THE MORECAMBE BAY
MATERNITY AND NEONATAL SERVICES INVESTIGATION

Wednesday, 12 November 2014

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

Before:

Dr Bill Kirkup CBE – Chairman
Professor Stewart Forsyth – Expert Adviser, Paediatrics
Julian Brookes – Expert Adviser, Governance
Dr Catherine Calderwood – Expert Adviser, Obstetrics

DR WARD

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DR WARD: Hello, Dr Ward speaking.

THE CHAIR: Oh hello Dr Ward, it's Bill Kirkup here from the Morecambe Bay investigation panel.

DR WARD: Oh hello Dr, yes, I'm just going to put you on speakerphone is that's alright.

THE CHAIR: Alright.

DR WARD: Thank you, can you hear me now?

THE CHAIR: Yes, that's absolutely fine, thank you. Could you just clarify there whether you have anybody else present at your end?

DR WARD: No, I'm in my own office.

THE CHAIR: Alright. You are being joined by some Panel members here today, and I'll ask them to introduce themselves to you.

DR WARD: Sure.

PROFESSOR FORSYTH: Good afternoon. My name's Stewart Forsyth. I'm a paediatrician and a medical director from Dundee.

DR CALDERWOOD: Catherine Calderwood, I'm an obstetrician in Edinburgh, and Medical Advisor for Scottish Government National Clinical Director for Maternity and Women's Health for NHS England.

DR WARD: Thank you.

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

DR WARD: Thank you.

THE CHAIR: We are recording the call and we will produce an agreed record of it at the end. We don't have any family members present as observers, but they may ask to listen to the recording.

DR WARD: Yes.

THE CHAIR: We'll have a second part of the process where we won't share the recording, where we can talk about any clinical confidential matters.

DR WARD: Okay.

THE CHAIR: And we would ask you to make sure that nothing of the conversation goes outside of this process, until we're ready to produce a report.

DR WARD: Okay.

THE CHAIR: Is that all alright?

DR WARD: That's fine, thank you.

THE CHAIR: Any other questions for me about the process?

DR WARD: No.

THE CHAIR: Okay, well, I'll start off with a general question which is can you tell me when you started at Morecambe Bay and how long you were there?

DR WARD: Yes, I started on 12 September 2000, and I was there until about 8 or 9 December 2013.

THE CHAIR: Okay, that's very helpful, thank you, I'll pass you over to Stewart Forsyth.

PROF FORSYTH: Thank you, Dr Ward, can you give us just a brief outline of your career to date, just where you had your training initially and then we'll go into a little bit more detail about your job with the Morecambe Bay Trust.

DR WARD: Of course. I qualified in 1986 98 at the Royal College in Dublin, and I then did about a year and a half of general adult medicine; and then I applied to the Children's Hospital in Temple Street for a paediatric SHO job for a year, and following that I went on to be a paediatric Registrar and then went on there, prelim the training that we would now have in place and then I then went on to be a Fellow of Paediatric Metabolic Medicine at Temple Street hospital and so I've done, I suppose, about 25 odd years of acute general paediatrics. And I now have a different job in that I'm community and designated doctor for safeguarding child protection on the Isle of Man.

PROF FORSYTH: Okay thank you. Can you give us again an outline of the job that you applied for in the Morecambe Bay Trust; what was the nature of the job?

DR WARD: It was as an acute general paediatrician and at that stage there was just three paediatricians based there, with a partial middle grade tier base here of paediatrics.

PROF FORSYTH: And what particularly attracted you to the Morecambe Bay post?

DR WARD: Well, I very much wanted to do acute general paediatrics with a component of neonatology, which was where I was at, at that stage of my life. And a beautiful part of the world to come to, and it was, as I respect now, a decade and a half ago, which was a very different environment within the NHS at that time.

PROF FORSYTH: Okay, and can you just again describe your job plan in a bit more detail; how many sessions of child paediatrics and ~~haematology had you etc.~~?

DR WARD: Yes, well the division was essentially a 10/12 PA contract, as it was then at that time; but it was quite onerous because out of hours services were very, very difficult because, you could, on occasions be with the most junior doctor, which could be a

GP BPF trainer in those days. And we did our original diary exercises; I think my PAs were coming out in excess of 13.

PROF FORSYTH: So, in terms of your day work, I mean, what kind of clinics did you do?

DR WARD: Oh, I developed a whole series of clinics whilst I was there, I had an acute general paediatric clinic, and then I was the lead for the local Cystic Fibrosis ~~coliac~~ population, rheumatology, gastro-enterology, and shared care oncology. And in 2005 I think I took over as the designated lead, as it were, for the neonatal services there.

PROF FORSYTH: So, how did you maintain your skills in all these different specialties?

DR WARD: Well, I suppose my background training was that when you were a paediatric Registrar you also did a year of oncology, endo-chronology, all of those things; so in those days it was quite easy to accommodate all those skills. It was probably when I was working in Barrow, in time the pressure was cover and getting away for courses and things like that was all meant to be very difficult.

PROF FORSYTH: And did you have visiting specialists come?

DR WARD: We did yes, we've had in neurology, Richard Newton came from Manchester. I'm trying to think back now; [Liz Babtain?] from nephrology.

PROF FORSYTH: Right.

DR WARD: And gosh, I'm just trying to think, they were the two predominant visiting specialists at the time.

PROF FORSYTH: You said you looked after cystic fibrosis as well, did you have someone visiting?

DR WARD: We didn't, we didn't at that stage. So they were in a shared care arrangement with Manchester, so they would have an annual review at Manchester, and they would be seen by me locally providing the local acute services for problems.

PROF FORSYTH: Okay, tell me a little more about neonatalogy then, you said you took over the neo-natal lead in 2005.

DR WARD: Yes.

PROF FORSYTH: So what – how did you find that and what were the key issues?

DR WARD: Well, in the early days, and we're going back to 2000, the unit was a level 1/level 2 unit, because it's geography. The geography dictated a great deal in there, so we were capable of taking babies there short term and then relied on the transport network when the baby was later became a popular relator to distribute

babies to tertiary care centres when their needs, of those of what we could provide locally safely.

PROF FORSYTH: You said that is what it was initially.

DR WARD: Yes.

PROF FORSYTH: Suggesting, I think, that things changed?

DR WARD: They went through a period of transition in that the unit sort of downgraded as the network developed in terms of the number of cots we had and cut offs for gestation of babies that we could safely care for.

PROF FORSYTH: So when was that?

DR WARD: I'm just trying to think now; I think we'd gone down to about 32 weeks before I left.

PROF FORSYTH: But was there not a downgrading before that, the way you were saying that, expressing that, I thought it was – because you left in 2013.

DR WARD: In that year.

PROF FORSYTH: So, your understanding was that this was a level 1 unit?

DR WARD: Yes. Well, when I first started, back in 2000 that's why I say it's a long timeframe.

PROF FORSYTH: Yes.

DR WARD: We were certainly ventilating babies there; I remember very clearly one evening we had a baby with a diaphragmatic hernia and another baby in the unit and a particularly difficult winter and trying to get the baby to the specific unit. You just had to roll up your sleeves and get on with it, if nobody could come and collect the baby. The cot bureau, when it came into play was excellent, because up until that point in time, and I'm talking 2000 up to 2005 ish, we would have to ring every neonatal unit in the north west of England to try and find available cots, so to give you a percept of what we were doing.

PROF FORSYTH: Yes. So, did you actually move from that ventilating diaphragmatic hernia babies to actually sticking within the level 1 criteria as set out by BAPM?

DR WARD: Oh yes we did, I mean at the end of the day the unit, just before I left, became I suppose you would call it – it moved from where it was geographically, onto the maternity ward, and it was a much smaller unit; it was down to four cots, so five at that juncture included the stabilisation area.

PROF FORSYTH: And at that – how did these changes take place; were they accepted by your paediatric colleagues and midwives and neonatal nurses and obstetricians?

DR WARD: That's difficult to ask when I think back. It was very much a fait accompli. My argument at the time was we had special reference because of our geography; we were assured that there would be available transport, and transport given. And therefore because the nature of what we were doing, I mean high risk deliveries were going to go elsewhere if we could get them to where they should be.

PROF FORSYTH: Uh hum.

DR WARD: Well, in any perinatal area if the – and the unpredictable geographic isolation, you have to be able to accommodate anything that walks in the door. Does that make sense?

PROF FORSYTH: Yes, you certainly need to be able to do initial first line resuscitation and stabilisation.

DR WARD: Yes.

PROF FORSYTH: But you also need to be able to move the patient out as quickly as possible.

DR WARD: Yes, as quickly as possible, and that's where the geography comes into play. You know, whether everyone is there exercises in terms of within the Trust working out where we should locate our resources, on the day in question the main road closed, so the two sides of the Trust couldn't get there, which gave you an example of what would happen with the geography.

PROF FORSYTH: So what was the – you're the clinical lead in neonatology, what were you advising the Trust then?

DR WARD: Well, it's interesting when you ask that; whether I was recognised as the clinical lead there or not I don't honestly know; I'm not sure I was assigned a specific PA to do the work, it just had to be done on day to day management. In terms of advice, in terms of the skills; when we opened the unit I think it's important to understand that there was an open door revolving policy. In other words we were concerned about any baby on the labour ward or the post natal ward that baby would immediately have come into special care, they were reviewed by a neo-natally trained nurse. And if there were any concerns then a consultant would be called.

And then a whole series of guidelines and protocols came into place, in which a lot of that was delegated to the midwifery staff on the post natal ward. We were assured at the time that their skills and competencies were appropriate to do that.

PROF FORSYTH: And do you think that move resulted in new born babies receiving a lower standard of care than they had previously?

DR WARD: I think the change in arrangement meant that the people who were in the front line seeing those babies may not – may not have had all the skills and competencies they should have. They were being asked to do a very different job. They were being asked to see babies who particularly had risk factors and they had to have the appropriate skills to identify those babies. In the past, whatever the concern was they just referred the baby to special care.

PROF FORSYTH: So, just to be absolutely clear; so these babies who might have previously gone into your larger special care baby unit.

DR WARD: Yes.

PROF FORSYTH: Were left - where were they, within the labour suite or were they within the post natal wards?

DR WARD: It could be either. It could be on the labour ward or post natal suite. And again, of course, there were other factors coming onto there during this interval of time was that now there was rapid discharge policies for mothers taking babies home etc.

PROF FORSYTH: Right. How did you get on with your – first of all your paediatric colleagues; were you an effective team?

DR WARD: I think in the early days, when I came there, I spent a lot of time doing references for colleagues and within a year and a half of my arrival the lead clinician left and we struggled very deeply to try and develop a community paediatric service there, because a whole bulk of community work ended up within the acute services too. And arising out of that we wrote a job plan for a community paediatrician; it was viewed at the time that they would contribute to the acute on call but the job description then excluded that on the basis of trying to attract somebody to community paediatrics.

We then went through a period of time where they decided then that they would look at a generic paediatrician and they appointed two paediatricians who covered those roles, both within acute and community, and that was very difficult for those people because they were like a dog being taught new tricks in one regard, at a stage in their career when it was very difficult for them, so my heart went out to them in one respect. They were being asked to do a lot of things that they had previously not had the experience of doing.

PROF FORSYTH: That the initial care?

DR WARD: Not to do with their acute care, they both worked within acute; and in my day you weren't appointed as a consultant paediatrician unless you could do neonatology, it was a part of being appointed.

PROF FORSYTH: Okay, so you felt that as a team the paediatricians were a functional unit?

DR WARD: Oh yes, I would say that we had good working relationships, or certainly I did, for most of my career there with my colleagues, up until the very end; which was another flavour to the job as it was then.

PROF FORSYTH: Right, and obviously from your neonatal involvement you would have close working with the obstetricians?

DR WARD: Oh yes, I mean they – I'm trying to remember people's names now as I go back. But we had a very, very good – I mean, the style of medicine changed in that huge period of time, in that, you know, on a day to day basis there were concerns, consultant obstetricians would turn up and consultant paediatricians and vice versa and they discussed, follow it up with a letter, all of those sorts of things. But there was very, very close – when the whole perinatal medical changed you had foetal medical departments referring to obstetricians and any obstetrics would copy those in or we would provide a form. Because in essence a lot of it became fragmented in time, because you had more and more bodies, more and more hands, but when you had smaller numbers of people the communications were much easier, I always felt.

PROF FORSYTH: So, on reflection, what do you think you're – what are your thoughts on the various incidents that took place down at Furness General Hospital in the maternity and neonatal unit?

DR WARD: Yes, I can only comment on one particular case.

THE CHAIR: We don't want to get into clinical details at this stage; we have a second part where we can do that.

DR WARD: Sure, in general.

THE CHAIR: Yes.

DR WARD: I think one of the things that we noticed and two of us certainly raised our concerns, was when the unit, the special care baby unit, adopted a less open door approach, and responsibilities were transferred to the post natal ward and the labour ward. We certainly felt that they were being asked to do thing that maybe they weren't wholly competent at doing. But we were assured that their skills and competencies were in place for that.

PROF FORSYTH: So, you're saying that that contributed to the risk for unborn babies?

DR WARD: I think it contributed to the risk in terms of identification of risks within groups of babies.

PROF FORSYTH: So when was that change?

DR WARD: I think it – I'm having to reflect; certainly it was around the 2006 2007 era.

PROF FORSYTH: Okay. What about with your involvement with middle management and higher management within the Trust; did you feel they were – understood the issues and were supportive?

DR WARD: My view now on mature profession, as they say, is that the Trust's major concern was survival and so survival in obtaining Foundation status; and that all of the other issues could be dealt with in time. But the primary drive seemed to me, at the time, was we had to obtain Foundation status to go forward and that everything else would follow suit following that. When I look back at the manager we had originally, am I allowed to mention the name?

THE CHAIR: Yes.

DR WARD: Yes, Steve Evans. He was a gentleman, and he was highly respected, both by the staff at all levels throughout the women and children's unit, he had an intimate knowledge of everybody and also maternity and children's services. He got it, as it were, he understood the staff, he understood the geography, he understood all of these things. And he was, if anything he was always supportive towards us if anything that was brought up or was a concern, and he worked in the sense that he was very professional, he always came back with an acknowledgement, answer and he was religious in his attendance at minutes and even minute taking.

PROF FORSYTH: So when did he go?

DR WARD: He left, I think around 2012 sir, I think, roughly.

PROF FORSYTH: 2012. Okay and then what happened?

DR WARD: Then we had a series of managers; in fact it became confusing at times as to who was the manager. They were such people who were brought in and then they quickly left, they didn't feel part of the team, for a better word in that there's always a mutual respect in an organisation between the managers and the clinicians. And it was a good, what I call a good working relation; it seemed to be a one door place, in other words you could bring forward your problem but you didn't necessarily get an answer to your problem, does that make sense?

PROF FORSYTH: Yes that's alright. I'll just hand over to my colleagues, but my last question is the reason for you to change job and to go to the Isle of Man, has that

anything to do with issues in relation to Furness General Hospital and the Morecambe Bay Trust?

DR WARD: Yes it did in the sense that it was a place, I still have my home there in the Lake District, I'm very fond of the people I worked with and the community I served there, and it was with great sadness, witnessing the events that unfolded, and the reassurance that the problems were being fixed were, as a clinician and on the shop floor, I began to notice that wasn't true, and I was losing confidence in the organisation. And I also, to be honest, at the end of the day I think there was a lot of respect for us as clinicians too and the striking thing that upsets me, that I still find very painful; I was referred to once as a shift worker, which as a consultant paediatrician, of many many many years now standing, and when you've got to consultant grade; there was a lot of self-sacrifice along the way to get there. I found that very, very upsetting as a remark to me.

PROF FORSYTH: Sorry, just finally, had you written at all directly to the Chief Executive or senior management people expressing your concerns?

DR WARD: Oh yes, I mean I think every one of my colleagues will remember when we went to the medical seniors meeting and I did tell the Chief Executive, on the floor, of my concerns and where this was going. It was almost in anticipation sometimes, of some of the events that subsequently unfurled, and it was particularly painful for me to – in fact some colleagues were very gracious to me afterwards and they came up, as I was leaving, they were saying "Well Patrick, you did do your job. You did tell them. The fact that they didn't action, or take on board what you were saying is not your fault." Because every clinician involved with families, whether directly or indirectly, through their department, when an outcome is not as it should be, that will affect you, you know. If anybody can tell me that they can walk away; you cannot, you – I lived amongst a community where I was respected and appreciated and to this day, when I go into Ulverston village, the children who I looked after, cared for, and their families, run up to me when they see me.

PROF FORSYTH: And did you get any sort of response or – from the Chief Executive following your comments at that meeting?

DR WARD: No I didn't really.

PROF FORSYTH: Okay.

MR BROOKES: Sorry, can we just check which Chief Exec that was?

DR WARD: Mr Tony Halsall ~~Hartley.~~

MR BROOKES: Thank you.

THE CHAIR: Okay, thanks very much Patrick, I'll hand you over to my colleague Dr Calderwood.

DR CALDERWOOD: Thank you. Thanks very much; that's been very helpful and I'm an obstetrician and I suppose I'm interested in hearing that you felt that there were good relationships with your obstetric colleagues. The midwifery colleagues and the neonatal nurses, and the communication; did you have regular meetings, perinatal meetings?

DR WARD: We did. We sort of evolved with time and I was a little disappointed when people said in the past that there was poor communication between obstetrics and paediatrics; we were not, we were very, very close and we were much supported by our obstetric colleagues from very early on with the appointment of consultants with good neonatal experience, because those obstetricians realised the geography, realised that a woman 9 centimetres dilated isn't going to be leaving the peninsula; she's going to be having her baby there. And you had to have the right skill set of good people around you, working as a team and I have a very warm regard for my obstetric colleagues, midwifery colleagues and neonatal special care nurses, through many, many, many difficult nights, with many difficult problems to deal with.

DR CALDERWOOD: And the – you've talked about the unit's changing from level 2 to a level 1 unit.

DR WARD: Yes.

DR CALDERWOOD: Which must have then meant that there was – with these babies then being kept on the post natal ward; did you feel that there was – were the paediatricians, the middle graders, your consultant colleagues, would they have attended the post natal ward if there were issues?

DR WARD: Oh yes, I mean if there was a query in relation to any baby and you were on the suite that baby became part of your ward round. The morning ~~blue team~~ baby checks they were looked after by the junior grades and any problems they had they came back to the consultants and the consultant would come round to see the baby, whether it's a query for a murmur or just advice and support dealing with a particular issue, it became part of the teaching and training as to how to communicate to parents, you know, if a flag was raised, it was very important that this matter's addressed and that if there's nothing there there is absolute reassurance when you take the baby home.

DR CALDERWOOD: And without – obviously we're not going to go into clinical details at this point, but we are aware that there were babies who became unwell on the post natal ward.

DR WARD: Yes.

DR CALDERWOOD: That perhaps should not have remained there; given what you've just told me that the closeness of the relationship, the very easy access to paediatric advice; how could that have happened?

DR WARD: I think what happened was you see the conduit was special care is that the – going way back there would have been a rotation of midwives through special care, in terms of teaching. So their relationships, their immediate communication relationships with one another; when they were charged with caring for the babies on the post natal ward, to assess they were then self-reliant in identifying the risk; and having identified the risk where they were to go with that. You know, as I understood the midwife caring for a baby on the post natal ward was concerned about that baby she would call the house officer or if it was a really serious situation, the consultant would be called and contacted directly.

But what happened was when you took special care out of the equation they were left, as it were, somewhat on their own feet to identify there is a problem; does that make sense to you?

DR CALDERWOOD: Yes.

DR WARD: Yes, so they were left in a very, as I see it, I think they were being supercharged to do this role, and what didn't stop to ask, or what people weren't asking is "Have I the right skills and competencies here", you know, if you motivate people a lot but they don't have the training you know, they're very enthusiastic but they just don't know what it is they're looking at.

DR CALDERWOOD: And do you think then that when there were these cases and issues and poor outcomes, what happened then as a result of those?

DR WARD: Well, as I understood, when we asked about this question; that I was again assured that the midwifery staff, their skills and competencies had been assessed and that they were fit for purpose. In other words they knew now what they were doing; but I have to say later on I realised, you know there was near repetition of the same events again, so I questioned whether this was too – I wasn't involved in their training or teaching or responsible for recording that they knew X, Y or Z. you know, I was told they did.

DR CALDERWOOD: So who did train them then Dr Ward?

DR WARD: Well there was somebody who was charged from the nursing corp., from special care for Lancaster to look after, and it was solely responsible. And you know, I did challenge her on this several times and again I was told that they had done – that they know their training. When I first started in 2000 it was part of my weekly routine to go through the neonatal sub-rotation with the midwives; that was me as a consultant and I was – I still have reflections of the meetings I had, on the labour ward, with our dolly and going through our ABC and our pyramid and everybody feeling confident; because you wouldn't have to do it every day of the week, but the fact that you were doing it on a regular basis refers, so it brought confidence of going through it again and again. Does that make sense?

DR CALDERWOOD: Yes.

DR WARD: Yes, and waiting for the more unusual neonatal problems or things like that, again midwifery staff would turn to the nurses in special care immediately to seek advice, or if they just didn't know the babies were shuttled over. We're not talking a huge distance here; we're talking four or five feet across a corridor. I mean, it used to upset me when they relocated the unit as if it was the other side of the hospital precinct. It was literally across the corridor. We didn't want to separate mothers and babies or anything, but most times I had – after delivery, if Mum was tired there was a little concern about the baby, we would tell the mother the baby's just going across the corridor and would be seen by the neonatal nurse, and they would ring if there was something there, or you know, there was an identifiable risk that they had come across, you know, and asking questions whether there was maternal pyrexia, intrapartum antibiotic, prematurity, previous GBS, unknown GBS or feeding – you know, they were very experienced nurses in special care, they knew what they were doing.

DR CALDERWOOD: There were also some issues, as you know, with transferring sick babies away from Furness General. Without again mentioning any clinical details; can you give us your reflections on that, whether there was a reluctance or a reluctance or a slowness perhaps to confer?

DR WARD: No, there was no slowness or reluctance to immediately transfer a baby. Once an immediate need had been identified in that baby, the most important thing then was to get the baby as safely from A to B or waiting for A to B to happen if the baby to go.

DR CALDERWOOD: And so that a transport team would be called very rapidly and all of that process be put into place.

DR WARD: Yes, once the decision had been made to transfer a baby, if it was still that criteria, that went ahead. There's no question about that.

DR CALDERWOOD: And although we know that in some of the well-known cases there was delay; how do you square that?

DR WARD: When you say "delay" I know it's difficult for me to square it because without mentioning a particular case; in any transfer of a baby from Barrow the minimum period of time for that to happen would be 2 ½ hours. If a team, a transport team is out of the time, that baby could potentially be at Barrow, and this is my point about the geography for up to 6 or 8 hours or longer. If there were inclement conditions, or any of those things, those things will influence the timeframe. You have to remember that Barrow is on a peninsular and like one or two other hospitals in the UK, you know, you're not going across London or the next hospital. You're a long journey from anywhere.

DR CALDERWOOD: I think I'm referring more to the delay in making the decision, I absolutely understand the mobilisation of a team from elsewhere.

DR WARD: I can only talk about my own particular experience.

DR CALDERWOOD: Yes.

DR WARD: But I never had – I never conceived that there was a delay in the transfer of a baby.

DR CALDERWOOD: And not when you came on duty after one of your colleagues had been on overnight, I'm not – I'm sure your own practice and also -

DR WARD: Yeah.

DR CALDERWOOD: And practice within the unit.

DR WARD: Now I've given more I understand what you're saying, yes and that was about who was making the decision really and whether that decision should have been made earlier.

THE CHAIR: And again without going into details at the moment.

DR WARD: Yes.

THE CHAIR: You think there are incidents when that happened. We have been through all the cases and there does seem to be a -

DR WARD: That is true that there were -

THE CHAIR: - wait and see approach by certainly some of your colleagues.

DR WARD: Yes I think so. I think that is fair. I don't know the exact details doctor, so that is why it's difficult for me to make anything other than a general comment in relation to it, yes there probably were cases where a more experienced, more balanced view might have been that this baby should transfer because it's needs will not be met here.

THE CHAIR: Yes, okay.

DR CALDERWOOD: And were you involved in any of the route case analysis work or the investigation for many of the babies with poor outcomes?

DR WARD: No.

DR CALDERWOOD: And you wouldn't have been because it wasn't your role within the unit?

DR WARD: I wasn't tasked with it as a role.

DR CALDERWOOD: And when there were adverse outcomes were there any learning then that went back from any investigations, so when you say you weren't involved what would have happened; would there have been teaching sessions or any sort of reflection if – within -

DR WARD: Sure.

DR CALDERWOOD: I've worked within small units myself, so that these things are often felt very far from, you know, within the unit, particularly the nursing staff, the staff have dealt with the family, but the rest of the people tend to be affected by a poor outcome, particularly a baby death.

DR WARD: Yes, well when I first took up the reins of the lead we used to have an annual perinatal meeting and we were free Badger, so it had to be done manually, but I was used to doing it manually, so collecting all the notes and going through it and everything, presenting the – and then drilling down, specifically where there had been adverse outcomes, to see if there were issues that we could address. There were a number of times that we did look at specific cases and that we then moved to quarterly figure analysis of that data, each four months which was challenging in germs of time and again; it's the joint meeting with the obstetrics, midwives, special baby and ourselves. And again it highlighted specific cases and the outcomes weren't as good as we wished for and to see what factors we could influence to change that. So there was that process in place.

DR CALDERWOOD: But I suppose the learning or the actions, were you aware then of things changing within the unit?

DR WARD: Oh yes, there were a number of examples that come immediately to mind. We've had a number of babies with, over the years, transposition and these are the babies who would be very risk specific, and would present to us. And we came up with the philosophy or the practice should I say, where babies who were having colour changes, or poor feeding, were very strictly monitored and we put in place a guideline to try and capture that group of babies. Because we had a number of which we had been assured by the foetal assessment unit that they had four chambered hearts and everything was normal but as is the case sometimes, it can be very difficult to diagnose this. But you know what you're dealing with when it presents, but only up until that point in time. So there were things like that that did change, we looked at the route these tests covered protocol and we went through quite a few things to try and identify and improve outcomes.

DR CALDERWOOD: Thank you. I think - we then I shall in turn move you on to my colleagues, thank you.

DR WARD: Not at all.

MR BROOKES: Thank you. I just want to just touch on the relationships type of thing you were describing earlier. I just want to understand; there's been a number of reports which have been critical of the working relationships between the different parts of paediatrics, obstetrics, maternity; there's also evidence been given which would indicate or support that. Yet I get a very different feel from what you're describing. I just wonder if you could sort of try and tease out the reasons for that.

DR WARD: Yes, it's very interesting when people said this in the past. Maybe it's my nature but Ibrahim Hussein and I were good colleagues and good friends and we could work with one another very clearly, and he was a good leader in the department. If I had a problem in relation to a baby or if he had a baby that was identified – you know, these were good working relations. Out of that evolved the form where we could have very clear documentation in each of the charts so that any baby subsequently coming along, you know, it was very clear to everybody what the decision making process had been and what was going on.

So it was very sad when I heard that people said that there was this – always, in any department, you always have natural rivalries and frank discussions; but it was warm and it was with one objective, to have a good outcome for the mothers and babies there. So, I only ever witnessed that myself. I did not see the situations where, you know, people weren't talking to one another. They certainly did and if

anything the communications improved over time with all of the available technologies that came along, like email and all of these things.

MR BROOKES: So, just to be clear, from your perspective there were good working relationships between paediatricians, there were good working relationships between paediatrics and obstetrics.

DR WARD: Yes.

MR BROOKES: And there were good working relationships between midwives and paediatricians?

DR WARD: Yes. I can't recall any major instances that we saw, you know, after – there was change, for any reason and we did look at things for when paediatricians should be called to deliveries and we worked through all of those things together, collectively, and we had a forum for meetings with one another. So I never personally witnessed that. And when it was raised previously I kept on asking "Where has this come from?" you know, because I never witnessed this at ground level.

MR BROOKES: Okay, so in terms of case discussions about cases with obstetrician colleagues, that all happened routinely, there were reviews of cases, there were lessons learned?

DR WARD: Yes.

MR BROOKES: Okay. I'd like to just look at – you talked about Steve Evans, and I understand that and the general management links, but clearly there were clinical lines of accountability as well through your department into your clinical director?

DR WARD: Yes.

MR BROOKES: How did that work?

DR WARD: Well, I think, when I look back, the clinical director at the time, when I was there.

MR BROOKES: Yes, and who was that?

DR WARD: That was I think Paul – oh gosh -

THE CHAIR: Would it be Gibson?

DR WARD: Yes, yes, Paul Gibson was the then appointed clinical director for – in anticipation, delighted to be a paediatrician coming in to post to do this because we felt small, we felt isolated and we hoped he would be a great voice; but I have to say that the first impressions, when he arrived were very, very poor to two of us, because we had been there on the Barrow side, struggling for years with staffing, recruitment

and everything. And what we hoped for, and what we got were two very different things.

My own feeling was that Paul was more driven by where the Trust was going in terms of achieving a Foundation status, doing all of these things, being seen to be one of the team, rather than, you know, appreciating his colleagues. To give you an example of what happened when he arrived is we were each called separately into a room and he was waving a contract in front of us, telling us that we were being overpaid and all of this, and I have to say the embarrassment of pointing out to Paul the contract he was waving in front of our faces was our predecessor's contract. In other words we worked on the 1 and 2; we were on the 1 and 3 at that stage. And that just gave a flavour of the opening gambit for what went on.

MR BROOKES: Yes. So it's fair to say that you didn't have the best of relationships with the clinical director.

DR WARD: I find it difficult at the end of the day.

MR BROOKES: And did that lead to any particular complaints or concerns being raised with management in the organisation?

DR WARD: Yes, on one occasion there had been an incident with one of our colleagues, and he was a very mild mannered man and he actually walked out of the hospital that day, he was very, very upset by the style of the directorship.

MR BROOKES: And what about further up, the medical director, what was your relationship with them?

DR WARD: They were quite distant in the sense of they were distant actually. I mean I did, on occasion once write, but didn't receive a reply, in relation to some of my concerns about the special care and where it was going and what was happening and the new unit and it's suitability for a better word, whether it was fit for the purpose it was designed for, why had people not listened to the local people who would understand the local needs, the local issues, you know. It's just we felt voiceless towards the end.

MR BROOKES: That's very interesting. And just one last thing from myself, which is in terms of incidents that may have happened within the unit; can you just explain to me how those would – what the governance arrangements around them were, who would you report them to, how would that operate, would you get feedback?

DR WARD: Yes and we went from paper to electronic and I'm of the age where I had to learn all of the electronic bits, the Chrysalis reporting team and prior to that, and I

say this to everybody generously; going back over a decade and a half, but initially if I had a concern about something I went and talked to Mr Hussein.

MR BROOKES: Yes.

DR WARD: Mr Hussein was the clinical director for women and children and then I would follow it up with a letter and I would always receive a reply from him. And I was told of an action as to what would happen and that that would be imbedded in practice. When we went down to the Chrysalis team, and bearing in mind there were so many areas, you know, when I did Chrysalis reporting it was something major, it was something that I considered life-changing or potentially life-changing, if it wasn't identified. I know there were other issues that wouldn't be the same severities or worries, but nonetheless they needed addressing.

When we went to the Chrysalis reporting team you didn't always get a feedback instantaneously, it's not like I've seen somebody on a face to face basis, and it would be fed back. I'm not sure how imbedded the learning then became in that. Because if this is a non-blame culture, but I think some of the people did feel like it was becoming a blame culture.

MR BROOKES: Right.

DR WARD: And the value or the effort you put in into the instant reporting didn't measure up to what the reply was; does that make sense?

MR BROOKES: It does, it does, thank you.

DR WARD: Yes.

MR BROOKES: Okay, thank you very much.

DR WARD: Not at all.

THE CHAIR: Okay, I want to move into the confidential part of the interview in that case, so we will just recall the fact that the nature of the recording changes now, nobody else will be able to access it, and I think Stewart there were a couple of cases, and I have a question too.

[The hearing went into private session]

THE MORECAMBE BAY INVESTIGATION

Wednesday, 9 July 2014

Held at:
Park Hotel
East Cliff
Preston
PR1 3EA

Before:

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

KAREN WEAKLEY

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DR KIRKUP: Thank you for coming. My name is Bill Kirkup. I'll ask the other colleagues of the Panel to introduce themselves.

PROFESSOR FORSYTH: Stewart Forsyth, I'm a paediatrician and, latterly, a medical director in Tayside, Scotland.

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

PROFESSOR WALKER: I'm Jimmy Walker, I'm an obstetrician and University Professor in Leeds. In the past I've been chairman of CMACE, and also worked with the National Patient Safety Agency, so I have an interest in governance.

DR KIRKUP: As you can see, we're wired for sound. The intention is that we make a recording of proceedings, and then produce an agreed record at the end. You'll also be aware that there are some family members present as observers of the session. You, they and us have all foregone any electric devices that might serve as recorders or transmitters. It's very important that nothing goes out of the room until we're ready to produce a full report that contains everything in context. Do you have any questions that you would like to ask us about the process?

MS WEAKLEY: No, thank you.

DR KIRKUP: Okay. I'll start out just by asking you a fairly general question, which is can you explain when you first became involved with the Trust, and what you've done since then?

MS WEAKLEY: I've always worked for the Trust since 1981. I qualified as a nurse

in 1984, and I qualified as a midwife in 1995. I worked as a band 6 and then a band 7 midwife for eight years, and then I became a matron, and I did that for nine years. I presently work as a labour ward co-ordinator at Barrow.

DR KIRKUP: Right, so what was the start date of you becoming a matron?

MS WEAKLEY: I can't remember.

DR KIRKUP: Okay, we'll fill in the blanks.

MS WEAKLEY: I held several different matron's posts because the job kept evolving and changing.

DR KIRKUP: Yes, I'm aware of that.

MS WEAKLEY: So I think it was 2001 or 2002 that I first became a matron.

DR KIRKUP: Right, okay, and when did you switch to becoming a co-ordinator, labour ward co-ordinator?

MS WEAKLEY: Two years ago.

DR KIRKUP: Two years ago, okay. Was there a particular reason why you stopped being a matron and became a labour ward co-ordinator?

MS WEAKLEY: There were several reasons, yes. I had been involved in lots of the investigations that had happened. It was extremely stressful. I know that that doesn't stop me being involved [redacted] therefore I always intended to go back to clinical practice before I retired, and I just brought it forward a couple of years.

DR KIRKUP: Okay, thanks for being frank about that. That's helpful. Jim.

PROFESSOR WALKER: Right, so what I want to talk to you about is the – I

suppose your time as a modern matron, I believe, and also time more recently. What was your role?

MS WEAKLEY: At the time, the matrons didn't work across the three sites. We worked in our own home site, but – however, we did meet each other quite regularly and hold meetings around different things, and worked as a team to get – so my role was basically at Barrow, to start with. It did become across the Bay in one of the roles that I took, but mostly it was at Barrow. And my role – when I started in the post I worked very clinically. It was a very clinical role, and it was a lead role within the unit. It was to provide a senior presence on the unit. And I worked shift work with the rest of the midwives.

That developed over the years into more of a nine to five, Monday to Friday role, that I wouldn't work clinically in. I would be office-based, and my role was still quite connected to the clinical workforce in that I managed sickness and I managed the day-to-day running of the unit. It didn't become – I don't know what the word for it is – a larger, definitely non-clinical role until fairly near to the end.

PROFESSOR WALKER: Okay, so when you say you had a presence on the unit, would that be for labour wards, the wards, you know, other patients?

MS WEAKLEY: It started off on the ward. When I first took the role it was for the maternity ward only. It then became gynae and maternity ward, and it then became labour ward, maternity ward and gynae, because the labour ward matron left, retired, and she wasn't replaced.

PROFESSOR WALKER: When was that, can you remember?

MS WEAKLEY: 2008.

PROFESSOR WALKER: 2008, so that was shortly after – about a year after you took over.

MS WEAKLEY: Yes.

PROFESSOR WALKER: So you were then the only matron on the unit?

MS WEAKLEY: I was for a short time. However, one of the matrons from Lancaster was drafted in to help, particularly with the community aspect of the role, and then the gynae became separate as well.

PROFESSOR WALKER: So who were you answerable to? Who did you report to?

MS WEAKLEY: The head of midwifery.

PROFESSOR WALKER: And was that a straightforward referral? Did you meet that person on a regular basis?

MS WEAKLEY: Yes, I did, yes.

PROFESSOR WALKER: And were they open to – if you had concerns of problems could you contact them quite easily?

MS WEAKLEY: Yes.

PROFESSOR WALKER: And did you feel you got support from them to help solve the problems you had?

MS WEAKLEY: As far as she could give me support, yes. I quite often felt that she had nowhere to go after – and some of the stuff stopped at her. I felt that it wasn't escalated, certainly to the Trust Board, as it should have been, some of the time, not all of the time.

PROFESSOR WALKER: Okay, but you seem to imply that she couldn't do that rather than she didn't do that, so...

MS WEAKLEY: Yes.

PROFESSOR WALKER: ... she tried to and – where was the block?

MS WEAKLEY: Well, it was – I know it was particularly difficult when we were in a division with surgery, because at times I stood in for her in meetings, in divisional meetings, and we became a very small fish in a very large pool, and the whole focus of everyone at that time was the cost improvement programme. And it was very much target driven; the meetings became very much target driven. It was around the surgical divisions' problems and what we needed to do, and I felt that when it was our turn to speak about what was happening in obstetrics and midwifery, not a lot of notice was taken of that, that we – it was kind of frowned upon if we said anything about babies, mothers, and we weren't listened to as we should have been, and things weren't escalated from there. It was kind of shoved to the side a little bit. I felt that we were marginalised by being in that division.

PROFESSOR WALKER: Did you sit in these meetings?

MS WEAKLEY: I did. I stepped – when the head of midwifery wasn't available, the matrons would step in for her to those meetings.

PROFESSOR WALKER: And did she give feedback to you from these meetings, the same feelings that you've just expressed?

MS WEAKLEY: She did.

PROFESSOR WALKER: And when you say the cost improvement programme, were you given targets to reduce costs within midwifery?

MS WEAKLEY: Yes.

PROFESSOR WALKER: So what sort of targets, and were you given any advice on how to do it?

MS WEAKLEY: Not particularly – we weren't given a set target, but at every meeting, we went to every single one, it was around the cost improvement programme that we had in place, and what we were going to do about – you know, 'This month we need to save this amount of money, and what are we going to do, because if we don't come up with something you will lose midwives.' That was what, you know, was said to us.

PROFESSOR WALKER: Who said that to you?

MS WEAKLEY: Our ~~regional~~ Divisional general manager. But it sort of came down; it came down from them to the head of midwifery to us, to say we have to come up with ideas, we have to do something. And we came up with all sorts of different small money-saving things like charging for amenity beds and doing new posters, and charging for scans that came in at that time. And it was a constant pressure on everyone to get – to balance the books because it was around foundation status that we had to get that. It was an absolute have to; there is no – there's no not getting it, and we have to save that money. And the pressure was enormous on us to do that from everywhere.

PROFESSOR WALKER: Okay, so if you, as the matron, decided that you were concerned about labour ward staffing, for instance, and you felt that you worked out through Birth Rate Plus what numbers you should have and whether you would match it. What would then happen with that data, and what response would you get when you said, 'Well, I need another five midwives'?

MS WEAKLEY: They would say, 'You can't have them because you overspent last month.' What happened with Birth Rate Plus was they came out with a figure that were needed across the Bay. The matrons and the head of midwifery

went to a meeting with the finance manager, and they talked for about an hour around what Birth Rate Plus said we were meant to have, and the reasons that we couldn't have them, and it was around, 'You overspent here, therefore we've taken that from there, and that's knocked off. And last month we spent such an amount of money on band 6 midwives, and we've knocked that off.'

And actually, in the end we never got what we were meant to have from Birth Rate Plus, and there was no arguing with that. We were just told that that's what was happening, and at one point we had a form where if – I devised a form for the staff to say if you feel that you're unsafe at any time on your shift, I want you to fill this form in. And I collected them all and I gave them to the head of midwifery saying, 'This is our case. We are overspent this month because we're understaffed and we're having to use extra hours of the existing staff or bring in bank staff. That's why we're overspent, and that didn't make any sense to me, that we weren't recruiting to fill those posts, to fill that gap, and I had the evidence in front of me to say, 'On this number of shifts the staff felt that their staffing levels weren't adequate.'

PROFESSOR WALKER: You said you used bank staff.

MS WEAKLEY: We did.

PROFESSOR WALKER: You did. So how often did you use bank staff? Most weeks you had bank staff?

MS WEAKLEY: Most weeks, yes. Yes, it was mostly part time staff doing extra hours, I've got to say, because there wasn't a big bank. There was only two or three midwives on it.

PROFESSOR WALKER: Okay, so there was your own bank as such.

MS WEAKLEY: Yes.

PROFESSOR WALKER: Okay.

MS WEAKLEY: But we had to go through a massive – a massive system in order to get those bank staff. We had to get those signed off first, and we had to put our case for every single shift about why we needed those bank staff, and what it would mean if we didn't have them.

PROFESSOR WALKER: So what happened if someone didn't turn up for a shift?

MS WEAKLEY: We would phone around our staff and cover it internally.

PROFESSOR WALKER: Is that something that happened increasingly or...

MS WEAKLEY: Absolutely regularly, yes. We had, very fortunately, very flexible staff who were willing to come in at short notice.

PROFESSOR WALKER: Now we talked about how you referred up. What was your structure underneath you, in that you have band 7s that reported to you, or was there someone in charge of the labour ward that reported to you, or did you – were you there and then the next level down were just not on an equal level of group?

MS WEAKLEY: Yes, there was a ward manager, and there were labour ward co-ordinators on, or they weren't called that then, working on the labour ward, the rest of the band 7s. On every shift there would be a band 7.

PROFESSOR WALKER: And a labour ward co-ordinator as well?

MS WEAKLEY: No.

PROFESSOR WALKER: No, they would be the...

MS WEAKLEY: They will – they're called – they are labour ward co-ordinators now, but at the time they were...

PROFESSOR WALKER: They were band 7.

MS WEAKLEY: ... senior midwives.

PROFESSOR WALKER: Okay, senior midwives.

MS WEAKLEY: Yes.

PROFESSOR WALKER: Okay. And would they take a caseload?

MS WEAKLEY: Yes.

MR WALKER: So would they always have a caseload?

MS WEAKLEY: Yes.

PROFESSOR WALKER: So how – if you then had a problem within the labour ward, if a midwife or something was concerned about a patient she had, how was that escalated? Would it be escalated through the co-ordinator, or would she escalate to the director?

MS WEAKLEY: When are we talking?

PROFESSOR WALKER: Or say you'd got someone that you were concerned about, a CTG or – and there was an [acute proxy?], a bradycardia, what would happen at that point? How would that be escalated to...

MS WEAKLEY: It would – are we talking now or before?

PROFESSOR WALKER: Well, you were there before.

MS WEAKLEY: Yes. It would go to the co-ordinator first, the band 7 first, and then she would escalate to either the registrar or the consultant.

PROFESSOR WALKER: And how easy was that, as a sort of system?

MS WEAKLEY: That was easy.

PROFESSOR WALKER: And would there be any delays in getting say medical staff there to see somebody?

MS WEAKLEY: Only if they didn't answer their bleep.

PROFESSOR WALKER: Or was that something that happened commonly or...

MS WEAKLEY: It happened now and again. It did happen.

PROFESSOR WALKER: But was it something flagged up by your midwives as being concerning that they couldn't get medical support?

MS WEAKLEY: Yes, and we changed the bleep system. We changed to baton bleeps.

PROFESSOR WALKER: Okay. And so the baton bleep would be passed over at handover presumably.

MS WEAKLEY: Yes.

PROFESSOR WALKER: So what medical handover was there within the delivery suite?

MS WEAKLEY: There was handover from the medical staff to the next medical staff. There was handover between the midwives, the midwifery staff, but what wasn't particularly successful was the hand – the multidisciplinary handover, which included the paediatricians, the obstetricians, anyone involved in the care of the women. It's – it's normal now, but before it wasn't.

PROFESSOR WALKER: Well why wasn't it normal then and why have you changed?

MS WEAKLEY: I think it was just – it was just practice then that the doctors would just handover to the next coming on doctors, and you know, there was not a set time to do that particularly, just when one was going off and one was coming on ~~home~~, and it was as it had been for a long time. And we changed when we realised that the communication between the midwives and the

doctors and the whole team, the anaesthetists, the paediatricians, that everyone needed to be involved and updated on a regular basis as to what was happening with those women. You know, they did know in silos, in their own part of it, but the whole team needed to communicate in order to give the best care.

PROFESSOR WALKER: In the old system before you had the new multidisciplinary system, would the labour ward co-ordinator be present at the handover for medical staff?

MS WEAKLEY: No, not all the time. Sometimes, but it wasn't a given that that would happen.

PROFESSOR WALKER: So would the handover of the midwifery staff be transparent to the obstetricians, and the handover of obstetricians would not be – you know, the midwives wouldn't necessarily be aware there's been a handover apart from the person changed?

MS WEAKLEY: That's right, yes. The band 7 would often speak to the consultant and the registrar that was coming on, and tell them about any women that were of concern.

PROFESSOR WALKER: And would that be just for the labour ward or would that include the antenatal ward as well?

MS WEAKLEY: The labour ward. The antenatal ward, the doctors would go there at nine in the morning when they came on, and there was more likely to be a round there.

PROFESSOR WALKER: So they'd go there first before they come to the labour ward?

MS WEAKLEY: No, they would tend to come to the labour ward first.

PROFESSOR WALKER: And you say there was more likely to be a round, does that mean there wouldn't be a round in the labour ward?

MS WEAKLEY: Not all the time.

PROFESSOR WALKER: Would that be because – that the midwives don't feel the patients need to be seen, or would it be because it just didn't happen or what?

MS WEAKLEY: It depended on the doctor, on the individual coming on.

PROFESSOR WALKER: What, registrar or consultant?

MS WEAKLEY: Yes.

PROFESSOR WALKER: So would there be times when a midwife – midwives would want doctors to see the patients but the doctors didn't?

MS WEAKLEY: Yes, and they could ask them to see the patients and write something in the notes.

PROFESSOR WALKER: And did they?

MS WEAKLEY: Sometimes, sometimes not.

PROFESSOR WALKER: So you're hinting that there's a sort of a – or more than hinting there's a sort of – a divide in a way between the way the midwives ran things and the way the doctors ran things. I mean did the midwives feel protected and covered by the doctors?

MS WEAKLEY: It wasn't felt at the time that there was a divide between doctors and midwives. I know it's been very criticised, the communication between doctors and midwives, but actually – you know, and it's been said that the midwives rule the roost. But actually, from a midwifery point of view, it was the total opposite of that. It was a very hierarchical system. It came from the

clinical director through the consultants through the registrars, and the midwives were at the bottom. And it didn't happen that the midwives made all the rules up and the doctors just followed. It was the other way round.

PROFESSOR WALKER: Yes, but I was asking that there was a divide, I wasn't asking who was in charge or who was making...

MS WEAKLEY: It didn't feel there was a divide between us, but sometimes the message that was communicated was different from between the doctors and between the midwives. The multidisciplinary aspect of the care of the women wasn't particularly as highlighted as it is now.

PROFESSOR WALKER: Okay. I mean obviously, as you well know, the majority of women can be looked after by midwives quite happily.

MS WEAKLEY: Absolutely.

PROFESSOR WALKER: They don't need a doctor, and there's a group will always be looked after by doctors.

MS WEAKLEY: Yes.

PROFESSOR WALKER: And there's this group in the middle that you never quite know are going to stay low risk or move into higher risk. And that's the group that's concerned. I mean did the midwives feel that that group; there was an appropriate sort of communication and interaction between the doctors and midwives to keep that clear and safe?

MS WEAKLEY: We had had – still have a traffic light system which categorises the women into red, amber and green. The green, the low-risk midwifery care women. Red, obviously high risk, and those that you're talking about, the amber, were in the middle. And if at any time we escalated those women up

into red, or indeed the other way round, to green, we would let the on-call registrar or consultant know that, and it would be written in the notes.

PROFESSOR WALKER: But then did they come to review the case?

MS WEAKLEY: They didn't always do a four-hourly look at the patient, look at the woman, as the rules around the traffic light system state.

PROFESSOR WALKER: Did you feel at the time when this system was working that it was a safe system?

MS WEAKLEY: I felt that it flagged up the women who were moving up in their risk. I think the system itself was safe, if everyone followed the rules.

PROFESSOR WALKER: Okay.

MS WEAKLEY: Yes.

PROFESSOR WALKER: So the follow-on question was did you feel it was safe, did they follow the rules, or was there concern that the rules weren't followed and therefore the system wasn't acting as it should do?

MS WEAKLEY: Sometimes.

PROFESSOR WALKER: Okay. Can I ask specifically about if you – if an incident occurred that had been flagged up by somebody, that an intrapartum event has occurred, or a severe possibility of a haemorrhage or admission to special ~~[inaudible]~~?care or something, and this is flagged up as an incident, how would that be handled?

MS WEAKLEY: Can you say it again, sorry?

PROFESSOR WALKER: Sorry. A clinical incident, so whether you'd call it a serious untoward incident or incident reporting Level 2, or whatever, how would these be handled by the system? Who would report it and what would happen

to that report – that incident when it's reported?

MS WEAKLEY: Now or at the time?

PROFESSOR WALKER: At the time.

MS WEAKLEY: The midwife usually who was looking after the baby or – would report it into the clinical incident system, and it would go to the risk management team. And at the time it would usually be the risk manager who handled the subsequent investigation. It's different now, but at the time – we didn't have a big risk team at the time.

PROFESSOR WALKER: Would you be involved in any of these? Would you [inaudible] them in any way or...

MS WEAKLEY: If she felt that I would be best to do that, she would then come to me.

PROFESSOR WALKER: And if there were – but if there are things that had to be changed or implementations to patient care for an individual, would you be involved in handling that individual?

MS WEAKLEY: Yes.

PROFESSOR WALKER: Okay. If a midwife was involved in a practice where they were unhappy with the way a doctor was carrying out a forceps delivery, whatever, and there was an incident involving that, now who would you expect to report the incident, the midwife or the doctor or both?

MS WEAKLEY: I would expect the midwife to report it.

PROFESSOR WALKER: Would you not expect the doctor to report it? Do you not think the doctor should have reported it?

MS WEAKLEY: If it was his practice.

PROFESSOR WALKER: But would you not think the doctor should report it?

MS WEAKLEY: I would, but I know they wouldn't.

PROFESSOR WALKER: So was there any problems created by midwives reporting doctors for practice?

MS WEAKLEY: Yes.

PROFESSOR WALKER: And how were they handled from the medical side?

MS WEAKLEY: I had several heated discussions with our clinical director about the doctors, about some of the doctors that we – particularly some of the locums that we had. Some of them – you know, when it was a locum it was kind of taken more easily and he would tend to listen and say, you know, and quite often they would go and we wouldn't see them again. If it was one of our own doctors it was more difficult, and on several occasions I was told that my job isn't to question the practice of my colleagues, and it would stop at that point.

PROFESSOR WALKER: So nothing would be done.

MS WEAKLEY: No.

MR BROOKES: Sorry, can I just ask, who said that to you?

MS WEAKLEY: The clinical director.

MR BROOKES: Okay, thank you.

MS WEAKLEY: He felt it wasn't his role to oversee that, to do anything about it.

PROFESSOR WALKER: Okay. Sorry, was he then saying he felt it wasn't his role to criticise the practice of another doctor, or wasn't your role, or a midwife's role, to question the practice of doctor, or both?

MS WEAKLEY: Both.

PROFESSOR WALKER: Okay.

MS WEAKLEY: Yes.

PROFESSOR WALKER: So you basically felt that – don't stick your nose in, and he was going to do anything about it anyway.

MS WEAKLEY: Yes, it was a really hierarchical system of – you know, really what we see now as extremely old hat, but that's how it was. And, you know, that was where the buck stopped, and the doctors weren't as visible as they are now. They certainly didn't sit on labour ward when they were on for labour ward. They weren't around us; they were elsewhere. And they came if we called them, but they weren't around – they weren't part of – that's why some of the communication failed because they weren't with us. We had to stay on labour ward, that's where we are. We don't go off it, but actually they only came if we called them.

PROFESSOR WALKER: So you're hinting at the fact, again, that now that's changed that the...

MS WEAKLEY: It has.

PROFESSOR WALKER: ... that the doctors are there and would a similar incident now, a midwife picked up a problem with an incident on delivery, how would that be managed now compared to what it was before?

MS WEAKLEY: That midwife would feel able and quite happy to do it, to report that through the incident system, and then it would come back to the labour ward co-ordinator to either do a management report on it, or if the risk manager and her team felt that it needed a rapid review or further investigation, it would come to us to do, to the labour ward co-ordinators. It's much more entrenched in daily work now.

PROFESSOR WALKER: And how would the medical person be handled at that time? Would the medical director now be more inclined to involve and to talk to the doctor?

MS WEAKLEY: I think the midwives, all the midwives that I can think of would feel happy to say to him, 'I'm not happy with this, and I'm going to put it in as an incident,' and explain why. They wouldn't feel under any sort of threat from that, they would be quite happy to do that. And usually whichever band 7 was on would talk to the consultant that was on at that time to say, 'We're not happy with this; this needs addressing, and this is what we've done,' and we would have a discussion around it at the time.

PROFESSOR WALKER: So you're suggesting that things have greatly improved and things are better now than they were.

MS WEAKLEY: Yes, they're easier. Yes, they are.

PROFESSOR WALKER: Does that make it safer than it once was?

MS WEAKLEY: Yes.

PROFESSOR WALKER: So does that mean it wasn't as safe previously?

MS WEAKLEY: It's difficult to think back what happened then because you just think about what happens now. But I think there were times when it wasn't safe. The biggest problem that we always had was our labour theatre ~~ward~~, not being on our labour suite. We used to turn up to labour theatre~~ward~~ in the middle of the night and it was locked, without any staff, and that definitely wasn't safe. And time and time again it was reported. That was the most scary part about working on that labour ward, because when there were no theatre staff in the building and they had to be called in, I have been at a

theatre ~~labour ward~~ door trying to get in with a foetal heart in the 60s, not being able to get through it, and that's scary. That's unsafe.

PROFESSOR WALKER: And what was in the past?

MS WEAKLEY: It was in the past.

PROFESSOR WALKER: But you don't think that would happen now?

MS WEAKLEY: No.

PROFESSOR WALKER: Okay.

PROFESSOR FORSYTH: You mentioned about locum doctors.

MS WEAKLEY: Yes.

PROFESSOR FORSYTH: How often did you have a locum doctor on at whatever level? What levels were they mainly? Were they middle grade or consultants?

MS WEAKLEY: Middle grades, sometimes old SHOs – we don't call them SHOs any more, do we? But it wasn't – it wasn't very often. It was only if they couldn't have enough for the rotation, or someone was off long-term sick, it tended to be that kind of cover.

PROFESSOR FORSYTH: Right, okay. In terms of maintaining clinical skills of the midwives, particularly those working in the labour suite, but across the community and antenatal as well, what systems did you have in place in the past to try and maintain skills?

MS WEAKLEY: We had mandatory study days that we all had to attend, multidisciplinary study days. And we had – unfortunately when the cost improvement programmes came into play we had a cut in the training budget, so it was very difficult to send people. Because where we live it's quite isolated and it's always quite a long train journey to get to any study days in

Manchester, London or wherever they may be, the midwives had to pay for their own accommodation and train fares. The Trust would often pay for the actual course, but that, you know, could be quite a cost to the midwives, which didn't give them an incentive to kind of go and do – and quite often we'd find that the better – the good study days were miles and miles away from us.

We did all attend the [ALSO~~Also~~ Course?] at one point, we all did it once. And we actually hosted an Also Course as well, because we had a couple of Also trainers within the midwifery workforce. But – and we did the mandatory stuff that we had to do, which it was based on Also. Our training days, they were around the emergency situations that everyone does, and we had scenarios, we had – you know, we used to use the education – the nurse education people to help us to put those on. And we did those across the Bay. We used to travel to the other two sites, and we used to try and cross the midwives over so that they could talk to their colleagues across the Bay. So we did those, but unfortunately, a lot of the – as I say, when the training budget was cut and the midwives had to pay for their own, it was difficult to get them to go to. We could identify what the midwives would like to do through the appraisal system, but it wasn't always possible to do that.

PROFESSOR FORSYTH: Did you appraise each member of staff working in the labour suite, assess their skills and identify those who were at risk?

MS WEAKLEY: We had a cascade system for doing the appraisals in that the band 8s would do the band 7s would do the 6s would do the – we didn't have band 5s at that point, but down to the band 3s and the 2s, and they were divided out between them, the staff. And that's how we managed it.

PROFESSOR FORSYTH: So really – I mean to more strictly assess a performance did you – I mean did you have assessments that identify which midwives have difficulties, whether it's interpretation of CTG or resuscitation skills or whatever?

MS WEAKLEY: We did the K2 Package; we had that that we did. And CTGs were part of the mandatory study days. We didn't do particular clinical observation and clinical practice, unless you happened to be in with another midwife who was doing something. We didn't assess skills that way.

PROFESSOR FORSYTH: As you hinted earlier on, there were a number of incidents in the unit. What do you think were the, from your perspective, the underlying causes of that?

MS WEAKLEY: Of incidents?

PROFESSOR FORSYTH: Yes.

MS WEAKLEY: I think the move of our special care baby unit to not accept direct referrals from midwives didn't help. I think the move to put...

PROFESSOR FORSYTH: So what was the procedure?

MS WEAKLEY: I mean I'm talking about incidents with babies.

PROFESSOR FORSYTH: Well not necessarily the babies, I'm talking about both from a mother's perspective and the baby's perspective, but...

MS WEAKLEY: I think the issue around special care was when – when the division was trying to pull the midwifery and obstetric services together across the Bay and have us work as one whole integrated service, a lot of what happened at Lancaster was transferred over to Barrow, and...

PROFESSOR FORSYTH: Such as?

MS WEAKLEY: What happened was they said, you know, 'This is what happens at Lancaster, therefore this is what you're going to do.' However, Lancaster's special care baby unit was very different than the one at Barrow, it was a different level for a start. They had an outreach team, and there was nothing like that at Barrow. So what happened was the babies were moved from the special care – I don't mean physically moved, I mean weren't admitted to the special care baby unit. They became transitional care babies, but without the term 'transitional care' and without any support from anyone around teaching, helping – you know, asking midwives if they could identify any gaps in their knowledge. Nothing was put into place. And that happens by stealth really. It wasn't a 'This day we are going to do that,' it kind of migrated onto the maternity ward, and that put a lot of pressure on the midwives, and that was one factor in some of the incidents that happened with the babies that were here, were in the middle.

Certainly taking a midwife off every shift was one of the reasons. We had to put in an on-call system to keep the service safe at night, which we didn't have before because we had another midwife on the shift, but one midwife on each of the shifts was taken away.

PROFESSOR FORSYTH: So take a midwife off the shift but have someone at home on call.

MS WEAKLEY: On call overnight, yes. I think the lack of visibility of supervision of midwifery was one of the factors, because although it was there, it was a very – it was an underlying thing. It wasn't visible, it wasn't particularly active. I think there was a lot of miscomprehension about why it was there and what it did,

and what it seemed to do at the time was only to come into play when an incident happened, and actually that's really not what supervision is about, so that the lack of visibility of that was a factor.

I think the lack of training for some of the midwives was a factor, absolutely. I think the lack of recruitment of empty posts was a factor, or filling midwifery posts with band 3 and band 2 posts instead because it was cheaper. In fact not being able to recruit from out of the area was a factor, or not being able to recruit at all. The fact that on a day-to-day basis, although there was a band 7 who was responsible for the unit, that band 7 was more often than not working very clinically and in with a labouring woman, or wasn't immediately available on the unit. That didn't help.

I think it was multifactorial, and there's a lot of things that made those holes in the cheese line up, and a lot of it was around the systems and processes that we didn't have in place, and that we did have in place but weren't effective.

PROFESSOR FORSYTH: So what – I mean from the midwives' perspective, I presume you made representation to your manager about some of these issues?

MS WEAKLEY: Mmm-hmm.

PROFESSOR FORSYTH: And so then what happened to that?

MS WEAKLEY: I don't know, and – because a lot of it never came back down to me, I never heard anything after that. There were emails, there were – you know, we had lots and lots of meetings about different things. We felt, as a group of matrons, that the Trust Board was unreachable. We didn't know that

– we didn't know who they were, most of them. We never saw them. We felt that we couldn't approach them. And while I'm saying this to you now, it seems really strange now, because – but that's how it was. They weren't a visible part of our support system. I don't think they had much understanding of midwifery and paediatrics at all, so much so that, you know, they split midwifery – they split obstetrics and paediatrics when they changed the divisions; they put us in two different divisions. Well, you know, it was almost impossible to have one without the other working in different divisions, having different sets of goals, and it was really difficult to bring people together when they were so far apart.

PROFESSOR FORSYTH: Did you think that trying to take an area approach to delivery of midwifery set up certain sort of disadvantages to Barrow and how they delivered the care?

MS WEAKLEY: Taking the Lancaster...

PROFESSOR FORSYTH: Yes.

MS WEAKLEY: ...site you mean? I think a lot of the things that Lancaster did were extremely good, but we also did some things extremely good, and I think what needed to happen was that we shared best practice across the Bay. We felt very much that Lancaster did it right, and they were the people that we were all going to follow, but actually it's never like that in one unit, and we didn't share best practice as we should have done. We didn't sit down and say, 'Right, okay, we've got this idea. This is what we want to do at Barrow. How can we make that happen with the workforce that we've got and the culture that we've got and everything else that we're working with here? How are we going to implement that in the best way possible and in the safest way possible?' And

those conversations didn't happen, and it was just, you know, 'This is what we're doing,' without – and we would just find out in a meeting that's what was happening. We'd had no input into that, it wasn't at that level.

PROFESSOR FORSYTH: And my final point, the rate of paediatricians with midwives and also with obstetricians, do you want to elaborate on that, how effective that was or not?

MS WEAKLEY: As a midwife, I feel that we could speak to a paediatrician whenever we needed to, when we were concerned about any aspect of the care. The paediatricians were under a lot of pressure because there were no middle grades at the time. They had the consultants and the quite junior often SHOs, and it was quite a pressurised service. They found it difficult to recruit, and it was difficult to have a paediatrician in all the meetings, particularly the risk meetings that we needed them to be. They couldn't always attend, and that wasn't any fault of them, it's not that they didn't want to attend, but the clinical pressure was – you know, there was no one identified as the risk lead for paediatrics. So therefore, and it was in the risk meetings and in the development of the guideline meetings that we particularly need them, because it's difficult with guidelines because the more people you have in a room, the longer it takes to agree. You go backwards and forwards, but we needed that paediatric input, and it wasn't constant.

And therefore, some of the guidelines that crossed over between the two disciplines were really difficult to get ratified and to get an understanding and, 'Right, we're definitely all doing this.' And not only did we have the paediatricians on the two sites, the Lancaster site and the Barrow site not

agreeing, we also had the obstetricians and the paediatricians, so we had four lots of people and the midwives in the middle trying to keep everyone happy, and it was a – identifying of the rules would have made it so much easier. An actual, 'This is you and you are our lead for this, and you can – you know, we'll free you up to go to that meeting every other Monday,' didn't particularly happen. It was really difficult to get representation from all we needed, so that – it's that level of communication that was really difficult.

As a midwife, I didn't find on the clinical floor a problem with speaking to the paediatricians, and that communication was okay.

PROFESSOR FORSYTH: Okay, thank you.

DR KIRKUP: Just on that point, I mean that's not quite the picture that some other people have painted for us about the relationships of the paediatricians. Is that just personal differences in approach?

MS WEAKLEY: I think so. I think that's me as a – you know, I'm talking about when I was working clinically. I didn't have a problem with speaking to any of the paediatricians, but I saw it at a different level. As a matron, I saw that there would sometimes be absolute – you know, it was a bit of a – you know, 'I'm puffing my chest out bigger, so therefore you're going to do what I'm going to do,' and there could be clashes, absolutely clashes. But at the meeting level there could also be differences of opinion clinically, particularly when we were talking about transfers out. That was a difficult area. And particularly...

PROFESSOR FORSYTH: Can I just clarify that point again to be sure? We discussed it earlier, but which side was taking what in the issue of a transfer out?

MS WEAKLEY: The paediatricians would tend to want to transfer out. It would be a neutral transfer sometimes. The obstetricians wanted to keep them, so we always had...

PROFESSOR FORSYTH: It was left that you had the Level 1 unit in Barrow.

MS WEAKLEY: Yes, absolutely. And there could be clinical decisions that were really difficult, and they would go behind the door on the labour ward and fight it out between them.

DR KIRKUP: Was it always clear what the decision was at the end of that process?

MS WEAKLEY: No. No, it wasn't, no.

MR BROOKES: Just a couple of areas, just to make clear, I think for myself as much as anything, but can we go back to the cost improvement programme?

MS WEAKLEY: Yes.

MR BROOKES: Just to be clear, did maternity services have a specific cost improvement target?

MS WEAKLEY: It did, but it changed from month to month. It was never particularly clear what exactly we were meant to be saving. I'm sure it was clear to the finance people, but as it filtered down it kind of – yes, they would say, 'This was our original cost improvement programme, but now we've taken this into account, this is what it is now.' It was a really difficult thing to keep hold of, and really when it came down to the matrons, it was around, 'Keep your staffing costs down, we don't want to see an overspend in the monthly figures. If there is an overspend you will be held accountable, and you will have to answer to it,' which was fine. I had no problem with that.

But it wasn't always clear to me exactly what, as a team, we were

pulling together to put forward for the cost improvement programme. As I say, the thing that astounded me most was when they said that, 'We've put a CNST 2 Level 2 forward, that's part of our cost improvement programme, and if you don't meet it you will lose midwives.' And we hadn't even had the assessment at that point, and we were saying – the risk manager was saying, 'We are not ready. We're not ready for this.' And she was almost castigated for saying that.

MR BROOKES: So partly there was unreasonable expectations?

MS WEAKLEY: Yes, absolutely. Totally unreasonable.

MR BROOKES: A cost improvement plan which was not necessarily that well-costed.

MS WEAKLEY: Yes.

MR BROOKES: Okay, I understand that. Because it leads me to the big thing I've been struggling with quite a bit this morning and this afternoon is – from your opinion, who was in charge of the maternity unit?

MS WEAKLEY: At Barrow, the clinical director.

MR BROOKES: The clinical director. Was he responsible for the delivery of the cost improvement programme?

MS WEAKLEY: No.

MR BROOKES: Okay. And what was the relationship between the clinical director and the divisional manager, for example? How, in the light of accountability, it worked – that's what I don't understand about...

MS WEAKLEY: Yes.

MR BROOKES: ... this organisation.

MS WEAKLEY: I don't really know because we were never part of any meetings. The only meetings that we were all at were the risk meetings and the guideline meetings. Their meetings took place away from me as a matron, and I've no idea, they never spoke about what happened. I don't know.

MR BROOKES: Okay, so the clinical director was responsible. So was it their responsibility to ensure the overall quality of the service?

MS WEAKLEY: No, it was all of our responsibilities.

MR BROOKES: I accept that, but in terms of accountability, were they accountable for that?

MS WEAKLEY: I think he felt that he was. I didn't see that he was particularly, but I think that's what came over to us, that the – him and the head of midwifery, they were all three of them accountable to the Board for that, yes.

MR BROOKES: Okay. Just one question about – it links to the cost improvement programme. Your bank costs, was that your main overspend? Was that the main area of pressure within your budget?

MS WEAKLEY: Staffing was our main overspend, yes.

MR BROOKES: And can you just explain that? Is that because you couldn't recruit to post so you were using bank, or was it because of sickness, and then we get a double-whammy because you were paying for the person to be sick and also paying bank costs?

MS WEAKLEY: Both of those things, but also we couldn't recruit. We weren't allowed to recruit.

MR BROOKES: You weren't allowed to?

MS WEAKLEY: No, they put a stop on recruitment.

MR BROOKES: So your budget that was set didn't recognise that the only way you would be able to fill posts was through bank expenditure?

MS WEAKLEY: No, we had no part in setting our budgets. We didn't even know where they'd come from.

MR BROOKES: Who set the budget?

MS WEAKLEY: No idea.

MR BROOKES: You don't know.

MS WEAKLEY: But the staffing – you know, they were there, and when we questioned it, said, 'We need to get this right because we're overspending because you won't let us recruit, and we're trying to fill sickness, so surely it'll be cheaper to recruit staff into those empty posts,' but we weren't allowed – you know, 'No, you can't do that. This is how it is,' and when – I think the first person that really asked that really serious question and did something about it was our new head of midwifery, the one that we've got now. And she said when she came into post, she said, 'So you matrons, do you set – you know, you know exactly what?' and we all looked at her as if to say, 'No, we don't.'

MR BROOKES: And do you now? Do you now?

MS WEAKLEY: I'm not a matron now.

MR BROOKES: But do they now?

MS WEAKLEY: But they do now.

MR BROOKES: Okay, thank you.

DR KIRKUP: Okay, thanks. A couple of things just to follow up on briefly. When you started as a matron in 2007, I think, did you have any concerns about midwives' skills at that point?

MS WEAKLEY: Not any particular midwives. There were midwives that were junior. We didn't have band 5 midwives then, and we didn't have preceptor ~~reception~~ ones. So midwives tended to qualify and go straight into band 6 posts, and the junior band 6s, we wrote some paper – it was kind of a preceptorship programme, but not called that, to – because they were expressing that they had some difficulties in gaining the clinical skills that they needed. So the matrons wrote some – a small programme that we felt, you know, with their input, to say, 'What do you feel you need in the first year of your...?' So they were the people that we felt – there wasn't a particular midwife on the unit that I was aware of...

DR KIRKUP: Or a particular skill gap across the...

MS WEAKLEY: Yes, I see what you mean. No.

DR KIRKUP: No. Did you develop a view later that there were skill gaps?

MS WEAKLEY: Well the incidents highlighted some of the skill gaps, absolutely, yes.

DR KIRKUP: But they weren't apparent before that.

MS WEAKLEY: But we were aware that they were there.

DR KIRKUP: Okay. Did anybody express any doubts to you about their ability to monitor babies in postnatal wards, whose clinical condition might have been deteriorating?

MS WEAKLEY: Yes, when the babies started to be nursed on the maternity ward. Before that point they always went to the special care unit. And so the midwives, the majority of midwives have never worked on a special care baby unit ever.

DR KIRKUP: Sure.

MS WEAKLEY: Well, three weeks in the training maybe. And yes, it absolutely was, and it was raised at the risk meetings.

DR KIRKUP: And what action was taken to improve that level of knowledge?

MS WEAKLEY: What was said was, 'You can go through and spend shifts on special care baby unit if you want to,' and this was at the time when we were really struggling for staff, we were trying to do lots of other things like, you know, we were asked to go out to community centres to hold drop-in sessions. That was an absolute – you know, 'You must do this. This has got to happen with the staffing that you've got, you've got to make it happen.' So we were trying to do that as well, and to put people into the special care baby unit one day a week was – it was totally impossible. It wasn't ever going to happen because of the staffing levels that we had.

DR KIRKUP: The consequence of that then though, was that you had people monitoring babies whose condition might have deteriorated, who'd already said they didn't have the skills to do that.

MS WEAKLEY: Yes.

DR KIRKUP: Did you take any steps to report that, to say that that was a problem?

MS WEAKLEY: Yes, the midwives themselves would report it.

DR KIRKUP: To who?

MS WEAKLEY: To – via the incident reporting system.

DR KIRKUP: Yes, when incidents happen, I appreciate that, but before that?

MS WEAKLEY: No, they would put in that it wasn't particularly anything, it was – you know, we are short of staff. They were encouraged to put in when they

were short of staff and felt that the unit was...

DR KIRKUP: Right, my mistake. I didn't understand that.

MS WEAKLEY: Yes. Yes.

DR KIRKUP: And did any action happen as a result of that?

MS WEAKLEY: I didn't see any.

DR KIRKUP: Okay. Where would those reports go to?

MS WEAKLEY: I think we were talking to the neonatal practice educator around sessions for the midwives, because the more midwives said 'I don't feel that I've got the appropriate skills to do this, and you're making us have these babies,' and certainly the ward manager said, you know, and we were speaking to, as I said, the neonatal practice educator came to some of the risk meetings that we held, and we were speaking to her about putting sessions on. The midwives, the ALSO trainers and the midwives that did our managed training, didn't feel they were able to do it because it wasn't their speciality. You know, they needed help from the paediatric side of things, and so it was in the pipeline. You know, it was... people knew about it.

DR KIRKUP: Okay. We'd like to ask some questions about individual cases, so for reasons of patient confidentiality we'll just have a short pause while the observers withdraw, please.

[*Attendees withdraw*]

THE MORECAMBE BAY INVESTIGATION

Thursday, 25 September 2014

Held at:
Park Hotel
East Cliff
Preston
PR1 3EA

Before:

Dr Bill Kirkup CBE – Chairman
Mr Julian Brookes – Expert Advisor on governance
Professor Jonathan Montgomery – Expert Advisor on ethics

DICKON WEIR-HUGHES

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DR KIRKUP: Thank you for coming. Please take a seat. I'm Bill Kirkup. I'm the Chair of the investigation panel. I'll let my two colleagues introduce themselves.

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

MR WEIR-HUGHES: Nice to meet you.

PROFESSOR MONTGOMERY: I'm Jonathan Montgomery. I'm Professor of Healthcare Law at University College London and Chair of the Health Research Authority, but in the past I've chaired provider trusts, an SHA when there were 28, and a PCT.

DR KIRKUP: Thank you. You'll have noticed that we're wired for sound and that we are making a recording of proceedings. We will agree a record of them subsequently with you. We also have asked family members if they'd like to be in attendance and they have been in some of the interviews but not always. As it happens, we don't have any today but they will be able to listen to the recording of proceedings afterwards if they want to do that. We've also asked you to hand over any mobile phones, recording devices, etc. That's just to underline the importance that nothing leaves the room until we are ready to produce a report that has everything properly considered in context.

Is there anything that you would like to ask us before I start?

PROFESSOR WEIR-HUGHES: No, I don't think so. I did just want to, for the sake of openness and transparency, say two things. One is that – and I know she's not here today, but I've known Geraldine Walters for 20-odd years. That won't be of surprise to you, I'm sure; it's a fairly small world.

DR KIRKUP: Indeed.

PROFESSOR WEIR-HUGHES: And the second thing is that obviously it's a while since I've been involved with this, so, again for the sake of openness, I did meet with Jackie Smith for a briefing and a bit of an update and to refresh my memory.

DR KIRKUP: Sure thing.

PROFESSOR WEIR-HUGHES: So I just wanted to be open about those things.

DR KIRKUP: That's absolutely fine – thank you – and I think that's helpful. Okay. I will start with a reasonably general question, then, and then hand over to

Jonathan in a moment. Can you just tell us about your time at the NMC and how – when you started and what you did there?

PROFESSOR WEIR-HUGHES: Yes. So, I was appointed in 2009 and was there until 2012, and I was Chief Executive and Registrar. So – I don't know how much detail you want me to go into in relation to the –

DR KIRKUP: Just give us a flavour of how much you would have been aware of individual cases and so on that the NMC was handling.

PROFESSOR WEIR-HUGHES: I would have been aware of high-profile individual FTP cases, but, I mean, as you will know, there are thousands in the system, so I wouldn't have been aware of the individual detail of all of them unless it was brought to my attention for some reason. High-profile would normally be defined as either a high-profile individual who's in the system or a high-profile case because it's something that's particularly difficult or unpleasant or what have you. But of course the Registrar has no direct influence anyway on the work on the panellists, so in that respect one has to have a little bit of distance anyway. But the rest of the Registrar role really is about managing the register, about, you know, approving university departments to run nursing courses – all of those sorts of things. So, a lot of the role is completely removed anyway from fitness to practise.

DR KIRKUP: Yes, indeed. Okay, thank you; that's very helpful. Jonathan.

PROFESSOR MONTGOMERY: Thank you. Could I just check one other thing about the career? I know that you were at Barking, Havering and Redbridge previously.

PROFESSOR WEIR-HUGHES: I was, yes.

PROFESSOR MONTGOMERY: That name came up when we saw one of the CQC people about a Section 48 system review inquiry, but I'm guessing that was after your time. Were you there then?

PROFESSOR WEIR-HUGHES: Yes, I was – I left in 2009.

PROFESSOR MONTGOMERY: So I think that would have been later.

PROFESSOR WEIR-HUGHES: So I think it was afterwards, yeah.

PROFESSOR MONTGOMERY: Had you been there, it would have been interesting to understand a bit about the experience, but I just wanted to check that that wasn't the case.

PROFESSOR WEIR-HUGHES: I'm happy to talk about Barking, Havering and Redbridge. It's an interesting place.

PROFESSOR MONTGOMERY: But I think probably we don't need to do that this morning.

DR KIRKUP: Yes, thank you.

PROFESSOR MONTGOMERY: Thank you. I wonder if you could just take us through how University Hospitals Morecambe Bay reached your attention and radar. And I want to go back to the particular NMC reports a bit later on, but if we could understand how it arrived on your desk, as it were.

PROFESSOR WEIR-HUGHES: Okay. So, I think it would be fair to say that it was escalated to me, but in a way similar to other escalations, so it wouldn't have been extraordinary that it was escalated, if that makes sense.

PROFESSOR MONTGOMERY: It would be helpful to have a sense of scale. We know there are thousands of fitness to practise issues. How often are things escalated to you?

PROFESSOR WEIR-HUGHES: Gosh, it would – it's variable. I suppose other similar escalations would have been serious departmental problems in certain hospitals, perhaps whistleblowing from students – that sort of thing. So – and those things happen when they happen, really, but – you know, all over the country, so –

PROFESSOR MONTGOMERY: But in a rough sense, would you expect every week to have one?

PROFESSOR WEIR-HUGHES: No. Probably every couple of months.

PROFESSOR MONTGOMERY: Okay. That's helpful. And who would escalate them to you?

PROFESSOR WEIR-HUGHES: So, it would either – probably one of the directors. So, it could be – if it's an educational issue it would obviously be the Director of Education; if it was a fitness to practise issue it would have been the Director of Fitness to Practise, who at that time was Jackie Smith. So, a range of people, really. Or it could also be because of very careful media scanning that all the regulators do. So, in fact, it may be something that hasn't come to our attention through the NMC but a case that's in the media for some other reason. One of the things that I really tried to work very hard on while I was there was better relationships with the CQC and the police. So, one of the

things that I did was to get an MOU signed with CQC and with Monitor. And I know that MOUs are sometimes regarded just as fairly meaningless bits of paper, but for me the purpose of it was to get us sitting in a room to talk about the relationship. And that relationship in fact I think is much, much better now than it was before. So I'm pleased that we started down that road.

PROFESSOR MONTGOMERY: So, I was asking you about how it came to your attention. Do you remember who escalated it and why? Morecambe Bay.

PROFESSOR WEIR-HUGHES: I don't. I don't; I'm sorry.

PROFESSOR MONTGOMERY: And what was it that was escalated to you? Was it a media thing? Was it fitness to practise? Was it an education...?

PROFESSOR WEIR-HUGHES: From memory – and this is absolute memory – it was because of the LSA report, and think it would probably have been somebody in the Midwifery team that would have escalated it to me. But that really is, you know, from memory.

PROFESSOR MONTGOMERY: And when would that have been?

PROFESSOR WEIR-HUGHES: I honestly can't remember. I'm really sorry.

PROFESSOR MONTGOMERY: Okay. And do you remember what you did once it got on your desk?

PROFESSOR WEIR-HUGHES: Well I suppose it depends what you mean by 'it' because it's a fairly multifaceted issue. So – but there were a range of discussions, some of which related to FTP, some of which related to LSA functioning, and that would have been discussed in my regular meetings with the Head of Midwifery. The NMC Head of Midwifery I'm talking about. So, I suppose it's difficult to say what I did about 'it' because it was a range of different issues.

PROFESSOR MONTGOMERY: So, let's say: what did you do about them as a range of – cluster of issues there? And perhaps we can talk about whether it was a cluster in a minute, but...

PROFESSOR WEIR-HUGHES: Yeah. Again, this is memory, and it's so hard to recall particular meetings that were sort of four years ago, but the FTP piece of course had to just take its course and, other than being aware of it, there wasn't very much that I could do. I was involved – and I have re-looked at the correspondence – with writing to the then Chief Executive about a blog, and

the reason I wrote to him was because I thought that the blog was ill-advised and it went into too much specific detail about individuals.

PROFESSOR MONTGOMERY: And why was that your issue?

PROFESSOR WEIR-HUGHES: Because he was specifically referring to some of the midwives who had already been put into a fitness to practise process and I was worried that personal comments that he was making on the blog might influence their –

PROFESSOR MONTGOMERY: Might prejudice the –

PROFESSOR WEIR-HUGHES: Exactly – their cases. And I wrote to him to ask him to cease, really, and he didn't agree with me.

PROFESSOR MONTGOMERY: And we have that correspondence so we can see the exchange. So, I mean, one of my questions really is around what the NMC did to consider whether there was a cluster of fitness to practise questions that might raise a bigger issue or whether it was sufficient to process them one by one, going through the process. Was that something you discussed at the time?

PROFESSOR WEIR-HUGHES: No, because I think – I actually wasn't aware of the number. Now, it's quite difficult, actually, at the NMC, because of the way that the systems work – and I suppose other regulators would be similar – and the different stages of the fitness to practise process – it's quite difficult to work out if there is a cluster or not. And that's because quite a lot of those very early cases are inappropriate referrals in the first place, so just because you had a lot of referrals from one particular trust or about nurses or midwives working in one particular trust wouldn't necessarily mean that there was a problem. The problem might –

PROFESSOR MONTGOMERY: But it might be a flag that makes you ask that question.

PROFESSOR WEIR-HUGHES: Absolutely. Certainly it could be that. But certainly at the time that I was at the NMC – and it may have changed since, but we didn't routinely look through all of the fitness to practise cases to see how many came from a particular organisation.

PROFESSOR MONTGOMERY: Could your database have enabled you to find that out if you wanted? If you'd wanted to find out how many people were currently

in the FTP processes from University Hospitals Morecambe Bay, could your database tell you?

PROFESSOR WEIR-HUGHES: The database as it was – and again, it may have changed – was extremely problematic, and that's been widely reported elsewhere. So, we may have been able to make some attempt to do that, but of course it's very – very often, a nurse or midwife is referred by one organisation or one individual; they then move on, they retire, they are not working, so the referring organisation sometimes isn't the employer at the time of the hearing and all this sort of thing. So, one could of course try and interrogate the system, but it would need a lot of human input to validate those data.

PROFESSOR MONTGOMERY: And what about the media scanning? Another way you might get a warning that there was a group is that there's media coverage of an area. Would that have ever flagged up a question: 'I wonder where we are in...'? You presumably would have seen media about alleged misconduct from nurses or midwives and then you might have asked the question, 'Do we know about this?'

PROFESSOR WEIR-HUGHES: Yes. Interestingly, at the time, I don't remember a huge amount of media about Morecambe Bay. And our media scanning service was pretty robust; it was externally operated and daily. And it's – one of the sort of interesting things I was reflecting on when re-reading some of the notes in preparation for today was how little was in the media, and in particular the national media.

DR KIRKUP: Yeah. I was going to ask, actually – if I could break in very briefly – did you – when you say you scanned the media, did that include the regional media or just national?

PROFESSOR WEIR-HUGHES: Yeah. No – well –

DR KIRKUP: The regional as well?

PROFESSOR WEIR-HUGHES: Yeah. Absolutely, yeah. But with pretty generic search terms – so, things like 'nurse', 'midwife', 'NMC', obviously – that sort of thing.

PROFESSOR MONTGOMERY: And then would you get a digest of cuttings? Is that how it operated?

PROFESSOR WEIR-HUGHES: Well, not actual literal cuttings anymore, but links in an email, yeah.

PROFESSOR MONTGOMERY: Yeah. Okay. Thank you. So, it didn't reach your desk as a cluster of fitness to practise but it did reach your desk as a question of possible compromise of process from the blog.

PROFESSOR WEIR-HUGHES: Yeah.

PROFESSOR MONTGOMERY: It didn't reach your desk by the scanning of media. Tell us about the LSA issue, because that's what you set up the report into. So, how did that reach your attention?

PROFESSOR WEIR-HUGHES: Again through the midwifery team, and in particular their communications with Mr [redacted]. So – which is – it's quite unusual, actually, for a relative or carer or patient, even, to have that sort of communication with the NMC, and in this particular case it was very helpful, but it's not a regular occurrence at all, which is interesting. I think that perhaps reflects some of the public's misunderstandings – which is the fault of the NMC, actually – around the role of the NMC and the confusion with the RCN and RCM – those sorts of things.

PROFESSOR MONTGOMERY: The other confusion is with the difference between the supervisor of midwives and the local supervising authority.

PROFESSOR WEIR-HUGHES: Yes.

PROFESSOR MONTGOMERY: So, once you learnt about it from the Midwifery team, prompted by Mr [redacted], I guess one of the questions is: where do the issues belong? Do they belong with the regional health authority as the local supervising authority? Do they belong with the supervisors of midwives individually, all of whom would be your registrants, wouldn't they? So, talk us through sort of how the question was framed for you. What was the NMC's interest and concern about it?

PROFESSOR WEIR-HUGHES: Well, the predominant interest of the midwifery team would have been the role of the supervisors and the supervising authority and so on. I think – I mean, it is a massively complicated system and in fact – well, I think the ombudsman's report sets it out very clearly and the recommendations and so on very clearly, but it is a terribly confusing system, not only at the regional health authority but even within the trust. So, in my own experience as a director of nursing in an acute trust – BHR – there is

quite a lot of tension often between the director of nursing and the supervisors of midwives.

PROFESSOR MONTGOMERY: And explain what that tension is often over.

PROFESSOR WEIR-HUGHES: Well – and this is my own experience, of course; other places might have perfect relationships, but I think not. Very often it's because the supervisors, of course, don't necessarily want to escalate things; they want to retain confidentiality, which is understandable up to a point but not when it is about a patient-safety issue, in my opinion. There is also this kind of push/pull tension – nurse/midwife tension very often, which in my opinion has got worse since direct-entry midwifery, not better.

PROFESSOR MONTGOMERY: I should say, perhaps – a semi-declaration – my wife is a midwifery lecturer, so –

PROFESSOR WEIR-HUGHES: There's nothing wrong with that.

PROFESSOR MONTGOMERY: – I'm aware of some of those tensions. But – in case it's significant.

PROFESSOR WEIR-HUGHES: So I think it's – there is that tension, and one can understand how that tension comes about, because people often feel that there is a smaller profession which is sort of merged with a larger one, and so I absolutely understand that. But, again, those professional interests should not take precedence over a patient-safety issue ever. So –

PROFESSOR MONTGOMERY: And your code of conduct makes that clear, I think.

PROFESSOR WEIR-HUGHES: Perfectly clear. To me, anyway. So, I think – in my own experience, it's very important for the director of nursing in an acute trust to have a productive relationship with the head of midwifery, who's normally – they're normally their line report – and with the supervisors of midwives, but it's not always very easy. So I think there's confusion at that level. I then think there's confusion at the regional level, and I think – I assume that confusion continues to exist, but I'm not involved in that world anymore – but I imagine it does. And then, of course, there's confusion with the NMC – their role in relation to these individuals as registrants but also as supervisors who they don't employ or pay or select. And then, of course, there's also the regulatory confusion about the CQC, or their equivalents outside England, because this is not just an England issue – the CQC and the NMC. So, in a way, it's a

system which is – if one was to design a system that was going to confuse, one would probably do it like this, in my opinion.

PROFESSOR MONTGOMERY: Okay. Can I try and disentangle some of the strands?

PROFESSOR WEIR-HUGHES: Yes.

PROFESSOR MONTGOMERY: One is around the responsibilities around this confidentiality question, and it seems to me that there are at least two things that you probably have a view on from the NMC and I'd like to know how clear you think it is to a supervisor what their responsibilities are. One is the fitness to practise question, where in the course of supervision they see there may be a case to answer in relation to the registrant. The other is the patient-safety question. One is broadly backward-looking – you know these things about something that's happened; what's the accountability and how should you deal with that? The other is a current or feared future issue about patient safety. So, can you explain what, in your view, would be the responsibilities of the supervisor if they had one or other of those concerns – how they would determine whether this was sufficiently significant that they should do something outside the relationship with the supervisee? So, how do they police those boundaries?

PROFESSOR WEIR-HUGHES: So I suppose I would always be urging them to be open, so – and in particular to be open with the board member of that trust who has accountability, who is always the director of nursing. So – and I think that's just an essential axis. But bearing in mind that some of the supervisors won't even be open with the head of midwifery, it may be a step too far and I may be being too idealistic to think that –

PROFESSOR MONTGOMERY: And the right place to go would be there. Would they also go to you directly if they felt that they were not getting...? I'm trying to think what the – if it worked smoothly.

PROFESSOR WEIR-HUGHES: Absolutely. And I was fortunate and I enjoyed very good relationships with the head of midwifery that I managed, and we met weekly and we had action plans and all the rest of it. It was a good relationship. But certainly, if the midwives were not receiving sufficient support from the head of midwifery, I would expect them to come directly. And, I mean, likewise, if obstetricians have concerns about midwifery and they were not

getting satisfaction, I would expect them to come too. So, I think on every level people have to absolutely prioritise patient safety and not prioritise professional boundaries.

PROFESSOR MONTGOMERY: Okay. So, you're notified of the issues. They're sufficiently significant that actually you set up a panel to go in and find out more about it. How often did that happen in your time? Was this a common challenge on...? Is this the only time that you've had to send a team to do this? Because presumably you start by just trying to find more about it, exchanges of correspondence on questions, but you set up a panel to have a look at this.

PROFESSOR WEIR-HUGHES: Yes. So, no, it wasn't the only time. So, we had a very similar exercise, which was nothing to do with midwifery but as a result of student whistleblowing in an A&E department in Essex, and in fact – and we sent in a very similar sort of team, really. Not midwives, obviously. So, no. I suppose the – it is extremely tricky, because theoretically the NMC is a professional regulator – professional individual regulator, not a system regulator, apart from in education, where it's a system regulator because it regulates the universities rather than the individuals. So, of course, if there's something that is raised through education, that has to be dealt with in a slightly different way. And that's often something that is not recognised about the NMC; it's seen very black and white as a professional regulator, but actually I think its responsibilities in relation to education regulation are really key.

PROFESSOR MONTGOMERY: Can I come back to that? Because you also did an audit [and assurance about?] regulation, but I'm trying to understand the LSA piece of work. So, I think it's – there's one other example in your period, so that's quite unusual but not unique. You went in in collaboration with the CQC, so what were the discussions about what the right way to get to the bottom of this challenge were between yourselves and the – did they fell within the MOU already or was it needing to be something tailor-made for this?

PROFESSOR WEIR-HUGHES: I guess to some extent it was tailor-made, because the MOU was pretty high level, so inevitably it was tailor-made. And the discussions took place between the NMC Head of Midwifery and CQC colleagues.

PROFESSOR MONTGOMERY: Do you know who in the CQC?

PROFESSOR WEIR-HUGHES: I can't remember.

PROFESSOR MONTGOMERY: And just for our clarity, your Head of Midwifery at the time was...?

PROFESSOR WEIR-HUGHES: So, there were two while I was there: Christina McKenzie initially and then Carmel Lloyd after that. But we restructured slightly so that, in fact, midwifery came into the whole fold of professional practice rather than sort of sitting on the side, and Carmel was part of that change.

PROFESSOR MONTGOMERY: Okay. So you set up that team and they went in. Who were they reporting to? Who was the report they were producing for?

PROFESSOR WEIR-HUGHES: Well, I guess both CQC and NMC, but certainly from the NMC point of view it would have been for the Council ultimately. Also within the NMC there is the Midwifery Committee, of course, which is fairly sort of standalone. It's within the legislation; it has to be there. I think quite a few of us often wondered why, really, and why it couldn't have just been part of the overall Council, but it was there.

PROFESSOR MONTGOMERY: And was the report discussed at either the Committee or the Council?

PROFESSOR WEIR-HUGHES: From memory, it was, but I haven't gone back and looked at minutes.

PROFESSOR MONTGOMERY: Okay. We may be able to find that out. Okay. And, I mean, what's your sense of what the report shows us?

PROFESSOR WEIR-HUGHES: Well, I think there were some practical things that needed to be sorted out. I'm – on reflection, I'm not really sure that it went far enough.

PROFESSOR MONTGOMERY: Elaborate a little. What do you think might have gone further? Where might it have gone further?

PROFESSOR WEIR-HUGHES: I'm not sure it really focused on some of the organisational issues – some of the relationship issues. I think that – well, you know, there were some kind of very low-level practical things included within it, which were important – they were about patient dignity and so on; obviously they're important – but not as important as sorting out some of the organisational issues. Now, again on reflection, it may have been because the

people that we put in to look at it were looking pretty much with blinkers on at midwifery rather than other, perhaps, contributory factors and so on.

PROFESSOR MONTGOMERY: You could say that the organisational things were more the CQC's part of it than yours.

PROFESSOR WEIR-HUGHES: You could.

PROFESSOR MONTGOMERY: How were the terms of reference developed? Did the CQC have a set of things that it wanted sorted out?

PROFESSOR WEIR-HUGHES: I honestly can't remember how they were developed. I'm sorry. I can't remember so much of your questions; I'm really sorry.

PROFESSOR MONTGOMERY: That's okay. My sort of overarching question – I'm interested in your sense of the report, and I think this is reflecting on it as opposed to at the time – is – one of the things that I want to disentangle in my own mind is: does the report tell us that the system of supervision of midwives is flawed, or does it tell us that in this place it was implemented in a flawed way? So I'd be very interested in your reflections on that question.

PROFESSOR WEIR-HUGHES: I think the latter, sadly. And I say 'sadly' because I think that in a way the NMC has been sort of – because it's been required to as a result of the legislation, it's been kind of complicit in peddling supervision as the answer, and almost believing its own – the rhetoric, really. That's kind of unfortunate, and I'm not sure, on reflection, that the NMC – we, the NMC, were assertive enough about some of the downfalls and difficulties with supervision as we might have been.

PROFESSOR MONTGOMERY: So, just to clarify, then, I think what you're saying is that what it really shows is that we shouldn't have been using supervision as a tool for regulating. To what extent does that let the individual supervisors of midwives slightly off the hook if they're put in a dysfunctional system?

PROFESSOR WEIR-HUGHES: I suppose it does let them off the hook a little bit, but I suppose I'm thinking less about the hook and how actually one can change things for everybody's sake for the better for the future. But, you know, there are a lot of midwives who are incredibly disenchanted with supervision. I mean, it's – you know, the popular belief is that everybody thinks it's fantastic, but they don't. You know, just like any other sort of concept, there are people within that profession who don't agree with it and some people who disagree with it very strongly.

MR BROOKES: Sorry, can I just clarify: is it supervision per se or is it the system of supervision that was in place?

PROFESSOR WEIR-HUGHES: In that trust, do you mean, or --

MR BROOKES: Generally, in terms of the concerns about supervision.

PROFESSOR WEIR-HUGHES: I'm slightly confused by your question; sorry.

MR BROOKES: I'm just trying to – there's a difference between supervision as a concept and working potentially well, and supervision being a good concept and not working well because of the way it's been implemented. Do you see what I mean?

PROFESSOR WEIR-HUGHES: I do.

MR BROOKES: So, I'm trying to work out whether or not the disenchantment you were reflecting on from some is because of the way supervision works or it's because of supervision, if you see what I mean.

PROFESSOR WEIR-HUGHES: Both.

MR BROOKES: Both.

PROFESSOR WEIR-HUGHES: I think both. But I think that the root, clearly, is the fact that it exists and, you know, that midwives are the only healthcare professionals with this, and is that logical? And, you know, there are other healthcare professionals who are perfectly safe without the equivalent of midwifery supervision in place. So, I think the answer to your question would be both, but I think the root cause is the fact it exists.

MR BROOKES: That's helpful. Thank you.

PROFESSOR MONTGOMERY: Thank you. In the 2011 report, it says that what they'd found at Furness was that the supervisor seemed to be so focused on supporting midwives, not protecting mothers and babies. I just wonder whether you thought that was a regulatory – fitness to practise issue there. I don't know – are they failing in their professional responsibilities, those supervisors?

PROFESSOR WEIR-HUGHES: I guess on one level they are, because, you know, their duty is to protect mothers and babies. It's very interesting to me – I read through quite a lot of the minutes of meetings from that particular LSA before today and it was very interesting to look at the focus of those meetings, because really – and again, this is reflection, but, you know, a lot of the content is about sort of very general professional practice, professional

development. There's nothing wrong with that per se, but it's not about patient safety necessarily, which is what they're supposed to be doing, you know? So, it's almost as if the supervision in the case of that particular LSA has almost become a sort of a – a bit like a sort of midwifery club. Do you know what I mean?

PROFESSOR MONTGOMERY: I have read those papers as well and I understand what you're saying.

PROFESSOR WEIR-HUGHES: I'm struggling to find the right words, really, but –

PROFESSOR MONTGOMERY: I mean, one illustration of that is the re-doing of some of the investigations because they didn't follow the local guidance. I'm just wondering, from an NMC perspective, I mean, that seems to raise questions around the professional practice of the people who were supervising. Did the NMC consider whether there was any regulatory action that was appropriate?

PROFESSOR WEIR-HUGHES: We didn't at the time, but I don't know – I can't answer for Jackie, clearly.

PROFESSOR MONTGOMERY: And do you have a mechanism for the NMC triggering that without a referral?

PROFESSOR WEIR-HUGHES: Oh yes. The Registrar is allowed to open a fitness to practise case. That's in the Order. Section 5.2, from memory.

PROFESSOR MONTGOMERY: Thank you. I wonder if I can shift to the education question, because we've touched on the fitness to practise, we've touched on the LSA, we've touched a bit on the media scanning, and the other big thing you were talking about was the education, where you do have system responsibilities. And again in 2011, there was a question about the quality of education at Morecambe Bay and you sent a team in to do an assurance audit for that.

PROFESSOR WEIR-HUGHES: Yes.

PROFESSOR MONTGOMERY: So, how did that come about?

PROFESSOR WEIR-HUGHES: So that – I mean, that sort of extraordinary visit for education – again, it wasn't the only place where that was done.

PROFESSOR MONTGOMERY: And that, I'm guessing, was a bit more common to send someone in than the reports we've just talked about.

PROFESSOR WEIR-HUGHES: Absolutely. And – so that was – it was a normal process. Normally speaking, it would be triggered by students writing in or emailing or what have you, or because of something else that would have come to our attention. So, I don't know, perhaps if I was out on a visit and I would speak to students without anybody else there and discover that they hadn't seen a tutor for a year, then clearly that would be something I would pick up on, or a director of nursing perhaps might raise it and say they weren't very comfortable with the provision from a particular university. So that would be a very normal process, and sometimes that would be about us then removing students from particular clinical areas. It's interesting, because if there's one thing the NMC does that is guaranteed to absolutely have a trust board on the ceiling, it will be removing students from particular areas.

PROFESSOR MONTGOMERY: So what triggered this one for Morecambe Bay?

PROFESSOR WEIR-HUGHES: I think the fact that we knew other things were going on, and for me an appropriate learning environment is only – sorry, a clinical environment can only be an appropriate learning environment if the practice is optimal. It's completely at odds otherwise. So – and I'm not sure that's always been well recognised. The fact that, for example, students were not initially removed from Mid Staffordshire was quite extraordinary to me. They were eventually removed, but –

PROFESSOR MONTGOMERY: So, what was the process that enabled you to...? Because – I was going to ask you this question at the end, really. You have this cluster of reasons to be concerned; how do you see them together? You must have done that. Or, if that was the trigger for you sending in the education audit, who sits round the table and says – or how do – you know, is it initiated by you saying, 'I've got these two things coming in'? Is there a standing committee of your top team? How was that generated?

PROFESSOR WEIR-HUGHES: It would be by the directors – the group of directors. When I say 'the directors', I don't mean all the directors – I mean, clearly the Director of Finance wouldn't have too much interest in it – but the directors with an interest would get together. But it's very –

PROFESSOR MONTGOMERY: Can I just push a bit? 'Would get together' or 'Did get together'?

PROFESSOR WEIR-HUGHES: Did get together.

PROFESSOR MONTGOMERY: Yes. So this is about this particular case.

PROFESSOR WEIR-HUGHES: Well, we'd get together regularly anyway. I mean, we'd have regular sessions. But the NMC's a very small organisation, really, in terms of the kind of headquarters of it, so it's very fluid. I mean, people are – it's not maybe quite as formal as one thinks in terms – I mean, the Council obviously is, but in terms of day-to-day operations, you know, people are calling in and saying, 'Can I just – I've got a bit of a niggle about this. Can we have a discussion about it please?' You know?

PROFESSOR MONTGOMERY: And what did that 2011 audit tell you?

PROFESSOR WEIR-HUGHES: I can't remember the detail of it.

PROFESSOR MONTGOMERY: Okay. But did it – it didn't lead to anything.

PROFESSOR WEIR-HUGHES: No.

PROFESSOR MONTGOMERY: No.

PROFESSOR WEIR-HUGHES: No. And on reflection, perhaps it should have done.

PROFESSOR MONTGOMERY: So, I guess on the one hand there was enough of a sense that there might be a combination of issues that the NMC looked at it.

PROFESSOR WEIR-HUGHES: Yeah.

PROFESSOR MONTGOMERY: On the other hand, with hindsight, it feels as though the NMC didn't quite get to the bottom of what there was to be picked up.

PROFESSOR WEIR-HUGHES: I would agree with that.

PROFESSOR MONTGOMERY: Is that fair?

PROFESSOR WEIR-HUGHES: Absolutely.

MR BROOKES: Sorry, can I – just on that point, is that because the information you received back didn't indicate there was a problem, in which case there's a question about the process, or was it that there were sufficient signs in there for something else and nothing was done?

PROFESSOR WEIR-HUGHES: I think it's the former. But I think it comes back to something I said earlier, which is: on reflection, it may also have been about the seniority of the people doing the review. It was very much midwifery-led, and on reflection I think somebody with broader organisational skills in healthcare would have perhaps taken a different view, and in hindsight I perhaps should have appointed somebody else to go with them to look at the non-midwifery aspects or the more generic aspects.

PROFESSOR MONTGOMERY: I want to ask you a couple more things around that report, and that gets straight into, I think, the area I'm interested in, which is: this is triggered from the NMC; it also involves the CQC. You've said a little bit about why the NMC thought it had done its job, having got to the end of that, but what you've just described are issues that probably were not particularly within your remit but would fall fair square within the remit of the CQC and fair square within the remit of the trust board in terms of organisational issues, so I wondered what you could tell us, if anything, about your understanding of what the CQC did when it saw the 2011 report and any connections with the trust board about it.

PROFESSOR WEIR-HUGHES: I agree with you. I mean, I don't think this is just about the NMC by any means, and I think one of the things that this – and I know we've seen this happen in quite a number of different problem trusts, but one of the things that this highlights for me, again, is the importance of a really well functioning board. CQC or no CQC and NMC or no NMC, the board has to be fully functioning, in my opinion. So, I guess it's important for me to state that, I suppose. In terms of the CQC, I'm not sure why they didn't look at some of the broader organisational issues and push those more.

PROFESSOR MONTGOMERY: They presumably received the 2011 report in the same way that you did, if they were involved in discussions.

PROFESSOR WEIR-HUGHES: Yeah. Who read it there I wouldn't know; what sort of level it reached within the organisation again I don't know. But yes, of course they had access to the report.

PROFESSOR MONTGOMERY: And in relation to the trust board, I mean, you talked about the exchange of letters with the Chief Executive, where there's a fairly robust response, shall we say, on that. Was there an exchange over the two things that you did in 2011 – so the supervisory report and also the education audit?

PROFESSOR WEIR-HUGHES: Not between me and him. And perhaps there should have been, I suppose. I think very often when one comes at these things – and having come from the NHS myself – and in fact I'm – I think at the time – and now there are none – the only NHS person who was a regulator – or ex-NHS person who was a regulator – I suppose one does still think, actually, that people will do the right thing. So, there is a – you know, one – at

least I, I suppose, would come to a table thinking, 'Well gosh, they're, you know, NHS manager, ex-clinician; of course they're going to do the right thing because it's the right thing to do. They don't need me to tell them that.' You know? So I – which sounds terribly naïve.

PROFESSOR MONTGOMERY: But in this case you knew he hadn't done the right thing, because you've corresponded with him over his blog and he – from the tone of your letter – has a very different sense of patient confidentiality and privacy than you and your lawyers had.

PROFESSOR WEIR-HUGHES: Yes.

PROFESSOR MONTGOMERY: So I'm just wondering what – you know, having had enough concern about this on your radar to do that series of activities, each of which is quite unusual – the cluster of them would have been more unusual still – is there some responsibility on the NMC to prompt the board a bit to, you know, at least acknowledge that it has to think about it?

PROFESSOR WEIR-HUGHES: On reflection I think you're right.

PROFESSOR MONTGOMERY: Okay. I've got some things I want to ask about external reports, but those are all – on the NMC reports themselves, the only questions I had, so I don't know if...

DR KIRKUP: Do you want to come in at this point, Julian?

MR BROOKES: Yeah. I've just got some – I want to follow up on some of those things, but it'd be just helpful for me as well in terms of just some context-setting as well – I'd just like to understand – get a feel for what was on your priority list with the organisation. Because we've talked about some of the things coming in, so what were the key issues that you felt needed addressing when you came in as Chief Executive?

PROFESSOR WEIR-HUGHES: Well it's a massive job and – it really is, and I'll be very open and honest with you and say that it did nearly kill me, quite literally. It's a breathtakingly enormous job, and obviously, you know, high up on the list of priorities was sorting out FTP – Fitness to Practise Directorate. And there were a whole range of different –

MR BROOKES: Sorry, when you say 'sorting it out', there was an understanding that it wasn't fit for practice itself, or...?

PROFESSOR WEIR-HUGHES: Well, there had been a number of reports to that effect.

MR BROOKES: Yes.

PROFESSOR WEIR-HUGHES: The root cause actually is the legislation, not the management, and it took me a little while to work that out, but the legislation doesn't help the NMC to operate a swift process. But inevitably there were some management issues as well, as ever; nothing is completely black and white. So, fitness to practise was certainly well up there, and training of panellists and selection of panellists; a lot of very practical operational issues about lack of space, lack of hearing suites – that sort of thing. So, you know, getting that work underway was enormously time consuming, and trying to make some headway there was enormously time consuming.

Then I think sorting out some of the kind of external relationships as well. And of course that's complicated, because although we tend to think very much of the regulators in England and being heavily involved with the DH and so on, a huge amount of the time of the Registrar/Chief Executive is spent also in Scotland, Wales and Northern Ireland and with all of those associated different systems, and that's very time consuming indeed. And of course you can't assume that because DH England want to do something other places will do it; of course they're separate countries. So, you know, that external environment piece was very time consuming and a priority, because at the time there were quite a lot of issues about that from ministers in different countries and so on, so – other countries.

The education piece was also time consuming and a problem. It was contracted out at the time to a company called Mott MacDonald to do the inspections, and that wasn't something that I was very comfortable about. I think educational inspection, if a regulator has that as part of their remit, should be one of the most important things they do, because actually an FTP case impacts one nurse but an educational approval impacts thousands and thousands of students and the future of the professions. So, I think one has to take the educational piece extremely seriously and it's not just a little sort of add-on, really, to be contracted out or what have you.

And then of course, as in any job, there are all the normal internal stuff that has to be managed, as you know better than me. So, I don't know if that gives you a reasonable overview.

MR BROOKES: No, that's really helpful. I think it's important just to, in terms of – just to recognise the scope of things that's happening there. So, we've talked about how you dealt with the individuals, and I know Jonathan's touched on this, but I just want to sort of test a little bit about whether or not there was a systematic way of dealing with systematic problems. So, you have identified there's an individual there – and we've talked about the cluster, but if you step back from this particular example, were there processes and procedures in the organisation for saying, 'Hang on a second. There is clearly systemic failure here. This is what we should do' or was it more ad hoc than that?

PROFESSOR WEIR-HUGHES: So when I arrived, there were no processes in place for dealing with that and we developed them, really under the banner of this Section 5.2 in the Order, which refers to any issue, really, which comes to the Registrar's attention should be investigated in some way. So, I think that previously the NMC had been seen as very much a sort of reactive regulator and, for a whole range of different reasons, that didn't make me feel very comfortable, because it's almost like watching car crashes happen otherwise, you know, and because the legislation is there and is supposed to be used, you know, and because at that time, of course, we'd seen not just Mid Staffordshire but Castlebeck and that problem in the learning disabilities world. And so for me, all of those things pointed us at us being more proactive. So, we basically, with legal advice, developed a sort of a protocol, I suppose, for how these sorts of things would be taken forward, and I think it's fair to say that we kind of – when we started to go down that road and we started to investigate things or make visits or what have you, we were learning as well. But I think it's – and key to all of that, of course, was the relationship with CQC and the other systems regulators in the other three countries.

MR BROOKES: So was –

PROFESSOR MONTGOMERY: Is that protocol a public document?

PROFESSOR WEIR-HUGHES: I imagine so. I mean, it would be a question for Jackie, I guess, now.

MR BROOKES: Yes. So, was the protocol in place when Morecambe Bay became a key issue?

PROFESSOR WEIR-HUGHES: I believe it was, but I can't remember the date on it and – but all the dates are on the –

MR BROOKES: Okay. And if it did, did it trigger that protocol?

PROFESSOR WEIR-HUGHES: I can't remember. I honestly can't remember.

MR BROOKES: Because what I'm trying to get at is that you're accepting that there was a need to have something in place to do that; I'm just interested in whether or not – you know, how those were triggered, because if this one didn't trigger it, is that – 'Why not?' I suppose is the question.

PROFESSOR WEIR-HUGHES: I just can't remember the date – the chronology, I'm afraid. I'm sorry. I don't think it would be difficult to work it out from the dates on the protocol and so on.

MR BROOKES: Okay. Just one more question. I'm just interested – clearly, as you say, it's unusual for a member of the public to contact you, and you had that in this particular case. How influential was that in action being taken?

PROFESSOR WEIR-HUGHES: I would say very influential, actually. I mean, the key contact was with the midwifery team – between [redacted] and the midwifery team – rather than me directly, but that's appropriate. So, I think it was very influential, actually.

MR BROOKES: So, you might not have investigated if he hadn't contacted you.

PROFESSOR WEIR-HUGHES: I don't know. I can't answer that question. I honestly don't know. I wouldn't – I'd just be guessing.

MR BROOKES: Yeah. I'm just trying to understand why the sequence of events that happened in this particular case... You know, we know there are individual issues – those go through, as you say, a process – we know that there's a recognition within your organisation that there needed to be something to identify and react to systemic issues – we're not quite clear where that was in terms of the timeline – and then we have an individual contacting you, which generated some specific actions. I'm just trying to find out how much of that is reactive, ad hoc assessments of a particular issue and how much of that was a system in place which would allow confidence from a governance point of view that you were working as an effective organisation.

PROFESSOR WEIR-HUGHES: Yeah. I know exactly what you're asking and I'm struggling to answer because of the – it's so distant in my memory and I'm not clear about the timelines either. And actually – and I – within the context of the LSA reports, Mr [redacted] making contact, the FTP cases going through, from memory, those things were all happening kind of together, you know? It

wasn't iterative. So I think it's difficult to kind of hazard a guess at what may have happened or may not have happened if things hadn't happened in the way that they did, if that makes sense.

DR KIRKUP: Just a couple of follow-ups from me on those particular areas, if I can. Clusters. I take on board what you have said about the difficulties in identifying FTP clusters proactively, but when something does get escalated, do you then do – or did you then do a full review of all the information coming into the NMC, including the FTP referrals?

PROFESSOR WEIR-HUGHES: Do you mean routinely for anything or on this particular –

DR KIRKUP: No; when something got escalated. When something, because of media interest or an individual complainant or something else, made you say, 'Okay, Morecambe Bay's an issue for one reason or another; it's been escalated' did you then systematically look at all the information, including the FTP referrals?

PROFESSOR WEIR-HUGHES: The Registrar can't get involved in looking at FTP referrals, so –

DR KIRKUP: I just meant counting them as much as anything.

PROFESSOR WEIR-HUGHES: So, I suppose – the counting is fine, but actually there are real issues about kind of abuse of process if the Registrar gets deeply into reviewing individual cases. Which – I'll be honest with you – I struggled with a bit; I'd have loved to have been far more involved and more directional, but that wasn't the role. So, I mean, I guess the answer to your question is it would depend on the nature of the escalation or what it was or where it was from or whatever, but usually if we had cause for concern about a particular organisation we would look at a range of different things. So, you know, we would look at numbers; we'd look at education reports; we'd look at any other information that we had coming through – letters, whistle-blowers, that sort of thing.

DR KIRKUP: I can absolutely understand why any input from the Registrar into the FTP process is wrong, but I'm struggling a bit with the notion that the FTP people couldn't brief you about where they were up to factually with *x*, *y* and *z* cases.

PROFESSOR WEIR-HUGHES: They could. They could do that – absolutely could do that, and did do that.

DR KIRKUP: And that would have happened as part of the –

PROFESSOR WEIR-HUGHES: Yeah. Yeah, absolutely.

DR KIRKUP: Okay. I should know the answer to this, and forgive me that I'm not absolutely sure, but is there a regular inspection/accreditation programme for the training establishments?

PROFESSOR WEIR-HUGHES: Yes, there is.

DR KIRKUP: There is. And is that what's subcontracted to Mott MacDonald?

PROFESSOR WEIR-HUGHES: It was, yes.

DR KIRKUP: It isn't any longer?

PROFESSOR WEIR-HUGHES: Unless it's gone back since I left, then no.

DR KIRKUP: Right, okay. And did any concerns arise from the regular inspection process in relation to Morecambe Bay?

PROFESSOR WEIR-HUGHES: No, not as far as I remember, but in a way therein lies – therein was part of the problem with that particular inspection regime. So, as a result of an inspection, you would end up with, you know, several London telephone books' worth of paper but nothing really telling you sensibly, 'Listen, is this a good university or not?' You know? Just on one side of A4: 'What is happening here?' You know? And so – and of course the different – what Mott would do would be to use peer reviewers from different universities to go in and have a look against some criteria, but actually, when I tell you that Staffordshire University was able to get accreditation and most of their clinical placements were Mid Staffordshire Trust, you'll understand of course –

DR KIRKUP: I see.

PROFESSOR WEIR-HUGHES: – that there was very little link-up. So, I mean, you know – and it comes back to this thing that I said earlier about the fact that for me, you know, good learning can only take place in a good clinical environment. And so it's extraordinary to think that students were going through Mid Staffordshire right the way through.

DR KIRKUP: Yeah. Was the focus, though, primarily on the educational aspects and not on the service/practical elements?

PROFESSOR WEIR-HUGHES: Exactly. But you see therein lies for me the problem, because it has to be both, you know. And obviously what goes on in the university is key, but then what happens in practice is equally so.

MR BROOKES: Can I just ask for my information: through that process, has any service ever been decommissioned?

PROFESSOR WEIR-HUGHES: There have been particular courses that have been stopped, and certainly students have been removed, but it's typically because the NMC has stepped in rather than the Mott process has stepped in, if that makes sense.

MR BROOKES: Yes. So the answer's no.

PROFESSOR WEIR-HUGHES: The answer is yes, there were some small courses that were removed, but I don't think there's ever been a case of an entire university department being stopped – put it that way.

DR KIRKUP: Okay. Jonathan.

PROFESSOR MONTGOMERY: Thank you. There's one other area I wanted to ask about, and one of the things we've discovered as a story as meetings unfolded is an awful lot of reports of people going in, looking at the place, [trying to get views?] and I just wanted to understand the professional responsibilities of people who take part in those sorts of exercises. And I don't know whether the NMC gives any guidance on what your responsibilities are. You're only asked to do this because you are a nurse or a midwife, so it must be a professional role that you're doing. Is there any guidance on responsibilities?

PROFESSOR WEIR-HUGHES: Only within the Code, but it doesn't specifically talk about being a peer reviewer or reviewer; it would just be bound up with everything else that's in the Code. In my time we didn't have specific guidance for people going in. I don't know whether Jackie's developed that since, but no, we didn't provide anything specific.

PROFESSOR MONTGOMERY: And are you aware of any other bodies that might have done that – you know, the Royal College of Nursing or Royal College or Midwives or anything of that sort?

PROFESSOR WEIR-HUGHES: I'm not aware, although I suppose it would be a little unusual for what are in effect unions to produce those pieces of guidance, but if they have, that's great.

PROFESSOR MONTGOMERY: Well there's plenty of guidance of obligations on confidentiality and those sorts of things that they produce as well as yourselves, so I just wondered if – you know, because if there was something, it would be helpful to find it. And I'm just trying to – so, essentially, we're trying to understand what the professional responsibilities of people going in to do this – which I guess includes your team of inspectors going in.

PROFESSOR WEIR-HUGHES: Yeah.

PROFESSOR MONTGOMERY: It would have been the code of conduct that was the guiding factor.

PROFESSOR WEIR-HUGHES: Yeah.

PROFESSOR MONTGOMERY: So there's one sort of long-running theme that lots of people have gone in and seen about privacy and dignity around emergency caesarean sections in Furness, and in the 2011 report – you know, it particularly draws attention to that being in potential breach of the required standards. I just wanted to know what your view was of the difference between the responsibilities of people going in professionally to record that and what would trigger a more urgent step of saying, 'This is so important that I need to do something now to meet my obligations to protect patients'.

PROFESSOR WEIR-HUGHES: I guess it's difficult to answer it generically, but I suppose to personalise it, if I had been one of those inspectors I would have been at the Chief Executive's door about that particular issue that you've mentioned, which I also read and knew about. And I think – I mean, from memory, when the NMC people came back, they said that the trust had developed a workaround, which seemed to me to be a very sensible thing to do very short term, but actually the organisation shouldn't be really relying on little workarounds for such significant things in relation to patient dignity.

PROFESSOR MONTGOMERY: And it's even more perplexing that much the same issue has just been discovered by the CQC going in many years later. So there's something around – I mean, if you had to – if someone said to you, 'I need some advice on my obligations under the Code. Can this wait until I write up my report and it goes through various drafts or is this something I have to stop everything else and address straightaway?' I mean, how would you advise them as to drawing the line?

PROFESSOR WEIR-HUGHES: I would always urge them – not to frighten the horses, but I would always urge them, if they were worried about something, to escalate it. And that's in the Code; it's in escalating concerns guidance – it's littered with that advice already – not specific to inspections but specific to any form of clinical practice. So, you know, of course they should have escalated concerns and not stopped.

PROFESSOR MONTGOMERY: Thank you. And then things get even murkier as we look at the different sorts of reports that are commissioned, and your people go in with a very clear remit but I'm wondering whether there are professional responsibilities to make sure that if you go in, you go in a way that you're satisfied is professional. So, for example, a report that seems to be buried – you know, you've identified concerns and you don't know, as a professional, whether anything's been done about them – do you have a professional responsibility to satisfy yourself either that the organisation is doing something or to escalate it in some way?

PROFESSOR WEIR-HUGHES: I would say yes.

PROFESSOR MONTGOMERY: That's helpful. And are there jobs that it's unprofessional to take on? We've seen some terms of reference that look very plausible and some really vague sort of, 'Come in and do this' and we're trying to work out whether or not professionals have been used, if you like, by the organisation to cover something from scrutiny or whether they've been used to shed light on something. And it feels to me like there's a professional responsibility to not be sucked into that inappropriately.

PROFESSOR WEIR-HUGHES: I agree with you completely. I suppose when one is sitting in a room like this discussing it, it sounds pretty straightforward to say yes or no, you know? I suppose in the heat of a clinical problem it's sometimes a little different. And also I think, you know – my expectation is that many of those individuals will have been trying to do the right thing and thought they were doing the right thing by helping. One thing I suppose I didn't know until I read some of the paperwork in preparation for today was quite how many different organisations, consultancies – PwC, etc. – had been into that trust, and actually, you know, just speaking as a former NHS board member myself and director of nursing, I just don't know how an organisation manages that volume of inspections, visits, consultancy things, reports, action

plans and so on. I mean, it's quite breath-taking. So, you know, I'm not sort of – I wouldn't want to appear to be kind of going soft on them, but it just – you know, there does seem to be an awful lot of different sorts of –

PROFESSOR MONTGOMERY: Can I reflect that question back a different way? If you were joining a board and you discovered that, wouldn't it tell you that there must be something very wrong with this organisation if it's had to have all that scrutiny?

PROFESSOR WEIR-HUGHES: Completely. It would make me extremely nervous. Extremely nervous. And I suppose – well, it would make me question the management of the whole system, really.

PROFESSOR MONTGOMERY: And do you think – what sort of continuing responsibility would you expect of professionals who'd been called in, had a chance to look at things as the story unfolds and it becomes apparent they're not the only ones who've been called in and other people have been called in? I mean, are there professional responsibilities for them to consider whether it's not quite a whistleblowing case because at the time what they saw may not have been that significant, but when they get the picture that you've just described of all these things, would you be expecting your registrants to be coming forward and saying, 'I need to check whether or not that thing that I saw and recommended was dealt with had actually been picked up'? Would that be a professional responsibility?

PROFESSOR WEIR-HUGHES: I definitely think there's a professional responsibility there; I suppose it's how an individual does that, you know? And, you know, just reflecting on this discussion, I mean, some guidance for people around that may be a really useful thing to come out of this inquiry, because perhaps people aren't quite as clear as they might be. And of course the whole – the kind of peer inspection thing has really grown in the last sort of two years, I suppose, hasn't it, particularly? So I think that might be a really interesting thing to do. I mean – and I suppose it's quite difficult to say who exactly they must go to to kind of check off that these things have been done, because I suppose it depends on the issue a bit, but I think the principle of escalating would remain.

PROFESSOR MONTGOMERY: That's – I mean, I think there's a tricky set of questions there.

MR BROOKES: Yeah. Just linked to that as well, something I wanted to come back to on this is – I just wanted to understand whether or not the people that go in on your behalf as an organisation – have they any training in investigating? Because there's a set of skills about understanding professional dynamics; there's actually a set of skills about being able to clearly understand what's going on here, to ask the right questions and then to act on those questions.

PROFESSOR WEIR-HUGHES: Yeah. I can't speak for the NMC now, but when I was there, the people who were going in – so, for example, from that midwifery team – all had NHS backgrounds with root cause analysis training and that sort of thing. Whether that's sufficient is another question.

MR BROOKES: Thank you.

PROFESSOR MONTGOMERY: I've got one last question in this section, and that's – I'm wondering whether part of the professional responsibilities that need clarifying is around potential conflicts of interest. So, you can see why in some circumstances you want someone back who knows the organisation well, who's been closely connected; in other circumstances you'd say the very last person you want is someone who's seen it before, because you need some degree of separation. So I wondered if you – so I think I'm suggesting that if we did recommend some sort of advice on this it would have to address that question, but I'm wondering whether you had any ideas on how you might draw the line, because I think we'd be wanting to say: 'Are there circumstances in which you should decline an invitation to take part in an inquiry?'

PROFESSOR WEIR-HUGHES: Completely.

PROFESSOR MONTGOMERY: What sort of thing might be examples of that?

PROFESSOR WEIR-HUGHES: Well, I suppose if it was me I would be declining an invitation if I knew significant players in that organisation, if I'd been involved in some way previously. So, I think it's about individuals having some integrity, really. And I think – if one takes CQC inspection as an example – and I'm in the thick of it because I'm about to start doing it myself, but, you know, when I get that list of, 'Are you free on these dates?' of course I would never be volunteering to go to a trust I'd worked in; Morecambe Bay; Mid Staffordshire, because I was at the Francis Inquiry. You know, you just wouldn't do it. You

just simply wouldn't do it. But I think – so I do think it does come down to individuals being sensible.

PROFESSOR MONTGOMERY: Does the CQC have a protocol on that that gives some advice on when you should decline?

PROFESSOR WEIR-HUGHES: Well they haven't shown one to me, but they may have one.

PROFESSOR MONTGOMERY: Okay. Well we can ask them that question ourselves. Thank you; that's all I had.

DR KIRKUP: Were there any further sections that you wanted to pursue?

PROFESSOR MONTGOMERY: No.

MR BROOKES: I've one question, if that's okay. It's touching on one of the things which has come up as a theme a number of times, not just with yourself. I'm just interested – I know you said about you recognise the importance of a better dialogue with the other regulators, etc. You talked about a memorandum of understanding with CQC. What information can you recall was shared with other regulators about what you were doing at Morecambe Bay?

PROFESSOR WEIR-HUGHES: So, CQC would have been the main one because they were the most relevant, and there was a lot of discussion with CQC at the time – between the midwifery team and CQC.

MR BROOKES: About Morecambe Bay?

PROFESSOR WEIR-HUGHES: About Morecambe Bay. But we didn't share with other regulators because it wasn't seen to be relevant. I suppose we – I mean, a good example of where we would have shared would be that we would often share with the GMC if we discovered an issue, and there was a very good relationship with the GMC and quite a lot of staff moving between the two organisations. But really the GMC and NMC and the CQC I suppose have more need to communicate than the NMC does with the opticians or osteopaths or whatever.

MR BROOKES: So they would have been – so CQC would have been aware of the outcomes of the work that you were doing – the work that you were actually involved in.

PROFESSOR WEIR-HUGHES: Yes.

MR BROOKES: Okay. Thank you.

PROFESSOR MONTGOMERY: Just a follow-up from that. Are there ever any circumstances where you have an FTP that feels as though it involves systemic questions and you talk to the GMC about whether they've had a similar...?

PROFESSOR WEIR-HUGHES: Yes. That's –

DR KIRKUP: Does that include Morecambe Bay?

PROFESSOR WEIR-HUGHES: I can't remember whether specifically about Morecambe Bay or not, and of course there may have been discussions since about Morecambe Bay, but the interchange of information and discussion with GMC and NMC I think is excellent. It's one thing that I don't think has ever been an issue.

PROFESSOR MONTGOMERY: There is a perception that the NMC treats nurses more harshly than the GMC treats doctors in the same mishaps.

PROFESSOR WEIR-HUGHES: It was ever thus. As long as I can remember that's been the case.

DR KIRKUP: Do doctors share that view?

MR BROOKES: It depends where they are in the system.

PROFESSOR WEIR-HUGHES: I think – I absolutely agree, and it's – there's different legislation, which is one of the problems. The most striking difference was – and I really worked hard to get the Privy Council to try and move on this, but – was to allow nurses or midwives to de-register as part of an FTP process, which is what the doctors are allowed to do. If they voluntarily remove themselves from the register and no longer with to practise – doctors have always had that privilege.

DR KIRKUP: Actually they don't any longer.

PROFESSOR WEIR-HUGHES: Have they stopped that?

DR KIRKUP: The GMC can block it now. They can say, 'No you can't until we've considered the case'.

PROFESSOR WEIR-HUGHES: Oh, well, no, they can block it, but it's possible, I believe.

DR KIRKUP: Oh yeah, they can allow them to do it, but they can also say, 'No, we want to hear the case first and then we'll decide'.

PROFESSOR WEIR-HUGHES: Yes, that's right. But it's just one example, really. So I suppose there has always been this view that the NMC have been more harsh.

PROFESSOR MONTGOMERY: Yeah, and I say it's a perception. I think what's of interest is if we have a systemic problem and it is picked up and nurses go through the FTP process but in that it appears that there may also be other professional staff who similarly need to have their practice examined, is there a mechanism for you referring that to the GMC or –

PROFESSOR WEIR-HUGHES: Absolutely. And that would be – it would be a common discussion. Not weekly, necessarily, but it would be a fairly common discussion with the GMC.

PROFESSOR MONTGOMERY: Fine. But you're not aware of that happening.

MR BROOKES: But you don't recall whether that was what happened in Morecambe Bay.

PROFESSOR WEIR-HUGHES: I can't remember.

PROFESSOR MONTGOMERY: No. Thank you.

DR KIRKUP: Okay. Are we all done? Is there anything else that you would like to tell us that you don't think we've adequately covered?

PROFESSOR WEIR-HUGHES: Do you mind if I just very quickly –

DR KIRKUP: No. Please go ahead.

PROFESSOR WEIR-HUGHES: I've got some little notes here. I've perhaps made this point I think, but I guess one of the key pieces of learning for me is the relationship between the supervisors, the head of midwifery and the director of nursing, and I think that it's very often the director of nursing's practically treated with – ignored by the supervisors, and I think that is problematic, and this has been a worry for me for a long time.

DR KIRKUP: Are you saying that's a general problem or are you saying that's particularly the case at Morecambe Bay?

PROFESSOR WEIR-HUGHES: I think it's not a problem everywhere but it's a common problem. And I think – you know, the midwives basically have to understand that this director of nursing is accountable and they must communicate with them. It's not about whether they like them or not, but they must communicate, just in the same way that the director of nursing also has the chaplains reporting to them and whoever else. Do you know what I mean?

PROFESSOR MONTGOMERY: In the 2011 report there's a particular set of things and a specific recommendation about engagement with the board. Would your take be that that was addressing the point you've just made about connection with the accountability structure for the director of nursing as opposed to the non-executive directors?

PROFESSOR WEIR-HUGHES: Absolutely. Because for me, the conduit is the director of nursing – or should be the director of nursing.

PROFESSOR MONTGOMERY: Thank you.

PROFESSOR WEIR-HUGHES: I think we've talked about the confusing system quite enough.

PROFESSOR MONTGOMERY: We may not be any the wiser.

MR BROOKES: Yes. We've certainly got the message, though.

PROFESSOR WEIR-HUGHES: The only thing I didn't mention but I'm sure others have are midwives rules, and within the NMC – within the legislation the differences that seem to be there for midwifery. And, you know, obviously supervision is one of those things, but, you know, those midwives rules really were written at a time when *Call the Midwife* was written, you know? And so I suppose it's whether or not it's timely to prompt a rethink of them.

PROFESSOR MONTGOMERY: Can I ask a particular question on that, then, because that hasn't been raised quite as much? I mean, one of the key things there is about the relationship between midwifery care and obstetric care and the obligation to refer when things depart from the norm I think was the phrase at that stage. And we've heard a bit about that in terms of systemic questions about relationships. It would be very interesting to know whether there's any experience in the NMC of having to look at that question in individual fitness to practise cases and whether there is any guidance on learning how people can tell whether there was inappropriate failure to refer.

PROFESSOR WEIR-HUGHES: So, there would be – I mean, if one was to look back through previous FTP cases one would find quite a lot in relation to midwifery where there was an accusation of failure to refer. Where I think – and I did touch on this earlier, but where I think it's a particular problem – and there are plenty of heads of midwifery who would support this view – where it's a particular problem is where you have a patient population, or population of women, who have multiple comorbidities. And that's increasingly the case, of

course, because people are having babies later; more people have diabetes, obesity, blah, blah, blah. And actually, where people – so this so-called healthy normal process is – that bit of the process may be healthy and normal, but the surrounding – the context is less so. So actually, you know, the need in my opinion for dual-trained nurse-midwives has not gone away, and it's a real worry to me and many heads of midwifery that very few universities are now offering that 18-month programme when actually it should be now the other way about because the patient need is for us to have more people with medical clinical knowledge looking after these women, not fewer, and yet now of course the bulk of midwives do the three-year direct-entry programme. Now, right at the minute, with the workforce as it is, there are still midwives in the system who are dual-trained, but in another 20 years that won't be the case, and of course the midwifery population is very much an ageing population. So –

PROFESSOR MONTGOMERY: So, can I ask: is that a regulatory issue or a commissioning issue? Is that for Health Education England or is it for the NMC?

PROFESSOR WEIR-HUGHES: It's absolutely for Health Education England and for midwives to shout about, but of course it's not a popular issue to talk about, and if I say this with a group of midwives I'll be pretty quickly shouted down, believe me.

PROFESSOR MONTGOMERY: At home I might find that. But I'm just trying to tease out – because actually, if it is that clear, isn't that a regulatory issue? Because you have the educational responsibility of defining the competencies of midwives and if you don't think that [inaudible], isn't that a regulator's issue?

PROFESSOR WEIR-HUGHES: Well, I guess in that respect it is. I suppose in terms of student numbers it's for Health Education England. So, that for me is a really big concern for the future of the –

PROFESSOR MONTGOMERY: And if I could relay that back to the midwives rules issue, where you prompted it, is it your view that having that type of demarcation – it's one of the very few places, you know, where you have a line which implies a particular transfer. Does that discourage collaborative working, in your experience?

PROFESSOR WEIR-HUGHES: I think, you know, that if one looks at this within recent history – sort of, I suppose, from the 70s and 80s – then actually, you know, there was that time with the Association of Radical Midwives, the, you know, de-medicalising childbirth and all the rest of it, which was an interesting part, perhaps, of the midwifery profession developing. But – and I'm not saying things have necessarily gone too far down that road; I'm just, I suppose, really saying that midwifery and nursing can work perfectly well together, just in the same – you know, mental health nurses operate completely differently from ICU nurses, you know?

PROFESSOR MONTGOMERY: That's a slightly different question from the midwifery-and-obstetric question, which is what the midwives rules actually deal with, isn't it? So, you deviate from the norm; it ceases to be a midwifery issue; it becomes an obstetric issue, although the obstetrician may say, 'That's fine; carry on'. And if one of our questions is, 'Have we got' – is – we may be observing something where silos have been created between professions and if there's a regulatory source for those silos, I think that would be something we'd be quite interested in.

PROFESSOR WEIR-HUGHES: Well, I think in a way – I suppose where in my thinking I'm going to is there's a code of conduct; why does one need midwives rules? That's my bottom line, I suppose.

PROFESSOR MONTGOMERY: Yeah. I think that's slightly different from the thing I was picking up, but I take that point. Thank you.

DR KIRKUP: Okay.

PROFESSOR WEIR-HUGHES: Thank you very much.

DR KIRKUP: Anything else?

PROFESSOR WEIR-HUGHES: No.

DR KIRKUP: No? Thanks very much for coming, then. It's much appreciated.

THE MORECAMBE BAY INVESTIGATION

Friday, 10 October 2014

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

Before:

Dr Bill Kirkup CBE – Chairman of the Investigation
Mr Julian Brookes – Expert Adviser on Governance
Ms Jacqui Featherstone – Expert Adviser on Midwifery

SASCHA WELLS

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(At 11.34 a.m.)

DR KIRKUP: Hello, my name's Bill Kirkup. I'm chairing the panel. I'll ask my colleagues to introduce themselves to you.

MS FEATHERSTONE: Hi, I'm Jacqui Featherstone. I'm head of midwifery and head of nursing for women's health in an acute trust in Essex.

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

DR KIRKUP: You'll see that we're recording proceedings and we'll produce an agreed record at the end. You'll also know that family members are entitled to be present as observers, and we have some today; others can listen to the recording at a subsequent stage if they want to. You'll also know that we've asked you to hand in any mobile telephones, laptops, recording devices. Just to emphasise that nothing goes outside the room until we're ready to produce a report with the findings in context. Do you have any questions for me about the process?

MS WELLS: No, not at all.

DR KIRKUP: Okay. I'll start with a general question and then hand you over to colleagues, and my question is, when did you start in the trust and what have you done – what different roles have you done there?

MS WELLS: I started in the trust on 2 May 2011, and I took up post as head of midwifery, obstetrics and gynaecology, and that's been my role for the last three and a half years here at Morecambe Bay.

DR KIRKUP: And still is.

MS WELLS: Yes. Well, no, sorry, I need to correct that. Actually, in March of this year, my role changed to deputy director of midwifery, women's and children's services, and I'm also the portfolio holder for safeguarding adults and children, and I'm also the professional lead for education of nurses and midwives in the trust.

DR KIRKUP: Okay. So you've taken on some expanded responsibilities since March.

MS WELLS: Yes.

DR KIRKUP: Where did you come from? How did you get to Morecambe Bay?

MS WELLS: Where did I work?

DR KIRKUP: Yeah.

MS WELLS: Okay. Do you want me to start from the beginning of my career, potted?

DR KIRKUP: No, just briefly.

MS WELLS: Okay. So, prior to me taking up the post here, I was matron for maternity services at Nottingham University Hospitals NHS Trust. I was the only matron in that service for what is a multi-sited tertiary service, caring for about 10,500 women on two very busy labour suites and maternity units. I was there for two years, and, prior to that, I'd been a labour-suite coordinator and supervisor of midwives in the West Midlands, at Good Hope Hospital, and I had also worked as an agency midwife, just to be able to expand my knowledge and skill set really through working in other services.

DR KIRKUP: Okay. Thank you, that's very helpful. Jacqui.

MS FEATHERSTONE: Just when you took up post, what were the big issues for you as a head of midwifery?

MS WELLS: Well, I think the first thing that I had to do and I did do was obviously understand the service, the fact that it's multi-sited and very small services on each of those sites, with two obstetric units as far apart as they are. So I needed to understand how the services were working, what the workforce was like, what education and training and development there was, what the systems and processes were. And I think, very quickly, before the CQC and the NMC undertook their reviews in the July, I recognised straight away that there was significant shortages of staffing and also poor training, development and education for the workforce, and there were no robust processes in place to ensure that the governance around maternity services was as it should be.

MS FEATHERSTONE: Okay, so, dealing with each one, so staffing – what did you do with staffing, to begin with?

MS WELLS: We undertook a big review against Birthrate Plus recommendations, as they were at the time, and whilst on paper we looked like we were achieving the midwife-to-birth ratio of 1:28 as a whole maternity service, the challenge was that that wasn't giving us a minimum safe-staffing level on each of the units, particularly in the obstetric units. So we identified that gap and we took several papers to board to make them aware of that staffing shortage, and I think we put forward, at that time, for an additional 15 midwives to put into the

acute services to get us to where we needed to be to achieve minimum safe-staffing on each of the obstetric sites.

MS FEATHERSTONE: So, going on from that, so is the staffing – did it remain good throughout, then, and did you have a good recruitment drive to get it to that?

MS WELLS: We actually did a really big recruitment drive in December 2011, where we appointed six band 7s into the service, and seven band 6s. That was a multidisciplinary, multifaceted recruitment day where we asked midwives to undertake clinical skills, a medication exam and also to work as part of a team to demonstrate how they would work as part of a team in our services. And, yes, we successfully recruited to all of those posts at that time.

MS FEATHERSTONE: And your staffing has remained good.

MS WELLS: We have recruited preceptorship midwives, band 5 midwives, and, by virtue of that, we've pulled from all over the country actually, so as far as Scotland down to Bournemouth and London, and our preceptorship programme, up until fairly recently, was a 12-month programme. And what we found was that they would stay with us and gain all of their competencies through our preceptorship programme, which is very robust, and then, at the point that they got their band 6s, they would then apply for jobs nearer to their original home.

As such, and with feedback from those two cohorts that we've had now, we've actually extended the preceptorship programme to two years, so no band 5 midwife can get their band 6 now until they've undertaken two years of preceptorship, and, within that, we're requiring them to undertake their sign-off mentorship course in the second year, and so, hopefully, by the time that two years is up, they'll have found a lifestyle up here in Morecambe Bay and choose to stay with us.

MS FEATHERSTONE: I've lost my train of thought that I was going to say next to you. So just going on from the staffing, what about your retention, then, of your other – your senior staff?

MS WELLS: Retention's very good. We do have a large cohort of our workforce that are now reaching – and predominantly over – retirement age, so we do have a very clear workforce plan in place for the next two to five years as to how we're going to address that gap. But we haven't lost midwives that have worked in our services for a good few years; it's actually the newly-qualifieds

that we have struggled to retain, not those that have been with us for some time.

MS FEATHERSTONE: Okay, and what about agency staff? Are you employing agency staff at the moment?

MS WELLS: Yeah. It was very obvious very quickly that we weren't meeting the minimum safe-staffing levels, so, until such times as a decision was made by the board, I had agreement that I could get agency midwives in. And, at times, due to pressures in the system and exceptional sickness due to things that were going on around the organisation and in the media, we experienced really high levels of sickness. So, at times, we've used about 40% agency staff against 60% of our own, but we've always been really clear that we would never go above that threshold in order to try and minimise the risk of having agency staff in. I think what's really important to say on that is that we worked very closely with that agency right from day 1, and we've maintained contact with one agency only; we haven't used multi-agencies, and, as a result of that, we've actually got agency staff that have now been working for us for over two years, so they're almost like our substantive staff now, in many respects.

MS FEATHERSTONE: Okay, so what is your midwife-to-birth ratio now, then?

MS WELLS: If we take into account the vacancy factor that we're carrying currently, although we've just had two recruitment days, so hopefully we've recruited to those, we're looking at an overall ratio of 1:29, 1:30.

MS FEATHERSTONE: Okay, and what's your vacancy rate at the moment?

MS WELLS: Our vacancy factor has been about 12 whole-time equivalents across Morecambe Bay, but we've also just had approval to appoint a further 16 whole-time equivalents into the community service so that we can meet the midwife-to-caseload ratio of 1:98.

MS FEATHERSTONE: Okay, and, because it's across-site, who's your most senior midwife in each site?

MS WELLS: So I have a matron who is a matron at RLI, who's responsible for maternity services, inpatients and outpatients at Lancaster. I have exactly the same at Barrow, here in Barrow-in-Furness. I have a matron who covers community, midwifery and a standalone midwife-led unit in Kendall. And then I have a separate matron who works cross-bay for gynae services.

MS FEATHERSTONE: You talked about students was one of your other issues, so you have students across all sites.

MS WELLS: I do, yes.

MS FEATHERSTONE: And you've never not had students.

MS WELLS: Never not had students, no.

MS FEATHERSTONE: And all your midwives are sign-off mentors.

MS WELLS: Not all of them.

MS FEATHERSTONE: Except the ones that are part of a preceptorship, and your live register is all up to date.

MS WELLS: Yes, it is, although there is a cohort of band 6s that weren't put forward for the mentorship programme, so we're in the process of doing a mop-up in respect of that to get them all onto the mentorship database, and, as such, in my new role as lead for education, we're currently taking a paper to board about bringing the mentorship training in house rather than through the universities so that we can actually get more nurses and midwives through that mentorship training.

MS FEATHERSTONE: Okay, so your nurses – have you got nurses within maternity, or is it part of your gynae, women's health?

MS WELLS: Part of gynae, women's health, but also I'm also responsible for nurse education across the trust now as well.

MS FEATHERSTONE: Then, with regard to governance, just how does the governance structure work within your units?

MS WELLS: Currently?

MS FEATHERSTONE: Yeah – well, how did it work when you started?

MS WELLS: Okay, so when I started in 2011 there was one person who undertook the role of governance. She was 0.6 whole-time equivalent. She worked cross-bay and she was basically undertaking all of the pillars of governance and risk-management, as well as supporting corporately the NHSLA and the CNST agenda. There was no practice-development midwife; there was no audit-lead midwife, and we didn't have a dedicated risk manager or overall governance lead; it was down to that one individual.

So, over the last three years, we've put a very strong governance team in place, so now exists is a divisional governance lead that covers the division of women's and children's. Underneath her is a risk manager for maternity

services at band 7, and we've just appointed a risk manager for paediatrics and neonates at the same grade. In maternity services, we've got a band 6 quality and safety midwife whose role is predominantly around triaging the clinical incidents and making sure that we're managing those appropriately and taking them through the right process. And we also have a audit midwife now at band 6 and a practice-development midwife at band 7, whose responsibility is education and development of the entire midwifery and gynae nursing workforce.

MS FEATHERSTONE: So an incident happens; what happens then? So how does the information get to the appropriate midwife, and how does the information get back to the shop floor midwives?

MS WELLS: Okay, so we obviously have the national trigger list for maternity services, and the clinical incident will be inputted onto a system called Safeguard. That incident is then emailed to myself and to all of the senior team, so all matrons, all of the governance team and also all supervisors of midwives. That is then triaged, as dependent on how it's been classified, either no injury, minor, moderate or major. If it's moderate and above, immediately a rapid review is undertaken within 48 hours.

In addition to that, the supervisor of midwives who's on hot week will be looking at that from a supervisory perspective in terms of clinical practice and they do that in conjunction with each other. So, within 48 hours, and often less, we know whether or not we need to take it to a full root-cause analysis investigation and whether or not we need to undertake anything further from a supervisory perspective.

That then is obviously fed through to the patient-safety meetings that we have every Wednesday morning now as an organisation, and those cases are discussed and actions are decided and determined by the executive chief nurse and our medical director. And the root-cause analyses are obviously undertaken, multidisciplinary, multidisciplinary team are identified, and that's undertaken in the timeframe that's been agreed with our clinical commissioning groups, and then is reported through our serious-incident panel, which occurs monthly.

MS FEATHERSTONE: So, just going back to when an SI happens, so is the decision taken within the department or is that going to exec level?

MS WELLS: The initial decision is taken by us, but, like I say, that's discussed on a Wednesday morning meeting, so it does sit at exec level. So we might have made a decision as a maternity service, but actually the execs might request or require something that we haven't made a decision on as a service. So there's kind of a different level of overview on that, and, as such, there are some cases where we've been asked to take something to an RCA, where initially, as a rapid review, we might not have decided to do that, as a maternity service.

MS FEATHERSTONE: Okay, and who undertake the RCAs?

MS WELLS: As I say, it's multidisciplinary, so it will be clinical midwives, supervisors of midwives, obstetricians, consultants, registrars; dependent upon the nature of the incident, it may well include paediatricians, neonatal nurses. We've had cases where obviously we've needed to have external input into that, say from the ambulance service, GPs, health visitors, ED department, surgery, medicine. So, often in maternity services, an incident is not just within that service; it might be multifaceted, so wherever that woman has touched another service, we involve them in the RCA and they're part of that RCA team.

MS FEATHERSTONE: And then who are the reviewers of the RCA?

MS WELLS: So we go through a quality assurance process within the division. That goes through divisional governance. The governance lead, the consultant obstetrician governance lead and myself review all RCAs and quality assure them, but ultimately the decision on the completion and the finality of that RCA is decided at the SUI panel, which is chaired by a non-exec director from the trust, but also has our colleagues from both CCGs sat round the table as well.

MS FEATHERSTONE: And then how do the midwives on the shop floor hear about them and lessons learned?

MS WELLS: Okay, so, as soon as a midwife logs a clinical incident, all of the actions that are undertaken around that clinical incident are also recorded on that system, and, when the final decision is made and the outcome of that is made, the system emails the midwife or whoever the reporter was to let them know that the incident's been closed and these are the actions that have been taken. However, that's just one part of that lessons learnt and that feedback directly to that individual. We do one-to-one feedback obviously if somebody's been

really heavily involved in what's resulted in a poor outcome. Supervision will obviously pick that up from a supervisory practice, but also their direct line manager, and also we inform through ward meetings, unit meetings, the overall themes of RCAs and the learning that's come out of those. In addition, we have a newsletter that details particular incidents or complaints or even inquests where themes have been identified or areas have been identified that we need to change, what's changed as a result of that and how that affects frontline and clinical practice and what they need to change as a result of that.

MS FEATHERSTONE: Would you meet with the parents or – you know, if there's an incident, would you meet with the families?

MS WELLS: I don't personally meet with every single family, but my senior team do, so, if an incident happens on the ward or on the labour suite, the senior person will speak to the family immediately, make them aware that a clinical incident will be being logged and that, as a result of the incident, dependent upon the nature, it will be investigated, either through supervision on its own or through the clinical governance process or both, and we then keep them well informed.

We maintain contact with them. We obviously now complete the duty of candour letter and send that to them, but we also maintain regular contact with them and visit them if they wish us to, but we then also feed back and provide them with a copy of supervisory investigation outcomes and also the full root-cause analyses, and, in some instances, we have actually sought independent reviews of some of the cases, and we've shared the outcomes of those with families as well.

MS FEATHERSTONE: Okay.

DR KIRKUP: Do you ever take the family – sorry to interrupt – do you ever take the family's information into account in investigating incidents?

MS WELLS: Yes, we have. We've obviously met with families and asked them to give their view –

DR KIRKUP: Their account of – yeah.

MS WELLS: – and their account, yes, and that has definitely fed into some quite significant incidents where it's really important we've got their view.

DR KIRKUP: How do you decide whether to do that or not?

MS WELLS: I think it depends very much on the nature of the incidents. We've had a couple of incidents recently where that's really important for learning for the organisation of a service.

DR KIRKUP: Yeah. Sorry to interrupt.

MS FEATHERSTONE: That's alright. Not going into any detail, but prior to coming in post there were obviously incidents that had happened within the trust. How did you find out about them? What information were you given, or did you have to do a lot of searching yourself?

MS WELLS: I think it would be really fair to say, Jacqui, that, when I took up post, I was unaware of any of them, and I can't remember exactly when I found out. I was made aware of one particular incident in June of 2011, but I wasn't really fully aware of all of the other incidents until after the CQC and the NMC had been in, and then, as a result of that, I took it as my responsibility to look into those and review all of those cases.

MS FEATHERSTONE: Right. We talked about complaints, so just the way you answered complaints, again – meeting parents and trying to deal with them on the ward – would you say that all the staff are able to deal with them?

MS WELLS: If you're asking me about now, yes, it's a much stronger position than when I came in three years ago. The only way that we dealt with complaints three years ago, when I first came in, was through the formal complaint process. Meetings weren't being offered to families to meet with people. It was very much a written response, and a response that was based on what we thought they wanted to know rather than saying, 'What are the specific questions that you would like us to answer?' or, most importantly, offering up a face-to-face meeting.

Staff are very well able and capable now of dealing with complaints in the ward area, and, if they're concerned that perhaps they don't feel that they've addressed it as well as they think they should have, a senior member of staff is contacted. But we also now have a PALS service, where people can contact that department and alert them to any concerns that they might have whilst they're still in that service, and then that's shared with the senior team, the most appropriate person, who will then go and deal with it whilst they're still in the service.

MS FEATHERSTONE: I was just going to ask, does that involve your consultants? Because it's not often just one – it's a process, and so the paediatricians and the obstetricians.

MS WELLS: Yeah, so, where it's appropriate, yeah, based on the concerns, then absolutely, yes.

MS FEATHERSTONE: And what would you say the relationship is with the obstetricians, the paediatricians and the midwives? Start from when you came in.

MS WELLS: Yeah. Very disconnected, very disjointed. They weren't working as a team.

MS FEATHERSTONE: Did they...? Was it because they just did their own jobs, or just they weren't talking to each other? What were the issues then?

MS WELLS: I think it's hard for me to put my finger on it really. And I don't know why I'm getting emotional about it, actually, but –

MS FEATHERSTONE: But, okay, what did you do, then? So you recognised that, so how did you...? You knew it wasn't right, so what did you look at to...? And did you have help and support to change it, then?

MS WELLS: I definitely do now. I think there was a lack of acceptance from obstetricians that what was going on in the organisation was as much their responsibility as it was midwives', and certainly, with paediatricians, it looked very much to me like midwives were desperately trying to do the right thing by women and had escalated or referred on, but were getting very little feedback and very little support from the multidisciplinary team. And then what I witnessed was midwives stepping outside of their sphere of practice and absorbing risk that they shouldn't really be absorbing, and I think... I can't speak for what happened that got them to that point, but there wasn't that shared decision-making, acceptance of each other's professional role and acknowledgement of the importance of each professional being able to contribute along with the woman and her family to that plan of care. It just wasn't there.

And I think for you to ask me how we've changed that, we've had to lead by example. So, when I first went in, I had to be quite operational; I had to be quite on the ground, supporting midwives in referring on and encouraging midwifes to refer on and also log clinical incidents when they

weren't getting the response that they should be getting from the medics. If things weren't documented and management plans weren't being done, we encouraged them to report that, to raise that profile. And that's obviously in conjunction with working alongside the clinical lead for obstetrics and gynaecology, creating that culture of: we need to work together as a team; we shouldn't be doing this in isolation; and, when we're not doing it right, we need to be alerting people to the fact that it's not right.

MS FEATHERSTONE: And so we're talking about one particular hospital out of the ones that you were managing.

MS WELLS: No.

MS FEATHERSTONE: All of them.

MS WELLS: Yes. I'm talking about both sites.

MS FEATHERSTONE: Okay, and so were you supported doing that? Were you supported by your consultants? Were you supported by your exec...? Because this was a difficult time, so did you feel like you were doing it on your own?

MS WELLS: In the last year, I've felt much more supported – very much more supported. I think, in the first year and a half, no, I wasn't.

MS FEATHERSTONE: So did you escalate? Who were you telling that you were having problems?

MS WELLS: The director of nursing at the time and the – yeah, director of nursing at the time and the board members at the time, you know, that there was a real disconnect between the professions.

MS FEATHERSTONE: And so how has it changed now, then?

MS WELLS: Well, we've had quite a few new consultant obstetricians that have come into the service, particularly here in Barrow, and they're absolutely and fully engaged with the governance process and take their responsibility around governance and clinical effectiveness as they should do, and we've built those relationships over time between the midwives, obstetricians and paediatricians. I think moving – for example, moving special care into the postnatal ward has really helped at Barrow to help to develop those relationships between the neonatal nurses, midwives and the paediatricians, because they're very much there. And certainly, with obstetricians, we're working much closer together and they're very much a part of the audit process, the RCA process, the

clinical incident reporting. I'm not saying we're perfect and I don't think we've cracked it yet, and I still think there's some way to go on both sides, but it's a much better position than we were in three years ago.

MS FEATHERSTONE: And just what you were talking about, the midwives sometimes stepping over the line and perhaps not letting the consultant – you know, a doctor in and doing their own practice, do you think that has changed now? Are you transferring more women out, as in because of the – you know, you haven't got the level... It's a level 1, isn't it?

MS WELLS: Yes, it is, yes.

MS FEATHERSTONE: So are you transferring more women out?

MS WELLS: Yes, and I often get phone calls of an evening, asking or letting me know of a particular case, and I've had phone calls from obstetricians, seeking support and just creating an awareness with me that this is what they're doing and this is the decision that's been made. And, recently, I was asked to support a transfer of a lady to Newcastle at night, and the doctor wasn't happy for her to go by road, so we needed to mobilise a helicopter for transfer and they were discussing that with me. The midwives were very much in the room, and the supervisors, so it was a multidisciplinary kind of discussion around that particular case, and subsequently in other cases.

And I think what's really encouraging now is, when we do have some complex cases, what is happening is discussions outside of our organisations. So, recently, we had a case where somebody was in our ICU, and discussions were happening with Preston obstetricians about what the best care was and whether or not we needed to transfer her out or keep her in the service and suchlike. So there's a much greater discussion and professional debate and involvement of other people, with other people's expertise, which is much more appropriate.

MS FEATHERSTONE: So that happens now. Why do you think it didn't happen before, then?

MS WELLS: I don't know, Jacqui. I don't feel I could really answer that question because, if I'm really honest, it was alien to me.

MS FEATHERSTONE: Okay. Just now, do you see that – you see your exec board on the shop floor? Is it quite a good connect?

MS WELLS: Yeah, absolutely, Jacqui. Our chief executive has done numerous walk-arounds with me in all of our services, as has our executive chief nurse. We've had clinical directors from other divisions doing walk-arounds with us, and the deputy chief nurses have also done walk-arounds. We have governors, chairmen and non-exec directors have all engaged in the walk-arounds that we do, which are quite numerous, but are kind of looking at different aspects. So we've implemented 15 Steps, so we involve service users in that, and we also do patient safety walk-arounds and we've just implemented something that is called RAID; it doesn't sound very nice, but it's about reviewing departmental standards, and that's multi-professional, multifaceted. And, yeah, they're very much more visible.

I think what also has helped is our executive chief nurse has development days for nurses and midwives and AHPs on a regular basis, and she does that kind of by band, so ward sisters, clinical leaders and then our main workforce, and there is a much – well, there is a relationship now between the executive chief nurse and the frontline workforce that there never was when I first arrived.

MS FEATHERSTONE: You talked about training. What training are the staff offered, during their time, every year – so annual training? What do they have?

MS WELLS: Okay, so, when I first came into post, Jacqui, there was one day that they undertook every six months. They were set, on certain days in a two-month – in a six-month block, so there would be so many days every six months that they had to try and get all midwives and support workers and obstetricians through. So the first thing that we did was we needed to really understand the skill and knowledge of our workforce that we had with us, and so we asked all midwives to complete the skills passport so that we could really know what their skill set was, what their additional clinical skills were and how up to date they were with those.

And what we then obviously did – once the practice-development matron was in post, we undertook a review of the mandatory training that needed doing, and it wasn't robust; it wasn't meeting the needs of midwives or the obstetricians, really, and it wasn't keeping them up to date with national guidance and changes in agenda. So, now, as I sit here now, they attend three days throughout an 18-month period, so they have to attend a day every

six months. On all of those days, there's a CTG update so that they maintain their competency every six months.

And, in addition to that, we have a PROMPT training now, so we supported a multidisciplinary team to go and undertake the PROMPT training, and they now deliver that in house. We do skills drills on the labour suite anyway, in addition to this mandatory training programme, and we also have public health updates, safeguarding, domestic violence, substance and drug and alcohol misuse, all of those really important things that midwives need to have continuous updates on in order to be effective and to be able to do their role as a midwife and support women appropriately.

We're just reviewing it again, actually, to include a fourth day, which is around accountability and responsibility as a health professional, and, whilst we've been delivering documentation as a training and an update within the three days, we're actually giving it a much larger focus, because we've recognised absolutely that the documentation in service, whilst improving, is still not to the standard that we would expect it to be.

MS FEATHERSTONE: Okay, and then the other thing I was just going to pick up on was the users. You talked about users, so have you got a maternity service liaison committee?

MS WELLS: We do now. When I started in 2011, there was no patient feedback apart from formal complaints, so we weren't listening to people and we weren't even asking them. So we undertook the development of a patient-experience survey, which now all women get on discharge from the services, and we're asking them to tell us their experience throughout pregnancy, labour and their postnatal period, so the full continuum of care. That's one thing that we've done, and that's –

MS FEATHERSTONE: And the response rate?

MS WELLS: The response rate – anywhere between 17% and 21%. It fluctuates. We have also now, in Lancashire North, got a well established maternity services liaison committee. That's been going for about 18 months, and that was something that, if I may be so bold, I had to drive with the commissioners for the commissioners to do, but absolutely they've have bought into it and they're obviously leading it. And we've, in the last six months, started to do the same here in Barrow-in-Furness locality, and we've had three meetings.

It's been a bit harder to get service users to those meetings, so, to try and ensure that we're reaching all the groups of people that we need to, we've been going into children's centres, but we've also been going into play areas and holding meetings there to try and get more and more women involved in those services.

We've obviously implemented Friends and Family in October and our return rate, again, is about 21-22% on that, and all of that in terms of patient experience, both from the Friends and Family, the internal survey that we do, complaints, concerns, compliments and the outputs from the maternity service liaison committee is all brought together and reported in terms of identifying themes, commonalities, so that we now have a really clear understanding of what we need to do in service to meet our service users' needs. The forum that we use to feed back to our service users is the MSLCs.

MS FEATHERSTONE: Okay. Would you ask complainants to be part of the MSLC, where you've met with them?

MS WELLS: Absolutely, yeah.

MS FEATHERSTONE: They could also be part of it.

MS WELLS: Yep.

MS FEATHERSTONE: And what about staff survey? Have you had a staff survey recently?

MS WELLS: There has been a staff survey recently, and I'm not going to remember the exact –

MS FEATHERSTONE: No, that's fine, just a feeling.

MS WELLS: – output of that. It's an improving picture than it was last year, but there's still – for us as an organisation and the trust board, there is still a concern around the level of staff who are reporting having experienced or witnessed bullying or harassment in the workplace.

MS FEATHERSTONE: And what are the trust doing about it?

MS WELLS: The trust are really clearly setting out the respect charter. They've done a lot of work with frontline staff around the values and beliefs as individuals but also the organisation's values and beliefs, really engaged with the workforce in helping them to define those. So it wasn't just the board deciding what those values and beliefs were going to be; they encouraged the staff to be a part of that. And I think the most important thing is the fact that

the board send out a very clear message that bullying and harassment in the workplace is not accepted and that it will be addressed through the appropriate channels and systems and processes, and that if anybody witnesses it they should either challenge it or report it to the relevant person.

MS FEATHERSTONE: Who were they saying they were being bullied and harassed by?

MS WELLS: I don't think the question was that specific, Jacqui.

MS FEATHERSTONE: It wasn't colleagues or managers or –

MS WELLS: From memory, it didn't break it down by, 'Who are you being bullied by?' It didn't break it down by professional group.

MS FEATHERSTONE: Okay. That's all I wanted to ask.

DR KIRKUP: Just on the generality of the staff survey, you said it was improving. Am I right in thinking that the impression you're giving there is it's improving from a low baseline?

MS WELLS: Yes. I think we were probably in the bottom 20% of trusts last year. I think we're now sitting kind of in the middle of the organisations, and it's improving in terms of staff wanting to work at the organisation, feeling supported by managers and senior staff and also getting feedback.

DR KIRKUP: Okay, thanks. Julian.

MR BROOKES: Just on that one, is that the generality of the trust in terms of the staff? The picture you were just painting – is that the trust's picture?

MS WELLS: Yes.

MR BROOKES: What kind of analysis have you done about your service, then? Where do you fit? Are you better or slightly below or...?

MS WELLS: We have actually undertaken a pulse-point survey just within the maternity services, and very specifically another survey around incident reporting, risk management and feedback. And that was... Whilst I can't remember the exact – it was a positive and improving picture, so people's awareness of incident reporting, who they would escalate to, whether or not they felt that they were getting relevant feedback and did they feel supported enough to raise concerns and who they would raise those concerns to was a much improved picture than 2011.

In terms of staff wanting to work for us in maternity services, I can't remember exactly what the breakdown of that was from the overall survey.

MR BROOKES: Okay, thank you. I'm asking that because what I'm quite interested in, one of the reasons for my questions, is the relationship – what you've described within maternity services etc. and its relationship to the wider trust in terms of governance arrangements etc. And the survey's a good example to get into, because I'd be interested on the impression – the importance the board places on the staff survey and how the messages that come out of that staff survey are actioned across the trust.

MS WELLS: So the importance that they put on it is one of their high priorities, because they are very clear that they want the organisation to be a good place to be cared for, but equally a good place to work, and it's really driving the improvement board that's been put in place, but also, as a result of that, they've just signed up to and starting to implement Listening into Action. So that's about getting frontline staff in a position where they have the – they can talk; they can suggest; they can give ideas as to how to improve things. But I suppose what it's doing is it's taking out a hierarchy and it's making it, 'Right, we're all in this together. We want to provide good care to the patients that use our services, but, equally, we all want it to be a good place to work, so what can we do across the organisation together? Regardless of title and band, what can we do to do that?' So that's in its very early stages.

MR BROOKES: Do you get divisional breakdowns from the survey, or is it...?

MS WELLS: Yeah.

MR BROOKES: Yeah, so how do you take that information and use it to improve the services you're providing?

MS WELLS: So we got our breakdown. That was obviously shared with all of the staff through ward meetings and unit meetings, but also not just that, the outcome of that survey, but what we were going to do as a division. So actually within the division, we've had lots of organisational development days and cultural workshops, which has enabled every single member of staff within the division to be able to be honest about what they think is good; what we could improve on; how they would want senior staff, clinicians and senior managers to engage with them more effectively; what are the quick wins; how we can do things more quickly for them to improve their working lives and to improve the enjoyment that they have out of coming to work, really. So it's –I

don't feel like I've done that justice, but there's an awful lot that's happened over the last three years.

MR BROOKES: That's fine. That's really helpful. I understand – because you've gone into some detail, and it's very helpful, about how you deal with incidents and things within your division. Can you just describe how that links to the rest of the organisation and the governance of the organisation?

MS WELLS: So our divisional governance leads obviously linked in with the director of governance, but there's also that direct link into the corporate governance team. So they help us to manage and – yeah, to manage and triage our incidents, help to support us in STEIS reporting but also keep things up to date for us and enable us to feed back robustly to the areas, and they make those links with the CCGs and local area teams where relevant.

MR BROOKES: So that's outwards, but upwards, is there a quality board, or...?

MS WELLS: Yes, so, sorry, we have a divisional governance committee within the division, and that divisional governance committee provides a report to the quality committee, which is chaired by a non-exec director every month, and, on a regular basis – I can't remember; I think it's every quarter – we provide a report to that committee around our governance, quality, experience, safety, etc.

MR BROOKES: Who represents your division at that meeting?

MS WELLS: The divisional governance lead, the risk manager, myself, CD and our divisional general manager – sometimes not all of us.

MR BROOKES: Yes, I understand. And are you satisfied that that mechanism – if you've got a real problem – would allow a mechanism for resolution?

MS WELLS: Absolutely. I took a problem to them in relation to... There was no clear guidance in terms of how – the frequency by which consultant obstetricians needed to undertake CTG updates. I think CNST described it as every three years as a minimum, but my concern was that we were asking midwives to do that far more frequently and actually we needed our obstetricians to be doing it equally, at the same timeframes. So I took that concern to that quality committee, and they supported me and the consultant obstetrician for governance to actually put that into our policy and our guidance that obstetricians need to undertake the training at the same timeframes as midwives.

MR BROOKES: So that's an upwards. They're looking at stuff across the whole of the trust and they may spot things which you can't see. Do you get feedback and actions coming down to you which have been identified as particularly important for the trust?

MS WELLS: So we get overall themes that have come out of the trust's trust-wide incidents. So we've very much aware that documentation, whilst we've recognised it in our division is an issue, it's actually a trust-wide issue – nursing documentation. And that has filtered down through those committees, and also through the patient-safety meetings that we have every Wednesday morning. I think it could be better. I think it could be stronger, and possibly the process up is very well defined, but I think the process down need a bit of fine tuning.

MR BROOKES: Okay. You're on a journey.

MS WELLS: Yeah.

MR BROOKES: Where do you think you are? Have you got halfway? What are the things which you think need to be done and the priorities for you going forward?

MS WELLS: As an organisation or as a maternity service?

MR BROOKES: As a maternity service and as an organisation, but maternity first.

MS WELLS: I would like to be so bold as to say we are more than halfway there, and I think I say that in respect of the fact that I really believe that we've got good, strong systems, processes. We've got absolute buy-in by the teams. I still think we've got a way to go with culture, and I think culture takes a long, long time to change, and I think the future of the services is very dependent upon a much bigger piece of work, which is Better Care Together, but I think, in terms of where we are now, it's much stronger; it feels much safer, but it's about never taking our eye off the ball.

MR BROOKES: And as a trust?

MS WELLS: I think, with our recent CQC review, we need to absolutely take on board everything that that review found, and I think we're probably a quarter of our way through that journey, really, as an organisation. And I think that might well be because of reputation and, again, culture. Culture takes a long, long time to change, and I think that's going to be the bit that we really need to focus on, moving forward.

MR BROOKES: Thank you.

DR KIRKUP: Just a couple of specific follow-up questions, if I can. You talk about the one governance lead across the bay, moving to a fuller system now. We sometimes struggle with the same people having different titles and different people having the same titles. Can you just tell me who was the initial one governance lead and what's the staffing now?

MS WELLS: As in the person's name?

DR KIRKUP: Yes.

MS WELLS: It was Jeanette Parkinson.

DR KIRKUP: And is now?

MS WELLS: It's Louise Jones.

DR KIRKUP: Okay, and the risk managers?

MS WELLS: The risk manager is Sharon Perkins for maternity services. We've just literally appointed Louise Copeland as paediatric and neonatal risk manager, so she's not technically taken that post; she's in notice period.

DR KIRKUP: Okay, that's helpful, thank you. It's sometimes difficult to keep track –

MS WELLS: Yeah, no, that's a problem.

DR KIRKUP: – of organisation charts; they keep changing. When you arrived in May 2011, what kind of briefing did you have about the events of the previous couple of years?

MS WELLS: I didn't.

DR KIRKUP: You didn't.

MS WELLS: No

DR KIRKUP: Okay. How did you find out?

MS WELLS: I found out when I was first informed of an inquest that was happening in June of that year.

DR KIRKUP: That would be [redacted] inquest.

MS WELLS: Yes.

DR KIRKUP: Okay.

MS WELLS: And I think I'd actually been in post by probably about two and a half weeks by that point, and I was made aware of that very sad case and that it was going to inquest. I can't remember if I reviewed that case in terms of the clinical notes prior to or after.

DR KIRKUP: Okay. Don't talk about the clinical details –

MS WELLS: Right, no.

DR KIRKUP: – because, if you want to do that, which is fine, we'll offer you a second session where we don't have observers present.

MS WELLS: No, I didn't, but I can't remember if I looked into it in any real detail until afterwards, but I think what then happened was that inquest happened and then I think it was literally weeks later the CQC and the NMC arrived, and that's when I really started to learn about what had been happening in that service.

DR KIRKUP: Okay. Did you talk to staff who had been involved about what had happened in nursing?

MS WELLS: I predominantly spoke to the risk manager at the time, because obviously she kind of had a real understanding of what had been going on. I talked to supervisors of midwives, and I talked to the senior teams. I became made aware of a particular action plan just as I took up post, actually. I'd visited the service just prior to me taking up post, so I became aware of the action plan, but I wasn't aware of the context in which it had been commissioned.

DR KIRKUP: Okay, and which action plan would that have been?

MS WELLS: The Fielding.

DR KIRKUP: Right, okay.

MS WELLS: And I was made aware by the senior matron that they'd only found out about that action plan when my predecessor had left.

DR KIRKUP: Right, okay. Did you read the Fielding report?

MS WELLS: I did.

DR KIRKUP: And what were your conclusions?

MS WELLS: I agreed with them, in the main, from what I knew, at that time. I wasn't in any position to question it, to be honest, at that time.

DR KIRKUP: And that would have indicated to you – tell me if I'm putting the wrong words into your mouth here, but that would have indicated to you that there were some fairly deep underlying problems to do with relationships – working relationships, teamwork, escalation of issues.

MS WELLS: Yeah, so that goes back to what I described to Jacqui. You know, that was evident to me very early on, but I didn't understand all the context that had gone on in 2008 etc.

DR KIRKUP: Yeah, I understand, okay. When you looked at the action plan, which had only recently been developed at that stage, I think, when you'd arrived, did you think that it hit the buttons that it needed to, in response to the Fielding report?

MS WELLS: Without it in front of me I can't say absolutely.

DR KIRKUP: No, I'm just asking for a general impression, not a line by line. Just were you happy with...?

MS WELLS: But it kind of lined up with what I was seeing –

DR KIRKUP: Okay, yeah.

MS WELLS: – and what I felt we needed to do, but I also had to build a relationship with my workforce, because I'd literally just started in post, so I needed to kind of understand what team I was working with, what the dynamics were within that team, where the strengths were, where the weaknesses existed, and so I kind of needed to take a step back and look at it all together, really, before I did anything. And then obviously the CQC and the NMC came in; that kind of took over.

DR KIRKUP: Okay. You've kind of touched on this, but I just want to return to it. You've presented quite a persuasive account that lots and lots of things are different now and that you're a substantial way along the journey, but you've also said – and I very much agree with this – that underlying cultural issues take a long, long time to sort out. I'm concerned that, overall, you're, for very understandable reasons, painting too rosy a picture, and I just want to challenge you on that and say you're not really that far along in addressing some of these underlying issues, are you, because you couldn't be? It's too soon.

MS WELLS: Well, obviously I respect your view. I guess it's based on the journey that I know we've been through in the last three years. I think what's really helped to get us a bit further on is the appointment of new obstetricians, paediatricians and lots and lots of midwives. I mean, by the time that we've actually recruited to the budgeted establishment that has now been agreed for maternity services, there'll be 43 new full-time-equivalent midwives in that service. So of course they bring with them a fresh view and fresh outlook and a positive culture.

DR KIRKUP: Absolutely, but have you evidence that that positive culture is diffusing out to the existing people – obstetricians and midwives – in other words, that the peer effect is working?

MS WELLS: I believe so. I am very encouraged by the fact that I see clinical incidents put in by midwives, both new and old, in recognition of the fact that they've missed something themselves. I think we have a bit of a way more to go with my medical colleagues, and I don't deny that, but I certainly feel much more positive about the midwifery workforce and the acknowledgement that they now have about their accountability and responsibility as individual practitioners.

DR KIRKUP: Okay, that's very helpful.

MS WELLS: And that, for me, is a positive culture.

DR KIRKUP: Don't get me wrong. I've got no doubt at all that what you're describing is fantastic progress. I'm not in any doubt about that, but I don't want us to get carried away and say that, because it does represent fantastic progress – back to my point about the very low baseline – that all is well.

MS WELLS: And I don't say that we're completely fixed. I don't believe that we have got it all right, absolutely. I have acknowledged that I think we've still got some way to go, and, actually, we'll never move... You know, I don't think that we'll ever reach an endpoint because I don't believe that there is ever an endpoint. It is continuous. We need to constantly keep ourselves monitoring ourselves, reviewing what we're doing, questioning ourselves and I think one positive that will come out of this, in the next couple of months, is that we're actually seeking a stability partner with another organisation.

And what that does is that generates a fresh-eyes approach into our services, and equally into theirs, because all of us in a senior position – my team have changed. There's only one existing member of the senior team that is still in place, but all of us, if we're in these for in excess of three to five years, will stop seeing, so it's important that that kind of fresh approach from outside is there. So I think we are in a much stronger position, but I don't believe that we're at the end, and I don't think we'd ever get to the end, actually.

DR KIRKUP: Okay. Anybody like to follow up?

MS FEATHERSTONE: No, I'm okay.

MR BROOKES: No, it's just, on that point, it's a real challenge, as you say, when you've been at a place for a significant period of time, to continue to see the wood and the trees, and I know a little bit about this Lincolnshire Partnership. So how are you planning to ensure that your long-term, well established members of staff get the opportunity to experience a different environment or a different way of working to keep that freshness?

MS WELLS: Well, it's not well defined yet. I think we're probably the first organisation in the country, maternity-services-wise, to kind of put this through as a proposed model. I think, for example, it's already been agreed internally that we would support some of my senior team going for secondments and rotation, so swap like for like, really, with those services, to give them exposure to another service and see things – how other services are doing things, share ideas, bring ideas back, vice versa. We look at... One of the offerings, obviously, is around the governance of things and getting that independent review of cases and incidents.

But I think predominantly what we've got to look at, in order to make this really work for us and to keep the skill set of our staff up and that fresh approach, is, whilst challenging, seriously look at rotation of staff between those services, and I think we have to acknowledge that we aren't in any way, stretch of the imagination, a tertiary service, so, by virtue of that, there's a skill missing there, if we don't do that for our staff. So they need to be able to have that opportunity to go and work in a tertiary service, to be able to then deal with those difficult situations when they do come into our services, and there's nowhere in the whole of Cumbria that provides a tertiary service, so we are having to go further afield to do that. And I think that's a really important part of this process for our existing staff, but also our midwives – junior midwives – because I do believe that you reap what you sow, and, if we're not training them right in the first instance, then we're not going to have the workforce that we actually want.

MR BROOKES: And is that extended to different clinical groups, or is it purely around...?

MS WELLS: Yeah. There is – obviously, again, the complexities of how you would do it and support it need to be really well worked through, but, absolutely, paediatricians and obstetricians too.

MR BROOKES: Thank you.

DR KIRKUP: Okay. We weren't going to ask you any questions that would broach any clinical confidentiality, but is there anything that you would want to say to us that would do that, because we'll offer you a closed session, if that's what you want?

MS WELLS: No, I don't think so.

DR KIRKUP: If you don't, then that's fine. Is there anything else, more generally, that you would want to say to us?

MS WELLS: I think one of the things that was really concerning to me when I first took up post and got through some of the initial things that I needed to deal with in terms of the CQC and the NMC with the team was that the commissioners had very much worked separately from each other. So they were commissioning Morecambe Bay maternity services in South Cumbria and Lancashire North separately and had never, ever come together.

And what really troubled me was that there was no maternity specification for that service, so, actually, maternity services didn't know – truly know – what they were being commissioned to provide. There was no real understanding amongst the commissioners, the differences between the two obstetric services and actually how they support each other; without each other, neither would really exist, or not very well. And also I don't feel that the questions were being asked – the right questions weren't being asked. So, as a result of that, what we've done is we now have joint maternity commissioning groups, which is absolutely fundamental in getting the services right.

MR BROOKES: And do you have a maternity specification?

MS WELLS: And we now have a maternity spec, yeah, and that was in place from 1 April last year. We have clear key performance indicators that we have to report to commissioners. A lot of that obviously exists within our clinical governance maternity dashboard and it feels much more robust in what's expected of us but also what the commissioners would be asking of us and expecting of us, really.

MR BROOKES: Thank you.

DR KIRKUP: Okay. Thank you. Thanks very much for coming

(The interview concluded at 12.41 p.m.)

THE MORECAMBE BAY INVESTIGATION

Thursday, 24 July 2014

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

Before:

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

ANN WEST

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

PROF: FORSYTH: Good afternoon. My name is Stewart Forsyth. I'm a paediatrician and a medical director from Dundee.

MS FEATHERSTONE: I'm Jacqui Featherstone. I'm the Head of Midwifery and the Head of Nursing, at a district general hospital in Essex.

PROF: WALKER: I'm Jimmy Walker. I'm an obstetrician. I'm the Professor of Obstetrics in Leeds. I also have a background in the National Patient Safety Agency and CMACE.

DR KIRKUP: You'll be aware that we're recording proceedings, and we'll make an agreed record at the end. We also have family members present, as observers of the session, and others will be able to listen to the recording subsequently, if they want to do that. You also know that we've removed mobile telephones, laptops – any other recording devices – just to emphasise that the importance of that is that nothing goes out of the room until we're ready to produce a report that has all the findings considered in context.

Do you have any questions for me about the process?

MS WEST: I don't think so.

DR KIRKUP: Okay; thank you. Can you just start off, then, by telling us when you first started in connection with the Trust, and what you've done there?

MS WEST: I came to work for the Trust in 2001, but eventually took the role as modern matron for paediatrics, in 2005.

DR KIRKUP: What did you do from 2001 to 2005?

MS WEST: I didn't have a job when I first came, so I was just band nursing with my husband's work, really. So, I'd left the post as ward manager where we lived previously, knowing that I could get some work after – [*Pause*] So, when we arrived here, there was no vacancies, so I just started working on the [inaudible]. I did some band work on the special care baby unit, as well.

DR KIRKUP: Okay. And in 2005 you were modern matron for paediatrics? How long did you –

MS WEST: Yeah. I eventually got a post as a deputy ward manager for three days a week, on the ward, and eventually the post came up for paediatrics diabetes nurse, which I took. That was three days – I think I did two days on the ward. Then, the matron post came up.

DR KIRKUP: Okay and how long did you do the matron post?

MS WEST: I did the matron post when I retired, in 2009.

DR KIRKUP: Okay; thank you.

MS WEST: It was only two days a week, initially.

DR KIRKUP: Initially?

MS WEST: Yes, and then it went to three days a week.

DR KIRKUP: Can you remember when that was?

MS WEST: I think it was probably a year later – just about 18 months after I took the post.

DR KIRKUP: Okay; thank you. That's very helpful. I'll ask Jacqui to start her questions.

MS FEATHERSTONE: Do you want to just clarify what the role of the matron of paediatrics – what did it encompass? What was your remit?

MS WEST: It was very much really an evolving role, I think. There was already a matron in the post in Lancaster for paediatrics, and a matron for neonates in Lancaster, but it was felt that somebody was needed at the Furness end. So, it was a combined role for paediatrics and neonates. Really, we were looking at the hygiene, health and safety and, you know, the cleanliness, governance – ensuring that we've got what we hope were the right policies and the right procedures in place, and ensuring they were maintained.

MS FEATHERSTONE: So, you were looking after special care. And you were looking after a paediatric ward as well, were you?

MS WEST: Yes.

MS FEATHERSTONE: Was there any paediatrics A&E there?

MS WEST: There's not a specific paediatrics A&E, no.

MS FEATHERSTONE: Okay, so, it was the ward and special care was really your remit.

MS WEST: Yeah.

MS FEATHERSTONE: During that time, was there integration within maternity, as well? Did you meet with, you know, your colleagues in maternity?

MS WEST: Mainly at matron meetings, and if there were any problems – or perceived to be any problems – between – sorry, with obstetrics, you mean?

MS FEATHERSTONE: Yes.

MS WEST: If there was perceived to be any problems between the care and maternity services, then we would meet together and work on it in that way.

MS FEATHERSTONE: But not – generally, there weren't joint meetings between the two?

MS WEST: The only joint meetings were the general matron meetings.

MS FEATHERSTONE: Which would involve the general side as well.

MS WEST: Yeah.

MS FEATHERSTONE: So, with regard to multi-disciplinary meetings within maternity – so, from governance; you talked about governance point of view – were they joint meetings, or did paediatrics and neonates have their own, and maternity have – did you have anything together like that?

MS WEST: No, nothing, no – not that I was involved in. I think they had review meetings in maternity, which the paediatricians attended.

MS FEATHERSTONE: Perinatal review?

MS WEST: Yes, but I wasn't involved in it at all.

MS FEATHERSTONE: Okay. So, with regard to guideline and policies and, sort of, joint ones, did you get involved with those for maternity as well, then, when there was some crossover between them?

MS WEST: Not too much – yeah – not so much when they were being written, because of the hours that I worked. It simply wasn't possible to do it all. I was very involved with the paediatrics side. As there was a matron in the neonatal services in Lancaster, she actually attended those meetings – because it covered the whole Morecambe Bay. I would have copies of them before they actually went out, just to see if I've got anything, you know, I needed to say about them or –

MS FEATHERSTONE: So, during your time when you were the matron, what was the remit of the special care, then? What level were you then?

MS WEST: We didn't have any intensive care babies, as such.

MS FEATHERSTONE: So, it was only special care. From how many weeks, though?

MS WEST: They were trying make it to 32; I think there was some discussion. I think 28 is what they were taking at the time, but ideally 32 – that's what we were trying to establish. I think it depended on the babies, as to whether they moved them out or not.

MS FEATHERSTONE: With regard to training, did the training that the nurses within special care – were they getting the same as the midwives? Again, was there any integration between the training between the two?

MS WEST: Once the practice educator was in post, which is whilst I was in post, yes. They had training sessions together.

MS FEATHERSTONE: And neonatal resuscitation – who did – did anybody on your side take those, or were they done by the midwives for their own training and –?

MS WEST: The practice educator.

MS FEATHERSTONE: She did them – for both?

MS WEST: For both, yeah.

MS FEATHERSTONE: So, generally, the training was the same across the board?

MS WEST: The same, yes.

MS FEATHERSTONE: So, they were getting the same things.

MS WEST: Yeah.

MS FEATHERSTONE: And the same with – if there was an incident with a baby – an unexpected [inaudible] or an investigation – would you be involved with that, alongside maternity? How did that work, when there was an issue with a baby coming into the special care – something that would have raised an incident?

MS WEST: The staff on special care would almost always call me, if there was any problems. I used to pop in twice a day anyway; I always popped in morning and evening. But if there was any issues – if they've got a sick baby; they'd been called to a sick baby; they were having to transfer a baby – they would always call me. Invariably, there was a staffing issue and they would need help covering, even if it was only for a short period of time. So, I'd always go round to –

MS FEATHERSTONE: To work? Would you go round there to help them, or –?

MS WEST: I would go round there to support them, to help them cover the unit and find cover for them. There were times when I stayed and helped them out round there, and I would usually be looking after the other babies, rather than the – whilst they – because they were, you know – they knew these babies and were already working with them, so I would very often support them in looking after the other babies, whilst they were dealing with the sick baby. But I would be there when I was around, and in the Hospital and available.

MS FEATHERSTONE: While you were there – just if you'd been called there – were you ever involved in when they needed to transfer a baby out? You know, were you involved in actually that happening, or you know that a retrieval team was coming for them or they were going to transfer the baby out to another hospital? If you know of any, did that work well?

MS WEST: Yes, I think it worked very well, once they got the team and they knew the team were coming. I think sometimes there was a delay getting the team to us.

MS FEATHERSTONE: Because it was a delay from the team coming, or it was a delay calling them?

MS WEST: No, a delay from the team coming, very often, in that they had to find a cot for the baby and then sort out the team coming to pick it up – because they didn't always come to Preston; obviously, it was wherever it was –

MS FEATHERSTONE: And they would go quite a distance, then, would they?

MS WEST: Yeah.

MS FEATHERSTONE: Okay. I think that's just fine for the moment, thank you. I'll pass you onto the others.

DR KIRKUP: Okay. Stewart?

PROF: FORSYTH: Can I begin by maybe going back a bit, to – you're a sick children trained nurse, yeah?

MS WEST: I'm a sick children's trained nurse, yes.

PROF: FORSYTH: Before you went to Furness, how much experience had you had in looking after a special care unit?

MS WEST: Not a lot. I'd worked in the special care baby units, but I hadn't managed a special care baby unit.

PROF: FORSYTH: Right. So, where had you worked in special care?

MS WEST: When I lived on the Isle of Wight, there was a special care baby unit there and I'd spent quite a lot of time there. I think we had one intensive care cot there.

PROF: FORSYTH: So when was that?

MS WEST: That was just prior to –

PROF: FORSYTH: Just prior to coming here?

MS WEST: Yes, and I'd been there for about 20 years.

PROF: FORSYTH: Right. So, just to try and get a feel for the staffing of the special care baby unit in Furness – what staff did you have? How many nurses were neonatal trained?

MS WEST: Almost all of them. As I was leaving, the last few – the last ones that had come in were actually doing their neonatal training.

PROF: FORSYTH: Right. So, how many nurses – what was the staffing allocation for –?

MS WEST: There was normally two on per shift – two trained nurses.

PROF: FORSYTH: So, on average, how many babies would be admitted to that unit each year?

MS WEST: I can't tell you off the top of my head. No, I can't remember, sorry.

PROF: FORSYTH: So, were there periods –

MS WEST: There were periods in the unit where there would be no babies, and there'd be periods in the unit where there would be six or seven babies.

PROF: FORSYTH: How did you manage these peaks and troughs?

MS WEST: With difficulty. Obviously, if there was a lot of babies – it depends what their dependency was. If it was six, just growing babies that, you know, two nurses could manage, that was fine. If they had a sick baby, then they would need support. Very often, staff from Children's Ward would help. They would go along to help in the unit, which gave them experience as well, of handling and feeding –

PROF: FORSYTH: So, you didn't transfer babies out because you're over capacity?

MS WEST: We did transfer babies out if we've got over six, yes. But that was often difficult, finding somebody that was able to take them.

PROF: FORSYTH: Yes. What about – in terms of medical staffing, covering the special care baby unit, what was the arrangement there?

MS WEST: There was a consultant that was on hot week that covered both.

PROF: FORSYTH: So there was somebody covering paediatrics and special care?

MS WEST: Yes. And so were the – the junior doctors as well were covering both. They used to allocate between themselves; one would be responsible for neonates, and one would be responsible for paediatrics. But that was during the day, and at night-time, obviously, there was just the one covering both.

PROF: FORSYTH: How many consultant paediatricians were there?

MS WEST: I think there was three, when I first –

PROF: FORSYTH: And middle grade doctors?

MS WEST: I think we had two, because we were still on the old system then.

PROF: FORSYTH: Did you find that difficult, that structure?

MS WEST: I suppose it was very similar to the structure that I'd worked in before.

PROF: FORSYTH: On the Isle of Wight?

MS WEST: Yes – yeah.

PROF: FORSYTH: And did you feel at times you had babies in the unit you felt were too high risk to be in the unit?

MS WEST: Yes.

PROF: FORSYTH: Did you have discussions with staff about that?

MS WEST: Yes, with –

PROF: FORSYTH: With medical staff, or managers?

MS WEST: With medical staff, yes.

PROF: FORSYTH: How did they go?

MS WEST: Well, they sometimes weren't terribly happy that they were being challenged, but they were always very approachable and would listen.

PROF: FORSYTH: Did you transfer babies out of that?

MS WEST: Sometimes babies were transferred out. Sometimes they had a good reason, that they could explain to me that they felt they needed to keep them, but other times – yes, if I'd spoken to them and the staff on the ward had spoken to them, they would then, you know, transfer babies out without me having to go – I think there was an odd occasion where I had to go to my manager, to say, 'I need support on this because we've got a sick baby that really should be transferred. We've got too many in the unit. We can't manage it.'

DR KIRKUP: Can I just ask – sorry to interrupt. Those conversations were in connection with individual cases. Did you have conversations about the general policy?

MS WEST: That happened quite frequently.

DR KIRKUP: They happened quite frequently?

MS WEST: Yes.

DR KIRKUP: And was there a shift in the general policy as a result of those conversations?

MS WEST: An unhappy shift, I think.

DR KIRKUP: And maybe it drifted back again later?

MS WEST: Yes.

DR KIRKUP: Okay. Sorry to interrupt, Stewart.

PROF: FORSYTH: That's fine. What about the conversations between yourself and the modern matron for the labour suite? Did you have discussions? Did you keep you up to date if there's a woman in labour that was going to potentially have a baby come to you?

MS WEST: No. I found out through the special care staff.

PROF: FORSYTH: So, was there poor communication, do you think, between yourself –?

MS WEST: They kept – they had a folder, so they were informed of any risky deliveries. That was on the unit. So, we'd look at that on a regular basis, just to review what they were expecting.

PROF: FORSYTH: So, the idea of trying to head off a baby coming into the unit at an earlier stage, and having the baby transferred to Lancaster or wherever else – there wasn't really a good system for discussing the best possible management for the lady who was high risk?

MS WEST: Not at my level. I think the consultants – the paediatrician and obstetrician – did have discussions about it. I suspect that – well, I know that – the obstetricians liked to hang onto their ladies if they could, to deliver the babies. They felt it was safer than transferring them at a late stage to Lancaster or Preston.

PROF: FORSYTH: What about – again, with the labour suite – you know, a mother has delivered a baby and the baby has to be resuscitated, but seems to have recovered from resuscitation. Were you or your colleagues in neonatal contacted to go and review the baby?

MS WEST: Any baby that needed resuscitation in the labour suite, the special care baby unit staff were called and actually did go round. There was a nurse practitioner on the special care baby unit, and if she was on duty she would certainly always go round to the unit later. If the baby stayed with mum, she would certainly always go round later.

PROF: FORSYTH: What if the baby is then moved to the postnatal ward with the mother? What's the contact there? Does that baby then just being monitored by the midwives on the postnatal ward?

MS WEST: Yes, unless the nurse practitioner had been involved.

PROF: FORSYTH: Right. She would go and check?

MS WEST: She would then pop round at irregular or regular times, just to check the baby.

PROF: FORSYTH: Who does the newborn examinations at Furness?

MS WEST: The SHOs were doing most of it. I think they were doing most of them.

PROF: FORSYTH: Okay. So, there'd be no, sort of, progress at the time to the midwives?

MS WEST: No. I think the nurse practitioner from the neonatal unit was doing them, and I think the midwives were certainly having training for doing the newborn examination, yeah.

PROF: FORSYTH: So, maintenance of skills, with a lot of the small number of babies coming through. Was that an issue with the nursing staff and possibly, from your insight, into the medical staff?

MS WEST: I think they found it very difficult, yes. I mean, you can train people; you can train people as much as you like, but it is the hands-on practice that makes it work. Whilst they were all trained – and they were more than able to do it – a lot of them did have anxieties about the sick baby and being called. They coped fine when they did it, but they did have anxieties about it.

PROF: FORSYTH: What about the medical staff, particularly the junior doctors, when you called them? Did you find there were skill issues there?

MS WEST: I would think yes.

PROF: FORSYTH: In terms of what sort of –?

MS WEST: Just lack of experience of dealing with neonates and sick units, and the same with, you know, sick children – very young children.

PROF: FORSYTH: Contact with Lancaster – did you have the equivalent person in Lancaster? Did you have regular communication there?

MS WEST: The matron in paediatrics? Yes.

PROF: FORSYTH: Did you – in terms of trying to maintain the skills, the nursing staff, did they go to Lancaster at any time for –?

MS WEST: The special care baby staff, they were trying to do a rotation of staff to Lancaster. That was met with a lot of reluctance, at times.

PROF: FORSYTH: By who?

MS WEST: By the staff themselves.

PROF: FORSYTH: By your staff?

MS WEST: Yes, because: a) the travelling to Lancaster, and –

PROF: FORSYTH: And the fact that they were obviously anxious, if they had to do managing a sick a baby –

MS WEST: Yes, but there was still some reluctance. I think it dates back to the time when the Trust came together, and there were some issues between – it was before my time; I've not got a lot of experience of it, but I sense there were still some issues between the Trust coming together in Furness and Lancaster. There was some degree of ill-feeling about it all happening, and I think that had continued. I don't know more about it, but it was just a feeling that you had about it.

PROF: FORSYTH: Thank you.

DR KIRKUP: Thanks. Jimmy?

PROF: WALKER: Good afternoon. You said at one point that you would talk to your manager about something. But I'm struggling to work out who your line manager would be, because you were the modern matron for obstetrics and neonates, but there was a modern matron for neonates and paediatrics in Lancaster.

MS WEST: I was the matron for paediatrics and special care baby unit. There were matrons for obstetrics.

PROF: WALKER: Yes, I know, but as far as – who were you answerable to? Who was your next in line?

MS WEST: The paediatric nurse manager.

PROF: WALKER: Right – within Furness?

MS WEST: No, it was a cross-base post – so, probably did three days in Lancaster and two in Barrow.

PROF: WALKER: But you made some comment, I think, that the matron in Lancaster, I think, was neonatal –

MS WEST: There was a neonatal matron and a paediatric matron – separate; two posts.

PROF: WALKER: But the neonatal matron would have some input into guidelines, and interface with the obstetrics in Furness?

MS WEST: Yes, because they work together as a group.

PROF: WALKER: Okay. So, how did you relate to these matrons in Lancaster? Were you equal to them? Did you discuss things with them? Did you pass things onto them?

MS WEST: Yes. Whilst the matron from Lancaster was involved in writing guidelines – because that's what she did – because of the limited time I had, I didn't do that. I tended to do the paediatric line of things. But I always had copies of them, and could discuss with them anything that I was worried about. Equally, if I was worried about anything on the unit, I could speak to the matron in Lancaster without any problems at all.

PROF: WALKER: So, if there was a problem in the unit within Furness, they would come to you about it? So, you would be in charge of the special care unit in Furness?

MS WEST: Yes.

PROF: WALKER: So, that unit – you managed that. But I'm just trying to work out where fitted in with the ones who were in Lancaster. I think I've got that. The other thing is that you said you had particular interest in clinical governance and care, and particularly about hygiene and various other aspects. But you weren't involved in incident reporting or incident feedback?

MS WEST: If I – I didn't fill in any of the forms, but, yes, I would be involved when there was feedback from them. I mean, there may have been times when – I don't think there was – when I actually instigated an incident form. But, yes, if there was any feedback, I would be involved with that – and any meetings from that, I would be involved in that specific meeting.

PROF: WALKER: So, you were involved once the report had been reviewed and conclusions made.

MS WEST: Yes.

PROF: WALKER: Okay. So, you'd be involved in implementing recommendations?

MS WEST: Yes.

PROF: WALKER: Now, the other thing is that the – in your experience within the Hospital, and I know you didn't have a lot of contact with the obstetrics side of things – but with the matrons, was there any fill-in with how the midwifery and matrons who worked, compared with how you worked and how the surgeons worked, or the physicians worked, about the governance ideas and other

developments that you were doing, or similar things happening in midwifery – or was there not? Was there any cross-site discussion about these things?

MS WEST: I wasn't involved in any, but I'm sure that they were happening as well within their unit – their area. But I certainly wasn't –

PROF: WALKER: Are you sure they were happening?

MS WEST: No. I think they were happening.

PROF: WALKER: Okay; alright. The other thing I was going to ask is – and you partly answered it – was: if there was an emergency call to labour ward, for resuscitation of a neonate, you said the staff from the special care unit would go. Was there any trouble in getting staff to go, from the point of view that if it was busy –?

MS WEST: No. They would go, and usually ring either me or children's ward. If I wasn't around, they would ring the ward and ask for someone to cover. They usually had five or 10 minutes to get there. Sometimes, if they just had to go, they would leave one person on the unit and they would ring, to get somebody to come and cover them.

PROF: WALKER: And lastly, again, following up something someone asked earlier, there was no, sort of, outreach service, apart from this – what you said was a neonatal, a special care person, who went round and reviewed babies in the ward. Was there any supportive midwives, looking after babies in the ward, or any requests from midwives to actually have some training or updating on how to monitor or care for babies on the ward?

MS WEST: The nurse educator was obviously doing a lot of work with them. I mean, she came into post after I did, so, you know, that started. She was doing a lot of work with them.

PROF: WALKER: Okay.

MS WEST: As for them asking, I'm not aware of them asking.

PROF: WALKER: So, you're only talking about after 2009, that these things started happening?

MS WEST: No, they started before – I finished in 2009, so, they started before that.

PROF: WALKER: Okay.

MS WEST: I'm not aware of them actually asking. There were times when they would phone the special care baby unit, and say they'd got a baby they weren't happy about and they would bring it round to the unit, for the special care staff

to have a look at and monitor for a few hours. But as for specific training, I don't think they were asking.

PROF: WALKER: Did that sort of transfer of babies require a paediatrician to approve that, or could the midwives do that themselves?

MS WEST: They could do that. And then staff used to inform the paediatric SHO on call that they'd brought a baby round for assessment, and ask them to come round and see the baby.

PROF: WALKER: Okay. Thank you.

DR KIRKUP: I've got a couple of questions that I'd like to ask you, but they're very much about the details of individual cases – not necessarily that you were involved in personally, but about policies that were in operation. To make sure that we don't breach any clinical confidentiality, I'm going to have a short pause while we ask if the observers could leave, please.

[*Observers leave*]

THE MORECAMBE BAY INVESTIGATION

Wednesday, 16 July 2014

Held at:
Park Hotel
East Cliff
Preston
PR1 3EA

Before:

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

MS KAREN WESTALL

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DR KIRKUP: Hello, thank you for coming. I'm Bill Kirkup, I'm chairing the Panel. I'll ask everyone to introduce themselves to you.

DR WALTERS: Geraldine Walters, director of nursing at King's College Hospital.

PROF: FORSYTH: Stewart Forsyth, paediatrician and medical director at Dundee.

PROF: MONTGOMERY: I'm Jonathan Montgomery, I'm professor of healthcare law at University College London, and chair of the Health Research Authority, but I have in the past chaired an SHA, PCT and a couple of wider [?] Trusts.

DR KIRKUP: As you can see, we're recording proceedings, and we'll produce an agreed record at the end of the process. We have over the proceedings had family members as observers. As it happens, there aren't any present today, but [inaudible]. And you'll know that we've removed recording devices and so on, apart from this, and it's important that none of the material we talk about is discussed until we're in a position to produce a full report. Any questions for me about the process?

MS WESTALL: No, I don't think so, thank you.

DR KIRKUP: Okay, thank you. I will start with a very general question before I ask Geraldine to continue with the questioning. Sorry, we decided that when you were out. When did you start at the Trust, and how long were you associated with it?

MS WESTALL: Well I started – I think it probably was a year after the three Trusts linked together. I had been on Lancaster Trust for – I think it was four and a half years, and then there was the merger and so I stood down. But then fairly soon after the merger I was approached and asked whether I would go back onto the Board because one of the non-executives had stood down – well,

given back word really. So they were one short, and they asked me if I would join. And then – so that was in 1998, so my 10 years on that Trust were up in 2008, and I ended a few months early, maybe because I felt we were working towards foundation status, and I felt it was important that if I was about to depart because of the 10-year ruling, it was unfair for somebody new coming in to have to be prepared for that ~~sham~~ (I cannot thaink what this word should be but it certainly was not 'sham'. What I would have meant was "the process of being interviewed to judge readiness for moving to Foundation Trust status" without having time to get to know the Trust itself.

DR KIRKUP: Okay, thank you. Geraldine.

DR WALTERS: What's your background?

MS WESTALL: At that stage I was ~~teaching.~~ Working as a freelance publisher's editor having taught in schools and colleges for many years.

DR WALTERS: Right so you know the local area?

MS WESTALL: Oh, very well. Yes, I've lived there since 1969. I've used Lancaster Hospital frequently, so yes, I know it well.

DR WALTERS: And before your experience with the NHS, had you done any sort of non-executive type, trustee type role before?

MS WESTALL: No.

DR WALTERS: So from 2004, when the Trust – when you took over the job at the Trust, what were the big issues?

MS WESTALL: I was there long before 2004.

DR WALTERS: But when they – perhaps when they merged together, would you say?

MS WESTALL: I think they merged together in 1998.

DR KIRKUP: Yes, I think so.

DR WALTERS: Right, okay. So what were the big issues around sort of the period we're talking about, which is sort of 2003 onwards, for the Board?

MS WESTALL: I can't say that I can pinpoint any real serious issues, I would say, except possibly running as...

DR WALTERS: So what did the Board spend its time on, thinking about and talking about?

MS WESTALL: Well, all kinds of issues. The issues of – I mean we had regular audit meetings, we'd have governance meetings. I wasn't on the governance panel, we had – I forget whether it was two or three non-execs representing on the governance board, but latterly, and I can't remember how late it was, we had – I made a note of what it stood for, so I had to look in my diary, financial services oversight committee. I'm afraid it's too long ago for me to remember the details of specific board meetings, but...

DR WALTERS: Okay. So when did maternity first sort of hit the board agenda?

MS WESTALL: I honestly can't remember it being a real concern.

DR WALTERS: Until it became an issue.

MS WESTALL: Specifically until after I had left.

DR WALTERS: Right, okay.

MS WESTALL: I mean that's when it – when it actually – the incident that resulted in the forthcoming investigations was after I had left.

DR WALTERS: Right.

MS WESTALL: So there was certainly nothing – I mean we, again, had regular

meetings with the person who ran the complaints department, and certainly there had been nothing to spark off any indication that there was a concern there, as far as I was concerned. And there was another non-exec who had regular meetings with the complaints department.

DR WALTERS: Right. Did you ever get any sort of reports about maternity, just generally, at the Board? Activity, performance, those sorts of things?

MS WESTALL: Possibly. I can't remember a specific report, but – I'm sorry, I don't – as I say, we're going back six years.

DR WALTERS: It's a long time ago. When you were on the Board, how did you sort of get assurances that things were running well? What sort of things were you told?

MS WESTALL: We had – well, as I say, we had audit meetings and we had – the head of audit would give us a report. We'd have a paper in front of us with all the things that had – they had raised. That was an opportunity for any member of the board to say that we would – you know, there was an annual report on, and these were the things that would be looked over in the next six to 12 months, and if we said, 'Well, we would rather such and such was investigated,' then that adjustment would be made.

I can remember actually raising the point that we get these reports back. How are we sure – how are we sure that something that they had recommended, the audit committee had recommended, was actually carried out? And I'm pretty sure we had what's called a traffic light system, where they would kind of highlight, and obviously they said they would return to. So in future we had reports that kept all the items that had previously been

investigated, and they would carry on checking that those items that had not reached the standard they required were followed up, and we had our green, amber and red system, so we were aware of progress being made.

DR WALTERS: And other than the sort of financial and counter-fraud and that sort of thing, what sort of other things did they tend to look at?

MS WESTALL: No, I'm sorry, I can't remember.

DR WALTERS: As a non-exec, did you sort of go out to the different hospitals?

MS WESTALL: The three sites?

DR WALTERS: Yes.

MS WESTALL: Well, more than three. Yes. I mean we always had – the Trust Board rotated round the three sites ~~there~~, and then I was going to meetings in any one of the three all the time.

DR WALTERS: Yes, and did you ever sort of go to clinical areas and meet the staff?

MS WESTALL: Oh, yes. I mean I – some of them were voluntary. I attended – when we were in Lancaster we – sorry, when I was on the Lancaster Trust Board, each non-executive ~~elected~~ director was linked to one of the directorships, and I was actually linked to pathology and radiology, so I would attend meetings either informally or their formal meetings, and so I found that a very useful way to find out a bit more about what was going on within the departments – I know they're totally clinical areas, but you know, you got to know staff more. And so I asked to carry on that. I can't remember if it NEDS linked to directorates in general stopped at the time of the merger, or whether it kind of tailed off, but I certainly did that right the way through all the years I was

a non-executive director.

And then ~~I was~~ I had meetings with the – well, at the time I think she was deputy nursing director, became acting director, [particularly among the people, and I attended meetings on – I don't know who was on the boards and that sort of thing] I cannot make sense of this section but I attended meetings and a conference on older patients, particularly concerning privacy and dignity, and this progressed to the Modern Matron meetings.. What else did I do?

So there, I was meeting nursing staff, and sometimes I would say to one of the matrons, 'Can I have a look round your department?' which I did.

DR WALTERS: So nobody was trying to sort of control your access to places or...

MS WESTALL: Not – do you mean on the – from the Trust Board's point of view?

DR WALTERS: Mmm.

MS WESTALL: No, not at all. Well, I mean if anyone had been I was not going to let that stop me doing anything. I mean I never got that impression at all. If I had any concerns I would always go either to the chairman or the chief executive, or if it was more relevant to one of the other directors, I would arrange a private meeting with them. So I never felt at all barred from anything at all, and I think I got to know – well, I think I was able to feel that other people on the staff at all levels were able to approach me if they had any concerns. But I didn't feel I spread myself over the whole Trust, I mean it was the areas where people would know me, but perhaps me rather than the other non-executive directors, better.

DR WALTERS: And did people see you as someone that they could raise concerns with?

MS WESTALL: I think so. I mean I remember saying this about comments that were made when I left rather than feeling I was [inaudible].I cannot add the inaudible word, but having left the Trust I met a consultant from Radiology who said how they missed having the direct link (via me) to the Board.

DR WALTERS:: And were you ever sort of given some sort of hot potato that you had to take back and say, 'I've been given this'?

MS WESTALL: I think there were times when things were raised with me that I felt I ought to pass on. I can't say – I'm going to struggle to think what they were now, but I certainly remember going to meetings where I felt some of the others ought to know about that. And so [inaudible].?

DR WALTERS: And then as one of the non-execs, would you generally feel well informed?

MS WESTALL: I think so. I can only say what I feel, I can't answer for them.

DR WALTERS: Yes, okay. So there weren't sort of wrangles amongst some people were less satisfied with the information they were getting at some level, you were all generally...

MS WESTALL: Yes, I think we had – we also had, not on ~~as~~ a very regular basis, but we would have the occasional meeting of just the a non-executives ~~meeting~~ with the chairman, and we could put issues to the chair. But I think ~~people~~ if people were being very concerned then we [inaudible]?.would approach the chair or a Director immediately.

DR WALTERS: Okay, [inaudible]? it's a long time ago, so thank you..

DR KIRKUP: I apologise if the noise [inaudible]. ?

PROF: MONTGOMERY: Thank you. There's just a few areas it would be really

helpful to have a bit more on. Boards differ enormously; did you have particular responsibility [inaudible]. You talked about radiology as being one of your [inaudible] particular responsibilities.

MS WESTALL: Sorry, [inaudible]? a little bit closer?

PROF: MONTGOMERY: Sorry, I'm wondering whether your Board, the non-executive directors had particular portfolios or responsibilities. You described an interest that you had in radiology that you wanted to carry on, but was there somebody, for example, responsible for keeping an eye on maternity services or did it not work like that?

MS WESTALL: I think there was another non-executive who had closer links than I did. I mean as I say, I had no links with maternity [inaudible].?

PROF: MONTGOMERY: But you weren't asked by the chairman to keep a particular eye out for areas – I mean some chairmen, like their non-execs, take responsibility for particular areas, and others like to step back.

MS WESTALL: Oh, I see. Well I mean the other thing I did was I sat on the IT Board meetings [inaudible],? I forget the name for...

DR KIRKUP: [inaudible]

MS WESTALL: [inaudible],? that's it. And then moving on to the electronic patient records and all that sort of thing, so I was involved in those meetings. I'm going to have to consult my list because I've gone blank on whether I did.

PROF: MONTGOMERY: But that doesn't sound like the sort of portfolio that I was wondering existed. That sounds as though the allocation of the meetings, and obviously the need to make sure that they're fully staffed. Can I ask you a bit more about the visiting programme? How many times would you have gone to

Furness General in a year?

MS WESTALL: In a year?

PROF: MONTGOMERY: I mean you obviously know the Lancaster area much better.

MS WESTALL: Well, obviously, because I was five years on – nearly five years on the Board there, but once – once – after the merger, I suppose probably more than a third of the meetings, slightly more than a third took place at Westmorland because most of the – most of the directors, not all of them, were based there, including the chief executive and the chair. Trust Boards, one a month, so that's four in each of the three sites ~~[inaudible]~~ in ~~of~~ the year. I'm trying to think what – certainly when I think, the radiology and the pathology meetings rotated around the three sites, so I saw them.

PROF: MONTGOMERY: And do you think you would ever have gone into the maternity unit at Barrow?

MS WESTALL: I don't remember going into the maternity unit, no.

PROF: MONTGOMERY: Do you have an impression of the difference between Furness General and the RLI, for example? One of the things we're trying to understand is the difference in the gradings in the organisation, so do you have a sense of the main differences as you perceived them, between the hospitals?

MS WESTALL: Well I think the – it definitely was recognised that the difficulty with Barrow was the difficulty in appointing particularly consultants, and the chair [inaudible]? consultant [inaudible]? because it's so stuck out on a limb. I mean that – when they are wanting to attend meetings or conferences?~~[inaudible]~~, they've got a lot further to go just to get out of the Lakes?~~[inaudible]~~. So it was

harder to appoint from outside to Barrow than it was to Lancaster.

I think some – again, you know, I wasn't linked to places where I felt there was any problem. I don't feel there was a terrific tension at all in those two areas that I had very close contact with. I think one or two – I get the impression that one or two of the other specialties would feel both ways actually. Either, you know, one side was getting all [inaudible]? or one side was getting all the – whatever it was potential. But that was purely amongst the consultants, I don't know whether that spread down into the whole departments or not.

PROF: MONTGOMERY: Thank you. The other thing I wanted to ask about was how the Board was informed of what the community and the public and patients thought. You had community health councils for some of your time, then you had patient [inaudible] involvement forums.

MS WESTALL: Yes.

PROF: MONTGOMERY: [inaudible] forums. How did you all connect with those main sessions which were about giving an opportunity for public concerns to find their way in? Were they comfortable being linked to the review?

MS WESTALL: We had – I presume that would have been covered by [Anne Strudley [?] and Emily Mederick [?] 20.02] I am sure I did not mention these names as I cannot think who they are. I do now remember that we received reports from Patient forums at Board meetings. The – would the complaints department have been – they would have been separate from that, wouldn't they? Mmm, because we used to get a regular report on complaints. I know we did have meetings, but I can't think. I can't think how they were organised.

PROF: MONTGOMERY: Don't just speculate. If you can't remember everything, that's fine. Thank you.

PROF: FORSYTH: During your time of office, were there financial difficulties you had at the Trust?

MS WESTALL: There were times when – ~~I know quite – you know~~, we knew we had several million to find at some stage, and I know leading up to Foundation Trust that it had been made clear those financial situations were being improved.

PROF: FORSYTH: Do you think that had an impact on the quality of service that they provided?

MS WESTALL: I never – I was never aware of – I mean I know that serious measures had to be made to make up the difference, but I can't honestly say that I knew as a result that the clinical area suffered, but...

PROF: FORSYTH: But you went around the hospitals and meeting clinicians. Did you get a feel from them that they were concerned that saving standards were going to impact on how you could provide a service safely?

MS WESTALL: Well, I mean comments ~~promises~~ were certainly made that they were concerned that they would, but at the end of the day, what was the result of that, I'm afraid I can't answer that something stood out in my mind.

PROF: FORSYTH: So there was no sort of – an evaluation coming to the Board indicating that the impact of the savings target was undermining some aspects of the service delivery to have an evaluation to the effect of the savings programme?

MS WESTALL: I'm afraid I can't remember – I can't answer that.

PROF: FORSYTH: If I can just take you back to appointment panels ~~[inaudible]~~ that you chaired, you said you chaired interviews for the clinical staff. And did you feel that – you said that you found it difficult to recruit in Barrow. I wonder whether you felt also the quality was not so good that was coming forward for interview.

MS WESTALL: No, I can't say that at all. In fact I can think of one or two, well certainly one interview where there ~~that I~~ was an outstanding person, so I wouldn't say that.

PROF: FORSYTH: So you weren't getting any sort of concerns around that at all?

MS WESTALL: No. I mean there were always periods where we knew in the whole, let's say North West area, or even nationally, that there was a shortage in a particular speciality ~~of whatever it was~~, and so therefore the number of candidates was small, and ~~you know~~, we might ~~would~~ be told, for instance, if there had been an appointment ~~to be~~ in the last month ~~appointments~~ made say in Manchester or somewhere, ~~and~~ obviously then, a month later, we would have a limited number of applicants. ~~can possibly [inaudible], and that's it~~.

PROF: FORSYTH: Right. Were you aware of staff moving who had come to say Barrow, and then after a short period of time moving on to a job in a larger centre?

MS WESTALL: I don't think so, no.

PROF : FORSYTH: No, okay.

DR KIRKUP: Any more questions? Is there anything else that you would like to tell us about?

MS WESTALL: No, I just wish I had a better memory.

DR KIRKUP: Right. It's all right, we do understand it's a while ago, and your period as a non-executive was coming to an end at the time when all this started to arise.

MS WESTALL: Yes, I left in the March, and as I say, I think I was certainly totally unaware of it until July.

DR KIRKUP: Well that's very useful to know that. So thanks for coming.

MS WESTALL: Thank you.

[Interview concluded]

THE MORECAMBE BAY INVESTIGATION

Monday, 3 November 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

ANGELA WHITAKER

Transcript produced by Ubiqus
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(At 3.44 p.m.)

DR KIRKUP: Okay. I'll say again, thank you very much for coming, and for the record, my name's Bill Kirkup. I'm Chairman of the Investigation...

PROF FORSYTH: Stewart Forsyth. I'm a paediatrician and I'm Medical Director in Dundee, in Scotland.

DR KIRKUP: We are making a record of proceedings, and we'll produce an agreed record at the end. You know that we do normally have family members present as observers at these proceedings.

MS WHITAKER: Yes.

DR KIRKUP: We don't have any this afternoon. They may ask to listen to the recording subsequently. So you just need to be aware of that.

MS WHITAKER: So the interview is recorded?

DR KIRKUP: Yes. That's it. That's correct. Is that okay?

MS WHITAKER: Yes, yes, that's okay.

DR KIRKUP: Alright. You also know that we've asked you not to make any recordings of proceedings, because we don't want anything to go out of the room until we're ready to produce a report with everything considered in context. And it is – we are grateful to you for coming along. It's important that we hear from as many people as we can, as many different perspectives. We've heard from – what are we up to? 80 something?

MS WHITAKER: I was told I was 88.

DR KIRKUP: It's a good number. So do you have any questions for me about process?

MS WHITAKER: No, I don't. But I might not find it easy.

DR KIRKUP: Yes. Okay. There are all sorts of reasons why you might not find it easy. Perfectly understand that. If, at any time, you want to stop and pause and have a think, or have a glass or water or have a break, that's fine, just ask, and we will absolutely do that. Alright.

I'm going to start off with a very straightforward question and then hand over to Stewart, and my question is can you just outline of us how long you've worked at the Trust and what you've done?

MS WHITAKER: Do you mean the last job that I had?

DR KIRKUP: Not just that, no. How did you start out?

MS WHITAKER: I trained at Lancaster. In '75 I did my registration there, and I did Midwifery and I qualified there, and practised there for a number of years. I've – I suppose I'm a bit like a boomerang. I've been in and out and in and out over a period of – well, since 1975 until when I left in 2013. So during that time I worked as a staff nurse, I worked as a midwife, I worked as a sister.

I specialised in neonates eventually, and that's where I'm – moved up to – well, as I was matron, the final job that I did there. But I worked there for many years, and I worked in all different areas. When I had my own family, I worked on the nurse bank, so I did lots of different things, but chose to go back to neonates.

DR KIRKUP: Okay. What took you from midwifery to neonates?

MS WHITAKER: I found that I was interested in the babies, you know, I liked to care for babies at birth, and I found that that was what I wanted to do.

DR KIRKUP: Okay. So you became paediatric matron in 2007?

MS WHITAKER: I was a neonatal matron.

DR KIRKUP: Neonatal matron. I need to get the terminology right there.

MS WHITAKER: Yes, I just mean – which means that I was just responsible for the care of sick new born babies.

DR KIRKUP: Yes, and that went on till August 2013?

MS WHITAKER: 2013.

DR KIRKUP: Yes. And you left then?

MS WHITAKER: I left [redacted]

DR KIRKUP: Okay.

MS WHITAKER: I went off [redacted] in November 2012.

DR KIRKUP: Okay. Sorry to hear that. I hope it's worked out okay since.

MS WHITAKER: It has taken 18 months really to feel anything like but, you know, that's how it was.

DR KIRKUP: Okay.

MS WHITAKER: But yes. I feel better.

DR KIRKUP: Thanks for explaining that. That's very helpful. I'll ask Stewart to continue.

PROF FORSYTH: Can we just start with when you took up post of paediatric matron back at neonates [inaudible]. Can you just describe what that was? What

areas you covered and where you were actually based and such like?

MS WHITAKER: Sorry, it's – I talked to Linda earlier and this whole [inaudible] a blur. The job changed dramatically throughout the time that I took up the post. Initially I was responsible for the neonates on the Royal Lancaster Infirmary site. I acted up for a while before I got the official post, and I was well aware of the job that I had to do there. It was then expanded to take over the Barrow site as well, and that was because the person who had been acting as matron retired. So...

PROF FORSYTH: Roughly when would that be? Do you know?

MS WHITAKER: I think I went probably – she probably went about the end of 2007, 2008. I hadn't really long been in post, but I had been acting up before I actually took on the post. But initially it was just for Lancaster and then became for Barrow as well.

PROF FORSYTH: So at that time how big was the unit? How many staff were you looking after in Lancaster and in Barrow?

MS WHITAKER: Staff at Lancaster's probably about 36. I'm sorry, I've not wanted to think about anything to do with it since I left, so...I haven't wanted to revisit any of it. It's probably about 30, 35 staff in Lancaster. And I can't remember how many there were in Barrow, but it was a much smaller unit. Probably between 15 and 20 staff.

PROF FORSYTH: In terms of when you first took up the post, this particular post, what were the sort of difficult aspects to the job, that you felt you needed to address when you took up the job?

MS WHITAKER: Initially when I took up the job in Lancaster, I was first asked to work ~~in~~ clinically and management, to do a dual role. That very quickly became impossible. It very quickly became very difficult, because there were a number of quite difficult staffing issues, and I found myself pulled more and more in towards the management side, and I felt that I couldn't maintain a high level of care and keep my practise up to date. Because I'd worked as a specialist practitioner with the neonates, and that was the expectation that I would continue to do that as a matron. Because hands on - I wasn't getting the hands on very often I decided I would go via the management route, because that was where the <u>need</u> ~~call~~ was, and what was necessary at the time.

PROF FORSYTH: So what were these initial pressing issues that...were they staffing issues? Or..?

MS WHITAKER: There's always staffing issues. The – well I had a particular problem. This was peculiar to my area at that time, and of course it happens everywhere where there are people. [redacted] an issue [inaudible]...

PROF FORSYTH: This was in RLI?

MS WHITAKER: This was in RLI. We subsequently – it is complicated, I'm sorry. It had gone on for years, [redacted] I didn't support any of the – the brief for any of those investigations. I didn't have any input as to what we were looking at. It was decided that this is what we would do and this is how we would do it, and I didn't agree with the way any of it was done.

Consequently, it caused a lot staff upset and – not some – I suppose there was some conflict. But it really caused a lot of problems amongst the staff on the RLI site, and subsequently it went to the Barrow site as well. It all became very difficult.

PROF FORSYTH: So how did it spread to the Barrow site as well?

MS WHITAKER: It spread to the Barrow site because the person [redacted] moved to the Barrow site.

PROF FORSYTH: [redacted]

MS WHITAKER: [redacted]

PROF FORSYTH: [redacted]

MS WHITAKER: Well, the suggestion was, because of what had happened, [redacted] agreed to that and [redacted] went to the Barrow site.

PROF FORSYTH: And so [redacted] went willingly?

MS WHITAKER: [redacted] didn't have a choice, really. [redacted] But that is certainly my experience.

PROF FORSYTH: Would you like to tell us who that was?

MS WHITAKER: Does it make any difference to this? I don't want to name names. It's not fair on the person.

PROF FORSYTH: It may do. We can come back to that. [Inaudible].

MS WHITAKER: You know, it was never proven, though my own experience was that that's certainly how I perceived her behaviour to be.

PROF FORSYTH: Okay. So you – this is a difficult start in RLI, and then what – you were then given also responsibility for Barrow.

MS WHITAKER: Yes.

PRO FORSYTH: So when you took over responsibility for Barrow, what were the sort of – your initial concerns then, or perceived difficulties?

MS WHITAKER: I found it a very hostile environment, and I quickly learned that Barrow was very resentful of anything or anyone to do with Lancaster site, and I found nursing [inaudible] extremely difficult, and the medical staff quite difficult.

PROF: FORSYTH: You're talking about paediatricians?

MS WHITAKER: Yes. The nursing staff who, in particular, were very reluctant to change any kind of practise. They – it was – it was really like going on back in time I suppose. It wasn't that I wanted them to be a carbon copy of Lancaster, but because we were the same Trust, it was important that we were doing things in the same way and that our practise was the same as it was in Lancaster.

I was proud of the team in Lancaster, with the standard of care that we had, and some really excellent staff who were updated, who, you know, did all the right things really. But the Barrow staff were very reluctant to engage with any kind of change at all, and the attitude seemed to be that, 'This is the way we've always done it, and we're not going to change now.' They were an aggressively hostile group of women.

PROF FORSYTH: Just to be absolutely clear. These were the staff who were involved in the neonatal unit. Not the paediatric wards?

MS WHITAKER: No, no. This is only neonate.

PROF FORSYTH: Just the neonatal unit.

MS WHITAKER: I'm only speaking about neonates.

PROF FORSYTH: Yes, and so there was a relatively small number of them, you said about 15 to 20.

MS WHITAKER: Yes. They were a very difficult group of women.

PROF FORSYTH: And did you feel that their practise was potentially harmful?

MS WHITAKER: I think yes, I do, actually. Yes, I do. And that I could see to some extent the reason – there was no excuse for them not updating and for not engaging with current and, you know, practise. But what I found that I could understand was that because they had very little confidence in the paediatricians with whom they worked, they were very reluctant to take any kind of authority position or responsibility. They wouldn't do it. Because they felt that they did not have the backing of the paediatricians. Or the paediatricians themselves, some of their practise was questionable.

So it was a very difficult situation for them, but also they were very – I found them very difficult to even move forward. They didn't want to move forward. They didn't want to be in a position where they had to be responsible for anything.

PROF FORSYTH: So who was your line manager?

MS WHITAKER: My line manager was the Head of Paediatrics.

PROF FORSYTH: Right. So who would be – who would that be at that...

MS WHITAKER: That's Lyn Shannon.

PROF FORSYTH: Sorry?

MS WHITAKER: Lyn Shannon.

PROF FORSYTH: Lyn Shannon. Right. And how did – did you feel you got support there?

MS WHITAKER: Lyn was brilliant. She was very supportive.

PROF FORSYTH: Alright.

MS WHITAKER: Yes. She was always supportive with me, and I've known Lyn for a long time because I'd worked in her department over the years, so we knew each other very well.

PROF FORSYTH: And so, with the support of Lyn, did you still have difficulty in trying to bring about change in Barrow?

MS WHITAKER: Oh yes. Yes. Yes, any attempt to update anyone, to change anything, was met with hostility and, you know, I had five of them and with the

small group they were it was a significant number who threatened that they would go off sick. They were quite happy to go to Occu Health and to complain about stress and that they're having pressure put on them. And those kind of things.

So it was very difficult to manage that group of women. And to fulfil the needs of the service because, at that time, there was a huge restriction on the amount of money we could spend. So any staff that were missing, it was very difficult to replace them in any case, because Barrow was a very difficult area to recruit for. And it meant having to take staff from the Lancaster site, which was in danger of compromising the care of the neonates in Lancaster, and that's not [inaudible].

PROF FORSYTH: And do you have a specific example of a particular area you wanted to change, that you could illustrate this with?

MS WHITAKER: In what way?

PROF FORSYTH: Well, if there was some aspect of clinical [inaudible] –

DR KIRKUP: Clinical practice.

PROF FORSYTH: That you wanted to change. But in fact they were particularly resistant to do that. I just wonder if you wanted to illustrate that for the – as a...

MS WHITAKER: The whole thing. Everything. Everything. It was updating with equipment. It was being familiar with the use of Cpap ~~c-cup~~ drivers. It was everything. They were not willing to engage in updating training. They were just – and even things like doing cannulas. Cannulation. I mean, it's a fairly common practise that registered nurses will cannulate babies. They wouldn't do that. Or very few of them would do that. It was only a couple who would do it willingly. And that kind of thing. They were very resistant to do anything like that. And even, you know, basic care of babies. Their practise in some respects was out-dated. You know, the kind of things that they did.

PROF FORSYTH: What, things like feeding machines?

MS WHITAKER: Feeding machines. Yes. Yes.

PROF FORSYTH: And so did this go higher up into the organisation? Did Lyn Shannon take this to her line manager?

MS WHITAKER: I'm sure she had many discussions about the difficulties that we were having at Barrow. On the unit. And I think also she had the additional

issues with the medical staff at Barrow, so it wasn't just the nursing staff, it was the medical staff as well. So Lyn would have to speak for herself. But I know it wasn't just that. It was also the medical side as well as the nursing side.

PROF FORSYTH: What about the relationship with the midwives and obstetricians?

MS WHITAKER: We had really – I, personally had not a lot to do with them. And the – there seemed to be real issues between obstetricians and paediatricians at Barrow. I was aware there was that kind of, you know, battle going on. But I was never involved with that at all.

PROF FORSYTH: We've heard about arrangements for babies being admitted to the special care areas. Was there a good understanding between midwives [inaudible] and yourselves?

MS WHITAKER: No. One of the issues that I had was that babies appeared to be admitted unnecessarily to the baby unit. The suspicion of that was to look like they had a need for the unit because we had so many admissions. But when you looked at some of those cases, it was questionable as to whether the babies really needed to have been admitted, and certainly to have stayed sometimes for as long as they did stay. But the – between the paediatricians and the obstetrician there did seem to be issues. And particularly to do with any pregnancy that might have been at risk. An early pregnancy or where there were issues of health to the baby or to the mother. Sometimes it appears that the obstetricians would keep those mothers a lot longer than they should have been. They should have been transferred out.

PROF FORSYTH: Were you ever involved in discussions whether a mother should be transferred out or not?

MS WHITAKER: Not really, no. I was aware of sometimes when it had happened, and I was more involved with when babies been born. But then not transferred out as quickly as they should have been, and that did happen quite a lot.

PROF FORSYTH: Why – what was the difficulty there? Where the obstetricians reluctant to – for the baby to have been transferred out? Or the paediatricians?

MS WHITAKER: It was the paediatricians and obstetricians prior to delivery.

PROF FORSYTH: They didn't want the baby to be transferred out?

MS WHITAKER: Sometimes that's how it appeared to be. That they wanted to keep them. But when we drew up quite strict criteria as to what level of care the units worked, Barrow was a level one unit, low level. It was the lowest level unit.

PROF FORSYTH: Yes, level one, yes.

MS WHITAKER: So any baby that required any kind of intensive care service should be transferred out as soon as possible. That didn't always happen as quickly as it should have done.

PROF FORSYTH: And did that result in, obviously poor care and potential outcomes as a result of that?

MS WHITAKER: Yes. I'm sure it did. Yes. I would be very surprised if it hadn't done, and I'm sure you were aware of the case where they needed high levels of [redacted]

PROF FORSYTH: We'll have a discussion when we go off the recording to talk about individual cases that may raise issues of clinical confidentiality.

MS WHITAKER: Right, I ~~can~~ understand.

PROF FORSYTH: What about – maybe it's where initially delivered and looked after – and either in labour suite in the process? Or did you feel that sometimes there were babies who were becoming unwell and that not being recognised in labour suite, or post-natal wards and slow in inform yourselves of that?

MS WHITAKER: I think that that – and I can't remember any particular cases that I am aware that that happened quite a lot. But it seemed that midwives didn't pick up things as quickly as maybe they should have done. But that's anecdotal. I wasn't immediately involved.

PROF FORSYTH: Were you involved in any of the training of midwives?

MS WHITAKER: No, you know, we have a practice educator, a [inaudible] practice educator who was very hands on, and did her best to update the midwives. She set up a whole program herself.

PROF: FORSYTH: When was that updated from? Was that in – around in 2007?

MS WHITAKER: [Inaudible] it would have been around that time, if not a bit later. It probably came out as a result of one of the other cases.

PROF: FORSYTH: Right, okay.

MS WHITAKER: Who I won't mention the name.

PROF FORSYTH: No, no, that's okay. You can feel free to mention the name. It's just that we mustn't talk about the details. That would be the Joshua Titcombe case

MS WHITAKER: Yes.

PROF FORSYTH: Yes, okay.

MS WHITAKER: She did [inaudible] various other programmes.

PROF FORSYTH: What about staffing numbers? Did you feel that you met the recommended numbers to cover neonates across both sites?

MS WHITAKER: No, I don't think we did at that time. Barrow was always run on a minimum of staff. Which was understandable because of the activity levels that it had on the whole. So – it's difficult, really. If you look at what the requirements are, there's nothing that's actually stipulated, 'This is what you must have', because even though you may have ten cots in your unit, or six cots in your unit, it depends of the need of those babies and whether they're special care, [inaudible] or intensive care babies as to how many staff you may need. So the tendency was to run on the, you know, the minimum number of staff.

The difficulties - if we had the amount of staff that we considered were the – was the minimum, we could manage with that most of the time. But we often had sickness and absent people. Particularly on the Barrow site and where there was – you couldn't leave the unit with only one member of staff there. So we were forever having to try and support the Barrow end from Lancaster and, as I said, there was huge restrictions from finance at that time, and it was very difficult to be able to replace with bodies, or justify the amount of money that staff were going to cost. I couldn't find the staff anyway. So it was always a battle to find staff to...

PROF FORSYTH: There were some changes made, weren't there, around – there was a transitional area? Was there a transitional area?

MS WHITAKER: At Barrow?

PROF FORSYTH: At Barrow.

MS WHITAKER: They've changed it. I mean what – it is now. It's different now.

PROF FORSYTH: Yes.

MS WHITAKER: And I was involved with working towards the changes that there are, and now the – what was the special care baby unit has moved – excuse

me – onto the post-natal ward. And there are some transition cots there as well, I think. But I've not seen, you know – I didn't have anything to do with it once it was, you know, once it was all done.

PROF FORSYTH: Just trying to pick up any – I mean, I'm interested – because of the staffing I think there was – because you have, just so I've got the geography right, you had the – obviously the post natal wards, and then there was, I believe, I thought there was a sort of transitional ward around labour suite was it, around…

MS WHITAKER: There wasn't when I was there. It was a separate special care baby unit. It was a separate unit.

PROF FORSYTH: And then there was a separate unit. But I thought that then there was a separate special care unit as well? I just thought there was some comments made in relation to – and had with staffing and things.

MS WHITAKER: No. There was just a special care baby unit, which was just a ward. And then there was the maternity ward, which was separate. It's since changed and, as I say, there are transitional cots as far as I understand.

PROF FORSYTH: Right and smaller special care…

MS WHITAKER: Yes.

PROF: FORSYTH: Okay. Do you want to?

DR KIRKUP: You've spoken about the really difficult situation that faced you with the neonatal nursing staff in Barrow. You mentioned a little bit as well that the – there were difficulties with the consultant paediatric staff, and I just wondered if you could expand a bit on that, and say, you know, what was the response to that? And I appreciate it wasn't your problem to sort out, but do you know, you know, was anybody making the attempt to –

MS WHITAKER: I think there were. I think there had been some attempts. From what I understood, some of the medical practise perhaps wasn't as robust as it might have been. There were some questions over some of the practitioners. And I think the – I can't even remember what it's called now. The paediatric, the clinical chap in charge…

DR KIRKUP: From Lancaster?

MS WHITAKER: From the – he was over both sites, so the one – and it was always someone from Lancaster, because it was – there were two that I was aware of when I worked there. One who is still in post and the other one who is not in

that role now, and I know that they had tried to address some issues with the paediatricians, which were very difficult, and I don't think were ever resolved.

DR KIRKUP: Right.

MS WHITAKER: As far as I understand.

DR KIRKUP: And was that done in conjunction with you? Or was that done on a completely separate track?

MS WHITAKER: They were done – I was aware of them, because the team that I worked with, we got on well together. So it wasn't that we were working in our own little silos. We did actually work quite well together. But the responsibilities that were his responsibility for the medical staff were – that was his responsibility. And of course it did impact on the nursing staff and the babies, but he would deal with those medical staff. I think he probably hit his head against a brick wall with those issues.

DR KIRKUP: Okay. That would have been Paul Gibson?

MS WHITAKER: Yes.

DR KIRKUP: Okay.

MS WHITAKER: It would be Paul, and then subsequently it would be...

DR KIRKUP: Yes, okay. You say he probably hit his head up against a brick wall. I mean, did you get any feedback about the outcomes? Or did it just disappear as far as you were concerned?

MS WHITAKER: The – what I know is only what I have been told. So it's not directly what I have first hand knowledge of.

DR KIRKUP: It's still of great interest to us. Because it reflects what people were talking about in the unit.

MS WHITAKER: It – I think Paul tried to raise some issues with one of the paediatricians, and it all turned on him and, in the end, he became investigated for harassment and that kind of thing.

DR KIRKUP: Yes. We did know that.

MS WHITAKER: Yes, and that was what I was aware of with Paul. But Paul was simply trying to do his job, and to, you know, to right a wrong, if you like. You know, he wanted to correct poor practise, and you know I have every respect for Paul. He's a really good doctor. Whereas other medical staff I couldn't say that about them. Paul I could say that about. He's an excellent doctor.

DR KIRKUP: Right, okay. And in your – was it your impression that that turnaround,

where it impacted on him and then he was investigated, did that damage his position and the ease with which he was able to try and tackle those kind of issues?

MS WHITAKER: Yes. Definitely he'd had his fingers burned. So I think he backed off from that. That's really what I think he did. And I think it hurt him, as a person. I don't think he –

DR KIRKUP: And I'm not asking you to comment on his behalf, but I'm specifically interested in what was the impression of the staff around, that you picked up? Did they say, 'Oh well, that's him put back in his box' – I don't want to put words in your mouth to too great an extent, but was that the reaction to it?

MS WHITAKER: I don't know. I don't know how it went. I think the medical staff at that time, and in fact the person that did raise that complaint against him, isn't working for the Trust any more.

DR KIRKUP: Sure.

MS WHITAKER: So that's probably a good thing. But there seemed to be an attitude of, 'It's Lancaster', so there was this kind of unspoken war going on between the two sides. So was just nonsense really, at the end of the day. But that's what it seemed to be like. So I never heard anybody make that kind of comment, but I wouldn't be surprised if that's how they felt.

DR KIRKUP: Okay. Okay, that's helpful.

MS WHITAKER: No...

PROF FORSYTH: I was about ask, sir, something that we mentioned earlier. So, yes, so I mean clearly there was concerns. There was concerns that you, as a matron. There was concerns about the head of – from the head of paediatrics [inaudible] they'd had concerns from the clinical director. Why wasn't – did this go – I mean, can you tell us, did it go higher? Did it get up to executive team?

MS WHITAKER: I'm sure it did. I'm sure there were conversations that were had about the – in fact, I'm sure it was the, kind of, hot potato that we'd – that was balanced between the executive board at the time. There was a lot of discussion about the issues at Barrow, and especially after Titcombe it was certainly raised with the exec board. I'm sure it was, but there were issues that, to me, seemed to be very difficult to resolve in any way.

I mean, you probably are aware that we had two paediatricians at the

Barrow site who were not practising for a very long period of time, and that went on for years. And there was that kind of thing going on, which – you know, I understand, you know, Medical Defence Union, and all that kind of stuff. It's very, very difficult for the staff who were trying to do the job. It made it extremely difficult. The executive board were well aware of what was going on, but I think what they did – nobody knew how to make it right, and I got the impression strongly from the nursing side and the medical side that actually none of this was new. It was – it had been like this for years, the way that babies were looked after, were managed, from medical and nursing perspective. That's how it had been for a very long time, and had been left unchallenged for a very long time. There was no easy answer and I think we often got to the point of saying, 'There's no easy answer to sort this out. How do we sort it out?', you know.

And also because of where Barrow is it did not attract good quality staff. I don't mean that unkindly. It just didn't. You know, if you were a career paediatrician or even someone in the nursing profession who wanted to progress as far as they could, your opportunities in Barrow are very limited. You know, so we didn't attract higher calibre staff, and that's the reality of it. The people who worked there would be very upset to hear me say that but, you know, looking at it from the outside I'm sure that is something to do with it.

DR KIRKUP: You mentioned two consultants who weren't practising. Did they still have some sort of role in the hospital? Were they given non-clinical work to do in the hospital?

MS WHITAKER: For a very long time they didn't do anything which was [inaudible] anyway.

DR KIRKUP: But they're still on the payroll?

MS WHITAKER: Mmm.

DR KIRKUP: Yes.

MS WHITAKER: It was – sorry, I shouldn't say that really. We found it very difficult to accept that that was okay, that these guys would wander in and out and do nothing.

DR KIRKUP: And that's exactly why you should say something please, because we need to understand what the perception of that was and what effect it had on the staff. It's very relevant to all of this. So, yeah, so you've got these two

people who are still on the payroll but they're not practising, and then were they given non-clinical roles?

MS WHITAKER: They didn't – they weren't when I was there.

DR KIRKUP: Right.

MS WHITAKER: Subsequently I think one of them was given guidelines to update. I was disgusted with the whole thing. I just thought it was completely immoral and wrong, yeah. And I didn't understand why they weren't given things to do that were non-clinical, you know. I think the senior team were very concerned about that situation. Myself and I know Lynn[?] was very upset about it. And my other colleagues were – the people on the shop floor, the nursing team, certainly I don't know how they really felt about it. They just knew that these guys were around but not appearing to do very much. But there was also the feeling that it might be to the patients' advantage if they weren't actually doing anything clinically.

DR KIRKUP: Yes. Surely more to the patients' advantage would be if they'd been replaced by people who were competent and who were doing things clinically.

MS WHITAKER: Absolutely, and we did recruit after that. Well, after some time. There was a period where they were very short staffed, but it's really difficult to recruit paediatricians to Barrow. And I think we tried to employ on a number of occasions when I was in post and there was just no applicants, or then you'd have an applicant and you would just grab that person because there was nobody else, you know, regardless of really what, you know, the quality was.

DR KIRKUP: Yeah.

PROF FORSYTH: During this time did you feel, you know, when you went home at night, did you feel anxious about the safety of the babies in the unit?

MS WHITAKER: Of course I did, yeah. I was very concerned about them.

PROF FORSYTH: And did you think seriously the unit was unsafe?

MS WHITAKER: Yeah. Yes I did, and partly I – one of the reasons why I tried to update the nursing staff, I wanted them to be – take more responsibility and be competent, and where there were shortfalls in the medical staff use these girls to identify what the problems were with the babies. And, you know, to – for them to see the alarm signs, to recognise, 'Actually, there's something wrong here'. Whether the paediatrician wants to get up and have a look or not, they should know that there is something that they need to act on, and – but they

weren't willing to do that.

PROF FORSYTH: So did you not make any progress at all?

MS WHITAKER: It felt like it. I did try obviously.

PROF FORSYTH: Yes, yes, yes.

MS WHITAKER: I think the situation has improved now, because – and I'm not there. I think probably – I don't know. I don't know that it made any difference to be honest. I felt like I was bashing my head against a brick wall, but the staff that I did send there and the staff that was sent there, the member of staff that was sent there from Lancaster, albeit she went there because she wasn't really given any other choice, she was actually a good practitioner. So I think from that point of view she would have been a better example. She would have been a good example to her colleagues. So that would have been a positive outcome.

PROF FORSYTH: So did this difficulty with – you've mentioned these individuals, [redacted]

MS WHITAKER: I don't think it helped. I think I had many years of this person being a problem to me.

PROF FORSYTH: So this person was in Barrow and you [inaudible] so that continued to be very difficult as it was –

MS WHITAKER: Yes, it was. Yeah. It was and, you know, I was told – I was warned by staff and said, 'She's out to destroy you', and, you know, that's really how it felt. Whether or not I just became paranoid I don't know, but I found that she would email me with ridiculous demands. But she was very good at knowing what her rights were, and she put pressure on me all the time, and I found her very, very difficult.

PROFESSOR FORSYTH: Is she still there?

MS WHITAKER: Yeah. As a practitioner she was very good.

DR KIRKUP: Not so good on the human relations.

MS WHITAKER: It depends who you were. This is only my opinion, you see. You might meet her and feel that she's an absolutely lovely person. She wouldn't – she knows how to play people.

DR KIRKUP: Yeah. Okay. But was this just you that was on the receiving end of this or were there other people who were on the receiving end of it?

MS WHITAKER: No, she would target people.

DR KIRKUP: But not just you? That's important.

MS WHITAKER: I seemed to be continuous, whereas she would then choose and target different individuals.

DR KIRKUP: Why do you think that was?

MS WHITAKER: She hated the fact that I was the matron. She didn't like that at all.

DR KIRKUP: Okay.

PROF FORSYTH: Okay. Did she want to be the matron or is she just –

MS WHITAKER: Yes, I think she probably did. She probably thought she was far more suitable, but she was a very destructive character.

DR KIRKUP: It would seem so. Do you have any more questions on the general parts?

PROF FORSYTH: No, no thanks.

DR KIRKUP: Can we move into the second part of the interview then, because there are some questions on there that raise issues of clinical confidentiality, and at that point, although we'll still carry on making a record just for our own internal purposes, this doesn't become disclosable to anybody. So you are – we're all now bound by the rules of confidentiality.

MS WHITAKER: Okay.

DR KIRKUP: Is that okay? Right.

[The remainder of the meeting was heard in private session]

THE MORECAMBE BAY INVESTIGATION

Tuesday, 15 July 2014

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

Before:

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

ROGER WILSON

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THE CHAIRMAN: I'm Dr Kirkup, I'm the Chair of the Panel. I'll ask my colleagues to introduce.

DR WALTERS: Geraldine Walters.

PROF FORSYTH: I'm Stewart Forsyth, I'm a Paediatrician and a medical director from Tayside, in Scotland.

THE CHAIRMAN: You'll see that we're recording proceedings, and we'll produce an agreed record of what's been said today. You'll also know that we've removed all recording devices, telephones, tablets, whatever from the room, including panel members. Just to reinforce the fact that it's important that nothing we talk about in the room leaves the room until we produce the final report, with everything in context and taking into account all the evidence. We do sometimes have family members present as observers during these proceedings. As it happens, there aren't any in this session, but they may exercise the right to listen to the recording that's being taken. Do you have any questions?

MR WILSON: I'm clear about the process, thank you.

THE CHAIRMAN: Okay. I'll start off with a general question, and then hand you over to Geraldine. My general question is can you tell us when you started at the Trust and what you did when you left?

MR WILSON: Yes, certainly. I started with the Trust in July 2007. I was appointed in March 2007 as a Director of Human Resources and Organisational Development and I left the Trust, still with the same job title at the end of June 2012.

THE CHAIRMAN: What have you done since then?

MR WILSON: I decided to take a slightly different tack and settle in consultancy, so I've been an HR and OD consultant, working primarily within the NHS for the last two years.

THE CHAIRMAN: Okay, thank you. Geraldine?

DR WALTERS: Hello Roger, so when you first started working in the Trust, what were the big issues going on, sort of within the organisation and in your role?

MR WILSON: Yes, okay. Several things really, Geraldine. I recall being interviewed somewhere on or around 21 March 2007, and as you're probably aware, the staff survey, the national staff survey was published in – at the end of, towards the end of March of every year. So, the staff survey wasn't out when I was interviewed and following the offer of the employment, the staff survey came out and when I read it I was really quite deeply shocked. Genuinely, so much so that I considered reneging on the offer, because I thought, 'That's a huge, huge mountain to climb', and you know, what it sort of said to me was that people were really, really disaffected; they were really disengaged; they were unhappy but they'd stayed there for a long, long time, and that was always going to be one of the challenges because, say, for argument's sake, if you lived in Barrow and you wanted to work in the NHS, and you wanted to work in acute care, the only, really, place you could work at, realistically, was Barrow.

That was the sense then, and then I gave myself a talking to, and decided that I would take up the offer and I would go on to take on the challenge, really.

So the other big issue – the staff survey, I think, was all-encompassing, really, in terms of morale, and where the organisation sat in terms of their acute peer group ~~[inaudible]~~The Trust was in the lowest ranking category

across a number of survey areas. Sickness absence was somewhere around 8%, so it was very high. I did a day - ~~[inaudible]~~ in each site before I started full-time in the role, so I visited Lancaster, I visited Kendal and I visited Barrow. I talked to managers and broadly asked them the same question, 'If you were the new Director of HR and OD, what would you do?'

One of the consistent responses to me was bring somebody called Steph back. Now I can – I don't know Steph, but Steph used to manage sickness absence within the organisation; she was part of the HR team. And I was always very clear with the managers when I talked to them that Steph wouldn't be coming back, nor would anybody else manage their staffs absence within the HR function. The managing absence, we would support managers to manage absence, and we would give them the skills and a policy and all of those things to help them manage absence themselves.

Other issues, was a huge equal pay legacy in the organisation. So there was – equal pay really was an issue that started in the north of the county, north of Cumbria, and there was a big increase in the number of claims. There was a solicitor who was – in Newcastle, who was running a no-win, no-fee sort of campaign and bringing a lot of people on-board. So there was really quite a big issue in the organisation at that time.

One of the other ones which you'd probably regard as being peripheral was there was still about 1,000 people on the ~~monthly~~ weekly payroll; the rest of the NHS had moved on, ~~much beyond that~~from that situation (ie weekly pay) quite a while ago.

So I think there was – to conclude, really – there was a whole host of issues specific to my portfolio. We didn't know what the appraisal rates were in the

organisation; we didn't know a lot ~~of manager training and clients we had~~Our mandatory Training Compliance rates; our staff survey was low; our absence was high; engagement was low; we had a big threat hanging over us around equal pay and work of equal value; and there were a lot of people on weekly pay.

I think we had some practices that needed to change and thinking that we needed to modernise – I think that is the best word for it.

DR WALTERS: And would these things, then, that were coming up at the Board.

MR WILSON: Well, that's interesting. I remember having a conversation with Karen Westall (one of the NEDs at the time) when we did the first position statement around appraisal and ~~manager~~ mandatory training, because I remember Karen had commented at the time, the figures were really, really poor ~~[inaudible]~~ (when we did a stocktake) and I asked the question ~~[inaudible]~~ of Karen what were they ~~[inaudible]~~ last year? Karen couldn't answer the question because they hadn't presented to the Board, if you follow my logic. So, we didn't know where we were last year; but we know where we are now, because we tried to quantify and understand how many people do have live appraisal, how many people ~~do have manager~~ had completed mandatory training in the organisation. So did it get discussed a lot at the Board? Yes. We – very early on, I embarked upon a consultation process through the summer of 2007, around a new ~~people~~ People ~~strategy~~ Strategy for the organisation, which then we launched – I can't remember the detail, it was somewhere around the end of 2007, maybe early-2008 (it was October 2007). So, every month there would be – we also developed an operational plan that sat underneath the people strategy, so what will we achieve in the first 12

months? And we used to monitor progress against that plan at every Board meeting.

DR WALTERS: Okay, so you've got some air time at the Board and you've got a plan, then. Was any of it resourced?

MR WILSON: Well, I think in terms of resource, we were, at the time – again, another important piece of context was coming into the organisation, which we ~~was~~ were fully aware of, the organisation had had a longstanding debt issue and had received a loan from the Department of Health, as I recall. What effectively ~~[inaudible]~~the situation was and so I knew the context in which ~~it was~~ I was moving into the organisation. So, I think you go into the organisation, given the knowledge of that context, to say, 'There is not going to be a huge amount of money to resource this'. But what I wanted to do, what I needed to do, was ~~resource~~ resourced, and say, for argument's sake, in 2008, we started – which marked the 50th Anniversary of the NHS – we launched our first, sort of, loosely termed, 'Summer of Celebration'. So, we wanted to try ~~and recognise~~ and develop staff recognition, for long service awards, staff achievement awards, staff recognition awards, you know. We got that set up, and that was supported well by the Board. I was able to reshape my senior HR team, bringing in a new deputy, a Head of Human Resources. As with all these sort of occasions, and yes, there was quite a lot of churn around some of the senior posts, as a new person comes in, people will move on, that's the way the world is. I was able to bring some people in, I had worked with before.

DR WALTERS: So, a bit of resource, then, of the sort of feel-good...

MR WILSON: There was resource for staff recognition, yes; and certainly, I wasn't under any pressure to reduce the resources we had. We reshaped where we

worked; we introduced ~~[inaudible]~~ HR Business Partners as opposed to - and tried to instil in the HR Business Partners that they were very much part of the divisions, of their areas; and they were expected to – you know, they had permission to act, and we gave them a context in which to work differently and coaching and support to help them do their jobs.

DR WALTERS: Okay, being there's also the issue around financial turnaround were there sort of ongoing ~~CIB~~ CIP ~~[?]~~ programmes?

MR WILSON: Yes.

DR WALTERS: And what do you recall the impact of headcount reductions in layman's...?

MR WILSON: Well, I can't remember – what we never did, but what I can recall – and I would – if you wanted a really detailed answer, I know what was in the Integrated Business Plan that was put forward to Monitor, which will have, all of the year-on-year, the plan – but there was never a big piece of work where a number of people left. So I can't ever remember making anyone compulsorily redundant. I can't recall that; I'm not saying we didn't, I just can't recall. We ran things like ~~reaching~~ introducing a mutually agreed resignation scheme, which was a national scheme anyway, and we were able to support some people to exit the organisation around that.

DR WALTERS: But do you think this was then – could some of that been at the business partner level?

MR WILSON: Simply, well, yeah. I mean, if you think about the layers, the layers of my function. So I was Director of Human Resources and Organisational Development; we had a Deputy Director of HR; a Head of HR and then Business Partner. But it wasn't that I was – I must make the point that I

always try to be, not too remote from them. I'll try to sit down on a Thursday morning when they had a team meeting, if I had some time, and capacity, that I will sit down and help them to understand how they're working in context. I also had regular 1 to 1 meetings with my reports.

DR WALTERS: But presumably, if you've got a sort of division having a strategy of not recruiting to make – in order to save money –

MR WILSON: I wouldn't be very close to that. That was never, from a strategic perspective, it was never encouraged.

DR WALTERS: But then there was probably not any assurance around it that it wasn't going to happen?

MR WILSON: Well, one of the challenges for the whole of the northwest, to be honest with you, and when we used to go to HR Director meetings at NHS Northwest, one of the first slides I was ever shown was the slide looking at headcount. I think ~~it~~ there was an overbearing pressure around reducing staff, but certainly in 2010 as a Board, I remember a ~~time~~ Board time out event [inaudible], and we absolutely adopted the principle of the employment ~~[inaudible]~~ over earnings. We didn't want to lose a lot of people in terms of ~~[inaudible]~~ huge reductions in headcount, partly due to clinical quality, and partly due to awareness of the communities in which we sit, really. If there was – if we were taking a lot of posts out of healthcare in Barrow or Kendal, we were the biggest employer in each of the towns, it would have a huge economic impact and we were very conscious of the fact that Cumbria, as a wider county relied heavily on public sector employment. So there is this multifaceted approach –

DR WALTERS: Yes.

MR WILSON: But we did as a Board agree that as a principle, ~~that after~~ employment ~~[inaudible]~~ over earnings, this led to some of the stuff we did around incremental progression.

DR WALTERS: Okay, as a member of the Board, do you recall up until about 2010, being any concerns about maternity?

MR WILSON: Certainly. I mean, I've really genuinely tried to think about the time – I recall the feeling on the Board being ~~[inaudible]~~ one of concern and I may be incorrect, but in my mind, I am sure that was talked about at the Board to Board meeting, with Monitor, about those sort of issues, and I know there had been a number of incidents which were absolutely tragic. I cannot say that enough, that we were aware of as a Board. I think some of the close operational details of the actual incidents and the clinical nature of the incidents ~~was~~ were dealt with very much a kind of triumvirate between Tony, Peter and Jackie, and June as a non-exec, who had a clinical background and lead on some of those discussions. This is what I recall.

DR WALTERS: And do you remember what was intended to come out of the Fielding Report, or what actually did come out of it?

MR WILSON: To understand what some of the – the DNA of some of these issues were, and how we could improve the experience of ~~mourners~~ mothers, and families, and of the maternity experience, my view always was that we had a team who took that extremely seriously and wanted to improve services and learn from lessons that – you know, from the incidents that had occurred. One of the hallmarks around people strategy was around the concept of a learning organisation, where we try and learn from our mistakes and make sure we've got it right for next time.

DR WALTERS: So the Fielding Report took place. What was the Board-level scrutiny, when the actions were delivered?

MR WILSON: I think that is something that, in hindsight, could've been improved. Whether we – I can recall looking at the action plan, but I can't – I must admit, I can't remember the detail. ~~It~~ If you wanted me to go through all the past Board papers, I could ~~view that, and~~ give you a much more informed critique of that level of scrutiny at the Board–

DR WALTERS: So did the –

MR WILSON: But I do recall monitoring it.

DR WALTERS: Yes, it monitors the action plan, and then after that, was there a sort of belief that things are being put in place and that things were better?

MR WILSON: I think several factors really. I think there was a CQC report in 2010 which was positive about maternity services, ~~potentially~~. There was a CQC then.(as opposed to the Healthcare Commission) And some of the informal stuff around complaints and understanding what some of the issues were, and SUIs around it. I think there was also the fact that James Titcombe's daughter was born there ~~[inaudible]~~in Barrow and Tony Halsall reported back whether it was to the Board or whether it was to the exec team, ~~and~~ that he had met with James and he discussed his experience of the birth of his daughter, and I recall ~~somebody~~ Tony saying that James had commented that it was palpably different. (to the experience of Joshua's birth)

Now, that's not assurance – it was the softer intelligence as well as any formal external report. But from my recollection, there were regular reviews. Because clearly, if we think about the history of the organisation, back in December 2009, when we were in the Foundation Trust process in 2009,

when the Healthcare Commission was still *in situ*, I think the reason why we were kind of held in abeyance around that (FT) process was due to the fact that there had been some concerns lodged with the Healthcare Commission and Monitor, ~~under~~ and the Healthcare Commission's risk ratings, weren't properly aligned with Monitor; they didn't really know what to do WITH US, from what I can recall. We got the green light in about April 2010 from the CQC as it was then, around our clinical services. I recall Monitor leading the contact with us, rather than the other way around, and saying that they wanted to come back and have a look at us. Certainly the first time ~~[inaudible]~~ we went to a Board-to-Board with Monitor, I believe that the ~~feeling~~ Fielding Report was discussed at the Board-to-Board. I know that there was some discussion around maternity services, at the first Board-to-Board. Certainly it was an issue at the second Board-to-Board, from what I can recall. But again, I would need to see the notes of our Board-to-Board meeting with Monitor, which would've been about September 2010.

DR WALTERS: So when you got to about 2011, you had the Monitor return, and the HSA interventions, and Manchester [?] Report, there seems to be a lot of activity there?

MR WILSON: Well, yes. I think there was a lot of activity that was driven by the Inquest into Joshua's tragic loss. And I know that there was a lot of media coverage; a lot of police interest came ~~from~~ from the inquest too. So there was a lot of activity, a lot of media scrutiny on the organisation, and yes, we did other things like twinning up with Liverpool Women's Hospital to get help and support from them – I can't remember the exact dates around that. There did seem to – obviously there was a huge sort of confluence of issues that

came to a head around Autumn 2011 right through to my departure at the end of 2012.

DR WALTERS: Do you think, as a result of all that activity, you felt better, more reassured?

MR WILSON: Well, the Board were less assured from what I can recall. Certainly the CQC report was highly critical. (It was very different to the 2010 report)

DR WALTERS: They doubted the actions of – once [inaudible] taken place –

MR WILSON: I think there was more of a sense of grip – a range of other issues that were also taking place at the time, when everything did just feel very, very chaotic, which obviously led to Sir David Henshaw coming in as Chair to – how I would describe it – 'steady the ship'. It did seem to be that there were issues coming in at all angles into the organisation, at the time, not just about maternity services, ~~[inaudible]~~ other services too.

DR WALTERS: So around this time, from your role particularly, a sort of dignity at work metric tells you about things like concerns and whistle-blowing. How strong had been those sorts of processes and did you see any difference?

MR WILSON: Well we certainly changed the policy around dignity at work. I can't remember when the policy was renewed, but we did – I remember a ~~Commons~~ communications [?] campaign around raising concerns, and how we set up a helpline around that. I think that was run by West Midlands Ambulance, from what I can recall, to try to see where there were other issues that we could kind of get from our staff and give them the opportunity to raise any concerns that they had. I was looking after communications at the time, and certainly ~~there were quite [inaudible]~~ there was a real drive about getting ~~that~~ the helpline set up and making sure that was run effectively, (probably

[inaudible] around how that might work differently) we wanted this to be run independently so our staff were assured.

DR WALTERS: So from 2007 onwards, were there many whistle-blowing concerns raised?

MR WILSON: Not that I can recall. [redacted]

DR WALTERS: So you did this engagement exercise when you started, the sorts of issues people were raising were mainly about – you mentioned sickness absence, how you managed that, or used to manage it – and pay issues. Anything else?

MR WILSON: Well I think it was just sort of – they needed some sense of direction and modernisation. One of the issues that I was asked to present on at my interview– ~~it~~ which was a very, very involved eg Psychometrics etc recruitment process, stakeholder groups, a whole range of stuff around that. I remember presenting around how we try to get a unified culture for the three hospitals. That is partly why we did what we did around some of the staff recognition, because what we wanted to do, we held it at, like, a kind of neutral venues, in Kendal and Grange, so it was kind of relatively central for all of our staff– I know it's a minor detail, but it's to explain the feeling behind it, so we provided transport in from Barrow, transport in from Lancaster, so people would get together in a room and try and build up a sense of belonging with the Trust –

every year, every summer, we did it an staff achievement awards was recognising all staff who'd completed a formal piece of study. So whether it was NVQ Level 1 in cleaning or catering, up to somebody getting an MBA. So all those people came together in a room, and there was thinking behind it; it wasn't more by luck than judgement, that we were trying to develop this – a more unified culture where the Trust meant something to people, even though – if you were to probably go out of the room, now go 20 miles down the road to Lancaster and ask them whether they've got anything in common with the people in Barrow – I don't think they would feel that they did. And maybe, less so Kendal. I think that has always been one of the challenges, so it's kind of a ~~[Vie de France?]~~Esprit de corps for me, because you wanted to do something where you were able to celebrate Furness General Hospital and its history. ~~So that had~~(As part of an approach to staff engagement) FGH an anniversary while I was in post, and we did something around that, a bit of a campaign around that for people to hopefully feel proud of that hospital but also we tried to do some of the Trust-wide things around bringing people together in a room to celebrate their success and to be able to see some of the successes of their colleagues in Lancaster who they might speak to on the phone but they would never see. It's 70 miles away.

DR WALTERS: So one last question from me: you talked a bit about the engagement and the OD aspects of the role. Whose responsibility would it have been to look at things like turnover, recruitment, adequacy of staffing, [inaudible] guidance, and that sort of thing?

MR WILSON: Well we did ~~[inaudible]~~not have defined staffing number guidance at that time – I mean, there still aren't set guidelines, staffing levels in place are

there? So that debate is running, actually now, in terms of what safe staff guidelines –

DR WALTERS: Well, I suppose in terms of midwife numbers, obstetrics, neonatal. There's probably more around that than there is – (note – we did use external tools to ensure right skill mix)

MR WILSON: And that's specifically clinical, would tend to be Jackie. Certainly the turnover stuff, we look at turnover every month from, when I started again, what I can recall, in terms of the Board papers. That was a set stat in our dashboard, and turnover really didn't fluctuate. We did do some, recruitment campaigns you know – clearly we always knew that Barrow was a difficult area to recruit to. A beautiful part of the world, but it might not be as attractive as, say, Lancaster, in terms of – take consultants for argument's sake. Let's go on a really basic level, and say, school provision. So, Lancaster have a really good reputation; you've got a secondary school; you've got schools that have a good reputation, and that is what you've got to try and think of when you're trying to recruit for people. We did a range of initiatives to try to improve recruitment at Barrow, to try to improve the facilities for junior doctors at Barrow, in terms of their accommodation and a range of things to try to get that better for people, so we had a better chance of recruiting. So turnover-wise, that would be me presenting that information at Board level. In terms of detail, how many midwives we'd got at any one time, you'd expect ~~[inaudible]~~ that to be gripped locally and if there were any concerns, to flag that up. Probably, if I remember the way it worked in practice that would be to Jackie but if there was any concerns with people had, I would regard myself was reasonably visible and reasonably approachable and open to people. So

there wouldn't be a sense that people – I would really hope – feel unable to talk to me if they had any concerns.

DR WALTERS: Right.

[Crosstalk]

PROF FORSYTH: What is the sort of systems are in place for performance managing the clinical side?

MR WILSON: What systems do we have in place?

PROF FORSYTH: Sorry?

MR WILSON: What was the question...?

PROF FORSYTH: What systems did you have in place for performance managing clinical staff?

MR WILSON: Clinical including doctors...?

PROF FORSYTH: Doctors, nurses, midwives...?

MR WILSON: Yes, well first of all, we had – I'm not a great believer in capability procedures. I work on the assumption that everyone is capable if they've been recruited into the organisation; I much prefer developing the ethos of performance improvement. That might seem like almost semantics, but really, genuinely, there is quite a bit of thought that goes on behind that, it's like improving people's performance, as opposed to saying, 'You're not capable of doing your job'. So, that was a general policy that was in place for doctors, nurses, physiotherapists, radiographers, etc.

We have appraisal; we'd have appraisal systems as well, which ~~[inaudible] not~~ should not be used for performance management – NB I neglected to say we used MHPS too and linked well with NCAS.

PROF FORSYTH: Was that peer appraisal?

MR WILSON: That would be peer appraisal, yes.

There were a number of issues, certainly from the disciplinary issues ~~that parked out~~ we dealt with – because there's a difference between capability and disciplinary. Very simplistically, I'd say capability is 'can't', and disciplinary is 'won't'. I'm summarising it very briefly, but that's some of the thinking, and we dealt with, certainly, [redacted]

PROF FORSYTH: Which specialities were they?

MR WILSON: Radiology and in ophthalmology. And I guess – I actually think that is quite unusual ~~full stop~~ (taking that approach) for the NHS; that was not common ~~[inaudible]~~ practice, doctors were often put on ~~HPS~~ MHPS [?]. Clearly we had a ~~HPS~~ MHPS as well, and we managed a number of doctors ~~who have HPS~~ through MHPS. I worked closely with Peter ~~[inaudible]~~Dyer ~~and Peter Wood~~ on this.

PROF FORSYTH: What sort of issues? Were there issues brought to your attention from the maternity and paediatric services?

MR WILSON: From what I can recall, there were issues around some of the doctors, and not only issues about their abilities but also some of the communication, clearly, was an issue around the Joshua Titcombe case, and we put some OD support in there to try and improve those relationships.

PROF FORSYTH: Could you go into a bit more detail? Do you recall what the specific issues were?

MR WILSON: I can't remember what the specific issues were. The specific issues that I recall was around midwives dealing with an on-call doctor when there some signs of distress with the child, and if they did, did the doctor respond in

a timely manner? Some of the deliveries, as you'll be aware I'm sure, ~~[inaudible]~~ can be difficult, some of the doctors, you have control of and some of the doctors you don't have direct control of, in terms of people who are on training schemes managed by other ~~people, training teams~~TRUSTS. Does that make sense?

PROF FORSYTH: Yes, I realise that, but still the organisation is responsible for the care of the patients?

MR WILSON: I'm not saying for one minute they're not, I'm just saying there were some issues were complicated by external bodies, that's all I'm trying to say. The ~~[inaudible]~~ relationship with the midwives supervision arrangements was another example of that, in terms of how transparent some of the issues were that they were dealing with, and we'd have a struggle with them around understanding what some of the issues that had been discussed in supervision which was seen as being something we couldn't get access to– as an employing organisation, ~~it involved a number~~ we were involved in a range of correspondence around that issue.

PROF FORSYTH: So in relation to the example you gave about the telephone call issue, were you involved in that? Investigating that or managing that?

MR WILSON: I wasn't involved in investigating it, no.

PROF FORSYTH: So do you know what the conclusion was in relation to that?

MR WILSON: I can't remember the conclusion. If you – if I was able to have sight of the case files, I would be able to look at those case files and understand what it was.

PROF FORSYTH: And what about – I mean, in terms of clinical practice, can you say whether there were other issues that were brought to your attention by members of staff, particularly in Furness in maternity and neonatal services?

MR WILSON: Well, I mean, I remember ~~– we had certainly there was –~~ I remember directly dealing with an [redacted] But I can't remember being directly involved – as I explained to Geraldine, it would have been a divisional issue, but I don't remember that being escalated to me, but it would've been dealt with, it should have been dealt with at the division nothing was directly escalated to me.

PROF FORSYTH: Right, so if there was a midwife or a doctor thought to have performed badly, whether it was clinical practice or communication issue or conduct, would that be dealt with at a divisional level as well?

MR WILSON: There was an associate medical director, and an associate nurse director within each of the divisions. We also put in place, quite a lot of work around what I would describe and we described at the time as ~~[inaudible]~~ people management training. So what you'~~d need to do [inaudible]~~ needed to do as a UHMB manager, how you ~~need~~ needed to do it. Certainly I could provide some of the background materials around what we said to people at the time, but that was quite a detailed programme. We also developed a clinical leadership programme.

PROF FORSYTH: So was an HR manager part of the division –

MR WILSON: HR Business Partner. As I explained to Geraldine, the thinking around that, rather than an HR manager – how I would describe it, in my phrase, we need to get away from 'blue light HR', which was – what I mean by that is somebody who needs ~~to stand in at~~ you to suspend someone in Barrow; you leave Kendal, you drive to Barrow, you go and suspend them, and then you come back. They needed to be much more involved in the business of the Division. We put a lot of time and effort and money was invested in coaching our once HR managers to become business partners. It was always very clear for them, that they should regard themselves as being the director of HR for the division; that they worked within a Divisional Management Team – you had a senior nurse, a senior doctor, a divisional general manager, who would be paid quite high on the scale, and you had a divisional accountant, and you had a doctor and nurse – but there was a leadership team in place within the division, and then there was HR support there, and a Head of HR deputy director of HR and then myself.

PROF FORSYTH: Okay, in terms of – you mentioned about a doctor who was – we were talking about whistle-blowing and such. Do you recall having sight from a doctor complaining about – expressing concerns about standards of care within their particular specialties?

MR WILSON: I can't. But if you were to put a letter in front of me, and say, 'Do you recall seeing this letter', I would personally find that helpful. If such a letter exists, I would be grateful for you to show it to me.–

PROF FORSYTH: There's nothing that stands out from your – you don't –

MR WILSON: No, I can't remember anything specific– because when I was in ~~the~~ preparation for the session today, it was stated that we would talk about the

broad issues and so I haven't tried to think about specific details; I've just tried to think about the broad experience. I remember one doctor in Lancaster who was – it wasn't about concerns about the quality of care, it was ~~[inaudible]~~ his inability to follow through requests from clinical colleagues. I remember that being an issue, and that was ~~[inaudible] and that was~~ dealt with –

PROF FORSYTH: [Inaudible] – It is very hard to respond to this as I can't recall what the question was?

MR WILSON: And I think that's the case. I'm not undermining that for any one moment or trying to make light of it. What I am saying is I can't remember that – it never came directly to me that somebody was saying, 'I have real concerns about this and nobody's doing anything about it'.

PROF FORSYTH: Finally, from my understanding, there were no suspensions of paediatricians during your time in office?

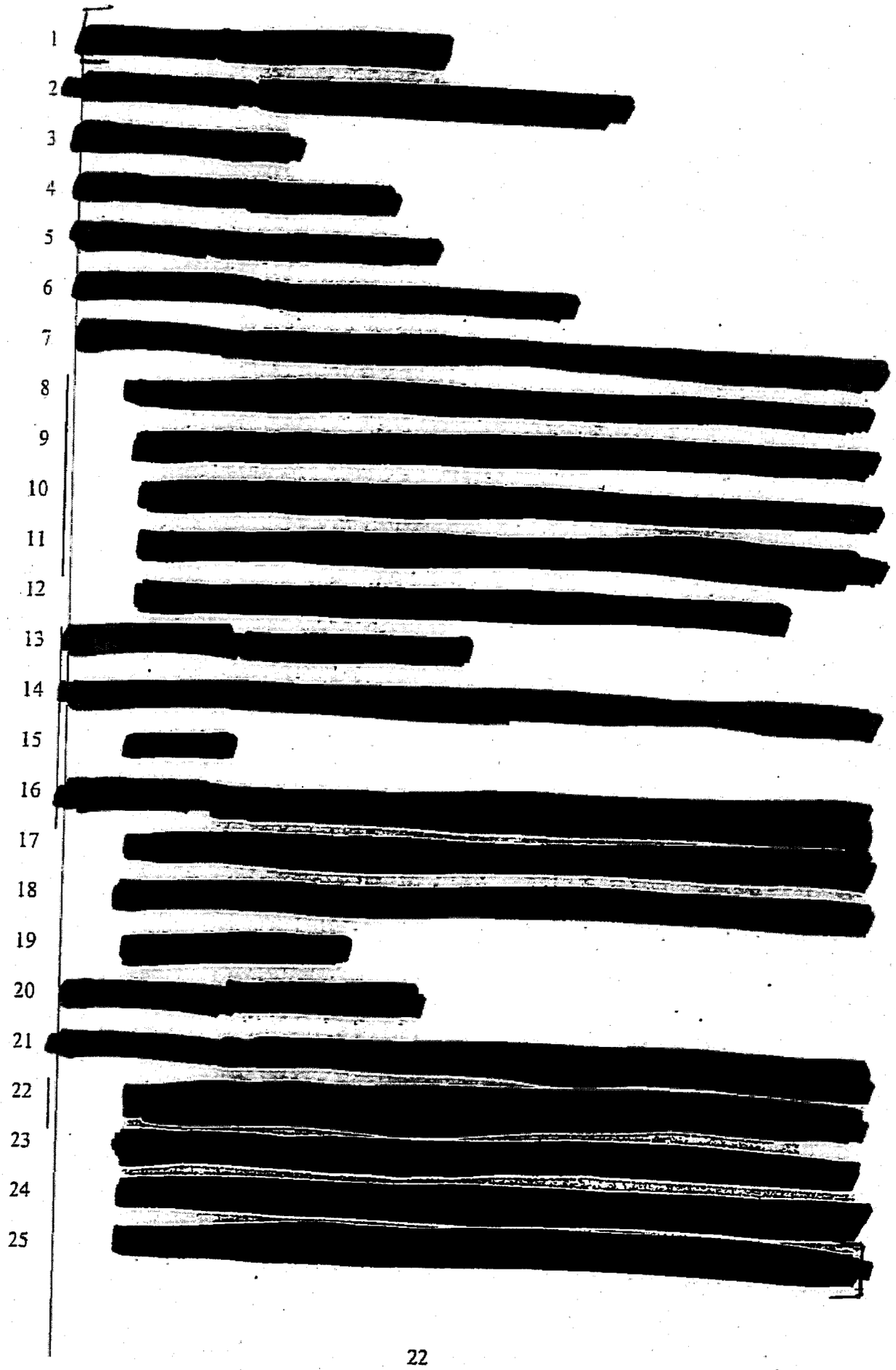
MR WILSON: I cannot remember there being, but that's not to say there wasn't. I would need to – if I was to have in front of me the employment records of all the doctors; I know there was some investigation around doctors at Barrow, but I think that was towards the end of my time; it was being dealt with by an external body.

PROF FORSYTH: Okay, thanks.

MR WILSON: I'm sorry I can't be more –

PROF FORSYTH: No that's fine.

[redacted]



[redacted]

THE CHAIRMAN: Okay, thank you. Did you have any concerns about maternity staffing, whether at Barrow or across the Trust?

MR WILSON: Yes, in as far as we did a huge recruitment campaign – that would have been about September – sorry, December 2011, so it would be maybe early 2012, where we knew we needed a refresh. I think it comes back to what Geraldine was saying – right at the beginning of my time with the organisation, it was a really flat organisation. When I say, 'flat', I mean mood. The staff surveys ~~[inaudible]~~ demonstrate this, you'd be able to plot a path through those from 2007 onwards. We did improve and enhance our –staff engagement scores again, with the divisional structure, from what I recall, each of the divisions received their detailed breakdown of their own staff survey results. Obviously I had to spend my time looking at the global picture and we did improve year-on-year-on-year.

THE CHAIRMAN: That is –

MR WILSON: But those issues were never really flagged, that I can recall.

THE CHAIRMAN: And specifically, staff levels weren't brought to your attention as something that should be a matter of concern?

MR WILSON: Certainly not, no. Not that I can recall, Chair.

THE CHAIRMAN: Anything? No, is there anything else that you'd like to say to us?

MR WILSON: No. I mean, I can't undo what's been done.

THE CHAIRMAN: Thank you.

[Interview Concluded]

THE MORECAMBE BAY INVESTIGATION

Thursday, 18 September 2014

Held at:
Park Hotel,
East Cliff,
Preston.

Before:

Mr. Julian Brookes - Expert Adviser on Governance (in the Chair)
Professor Jonathan Montgomery - Expert Adviser on Ethics
Professor Stewart Forsyth - Expert Adviser on Paediatrics
Dr. Geraldine Walters - Expert Adviser on Nursing

VALERIE WILSON

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

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MR BROOKES: Good morning. I am Julian Brookes. First of all, an apology from Bill Kirkup who Chairs this investigation, he is unfortunately unable to be with us today so he has asked me to chair.

We are going to introduce ourselves and then I will ask you formally to introduce yourself. Just a few housekeeping things and I will ask some questions.

(Following introductions by The Panel and housekeeping matters)

MS WILSON: I am Val Wilson and I am Interim Governance Lead working at Morecambe Bay.

MR BROOKES: Thank you. We are going to ask some questions. We will take it in turns and we will go through that.

MS WILSON: Okay.

DR WALTERS: Hi, Val. Just tell us a about your role at the Trust. When you first started, what was your job?

MS WILSON: I was invited to the Trust in October 2011, initially just to do some education plans, for 12 weeks. At that time, I do not think the size of the problem had been recognised and I was literally there to do some development plans, educational plans for midwives and to look at the training needs analysis for the service.

24 The role developed as the story untold a little bit

25 really and I then took over the action plan for the

Monitor -- the response to the Monitor findings. I subsequently took up a role as Deputy Head of Midwifery and Governance Lead and I am now working -- the corporate governance sharing some of the lessons we have learnt across the organisation.

DR WALTERS: Who did you report to?

MS WILSON: Sasha Wells, who was the newly-appointed Head of Midwifery.

DR WALTERS: What was that job? What were your key tasks in that job?

MS WILSON: The initial job was literally reviewing the provision of education for midwives. That then went on though a wholesale review of the service in light of the recommendations from the Monitor action plan, but also not just to meet those requirements just to root and branch review of the governance arrangements as well as undertaking an operational to role to support Sasha in the turn around of the service.

DR WALTERS: That is quite a lot; isn't it? This sort of education lead, deputy to the head of midwifery, service review and quite a big governance remit.

MS WILSON: Yes.

DR WALTERS: Was anyone else doing governance in the

24 division?

25 MS WILSON: There was a governance lead that been in post

about three months when I arrived but one of the first thing we did was review the structure because there were not the appropriate people in the appropriate posts. So one of the first thing we didn't was develop a structure with risk manager and audit midwife, and managers, more managers, a risk and safety midwife.

So the whole service had been the -- there had been under-resourced in terms of a management structure and a governance structures so that is one of the first things.

So yes, initially it was two or three of us sort of doing that but then very quickly we appointed some key roles.

DR WALTERS: So with all the people doing different aspects of the role, how did that sort of make sense in the structure? Who pulled it altogether and ...

MS WILSON: We had a very clear role with Sasha sitting at the top, me sitting under need her as temporary post initially with those two posting companies. -- unsure of what this means but think it refers to dual role of DHOM (Deputy Head of Midwifery) /Governance Lead They are now separate posts in the new structure so there is a Governance Lead and there is a deputy Head of Midwifery which is being appointed to this week.

It all came? -- it was a very tight robust structure to begin with because it needed to be because none of those

processes were in place. So there were lots of reiterations, lots of reviewing, we constantly had to look at things and it grew very quickly. So, you know, I cannot

say to you, "we designed it this way from day one and that is how it happened", we constantly had to keep reviewing and looking at things as we went and as the size of the problem became very clear.

DR WALTERS: Right. So when you were first in post, so sort of putting education bit which I am picking up was very early bit, what did you find as you got there in terms of the quality and safety?

MS WILSON: There were just no -- there was no clarity in terms of who was responsible for any of that. There were education midwives, there was one full-time equivalent across three sites, and there was a programme for obstetricians training but it was one day a year and very disparate because it was one full-time equivalent delivered by four education midwives as part of another role across three sites.

So it is quite disparate. There was different training on different sites, it was not aligned with guidelines, there was no robust programme for skills training. So it is not that there were not pockets of very good stuff going on, but we could not have evidenced it and it certainly was not across the Bay.

So it was about looking at what we needed, how we might

deliver that. We put a practice development matron in post. We kept the full-time band seven and we recruited a further

three full-time equivalent band six midwives. The training went up to three days per week plus workshop plus skills drills.

DR WALTERS: So if I was midwife in Barrow in 2011, how much training might I get a in a year?

MS WILSON: My understanding from what was available in terms of evidence that that would have been one maybe two days a year, but that training might have been different to what was offered on other sites. It was disparate.

MR BROOKES: Sorry, is that in addition to health and safety training, et cetera?

MS WILSON: That was just maternity and obstetrician training so there was -- how the Trust delivers its mandatory training is via a work book. So you would have your face-to-face training on your first join the Trust and then there is quite a comprehensive work book that you receive and then you do most of your mandatory training online. There will be some fire training, some health and safety things that are done face-to-face, but there is actually quite a robust, even then, quite a robust programme for those things.

MR BROOKES: Thank you.

DR WALTERS: Were there any other ways that midwives

might be updated other than this one day? Were they doing things themselves independently?

MS WILSON: It was not evident to me if they were. There was no evidence of it. They were pockets of very enthusiastic midwives. For instance, they were doing training for community midwives in homes, so they were doing some skills drills training actually in homes.

There was skills drills going on, but the evidence was not collated it was not available to see, there was not -- it was not measured in any way. So you have no idea of knowing how successful it was or what training might have come out of it.

So it was just the organisational side of it, I think. It was not about lack of will to do it, people were very up for doing it; it was just lack of organisation and what was the purpose of it and where did it feed into. There was no training needs analysis in place.

DR WALTERS: What about the obstetricians, what did they get?

MS WILSON: They shared training with the midwives so it was an obstetric study day delivered by band seven midwives.

DR WALTERS: So the obstetricians were not really getting any other regular or routine updating either?

MS WILSON: Not to my knowledge within the Trust other than that particular day.

DR WALTERS: So when did all that -- when did you get the new training in place?

MS WILSON: We quite quickly did a training needs analysis and reviewed the training days and we went to the three days fairly quickly really. There were lots of very keen people who were very keen to take on roles within that. So -- we recruited to the actual post, that was already happening.

We did have to balance it with the fact that it was a massive resource. Given we knew we were short staffed of midwives, to suddenly say "you will be doing this". So we had to be creative about it to start off with but I will certainly say within six months we had something that I felt was robust.

DR WALTERS: Right.

MR BROOKES: Sorry. I just want to -- you talked about training needs analysis.

MS WILSON: Yes.

MR BROOKES: Were you -- did you look at people's personal training plans? Were there personal training plans? Was there therefore a programme -- a coherent set of needs that was already there which were not being met or was that something that needed to be done as well?

MS WILSON: In terms of being able to go to their place and say, "These were the training plans that had fallen out of the appraisals", that was not available at the time. We

fell back to the TNA ~~T&N~~ that we were required to do for CNST at the basis of this is bottom line what we have to have and

then we have since built on that in terms of the service need.

So there is lots of other training that has gone on outside of the training needs analysis now, but there is a start point. We just did what we had to do. What we knew was required for a safe service as a starting point.

MR BROOKES: So to make sure I understand that, there is no single place you could go to these and say, "these are the identified needs that our midwives, et cetera, need." This is not -- this is the training. That was not clear, so you went CNST basic standards and looked at those as being the basis on which people need to be trained.

MS WILSON: There is an electronic system in the Trust called TMS. It is very locally managed so you can? -- it is still the system we use. You can designate what training is required on that, but it was not used as a wholesale -- if we go to TMS, we will be able to look at it and be very sure that are staff were trained.

Something's were on it something's were not so we just decided rather than unpick all that, that we would start again afresh, that seemed the quickest thing to do and we have kind of look at TMS as we have gone along. It is now very robust and all our training is on it.

24 DR WALTERS: Had they got CNST when you arrived?

25 MS WILSON: Apparently they had CNST level one but I was not

able to find a training needs analysis, but again, to be fair, I didn't spend a lot of time -- we were not in a position to rake through history. We knew we needed to act very quickly and it was as quick to do it again and get the training going.

DR WALTERS: Were you surprised that they managed to achieve CNST level one?

MS WILSON: Given the work we did with it guidelines subsequently where we had to wholesale review all 50, yes.

MR BROOKES: Okay. Jonathan, did you have a question?

PROFESSOR MONTGOMERY: It was really understanding how you assess training needs. I think what I have heard is that -- qualification time spent, what was the component of the training analysis that which -- is it the right training, given the challenges?

I am particularly interested in the difficulties that arise in work force who work in an isolated unit and we have been asking and -- how did people find out whether it would be done the same way in a different unit and I have not had a very good answer to how we know that happens. I wonder whether that part of the analysis?

MS WILSON: Not initially, no. We just decided we had to standardise across the three sites and, actually, that is --

24 a decision we made really quickly is that everything had to

25 be done the same over three sides and we very quickly

started rotating staff as well to help with "this is how we do it there", "that is how we do it in other places".

So all training, we actually stopped doing it on the two main sites and we started doing it at the Westmoreland site. That became our education site, so that staff would come from both of the obstetric units to do the training together. Midwives --

PROFESSOR MONTGOMERY: So that would help for the two site or three site problem.

MS WILSON: Yes.

PROFESSOR MONTGOMERY: It does not help with "is the Trust doing thing that are different from what might be done in Manchester or --"

MS WILSON: Well CNST helps with that because it is a national standard level one and you have to have that training needs analysis. You do not have to give evidence that you are delivering it at level one, but actually from -- right from the start, we have tried to aim for the evidence which we required, level two, and level three. So we have had that evidence right from the get go as part of our assurance processes through our governance process.

DR WALTERS: Did you notice a difference between the different sites in terms of engagement in governance?

MS WILSON: I could hand on heart say Barrow was the always the place we find it most easy to engage with people.

DR WALTERS: Most easy?

MS WILSON: Yes, definitely. I think there were perceptions sometimes at Lancaster that this was not their problem, that this was a Barrow problem.

DR WALTERS: Is that because at that point the focus was on Barrow so they were more receptive?

MS WILSON: Yes and some of the processes were very separate at that time.

DR WALTERS: In terms of your perceptions of clinical quality, was there a difference between the units?

MS WILSON: Once we had started to gather the evidence on which you could make a judgment about that, no, no.

PROFESSOR MONTGOMERY: Can I just -- does that lead you to conclude that standards are high across the Trust or low across the Trust?

MS WILSON: At that time, when we first started evidence, there were worrying themes very much so but it was across the board. For me, Barrow was never an outlier.

MR BROOKES: And those themes were?

MS WILSON: It is just the stuff that is everyday stuff, such as: emergency equipment, check lists, guidance, the use of guidance, the updating of guidance, the availability of guidance, the clinical incident reporting, investigations,

all the things that have come out.

There was just no clear processes for any of that and

even if it was done well, it was not discussed, it was not learnt. It was done in pockets so it was something that was almost done behind closed doors and I do not mean that in a Machiavellian sense but it was done very disparately to the service improvement side.

MR BROOKES: Why do you think that was?

MS WILSON: I do not know and it would be speculation if ...

PROFESSOR MONTGOMERY: How easy has it been to change?

MS WILSON: In terms of putting systems and processes in, it has been very easy. Engagement has not been easy and I think that would be true anywhere.

You know, my experience has been part of CNST when I first became about and everyone saw it as, you know, a layer that we did not need and I think that has been the experience of some of the staff. That a lot of this is "why do we need it?" That it is -- a lot of paperwork and when it all comes at you very quickly in one go, that must feel quite restrictive.

So we have had lots of voices but we have not -- I do not feel that has ever stopped us making progress we have needed to. You know, we have not done it despite that. The noises have been there but no-one has stopped us doing what

we have needed to do. We have got really good engagement now, multi-disciplinary engagement.

PROFESSOR MONTGOMERY: So one possible inference of that is that people have not tried to do it very hard before and people were receptive to it once it was done properly?

MS WILSON: I just don't know that they knew there was another way of doing it is the experience. I don't think it is that people knew they should and they did not.

DR WALTERS: To what extent do you think it is because -- we know in a lot of organisations this can be tough, but this is an organisation with a real learning platform with a lot of scrutiny. How much did that play a part?

MS WILSON: It was a very useful stick sometimes, absolutely.

DR WALTERS: Just give us an overview about the governance structure within the division and how structurally it worked from a sort of engagement reporting point of view.

MS WILSON: Once we had got the appropriate framework in place, we tried ~~tied~~ to make it very much a ~~re~~ward to board journey. So that this was not something we did for staff, this is very much about engaging managers in being part of that process and being responsible and accountable for their own areas.

So we have a series of meetings, very structured reporting. We have something called the "We See" framework,

which is Workforce Experience Safety Effectiveness and Efficiency, so very broad themes but then very detailed breakdowns. Every area is reporting on similar things, they come together as a cross-Bay team of managers to discuss that once a week and those reports then formulate the governance report.

DR WALTERS: Is that now or has that been developed a since 2011?

MS WILSON: It is what we have been working towards.

DR WALTERS: Right so things have not changed in between --

MS WILSON: Absolutely, yes. Absolutely because there is no way we could have put something as sophisticated as that in place in that service and for, you know, for part of the time we just had to do it to know if we were safer or not.

DR WALTERS: Yes.

MS WILSON: So yes, it has been a journey. That did not happen in 2011 or 2012. You know, it was a very small core team of people, putting processes in place and then bringing people along.

DR WALTERS: So it is been developing a long way, you have not had any sort of interference of external reports saying, "You have got to do it like this", you have sort of

started off with the way you wanted to do it and you would say it has been developing -- same journey but development.

MS WILSON: Yes, absolutely. So we were clear about where we wanted to get to and we have, you know, we have been on the journey, yes. The external has not been -- I say, for me, having the external scrutiny has as a requirement has actually been a help to the detractors. The people that don't want to come along. We have not had a lot of choice really.

DR WALTERS: Who is the lead clinician for governance in the division?

MS WILSON: The lead clinician is Alison Sandbrook, who is a Consultant Obstetrician Gynaecologist.

DR WALTERS: She is relatively newly appointed; is she not?

MS WILSON: She was in post when I arrived.

DR WALTERS: Right.

MS WILSON: Yes but was new at that time. Had come from Preston, I believe.

DR WALTERS: Just take me through how -- just to take one element of the governance whole, how does the risk management system work?

MS WILSON: Okay. So, slightly different now but I will talk you through it. From what we did -- very low reporting levels when we first went, so we did lots of education, and

we went from very low to incredibly high very quickly, right

from the stuff we wanted to -- there was no toilet role in

the toilets.

We put a quality and safety midwife in place to triage those incidents as they came in five days a week so that they were very quickly dealt with and just the sheer volume required someone looking at that five days a week. We have not got a robust ~~rew does~~ management processes at that time so we could not leave it at a local level. Anything moderate and above was dealt with by the team which was myself, the risk manager, and the clinical lead Alison for obstetrics.

We put -- we put a five day turn around on anything less than moderate and a two day turn around on anything moderate and that has been taken up across the Trust now in terms of the five day. So anything moderate and above in the Trust now goes to a patient safety summit; ~~it is now called~~ on a Wednesday.

So things were turned around very, very quickly, we developed multi-disciplinary RCA teams, the ~~M~~NPSA came in and did a massive two day training with staff with multi-disciplinary team. So that kicked off really quickly. It was a big criticism from Monitor that previously it had been one person doing all the RCAs.

We had local ~~ly~~ incident meetings on each site once a week or every other week at Kendal because of the -- such a

small unit where a supervisor of the midwives, an obstetrician, the risk midwife and the manager would sit and

discuss the incidents from that site for that week.

That is now managed actually at hand over. They have a hand over four times a day and so, rather than having a meeting because now everyone is used to dealing with incidents, they discuss incidents at hand over so it is even quicker now actually. It is very responsive.

DR WALTERS: What's highest -- what is the highest things on your risk register at the moment?

MS WILSON: I have not worked with maternity for three months but when I left, our highest risk would have been ... for children's it was CAMS, for maternity it was community staffing, I think. We have just done a massive review of community staffing, and the advert is out ~~at~~ now. We have had a massive input from —The Board because we could not quite meet the 1:98 ratio.

DR WALTERS: How due the Trust Board get to know about the risks?

MS WILSON: The process is we have a -- the risk register is anything 12 and above, goes up through the divisional management boards to the performance meeting. We also were invited to the quality meeting to discuss our risk register and they have actually just developed a standardised reporting template based on the risk management policy where

24 the clinical directors are required to attend the Audit

25 Committee to discuss the management of the risk register.

DR WALTERS: What's the response of the Trust like to risks?

MS WILSON: I feel because of the access we have to them through the intensive support programme because of Monitor, we had very, very good access and they were very responsive. We had massive injections of not just resources in terms of money but in terms of people.

I would see that being replicated now across the Trust with how the reporting processes going with the standardised reporting, clinical directors being responsible so it is very much joined up.

DR WALTERS: For your serious incidents, do you have any external review?

MS WILSON: Sometimes, yes. Yes. We work very closely with the CCGs. We had a very low threshold for a very long time, so things that other people perhaps would not consider a serious incident we chose to review as if it were.

So we have had various people coming in as experts witnesses, we have asked for independent reports on many things and not just to make sure that we do it right but as a sense check really because it is a stand-alone unit in lots of ways. It is geographically removed from a very long way from anywhere else. So yes, we have quite regularly

asked for independent review.

DR WALTERS: How many serious incidents have you had

this year?

MS WILSON: I can only comment up to June for maternity and I think that we had three, but I am guessing, if I am honest. I have not been anything to do with maternity for some of months now.

MR BROOKES: Can I clarify that, what's the reason for that? We have got you as being currently still there.

MS WILSON: I am currently still at Morecambe Bay, but they have appointed to a permanent governance lead now and another as -- I think they are interviewing this week for a Deputy Head of Midwifery so I have been working corporately for the last three or four months and they are just about to appoint to a Deputy Director of Governance so I will shortly be on my way back to the Midlands.

MR BROOKES: Thank you, that is helpful.

DR WALTERS: In the corporate governance role then, what sort of insight and engagement have they got with the maternity issues?

MS WILSON: There is always been massive engagement, I think initially my impression was that we were an outlier, that maternity was an outlier, but quite quickly, I think that there was an appreciate that these systems and processes were not in place. So there has been a massive amount of

investment in governance across the Trust.

DR WALTERS: In the last (inaudible) incidents that

you dealt with, what was the communication for the families?

MS WILSON: I would like to think very good. We had be doing duty of candour long before duty of candour came along. We have really tried to engage with families right from the get go, I think, because Sasha and I, we felt -- not that we were not part of the problem but we were separate to the work force who had been there before.

We have always tried to engage with people face-to-face. All complaints, all serious incidents, we always try to have a face-to-face communication with the family.

We included families in our root cause analysis now so they are invited into look and contribute to root cause analysis and certainly into action planning and we like to meet with them afterwards to say, "Is anything else that you feel we have not addressed?" So it is very, very open.

DR WALTERS: And do you usually find they go well those meetings?

MS WILSON: Yes.

DR WALTERS: Just a little bit about guidelines, just to take us through how they are updated, how you engage with people, how you log risk.

MS WILSON: Okay. The initial piece of work -- because

quite quickly CNST was up for renewal and we did not have the guidelines, so that was a massive piece of work. So we

did a succinct piece of work about getting those guidelines in place.

We have always had a multi-disciplinary team around each guideline. It is ~~has~~ developed and it then goes out to consultation for a six week period. It comes back in and we have a guideline group. Because Alison has been so involved in the guidelines she does not have chairs rights to ratify in that group. All guidelines have to go to the governance group just because she is so closely involve with them.

So we did the initial guidelines sprint around the CNST guidelines and anything else -- we basically pulled every guideline that we had, or should have had, and did a RAG rating as to which we needed to address first and worked through those, including the CNST guidelines.

Once that ~~accounts~~ was done, we put a process in place -- we have an electronic resposritary ~~standing orders~~ system calling Heritage which gives us a three month heads up that something is coming up for renewal, we can then put team around it, it goes out for multi-disciplinary consultation including the supervisors.

It then comes back into the guidelines group for agreement and off to the governance Committee for approval. And then it goes into our lessons learnt bulletin, which

goes electronically and onto our high visibility boards so that everyone is aware that there has been a new guideline

or a change to a guideline.

DR WALTERS: Are you able to audit whether they are used in practice or not?

MS WILSON: We have got a massive audit programme going on now. We appointed an audit midwife and audit lead about 18 months ago. Audit across the Trust has undergoing a massive overhaul so the -- I cannot sit here today hand on heart and say all guidelines are always followed, but what we do know is where they are not, we get incidents.

That is how we -- along with the monitoring, we look at the indents for -- it used to be called failure to follow guidelines but it is not always a failure, but it is guidelines not followed. So we have a triangulation between anything coming out of audit, and those incidents that go on so we can have a look at decision making around that.

DR WALTERS: Can you give us some examples of things that have changed in practice as a result of the new governance system that has been put in?

MS WILSON: Certainly, yes. We have ... there is so much. Daily checklists are done; we have standardised working practices for our band seven coordinators; record keeping, much more standardised now. Our administration and paperwork is much more standardised across the whole

pregnancy pathway actually.

Fresh eyes, so two-hourly reviews of CTGs by someone

outside of the room, that is absolutely, you know, in place, well embedded now. The local workshops that we do, has all come about from things we have learnt from governance so we have a very responsive education team.

When we do the triangulations from things that have come through incident reporting and audits we have, our band six actually work out in the clinical areas so we are able to put on workshops very quickly. So if we get a cluster of incidents around record keeping or CTG interpretation whatever, they are able to go into the clinical area very quickly and do local education.

So there is lots and lots and lots.

DR WALTERS: Good.

How shall I put this? Are you able, through the processes you have got, to really look at whether routine clinical assessment is as it would be anywhere else?

MS WILSON: I think through the audit process -- I think the incident reporting -- we have got a huge trigger list because we needed to learn so much. We have left it in place because it works so well. Our supervisors do regular audits, we have got self-audit going on. So yes, I think we have got various processes that would help us to make that judgment.

We have got members of the team on the expert maternity group, the -- forgot the name of the group that -- it is the

no harm group, I think. So we are part of the national bodies now. Our supervisors are part of geographical meetings.

So that it is not just about what is going on it is the influence of the outside world that, you know, would happen anywhere else. That was not going on at Morecambe Bay. So it was almost like they were practicing behind closed doors almost.

DR WALTERS: That is reassuring. All of our other colleagues were saying it is a small unit.

I do not know if you would expect, with all of the changes that you have made, that the case base might have subtly changed. So if you are actually more aware of who high risk women or your tolerances to high risk have changed, then you might expect that you get fewer of those than somewhere like Barrow. Is that something that has been talked about?

MS WILSON: Absolutely. One of the things, very quickly, we realised is that -- I would say midwives -- the culture was of absorbing risk. So it is not that they didn't identify the risk, it is just that there was no process where they might escalate that risk. So patients that really should not have stayed at the Barrow, did stay at Barrow.

So one of the first policies that we looked at was an escalation policy. We have clear guidelines about when we

transfer and when we do not.

It was not just at Barrow, the culture at Lancaster was that they never closed. They were very proud about the fact that they never closed.

Well, that is not always a thing to be proud of and you know we close like all units do now because it is about keeping the people you have got safe. But that was a big cultural change that we had to make.

DR WALTERS: But there is something about closing the unit and closing because of capacity and there is something else around, actually, this patient --

MS WILSON: Should not be here?

DR WALTERS: You probably should send them somewhere else.

MS WILSON: Yes. So much clearer guidance about what is acceptable and what is not and that happens now. We don't even -- it is not even something that worries me anymore. I am confident that those transfers -- we look at all transfers. So all women that are transferred are looked at.

DR WALTERS: Have you seen an increase?

MS WILSON: Definitely. Oh, yes. Yes.

DR WALTERS: Then if you were running about 1,000 births a year, some of those would -- have the births gone

down?

MS WILSON: The birth rate is on the rise so we have not

seen a tangible difference in terms of numbers.

DR WALTERS: Yes. Okay, thank you.

PROFESSOR MONTGOMERY: Thank you. There is a little cluster of things that you have touched on that I would just like to come on to make sure that I have got clear.

Perhaps before I ask you them, I am not sure if we asked you right at the beginning what you were doing before you came to Morecambe Bay and what your background is.

MS WILSON: My background is practice development, education and then universities. I was actually a band six jobbing midwife which is what I go back to from time to time to keep me real. I was actually working at a community midwife when the telephone call came but my it was my background in education that ...

PROFESSOR MONTGOMERY: Where were you worked around the country?

MS WILSON: Mainly in the Midlands, so some of the bigger hospitals around the Midlands and I was working for Burton NHS Trust before I came.

PROFESSOR MONTGOMERY: Thank you.

I just want to pick up one or two thing that you talked about. So the CNST -- and I think, you have explained very clearly what you were doing now, I just would like to ask

you about what you reflections were on what you inherited.

I think, that you said that you would have expected to

have found a number of things if it were the case that they properly got the CNST one previously which were not accessible to you.

I just want to ask you a bit about that. I appreciate your job was to make it right but you must have formed a view about the quality of the past?

MS WILSON: There were not 50 guidelines that I could access and tweak, it was a wholesale need to start again.

PROFESSOR MONTGOMERY: Does that sound as though -- I am not asking you to work out where it happened, but it sounds as though the accreditation previously had been flawed.

MS WILSON: I think accreditation generally was less formal than it is now, and a lot of it was sitting at a desk top showing people. You know, I remember the early days of CNST and that is what we did.

I think my concerns was that what was not evident is that those guidelines were the ones that were used ~~would use~~ in practice. So that is what as a practitioner I would expect. To be able to go into a service, pick up the guidelines, and go with them and there was absolutely no straight forward process for knowing where those guidelines were. There were different guidelines on different sites with no clear way of knowing when they were last updated.

24 PROFESSOR MONTGOMERY: Would your impression be that the

25 Trust had believed it was compliant but didn't know what it

did not know or was this an exercise to keep the process separate from the practice? That is to say, people were focused on getting through the process and they were not focused on whether or not the service was safe.

MS WILSON: Impossible to say. All I can say is that there was no robust process in place to ensure that they had got good quality guidelines and that they were being used in practice.

MR BROOKES: Okay. Can I just follow that because this one is one of the things I wanted to ask about as well because -- I am trying get it in my head. I understand that at the time CNST, particularly CNST one, level one, was mainly a portfolio exercise if I remember correctly.

MS WILSON: Yes.

MR BROOKES: So in effect, what could have happened is that they were able to get CNST one by providing a portfolio which ticked boxes but the actual -- what you are saying is that in reality, that not reflection of what was happening in the service.

MS WILSON: I would agree that was the case.

PROFESSOR MONTGOMERY: I think you just said more than that. You also said there was not really a portfolio. There must have been a list of things --

MS WILSON: There must have been 50 guidelines somewhere.

MR BROOKES: Exactly. There must have been something in the

portfolio to tick the box I would expect from what I know about it, yes.

MS WILSON: What I couldn't is track that portfolio into clinical practice.

MR BROOKES: Absolutely, yes. So there was a question on that, but I would expect that something had to be in the portfolio, other than what you looked at across the CNST.

MS WILSON: Or indeed whether there were -- there was no process of knowing. There was no way of knowing how they arrived at those guidelines, whether they were the guidelines in place.

PROFESSOR MONTGOMERY: Thank you.

The second thing is around the incident reporting processes there. I think you have described very clearly how you built up the system there, you have described your concerns about under reporting. There were two thing I would like to ask you about.

1 is around the use of the external reviews and you have answered partially answered this but one of my perceptions is that. Almost everybody we talked to and you are not in this category which is got a we discovered another external review has been done at some point. And one of the questions, therefore, is whether there was a

culture of displacing internal governance by always thinking to look elsewhere. But would that BT a perception you have

as well.

MS WILSON: Yes definitely but I understanding their nervousness about not trusting what was there so I didn't ever see it as a negative thing, but it was just having that sense of assurance that what we said we were doing we were doing because in the early days you are not actually able to provide very robust evidence and it is a little bit on your say so. So it never felt we never felt under mind.

PROFESSOR MONTGOMERY: I am thinking probably before your actual time there.

MS WILSON: Yes. Yes, there were a number of reviews that when I arrived there was outstanding action plans all over the place actually which we did try to draw together and address as part ~~pardon~~ of the 118. Action plan.

PROFESSOR MONTGOMERY: What yours assessment of why they were so many outstanding action plans. I can give you a continuum there is one that says just move from one to another, and actually the never close the loop because.

MS WILSON: That is what its looks like actions were just perpetually moved into the next thing. We they just that is how I felt to me you would read one report you go on to read the next report and it was not I similar to the one that had happened. Before and I don't think it I people were not

24 responding, but it is about the being asked the right

25 questions, I think, about that response has it gone thru are

people engaged what's the evidence it has worked and I do not think those questions were ever asked.

PROFESSOR MONTGOMERY: Thank you.

DR WALTERS: What do you think the impact O was of the receiving all the action plans, but I does not seem like until into 2011 that the staffing started to increase. Do you think they were sort of busy giving action plans to people who did not have the capacity to do anything about them?

MS WILSON: I think potentially the structures were so small that the best will in the world it is how you fit had into your day job. There had been again this is my opinion, it is not based on anything but I know staffing had been cut quite significantly particularly in band sevens for the midwives, so I just do not know that there were the people on the ground even they have had known would have been able to dory much about it. Staffing was a big issue.

DR WALTERS: Were you aware of the Fielding Report action plan was that still around when you.

MS WILSON: It was amalgamated so as I -- by the time I didn't really get involved in action plans until the very big Monitor rate came in and just as a process of triangulating ~~Triad Lancaster tin~~ everything as we were doing this massive action plan that is the only reason I read the reports

really is to make sure that everything that was in previous action plans was covered in this 118. Action plan. So only

aware of it in so much as slotting it into our response and the turn around.

DR WALTERS: Did the staff on the ground actually know anything about these previous reports and action plans?

MS WILSON: Not in a meaningful way would be my impression.

PROFESSOR MONTGOMERY: The other question in had about the incident reporting, is whether you had in your time the need or opportunity to test out the challenge that, I think, the Fielding Report stage had as you handle incident one by one but you also at some point have to ask the question about whether there is any common pattern between them. So, I think, you have described very carefully and clearly for us how incident by incident you are working it through but what about the question of flagging up are other common factors.

Vic start here*****

MS WILSON: We do a themed report, and we have done right from the get-go. Every month we do a themed analysis to look at trends and patterns. We don't just do it on that month, we do a 12-month look back -- it is a rolling review. As we report it we have been continually looking back.

We have had themes arising that we have been able to respond to very quickly. Fresh Eyes came out of one of

those that we had a cluster of incidents around poor

interpretation of CTG; so we were able to implement Fresh

Eyes.

There has been several themes that have come up. Now we have an Audit Department that is very reflective those things happen much more naturally. So, as I say, we do this triangulation once a month. We started off doing it to assure ourselves that the dashboard was correct actually because we had some glitches with the pull-through of data. So we used to do a triangular process around the dashboard data.

Actually, what it gave us was really rich evidence in terms of not just what was being reported, but the stuff that was coming out of evidence and being able to triangulate it on the data that was coming through into the dashboard. We kept doing that every month.

Sometimes things -- it is just the evidence ebb and flow of data, it is nothing significant. Other times it is stuff that we would move to act on more quickly.

PROFESSOR MONTGOMERY: I wonder if I can ask you to illustrate that. I have seen an e-mail you have been copied into about a cluster of things on June 13 the neonatal death; inter-uterine death; the unexpected neonatal death; a maternal death. I do not need -- and I am not asking -- unless you feel you have to identify any of the details --

if you do we will need to go into confidential session.

What I am interested in is, given the history, I would

expect, you know, alarm bells to say, "We need to ask the question; is it happening again like it did appear to do, or may be did not" -- that is what we are trying to get to the bottom -- "of five years ago?"

MS WILSON: It should not be an "alarm bell" that it happened here before; it should just be: We have got an incident or we have got a cluster and we need to deal with it.

PROFESSOR MONTGOMERY: Can you tell us how people thought about that at the time?

MS WILSON: It has just become ingrained that that is the stuff that we would do. The Clinical Lead would expect to be informed. We would move to look at all those with root cause analysis, look at them as a cluster. We would be expected to report on that very quickly to the Executive. I cannot remember -- I cannot give you details of this particular cluster without going... I remember it, of course, what the outcome of it was. I do know two reports came out of that. One was to do with CTG interpretation; one was to do, I think, with post-partum haemorrhage.

PROFESSOR MONTGOMERY: What would the Board know about that? It goes to the Executive Team --

MS WILSON: Where you have a serious incident. We have a 12

o'clock dial in with the -- that happens every day with the Corporate Team. If you have serious incident you dial in to

a 12 o'clock meeting to discuss them. That happens every day. You do not dial in every day. We used to, we used to have a dial in every day in the early days, but this would just be if you have a serious incident or something moderate and above that was not straightforward or that you suspected might be more serious.

We do a rapid review, which we like to turn around in two days. That gives us an idea about whether this is something that will go to root cause analysis, or may require STEIS very quickly. There is involvement outside of the division; none of this is done within. There is much broader links now with the Corporate Team. Much closer links with the Chief Nurse.

PROFESSOR MONTGOMERY: That was not quite the question I asked, which is about the Board. The board is part of the Executive Team, but it is also the Chair, executive directors. Would you have expected this to have reached them or not?

MS WILSON: I am not sure it would have then in a very clear-cut easy to see process. I would be confident it did now. The congruence is much easier to see now; much more clearly.

MR BROOKES: There is a routine report to the Board on

24 incidents?

25 MS WILSON: There is now I could not be absolutely

certain --

PROFESSOR MONTGOMERY: When you say "now "-- roughly when would it have started?

MS WILSON: I am aware of it because that is where I am working now. I know they would be cited. I am not sure in June 2013 that would be the case.

PROFESSOR MONTGOMERY: That is fine.

You did a review of governance arrangements. You have got a sense of what you inherited and you have described what has been put in place. One of the questions is trying to understand how the various approval processes for FT and the rest could have been passed, given what appears when people come in later to be either non-existent or non-functioning. Does it surprise you that this was an FT when you did your review of governance process?

MS WILSON: I am wondering how they would have gained assurance.

PROFESSOR MONTGOMERY: I think we know the details going forwards.

The only other thing is, and there may be nothing in this, but I will be interested to check. I understand that you have a local Government position as well. Is that right?

MS WILSON: Sorry?

PROFESSOR MONTGOMERY: You are a councillor as well. Is

that right?

MS WILSON: No.

PROFESSOR MONTGOMERY: That must be cross-purposes then.

MS WILSON: Not that I am aware of.

MR BROOKES: Have you ever been?

MS WILSON: No.

PROFESSOR MONTGOMERY: I will ask the question I was going to pick up anyway because we find it quite hard to understand how the public and patient involvement connects to the governance processes. We have been trying to find out was this a part of the world in which the links were powerful. I just wondered how you linked what you have described us to, in terms of the governance process, with the public engagement?

MS WILSON: The public engagement that has been going on as part of Better Care Together or just within the service?

PROFESSOR MONTGOMERY: It is really about managing risk and the serious incidents and things about whether this is something which pulls views in from patients or not.

MS WILSON: We have sort of been open and honest right from the get-go. That is about one, you know, in particular cases we have always tried to engage. We have really encouraged our managers to have bedside conversations with

everybody actually, not just people who have had serious issues, just as a reassurance that people are coming into a

hospital that has clearly got a very poor reputation. We have tried to encourage that. Is there anything we can do better? That has been going on for a long time.

In terms of where people have had incidents that is about a telephone call?. We try and get a senior person to that person really quickly. It does not necessarily have to be me or Sasha; it can be a matron or manager. We like to give them a point of contact; that is often useful if it someone outside of the investigation.

Certainly all complaints I co-ordinate, but I do not deal with them, so that would be me for complaints.

We always try to do a face-to-face with the clinicians involved, if we can.

We have tried really hard to get our users on our groups and committees. That has not been easy, I have to say. We have got the Maternity Services Liaison Committees on in both CCGs now, which has been hugely beneficial --

PROFESSOR MONTGOMERY: They seem very recent compared to what we might have expected.

MS WILSON: Certainly the one towards Barrow is very recent. The one in North Lancashire has been going for a little while now.

PROFESSOR MONTGOMERY: Do you have a sense of why it has

been difficult here to get people in the process?

MS WILSON: I do not know if it is a trust thing. I do not

know whether it is that. I do not know. It is not normally something we struggle with; in maternity people are usually very keen to be involved in maternity services. When we have done some of the commissioning stuff they have been terribly fraught meetings. Really fraught.

PROFESSOR MONTGOMERY: Elaborate a little on that.

MS WILSON: We had lots of tears on both sides. We really did not get to talk about commissioning because people still have a story to tell. People do access -- we have listening services, but, I think, the pain of what has happened at Morecambe Bay is going to be a long time coming out. It is not easily fixed.

PROFESSOR MONTGOMERY: Can I push you a little? There is the theme that has come up in a number of places; it is a theme about what it is that people think has happened. There is one set of themes, which is people are very anxious they might lose their maternity services so they become anxious about being seen to be involved in anything that is critical to the service so they deal with that. They are the sort of the story would be actually, "We have a good experience and we might lose", as opposed to the tragedies of the families that have come to talk to us, where the story is quite different. Can you --

MS WILSON: Is a real dichotomy because you hear very loud voices, quite rightly. For instance, when we needed to step

down services, when we moved to step down services because we could not maintain safe staffing in SCBU, the speed and force of reaction, that did not enable us to do that, was surprising because we thought we were acting to safeguard women and their families, but actually they wanted a service whatever the risk. There is a bit of a dichotomy. You are right; people do not want to lose that service.

PROFESSOR MONTGOMERY: The emotion is charged all round; it is not in one particular group?

MS WILSON: Yes. Yes.

MR BROOKES: Thank you. I want to go back to some of the themes we have touched on. I am really interested in your assessment, which you have made, when you came into post, about the deficiencies in the governance arrangements at the time. If you could summarise that for me, that will be really helpful.

MS WILSON: Okay. My impression was that governance had been left to one part-time person on each site and --

MR BROOKES: Is this maternity services?

MS WILSON: Yes. It was under-valued. Governance was not understood. The value of governance in safety, it just was not understood. It was not wilful blindness; they just did not know what they did not know.

MR BROOKES: Okay. How does that relate to governance at a corporate level across the organisation?

MS WILSON: At that time?

MR BROOKES: Yes.

MS WILSON: In my opinion, that is all I can say, at that time, was that that was the model that was replicated. It was minimal. There were teams dealing with incidents, dealing with serious case reviews, dealing with the risk register. But corporate sat fairly separate to the divisions and the divisions all did their own -- made their own arrangements.

PROFESSOR MONTGOMERY: Can I touch on something? Our remit is particularly around the maternity services. One of the questions we have been asking ourselves is around the Care Quality Commission visit and other services. It feels a bit odd that there is one part-time person dealing with maternity governance, given the history that emerged there. Is your sense that the risk and governance in maternity were any better or worse managed than the rest of the Trust? The CQC uncovered all sorts of things about A&E --

MS WILSON: I would say that maternity was not an outlier.

PROFESSOR MONTGOMERY: Yes.

MR BROOKES: It was typical. Yes.

MS WILSON: Yes.

MR BROOKES: Would you recognise issues which had been

raised with us about concerns being raised with clinical leaders within a service, but feeling it does not go

anywhere or it was not heard?

MS WILSON: Yes.

MR BROOKES: Do you think that is symptomatic of the processes or the approach to governance at the time?

MS WILSON: Yes.

MR BROOKES: Thank you. You mentioned transfers. What was your assessment of the processes for procedures for transfers at the time when you arrived?

MS WILSON: There was no clarity about when -- who would make the decision, when it was appropriate to do so. There was no clear guidance and it was not the culture to transfer.

MR BROOKES: Would you be surprised if people felt comfortable that they were transferring appropriately at the time?

MS WILSON: I would not be surprised that they felt comfortable.

MR BROOKES: You wouldn't be surprised?

MS WILSON: No, because that was normal. That was the culture. That was acceptable.

MR BROOKES: That is very helpful.

Similarly can I ask about the process of root cause analysis? I have seen some of the evidence of root cause

analyses that has been produced which, I think, was call four. Is that a fair assessment?

MS WILSON: Yes.

MR BROOKES: How does that compare to what happens now?

MS WILSON: The root cause analyses now are of a high quality. There is a quality assurance process. There is fresh eyes on them before they go outside of the division, before the action plan is agreed.

We have done very robust training. They are multi-disciplinary; they are not led by one person. There is a team around each RCA. They are very practiced because we did so many because we chose to have heightened vigilance in terms of what required an RCA. I cannot think of any consultant that has not had to do one. All the matrons are fully versed. Our supervisors get involved. It is just the normal thing now that people are asked to be involved in.

MR BROOKES: Thank you.

You have described it as being on a journey. It has been very helpful to hear that. Where would you say that you are on the journey? What are the big things you still need to achieve?

MS WILSON: In terms of the process, in terms of being absolutely sure we know want we need to know, I think that they are there. In terms of that is forever, it is a continuous cycle and there will always be things that you

find, that is forever. We are never not going to find anything. The thing is now we have got the processes in

place where we are looking in a very robust way and we are acting upon the things that we find.

MR BROOKES: Would you describe your governance processes now as being safe and robust?

MS WILSON: Yes.

MR BROOKES: Thank you, that is helpful.

One final thing. The whole purpose of governance is to improve and make sure that there is safe patient care. Can you equate improvement in safe patient care to what has happened in the changes in governance.

MS WILSON: Not as a stand-alone because it is the staff that have made changes. In terms of having a very clear framework for how that works, yes. But it is about the staff implementing the changes; that is the biggest change for me.

DR WALTERS: A few specifics. You have cot central monitoring now have you?

MS WILSON: Central monitoring?

DR WALTERS: K2 central CTG monitoring?

MS WILSON: In terms of training?

DR WALTERS: No, in terms of CTG monitoring. Have you got the K2 software?

MS WILSON: No, not unless it has been in the last few

24 months, but I do not think so.

25 DR WALTERS: K2 electronic CTG package.

MS WILSON: That is training.

DR WALTERS: Just training? That is not sort of on site --

MS WILSON: No, it is not with a central monitor, no.

DR WALTERS: The second thing that has been mentioned a few times is the out-of-hours arrangements for Caesarean Sections. What happens with that now?

MS WILSON: Again the rotas are very clear now, which they were not always. Our arrangements for contacting people are very clear now. We have always got a first team on-site. Always.

DR WALTERS: Yes.

MS WILSON: This is if we require a second team. But everyone is aware of who that is now and the contact is the same.

DR WALTERS: The access to -- physical access to theatres is easier?

MS WILSON: Absolutely fine. We have now got a second fit for purpose theatre at Lancaster. It is still co-located at Furness; there is not a theatre suite on delivery suite. They have one theatre, but it is down the corridor -- many theatres. There is one just only does maternity, but there is access to other theatres.

24 DR WALTERS: You were appointed in October 2011.

25 Gold Command was set up --

MS WILSON: Yes.

DR WALTERS: -- around that time. What we have been told from other people is that it was around the time of Gold Command that the resources started to be put in place and more started to happen.

MS WILSON: Yes.

DR WALTERS: Was your post prior to that? Were they going to appoint you anyway?

MS WILSON: I think Sasha came into post in May of that year, completely unaware of anything, and the gradual realisation of the size of the problem grew and the education of the midwives was obviously a priority. So my post, at that time, nothing to do with anything that had been identified; it was literally that we need to address that very, very quickly. It was when the second CQC visit and the enormous action plan report came out with 118 different risks, that that became a more substantive -- not substantive but a more long-term post.

DR WALTERS: Yes. You were saying that things are very different now. There has been a big change at Board level since then.

MS WILSON: Yes.

DR WALTERS: I suppose you would expect a new Board

to be more receptive to this sort of stuff because they are under pressure about it.

MS WILSON: Yes.

DR WALTERS: But do you think that the sort of understanding of risk and governance is any different?

MS WILSON: Totally. Totally, yes. Absolutely. It is all the very simple stuff that is very difficult to do. How things feed through, terms of reference making sense. All those things were very disparate. A massive exercise in mapping all that out has gone on so things work now. There is a process. You can stand back and say, "I know that goes there because this is the process". And how do we monitor that process is very clear. Attendance at meetings is now monitored very carefully so the right people are in the right place to make the right decisions.

None of that was in place. That is the changes I have seen that make -- it felt like a vacuum to begin with because we were not working to any of these processes outside of the division and that is the difference for me. Now as a division you could not fail because someone would be monitoring your performance.

DR WALTERS: Okay, thank you.

MR BROOKES: Anything else? No. We are going to pause there in terms of the public session. There is a couple of questions I want to ask about a particular case. I don't

think it will be very long but we want to clarify something.

If we can formally note that we have closed the public

session.

(The hearing continued in closed session)

THE MORECAMBE BAY INVESTIGATION

Interview with John Woodcock, MP for Barrow and Furness

Friday 2 May 2014

Investigation Interview Panel

Dr Bill Kirkup CBE -- Chairman
Professor Stewart Forsyth -- Expert Adviser, Paediatrics
Mr Jonathan Montgomery – Expert Adviser, Ethics

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(1.45 p.m.)

THE CHAIRMAN: Hello. Thank you very much for coming. I would like to welcome everybody who has been able to join us today. This is the first interview of the Morecambe Bay Investigation as part of our evidence-gathering process.

I am, with some apologies to you, sir, going to go through a little preamble because I want to make this the same for everybody at each interview, so it's a kind of standard thing. I am, though, grateful to you for making time in what I know is a busy schedule to come and talk to us. You've had a chance to meet just now Jonathan Montgomery and Stewart Forsyth, so I'm not going to go through their details again.

We three are the panel representatives today. We will be asking you some questions and seeking your views. Family members – who I am glad to see are here – have had the chance to tell us about their topics in general that they would like us to explore with everybody, but won't be part of the questioning process.

You'll note that we've got microphones and that we are making a record of the proceedings. This is to aid production of the note of the interview; it's not something that we will be making public at this time. But we will potentially give family members who can't be here today the chance to come and listen to it at a subsequent occasion.

Some of you will have found it unusual to have to hand over your mobile phones and electronic devices. Again, apologies. We have to treat everybody on a level playing field, and I can assure you that I've had to do exactly the same thing. That's to make sure that we don't have parts of interviews shared in advance of the full report being produced because I think it's very important that we make sure that all of the evidence is considered in context of the whole investigation, and not bits lifted out here or there and perhaps subject to misinterpretation. So apologies to everybody for

that bit of process, but I do think that it's important.

That also extends to any manuscript notes that people might feel like taking. Of course you are welcome to do that, but please would you keep strictly to what needs to be noted down and not share it more widely afterwards.

In the unlikely event that the fire alarm sounds, it will be a genuine alarm, and members of the team will escort you to a suitable place. I don't have any more housekeeping announcements to make, so without further ado I will pass over to Stewart please to begin the questions.

PROF FORSYTH: Good afternoon. I'm pleased to meet you.

MR WOODCOCK: Nice to meet you.

PROF FORSYTH: I wonder if we could begin by asking you: when did you become aware of concerns regarding the quality of healthcare in Furness General Hospital?

MR WOODCOCK: Of course. But would you mind if I could just take a couple of minutes or less, just to say something at the beginning.

PROF FORSYTH: Absolutely.

MR WOODCOCK: This is not a prepared text, but I just want, in the first instance, to thank... I am personally grateful, and I think on behalf of the constituents, for the fact that you are doing this at all and giving up your time. And I know that it has taken a long time to get to this point and you have actually been one of the catalysts for speedy resolution of it, in a process which has been – I have to say, this is difficult for me to say, as a Member of Parliament for the area – but one which has been almost entirely in the first instance driven by the grieving families themselves. And we would not be here – and I would not be here – if it were not for them. So I've said in the past in public that I am deeply grateful for them, but I think it is important that I start the evidence

that I am giving with that.

Just two further things briefly, if I may. There are many, many thousands of people I think – it's not an exaggeration to say that – who walk around the Furness area and Morecambe Bay, and the reason that they do that is because their lives have been saved by people at Furness General Hospital. And I'm not seeking... This is not a particularly dramatic point because often the ways in which people's lives are saved are pretty sort of mundane and routine, but I would say that, you know, my wife and my youngest daughter's lives were saved by midwives and the team at Furness General. It is a striking point to me and something that I have reflected upon a lot, but both of them picked up an infection when Molly was born – two years ago this month – which, if it had not been treated in a fairly routine way, would probably have ultimately have proved fatal. And obviously I see the parallel with the Titcombe family and others in that.

But all through this, and increasingly as time has gone on, I have seen the scale of failure which is culminating in this inquiry. And I think through all of the way in which you deal with this, and as a wider community we deal with this, I think those two points are important to keep in mind. It is so fundamentally important that we get proper resolution through this, which is why – again – I'm really grateful for doing this.

Anyway, to the question. I was aware of the problems at Furness General Hospital before I became a Member of Parliament, and that was principally through serving in a completely separate capacity. The former MP, John Hutton, I was his Special Advisor in a number of Whitehall departments in Government. So I had no formal role. And indeed I was formally kept completely separate from his role as a constituency MP. But I was, as you would imagine, aware of the problems. And when

I put myself forward for selection to replace John as the Labour candidate in Barrow-in-Furness, and then was selected and formally became the Labour candidate, clearly there was the ongoing issue. And James Titcombe in particular was already pushing and had – I was aware, though not in the detail – considerable engagement with John Hutton and his office.

I think my first formal contact with James, as a Member of Parliament, to my recollection and my records, came in June in 2010 when he was seeking assistance at that time to explore what avenues of – I think legal aid support – for his battle at the time to get the Coroner in Newcastle to agree to an inquest into the death, which, when he eventually got that, obviously set in train the circumstances which leads us here.

PROF FORSYTH: So what about wider involvement in relation from the local constituents regarding? I'm just trying to get a feel for the sort of wider concerns that may have come to you from your constituents.

MR WOODCOCK: Well I was struck at the beginning by how... by the stark difference – and we're talking in very general terms here – but in the difference between the majority of my constituents either instinctive or... instinctive feelings towards the hospital and its staff, all based on experience, and the, obviously numerically, relatively small group of people who felt wronged, and clearly had very substantial and tragic and very painful evidence of why they had been wronged. But I was struck from the beginning by the fact that that was not taken by – I guess the majority of feeling within the community – as signs that there were fundamental failings or problems in the hospital. I think it was seen as... they were seen as sort of isolated examples.

And I have to be honest – and I'm not doing that in naming anyone in particular. There were a lot of people who felt that, you know, well maybe... well, bad

things had happened, but sure bad things happen in hospitals sometimes, and these are people who have got this out of proportion, understandably in their grief, but really I wish they weren't giving the hospital such a hard time.

And that was a widespread feeling. It still exists to some extent, but I think the majority view has radically changed as time has gone on, and they have been determined to make their case of what has happened.

MR MONTGOMERY: Could I ask a bit more about that? Because one of the things we are trying to get clear is: at what point it felt as though there was a big question to be asked, as opposed to a group of tragic cases that needed to be understood individually. When did it feel as though there was a pattern?

MR WOODCOCK: Well let me be absolutely frank with you in a way that I have been when I have seen James and other members of grieving families, as I've been able to. I had a very difficult relationship – I'm sorry to digress, but I think this is important in answering the point – I had a really difficult relationship with James Titcombe, with Carl Hendrickson, with the Brady family, in my first two years... up to two years as a Member of Parliament because they were deeply frustrated generally, and particularly with me because they felt that their concerns were not being seen as part of a wider problem. And I have reflected back on this a lot and whether I did the right thing at the time. And I think my conclusion is – and I think this is to a large extent reflective of wider views in the community – I mean I think I did sufficient for them in terms of what they were asking at the time, in terms of support I gave as an MP, but I did also think – holding that view as well – that actually, at its core, this was a hospital that was doing its best and by and large succeeding. And if I had listened... if I had been prepared to see things as James and the others saw them earlier – and that was not for

want of evidence – my goodness, I mean he and others were incredible at providing evidence, given that they had no formal support whatsoever. If I had listened properly earlier, then I would have come earlier to the decision that I eventually did, which was that there were fundamental problems.

THE CHAIRMAN: What changed your view?

MR WOODCOCK: It was the Coroner's report in June of 2011. And I think I did what it was right to do, I think, in trying to support James to be able to get that report to happen. But it wasn't until actually you read what Ian Smith said on the scale of the failings. And I think, most alarmingly, he came to a categoric conclusion that there had to be collusion and lack of transparency and honesty amongst the witnesses in key parts of the evidence. And suddenly you thought, well hang on a minute, this really is very serious and this is not an isolated thing. And actually I think you saw the CQC from their immediately commission more investigations, which set off a train.

I mean I've been going back and reviewing my correspondence, principally with James and some others, in preparation for coming to talk to you today. And actually my most difficult point in my relationship with the families came immediately after this because my view then became 'Yes, clearly there is a very big problem.' But it took me some time to be convinced that a further independent investigation on top of all of the other investigations was going to be necessary, when you compared to the undoubted instability which this kind of thing unnecessarily creates within the Trust.

And for a long time I was convinced by the Government's argument that no consideration could be given to further inquiries while the police investigation was being carried out. In my defence, I guess, looking back, it was hard for me to come to an alternative... the factor mitigating against me in coming to an alternative view was

that I had no contact with the police at all, so it was very hard for me to know exactly what they were doing and what they weren't doing.

But as time went on and the families pressed and pressed further, it just became apparent to me that the scale of the failings were so great and that you could look at them in such a way that didn't necessarily go into what a criminal investigation would need to, that this ought to happen and it ought to happen as soon as could be managed.

THE CHAIRMAN: Sorry, Jonathan. Do you want...?

PROF FORSYTH: Can I just follow up in relation...? Obviously we're interested in the constituents' view of this. But I wonder if there had been much contact with yourself and staff who were working in the hospital and what was their perception of the events that had taken place, and obviously the continuing inquiries and investigations?

MR WOODCOCK: I think I saw... Well, I would always see staff when I visited the hospital, as I would do on a number of occasions, but that was not the forum in which these kinds of views would probably be aired. I probably had less contact with – although I had a substantial amount of contact with staff in various ways, I probably had less contact with them than with James Titcombe, again, thanks to his tenacity. But where there were points of contacts, whether they were formal through formal meetings, or actually probably more useful to me, informally through contacts in the community – you know, you've got thousands of people who work in the hospital. This is a close-knit community and so so many people have got family members there. And so I built up a very clear picture of staff who felt absolutely under siege by what was happening. And as more and more controversy was there, there was a feeling that they were struggling to do their jobs because of the level of attention which was on the

place, which I completely understood. But it was probably... you know, while all of the people that I spoke to I think generally wanted to do the right thing and ensure that justice was done, there was a core belief that actually the hospital was being unfairly criticised. There are no two ways about that.

THE CHAIRMAN: There is a natural tendency when these kind of things happen, which can be counterproductive, but it is a tendency to close ranks. But I guess what we're getting at here is: did you detect anybody who wanted to break ranks? Was there anybody who said, 'Actually, I've had enough of this and I need to tell you about some other things'?

MR WOODCOCK: Surprisingly, no one directly came to me. There was a sense that... There is a report of... I know when the former Chief Executive... Tony Halsall's position was clearly under threat, that a consultant spoke out anonymously. He or she did not do that to me, actually, and so it was quite... Now you ask the question, it was quite marked actually, I think, and I will revert to you if there has been an instance, on checking my records, where this has happened and for whatever reason it has slipped my mind. But actually it is quite marked by the absence of that.

Actually, with a proviso of – and this was third-hand – and I wasn't, for reasons that I don't want to go into to break confidence – of a couple of staff members who had come into the Trust from outside and then went away again, who were saying, 'We weren't very impressed by what we saw at all.' So that difference, I think, between community and potentially people coming in from the outside may be marked.

MR MONTGOMERY: Can you tell us roughly when that was? Part of this is to get our heads round what the timeline is.

MR WOODCOCK: Can I come back to you on that, if you don't mind?

MR MONTGOMERY: It would be very helpful just to have an understanding.

MR WOODCOCK: Yes. But you will not be able to treat this as definitive evidence because it was third-hand and I was not able to pursue it. And I'm sorry, also to be... I also should be clear that – and so it may rule it out, given how directly you would wish to continue focusing your investigation – this was not someone who worked in maternity or neonatal services directly.

THE CHAIRMAN: Okay. I mean that is relevant to us as well because we are obviously concerned with the governance of the whole hospital.

PROF FORSYTH: I mean, just to be absolutely clear though, you weren't... It wasn't brought to your attention or you weren't aware of a sort of divide between the clinical staff and management in the organisation?

MR WOODCOCK: I was... No one on the clinical side came to me blowing the whistle.

MR MONTGOMERY: Can I ask a connected question around the way in which, in this part of the world, community and patient groups sort of air and discuss their concerns? The NHS varies across the country in terms of whether it's done formally – and I'm thinking of things like client-patient involvement forum or Maternity Services Liaison Committee. In other places it's just very strong community groups. What was the way in which you might have expected to hear about concerns, if there'd been there?

MR WOODCOCK: Well, we have not... this has not been a question of something like Healthwatch knocking on my door. This is a tight-knit community and nearly everybody has strong connections with the hospital. And so... And, you know, I think my networks as a Member of Parliament are quite good. And I think the way of patients... I think I've been able to pick up a pretty accurate impression of the scale of content and discontent within patients. And then I think there probably is a question of staff voice through this and how that has been handled in the past, and whether changes

ought to be made in the future.

PROF FORSYTH: Can I ask about...? We have been very much focussed on Barrow – of course Furness General Hospital is part of a wider Trust. I wonder what your feelings were in relation to the wider Trust's involvement in these particular issues. Do you feel that... had you been in discussions with the Trust?

MR WOODCOCK: Well I... Every time I... Every visit as a Member of Parliament I made to the Hospital, I think I would see Tony Halsall, the then Chief Executive, and part of that would be... and part of whatever visit I was on would be catching up with him. To my recollection, on every time that I saw him I would raise James's case because that was principally... it was Carl Hendrickson as well, but it was James that was principally on my mind. And we would talk through the issues. Although I don't think... I think formal representation had been made previously by John Hutton, and so this was a follow-through on that.

And as Tony Halsall described it to me at the time, it was on the – and this will be reflected I'm sure in his official communications – he, on behalf of the Trust, was admitting that clear mistakes had been made and that the Trust had failed Joshua Titcombe and the Titcombe family. But it ended there.

And it was as the case went on and you saw, actually, that there was so much more outside of that, from the Fielding report, the compelling evidence that was crystallised in the Coroner's report about how the evidence that had been presented by practitioners could not be the totality of it – that I was then retrospectively looking back at those conversations, which to me were, I have to confess, you know, convincing at the time. And think, you know, that could not have been the full picture. And therefore... And as a Chief Executive, you know, you must... you had a responsibility

to know that – so if you didn't, you were either not doing your job properly or you were keeping something from me. And either way, you know, that was not good practice.

THE CHAIRMAN: Did you form a view on which of those two alternatives would have been the case?

MR WOODCOCK: If I could answer in relation to the practice of the Trust in general, rather than any particular individual…

THE CHAIRMAN: Sure.

MR WOODCOCK: There is in my mind a pretty compelling weight of evidence now, so that this was not a Trust that was being at all open. The criminal investigation obviously continues and we can't second guess that, but let me say that I completely understand why this ought to be a criminal matter. And I don't say that lightly.

And so there is that at the extreme end, but there is… A picture built up over time of some relatively minor incidents… of a Trust that was just not acting… whose first instinct was, as you say, to close ranks and protect itself, rather than being prepared to lay itself open to proper scrutiny.

If I can give you one example which stuck in my mind, which again was sort of, in the scale of things, relatively minor. But if you go to – I think it is on page 25 of… unfortunately this record was in my phone, which I was going to… I think it was page 25 of the CQC's report in September 2011 when they first raised the warning notice. And it talked about the issue of straps which could be deployed in contraction I think when – I don't know the biological… the medical use for them – but they were straps that were part of the maternity process. And it had been spotted by one of the investigators that these were being hung up in sluices, apparently having been washed. Now they are very clearly single-use straps. And so it was poor hygiene practice.

Now it stuck with me, and it has stayed with me, that the response of the senior official at the time when asked about this was effectively to make up a story about it. I mean, she didn't say, 'Oh yes, you're right, we shouldn't be doing it.' She said, 'Oh no, they are being used for training purposes.' Now when the staff were questioned about this, they had no knowledge of it. This is referring directly to the report. The staff had no knowledge about that. And they said, 'No, we do reuse them.' And then when I actually asked that official, as I happened to do – I didn't know which official it was, but when I asked the person who was showing me round, soon after the report, in a subsequent visit – I'd have to check the dates for you, but it was quite soon after this report – and I said, 'Oh I was concerned about that.' The first response from the official was: 'Oh I don't... I'm not sure what you mean. I don't know what you're referring to.' And then quite soon it was clear that that was not sustainable and she said, 'Oh no, actually yes, I do know what you mean, and yes, that was me who said that.'

And this is one snapshot, but I think it is one snapshot of many of a Trust who, at whatever cultural level – but there is, I think, a suggestion that unfortunately it did cascade down – that the attitude to external investigation was not one of being open. And that has had deeply damaging and almost certainly tragic consequences. So the seriousness of it... It is hard to over-exaggerate the seriousness of that.

MR MONTGOMERY: And if you were visiting now, do you have some illustrations of what the culture feels like now when you visit? Has it changed or...?

MR WOODCOCK: I do get a sense that there is now a clear recognition that the failings of... that the past culture was not right. And there is a very explicit... a very... The Chair and the Chief Executive very explicitly say to me that they will be open and deal

with this. Now I have no reason to doubt that, I don't think, but I have to say that the evidence is still... the jury is, by necessity, still out.

MR MONTGOMERY: Can I flip that round a bit? If people talk to you and they tell you things – in the way they clearly didn't in the early stage – at least that will tell you that things do bubble up to you. Now you might not be told anything because there isn't anything to tell, but have you been told things more than you were told before?

MR WOODCOCK: No. No I haven't. And then I guess I am... I mean I guess I ought not to be the first port of call. The CQC's investigation process is clearly more thorough than it was, and that is to be welcomed. And they have a greater degree of confidence in the unit than they had. And I have no doubt that the unit is staffed by people who absolutely want to do their best and improve. And I want to be absolutely clear as well, if there is... Criminal investigation aside – and it is very important to say that – the responsibility for the culture that I can sense in that organisation comes from the top, and it has filtered its way... it filtered its way down.

While we are talking about this though, I think it is important for me to flag up to you that I have an inconclusive but worrying sense that the issue of records going missing in important cases is not confined to maternity and neonatal. I think you will have heard from a number of families who feel they have incomplete records. And I hope this is something that you are going to look at, and I hope it's something that the police are looking at. But I have one definite example, which I am not at liberty to share with you at the moment, through patient confidentially, from an entirely unrelated department where it is... when you look at the sensitivity of the information that has gone missing. And in this instance, actually the family themselves have records of the information. It is hard to conclude that that was an accident.

THE CHAIRMAN: Okay. Now for us to—

MR MONTGOMERY: Just to be clear... When? Is this something recent or does it go back to the same sort of period as we were talking about?

MR WOODCOCK: It is certainly not since the management changeover.

MR MONTGOMERY: Okay.

THE CHAIRMAN: That is obviously something that is very relevant because it matters a lot to us how generalised this problem was. Given that that is clinical information, for us to be able to follow that up we need to be able to speak to the person concerned.

MR WOODCOCK: I know.

THE CHAIRMAN: All I can do is leave it with you. I would ask you to use your best offices to suggest that person makes contact with the Investigation Panel. And we will treat that entirely in confidence, of course, if he or she is able to do that.

MR WOODCOCK: I will pass that on. And I have had an initial conversation, and on the basis of that that is all I can say at the moment.

THE CHAIRMAN: Understood.

MR WOODCOCK: I hear you loud and clear. Can I possibly have some more water? I had some, but I've drunk it all.

PROF FORSYTH: Just again, to sort of clarify these points a bit more, obviously the Trust is beyond Barrow, and includes Lancaster.

MR WOODCOCK: Yes.

PROF FORSYTH: Do you think that the issues that you've described in relation to the Trust are throughout the whole Trust? Or do you think somehow Furness General is an exception within that Trust boundary?

MR WOODCOCK: Well I'm not... As I hope you'll appreciate, I'm not in a position to be

able to say. I certainly cannot point to examples that I know of outside of my constituency, but you would probably not expect me to be able to.

I mean I find it hard to conceive – if there was indeed a problem with openness and transparency and evidence – as I say, that it did not go towards central management function. And therefore I would be surprised if it was a single spoke which dealt specifically with one hospital and then went up into the middle.

MR MONTGOMERY: Can I take you back to something you picked up earlier, which I think you answered really helpfully about...? We were trying to get our head around the question of individual tragedies and a pattern. And you described how the Coroner's report made you realise that there was a big question to be asked, as well as the little questions.

MR WOODCOCK: Yes.

MR MONTGOMERY: One of the things you said then was that – and I think this is very understandable, from what we've read in the public domain reports – that there was a lot going on already in terms of investigating things. But it's not always clear who knew about which inquiries as they were going on. So it would be really helpful, in that pattern, before the Coroner's report in 2011, when part of your judgment was that you were aware that there were a lot of investigations going on – which ones the people were telling you about and how it felt to you, from what you knew from outside, they were going and how likely they were to resolve the problems?

MR WOODCOCK: Well I guess that, in my mind... When we were at the process of me having, I guess, woken up to the issue that this was a systematic problem, not one of isolated individuals, and before I formally changed my view and wrote to the Secretary of State asking for an independent inquiry and seeking the meeting with the minister

that we eventually got, with James Titcombe, where the minister did agree that this should happen. I was aware of the CQC's investigations into this. It is a sometimes complex relationship with Monitor, looking down. And the police investigation.

Now historically, by this point, I guess I was aware of the Fielding investigation, but that had of course concluded. And I don't think any of us were aware at this point of the internal investigations that were happening within the CQC, which finally came out in the Grant Thornton report last year, to which I wrote to you about, and I think you didn't fully agree with me.

THE CHAIRMAN: I take evidence into account. We—

MR WOODCOCK: No, what I meant was: I wrote to you at the time of the Grant Thornton report, saying, 'Look, I think this is the failure of the CQC,' and the idea that this could be part of a – as the Grant Thornton report put it – an ongoing conspiracy – is that the words that they used? – an ongoing suppression of information – I thought was very important and material and needed someone to look at it. It remains my view that if you feel that you are able through this to come to a view on that, you would be doing a great service.

THE CHAIRMAN: That is absolutely part of our remit and I'm sorry if I gave a different impression. I didn't mean to.

MR WOODCOCK: No, no, well, that's my point. I'm really glad to hear that, thank you.

MR MONTGOMERY: So if I can perhaps pick that up? I'd like to just try to understand your take on the various different external organisations that were dealing with this.

MR WOODCOCK: Yes.

MR MONTGOMERY: And clearly we are asking you to talk about what you were aware of. We've got the Grantham Report and are reading that. But can you just take us through

your impression of how the CQC sort of grappled with this?

MR WOODCOCK: Well my impression now is probably entirely unremarkable and I don't think you'll find anyone who would be prepared to put a counter view – was that they dealt with the matter pretty appallingly, in hindsight, with what we know now came out with the Grant Thornton report.

MR MONTGOMERY: On the basis of what you saw at the time, what—?

MR WOODCOCK: On the basis of what I saw at the time, this was an organisation which had looked... which had done a number of checks and had found, on a number of occasions, improvements. And therefore I don't think I was looking at it... I don't think I was... well, I don't know. There's a personal question for me, I guess, as to whether I was just wanting to believe that the hospital was okay, and therefore taking the word of the regulatory body over the... you know, the very detailed and thorough evidence compiled by James Titcombe, principally, and others. And, with hindsight, I was wrong. But this was a respected regulatory body who was saying, 'We've looked at this and at these things, but they're getting better.' So partly their word, I think, would always have carried weight, and it certainly did with me at the time.

I think also I would say probably in their defence – though I'm sure, you know, they will put this case much more strongly than I am – you know, this was a Trust that on a number of occasions said it recognised stuff and was making improvements. Now it was the job of the regulatory bodies to show that those improvements had been made. But part of my concern for this was that the Trust was quite good at saying that improvements had been made, when actually it turned out that the culture had not fundamentally shifted. And that's a difficult thing for any regulatory body to get into.

MR MONTGOMERY: And there's always going to be a question about at what point it

might have been possible to spot that – because there's always going to be a lag, and we'll have to work our way through, won't we, on that? You haven't said anything about the Strategic Health Authority remarks—

MR WOODCOCK: No, I haven't, and the PCT. There remains a big question for me that they have not yet been able properly to answer – you know, I hope that they will, through the course of giving evidence to this inquiry, and I hope that they have reflected very carefully because the lessons that draw from this locally and nationally are very important. They had an oversight responsibility that ultimately they did not discharge.

MR MONTGOMERY: And did you have any contact with them in this period?

MR WOODCOCK: I had significant contact with the Primary Care Trust, yes. And they were obviously aware and engaged in the issues. Now they will need to give you an explanation, and I'm not in a position to be able to interpret this, although I am very interested in the answer, about to how and what extent they felt that they were relying on the CQC. And I'm conscious that this was an organisation that was a pathfinder, as a GP-led shadowing and commissioning group. And they were doing, I think – I'm really... you know, I admire and I'm grateful for the job that the GPs did in terms of – through this period – in terms of making the case, arguing for, and analysing the kind of services and investment which was needed in acute healthcare through this period.

But there is a question for me as to why the PCT and the Strategic Health Authority, above them, did not step in and be able to understand what we now see, with hindsight, was a Trust which was failing.

THE CHAIRMAN: My impression is – if I can just, just for a moment – my impression is that the PCT were more aware of some of the problems within the Trust, in particular at Barrow, than the SHA were. Was that your view?

MR WOODCOCK: I'm not in a position to say because I didn't have enough to form a view of what the SHA knew. But I'm sure you will want to hear from John Ashton, in particular, and others, as to why he allowed, and others allowed, this situation to continue for so long, apparently.

MR MONTGOMERY: Can I ask something which I think is related to that? But it might be something you are able to say. I'm trying to understand what people thought the issues were – because, when you read the reports, there's a range of issues there. So in your dealings with the PCT, you describe them thinking about the investment needs and the need to deal with acute care. What would they have said to you about quality issues?

MR WOODCOCK: Well partly there was a sense of to how much one flowed from the other, in the investment situation. Because we've always been aware, in maternity services and others, that we are trying to run healthcare on a standard with resources that are optimised for one centre and, arguably, not meeting the optimal numbers for even one, spread over three. And that was a very difficult task. And I hope that the sort of sense of perpetually-defying gravity that there has been in this and other services for a long time is resolved satisfactorily in the current review, which is sort of a separate but related question. So there was that.

But then particularly onto the quality issues, well, the timing again with the reports that came through, the same things were being highlighted. And at every stage it was sort of thought that they had been satisfactorily tackled, and it was the lack of communication between the consultants and the midwives and how management oversaw that, and whether things like clinical governance were there. But I think probably every... and I'm seeking to recollect conversations which were had in the course of a number of meetings which dealt with a range of subjects, but my

recollection of those conversations were always that there was an awareness of those issues but at every stage it was thought that they were being tackled because I guess, to a large extent, the evidence always pointed to that. Although it turns out that the evidence wasn't right.

MR MONTGOMERY: And I can understand that. Can I...? This is just trying to disentangle things. I'm trying to get my head whether that conversation would have been a conversation about 'well the Trust as a whole doesn't have enough money' or 'there's a communication set of issues', or would maternity have been the focal...? When you talked to the PCT, would they have said 'Maternity is the thing we're worried about' or 'A&E is the thing we are worried about' or would they say 'We don't have enough resource here to deliver the services'?

MR WOODCOCK: There has long been a question – throughout the time I was there, there had been a question about maternity services and how you sustain them and whether you could sustain them. Now my view, as you would imagine, was always absolutely categoric and remains: it would be a complete disaster for the area if it were to lose its consultant-led service. And I was always heartened in my conversations with the PCT through this period that instinctively they shared that view, but there was the sort of... there was the question of 'well, how do we make these sums add up?' But I always got the impression – and this has been I think subsequently confirmed by the commitment that we have now to retain consultant-led services – that they were coming at it from a point of view that they recognised that this would be—

MR MONTGOMERY: So if I could just check how that plays out to me, imagining what it might have sounded like. That doesn't sound to me like they were saying, 'We are worried about the quality of staff and the services there. What we are worried about is

sustainability and we will have to find a way to sustain them.'

MR WOODCOCK: Well, look, there is a sort of—

MR MONTGOMERY: I'm just trying to understand how people understood the difficulties.

MR WOODCOCK: I think that was... I guess in the order of priority of conversations that we had that was one that... sustainability was prime. But there was a... there clearly was a focus on quality. But, you know, you are asking me to give my recollections of conversations which have happened over a number of years without minutes being taken.

MR MONTGOMERY: And you're not the principal person. And we will get to the people who can.

MR WOODCOCK: But I guess my overall impression was, from them and from others, that the quality thing was a thing that was important but was kind of being sorted through the CQC channel.

MR MONTGOMERY: I can understand that entirely. And you may not be able to say much about this, from what you've said, but we've got the same question about 'What did the Strategic Health Authority think the issue was?' And the CQC report indicates a discussion of what the challenges were in January 2009, and there's a whole series of challenges entirely consistent with what you've described about consistency and quality generally. But it doesn't list maternity as that specific quality issue. It lists A&E as a specific quality issue. So I'm just trying to get my head around what you saw in terms of the conversations.

MR WOODCOCK: I can't give you a useful read out of the Strategic Health Authority. I wish I could, but I can't.

THE CHAIRMAN: Did you have regular meetings with them?

MR WOODCOCK: Not with the SHA, no. It was through the PCT. And, looking back, that ought to have been happening. And I will take some responsibility for that. But, you know, they should as well.

MR MONTGOMERY: So there's also some other people involved. There's Monitor... When the CQC begins to look more closely, the Nursing and Midwifery Council is also involved. Did you have any contact directly with those organisations?

MR WOODCOCK: Yes. With Monitor, yes, regularly, and reasonably extensively, from the point of I guess the middle of 2011 onwards. And they clearly were very concerned from the point of I guess the things that were set in chain by the Coroner's report. I was just coming into office in May in 2010 while the process of establishing the foundation trust was being finalised. And given that the hurdles before that had been seen to have been overcome, Monitor was not my prime focus at the time because this thing seemed to be going through. But from... You got a sense – and I think this is another thing that I'm concerned about, from the limited perspective that I was able to have – and I guess you will be too – of Monitor and the CQC, and I guess the NMC as well, although I didn't have contact with them in the same way, all reacting when the alarm bell goes off. And whether they did that in the most effective combined way others will be best placed to answer. But I can certainly see a situation where if your prime responsibility is to sort this out as quickly as possible or maintain a stable, running hospital, as scrutiny increases, dealing with three organisations that crank up in the way that they clearly did, may be difficult.

MR MONTGOMERY: And so did you have a sense that their work was coordinated or did it feel as though they were operating on planned separate forays?

MR WOODCOCK: They may say something different, but I never got the sense that they

were particularly coordinated. I never got the sense that any of them were doing things overtly or not, and I always welcome the extra scrutiny. I guess that was not a universally popular view at the time, by any means, but I always thought it was a good and necessary thing, although difficult, for the increased scrutiny to be on the hospital. But I never got the sense that this was an integrated, seamless operation by any means.

MR MONTGOMERY: Okay. That's a definite question for us to...

THE CHAIRMAN: Yes, it sure is. There's a sort of emerging theme which I'm keen just to pick up on and take back to its source, if I can. It starts really with the sustainability, the challenge to sustainability of services that I'm sure you rightly said was a sort of general... there was general awareness of that. Did you talk to the Trust about that when you were having your meetings with them, and what was their view of it?

MR WOODCOCK: Yes I did. And this was something which concerned me at the time. And then it became subsumed in the wider questions of service quality, position of the Chief Executive, and everything which flowed from there. But there was a... Even coming into this job new – and I have to say that, as a new Member of Parliament, even someone who had spent a number of years within Whitehall dealing with some pretty complex government systems, there was a steep learning curve for me to just understand how this local health environment operated and the levers which were there. But I got a sense at the time of, you know, wanting to be able to... getting a strong positive sense from the Chief Executive that they wanted to retain maternity services.

THE CHAIRMAN: Yes. And that the best way to achieve that was to be a foundation trust and have more control over their own destiny.

MR WOODCOCK: Well, I guess, but that position was really settled by the time I was there.

THE CHAIRMAN: Okay.

MR WOODCOCK: But I was struck by the lack of any financial pathway. Even as a new Member of Parliament coming to grips with this for the first time, the lack of the financial map to get to where the ambition was, given what you recognised even then was the scale of the deficit.

THE CHAIRMAN: So you've got an organisation there which potentially sees its services as under threat because that is how... the serious questions about sustainability of some of their pretty key services. And they start to pick up – and I'm hypothesising here – they start to pick up signs of something going wrong in that service. It's a very powerful incentive for them, is it not, to suppress any information about something going wrong in that service? The last thing they want is three organisations coming in to scrutinise them at such a sensitive time. Did you pick up any signs of that?

MR WOODCOCK: Well at the time, no, but I think I was wrong. Looking back at the evidence which has subsequently come out, I think absolutely. It is hard to get a different view from looking at the actions and the picture which is painted. But my impression at the time, and I might have come to a different conclusion with the four years' experience that I have now that I didn't have back then, but I, at the time, found Tony Halsall's manner of talking about this and talking through about the ways in which he had tried to admit responsibility and... I found that convincing.

MR MONTGOMERY: Can I ask about the reactiveness and the pro-activeness of the local NHS? If you had just been elected as an MP in the part of the world that I live in, the SHA would have written to you, giving you a pack of background information and things that it held about health needs and strategies to make sure that you had an opportunity to get briefed. And I suspect the acute trust would have done the same. I mean, did people make the effort--?

MR WOODCOCK: The PCT did that role. The PCT carried out that role effectively actually, and I'm grateful to them for the way they did that.

MR MONTGOMERY: And when they did that, I mean – what was the tone of the briefing on the Trust and the challenges? Was it about sustainability and the financial strategy? Or was it 'These are the things that we're working on that you might like to know about'? Did you get a feel about how they were presenting it to you?

MR WOODCOCK: I'm afraid I can't give you a recollection beyond the general, but my general recollection of those conversations was that they were principally focused around sustainability rather than quality.

MR MONTGOMERY: Would that have been a written briefing? Would that be something that you would be able to dig out or would it have been in conversation?

MR WOODCOCK: They might be able to dig out the material that they gave me. I would have to go and see if I had it. I certainly don't have an electronic record of it. This was, I think, over two or three meetings that took place at their local HQ, talking through different issues. And I just can't remember, I'm afraid, as you ask me now, what the written material was. They may have kept a record of it or not.

THE CHAIRMAN: It's easier for us to find documents if we know exactly what we're looking for.

MR MONTGOMERY: I think if we knew what we were looking for, that would be helpful. Because one of the things that I'm a bit unclear about is, if you like, which of the things that people didn't think were important then and turn out with hindsight to be important, and which were the things that actually people identified.

MR WOODCOCK: I know. I'm answering the questions as best I can, and I can only apologise for my haziness on the…

MR MONTGOMERY: Well we can follow that up with the PCT, can't we?

THE CHAIRMAN: Indeed we will.

MR MONTGOMERY: It's very helpful to know that that was there. There's one other bit I wanted to ask about, just in that phase, and then perhaps it would be quite helpful to pick up a little bit of sense about what you think the challenges are for us as the investigation. And you mentioned a couple of times that you were in correspondence with the Department...

MR WOODCOCK: Yes.

MR MONTGOMERY: Can you just take us through the contact with the Department and how helpful and how quick and how responsive it felt, bearing in mind that you've already indicated that there's a phase at which what you're asking for changes, and we understand that.

MR WOODCOCK: Yes, of course. I have this written here, which I can hand to you at the end. My first ministerial correspondence was actually with the Department of Justice on the issue of legal aid related to James Titcombe's struggle to get the Coroner's report. I then wrote to Andrew Lansley, then Secretary of State for Health, in July of 2011, passing on material that James had provided, and asking about the award of the foundation status and particularly about the need for a statutory duty of candour, which I think was, understandably and rightly, a focus of the families at the time.

I got a response back from Simon Burns, the Minister of State, in August 2011, declining to comment on the police investigation, giving reference to the regulatory bodies who were looking at this issue, and then setting out as to why the Government was currently minded towards a contractual duty of candour, which obviously subsequently they changed their minds on. Do you want me to go through

this?

MR MONTGOMERY: I don't think you need to go through it, but it would be very helpful to have it.

THE CHAIRMAN: It would. If you could let us have it, that would be great.

MR WOODCOCK: And the correspondence, yes.

THE CHAIRMAN: Thank you. That's really helpful.

MR MONTGOMERY: One very last question before we ask about what you think the challenges of the investigation will be. You've indicated you had—

MR WOODCOCK: Can I actually just say...? If you want me to give a flavour of the Department's—

MR MONTGOMERY: Yes, a flavour, I think would be really helpful.

MR WOODCOCK: I'm not passing judgment on this beyond – well, if I'm passing judgment on them, it is a judgment which I also reflect upon myself, I'm clear. There was, I think, a clear tone as you read this of 'Look, well, bad things might be happening but, you know, there are these people that are there to sort it out and really and frankly I'm not going to get personally involved in this from a ministerial level.'

And just as I did not at the time I think pay sufficient regard to the weight of evidence which James Titcombe had amassed, they didn't either. And it was clear from here that there were pretty radical failings. And it was not enough for the minister just to say, 'Well, you know, these people are dealing with this.' Given what we knew about other hospitals... And I've set out publicly as to why talking about Morecambe Bay as the next Mid-Staffs is wrong and it's very damaging to do so, but given what was happening there, more regard ought to have been paid at the time by the Department for the need to do more.

MR MONTGOMERY: Leading with that, did you have any reason to think or any sense that either at ministerial level or departmental officials or even in senior NHS circles nationally, Morecambe Bay registered as a quality issue? Did it just seem to them to be, you know, something working its way through the system and the system was designed to address these various questions that with hindsight looked like a pattern but might not have done at the time?

MR WOODCOCK: Well it registered as a... With the Department it clearly did register. It did register as a quality issue in one sense, but I never got the sense that actually... in a fundamental way. Now I ought... Monitor perhaps slightly differently – and I'm afraid if you want me to provide detail we need to go and reflect as to where these recollections came from, and it may be that I am being coloured by more recent conversations with David Bennett – once the issue of sustainability and the review into service provision was full-blown after this all... over this last year.

But I have more of a sense of... Monitor looking at this as potential – I mean, my view, as a potential threat to services. Because the last thing I wanted Monitor to do was to conclude that all of this was wrong and unsustainable and that the root cause of this was the fact that there were three hospitals, not two or one, and that therefore... I mean I thought, and I continue to think, that a process of the Trust going into the kind of administration with a view to slicing services off and making my constituents travel an hour down the road is a significantly worse outcome than what we have at present, but in terms of the number of... bluntly, the number of people who would die if that happened. And that in no way – I hope no one takes a view from that that I was prepared to minimise or overlook quality failings – I genuinely don't think that I was.

THE CHAIRMAN: I understand that absolutely. It also presupposes that anybody might

think that the root cause of all of what has happened to people in Furness General is because of the geography.

MR WOODCOCK: Well it does, but then—

THE CHAIRMAN: I think it would be a very moot point.

MR WOODCOCK: Well, sure, and I hope you will ask others about that because this is floated a lot. I mean, I guess you will be calling Sir David Henshaw for evidence.

THE CHAIRMAN: Yes, sure.

MR WOODCOCK: And I was highly alarmed by his sudden... by the Trust's sudden conclusion when he was there that actually the particular rota problems which happened to be there at the time meant that there needed to be this sudden downgrading of Furness General to a midwife-led services rather than consultant-led, which was going to happen within five days, with no end point as to when it was going to come back.

Now you will be in a better position than me to question exactly where the assumptions came from for that, but certainly I thought that that would be disaster. And I had deep suspicions that that could be being driven by a general feeling that this was unsustainable and if you could just find a way to short, sharp shock change it, then maybe that was for the best. And we stopped it happening. You will probably be aware of the details. It was stopped happening because of a lack of ambulance cover, but, you know...

THE CHAIRMAN: Yes. What we're doing here is drawing evidence-based conclusions; not jumping to conclusions that aren't based on evidence.

MR WOODCOCK: No, sure.

MR MONTGOMERY: I think this is the last bit, for me anyway. We were particularly keen to try and make sure that we addressed, as part of the investigation, the things that our

stakeholders need to get sorted out to the best that we can. We may or may not be able to get to the bottom of them, but we will do our best to try. And we clearly met with the families and asked them what they needed. But in terms of your constituents, what are the things that you would want to make sure that we knew had to be thought about as part of the investigation? So that we don't miss them.

MR WOODCOCK: Sure. I think they have come out through the course of this. I am deeply concerned by the lack of... the apparent lack of transparency from the organisation and how far that reaches. And it is fundamentally important that any vestiges that remain of that culture are absolutely smashed through this, and we can never go back to those days.

People have died because of this. I think this raises a much broader question on the way that the regulatory authorities... the regulatory bodies interact, and the gaps in that process. And if you feel able at the end of that to give wider recommendations for change, I think that would be very welcome.

And then there are, as you know now even better than I do, there are families who just feel that they have been given the run-around for many, many years, who are looking for answers through this. And I guess there is always a question as to what any inquiry – even any police investigation – can ultimately do. But this for me is, I hope, their opportunity to have closure on this.

And finally, it remains critically important to the area what the make-up of service provision is. I don't know to what extent you are going to be able to expose and shine a light on things which are useful to the separate review into service provision, but obviously I'm hoping, given the level of focus you are being able to put on it, that this will be helpful to that separate process.

THE CHAIRMAN: Yes, I hope so too. And I think one observation that I would make about this investigation as opposed to a police investigation – yes, they have legal powers that we don't have – but we have the great advantage, I think, under the present circumstances, that we are not bound by proving something beyond all reasonable doubt. We will demonstrate something on the balance of probabilities on the evidence provided.

MR WOODCOCK: Yes, of course.

THE CHAIRMAN: And I think that is an advantage to us. Thank you. We appreciate that.

MR WOODCOCK: Could I ask you two just brief questions, if I can and I've got the opportunity? First of all, in terms of your current timescale because your original terms of reference set a deadline for July I think, and I don't know where you are on that.

THE CHAIRMAN: Revised now to November.

MR WOODCOCK: November, ah yes, I think I should have known that. And then the issue of what the Ombudsman is able to do and not do. Even after the letter which you kindly sent me, I was unclear as to where the parameters were and if you feel you can get sufficient from the Ombudsman.

THE CHAIRMAN: I think it would be wrong to say that we are at the end of the process, but it would also be wrong to say that we have hit a brick wall. We are still making progress with them and I am hopeful, as we speak, that we will be able to get what we need from them.

MR WOODCOCK: Okay, thank you.

THE CHAIRMAN: Stuart, was there anything else you wanted to ask?

PROF FORSYTH: No, thanks. I think the last question I had was about the learning points from this, and I think you've covered that.

MR MONTGOMERY: Thank you. It's been very helpful.

THE CHAIRMAN: Thank you very much. Thanks for helping us. I think that you've been very frank and honest with us, and I am grateful to you for that.

MR WOODCOCK: Thank you.

THE CHAIRMAN: So with that I will bring these proceedings formally to a close.

[The meeting concluded at 3.08 p.m.]