THE MORECAMBE BAY INVESTIGATION

Wednesday, 1 October 2014

Held at:
Park Hotel,
East Cliff,
Preston.

Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes - Expert Adviser on Governance
Professor Jonathan Montgomery - Expert Adviser on Ethics

IAN ~~ELLIOT~~ELLIOTTT

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

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1 DR KIRKUP: Good afternoon. Thank you for coming. We
2 appreciate it. I will say for the record that I am
3 Bill Kirkup and I am Chairing the Investigation Panel;
4 I will ask my two colleagues to introduce themselves.
5 MR BROOKES: I am Julian Brooks, currently the Chief
6 Officer for Public Health England but previously head
7 of Clinical Quality at the Department of Health.
8 PROF MONTGOMERY: I am Jonathan Montgomery, I'm a
9 Professor of Care Law at University College, London and
10 I Chair the Health Research Authority. In the past I
11 have chaired PCTs and SHAs for the provider Trust.
12 DR KIRKUP: You will notice that we are wired for sound
13 and we make a recording of the proceedings to produce
14 an agreed record at the end of the process. You are
15 aware that we open the proceedings to family members,
16 as it happens we have some family members present
17 today. Others may listen to the recording subsequently
18 if they wish to.
19 You will also know that we have asked you to leave
20 behind any mobile phones, tablets, other recording
21 devices just to reinforce the fact that nothing goes
22 out of the room until we produce the final report with
23 everything considered in context.

1 MR ~~ELLIOT~~ELLIOTTT: No, thank you.

2 DR KIRKUP: I will ask a general question to start with

3 and then hand you over to Julian. The general question

4 is what has your involvement been with Morecambe Bay

5 and in what capacity?

6 MR ~~ELLIOT~~ELLIOTTT: We received an invitation to tender from

7 the Trust for the Governance~~Government's~~ review work, which would

8 have been middle of November 2011, I think, to which we

9 responded and then we met in the Trust, we talked

10 through the what we said we would do and they selected

11 us as the supplier for the Governance ~~Government's~~ review. So

12 ultimately we were engaged by the Trust and by Monitor

13 jointly. So before then I had no involvement with the

14 Trust at all.

15 DR KIRKUP: How long did that governance review take?

16 MR ~~ELLIOT~~ELLIOTTT: We reported in February 2012. We started

17 in December, so we were there for two months leaving

18 aside the holiday period over Christmas.

19 DR KIRKUP: Have you had any dealing with the Trust

20 subsequent to that?

21 MR ~~ELLIOT~~ELLIOTTT: Yes. Limited. We did a follow-up review

22 in March and April, 2013. We reported, I think it was

23 in July eventually, which some of my team did. I had

24 some involvement, not as much as I did in the first

25 piece of work since then. I think our last contact

1 would be July, I think. When I say our, I mean, my
2 team. Other people at PWC may well have had some
3 involvement. I am talking from within my own knowledge
4 here.
5 DR KIRKUP: Thank you.
6 MR BROOKES: Yes. If we can just follow on from your
7 description of your engagement by Monitor and the Trust
8 jointly, was it?
9 MR ~~ELLIOT~~ELLIOTTT: Ultimately it was, we were engaged by the
10 Trust originally and then Monitor ~~for~~ joined into that
11 agreement. So our report was prepared for both Monitor
12 and the Trust.
13 DR KIRKUP: Can you take me through how you went about
14 that particular review?
15 MR ~~ELLIOT~~ELLIOTTT: Yes. The review was -- the exam question,
16 I guess, was to cover three broad areas, so Board
17 capability and effectiveness; board governance
18 processes and procedures and risk management and risk
19 escalation. Can I just ask before I go any further,
20 have you read the report? I do not want to tell you
21 everything that is in there.
22 MR BROOKES: Yes. Yes, it will be helpful to summarise
23 the key points for the record but, yes, we have read

24 the report.

25 MR ~~ELLIOT~~ELLIOTTT: Fine. So the way we went about that, I

1 didn't do it on my own, I had a team of, people

2 probably would have been around half a dozen of us

3 including clinical advisers., One ofone. Of my team was a

4 former chief nurse in various Trusts, so she was

5 involved. We had former medical directors as advisers

6 or one in this case and Tthe review consisted of, you

7 know, we asked the Trust for a large volume of written

8 information, documents around governance and risk

9 management and so on which we reviewed to form a view

10 on those. The bulk of it was through observations, so

11 we observed a number of Board meetings, sub-Committees,

12 some clinical quality and safety Committee we observed.

13 We observed divisional governance meetings to the

14 extent they were happening in the period that we were

15 there and we interviewed, I think, all of the

16 directors, couple of them had gone by the time we

17 started but we interviewed directors and then a number

18 of other people who were relevant to our work. So

19 associate Medical Directors.

20 MR BROOKES: Did you interview any non-executives?

21 MR ELLIOTELLIOTTT: Yes. The executives and non-executives and

22 we started out at Westmoreland but we visited Furness

23 and RLI as well and, you know, we talked to a number of

24 staff whilst we were there.

25 PROF MONTGOMERY: Including front line

1 professional staff?

2 MR ~~ELLIOT~~ELLIOTTT: Yes.

3 MR BROOKES: Did you do any triangulation with external

4 organisations?

5 MR ~~ELLIOT~~ELLIOTTT: To a limited extent. So we had all

6 publicly available data. We talked to Commissioners As

7 well.

8 MR BROOKES: So that will be the two PCTs?

9 MR ~~ELLIOT~~ELLIOTTT: Yes, okay.

10 MR BROOKES: Okay. In terms of what you found, we have

11 had the benefit of that but to summarise the key

12 findings that will be extremely helpful.

13 MR ~~ELLIOT~~ELLIOTTT: I mean, you have got a sense of a Board

14 that was a bit overwhelmed really. We went in there at

15 a time of, you know, they were in crisis mode at that

16 stage after everything that had happened to them but I

17 would summarise it overall by saying the governance

18 processes and procedures were broken really and given

19 the way governance was not working, it was not

20 operating properly, I do not think the Board could have

21 known everything that could have gone on because it

22 just was not getting the right information and the

23 problem was it did not realise it.

24 MR BROOKES: You say it is broken. Were there

25 mechanisms in place and not functioning or were the

1 mechanisms absent?

2 MR ~~ELLIOT~~ELLIOTTT: I think it varies. I would say on risk,

3 for the risk management and escalation the policies and

4 procedures they were there, they were ~~we~~ written down but

5 when we talked to front line staff about that they

6 would not have known where to find them. A lot of them

7 did not know how to go about reporting incidents or

8 escalating risks they were observing from day to day ~~today~~.

9 On governance again, I mean, there was a governance

10 structure that looked like it could have worked, you

11 know, it looked like most governance structures that

12 lots of other Trusts with a Board and some

13 sub-Committees reporting in and then divisional

14 governance below that.

15 MR BROOKES: But when tested it was not happening?

16 MR ~~ELLIOT~~ELLIOTTT: No, I mean, I do not want to make too many

17 broad statements but ultimately, it was not. So

18 divisional level, for instance, governance was very

19 inconsistent so.

20 MR BROOKES: When you talk about governance, are you

21 meaning corporate governance or clinical governance or

22 both?

23 MR ~~ELLIOT~~ELLIOTTT: Both. I mean our focus was on clinical or

24 quality governance but, I mean, we could tell by

25 observing Board meetings that it was problems were

1 wider than that.

2 MR BROOKES: Okay. Therefore, your conclusion was that

3 the Board -- was the Board receiving information and

4 not acting on it or not receiving information?

5 MR ~~ELLIOT~~ELLIOTTT: Both. The information that it did receive I

6 think a lot of the time that there was -- from what we

7 observed anyway there was too much time talking about

8 whether the data itself was valid rather than looking

9 at what it told you. That was partly because the

10 Board, I think, you know, we interviewed them all and

11 they all did self-assessment questionnaires as well.

12 They did not feel assured of the data they were

13 receiving but, you know, there was no evidence they had

14 done very much about that unfortunately. There would

15 be a focus, so if there was a discussion around

16 mortality, for example, then too much time would be

17 spent on debate about whether the data was right and

18 maybe it was possible that there were errors in the

19 coding and so on that which meant showing a higher

20 number than was actually right, you know, rather than

21 thinking about which specialties or which divisions

22 might be the real problems and, you know, what to do

23 about it.

24 PROF MONTGOMERY: Did you have a perception of

25 whether that was always slanted in a way that was

1 wanting them to believe optimistically that things were
2 going well? You have look at low rates and ask the
3 same question?
4 MR ~~ELLIOT~~ELLIOTTT: No, the evidence that we saw was there was
5 a tendency to wish things were better than they
6 obviously were. To an outsider, anyway.
7 MR BROOKES: Could a Board member, on the basis of the
8 information they received, have made a proper
9 assessment of the current state of affairs within the
10 organisation?
11 MR ~~ELLIOT~~ELLIOTTT: No, I do not think so because the
12 information just was not getting up there. So if you,
13 as an example, if you think about the out-patients
14 issues, which we did not, I think, you will understand
15 from the report we did not investigate any. We were just
16 looking at governance as it was when we saw it but when
17 you delved into things like complaints if you looked at
18 it you could see that, that was one of the things we
19 did, you could see that complaints from out-patient
20 were increasing so, you know, there was a trend which,
21 if you stepped back and looked at it. You would have
22 thought, well, I wonder why? We need to look at~~apt~~ that.
23 We are getting far more complaints than we did before

24 and serious incidents there was a similar trend.

25 I think the information that the Board was getting

1 it tended to look at it as of today rather than
2 thinking about what it actually meant, you know, there
3 was no analysis of trends or anything like that but
4 there was clearly information that was within the
5 organisation, it was there, that was not working its
6 way up to the Board.
7 MR BROOKES: Where were blockages if the information
8 was in the organisation?
9 MR ~~ELLIOT~~ELLIOTTT: I think, there was a lack of prioritisation
10 amongst a lot of people down at the divisional level.
11 you felt that talking to people that middle management,
12 I use the word overwhelmed before, that it was
13 overwhelmed by the amount of work it had to do. There
14 were action plans ~~for~~ all over the organisation but it
15 would have been virtually impossible for anybody to
16 actually locate them all and work out who was
17 responsible for what. I would not use the word
18 blockage. We did not see people deliberately covering
19 things up.
20 MR BROOKES: That is one of the things we want to test.
21 So it was a system that was not fit for purpose and
22 was, therefore, causing the blockage?
23 MR ~~ELLIOT~~ELLIOTTT: Yes, ~~there~~.

1 MR ~~ELLIOT~~ELLIOTTT: No. We as a team and I personally did not
2 see any evidence of people who must have known things
3 but decided not to volunteer them.
4 MR BROOKES: Okay. You have referred to and we are
5 aware of there being a multitude of reports at this
6 stage with a variety of action plans in place. Do you
7 think that what you saw was weaknesses because of the
8 system overheating because of these or was there a
9 fundamental weakness prior to that additional set of
10 pressures on the system?
11 MR ~~ELLIOT~~ELLIOTTT: It is difficult to say conclusively but I
12 think things were, certainly as I saw them when I was
13 there, things were so far short of what I would have
14 expected to see that it must have been in large part
15 broken before, you know, before all of the action plans
16 and you would think that in a Trust where things were
17 working properly some of the things that unfortunately
18 did happen would not have happened if processes had
19 been there to start with.
20 MR BROOKES: Yes. This was an organisation with a poor
21 governance structure, some of it on paper but not
22 operating properly?
23 MR ~~ELLIOT~~ELLIOTTT: That is fair.

24 MR BROOKES: We are trying to get to understand whether

25 when you went in this was something that had recently

1 happened, or whether, from your view, this was a

2 symptom of a historic position in terms of poor

3 governance. Have you any insight into that?

4 MR ~~ELLIOT~~ELLIOTT~~ELLIOT~~ELLIOTTT: I think it must have had poor governance

5 for a while, I think, because otherwise it had literally fallen,

6 excuse the pun, where we are, literally fallen off a

7 cliff very quickly. I think, some of the it felt so

8 systemic that--

9 MR BROOKES: In the sense of talking to staff there

10 being feeling of saying, "God, this has gone really bad

11 quickly"?

12 MR ~~ELLIOT~~ELLIOTTT: No, no, no, I think, that--

13 MR BROOKES: "It was really good a year ago".

14 MR ~~ELLIOT~~ELLIOTTT: What you did clearly get was that people

15 were increasingly overwhelmed by everything that was

16 facing them but I think if you think about what was on

17 people's plates by then that is understandable.

18 MR BROOKES: Okay. Part of the reason for asking that

19 is that this is a relatively new FT.

20 MR ~~ELLIOT~~ELLIOTTT: Yes.

21 MR BROOKES: Which will have gone through an assurance

22 processes as part of the its FT application and I

23 cannot square in my mind that it was -- I get the

24 impression that there must have been problems with the

25 governance arrangements at the time of the FT

1 application.

2 MR ~~ELLIOT~~ELLIOTTT: Yes I think that has to be right. I mean,

3 I do not know, I was not there in 2010 but, I mean, the

4 gap is -- we were there, what, a year, a year and a

5 month, year and two months after FT authorisation, I

6 suppose~~space~~.

7 MR BROOKES: Yes, you were there about 18 months.

8 MR ~~ELLIOT~~ELLIOTTT: It is hard to see that and I worked,

9 because I had worked on a number of occasions with

10 Monitor, and I helped Monitor put the quality

11 governance framework together, which was not fully in place,

12 you know, at the time that the Morecambe Bay was

13 authorised but I cannot see how Morecambe Bay would

14 have got through but you know, as I say, I was not

15 there.

16 MR BROOKES: I know you are not there but it is quite

17 helpful that you have had some of that experience

18 because from my understanding around that time when you

19 are monitoring Board self-assurance process for

20 governance for came in as part of the FT application,

21 which seems to be a Board self-assessment and

22 predominantly in terms of the tools used by Monitor.

23 From your understanding is that correct?

24 MR ~~ELLIOT~~ELLIOTTT: At that time, yes, I think it is.

25 MR BROOKES: You have got a board which is assuring

1 original itself based on the evidence it has produced.

2 From you saw about the systems, do you think the Board

3 would have been capable of making a fair judgment in

4 its own systems?

5 MR ~~ELLIOT~~ELLIOTTT: It ~~is~~ did not seem to be capable of making

6 the right judgment. I think it was, you know, I think

7 it was doing its best. Depends what you mean by fair.

8 it did not seem to be making the right judgments, I

9 mean, you know, in terms of where it was when we were in

10 there, compared to the quality governance framework, I

11 mean, you will know that the authorisation, the level

12 was less than four in terms of scoring. It was a long

13 way north of that.

14 MR BROOKES: Okay.

15 You have mentioned you did a follow-up review.

16 Could you just summarise what came out of that and what

17 you found when you came back?

18 MR ~~ELLIOT~~ELLIOTTT: I would describe it as a Trust that in

19 governance terms was in transition at that time. So I

20 mean, it had undertaken a -- I think, virtually the

21 whole Board had changed, not quite, but, you know,

22 there had been a lot of changes about that, I think,

23 probably around a dozen in terms of executives and

24 non-executives. You know, the new team had worked hard

25 to put a new governance processes in place. They had,

1 I think, done, a lot ~~o~~ around clinical leadership,

2 which was one of the big things that was not really in

3 evidence at all in the work we did and they had started

4 to make some progress on risk but it was very early

5 days. I mean, our conclusion was that things were

6 still below what you would have expected in governance

7 terms as an FT. That is not a criticism of the new

8 team, that is an inevitable consequence of where they

9 started.

10 DR KIRKUP: Did I take it there was some delay in

11 producing the report at the follow up visit? You said

12 that it was eventually produced.

13 MR ~~ELLIOT~~ELLIOTTT: There is nothing unusual in that. It was

14 just to receive comments and so on.

15 MR BROOKES: One of the things you looked at in the

16 initial review was risk management. Can you just very

17 briefly say what you found in terms of the risk

18 management in the organisation?

19 MR ~~ELLIOT~~ELLIOTTT: Well, I mean, it was inconsistent, it was

20 very patchy across the different divisions. There was

21 -- we did not found any sort of consistent methodology

22 for evaluating, recording, moderating and mitigating

23 risk. You know, there were differing formats in terms

24 of risk registers, the way risks were recorded. You

25 would then find that individual divisions would

1 moderate their own~~on~~ risks usually downwards, I have to

2 say, in differing ways. So there was no consistency so

3 that -- what then got to the Board, because issues

4 around the moderation~~ and just think~~ that were not

5 identified, was, I am afraid, just did not reflect the

6 real picture of what was really going on in risk terms.

7 MR BROOKES: Did you do an assessment of the Trust risk

8 register against the kinds of risks you find in

9 divisions and what did you find?

10 MR ~~ELLIOT~~ELLIOTTT: Well, in our analysis there were, you know,

11 large numbers of risks that appeared reasonably

12 evident, you know, when you first went in to have a

13 look that did not find their way up to the Board. So

14 that, you know, the corporate risk register was not a

15 fair reflection of what was really happening.

16 I think that the other thing was that the risk

17 registers were not particularly dynamic, by which I

18 mean they were not revisited. You will know what I

19 mean.

20 MR BROOKES: I do.

21 MR ~~ELLIOT~~ELLIOTTT: They were not revisited frequently enough.

22 You find the same things tended to remain on there

23 despite~~decide~~ the fact that things had moved on.

1 MR ~~ELLIOT~~ELLIOTT: Yes.

2 MR BROOKES: What did you find?

3 MR ~~ELLIOT~~ELLIOTTT: I think things were looked at, action

4 plans, as I think I have already mentioned, were very

5 variable, some of them made their way to the Board,

6 some of them did not. I mean, you would not expect all

7 of them necessarily but as a Board member I would not

8 have felt assured that serious incidents were being

9 acted upon. I think what was really missing was a

10 lessons learnt culture. So in a really good, Trust

11 again I am telling you what you know, but in a really

12 good Trust you would expect to see some forum or some

13 way that lessons can be learnt, so if something happens

14 in specialty 1 that should not have done, then

15 specialty 2, 3, 4, and 5 and everybody above is going to

16 understand how and why that happened. You know what

17 needs to be done to mitigate the risk of it happening

18 again and there just was not really any of that.

19 MR BROOKES: Did you get any feel for how well the

20 incidents were investigated?

21 MR ~~ELLIOT~~ELLIOTTT: Again, I am repeating myself, it was

22 inconsistent. So, you know, I think that some of them

23 were looked at in a bit of depth but typically, you

24 know, not as robust as you would expect and maybe, you

25 know, a hint of the sort of optimism bias that I

1 mentioned before around forming conclusions.

2 MR BROOKES: My understanding is that the focus for

3 initial Board scrutiny was through the Quality and

4 Governance sub-committee?

5 MR ~~ELLIOT~~ELLIOTTT: Yes, CQSE, clinical quality.

6 MR BROOKES: Thank you. You attended some of those

7 meetings?

8 MR ~~ELLIOT~~ELLIOTT: Yes.

9 MR BROOKES: You did that function effectively?

10 MR ~~ELLIOT~~ELLIOTT: No.

11 MR BROOKES: In what way?

12 MR ~~ELLIOT~~ELLIOTTT: It was, well, in most ways, unfortunately.

13 I mean, I think it was not really sure of what it was

14 trying to do. What it should have been, of course, is

15 an assurance Committee for the Board, giving the Board

16 assurance that it could rely on, you know, the systems

17 that were there to identify quality risks and so on,

18 such that the right things went to the Board. We saw

19 very long agendas, debates about whether the data was

20 right, as I mentioned before, the committees that were

21 supposed to feed into the Clinical Quality Committee

22 did so in a very inconsistent basis. The Clinical

23 Quality Committee only met every other month, that was

24 pretty unusual.

25 MR BROOKES: You have got the Committee. Again, just

1 in clarity, was information, the right information

2 coming to the Committee and it was they were not

3 operating effectively and, therefore, acting on it or

4 was it not even getting to the --

5 MR ~~ELLIOT~~ELLIOTTT: No, the right information was not getting

6 there. So what we did not see at any time throughout

7 all of the work we did was any way that that Committee

8 or the Board could really see what was going on in the

9 different specialties and divisions. There was no

10 proper integrated reporting that would enable you as a

11 Board member to say, in terms of quality here are the

12 eight things I need to worry about. I have got

13 assurance that things are working so I know that the

14 information is -- this will not help for the voice

15 transcript -- the information in the sort triangular

16 form, the right information is getting up to the Board.

17 So that was a long answer for no.

18 MR BROOKES: That is all right.

19 Did you interview the Medical Director and the

20 Nurse Director?

21 MR ~~ELLIOT~~ELLIOTTT: Yes.

22 MR BROOKES: What was your views in terms of their

23 understanding of those responsibilities as far as

24 clinical governance concerned?

| 25 MR ~~ELLIOT~~ELLIOTTT: I think they understood what they were. I

1 don't think they necessarily -- they did not realise
2 that things were not working properly. Certainly not
3 in a way as Board directors they ought to have done.
4 MR BROOKES: Okay. What about the clinicians on the
5 ground? I think you have already said that certainly
6 in some of the areas they were not aware of the
7 responsibilities? Were there training issues? What
8 was the --
9 MR ~~ELLIOT~~ELLIOTTT: They did not have the responsibilities in a
10 way that you would expect. A lot of the
11 responsibilities for things you would expect clinicians
12 to be leading on, you know, divisional level, for
13 example, it was operational managers who were held to
14 account. Which is kind of what used to happen many
15 years before that. So a lot of them did not have that
16 responsibility and as a result were deeply disengaged.
17 I mean, they really were a very disengaged bunch of
18 clinicians on the whole, I mean, not everybody was like
19 that but.
20 MR BROOKES: Let us be clear, is that the across the
21 whole of the Trust on three sites?
22 MR ~~ELLIOT~~ELLIOTTT: There were differences. The geography
23 clearly was a challenge that I think that the Board

24 that never really, certainly from what I saw the Board

25 just had not grasped at all. I mean, I understand why

1 they were doing things like they were around the sites.

2 They were trying not to create silos. They trying not

3 to have a leadership team at Barrow and a leadership

4 team at Lancaster. I think it was maybe done with the

5 best of intention but it was not right. There was a

6 huge disconnect between the two sites in clinical

7 terms.

8 MR BROOKES: One last area for me. Your assessment of

9 the Board, the Board has a responsibility to receive

10 assurance but also to ensure it is getting assurance?

11 MR ~~ELLIOT~~ELLIOTTT: Yes.

12 MR BROOKES: Was there a good skill mix there? Was

13 there the right people on the Board, in your view?

14 MR ~~ELLIOT~~ELLIOTTT: I cannot comment too much on individuals

15 but collectively I don't think there were.

16 Particularly amongst the non-executives, I think.

17 MR BROOKES: I was particularly thinking about the

18 non-executives in this case.

19 MR ~~ELLIOT~~ELLIOTTT: Across the whole Trust it was very insular.

20 You did not get a sense that people were alive to what

21 was going on in other parts of the NHS that they could

22 maybe learn from and I think that felt particularly

23 acute amongst the non-executives.

1 PROF MONTGOMERY: Thank you. Just asked you
2 something I was going to ask you about and that is very
3 helpful. Can I ask you about the visibility of the top
4 of the leadership. I have been asking this of lots of
5 people. Did the front line people see the Board? Did
6 they see the Nurse Director? Medical Director? Did
7 you get any impression of how aware the front line
8 staff were of what the Board was doing and how aware
9 the Board was? Was there a walk about system?
10 MR ~~ELLIOT~~ELLIOTTT: I mean, the front line staff we talked to
11 did not really feel that the leadership from the top
12 was really something that impacted on them. So, you
13 know, they did not see the Board particularly often. I
14 think we were told there was a sort of rota of walk
15 about or something and I think that might have been
16 relatively recent. I do remember being very surprised
17 the first time I went to Westmoreland and I could not
18 really fathom why the Board was based there but anyway.
19 Staff would tell us that, they did tell us that they
20 did not regard leadership as visible but I think
21 perhaps more importantly than that they did not
22 understand what the priorities were, what the strategic
23 priorities were for the Trust and we talked to a lot of

24 people about the priorities in terms of quality, so

25 what is the Trust's clinical strategy and what are the

1 things that your part of the hospital is focused on in
2 quality terms and I think that people wanted to know
3 but they felt that they did not.
4 PROF MONTGOMERY: Was that any different when you
5 followed up than it was in the first place?
6 MR ~~ELLIOT~~ELLIOTT: It was getting better, I would described it
7 as.
8 PROF MONTGOMERY: Still below par?
9 MR ~~ELLIOT~~ELLIOTTT: The communication was a lot better from the
10 top when we did the follow-up review, I think
11 leadership was a lot more visible but at that time the
12 Trust was still working on the forward looking clinical
13 strategy so I think that there was still feeling that
14 people didn't really know what was going to happen in
15 the future but people were very sore, as you might
16 imagine, the front line staff particularly.
17 PROF MONTGOMERY: I was wondering what you could
18 tell us about the response to you being brought in? Did
19 people resent it? Were they relieved that there was
20 some opportunity to talk about things?
21 MR ~~ELLIOT~~ELLIOTTT: Depends which people you mean, I think.
22 Are you talking about front line staff?
23 PROF MONTGOMERY: I will be in interested in the

24 variation as much as anything.

25 MR ~~ELLIOT~~ELLIOTTT: Some of Board members I think felt like --

1 I think particularly the non-executives it felt a bit
2 like we were an outlet in terms of them being able to
3 say, well, you know, we have not really felt assured
4 about data for quite some time and I think my next
5 question was, "Why didn't you say anything?" to which
6 nobody ever had response to. The front line staff in
7 particular, I mean, you certainly got the feeling that
8 they were pleased to talk to people externally about
9 the Trust and just wanted to understand why things had
10 happened, I think.
11 PROF MONTGOMERY: Can I probe that a little bit?
12 Was your sense that they felt that it was going wrong
13 and they felt it was a relief to be able to tell
14 someone?
15 MR ~~ELLIOT~~ELLIOTTT: Say the first bit again.
16 PROF MONTGOMERY: Was your sense that they felt
17 that there was lots of stuff going wrong here and we
18 have got no-one to tell and you have got someone coming
19 in so they have got someone to tell about it? Or was
20 your sense they felt in ignorance and they just needed
21 to understand better.
22 MR ~~ELLIOT~~ELLIOTTT: I think it was mixed. I think that for
23 some they wanted to understand better. I think some

24 felt that they had tried to escalate things, but that

25 things had not -- a lot of people told us that when

1 they had escalated risk they then never heard back
2 about what had happened, which, of course, ultimately
3 does stop people from doing the right thing -- not
4 through any malevolent thought.
5 PROF MONTGOMERY: Was there a pattern for that? A
6 seniority/type of profession staff/geography --
7 MR ~~ELLIOT~~ELLIOTTT: No, I do not think so. I would say that
8 was pretty prevalent throughout.
9 PROF MONTGOMERY: -- the culture.
10 MR ~~ELLIOT~~ELLIOTT: But there was also a culture though, maybe
11 that was a function of people not being -- people
12 feeling what they had said had not been acted upon, you
13 then got the sense amongst a lot of people, they felt
14 once they reported something that was it; they did not
15 need to concern themselves any more. But I could maybe
16 understand why that was happening.
17 PROF MONTGOMERY: Okay.
18 You talked a bit about this, all these action
19 plans that are going on, you talked a bit about a lack
20 of sense of joining up across specialties in the
21 organisation.
22 MR ~~ELLIOT~~ELLIOTTT: Yes.
23 PROF MONTGOMERY: What about chronologically. Was

24 there a sense that these action plans were going over

25 things that had gone over before? Were they connected

1 to previous reports and --

2 MR ~~ELLIOT~~ELLIOTTT: Some were definitely. I think there was a

3 sense amongst middle management that, you know, for

4 some of the action plans, around some of the issues

5 that, you know, we had been here before. I mean,

6 ultimately the problem with the action plans was that

7 that there was no way for the Board to know -- and I

8 don't think, they did not ask the right questions,

9 having said that, but there was no way for the Board to

10 know whether things were really being done, you know,

11 at the right time, at the right pace and in the right

12 order. Nobody had a sense of that --

13 PROF MONTGOMERY: So at Board level there is

14 neither a sense of organisational memory, nor a sense

15 of the whole organisation cross-cutting things.

16 MR ~~ELLIOT~~ELLIOTTT: Yes.

17 PROF MONTGOMERY: Okay.

18 Were there any senior staff that you felt were

19 resistant to your work and not being open with you or

20 not sharing things?

21 MR ~~ELLIOT~~ELLIOTTT: No. I would not have said "resistant", no.

22 I mean, I don't think it will be true to say that all

23 clinicians were hugely engaged with what we were doing.

24 I would not experience any resistance, no.

25 PROF MONTGOMERY: A couple of other areas then. I

1 am interested to know what you were being told about

2 the interpretations -- the judgments they made on the

3 basis of what CQC was saying about them, what their

4 CNST status was. Were those used as evidence of

5 assurance in the systems -- CQC ratings/CNST approval?

6 I am trying to understand how they used those things

7 because in other areas it seems a bit of a disconnect.

8 MR ~~ELLIOT~~ELLIOTTT: I think "disconnect" is the fairest way to

9 describe it. There was a sense of denial, I think.

10 PROF MONTGOMERY: The other thing I want to ask

11 you about was Gold Command, which is going on around

12 the time that you are in there. What sense you had of

13 the impact of that on the people you were dealing with,

14 if any?

15 MR ~~ELLIOT~~ELLIOTTT: It was only really a sense but, I think,

16 that I got a sense that it was just another thing that

17 they felt they had to -- felt they had to deal with. I

18 would describe when we got there, start of December,

19 there was a real siege mentality around the place,

20 which, on one level, I could understand but, I think,

21 that if it would have been me I would have welcomed all

22 the help I could have got. People didn't really see it

23 like that.

24 PROF MONTGOMERY: To test that metaphor then,

25 "seige" unusually involves pulling up the drawbridge

1 and becoming defensive. Is that what --

2 MR ~~ELLIOT~~ELLIOTTT: Yes. You could -- I could live with that

3 as a metaphor.

4 PROF MONTGOMERY: We have had a phrase used around

5 "learned helplessness" by some of the people we have

6 talked to and a suggestion that somehow this external

7 scrutiny was -- your work, things like Gold Command and

8 people coming in from outside, somehow disabling the

9 ability of the Trust to get to grips with things. Did

10 you see anything that would give you a view on that?

11 MR ~~ELLIOT~~ELLIOTTT: I have heard the phrase. I understand what

12 you mean. I think things were already in such a state,

13 certainly in governance and risk management terms and

14 sort of capability of the Board, I do not really know

15 how much difference it made. I think -- you know, you

16 would say that in a good Trust a Board should have been

17 capable of dealing with those things without so much

18 external help. I think, as I have said before, part of

19 the issue was it did not feel like an organisation that

20 would seek help. Therefore, when it had help in its

21 mind imposed on it, then it was not necessarily

22 welcome.

23 PROF MONTGOMERY: Last question from me then. It

24 was not always an organisation that sought help; it was

25 an organisation that commissioned lots of external

1 reports and reviews -- we keep finding more examples,

2 people being brought in to have a look at things.

3 Can you reconcile those two activities? I dont

4 know if that is still going on when you went in, but I

5 have bene surprised at how many times people have come

6 in from outside and given advice or --

7 MR ~~ELLIOT~~ELLIOTTT: Yes. I am not sure how often it was

8 commissioned or how often it was suggested and there

9 was a feeling they ought to act on a suggestion, but I

10 think what you did not see enough of was the

11 recommendations that were made by people coming in

12 being adopted in a way you might expect. You felt that

13 they were so many different -- as I have mentioned

14 before a couple of times -- action plans coming out of

15 various activities that nobody could see the wood for

16 the trees any more.

17 PROF MONTGOMERY: There is another possible

18 explanation, which is that it was some form of "cover",

19 that they felt that they could keep people at bay by

20 inviting people in so they could say we have had a look

21 at this from wherever. Would you have seen anything

22 that would --

23 MR ~~ELLIOT~~ELLIOTTT: No, I did not see any evidence of that, no.

24 PROF MONTGOMERY: Thank you.

25 DR KIRKUP: To follow up on that particular point, a

1 multiplicity of reports with a multiplicity of

2 recommendations mean you can pick and choose which

3 recommendations you take. Were you aware of that kind

4 of activity?

5 MR ~~ELLIOT~~ELLIOTTT: I didn't see any evidence of it being

6 consciously done, but there was plenty of evidence of

7 recommendations not being implemented properly.

8 DR KIRKUP: Okay. I want to pick up three specific

9 areas as kind of follow up.

10 The first one is incident reporting. Can you just

11 talk me through more about why you think that there was

12 a scarcity of incident reporting. What was the issue

13 that was prevented --

14 MR ~~ELLIOT~~ELLIOTTT: I think, as I mentioned before, I think

15 that people became tired of what they perceived as a

16 lack of action after incidents were reported or risks

17 they observed were reported and, you know.

18 PROF MONTGOMERY: I get that one. I was picking

19 up a little bit when said you said that some people

20 didn't know that they should be reporting incidents or

21 how to report them, that was surprising me.

22 MR ~~ELLIOT~~ELLIOTTT: That is because there were procedures, the

23 Trust had procedures for incident reporting but they

24 were very inconsistent across different divisions,

25 there were different ways of reporting incidents. I

1 think that they had only recently or they were in the
2 process putting Datix in, so that there was a Trust
3 wide way of doing these things. So I think there was
4 just confusion about how you would go about it. I
5 think a diffing perception about what needed to be
6 escalated and what did not.
7 DR KIRKUP: Did you sample some of the investigations
8 into incidents, risk cause analysis and so on?
9 MR ~~ELLIOT~~ELLIOTTT: Yes.
10 DR KIRKUP: What was your conclusion on that?
11 MR ~~ELLIOT~~ELLIOTT: Again done in sort of wildly different ways
12 across different parts of the Trust.
13 DR KIRKUP: Were you able to identify where the
14 particular hot spots were of poor incident
15 investigation?
16 MR ~~ELLIOT~~ELLIOTTT: I would have to check that, which I can do
17 and send you something.
18 DR KIRKUP: I think that will be useful actually.
19 MR ~~ELLIOT~~ELLIOTTT: I would be guessing and I do not want to do
20 that.
21 DR KIRKUP: No, I would rather you did not. That would
22 be very helpful.
23 MR ~~ELLIOT~~ELLIOTTT: Of course.

24 DR KIRKUP: The second area is picking up a point about

25 Gold Command. Did the existence of Gold Command make

1 it more difficult for you to get a true assessment of
2 how the Trust itself operated because of the level of
3 support that was coming in?
4 MR ~~ELLIOT~~ELLIOTTT: No, I don't so. I think, unfortunately
5 things were pretty clear-cut in terms of how things had
6 worked and were working at the time. I can see how it
7 could have done, I understand the question. I think,
8 that unfortunately things were so black and white in a
9 lot of cases around whether things had been done right
10 or not that it did not really have an impact.
11 DR KIRKUP: Okay. If I reflect back to you a view that
12 has been put to us that there was no point in doing the
13 assessment while the Gold Command was operating because
14 the Trust would have passed. I am paraphrasing. When
15 I say passed you know what I mean, it would have ticked
16 all the right boxes. You would not subscribe to that?
17 MR ~~ELLIOT~~ELLIOTTT: No.
18 DR KIRKUP: Thank you. The final point is what was
19 your assessment of the response to the report produced
20 by the Trust? What would you make of it? How did they
21 respond?
22 MR ~~ELLIOT~~ELLIOTTT: I mean, as far as we could tell, I mean,
23 there was -- it was a totally different team, so you

24 mean how did they respond to the recommendations?

25 DR KIRKUP: Did they welcome the recommendations? Did

1 they embrace them enthusiastically?

2 MR ~~ELLIOT~~ELLIOTTT: The new team did absolutely, yes.

3 DR KIRKUP: Was that reflected in the follow up visit

4 that you did?

5 MR ~~ELLIOT~~ELLIOTTT: Yes, it was, I mean, they had so much to do

6 that I think that they could have got a little bit

7 further in certain areas I think but I really do not

8 think it was for the lack of trying but, I mean, you

9 know, they had a shopping list that was longer than I

10 have ever seen at a health Trust pretty much, I suppose

11 you would exclude Mid Staffs, something like that

12 maybe, but in terms of what had to be done then, you

13 know, they had a huge amount on their plate.

14 DR KIRKUP: Did you have direct experience of Mid

15 Staffs?

16 MR ~~ELLIOT~~ELLIOTTT: Some, yes.

17 DR KIRKUP: Okay. I should not pursue that any further

18 that is some about part of our terms of reference.

19 MR ~~ELLIOT~~ELLIOTTT: Whole a different conversation.

20 DR KIRKUP: I was just interested.

21 MR BROOKES: Just to try to get a feel for -- I do not

22 want to create a random scale but how far from good

23 were they? You know, it is clearly significant from

24 your report, significant failings in terms of the

25 governance arrangements and the things they need to do.

1 I want to have a feel from your experience did you have

2 a benchmark against which you would judging them and

3 how far short did they fall from that?

4 MR ~~ELLIOT~~ELLIOTTT: I mean, we were judging them against what I

5 would expect to see at foundation trusts in governance

6 terms, you know, having seen good and indifferent and

7 very good and bad. I mean they fell short in a lot of

8 areas and it was a long way short of what you would

9 expect to see in a Trust where the Board was

10 functioning properly.

11 PROF MONTGOMERY: Standard of authorisation for FT

12 or standard of a good FT? Falling short of what?

13 MR ~~ELLIOT~~ELLIOTTT: A good FT. I mean, one way to look at it

14 would be had it been up for authorisation in

15 December 2011.

16 MR BROOKES: Would it have passed the governance --

17 MR ~~ELLIOT~~ELLIOTTT: No, absolutely not.

18 PROF MONTGOMERY: What about July '13?

19 MR ~~ELLIOT~~ELLIOTTT: No, probably not. It was closer. But, I

20 mean, for December 2011, I mean, there is no -- had I

21 been assessing it anyway it would not have done.

22 PROF MONTGOMERY: So if I were if I ask you, you

23 have seen the progress for '11, '13, what would be the

24 appropriate time to go back in and assess them as if

25 they were up for authorisation? How much longer after

1 2013 would it be fair to wait for before you did that
2 assessment?
3 MR ~~ELLIOT~~ELLIOTTT: I would have said it would be another
4 couple of years at least. I mean, I do not know what
5 has happened since July, I mean, I have read the CQC's
6 report, the recent one but I would have said they still
7 had a lot of work to do but were moving in the right
8 direction.
9 PROF MONTGOMERY: I do not want to to put words in
10 your mouth. I want to clarify my understanding of the
11 processes. You would not have been able to draw
12 confidence from your July 13 assessment that they would
13 now be above the bar?
14 MR ~~ELLIOT~~ELLIOTTT: No, in fact we said in the report it was
15 still, the language in our executive summary was
16 something along the lines that it still fell short.
17 PROF MONTGOMERY: That is a judgment that s yet to
18 be made.
19 DR KIRKUP: The final follow-up question from me, did
20 you report back -- presumably it was jointly
21 commissioned. You reported that view to Monitor in
22 1211/12?
23 MR ~~ELLIOT~~ELLIOTTT: Yes.

24 DR KIRKUP: Was there a reaction to that?

25 MR ~~ELLIOT~~ELLIOTTT: I do not think they were surprised after

1 everything that had happened.

2 DR KIRKUP: Okay. Thank you. Anymore?

3 MR BROOKES: It is a difficult one for you to answer

4 so --.

5 MR ~~ELLIOT~~ELLIOTTT: You keep prefacing your questions like

6 that.

7 MR BROOKES: I am finding it hard to understand how

8 they could have been authorised 18 months before on the

9 basis of what you said. Is that something that I

10 should be struggling with?

11 MR ~~ELLIOT~~ELLIOTTT: Yes, I think so. I mean, I agree with the

12 contention it is difficult to -- I mean, you would

13 think that had the quality governance framework been fully in

14 place at that time and, therefore, that was a full part of the

15 authorisation process, as it is now for applicants,

16 then, you know, I --

17 MR BROOKES: Effectively the tool at the time was that

18 self-assessment tool so the Board itself assured itself

19 that it was okay. Yes. Okay. Thank you.

20 DR KIRKUP: Is there anything else you would like to

21 say to us? It is not compulsory but if you want to say

22 something.

23 MR ~~ELLIOT~~ELLIOTTT: No, I do not think so.

24 DR KIRKUP: Okay. Thank you very much.

25 MR ~~ELLIOT~~ELLIOTTT: I said I will follow up on one thing.

1 DR KIRKUP: You did, yes, and we will be in touch.

2 Okay.

3 MR ~~ELLIOT~~ELLIOTT: You will remind me. Thank you very much.

4 DR KIRKUP: Thank you for your time.

5 MR ~~ELLIOT~~ELLIOTT: Thank you.

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THE MORECAMBE BAY INVESTIGATION

Thursday, 9 October 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 Catherine Calderwood - Expert Advisor on Obstetrics
Ms Jacqui Featherstone - Expert Advisor on Midwifery
Dr Geraldine Walters - Expert Advisor on Nursing

STEPHEN EVANS

Transcript produced by Ubiqus
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1 **(At 1.49 p.m.)**

2

3 DR KIRKUP: Hello. Thank you for coming. Please take a seat. My name's
4 Bill Kirkup, I'm the chair of the Panel. I'll ask my colleagues to introduce
5 themselves to you, please, starting with Catherine.

6 DR CALDERWOOD: Hello. I'm Catherine Calderwood, I'm an obstetrician working
7 in Edinburgh and I give advice to Scottish Government and I'm also the
8 National Clinical Director for Maternity for NHS England.

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

11 MR EVANS: Sorry, where?

12 DR WALTERS: King's College Hospital.

13 MR BROOKES: I'm Julian Brookes, I'm currently Deputy Chief Operating Officer for
14 Public Health England, but was previously head of clinical quality at the
15 Department of Health.

16 MS FEATHERSTONE: I'm Jacqui Featherstone. I'm the Head of Midwifery and the
17 Head of Nursing at a District General Hospital in Essex.

18 DR KIRKUP: You'll have seen that we're recording proceedings and we'll produce
19 an agreed record at the end. You may also know that families are able to be
20 present during the interviews. As it happens, we don't have any observers
21 here today, but they can listen to the transcript subsequently. You also know
22 that we've asked you to hand over any mobile telephones, recording devices;
23 that's just to emphasise that we don't want anything to leave the room until
24 we're ready to produce a report that's got all of the findings in the right context.
25 Do you have any questions for me about the process?

26 MR EVANS: No, I understand that. That's all quite reasonable, thanks.

27 DR KIRKUP: Okay. I'm going to start out with a general question just to get us
28 underway and then hand over to colleagues. And the general question is: can
29 you tell us when you started with the Trust and what different things you have
30 done with the Trust up to the present day?

31 MR EVANS: I can. If it's okay with you, I would like to refer to notes.

32 DR KIRKUP: Of course.

33 MR EVANS: I retired four years ago and so if I rely completely on my memory I won't
34 get the dates right, so I did take the precaution of writing down dates before I

1 came.

2 DR KIRKUP: That's absolutely fine.

3 MR EVANS: Okay. My association with women's and children's services in
4 Morecambe Bay goes back to November 1998, okay, but I was employed in a
5 number of different posts. My association with the South Cumbria area is
6 longer than that, it goes back to 1989, but at that time I was associated with
7 Westmoreland General Hospital, the small hospital in Kendal.

8 So, from November 1998 I was directorate manager for women's and
9 children's services.

10 In November 2003, the directorate was restructured into two separate
11 directorates so that paediatrics became one and obstetrics and gynae the
12 other. The major change for me was that rather than working to one clinical
13 director I was then working to two clinical directors, but otherwise my job was
14 essentially the same.

15 In 2007, the chief executive, Ian Cumming, left; I'm fairly sure it was
16 2007. And after an interim period when there was an acting chief executive,
17 Tony Halsall started. Prior to Tony Halsall starting, a management
18 reorganisation was put in train and as part of that the obstetrics and
19 gynaecology and paediatrics directorates were absorbed into a bigger division
20 headed up by surgery and it became surgery, critical care and family services.
21 And within that setup I became deputy divisional manager, again essentially
22 doing a very similar job. The major difference was that, at that point, the head
23 of midwifery and the had paediatric nurse, who had been accountable to me,
24 then became accountable to the head of division.

25 In 2009, there was more sort of change afoot with a proposal for a
26 Cumbria single provider for children's services. I suppose I might have had an
27 opportunity to put myself forward for that role. I didn't, because I thought it
28 was an unworkable idea, so another individual was appointed with the brief to
29 lead the Cumbria single provider project and that gentleman was Fraser Cant.
30 I don't know what happened to the project; it never saw the light of day. Well,
31 as far as I was concerned, it sort of disappeared into the ether in a fairly short
32 period of time.

33 DR KIRKUP: Which you weren't surprised about, by the sound of it.

34 MR EVANS: I don't know whether I was surprised or not. I always thought it was an

1 impractical idea. I didn't think the geography was manageable and I made
2 that point clear and that wasn't particularly a popular view, but that's the way I
3 felt. So the project didn't come to pass, but Mr Cant remained and became
4 divisional manager for family services, which became a separate division
5 again, okay?

6 DR KIRKUP: Yeah.

7 MR EVANS: So that's the sort of later part of 2009.
8
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10

11 DR KIRKUP: Okay. Don't say any more about that. If you want to say any more
12 about it, we'll have a confidential session at the end when you can tell us
13 about any details that you think might be relevant, but I'd rather you
14 didn't say any more about it in this – as I say, people can listen to the
15 transcript afterwards.

16 MR EVANS: No, that's absolutely fine. Well, suffice to say that
17 in the autumn of 2009,
18
19 I was off for a period of time, but after about
20 a month I did return to work. And in December 2009, Fraser, who had now
21 been in post for a little while, proposed a new management structure in which
22 my two colleagues, the head of midwifery and the head of paediatrics, became
23 heads of service and a new post was created, which was head of business
24 and performance, and I was invited to slot into that post. There weren't many
25 options, to be honest, and I expressed reservations about my suitability for the
26 post and my – I have to say it's not a job that I would have applied for if it had
27 been a matter of choice, but I said that I'd give it my best shot and I took up
28 the post. I formally took up that post of head of business and performance on
1 February 2010.
29
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31
32
33 was effectively in that post for three months.
34 went
off in the May 2010 and I never returned after that.

1 DR KIRKUP: Okay.

2 MR EVANS: [redacted]

3 [redacted] The Trust reached a point where they were keen to

4 reduce management costs and they offered an opportunity for people to leave

5 the organisation under the mutually agreed resignation scheme and so I

6 applied for it and was allowed to go. So my contract ended in November 2010

7 but, as I say, effectively I'd left post in the May.

8 DR KIRKUP: Okay, thank you. You really don't need to say any more about that

9 unless you feel that you want to or it's relevant, but you've told us enough,

10 thank you, I appreciate that. Geraldine.

11 DR WALTERS: Hi Stephen. So when you were in the deputy divisional manager

12 role from about 2007, can you just tell us what the main responsibilities were

13 in that?

14 MR EVANS: Yeah, I can. I can tell you what occupied most of my time. What

15 occupied most of my time was – and this might surprise you – medical

16 staffing. We'd been through the introduction of new staff rotas under the

17 European Working Time Directive and that was causing pressure, but we

18 always had problems in maintaining satisfactory medical cover in Barrow, in

19 Furness General Hospital, in particular, because of difficulty in filling posts,

20 people moving on before posts were due to complete and so on. And I

21 seemed to just spend enormous amounts of time fire-fighting to plug gaps in

22 the service, which I was happy to do because, as far as I was concerned, it

23 was important to provide a safe service and if we didn't have a safe level of

24 medical cover we couldn't do that. We did have – I did have medical staffing

25 backup for that, but it just seemed to absorb an awful lot of my time.

26 I had overall responsibility for the budget of the directorate or my part of

27 the directorate and for achieving the annual cost reduction programmes.

28 I spent again a lot of my time, probably secondary to the medical

29 staffing side, on the management of waiting times and the cancer two-week

30 wait. It wasn't particularly an issue in paediatrics, but in obs and gynae it was

31 and particularly, I remember, in relation to colposcopy.

32 I was involved in a number of capital projects, because most of the

33 departments on all of the three sites were refurbished during the time that I

34 was in that post. I was responsible for things like the annual capital equipment

1 programme, management of medical secretaries, running outpatient services,
2 because we had our own outpatients in both obs and gynae and paediatrics;
3 they were separate from the main department.
4 And I think that kind of covers most of the things that I was involved
5 with.
6 DR WALTERS: Tell us a bit more about the difficult medical cover. Did people not
7 stay or was it just never possible to fill all the posts?
8 MR EVANS: I can't honestly give you an accurate response in relation to turnover.
9 Occasionally, people might have moved on before the term that we'd
10 expected. I'm talking about junior and middle grade doctors here. So
11 occasionally people might move on earlier, but generally the issues I faced
12 were the result of difficulty in filling posts and that actually applied to – thinking
13 about it, that applied to consultant posts as well, particularly in paediatrics at
14 Barrow. So, difficulty in filing vacant posts and just the sort of run of the mill
15 study leave, holidays, sickness.
16 DR WALTERS: Were the consultants sort of active and supportive in trying to solve
17 that problem?
18 MR EVANS: Yes, yes. I mean, I can think of one consultant in particular at
19 Furness General, in obstetrics and gynaecology, who was extremely helpful in
20 that he appeared to have a very good network and could find, you know,
21 doctors of good calibre who were, you know, employable and that was very
22 good, so that was helpful. As regard to the rest of the consultants, I always
23 felt that they were supportive and that I could go to them for advice if I needed
24 to, but they weren't necessarily proactive in helping to come up with locum
25 doctors. As far as they were concerned, that was a management job and I
26 don't disagree with that. Does that answer your question?
27 DR WALTERS: Yes. So, in terms of the relationships between managers and
28 doctors and midwives, how did that all work?
29 MR EVANS: Right. I think it worked – I think it worked fairly well. I certainly had
30 good relations with my clinical directors. I had good relations with the head of
31 midwifery and the head of paediatric nursing and her matrons. Below that
32 level, I suppose my contact would be, you know, less frequent. I mean, I was
33 obviously on good terms with all of the ward managers and would try and get
34 around the wards as much as I could, but I didn't have a kind of detailed day

1 to day knowledge of what was happening with nursing and midwifery staff at
2 that level.

3 In terms of the relationship between doctors and nurses, I would say in
4 paediatrics it was very good, better at Lancaster than at Barrow; some
5 tensions, I would say, at Barrow.

6 And in terms of the relations between consultant medical staff and
7 midwives, I would say those were again generally good. The nature of the
8 relationship I think was different between Lancaster and Barrow. At
9 Lancaster, I think it was possibly – it was less formal and more, I don't know,
10 more easy somehow.

11 DR WALTERS: So, there's the relationships in how they got on on a day to day
12 basis, but did the division work in a sort of tripartite way? So, in terms of how
13 far did clinicians and managers work together to address things like the cost
14 reduction programme and did they look at things in the round in relation to
15 things like governance, all that sort of thing?

16 MR EVANS: Right. In terms of – you've given a specific example of cost reduction
17 programme, in terms of the cost reduction programme, I think clinical staff
18 would generally view that as being an issue that was a management problem
19 and, you know, the onus was on the managers to sort that out. If a suggestion
20 was put forward as to, you know, how could we make a saving, then ideas
21 would be brought forward.

22 In general terms, I think the relationship – the sort of tripartite thing did
23 work reasonably well. In the job that I did, my main sort of formal contact with
24 the whole team, if you like, or the senior members of the team was through the
25 directorate management team meetings, which took place on a monthly basis.
26 And I did sometimes feel that they could have been a bit more dynamic in the
27 sense of people putting things forward for the agenda, you know, suggesting
28 areas for debate and so on. I felt, at times, that it was me putting down on a
29 piece of paper what I thought were the important issues and presenting them
30 to my clinical director to agree, you know, 'That's the agenda for next week,
31 boss, is that okay?' That wasn't always the case, but sometimes I think it felt
32 a bit stale because ideas weren't necessarily coming through.

33 DR WALTERS: So how did you approach cost reduction? How did you achieve it?

34 MR EVANS: You're asking me to remember something now from more than four

1 years ago and I honestly can't give you specific details. All that I can say is
2 that I had an extremely good directorate accountant and we, by and large,
3 managed to find ways of shaving money by looking at things like supplies and
4 cheaper ways of finding products, things of that nature. I'm not conscious that
5 we ever particularly had to squeeze staffing costs.

6 DR WALTERS: Were you around then in the period when there was a regarding
7 exercise of all the midwives?

8 MR EVANS: Which time are we talking about here?

9 DR WALTERS: I can't remember now, actually. It was when there was a re-grade
10 banding of band sevens down to band sixes.

11 MR EVANS: Yes, I was around and I'm trying to remember whether that was during
12 the time when I was in the women's and children's directorate or whether it
13 was before even. It might have been before, I can't remember.

14 DR WALTERS: So would that have been about cost reduction?

15 MR EVANS: Well, no, I don't think it was. I mean, I seem to recall, sometime after
16 the re-grading exercise, there being comments about some grades being
17 inflated above what they should be, but no, I'm not aware that any – there was
18 any kind of management move to sort of keep the lid on costs by holding
19 grades down. I'm pretty sure that that didn't happen, but it was not a process
20 that I was actively involved in. That would have been the head of midwifery.

21 DR WALTERS: Were you involved in complaints management?

22 MR EVANS: Not a lot and, in a sense, I find that surprising. When I – in earlier
23 positions which I've held, for example, prior to be directorate manager of
24 women's and children's I was the operations director at Westmoreland
25 General Hospital. Now, it's a much smaller hospital and so naturally
26 everything is a lot easier: the volume of complaints is less, the
27 communications are easier and so on, but in that role I saw every complaint.
28 Every complaint went across my desk. I was involved in investigating a large
29 number of them and I thought that was a valuable thing to be doing.

30 Really things changed when Westmoreland Hospitals Trust merged
31 with Royal Lancaster Infirmary and Furness General Hospital and that would
32 be in the early 2000s, because Lancaster had a sort of centralised complaints
33 department and everything went through them. Now, I can see advantages to
34 that: because, you know, they become very expert at what they do because

1 they're dealing with it day in, day out and it's all they do and they deal with a
2 large volume. But I remember when the Trusts merged, at the beginning I
3 was quite surprised to find that I might be asked for my views on something in
4 relation to a complaint and I'd feed them in, but that was the last that I would
5 hear of it. And so, over a period of time, I would prompt people to say, 'Could
6 I see what happened with that one? Can I see the reply?' you know, 'How did
7 it go? What was the outcome?' But I always had to ask. It seemed to me I
8 always had to ask to get that information and, after a while, it became a bit
9 pointless doing it, so I stopped doing it. I just did the bit that I was asked.
10 Also, as time went on, increasingly I was cut out of that loop and it would tend
11 to be the head of midwifery or the head of paediatrics who the complaints
12 department would go to, to ask for the investigation. So I kind of became
13 sidelined in that respect.
14 DR WALTERS: So what was the sort of central point in the division where the
15 division would get to know about how many complaints there had been, how
16 many incidents had taken place, that sort of thing?
17 MR EVANS: I would say that would be the maternity services risk management
18 committee. There was a group of clinicians, consultants, head of midwifery,
19 senior – you know, the modern matrons and they would meet on a regular
20 basis to discuss risk issues and those sort of things would be covered there.
21 But again, I have to say, I didn't attend those meetings, I didn't see papers
22 relating to any of those meetings, so I'm – you know, I'm telling you my
23 understanding of the situation.
24 DR WALTERS: Sorry, what did you say it was called, maternity services risk
25 management?
26 MR EVANS: Risk management committee. I think that's the right title.
27 DR WALTERS: Was there any management representative on that?
28 MR EVANS: You mean as in general management? No.
29 DR WALTERS: So who would you say in the division was accountable for clinical
30 quality and safety?
31 MR EVANS: The clinical directors.
32 DR WALTERS: And that wasn't something then that managers would discuss with
33 the clinical directors.
34 MR EVANS: Well, again, it's to do with the way the organisation was structured.

There was a Trust-level clinical management committee. I mean, I might be getting the precise name of these committees wrong, but you know what I mean. There was a sort of clinical risk management committee at a Trust level and each of the individual clinical directors would attend that. And there was a clinical risk department, which was accountable to the Trust's overall clinical director. So the kind of chain of command, as I have it in my head now and bear in mind it is a few years ago, is that things would go up from a clinical group within the division to a clinical group at Trust level and then, when we became absorbed into surgery, there was actually another level inserted there. I don't know what or whether there was general management inclusion in those groups, but there wasn't at my level.

DR WALTERS: So, at your level and from your point of view, if there was a serious incident which had happened or there was a serious clinical risk issue, that wouldn't, by any formal route, come to your desk.

MR EVANS: No. I would be dependent on the clinical director or the head of midwifery or, I suppose, one of the matrons or any midwife coming to me and saying, 'Do you know we've had a problem with such and such?'

DR WALTERS: Yeah. Did that strike you as odd?

MR EVANS: I don't think it was ideal.

DR WALTERS: Did you have any involvement or know anything about the Fielding report?

MR EVANS: I'm aware of the Fielding report. Unfortunately, that happened in the middle of the first period that I was off [redacted] in 2009 and I do remember being asked to attend for an interview there and I did. I think I was – I can't remember whether I was off [redacted] at the time or whether I was just back, but I was interviewed. That is the sum total of my involvement. I didn't see a transcript of anything that I said. I didn't see a copy of the report. That was it.

DR WALTERS: So was the report available when you got – was it done when you got back? Do you remember?

MR EVANS: I don't know when it was published, so – it would have been, quote-unquote, 'done' at a time when I was still working in the organisation, it's fair to say, I'm sure.

DR KIRKUP: It was August 2010 would be the point when it was published.

MR EVANS: Okay, well, okay, August 2010 coincided with my second period of –

no, August 2010 was when I was off the first time, wasn't it? No, no, sorry. August 2009 was when I was off the first time. By August 2010 I was off [redacted] again, because I'd gone off [redacted] in the May and I left the organisation in November.

DR WALTERS: So you just might have missed it by sort of happenstance.

MR EVANS: By dint of not being there, yeah.

DR WALTERS: Can you remember what the gist of your interview was about?

MR EVANS: It was very much along the lines of the questions you've just asked me.

DR WALTERS: Was it?

MR EVANS: Yes.

DR WALTERS: I'll leave it just there for now.

DR KIRKUP: Okay, thank you. Catherine.

DR CALDERWOOD: Thanks very much, very helpful. I suppose – and you can tell me if this isn't a question you have insight into, but you've talked about the medical staffing and that taking a lot of your time.

MR EVANS: Yeah.

DR CALDERWOOD: Could you give me, as an outsider to the organisation, was there – do you have a feeling for why that was an issue? You said it was particularly paediatricians, but you also said it was all grades.

MR EVANS: Well, if I tell you, first of all, why there was a problem getting medical staff and then why I was involved in it and if I get lost along the way, can you please put me back on track. Furness General was always the more difficult area and I've been associated with the hospitals in South Cumbria since 1989, so I've got quite a long track record and I think it was always a problem and it wasn't just obstetrics and gynaecology and paediatrics. Medical staff issues in Furness General Hospital were always, I think, near the front of everybody's minds. Now, what I attribute that to is that Furness is a relatively small hospital in a geographically isolated situation, close to some very nice countryside but in a town which has probably seen better days and it's quite difficult to attract high calibre staff as a result of that. The people who worked there generally liked it and would stay, but getting people to work there was more difficult. And, as I say, I think there's a long history of that and it's not peculiar to women's and children's services.

To answer the question as to why I was involved in that, I was involved,

1 firstly, because I had to be, because it would have worried me sick to think
2 that there wasn't adequate medical cover and I just made that my priority.
3 Secondly, because I don't think our part of the organisation was properly
4 resourced. There was – within the HR function there was a small medical
5 staffing department and those people, I have to say, worked extremely hard
6 and were always very helpful to me and I had very good relations with them
7 and relied on them. But in other parts of the organisation there seemed to be
8 better support and to sort of illustrate that to you, this is an issue which I
9 banged on about for a very, very long time. I mean, in terms of the
10 management resource for family services generally, but in particular in relation
11 to medical staffing. And what happened was that when we were merged with
12 surgery and critical care I kind of let out a sigh of relief, because I thought,
13 well, we're now part of a bigger division. I will get the benefit of that in terms
14 of greater management support. And where I'd argued in the past, you know,
15 I needed more, I needed some additional management input, that had fallen
16 on deaf ears, so I just gave up. But once we were merged with surgery, I
17 thought right, I'm in a bigger bit of the organisation now, I'll be able to
18 piggyback onto what they've got.
19 They were also having problems with medical staffing and so they
20 created two medical staff officer posts, one for Barrow and one for Lancaster,
21 to meet the needs of the division. What I found was that, very quickly, they
22 were located in the surgical part of the division and, possibly because of their
23 physical location, they were sucked into dealing with the surgical department's
24 problems. I actually contributed to the funding of those posts, but when I
25 wanted to use them invariably the people were too busy dealing with surgical
26 problems.
27 That's why I got involved. I should have be doing other things, but I got
28 involved because that was a very important thing.
29 DR CALDERWOOD: You say it's been a problem for a long time and again this
30 might not be –
31 MR EVANS: To be fair, I don't have insight into other departments. I can only say
32 that, over a long period of time, I heard people saying, you know, 'Such and
33 such a department is having dreadful problems getting staff' and I can tell you
34 in paediatrics, for example, that for a very long period of time we had locum

1 consultants in Furness General Hospital.

2 DR CALDERWOOD: Was there any attempt made to find solutions for that? So, in
3 fact, across the country then there have been intermittent shortages of,
4 particularly, middle-grade paediatricians, but trust doctor posts, having
5 international recruitment, all of these things are tried. Did you feel that there
6 was a grasp of needing to find solutions or did it – I don't want to put words
7 into your mouth, but it did it seem to limp from crisis to crisis?

8 MR EVANS: No, I think there was an appreciation that, you know, we're in a difficult
9 position here, what can we do and we did establish trust doctor posts. In fact,
10 thinking about it, I'm fairly sure I made the business case for them and the
11 doctors we appointed at Barrow, we were lucky, we got two or three really
12 good guys at middle grade who were, you know, worth their weight in gold.

13 The other thing that was aired from time to time, and I'm sure this won't
14 be new to you, is the idea of rotating staff, because it was easier to get
15 consultant staff, in particular, at Lancaster than at Barrow and there was a – I
16 mean, we did go through a period where we expanded the consultant staffing
17 quite significantly. And what we did achieve was that the Lancaster
18 consultants, some of them, would go and do outpatient clinics in Barrow, but
19 whenever we had discussions about the Lancaster consultants actually
20 rotating to Barrow there was huge resistance to it and it was never achieved. I
21 don't know what we needed to do to make that happen, but it didn't happen.

22 DR CALDERWOOD: Were you aware then of that, of any attempts to keep – I think
23 that's a solution that, had it worked, was obviously very well thought through –
24 but any solutions for ensuring that the people in Barrow were keeping up their
25 competencies in a small unit?

26 MR EVANS: It's not something that I was personally directly involved with, but the
27 clinical director for paediatrics was responsible for performance management
28 of the consultants and agreed job plans with them and talking about training
29 needs and so on and, as far as I'm concerned, he did that job conscientiously.

30 DR CALDERWOOD: Thank you. That's all from me.

31 DR KIRKUP: Thanks. Julian.

32 MR BROOKES: Can I just carry on that theme a little bit, but broaden it? You've
33 talked about difficulties in recruiting to medical staff. Was there a similar issue
34 with midwives and other professional groups?

MR EVANS: The head of midwifery will be in a better position to answer that question for you and you may already have asked her, I don't know.

MR BROOKES: It wasn't something that came through you. It was basically –

MR EVANS: No. I mean, I think there were problems and I don't know whether it still exists, I guess it probably does. There were problems during the time that I was working in this area with midwifery recruitment nationally, so I was aware of that from my colleagues on the midwifery side. I don't think it was a particular issue locally. We may have sometimes struggled to appoint, but we always managed to appoint and to appoint, you know, what seemed like decent – make decent appointments. The turnover was higher at Lancaster, I am sure, than it was at Barrow. At Barrow, as in other departments, you had a very stable workforce and little turnover.

MR BROOKES: Okay. Again, you've touched on something there. I'm interested in your view on the ability for you to make good appointments. We've heard elsewhere that sometimes there was a question about it was so difficult to get particularly consultant people to go and work in Barrow, for example, that sometimes there might have been some discussion about compromising standards to make sure that there was somebody there. Is that something you experienced?

MR EVANS: I don't want to comment on particular individuals, but I recognise what you are saying. I think I mentioned to your colleague a few minutes ago that there were long periods at Barrow where a consultant post was covered by a locum and I can think of one very good female consultant, an Iraqi lady, who worked for us for a long time as a locum and, you know, she was a very good person to have on the team, as far as I was concerned. I can think of other people, whose names I've now forgotten, who, you know, equally seemed to me, as a non-clinical person, to be on the ball. But there were also intermittent periods where we would struggle to get people. Now, the ultimate decision about, you know, do we take this person or not, was with the clinical director.

MR BROOKES: You talked about cost improvement programmes and I'm quite familiar with the concept you were describing, which was to look at the margins and see how you could do it. When the FT application came along, was there a greater emphasis on cost improvement programmes, as far as

1 you could see? Did it have any impact at all in terms of what you were being
2 asked to do and the demands on you as a manager?
3 MR EVANS: I don't think so. It doesn't feel like that. I mean, if you hadn't asked me
4 the question I wouldn't have – it's not something that would have come into
5 my mind, no. It felt like it was just a year on year thing. I don't think it got
6 ratcheted up when the FT application –
7 MR BROOKES: You didn't see a significant increase over a period.
8 MR EVANS: It didn't feel that way, no.
9 MR BROOKES: Thank you. That's helpful to understand. Were you involved at all
10 in the FT application?
11 MR EVANS: No.
12 MR BROOKES: So there were no discussions with you about – or impacts in terms
13 of the strategic planning for and the strategic business plan for the foundation
14 trust.
15 MR EVANS: No.
16 MR BROOKES: That's helpful, thank you. Were there ever any concerns raised with
17 you about the clinical services in your division?
18 MR EVANS: Not specifically. I mean, I can remember a period – and again I can't
19 pin a date on it, but I can remember a period when there were issues being
20 discussed about the neonatal unit at Furness General Hospital, because it
21 was small, it had, you know, a small caseload and concerns being flagged by
22 the head of paediatric nursing about, you know, people's ability to maintain
23 their skills. And there was actually a group which was focused around
24 Preston, but which pulled in representatives of the neonatal units from around
25 the North West to discuss these kinds of issues. And my recollection is that,
26 as a result of that, the clinical protocols for the special care baby unit were
27 changed in order to kind of ensure that the more risky cases were moved on
28 to Lancaster or further afield rather than being treated in Barrow.
29 MR BROOKES: I know you described the sort of clinical governance arrangements
30 which would have been through the clinical leads, etc, but I'm just interested
31 that there was no staff coming to you saying, 'We're concerned about this
32 particular element of our service. We're worried about staffing resources in
33 these particular areas'. That didn't come anywhere near you.
34 MR EVANS: No. I mean, the only examples of that which I can think of would be,

1 say, a ward manager on the labour ward or something saying to me, 'We're
2 really short of staff, you know, tonight. I need to bring such and such a body
3 in, you know, can I do that?' And that would only happen if the head of
4 midwifery wasn't around and, if I was asked that question, my standard
5 answer would always be, 'If you need it, then do it and we'll, you know, we'll
6 deal with' – the finances didn't come into it. But generally, people didn't come
7 to me and say, you know, 'We've got a' –
8 MR BROOKES: I understand, yeah. I'm asking the question because I'm getting the
9 feel that there's a bit of a disconnect between the general management line
10 and clinical governance and the clinical management and provision of service
11 within the division. Is that a fair assessment?
12 MR EVANS: I'm not sure that is a fair assessment. I would say that I always had a
13 good relationship with my consultant colleagues and all medical staff, with my
14 clinical directors and with the head of midwifery and paediatrics. You know,
15 we respected each other, we got on well, we worked well as a team and things
16 would be discussed openly between us, but it seemed like in the area of
17 clinical risk it was kind of – that was in a separate box and I wasn't involved in
18 that. You know, if there had been an issue that such and such a midwife is a
19 problem and her practice isn't up to standard, then I would be told and I would
20 be brought in, because within the organisational structure I was the person
21 who had the authority to basically dismiss and to carry out the sort of –
22 MR BROOKES: So you would be surprised if those conversations were going on
23 and you were not being made –
24 MR EVANS: Well, I can remember instances where I have been involved in dealing
25 with individual cases relating to performance standards, clinical performance
26 and I can think of one instance where I dismissed a midwife. Not in Barrow or
27 Lancaster, actually, but there was one midwife who I dismissed and there
28 were, I suppose, one or two other cases where I chaired a disciplinary hearing
29 which resulted in a decision to recommend a period of retraining, for example.
30 But those are specific instances where the head of midwifery's come to me
31 and said, 'Right, I think you need to know we have a problem with such and
32 such a person. This is what's happened', laid out the facts before me, I would
33 then convene a hearing and chair it and we would deal with it appropriately.
34 Generally speaking, I wasn't aware of a whole lot of stuff going on. These

1 were just occasional things.

2 MR BROOKES: But it's possible stuff was going on because, as you said, you know,
3 it would have gone up through the clinical lines. It would have gone to the
4 local clinical risk group then it would have gone up to the divisional and then
5 up into the Trust-based group. You've already said you were not finding out
6 what was happening from there and also from complaints as well, you tried
7 your best but were not always able to find out what had happened over a
8 particular complaint. So there's a whole source of information there which,
9 potentially, would help you.

10 MR EVANS: Yes, yeah. Presumably, the organisation felt that the structure that it
11 had created was appropriate. I mean, I don't know what happened when it got
12 to the top level. I don't know, for example, you know, the medical director,
13 because he was ultimately responsible for the sort of risk management staff
14 and for that function, he would, I presume, have had a good overall view and I
15 would have – you know, I assume that that would have been shared with the
16 chief executive if there were concerns.

17 MR BROOKES: Yes, I understand that.

18 MR EVANS: But at my level, I was –

19 MR BROOKES: And do you think that way of working was similar across other
20 divisions or was it unique to your division?

21 MR EVANS: I don't truly know. I assume it was similar, because of the way the
22 organisation was set up.

23 MR BROOKES: Yeah.

24 MR EVANS: Because, you know, central complaints department, central risk
25 management department.

26 MR BROOKES: Okay, that's fine, thank you.

27 DR KIRKUP: Thank you. Jacqui.

28 MS FEATHERSTONE: I just want to pick up on a few points that Julian's brought up.
29 Just to go back, you said that you had a really good relationship with the head
30 of midwifery and the paediatric lead as well.

31 MR EVANS: Yeah.

32 MS FEATHERSTONE: So did you produce reports that went to the board? Did you
33 go to represent the directorate at the board?

34 MR EVANS: No.

1 MS FEATHERSTONE: So how did any governance report – did it go through
2 another route then, as you were saying earlier it went through the governance
3 lead to the board?
4 MR EVANS: I don't know, is the honest answer. The only time I can remember and,
5 you know, we're talking about quite a few years that I worked for the
6 organisation, the only time I can remember going to a board meeting on behalf
7 of the division was when we were asked to look at the overall arrangement of
8 maternity services in Morecambe Bay; i.e. is it sensible to have three separate
9 maternity units. And we did a sort of option appraisal looking at various
10 scenarios and I went and presented that. That's the only time that I can
11 remember being invited to a board meeting.
12 MS FEATHERSTONE: So involvement with PCTs, as they were then, were you
13 involved with any discussions about the division then?
14 MR EVANS: Not particularly. I mean, that's an area that, in a previous life, as the
15 operations director for Westmoreland General, I'd had a very strong network
16 and very close involvement in dealing with commissioners and I had close
17 relations with local GPs and so on. I didn't have anything like that in – once
18 the trusts merged and the organisation structure changed, I didn't really have
19 any particular involvement in that. I mean, I'd get calls from time to time. One
20 that springs to mind now is there was an issue with termination of pregnancy,
21 that service, at the Furness end and GPs not being able to – not feeling that
22 there was enough of a service to deal with the demand for it. So I can
23 remember having individual conversations with disgruntled GPs about that
24 and, leading on from that, having some discussions with a member of the
25 primary care trust, which led on to us revising the way that we provided the
26 service, which gave much better and easier access to the local GPs. So that's
27 one, but, you know, I had to really kind of rack my brains to think of that. What
28 I would say is I had very little contact with the commissioning side of health.
29 MS FEATHERSTONE: Okay, thank you. That's all I had.
30 DR KIRKUP: Okay, just a couple of specific points that I want to follow up with you.
31 When you were women and children's services directorate manager up to
32 October 2007, who did you report to?
33 MR EVANS: Up to October 2007, that would be the operations director
34 Graham Smith.

1 DR KIRKUP: Okay and what kind of a working relationship did you have?
2 MR EVANS: Reasonable.
3 DR KIRKUP: That is a less than ringing endorsement, if you don't mind me saying
4 so.
5 MR EVANS: The relationship worked. It was sometimes a little strained.
6 DR KIRKUP: Okay. Did you have regular conversations where you would brief him
7 on what the key issues were?
8 MR EVANS: From memory, there would be specific times where I would go to talk
9 with the operations director with my clinical director or directors. Obviously,
10 there would also be regular meetings between the operations director and all
11 of the directorate managers at which common issues would be discussed and,
12 naturally, there would be an opportunity for me to make my point of view about
13 whatever was on the agenda. And, to be fair, I could go and knock on his
14 door or make an appointment or ring him up to discuss something. That's as
15 much as I can say, I think.
16 DR KIRKUP: Okay.
17 MR EVANS: I mean, I'm struggling a little bit with dates again, because it is difficult,
18 with the time that's elapsed, fixing in my head who was my boss at any given
19 time, because the boss changed quite a bit over time.
20 DR KIRKUP: This was when you were directorate manager that I'm talking about.
21 MR EVANS: Yeah, well, that would – yes, that would be Graham.
22 DR KIRKUP: Yeah, okay. When you were working in that capacity, did you feel that
23 if you had a particular problem, a particular issue that you couldn't deal with
24 within the directorate that you could take that to the operations director and
25 you could discuss it?
26 MR EVANS: I would do. I'm not sure that I always felt comfortable doing it, because
27 – and I don't want to personalise this. This isn't just about the operations
28 director. I think there was a culture in the organisation which was quite macho
29 and you had to be seen to be getting on with it. There was an expression,
30 which isn't a very nice expression: 'just – something – do it'. That was used a
31 lot in the organisation. So if you went forward with a problem, you would be
32 told, 'Look, I've got enough problems of my own. Just do it. Go away'. Now,
33 as I say, I'm not personalising that to one individual. That was common for
34 quite a long period and it was an attitude which I found displayed by a lot of

1 senior people in the organisation. I can certainly think of one other individual,
2 who was my boss after Graham, who was every bit as bad. Sorry, who I had
3 a similar relationship with and at a time where [redacted]
4 I felt I might have been better supported, but I wasn't. The attitude was, 'I've
5 got enough problems of my own. Go away'.

6 DR KIRKUP: Well, you've kind of pre-empted the next question, which is: who did
7 you report to when you were the deputy divisional manager? Presumably that
8 would be the to the divisional manager. I just – we need to be able to put a
9 name to the post there.

10 MR EVANS: My boss at that time would have been Vanessa Harris.

11 DR KIRKUP: Okay. And the professional relationship there was in similar terms or
12 was there a difference?

13 MR EVANS: Well, on a personal level, I think I got along quite well with her and she
14 had a lot of – you know, a lot of aspects that I – which were very positive. I
15 think she was under a lot of pressure from the chief executive and I think she
16 probably felt when I – if I walked in with a problem, it was just another, you
17 know, it was just another thing on her back which she didn't want. And it's not
18 that I was trying to dump a problem, but it was just, you know, too much, go
19 away and work it out.

20 DR KIRKUP: Okay. Can you think of any specific issues where that would have
21 been a particular problem? I'm just looking for an example really.

22 MR EVANS: I can't really. I mean, to be honest, a lot of it revolved around this issue
23 that I felt, in the position I was in, I should be dealing with certain things which
24 were sort of higher order tasks, if you like. But because I didn't have an
25 adequate management structure, I was being pulled back and having to
26 fire-fight all the time and deal with things which were – really should have
27 been dealt with by somebody more junior. I didn't object to dealing with them.
28 It wasn't that I was too proud to do them and they were jobs that needed
29 doing, but it was really a waste of money someone on my grade doing them.
30 And so I would, from time to time, raise this as an issue and it was – I was just
31 batted to one side. Maybe they just didn't know what to do with me, because
32 ultimately what happened was that the head of midwifery and the head of
33 paediatrics became the service managers and maybe they should have been
34 all along, I don't know. All I do know is that I was put into a job which I neither

1 wanted nor was suited to doing. And there was a point at which I actually
2 wrote my concerns about that to another individual, who was
3 Stephen Vaughan, who you may have heard of, and that would have been in –
4 well, I know when it was because I've got the letter here, 31 August 2009,
5 which was following the appointment of Fraser Cant. And basically what I –
6 the view that I was putting across was it was good that we'd appointed
7 somebody to deal with this new Cumbria single provider for children's
8 services, but I had a concern that it wouldn't change anything in terms of the
9 day to day management and the pressures that I was dealing with at an
10 operational level. And I did take the opportunity to draw attention to the
11 disparity in management resources between the surgical division, which we'd
12 lately come out of, and women and children's services. I never received a
13 reply to the letter. I suggested we might have a meeting, but that offer wasn't
14 taken up.

15 DR KIRKUP: Okay. And the sort of operational concerns you're referring to there
16 are the things that you've told us about: about staffing and performance
17 targets and CIPs.

18 MR EVANS: Yeah.

19 DR KIRKUP: Okay. I'm going to take you back to middle to late 2008. Were you
20 aware of incidents, serious incidents that were happening in the maternity unit
21 around that period?

22 MR EVANS: I was aware – do you want me to use names or not?

23 DR KIRKUP: Yes, as long as we don't go into any clinical details.

24 MR EVANS: No, that's fine. I was aware of the case involving Baby JT.

25 DR KIRKUP: Yes.

26 MR EVANS: And it's fair to say that I was never directly involved in that, although in
27 the very early stages I was actually taken to a meeting at Mr T's house with
28 the new, as he was then, chief executive, Mr Halsall. But I didn't have any
29 involvement other than that one meeting. So I was aware through my
30 colleagues of, you know, the case.

31 DR KIRKUP: Yeah. And any other cases at a similar time?

32 MR EVANS: Not particularly, no.

33 DR KIRKUP: Okay. There were four, maybe five, it depends on how you define the
34 unit, I think, in a fairly short space of time.

1 MR EVANS: I can think of one where the mother died; I can't bring to mind the
2 name. But again, I was aware of it because the complaints department were
3 dealing with it and they were coordinating with my clinical colleagues the
4 response to the complaint, but I wasn't personally involved.
5 DR KIRKUP: No. Did the sort of slight knowledge that you had of it raise any
6 concerns about the functioning of the unit, in your mind, or was that not part of
7 your remit?
8 MR EVANS: I felt that, you know, as it was known and was being investigated as a
9 complaint that it would be dealt with, and I don't suppose my thinking went
10 really much beyond that. And at the same time, possibly like my boss who
11 was telling me, you know, 'Go away, I've got enough on my plate', I was – I
12 felt that I was, kind of, sinking under a mass of work that I could – and that I
13 was, you know, having difficulty coping with.
14 DR KIRKUP: Yes. There was a letter written in relation to another, not one of the
15 cases that we've discussed there actually, from the – one of the obstetricians,
16 Mr Misra, to the clinical lead in O&G, who was Mr Hussein at that time. Do
17 you recall that?
18 MR EVANS: No.
19 DR KIRKUP: You were copied in on the letter –
20 MR EVANS: Was I?
21 DR KIRKUP: – and you were mentioned in the letter.
22 MR EVANS: Right. Well, I can't remember that.
23 DR KIRKUP: He's raising fairly serious clinical concerns about an incident where a
24 baby died, and he's saying that it had happened before and that it was due to
25 relationship problems and inappropriate action and so on, that in his view it
26 would happen again unless something was done to address it.
27 MR EVANS: I can remember something around a coroner's inquest where Mr Misra
28 made some comments which were critical of clinical services. I can't
29 remember the details. I honestly can't remember having received that letter
30 but if you say it is I obviously did.
31 DR KIRKUP: No, no, I appreciate it was a long time ago. I'll read you the little bit
32 that mentions it in case it prompts your mind and then we can talk about it in
33 general terms rather than specifically if you can remember it. He says, 'I think
34 as the clinical lead' – he's addressing Mr Hussein in the letter – 'you should at

1 least have an internal inquiry, which should involve all the obstetricians and
2 midwives involved in the management of this case, along with the head of
3 midwifery and Steve Evans, to think about the future'. That is you, I presume.
4 MR EVANS: Right. Well, that is very, very clear and –
5 DR KIRKUP: Yes. If you haven't a recollection of it I understand. It is a long time
6 ago.
7 MR EVANS: Well, it – you know, I can see that it's – it probably looks peculiar that
8 something as important as that, which – to which my name is attached I can't
9 remember, but I genuinely cannot remember that. I can remember –
10 DR KIRKUP: Honestly, I don't want to be critical of that, but I do want to ask you
11 what would you have expected your response to have been? I know we have
12 to turn it into a hypothetical now: you get a letter like that, hypothetically, what
13 would you do about it?
14 MR EVANS: I would expect to have discussed it with Ibrahim Hussein, as the clinical
15 director, and if it had a bearing on the behaviour and performance of the
16 midwives with the head of midwifery, who at that time was – I can't remember
17 whether it was Denise Fisher or Angela Oxley, who succeeded her, but I
18 would have expected us to have a conversation about it and determine, you
19 know, what action, if any, was required, but I can't remember that having
20 taken place.
21 DR KIRKUP: Yes. One of the struggles that we're having with this is that we can't
22 find any record of a response to it at all. Would that surprise you?
23 MR EVANS: Yes, I think a letter of – I think if something is written down by a senior
24 clinician and is as serious as that, you would expect there to be a written
25 response to it. Otherwise it's left hanging.
26 DR KIRKUP: Yes. Can you think of any other case where somebody had felt
27 strongly – a consultant had felt strongly enough about something to write a
28 letter like that? Has it happened in other occasions in your experience?
29 MR EVANS: The only other example I can think of isn't in obstetrics and
30 gynaecology.
31 DR KIRKUP: No, that's fine.
32 MR EVANS: It's in paediatrics. And I remember one of the better locum consultants
33 we had in paediatrics at Furness General Hospital wrote a letter – and I can't
34 remember the period to be honest, but it would have been the, sort of, mid to

1 late 2000s – at the end of his locum, basically giving his views on the good
2 and bad bits of his experience in the paediatric department. And I recollect
3 that he had some concerns then about medical cover being thin at times. And
4 that was at the time that we then started having discussions about can we
5 rotate staff, can we bring some staff across from Lancaster to do clinics, to,
6 kind of, bolster the department. That's the only other occasion I can think of.
7 DR KIRKUP: And that generated discussion –
8 MR EVANS: Yes.
9 DR KIRKUP: – amongst the people who it received? And there was some sort of
10 formal response?
11 MR EVANS: I don't know.
12 DR KIRKUP: Maybe not to the paediatrician, because he would have left by then, or
13 she would have left by then, but some sort of formal response within the Trust.
14 MR EVANS: I don't know. The letter – again, I'm relying on my memory. The letter
15 wasn't addressed to me. If I'd received the letter and it was addressed to me,
16 whether it be Mr Misra's letter or this other gentleman, I would have felt
17 obliged to send a reply. I don't know – yeah, I don't know what I would have
18 said in it but I would have analysed it and got the information and given my
19 opinion back.
20 DR KIRKUP: Yeah. You weren't the principal addressee of Mr Misra's letter, you
21 were a copy.
22 MR EVANS: Right, and I think it was the same with the paediatric one. I'm sure that
23 the paediatrician in this case wrote to my clinical director, but I was either
24 copied in or shown a copy of it. I don't, I'm afraid, know whether a written
25 reply was sent to that. I do know that it had generated some discussion, so
26 hopefully a reply was sent.
27 DR KIRKUP: Okay. Thank you. Would anybody else like to come back on –
28 MR BROOKES: Just very briefly. You mentioned, and I recognise it of the time as
29 well, a macho culture in the organisation. Sometimes that can deteriorate into
30 a bullying culture. Was that something which you felt was relevant to this
31 organisation?
32 MR EVANS: I'll answer that in two ways if I may. When I first became responsible
33 for women's and children's services I was hit very, very early on with a
34 complaint of bullying by a member of the community midwifery staff in

1 Lancaster, Lancaster not Barrow. It seems strange now because in those
2 days we didn't talk about bullying. It was only – it's only around about 2000 I
3 think, something like that, you know, that we didn't talk about bullying, and we
4 certainly didn't have an organisational policy to deal with it. I think I was
5 probably the first manager presented with something like this to deal with.
6 And what I uncovered was that there was a very old fashioned management
7 culture within midwifery at Lancaster. And the head of midwifery and myself
8 spent an awful lot of time at the beginning of our journey, sort of thing, in these
9 new jobs, in addressing that and dealing with it, and trying to foster an
10 environment in which people felt that they could come forward with problems
11 without being jumped on from a great height. And I think we were successful
12 in that. Some staff left in the process. Some of them hadn't thought about
13 leaving but they left in the process.
14 I was not particularly aware of bullying in Furness General. I think there
15 was a culture in Furness where there was very strong hierarchy. And I think
16 the – for example, I think the clinical director was a good clinical director and
17 had the – you know, did everything he could for the best interests of the
18 division, but – I think I mentioned it earlier – I think the relationship between
19 the consultants in obs and gynae at Barrow and the midwives was really quite
20 formal and hierarchical in some ways. There was a lot of –
21 MR BROOKES: Sorry, I missed that. It was quite...?
22 MR EVANS: Quite formal and hierarchical in some ways. There was a lot of banter,
23 you know, and good humour, you know, so I think people got on, but it was
24 very clear, you know, what the pecking order was. But I never saw any
25 evidence of bullying at Furness General. In terms of my own experience, I
26 have to say there were times when I felt bullied, but thankfully I was a strong
27 enough person obviously to deal with it and get through it, but it didn't make
28 for a happy working arrangement.
29 MR BROOKES: Thank you.
30 DR KIRKUP: Thank you. Anything else? No. Is there anything else that you would
31 like to say to us?
32 MR EVANS: No. I hope that the interview has been helpful and I have to say that
33 the last few years of my career, after a long time in the health service, were a
34 very difficult and unhappy period and I just hope that some good comes out of

1 the process that you're going through for the benefit of – for the sake of the
2 families who've suffered, and also to make sure it doesn't happen in the
3 future.
4 DR KIRKUP: Thank you. That's what we all hope too. Would you like the
5 opportunity to say anything to us that might involve any clinical details?
6 MR EVANS: I would quite like to actually.
7 DR KIRKUP: Okay. Well, in that case can we formally record that we're moving into
8 a confidential part of the session? That means that what we say from now on
9 won't be – we will record it, because it's part of the interview, but it won't be
10 available to anybody to listen to and we won't make use of it.
11 MR EVANS: Right. I'm not clear of the purpose of recording if it's not going to be
12 given to anybody.
13 DR KIRKUP: If you'd prefer to talk to us without us recording it can we do that?
14 INVESTIGATION SECRETARY: The purpose of the recording now is so that the
15 Panel, who is seeing a huge number of interviewees, if they want to recall
16 what someone said to them can do so.
17 MR EVANS: Right, okay.
18 INVESTIGATION SECRETARY: So it's really for an internal use and [inaudible]
19
20 *(The remaining section of the interview was held in private session)*
21

THE MORECAMBE BAY INVESTIGATION

Thursday, 22 July 2014

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

Before:

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

MICHAEL FARRAR

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1 DR KIRKUP: Thank you for coming.

2 MR FARRAR: No, thank you very much.

3 DR KIRKUP: I know we have met, but I'll just say for the record I'm Bill Kirkup, and

4 I'm chairing the panel, and I'll ask my colleagues to introduce themselves.

5 PROF FORSYTH: My name's Stewart Forsyth, I'm a paediatrician and a medical

6 director from Dundee.

7 PROF MONTGOMERY: I'm Jonathan Montgomery, here as Professor of Healthcare

8 Law from the University College London, but also chair of the Health Research

9 Authority, and for the record I have spoken at a meeting you hosted and we

10 had one teleconference, I think, on Board responsibilities and values in the

11 period we're talking about in relation to that.

12 MR FARRAR: I think that's true, yes.

13 DR KIRKUP: You'll see that we are recording proceedings, and we'll produce an

14 agreed record. We're also attended by some family members as observers,

15 and others will be able to listen to the recording in the future if they want to do

16 that. You'll also know that we've asked you to hand over any telephones,

17 tablets, laptops. That's just to underline the importance that what we talk

18 about in the room stays in the room until we produce the report with all of the

19 findings in context.

20 MR FARRAR: Yes, that's fine.

21 DR KIRKUP: Do you have any questions for me about the process?

22 MR FARRAR: No, I don't. That's absolutely fine, thank you.

23 DR KIRKUP: All right. I'll start out with a very general question just about when you

24 were involved in the North West, and what you did until when.

1 MR FARRAR: Yes, so I was appointed to lead the North West SHA in 2006. We
2 went live, I think, in July 2006, and I was its chief executive until April 2011,
3 when I went on a secondment to – on a fixed term secondment to the NHS
4 Confederation.
5 DR KIRKUP: Okay, that's very helpful, thank you. I'll hand you over to Jonathan.
6 PROF MONTGOMERY: Thank you very much. I'd just like to start with the role of
7 the SHA, and how you made it work, because all SHAs were slightly different.
8 MR FARRAR: Yes. So the way in which we tried to help the North West by having a
9 good strategic authority was to identify the kind of key priorities right from the
10 word go. And in preparation for this I ~~kind of~~ looked back to what we
11 presented to the Minister at the time about what we saw our inheritance was in
12 the North West, and what we were going to try and focus on doing. And we
13 identified at the time that financial stability was very good in the North West; it
14 had a long track record of being able to deliver, and that was important
15 because at the time in that decade, the NHS had gone into significant deficit,
16 so we – the shake-up of SHAs had largely been about overspend, but actually
17 the North West didn't have those problems, but we had very poor to variable
18 quality. We had some good examples, but quality of care was an issue. And
19 we had very, very poor underlying health, so we had high problems associated
20 with lifestyle factors ~~and~~ such as diabetes, high smoking rates.
21 So our priorities were really to try and get to tackle to the health
22 problems and to improve quality whilst maintaining financial stability. So in a
23 nutshell, that's what we set out to do. I think it's fair to say, and it would be
24 difficult, I think, for families to understand this, because they're hearing about
25 one strategic health authority, but we tried very hard, given the scale of our

1 patch, we were the second largest of the strategic health authorities behind
2 London, but we tried to devolve responsibility as close as we could to the
3 frontline, and we tried to work very much with the National Health Service as
4 opposed to trying to adopt a ~~commander control~~command and control model,
5 and so we – I think by the end of my tenure anyway, we had a reputation for
6 strongly supporting the NHS. And I hope, despite the circumstances which
7 we're in, which are very tragic, I hope that we were able to do some things to
8 improve the quality in the North West.
9 If I can give you any example, I mean we've probably got time to talk
10 some so it gives you a bit more detail, but for example, we set up Advancing
11 Quality, which was a programme that was designed to publish variable
12 performance between Trusts in terms of compliance with best practice in a
13 number of big areas like pneumonia and hip and knee replacements, and
14 treating people post-heart attack, and actually that was peer reviewed in the
15 *New England Journal of Medicine*, and showed that we were able to save
16 some lives, and in fact it concluded that in the first 18 months of that
17 programme there were 980 deaths that were avoided because of the work we
18 did on quality for pneumonia, for example. So I think we did try very hard as
19 an organisation to focus on quality of care, and we recognised the scale of that
20 challenge, and the scale of the patch, so we tried to create systems that
21 reinforced that.
22 PROF MONTGOMERY: Can I ask you to elaborate a little bit more around whether
23 or not the Advancing Quality initiative had anything around maternity care?
24 MR FARRAR: No, it didn't, but actually the – so Advancing Quality was – we took
25 the health demonstration project from the United States HQID Initiative

1 undertaken by Premier Hospitals, and we lifted their metrics and their
2 technology of collecting data into the North West. We went to NICE, and we
3 got the standards adjusted for NICE approved standards for the UK, and
4 effectively we then put investment in and we monitored against these five big –
5 the five big areas were myocardial infarction, coronary artery bypass graft,
6 congestive heart failure, hip and knee replacement and community acquired
7 pneumonia, so they were big projects. It's the one thing that I've ever done in
8 my career where people demanded – clinicians demanded to be part of it, and
9 ~~we~~ some were upset that they weren't. So we had neurologists, for example,
10 ~~and~~ who said, 'We'd love you to do some neurology,' and in fact we expanded
11 it later into mental health.

12 But the reason that's a really important question in the context of today
13 was that we were doing some major changes to maternity and paediatric
14 services across Greater Manchester. I don't think any other region was doing
15 it on the scale that we were. And we had in mind that we were going to try
16 and reduce child and maternal deaths by around 30 a year, and a very strong
17 ~~point~~ priority to address, but it became quite controversial as we were moving
18 from 13 sites with obstetric cover to eight, and we were ~~improving~~ increasing
19 our neonatal units from two to three. And so it meant that some places lost
20 out, and Salford was an obstetric main service that effectively was to lose it.

21 And they were very upset about it, and there was a right of appeal, and
22 it went through the whole process. And in fact Andrew Lansley, when he
23 came in, insisted that strategic health authorities go through four tests. Now
24 we've put the four tests into place and we've concluded it was the right thing to
25 do, but Salford and the parents came to the Board meeting, and one of the

1 commitments that we made was, given that by that time Advancing Quality
2 was showing real success improving clinical outcomes and performance, that
3 we ~~would do that~~introduce it for maternity and children's services. So we
4 made that commitment.~~,~~ B~~b~~ut that was at my last board meeting, and
5 Advancing Quality, and the organisation, AQuA, which we created to oversee
6 all the quality programmes, ~~that~~ then took it forward~~,~~. ~~and~~ I don't know whether
7 they actually did take that forward, but that was a commitment that I made
8 personally during my tenure, that that would happen. But as I say, it was right
9 at the end of my time in the North West, and so I wasn't the person to follow
10 that up.
11 PROF MONTGOMERY: There's a few things there I want to come back to a little bit
12 later on, but can I ask you about the devolution of commissioning responsibility?
13 You talked about the prioritisation for the SHA, particularly for Cumbria PCT,
14 and we talked about how you hold that to account for prioritising or what their
15 priorities were.
16 MR FARRAR: Yes, so this is going to feel slightly parochial, and I don't – I really
17 don't want to be parochial at all, but one of the things that the North West
18 faced is that we had the same running costs of every other SHA, apart from
19 London. So we had £9 million to run the – all our functions; London had £13
20 million. What that meant was being such a large SHA – covering such a large
21 patch, there were 24 primary care trusts, is that we worked very quickly on
22 devolving responsibility to the primary care trusts, and having a system
23 whereby we could elevate problems if we thought that the PCT wasn't doing
24 what we hoped it would. And ~~it~~ this process was described, and indeed was
25 minuted and went through our Board, and it went through ~~everyone on~~ every

1 one of the PCT's Board, and it was called the PCT SHA Compact. And it set
2 out the rules by which we effectively supported PCTS, and it was our job to
3 make them as good as they could be, but it was also our job where they
4 weren't doing their job as well as they should be, to intervene.

5 And that compact effectively set the formal approach between the SHA
6 and the PCTs. Now there are a number of other things along the way where
7 formally functions ~~where you got~~ were devolved – so for example, the
8 management of untoward incidents, which we always felt, as a strategic body,
9 needed to be handled in the context of local understanding of services, that
10 actually we should empower our PCTs to take that on, and in fact that's
11 exactly what happened in 2008, and we agreed it with all PCTs. We had a
12 formal process for transfer of that responsibility. It later became part of the
13 national contract that untoward incidents were handled locally, but when we
14 started it wasn't. But we went through a process of assurance whereby PCTS
15 were ready to take that on. And in fact Cumbria PCT was one of the first
16 PCTs to take on the management of untoward incidents.

17 Now, is that right? I think it was important, because what it meant was
18 that we were trying to get the right responsibility in the right places, so if we
19 saw systemic failures then there were issues where the SHA should be
20 involved. And if we had things that had to be understood in the context of
21 local services, you absolutely had an alignment of the contracting piece, the
22 commissioner's overview. And bear in mind that places like Cumbria have
23 very strong clinical commissioning before clinical commissioning came into
24 existence, so we felt that that relationship for the management of 'untoward
25 incidents'– and it's a terrible – I felt very conscious about using 'untoward

incident' in the context of what we're talking about today, where people and babies died, but the – that whole process was described as an 'untoward incident handling process'. But it was right that it was local in the first instance, with a view that you could elevate if it seemed to be a systemic issue.

PROF MONTGOMERY: So tell us about the processes to what would elevate it, and also how you got your assurance to take the decision whether something needed elevating.

MR FARRAR: Yes, ~~so I don't –~~ this is where my personal involvement and what was done in my organisation are slightly ~~seperate~~separate – so my own involvement and ~~what my organisation did, or~~ the organisation did~~,~~. ~~s~~So – we had very experienced clinical teams~~, so – unlike they had~~. Ruth Hussey was a very experienced public health doctor. I also had Ann Hoskins. I had a great challenge at first when ~~they came to me~~the SHA was established because we had to interview from a pool of staff, and I had two very, very good public health doctors; Ann Hoskins from Manchester, and then from Cumbria I had Ruth Hussey, from Merseyside and Cheshire. We appointed Ruth, but we were able to keep hold of Ann, which was helpful.

And then probably around 2008/9, when Bruce Keogh was appointed, he said he wanted a separate medical director ~~hosting~~ hosted by the SHA, so we also had a doctor called Mike Cheshire. Mike had been the lead vice-president of the Royal College of Physicians for quality. So I had three very experienced doctors. I also had an experienced and talented nurse director who was responsible for quality, we had nursing, quality and performance ~~in~~ managed by Jane Cummings. And then I had two – well, two particular associate directors in Chris Dent and – Christine Dent and Angela Brown, as

1 report, and I've looked at the Fielding Report, and all seem to suggest, but I
2 think ~~you~~ one would take a view, that that was a reasonable decision to take.
3 (i.e. treat them as a series of untoward incidents)
4 But the key thing from my perspective is it would have changed the
5 nature of the intervention had it been ~~determind~~determined as systematic~~,~~.
6 ~~s~~So where we had things that were systemic, for example, ~~the – you know,~~
7 where we looked at child ~~[inaudible]~~ death rate and maternal problems around
8 Greater Manchester~~,~~ or another ~~a –~~ good example of where things were
9 systemic is that when Dr Foster first produced our reports on HSMRs, we had
10 nine Trusts that were effectively in the bottom group. Now, what we did as a
11 consequence of that was the SHA then acted, we set up a collaborative, and
12 that collaborative improved performance with those nine Trusts~~, so~~. ~~a~~Again,
13 because we ~~had – overall we weren't – we~~ didn't have enough quality that we
14 were proud of in the North West when we inherited~~,~~ the patch that's why we
15 intervened to create AQuA. We were also concerned about ~~did~~ whether we
16 have systemically enough leaders coming through? So we set up the North
17 West Leadership Academy.
18 PROF MONTGOMERY: I'm trying to get sort of the balancing bit, because I can
19 understand the promotion and the improvement bit, and then there's the
20 assurance bit. So can I just – who brought to you the view that it was
21 unconnected incidents?
22 MR FARRAR: Well, this is where – and I really apologise to yourselves and to the
23 families; I can't recall effectively being brought the question. I think I was
24 brought an approach to the management of it with a view given that, 'We don't
25 view this as a cluster.'

1 associates who were, ~~I think – had been~~ very experienced and worked around
2 quality and assessment.
3 So in essence, I relied on their approach to effectively assessing the
4 judgments that they made about were matters systemic, or were they isolated
5 to particular incidents, and we took different perspectives on different
6 occasions. And I think it's absolutely critical in the context of this investigation
7 that the grouping or the number of serious untoward incidents relating to
8 children and childbirth and maternal deaths were scrutinised and seen as
9 disconnected incidents. They weren't described as a cluster with a systemic,
10 underpinning – you know, that was a judgment taken…
11 PROF MONTGOMERY: And who looked at that?
12 MR FARRAR: Sorry?
13 PROF MONTGOMERY: Who made that judgment?
14 MR FARRAR: Well that judgment was made inside my organisation. From my point
15 of view, I can't tell you what that process was other than from my view; it was
16 brought to me, as the chief executive, ~~as it was~~ that the issues were going to
17 be taken forward as a management of untoward incidents with ~~a~~ the proper
18 process in place between the PCT and the SHA to look at what was
19 happening.
20 Now, I wasn't involved in any specific judgement myself that said, 'Are
21 we sure or not?' There was a~~n~~ formal integrated governance committee that
22 sat and oversaw, ~~so there was a kind of form with~~ these issues and
23 determined the process, but the original judgments were made by the
24 clinicians, and I think it would be important to ask my clinical colleagues as to
25 what basis. I mean I've looked at them since and I've read the ombudsman's

1 PROF MONTGOMERY: I understand that; I wondered who brought it to you.

2 MR FARRAR: Sorry?

3 PROF MONTGOMERY: I understand that, but I'm wondering who brought it to you.

4 MR FARRAR: Well, we have a Monday morning management meeting every
5 Monday, which looked at all our issues. And again, there were notes and
6 things from that, but they don't seem to be in the papers, and that's not helpful
7 in terms of understanding how that view came. But my recollection was that
8 ~~that~~ it was brought as 'this is the way in which we're going to take it forward.'
9 But I – my insight into...

10 PROF MONTGOMERY: And who would that have sat with? Whose directorate
11 would that...

12 MR FARRAR: Essentially through Angela Brown, but she would have drawn on the
13 experience of the public health doctors, and in fact we deliberately created
14 Ann Hoskins in a post which was responsible for looking at child and maternal
15 issues. And we did that because if we were serious about the health in the
16 North West, we felt that ~~the~~ bearing in mind that – we had a wonderful
17 opportunity of having two very experienced public health doctors, and so we
18 thought it was a really good idea to effectively create a dedicated post looking
19 at children. So Ann's role was specifically to champion and oversee childrens
20 health issues– in fact we published data that looked at child maternal deaths
21 and infant mortality across the patch that gave us comparative data. Ann was
22 able to set up a steering group to look at paediatric surgery rates, for example~~,~~
23 ~~the surgery rates~~. You know, we were very interested in children's health,
24 which is why this is so mortifying.

PROF MONTGOMERY: So from that surveillance system, what fell out of the priorities for University Hospital Morecambe Bay?

MR FARRAR: Well our priorities were, in terms of children and maternal services, our systemic approach was largely focused on Greater Manchester. We had ~~sourced~~ focused on Greater Manchester because when I look back, and again this is reflection rather than wondering at the time, I don't remember doing this at the time, but I was very conscious that all the death rates, all the – whether it's perinatal stillbirth or neonatal, were showing that the big problems in the region were around Greater Manchester, Oldham, Bury – well not so much Bury, but Oldham, Manchester, Trafford, and so we had a major programme focused on ~~–~~these areas I mean, we did say at the time, and I hope it's been proven to be true, that we were determined to try and save 30 babies' lives a year, so the strategic priorities of the health authority were geared to children's…

PROF MONTGOMERY: I fully understand that for the health authority. Was that information made available to the PCT so they could do the similar prioritisation for their commissioning strategy?

MR FARRAR: Well our information I think we shared with everybody; it was put in the public domain. We didn't have any problem with putting information in the public domain, so therefore when we met the PCTs and talked about ~~,~~priorities as we did on a regular basis, I had a monthly meeting with all the chief exec community, that was the providers as well as the PCTs~~,~~. ~~but that was before then we had a meeting just with our PCTs, s~~ So the way the sequence went is that we went into a meeting with the PCTs, and then we went into the big arena with all the chief execs.

So where we had problems we were making them visible to the whole community. And we also had, by the way, which I don't know whether you've seen, but a very extensive dashboard about quality of performance that the SHA took to every board, and it was developed ~~with~~ by PA ~~c~~Consulting and the SHA, and it had a whole series of metrics for PCTs down to, for example, the rate of alcohol related deaths or harm that we would see in our system, so it had lots of information.

PROF MONTGOMERY: And was that a PCT dashboard or did you have a provider one as well?

MR FARRAR: It had both – sorry, it was a combined dashboard. In terms of my relationships with the PCT and we spent the most time talking about priorities and ~~,~~ my personal relationship focused largely on ~~the~~ these questions~~,~~. ~~so~~ But the relationship I had with the PCT, Cumbria was a difficult one. It didn't start as a difficult one, but it became difficult, and it became difficult because in terms of the compact, we triggered a concern about the Cumbria health system and what was happening.

So just to give you some insight, I was very pleased with appointing Sue Page into the PC Trust, it was very helpful. She had lots of acute experience. When ~~we took on~~ established Cumbria PCT~~,~~. ~~we~~ The SHA had a £39 million deficit. Now, at the time ~~it wasn't supported~~ the SHA wasn't encouraged to do this, but we took a decision at Board to put £28 million into Cumbria to give them a fighting chance, so effectively the SHA corrected the underlying financial problem, along with work that the PCT had to do in the first year. So ~~they~~ the PCT did £11 million of savings, but bear in mind we had

1 quite a lot of growth, so that was a good time to do it. And we put in £28
2 million to square it.
3 Now, they had a strategy on care closer to home that they were
4 pursuing. It was struggling, I think it's fair to say. There was also a lot of
5 interest in Whitehaven Hospital, a lot of political interest~~ing~~ in building a new
6 hospital, and the PCT's focus at the time was very much around North
7 Cumbria. That was —clear so virtually all the conversations I had related to
8 North Cumbria, not to the Morecambe Bay, and in fact on many occasions the
9 PCT said, 'If only North Cumbria would be like Morecambe Bay,' and ~~we find~~
10 ~~that~~ we had as good a relationship. So that was —how it felt in terms of local
11 information coming up to me, I wasn't getting back a story from Cumbria PCT
12 that said, 'We have got major concerns around Morecambe Bay,' and I think –
13 and again, I discovered this afterwards, but if you look at the Morecambe Bay
14 Trust's quality account for 2010, in which they set out their stall and they say,
15 'This is what we think the quality of Morecambe Bay's Trust ~~performed since~~
16 care was,' the PCT was invited to comment on that, and actually you can see
17 the letters that are published verbatim, and Cumbria PCT's response to that
18 statement about quality is effectively saying, 'We agree with what you're
19 saying about the quality of care. Our problem, if we've got one,' and it's a
20 fairly minor problem as it says, 'was waiting times.' So...
21 PROF MONTGOMERY: What did North Lancashire say about it?
22 MR FARRAR: Sorry?
23 PROF MONTGOMERY: What did North Lancashire PCT say about it?
24 MR FARRAR: I'd have to go back to it; I've not got it with me.
25 PROF MONTGOMERY: I think they might have taken a different view.

1 MR FARRAR: North – well, when we come to North Lancashire, I think North
2 Lancashire did have a different view, and in fact I know North Lancashire's
3 view at that time in the middle of that year about – but it was largely about
4 Lancaster. So ~~when – so~~ for reference we had this interesting problem around
5 the structure of commissioning for Morecambe Bay Trust because such a lot
6 of its work, a high proportion, 40% odd came from Cumbria, and the other bit
7 came from North Lancashire. This meant that each PCT tended to monitor the
8 hospitals within their own patch but Cumbria PCT led the contracting process.
9 So when Janet Soo-Chung, I think, talked to us about Morecambe Bay, she
10 was largely talking about Lancaster. And I think the problems that she
11 identified were problems relating to Lancaster. Janet didn't say to me, and I
12 don't believe she said to anybody at the SHA, but please check that, 'Our
13 problem with this Trust is that it's maternity services,' or indeed maternity
14 services at Furness. And I think that...
15 PROF MONTGOMERY: Because I got a picture then that the priorities for Cumbria
16 were to the north rather than the south, and they were principally financial
17 sustainability and pressure going onto the acute sector as opposed to other
18 aspects, of course.
19 MR FARRAR: Yes, indeed, yes. Can I carry on? Sorry, I don't want to interrupt, but
20 I think it's worth just noting, the relationships with the [inaudible] chairman of
21 the ~~PTC~~ PCT soured over an arbitration, and that arbitration was about ~~2000~~ –
22 I think the 2010/11 contract. And the reason ~~being is that it was~~centred on a
23 dispute in North Cumbria, not in Morecambe Bay. It was a dispute there, and
24 there was a £22 million gap between what the N Cumbria Trust effectively said
25 they needed and what the PCT wanted to give them.

Now, there was a formal arbitration process put into place, which is a failure in itself because they couldn't ~~get that right~~ agree~~,~~. ~~b~~But they came to the SHA for arbitration. I wasn't party to that arbitration, it's always important – ~~so~~to be clear, but there was a whole internal process; it was chaired by one of my directors, and effectively it came to a view that broadly, it wasn't exactly a 50:50 split, but broadly on the technical issues of the arbitration over contract issues, but it should be something like a £9:13 million sort of split really, so the PCT was able to take some of the resources away from its contract, but not all of it.

Now, it created some very bad feeling at the time, and I know – and I went up to Cumbria personally, and I went up to talk to them because what I felt was I was having bilateral conversations through the PCT chief executive, but actually the GP clinical commissioners at the time, (those senates as they were, then) were acting – were kind of not ~~cited~~ sighted on the logic of it. And I went up to try and build relationships. What I was able to show is, and I don't know whether you've got this data, but – and I've not got it to hand – is that Cumbria was a very, very low spender per head of population of its hospital services, but a very high spender on community primary care. And so I was trying to get across to them that ~~the balance of how do you~~in order to help and provide a change to acute hospital services, you had to manage the risk of a provider being able to transform, but if you took too much money out quickly you were at risk of forcing them into a problem, and I think history has proven that the way in which North Cumbria then was put under financial pressure and effectively pushed to the point where they couldn't get to FT, (which I have

1 to say was probably right), but effectively ~~that~~ the right balance of risk to help

2 and provide a change was not deployed.

3 But I come back to the point that all those conversations with the PCT

4 were about North Cumbria, and the issues we have related to finance not to

5 quality. I was very – I was very pleased with North Cumbria. I mean they

6 were doing some really interesting things. They had great clinical support for

7 commissioning well in advance of anybody else. They were bringing GPs into

8 the room, they were trying to do something around The Year of Care for

9 Diabetes. I think that they were trying to be helpful from a clinical sense, and

10 our dispute with Cumbria was not centred around ~~they were~~ them saying

11 something ~~to~~ about the quality of care that we didn't support or we weren't

12 supporting them. It was largely a financial issue.

13 PROF MONTGOMERY: And I think what you've just described is when the financial

14 pressures can't be handled locally you were going in and you were mediating.

15 Were your arbitrating or...

16 MR FARRAR: Well we were formally arbitrating, it wasn't just a – you know, we

17 actually went in because they couldn't settle their financial contract round, and

18 we – the SHA decision based on the Panel who looked at it, taking all the

19 evidence into account, was that about 50% of the PCT's case was proven, but

20 about 50% wasn't. So there was a...

21 PROF MONTGOMERY: And how many of those would you have done in the

22 contract round that year? Was it unusual that...

23 MR FARRAR: I ~~don't~~ think that that was our only one. So the relationship that we

24 had with every other PCT in the patch, I think, was a stronger one. I don't

25 know whether you were interviewing anybody else from the PCTs, and I know

this is not just about the SHA's relationship, but if it's material then I think that it would be wrong to assume that the relationship we had between the SHA and the Cumbria PCT was typical – and I come back to this. This was not dysfunctional in the sense of disputes over quality, this was – it was a financial dispute, and the territory that we were disputing was how fast the PCT could disinvest in North Cumbria Trust in order to pursue their strategy of care closer to home. And we were at the same time trying to support a case to rebuild Whitehaven Hospital, which had a lot of political support for it. And again, that was another ~~place~~ issue where the PCT, I think, felt that actually they might have wanted to take more services to Carlisle.

I mean again, it's – you would need to talk to the PCT about that, but there was a lot of interest in rebuilding Whitehaven Hospital connected to the nuclear industry and making sure there was a good hospital there, but it was hard – Cumbria PCT had a very difficult job. Its complexity was – and, you know, it's – the commissioning in Cumbria is still problematic, and you know, I happen to know, because I know that people have been into Morecambe Bay since, and people in turnaround, and one of the issues is the funding for rural health systems. Does the allocation formula properly address the needs of families and people who live in rural areas? I think that's ~~on the piece~~material to these issues.

PROF MONTGOMERY: I think we're aware of particular issues around sustainability and return to services. Can I shift to the quality assurance around quality issues? So you talked a little bit about the dashboard. We're aware that at various points there are risk summits and later on quality surveillance meetings and things going through, so can you just take us through how the

1 SHA assured itself that it was safe to leave quality issues devolved to the
2 PCTs?
3 MR FARRAR: Well, I mean – so I don't think it's right to say that the SHA devolved
4 all quality issues to the PCT, so I – just to put...
5 PROF MONTGOMERY: Yes.
6 MR FARRAR: So the specific devolution was around...
7 PROF MONTGOMERY: So explain about this, yes.
8 MR FARRAR: ... management of the outcomes from untoward incidents because of
9 the need to follow up on the actions locally. So in terms of quality, I think we
10 had – there's a whole system in place~~, but~~ at the time and I think it's fair to
11 say that the national focus on quality was growing. CQC as an external
12 inspectorate were starting to change and to be part of the landscape in a
13 slightly different way, so they were becoming an external inspectorate rather
14 than an assessor, as they had been with the Healthcare Commission.
15 And so there was a variety of ways, including the CQC's assessment of
16 whether standards were being met, that was extremely important. There were
17 a number of metrics of quality of performance that were assessed by the SHA.
18 It was a small group of metrics, which we had to report up to the centre. They
19 included waiting times, but also there were metrics like the healthcare
20 acquired infections – hospital acquired infections that we looked at. There
21 were some input measures at the time around numbers of – I think we had
22 numbers of midwives and district nurses and things that – so there was a
23 whole mix of information and data about quality of care, but ultimately the
24 determinant of quality rested with the fact that we had an external inspectorate

1 who made assessments, published assessments of the organisations where,
2 of course, we saw there were problems.

3 Now, in addition Brian Jarman had started to publish HSMRs, and at
4 the time I know there was a lot of controversy over that measure, but we took
5 a view that that HSMRs were was something that we should act on, and
6 therefore we set up aan Improvement collaborative, and in fact of the nine
7 hospitals in the NW with very high HSMRs , two were noted in the following
8 year as the best performing hospitals in terms of improvements. So we had
9 some understanding that that was working. We set up AQuA deliberately to
10 put in place quality improvement programmes to support. We also – we set in
11 place something called Patient Opinion, and you might not have heard about
12 this, but Patient Opinion was the first —of its kind. wWe contracted with a GP
13 called Paul Hodgkin, its founder to say, 'You can't just have one leg of quality
14 assessment here without quality outcomes. You've got to look at patient
15 experience.'

16 And so Patient Opinion actually was set up in the NW first, as a whole
17 region and every single PCT in the North West had it, but we instigated that.
18 And effectively it was to allow patients to put their stories onto public websites,
19 to effectively describe their experience of care, good or bad. And we were the
20 first region to do it. I also took one of my directors, Mandy Wearne, and we
21 created her as a director of patient experience, and she set up something an
22 organisation called Inspiration North West. And we were—a good example of
23 what they did, is that they did a lot of research in Wigan Trust, and they
24 identified that for patients, particularly older people going into wards, a kind of
25 formal checklist of quality of experience wasn't—didn't cover what they

1 needed, so we created ~~a~~ an adapted card set. I think it almost won awards, this card set, and it was a way of saying ~~to~~ —there were nine cards that were given to people, and they had values written on them and things like I want to be treated with dignity, 'I want to be given privacy, I want to make sure the information's available to my relatives,' and they were able to prioritise ~~that~~ them, and that was assessed on entry when they came into the hospital, and it was assessed on discharge to see if the hospital delivered. So we had a whole raft of things about quality.

PROF MONTGOMERY: And who had access to the outcome of that information?

MR FARRAR: Well that information was available to the Trusts, and we shared it as a measure for ~~the~~ good practice, so the Trusts began to take that up. So we – so I mean, like I say, it feels hard in the context in which we're talking about to say that – you know, we deliberately tried to look at a broad range of quality, including patient – and the Advancing Quality work assessed patient reported outcome. We were the first region to do that.

PROF MONTGOMERY: And what picture did those systems throw out about Morecambe Bay?

MR FARRAR: Well, Morecambe Bay, on those systems, was pretty much middle of the pack. You know, on HSMRs it wasn't in our – you know, it wasn't in the first collaborative. And if you read the Dr Foster Report and the point at which we've got now, obviously there's a timeline, but the Dr Foster Reports were coming into the SHA in the first instance. I've got the data somewhere, but the first instance it showed that the – that Morecambe Bay wasn't either mentioned as high or low. In the second instance in 2009, again, it wasn't in the worst quartile. It was only the report for the year 2010, which came in six

months after I left and other problems had started to emerge about Morecambe Bay that effectively the HSMR was declared as – and of course at that point the SHA, after I'd left, had then started to take action.

So from the dashboard that I had from a whole variety of places, including Advancing Quality, including HSMRs, there didn't appear to be a systemic problem of quality in Morecambe Bay.

PROF MONTGOMERY: And with hindsight would you change that system? I mean it did show up as a systemic problem, as you say, a bit later. Is it that it took time for that to come through?

MR FARRAR: Well, I can't tell you how much I've tried to think that through. The minute that I became aware of problems that emerged – you know, this is going to sound defensive and I don't want it to mean – to be defensive. But I had a belief that the issues relating to maternity services at Morecambe Bay, related specifically to the case of James Titcombe ~~that~~ and I understood chapter and verse about James's case, because James had provided all that information and we had investigated. We had three tiers of investigations into that. In my head, ~~that was~~ – that related to a specific incident, and although there were a number of other untoward incidents. –I mean the region has over 2,000 untoward incidents every year. There was also The number ~~of~~ other unrelated investigations and, ~~you know, there were some~~ other things around~~,~~ ~~so~~ on my dashboard, but I believe that ~~think~~ in 2009 at one ~~of these conferences~~ meeting, because they weren't risk summited then, the CQC had been invited to ~~[inaudible]~~field their investigation team, the same investigation team that looked at Mid Staffordshire, and ~~said~~ had identified that there were things wrong in Mid Staffs, ~~'Something's wrong there,' said,~~. But they

concluded 'We don't propose to investigate Morecambe Bay. We don't see it as a problem trust – it doesn't have those kind of issues that leave us to believe that we should investigate.'

So when I think back, did I miss something, was I – you know, could I as the chief executive, and then secondly did my organisation miss something, ~~what was in the organisation?~~ It's hard to conclude that we did~~n't~~ miss something, when you consider all the information at the time – it's hard to conclude that ~~it wasn't~~the SHA didn't adopt a reasonable position~~, to take~~. Do I wish that we'd perhaps taken some steps sooner? I think so, because obviously if we could have been perhaps a bit clearer sooner, it may well – it may well have triggered something, but I didn't have any reason. So even around the case around Joshua, the LSA Report that I – I absolutely agree with James, the first LSA Report was in-adequate, but the data I had on my LSA at the time from the NMC's quality assurance process, was that it was a good process and run well– not only was it a reasonable one, but the NMC report said they actually had elements of very good practice in it. I'd no reason to suspect that they would not do their job properly in terms of the very first investigation~~,~~. ~~so t~~There was something else that's material to this, so – so at that point Morecambe Bay was the leading Trust in the country for implementing the new system of IT, right? So this ~~was~~ involved an IT programme called Lorenzo, which was ~~going – now that~~ being introduced. ~~t~~The whole purpose of Lorenzo was to try and improve patient care, about connecting the records so that all clinicians had the same information, and you could audit properly, you could do quality assessments ~~now~~.

1 The fact was that ~~—so—~~I knew a lot about Morecambe Bay's
2 implementation of Lorenzo because it was extremely high profile. We took a
3 decision as a strategic authority to audit the governance of the IT programme,
4 the Trust's ~~—the~~ governance and the IT programme to effectively say, 'This
5 flagship programme, this Trust that's supposed to be doing – are they capable
6 of delivering it?' So at the same time as you had an insight into the
7 governance, we had an insight into this Trust's governance around its IT and
8 its information management that actually said – and we took that through our
9 Board – that said, 'Actually their state of readiness is quite good.' And we did
10 that to reassure ourselves that this Trust could deliver~~,~~. ~~s~~So at the very least –
11 at the very least they were mixed signals, but actually most of the signals were
12 saying to me its reasonably well governed ~~that~~ notwithstanding the fact that
13 the care of some specific examples had been found wanting, and the first
14 assessment that the LSA did into it had been unsatisfactory, and in fact it was
15 only really when I said, 'Well the SHA needs to look at this as opposed to
16 having another LSA person,' I think we'd got some insight in the fact that
17 there'd been real problems around that specific case.
18 PROF MONTGOMERY: And that point came when?
19 MR FARRAR: So that was the second half of 2010. So James first brought to the
20 attention of the SHA his dissatisfaction with the LSA Report, I think, in January
21 2010. It was brought to my attention by Christine Dent – Chris Dent, who said,
22 'I think James is right, and I think we need to do something,' and I agreed with
23 that. And what we did was we get an external LSA officer ~~in who effectively –~~
24 from Scotland – who was independent, ~~n't my choice, it was –~~ we were
25 suggested that that would be a good way. And what I was advised at that

point is that this has to look at was the review done properly, not reinvestigate the issues. So on the basis of that it came in – Yvonne ~~Rispin Bronsxy~~Bronsky looked at it and produced a report which said, 'Actually that first report was done properly.'

Now, I wrote at that time, setting out that I thought on the basis of Yvonne's Report that had been done properly, so there's a letter on record from me, I think, to James saying, 'I think this has been done properly, that's the advice I've been given.' But when James came back and said, 'I don't agree with you,' and then I spoke to Christine Dent and I said, 'What do ~~we~~ you think?' I agreed with James, and so we commissioned a third one~~,~~. ~~and t~~The issue for me about the LSA is that it was an unusual bit of the strategic health authority. So its quality assurance was with an external body, not the SHA ~~and I – you know,~~. I've read the ombudsman's report, and I couldn't agree more, with her conclusions that ~~but~~ the system of regulating and quality assuring midwifery was very difficult to navigate, and it wasn't clear~~,~~. ~~and s~~So effectively in the middle of that year I asked Chris Dent, my own person who I had control over if I put it like that, who I believed to have relevant experience, and Angela Brown, to look at those issues relating to the handling of that particular case.

And I don't know what James feels like now, but at the time when we reported, and in a nutshell, what I was told is that there were some significant problems with the two reports to date. We tried to correct those by being clear about what had happened. What I was advised was it was difficult to ~~go~~ investigate further because of the absence of a bit of the clinical record. That's what I was advised, and I said, 'Well in that case, I would like to meet

1 James personally to say I don't think we can get beyond this point.' And so it
2 was agreed that the NMC and the SHA together, ~~because that was the~~would
3 explain what would happen next.~~—t~~There was such a lot of confusion~~,~~ of roles
4 and I think James had asked a lot of organisations to be involved in potentially
5 looking at the case, which meant that there were a lot of separate jurisdictions
6 trying to get to the bottom of things. And I asked that the SHA and the NMC
7 did their briefing together on what we'd found and what actions would then
8 take place.
9 And I asked if I could be part of that. I know in the minutes it said 50
10 minutes; my recollection is that it was slightly longer than that, but that wasn't
11 the point. The point was that I personally wanted to say sorry for the NHS
12 failings. I'm really conscious that I do have friends who have had similar
13 situations, and I can't imagine what it's like to go through what ~~you've~~ they've
14 gone through, but I only know from other people, and so I wanted personally to
15 say sorry, and to say, 'This is where we've got to, and I don't think I can go
16 beyond this point.'
17 Now, I don't know what James feels about that now, but I know at the
18 time James wrote to us and said, 'Thank you,' and I know he was very
19 sceptical about why a third investigation would help, right? He was very
20 sceptical, and I know there was lots of correspondence between him and Chris
21 Dent about, 'If this is going to be another fudge, and all the rest of it, then don't
22 bother. Don't bother.' And I said to Chris at the time, 'You must do this well.
23 We must be absolutely clear, and everything that we find must be made
24 available to the family.'
25 And we had support. Where I think James fell out with it – sorry.

1 DR KIRKUP: Can I just stop you at that point? You're skirting along the edges of
2 things that are potentially confidential between you and an individual
3 complainant.
4 MR FARRAR: I'm sorry.
5 DR KIRKUP: If you want to go into that kind of stuff then we need to have observers
6 not present, and we'll arrange a follow-up session at the end of this one to do
7 that. I don't think you've quite crossed it, but I'm just very concerned that
8 you're about to.
9 MR FARRAR: I apologise. I apologise for that, I was trying to give you what I saw.
10 DR KIRKUP: Yes.
11 MR FARRAR: So what then followed was effectively a correspondence about should
12 there be a further LSA investigation. Having done our work, should there be a
13 further investigation~~,~~? ~~a~~And I was advised, and in fact I agreed by the way, ~~so~~
14 ~~I was advised I could have said no,~~ that actually because these issues and
15 staff had been elevated to the NMC at that point, to a higher level, that actually
16 repeating an LSA investigation would not be helpful. That's what I was
17 advised, and I tried and I asked if we could make it very, very clear in the letter,
18 the grounds on which we had ~~not~~ said that. And I think – the ombudsman, in
19 the ombudsman's report, which has looked at this specifically, concludes, I
20 think, that that was a reasonable judgment to have come to. Again, you will
21 make a view of yourself, but it was the ombudsman that seemed to suggest
22 that that was a reasonable thing to do in that circumstance.
23 DR KIRKUP: I'm conscious we've got quite a lot to get through.
24 PROF MONTGOMERY: Can I shift onto the Fielding Report? I'm just thinking of any
25 examples – points at which decisions were made that could have picked up

1 systemic as opposed to – so were you aware of the commissioning of the
2 Fielding Report?
3 MR FARRAR: I think I must have been. I think I must have been, but I don't
4 remember being part of the decision to commission. We had used Pauline
5 Fielding for an investigation into Tameside Hospital, which is a good example
6 of where the SHA two years earlier had taken the decision to say, 'We think
7 there is something systemic here. We don't believe that the Trust's actions
8 are in the right way going to address it, and therefore we took the decision to
9 have our own independent investigation.' And Pauline Fielding conducted that
10 for us.
11 It's fair to say that even at the time, the Healthcare Commission – CQC,
12 as I think they'd just become, wasn't particularly happy about that. But two
13 years on...
14 PROF MONTGOMERY: So they were aware at the time of commissioning that that
15 was happening?
16 MR FARRAR: Sorry, when we did the Tameside?
17 PROF MONTGOMERY: Tameside, sorry.
18 MR FARRAR: ~~Tameside would be, that we kind of said we were going to do, but~~In
19 the case of Tameside, CQC were fully aware and we said we'd keep
20 everybody informed. ~~So~~ In the case of Morecambe Bay Pauline Fielding, as I
21 understand it, and this is because I've asked people as opposed to being party
22 to the decision, was a suggestion that we i.e. staff in the SHA made to the
23 Trust, who asked us about a further investigation for assurance purposes.
24 And we suggested Pauline Fielding would be a good person to do that.

PROF MONTGOMERY: And can you tease out a bit what you mean by a further investigation for assurance purposes? And we're trying to understand what the understanding of everybody was.

MR FARRAR: Well, if – so we had a process which was about the conduct of the midwives, which is the bit that I was very ~~cited~~ sighted on, which was about professional conduct and our handling of the LSA's responsibilities. But alongside that, was this process of untoward incident management and the Trust's assurance that it was improving services in response – so for example, the work ~~on~~ that the LSA couldn't get into, such as 'Did the paediatricians do their job properly?' ~~It~~ because the LSA was specifically for midwives. This is where these jurisdiction complications come into play~~, because that bit was looking at that~~.

Alongside that, in parallel was a look at was the Trust doing its work properly? And the Fielding Review came on the back of an earlier review that the Trust had done, which I think ~~it~~ had been done by Charles Flynn, and it was designed to look at the wider issues relating to maternal and child services, and was also really in parallel with the PCT and the SHA's work with the Trust looking at where they are doing the – where they are implementing the recommendations of the untoward incidents. And I think if you look at what Pauline Fielding says in the report when it was finally made available, I think she concludes that the Trust was making good progress against the action plans emerging from the untoward incidents~~–~~ ~~s~~She takes a view, I think, that was similar to that which was described to me, which was that the Trust was making good progress against the untoward incident handling, and was more open in its reporting of them. And also, I think, going back to the point

1 about systemic, I think she also says it was not unreasonable, I think she puts
2 it that way, to believe that these were unconnected incidents.
3 PROF MONTGOMERY: So your assessment is that she'd made a judgment on
4 whether or not they were connected incidents?
5 MR FARRAR: I think she took – I've not got the Fielding Report with me, but I think
6 she does comment on that, ~~so – and I think she – you know,~~ and I come back
7 to this – I talk about reasonable judgment, you know, hindsight's wonderful,
8 but ~~you know~~, I think her position is it was not unreasonable to believe that
9 these specific issues were unconnected. I mean the nature of the deaths, ~~you~~
10 ~~know~~, did I think suggest, now that I've looked at them, that there were
11 different elements in play in terms of the specific clinical interventions for the
12 children and mothers.
13 PROF MONTGOMERY: And was it your impression that she'd been able to have a
14 review of the case notes and things to satisfy herself that the untoward
15 incidents programme was working its way through?
16 MR FARRAR: I can't come up with an answer, to be fair. I've got no idea. I would
17 have hoped – I would have absolutely hoped that the Trust, or indeed anything
18 that we the SHA had, would have been shared fully with Pauline Fielding. I
19 would be hugely bothered if I believed that my organisation had ~~not made –~~
20 ~~but~~ deliberately not made things available to Pauline that she wanted. And in
21 fact, the reason why I would be confident that Pauline would ~~assess~~ access
22 them, because she'd worked with us before. Working for us, she knew the
23 people and, you know, Pauline was a very – really good person, I think. I think
24 she did her job well and I don't think she would have tolerated not being able
25 to do her job well. ~~done her job –~~ I think she would have said, 'I haven't been

1 able to get access to case notes,' or 'I've been deliberately blocked...' ~~b~~But ~~I –~~

2 ~~and~~ had she have come to me and said, 'I can't get case notes,' I would have

3 said, 'You must have case notes.'

4 PROF MONTGOMERY: So your understanding was that she had that opportunity.

5 I'm just trying to understand what assurance people felt they could draw.

6 MR FARRAR: Yes, I was – I would have absolutely understood at that time that she

7 had absolutely open access to anything in the Trust, in the PCT, in the SHAs,

8 so absolutely open, and had I been told otherwise I would have absolutely

9 said, 'Those must be made available.'

10 PROF MONTGOMERY: And would your understanding have been that she would

11 have seen through whether the Trust responded to her own report?

12 MR FARRAR: Sorry?

13 PROF MONTGOMERY: Would you have expected her to have seen through

14 whether she was satisfied the Trust had taken her report seriously and

15 responded to it?

16 MR FARRAR: Yes. Yes.

17 PROF MONTGOMERY: So it would surprise you that it was – she didn't follow up

18 and didn't present to the Board?

19 MR FARRAR: Well, you see, there's a slight problem for the SHA, because we

20 weren't commissioners of that report.

21 PROF MONTGOMERY: No, I understand that.

22 MR FARRAR: You know, and all I can say is when we had commissioned

23 Pauline Fielding to investigate Tameside, not only did we make immediately

24 ~~public~~ hold a press conference on the day of release, but also we put in place

25 six months and 12 months reviews where Pauline herself went back in to see

1 whether the action plans were being followed. You know, that was what we
2 did – that was our style. Had that been ~~my~~ the SHA's report, then that would
3 exactly have happened, so the fact that it wasn't ~~my~~ our report meant that my
4 jurisdiction and my sight – more importantly, my sight on what was going on
5 was much less clear in terms of visibility.
6 PROF MONTGOMERY: I guess that's the question I'm really asking with – you
7 would have assumed that those things would happen. They didn't in fact
8 happen...
9 MR FARRAR: Yes.
10 DR KIRKUP: ...but would you have proceeded on the assumption that they had?
11 MR FARRAR: Yes, absolutely. And I don't know whether you're interviewing
12 Angela Brown, but I spoke to Angela, and Angela – because my first question
13 was, 'Did we have a copy of this report? Did it come into us?' Now, I believe
14 that Angela had seen it. I think that's the case, but I ~~don't – this is very unfair~~
15 ~~because I~~ think it's for her to say.
16 What I know is that I haven't seen that report, and I know that Angela,
17 when she told me, she believed that they, the Trust, had made that available
18 to everybody who should have got it. And Angela said, when she understood
19 that not to be the case, she immediately told them that they should do, so all
20 our assumptions – now, this feels incredibly pivotal to me, because there's
21 some implication potentially that the SHA we – and all I can say to you is that I
22 absolutely – I absolutely, and we're not on oath, but I would say this on oath, I
23 absolutely was not aware that that report had not been made available to the
24 key people who needed to see it, nor that actions following it weren't being
25 pursued. Absolutely was not aware.

1 And the thing that I would say, to point to, to say if you – sorry, this is
2 sounding far too defen – this is not about me. Not about me, but the point
3 being that where we had convened a report by Pauline Fielding into Tameside,
4 the evidence is there about what we, the SHA did with her report and follow up.
5 PROF MONTGOMERY: I'm asking really, I think, something slightly different, which
6 is...
7 MR FARRAR: Sorry.
8 PROF MONTGOMERY: ... the understanding the SHA had of what had been done,
9 because It think if you trace through comments that are made by members of
10 the SHA about what the Fielding Report did, the further they get away from the
11 report, the more ambiguity there is about what its terms of references were
12 and what it was actually being asked to do, so it's just understanding that.
13 MR FARRAR: It was the Trust's report. That's a great hindsight point; should we
14 have commissioned that report?
15 PROF MONTGOMERY: That's it, yes.
16 MR FARRAR: But the CQC, and I know you know it's [inaudible] CQC, the CQC
17 were at that point the external inspectorate. And one of the reasons which is
18 ~~what – ~~why I ~~think it's important is that I think James had every right – sorry, I~~
19 ~~think the – so I think~~ given that the first LSA function hadn't done its job
20 properly, I took a view that the external inspectorate was the right place. So
21 the SHA~~, if you like, it~~ was not an inspectorate. We didn't have the ability to go
22 in to wards in the same way – you know, we were ~~the~~ not an inspectorate.
23 There was an inspectorate – The CQC, with its proper terms of reference and
24 powers supposed to do that.

1 PROF MONTGOMERY: I'd like to get onto the CQC next; that would be really
2 helpful. Just one other question on the back of Fielding, and it's the extent to
3 which the Fielding Report showed things that weren't already known from the
4 Flynn Report, because in some ways it's a follow up, and we know there's
5 awareness of the Flynn Report, but were there different things or was it just
6 corroboration of what was already something to be anxious about?
7 MR FARRAR: Well I think that the Fielding Report ~~sort of like~~ talks a lot about ~~the~~ –
8 some of the relationships in the Trust. Now, you know, between maternity and
9 paediatrics, ~~you know,~~ a lot of Trusts had difficulties with that relationship, and
10 ~~you know,~~ it was in part something about children's services where we wanted
11 to try and do something better and we were trying to do something better in
12 Greater Manchester, for example, because of their much higher death rates
13 than we were seeing in other parts of our patch. And that was a ~~real~~ place ~~I~~
14 ~~wanted to tackle this,~~ the SHA was tackling this. ~~b~~But I think ~~it~~ The Fielding
15 Report got a bit more under the skin of the issues and ~~, but~~ it also confirmed
16 some things for us. It was – you know, when you read the Fielding Report, it
17 describes some of the things in there that it supports, and those things largely
18 related to the fact they were making progress against untoward incidents.
19 So in essence, what I had from my people was specifically about the
20 untoward incident process where we were still party to it. And right from the
21 word go, I think the CQC were invited to be part of that process, but as I
22 understand it, they didn't come to a meeting, and again, I'm told that they said
23 they were going to do their own thing. And interestingly, I think five days
24 before Pauline Fielding's Report was ~~published or~~ given to the Trust, they did
25 an unannounced visit into the same unit and found that it was compliant with

the standards but with some minor issues ~~—so I feel—you know,~~. So it's hard ~~not~~ to see why the external inspectorate ~~element of this~~ didn't necessarily pick up on some of those aspects that were in the Fielding Report. But again, it was giving mixed signals, and critically, CQC signals were going into other bits of the system about this Trust, and it was the external inspectorate. If the SHA had a view about them, that's one thing, but the external inspectorate is there to serve the public interest through external eyes.

PROF MONTGOMERY: That's exactly what I wanted to ask you to talk about next really, because we can obviously ask the CQC about what they did, but it's the signals that you and others in the system took from what they did. So can you just take us through what it felt to you that the CQC was telling you about Morecambe Bay?

MR FARRAR: Well, again, I think it's a really important question to ask my team because my team had working relationships on a day-to-day basis with the CQC people who have detailed knowledge. So I think it's the performance and the clinical teams that are more relevant to that. My view is that they were not telling me that Morecambe Bay had systemic problems, so they chose to license them in April without condition. And they, as I understand it, they had this further unannounced visit. Again, so I wasn't aware of the unannounced visit in ~~that sense~~at that time, so my personal view on it was that I wasn't being told CQC were going to do it, and I wasn't then told that it gave them a clean bill of health. They also weren't giving information to the SHA about what they said to Monitor, for example, and the conversation between Monitor and CQC, or between CQC and the ombudsman.

1 So my ~~citing~~ sighting on the CQC would have only been elevated if
2 they'd been saying there were significant problems. Now I read the Grant
3 Thornton Report, which I think is appalling, because it didn't interview anybody
4 else other than people from the CQC, or give ~~them~~ all stakeholders the chance
5 to say what they saw. And it talks about SHA assurances, but I think the
6 assurances – but I don't know for certain—I think the assurances that they
7 were getting from the SHA related to: was the Trust making progress against
8 the management of untoward incidents, and did we at that time have any
9 reason to believe anything different about that Trust's overall state. And I
10 come back to the questions you asked me before about HSMR and what we
11 saw at the time. So I think the problem I have is that the CQC is supposed to
12 be an external inspectorate that goes in and looks at these things
13 independently, and it should have been signalling its views to me, or to the
14 SHA. The SHA should have absolutely made available to CQC everything
15 that we had. And again, I'd be very disappointed if you can show that wasn't
16 the case, but if we had anything at that time that I thought should have been
17 given to the CQC, I think I would have insisted and I would have personally
18 given it.

19 PROF MONTGOMERY: Do you have experience of other organisations elsewhere
20 in the SHA where relationships with the CQC has been different, where there's
21 been...

22 MR FARRAR: Well we – I think what happened at that time, and my recollection is
23 slightly cloudy – I think the person who I used to meet from CQC on an
24 informal basis to take stock of the region, ~~and that was~~ at a meeting where we
25 gave early, early warning signs, including should we have a more in depth

1 meeting. I had a regional manager called Jo Dent, and I had a good
2 relationship with Jo Dent, which has built up over a number of conversations,
3 and we talked to each other about ~~—well, more recently, I think~~ something like
4 every six to 12 months, so that was my relationship. And it changed, and I
5 think it changed about that time. And I think there was an individual called
6 [Alan Jefferson?], who I didn't have the same approach– and I don't think –
7 again, because I don't have access to diaries, I can't – I can't say for definite
8 on this point, but I can't remember a conversation with Alan that specifically
9 related to Morecambe Bay.

10 So in terms of any assurance that I was supposed to be giving him
11 about Morecambe Bay, or he either had concerns about Morecambe Bay for
12 me to say anything different, I don't recall ~~that~~ any conversations.

13 PROF MONTGOMERY: There was some discussion in early 2009 about the Trust
14 and a risk summit, which the outcome seems to have been that the SHA
15 would take the lead, and it wasn't about maternity issues, it was about other
16 issues. Do you have any recollection of those early 2009 discussions?

17 MR FARRAR: I really don't. I don't, but I know my team would have had that. But,
18 you know, so just to give you a flavour of this, and I think this is so important
19 for families, the Morecambe Bay Trust, in the context of all the other things in
20 the North West and what we were looking at, so there's this issue about was it
21 systemic or did we deal with it as individual set of events– and that's not
22 saying because we deal with these individual incidents there wasn't a desire to
23 improve services, as I can try to evidence, but it wasn't a Trust that was on my
24 radar screen because either of reports or concerns from the ~~the~~ PCT or CQC
25 or anybody else. ~~—i~~ In fact in 2009, when it first went through the application

1 process for Foundation Trust status, there was a letter, I think that came in,
2 from the PCT from Lancaster saying, 'Yes, it's fine.' So – so the early
3 business around in 2009 around risk wasn't ~~certainly reflected~~ flagging
4 Morecambe Bay Trust on my radar screen, and it wasn't ~~the~~ a Trust that I saw
5 as a particular problem.

6 PROF MONTGOMERY: And did your quality dashboard of that incorporate CQC
7 ratings and broader health condition ratings?

8 MR FARRAR: Yes, it did. So I know that they were part met for the Trust, and for
9 some of the standards that they looked at. So – and it was rated as fair, but it
10 was one of seven Trusts that was rated as fair, and I also ~~have~~ had, I think,
11 nine PCTs that were rated as fair. But it was rated as fair.

12 PROF MONTGOMERY: Okay, thank you. Can I move to the FT pipeline and the
13 relationship with Monitor, which is another bit of this jigsaw we have to put
14 together. So what were the big issues in the FT application process for
15 Morecambe Bay?

16 MR FARRAR: Well, the FT application process ~~when it went through from the~~ as it
17 applied to The SHA's ~~perspective, so~~ element of it during the first time round,
18 largely focused on governance membership and finances. And at that point,
19 financial stability at the Trust was good~~, seemed to be~~. And CQC affirmed that,
20 so it had a rating that the new financial management was…

21 PROF MONTGOMERY: It had previously been an ~~internal round~~ in turnaround,
22 hadn't it? So that's quite good progress from a few years before.

23 MR FARRAR: I don't know if it was formally internally. It certainly wasn't in my time
24 ~~internal round~~ in turnaround.

25 PROF MONTGOMERY: This would have been 04 or something like that, I think.

1 MR FARRAR: Yes – no, so – and certainly when I got my handover from Cumbria
2 and Lancashire SHA, they didn't signal Morecambe Bay Trust as a problem.
3 In fact what had happened in Morecambe Bay and in Cumbria is that the
4 financial deficit which kicks around Cumbria had been passed to the PCT at
5 the time. So effectively the Trusts at that point were quite stable, and their
6 financial problems started to merge as the PCT effectively passed risk back to
7 the Trust and reducesd its contracting, etc. So at that point, financially it met
8 the challenges. On governance there was a Board-to-Board that we did, but
9 effectively the SHA's role was to say, 'Is this fit to go forward?' It wasn't to
10 approve it as an FT, and I think it's really important to remember what our role
11 was.

12 And in 2009 it was deemed fit to go forward, and I think that...

13 PROF MONTGOMERY: And what was your assessment of the leadership? So you
14 had a Board-to-Board...

15 MR FARRAR: Well – so I'd never met Tony Halsall prior to working in the NW SHA.
16 I had met Eddie Kane. Eddie Kane had been a very senior person in the
17 North West, he'd been a senior person in London's health services. As a chair,
18 he seemed to understand what the Trust was doing. Tony Halsall came to
19 Morecambe Bay from being at Clatterbridge NHS Trust, where again he'd
20 been deemed to be a successful chief executive. So at that point in time, our
21 judgment in 2009 was that they were not a problem– they also had a very
22 good medical director, Peter Dwyer – who I – Dyer, sorry, Peter Dyer, who I'd
23 met on a number of occasions because ~~they~~ he participated in quite a lot of
24 the work we did around quality and leadership and medical directors, and so in
25 terms of ~~their~~ these three key ~~areas~~ officers they had a decent finance director;

1 their leadership team looked a reasonable team at the point which they
2 entered the FT process.
3 PROF MONTGOMERY: And did you have any reason to change that view as things
4 unfolded over the next few years?
5 MR FARRAR: Well, when I look back on what happened, and that's one of the
6 reasons why I'm very pleased that there is an investigation to this, because I
7 look back and I think that there are things that have emerged since which I
8 certainly don't think was anywhere near as good as it should have been. I
9 didn't know why Eddie Kane left. That was – so because when of course an
10 FT is approved, Monitor takes over the day-to-day relationships, and so I lost
11 track at that point. And again, it's for you to decide not me, but you know, I
12 think that there are things that you can look back and see the Trust didn't do,
13 like make available the Fielding Report, that I think should have happened. So
14 I would have to question whether the judgment at that time, and where that –
15 judgement was mad and was a full Board decision taken not to make that
16 available? Was it – wWho else in the Trust had a view about whether that was
17 made available or not, I don't know. So I don't know who was responsible.
18 But the original decision for them to go forward and be assessed by
19 Monitor, it seemed to me was not unreasonable to saya route – that the SHS
20 SHA came to a fair decision, and I think there were other Trusts who we'd
21 turned down. You know, there wasn't in the SHA a desperate desire to get
22 everybody to FT. I wasn't – I wasn't on performance related pay by getting
23 people to FT, that was not one of our —must be dones! FT status was a
24 means to an end. Obviously it was the Government's priority, and they

1 expected us to support Trusts to become FTs, so don't get me wrong, it was
2 part of the job, but it wasn't my...
3 PROF MONTGOMERY: In your SHA did you draw much distinction between the
4 statuses? I mean did you have all the providers coming to the meetings you
5 described whether they were FT or not?
6 MR FARRAR: We had a very, very positive relationship with FTs, which I think was
7 better than my predecessors. So when I took on the job, Chris Burke, who
8 was the FT chief exec at Stockport, and said, 'It changed from having to be a
9 good provider despite the SHA to being a good provider as an FT supported
10 by the SHA.' So the FTs came to our meetings, and in fact the FTs led quite a
11 lot of our quality work, so ~~Dave Cunningham~~David Fillingham left Bolton to set
12 up AQuA. David Dalton was the chair of AQuA, they're an FT. Tony Bell –
13 well, they weren't an FT. I'm trying to think of some other examples, there
14 were a number. But a lot of the leadership ~~[inaudible] and~~ programmes were
15 led by chief execs. The Social Value Foundation that we set up to make sure
16 that we were creating value back into our communities was chaired by Chris
17 Burke, an FT CEO from Stockport, so we had a good relationship with FTs,
18 and a decent relationship with ~~our own FTs~~PCTs as well.
19 PROF MONTGOMERY: So from your perspective it wasn't a priority other than the
20 fact that it was a national process to push people through, and there wasn't
21 that much gain for people in becoming an FT in their ability to contribute to the
22 system?
23 MR FARRAR: No, and I would hope that people who looked at the way in which we
24 ~~are present~~ operated in the North West would share that view. There were
25 occasions, ~~so~~ specifically two, where effectively we deferred, ~~so~~ FT applicants

1 as well, – and there were ~~kind of~~ agreements with Monitor around supporting a

2 deferral that Monitor ~~did~~ proposed. So – I shouldn't say, The SHA ~~we~~ deferred

3 them because it was Monitor's decision to defer. But we supported Monitor

4 and tried to help the Trust regroup and respond positively, so we...

5 PROF MONTGOMERY: Those are two – those are different from the suspension

6 that happened in Morecambe Bay.

7 MR FARRAR: Yes, indeed. So deferral was a ~~kind of~~ more formal process where

8 you went through the process and the trust was deemed not ready, and then

9 voluntarily withdrew as a consequence of conversations, and then came back

10 a year later. But it kind of extended the assessment process, whereas what

11 happened for Morecambe Bay, I think one of 12 Trusts in that situation, was

12 that they were put on hold because the criteria were changing– there was a

13 question about changing the criteria of the assessment after the first Francis

14 Report. And ~~that~~ therefore it was Monitor's decision to put them into what

15 they described at the time as a holding pen. And it was Monitor's decision to

16 pull them out of the holding pen.

17 PROF MONTGOMERY: But what did you do? I mean you then have a bit longer

18 responsibility than you expected to do, so how did the SHA respond?

19 MR FARRAR: Well we weren't effectively doing a lot. I mean it is true to say that the

20 – that I know the Trust was frustrated about that, so I think this was something,

21 again, that you should talk to the Trust people about. They felt frustrated

22 because they felt that they had been ready ~~in~~ to be FT, and you know, they

23 spoke to me about that frustration.

24 PROF MONTGOMERY: I think the sort of bigger question around all of that for me is

25 around the pooling of what you might call soft intelligence on – was there any

formal process for you testing [inaudible], your understanding of what CQC's thought, right, what's Monitor's understanding?

MR FARRAR: Yes, well not ~~in~~ really – so Monitor – I assume you're interviewing Bill ~~Morris~~Moyes, but Monitor had a very interesting view about SHAs~~,~~. ~~s~~So ~~a –~~ they thought that the SHA role in the process was to get them to the starting gate, but they weren't particularly interested in what the SHA thought about them as they went further through the process. They effectively said, 'You don't understand what Foundation Trusts are about; we do, and it's our job to assess, and therefore what you believe about them was material previously, up to this stage but actually now this is an assessment process that we Monitor undertake.'

They were interested in what PCTs thought because they believe that PCTs had the important role as commissioners – I think if you ask Bill ~~Morris~~ Moyes what he thought the system should be, ~~it~~ he wouldn't have had an SHA in place, it would have just been commissioners with a regulated market. So when…

PROF MONTGOMERY: And this was Bill ~~Morris's~~ Moyes time, was it, as it was going through?

MR FARRAR: Yes. So when Monitor brought them back out of the holding pen, I don't think we were informed. That's the first thing. So I don't think there's a formal letter that passed to us to say, 'We've now ~~[inaudible]~~ reinstated them, so there was no real communication with us about that. And the assessment that they ~~did~~ undertook didn't ask the SHA formally for a view at that stage. They asked the PCTs, and I understand that the PCT spoke to them.

Now, I think I'm right in saying that it was one of the PCTs, not both, because when they came up to do their next level of assessment – but that's what I've been told, not what I absolutely know – but I understand that North Lancashire did speak to them, and I understand that the chief executive at North Lancashire spoke to one of my directors and said, 'Look, we don't believe that <u>they are ready</u> – you know, we think there are some issues about this Trust. What do you think we should do?' And as I understand, my director said, 'You should tell them exactly what you know, but it's important that you put an evidence base against that because Monitor looks at evidence.' And again, from what I understand, but I can't <u>be certain</u>– it's for you to get more detail than I've got, is that the issues of concern related to Morecambe Bay~~'s~~ <u>Trust's</u> problems in Lancaster, and particularly <u>their</u> relationships with GPs~~,~~<u>.</u> ~~n~~<u>N</u>ow I come back to it, in the middle of that year, almost exactly the same time the quality account for ~~Cumbria – for~~ that Trust was signed off by Cumbria PCT with a <u>lead commissioning</u> GP saying, 'We're satisfied with the quality apart from working times.'

PROF MONTGOMERY: So from your perspective it's the differences between the PCTs rather than about the Trust.

MR FARRAR: So I think that ~~whilst – and~~ we, again it comes back to this point, we did absolutely nothing to suppress any information that the PCT could have given to Monitor at that time.

PROF MONTGOMERY: I think the last few months I need to ask about are the end of 2011, so it's coming towards the end of your time.

MR FARRAR: So I left in April 2011.

1 PROF MONTGOMERY: Sorry, in which case I probably can't ask you about those
2 then, because I was just thinking about the summer then when the warning
3 came out, whether it was a surprise. But can I ask that question and you can
4 say you don't know if...
5 MR FARRAR: So was it a surprise? Well, no, because I think by the time we got to
6 the end of my tenure at the SHA things were starting to change and emerge.
7 And I think that – you know, I think that – and in fact I think in some of the
8 things – Pauline Fielding mentions some of those issues later. So it wasn't
9 surprising, of course, around that time in April 2011 the CQC had been in and
10 done a different inspection and said they were failing, they weren't compliant
11 with standards. And so I think that the – it wasn't a surprise, but I was even
12 less ~~cited~~ sighted then, because of Monitor took responsibility in November
13 2010 for the key relationships on quality, so I – and I – I know it's not for me to
14 speak ~~to~~ for colleagues, but I think the SHA then went into a different mode
15 because the evidence that was then present on their dashboard looked
16 different to that which it had when I was there.
17 PROF MONTGOMERY: Thank you. The only other thing I wanted to ask was the
18 SHA will have gone through an assurance process in 2009.
19 MR FARRAR: Yes.
20 PROF MONTGOMERY: What was the feedback on that?
21 MR FARRAR: I think the feedback ~~of it~~ on the SHA was that we had very good
22 relationships with our constituents. They found that we were very innovative,
23 they found that we had a good focus around quality improvement. They said
24 that the organisation should be sharper on some of its systems and processes.
25 There was a long conversation between myself and David Nicholson at the

1 time about the SHA's performance. It wasn't a difficult conversation; we
2 agreed that there were things that we could do to improve things. I think it was
3 – I think compared to where the others SHAs were it put us at the leading
4 edge for some things and it put us in the pack for some things, and it put us
5 with some work to do in others, and we absolutely did those. In fact there was
6 a kind of an action plan that we agreed that we put into place to try and
7 improve those, and we had – yes. So ~~there was a – you know,~~ it felt to be a
8 fair outcome.
9 PROF MONTGOMERY: And the things that you then improved on in the action plan,
10 do you recall what they were?
11 MR FARRAR: Sorry?
12 PROF MONTGOMERY: The things that were for improvement, so the ones that you
13 had in your action plan?
14 MR FARRAR: It was largely around, I think, how we structured some of our decision
15 making process around our management meetings. They felt that we could do
16 more to communicate to the rest of the organisation, so part of what we had
17 was a group of executives, very experienced executives, and some of the
18 people in the organisation said we weren't – we weren't as clear about some
19 of the decisions that we should have been. I mean they were – they were
20 deemed to be helpful comments. You know, ~~I can't –~~ I don't think ~~we –~~ we
21 ~~have~~ had any difficulty with believing them. We ~~should try~~ agreed as an SHA
22 to do better in the areas that they ~~did~~ identified, and ~~be~~ were pleased about
23 the things that they said we did reasonably well.
24 PROF MONTGOMERY: Thank you.
25 DR KIRKUP: Okay, Stewart?

1 PROF FORSYTH: Briefly, at the beginning you pointed out that the scale of the SHA
2 that you were chief executive of, and you have – I know you have contracts,
3 you've got the Greater Manchester area, because you have a very rural area
4 such as Cumbria. I just wondered whether possibly in hindsight that the vision
5 in your sort of – you mentioned about not being on your radar, but I wonder
6 whether in fact things could have been done differently to try and ensure that
7 what was obviously a large rural area, which has different needs, a very
8 different demographic and geography from the Greater Manchester area,
9 there's different needs, could have been established which might have taken a
10 different approach to the – what sort of health needs in that area, but also the
11 governance of the healthcare delivery in that area.
12 MR FARRAR: Well one of the issues I think is a problem for – was a problem for the
13 SHA in hindsight is that we often got aggregate data for the Trust. So that
14 Trust was off three sites, and therefore there was an aggregate that came in.
15 And of course, therefore it might have masked variation– so for example, we
16 know that the inverse care law applies massively in terms of those with
17 greatest need, and of course there were some real pockets of depravation in
18 Barrow, but when you looked across the whole of the Morecambe Bay area,
19 they may well have been masked, ~~but~~ compared to if we had site-specific data.
20 I also believe that when we looked at comparisons of fatality rates, that the
21 fact that for isolated units very often babies got transferred, and therefore
22 deaths would be recorded in other places, but didn't help ~~sort of~~ reveal if there
23 were problems in particular ~~areas~~sites. And I absolutely believe that we can
24 improve an understanding of maternal and child issues by having site-specific
25 information, and by having some way of recording where the presentation of

1 the baby and mum was in the first instance, rather than if it was transferred to

2 a specialist unit and got recorded as a death at that specialist site.

3 Now, that problem of recording must have been true across the whole

4 country, so at one level, had that been different in Morecambe Bay it ~~might still~~

5 may or may not have indicated something to them in terms of relative~~, right~~

6 rates? But I think your point is a very good one, that rurality, it seems to me, is

7 a big, big issue in some of the quality of care issues across this country. And

8 I've seen this more as I've come out to do national jobs. So Cornwall,

9 Staffordshire, North Yorkshire, Lincolnshire, Cumbria all have, I think, higher

10 than average problems around delivering healthcare. And I'd very, very

11 happily be on record saying I believe that problems of rural funding. –

12 ~~d~~Delivering rural healthcare ~~are~~ is under-resourced in the context of the

13 national health system. I absolutely believe that, and I think that – I've seen a

14 piece of work that said, after the event, because it was done by a consultancy,

15 but Morecambe Bay may well have something like a £15 million starting

16 problem each year as a consequence of having to deliver off three sites, which

17 is not recognised in its allocations or its contracts. So that where the tariff puts

18 money into the Trust, it doesn't recognise the logistical challenge of providing

19 rural healthcare. So I can't validate that, but that's just what I've seen. So I

20 think rural healthcare is an issue.

21 From an SHA point of view, were we interested in rural healthcare? I

22 think we were. I think we were; I think we tried to support quality so we didn't

23 exclude any of the Trusts from Advancing Quality. We didn't just go with a

24 partial group – we didn't exclude any of the Trusts from the collaborative. We

25 didn't exclude any of the leaders from accessing leadership development and

1 clinical development. We—you know, we—eEverything that we did was equal applied equally other than where there were systemic issues that we felt needed a particular programme, and so Greater Manchester wasn't Greater Manchester prioritised on the its children and maternal changes because it was urban, it was because its death rates were higher than the national average, and in the case of Morecambe Bay, they weren't.

7 And so in essence Greater Manchester, it wasn't a rural/urban thing, it was the fact that we were seriously concerned,– and the credit for the beginning of that, by the way, needs to go back to my predecessor, because it the programme was started before my time, but we could have very easily not taken that programme through, and in fact especially as we were under considerable pressure at one point from the current Government to drop some of its proposals, but we took it —on. wWe saw that as a big priority.

14 PROF FORSYTH: To go back to Cumbria, do you think that, again in hindsight, that the configuration of health systems that happen in Cumbria were beneficial or did they get in the way of delivering good care?

17 MR FARRAR: Cumbria is a hugely complicated area in its own right because it has this north/south component to it, and therefore...

19 PROF FORSYTH: My understanding is, and I'm struggling to understand the system, but I mean you've obviously got three Trusts.

21 MR FARRAR: Yes.

22 PROF FORSYTH: Two primary care trusts.

23 MR FARRAR: One primary care trust.

24 PROF FORSYTH: One primary care trust; two commissioners involved, well...

MR FARRAR: Well, local authority and the health service. And we have North Lancs and – yes.

PROF FORSYTH: Yes, for what is, you know, a relatively low population with clearly rural issues and approaches, it seems to me – integration seems to be the – would help to try and concentrate the sort of expertise on the needs of the people.

MR FARRAR: Well – so I think integration is an interesting point because Cumbria PCT did take some action around diabetes management to have a whole Cumbria approach to that, and in fact – I can't guarantee this to be true – but I have a recollection, so – that actually Cumbria PCT went for a whole children's services approach, tendered for a whole children's service approach, and actually Morecambe Bay Trust were considered a serious candidate to provide that. So again, coming back to the PCT thing, the Trust was not ~~[inaudible]~~ considered problematic whereas they decided they were going to ~~be~~ focus on North Cumbria.

But this whole Cumbria ~~thing was born because for~~ complexity relates to the fact that most of the care for North Cumbria, the route was across to Newcastle, and for most of the care around Morecambe Bay it was down into Preston and Lancaster. So it didn't often make sense to take a whole of Cumbria approach. But I mean – so the one bit that I'd probably say was a recognition on our part of trying to help Cumbria and its complex rurality was – I'll go back right to the beginning about the £28 million that we put into Cumbria that they would have otherwise had to find by taking money out of services. So we recognised right from the word go that Cumbria was different.

1 Our performance management approach, this compact, and about why
2 we had meetings with Cumbria especially, was about how do we help? It
3 wasn't to ~~sort of like~~ beat people up, it was ~~like~~, 'What can we do that would
4 help more?' And all the focus from the PCT was, 'Help us with North Cumbria.'
5 And I helped a lot around supporting them with their MPs around the
6 Whitehaven development, so I spoke to the MPs, went there on a number of
7 occasions. I helped a lot with putting in some business case to get money
8 when they had floods, which was a big issue. I went up first when we'd had
9 the Cumbria rail disaster to thank and support the Ambulance Trust for the
10 work that they did. So we did ~~kind of~~ recognise it in trying to support it, but
11 Cumbria PCT wasn't a great one for asking for help. They liked to be
12 autonomous, they had strong leadership. Sue's approach, she was probably
13 the least participative ~~of~~ in regional things because she believed that Cumbria
14 could do its own thing, and she – you know, she probably ~~what~~ felt that what
15 we were trying to do was not always what she needed. But I – you know, and
16 I thought she was an experienced chief executive and tried to give her space
17 to do her job.
18 PROF FORSYTH: Okay, thank you.
19 DR KIRKUP: Just some points to pick up from what we've already talked about. You
20 described a very supportive relationship where you trusted the Trusts to do the
21 right thing, and I absolutely understand that. But how do you guard against
22 getting too close and too cosy so that you don't spot when there are problems?
23 MR FARRAR: Yes, and I think that is a judgment that you're making all the time.
24 And it's a judgment based on the evidence available to you. So in the case of
25 Tameside, we took the view, when the Coroner said, 'There's been four

1 deaths here and there is real negligence,' we took the view that we did not
2 trust the Trust to do its own internal investigations. We externalised that; we
3 took responsibility; we said we were going to do it. When we had nine Trusts
4 in the lowest performing category on HMSRs, we said, 'We're not going to
5 allow you to just do your own improvement, we're going to put on this
6 collaborative where effectively we are going to give you skills to improve.'
7 We had specific incidents in other organisations where we went in,
8 some of them related to primary care provision. So the case of
9 which was a big one, that we went and talked to all the families and we
10 conducted ~~that~~ the interview ourselves. So ~~we —~~ there was a judgment all the
11 time about where we are, but it wasn't cosy to the extent to which we couldn't
12 demonstrate that when something significant was happening we didn't
13 intervene.
14 DR KIRKUP: So there's two things there that you described as kind of warning
15 signals. One of them was external data, and I appreciate that that doesn't
16 really apply in the case of Morecambe Bay. But another one was external
17 reports, and that does apply, doesn't it? So why did you take a different
18 judgment in the case of Morecambe Bay that they could deal with it
19 themselves?
20 MR FARRAR: Which is that report – would you...
21 DR KIRKUP: Well the series of untoward incidents would be one.
22 MR FARRAR: Well we were taking action~~, so t~~The SHA and the PCT effectively ~~was~~
23 were leading on this, I think, Professor Ashton chaired a meeting of the SHA
24 and the PCT to effectively set in train action plans to pick up on all of the

1 recommendations that came out of the analysis on the untoward incidents. So
2 in essence, what we didn't do at that point is commission our own review.
3 DR KIRKUP: Yes.
4 MR FARRAR: We agreed, and suggested to the Trust that they have a review by an
5 external person, but we were pursuing throughout that entire time their
6 progress around how they were taking forward the recommendations on
7 untoward incidents.
8 DR KIRKUP: Okay, but when we were talking about the Fielding Report, for instance,
9 I mean that was the time when you said you trusted the Trust to do the right
10 thing. I was wondering why you made a different judgment in the case of
11 Morecambe Bay than you did in...
12 MR FARRAR: Because I was led to believe that throughout the first part of that year
13 they were doing the right thing against the insights and feedback information
14 that they had already been given. So there's two things there.
15 One, they commissioned a second review, which I think has to be
16 creditable. Now what they did with it I think is not as creditable, but what they
17 commissioned, you know, to commission that review, I think was creditable.
18 When they – all I can say is what I was effectively led to believe was
19 happening with the untoward incidents was that they were being progressed
20 and recommendations were being put into place. And I think that at the
21 beginning of Pauline Fielding's Report, which I hadn't seen at the time, as I
22 said, but when I look back and say, 'Did we miss something? Should we have
23 done something else? Could we have done something different?' she seems
24 to agree that the recommendations were being put into place. And I – so if ~~my~~
25 an external person, or the external person agrees that, to be true and CQC go

1 in and do their own unannounced visit and agree that ~~,~~ to be true and therefore

2 ~~it's not told me that~~ I'm not told that anyone including importantly CQC found

3 systemic failure, the actions that I think we were taking look appropriate.

4 ~~which was~~ And so, what we did was to make sure for the untoward incidents,

5 having said that they weren't connected, we then had to say, 'But ~~there were~~

6 ~~problems~~ these still reveal,' and so we needed to see those things fixed.

7 But for the untoward incidents, the action plans according to what I was

8 told were effectively ~~— they were~~ being put into place.

9 DR KIRKUP: Okay. The basis for deciding – I know it wasn't your decision, but the

10 basis for deciding that these untoward incidents were unconnected appears to

11 be that they've followed a different clinical pathway in each case. Something

12 clinically went wrong in each case. Is that your understanding?

13 MR FARRAR: That's my understanding of how that ~~— that~~ was the basis for the

14 judgment. The process by which the SHA took that I'm less clear of.

15 DR KIRKUP: No, I understand that. It's the judgment.

16 MR FARRAR: But I come back to the point that I had very, very experienced

17 clinicians who had been involved in very serious incidents previously, like

18 ~~[inaudible]~~ Tameside, who had very clear roles, and I believed that if they

19 thought that there was a cluster in the sense of – that where clusters were

20 deemed to be clinically connected, that they would have told me, and we

21 would have taken a different path.

22 DR KIRKUP: Yes, you've said clinically connected again there, and I accept that in

23 some cases you can have a cluster of incidents that are clinically connected.

24 But in other cases you can have a cluster of incidents that are behaviourally

25 connected. They're a result of the same sort of behavioural relationship

1 problems within a unit but they express themselves in different things going

2 wrong at the very last stage.

3 MR FARRAR: Yes. I think that's probably true. And I would have believed that

4 that's what would ~~have been – that would~~ have been considered as part of the

5 decision at the time to treat them as a series of untoward incidents. I mean

6 they were –treated as one lot~~,~~. ~~t~~They were being grouped together because

7 the process of assessing the actions plans that came out were being handled

8 together~~,~~. ~~b~~But ~~I – and~~ in that year, ~~so if – should I have known,~~ for example,

9 on volume ~~that there was a problem, well there~~ there were 2,000, I think,

10 untoward incidents reported to the SHA ~~in that year.~~ from across 40 provider

11 organisations.

12 So five around a service – you know, do I think that we should have –

13 did we take a reasonable decision? I think we probably did. Do I wish we'd

14 have taken a different view? Yes, I do, because I think that had we taken a

15 different view we might have been able to get to a deeper understanding

16 sooner, ~~and~~ – but ~~I – you know,~~ do I think that any of those senior clinicians

17 did their job badly? I think that's very hard to say that. ~~You know, I – I think~~

18 ~~they – and, you know, t~~That's why this investigation is so important because I

19 think the key thing is, if this was to happen anywhere else in the country and

20 similar things were occurring, what would trigger something that might ~~leave~~

21 lead the authorities to take a different view is absolutely crucial. I can't do

22 anything for the families about bringing back their children or…

23 DR KIRKUP: No, we understand that.

24 MR FARRAR: But we can find a way of –improving insight and so I think, you know,

25 that's entirely material.

1 DR KIRKUP: Okay. I go back for a moment to the relationship between the SHA
2 and the Trust. When you have a supportive relationship and you're watching
3 out for signs that you might have to modify that stance a bit, one of the things
4 that people often describe is when the flow of information starts to dry up and
5 the Trust starts to put its arms around the information a bit. Did you pick up
6 any signs of that in Morecambe Bay?

7 MR FARRAR: Well, what I understand – and again, this is something that I spoke to
8 Angela Brown about, was that their original untoward incident reporting was
9 quite low, but actually, one of the things that she believed was helpful in the
10 context of that Trust is it started to increase. So I've not got the data
11 specifically by Trust for untoward incidents, but I think it was something that
12 concerned us. But on the back of things like the Flynn Report and the
13 emergence of the problem around ~~the four~~ that time, they did start to report
14 more untoward incidents. That's as I understand it. I didn't have in front of me
15 the data that absolutely corroborated that, and I wish I could go back to find it,
16 but I can't, but I believe that to be the case.

17 DR KIRKUP: It might not just be a question of data. I mean let me put it to you;
18 other people have described to us a pattern where the Trust were pulling up
19 the drawbridge. They were in denial; there were no problems. You didn't pick
20 that up? None of your officers picked that up?

21 MR FARRAR: I don't know whether that's what was picked up. I think – I think it
22 would be true to say that the Trust was – was incredibly keen to become a
23 Foundation Trust. And I think ~~that they were drive – I think they~~ they were
24 trying very, very hard to become an FT, and I think whilst in the case of these
25 specific incidents, ~~you know,~~ they – I am led to believe that they were being

1 fully open in terms of the action plans for these incidents. But I – but I think
2 that they – I think if there was anything driving the mindset of the leadership
3 was that – was that desire. And I – it – you know, I go back to where I started
4 before, it really wasn't something that we colluded in ~~a battle~~ at all.
5 DR KIRKUP: Okay. You've talked a bit about the relationship between the SHA and
6 the CQC.
7 MR FARRAR: Sorry, can I come back to one point, because it's – I don't know
8 whether you're going to raise this or whether or not you deem it fit, but I do
9 know, because of social media that there is a report of a conversation I had
10 with the chair of the Trust, which was not in my words and ~~it's not — that I —~~
11 that suggests that I would do anything I could to help the Trust become an FT.
12 I just want to say absolutely for the record that my job was to enable Trusts to
13 become FTs, so therefore saying I would do something to help them was not
14 inconsistent. But what I would absolutely not do is anything to – illegal or false
15 to enable someone to become an FT that shouldn't have been an FT. So I
16 didn't say, 'I can help anyway I can't,' which is the phrase. I said I would help
17 in ways that I could.
18 As it happens, I don't believe that there were any actions that then
19 followed in which I was able to be that helpful. So I want to just address that
20 because if you're not going to raise it with me but I know that people think that
21 that is somehow — what happened, that is absolutely not the case that I would
22 have done anything illegal or inappropriate to help any Trust become a
23 Foundation Trust. It simply wasn't that important.
24 DR KIRKUP: I think the important thing is…
25 MR FARRAR: And I've never done that in my life.

1 DR KIRKUP: Okay, I accept the point about illegality. I don't think there's any
2 question of that, but you describe lots of processes that depend on the
3 application of judgment. And the key question is, is there a possibility that that
4 desire to be helpful in the Trust's process of becoming a Foundation Trust
5 might have shaded those judgments?
6 MR FARRAR: Shaded my judgment or their judgment?
7 DR KIRKUP: Either or both.
8 MR FARRAR: I don't think it shaded my judgment. And I can absolutely say, you
9 know, that I had I been aware that the Trust was deliberately trying to –
10 conceal anything and it'll be for you to decide whether or not you think it did –
11 to keep any information away from Monitor, as it would have been in this case,
12 or indeed CQC, then I would have absolutely been on the phone to Monitor
13 and CQC, irrespective of the fact that they weren't interested in my opinion, I
14 would have been on the phone to them saying, 'There is a serious problem
15 with this Trust.'
16 DR KIRKUP: In the run up to Foundation Trust status, you were – or your SHA was
17 having conversations with the CQC about the Trust and about the level of risk
18 attached to the Trust. And you described a process where you took
19 reassurance from the fact that the CQC were regarding it as making
20 improvements. It's on record, I think, that the CQC say that they took
21 reassurance from the SHA that things were improving in the Trust. It sounds
22 as if you each were reassuring each other.
23 MR FARRAR: So this is really – this is a really important point because it was
24 entirely the job of the SHA to give the CQC every bit of information we had
25 about the Trust. The CQC have a responsibility as an external inspectorate to

1 determine whether that Trust should have been licensed, and whether or not it
2 was deemed to have met its standards. So taking reassurance from me – well
3 one, I don't remember any conversations with the CQC. They might well have
4 spoken to my people, but my people should have effectively given them all the
5 information that we had.

6 The CQC has the ability to go into hospitals, to spend time on the wards.
7 Indeed they did that for a whole day in June, and concluded that there weren't
8 problems. I do not accept that the SHA was ~~either~~ giving false reassurance...

9 DR KIRKUP: I wasn't suggesting that.

10 MR FARRAR: No, but there is an implication. I'm really sorry, sir, I'm...

11 DR KIRKUP: It's all right, I appreciate that you find it frustrating.

12 MR FARRAR: I'm trying not to be defensive, I really am.

13 DR KIRKUP: I appreciate that you find it frustrating, but I have to put these points to
14 you.

15 MR FARRAR: Of course, of course, and it's absolutely right that you do. The
16 assurance process had to be that we gave all the information we could about
17 that Trust to CQC. CQC decided whether that information met their own.
18 They had the opportunity to go into the Trust. They had the opportunity to test
19 our assumptions against anybody else's assumptions. They had powers that
20 we didn't. We were not an inspectorate. You know, what I expect of the
21 people in the SHA, and I've no reason to believe they didn't do this, was to
22 give CQC all the information that they had, hard and soft about the Trust. And
23 then CQC legally had the responsibility to take action.

24 And if CQC concluded that they the Trust weren't doing their job
25 properly and they should be licensed with conditions, it then came back to us

1 to make sure that they were going to improve. And that's the way it should
2 have worked, so I – that was why I was so upset with the Grant Thornton
3 Report, because it implied that the way round was a different way round. It
4 wasn't; we weren't an inspectorate. We have no powers of inspection.

5 DR KIRKUP: No, I understand that. Okay, the last thing from me is – and I'll ask my
6 colleagues if they want any further follow up, it's another point about this
7 reassurance that things were improving. And you're not the only person to say
8 that they read the Fielding Report and took it as reassuring. I have to say,
9 there's a very different way of reading it, which is, yes, there were some things
10 that were getting better, but here's a long list that require to be addressed.

11 MR FARRAR: Yes, and I agree with that. So when I read the Fielding Report, which
12 was well after...

13 DR KIRKUP: After the event.

14 MR FARRAR: ...after the event, what I effectively saw was some points that said,
15 'There are some good things about this Trust,' and because the things about
16 the Trust that she said were positive related in part to the responsibility that my
17 organisation had ~~had around that — the~~ two things in particular~~,~~: ~~was Pauline,~~
18 ~~d~~Did she feel that they were making progress against their untoward incident
19 action plans? She says right up front, and I've no reason to believe she would
20 have put that unless she believed it, 'Yes, I think they were.' If she'd not been
21 ~~cited~~ sighted on it I don't think she would have necessarily commented. That
22 was my reading.

23 And the second thing was that she does actually describe this issue of
24 judgment about the connectivity of the cases and she says, 'I think that was a
25 reasonable ~~thing to do~~ judgement to make,' as far as I read that. Now, when

1 you go into ~~these~~ other things, and I've now gone into them, there are things – 2 all kinds of issues – so one is the journey time between units, and is there a 3 place for the midwives to eat their food? You know, so at one level there's 4 some things, good things, some small but then there's another one which 5 frankly would have worried me enormously. It says, 'The Trust has got no 6 concept, or it's got a very poor concept of clinical governance.' You know, ~~that~~ 7 ~~would have~~ — that is a very damning bit of the Fielding Report, which no one 8 should take any assurance from at all. Frankly, that – as I say, had I been 9 aware of that and seen that and said, 'There's ~~no~~ an issue with clinical 10 governance,' I think that is something that would have triggered a different 11 reaction from the SHA.

12 DR KIRKUP: Okay. Jonathan.

13 PROF MONTGOMERY: Just one. You've explained why there wasn't pressure to 14 become an FT from the SHA. Who was so keen to become an FT in the Trust? 15 Was it just the chair and chief executive or...

16 MR FARRAR: Well it was the chair and chief execs who expressed it to me. I can't 17 say that I had any conversations with anybody else in the Trust about that. 18 And there weren't a lot of conversations, but I mean it wasn't that there was a 19 constant haranguing; it was they were frustrated because they believed, I think, 20 and it'll be your judge if they reasonably believe d, but I believe they thought 21 that they were doing what they needed to address the issues which had been 22 presented to them on the untoward incidents.

23 PROF MONTGOMERY: And was your sense from the Board-to-Board that the 24 whole Board was really keen or were they following the lead?

MR FARRAR: To be honest, I can't remember the Board-to-Board, and I don't know whether I was at that one. We did Board-to-Boards for probably 16 or 17 Trusts. I can't – I don't know. ~~[David Henshall?]~~ David Henshaw and myself at the time split ~~or – you know~~ the assessments~~,~~. ~~w~~We chaired ~~an occasional~~ on occasions, or the other non-executives chaired, depending on how difficult they were~~,~~. ~~b~~But ~~I –~~ most Boards were, I think, keen to become FTs because it had a kind of element of 'We've got our status now and we can operate as a Foundation Trust'.

PROF MONTGOMERY: Thank you.

DR KIRKUP: Stewart?

PROF FORSYTH: No.

DR KIRKUP: Would you like the opportunity to talk to us about any of the individual issues that you touched on? In which case we'll ask the observers to leave, or do you think we've covered the ground?

MR FARRAR: No, I apologise for raising those issues in the way that I did. I hadn't intended to cause offence to anybody.

DR KIRKUP: No, no, I think that I was stopping you just in case you might have, but I don't believe that you did. Is there anything that you would like to tell us?

MR FARRAR: Only that this ~~is a –~~ and its what I said to James when I met him, which is I think is mine to say ~~because it was – you know, I don't –~~ I've got four children, and they're fab, and I had actually incidences of having a couple of, you know, pregnancies that didn't go full term. That's about as close as I can get to understand what it must be like if you lose a baby. If you lose a mum as well, it must be terrible. I came to the North West, my family are in the North West, my parents – my dad still lives there. My mum died sadly, but got good

care. My family are there. I wouldn't do anything to harm good patient care.~~–~~ I was delighted to get the North West job because I thought I could do something for people who had very poor health, and some quality of care wasn't as good as it should be.

I've been mortified about the fact that ~~we didn't — you know, I fully accept~~ the LSA's first investigation was poor. I think the second investigation didn't do the job and it should have been better, and I apologised at the time, and the ombudsman said we should have done better. I apologise again now. I do believe that we tried really hard with the third investigation to do the right thing and to find the right way to do it, and I believe that we took a decision not to complicate things when the NMC became involved, and the police and everybody, and I think looking back, that was a reasonable thing to have done. But I am so, so sorry that we – in the cases of the families that the NHS let them down.

And I just really – I have said on record I welcome this investigation. If you can help to improve things so that in the situation that we were in, we came to a different judgment ~~as to~~ so we could look at things differently for the future that would be a great outcome~~,~~. ~~and~~ I think you can, because I think there are things that are so much better. I think the CQC inspection regime is so much better and more robust now. But I'm still not certain in the new system ~~where~~ whether the ~~scrutinising~~ regulatory system is right, and I worry about that. I think the NMC ~~—~~ especially what the ombudsman said about the regulatory process for professionals needs to be implemented.

But I just wanted to say I'm deeply sorry.

1 DR KIRKUP: Thank you. And that's the end of the interview. Thanks very much for

2 coming.

3 [Interview Concluded]

THE MORECAMBE BAY INVESTIGATION

Wednesday, 21 May 2014

Held at:
Park Hotel,
East Cliff,
Preston
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Before:

Dr Bill Kirkup – Chairman of the Investigation
Mr Julian Brookes – Expert Adviser on Governance
Dr Catherine Calderwood – Expert Adviser on Obstetrics
Ms Jacqui Featherstone – Expert Adviser on Midwifery
Professor Stewart Forsyth – Expert Adviser on, Paediatrics
Professor Jonathan Montgomery – Expert Adviser on Ethics
Professor James Walker – Expert Adviser on Obstetrics
Dr Geraldine Walters – Expert Adviser on Nursing

Professor Dame Pauline Fielding DBE

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1 [11.02 a.m.]

2 DR KIRKUP: Hello. Thank you for coming. Thanks to everybody who's able to
3 come today. I'm grateful to you for making time in a busy diary to come and
4 talk to us. I'm Bill Kirkup. I'm the Chair of the investigation and I'd like to start
5 by asking each of the other Panel members to introduce themselves to you,
6 please.

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

10 DR WALTERS: I'm Geraldine Waters and I'm Director of Nursing at King's College
11 Hospital NHS Trust.

12 PROF FORSYTH: My name's Stewart Forsyth. I was recently consultant
13 paediatrician and medical director in Dundee.

14 MR BROOKES: I'm Julian Brookes. I'm Deputy Chief Operating Officer with
15 Public Health England, with a background in governance.

16 PROF MONTGOMERY: I'm Jonathan Montgomery, Professor of Health Care Law
17 at University College London, I also Chair the Health Research Authority, but I
18 have a background as a chairman of a PCT and SHA in the past.

19 MS FEATHERSTONE: I'm Jacqui Featherstone. I'm Head of Midwifery and Head of
20 Nursing for Women's Health at a district general hospital in Essex.

21 PROF WALKER: I'm Jimmy Walker; I'm Professor of Obstetrics and Gynaecology
22 at the University of Leeds.

23 DR KIRKUP: Thank you. I should just explain that Jimmy has kindly agreed to help
24 us out as an associate Panel member, for the record, assisting on expert

1 advice particularly on obstetrics, but we'll no doubt draw on your experience in
2 other things too, thank you. Only the Panel will be asking you questions.
3 We have a family member here and I'm glad to see you, thank you for coming
4 along. You'll note that we've got microphones, which occasionally work, on the
5 tables and we'll do our best to make a full recording of questions and answers.
6 This is partly so that we can produce an agreed record with yourself of what's
7 been said and what you've asked, and it's partly so that other family members
8 who may not be able to or may prefer not to come along today can listen to the
9 transcript. So I think you understand that and we'll put a summary note on the
10 Panel website when we can.
11 You will know that you've been asked to hand over mobile phones and
12 electronic devices. This is because we are particularly keen to make sure that
13 what is produced as a result of this investigation is produced as a whole and in
14 context and that we don't have any partial releases of any information. All of
15 us, including the Panel members and any other attendees, are operating under
16 exactly the same strictures.
17 I don't think we're expecting any test fire alarms, so if there is a fire
18 alarm it'll be the real thing and somebody will help us to go to the right place,
19 wherever it should be.
20 Do you have any questions for me about the process?
21 DAME PAULINE FIELDING: No, thank you.
22 DR KIRKUP: Thank you. In that case, I'll hand over to Jonathan and see if we can
23 make this work. Yes.
24 PROF MONTGOMERY: Thanks, Dame Pauline, for coming. I've got the lead

1 amongst the group for sort of understanding the relationship between the Trust
2 and the external reports and agencies there, so I get to start the questions, but
3 colleagues – at sort of each phase there'll be a natural break and there may be
4 other questions that come in.

5 I'd like to start by asking you just really how it all got started, so how
6 you first became involved and I'd just like to work through and ask you a few
7 questions later on about how you gathered your evidence and how the report
8 was finalised and then tracing through what was done with it afterwards. But if
9 we could just start right at the beginning of your involvement and how you first
10 got involved that would really helpful.

11 DAME PAULINE FIELDING: Certainly. I was approached in the summer of 2009 by
12 Angela Brown who was an assistant director at the Strategic Health Authority
13 NHS North West and she asked me if I would be willing to lead a review into
14 maternity services in Morecambe Bay. I was a little bit hesitant because I'm
15 not a midwife, but she confirmed that what they were looking for was
16 somebody who'd got experience in managing an investigation and that the
17 Trust would be providing two clinical experts, a midwife and an obstetrician, to
18 work with me. So on that basis I agreed to undertake – to lead the review.

19 I then had a meeting with the Chief Executive of the Trust,
20 Tony Halsall. I wrote the – there were no terms of reference, so I wrote the
21 terms of reference for the Trust and they were agreed by the Chief Executive.

22 It took a while for the Trust to find the midwife and the obstetrician and
23 so they were not identified, I think, probably until October 2009. We tried to
24 start the investigation, I think – it is quite a long time since now, so you'll have

1 to forgive me if my memory is not that accurate, but I think we tried to start the
2 investigation before Christmas, but that winter was particularly bad and there
3 was a lot of snow and ice around and the obstetrician couldn't get to us on the
4 due date. And so the start was delayed, I think, until January and continued
5 until March. Do you want me to go into how we carried out the review now
6 or...?

7 PROF MONTGOMERY: I think if you unfold the story and then I can go back if you
8 don't cover some of the things, because we'd like to hear it as it was to you.

9 DAME PAULINE FIELDING: Yes. I did suggest to the Trust that this would be a
10 very limited review given the resources that we'd got available to us. And I also
11 suggested to the Trust that requesting another review from the
12 Healthcare Commission might actually be a better way forward to do what they
13 seemed to want to do. The Trust didn't want to involve the
14 Healthcare Commission again and I was a little bit concerned about that, but
15 we went ahead. We went ahead with the review, but on the understanding
16 that, you know, with only three people it was actually going to be quite a limited
17 review. We didn't have any statistical support. In fact, the support that we had
18 from the Trust in terms of administering the review was actually quite limited,
19 so it was quite difficult to identify the people we wanted to interview. The
20 clinical staff were very willing and keen to talk to us, management less so and it
21 took us until March, I think, to conduct the interviews with the staff and do the
22 visits that we did to each of the clinical sites.

23 We then – between the team we agreed on what our
24 recommendations would be and submitted a report to the Trust in June 2010 –

sorry, in March 2010 and there were a couple of amendments that the Trust wanted us to make. These were actually quite minor and didn't affect our recommendations, but we submitted the final report in August of that year.

When I agreed to undertake the review, my understanding was that we would return after a period of, say, six months to look at what progress had actually been made against the recommendations. The Trust didn't commission that return review – that follow up review and so I really can't tell you what the Trust did with the report.

PROF MONTGOMERY: Perhaps we'll come back to that later on. That's really helpful and sketches out a number of the areas that we wanted to hear a bit more about.

Can I go back to the commissioning process and you were approached by the Strategic Health Authority?

DAME PAULINE FIELDING: Yes. I'd done work for them before, so...

PROF MONTGOMERY: We're finding it quite hard to get an understanding of how the different organisations related to each other on this. So you've identified that SHA APPROACHED YOU ~~you approached the SHA~~, but the Trust had clearly done some – had to make some sort of commitment to finding support for this already. Can you elaborate a little bit on what your understanding...?

DAME PAULINE FIELDING: Well, my understanding of what had happened was that the SHA had been in conversation with the Trust about the need for a review to identify improvements that the Trust could make and the SHA had suggested that I would be an appropriate person to lead that review. And because I had done previous work for the SHA, I presume that's why the initial

1 contact came from them.

2 PROF MONTGOMERY: And as you shaped the terms of reference and worked that
3 through, were the SHA still involved in that?

4 DAME PAULINE FIELDING: No. No, the SHA were only involved in terms of the
5 initial contact asking me to undertake the review. At least that's how I
6 understood it. As far as I'm aware, they weren't involved at a subsequent
7 stage.

8 PROF MONTGOMERY: And were they at all involved in the later stages of your
9 work? Did they see any of the drafts? Did you go back and interview them or
10 was it all between you and the Trust at that point?

11 DAME PAULINE FIELDING: No, it was all through the Trust, yes.

12 PROF MONTGOMERY: Thank you. And can you say a bit more about the early
13 discussions with the Chief Executive Tony Halsall and particularly how the
14 terms of reference developed? You said that you drafted them, but –

15 DAME PAULINE FIELDING: Well, I had a conversation with Tony Halsall who... His
16 view was that there had been these five serious untoward incidents, which he
17 was very specific about the fact that this review was not to reinvestigate those
18 incidents. That those incidents had been investigated and that part of the story
19 was over and that what he wanted us to do was to ~~look at the review~~ – look at
20 the service and identify ways in which the service could be improved. So the
21 emphasis was on improvement, not investigating the things that had gone
22 wrong, although he did make the reports that had been carried out into the
23 incidents, he made those available to us. The Trust were very specific about
24 the fact that we were not to reinvestigate those.

1 PROF MONTGOMERY: And what was your impression of those reports?

2 DAME PAULINE FIELDING: They were quite brief.

3 PROF MONTGOMERY: Were there action plans that went with them that you saw?

4 DAME PAULINE FIELDING: I can't remember.

5 PROF MONTGOMERY: You can't remember. And did you discuss those just with

6 Tony Halsall or was there a group of directors or the Board? We're trying to

7 understand what the Board's engagement was with this, whether it was an

8 executive initiative or a board initiative.

9 DAME PAULINE FIELDING: I only discussed it with the Chief Executive.

10 PROF MONTGOMERY: And do you know whether the Board discussed the remit

11 that you were taking on or was that an agreement between you and the Chief

12 Executive?

13 DAME PAULINE FIELDING: It was an agreement between myself and the Chief

14 Executive. I had the impression that the Board had agreed, but I don't have

15 any specific evidence of that.

16 PROF MONTGOMERY: And did you have any contact with anybody else on the

17 Board other than the Chief Executive?

18 DAME PAULINE FIELDING: Yes: we interviewed the Medical Director, the Nursing

19 Director and a Non-Executive Director.

20 PROF MONTGOMERY: You don't happen to know which Non-Executive Director.

21 DAME PAULINE FIELDING: I can only remember that it was a woman. I can't

22 remember her name.

23 PROF MONTGOMERY: Thank you. And can you give us a bit of a flavour of where

24 you thought they sat, those three, in terms of the Board's engagement with the

1 issues that you were looking at?

2 DAME PAULINE FIELDING: I'm not sure I understand your question.

3 PROF MONTGOMERY: We're trying to understand where this sat in the profile of

4 the Board's picture of – so you've described a picture where the Chief

5 Executive is saying there has been an investigation into five incidents, they've

6 got that being handled in a different way, it wasn't for you. And so we're trying

7 to understand how the Board saw that picture and we wondered whether, when

8 you spoke to the Medical Director, the Nurse Director and Non-Executive

9 Director, those conversations felt as though this was about Board assurance or

10 whether it was about trying to get to the bottom of how the service could be

11 improved separately from assurance about what had happened in the past. If

12 you don't recall then you don't recall.

13 DAME PAULINE FIELDING: I would think the emphasis was on improvement of the

14 service rather – because we weren't reinvestigating those cases, so we didn't

15 discuss those cases when we did our interviews, so I think our only focus was

16 actually on improvement of the service.

17 PROF MONTGOMERY: And the terms of reference, you said that you drafted them.

18 Was that after the conversation with the Chief Executive?

19 DAME PAULINE FIELDING: Yes, it was after the conversation with the Chief

20 Executive.

21 PROF MONTGOMERY: So you take from that what he was looking for and you

22 crafted those into a set of terms of reference.

23 DAME PAULINE FIELDING: Yes.

24 PROF MONTGOMERY: And was he immediately happy with those? Was there a

1 process of amending them or –

2 DAME PAULINE FIELDING: No.

3 PROF MONTGOMERY: So you proposed those and he was happy with them.

4 DAME PAULINE FIELDING: Yes.

5 PROF MONTGOMERY: You said a bit about the resourcing of the process. It
6 would be really helpful for us to have a sense of, given an agreed terms of
7 reference that the Chief Executive had accepted, how you went about checking
8 whether the Trust was going to enable you to meet those terms of reference.
9 So, in general terms, you said you didn't have much resource, but perhaps you
10 could spell out a little bit more the administrative resource that you had to
11 support you.

12 DAME PAULINE FIELDING: We had access to a secretary in the secretariat. It was
13 quite difficult to get staff lists to identify who we wanted to interview. It didn't
14 seem to be a terribly high priority for that person and it was quite difficult.

15 PROF MONTGOMERY: And we saw from the report that you actually managed to
16 do quite a few interviews. Were there interviews that you wanted to do that
17 you couldn't do?

18 DAME PAULINE FIELDING: I think we would have liked to have interviewed more
19 of the Trust Board, but it was very difficult to get access to them.

20 PROF MONTGOMERY: Difficult because of the time or the reluctance?

21 DAME PAULINE FIELDING: Time commitments; they were always busy doing
22 something else.

23 PROF MONTGOMERY: Thank you. The other big thing I think we are slightly
24 confused about having read the report and it's sort of partly shaped, that is who

1 the report was for. So it was initiated in conversation between the SHA and the
2 Trust. Your contacts with the Chief Executive, your understanding is that the
3 Board was aware. Can you just take us through who they key audiences were,
4 as you understood it, that you were being asked to write for? So was it going
5 to be a Board paper, was it going to be a public report, was it for the staff
6 planning services? A bit of a sense of what the commission felt like from
7 Tony Halsall.

8 DAME PAULINE FIELDING: I wrote the report for the Chief Executive, well, for the
9 Trust Board. I expected to be able to discuss that report with the Trust Board;
10 that didn't happen. And I expected that there would be a process of
11 engagement with staff following the report, to take it further in terms of how
12 they were going to implement it and what would happen. None of that took
13 place.

14 PROF MONTGOMERY: Thank you. And did you think that the Chief Executive
15 shared those expectations when you started the process?

16 DAME PAULINE FIELDING: Well, with the benefit of hindsight, no. I did think at the
17 beginning, but perhaps quite naively.

18 PROF MONTGOMERY: So, just to make sure I've got that right, because I think
19 that will be really important for us to think about. So the immediate discussions
20 on the task were with the Chief Executive. Your expectation, which you
21 understood he shared, was that it was an intense piece of work which would be
22 followed by some form of presentation/discussion with the Trust Board and
23 some opportunity to engage with staff.

24 DAME PAULINE FIELDING: Yes.

1 PROF MONTGOMERY: And then there would be some follow up work at a period
2 to be agreed later on where you'd come back and see what had happened with
3 that. When did it become apparent to you that those things weren't going to
4 happen?
5 DAME PAULINE FIELDING: I think most clearly after I'd submitted the report.
6 PROF MONTGOMERY: Thank you. One other bit about the origins of the report
7 and then I'll check what other questions people have got and then we'd like to
8 hear a bit more about just the processes by which you were to gather
9 evidence. If I've understood you correctly, your principal relationship in the
10 commissioning is with the Chief Executive.
11 DAME PAULINE FIELDING: Yes.
12 PROF MONTGOMERY: So the Medical Director, the Nurse Director, Non-Executive
13 Director, they were interviewees as opposed to key people you were working
14 with about the report as a whole. Have I understood that correctly?
15 DAME PAULINE FIELDING: Yes.
16 PROF MONTGOMERY: And how often did you see the Chief Executive, just at the
17 beginning and the end or were there periodic conversations?
18 DAME PAULINE FIELDING: No, not regular conversations; right at the beginning
19 and, I think, one more time after that.
20 PROF MONTGOMERY: Okay. And you can't recall how far through the process
21 that was.
22 DAME PAULINE FIELDING: It was towards the end.
23 PROF MONTGOMERY: Thank you. I'll come back in a minute with the process
24 questions, but, Chair, I don't know whether there's anything else.

1 DR KIRKUP: Okay. Let's ask whether anyone else has any questions on the origins
2 of the report. Catherine.
3 DR CALDERWOOD: Thank you; that's been very helpful so far. When you were
4 having conversations with the Chief Executive about this, did you feel that
5 there had been any clinical input into the reasons why he was asking that?
6 Was there any sense that the Medical Director or other members of medical or
7 midwifery staff were wanting something like this to be done?
8 DAME PAULINE FIELDING: My impression was that the Trust felt that something
9 had to be seen to be done on the serious untoward incidents and that it was
10 just necessary to be seen to be trying to improve the service. I don't think I
11 could comment on how much clinical feeling there was right at the beginning.
12 DR CALDERWOOD: Thank you.
13 DR WALTERS: Was anybody you spoke to – Medical Director, Nurse Director, at
14 the Board level – did they give you the impression they were worried about
15 service?
16 DAME PAULINE FIELDING: Not overly.
17 DR WALTERS: Right. So did you think they were trying to reassure you or were
18 they very sort of objective-style conversations in terms of –
19 DAME PAULINE FIELDING: I think they felt that the work had been done on the
20 SUIs. I thought they felt that had been done and that it was finished and that
21 now there was a need to demonstrate to a wider public that the service was
22 moving forward and how could they do that.
23 DR WALTERS: So you say in the first bit of the report that the cluster of episodes
24 appeared to the review team to have been coincidental.

1 DAME PAULINE FIELDING: Yes.

2 DR WALTERS: So the review team did look at them then, did they?

3 DAME PAULINE FIELDING: We looked at the papers from the investigation, that's

4 all.

5 DR WALTERS: And they sort of agreed with the Trust that actually it was a

6 coincidence.

7 DAME PAULINE FIELDING: As a review team, we didn't feel that there were clinical

8 links between the individual incidents and we weren't reinvestigating that, you

9 see, so we saw the papers and that really was the extent of it.

10 DR WALTERS: And were you aware of the profile of serious incidents generally or

11 was the attention just on these five?

12 DAME PAULINE FIELDING: Well, the attention from the Trust's point of view was

13 around these five.

14 DR WALTERS: So the obstetrician and midwife you were working with didn't really

15 get into looking at previous SUIs other than these five.

16 DAME PAULINE FIELDING: No.

17 DR WALTERS: Right.

18 DR KIRKUP: Thank you. Stewart.

19 PROF FORSYTH: The neonatal services need to work very closely with maternity

20 services and I wonder if there had been any discussion when you were

21 establishing the review group whether you'd have a paediatrician in the group.

22 DAME PAULINE FIELDING: No, there wasn't that discussion.

23 PROF FORSYTH: I just wondered when you were undertaking the review whether

24 you felt this was an area that – I mean, it's a very brief section in terms of the

1 paediatric service and I just wonder whether you felt you had been able to
2 cover that appropriately.
3 DAME PAULINE FIELDING: Not in any depth, no.
4 DR KIRKUP: Thanks. I just wanted to pick up briefly this point about the exclusion
5 from looking at the five previous SUIs. Did you think that that was a significant
6 constraint around your work or were you happy to accept that? You said that
7 the Chief Executive was pretty strict about that being one of the ground rules,
8 but did you accept that readily or did you think it was a constraint?
9 DAME PAULINE FIELDING: I didn't feel that it was a constraint if we were
10 concentrating on ways that the service could improve, because we did have – I
11 mean we did know about the background of those serious untoward incidents,
12 so it's not as though we were ignorant of them, but we didn't feel that it was
13 necessary for us to reinvestigate them in order to identify ways in which the
14 service could improve.
15 DR KIRKUP: Okay, thanks. Julian.
16 MR BROOKES: Thank you. I think I know the answer to this, but just to double
17 check in my mind. The role of the Strategic Health Authority was purely to find
18 somebody on behalf of the Trust, is that correct?
19 DAME PAULINE FIELDING: That's my understanding, yes.
20 MR BROOKES: So you were commissioned and, I assume, paid by the Trust to do
21 the review.
22 DAME PAULINE FIELDING: Yes.
23 MR BROOKES: So it was a Trust-based review.
24 DAME PAULINE FIELDING: Yes.

1 MR BROOKES: Thank you. I just wanted to be absolutely certain of that.

2 DAME PAULINE FIELDING: Yes, it was the Trust who paid for it.

3 MR BROOKES: Okay. In terms of the terms of reference, which I understand how
4 that was agreed, did you feel there was any constraint placed on you in terms
5 of being able to meet those terms of reference?

6 DAME PAULINE FIELDING: Well, only the limitation in terms of our resources. You
7 know, three people who would be meeting for a fixed number of days, you can
8 only carry out so much work. So I did feel that it was going to be limited, but
9 that was what the Trust was commissioning.

10 MR BROOKES: Okay. And do you think that the Trust entered into this willingly? In
11 other words, was this their idea? Did you get an impression from your
12 conversations with the Chief Executive this was something that they were
13 generating or something that they had that had come up through conversations
14 with external parties?

15 DAME PAULINE FIELDING: I don't know. I really don't know whether it was the
16 Trust thinking it needed to do something or whether it was the Strategic Health
17 Authority telling the Trust that they needed to do something. I really don't
18 know.

19 MR BROOKES: Okay. But I get a sense that it wasn't the highest priority within the
20 organisation.

21 DAME PAULINE FIELDING: I didn't get that impression.

22 MR BROOKES: And do you think that influenced the ability of you, as a group, to
23 get to what you wanted to do?

24 DAME PAULINE FIELDING: I think it made it more difficult. As I said, the clinical

1 staff were very keen to talk to us, but we got the impression that the Trust was
2 in the process of organisational change and so several roles were not bedded
3 down and, you know, you got the feeling that the Trust was in a bit of state of
4 flux.

5 MR BROOKES: Okay. And just one final one in terms of the terms of reference.
6 The terms of reference was very much about taking the governance route
7 through to the Board level. Did you feel you were able to look at that as
8 robustly as you would want to?

9 DAME PAULINE FIELDING: There wasn't really a lot to look at actually, in truth,
10 because the governance arrangements were skimpy and they were in the
11 process of organisational change and they didn't have any processes in place,
12 except for risk management, which seemed to be if you talked to anybody
13 about governance that was what they thought governance was about, was
14 about risk management. They didn't really have the robust processes in place
15 for the other aspects of governance.

16 MR BROOKES: And so in conversation with the non-executive member of the
17 Board, did they have a good feel for what an organisation should have in place
18 in terms of governance?

19 DAME PAULINE FIELDING: I don't think so, no.

20 MR BROOKES: Okay, thank you.

21 DR KIRKUP: Jacqui.

22 MS FEATHERSTONE: I just want to recap again about the terms of reference and
23 just how much information did you have about the maternal and infant deaths,
24 you know, with your conversation with the chief exec? The five incidents, how

1 much detail did they go into for you to be able to form part of your terms of
2 reference about confirming the safety of the Trust?
3 DAME PAULINE FIELDING: You mean apart from the investigation reports.
4 MS FEATHERSTONE: Oh, so you had full – sorry, I probably missed that. So you
5 had full – all the reports to read prior to – and the information when you were
6 discussing with the chief exec, did you have quite a lot of information about all
7 the maternal and infant death part of it?
8 DAME PAULINE FIELDING: Not at that point, no. Subsequently, when we asked
9 for information, but not at that point.
10 DR KIRKUP: Thank you. Jimmy.
11 PROF WALKER: Thank you. Just a couple of things. One is to go back to the
12 support you got. When you had these meetings in the Trust, was the room you
13 were given an adequately sized room to interview people freely?
14 DAME PAULINE FIELDING: Yes.
15 PROF WALKER: And were you given a secretary to take notes for you or did you
16 take your own notes?
17 DAME PAULINE FIELDING: No, we took our own notes.
18 PROF WALKER: Right, okay. The other thing was just back on to observations that
19 have been made already. When you wrote the terms of reference you very
20 much highlight the importance of patient safety and patient experience and the
21 clinical effectiveness, but from what you're saying, with the restriction on
22 looking at the previous SUIs and not actually seeing them and then you said
23 there wasn't a lot of information necessarily about clinical incidents that have
24 occurred other than these, did you feel you could make a reasonable

1 assessment on clinical practice and clinical effectiveness and where the
2 problems were and where the improvements would be, from the information
3 you were given?

4 DAME PAULINE FIELDING: Well, from our discussions with the staff, yes, because
5 the staff were very forthcoming and I think we got a lot of information from
6 them.

7 PROF WALKER: Okay, thank you.

8 DR KIRKUP: Thanks. Back to you, Jonathan.

9 PROF MONTGOMERY: Thank you. That's a nice bridge to what we wanted to hear
10 a bit more about, which is really the ways of working. So could I start just by
11 asking how much time was resourced? The Trust commissioned a limited
12 number of days. How much time did you have?

13 DAME PAULINE FIELDING: No, they didn't. I think my initial discussions were
14 around the process taking about three months, but of course within that three
15 months we had to identify days when the team could get together and so it
16 wasn't three months of time, it was three months of the time period in which to
17 identify a number of days. If you're asking me how many days we spent doing
18 it, I would probably say, although I can't really remember now, it would
19 probably be about two weeks' worth of interviewing in terms of the number of
20 days.

21 PROF MONTGOMERY: So can you take us through the process? We can see
22 from the report a list of documents that you saw.

23 DAME PAULINE FIELDING: Yes.

24 PROF MONTGOMERY: We can see from the report that you interviewed a

1 significant number of people, but we don't have much of a flavour of who they
2 were and how you selected who you wanted to interview. So can you just walk
3 us through how you got started in it and at what stage you looked at the
4 documents and who you wanted to interview, who you managed to interview
5 and...?
6 DAME PAULINE FIELDING: I think, in the first instance, the team met together and
7 we identified a number of sources of information that we wished to have. In
8 the course of interviews we identified more information that we needed to have
9 and all the information that we asked for was provided. We didn't have any
10 trouble accessing the information. I think at that first meeting we identified
11 visits that we wanted to undertake and staff that we wanted to interview. We
12 then gave that information to the secretary and asked for interviews to be set
13 up on particular days. That was actually quite difficult to do, because when
14 you're dealing with clinical staff you're matching their availability with the team's
15 availability and that was quite tricky, but I think in the end we probably
16 managed to interview 90% of the people that we wanted to.
17 PROF MONTGOMERY: And the people you didn't manage to see, did they fall into
18 similar categories or – because that's only three or four people you didn't
19 manage to see.
20 DAME PAULINE FIELDING: Yes, it wasn't – I didn't feel that it was significant.
21 PROF MONTGOMERY: And what was the range of people that you interviewed?
22 Can you break it down a little bit in terms of type of clinical staff, managerial
23 staff?
24 DAME PAULINE FIELDING: Yes. We interviewed managerial staff who had

1 particular responsibility for the maternity services, staff for – in – one member
2 of staff, I think, in clinical audit. We interviewed – our focus was mainly on
3 clinical staff, so obstetricians at Furness and at Lancaster, midwives at all three
4 sites and some health care assistants at, I think, all three sites, and we talked
5 to some service users at Furness and Lancaster. So we tried to get a range of
6 staff.

7 PROF MONTGOMERY: And did you ask for those staff by name that you'd
8 identified from the documents you particularly wanted to see, particular people,
9 or did you ask the Trust to identify three midwives that you could see or how
10 did that work?

11 DAME PAULINE FIELDING: In the sort of more junior clinical staff, yes it was
12 asking them to identify a midwife that we could interview. For the senior staff
13 we sort of asked for them by name really or by position.

14 PROF MONTGOMERY: Paediatricians, did you interview any paediatricians?

15 DAME PAULINE FIELDING: ONE PAEDIATRICIAN INTERVIEWED. ~~I don't think~~
16 ~~we did.~~

17 PROF MONTGOMERY: Thank you. And can you take us through a little bit of the
18 flavour of the interviews? Did you prepare particular questions that you
19 wanted…?

20 DAME PAULINE FIELDING: Yes, we did.

21 PROF MONTGOMERY: Yeah. And did you let them know in advance what you
22 were going to ask them?

23 DAME PAULINE FIELDING: No.

24 PROF MONTGOMERY: So if we took, say, the obstetricians as a group, what was

1 the sort of thing that you particularly needed to find out from the interviews and
2 what's the balance of what you were able to get from the documents? I'm just
3 trying to get my head around how you sought out the things that you were
4 wanting to see.
5 DAME PAULINE FIELDING: Well, in terms of the obstetricians, we were, I think,
6 particularly interested in how the service was managed and how their – in
7 terms of their commitment to different parts of the service and what proportion
8 of time would be allocated to, you know, the gynaecology or the obstetrics, and
9 their ways of working with colleagues and their timetables really. And
10 obviously the obstetrician led on those particular interviews.
11 PROF MONTGOMERY: Similarly for midwives, what were the issues with the
12 midwives?
13 DAME PAULINE FIELDING: Well, we – I mean we talked to all of the staff, I think,
14 about management of risk and about educational opportunities. The midwives
15 sometimes came with their own issues and they were very keen to tell us about
16 what they felt was good practice in their patch. So we did quite a lot of
17 listening to, you know, what they felt was important and the issues that they felt
18 concerned them. They knew why we were there, so they often came prepared
19 – the midwives often came prepared with things that they wanted to tell us. So,
20 you know, it wasn't difficult to identify the issues for them at all.
21 PROF MONTGOMERY: Did you feel that they overlooked issues that you thought
22 were important?
23 DAME PAULINE FIELDING: No. No, I don't think so.
24 PROF MONTGOMERY: Thank you. And the health care assistants, did they have

1 a similar view to the obstetricians and midwives or did they highlight different
2 things?
3 DAME PAULINE FIELDING: I think – I mean, the health care assistants had their
4 own particular view of what it was about, but I think needed, you know,
5 obviously they were more reticent to speak their mind and more concerned
6 about what the impact would be on their jobs, so they had a much more sort of
7 focused, local, you know, focus about what they were willing to talk about, so it
8 was a bit harder really.
9 PROF MONTGOMERY: That feels like a bit of a tease. Can you elaborate a bit on
10 what they felt things were –
11 DAME PAULINE FIELDING: Well, I think, you know, they could see that there were
12 problems with particular parts of the service. I'm thinking particularly about
13 maybe Helme Chase where they'd once had a role overnight on Helme Chase
14 and now that role had been withdrawn and they felt very aggrieved about that,
15 so they were keen to tell us about that.
16 PROF MONTGOMERY: Thank you. One of the questions, I think, which emerges
17 from a number of the published reports is the extent to which there was
18 awareness of practice in other places amongst the staff.
19 DAME PAULINE FIELDING: Yes.
20 PROF MONTGOMERY: And it's clear that, particularly at Furness, it's
21 geographically isolated.
22 DAME PAULINE FIELDING: Yes.
23 PROF MONTGOMERY: Did you have a sense of it being professionally isolated as
24 well?

1 DAME PAULINE FIELDING: Fairly, although I think there were one or two
2 individuals who had started to bring views from a wider professional remit, but
3 that was quite limited. The staff at Furness, by and large, were local, part of
4 that local community and were clearly not going to move elsewhere. And the
5 Trust did – that unit particularly had difficulty in recruiting people to come there,
6 because people didn't want to come and work in Barrow. It was less so at
7 Lancaster and I think Helme Chase was just sort of an oasis of calm in the rest
8 of the Trust really.
9 PROF MONTGOMERY: That raises a question: did you interview people from HR
10 about – did they tell you about their recruitment – the things they tried in terms
11 of recruitment and their difficulties? Was that in the papers or –
12 DAME PAULINE FIELDING: No, we didn't interview people from HR, but we did
13 interview clinical staff who'd been involved in recruitment.
14 PROF MONTGOMERY: Thank you. And did you interview the Chief Executive as
15 part of this process?
16 DAME PAULINE FIELDING: Yes.
17 PROF MONTGOMERY: So can you tell us a bit about the interview with the Chief
18 Executive?
19 DAME PAULINE FIELDING: In what sense?
20 PROF MONTGOMERY: Just what he wanted to tell you about, what you wanted to
21 ask him about, what it felt like in the interview, did you get to the bottom of the
22 questions that you wanted to ask him?
23 DAME PAULINE FIELDING: Gosh, that's quite difficult really.
24 PROF MONTGOMERY: We're assuming there are no records of these interviews if

you didn't have anybody to take a record.

DAME PAULINE FIELDING: We took our own notes at the time. I think – my recollection is that the Chief Executive was keen to move on from the serious untoward incidents and wanted to identify a way of doing that fairly quickly.

PROF MONTGOMERY: Was your impression that that was because there was a lot of work that had been done to get that right that he didn't want to reopen or that he felt was sorted and in the past?

DAME PAULINE FIELDING: Sorted and in the past.

PROF MONTGOMERY: And what was the view of you and your colleagues about how convincing that position, that it had been resolved, in the past and could move on? How convincing was his account?

DAME PAULINE FIELDING: Well, I think initially his account was fairly convincing, but I think we came to a different conclusion towards the end of the work.

PROF MONTGOMERY: So, having reached that conclusion what did you do with the dilemma that presented you?

DAME PAULINE FIELDING: Well, I think we produced our recommendations in the light of our knowledge at the time. I mean, what else could we do except produce recommendations that we thought were relevant and that needed to happen. It was... I've no idea what the Trust did with the report, I really don't know.

PROF MONTGOMERY: Did you try and find out or did you hit a stone wall when you did or what?

DAME PAULINE FIELDING: Well, when you're commissioned to do a piece of work that work is for the people who are paying for it. I didn't feel that it would be

1 appropriate for me then to find a roundabout way of discovering what the Trust
2 had or hadn't done with it. So I didn't do that, because I didn't think that would
3 be appropriate.
4 PROF MONTGOMERY: We'd quite like to come back, when we're all the way
5 through the process, with a hindsight question about what, looking back, you
6 might have liked, so we'll come back to that later on, but it's been really helpful
7 to understand the story as it unfolds. You've told us a bit about the
8 management you saw and the clinicians, but you said you'd also seen some
9 user representatives, so can you take us through what you learnt from them
10 and what their concerns were, and who they were?
11 DAME PAULINE FIELDING: There were very few of them really, but our impression
12 was that their experiences of the service, the people that we did talk to, was
13 quite positive and that they, you know, the concerns that they had were about
14 the material environment rather than the clinical care that they'd received.
15 They didn't seem to have any concerns about their clinical care. You know, it
16 was about things like, you know, how easy to park the car, the sort of physical
17 environment rather than clinical care. But we didn't really have the time, I
18 think, to talk to very many users of the service.
19 PROF MONTGOMERY: And how were those user representatives that you
20 interviewed identified and selected?
21 DAME PAULINE FIELDING: On visits to the sites.
22 PROF MONTGOMERY: So they were people you met on the visits.
23 DAME PAULINE FIELDING: Yes. Yeah.
24 PROF MONTGOMERY: So did they have any formal place in the Trust processes?

1 Were they Friends who were –

2 DAME PAULINE FIELDING: No, no.

3 PROF MONTGOMERY: They were just people who happened to be there.

4 DAME PAULINE FIELDING: Yes.

5 PROF MONTGOMERY: Thank you. And were you aware – we've been trying to
6 find this out – of any formal processes for user feedback into the governance
7 structures?

8 DAME PAULINE FIELDING: I think we felt that they were quite... They were not
9 very robust or extensive. My recollection is that the maternity services liaison
10 committee wasn't meeting. The Trust had just appointed a new Head of
11 Patient Experience. I think she'd been in post for a couple of weeks when we
12 interviewed her, so she hadn't really had time to do anything. So I think – at
13 Barrow there were some attempts to engage with teenage mothers and I think
14 at all three sites there was a listen to mother service, but we didn't get the
15 feeling that they'd got very extensive systems for gathering user feedback.

16 PROF MONTGOMERY: And in either the interviews or papers that you saw did you
17 see any evidence that the service had changed as a response to any of that
18 feedback?

19 DAME PAULINE FIELDING: No.

20 PROF MONTGOMERY: Thank you. My last question on the process bit and then,
21 when we've had the other group questions, we'd like to understand how the
22 report got pulled together, but did you only interview interviewees once or were
23 there some that you saw more than once?

24 DAME PAULINE FIELDING: I think there were one or two people who we saw

1 subsequently and talked to in the course of our visits that we'd also
2 interviewed, but I don't think we really interviewed anybody.
3 PROF MONTGOMERY: And just the sequencing of it, so in my head I think I'd
4 understood you did visits early on. Each time you were doing interviews you
5 did a visit as well, is that how it operated?
6 DAME PAULINE FIELDING: Probably, because it was a case of making the best
7 use of our time and if we had – there were a few occasions when we thought
8 we were going to be interviewing all day and the people had not been made
9 available, so we did visits instead. So it was a case of making the best use of
10 our time when we were there.
11 PROF MONTGOMERY: And you said it added up to about two weeks of work.
12 DAME PAULINE FIELDING: That's my recollection, yes.
13 PROF MONTGOMERY: You had roughly 10 days in the place, no more than that.
14 DAME PAULINE FIELDING: Yes, about 10 days.
15 PROF MONTGOMERY: And how was that split between sites?
16 DAME PAULINE FIELDING: Probably less at Kendal than at the other two sites, but
17 probably about the same between Lancaster and Barrow.
18 PROF MONTGOMERY: Thank you. I think that's this phase.
19 DR KIRKUP: Okay, thanks. Let's go round the table again for any supplementary
20 questions on the process. Catherine.
21 DR CALDERWOOD: Thank you, that's been – obviously what's written is only a
22 part of what knowledge you've gleaned. I suppose I have several areas to
23 touch on. You've said that midwives – particularly midwives and obstetricians
24 had flagged some issues that they felt. Can you elaborate a little bit on what

1 exactly those issues were? Were there themes that several people
2 mentioned?
3 DAME PAULINE FIELDING: Oh gosh. It's very hard to think my way back into the
4 interviews now, more than four years ago now. I think one of the themes that
5 did come up quite strongly was the lack of team working between the different
6 professional groups and the relationships between the various parts of the
7 service, particularly between Lancaster and Barrow. Kendal was pretty much
8 on its own and didn't appear to interact much in terms of staffing or issues with
9 the rest of this service, apart from the issues about transferring patients back to
10 RLI after they'd given birth, which – sorry from Lancaster to Kendal after
11 women had given birth, which didn't seem to be very appropriate. But I think in
12 the main it was probably the team-working issues that came through from both
13 obstetricians and midwives and between the obstetricians themselves, they
14 didn't appear to be very cohesive as a group.
15 DR CALDERWOOD: They obviously understood why you were there.
16 DAME PAULINE FIELDING: Yes.
17 DR CALDERWOOD: Did you get the impression that the clinical staff were
18 concerned, that they thought that things were, as you've put it, sort of sorted
19 and in the past, or did you get the impression from them that they were worried
20 about the service?
21 DAME PAULINE FIELDING: I wouldn't say that they were worried about the service,
22 but I think they did understand that it wasn't working as it should and that the
23 relationships between the different parts of the service were not good. And I
24 think, to a certain degree, there was almost an acceptance that that was the

1 way it was.

2 DR CALDERWOOD: And just a little bit more detail about the process of the review
3 that you did of the case notes. I don't know whether you saw the notes
4 yourself or whether it was midwife and obstetrician. How were those selected?
5 I think the report says you saw nine from each unit. Were they just notes that
6 happened to be there or did you specifically ask for them?

7 DAME PAULINE FIELDING: No, those were notes that happened to be there.

8 DR CALDERWOOD: At the time that you were visiting.

9 DAME PAULINE FIELDING: Yes.

10 DR CALDERWOOD: And if you saw them yourself, did you notice any differences
11 between the notes or the cases in the three units?

12 DAME PAULINE FIELDING: I don't think I can comment on that.

13 DR CALDERWOOD: And what sort of details were looked at; was it reading the
14 notes from start to finish or how did that process occur?

15 DAME PAULINE FIELDING: My recollection is that it was reading through the notes
16 of the clinical episode. I don't think I can say more than that at this stage. It
17 was mainly done by the midwife and the obstetrician.

18 DR CALDERWOOD: And there weren't particular notes – how did you pick them on
19 the antenatal ward, postnatal ward, labour ward?

20 DAME PAULINE FIELDING: We looked at them during the visit, so it wasn't – we
21 didn't look at, you know, particularly – any one particular section.

22 DR CALDERWOOD: Right. And how did you choose which ones to...?

23 DAME PAULINE FIELDING: Whichever were available.

24 DR CALDERWOOD: So talk me through, you visited the antenatal ward, I don't

1 know, and said, 'Could we see some notes?'

2 DAME PAULINE FIELDING: Yes.

3 DR CALDERWOOD: And...?

4 DAME PAULINE FIELDING: And just selected some at random.

5 DR CALDERWOOD: From the trolley.

6 DAME PAULINE FIELDING: From the trolley, yes.

7 DR CALDERWOOD: And similarly the labour ward and postnatal ward.

8 DAME PAULINE FIELDING: Yes.

9 DR CALDERWOOD: Okay. And was there much – you've alluded to the time and
10 the pressure that there obviously was. Was that then done as just part of that
11 visit or did you take the notes away and have a second look?

12 DAME PAULINE FIELDING: Oh no, it was done as part of that visit.

13 DR CALDERWOOD: Just standing in the ward.

14 DAME PAULINE FIELDING: Yes.

15 DR CALDERWOOD: Rather than dedicated time.

16 DAME PAULINE FIELDING: Yes.

17 DR CALDERWOOD: Okay, that's very helpful. Were you then – I think the report
18 really just comments that the notes seemed to be legible, better from midwives
19 than doctors. You didn't then, or perhaps this wasn't part of what you were
20 doing, flag up any issues with any of those notes.

21 DAME PAULINE FIELDING: No, we didn't.

22 DR CALDERWOOD: Whether it was clinical issues or safety issues.

23 DAME PAULINE FIELDING: No. Not at the time, no.

24 DR CALDERWOOD: And I think – well, we'll come back to the other issues that the

1 report flags up later, so thank you.

2 DAME PAULINE FIELDING: Okay.

3 DR KIRKUP: Thanks. Stewart.

4 PROF FORSYTH: I just wondered how, in terms of your process, you really
5 assessed the clinical competence of individuals who are working within the
6 Trust. Clearly you've looked at case notes and that might be – but I just
7 wondered if there were any other measures you had to ensure that the clinical
8 staff, medical, nursing, midwifery were competent in the various aspects of
9 their job.

10 DAME PAULINE FIELDING: I don't think we did. I don't think that was part of our
11 remit at all.

12 PROF FORSYTH: Okay, thank you.

13 DR KIRKUP: Thanks. I just wanted to pick up another point about the service users
14 who you interviewed. You commented that they mostly focused on
15 environmental issues and car parking and so on.

16 DAME PAULINE FIELDING: Yes.

17 DR KIRKUP: But my experience is that's what people do, because they take the
18 safety elements for granted and why wouldn't they?

19 DAME PAULINE FIELDING: Yes.

20 DR KIRKUP: Were you able to speak to anybody who had had an adverse
21 outcome?

22 DAME PAULINE FIELDING: No.

23 DR KIRKUP: Okay. Was that a conscious decision on your part?

24 DAME PAULINE FIELDING: We were particularly focused on identifying ways in

1 which the service could improve, so we weren't wanting to pick up and investigate individual issues, so, you know, we didn't look for people who'd had an adverse outcome, no.

DR KIRKUP: Okay, thank you. Julian.

MR BROOKES: Thank you. Just a couple of things, if I can. Quite often in these kinds of investigations, certainly some that I've been involved with, there's an explicit discussion at the beginning that if something comes to light during the investigation which you have concerns about, that that is something that will be immediately brought to the attention of the organisation.

DAME PAULINE FIELDING: Yes.

MR BROOKES: Did you have that conversation in this?

DAME PAULINE FIELDING: Yes.

MR BROOKES: And was that how you worked and it was clear to everyone that that was the way it was working?

DAME PAULINE FIELDING: Yes.

MR BROOKES: From that, I'm assuming that there were no big patient safety issues that you identified during that that you felt you needed to bring to the attention of the Board.

DAME PAULINE FIELDING: There was one and that was about the unit at Helme Chase, in that we became aware that they were admitting high-risk women if those women were willing to sign a disclaimer form. And we felt that that was so unacceptable that we brought that to the attention of the nursing director on the same day.

MR BROOKES: On the same day.

1 DAME PAULINE FIELDING: Yes.

2 MR BROOKES: That's really helpful.

3 PROF MONTGOMERY: And did you see any evidence that something had been
4 done about that quickly?

5 DAME PAULINE FIELDING: I think that was towards the end of our time there, so I
6 don't think I can comment really as to whether they did anything about that at
7 all.

8 MR BROOKES: And did you bring that to the attention in writing?

9 DAME PAULINE FIELDING: Yes, that's in the report.

10 MR BROOKES: Yes, I know, but at the time did you write to them or did you just
11 bring that up in conversation?

12 DAME PAULINE FIELDING: No, we brought it to their attention verbally.

13 MR BROOKES: Thank you. And just one other, just for my clarification. Your first
14 term of reference, which is very much about providing further assurance to the
15 Trust about – following on from the report about patient safety, patient
16 experience and clinical effectiveness. Were there any barriers to that with the
17 process you were able to go through, if you understand what I mean?

18 DAME PAULINE FIELDING: Well, the time constraints. I think it – the process was
19 much more laborious than I had imagined in terms of actually getting the
20 interviews done and getting the staff available. I think it took – I think at the
21 outset I thought that we would have been able to conduct a much more
22 comprehensive review than we subsequently were able to, so that was a
23 disappointment really.

24 MR BROOKES: Okay. And –

1 PROF MONTGOMERY: Could I just be clear, was that because the team couldn't get itself together easily or because you wanted to interview particular staff who weren't available?

4 DAME PAULINE FIELDING: I think it was both. It was both. The availability of both the obstetrician and the midwife, although mainly the obstetrician, was such that our time in the Trust was extremely limited.

7 MR BROOKES: Okay, and just related to that term of reference, you've said that the Chief Executive felt that these were problems in the past. I think you said that that wasn't necessarily a view shared by the group. Is that correct?

10 DAME PAULINE FIELDING: I think, by the end of the process, yes.

11 MR BROOKES: So do you feel you were able to provide assurance to the Trust that, following the report, that there were processes in place, with the exceptions of your recommendations?

14 DAME PAULINE FIELDING: Well, no. No, I don't think they were.

15 MR BROOKES: Okay, thank you.

16 DR KIRKUP: Thanks. Jacqui?

17 MS FEATHERSTONE: You talked about the visits generally were ad hoc, if you hadn't completed all your interviews – or you'd completed your interview –

19 DAME PAULINE FIELDING: No, not all of them. Some of them were planned, but, if we had a couple of hours to spare between interviews, then we would visit again.

22 MS FEATHERSTONE: So the ones that were ad hoc, did you have free rein? Did you just walk around the wards?

24 DAME PAULINE FIELDING: Oh yes.

1 MS FEATHERSTONE: And you talked about that it came from the staff, in
2 particular, about the lack of teamwork. Do you get any impression, when you
3 were walking round the wards, that that was the case?
4 DAME PAULINE FIELDING: No, I think it was mainly in conversation with different
5 members of staff that it became apparent that there were sections of staff that
6 didn't talk to other sections; you know, the obstetricians didn't really talk to the
7 paediatricians – I think we did interview one paediatrician – and the midwives
8 didn't have much of a rapport with the medical staff, particularly at Barrow. So
9 it was really in the interviews that that came out, and the obstetricians didn't
10 present as much of a team themselves.
11 MS FEATHERSTONE: And, just generally, when you were visiting, did you get any
12 feel? Was it generally that you felt that, whatever you needed to know, people
13 were talking to you quite freely, when you were out on the ward?
14 DAME PAULINE FIELDING: Yes I think they did, yes.
15 PROF WALKER: Just a couple of things about process. One: did you interview an
16 anaesthetist?
17 DAME PAULINE FIELDING: No. I don't think we did, no.
18 PROF WALKER: And the other thing is, in looking at – a lot of the report goes on
19 about the safety factor's important, and also the second bullet point is about
20 processes, contractors all the way up to Board level. Did you manage to get
21 an idea that, if an incident occurred, how that – what its journey was after that?
22 Because you've mentioned that the Supervisor of Midwives knew about things,
23 and there was a computer system, but what happened to it? Was there
24 information and reviews, some form of level of review made, conclusions

passed on to someone else who summarised it then talked about it at a certain level, all the way up to Board level, or did it just disappear into some sort of ether somewhere?

DAME PAULINE FIELDING: I think a bit of both, really. Some of the systems and processes were there for matters like that to get to Board level, and, obviously, for the serious untoward incidents. What seemed to be more lacking was any robust system for the organisation to learn from less serious incidents and informal complaints. There didn't seem to be a capturing of that kind of data which would enable the whole organisation to learn from it.

PROF WALKER: You commented, at varying points, about the lack of information of the complaints and the reporting of incidents as well. Your comment on the SUIs that you said were – I can't remember what you said, but they were not necessarily at a robust level. I can't remember what word you used when you were talking about the SUIs you looked at, the five SUIs. You felt there was something about – you used a term earlier on in the interview. I can't remember what it was.

DR WALTERS: She said 'skimpy'.

PROF WALKER: 'Skimpy', okay. The thing is, with the skimpy SUI and the lack of information and lack of incident reporting and the things coming through, how did you manage to get a feel of the governance processes? I mean, you would have interviewed staff and they would have told you things, but were you quite content there was – although these processes weren't in place, that there was something there, or were you hopeful that the new structures being put in place would solve these problems?

1 DAME PAULINE FIELDING: Well, I think we were hopeful that new processes
2 would solve those problems, but the Trust wasn't actually – you know, it was
3 undergoing a reorganisation of directorates. Maternity services were part of
4 the family services unit, which was dominated, for some reason, by surgical
5 services, and it didn't really seem to have its structures sorted out at the time
6 that we were there, but we hoped that it would.
7 PROF WALKER: Were you confident at the time, though, that, say if an incident
8 occurred in Barrow, that the right processes of reporting, handling, reviewing
9 and so on would have carried on or would have happened, or were you fearful,
10 at that time, that that system wasn't robust?
11 DAME PAULINE FIELDING: I think, for the risk issues, the processes were fairly
12 robust. That was really the only aspect of governance that the Trust appeared
13 to be focused on, so I think, for risk, they were not bad.
14 MR BROOKES: Sorry, can I just clarify what you mean by 'risk'?
15 DAME PAULINE FIELDING: I mean clinical risk and things happening that shouldn't
16 have happened.
17 MR BROOKES: Thank you.
18 DAME PAULINE FIELDING: I'm sure they weren't perfect, but we felt that the trust
19 actually was fairly focused on this, presumably as a result of the serious
20 untoward incidents.
21 DR KIRKUP: Jonathan?
22 PROF MONTGOMERY: Thank you. I think the next of couple of areas will
23 probably be a bit briefer, because I think you've actually covered them, and
24 they're about the process of finalising the report and what happened next. I

1 think the 'what happened next' is quite a quick area, from what you just
2 described, but you touched on the report, and we were intrigued to see that, on
3 the face of the report, there was a March draft and a June draft and a final
4 report in August, and one of our questions was how you put the report together
5 and what the process was for checking it with the Trust and anybody else, and
6 how much the reports changed, so could you just explain how you got the
7 report ready? Did you split it up? Did you invite them to check it?
8 DAME PAULINE FIELDING: No, we didn't split it up. I think the report, in its
9 entirely, was written by me, but we discussed between the three of us what our
10 recommendations were going to be. I drafted the report, sent it to the other
11 two members of the team, who commented on it, and I redrafted it until we had
12 a report ready to send to the Trust. The Trust came back twice with fairly
13 minor – I think one was a factual change. You know, I can't actually remember
14 the exact changes, but they were fairly insignificant and didn't change our
15 recommendations, so, after discussion with the other two members, we were
16 happy to do that. I think the most significant one was perhaps just a slight
17 toning down of our implied criticism of the Clinical Director, in terms of when he
18 retired, that they should look for somebody who would have been better in the
19 post.
20 PROF MONTGOMERY: So sometimes you get requests for changes that put you
21 under some pressure, feeling, 'Are we happy with these changes or not?' That
22 sounds like –
23 DAME PAULINE FIELDING: No, we were not unhappy with the changes.
24 PROF MONTGOMERY: And did you meet to discuss them, or were you able to

1 deal with that by correspondence with the other Panel members?

2 DAME PAULINE FIELDING: No, just by correspondence, by emails and telephone

3 calls.

4 PROF MONTGOMERY: And so, if I've understood that right, there wouldn't look to

5 be a big difference between the first, second and third drafts. They were minor

6 changes.

7 DAME PAULINE FIELDING: No.

8 PROF MONTGOMERY: Okay. I think probably that's all we need on that process

9 of finalising the report, unless others have got –

10 MR BROOKES: Just a clarification, if that's okay. In terms of elements which

11 related to particular individuals, did you go back to any of the individuals who

12 provided evidence to clarify that they were factually accurate, what you were

13 intending to say, or wasn't that necessary in this process?

14 DAME PAULINE FIELDING: I don't think that came up, actually. I don't think so.

15 MR BROOKES: So individuals involved who had given evidence wouldn't have seen

16 the report or elements of the report prior to –

17 DAME PAULINE FIELDING: No. No, they wouldn't.

18 MR BROOKES: Thank you.

19 DR KIRKUP: There's just one point I wanted to pick up as well. You've described

20 the process of redrafting as being relatively minor. There were three months

21 between the first draft and the first redraft, and another two months between

22 the first redraft and the second redraft. That seems, on the face of it, to be a

23 slightly more elaborate process than the one that you've described.

24 DAME PAULINE FIELDING: It was just waiting for the Trust to respond.

1 DR KIRKUP: Okay, and why two goes at it, if they were fairly minor changes?

2 DAME PAULINE FIELDING: I don't know. It was just they came twice, but they

3 were each fairly minor things.

4 DR KIRKUP: On each occasion?

5 DAME PAULINE FIELDING: On each occasion.

6 DR KIRKUP: Okay. Anybody else want to – or shall we move...? Let's keep the

7 other points and go back to you, Jonathan.

8 PROF MONTGOMERY: Thank you. So the next bit was really understanding the

9 life of the report after you'd presented it. I think you've indicated that, from

10 your involvement –

11 DAME PAULINE FIELDING: I have no idea.

12 PROF MONTGOMERY: – you can't track that through.

13 DAME PAULINE FIELDING: No.

14 PROF MONTGOMERY: Right, so you didn't have any queries back on what you

15 meant by anything or anything of that sort.

16 DAME PAULINE FIELDING: No.

17 PROF MONTGOMERY: So, on that basis, you can't tell us whether the Board ever

18 saw it.

19 DAME PAULINE FIELDING: No.

20 PROF MONTGOMERY: Okay. Probably we can't move much on that, then. I think

21 that's been very clear, and obviously we'll try and track that through from what

22 we can pick up. So I guess I should ask the hindsight question, really, before

23 my colleagues pick up some more specific things that were in the report that

24 they just want to make sure that they'd understood. Looking back at it, you've

1 expressed some areas of frustration, I think, in your account. It would be
2 helpful for us to understand whether you think those frustrations were
3 avoidable and how they might have been avoided.
4 DAME PAULINE FIELDING: I think I could have been clearer, maybe, with the
5 Trust, at the outset, as to the resources that we would require. I think I
6 underestimated... Well, no, I think I overestimated the Trust's commitment to
7 the review, which was perhaps a little naïve, but I genuinely thought that the
8 Trust was fully committed to it. With the benefit of hindsight, I'm not sure that
9 that was the case.
10 PROF MONTGOMERY: When did that benefit begin to emerge, do you think?
11 DAME PAULINE FIELDING: I think, during the review, when it became quite difficult
12 to undertake and quite difficult to access certain people, it began to dawn on us
13 that maybe there was a bit of a lack of commitment there.
14 PROF MONTGOMERY: Which people do you have in mind, particularly?
15 DAME PAULINE FIELDING: The senior team.
16 PROF MONTGOMERY: Okay. Did you have any discussion about whether you
17 should confront them on that?
18 DAME PAULINE FIELDING: Well, we did interview them, but we didn't – I don't
19 think we did raise the commitment issues. I think we rather took that for
20 granted.
21 PROF MONTGOMERY: And there wasn't any stage at which you had a discussion
22 about whether you were prepared to give them the report that they wanted until
23 you'd had a bit more support?
24 DAME PAULINE FIELDING: No.

1 PROF MONTGOMERY: Thank you. In terms of the terms of reference, with
2 hindsight, would you have drafted them differently?
3 DAME PAULINE FIELDING: I don't think I would have drafted them differently,
4 given the stage at which I was drafting them. I think I would have been more...
5 Well, I think I would have spelled out the resources that we would need more
6 at the outset. I think that's probably my regret in that.
7 PROF MONTGOMERY: And, in your experience of other reports like this, have you
8 had previous experience of there being no follow up and opportunity to present
9 the report to the Board?
10 DAME PAULINE FIELDING: No, I'm quite surprised at that really. If it's a report that
11 the organisation commissions and wants, you would expect that they would
12 require some presentation of that report, and some discussion and an
13 opportunity to maybe discuss the nuances that don't actually come out in the
14 written word, but there wasn't that opportunity.
15 PROF MONTGOMERY: And, given that you weren't given that opportunity, did you
16 give some thought to whether or not you should force that case, or whether it
17 was a regulatory issue for the Healthcare Commission or the SHA, who put you
18 in touch with them in the first place?
19 DAME PAULINE FIELDING: Well, I think maybe, in the Trust and its wider dealings
20 with the Care Quality Commission and subsequent events, I think, probably,
21 events overtook them and it didn't then feel appropriate for me to go back and
22 say, 'Well, hang on a minute. What are you going to do about my report?' It
23 just didn't feel appropriate to do that, given that this was an independently
24 commissioned report; it wasn't something that was being done within the family

1 of the NHS. We were independent people carrying out this, so I didn't feel it
2 was appropriate for us then to go into the NHS via another route and find out
3 what was being done.
4 PROF MONTGOMERY: The CQC report expresses some surprise that they didn't
5 see your report earlier than they did. Are you surprised by that? Would you
6 have understood that the Trust would have made it available?
7 DAME PAULINE FIELDING: I would have expected the Trust to have made it
8 available, yes.
9 PROF MONTGOMERY: Okay, thank you, and have you any other experiences
10 where these independent reports have been so closely within the
11 commissioning organisation that actually you wouldn't have had any contact
12 with the SHA, or is it more normal for you to be commissioned by one
13 organisation but still keep some contact with the supervisory organisations?
14 DAME PAULINE FIELDING: I suppose a comparable review which I undertook was
15 into elderly services in Tameside, and that had extensive contacts with the
16 SHA and with patient organisations, so this was quite – this did feel quite
17 confined, yes.
18 PROF MONTGOMERY: And did it feel confined by the Chief Executive or...?
19 DAME PAULINE FIELDING: I think it was confined by the Trust, yes.
20 PROF MONTGOMERY: The Trust, yes, thank you.
21 DR KIRKUP: Okay, thanks. I'll go once more round the table and we'll pick up
22 some specific questions about the report and anything else that hasn't been
23 covered. Catherine.
24 DR CALDERWOOD: Thank you. You mentioned the issue with Helme Chase and

1 the issues about high risk women. It's very clearly described about the
2 arrangements for emergency caesarean sections in your report, both daytime
3 hours, when staff had to be freed up from an existing theatre list at times –
4 DAME PAULINE FIELDING: That was at Barrow, not Helme Chase.
5 DR CALDERWOOD: No, sorry, I understand that – and that, at night time, again,
6 potential delays in emergency caesarean section because of a lack of an on
7 call rota. I, as an obstetrician, knowing the rapidity at which an emergency
8 section may be required – and I understand that this doesn't happen very
9 frequently in a unit with a small number of deliveries – was that flagged up by
10 your clinical colleagues as something that needed to be dealt with as an
11 urgent?
12 DAME PAULINE FIELDING: Yes.
13 DR CALDERWOOD: And how did they communicate that?
14 DAME PAULINE FIELDING: I think we discussed that with the medical director.
15 DR CALDERWOOD: And the response that was given?
16 DAME PAULINE FIELDING: I'm not sure I can remember, actually. It's very
17 difficult, actually, to think back and exactly what the medical director said about
18 that.
19 DR CALDERWOOD: But I suppose what I would be wondering about, given you
20 were wishing for assurances, without remembering the specifics, was your
21 impression that they got it, that this was unacceptable –
22 DAME PAULINE FIELDING: They did know it was unacceptable, yes.
23 DR CALDERWOOD: – but that they were going to do something different?
24 DAME PAULINE FIELDING: The intention was to do something about it, yes, but I

1 can't tell you whether they did.

2 DR CALDERWOOD: Yes, I know that. Again, I completely appreciate that it's not

3 easy to remember the detail. Did this appear to be something that you were

4 telling them that has never occurred to them before?

5 DAME PAULINE FIELDING: No, they already knew about it. They were aware of it.

6 DR CALDERWOOD: But hadn't acted on it.

7 DAME PAULINE FIELDING: Yes.

8 DR CALDERWOOD: And no thoughts as to what the reasons behind that would be

9 from them.

10 DAME PAULINE FIELDING: No.

11 DR CALDERWOOD: There wasn't a dialogue, 'We've tried to, but we...'

12 DAME PAULINE FIELDING: No, I don't think so.

13 DR CALDERWOOD: I think that, certainly, is a significant safety issue, as a unit

14 delivering obstetric led care. My other question, then, about a safety issue –

15 and I think Stewart will probably want to pick this up further – was the – again, I

16 think it's probably an impression of awareness of this neonatal paediatrician

17 sort of cover, not just the communication but the fact that – did it seem to be

18 that they recognised that that wasn't ideal, the service that was provided?

19 DAME PAULINE FIELDING: Yes, I think they did recognise that it wasn't ideal.

20 DR CALDERWOOD: And any more dialogue about that?

21 DAME PAULINE FIELDING: No, there seemed to be an acceptance that this is the

22 way it was.

23 DR CALDERWOOD: I don't know whether it's appropriate, Stewart – do you want

24 to follow up anything? I was also... I mean, again, it's the transport, transfers,

1 but I'm not getting the impression that you had the opportunity, perhaps, to find
2 out very much about that sort of level of detail.
3 DAME PAULINE FIELDING: No, we didn't.
4 DR WALTERS: So in the hindsight question, I've got a bit of sympathy with Chief
5 Executives who might not be clinical people; they've got five incidents; they've
6 been told by colleagues that, actually, it's a coincidence, and there's a need to
7 reassure people, so let's have an external review. For all the times something
8 like this happens, probably a lot of the time they are five unconnected incidents
9 and people do a review and they're reassured and that's fine. Was there a
10 point in the process where you thought, 'Actually, there is more to worry about
11 here'?
12 DAME PAULINE FIELDING: I think we certainly felt that there was quite a bit to
13 worry about at Furness and at Helme Chase, and I think the serious untoward
14 incidents were the background to that, but, as I've said before, we weren't
15 reinvestigating those.
16 DR WALTERS: No. So some of the issues that were alluded to in the report – the
17 theatre issue, the neonatal issue, the staffing levels, the relationships, the unit
18 facilities, the skimpy governance – were your clinical colleagues on the Panel
19 getting agitated about that at all?
20 DAME PAULINE FIELDING: Well, we were a team who discussed things away from
21 the clinical areas, and, yes, they were concerned about it.
22 DR WALTERS: With hindsight, then, do you think the recommendations were
23 forceful enough about some of those things? Because, under the theatres,
24 there's a bit about estates and maybe a coffee room, but there's nothing about

1 'There is no team in the middle of the night for emergency sections'.

2 DAME PAULINE FIELDING: Well, we do say that.

3 DR WALTERS: Is that a recommendation?

4 DAME PAULINE FIELDING: But there wasn't a team available, but 'arrangements

5 should be made for out of hours'.

6 DR KIRKUP: I think it says there should be an on call rota.

7 DAME PAULINE FIELDING: Yes.

8 DR WALTERS: But was there any discussion around 'Should you really be

9 providing this service if you haven't got one'? Did the clinical reviewers feel

10 strongly about that, or did they just think, 'We can flag it to them, then it's up to

11 them'.

12 DAME PAULINE FIELDING: No, I think they did feel strongly about it. I can't

13 answer for them, really, but I think they did feel strongly about it, but I don't

14 think I could really give you more indication than that, actually, as to what they

15 really felt about it. You'd need to talk to them.

16 DR WALTERS: So, as the sort of team manager on the review, were you happy

17 with the advice that you were getting from them?

18 DAME PAULINE FIELDING: From the obstetrician and the midwife? I was very

19 happy with the advice I was getting from the consultant midwife. I suppose I

20 was less sure about the advice that I was getting from the obstetrician, but that

21 – it's a different discipline and it's hard for me to understand whether that was

22 really the advice that should have been forthcoming.

23 DR WALTERS: Okay, thank you.

24 DR CALDERWOOD: Sorry, it's coming back, because it's on the second topic, I

1 suppose, a little bit following up on Geraldine's comments about whether the
2 recommendations were strong enough and also Bill's observation about the
3 length of time it took. I just wonder about this. For example, a category 1
4 caesarean section is supposed to be within less than half an hour, but might
5 take two hours, and you had that discussion, I appreciate, but there would be a
6 feeling in my mind that everything possible should have been done
7 immediately to change that situation. The bullet point here, which appeared,
8 then, many months later, doesn't reflect any urgency or any particular firm
9 criticism of the existing structure and a need to very firmly change that
10 completely.

11 DAME PAULINE FIELDING: Well, I think that was our intention. I mean, if it doesn't
12 come across as sufficiently strong, then that's a criticism I would have to take
13 on board, but the intention was there. Maybe it's not expressed as strongly as
14 it should have been.

15 DR KIRKUP: Thank you. Geraldine, are you done? Stewart?

16 PROF FORSYTH: You've probably pinched all my questions. Just to summarise
17 this, because I think it's a fairly crucial part, was there a time that the group,
18 your group, thought, 'This maternity service is unsafe and action should be
19 taken immediately to deal with it?' rather than go through the process of the
20 report being consulted on, going through governance meeting etc., etc.? Was
21 there a time where you felt, 'We need to take immediate action'?

22 DAME PAULINE FIELDING: No. I think, if we had felt that, then we would have
23 done that. There were many things wrong with the service and that could have
24 been improved, but I don't think we came to that point that you were

1 describing.

2 PROF FORSYTH: With the benefit of hindsight, and we all enjoy the benefit of

3 hindsight, do you feel that – again, picking up the point about whether, if your

4 report had been more explicit in some of these points, action might have

5 happened quicker in dealing with the service?

6 DAME PAULINE FIELDING: Well, I don't know whether it would or not. As I say, I

7 had no control over what happened to the report or the recommendations. It's

8 entirely possible that, had the recommendations been stronger, that the Trust

9 would have taken action, but I don't know.

10 PROF FORSYTH: You don't know the answer.

11 DAME PAULINE FIELDING: I don't know the answer to that.

12 PROF FORSYTH: No. Okay, thank you.

13 DR KIRKUP: Thanks, Stewart. I'd just like to pick up a point and test my

14 interpretation of it and see whether you agree or not, and, if you don't, then you

15 must tell me. You didn't do a review of the five preceding SUIs, or however

16 many there might have been. I understand that that was a constraint in the

17 way the investigation was set up. You commented that there weren't any

18 clinical links between them, but you didn't comment on whether there might

19 have been behavioural or relationship factors that might have been in common

20 between those. Were you able to form a view about that from reading the

21 reports or not? Because my interpretation – I did say I would test it out with

22 you – my interpretation is that, although the clinical mechanisms underlying

23 what went wrong in each case might have been different, there were some

24 common factors that related to things that you picked up in your report about

1 behaviours and team working and relationships.

2 DAME PAULINE FIELDING: Yes, and maybe the report doesn't identify those as it
3 perhaps should. I think we just didn't focus on those five untoward incidents,
4 although we had that information.

5 DR KIRKUP: Sure. Nevertheless, reading the report, one of the two or three points
6 that comes through loud and clear – Catherine and others have alluded to the
7 other two, but one of the points that comes through loud and clear is you
8 definitely identified poor team working, relationship factors, behavioural factors.
9 How important did you regard those in assuring the Trust that things were,
10 indeed, getting better?

11 DAME PAULINE FIELDING: Well, I don't think we did reassure the Trust that things
12 were getting better, and those issues were clearly a barrier to that.

13 DR KIRKUP: Yeah. I've expressed that badly. I didn't mean to say that you did. I
14 just meant to what extent did you regard that as a key part of the process of
15 things getting better?

16 DAME PAULINE FIELDING: Oh, absolutely key, absolutely key, because, if
17 different groups of staff weren't working together, and, within particular groups,
18 there was evidence of consultants, for example, not working well together, it's
19 very difficult for the organisation as a whole to identify any strategy for
20 improving.

21 DR KIRKUP: Yeah, okay. You've identified – in fact, I think it's the longest of your
22 recommendations to address this – about leadership, regular weekly fora
23 where people would get together and discuss cases; this would be an essential
24 component for the working week, and so on. It's page 15, at least in the

1 version I've got. Were you able to test out that recommendation in advance
2 with the clinicians as you were talking to them? Did you sound them out about
3 how feasible it would be to introduce those changes?
4 DAME PAULINE FIELDING: Yes, and I think there was... We didn't encounter, I
5 don't think, any opposition to team working. I think there was just a worrying
6 acceptance that it wasn't good, this is the way it is between Lancaster and
7 Barrow, and I think the clinicians were so focused on their own clinical practice
8 that they really didn't take that wider view of the service as a whole.
9 DR KIRKUP: Okay. I know you haven't seen any action plans and so on, but would
10 you be surprised if that particular recommendation hadn't formed a part of any
11 of the action plans? Would you regard it as an essential component?
12 DAME PAULINE FIELDING: Well, yes, it would have been crucial, yes.
13 DR KIRKUP: Okay, thank you.
14 MR BROOKES: Just a couple of quick questions, one just to clarify in my own mind:
15 as part of your looking at the governance arrangements in the organisation,
16 and accepting what you said about the five cases particularly, did you look at
17 the SUIs process – not the specific cases, in other words – as part of that
18 governance?
19 DAME PAULINE FIELDING: Yes.
20 MR BROOKES: Yeah, and what were your views on that?
21 DAME PAULINE FIELDING: Our views were that, in principle, that the process was
22 there, that these untoward incidents would be reported upwards. That's all I
23 can say really. The Trust did seem to have the mechanism there.
24 MR BROOKES: So there was a clear process for reporting serious untoward

1 incidents, investigating serious untoward incidents and the learning from those
2 serious untoward incidents.
3 DAME PAULINE FIELDING: Well, I think the learning from it was maybe not as
4 robust as it should have been. The dissemination to the rest of the
5 organisation was a bit problematic, and I think it was problematic because of
6 this issue with team working, that clinicians were very wedded to their own way
7 of doing things, and the process of putting guidelines in place seemed quite
8 chaotic.
9 MR BROOKES: Thank you. Just turning to your section on clinical governance in
10 the report as well, which is very interesting, I just want to clarify my
11 understanding. You were describing the process across the Trust, and I get
12 the flavour that it was very committee based. Was your view that it was owned
13 and lived as part of clinical practice within the various parts of the Trust, or was
14 it very much a process driven to the Committee reports kind of thing?
15 DAME PAULINE FIELDING: I think, with the exception of maybe the risk
16 management issues, which staff did seem to own and talk about, and were
17 able to talk about, I think the rest of it, you're right, was committeed driven.
18 MR BROOKES: Okay, and was there any difference that you experienced in terms
19 of the governance processes and application at different sites, different units?
20 DAME PAULINE FIELDING: I don't think I could comment on that.
21 MR BROOKES: Okay, thank you.
22 MS FEATHERSTONE: I appreciate that one of your colleagues was a consultant
23 midwife, and it may be that you might not be able to remember some of this,
24 but there was a comment within the report about midwifery supervision. Can

1 you remember...? It's on page 17. The three recommendations – can you
2 remember how you came to some of those recommendations, particularly
3 about the supervisory midwife not being on call? Can you remember anything?
4 DAME PAULINE FIELDING: If I can remember it correctly, there was a confusion
5 amongst staff about what a supervisor was properly meant to deal with. There
6 was a tendency, I think, for midwives to expect the supervisor to sort out
7 staffing issues or managerial things, rather than the proper work of a
8 Supervisor of Midwives, and certainly the consultant midwife, Yana Richens,
9 felt that having a Supervisor of Midwives on call when they're not on duty was
10 actually inappropriate and encouraged this going to the supervisor to sort out
11 what really should be managerial issues, so that's the background to it.
12 MS FEATHERSTONE: Okay, lovely. Thank you.
13 PROF WALKER: Can I go back to the glossing of the investigation in the first
14 place? In the terms of reference, they say 'to provide further assurance'. Now,
15 that assumes that there has been assurance before and everything's okay, and
16 what you're coming in to do is just confirm that things are fine and moving
17 forward, so you're being given a starting point which assumes a certain
18 conclusion, so it's not an open investigation to go and see what the problems
19 are. I mean, in looking at the report, you seem to have highlighted there are
20 certain problems, and you say yourself you didn't feel you reassured them, so
21 do you feel, first of all, that, in fact, the whole starting point of your report or
22 your inquiry and the terms of reference you were given, in retrospect, were
23 probably directed in the wrong way?
24 DAME PAULINE FIELDING: Well, I wasn't actually given these terms of reference.

1 I actually constructed the terms of reference in the absence of any terms of
2 reference.
3 PROF WALKER: But that was after discussion with the Chief Executive.
4 DAME PAULINE FIELDING: That was after a discussion with the Chief Executive,
5 yes, and I think I maybe had the feeling that, at that point, that a lot of the
6 issues had been dealt with. So I can only say that I wrote the terms of
7 reference at the point that I thought we were at then, and maybe that turned
8 out not to be the case.
9 PROF WALKER: With the remit of your inquiry, do you feel now, in retrospect, if you
10 knew what you know now then, would you have directed the terms of reference
11 in a different way or asked for a different remit?
12 DAME PAULINE FIELDING: Well, I think the terms of reference are still relevant. I
13 think, if I was writing them now with the benefit of hindsight, they would be
14 more constrained in terms of the time and resources that were available, but, I
15 think, at the time they were reasonable terms of reference.
16 PROF WALKER: And the other thing is, through the report, you have written, saying
17 there's changes in management, there's a new person been appointed and so
18 on. Did you get any idea of what that change of management or new person
19 was going to do, what the plans were, which would actually alter the practice
20 for the better, or was there an assumption that this person was going to make it
21 better?
22 DAME PAULINE FIELDING: I think the only person that we identified who was new
23 in post in a significant post was the Head of Patient Experience, and I don't
24 think – you know, we certainly didn't expect that person to remedy all the

1 problems that we had identified, so I'm not sure that I could really comment
2 very much on that.
3 PROF WALKER: Well, you might have got some feel of the idea that they had
4 already picked up what the problems were and where the solutions were going
5 to be, or do you feel that they didn't have a handle on that?
6 DAME PAULINE FIELDING: Right, I think the Trust Board, certainly from our
7 discussions with the Chief Executive, the Nursing Director, the Medical
8 Director, I think they felt that the organisation was in a better state than it was.
9 PROF WALKER: Okay. Lastly, there are various national documents about
10 guidelines of practice or recommendations of practice, particularly within the
11 labour ward – the role of ward rounds, team working, etc., and how clinical
12 governance issues are handled. Did you use these as a template to review
13 how they practise, and then would you make your recommendations more
14 robust by saying – things like guidelines for instance – if there's a NICE
15 guideline, then people can't not follow it; they're meant to follow it, so did you
16 do that?
17 DAME PAULINE FIELDING: To a limited extent, I think, but not to a great extent. I
18 relied on my clinical experts to bring that information to the table, so maybe we
19 didn't do that to the extent that we should have done.
20 DR KIRKUP: Thank you. Jonathan, you wanted to come back.
21 PROF MONTGOMERY: Thank you. There were just a couple of things that you've
22 said in that that I just wanted to make sure that I understood the context to.
23 One of them was around the degree of confidence you felt you had in the
24 advice you got from your clinical colleagues, and that made me realise that I'm

1 not quite sure I understood the recruitment process, because you talked, very
2 early on, about the Trust providing those experts. Can you talk us through a
3 little bit about your understanding of how those two people were identified?
4 DAME PAULINE FIELDING: I don't know what the process within the Trust was.
5 The Trust simply informed me that the consultant midwife was Yana Richens
6 and the obstetrician would be Professor Calder, so I don't know what process
7 the Trust went through in order to identify those people.
8 PROF MONTGOMERY: And did any of the three of you have, previously, links with
9 the Trust? You said you were known to the SHA. Were you known to the
10 Trust as well?
11 DAME PAULINE FIELDING: I did know the Chief Executive and I knew the Nursing
12 Director because I'd worked in – I was previously Nursing Director at
13 Lancashire Teaching Hospital, so obviously I knew of them, but I didn't know
14 either the midwife or the obstetrician, no.
15 PROF MONTGOMERY: And did they know people in the Trust?
16 DAME PAULINE FIELDING: No, not to my knowledge.
17 PROF MONTGOMERY: And what sort of contact had you had with the Chief
18 Executive previously? Did you know him or know of him?
19 DAME PAULINE FIELDING: I knew him. I'd been on a management programme
20 with him previously.
21 PROF MONTGOMERY: Thank you. That's helpful. The other thing – if I can find it
22 – was a phrase you used, and I wrote it down, but I realise, looking at it again,
23 I'm not quite sure whether I understand what it means. You talked about the
24 report being an independent report, not 'NHS family'. Can you just elaborate a

1 little about what you meant by that?

2 DAME PAULINE FIELDING: I meant that the people who were commissioned to do

3 the report, myself and Yana and Professor Calder, were not doing it as NHS

4 employees, so, in that sense, we were not within the hierarchy of the NHS in

5 terms of doing this report.

6 PROF MONTGOMERY: Thank you, and do you have any experience of doing

7 reports like this, but inside the hierarchy – is that...?

8 DAME PAULINE FIELDING: Yes, I mean, the work that I've done with the

9 Healthcare Commission and Care Quality Commission.

10 PROF MONTGOMERY: Thank you.

11 DR KIRKUP: Thank you. I think I know the answer to this, but I need to ask my

12 colleagues. Are there any questions of a patient confidential nature that you

13 want to ask? I don't imagine so, in light of the subject matter, but... And is

14 there anything of that nature that you wish to raise with us?

15 DAME PAULINE FIELDING: No.

16 DR KIRKUP: Okay. Is there anything else that you'd like to say to us before we

17 bring the proceedings to a close?

18 DAME PAULINE FIELDING: No.

19 DR KIRKUP: Okay. Thank you very much for your help. Thanks for your answers.

20 Much appreciated.

21

22 [The meeting concluded at 12.47 p.m.]

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 Adviser on Governance
Professor Stewart Forsyth – Expert Adviser on Paediatrics
Professor James Walker – Expert Adviser on Obstetrics

DENISE FISH

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1 DR KIRKUP: Hello, my name's Bill Kirkup. Thank you for coming. I'll ask the other
2 panel members to introduce themselves.
3 PROF FORSYTH: Good morning. My name is Stewart Forsyth and I'm a
4 paediatrician and, latterly, a medical director in Tayside, in Scotland.
5 MR BROOKES: I'm Julian Brookes. I'm Deputy Chief Operating Officer for
6 Public Health England and I'm here looking at governance arrangements.
7 PROF WALKER: I'm Jimmy Walker. I'm Professor of Obstetrics and Gynaecology
8 in the University of Leeds, but I have a background in the National Patient
9 Safety Agency in clinical governance.
10 DR KIRKUP: Okay, you'll have seen that we're wired for sound and the intention is
11 that we're making a recording of this to produce an agreed record of
12 proceedings. You'll know that we're not having any other recording devices or
13 potential recording devices in the room and it's just to reinforce the fact that the
14 reason for that is what we don't want is for bits of information to be coming out
15 in bits and pieces. What we want to do is to produce a report, put everything
16 into context and draw the appropriate findings. So, just a reminder that what
17 goes on here stays here until the report's completed.
18 MS FISH: Yes.
19 DR KIRKUP: Okay.
20 MS FISH: Yes, thank you.
21 DR KIRKUP: Is there anything that you would like to ask me before we start or are
22 you content with that?
23 MS FISH: I'm content with that, thank you, sir.
24 DR KIRKUP: Okay, thanks. I'd like to start off, before handing you over to other

panel members, just with a very general question, which is can you tell us what your first association was with the hospital or the Trust and what you've done since then?

MS FISH: My first association was in 1984. Prior to that, I'd been working in a London teaching hospital, a centre of excellence where I took charge of the delivery suite for some time.

DR KIRKUP: Okay, which hospital was that?

MS FISH: Queen Charlotte's.

DR KIRKUP: Right.

MS FISH: When I came, in 1984, it was to close the old maternity hospital ~~in September~~ and open the new one in September ~~November~~. And when I arrived there were very few guidelines, so ~~I set to with~~ two of the other senior midwives and myself ~~we~~ developed all the guidelines that were then introduced and they currently went on to become evidence based and then went forward towards the CNST accreditation.

DR KIRKUP: Okay. And what have you done since then?

MS FISH: Well, one of my proudest moments was when we actually introduced the midwifery training school and that was in the late '80s. I then developed midwives who were then becoming responsible for mental health and domestic abuse and we also created ~~developed~~ a newspaper called *Maternity Matters*, which was distributed locally. ~~And~~ Then, later on, up until 1998, I had sole responsibility for Furness General and I knew exactly what was going on in the unit. ~~at Furness General~~. In 1998, we then amalgamated with Lancaster and Kendal and became the Trust, covering 1,000 square miles with a journey time

1 of – ~~it was~~ 50 miles, 100 miles round trip to Lancaster.

2 I split my time between Lancaster and Barrow and Kendal: two days at
3 Lancaster, two days at Barrow, one day at Kendal, but I also had other
4 responsibilities nationally, regionally and local, so quite often I wasn't in the
5 units on those particular days.

6 DR KIRKUP: What was your position at that time when you were splitting your time
7 between the three?

8 MS FISH: I was the head of midwifery services.

9 DR KIRKUP: Right, okay, and covering each of the three sites.

10 MS FISH: Yes.

11 DR KIRKUP: Yeah, okay.

12 MS FISH: And community midwifery ~~an~~and gynaecology services as well~~.~~
13 ~~community midwifery services as well.~~

14 DR KIRKUP: Okay. There's a kind of implication in what you said there that you
15 then felt less able to have your finger on the pulse of what was happening at
16 each of the individual sites, particularly Furness General. Is that right or am I
17 putting words in your mouth?

18 MS FISH: No, you're not putting in words; that was correct. There were major
19 issues in one of the other hospitals and they resented, I think, us all coming
20 together. It was difficult ~~like three tribes~~ trying to make it into one team and I
21 spent a lot of time at that hospital over the next few years.

22 DR KIRKUP: Right. Just to be clear, which hospital was that?

23 MS FISH: That was Lancaster and they were all to do with personnel issues.

24 DR KIRKUP: Yeah, okay. And at that stage, was your view that Furness General

was functioning satisfactorily?

MS FISH: Yes.

DR KIRKUP: So you would perhaps have given it less attention because of the problems on the other site.

MS FISH: I couldn't give it the attention that I gave it previously. ~~I mean,~~ P~~p~~reviously I would be walking the wards, going on the labour ward, knowing exactly what was going on, going out with the community midwives.

DR KIRKUP: Did you have a deputy who was solely responsible for Furness?

MS FISH: I didn't have a deputy. I had three matrons there, but not a deputy as they have today.

DR KIRKUP: Okay. What was your view of the state of that maternity unit at Furness when you left in 2007?

MS FISH: 2007, I was very proud to have left that unit. I thought it was a good unit. We had been inspected and the inspections that we had were always complimentary. If there were any issues, they would be addressed and, yes, I was very proud to have been the head of midwifery of that unit.

DR KIRKUP: Okay. What did you go on to do?

MS FISH: Retired.

DR KIRKUP: You retired, okay. Thank you. I'll hand you over to Jimmy.

PROF WALKER: Hi. I just want to follow up on that, just some more detail. When you were head of midwifery who did you report to?

MS FISH: There was a directorate manager above me and then there was a director of nursing and midwifery at Trust level.

PROF WALKER: Okay. And was that true before the merger and after the merger

1 or when you were at Furness before the merger, were you directly –

2 MS FISH: Initially, I was solely responsible for financial and midwifery services, but
3 once we started to go into units and district hospitals then they introduced
4 managers above me.

5 PROF WALKER: So, at that change, did you find a difference in how you could
6 tackle a problem? Do you feel you were at the centre of things beforehand and
7 then, all of a sudden, you were then buffered from the decision-making?

8 MS FISH: Yes, particularly in relation to finance~~ial~~. I mean, I could move the
9 finances around and I found that very daunting when I no longer had control
10 over the ~~financial~~finances... ~~the monies for the financial,~~ because I could have
11 employed extra midwives or I could employ extra nurses, but that responsibility
12 then was taken away.

13 PROF WALKER: A further thing would be, did you find that – reporting to a director
14 of nursing, did they have any midwifery background or not?

15 MS FISH: No.

16 PROF WALKER: Did you find that they had understanding or empathy with you for
17 the problems that you had in midwifery?

18 MS FISH: I found the director of nursing and midwifery who was there when I was
19 there was very supportive.

20 PROF WALKER: Okay. Now, downwards you were saying you had three matrons.
21 Were these matrons in the three individual hospitals or were they three
22 matrons within the structure?

23 MS FISH: ~~They were three matrons at —~~ Tthere were ~~was~~ more than three
24 matrons across the new Trust. There were seven. There were three at

Lancaster, three at Barrow and Furness and one in Kendal.

PROF WALKER: Did you have a lead midwife for the maternity in each of the different hospitals that you could rely on as a main deputy?

MS FISH: Yes. I would talk to each one of them about the specific areas. I mean, there was one for the labour ward, one for ante and postnatal and one for community, so I could talk to those three.

PROF WALKER: Okay, so there would be a matron for antenatal and wards or whatever it was in each of the hospitals and they all report to you.

MS FISH: Yes.

PROF WALKER: So there was no one person with responsibility for Furness, for instance.

MS FISH: No.

PROF WALKER: No, okay. Now, obviously you saw a lot of changes over the period of time you were there and particularly with the whole concept of clinical governance which was coming as a developing sort of entity and you mentioned about, first of all, guidelines. How did you set up the system for developing guidelines and then how did you show that they were being implemented?

MS FISH: In the early stages it was midwives and we -then discussed them with the Consultants ~~sat down and we introduced them and then~~, and latterly, we had a team of people. ~~-We had~~ Tthe consultants, midwives ~~-and the~~ paediatricians and the users and we would go through ~~sit round and look at~~ them and made sure they were evidence based.

PROF WALKER: Okay. And how would you make sure they were evidence

based?

MS FISH: We would research them~~ and check~~, benchmark other units and look what was happening there.

PROF WALKER: Okay. Now, you said you started off as midwife-driven really. I mean, how much did the obstetricians particularly get themselves involved in developing the guidelines?

MS FISH: One or two of them were very supportive.

PROF WALKER: And as far as documentation was concerned, did you feel that the medical staff accepted them and implemented them as much as the midwifery staff did?

MS FISH: Some of them, yes~~, they did~~, but not all.

PROF WALKER: And did that cause problems within the labour ward as far as between the midwives and the doctors and the doctors versus the doctors?

MS FISH: No, it didn't, because we made sure that before it went to that level it was agreed ~~sorted~~. The discussions took place in meetings where we said, 'We have to agree these before they can go to the wards'.

PROF WALKER: So when the guideline was eventually produced, would everyone be signed up for it?

MS FISH: Yes, ~~yes~~.

PROF WALKER: And would they then be followed? There would be no situation where one consultant would feel that their patient should be managed in a different way.

MS FISH: No, because they had been agreed. ~~were — no, because they were there and they were the guidelines.~~

1 PROF WALKER: Okay. Now, on the other side of governance is the assessment
2 and reporting of incidents. So, if an incident occurred, within, say, the delivery
3 suite and which came with a bad outcome, how would that be tackled?
4 MS FISH: The midwife or the doctor responsible would fill out a serious incident
5 form. That would go to the risk management midwife and be discussed with
6 the leadn clinician and if they could action it ~~that~~, they would do so ~~action it~~.
7 And then – it was all a paper trail – The ~~and then~~ forms would come to myself
8 and the Clinical Director ~~lead clinician~~ and he and I would sign them off and
9 see if there was anything that we needed to action ~~address~~.
10 PROF WALKER: Okay, so I'm a bit confused. Someone reported an incident and
11 then, at the end of the day, you would sign something off, but what's the bit in
12 the middle? How is it reviewed, how is it sort of assessed, who assesses
13 them, what recommendations are there, etc?
14 MS FISH: It tended to be the risk manager and the lead clinician, -then it would be
15 discussed by the Directorate team on each site. ~~and, for example, if~~ If there was
16 a policy that needed changing, (the policies and procedures were reviewed at a
17 maximum every three years), but if something occurred that we needed to
18 change those, then it was implemented and become ~~they would be~~ part of ~~that~~
19 ~~implementation of~~ that new guideline.
20 PROF WALKER: Okay. If an event had occurred and, say, a bad particular even
21 had occurred, how was it followed up to make sure that it was reported?
22 Because if it's dependent on the doctor or the midwife involved, they may not
23 report it. Was there another way of picking it up?
24 MS FISH: ~~Well,~~ Wwe had supervisors of midwives ion all the areas. They would

audit notes, ~~but it would be~~ – it wouldn't be hidden, sir. Someone would report it.~~I mean, the unit was such that we knew exactly what was going on and that would be reported~~.

PROF WALKER: So you're fairly confident that all the events would have been flagged up and some sort of process started.

MS FISH: Yes whilst I was in post.~~.~~

PROF WALKER: Okay. Now, after an event like this occurred, obviously there's a lot of distress caused within not only the parents involved but also the staff involved. Was there any debriefing of the staff immediately about events that occurred, discussing what went wrong and just getting an open discussion about the problems that were there?

MS FISH: It depended on the seriousness. I mean, I'm thinking of ~~-~~one ~~some~~ serious incident~~s~~ where we actually got counsellors in ~~and~~ to talk to the staff~~I sat down with them~~, the consultant came in ~~as well~~ and the~~y~~ staff were given the option of going on to further counselling if that's what they needed. ~~-But~~ T~~t~~hen we would discuss ~~sit down and say~~ what could ~~can~~ we do about this, how can we change it, how can we make sure that this doesn't happen again?

PROF WALKER: Okay. And what system was available for the parents of a child which was damaged or died within childbirth? Was there a particular system external to that that would pick up problems for them and discuss with them and feed back to them?

MS FISH: If we had a baby who had died, I would go out and see the parents myself with one of the midwives. We also had a bereavement midwife – sorry, she was a nurse, a bereavement nurse within the unit and she would keep in

1 contact with the parents. They were also given the opportunity to come and talk
2 to members of the Trust.
3 PROF WALKER: Now, when you say you had all these things, when were they in
4 place? Were they in place from the beginning right when you were there or
5 were they...?
6 MS FISH: They were certainly there in the late 1990s and 2000s.
7 PROF WALKER: And did you feel that when the merger occurred of all the
8 hospitals that this sort of service and hands on knowledge and approach was
9 still available in all the hospitals? Because you presumably couldn't have given
10 the same input for all three hospitals that you gave for Furness initially.
11 MS FISH: We certainly had. – I know that for the bereavement counsellors post at
12 Furness, the money was gradually withdrawn and her hours were drastically
13 reduced.
14 MR BROOKES: Sorry, I just missed, who was that?
15 MS FISH: That was the bereavement counsellor.
16 MR BROOKES: Okay, thank you.
17 PROF WALKER: Okay. And did you have any feel of how that affected the service
18 you could provide the patients attending the hospital?
19 MS FISH: We had a number of midwives who were particularly interested in
20 speaking to parents after the bereavement, so there were a number of those
21 who were available.
22 PROF WALKER: Did they have particular training or were they just interested?
23 MS FISH: They were interested. They may have attended study days. ~~They didn't~~
24 ~~have particular training~~.

PROF WALKER: But did you feel that the service was maintained by these volunteer individuals or did you feel the service was reduced when the bereavement counsellor's hours were cut?

MS FISH: ~~I think it was decreased.~~The ongoing Community Service by the Bereavement Counsellor was decreased.

PROF WALKER: Okay. The other source of problems for a delivery suite is complaints from users. How were the complaints handled?

MS FISH: The letters of complaints usually came to me. If I could address them, I would and I would also ~~could~~ go out and see the parents.~~, talk to the parents, then I would.~~ If it was more serious than that, it went to the director of nursing and midwifery and ~~often~~ we would arrange a meeting ~~sit down~~ with a number of people and invite the parents to come and talk to us.

PROF WALKER: A lot of this, plus the follow up of bad events, appear to be very much personally done by you, as the head of midwifery. I mean, it's very good that you were involved, but that seems to be quite a large remit for you as well as the management.

MS FISH: ~~I'm sorry, sir,~~ T~~t~~his was really in relation to Furness~~, even when we took over the other three~~. The others I would leave to the matrons at Lancaster although I did meet parents at Lancaster and Kendal.

PROF WALKER: And did you feel that they provided the same level of personal level as you did?

MS FISH: Yes.

PROF WALKER: Okay. Within the delivery suite in a lot of cases which we've looked at and so on, there's some conflict sometimes between the midwives

1 and the doctors or things have not been done as quickly as the midwives seem
2 to want them to be done and so on. Was this a common problem or would
3 these be isolated incidents or was there problems between the midwives and
4 the doctors?
5 MS FISH: I didn't see any problems between the doctors and the midwives. The
6 consultants that I had worked with, again the two at Furness, we had a very
7 good working relationship. We did have new consultants and I had very little
8 input with the new consultants. ~~But from going on the labour wards,~~ Wwhen I
9 went on the labour wards there seemed to be a good relationship between the
10 medical staff and midwives.
11 PROF WALKER: Okay. One of the sort of guidelines or comparisons you do is the
12 ability to react to a problem in hospitals and particularly if an event occurred of
13 acute foetal distress, the ability to deliver within 30 minutes is the sort of target
14 time. Did you feel that Furness was equipped adequately to do that, to fulfil
15 that requirement?
16 MS FISH: I did.~~, because we'd introduced –~~ Wwe had skills and drills training. I got
17 as many of the midwives as we could on to the advanced life support obstetric
18 course and the junior doctors also went on that, so they should have been~~, yes~~.
19 PROF WALKER: So you felt that – did you audit the sort of the time – the decision
20 to deliver interval at all within the hospital? Do you have any feel of how well
21 you did at practising that?
22 MS FISH: I can't remember that, sir.
23 PROF WALKER: Okay. I mean, audit is one of the other pillars –
24 MS FISH: Oh audit, yes, we audited and we had annual audit meetings where we

1 could compare across the Trust.

2 PROF WALKER: Okay, but would you have audit of, say, decision to deliver

3 intervals? Would that be one of the audits you would do? You may not

4 remember.

5 MS FISH: I am sure we did ~~that~~ but I can't remember the details, I'm sorry.

6 PROF WALKER: So what sort of things did you audit?

7 MS FISH: We audited the clinical notes. We would do spot checks on the

8 midwives' notes, seeing if they were contemporaneously maintained. We

9 would look at training programmes, what the doctors and midwives had

10 undertaken, Induction of Labour, Caesarean Section rates ~~and~~... I can't

11 remember anymore.

12 PROF WALKER: Okay.

13 DR KIRKUP: Okay, thank you. Stewart.

14 PROF FORSYTH: Good morning again. Can I ask about some of the operational

15 management aspects of, particularly, the midwifery unit in Furness? You've

16 given an impression that things were running fairly smoothly in Furness. There

17 must have been some day to day issues arising and I just wonder what you felt

18 the current – what the issues were that you were met with while you were

19 responsible for the unit.

20 MS FISH: I think a lot of them were to do with staffing levels, staff shortages, staff

21 coming in on their days off at short notice.

22 PROF FORSYTH: Can we just ask a bit more about the staffing? Were there

23 issues about meeting about recommended levels of staffing?

24 MS FISH: Yes, we – I think it was about 43.5 ~~32~~ full-time equivalents at Furness

1 General.

2 PROF FORSYTH: Sorry, how many?

3 MS FISH: It was 43.5 (~~Thirty-two~~), I think it was, full-time equivalent midwives at
4 Furness General. I'm going back seven years, but I think it was about that.
5 And then we were told, because of financial restraints, we had to reduce the
6 number of midwives ~~and~~ I was very much against this. I actually said, 'It's the
7 most litigious area within the Trust and to reduce midwives ~~is~~ –could put the
8 Trust at Risk.

9 PROF FORSYTH: So what was the reduction you were...?

10 MS FISH: For example, we would have two midwives on the ante and postnatal
11 ward at night, three midwives on the delivery suite and we were told to reduce
12 the numbers of midwives ~~on the labour ward — sorry~~, on the postnatal ward, so
13 there was only one midwife and two Maternity Care Workers on ~~maybe a~~
14 ~~support worker or two,~~ the antenatal and postnatal ward. I felt that was
15 insufficient. The idea was that we took a midwife from the labour ward and
16 they would help out on the postnatal ward, but if they were busy and the
17 postnatal and antenatal ward was busy, there would be somebody on call.

18 MR BROOKES: When was that change introduced?

19 MS FISH: That was ~~round about~~ just before I left. It would have been around
20 2006~~5~~. And then ~~we got involved with~~ the unions got involved at Furness
21 General, which had never happened before, because they were ~~so~~ concerned.
22 So we said we would put a midwife on call, to call her in if it was getting busy,
23 ~~but I didn't think that was safe.~~ We also had a Supervisor of Midwives on call
24 each night and they would be called in if the unit became busy. I have also

1 been called in.

2 PROF FORSYTH: So what were you using as a benchmark for calculating your
3 midwifery requirements?

4 MS FISH: We did Birthrate Plus.

5 PROF FORSYTH: Does that allow for small units as well as large units?

6 MS FISH: Not for Kendal. It was very difficult doing Kendal, but Kendal were fine.

7 PROF FORSYTH: Yes. Yes. And so did you feel that this had a consequence on
8 the level of care that was being provided?

9 MS FISH: It could have had. I think the midwives were working as hard as they
10 could to make sure it didn't. Yes, it did, because they couldn't aways offer
11 women – ~~they couldn't~~ help ~~somebody who was~~ with breastfeeding, they hadn't
12 the time.

13 PROF FORSYTH: And so that you're having to pull in midwives at the last minute to
14 come in and do extra shifts. And were they local or were they coming from
15 locum agencies?

16 MS FISH: We didn't have agency midwives. It would be Bank or Part time midwives.

17 PROF FORSYTH: Right, right. Did this affect the midwives in terms of – you said
18 you were providing training, etc. Did this impact upon training opportunities for
19 staff if they were so busy just trying to maintain the service?

20 MS FISH: No, each student had – we didn't have many students, but each student
21 had their own mentor ~~and~~ –

22 PROF FORSYTH: I was thinking of the substantive members of staff maintaining
23 their skills in resuscitation, for example.

24 MS FISH: They had to do an annual update, at least an annual update and,

following an incident, the ~~they actually did their~~ skills and drills increased to twice a year.

PROF FORSYTH: And were there midwives coming in at times of short notice who would generally spend most of their time working in the community, for example, and therefore were not particularly having a large part of their job within the labour suite?

MS FISH: ~~Not really in my day, no.~~ Not while I was there. We did bring the Community Midwives into the unit for updating.

PROF FORSYTH: Not in your day.

MS FISH: No.

PROF FORSYTH: Okay.

MS FISH: They were coming in for updating, but that was during the day time.

PROF FORSYTH: Yes, yes, okay. So did you feel that – again just to be absolutely clear – that the unit was under pressure because of the staffing issues?

MS FISH: Yes, ~~latterly.~~ On occasions. But encountering the same problems as any other Maternity Units when pressures of work and sickness levels reduce staffing levels.

PROF FORSYTH: And was that information being taken to a higher level within the Trust?

MS FISH: ~~Oh yes. I mean,~~ Wwe discussed it at our –Directorate Meetings

PROF FORSYTH: So can you just explain how it got up to – did it get to the highest level within the Trust, this?

MS FISH: Yes.

PROF FORSYTH: Was it discussed at a Trust board meeting, for example?

MS FISH: Yes, because I did a presentation at the Trust board meetings.

PROF FORSYTH: You did a presentation. When was that, do you have any idea?

MS FISH: It would have been between 2004, 2007. It was just to give an outline of what was happening. I cannot remember ~~Now, I don't know~~ if we actually talked about the pressures then. I could see if I could try and find that report, but I don't know- who has it or where it is. But I did talk to the director of nursing and midwifery and I did actually go and talk to the chief executive, because he had an open door and I told him that I was unhappy about the staffing levels.

DR KIRKUP: What was their response?

MS FISH: 'We're under financial pressure. We need to be cutting back. You're well staffed' ~~and we weren't~~.

DR KIRKUP: Sorry, Stewart.

PROF FORSYTH: Okay. It was touched upon earlier about escalation of care. Were there examples of any of the incidents that took place in your time that there was a slow to respond to a changing clinical situation in the unit?

MS FISH: Do you mean a specific?

PROF FORSYTH: Well, I'm thinking of the maternity unit, in ensuring that the midwives are quite clear when they needed to seek help from medical staff and the medical staff needed to seek help from elsewhere.

MS FISH: Yes, sir, they were.

PROF FORSYTH: They were.

MS FISH: They were.

PROF FORSYTH: And what do you think was the explanation for that?

MS FISH: I think for one particular incident it was the time. They didn't realise what the time factors were. They were busy. But my comment to that particular incident was that medical aid should have been called immediately as soon as they detected an issue. That's what I would have done. And other things should have been done within that case as well.

PROF FORSYTH: Do you think that at times there were cases being looked after at Furness that would have been better off in a facility with more intensive care or other specialist care around?

MS FISH: I think there should have been clear guidelines on some notes to say this is a medical and the consultants, the registrars should have been informed as soon as that lady went into labour.

PROF FORSYTH: And, as head of midwifery, I just wonder what action you could or should have taken to try and make that happen.

MS FISH: ~~Well, I introduced -- I obviously spoke -- do you want me to go into details?~~ I spoke to Senior Midwives and Supervisors and re-iterated the need to tell midwives they must inform Medical staff if they have any concerns over a ~~womens~~woman's care. Or if they felt she should be under the care of the Medical Team.

PROF FORSYTH: Well, if you're saying there were certainly cases that should be medical, but in fact were coming through and being looked after by midwives, as head of midwifery were you not --

MS FISH: There was one particular incident.

DR KIRKUP: Can I just say we don't want to talk about individual incidents at this stage, for reasons of patient confidentiality. If you can keep it general, that

1 would be helpful.

2 MS FISH: Right, thank you. Yes, we would have ~~sat down and~~ looked at that
3 particular case. There would have been a supervisory review on the midwife
4 concerned. I would have spoken to the midwife and then I would have acted
5 upon that supervisory review and made actions from that supervisory review.
6 The other midwives would have told about the changes and what had
7 happened on that particular occasion. Record keeping was audited more
8 frequently and, as I said earlier on, new guidelines were introduced, so
9 everybody was very clear as to what should have happened.

10 PROF FORSYTH: Did you cover the neonatal unit?

11 MS FISH: No. I did in the very beginning, in the '80s. It was a little special care
12 baby unit, but then, once we went into the main Trust, it became part of
13 paediatrics.

14 PROF FORSYTH: It became part of...?

15 MS FISH: The children's services.

16 PROF FORSYTH: Children's services, yeah. Again, in your time, how did – the
17 relationship between paediatricians and midwives in the labour suite and
18 paediatricians and obstetricians, how did those relationships work out?

19 MS FISH: They were quite... I'm trying to think of the right words to say. Some of
20 the paediatricians I don't think had any respect for the obstetricians and there
21 seemed to be quite a clash between ~~the~~ two of them. ~~And in relation to – I~~
22 ~~mean, some of them would just go off at – I'm sorry, I'm waffling.~~

23 DR KIRKUP: No, that's fine. We want you to be frank and bear in mind you're not
24 the only person who's talked to us about all of this, so please just say what you

1 think.

2 MS FISH: ~~Some of the paediatricians were kind of in their own world and~~ Iit was

3 very difficult ~~hard~~ to get ~~them~~ Paediatricians to come to meetings. It was very

4 hard to ~~kind of~~ introduce new concepts to them. And there wasn't very many of

5 them. ~~I mean,~~ Tthere was just a couple of consultants and they didn't ~~seem to~~

6 have any Middle grades- the next level down was very junior staff, so quite

7 often the senior midwives were more experienced than the ~~very~~ junior staff.

8 PROF FORSYTH: So, from your perspective, covering the labour suite, for

9 example, did you feel, therefore, that the paediatric input was substandard?

10 MS FISH: Yes.

11 PROF FORSYTH: What about –

12 MS FISH: Having come from a London teaching hospital, yes.

13 PROF FORSYTH: Okay. We'll maybe talk about that a bit more later. In relation to

14 networks, there is obviously the Trust network of hospitals, but there is the

15 regional network for transferring obviously more high-risk mothers and, clearly,

16 sick babies in the newborn period. Do you feel that worked adequately when

17 you were in position?

18 MS FISH: Yes, ~~yes~~. I'm thinking of a couple of cases helicoptered out ~~and things~~

19 ~~like that or~~ and decisions made well in advance. Because this small ~~little~~

20 special care unit couldn't cope with at-risk women.

21 PROF FORSYTH: No. So, when you were in post, if a baby – a mother came in, in

22 pre-term labour and had to go ahead and have a delivery in Furness, would

23 that baby of maybe less than 34 weeks gestation be transferred out?

24 MS FISH: Not in the early days, no. The consultant paediatrician was always there

~~—was usually there and the baby would be transferred and they~~ the baby could be resuscitated and maintained at FGH.. But if there were further problems with the baby, then it was transferred out and it could be Manchester or Leeds or Newcastle.

PROF FORSYTH: Okay.

PROF WALKER: Can I just follow up on some of the things? You talked about cases coming through the hospital. I mean, how were the cases risk assessed when they first booked in?

MS FISH: The consultant would look at them and say that this particular lady, her previous history, for example, or whatever problem there was he would say, 'Well, if she comes into preterm labour, she's for transfer' and then they would discuss it with the paediatricians.

PROF WALKER: What about other things, like risk of maternal disease if they were diabetic or they had high blood pressure, would all these cases be –

MS FISH: No, some of them were looked after at Furness General or at Lancaster.

PROF WALKER: So some of them would be seen by somewhere else, so the obstetricians would screen them.

MS FISH: Yes.

PROF WALKER: So there was an acceptance that a certain level of patient would be looked after elsewhere.

MS FISH: Yes.

PROF WALKER: The other thing is that within the labour ward during the day, you said you would have two or three midwives on, would that be right?

MS FISH: ~~Yes.~~ No there were more on during the day.

PROF WALKER: Would there be one of them who would coordinate for the unit or would they all just be the same level?

MS FISH: There was usually a matron who was a supervisor of midwives; she was in charge of that labour ward. And then would be what we would call sisters, G grades, and other midwives. There may be more midwives on during the day, because they were obviously doing more procedures.

PROF WALKER: But would the matron be there all the time? Would she be coordinating what goes on?

MS FISH: Yes, during the day she would be.

PROF WALKER: So that if there were at-risk patients, she would know about them or should know about them, be allocating care, making sure medical staff are there. That would be her role.

MS FISH: Yes.

PROF WALKER: Did that work well, as far as you're aware?

MS FISH: It did. And, I mean, when I used to go down to the labour ward often the doctors were there discussing it with them. ~~Yes,~~ Tthe matron there was extremely good.

PROF WALKER: What sort of handover occurred in the morning?

MS FISH: The midwives would sit down and they would hand over their cases to the midwives coming on duty and if they were still looking after a mother or they were delivering her, then they would hand over later on. So there was a full handover of care.

PROF WALKER: What about medical staff handover, were they involved at all in that?

1 MS FISH: Sometimes, but not always.

2 PROF WALKER: And would there be a ward round every morning with medical staff
3 round the ward?

4 MS FISH: Yes. ~~Yes.~~ The consultants did early morning rounds.

5 PROF WALKER: And what other rounds were there on the labour ward routinely?

6 MS FISH: The consultant would normally go round. There was a board with names
7 of women on the Labour Ward. ~~and~~ Tthey would review the women and their
8 care and often ~~look at the board and discuss that and then for his patients or if~~
9 ~~he was on for the labour ward,~~ they would go and see the women.

10 PROF WALKER: Would there be another ward round at lunchtime or at five o'clock
11 or 10 o'clock?

12 MS FISH: I think it was hit and miss, sir.

13 PROF WALKER: Okay. So the five o'clock handover – or did consultants do
14 24 hours on call or were the consultants handing over at five to another
15 consultant or can you remember?

16 MS FISH: I can't remember, because it was all changing because of the new
17 working time directives.

18 PROF WALKER: But there was only one formal ward round in the morning and that
19 was all.

20 MS FISH: ~~As far as I remember.~~ No there were more.

21 PROF WALKER: After that, it was just ad hoc coming to see patients at varying
22 points.

23 MS FISH: Yes. ~~, yes.~~

24 PROF WALKER: Okay. And what about the registrars? If they were on the labour

ward, were they committed to the labour ward or were they doing other duties as well?

MS FISH: They may have been~~were~~ doing other duties but they should have been available to come to the Labour Ward at all times.~~-~~

PROF WALKER: What, like gynaecology or being in theatres and things like that?

MS FISH: ~~Yes.~~ I do not think they would have been in theatre.

PROF WALKER: So you had no dedicated medical staff within the labour ward.

MS FISH: They did have but they didn't always stay on the labour ward ~~As far as I can remember, no. I mean, because -- no,~~ they used to have to call for them. Quite often they would be calling for the registrar.

PROF WALKER: And what about anaesthetic support, what sort of anaesthetic support did you have?

MS FISH: There was an anaesthetist on call. We wanted an obstetric anaesthetist but it wasn't always possible at FGH.~~and that was pretty hit and miss.~~ Sometimes we did have an obstetric anaesthetist and other times we did not.

PROF WALKER: So when I go back to the question I asked you before about decision to delivery interval, the decision would be made by the medical staff, but there may well be a delay getting the medical staff there to make the decision.

MS FISH: ~~Yes.~~ If a problem was developing-Doctors would be notified and if delayed an emergency call out would be made.

PROF WALKER: So that might be quite a long time if he's in the middle of theatre. How far was the gynae theatre away from the unit?

MS FISH: It was a long way.

PROF WALKER: A long way.

MS FISH: ~~When we first opened, it was on the unit and then~~ It was in general theatres, which was down a main corridor with the general public walking up and down.

PROF WALKER: So how far away, 10 minutes away, 15 minutes away?

MS FISH: By the time you got the mother on the trolley and you ran, it would probably be between five and eight minutes, I would think.

PROF WALKER: Okay, but the doctor may be in theatre and would have to come to the labour ward first to make that decision.

MS FISH: ~~Yes, yes.~~ No. He would have been allocated to a labour ward and would not be in theatre.

PROF WALKER: Okay.

MS FISH: If there was a major decision, then we contact another consultant as well.

PROF WALKER: Right, okay. Thanks.

DR KIRKUP: Thank you, Julian.

MR BROOKES: Thank you. Hello. Can I just go back to the way in which serious untoward incidents were handled? I think I've got a reasonable handle on you saying that they would be identified. Was there any criteria by which they were identified? Because there's a lot of things which may be a serious untoward incident or people don't think they're quite in that category, they're still serious, but they're still not a serious untoward incident. So was there a categorisation? What constituted a serious untoward incident and that you know?

MS FISH: Anything that really had affected the mother or the baby, there was a poor outcome for the mother or the baby. If there was a stillbirth, if there was a

1 serious incident.— Those were what I would class as serious. If there were
2 staffing issues and the mother had been left, I would class that as a serious
3 incident.
4 MR BROOKES: You'd class that, but was there clarity amongst the staff about –
5 and consistency about what was being reported through the serious untoward
6 incident procedures?
7 MS FISH: It was very early days when I was there, that they were actually
8 introducing serious incident reporting and TRIGGER LISTS. We were telling
9 them that they had to do this, but quite often if there was an incident, the
10 midwives would talk to their supervisor and then I would get to hear about this
11 or the matron in charge of the labour ward would.
12 MR BROOKES: And was there any monitoring outside of the unit of your serious
13 untoward incidents?
14 MS FISH: ~~I don't think so.~~ The local Supervising Authority.
15 MR BROOKES: So it was very discrete to you. They weren't reported to the board
16 or –
17 MS FISH: Oh, sorry, yes. Yes, we had a governance group and it would be
18 discussed at the governance group and also at the Trust as well.
19 MR BROOKES: Okay. And there's a group of incidents which are not as serious,
20 but if they're consistently happening may cause concern and medical cost. Did
21 those kinds of things get picked up through the unit and, if so, how?
22 MS FISH: That was really because of the paper trail – because it was new., It ~~that~~
23 would be word of mouth or auditing the notes, but usually word of mouth and
24 actually observing things that had gone wrong or looking at the notes or a

1 consultant saying to me, 'Look, I'm not happy about this situation'.

2 MR BROOKES: And what would happen then?

3 MS FISH: The midwives would be spoken to, they would be seen. There would be

4 training programmes, ~~if necessary,~~ introduced <u>if necessary</u>.

5 MR BROOKES: And did much of that happen?

6 MS FISH: Yes. There was certainly a lot of updating. ~~We did, as I've said – we~~

7 ~~would do~~ – if the labour ward was quiet, they would look through the guidelines

8 and they would also do skills and drills.

9 MR BROOKES: Was there learning between the three units?

10 MS FISH: We were trying to bring it together so that we had the same things on

11 each unit.

12 MR BROOKES: So there was a degree of isolation in terms of these things are

13 happening on our unit, we will address them in our particular way, but that

14 might have been also happening at one of the other units, but you might not

15 have known that.

16 MS FISH: Yes.

17 MR BROOKES: Thank you. That's helpful to understand. You talked about

18 changes in the way in which – of the control that you, as head of midwifery,

19 had and about the introduction of general management and management into

20 the line of command. Am I right in understanding that that meant that the

21 resources for the service were managed through that management and taken

22 away from you, as head of midwifery?

23 MS FISH: Yes.

24 MR BROOKES: Is that correct?

1 MS FISH: Yes.

2 MR BROOKES: When did that happen?

3 MS FISH: That happened when we went into units and districts and general

4 hospitals. That would be probably the early '90s.

5 MR BROOKES: Okay. And what was the impact, in your view, on the service from

6 doing that?

7 MS FISH: Initially, because we were fairly well staffed at that point, there were no

8 issues. It was latterly when the three trusts came together. That's when the

9 problems really started.

10 MR BROOKES: And that was in 2005.

11 MS FISH: 1998.

12 MR BROOKES: 1998, okay, so that's when the problems came. But you described

13 the staffing coming to a point in 2005, is that right?

14 MS FISH: Yes. I mean, 2005, 2006, when the chief executive –and Director of

15 Nursing and Midwifery left.

16 MR BROOKES: Yeah.

17 MS FISH: The chief executive, the director of nursing and midwifery both left in

18 2006 and were replaced and, in my mind, that's when the problems started.

19 MR BROOKES: Okay. Let's just explore that. So that was when the staffing was

20 cut in the midwifery units.

21 MS FISH: It was later, 2006, yes, because I left in 2007, so it was within that

22 12-month period.

23 MR BROOKES: Okay. And that decision was taken by the senior team in the

24 organisation on the basis, from your understanding, of reducing costs.

1 MS FISH: Yes.

2 MR BROOKES: Okay. And the impact on the staffing level was as you described it

3 at Furness, which was the reduction of one person.

4 MS FISH: One person and, also at Lancaster, Lancaster were always desperately

5 short of midwives.

6 MR BROOKES: Okay. And that was one person on the establishment.

7 MS FISH: Yes.

8 MR BROOKES: And were you normal well up to establishment in terms of people

9 in? Sickness and others weren't impacting on that.

10 MS FISH: No, sickness levels were not bad at all at that time.

11 MR BROOKES: At that time, okay. Had you compared yourself with any units of a

12 similar size in terms of your staffing? I'm thinking of the discussion you had

13 with the chief executive in terms of him saying that you were well staffed. Was

14 there any discussion about comparators? Were you well staffed compared

15 with similar size organisations?

16 MS FISH: I think we were short of staff compared with other organisations and we

17 did go to other units ~~and~~ I can't remember which ones ~~we went to just off~~ – we

18 did compare with them.

19 MR BROOKES: So, just to be clear, your understanding, if you were benchmarked

20 against similar sized organisations your staffing would have been lower.

21 MS FISH: Yes. In 2006-2007, ~~yes.~~ I certainly think so.

22 MR BROOKES: Yes, but prior to that, was it comparable?

23 MS FISH: It was okay before that.

24 MR BROOKES: Okay. So that's when the staffing levels reduced.

1 MS FISH: Yes~~ah~~.

2 DR KIRKUP: Can I just ask did you have any problems recruiting to that pre-2006
3 level?

4 MS FISH: No, we didn't. It got to the point where we couldn't actually employ the
5 midwives that we'd trained.

6 DR KIRKUP: Okay, thank you. Sorry, Julian.

7 MR BROOKES: That's alright. That's fine. So, from your point of view, that
8 decision impacted on not just the staffing but the quality of the service that was
9 provided.

10 MS FISH: Yes.

11 MR BROOKES: Okay. And that was something which you, as head of midwifery,
12 had talked to the chief executive about and was the board aware of that?

13 MS FISH: ~~I can't remember.~~

14 MR BROOKES: Okay.

15 MS FISH: The director of nursing and midwifery certainly was and she was board
16 level.

17 MR BROOKES: And was she supportive of your views or was she supportive of the
18 organisation's view?

19 MS FISH: Obviously supportive of the organisation. The one that I was talking to
20 earlier on had left. This was a new acting post.

21 MR BROOKES: Okay. And you mentioned at that stage there was trade union
22 involvement, etc.

23 MS FISH: Yes.

24 MR BROOKES: What was the impact in terms of the service, in terms of morale,

sickness, etc, from 2005 to when you left?

MS FISH: Morale just plummeted and the sickness levels were certainly increasing, because they were just working so hard. Talk about a working time directive; it was difficult to ~~didn't~~ apply, because these midwives ~~girls~~ were working and then their normal duties ~~coming back and~~ working extra shiftsto ensure a safe service..

MR BROOKES: Was there any look at quality of service and the impact the changes had made on the quality of service in terms of increased numbers of incidents, etc?

MS FISH: No, I don't think there were that many. I mean, looking at our perinatal mortality rate, it was very low compared with the rest of the country.

DR KIRKUP: Do you want to come in there, Stewart?

PROF FORSYTH: In relation to the falling numbers of staff and the working hours, what were some of the midwives working per week at that time in terms of number of hours?

MS FISH: We had to be careful because we couldn't break the working time directive, so it was usually people who were on days off who we brought back in again. Or asking Part-time staff to do more hours. ~~So instead of doing their 40 hours a week they could be doing 47 or even more~~.

PROF FORSYTH: Right. So there were examples of certainly working beyond 40 hours a week.

MS FISH: Yes.

PROF FORSYTH: Thank you.

MS FISH: Yes.

1 MR BROOKES: Okay. You've described your role changing when the three
2 hospitals came together and also a need to focus on other parts of the system,
3 because of HR issues and other problems. So I think we're correct in saying
4 that there was a supervisory midwife who would have been basically – would
5 they be doing the walking of the wards and the focus that you would have been
6 doing prior to that?

7 MS FISH: Yes.

8 MR BROOKES: What's your view in terms of how that worked? Do you think that
9 worked well?

10 MS FISH: Yes I do, because we had regular supervisory meetings. They had them
11 monthly within the units and I would meet with the midwives and the senior
12 midwives, supervisors, on a fairly regular basis.

13 MR BROOKES: So they would have notified you of any concerns within the actual
14 unit and the way it was operating.

15 MS FISH: Yes.

16 MR BROOKES: And you're confident that that worked well.

17 MS FISH: Yes.

18 MR BROOKES: Okay, thank you. A slightly general question: what kept you awake
19 at night?

20 MS FISH: I think it was knowing that the ward, the unit, wasn't adequately staffed at
21 times and waiting to be called in.. I think it was the loneliness of being head of
22 midwifery, because I kept a distance between the midwives and myself and it
23 was just worrying about the safety of the mothers and babies.

24 MR BROOKES: And what was your response to that? Did you look to take

1 additional measures to ensure the safety of the patients going through that
2 unit?
3 MS FISH: Just reiterated to the senior midwives, just to make sure that they were
4 following the juniors, they were looking after the juniors, they were watching the
5 junior medical staff and, again, to make sure that they sat down with the staff
6 and they talked to the staff and we had staff meetings and supported them that
7 way. If they felt they needed to bring in extra staff they should do so.
8 MR BROOKES: Thank you.
9 DR KIRKUP: Thanks. Just some follow ups really. I want to go back to this issue
10 about working relationships in and around the labour unit. You've talked about
11 the consultants a bit and that's been helpful, thank you. You haven't really
12 mentioned the junior medical staff. What were the working relationships like
13 between midwives and junior medical staff?
14 MS FISH: I think it depended on the junior medical doctor. I mean, some of them
15 were keen and they were supported. Others were not as keen. Some of them
16 were very inexperienced.
17 DR KIRKUP: Indeed. Could you have conversations with the consultants about
18 those?
19 MS FISH: Oh yes, yes.
20 DR KIRKUP: And what was the upshot? Were they helpful?
21 MS FISH: Some were. Others were not so helpful. But I would say to them, you
22 know, 'We've got a junior doctor here. He really doesn't know what he's doing,
23 we need a registrar'.
24 DR KIRKUP: And that would be listed to and people would respond to it?

1 MS FISH: Yes, on the whole it would, yes. I mean, as I said before, I had a very
2 good working relationship with the two senior consultants. The two new ones, I
3 didn't work as well with them, but had I spoken to them about that I am sure
4 that they also would have...actioned my request.

5 DR KIRKUP: Yes. I want to be clear about the two new ones. Is that because you
6 didn't have time to work with them or are you saying they had a different
7 approach?

8 MS FISH: No, ~~no,~~ I didn't have time to work with them.

9 DR KIRKUP: Okay. Did you have any concerns about the clinical skills of the
10 midwives that you were working with or that were working to you?

11 MS FISH: Not at the time I didn't.

12 DR KIRKUP: Okay. What would you have done if you did have? What was their
13 response to that?

14 MS FISH: Certainly supervisory review. They would ~~will~~ have seen me and extra
15 training would have taken place.

16 DR KIRKUP: And there were occasionally instances of that, you were saying
17 previously, I think, where that was – how did you follow up after that to see that
18 it had had the right effect?

19 MS FISH: The supervisors would then have, because there were seven supervisors
20 within the unit and three matrons, one of whom was also a supervisor and the
21 labour ward matron was also a supervisor. They would have observed and
22 supervised their practice.

23 DR KIRKUP: And did you get feedback about the results of that? Would they say,
24 'That's adequate' or 'We still have concerns'?

MS FISH: Yes. They would say to me, you know, 'We need to move on. We need to do something further with this' or 'We need to do' – yes, yes, most certainly.

DR KIRKUP: So you would have needed to have had a pretty good working relationship with the supervisors of midwives and the matrons.

MS FISH: Yes.

DR KIRKUP: And would you say that was the case during your time?

MS FISH: Yes, yes, across the Bay I was very well supported by them.

MR BROOKES: Can I just ask a supplementary? One of the things, when resources are tight, that often goes is the training budget. Was there any constraint on the training budget?

MS FISH: No.

MR BROOKES: You didn't have a concern about that.

MS FISH: No I didn't, ~~no~~.

MR BROOKES: Thank you.

DR KIRKUP: I'd like to ask a bit about midwives staffing the postnatal wards. Was that a satisfactory arrangement, in your view?

MS FISH: Not always at night ~~it wasn't~~, no, sir.

DR KIRKUP: Was that because of the shortage of staff that you were referring to earlier?

MS FISH: Yes, ~~yeah~~. I mean, we had antenatal mothers and we had women in early labour on that ward and we had postnatal women. We were encouraging breastfeeding, although our breastfeeding advisor, when she left that post was not replaced. So the midwives ~~girls~~ were trying to help the mothers with breastfeeding or feeding. One midwive ~~person~~, it was very difficult although

1 she wasn't alone. There would be Maternity Care Workers with her and it
2 wasn't always busy..
3 DR KIRKUP: Okay. How about their ability to spot when something was going
4 wrong with a baby? Clearly, there were babies who were expected to be
5 reasonably healthy, but sometimes babies who are expected to be reasonably
6 healthy can decline clinically. Did you have any concerns about their ability to
7 monitor well babies and make sure that they were still well?
8 MS FISH: There wasn't any concerns about babies when I was there in that
9 respect. I think things may have happened after I left in 2007, but while I was
10 there I didn't have any concerns. ~~But maybe — you said to me, 'What kept you~~
11 ~~awake at night?' and possibly it was just by good fortune that nothing~~
12 ~~happened then. Because if they were looking after a labouring woman and~~
13 ~~you're monitoring her, the baby could be in another room, but that could~~
14 ~~happen today, couldn't it? I mean...~~
15 DR KIRKUP: It's not so much that several things might happen at once that I'm
16 pushing at here. What I'm trying to get at is if they had seen signs that you
17 would recognise as indicating that a baby's clinical condition was deteriorating,
18 would they have picked that up? Did they have the skills and the knowledge to
19 pick that up?
20 MS FISH: ~~They should have had,~~ Yyes, and they would call the paediatricians.
21 DR KIRKUP: Okay.
22 MR BROOKES: And would you be confident that you would have got a rapid
23 response from the paediatrician in those circumstances?
24 MS FISH: Not rapid, no.

MR BROOKES: And why was that?

MS FISH: It depended where they were. ~~Yes, you would get a junior, yes, sorry.~~ You would get a junior coming, but if you wanted a consultant he may be at home.

DR KIRKUP: But presumably living with 10 miles of the hospital and available within half an hour.

MS FISH: Yes. ~~Yes~~, most of them lived at Ulverston, which was seven miles away.

DR KIRKUP: Yeah. I'm sort of picking up hesitation on your part to say that they would come in the time that you'd expect them to come.

MS FISH: No, I think that's right, I think they would.

DR KIRKUP: They would.

MS FISH: Yes.

DR KIRKUP: Okay. Did you have clinical meetings to review cases that had gone wrong?

MS FISH: Yes.

DR KIRKUP: Were they attended by all the relevant parties?

MS FISH: There was one main issue that I was involved with and we had arranged a meeting, but the consultant didn't come to that meeting.

DR KIRKUP: Okay. What action did you take as a result of that?

MS FISH: I obviously spoke to him, but we wanted to meet with a number of people, midwives and supervisors. So I just spoke to him, but I had to speak to him privately about it.

DR KIRKUP: Yeah. I'm not sure we're talking about the same meetings exactly here. I'm thinking of a general meeting attended by obstetricians, by midwives,

1 by paediatricians where you discuss the cases over the last month or however
2 long it had been. Did you have those?
3 MS FISH: We had our directorate meetings where we would discuss issues and we
4 also had our clinical governance meetings where we would sit down and talk to
5 them about issues and Perinatal Mortality Meetings.
6 DR KIRKUP: Right. And were they fully attended?
7 MS FISH: Mostly, yes, ~~yes~~.
8 DR KIRKUP: When you say mostly -
9 MS FISH: ~~No, they were, they were.~~ People were late, but they attended ~~yes, they~~
10 ~~were~~.
11 DR KIRKUP: But were there serial offenders, if you see what I mean? Were the
12 same people would never turn up time after time?
13 MS FISH: Yes, ~~yeah~~.
14 DR KIRKUP: Okay. Any particular group of staff?
15 MS FISH: No.
16 DR KIRKUP: It didn't particularly apply to the paediatricians, for example.
17 MS FISH: The midwives attended.
18 DR KIRKUP: Yes, but not so the obstetricians, not so the paediatricians.
19 MS FISH: Yes~~ah~~, sometimes.
20 DR KIRKUP: Okay.
21 MS FISH: And that sounds like I'm ~~ganging-up~~ against the doctors when I was~~'m~~
22 not. ~~It was not.~~
23 DR KIRKUP: No, that's alright, we're getting a full range of perspectives on all of
24 this, so that's fine. Did you have a clear set of policies about foetal monitoring

1 in labour?

2 MS FISH: Yes.

3 DR KIRKUP: And were they well adhered to?

4 MS FISH: Yes. They're evidence based and we looked at the NICE guidelines.

5 They were clear guidelines on what was to happen during labour.

6 DR KIRKUP: What would you expect to happen if somebody was having trouble in

7 a particular instance? I don't mean an individual case that we're concerned

8 about, but just in a hypothetical case where they were having trouble getting a

9 CTG reading. What would you expect them to do?

10 MS FISH: Call medical aid.

11 DR KIRKUP: Yeah. Okay.

12 PROF WALKER: Can I just pick up on that? What is the actual process? Because

13 if a midwife is concerned about a CTG, who does she contact immediately?

14 Does she directly go to a registrar or a consultant or is it the matron? What is

15 the process?

16 MS FISH: She would have gone to a ~~the~~ senior midwife ~~— she would — I mean~~,

17 there's an emergency buzzer in the room. If she was that concerned, she

18 would ring the emergency buzzer and the senior midwife would attend. ~~come~~

19 ~~in~~.

20 PROF WALKER: And would they then review the CTG and see what they thought?

21 MS FISH: Yes.

22 PROF WALKER: So if they thought it's okay, they would go no further. If they were

23 then concerned, what would they do?

24 MS FISH: They would call ~~then get hold of~~ medical aid.

1 PROF WALKER: And that would be by - is there an emergency buzzer or was it

2 paging?

3 MS FISH: It was paging.

4 PROF WALKER: Paging. And that depends where they are.

5 MS FISH: Yes.

6 PROF WALKER: They could be at the other end of the hospital.

7 MS FISH: Yes. But if you knew, as a midwife, that we need to get to theatre here,

8 we would already be preparing that lady ready for when the Doctor arrived–

9 PROF WALKER: Would you start taking the lady to theatre before medical staff

10 arrived?

11 MS FISH: No.

12 PROF WALKER: No.

13 MS FISH: No.

14 PROF WALKER: Okay. Thank you.

15 MR BROOKES: Something slightly different. You talked about the clinical

16 governance meetings. Was there every any discussion there about the quality

17 of the recording of cases, medical records, etc?

18 MS FISH: We tended to do that at the perinatal mortality meetings and that would

19 be discussed, certainly, yes.

20 MR BROOKES: Would there be any review of notes across the unit?

21 MS FISH: Yes, ~~yeah~~.

22 MR BROOKES: And who would do that?

23 MS FISH: It would be the consultants and the matrons.

24 MR BROOKES: And what would be the action coming from that if there was

1 unsatisfactory record-keeping in particular cases?

2 MS FISH: I'm not sure what would happen with medical, but in relation to me, it

3 would be supervisory review and possible discussion with me.

4 MR BROOKES: And did that occur regularly in that unit?

5 MS FISH: We didn't have that many problems, but yes if it did happen...

6 PROF FORSYTH: You found issues regularly.

7 MS FISH: No, ~~no~~ – we didn't find them. But if we did find issues then they would be

8 followed up.

9 PROF FORSYTH: Okay. I apologise if I missed this. Did you have a users' group?

10 MS FISH: Yes, we did.

11 PROF FORSYTH: And what sort of things did you discuss at this users' group? Did

12 you discuss staffing issues at the users' group?

13 MS FISH: ~~I think~~... No. Not to inform them that we had really serious problems. I

14 think we would just ~~kind of~~ briefly talk about the ~~high~~ levels...

15 PROF FORSYTH: Do you think that was fair not to tell them?

16 MS FISH: Maybe not.

17 PROF FORSYTH: I know that it's difficult.

18 MS FISH: It is. We also had a labour ward forum group, and we had users

19 attending that as well.

20 PROF FORSYTH: So that continued throughout the time you were head of

21 midwifery.

22 MS FISH: Yes. We introduced them as I was there.

23 PROF FORSYTH: You introduced the...

24 MS FISH: We introduced the labour ward forums on all three sites.

PROF FORSYTH: Right.

MS FISH: So that was one group, and then we had the maternity advisory group, to which we had users, and up until 2006 that was chaired by a board member on each site.

PROF FORSYTH: Right.

DR KIRKUP: Okay, thanks. If there are no more...

MS FISH: Sorry, can I just say... We would have said to the mothers, ~~you know~~, there is a shortage of midwives here, but I don't think we'd have gone into the depth that I've spoken to you about .and some people would say the unit was adequately staffed for ~~it's~~its size.

DR KIRKUP: Okay.

PROF WALKER: Can I just, you know, in general terms... you brought in a lot of changes when you came, and a lot of, you know, moving towards clinical governance and everything else. Do you feel that midwives bought into this? Did they really want to... take to it, or was it had to be largely driven by you?

MS FISH: ~~No, I think they really~~, they really wanted this, and a lot of them had come from other units with new ideas. ~~And~~ Iit was an extremely happy, well-run unit. And as I said earlier on, all the inspections that we had we got good ~~glowing~~ reports, and midwives certainly wanted all this training, and they received it. ~~got it~~.

DR KIRKUP: Okay. Thank you. There are one or two individual clinical items that we want to ask you about which bear on patient confidentiality, so if I can ask the attenders to withdraw at this point.

[*Attenders withdraw*]