit?

MRS OXLEY: Yeah. There was a trigger list.

PROF WALKER: Okay. So what then happened once this was triggered?

MRS OXLEY: Right. When it was triggered, it would go to the risk management midwife, would do initial review.

PROF WALKER: When was she appointed? Was she there all the time?

MRS OXLEY: She was there all the time.

PROF WALKER: Okay.

MRS OXLEY: When I first started there, she was there full-time. And then her time was halved and half her time went to the general side as the CNST NHSLA lead on the general side.

PROF WALKER: Okay, so it would go to her. And what happened after that?

MRS OXLEY: Well, all incidents were brought to a joint group, where the lead clinician would be there, the lead obstetrician would be there, the matron in charge of that unit and the risk manager, and sometimes the supervisor of midwives as well would be there to review the case. If it flagged up as, 'There is issues around this case,' then it became... At first, it was the risk management midwife who would do a root cause analysis or a serious incident review. For the first year, that's probably the way it worked. After that, we put some changes in whereby I used to ask – if there was midwifery issues involved, I'd ask a matron from one of the other areas to come and do the root cause analysis. So if it was the Barrow incident, there would be a Lancaster or Kendal matron, just to give a more diverse view.

PROF WALKER: And what if it was a medical problem?

MRS OXLEY: If it was medical, it went through the medical side.

PROF WALKER: So there was no joint root cause analysis?

MRS OXLEY: The root cause analysis was... No, I don't suppose there was, really. The root cause analysis was taken to the medical...lead You know, it was taken back to the group.

PROF WALKER: Okay. And what would happen to it then?

MRS OXLEY: To the root cause analysis?

PROF WALKER: Yes.

MRS OXLEY: It may well produce an action plan.

PROF WALKER: But what if the doctors didn't agree with it or ignored it or...?

MRS OXLEY: The risk midwife was part of the governance team. She reported directly to the clinical executive of the Trust, was on that team. She could take it up that way if she felt that things were being ignored.

PROF WALKER: Well, a midwife doing a root cause analysis, even a good trained risk management midwife, may not be able to pick up and assess all the nuances of medical care, of the practice. Now, you're suggesting that the medical side of it wouldn't do a root cause analysis; they would just read the –

MRS OXLEY: I don't think they did. The root cause analysis that the midwife did, that the risk midwives did, it was taken back to the clinical lead for review. So he would have sight of it and see if he agreed with it, but I don't think they did a separate one.

PROF WALKER: And they would ask for external review of any cases?

MRS OXLEY: Yeah. Some external reviews were done. Yeah.

PROF WALKER: And again, was that a separate medical review, separate from the midwifery review?

MRS OXLEY: In particular, there was at least one joint medical external review, done by an external obstetrician, neonatologist and head of midwifery.

PROF WALKER: Okay. Were you happy with that arrangement?

MRS OXLEY: With...?

PROF WALKER: The separate midwifery review and medical review of the

situation.

MRS OXLEY: I think my view changed over the three years. Some things that I thought were happening in the first year weren't. We changed things and put things in place. Was I happy?

PROF WALKER: You obviously brought changes or put changes in place. Towards the end of your time, you had a governance role. So what changes did you put in place?

MRS OXLEY: When I started in the governance role, we started having – tried to have proper governance meetings and review these cases more thoroughly, I would say. We brought the cases to the governance meeting, the family services governance meeting. But I was never 100% happy with them because they didn't seem to be... I don't know what the word – they just didn't seem to be embedded. It didn't seem to be... That was towards the end of my time there.

PROF WALKER: Particularly, you know, when things appear to be... There were more things happening and concerns within the unit. Did you feel that they were being assessed properly and there was learning from it? You know, with these reports that was done, there must have been recommendations taken from them, there must have been timescales for that. Was there any system to make sure these recommendations were carried out?

MRS OXLEY: Yes.

PROF WALKER: And people were responsible for those recommendations?

MRS OXLEY: There wasn't... Things were in place for the serious incidents that we had; things were in place to see that everything was done on the action plan.

And whether it was an actual system or whether it was just what we put in place, and then it was overseen by external agencies as well. I mean, there was supposed to be a closing of the loop. And I feel, in midwifery, I felt we tried to achieve that, as a group of matrons and myself and the risk management midwife. Everything that we identified on the action plan, we had proper review of that action plan, through review of it and, you know, was everything put in place, did we have the evidence that it was put in place, where was the evidence, you know, put the evidence with the action plan. How are we going to make it sustainable for the next few years, not just...? We've done it now, but how is it going to be sustained for the next 12 months, for the next two years? So we did –

PROF WALKER: But there's a 'but' to that question. You said, 'In midwifery we did...' Does that mean on the medical side, they didn't?

MRS OXLEY: The medical side I found quite difficult, because for a long time I felt all the... I think with quite a number of the reviews, I flagged up very early on that mistakes, serious mistakes, were made by midwifery staff; they were also made by medical staff. Although they were happy for me to do all this about midwifery and I was flagging it up and saying this was an issue, there wasn't the same response from the medical staff.

PROF WALKER: There seems to be a divide between midwifery staff and the medical staff as far as governance is concerned. Did that follow through in clinical practice as well? Was there this almost separation of the two?

MRS OXLEY: Yeah. I mean we put in a lot of things, fairly basic things but fundamental things to try to get the staff working together, because it came out

in some of the reviews that they weren't working together. They saw themselves as separately. They weren't working as a team around that woman and we brought in a lot of things to try and deal with that.

PROF WALKER: When an incident, say that has occurred, what happened then as far as debriefing for staff? Within the days afterwards, were the staff involved brought in to discuss it? Were the medical staff involved?

MRS OXLEY: Yeah.

PROF WALKER: And everyone relevant was there to support each other and talk through the...?

MRS OXLEY: I remember attending – initiating, I think, and attending a couple of big debrief sessions where we had the theatre staff and the obstetricians, neonatal, everybody around a case as to create an understanding of what had happened and who was called when and what decisions they had made. And that was part of the kind of root cause analysis, so we did have a least a couple that I was present at.

PROF WALKER: What did that feel like? Did that feel like people coming together and talking about it and where we can improve, or did it feel about people talking about what other people did wrong, rather than they did?

MRS OXLEY: I can remember one that I attended felt positive, because we did flag up all sorts of different issues, not accusing people but just saying, you know, 'This is what was happening, what was going on,' and they became changes in the action plan; they were put into the action plan, things that were flagged up. But it wasn't... I don't think it occurred with every case. or I was not present in some cases.

PROF WALKER: Okay. You commented at one point you felt the unit wasn't fit for purpose. Did you feel when you left it was fit for purpose?

MRS OXLEY: I don't think there have been... If we're talking the structure of the unit, no. I still didn't feel it.

PROF WALKER: Okay. Thank you. Stewart.

PROF FORSYTH: Thank you. Can I just go back to the band 7 re-grading again, which seems fairly critical. To be absolutely clear, what was the driver for the re-grading?

MRS OXLEY: There was two big drivers. One was a financial and the second one was to have band 7s who were taking the responsibility for managing a clinical service, which I didn't feel that they were at the time. I felt that they saw – many of them, not all of them – many of them saw that role as being the band 8 matron role. We also did... There was a lot of national drivers around that time of sort of public health related issues that needed bringing into midwifery and I wanted a band 7 to lead a number of those public health issues for maternity services. So the job descriptions reflected that very, very strongly.

PROF FORSYTH: In retrospect, did it meet your objectives?

MRS OXLEY: I think I probably left about three or four months...

PROF FORSYTH: Sorry?

MRS OXLEY: I left about three or four months after it was all changed and implemented. And I expected to have a time to kind of upset quite a few staff, saying, you know, 'Well I've worked for 15 years,' but I was confident then that we'd got some really good, strong band 7s who knew what their role was, who knew that we were taking midwifery forward.

PROF FORSYTH: So you left in 2011. Was that right?

MRS OXLEY: Yes.

PROF FORSYTH: So when did this whole process start?

MRS OXLEY: It was probably 12 months before that.

PROF FORSYTH: Sorry?

MRS OXLEY: It was probably about 12 months before that.

PROF FORSYTH: So you're talking about the re-grading was between sort of 2009, 2010, around there.

MRS OXLEY: 2010 to 2011.

PROF FORSYTH: Right.

MRS OXLEY: During 2010.

PROF FORSYTH: Okay. When you took over as head of midwifery, what were the sort of key issues that you felt needed to be addressed? Were there any key issues that you felt needed to be addressed?

MRS OXLEY: Yeah. The key issue... My biggest challenge was to bring midwifery services across the Bay into an autonomous... Every woman across the Bay will get the same good service. There was pockets of good service all over the area. There was pockets of excellent mental health support in Lancaster, but it wasn't there in Barrow. There was a kind of 'listening to mother' service at Furness but it wasn't in Kendal. I wanted to take the best practice in each area, the whole place to be brought up to the best practice in each area. Plus, there was quite a number of new reports out at the time about midwifery matters and ~~nice~~ NICE guidelines and public health related guidelines, choice guidelines, that were national that needed implementing into Morecambe Bay

and the whole service needed to pull up. The other big area was that I wanted... The previous head of midwifery had never talked about what went on at Barrow with Lancaster midwives or staff, and vice versa, and I didn't feel that was the right way. I felt the matrons were matrons of the whole maternity service and that we should discuss all cases across the Bay, and that that was really important for change. That took a while to get in, but I felt eventually that the matrons did feel that they were responsible and could comment equally across the Bay. But it had been run as two very separate situations. Medically, I feel it continued to be run like that.

PROF FORSYTH: Did you feel that –

MRS OXLEY: They didn't discuss cases across...the Bay You know, it wasn't the group of obstetricians who sat round and discussed a case; it would be the Barrow ones or the Lancaster ones.

PROF FORSYTH: Yes. And so you're working hard to try and get an area-wide approach to midwifery care, but that needed to be presumably done in parallel with an area-wide approach for obstetric care. Did you try that?

MRS OXLEY: Yeah, I mean, but I don't know... They just didn't work together. One thing that I was very, you know, I felt like giving up in the end about was that we eventually – in my third year there, we had a newly appointed consultant at Lancaster who was newly appointed into the role of obstetric lead across the Bay, and yet most weeks he wasn't at Barrow. The issues I raised with him, you know, he said, 'Well, the clinical director, he's at Barrow, don't involve me,' kind of thing. And I didn't feel I got any support from him. I brought it up a number of times and the divisional lead discussed with that lead

obstetrician across the Bay his role, but it didn't change. I thought maybe we've now got...a chance to change things But it didn't change at that point, which was very disappointing.

PROF FORSYTH: In terms of taking this wider view of service delivery, what about training and education? Did you take a similar approach there to utilise...?

MRS OXLEY: Yes. It hadn't been in the past, but again I pulled the midwives across the Bay together to look at the way forward and midwifery strategy. We had joint 'Away days' with something like 60 midwives from across the Bay. We pulled them all together. I knew the best practice ones, so they did a lot of the presentations on this day. But we looked at national guidelines and how we could implement those guidelines into Morecambe Bay and set it up in a proper, formal strategy of, 'This is the way forward.' So based on – I think there was four or six national guidelines, we developed our strategy. We then held strategy development meetings – again, big cross-Bay ones – looking at who'd done what in which area of the strategy. But the obstetric emergency training that we did, they were done on each site but I asked that at least three or four midwives from other sites – you know, three or four of the Lancaster midwives would go to the Barrow one, and vice versa. We also held quite a lot at Westmorland which were completely cross-Bay to pull people in to meet with each other across the Bay. The other –

PROF FORSYTH: Can I – Sorry, carry on.

MRS OXLEY: There was a lot of work. I'm flipping through things quite rapidly, but we put in quite a lot of work to try and get some integrated working and some outside views and outside practice implemented across the Bay. As I say,

working together, that was one area. Another area was that I encouraged the matron and some of the band 7s to register for the Masters or at least for the degree at UCLan so that they came out every week, met with midwives across Preston, you know, just to get kind of the psych as modern midwives practising in a modern way, looking at each of those points of view, picking up areas across...

PROF FORSYTH: Some of the incidents are around poor basic skills. I just wondered how this education and training really was... Have you got evidence of it somehow improving the basic skills of midwives and doctors and other staff as well?

MRS OXLEY: Yeah. I mean, yeah. The actual individual... In one of the incidents, it flagged up quite a number of basic skills were lacking. And when I talked to people across the Bay, I found a number of midwives lacked those basic skills. So along with a new guideline and new policy, new forms to use, we put in training for every single midwife across the Bay on that factor, but we also...

PROF FORSYTH: When was that? Over what period of time?

MRS OXLEY: 2009.

PROF FORSYTH: 2009.

MRS OXLEY: Yeah. No, 2010. No, 2009, it would be.

PROF FORSYTH: And what basic skills were you covering in that?

MRS OXLEY: Basic skills about neonatal, the care of a higher risk neonate. We put in, as I say, a new guideline, new ways of doing the actual check-up, when to refer, who to refer to, how to document it. We covered a whole big chunk of that. We put in audit prior to that and we re-audited... It was eight months,

nine months down the line, again to see if that had been implemented.

PROF FORSYTH: Was this formally done? I mean, the measure of when you were going around, speaking to midwives and identifying what skills they needed for their training. Was that documented somewhere?

MRS OXLEY: Yes. My initial talking to them flagged up all these skills. They also came out of the root cause analysis as lacking.

PROF FORSYTH: What were the main skill deficiencies that came out?

MRS OXLEY: The one that I'm thinking of is recognising a sick neonate. And joined-up thinking of, you know, if a baby's temperature drops, it's probably because it needs a woolly hat on and wrapping up warm. But if a baby's temperature drops but it's already a high-risk neonate that you're doing observations on, then it's something else. And you don't just say, 'Oh, we'll just warm it up'; you refer it to a paediatrician. And we made new guidelines –

PROF FORSYTH: What other skills were identified?

MRS OXLEY: Record keeping – big, big area, record keeping. We brought in new records, we did record training, we did an audit on record keeping. Obstetric emergency skills. Anything that was flagged up as, 'Maybe there is a lacking in this area.' I'm not talking big incidents now, but we would then incorporate that into the next obstetric emergency study day.

PROF FORSYTH: What about resuscitation?

MRS OXLEY: Yeah. I mean, the basic obstetric emergency skills were covered: some yearly, some every six months. The six monthly obstetric emergency training days attended by every midwife, were taught by certified Advanced Life Support in Obstetric (ALSO) trainers who also taught regularly on the National

ALSO courses. Adult and neonatal resuscitation, shoulder dystocia, post-partum haemorrhage, eclampsia – all those were covered by these obstetric emergency days: some six-monthly, some 12-monthly. They were always covered. They were kind of core of those days, but we did introduce other things. For example, the advanced nurse practitioner, advanced neonatal nurse practitioner, every year she did a slot and we brought her in. So it wasn't just that she did a one-off to try to identify a sick neonate. We then said, 'Every single year, you need to identify something that you feel they need an update on and do it across the Bay.'

PROF FORSYTH: Can I ask you about the relationship... We touched upon relationships between midwives and obstetricians, but paediatricians with midwives and paediatricians with obstetricians; what was the working relationship like there?

MRS OXLEY: Very different to what I'd been used to at Lancaster, almost like very separate camps. Hard to describe, really. I think part of the problem, there didn't seem to be many middle grades, registrars. The setup was that we just had juniors – I think this is right – juniors and consultants, so there wasn't this... You know, normally on a labour ward, on a maternity ward, you really know the registrars. Any issues, you go to the registrar and discuss it with them. They're the ones that you're working with all the time, but that band of people didn't exist in Barrow.

PROF FORSYTH: So was the availability of paediatricians when you needed them difficult at times?

MRS OXLEY: I didn't work clinically there. I don't think incidents were reported to

me about that. But it was a very different... I was used to the consultant obstetricians and the consultant paediatricians getting around to discuss a case. They might have a ding-dong battle about what they were going to do and when we're going to get these babies out, but they would sit and discuss it and form a plan, whereas it seemed to be the obstetrician's decided to do this, the paediatrician's stamping up and down outside the corridor, you know, he's very upset about it but the obstetrician's going ahead anyway. It wasn't that joined-up.

PROF FORSYTH: I mean, are you familiar with these discussions? What was the main issue? I mean, for example, was the obstetrician wanting to deliver what could be a high-risk lady in Barrow –

MRS OXLEY: Yes.

PROF FORSYTH: – Whereas the paediatrician might be saying, 'Actually, we're on the level one unit.' Is that –

MRS OXLEY: That kind of thing. Or the paediatrician would be saying that 'The neonatal unit is too busy at the moment, we can't take these.' And the obstetrician would be saying, 'Well, how can it be too busy? They've only got two babies. We're going ahead.' It was just... You know, I was used to constructive discussions which they might have disagreed with each other but at the end of the meeting they had a plan of what they were going to do and what was... You know, there was always a lot of discussion, but there didn't seem to be that.

PROF FORSYTH: And so do you think that there were babies being delivered in Furness that was inappropriate, either time-wise or because of the risk?

MRS OXLEY: Yeah. I mean, we tried to stop that and reduce it right down, but there certainly was up to the time I started there.

PROF FORSYTH: So were there breaches of the guidelines, when you had guidelines?

MRS OXLEY: I think we ~~broke~~ wrote the guideline to stop it. I don't know if there were guidelines initially. There must've been some guidelines of who could deliver there. But we – I mean, the neonatal lead will know more about exactly who should've been delivered there and who shouldn't.

PROF FORSYTH: Just one final question, then. With all these components of your final jobs there, do you think the senior management felt was your priority when you had all these different jobs? Which area do they feel you should be focusing on?

MRS OXLEY: Whatever got us the Foundation Trust status.

PROF FORSYTH: Do you want to elaborate on that a little bit?

MRS OXLEY: I felt – for example, I'd go to a meeting thinking I need to flag this, and this, and this as things that I'm concerned about. I'd go to the meeting and before anybody spoke, the execs would say, 'We need to save £24 million; we need to tick these boxes on service management, and there mustn't be any breaches; I want you to get round in circles and discuss this and tell me how you are going to save so many million in your division'. That was the big priority; that's what we had meetings about. Therefore, I found I very difficult, although I did do it, to say, 'We actually need some more midwives on the labour ward'. And it was like, 'What's that got to do with Foundation...', you know, 'We need to save £24 million, how're you going to get that money, you

tell me...' – it was very, very difficult. Because as with every maternity service, it's something like – I can't remember the statistics now – but 80, 90% of the costs are staffing. Therefore, 'save', when you are short of staff in some areas is incredibly difficult. And we did do some savings on some reorganisations and some better work in the service management part of my job. But you know, the Trust wanted to get Foundation Trust status; we were also – because they'd failed and one of the reasons they'd failed was because of the incidents in the maternity, was like – there was a big stick for us, i.e. maternity services, if we put any more delays in the way of the Foundation Trust, it was – you know, you could be hit with a big stick kind of... because we'd already let the Trust down once, in their attitudes.

PROF FORSYTH: [inaudible]

MR BROOKES: Thank you, well, can I just go back a little while just to make sure I'm clear in my mind? It sounds like there was three re-organisations in four years? Where you say you changed roles? Was that organisations in your area or was that specifically about you?

MRS OXLEY: That was a Trust – they were related to –

MR BROOKES: You say you were displaced and then you took on the job of Head of Midwifery, which would imply – because of the displacement, there was some kind of reorganisation?

MRS OXLEY: That was – the first one, of the Head of Midwifery, was within the division, because it was still Women's Services, and when I took over as Head of Midwifery, it was in the Women's Services Directorate. So that was still –

MR BROOKES: That was a reorganisation within the Division?

MRS OXLEY: Yes. Then, not long after that, the Trust reorganised into the big divisions instead of directorates, and that's when it became the Surgical and Critical Care?

MR BROOKES: And that's when you took on Service Manager roles?

MRS OXLEY: Yes. It was as part of that, shortly after that I took on Service Manager role.

MR BROOKES: Then you had another reorganisation?

MRS OXLEY: Then there was another reorganisation of the Trust, the whole Trust structure.

MR BROOKES: So there's three reorganisations which have affected you, two which were Trust-wide, and one which was divisional-wide within that period, of the time, that four years?

MRS OXLEY: Yes, it was about three and a half years.

MR BROOKES: Yes.

MRS OXLEY: Three and a bit years.

MR BROOKES: Yes. And at the end of that, you still were responsible as Head of Midwifery, you still had that as part of your role, and it's just following one from what was said earlier. Can you just give me an indication about a proportion of your time was available for that job, as Head of Midwifery?

MRS OXLEY: A large proportion of my time, as the Business lead, was split between the two PCTs, the Strategic Health Authority – but I was also managing the – like the job descriptions of the consultants, along with the clinical lead – but I was also being phoned up on a Friday to say, 'There's no registrars in Lancaster, they've not turned up'. There was nobody in post; to

manage medical staffing. there had been, but again, she'd been taken out. To save money.

MR BROOKES: Sorry, just so I understand, what was the Service Manager job? It sounds like the Director or Head of Operations?

MRS OXLEY: Yes, well, it was the – the Service Manager job was getting all the people who applied to the Trust through the system, in line with all the –

MR BROOKES: That's right across the Trust? It's not specifically –

MRS OXLEY: Across the Trust for Gynaecology –

MR BROOKES: Across the Trust for –

MRS OXLEY: For Gynaecology and Obstetrics, inpatient and outpatient.

MR BROOKES: So back to my question, in terms of how much of your time would you say you could place in terms of Head of Midwifery?

MRS OXLEY: It started shrinking.

MR BROOKES: Yes, I understand; that's why I'm asking. I'm just trying to get a feel for how much time you actually had available to you to do that part of the role you'd been given?

MRS OXLEY: It's difficult to say exactly how much, but I would say, 50% of my time was taken up with these other issues, and then in the final year, that increased again, 50, 60%. or more.

MR BROOKES: So that's there, and at the same time, there's changes in the maternity units, in terms of staffing levels; also in terms of grading levels going on as well?

MRS OXLEY: Yes.

MR BROOKES: Tell me, in terms of the Grade 7 redesign, to move some to Grade

6, etc. I know you said already, there was two reasons; one of those reasons was around suitability of people for filling appropriate roles, but other was cost?

MRS OXLEY: Yes.

MR BROOKES: Was that cost reinvested back into the midwifery service?

MRS OXLEY: No.

MR BROOKES: So it was basically taking money out of maternity services?

MRS OXLEY: Yes.

MR BROOKES: Okay, that's helpful to understand.

MRS OXLEY: Yes.

MR BROOKES: Whose idea was it? Where was the initiative led from?

MRS OXLEY: From the Band 7 moving?

MR BROOKES: In terms of the banding reorganisation?

MRS OXLEY: I needed to have Band 7 managers, and when you compared our Trust to the number of Band 7s that other Trusts had, we had way, way more than most other Trusts. The other big problem that I had, when I said, 'Right, who's going to lead on this', when there's a bunch of six, it was like, nobody stuck their hands up. Whereas if I had two, and said, 'You are the two leaders, you lead on this', that's where my problem was. I needed people to take responsibility as managers; whereas they felt they were Band 7, experienced midwives working in clinical – areas with no managerial responsibility

MR BROOKES: So it was effectively your take on what was required in that service to improve that service, was to create the Band 7 managers, and in the process of that, was to actually redesign some of the other jobs in that area which meant re-grading of those posts?

MRS OXLEY: It was a big redesign of all the different jobs, yes.

MR BROOKES: I understand that, but it comes back to my point, and you've just touched on that as well, with so many there, I'm really unclear who's in charge of the midwifery –

MRS OXLEY: Who's in charge of...?

MR BROOKES: Well, at the end of the day, good governance would say –

MRS OXLEY: The Band 7 –

MR BROOKES: Somebody is accountable for the service and you've got element of service, you've got the midwifery service in there, and you've got your Band 7; you've got Obstetrics and you've got Neonatal. Who was in charge overall? Who was the person that was trying to make – who was the person responsible for ensuring that that unit worked as a single unit, rather than as three separate strings?

MRS OXLEY: In Obstetrics and –

MR BROOKES: Well, you've got three elements of the service – I'm not a clinician, so – you've got midwifery service, you've got Obstetrics, you've got Neonates. Who was responsible for ensuring that service ran properly and effectively. Because I'm clear where your responsibility around midwifery was. Who was responsible overall?

MRS OXLEY: There is the clinical lead is there.

MR BROOKES: What are they responsible for?

MRS OXLEY: The clinical care that happens within that unit. The Divisional clinical director is overall responsible for the safety and standard of clinical care of patients - regardless of whether care is medical or midwifery

MR BROOKES: But are they responsible for the midwifery service?

MRS OXLEY: ~~No.~~Yes

MR BROOKES: No, so I'm just trying to go up a little bit in the organisation. Who was responsible for it?

MRS OXLEY: In the final year, the management side (not clinical) that was the responsibility that I was taking on, but it was very difficult. But in the final year, I – there was a person, for the first two years, there was somebody in post, as Operational and Performance Lead for Obstetrics and Gynaecology. The actual running of the – but he wasn't clinical.

MR BROOKES: Am I right in saying there was no clarity in terms of leadership in that unit?

MRS OXLEY: The Clinical Director Obstetrician was always seen as the lead in Barrow. Yes, (This answer doesn't make sense – I'm unsure why I said this – some confusion) probably from the time that the Head of Midwifery was taken out of that unit.

MR BROOKES: Thank you. I've picked up a number of things which you've been saying, I just want to feed them back to you, because you talked about a lack of basic skills around some of the staff?

MRS OXLEY: Yes.

MR BROOKES: That's correct? And particularly around record keeping, and some neonatal care. You talked about the unit being split physically between – with a corridor running down it. You talked about the theatre which was remote from the actual unit?

MRS OXLEY: Yes.

MR BROOKES: Staffing below levels, was something which we've heard – below, reduction of staff, change in skill mix, and no necessary buy-in by all the clinical groups to the way in which the unit was operating. Are all those correct?

MRS OXLEY: Yes.

MR BROOKES: It just leads me to ask the question: in your view, was the unit safe?

MRS OXLEY: It's on the – I mean, we were trying to make it safer, and therefore is it safe when you're trying to make it safer? At times, I didn't feel it was and we were – that's where we were trying to put things in place to make it safe, to make it as safe as possible.

MR BROOKES: All these are genuine concerns which you'd raised at different times, I think is what I heard you say?

MRS OXLEY: Yes.

MR BROOKES: Was there ever any packaging of them all together to show the composite position? When you add all these together, you've got a real issue here within the service, which needs to be addressed?

MRS OXLEY: I think there was not the specifics of what you've just said, what we've just said. I think, me, as time went on, it became clear to me that Furness was running as a – nobody really wanted to work there; the doctors, you couldn't get doctors; midwives, you couldn't get midwives; there was no money being invested in there; there was no education departments supporting it; there was no Professors of anything. It was very, very isolated and it was running in Barrow, which is a very deprived area, with very high-risk, vulnerable women.

MR BROOKES: So what was the response of the Trust to that picture? Why, in your view did they not respond more positively to the changes which you felt

needed to happen?

MRS OXLEY: I think that the big Trust issue was the Foundation Trust issue; that seemed to be the one big driver that was, you know, if it came within Foundation Trust, you had a possibility of getting it if you could, but if it didn't then the pressure was one to get Foundation Trust status. That's what was thrown down to my level.

MR BROOKES: From any person, it doesn't have to be from yourself, in terms of raising these concerns, were they ever raised directly with the Trust senior management?

MRS OXLEY: Yes, the different concerns, as individual concerns, I raised with my divisional lead and with the Executive Nurse.

MR BROOKES: Do you know what they – whether they raised them higher up the chain? I'm just trying to understand who knew the level of concern that you had and others had about that service?

MRS OXLEY: I mean, I presented the birth rate, plus staffing levels to – there was three or four – or at least two or three – executive members. So, they definitely knew about that. I think I had a better understanding of it so I was asked to do it direct. But I didn't speak to the Trust Board as –

MR BROOKES: Did anyone speak to the Trust Board? I'm just trying to understand where the barrier was within the organisation?

MRS OXLEY: The different – the Trust Board knew about the concerns that were going on very, very clearly. Any serious incident, as soon as it happens, as soon as it was reported to me, I reported to the Trust Board, to let them know that it had happened.

DR KIRKUP: Can I clarify: when you say, 'Reported to the Trust Board', do you mean a full Board meeting or to an individual?

MRS OXLEY: No, to an individual, whoever was on for that day.

DR KIRKUP: And do you know if those concerns in turn were reported to the full Board?

MRS OXLEY: I don't know that.

MR BROOKES: I'm just trying to understand where the blockage was in the system and then the reason for it. You've expressed, clearly, that you felt that part of this was to do with the Foundation Trust process, but if the right people didn't necessarily know the level of the concern, that's why I'm asking. I'm just trying to understand where this was?

MRS OXLEY: Yes.

MR BROOKES: Okay.

DR KIRKUP: Okay, just some loose ends. I'll just change the subject for a minute: you've described a pattern of having multiple bits added on to the initial Head of Midwifery role, and had been unhappy with that, basically because you felt that it jeopardised the 'do-ability' of the job? Is that correct?

MRS OXLEY: Yes. I have – I still have documented a – when I met with the Divisional Manager, and it was an HR business lead, the HR business lead made notes of the interview, and one of the things that I flagged up was my – she's written it very professionally, but I was very wound up about given even more responsibilities, that I hadn't applied for, that I didn't want at the time.

DR KIRKUP: Okay, I understand.

MRS OXLEY: And the answer was that I could have a buddy mentor, which I never

got.

DR KIRKUP: Did you not?

MRS OXLEY: No.

DR KIRKUP: Okay. I presume that the job you're doing now is a do-able one. What's different? I'm not asking you to give details of what you're doing at the moment, but in what way have things changed for you that makes the job now do-able?

MRS OXLEY: The job that I'm doing now is as a clinical midwife. I consider myself a very experienced clinical midwife, up to date with everything.

DR KIRKUP: Okay, you don't have managerial responsibilities?

MRS OXLEY: No.

DR KIRKUP: Thank you for clarifying that. You've mentioned concerns about clinical skills of midwives during your time at Barrow?

MRS OXLEY: Mmm.

DR KIRKUP: One specific area, do you regard it is as appropriate that midwives are monitoring healthy babies on a post-natal ward? Should they be able to do that?

MRS OXLEY: Yes, of course they should. Yes.

DR KIRKUP: You mentioned one particular area of concern about hypothermia. Just leaving that aside, were you otherwise content that they had the skills to do that?

MRS OXLEY: That they had the skills to – yes, absolutely, a midwife should know when a baby's healthy and when it's not healthy, and should refer.

DR KIRKUP: Yes, and did they? Leaving aside that particular exception?

MRS OXLEY: Umm, I think we did a full audit of the records. These were babies that were not – what's healthy – they were healthy babies but they were on observations for a reason, and we did a full audit and identified across the bay that some babies were not being referred, when they should've been.

DR KIRKUP: You say, 'Across the bay', so there was a problem at both Lancaster and Barrow or a particular problem at Barrow?

MRS OXLEY: Yes. The other issue that I felt had happened with that was that there was a change over the last – probably 10 years ago now – from any baby that had any risk, going to the neonatal unit for observation and then going back again 24 hours or 12 hours or whatever later, to any baby that had any risk ~~that seemed to~~ but was reasonably okay, being monitored on the maternity ward. So this was extra responsibility and I think when that came in, I was in charge of the midwifery service as ~~Western~~Westmorland General, and because we were – because we didn't have any paediatricians, quite a lot of the midwives did extra training, advanced training for neonatal examination and you cover a well baby and an unwell baby during that formal training. So that's where I was coming from. But I don't think that had happened in the other two units. I think it was a great idea that well babies stayed with their mothers, and there was better bonding, but no training was actually put in place as to – that's what I felt. I felt this incident flagged some of that up; I don't know how many – maybe 70% of the midwives knew what they were doing and were happy and confident with it, but there was a significant number across the bay who said, 'I wasn't sure of that'.

DR KIRKUP: What was the timing of that change?

MRS OXLEY: The time of the change?

DR KIRKUP: When the babies started to be looked after –

MRS OXLEY: I think it was national – I think it was a national change that happened, but it was probably 10 years ago now. But it was a gradual thing as well.

DR KIRKUP: 2004?

MRS OXLEY: It was very gradual, you know, and then you'd find babies that were 35 weeks but feeding okay, would stay on the post-natal ward. Whereas 10 years before, they'd be in the neonatal unit. It was that gradual change that occurred.

DR KIRKUP: Okay. Were there clear policies on foetal monitoring when you were at the Trust?

MRS OXLEY: There was – no, well, there was a clear policy, but it wasn't clear. There was a policy but it wasn't clear in that it was interpreted differently but different people. That's what we did an awful lot of work on; renewing that guideline, renewing the policy, renewing the – we called it an Enhanced Vigilance Chart, which was 12 hours of observations on the neonate – of how it was done by a set way. On the back it had all the normal parameters and who you should refer to if they were outside the norm. It's like an algorithm on the back.

DR KIRKUP: I think you're talking about neonates there, I was presumably referring to monitoring in labour?

MRS OXLEY: Oh, right.

DR KIRKUP: Sorry, I didn't make that clear, changing the subject.

MRS OXLEY: Maybe I'm just thinking that way. I mean, again, we made it clearer still, in that we – it was anybody that was higher risk should be continuously monitored, and after some of the incidents, we clarified that a whole lot more, in that they were flagged as green, amber or red, and there was very specific monitoring brought in for anybody that flagged amber or red. The monitoring was made clearer.

DR KIRKUP: Was it clear what action should be taken if somebody should've been monitored but, for whatever reason, the patient couldn't wear the belt or the CTG wasn't readable – was it clear what was supposed to happen?

MRS OXLEY: I don't know if it's a guideline but I would say that's a clinical norm. If you can't monitor the foetal heart, you do something about it. That is a clinical –

DR KIRKUP: And what would the something be? What would you do?

MRS OXLEY: If you can't hear it with a pinard, you'd maybe use a doppler or a strap around the abdomen. If you can't hear it with a strap around the abdomen, you put a clip on the baby's head.

DR KIRKUP: Does that require referral to a junior doctor?

MRS OXLEY: No.

DR KIRKUP: You have midwives putting clips on?

MRS OXLEY: Yes.

DR KIRKUP: And how was that policy put into practice? That's the theory?

MRS OXLEY: It's hard to say, because that to me is a clinical norm; that should be – that's a clinical norm, that's practiced by everyone. I don't know – is it written down as a policy? It's what you do, you know, to keep an eye on that baby.

DR KIRKUP: Yes, I absolutely get that. But what I'm saying is, did that actually happen in practice?

MRS OXLEY: I know at least one incident that it didn't.

DR KIRKUP: I think there may have been more than one. What I'm getting at really is the next question, what do you do about that? How do you make sure that that theory is put into practice?

MRS OXLEY: By audit, by review, by training, by discipline if necessary. You know, many different ways – having good guidelines that are properly audited. A whole range of measures to ensure that that goes on.

DR KIRKUP: Was that something that you talked to staff about, to follow through on foetal monitoring?

MRS OXLEY: It's something – I'm sorry, I don't quite know what...?

DR KIRKUP: You identified some shortcomings in your role as Head of Midwifery, albeit with potentially other things added on to it, what did you do when you became aware of those shortcomings? Did you talk to staff? Did you talk to them individually or collectively to follow it up?

MRS OXLEY: We talked to the individuals individually, that were involved. But then the bigger picture is to educate all your staff in the same, and that education tended to be at the obstetric emergency days, we'd put something on that was specific to – we'd cover foetal monitoring in obstetric emergency days. We covered things that had – quite often, things that had been flagged up in the incidents. We also, on the obstetric emergency days, the risk management midwife would present findings from major cases that had been reviewed; not even major cases, anything that had been flagged up as a learning issue,

would be put at the obstetric emergency study days.

DR KIRKUP: And how did you know that that was having an effect? How did you know that was improving things?

MRS OXLEY: We had audit; we audit specific areas. I also introduced – and this was part of the Band 7 thing – that every Band 7 across the Trust, every month, was asked to review three sets of notes to see if the care given in those three sets of notes was up to standard; and I asked them to be quite strict with it; and to contact the midwives themselves, and it was a kind of ongoing audit, review. So every Band 7 was to review three sets of records.

DR KIRKUP: How did you select the three sets of records?

MRS OXLEY: I left that to them. I asked them to make sure that –

DR KIRKUP: It could be random or...?

MRS OXLEY: I asked to make sure that they covered all, you know, that every midwife was – they weren't all from the same midwife.

DR KIRKUP: They were unselected whether there had been a problem, was concerned?

MRS OXLEY: If there'd been a problem, they would've been reviewed anyway. If there'd been a problem flagged, then it would be reviewed in the incident report meetings; the records would be there and reviewed by people. But these were cases that were completely not a problem, could well be very straightforward, but they'll be pulled and look at the records, 'Was everything done that should've been done?' etc., etc. There was all sorts of smaller areas looked at. For example, every transfer from the midwifery-led unit, generated a form and every single case, as a joint group of midwives in the midwife-led unit, would

look and say, 'Should this woman have been booked here in the first place? Was she reassessed correctly when she was admitted in labour? Was the care in labour done?' So there were quite a few smaller audits going on.

DR KIRKUP: So how did you feedback the results of those audits?

MRS OXLEY: Feedback to...?

DR KIRKUP: Well, exactly. That's what I'm asking, really. Where did it go back to?

MRS OXLEY: The Band 7s fed back individually to the record – they had a form, it was a form that they did, and they fed that back, directly to the midwife involved.

DR KIRKUP: Okay.

MRS OXLEY: Who'd done the records. Usually – it wasn't always the labour ward records; sometimes it was antenatally, there were things that had been missed. So they fed back directly.

DR KIRKUP: One of the things that you identified there, for instance, is, 'Should this baby have been delivered in Barrow in the first place?' If the answer to that was, 'Actually, no, it should've been delivered in a specialist unit', who do you feed that back to?

MRS OXLEY: Sorry, I was talking about the Westmorland Hospital at that point.

DR KIRKUP: Right. Okay, so you didn't audit decisions to deliver in Barrow as opposed to a specialist unit?

MRS OXLEY: No I didn't.

DR KIRKUP: Did anybody audit those?

MRS OXLEY: I'm not sure.

DR KIRKUP: Okay.

MRS OXLEY: I don't remember.

DR KIRKUP: Just briefly, on interpretation of CTGs, whose job would it have been to do that, and what would you do if you thought – or what would they have done if they thought that there was an abnormality?

MRS OXLEY: It's the midwife's role, when she is caring for the woman, and she would interpret it – this has changed over time as well, in that we now obviously have the second, fresh eyes, came in and a second person would review it as well. But at the time, it was the individual midwife would be reviewing that CTG. However, I would suggest that if you've got a CTG on a woman, she's not a low risk case; she's probably a higher risk case, maybe slightly higher risk, and you know, higher risk cases should be overseen by obstetricians as well. But on the minute-by-minute, it's the midwife's responsibility.

DR KIRKUP: Yes. Just picking up on that, you described a picture where higher risk women didn't have involvement from an obstetrician, and it was as if the obstetricians would say, 'Midwives, carry on with it, until they flag something up'.

MRS OXLEY: That was something we put in place; a very, very specific –

DR KIRKUP: What I'm concerned about is that you're describing a picture of that being – almost the obstetricians rebuffing the care, was there not an element that it worked the other way around as well? That midwives were very keen to keep cases away from obstetricians?

MRS OXLEY: It was a complex situation and –

DR KIRKUP: And there was an element of midwives perhaps overzealously guarding patients?

MRS OXLEY: I think there was at some points; it's very difficult to say where that lay, but there was something not going right. You know, there was quite a number – a couple of cases where the midwife would call the doctor, but the doctor did nothing when they came; then the doctor said, 'Well, the midwife then said they didn't need me'. You know, but it's a high-risk case; if you're calling a doctor to a high-risk case, surely that doctor is going to have a look at the case. It's his or her case, anyway; it's a consultant-led case. It's not a low-risk midwife case. So it becomes very difficult to understand, but yes, I mean, that point was brought up.

DR KIRKUP: Okay, anybody want to...?

MR BROOKES: It's a completely different question: what was the position in terms of use of agency staff, at Barrow, and was there ever any problems with that?

MRS OXLEY: We never had agency at the time.

MR BROOKES: Okay.

DR KIRKUP: There's one or two questions that we want to ask you about individual cases, so if I can just ask you to hang on while the observers step outside.

[*Attenders withdraw*]