THE MORECAMBE BAY INVESTIGATION

Wednesday, 9 July 2014

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

Before:

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

PRABAS MISRA

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1 DR KIRKUP: Hello, I'm Bill Kirkup; I'm the Chair of the investigation. I'll let the other
2 panel members introduce themselves.
3 PROF FORSYTH: Good afternoon. My name's Stewart Forsyth. I'm a
4 paediatrician and, formerly, a medical director from Tayside and Fife and that's
5 where I'm from, Scotland.
6 MR BROOKES: Good afternoon. I'm Julian Brookes. I'm currently Deputy Chief
7 Operating Officer, Public Health England, but I was head of clinical quality for
8 the Department of Health.
9 PROF WALKER: Hi, I'm Jimmy Walker. I'm an obstetrician and professor in Leeds.
10 In the past I've been Chairman of CMS and also –
11 DR KIRKUP: And now you're alright. Okay. As you can see, we're wired for sound.
12 We make a recording of proceedings and then we'll produce an agreed record
13 subsequently. We've also got some family members in attendance as
14 observers. We will have – oh, sorry, I should have said you'll be aware that
15 we've taken mobile phones and recording devices from all of us. None of us
16 have anything.
17 MR MISRA: I forgot to bring mine anyway.
18 DR KIRKUP: That's all right. It's just to underline the fact that nothing goes out of
19 the room until we're ready to produce a report with findings in the context of all
20 the information that we've had. We don't want information going out ahead of
21 time.
22 We will have a couple of questions about some individual cases in the
23 second part of the interview, when we won't have observers present for
24 reasons of clinical confidentiality.

1 Do you have any questions for me about the process?

2 MR MISRA: No, that's fine.

3 DR KIRKUP: Okay. Can I ask a very general question to start then, which is can you
4 explain when you first started at the hospital, probably pre it was a trust, I
5 would think, and what you've done since?

6 MR MISRA: Well, I joined on the 1st September 1990 at Furness General Hospital.
7 That was the individual hospital then. Subsequently it became a trust maybe
8 after five years, I don't remember. And five years after that, we merged with
9 Lancaster Hospital and became Morecambe Bay NHS Trust, probably the last
10 10, 12 years.

11 DR KIRKUP: So your position has been consultant obstetrician and gynaecologist
12 throughout the period.

13 MR MISRA: Yeah.

14 DR KIRKUP: Okay. Thank you. I'll hand you over to Jimmy.

15 PROF WALKER: Hi. When you first joined the Trust in 1990, how many
16 consultants were there here?

17 MR MISRA: There were three.

18 PROF WALKER: Three. And has that increased over the years?

19 MR MISRA: We are now four.

20 PROF WALKER: Four.

21 MR MISRA: Sorry, we are now five, but one of them is a resident consultant, the
22 last few months he has joined.

23 PROF WALKER: One is what, sorry?

24 MR MISRA: A resident consultant.

PROF WALKER: Okay. And what do the residents – they do night time resident on call.

MR MISRA: He is a night time resident on call without any middle grade support.

PROF WALKER: Okay. So what sort of rota does he do? How often does that happen?

MR MISRA: He has his own clinical sessions, theatre sessions, but on Thursday night he is on call. He's the ~~first~~ resident consultant on call.

PROF WALKER: Okay. So you had three consultants and, sorry, when did the fourth –

MR MISRA: Four consultants. The fourth one joined about 10 years ago.

PROF WALKER: Ten years ago and then a fifth one just recently, a resident one, okay. Now, how did you work – the three consultants work over the bulk of the time and now the fourth one work over the last 10 years? Did you work as individuals? Did you take areas of interest?

MR MISRA: We have some areas of interest individually. I used to do diabetic pregnancy and urogynae. Another consultant, he does infertility, the third one does lead in cancer service and the fourth one does general gynae and obstetrics.

PROF WALKER: Okay. And when you're on call, you're presumably on call for both obstetrics and gynaecology.

MR MISRA: Yes.

PROF WALKER: And what would be your day? Would you do a 24-hour on call?

MR MISRA: Since the College policy for 40 hours labour ward cover, we have individuals – consultants covering labour ward, either morning or afternoon and

1 our on call starts from five o'clock.

2 PROF WALKER: Okay. So when did that come in?

3 MR MISRA: I think about three years ago.

4 PROF WALKER: About three years ago, but prior to that...

5 MR MISRA: Prior to that, we'll be on call 24 hours.

6 PROF WALKER: Twenty-four hours. And on that 24 hours would you have other

7 commitments, like theatre lists and clinics and things?

8 MR MISRA: Daytime sometimes we used to have; now we don't have.

9 PROF WALKER: No, but in the time before, if we talk about –

10 MR MISRA: When we were one in three we used to have, we cover from clinics

11 sometimes.

12 PROF WALKER: Okay. Now, would you routinely go and do a ward round in the

13 morning on the labour ward?

14 MR MISRA: Yes.

15 PROF WALKER: And what sort of handover? Would you talk to the registrar from

16 the night before?

17 MR MISRA: Yes.

18 PROF WALKER: What about the midwives?

19 MR MISRA: The first on call, the second on call and the midwives, we are all there

20 together and then discuss about what had happened during the night and what

21 are the cases pending for the day.

22 PROF WALKER: Okay. Would this be a whiteboard round or would you go round

23 the patients as well?

24 MR MISRA: Consultants will go round the patients who are not midwife-only care.

1 PROF WALKER: And would that be with the coordinating midwife as well or just the

2 midwife looking after the patient?

3 MR MISRA: Just the midwife looking after.

4 PROF WALKER: So there'll be you, the registrar, the SHO grade and –

5 MR MISRA: And the midwife looking after the patient.

6 PROF WALKER: Okay. Now, what would be your day? Would somebody go to the

7 antenatal ward?

8 MR MISRA: Yes, after the delivery suite we go to the antenatal ward and then we

9 go to gynae ward, because we cover gynae as well.

10 PROF WALKER: Yes. When would you routinely return to the labour ward after

11 that?

12 MR MISRA: Normally around one o'clock and then, if you are not on call,

13 five o'clock somebody else will come and you go and handover.

14 PROF WALKER: So you'd go and physically hand over at five o'clock.

15 MR MISRA: Yes.

16 PROF WALKER: Would all your consultant colleagues do that?

17 MR MISRA: Yes.

18 PROF WALKER: So, routinely there would be a ward round at nine, a visit at

19 one o'clock and –

20 MR MISRA: Five o'clock, and then around nine o'clock the registrar or the

21 consultant will ring in to find out whoever is on call at nine pm.

22 PROF WALKER: Okay. And again that was the routine thing that all –

23 MR MISRA: Routine thing all of us will do.

24 PROF WALKER: Okay. In a situation where there was a problem in the labour

1 ward, like a midwife looking after a patient and they were concerned about the
2 foetal heart rate, what would you expect to happen at that point?
3 MR MISRA: Normally they will call the middle grade on call. We have got quite a
4 substantial – two associate specialists, two staff grade and three registrars as
5 middle grade cover.
6 PROF WALKER: Okay. So that's two associate specialists...
7 MR MISRA: Two staff grade.
8 PROF WALKER: Two staff grade and the three registrars, they're on rotation are
9 they?
10 MR MISRA: On rotation, yeah.
11 PROF WALKER: Okay. And they're in the what, the west –
12 MR MISRA: No, Manchester, North West generally.
13 PROF WALKER: Okay. And how long do you have the registrars here? How long
14 do they tick through?
15 MR MISRA: Sometimes they come for six months, sometimes they come for one
16 year.
17 PROF WALKER: Okay. And the associate specialists, how long have they worked
18 for you here, the two associate specialists?
19 MR MISRA: One of them, probably 10 or 12 years; one is about eight years. And
20 the staff grades are around eight, 10 years, quite a long time, both of them.
21 PROF WALKER: Okay. And do they have opportunities to upgrade their skills and
22 go on regular training programmes?
23 MR MISRA: They all go to keep up to their CME and we have, in house, mandatory
24 training, obstetric training programmes.

1 PROF WALKER: Okay. If there was a conflict, if the midwife didn't like the way a
2 registrar or a middle grade was handling a case, could that midwife phone you
3 directly?
4 MR MISRA: Yes.
5 PROF WALKER: Does that happen often?
6 MR MISRA: Well, it has happened, not many times, but it has happened.
7 PROF WALKER: And how do you then respond?
8 MR MISRA: Well, I personally always go there and look, see what has happened.
9 PROF WALKER: And what's your normal practice? Would it normally be that you
10 would probably agree with the registrar or would you –
11 MR MISRA: Not necessarily.
12 PROF WALKER: So, depending on what you find.
13 MR MISRA: What's the clinical situation?
14 PROF WALKER: And if you felt you disagreed with the registrar, how would you
15 handle that with the registrar themselves?
16 MR MISRA: Well, I'll deal – I'll do whatever I thought clinically was the best for the
17 patient.
18 PROF WALKER: And would you talk to the registrar afterwards about why you
19 disagreed with him?
20 MR MISRA: Well, he'll be there as well.
21 PROF WALKER: Sure, but would you take him aside afterwards and talk to him
22 about it?
23 MR MISRA: Yes. In fact, one particular case, the lady around term came with
24 reduced foetal movement and the CTG showed a very flat reading for half an

1 hour. The midwife didn't accept the registrar said it's sleep pattern, wait for
2 [inaudible], so she called me, said, 'With reduced foetal movement and this'.
3 So I said, 'We'll section her', but the baby came out 10 Apgar score, so
4 obviously he was right in that case and I was wrong.
5 PROF WALKER: Not necessarily.
6 MR MISRA: Well, it clinically was, because I showed the CTG to other the experts
7 from Manchester and they said we should have waited.
8 PROF WALKER: Right, okay. In a situation where there was an incident occurred,
9 a bad outcome, when you were on call the night before, would you know about
10 it the next day?
11 MR MISRA: Yes. They normally ring us. If they take anybody to theatre, discuss
12 the case before, they always ring us, not just the specialist, others.
13 PROF WALKER: But if there was an intrapartum death, a stillbirth, would you be
14 called about that?
15 MR MISRA: Yes. If I'm on call, I always go there and meet the patient.
16 PROF WALKER: Okay. And how would you handle that case, from the point of
17 view of the staff, the point of view of the mother, the family?
18 MR MISRA: Well, obviously we'll all go together and express our condolence and –
19 depending on the situation, because most of the time we don't know why it has
20 happened, so wait for the outcome and sometimes post-mortem.
21 PROF WALKER: And would you have a staff debriefing?
22 MR MISRA: Yes.
23 PROF WALKER: So would you handle that or would someone else do that?
24 MR MISRA: The next day, whoever consultant was in charge of the patient normally

1 handles it.

2 PROF WALKER: Okay. So not necessarily the person on call, but the person
3 whose patient –

4 MR MISRA: The person on call will go and see and meet, because the consultant
5 on call will probably know more about the patient and they will come back and
6 see him as well.

7 PROF WALKER: Okay. Now, if something was highlighted during that debrief of
8 concern about interaction or communication, how would that be handled?

9 MR MISRA: Well, it depends on the individual case. You raise this concern with the
10 junior, middle grade and the midwife.

11 PROF WALKER: Okay. If it was reported – an event like that would probably be
12 reported as an incident.

13 MR MISRA: Yes.

14 PROF WALKER: Now, how are incidents handled?

15 MR MISRA: We used to have before, last couple of years, every month at
16 Furness General Hospital clinical incident meeting where the midwives, the
17 middle grade and the consultant and the anaesthetists sometimes they come
18 and discuss and the issues are raised and investigated and then it's sent to the
19 clinical director and head of midwifery recommending whatever necessary
20 action to be taken.

21 PROF WALKER: And do you know of examples where action has been then done
22 upon recommendation from this meeting?

23 MR MISRA: Yes.

24 PROF WALKER: So you feel that's quite a robust system.

1 MR MISRA: At present, yes.

2 PROF WALKER: What do you mean 'at present'?

3 MR MISRA: Because there's a clinical governance group that meet every two
4 weeks. It didn't happen three years before. It was every month, but now every
5 two weeks they meet.

6 PROF WALKER: Okay. So, say five years ago, was the system not as robust then
7 as it is now?

8 MR MISRA: No.

9 PROF WALKER: And would events, if they were – would these events be discussed
10 at a meeting monthly?

11 MR MISRA: All events are discussed.

12 PROF WALKER: Even five years ago.

13 MR MISRA: Yeah.

14 PROF WALKER: But would a conclusion be made and recommendations made?

15 MR MISRA: Yes.

16 PROF WALKER: So what's different about now compared with five years ago?

17 MR MISRA: Because now there's a group of people who are directly responsible for
18 all the actions to be taken. Before, it used to go to the clinical director and the
19 head of midwifery.

20 PROF WALKER: Okay.

21 MR MISRA: There was no governance group as such in the department.

22 PROF WALKER: Right. So, you feel that even five years ago or 10 years ago there
23 was good medical and midwifery sort of relationship to look at incidents and
24 work them through to conclusions and recommendations.

1 MR MISRA: Yes.

2 PROF WALKER: So, did you feel that, you know, when the events occurred that
3 highlighted things leading up to this inquiry, were these things surprising to you
4 that they occurred or were you surprised by the relative repetition of some of
5 the things that occurred?

6 MR MISRA: Well, obviously probably you all know I was surprised with [redacted] case
7 –

8 DR KIRKUP: Can we leave discussion of the individual cases to the second part?

9 MR MISRA: Yes, alright.

10 DR KIRKUP: Just talk about general issues.

11 PROF WALKER: In general.

12 MR MISRA: In general, except this case, I have not seen any repetitive mistakes.

13 PROF WALKER: Okay. So you felt the system was robust enough to pick up
14 problems and correct them.

15 MR MISRA: Yeah.

16 PROF WALKER: Yes, okay. How comfortable or confident were you with your
17 junior staff at the time? When you were on call, did you sleep soundly in your
18 bed at night happy that the junior staff in the hospital were managing the cases
19 properly?

20 MR MISRA: It depends on the individual junior, if the associate specialist grade are
21 experienced enough, when we get young ~~SG4 or SG5~~ ST4 ot ST5, obviously
22 we are more aware and keep ~~work~~ awake. You don't have a sleepless night.

23 PROF WALKER: No, okay, but you felt that, in general, your staff grades and your
24 associate specialists were able and –

1 MR MISRA: Most of them, yeah.

2 PROF WALKER: Okay. And how did you feel, over the years, the relationship
3 between medical staff and midwifery staff has been? Has that been good or
4 have there been conflicts?

5 MR MISRA: Well, things have changed since last few years. I'm not sure how good
6 it is now.

7 PROF WALKER: You think it was better, say, 10 years ago than it is now.

8 MR MISRA: Yeah.

9 PROF WALKER: And what's the change? What do you feel the change is?

10 MR MISRA: I think that everybody's told to have incident form for everything they
11 feel they didn't think is right. So if they feel the doctor has not done what they
12 think should have been done, it's raised whether the patient was harmed in any
13 way or not, so that creates a very unpleasant environment. That's, to me, the
14 last few years it has happened.

15 PROF WALKER: So you feel the midwives are watching you all the time and are
16 criticising the medical practice.

17 MR MISRA: Criticising, to me, as a clinician, unnecessarily.

18 PROF WALKER: And do you feel that these are incidents in the past that they
19 would have ignored or in the past they would –

20 MR MISRA: If you have explained – well, I can say recently we had a case, one of
21 my consultants had a lady, two previous caesarean sections, primary PPH
22 more than two litres, the usual preventive measures, oxytocin and whatever.
23 This time, third caesarean section, he used prostaglandin and carboprost as a
24 preventive measure. Because the midwife didn't like it, she made it a big

1 issue, said he shouldn't have done it because it's not in the guideline. But the
2 patient actually, to me, as a clinician, benefited and went home second day
3 without any PPH or any harm. But because it is not the standard guideline that
4 you should not be using second-line oxytocin as a preventive measure, which,
5 to me, as a clinician, it makes very unpleasant –
6 PROF WALKER: Okay. What would happen to that incident? What would happen
7 to the report? Would someone look at it and review it or what?
8 MR MISRA: They raised an incident report and it went to governance head and
9 when I heard it, because the consultant was very upset, he said, 'This is not
10 the right way to practise clinical practice', so I asked this question to other
11 consultants and 11 of them agreed with the decision the consultant had taken.
12 But the consultant who is in charge of governance group didn't accept that. I
13 raised this question to the medical director, actually. I said, 'This is a clinical
14 decision on an individual basis. The patient actually has, to me, benefited — I
15 have practised 35 years obstetrics now — on this particular case'. So to make
16 a big issue, here you have used carboprost as a prophylactic method, to me, if
17 he hadn't used and the lady had PPH and they end up having hysterectomy or
18 even death, would have been more clinical damage rather than using and
19 benefiting from it. There was no harm. She had no side effect, nothing.
20 PROF WALKER: So do you feel that the current practice is causing conflict
21 between the midwives and the doctors?
22 MR MISRA: Current practice on individual – I'm not talking as a general – individual
23 cases should be treated individually rather than on the guideline, because this
24 is the guideline and you haven't done this. That's what I think has become

1 more unpleasant environment to work.

2 PROF WALKER: Do you think it's a safer environment now than it was 10 years

3 ago?

4 MR MISRA: Definitely safer, because we have a dedicated 24-hour consultant.

5 Well, at least nine to five, individual consultants with middle grade and expert,

6 senior midwives.

7 PROF WALKER: You were saying that the doctors now do a morning session and

8 an afternoon session on the labour ward.

9 MR MISRA: Yeah.

10 PROF WALKER: So there's a handover at lunchtime.

11 MR MISRA: Handover at lunchtime as well.

12 PROF WALKER: Again, that's a physical handover.

13 MR MISRA: Physical handover and we have recorded evidence also.

14 PROF WALKER: Okay. Thank you.

15 DR KIRKUP: Thank you. Stewart.

16 PROF FORSYTH: Thanks. Obviously the changing in the availability of the

17 consultant on the labour suite during the day has changed, but are there other

18 examples of how the obstetric practice has changed over the last few years in

19 the light of the incidents that have taken place?

20 MR MISRA: Well, probably, because when I started our section rate was 8%, 9%

21 and now it is 20, 25%, so the practice has changed probably more –

22 PROF FORSYTH: Is that a good change?

23 MR MISRA: Well, the perinatal mortality has come down, so it has to be a good

24 change. And I practise urogynae, so I see it as a good change. We might be

1 doing extra sections, but we don't take any risks with the babies; that's why.
2 But there is a change, obviously. I never thought that I have to section the
3 breach. I never thought I would have to section a twin when I was being
4 trained, but now obviously things have changed, so we take more precautions
5 and more safety measures and don't take any risks with any babies.
6 PROF FORSYTH: Can you tell me when the consultant who is on during the day, if
7 a lady comes up to the hospital in any way concerned regarding her
8 pregnancy, what is the process for the consultant to be informed about that?
9 She's clearly seen by the midwife to begin with, but I just wondered if there was
10 a criteria that would lead to a consultant –
11 MR MISRA: Well, they are all seen by the midwife and if there is obstetric concern
12 they call the middle grade. And if it is not serious obstetric concern, they call
13 the person on call, SHO – now they are not called SHO, the first on call and
14 then they involved. And from time to time they have called the consultant
15 directly.
16 PROF FORSYTH: Right. So they've got to go through a few people before they get
17 to the consultant, is that right?
18 MR MISRA: Sorry?
19 PROF FORSYTH: So they have to be seen by a midwife, a middle grade doctor –
20 MR MISRA: They're always seen by the midwife on admission and depending on
21 the individual, because if it is, say, cystitis, UTI or something, they are seen by
22 the first on call. If it is a problem with the baby, they are seen either by the
23 middle grade or the consultant.
24 PROF FORSYTH: And who has the right to discharge them home? Can the

1 midwife discharge them or the registrar?

2 MR MISRA: The midwife discharges those who are midwife-only patients. Those
3 who come in in early labour or something and there is nothing wrong, they can
4 discharge. But anything concerns is discharged by the registrar – sorry, middle
5 grade, whoever is.

6 PROF FORSYTH: Okay. So the consultant who is on the for the labour suite will
7 not be involved –

8 MR MISRA: Not necessarily in all cases.

9 PROF FORSYTH: So what is the consultant who is on for the labour suite doing
10 during the day, apart from attending to the very few deliveries?

11 MR MISRA: Well, he is available for anything to happen and sometimes – I teach
12 medical students in that time. We teach other junior doctors in the labour
13 ward, we have teaching.

14 PROF FORSYTH: Who does the obstetric ultrasounds in Furness?

15 MR MISRA: The sonographers.

16 PROF FORSYTH: So you have sonographers.

17 MR MISRA: Yeah.

18 PROF FORSYTH: So they're trained to do obstetrics.

19 MR MISRA: They are trained in obstetrics, yes.

20 PROF FORSYTH: And have you audited their work, because there did seem to be
21 a number of examples where the ultrasound didn't quite marry up with the final
22 birth weight of the baby?

23 MR MISRA: If they have any doubt or if they have concerns, we send them from
24 Barrow to Newcastle, Professor Robson's unit, if they are concerned about the

1 babies.

2 PROF FORSYTH: Yes, yes, clearly if there is concern, but I just wondered if you do

3 audits to compare the recordings or the reporting of the obstetric ultrasound

4 with the final birth weights of the babies.

5 MR MISRA: No, not that I am aware of. You mean birth weight or – any congenital

6 abnormality we have audited and they have not missed anything.

7 PROF FORSYTH: Yes. There seem to be some examples of what seem to be

8 normal foetal growth pattern and –

9 [Crosstalk]

10 MR MISRA: They are always fed back to the sonographers and we have a meeting,

11 a three-monthly perinatal mortality meeting, they attend that and it's fed back to

12 them.

13 PROF FORSYTH: So how many sonographers do you have?

14 MR MISRA: I think five.

15 PROF FORSYTH: Right. What about your relationship with paediatricians? Do you

16 have a good working relationship with paediatricians?

17 MR MISRA: It's a good working relationship. Not ~~very~~ socially friendly, but a

18 working relationship.

19 PROF FORSYTH: Yeah, well that's – you don't necessary give the same message

20 there. Why are they not very friendly?

21 MR MISRA: Well, they have their one work what to do, we do our one work and we

22 only talk to each other whenever we are concerned about the baby.

23 PROF FORSYTH: Right, okay, but the discussions you have about, for example, a

24 high-risk case are constructive.

1 MR MISRA: Yeah.

2 PROF FORSYTH: It must be quite difficult for yourselves in obstetrics when you do
3 have a high-risk woman, when you've only got a level one neonatal unit in
4 Barrow. Does that cause some dilemmas and some difficulties?

5 MR MISRA: It we pick up somebody who needs more than level one, they're
6 transported in utero to deliver somewhere else, as much as practical, because
7 Barrow is at least one hour away from the nearest other neonatal unit. So we
8 tend not to deliver any high-risk who will require more than level one neonatal
9 management.

10 PROF FORSYTH: Right. So the discussions about deciding on a high-risk woman
11 being transferred to Lancaster or elsewhere –

12 MR MISRA: Mostly Preston or beyond. Lancaster, they don't have that capacity as
13 well.

14 PROF FORSYTH: Right. And so what about, in terms of the neonatal service, do
15 you have any issues at all there, apart from – you are obviously content with
16 the practice of transferring out.

17 MR MISRA: Most of the high-risks are transferred out, so they only keep them for
18 24 hours, stabilise and send them out, those who are delivered. Most of them
19 are not delivered there. But interestingly, when I joined, they didn't ask us to
20 transfer any before. Because of the recent change – well, not recent change,
21 last 10 years, they have been insisting that we must transfer everybody out.

22 PROF FORSYTH: Okay, thank you.

23 DR KIRKUP: Thanks. Julian.

24 MR BROOKES: Thank you. If you were to look back at the last five, 10 years or so,

1 what would be your major concerns or did you have any major concerns about
2 the overall maternity service at Barrow?
3 MR MISRA: I don't.
4 MR BROOKES: You had no concerns at all.
5 MR MISRA: Actually, I know you must have the figures, Barrow perinatal mortality
6 has been less than the national average before I joined, since I have joined,
7 less than regional average also. I know we are in bad press the last few years,
8 but nationally our perinatal mortality is less than regional average and UK
9 average.
10 MR BROOKES: So the concerns that the midwives might have had around
11 reduction of their numbers was not a concern to you.
12 MR MISRA: It is a concern in the sense they had difficulty recruiting, but they use a
13 lot of agency midwives now.
14 MR BROOKES: Okay. If there had been a problem, how would you have tackled it?
15 Who would you have spoken to? How would you have escalated those
16 concerns?
17 MR MISRA: Sorry, I am talking in a clinical sense, but with the midwives, I think they
18 go out and try to recruit as much as they can.
19 MR BROOKES: No, no, I mean if there had been – say you come across a concern
20 which you felt was about how the whole unit was operating, who would you g
21 to? Who is the person that you would go and raise those concerns to?
22 MR MISRA: I would go to our clinical lead at the moment.
23 MR BROOKES: And did you ever need to do that?
24 MR MISRA: Yes, I have.

1 MR BROOKES: Okay. And did you feel that there was a positive reception to those
2 concerns? Was anything done about those concerns?
3 MR MISRA: The few times I have gone, yes, they have taken it seriously.
4 MR BROOKES: Okay. And how does the clinical director link into the overall
5 management of the organisation? Do you feel that that was responsive, that
6 the general management at the top of the office, the chief executive were
7 responsive to concerns that there might have been around your clinical areas?
8 MR MISRA: It's more the medical director rather than the chief executive who is in
9 charge of the governance and he will look into it.
10 MR BROOKES: Okay. But you don't think there were many cases of that that he
11 needed to look into.
12 MR MISRA: I don't think we had many serious cases. We had a few, but not many
13 serious cases he had to look into.
14 MR BROOKES: Okay. In terms of routine clinical governance, what kind of
15 mechanisms were in place or are in place?
16 MR MISRA: We have a consultant in charge and a senior midwife in charge of the
17 governance and two midwives from each ~~side~~ site and a consultant from each
18 side. They meet every two weeks.
19 MR BROOKES: That's the group that meets every two weeks.
20 MR MISRA: Yeah.
21 MR BROOKES: And they review all cases.
22 MR MISRA: They review all the cases raised in the incident form, yeah.
23 MR BROOKES: And has that raised anything that has led to a change in practice?
24 MR MISRA: They give us directives. This has been – I am not involved in those, so

1 we get directives that 'this has been done' and we also have a weekly meeting
2 on all the caesarean sections done in the hospital by the same consultant who
3 is in the governance group, to discuss what you have done wrong and what
4 you should have done.

5 MR BROOKES: So has anything in terms of the way in which you practice changed
6 because of that clinical governance group?

7 MR MISRA: Yeah, they have, more or less we are sticking to our guidelines, that
8 you should not go outside unless you can justify why you have gone outside
9 guideline.

10 MR BROOKES: Okay, thank you.

11 DR KIRKUP: Thanks. I'll just pick up a few points that have arisen. You've painted
12 us a picture, I think, of a unit that was functioning pretty well and safely up until
13 the last few years, when you felt that incident reporting and guidelines had kind
14 of prejudiced relationships. That's not a picture we're getting from other
15 people. Would you like to just qualify a little bit exactly what you mean by the
16 unit functioning well until recently?

17 MR MISRA: I think the unit is still functioning well clinically, but the relationship
18 between the midwives and middle grade doctors may not be that... It's not a
19 very pleasant working environment.

20 DR KIRKUP: You were suggesting that only applied fairly recently though. Can you
21 clarify how recent is recent? When did that unpleasant working relationship
22 start?

23 MR MISRA: The last four years, five years.

24 DR KIRKUP: Okay. It doesn't quite accord with other accounts that we've heard

1 that all was well in that relationship up until five years ago. That's 2009.

2 MR MISRA: Well, I personally, I was available as a consultant 24 hours, day and
3 night, at Furness General Hospital, whether I'm on call or not, whether they are
4 my patients or not and there are umpteen times I have come in and done that.

5 DR KIRKUP: Yes, I absolutely understand that, but I'm just testing really whether
6 you actually think that relationships were all that they might have been in, say,
7 2005, 2006, 2007, 2008.

8 MR MISRA: I think it has changed since 2009 and 2010, the last few years, since
9 we have gone through so many investigations. I think people are on the edge.

10 DR KIRKUP: Okay. Sorry, go on.

11 MR BROOKES: Just on that, why do you think you have needed to go through so
12 many investigations if your service is –

13 MR MISRA: Because we had two high profile cases which have gone to national
14 press and we are being investigated by everybody for that.

15 MR BROOKES: But doesn't that indicate that there may be some problems with the
16 service?

17 MR MISRA: Well, unfortunately, there have been a couple of cases where it has
18 happened, but still our perinatal mortality is less than the national average.
19 These cases happen everywhere in the UK, but they all don't go to national
20 press.

21 MR BROOKES: Okay. I'm just trying to balance the two in my mind, because
22 clearly there are concerns which have led to, among other things, this, a
23 number of independent reports already. It doesn't paint a picture of a service
24 which is functioning as well as the one you're describing. That's the bit I'm just

1 not quite sure of.

2 MR MISRA: Well, I am looking at the clinical outcomes from perinatal mortality rate.

3 I don't know, they might be reporting the staffing level or I don't know what

4 they are reporting. I am talking as a clinician from the outcome point of view.

5 DR KIRKUP: Yeah, the overall perinatal mortality rate is subject to a lot of

6 influences and it's also subject to quite a lot of random noise. You must be

7 aware of units where there can be problems without it showing up in the overall

8 perinatal mortality rate. A review of some of the cases that you refer to, I don't

9 want to get into individual details at this stage, but suggest that there may have

10 been some systematic problems in the unit. Is that something that you think is

11 just the wrong inference?

12 MR MISRA: No, there have been reports of systematic failure, I'm aware of that, but

13 that has improved.

14 DR KIRKUP: I'm trying to reconcile that with the fact that you're describing a picture

15 that all seemed pretty harmonious up until the last five years. It's difficult for

16 me to reconcile.

17 MR MISRA: Well, I felt it was a very pleasant unit to work. Now, in the last five

18 years, I don't feel it is a very pleasant environment to work, not by me: that's

19 what the junior, middle grade feel.

20 DR KIRKUP: Are you aware of any problems that might have affected other people

21 in the unit other than yourself? Okay. You've just got one perspective on it,

22 but are there other issues that you were aware of?

23 MR MISRA: I know there's a shortage of midwifery staff and they use a lot of locum

24 agency midwives. But I am not aware if they have difficulty recruiting now or

not, because I'm not involved with these things.

DR KIRKUP: Yeah, I understand that. Let me ask you about the relationship with the paediatricians a little more. You've described what the relationship was like, but just talk me through how you would make a decision about whether somebody should stay in Furness General to deliver or whether they should be transferred because they are a high risk.

MR MISRA: Some of them are picked up in the antenatal clinic if they have any problem, which we arrange with - mostly we go to Newcastle and they deliver at Newcastle. Those who come clinically on [inaudible], we have the guidelines, before ~~34~~ 32 weeks, if they are, can be transported out.

DR KIRKUP: So is it always easy for you and your paediatric colleagues to agree on who should be transferred and who should stay?

MR MISRA: We have standard guidelines, but sometimes if there is a difficult situation where clinically, say, somebody with bleeding at 33 weeks, they will say, 'You ~~transport~~ transfer', but I say, 'She is bleeding, I cannot ~~transport~~ transfer'. It happens from time to time. Or somebody with severe PIH, with very high blood pressure, if she's 33 weeks, I can't take the risk of transporting her until the blood pressure is controlled or she is delivered. So there are some cases we have they are not happy, but most of the time we try and manage or transfer out.

DR KIRKUP: Okay. Anybody want to...?

PROF WALKER: Can I just ask, you're currently not a clinical director. Have you ever been clinical director?

MR MISRA: No.

1 PROF WALKER: How is the clinical director chosen?

2 MR MISRA: By the chief executive or the medical director, I don't know. I was
3 never interested in the job, so I have no interest.

4 PROF WALKER: Also, you have a lead obstetrician within the hospital as well.
5 Have you ever been the lead obstetrician?

6 MR MISRA: I am the senior most GS, but not the [inaudible] lead obstetrician.

7 PROF WALKER: Okay.

8 DR KIRKUP: Okay. We want to ask you some questions about specific cases, so
9 we'll just have a brief pause while I ask the observers to withdraw.

10 MR MISRA: That's fine.

11 [Observers leave the room]

THE MORECAMBE BAY INVESTIGATION

Thursday, 24 July 2014

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

Before:

Dr Bill Kirkup - Chairman of the Investigation
Professor Stewart Forsyth – Expert advisor on Paediatrics
Ms Jacqui Featherstone – Expert advisor on Midwifery
Professor James Walker – Expert Advisor on Obstetrics

JOAN MOORBY

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1 DR KIRKUP: Right, thank you for coming. My name is Bill Kirkup. I'm the Chair of
2 the Panel. I'll ask my colleagues to introduce themselves to you.
3 PROF FORSYTH: Good afternoon. My name's Stewart Forsyth. I'm a paediatrician
4 and a medical director from Dundee.
5 MS FEATHERSTONE: I'm Jacqui Featherstone. I'm head of midwifery and head of
6 nursing at a district general hospital in Essex.
7 PROF WALKER: I'm Jimmy Walker and I'm an obstetrician and a professor at Leeds.
8 I've also worked with the National Patient Safety Agency and CMACE.
9 DR KIRKUP: You'll see that we're recording proceedings, and we'll make an agreed
10 record of them at the end. You'll also be aware that there are families present
11 as observers of the session and others may listen to the transcript, the
12 recording, later. You'll also know that we've asked you to pass over any
13 mobile phones, tablets, recording devices. That's just to emphasise the fact
14 that we're being very strict that nothing goes out of the room until we're ready
15 to produce a report with all the findings considered in context at the end. Do
16 you have any questions for me about the process?
17 MS MOORBY: No.
18 DR KIRKUP: Okay. I'll start by asking when you started at the hospital and what
19 you've done there.
20 MS MOORBY: Gosh. I did my training and my – well, I did my training, completed
21 my training in 1996. I did my first year's consolidation at Barrow and then
22 went away for four years and worked in Essex.
23 DR KIRKUP: Okay, so what was the year when you came back?
24 MS MOORBY: 2002, somewhere round there.
25 DR KIRKUP: And you came back as a midwife?
26 MS MOORBY: Yes, yeah.
27 DR KIRKUP: So have you worked as a midwife since then?
28 MS MOORBY: Yes, yeah.
29 DR KIRKUP: And still working?
30 MS MOORBY: Yes.
31 DR KIRKUP: Okay. Thank you, that's very helpful. I'll pass you over to Jacqui.
32 MS FEATHERSTONE: I just wanted to, sort of, look at what you're actually doing
33 now. So you're a midwife, and where are you working at the moment?

MS MOORBY: Well, at the moment I'm working on labour ward, but it can be anywhere in the unit, so...

MS FEATHERSTONE: Are you a band 6 midwife?

MS MOORBY: Yes.

MS FEATHERSTONE: How long have you been a band 6 midwife for?

MS MOORBY: Well, since qualifying, so I've been – I started off as a band 6 midwife in 96.

MS FEATHERSTONE: So you're on labour ward at the moment, and how long have you been on labour for?

MS MOORBY: Just four weeks.

MS FEATHERSTONE: And prior to that?

MS MOORBY: I was on post natal and ante natal.

MS FEATHERSTONE: And are you on a rotation, or –

MS MOORBY: I was off [redacted] for a year and came back working on post natal, so...

MS FEATHERSTONE: So how long have you actually been back now then?

MS MOORBY: September last year.

MS FEATHERSTONE: So prior to the year then were you rotating round the whole unit?

MS MOORBY: They actually stopped the rotation just as I was going off. We were rotating but they'd actually just stopped it, and when I came back they were no longer doing that.

MS FEATHERSTONE: Okay. So you had – prior to that you had worked in all areas?

MS MOORBY: Yes, yeah.

MS FEATHERSTONE: And since you've been back you're now doing exactly the same, only being on labour ward now.

MS MOORBY: Yes.

MS FEATHERSTONE: So with regard to communication, how does the communication – as a midwife on the shop floor, how do you hear about things that are happening within the Trust, within the maternity department? What are the channels that – how it gets to you?

MS MOORBY: I think mainly it's from my email now, so – mainly, or we occasionally have ward meetings, but they're not – I'm saying they're not... I haven't had

1 one since coming back in September, but I do know there has been at least
2 one. I haven't been to one, so...
3 MS FEATHERSTONE: So they are happening but –
4 MS MOORBY: Infrequently.
5 MS FEATHERSTONE: Okay. But would there be minutes from meetings to –
6 MS MOORBY: Yes, and that would come out by email or I think sometimes they pin
7 it on the board, but...
8 MS FEATHERSTONE: And any other meetings that you would attend as
9 multidisciplinary?
10 MS MOORBY: On an official basis no, but if there is, like, the doctors are doing, like,
11 a case review then we'll go to that, so...
12 MS FEATHERSTONE: And any governance meetings or anything on a weekly basis
13 that would happen that you would attend?
14 MS MOORBY: No.
15 MS FEATHERSTONE: If something happened, so a complaint, and it was
16 particularly about a ward or an area, how would you hear that something had
17 happened, you know, for lessons learnt really, how would you know?
18 MS MOORBY: It would be – if it was anywhere it would be by email, so... But to be
19 honest, maybe I just miss it, but I don't think there is an official way of actually
20 communicating that, so...
21 MS FEATHERSTONE: You've got a supervisor of midwives?
22 MS MOORBY: Yes.
23 MS FEATHERSTONE: And is it the same one that you've had for a while?
24 MS MOORBY: No. No, I've changed my supervisor. My supervisor actually retired
25 and I got a further supervisor who unfortunately had a bereavement and
26 reduced the amount of people she was supervising, so the one that I've got
27 now I've had for less than 12 months, so...
28 MS FEATHERSTONE: Okay. And do you have an annual review with her?
29 MS MOORBY: Yes.
30 MS FEATHERSTONE: And everybody does, that's quite standard practice?
31 MS MOORBY: Yes, yeah.
32 MS FEATHERSTONE: And with regard to training, what is provided for you by the
33 Trust on an annual basis?

1 MS MOORBY: Well, there's a general – what they call TMS where you have, like,
2 mandatory training that you do, that you complete, which are things like
3 looking at the CTG, looking at things like governance, safeguarding, you know,
4 all of these things that are relevant to the job that we do, so... Other training –
5 sorry, I just can't think. Sorry, what was the –
6 MS FEATHERSTONE: So mandatory you said, what about – do you have any CTG
7 training?
8 MS MOORBY: Yes, yeah.
9 MS FEATHERSTONE: And what do you –
10 MS MOORBY: It would be done as a kind of review. It's teaching training but an
11 update perhaps on what the current, sort of, knowledge was around CTGs.
12 MS FEATHERSTONE: And if something new came into the department, how would
13 that training –
14 MS MOORBY: There would be a meeting – there would be – not a meeting. There
15 would be training arranged.
16 MS FEATHERSTONE: And competencies to ensure that everybody –
17 MS MOORBY: Yes. We also have, like, the ALSO[?] training where we go to – it's a
18 three day event every year, so...
19 MS FEATHERSTONE: And have most of the midwives done the Also?
20 MS MOORBY: I would think all of the midwives, apart from maybe the new ones that
21 are coming in now. I think we're doing PROMPT from now on, and that is now
22 part of our – it's integrated into part of our three days, so...
23 MS FEATHERSTONE: And what about NLS[?], does anybody do the neonatal life
24 support?
25 MS MOORBY: Yes. There has been – they're encouraging that for senior midwives
26 at the moment but I think that will be something that will be cascaded down.
27 Well, there's a hope that that will be cascaded down to everybody but the
28 neonatal resuscitation does form part of what we do on the three days.
29 MS FEATHERSTONE: And what about skills and drills, so, sort of –
30 MS MOORBY: Yeah, we do them quite a lot.
31 MS FEATHERSTONE: And with obstetricians, with medical staff as well, as joint
32 training?
33 MS MOORBY: Yes, yeah. Everybody reacts because it's obviously planned but not
34 spoken about, so it's – everybody reacts like it was a clinical emergency, yeah.

1 MS FEATHERSTONE: So you're on labour ward now, and so generally the
2 relationship between medical and midwives is good?
3 MS MOORBY: Yes, excellent.
4 MS FEATHERSTONE: And if you are looking after a lady, you have an issue, you
5 can go out and speak to – who do you go and talk to?
6 MS MOORBY: I would go to the coordinator first and speak to the coordinator. I
7 mean, if it was a clinical issue that perhaps needed fresh eyes or something
8 like that then it would be, you know, the coordinator, the senior midwife. If I
9 felt that it was appropriate to escalate that to the registrar then obviously that
10 would be a decision that I would make alongside the coordinator, who would
11 generally listen to my views or what I feel my needs are in that.
12 MS FEATHERSTONE: What you're saying now and on the training is the same: that
13 happens now. Is that the same that would have happened five years ago?
14 MS MOORBY: No.
15 MS FEATHERSTONE: As in it did happen at all, or...?
16 MS MOORBY: It happened, yeah, yeah, but I think I would have been less likely to
17 take it to a registrar. I would be less likely to push it, I think, at that particular
18 time.
19 MS FEATHERSTONE: Why?
20 MS MOORBY: Just more – at that time it seemed to be like the coordinator... This is
21 just very personal to me, to be honest, but it would seem that the coordinator
22 was the only one that could escalate that.
23 MS FEATHERSTONE: Then? Then, at that time?
24 MS MOORBY: Oh yeah, not now. No, not now.
25 MS FEATHERSTONE: So if the coordinator was busy with another lady, what –
26 MS MOORBY: Oh no, I would actually say to her that I am going to, you know, but
27 generally I would put it through the coordinator at that point.
28 MS FEATHERSTONE: Okay. So therefore the relationship's good. And so even on
29 labour ward on a day to day basis you don't do anything within a
30 multidisciplinary team, you know, if there's any time for teaching or – now, now
31 do you?
32 MS MOORBY: Yes. No, we do that. We do do that. If there is something – like I
33 said, if there's something that's coming up that is, you know, discussed as part
34 of the team. I think mainly the communication side of things will be done when

1 the doctors have their rounds and, you know, we will talk about general issues
2 at that particular point.
3 MS FEATHERSTONE: When you were on the labour ward previously and if you
4 hadn't been there for a while, how would you – say you hadn't done, you know,
5 epidural top ups or something like that for a long time, how would you go
6 about it or what was in place to help support you when you were back up in
7 labour ward, especially if you'd not been there for a long time.
8 MS MOORBY: It would be again following whoever the coordinator was or a senior
9 midwife through the process before they actually arise. For instance, now I'm
10 back on labour ward it is one of the things that I've identified, because there's
11 a lot more than what there used to be when I previously went – worked on
12 labour ward. So, you know, I would look at things like the – look at the policy,
13 look at, you know, how, but generally everything is done in the same way, so –
14 and try to be a part of that when I'm not actually the lead midwife on that but
15 do that under, kind of, supervision.
16 MS FEATHERSTONE: And what about staffing? So on the – and I'm talking about
17 previous, was the staffing good?
18 MS MOORBY: No
19 MS FEATHERSTONE: Okay. What do you class as not good?
20 MS MOORBY: Again, it has to be an opinion. I think that we coped on very little staff,
21 to be honest. There was a lot of asking for extra staff – and this is just my
22 memory of it. There was a lot of asking for extra staff at that time and it was,
23 kind of, being told, 'There isn't any', you know. I think one of the terms was,
24 you know, 'Do you want me to knit a midwife?' You know, that kind of thing.
25 There was talk about having no money to do things. There was a point where
26 I know that midwives actually went on call for the unit, and that was not – that
27 didn't start off as an official thing, but it was like everybody had to take their
28 turn on on call because if it got busy they had to have somebody else in, which
29 felt inappropriate at the time but it was – ended up being custom and practice.
30 That went during the year that I was off, so...
31 MS FEATHERSTONE: Do you ever feel then sometimes when you were duty that it
32 was unsafe?
33 MS MOORBY: Yes.
34 MS FEATHERSTONE: And what did you do about it?

1 MS MOORBY: All you could do was again take it to the coordinator and the manager,
2 you know, and say. It was voiced on numerous occasions, you know, that –
3 MS FEATHERSTONE: Is staffing better now?
4 MS MOORBY: Yes.
5 MS FEATHERSTONE: And so were you looking after more than one woman at a
6 time or two or three women at a time previously?
7 MS MOORBY: Certainly more than one woman occasionally. The unit isn't a big unit
8 so it's not that you have – you know, you would occasionally have, you know,
9 four labourers at one time. I can't recall ever having more than that in my
10 experience, but it would be pulling people off the ward and obviously it
11 became like the poor relation. And I think to an extent that still happens, you
12 know. The unit itself is pushing for one to one with women in labour and
13 because of that people get pulled off the ward in order to make that one to one,
14 or there's a frantic searching around for bank staff. But on a general basis it is
15 reasonably well covered. It's not, you know...
16 MS FEATHERSTONE: Did you use agency staff to cover?
17 MS MOORBY: Not then, now.
18 MS FEATHERSTONE: You do now?
19 MS MOORBY: Yeah, although it seems like they're using less agency staff then
20 when I went off, [redacted] seems like there is more bodies
21 around.
22 MS FEATHERSTONE: Okay. The other thing, just about audit and record keeping,
23 what do you do for record keeping and do you do it under your supervisor or
24 do you do –
25 MS MOORBY: I would do it under the supervisor. I have to say self-auditing. I do
26 tend to have a look at my own notes on an informal basis if you like, but prior
27 to – well, I think just probably around that time the band 7s would audit the
28 notes and give you feedback. So they would look at, I think, sets of notes from
29 each midwife, so...
30 MS FEATHERSTONE: Would you say retrospective writing, record keeping is the
31 norm generally?
32 MS MOORBY: It would depend on the circumstances, but no, not at the moment, no.
33 MS FEATHERSTONE: So if you picked up a few sets of notes you wouldn't see lots
34 of retrospective?

1 MS MOORBY: No, I wouldn't think so, no. I mean, again I can only speak for myself
2 because what I do is audit my own notes, but –
3 MS FEATHERSTONE: Okay. Alright, that's all my questions for the moment. Thank
4 you.
5 DR KIRKUP: Jimmy?
6 PROF WALKER: Afternoon.
7 MS MOORBY: Afternoon.
8 PROF WALKER: You said when you qualified you went to work in Essex. Was that
9 as a midwife?
10 MS MOORBY: Yes.
11 PROF WALKER: What sort of unit did you work in there?
12 MS MOORBY: Sorry, in the…?
13 PROF WALKER: What sort of unit?
14 MS MOORBY: It was a consultant unit.
15 PROF WALKER: So how many deliveries approximately?
16 MS MOORBY: Four and a half, 4,500.
17 PROF WALKER: So you got – you had experience there of working in a busy unit,
18 with obviously quite a big team of people, working with different assistance.
19 When you came back to here what were the biggest differences you found
20 when you came to Furness?
21 MS MOORBY: It was much quieter, but I think clinically the big difference for me was
22 that although you had more bodies there was less emphasis on staff
23 development. I think at the bigger unit they were very conscious of staff
24 development and looking at your strengths and weaknesses and funding and
25 – well, you know, I certainly attended a lot more courses and there was a lot
26 more multidisciplinary things going on there than what there was in Barrow.
27 The communication I would say in Barrow wasn't as good between the doctors
28 and the midwives as what I experienced in Basildon, so… But development –
29 to take what I had in the four years, my development in the four years was
30 obviously very, very different to my development when I came back. The
31 encouragement there was to improve your midwifery skills and what you
32 improved bringing back to the unit. When I went back to Barrow it was like
33 nobody was interested in what you'd done, you know. It was kind of like, well,
34 you know, that was then, you know, and this is now, so…

1 PROF WALKER: So were you – do you feel when you came to Barrow you then
2 stagnated in the job you were in, or –
3 MS MOORBY: I don't – I mean, on a personal level, no, because I went to finish off
4 my degree and, you know, I've done a lot of self-funding courses in order to
5 keep myself up to speed with the things that I was interested in and also that I
6 felt would be beneficial to the unit.
7 PROF WALKER: Do you feel that the skills you learnt in Essex were – you weren't
8 allowed to utilise them in Furness?
9 MS MOORBY: Yes.
10 PROF WALKER: And was that because they stopped you doing it or –
11 MS MOORBY: They didn't stop me. There was just a whole load of – it wasn't
12 facilitated, you know. There was things that – I mean, I can – I'm talking from
13 a point of view, my passion is breast feeding, that's what I deal with, the infant
14 feeding side of things. That's, you know, where my interest lies and when I
15 was down south it was very much about developing that and developing it as a
16 teaching – you know, we were going for Baby Friendly down there, which is –
17 it involves, like, teaching and pushing forward with staff and looking at practice
18 and ways of changing it. And, I mean, that translates into absolutely
19 everything, and I think when I came back it was, sort of, like – well, you know,
20 that again was appropriate to there but not appropriate to Barrow. I mean, I've
21 done things I think, like, you'll know down south it's a lot more epidurals, so
22 I've done things like training for topping up epidurals, I'd done training to scrub
23 in for caesarean sections, a lot more variety. And Barrow didn't offer that
24 because there wasn't a theatre, so you didn't – you know, an integral theatre –
25 so you didn't have to do that. But it did just feel like I came back and it was
26 like, you know, what went on in that four years didn't matter.
27 PROF WALKER: Do you feel if after four years of working here then you went back
28 to Essex, do you feel you'd have to be retrained to get up to the level you were
29 expected to be in Essex?
30 MS MOORBY: Well, it would depend on what you were talking about. Were you
31 talking about clinical things?
32 PROF WALKER: Yeah, just – well, the things you'd be expected to practice in Essex?
33 MS MOORBY: I would need some element of training, yeah.

1 PROF WALKER: When you came to Furness did you feel you were working in
2 isolation or in a team?
3 MS MOORBY: I think we were working as a team, but I think the team was didactic.
4 It was very much consultant led, if you like. It wasn't – and I say that in the
5 sense of, I say consultant led but it... The doctors used to come through in
6 the morning and it was looking at the board and saying, 'Right, that's that', and
7 then just going. There didn't seem to be any formation of plans or – there
8 didn't seem to be like there is now where there's a communication between all
9 levels of staff and it's done as a group where things are discussed. They're
10 discussed from shift to shift, and things are brought up and the midwives have
11 a voice within that. It didn't feel like that at the time, certainly on the labour
12 ward.
13 PROF WALKER: And did – compared with how you worked in Essex, if you were
14 working during the day, looking after people, and would there be situations
15 where there'd be minor things you could maybe discuss with a midwife about
16 how you manage this or how you do that, and which you didn't have the
17 opportunity in Furness, or...?
18 MS MOORBY: I think we did. From a midwifery point of view, midwife to midwife,
19 yeah. I just don't think that – there wasn't a full integration between midwives
20 and doctors at that time. I mean, our doctors in Basildon would come round
21 on the labour ward if you were working on the labour ward. Not perfect – the
22 place wasn't perfect by any manner of means, but there seemed to be an
23 ongoing communication with the doctors that just didn't seem to be there on
24 the [Inaudible].
25 PROF WALKER: Because normally, when you came here, you expect it to have the
26 same communication, so you must have attempted to have the same
27 communication. So how did people respond when you did that?
28 MS MOORBY: They didn't respond negatively. I think people just didn't really listen,
29 to be honest. There were ways of doing things, that you'd be doing them
30 through somebody else, really, rather than - I think a couple of times when I'd
31 overstepped the mark, by talking not through somebody, but actually
32 approaching somebody directly. Again, it felt like it was being frowned on, but
33 not –

1 PROF WALKER: And that was by your midwifery seniors or by the doctors
2 themselves?
3 MS MOORBY: Probably more midwifery seniors, to be honest, but I think it was just
4 custom and practice, the way of things, the way things were at that time. But
5 again, you know, this is perception, as opposed to being – I can't say that
6 solidly.
7 PROF WALKER: You said earlier that you had voiced – that you felt things were
8 unsafe, in particular, staffing in practice. Was there any other areas of
9 practice you felt was unsafe?
10 MS MOORBY: Not in an overwhelming way, no. Well, I think staffing's a really big
11 issue. Perhaps in comparison to now, there's a lot more emphasis on looking
12 at protocols, you know. There's a lot – I see a lot of people referring to
13 protocols on a lot of occasions that I didn't see before, and I do myself. I have
14 to say that I'm more inclined to go to a protocol, perhaps, than I was years and
15 years ago. So I think that the knowledge is – certainly for myself, I would not
16 have been normally referring to a protocol on first stage of labour, or –
17 PROF WALKER: When – you say you voiced some unsafe practice, but did you feel
18 there was any way of you escalating that to a reporting line?
19 MS MOORBY: I didn't feel it at the time, no.
20 PROF WALKER: And would you feel now, if you felt the same thing, you could have
21 –
22 MS MOORBY: Yes, we have a PSI system where we kind of – we feel that the
23 staffing's not been appropriate to the care.
24 PROF WALKER: Were you aware at the time of problems that occurred within the
25 unit? Was there any education about shared experiences within the unit?
26 MS MOORBY: As far as I know, no. No formal.
27 PROF WALKER: Do you feel there is now?
28 MS MOORBY: Yes.
29 PROF WALKER: So when did this sort of change occur?
30 MS MOORBY: It's difficult for me to say, because as I said, I've been off for a year. I
31 would say it's occurred in the last 18 months. If there has been a sort of
32 change from one to the other, I would say it's in the last 18 months.
33 PROF WALKER: And do you feel more comfortable working in the work environment
34 now than you did, say, two years ago?

1 MS MOORBY: Yeah, I feel more supported.
2 PROF WALKER: Okay, thank you.
3 DR KIRKUP: Thanks. Stewart?
4 PROF FORSYTH: I'd like to go back to how this change took place, and probably the
5 factors that were needed[?]. In the earlier days, how did you relate to your
6 clinical managers?
7 MS MOORBY: I think – do you mean my ward manager?
8 PROF FORSYTH: Yeah, your matron, manager, [inaudible]
9 MS MOORBY: When I qualified, it was very much they were them and you were you,
10 and there was a very definite difference between managers and staff. Very,
11 very old-school. I'd [inaudible] and it felt very much like that, you know. The
12 sisters were on one level. As for consultants, you know, I think when I was a
13 student midwife, the main consultant didn't even say hello, you know, in the
14 corridor. It was that kind of relationship, you know. Almost like you felt like
15 standing in front of someone and saying, 'Speak to me.' But it felt very much
16 the holding up of the white coat for the doctor to –
17 PROF FORSYTH: If we wind forward to 2008, when some of the incidents were
18 happening, what was the situation there regarding the clinical leadership
19 group? Did you feel like you were being led well at that time?
20 MS MOORBY: No, I think it was very much – there was still a 'them and us' between
21 the managers and the –
22 PROF FORSYTH: Does this include the matron for the labour suite or the head of
23 midwifery? What sort of level are we talking about?
24 MS MOORBY: I don't think there was particularly good communication between the
25 managers or the head of midwifery at that time. I don't think it was – I don't
26 think we were well-managed, you know. If you were looking at –
27 PROF FORSYTH: And do you think the midwives as a body were responsive to
28 change at that time?
29 MS MOORBY: Yes, I do. I do think that with encouragement, the midwives would be
30 open to change. I don't think there was the opportunity given by management
31 to do that. There was no ownership of – I mean, a serious – again, it was my
32 experience, it felt didactic. It felt like, you know, you were – this was the way it
33 was going to be.

1 PROF FORSYTH: You mentioned earlier about the medicalisation of obstetrics, and
2 labour suite work in particular. How do you feel the changes of the balance
3 between the sort of [inaudible] and the obstetrician and the medical aspects,
4 and how the balance between these two have swung over the years?
5 MS MOORBY: I think there's very much an emphasis on team working; more,
6 perhaps, looking at the team working. There's more a conscious – how do I
7 put it? I'm more conscious of the fact that there is teamwork than I was five
8 years ago?
9 PROF FORSYTH: So five years ago, did you think it was – what was the situation
10 there? Do you think it was very medicalised, or not medicalised, around 2008?
11 MS MOORBY: It's difficult to say. It'd probably vary from work time to work time. It
12 would be difficult to say if it was more medicalised then or not medicalised now.
13 I think there's a lot more emphasis – again, it's – I would be probably doing
14 them an injustice, but I think things are jumped into very quickly. Ladies go for
15 sections very, very quickly now. There's a change in that kind of behaviour, if
16 you like.
17 PROF FORSYTH: Do you think at some point in the past, the midwives were trying to
18 protect the woman from medical intervention?
19 MS MOORBY: That was just the way it was. There was a huge respect for the
20 normal, but I don't think it was that midwives were trying to stop doctors from
21 being involved in cases. I think it was just, again, what was done. The
22 doctors were called if there was a problem, so –
23 PROF FORSYTH: In relation to the relationship between midwives and paediatricians,
24 how was that in the past and in the present?
25 MS MOORBY: Well, now, I'd say it's much better, but special care is an integral part
26 of the maternity ward now, and that has made a difference between the staff
27 and the paediatricians. I still think that there are areas of communication that
28 could be better – perhaps, you know, when there is an incident, more shared
29 time with all parties involved. I don't think the paediatricians are always
30 included in those times, but – then, looking back at 2008, I don't think the
31 communication was very good at all. It was very much they were on one side
32 of the fence and we were on the other, but we as a whole unit, as opposed to
33 us as medical midwives and paediatricians.

1 PROF FORSYTH: In terms of when you require a paediatrician now, do you feel
2 you're getting someone coming who is skilled and they will –
3 MS MOORBY: Yes. I don't particularly think that that was there in the past. Yeah, I
4 don't particularly think that was there. Would say that it was not clear that I
5 meant senior paediatricians. SHOs (lower grades) are not well trained in
6 basics now or then.
7 PROF FORSYTH: Okay, thank you.
8 DR KIRKUP: Excuse me, you caught me at a bad moment there. Were you aware of
9 the Fielding Report?
10 MS MOORBY: Sorry?
11 DR KIRKUP: The Fielding Report? Does that mean anything to you?
12 MS MOORBY: Yes.
13 DR KIRKUP: When were you aware of it?
14 MS MOORBY: As it came out, I think. I was aware that it was happening and then
15 told about it when it came out.
16 DR KIRKUP: It was published in the middle of 2010. Well, I say 'published'; it was
17 given to the Trust in the middle of 2010, I think. Would you have received it
18 then?
19 MS MOORBY: Yes, I would have heard about it at that time, and it would have been
20 something that came by email. In fact, I remember it coming, the link to it.
21 DR KIRKUP: Can you remember when the link to it came?
22 MS MOORBY: I can't, no. I'm sorry. It would have been around the time that it was
23 published and then made public.
24 DR KIRKUP: Some of your colleagues say – and there's some supporting evidence
25 from the time – that they didn't see it for about a year. Is that your recollection?
26 MS MOORBY: I can't remember. I'm really sorry. I honestly couldn't – I couldn't say
27 to you in all honesty that – if it arrived, and it arrived a year later, I would have
28 probably assumed that it had just been done.
29 DR KIRKUP: That's when it came out. Yeah, okay. I understand. What did you
30 make of it when you read it? Did you think, 'This is a fair reflection of the unit I
31 work in', or did you disagree with it?
32 MS MOORBY: I think it was probably – I probably felt – it's quite difficult, looking back
33 that time ago. I would have – I'm reluctant to say a fair reflection. I think,
34 probably, it was – I'm not sure what to say, really. I can't –

1 DR KIRKUP: Can you remember your reaction to it at the time? Did you think –
2 MS MOORBY: Not really, no.
3 DR KIRKUP: Did you think, on the one hand, 'Good, maybe we'll see some changes
4 that'll help?'
5 MS MOORBY: There was an element of that, I think. You look at things, and they
6 can be – initially, you look at them and think, 'Oh my goodness, that's a bit
7 damning there', but maybe it made you a little bit more hopeful about things;
8 that things were more open.
9 DR KIRKUP: And did you see any improvement as a result of the Fielding report?
10 MS MOORBY: At that time – I can't say that I did, no.
11 DR KIRKUP: Do you have clear policies for intrapartum monitoring?
12 MS MOORBY: Yes.
13 DR KIRKUP: And how long have you had those clear policies?
14 MS MOORBY: Again, I've been off for a year. It's very difficult. I mean, when I came
15 back, they were certainly in place.
16 DR KIRKUP: But before you went off?
17 MS MOORBY: I seriously can't remember. I'm not sure. I worked in the day
18 assessment unit before I went off, so we used the policies around there, which
19 were more to do with antenatal and –
20 DR KIRKUP: Yeah, sure. But the last time you worked reasonably regularly on the
21 labour ward, were you aware of policies on intrapartum monitoring?
22 MS MOORBY: That would be going back a fair few years, but no, I can't remember it.
23 No.
24 DR KIRKUP: Does that mean 'no, there weren't policies', or –
25 MS MOORBY: I can't say. I can't remember.
26 DR KIRKUP: Did you notice a difference in the amount of intrapartum continuous
27 monitoring that was going on when you came back?
28 MS MOORBY: There was probably less. You mean when I came back after –
29 DR KIRKUP: After you'd been off for the year.
30 MS MOORBY: Oh, no, there was more. Certainly more. There was less, you know –
31 when I came back from Essex, there was less monitoring compared to Essex.
32 DR KIRKUP: Yes. When you arrived from Essex, yeah, okay. That's helpful. Can
33 you remember whether the increase when you came back after the year you
34 were off was because of clearer policies?

1 MS MOORBY: It was because of clearer policies. Very, very clear; you could pick up
2 any policy to do with monitoring and it was very clear, you know, when the
3 trigger points were for putting someone on the monitoring or not. Much easier
4 to access and know.
5 DR KIRKUP: Okay. I want to come back a little bit to this point about the separation
6 between midwifery and obstetricians, and the lack of communication or that.
7 And two points on that, really: one, people have described to us that, yes,
8 there was some lack of engagement by the obstetricians, but also that there
9 was a culture amongst some – maybe many – of the midwives that they
10 wanted a normal delivery, and they really pushed hard for a normal delivery,
11 perhaps past the point where, in Essex, people might have done.
12 MS MOORBY: I was aware that there were certain midwives that would push past
13 boundaries that perhaps – you know, there were things said at the time like,
14 'She flies a bit close to the wind', you know. There was – so that did exist, you
15 know. I can't deny that. I would not say that so much amongst the Band Six
16 that were doing the rotation onto the labour ward, because that total
17 confidence isn't there when you're not doing it all the time, you know. What
18 they would perceive as being, you know, 'This is normal, this is normal' –
19 some people, like myself, who was coming back on there, there was not that
20 same feeling like, 'Yeah, we can push this a little bit.' I wouldn't have said
21 amongst the Band Sixes; I would have said more amongst the Band Sevens.
22 DR KIRKUP: Looking back on that time – say, around 2008, give or take a year or
23 two – do you think that you sometimes became reluctant to call people in at
24 that stage?
25 MS MOORBY: No.
26 DR KIRKUP: Are you sure about that?
27 MS MOORBY: Yes, I'm absolutely sure. On my own personal practice, and I think
28 there was an element with me of fear, you know. Because at that time, the
29 labour ward was very short, and I think we only had, like, a month at a time at
30 that point. It was very short-lived, and a lot of things to do in that period of
31 time, so no, I wouldn't have said that I was a person who ignored the need for
32 doctors.
33 DR KIRKUP: But you were aware that there was a spectrum, and some people –
34 MS MOORBY: Yes, absolutely.

1 DR KIRKUP: I understand. The last point about the relations between midwives and
2 obstetricians – you described that as lack of communication. Was there more
3 to it than lack of communication? Is it just that either or both sides weren't
4 very good at saying what they thought about situations, or was there
5 something deeper than that?
6 MS MOORBY: I would have said that there was definitely – of them and us. I have to
7 say, you know, the doctors were there and we were there, and it is difficult to
8 say with regard to – within the labour ward situation, you were probably a little
9 bit more conscious of it than you were in a ward situation.
10 DR KIRKUP: Sure, sure.
11 MS MOORBY: And most of my clinical time would have been in a ward, so, you know,
12 the labour ward experience was very short and sweet. But, yes, there was
13 definitely a big lack of communication. Whether that was a fundamental flaw,
14 you know, a fundamental – that was deeper than just not being able to talk to
15 each other on a clinical level, you know, I didn't experience that onwards, so
16 it's difficult for me to comment on labour ward.
17 DR KIRKUP: Sure. 'Them and us' situations usually require both parties to feel like
18 that. Is that true? Midwives felt like that about obstetricians, as well as
19 obstetricians feeling that about midwives?
20 MS MOORBY: Yes.
21 DR KIRKUP: Did you or anybody else that you were aware of try and build bridges?
22 MS MOORBY: I think the managers did. Not the managers – the modern matrons,
23 when they came around, they certainly seemed to try to build a bridge like that,
24 but –
25 DR KIRKUP: You're emphasising the 'try' there. Does that mean 'without success?'
26 MS MOORBY: I think – yeah. It was – a lot of the times, didn't seem to follow
27 through, or certainly as a Band Six midwife, we didn't get told if there was
28 something that had been brought up or pushed forward.
29 DR KIRKUP: Okay. We want to ask you some questions about cases where patient
30 confidentiality might arise, so there'll be a short pause while I ask the
31 observers to leave.
32 [Pause]

THE MORECAMBE BAY INVESTIGATION

Tuesday, 15 October 2014

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

Before:

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

ERIC MORTON

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1 (At 2.09 p.m.)
2
3 DR KIRKUP: Alright, thank you for coming. I'm Bill Kirkup, I'm the Chair of the Panel
4 when I'm here. I'll ask my colleagues to introduce themselves.
5 DR WALTERS: Geraldine Walters, from King's College Hospital where I'm Director
6 of Nursing and Midwifery.
7 MR MORTON: Hi.
8 MR BROOKES: And I'm Julian Brooks. I'm currently Deputy Chief Operating Officer
9 for Public Health England, but was previously Head of Clinical Quality at the
10 Department of Health.
11 MR MORTON: Okay.
12 DR KIRKUP: You'll see that we are recording proceedings. We'll produce an agreed
13 record at the end. You may also know that we've asked relatives if they would
14 like – families of the affected if they would like to attend as observers. As it
15 happens, we don't have anybody here this afternoon, but they may listen to
16 the recording subsequently. And you also know that you've handed any
17 mobile phones, laptops, recording devices. Just to stress that nothing goes
18 outside the room until we're ready to produce a report with all the findings in
19 context. Any questions for me about the process?
20 MR MORTON: No.
21 DR KIRKUP: Thank you. In that case can I start with a fairly general question, which
22 was what was your involvement with Morecambe Bay? When did it start?
23 When did it finish?
24 MR MORTON: Okay. I left Chesterfield Royal Hospital where I'd been Chief
25 Executive for 12 years on about the – I'll have to look back in me diary – 2
26 March 2012. And in Wednesday of my last week I got a call from David
27 Henshaw, Sir David Henshaw, who asked if we could meet up for a chat about
28 Morecambe Bay.
29 And so on 5 March, which was my first day of freedom, I met him in
30 Manchester, for lunch, and the gist of it was he asked me if I would be
31 prepared to go to Morecambe Bay as interim Chief Exec. To which I said no.
32 It was too far. That was my view. It was too far to travel from Chesterfield.
33 However, when we met, and knew we'd worked together 30 years earlier in a
34 previous life, and so when he rang me later that week, with a bit of persuasion,

I agreed. Until they appointed to a substantive CEO. So I started there on 19 March, and my last working day was 27 July.

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

DR WALTERS: So when you left Chesterfield, were you going to be a sort of like roaming, available for assignments and this one just happened to come up? Was that ...

MR MORTON: It wasn't –No, ~~–not~~ it actually wasn't even as scientific as that. I planned to take six months off and see things I'd never seen before, like – I still have the list: Stone Henge, Canterbury Cathedral. Never made it. And the call from David came kind of out of the blue, although I had done bits of work for Monitor before, and they'd asked me to go into organisations to kind of look after them if they were in a bit of trouble. But while staying in Chesterfield, so it was a – it was a kind of dual appointment.

DR WALTERS: What was his briefing to you?

MR MORTON: David? It was that the organisation had lost its way. That they'd got serious issues around clinical quality, clinical engagement. Lack of focus of where the organisation was going. Disengaged clinicians. I think that probably captures most of it, and it was a kind of two hour conversation. As I say, at the end of it, I wasn't intending to take it.

DR WALTERS: And what did you find when you got there?

MR MORTON: What did I find when I got there? It's interesting. When – in preparation for this I – the second week I was there we had board time out. And the board asked me the same thing and I'd done a bit of a kind of presentation, which I kind of referred back to. I think the Trust lost its way completely. It forgot what the day job was. It was utterly focussed – and this isn't a criticism, this is just kind of a statement of fact. They were utterly focussed on achieving FT status, as a lot of trusts were at that time. That, in itself, isn't a problem. As long as you do the day job.

Where it is a problem is if you focus on that to the detriment of the day job. And the leadership at the time was totally focussed on getting FT status. It was seen as very, very necessary. At that time, if you remember, there was no other game in town. You were either FT or nobody was sure what you would become ~~were~~. So there was a real impetus ~~there~~ for people to get through. And I think that contributed to the board's focus on, 'We've got to get

this at all costs.' And it did lose its way. There's absolutely no doubt.

I think it goes back beyond that. Because certainly from the conversations that I had, particularly in the first two weeks – because I spent the first two weeks out and about ever such a lot, around the hospitals, talking with the staff, from porters through to clinicians, to try and get – and the CCGs which were really important, at that stage, to have a conversation with. Because they were totally disengaged. I think they'd not got a good relationship with the Trust.

And it felt, to me, as though these problems went back some considerable period, and I think I had a ~~kind of~~ phrase which I used around the place soon afterwards, which was, 'This is a merger in logo alone.' So they put a logo above the merger. But what they hadn't done is to look at how they converged clinical services so they worked to common practises across both main sites, or all three sites in the case of certain specialities.

So very much the hospitals were still ~~kind of~~ going it alone a bit. There was no – there was no clinical hang together. There was almost competition between the two main sites. An unwillingness, I think, of some~~many~~ clinicians to move between the sites, or to work across them. And I ~~kind of~~ understand that in a way, because it's – it's some considerable drive from Lancaster to Barrow. But then it's a long drive from Lincoln to Boston. So this is not unique. And it can be done ~~ever~~ at other places. I managed to get over it. But it requires people to want to. And I think there was an attitudinal problem.

I think there was also a bit of poor relation, you know, and other. I think the Furness General looked at Lancaster and thought that that was the, you know, that was the golden boy, if I can put it that way. Lancaster looked at Furness and felt, 'We should be doing some of your services'. Which, in itself, is not a wrong thing, if it's done for the right reasons. But there was this kind of inner competition between them. I don't think the clinicians talked anything like enough and, by that I don't just mean the doctors, I don't just mean the nurses and the allied health professionals. There wasn't – there wasn't coordinated vision across the organisation at all.

~~I also felt that bringing back more up to date twenty [inaudible]~~?. When they got FT status it was almost as though they were looking for a mission. ~~We know that when we [inaudible]~~?. I was quite surprised, when I got there,

1 given the kind of issues that I understood they were facing around clinical
2 quality. Not just in obstetrics and paediatrics, but also in acute medicine. That
3 the game in town was, you know, 'How do we look to merge with Carlisle?'
4 Which struck me as bizarre. Again, it~~'s~~ leads to a lack of focus on the day job.
5 They'd got more than enough to do at home, rather than looking for
6 expansion, frankly.
7 MR BROOKES: Sorry, was that a merger or was that takeover?
8 MR MORTON: I don't know if it was ever flushed out, that. The reality was it would
9 have to have been a merger by absorption, wouldn't it? Because UHMB ~~UHB~~
10 was an FT and Carlisle wasn't.
11 MR BROOKES: Exactly.
12 MR MORTON: So – I'm not sure they thought of it in those terms. But that would
13 have been the practical reality. So, no, I don't think it was a merger.
14 DR WALTERS: Where did this – did the sort of FT at all costs, was that generated
15 internally?
16 MR MORTON: Oh yes, yes.
17 DR WALTERS: Right. So it wasn't under pressure from externally?
18 MR MORTON: No, not as far as I was aware.~~concerned~~. I certainly never picked
19 that up. And certainly having worked ~~been working~~ with other FTs that have
20 found themselves in a bit of distress, having got through to FT status. What
21 I've tended to find is there isn't pressure. It wasn't pressure from the FT unit
22 at the Department of Health. There was a – an attention to it, from the SHAs.
23 That in itself, you know, isn't wrong. So long as it's done in the right way and
24 it's taken in the right spirit by the Trust. But no. The impetus was very much
25 internally, and it was from the board. And I think actually, if you'd have
26 scratched down into the organisation, scratched down into the clinicians, that
27 wasn't top of their agenda. Neither should it have been.
28 MR BROOKES: Can I just clarify that? Was it from the board? Or was it from the
29 Chief Executive?
30 MR MORTON: I can't differentiate between the two, because I wasn't there. So I've
31 got to assume that if the board took that view, that the – it may well be driven
32 by the CEO, but the board must have signed up to it.
33 DR WALTERS: So given that you didn't expect to be there very long, what were your
34 key tasks, in effect, you wanted to achieve?

MR MORTON: Right. Well if again I tell you what I think was wrong, and therefore that formed a task, and I said, just going back through my slides from the board time out on the 28 March, so these were very much sort of, you know, from the go. Complete loss of direction. They'd forgotten their day job, so we needed to get attention back to the day job. To do the right things and to do them at the right time.

There needed to be a focus on service delivery. And the lack of focus on that was – the main issue there I thought was clinical disengagement. And, you know, I can't rake over why the clinical staff were disengaged. I can have a guess at it. But it felt that they weren't being listened to. It felt like they were distant. There wasn't what I would regard as senior – doctors in senior managerial positions in the way I would have expected in an acute hospital. So it was a kind of general management model with doctors involved. Rather than the organisation being clinically led.

So I certainly needed to focus the organisation back on what I ~~it~~ called the day job. Doing services right. I needed to look at the – I'm not a fan of changing managers just for the sake of it, but this was a message. This was about getting clinicians to run the organisation. They'd got three divisions at the time, which, from memory, were medicine, ~~which included the~~ surgery, which included obs-gynae – sorry, which included all surgery and anaesthetics. Then you'd got a third one, which I think was obs-gynae, paeds, and radiology and other services ~~all sorts of odds and ends~~.

It f~~F~~elt wrong. I mean intuitively it wasn't the right structure, and it was not going to deliver I didn't think. And I think what brought that home to me, when I first saw the structure, and given the issues that they faced around women's and children's services, why you wouldn't have a focus on that in isolation, rather than bundled in, in the nicest possible way, with radiology, pathology etc just escaped me.

So by the time I got to the board on 22 March I already had an emerging management structure to offer to the board. Which they signed up to. And that was to create five divisions. It was to create a division of women's and children's. These were pan-Bay divisions. So it was trying to send a message that there's one paediatric service across the Bay. There's one obs and gynae service across the Bay etc, and that's easier said than

done, and there's a lot of work to do beyond that. But it needed a very clear message.

So the directorate plans ~~it~~ was women's and children's. It was ~~emergency.~~ [Inaudible] surgery. It was acute medicine. It was non-actute medicine, and then ~~it was~~ the other services. ~~rest~~. So it – what it tried to do was to focus attention on the two areas which were the most challenging for the Trust, which were women's and children's and acute medicine. The others were, by and large, performing okay. I didn't have anything like the same issues. But what we needed to get was clinical leaders at the top of those, so I was looking for clinical directors for all five of those divisions, supported by – in four of them ~~–~~a head nurse~~,~~/ senior nurse, and also a divisional general manager I think I called them. I think they were originally called AD Ops – assistant directors of ops, which didn't sound like anything I had come across before.~~,~~ So we went very clearly for general manager. It was a triumvirate management team in the four clinical divisions, with the pinnacle of that being the clinical director, who had overall responsibility ~~for everything~~: Financial bottom line, waiting list, clinical quality, clinical governance.~~, the whole shebang~~.

There was not a good pool ~~of fish~~ to look at for clinical directors, so I'm afraid I didn't offer it for invitations. What I did was work with the new medical director we had at the time, George Nasmyth, and actually said to him, 'Look George, we've got to get this up and running. We've got to do it quickly. We can't take six months playing abοut it. I need clinicians who will step up to this, who will do it for six months on a probationary period, whilst we try and find out whether other clinicians are prepared to do it. Or these clinicians wish to continue. ~~[inaudible].~~ But we will get the job done then, and we'll have external assessment. And the ones that we put in at this time, we'll offer the development program to equip them for the kind of role they're stepping into.'

I mean we had success with that. We got some. We were struggling to fill one of them, which I think was non-acute medicine, from memory. But we got people to step up for the others. We were also not overly well-endowed, if I'm honest, with senior nurses, and that was a more difficult exercise, because there was a very small pool to fish from, and they were – they were on the staff, so we had to – to be honest use them and assess them and then take a

1 view about whether we moved any of them on or not. And the same applied
2 with the general managers.
3 DR KIRKUP: Who was the clinical director for family?
4 MR MORTON: [Inaudible], their name. ? Cannot remember their name.
5 DR KIRKUP: Right, yes, okay, got it. Yes. That would be right. Yes.
6 MR MORTON: Sascha Wells was head of midwifery. And the general manager,
7 Fraser...
8 DR KIRKUP: Fraser Cant, yes.
9 MR MORTON: Although actually I did suggest to him he might want to do the
10 radiology and pharmacy posts. I would have liked somebody who'd got more
11 experience of obs and gynae. But, you know, we were also subject to
12 ~~governed by~~ HR processes ~~forces~~, and he therefore had an option to elect for
13 that job. So we put him in it as part of an ongoing assessment, see whether
14 he was up to it or not.
15 DR KIRKUP: Yes. It's helpful to us to be able to put names to this, because the job
16 titles change and we have to keep track of who's who. Sorry.
17 DR WALTERS: That's fine. We've heard sort of various sort of interpretations...
18 MR MORTON: Sorry, there's a couple of other things I want to say, if you don't mind.
19 Other things that were important.
20 DR WALTERS: Yes.
21 MR MORTON: I mentioned that the organisation lost clinical engagement. It has lost
22 staff engagement as well. So it was wider than just the clinicians. So we'd got
23 quite a distant general staff. There'd been the introduction of one or two
24 unusual HR practises, like forfeiture of increments for staff ~~if~~ – with ~~sick~~ – poor
25 sickness records. Whether they were legitimate or not.
26 And one of the first things, again, that Sir David and I did was to meet
27 with the staff side, and to say, 'We're not doing that any more. It's cavalier, it's
28 not well evidenced, and this is not about treating one group of staff differently
29 to the others.' So we jettisoned some of the unique HR practises within
30 Morecambe Bay. That's the only time I've ever been to a JCC and got a
31 round of applause. I have to say, it's kind of spooky.
32 The other thing was the executive management structure. They'd lost a
33 couple of execs. The kind of director of ops had gone and, instead of what I
34 think is the right thing to do, which is to look at what responsibilities are and

1 make sure you've got a structure that's fit to deliver, they bundled
2 responsibilities into other execs portfolios. So I think medical director was
3 responsible for security management. It was some utterly bizarre kind of
4 combinations. It was almost a matter of, 'We've got to put this somewhere.
5 We'll put it over there, we'll put it over there.' So again, when...
6 MR BROOKES: Sorry, could you just be clear. Was that because some people had
7 left? Or was that...
8 MR MORTON: That was because the director of ops had left. So rather than looking
9 at whether they needed a director of ops, they'd distributed out the
10 responsibilities. In a way that they thought would best fit. What happened
11 then was that we were overloading some people who got more than enough to
12 do, and actually asking people to do things for which they didn't have the skills
13 or the expertise or interest. So again...
14 DR WALTERS: Was that supposed to be interim? I mean, was it while they thought
15 about it? Or was that...
16 MR MORTON: When I arrived there were no plans to fill an ops post. So – I can
17 only say what I found. They may have intended to replace, ~~been down track~~.
18 But I don't know. So again, on the whatever it was, the March board, Sir
19 David and I discussed a exec change – a change in the exec structure. Which
20 I put to the board, which they approved. Which was the appointment of COO.
21 To take responsibility to support the clinical divisions in stepping up to the
22 plate.
23 That also released the medical director from ~~sort of~~ his unusual
24 responsibilities. It took the finance director back from doing quite a lot of the
25 ops work, back into looking after finance. Because there were two big issues
26 facing them: One was it was a difficult Trust financially to manage, in any
27 event. Because of the costs of addressing the quality issues~~[inaudible]~~, but
28 also because the impetus was – because to put quality right, that inevitably
29 meant spending money. It's a fact of life that to get quality right you've got to
30 invest, and you're going to almost over-invest in it to get it up to a standard
31 before you can take a step back. So they were facing huge financial
32 challenges.
33 The other thing I found was a poor relationship with the emerging
34 CCGs, and the first time I met the Lancashire CCG – North Lancs CCG – I

attended their full meeting. Which I think was unusual for a chief exec from Morecambe Bay to attend – I was very taken with their opening comment, which was, "UHMB'S'~~Your~~ definition of contracting is that you tell us what you're going to do and send us a bill.' You know, which was from the heart.

And we worked really hard over the next two to three months to change that philosophy, and I think we did, with the CCG, because I think it was in the June they invited me ~~us~~ to speak at their annual meeting about change relationships. So I think we'd made a lot of progress with the CCGs. ~~And saw that was into us~~. They need to determine what services were being delivered on site, and I think, if I'm honest, the Trust had let the CCGs or the PCTs off the hook a little bit, by trying to keep everything going, and actually none of those services were sustainable at the right quality across the whole of the Bay, and there needed to be sort of really deep thinking here, about delivering services that were in the right place, but to the right quality, and understanding what some of the trade-offs might have to be, and I think, if I'm honest, both PCTs, both in Cumbria and North Lancashire, that was it. They kind of didn't want to have, and I absolutely understand that, but it was –

DR WALTERS: I mean just...

MR MORTON: Sorry, the final thing I got – I do apologise. Finally it was the board position was – with the greatest respect – and I think I've [inaudible] before I go there, but they managed to put some new NED's (NED= non executive director) ~~LADs~~ in who were taking it ~~life~~ incredibly seriously, and very much a common agenda. And the other big thing was there not a loss ~~lot~~ of reputation, I'm afraid. Both with GPs locally, with the press, with the public. Not with the MPs. The MPs were incredibly supportive but challenging, but they wanted the Trust to do well in the three localities. So there was a lot of affection for the Trust, but there was also ~~a lot of~~ disaffection, that it needed to get its act together and deliver, because their support can only be counted on for so long. Sorry, that was kind of my take on it when I got there.

DR WALTERS: Okay. I mean, some people have sort of alluded to here was a very complex organisation with very difficult issues, and were the executives sort of senior and experienced enough to cope with that. What do you think of that?

MR MORTON: It is a complex organisation. Predominantly because of the geography. Not just the fact that it's on three sites and they're quite distant,

but also because, frankly, it's an area where not everyone ~~you~~ would~~n't~~ want to work ~~in~~. But that's a similar issue that they face in Cornwall, and Lincolnshire and other parts of the country. But it isn't, ~~you know~~, ~~it isn't on a main road,~~ to be frank, you know, so it can be difficult to attract people. So you've got to attract people either because they want to live in the area or because they see it as a good place to work, where they'll be fulfilled.

The execs hadn't been together very long, and I think they were a mixed group. I think the – I think the Finance director I'd got a lot of time for. Good Finance Director. I think he did a – he'd been taken to where he shouldn't have gone, in terms of operation. I think he was stretched on that, and we couldn't afford that. He had to get his head back towards finance. I think he did a good job. I was okay with him.

Director of Nursing. I think she was working incredibly hard, and I think she was struggling. But she was, you know, there was no issue about commitment, hours that she was putting in, and so on. I think she was under resourced. I think the whole of nursing directorate ~~director~~ was under resourced.

They didn't have the pairs of hands and the expertise to aggressively look at clinical governance and quality. And to be fair they did get people in on secondment, and that was fixing something that had been wrong for a number of years, and actually should have been part of the structure that there was routine assessment of the quality of services on the wards that was being done internally, before you have an external inspection. So you get no surprises from external inspection. You should have done the inspection to ~~it~~ ~~to~~ yourself beforehand and, you know, we might not know when the inspectorates are coming. But we've got a pretty shrewd idea, haven't we, and we should be routinely assessing our services so it's no surprise when they arrive on site.

The Medical Director I think stepped aside, I can't remember, I think it was my second or third week, and we brought George – I know it was early – must be the first week. Because George Nasmyth, who we put in as interim, attended the timeout on the second week.

It needed a change of focus. It needed a different face at the helm of the medical side, frankly. With a different agenda. That is no criticism of –

1 Peter, I think was the outgoing Medical Director. But they needed somebody
2 who'd got street cred with the consultants, who could talk to them, bring them
3 – get them on board. And he was also, because of the position in his career,
4 he wasn't a long term medical director, which was a real positive. Because he
5 did it because he wanted to do it. He was doing it for the right reasons. It
6 wasn't part of a career plan. And he was sure that he was always going to
7 move on. So it was about a group of other people to get on with.
8 DR WALTERS: You said something about the Trust letting the CCGs off over things
9 like services and viability and cost. Do you think the obstetric service at
10 Furness was viable?
11 MR MORTON: I think the obstetric service across three sites is difficult to deliver,
12 and frankly, at times, if you're going to staff it appropriately and safely. So that
13 isn't a direct answer to your question, because there are other ways – there
14 are other things we could consider, ~~[inaudible] health committee~~. One is that
15 you don't have to stick to tariff.
16 You want to have a good service, then the issue for me, that the
17 commissioners have to make sure it's safe. Now if that means paying a
18 premium for a local service, well there this nothing actually wrong with that at
19 all. I have never advocated that to any of the commissioners. Because I
20 think, you know, we should aim ~~be able~~ to work at tariff. But if they want a
21 local service, they can't deliver safely at tariff, then there's a debate about
22 whether we change that composition of service, or whether there's a premium
23 paid to obtain local access. Nothing wrong with that.
24 In terms of, you know, if I take a step back now, and the obstetrics
25 service across the Bay, there aren't enough births to sustain, safely, in an
26 easy way, two consultant obstetric units. In my opinion.
27 DR WALTERS: And do you know if that conversation had ever been had, in those
28 terms, with the commissioners?
29 MR MORTON: I don't know if they had. It was certainly held in my last two months,
30 because we put together a group which included the CCGs or through a
31 company who were from the north west, to talk about future distribution
32 services. Because – and that did pick up obstetrics. Because it had to, you
33 know. That was a seriously big issue.
34 Without any preconceptions, you know, there was an assumption, I

1 think, from the Furness people that it was going to be one consultant they
2 knew and it was bound to be at Lancaster. No. It's about looking at where the
3 service needs delivered. Remoteness is a big issue around Barrow, whereas
4 actually Lancaster's not a million miles away from Blackpool. So there were
5 all sorts of service options, and what I didn't have was any that I was leading
6 on or pushing. It was about looking at what the population wanted, and how
7 that could be delivered locally, with the support of the CCGs.
8 DR WALTERS: What was your view on the sort of central handling and dealing with
9 risk? Identifying and dealing with clinical risk?
10 MR MORTON: Or, again, David Henshaw and I commissioned some work from
11 University Hospital of South Manchester, to look at our risk management
12 system. And one of the non-executive directors had got a background in risk.
13 Dennis Lidstone.~~Hiscombe[?]~~...
14 DR WALTERS: Hiscombe[?]...
15 MR MORTON: Thank you. Yes, Dennis. Who'd got a background in risk, and he
16 was a really good LAD to have on at the time. And there was a lot of – a lot of
17 focus pouring in onto assessing risk at an early stage, rather than being
18 reactive. One of the things I did do, again this was at the first board meeting,
19 is got the board to sign up to a insert in payslips to all members of staff,
20 requiring them to report incidents, near misses and that kind of thing. On the
21 basis that this was the right thing to do, this was about improving services.
22 This would not, necessarily, result in disciplinary or any penal action at all.
23 Didn't mean it wouldn't. Because, you know, it's – there may be occasions
24 when it has to. But it was about encouraging the staff to report upward
25 incident and not just when they happened. Because that can, if I'm honest,
26 near misses are more important than actual incidents.
27 DR WALTERS: So I – they talked about how they approached this, in the past.
28 Which is not unlike, probably, what a lot of other trusts were doing at the time.
29 I suppose it's just trying to pick out what are the features that they didn't do
30 properly. So they had systems. They had reporting systems. They seemed
31 to spend some time on it. But, for some reason, they weren't picking up
32 everything from the sharp end. What was your impression of how that
33 worked? Were they unconsciously incompetent? Or unconsciously not
34 knowing?

1 MR MORTON: I think it was – it's quite – I can't give you a forensic answer. I can
2 give you what I think, but it's un-evidenced. I don't think there was a culture in
3 the organisation of reporting up. I think there was a perception that actually
4 they didn't want to know, if I'm honest. Which is absolutely the wrong answer.
5 I don't think there was – I don't think the board was focussed on risk.
6 Again, one of the things that we put in very early on was a clinical governance
7 committee, which focussed on governance, clinical quality, SUIs, you know.
8 What you would expect a clinical governance committee to do. And underpin
9 that with something that I think I call clinical management team at the time,
10 which was the divisional clinical directors, the divisional nurses, the medical
11 director, the director of nursing, with an AED – sorry, without any AEDs
12 around the table, and that was the operation on the clinical governance
13 committee.
14 So that was to do with the heavy lifting on behalf of the clinical
15 governance committees. But then [inaudible] report came out, it would have
16 gone to the commercial committee to assess the report, what the implications
17 on UHB, and what are we going to do about it, by when. And that gave the
18 clinical governance committee then the ability to performance manage
19 improvement.
20 DR WALTERS: But they had something like that before, didn't they?
21 MR MORTON: It wasn't anything like as focussed as that. It was...
22 MR BROOKES: Risk committee.
23 MR MORTON: Sorry?
24 MR BROOKES: It was risk committee, wasn't it?
25 MR MORTON: Yes...I think you've got to have a clinical governance committee to
26 focus on the day job. That's not to say you don't have a risk committee as
27 well. Because other risks are not unimportant. But it's what we are. It's what
28 we do. You know. We provide clinical services. There are risks surrounding
29 clinical services that needs to have a focus, and needs to have the right
30 people round the table which have actually got their clinician to put it right.
31 DR WALTERS: Okay, thanks very much.
32 DR KIRKUP: Julian.
33 MR BROOKES: I've got a big question, but I'll come to that in a minute. I'm just
34 going to touch on commissioners again. CCGs were relatively new when you

1 were in – it was – so there was an inheritance here from PCTs. Did you get a
2 flavour that the PCTs were good commissioners?
3 There's a triangle in, as you know, with commissioners locally, SHA,
4 trusts and, depending on who we speak to you get a different – slightly
5 different feel for where the power was, and what was driving the system.
6 But, in quite a lot of those cases, the driving system seems to have
7 been the acute trusts, not necessarily the commissioners. And with not
8 necessarily the kind of scrutiny you would have expected from the
9 intermediate strategic health authority in this particular case. Is that fair
10 assessment? Or what was your feel going in?
11 MR MORTON: No, I think it'd be fair assessment. I think the facts of the matter
12 around that time was that the dominant partners ~~[inaudible]~~ in the community
13 were the providers. They'd got the history – they'd got the staff that had been
14 there for quite a while. And they were at the front end, delivering the services.
15 [Inaudible]. It's not for me. It's incredibly difficult.
16 I think what makes it more doable is if a provider's prepared to have a
17 proper conversation with the commissioners about the issues, rather than just
18 trying to carry on and paper over the cracks. Because actually they're in the
19 same business. They're about providing quality services, you know, and I
20 have to say in other trusts I've worked in, I've had a conversation with
21 commissioner and said, 'Are you comfortable with procuring a service that I
22 think is poor quality ~~think's unsafe~~?' And it's a shared responsibility. It isn't
23 just the providers. It's as much for the commissioners.
24 MR BROOKES: It is a shared responsibility. It's about commissioning on an
25 evidence base against the needs of your population, and having those tough
26 conversations about what provision needs to be and where it needs to be.
27 MR MORTON: Totally agree…
28 MR BROOKES: I don't feel that that's necessarily what was happening though.
29 MR MORTON: It wasn't. But I don't think that was unique, either, across the English
30 NHS, because I think we were just getting to the stage, beginning to get to the
31 stage, where those discussions were having to take place.
32 MR BROOKES: Okay.
33 MR MORTON: And we're seeing more and more of it now, aren't we?
34 MR BROOKES: We are. And you're right. There's a number of options open to the

1 commissioners, when you're having that, which is potentially pay a premium,
2 cross-subsidisation within the organisation itself, in terms of the tariff
3 arrangements, or some kind of compromise arrangement that comes to it.
4 And again it doesn't sound that that was the kind of conversation which had
5 happened to that date.
6 MR MORTON: No.
7 MR BROOKES: Okay.
8 MR MORTON: And those conversations were emerging around the time I left, when
9 we set up the, you know, cross-Bay group involving the CCGs looking at
10 service distribution.
11 MR BROOKES: Yes.
12 MR MORTON: But they'd only just started to work at that stage.
13 MR BROOKES: Okay. I'm trying to understand, I would agree with you that there
14 was a clear focus on FT application with the organisation. I'm just trying to
15 understand, you said that drive came internally. I'm just trying to work out why
16 there was such a drive on that? Clearly there was the feel that this was a big
17 badge of honour, across the NHS, to be part of the FT process. But different
18 organisations were more proportionate, shall we say, from what you were
19 describing. Did you get any feel why, from the conversations you had, about
20 why such a focus was being placed on the FT application?
21 MR MORTON: Nothing that I can evidence. It was certainly driven – the chief exec
22 was very committed to it. There's no question about that, from where you
23 could kind of pick up. But the board signed up to it so, you know, I've got to
24 take the view that it was the board pushing it. There were, at that time, some
25 clear freedoms from being an FT. They were kind of visible. They're perhaps
26 a little less visible now, but they were certainly visible at the time. And I think
27 one of the perceived benefits of being an FT was to have, in some ways, a
28 more equal discussion with other people within the NHS, including
29 commissioners. There was a feeling that that gave you a bit more of a – an
30 equal say. Not that that was the reality. I think, as much as anything, it was
31 because every hospital was expected to move to FT status. The question was
32 when. Inevitably there's an incentive on organisations to go as quickly as they
33 feel able, and that's what Morecambe Bay did. Wasn't ready.
34 MR BROOKES: What discussions were involved with external – Monitor, CQC, the

1 SHA was still around, sort of, at that time. Did you have any conversations
2 with ...
3 MR MORTON: Phone call with the SHA. Clearly a lot with Monitor. Pretty regular
4 meetings and talked down the phone with them. Also CCG and the NMC
5 when they came to visit. Also opened discussions with other providers:
6 Blackpool, Women's Hospital in Liverpool. Because one of the things I felt
7 really strongly about that area was it's quite isolated, and it didn't get out
8 enough, to be honest.
9 The clinical staff didn't get out enough, didn't see what it was like
10 elsewhere. So we did open up discussions with Blackpool about whether
11 there was an opportunity there to work more closely, collaboratively on
12 cardiology, cardiac work generally. Also on vascular. We opened up a
13 dialogue with Liverpool Women's about exchanging midwives so that they
14 could, you know, work with a centre which is recognised as providing really
15 really high quality services.
16 MR BROOKES: Okay. There was obviously clinical issues known around obstetrics
17 and maternity services. What else were you – did you become aware of, in
18 terms of clinical concerns across the organisation?
19 MR MORTON: Paediatrics. Because I came in on the back of a couple of bad
20 cases. Inquests. And I had to manage the turbulence from those. And acute
21 medicine. Particularly around the Lancaster site...
22 MR BROOKES: Emergency...
23 MR MORTON: Yes. It was pretty clear that the Lancaster site itself had been
24 neglected. It was in a poor state of repair. The buildings were not good.
25 Looked fantastic from the outside. Bit like this building. Fantastic on the
26 outside, not fit internally for modern medicine. That showed me things like
27 ailing performance. Barrow, by and large, did okay. Depending on who was
28 on shift. Lancaster struggled. And it struggled not because of the quality of
29 the staff, but around physical capability. So we did get into doing some
30 modular construction within the Lancaster site, to try and relieve some of the
31 tension and pressure, and to get some patients out of ward, which frankly
32 should be enclosed some time earlier. There were some really poor quality
33 wards in Lancaster.
34 MR BROOKES: I suppose it leads me to – I can understand your assessment, you

1 know, you've got poor clinical leadership. Poor systems, particularly around
2 governance. Concerns around particular clinical services. Not necessarily the
3 strongest board, or leadership within the organisation. And we've certainly
4 heard well there might have been desire to report upwards, but there was a
5 feeling that there was no point, because you reported so far and hit a glass
6 ceiling, and nothing went any further. So I suppose the question is, 'Why?'
7 Did you make any assessment – were you able to make any assessment
8 about how the organisation had got into the position it was?
9 MR MORTON: I mean, to be honest, my focus was on looking forward, not looking
10 back so much. But I didn't feel it was a recent phenomenon. I felt it went back
11 years. You know, maybe back as far as the merger itself. I – it wasn't a
12 merger. It was a collection of three hospitals under one logo, I'm afraid. And
13 they hadn't worked – the management that took that into merger didn't work
14 hard enough, and didn't have a clear enough vision about how it was going to
15 work as a three-hospital site, and how it was going to deliver service and what
16 its standards were. So for me, it goes back, I'm afraid, frankly way back. Way
17 back to that merger.
18 MR BROOKES: So you think it's, what, potentially a cumulative effect over a number
19 of years, from a number of factors?
20 MR MORTON: I think it became a way of life. And I think, after a period of time,
21 people forget what good is, and that's they way they've always done it. That's
22 the way they did it last year, so that's the way they'll do it this year. There was
23 – there wasn't the good relationship between the clinicians at Furness and at
24 Lancaster. They should have been delivering the same services.
25 MR BROOKES: Okay.
26 MR MORTON: But there'd also been no leadership to force those – yes, force those
27 together. Clinically. They should have been forced together clinically. They...
28 MR BROOKES: But there wasn't a common direction to travel.
29 MR MORTON: Sorry?
30 MR BROOKES: Was there a common direction for travel?
31 MR MORTON: Absolutely not. There was suspicion on both sides. The CCG in
32 Lancashire was very very clear that it was commissioning on the basis of
33 quality of services, and therefore, whilst it had every affection for Lancaster
34 Royal Infirmary it needs people to get good services, or it would move them

1 away.

2 I agree with you completely. That was absolutely the right thing to do.

3 ? ~~So if we defaulted back now to being UHBI we could deal~~ – if we couldn't

4 deliver proper service to the CCG then they're right to move them away, and

5 that was quite an uncomfortable discussion for the clinicians at Lancaster to

6 hear their chief exec saying, 'If you can't deliver to the quality they need, then I

7 agree with that they should be moving it. So the challenge for you guys is to

8 get up to standard.'

9 MR BROOKES: Absolutely, and that's the right debate to be having.

10 MR MORTON: It's the only debate.

11 MR BROOKES: That's all I have, Chair.

12 DR KIRKUP: You did get fairly deeply immersed in UHMB in your relatively brief

13 period.

14 MR MORTON: Yes.

15 DR KIRKUP: Yes. I mean, you know, it is – it makes a refreshing change hearing

16 somebody talk about it, where most people in your position are trying to

17 distance themselves, rather than being corporately part of it. Is the length of

18 time that you spent there enough time to change anything?

19 MR MORTON: No. Not to change it fundamentally. What it is enough time to do is

20 to make some changes, and it's – there is a lot to be said for somebody going

21 for a short period of time and making fast changes. Because, to be honest, I

22 can have a conversation with staff in a way a substantive ~~The Chairman of~~

23 ~~Medical Site Committee, and~~ the chief exec can't. ~~They can't [inaudible]; it~~

24 ~~can only be a [inaudible].~~

25 DR KIRKUP: Sure.

26 MR MORTON: But whatever it is we're going to change, then the issue is, 'Do we do

27 it together or do we not?'

28 DR KIRKUP: Okay. Were you happy that the changes you were making would be in

29 the right direction for the succeeding chief exec?

30 MR MORTON: Yes. I thought they were in the right direction...

31 DR KIRKUP: I realise that...

32 MR MORTON: I have to, don't I? Because ~~no~~, I genuinely believe they were the

33 right direction, but they were also done in a way which allowed the new chief

34 exec to come in with flexibility. So we'd set off the cross-Bay discussion on

1 clinical sustainability of services, but there were no decisions taken. Because
2 the new board, working with – you know, the CCGs were becoming
3 increasingly up to speed to make those kind of decisions, because they were
4 difficult. They were going to be very difficult decisions.
5 DR KIRKUP: Okay. Did you get the opportunity to brief the incoming chief exec?
6 MR MORTON: To a degree. And that's not a defensive comment. I have to say I've
7 never been a fan of outgoing chief execs and incomings walking around
8 corridors together. Because I think it's not good for the staff to see the two
9 together in some ways. They're not sure who's in charge.
10 Jackie and I met several times before she started, and it was an open
11 phone line when I'd gone, and, you know, I didn't have to in the end, but I was
12 always prepared to go back up. Not on site, because I don't think you ever go
13 back, but to have met her locally if she needed to. And we'd had some
14 conversations thereafter, but I think it was a pretty comprehensive handover. I
15 knew the continuity with David Henshaw was remaining as well. So there was
16 that degree of carry over.
17 DR KIRKUP: Yes, I appreciate that. What did you tell her in those two or three
18 meetings that you had, that you haven't told us just now?
19 MR MORTON: I think I can tell you, but what I emphasised with her is that we'd got
20 and emerging clinical management structure which wasn't working yet, but
21 there were the building blocks there. That there needed to be a lot of
22 investment – and I don't mean that in terms of money, but a lot of investment
23 in developing the senior – or doctors to become doctors in management. To
24 develop the senior nurses so that they could deliver a managerial or clinically
25 sensitive and, you know, role. I thought they were weak on general
26 management, and they needed a piece of work done on that. I think there
27 were a couple of changes as I was kind of going...
28 DR KIRKUP: Now is that at board level? Or is that sub-board level you're talking
29 about?
30 MR MORTON: That was divisional level. That was sub-board level...
31 DR KIRKUP: Divisional level...
32 MR MORTON: Yes. I did make some board level changes. The director of HR
33 moved on while I was there. Because I think we needed to refresh – we
34 needed to refresh HR, because I think it was perceived across the

1 organisation quite negatively, and actually should be perceived as quite
2 supportive, and working for the divisions, and – which again wasn't felt there
3 was [inaudible]. And so HR wasn't used as a leader for change, it was more
4 used as a transactional blunt instrument in many respects.

5 And the other thing I wanted to do, and again it's part of, I think, a
6 legacy to an incoming chief exec, is you've got to give them space on the
7 board to make some of their own appointments. So the director of HR left.
8 They needed a governance – stronger governance model, which we'd put in
9 place on a ad-hoc basis by using a local firm of solicitors to come in and
10 provide the company secretary role, pending an internal appointment.

11 So what I offered her up was an option of revised structure, which had a
12 kind of company secretary with HR in a corporate services division. For her to
13 use or to do something completely different. What she had was an empty seat
14 on the board that she could appoint it where she saw the fit need to.

15 DR KIRKUP: Okay, did you give her an appraisal of the board level posts that were
16 there, and would remain there?

17 MR MORTON: Yes.

18 DR KIRKUP: And…?

19 MR MORTON: Okay. I've already said I thought the Finance Director was really
20 good….

21 DR KIRKUP: Can we have a name for that post? Just for us?

22 MR MORTON: Tim Bennett. I thought that he worked his socks off. But was
23 struggling because of the volume of work and the non-financial work that was
24 loaded on him. So ~~once~~ I thought he did a really good job. And he did pick up
25 the kind of turnaround role, which he'd not been able to do while he was doing
26 other things.

27 The COO that we put in place, Juliet Waters? Walters? Appointed her
28 the first week <u>or so</u> I was there I think. I did quite a lot of research on her
29 before we had her in to have a chat. She had an excellent pedigree from
30 Addenbrookes, and she'd worked in Newcastle. ~~Still there~~ <u>She is still at</u>
31 <u>UHMB.</u>

32 DR KIRKUP: Yes.

33 MR MORTON: And she was exactly what was needed. Because she'd got a lot of
34 personality. She was infectious. She was fast. Impatient for change,

impatient for improvement. Which is what was needed, because one of the other things that the organisation lacked was pace. There was something needed fixing, so they'd submit a plan, and it would be thought about and it would be sent back, you know. So one of the other things that we instituted was, you submit a plan and there's only two answers: yes or no. It's not, 'Go away and think about it again. So get it right first time.' And sometimes they didn't, did they. So it went back with a no, and that really forced people to up their game.

DR KIRKUP: That sharpens minds, yes.

MR MORTON: It absolutely did. So there was some difficult decisions early on, by rejecting some very "necessary" improvements. But they had to get them right. Jackie was director of nursing. I think she was struggling. She was – this might sound a bit wrong, she was putting too many hours in to do the job. She'd lost the focus almost. She was sinking under the volume.

She'd got a couple of deputies in, if I remember the name of one, Mary – Mary Moore, who were trying to lessen the burden and take pieces of work off her. That was long overdue, and one of the other things I should have said that we did, as part of the divisional management structure, is that I gave the medical director two assistants, and I gave the director of nursing two assistants that would support corporately but also have site focus. So one of each of those would be focussing on Lancaster, and the other one on Furness and Kendal.~~[inaudible]~~.

DR KIRKUP: Okay.

MR MORTON: And I'm trying to think who else was on...

DR KIRKUP: Just on the director of nursing, and then we'll go onto the next one. Was that the nature of the job? Or was that that Jackie Holt ~~Horton~~ had lost her way to some extent?

MR MORTON: I think the job hadn't been thought through properly, as what was important. There wasn't enough senior support to take some of the heavy lifting off her.

DR KIRKUP: Yes, okay.

MR MORTON: I think Jackie's nature was that she wasn't strategic. I think she did get down into the detail almost too much, and I think she drowned in it.

DR KIRKUP: Okay, and the medical director, George.

1 MR MORTON: George was what was necessary at the time. And I don't mean that
2 to sound negatively. We needed somebody to come in and shake, and make
3 things different. And I think he did, and my view of his appointment was he
4 was going to be there for no more than 12 months. Because he was a bit like
5 I was. He was going to go in, make the changes, perhaps even be a bit
6 unpopular at making some of the changes. And then he needed to hand over
7 to a longer haul medical director, internally or not.
8 DR KIRKUP: Are you surprised he's still there?
9 MR MORTON: I was surprised, yes.
10 DR KIRKUP: Okay.
11 MR MORTON: And I don't mean this negatively, but I would have wanted to have
12 moved him on after 12 months, because I think we'd have got the best out of
13 him by then.
14 DR KIRKUP: Yes, understood.
15 MR MORTON: That's not a criticism of George at all.
16 DR KIRKUP: Understood. You mentioned that – and I wrote the word down so I'm
17 sure it's what you said, that there was a, 'Board shambles' before you go
18 there. Can you expand on that a wee bit?
19 MR MORTON: Just probably a bit unfair but, you know, I look back at the board
20 papers for the first couple of months and it didn't feel as though they'd got a
21 focus. There didn't appear to be a strategic direction. The board didn't know
22 where it was going. It had almost forgot what was important. It was sinking
23 under papers. And again, one of the things that we tried to do was to be very
24 clear how long board meetings would last. And the papers would be very
25 crisp. There'd be a presumption that the NEDs ~~LADs~~ had read them
26 beforehand, and the other execs would have read them beforehand, and we'd
27 concentrate on what – not rehearsing what was said in them, but what we
28 need to do as a result of it. So the boards meetings were slimmed down. It
29 was less, 'This is what we're doing', to, 'What do we need to do as a board, in
30 terms of what do we need to change, what direction of travel do we need to
31 take.'
32 DR KIRKUP: Okay. How long had David Henshaw been there when you arrived?
33 MR MORTON: Weeks. Probably not as long as [inaudible] months.
34 DR KIRKUP: So he inherited the board shambles as well? He hadn't really had time

1 to fix it?
2 MR MORTON: I think he inherited the original board. And I think he'd probably been
3 there two weeks before he spoke to me. And I started two weeks later. When
4 I got there there was a whole new crop of NEDs ~~LADs~~ in, so I think he'd –
5 well, he had made some changes. And then again, I'm not criticising the
6 original NEDs ~~LADs~~ because I don't know them.
7 DR KIRKUP: I understand.
8 MR MORTON: But it – clearly the board was not functioning and, you know, that
9 doesn't have to be forensic. It's a statement of fact. They were delivering
10 poor quality service, ~~that they were [inaudible]~~ and they weren't making sure
11 they were proper quality. ~~And they just stopped [inaudible].~~?
12 DR KIRKUP: And that diagnosis you would apply across the board? It wasn't
13 specific to clinical governance, or finance, or operations? It was across the
14 board?
15 MR MORTON: I think they'd almost lost purpose and focus on the day job, and it
16 was widely in clinical governance, but – and clinical quality, but that's where
17 it's shows up ~~[inaudible]~~ isn't it?
18 DR KIRKUP: Okay. I presume that your name came forward via Monitor? Do you
19 know whether that's the case or not?
20 MR MORTON: I suspect it probably did. But…
21 DR KIRKUP: You don't have any direct knowledge?
22 MR MORTON: I don't have any direct knowledge. But I suspect it probably did.
23 DR KIRKUP: Right, okay, well we can ask…
24 MR MORTON: I think my guess is, and it is only a guess, that David would have
25 spoken to Monitor and said, you know, 'I need to bring somebody in, do you
26 know anybody?' and I've no idea how many names they gave.
27 DR KIRKUP: Okay.
28 MR MORTON: It might have been one, it might have been ten, frankly.
29 DR KIRKUP: I'm not asking you. I'm going to ask him that.
30 MR MORTON: ~~But I know it [inaudible] available~~. No intention of taking the job at
31 that time.
32 DR KIRKUP: Were you aware of any serious untoward incidents, specifically in
33 maternity, during your period at the Trust? Did you get involved in them? Did
34 you know about them?

1 MR MORTON: I can't remember. I genuinely can't remember.

2 DR KIRKUP: You're...

3 MR MORTON: ? ~~I can remember the outcome [inaudible] Chris Hall[?] was there, but~~

4 ~~I don't remember.~~ There may have been, but I genuinely don't remember.

5 DR KIRKUP: Right, which were the inquests that were there? I should say, at this

6 point we need to move into the confidential part of the session, in case we're

7 talking about names here. But can you remember which inquests there were?

8 *[The interview continued in private]*

THE MORECAMBE BAY INVESTIGATION

Wednesday, 21 May 2014

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

Before:

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

AMANDA MUSGRAVE

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7th Floor, 61 Southwark Street, London, SE1 0HL
Telephone 020 7269 0370

1 [2.06 p.m.]

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3 again for coming to talk to us; we do appreciate it. I'm Bill Kirkup. I'm the chair
4 of the investigation. I'd like to ask each of the Panel members just to introduce
5 themselves briefly.

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7 and I also work for the Scottish Government and NHS England.

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

10 PROF FORSYTH: I'm Stewart Forsyth, a Consultant Paediatrician and Medical
11 Director in Dundee.

12 MR BROOKES: I'm Julian Brookes. I'm Deputy Chief Operating Officer at
13 Public Health England with a background in governance.

14 PROF MONTGOMERY: I'm Jonathan Montgomery; I'm Professor of Health Care
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16 And I was previously chairs of a PCT and an SHA.

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18 of Nursing in a District General Hospital in Essex.

19 PROF WALKER: I'm Jimmy Walker. I'm the Professor of Obstetrics and
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24 this afternoon, but we have offered people who can't attend or would prefer not

1 to attend the option of listening to what's recorded during the session, so as
2 long as you appreciate that...
3 You'll also have noticed that we've all handed in mobile phones and
4 recording devices. And the reason for that is I'm very keen that we produce a
5 report where everything is in context and we don't have bits of information that
6 come out of context ahead of when the report's produced. And I'd like to
7 extend that to taking notes as well. Obviously, you're welcome to take notes if
8 you would like to, but please respect the confidentiality of those after the
9 session.
10 I don't think there's any other housekeeping. If there is a fire alarm, it
11 won't be a test and we'll sort it out.
12 MS MUSGRAVE: Okay, I follow you.
13 MR BROOKES: No.
14 DR KIRKUP: No, follow the secretariat; unlike me, they know what they're doing.
15 MS MUSGRAVE: Okay.
16 DR KIRKUP: And I'd like to hand over to Jonathan to begin the questions. Thank
17 you.
18 PROF MONTGOMERY: Thanks very much. Thanks for coming up to spend the
19 time. I think there are two sorts of things it'd be really helpful for us to
20 disentangle. One is how the various organisations are able to fit together and,
21 within the CQC, how it organises things, and then just try and work our way
22 through the chronology, which involves the CQC at various points in the
23 process. So, what I'd like to, if I may, is start by asking you to explain a bit
24 about how the CQC works when it relates to Trusts and, when concerns

1 emerge about systems, who else it deals with on a sort of abstract level and
2 then perhaps we'll work our way through the points that we know about and try
3 and understand what's going on.
4 MS MUSGRAVE: Okay, I'll try to assist as much as I can. Because, obviously, my
5 understanding of the interview was for me to talk about the investigation report,
6 so...
7 PROF MONTGOMERY: This stuff all appears, I think, in the report, so I'm trying to
8 understand the context, so we'll bear with you as you take us through.
9 MS MUSGRAVE: Okay. I clearly won't be able to use Morecambe Bay as an
10 example of what worked there, because I'd not had involvement with the Trust
11 prior to my being asked to lead the investigation, but I was a Compliance
12 Manager with the CQC prior to that time.
13 The way that CQC was operating at the time was we had... Inspectors
14 had generic caseloads – and I'm talking about 2010 on there. Forgive me; I'm
15 not really sure on the dates of when you're looking for, because there was
16 different approaches at different times.
17 PROF MONTGOMERY: Yeah, there's a little bit of CQC contact – we're aware of a
18 risk summit in early 2009, but the bulk of it is in 2010, so take us through what
19 you know.
20 MS MUSGRAVE: Okay, so, in 2010, if I can set some context, I'd worked for the
21 Healthcare Commission prior to moving over to the Care Quality Commission.
22 And up to May – no it would be February 2010 I worked in the
23 national enforcement team, so I didn't have any regional engagement with
24 Trusts, so I wouldn't be able to give an example of what happened then. I

1 dealt with enforcement in the private and voluntary healthcare sector.

2 When I moved into the Compliance Manager role in May 2010, the
3 setup was we had inspectors who were relationship owners for organisations,
4 including NHS Trusts, independent healthcare sector organisations that were
5 registerable at that time and adult social care services. Above the inspector
6 was a Compliance Manager. I fulfilled that role from May onwards in the
7 Yorkshire and Humber patch and above the Compliance Manager there was
8 the Regional Director. I can't remember the exact time frames, but then
9 another role came in, which was the Head of Regional Compliance – or it was
10 termed in some way.

11 So, the way the CQC was set up was, from an operational perspective,
12 we had a team of inspectors, inspectors with a generic caseload, who were
13 responsible relationship holder under the supervision of a
14 Compliance Manager, who was responsible for their supervision and
15 management, and the Compliance Managers reported to the Regional Director
16 initially, but then a head of function came in between that.

17 PROF MONTGOMERY: That's really helpful. And what's the caseload of a
18 relationship holder? I'm trying to get a sense of the scale.

19 MS MUSGRAVE: I think it's fair to say it depended. I think it's been widely reported
20 in regards to the different caseloads that inspectors held. From my
21 perspective, what did my inspectors hold? It's four years ago. I should
22 imagine there were between 35-40 locations, allocations – there may be more
23 nationally.

24 Anecdotally, some had more, but I could only factually say what my

1 inspectors had – and that was a mix. Clearly, the predominance – because of
2 the services we register, we have a high propensity of adult social care, so the
3 bulk of the caseload would have been adult social care.

4 PROF MONTGOMERY: Presumably, some of those would be quite small
5 institutions, would they?

6 MS MUSGRAVE: Absolutely – but, equally, I think it's fair to say that some
7 independent healthcare services are exactly the same. You can go for a one...
8 I always talk about a one-man-band service – maybe a private doctor – up to a
9 big independent healthcare hospital, such as the one I used to work in.

10 PROF MONTGOMERY: That's helpful. And, so, caseloads around 35-40...
11 Compliance Manager, how many relationship holders report to a...?

12 MS MUSGRAVE: How many inspectors did I have that reported to me? Again, it
13 was variable. I covered the North and North East Lincolnshire patch and I had
14 four – I had five inspectors, but not five full-time equivalents, if that makes
15 sense.

16 But my patch, I think, was quite small. It had its challenges, but it was
17 quite small. But some Compliance Managers had more.

18 PROF MONTGOMERY: And the – obviously you'll have to try and guess. The
19 Regional Directors – how many Regional Directors across the whole of the
20 CQC?

21 MS MUSGRAVE: Gosh, I can't remember. For the North patch that I worked in, we
22 had one Regional Director. I think initially we had two and then with some
23 restructuring it became one. And there were – I think there were eight
24 Compliance Managers that reported to that Regional Director in my patch.

1 PROF MONTGOMERY: That's helpful, thank you. And can you take us through the
2 way that works when things are going relatively smoothly? So, what sort of
3 relationship is held by the relationship holder with, say, an NHS Trust that's
4 providing services? Is it a paperwork relationship? Is it oral? Do they visit
5 or...?

6 MS MUSGRAVE: I think it's fair to say that there are many different ways and many
7 differences in accordance with the organisation that you were managing at the
8 time. I think it would be unfair for me to give a generic response of how
9 everybody would manage their relationships with the NHS. How I managed my
10 relationship with the NHS was we would have – yes, there would be some
11 inspection, scheduled activity. There may be some concerning information that
12 came in through our National Customer Support Centre that would mean we
13 needed to make contact with the Trust.

14 PROF MONTGOMERY: That would tend to come directly from members of the
15 public, would it?

16 MS MUSGRAVE: It's a variety. I mean, we receive information from member of the
17 public; we receive information from MPs; we receive information from staff
18 using our whistleblowing mechanism; we receive information from the TDA; we
19 receive information from all our stakeholder partners.

20 PROF MONTGOMERY: And that initially would go to the relationship holder, would
21 it, to be looked at to see how significant it was?

22 MS MUSGRAVE: It may go directly to the relationship owner, but it depends what
23 relationship you've engendered with an organisation. So, for example, if I'd
24 attended a meeting with my inspector and we'd engaged in a dialogue, they

1 may come directly to me. But there may be things on a business-as-usual
2 ongoing dialogue such as following up information as a result of enquiries that
3 we've received, that my expectation would be – and it's my personal view –
4 that the inspector would have that engagement to elicit that further information.
5 PROF MONTGOMERY: So you'd expect a preliminary look to happen at inspector
6 level –
7 MS MUSGRAVE: Yes.
8 PROF MONTGOMERY: – and you would be brought in at Compliance Manager
9 level once there's a bit of sense of what the issues might be.
10 MS MUSGRAVE: I think it's a little bit more collegiate than that. I think I go back to
11 my point about it depends on the particular presentation of the organisation
12 that the information does come in about. So, there may be some more
13 concerning organisations that I'm close to and I want to be involved in at an
14 earlier stage.
15 Equally, it depends on the skills, knowledge and experience of the
16 inspector. Some can act absolutely autonomously; others need a little bit more
17 support and guidance. And it's about knowing the nuances of the individuals.
18 PROF MONTGOMERY: That's really helpful. If I ask a question and you do know
19 something about particular Morecambe Bay working, because it came through
20 in your report, it'd be really helpful to bring that up. Can you help us with how
21 other supervisory, regulatory organisations fit into that picture?
22 So, if an inspector receives some information from the
23 Customer Support Centre and is looking at it, would they expect to liaise with
24 NHS Commissioners, with Strategic Health Authorities, with Monitor – or does

1 the decision to do that come higher up in the organisation?

2 MS MUSGRAVE: I think it varies, in accordance with the organisation. Although I

3 haven't had a need to do liaising with stakeholders in relation to the

4 organisations that I had on my patch, my experience from other roles that I've

5 held in the CQC is absolutely we have engagement with Monitor and TDA and

6 with PCTs and with the SHA and there is regular engagement higher up than

7 the Compliance Manager at that time in regards to the information-sharing.

8 PROF MONTGOMERY: And is that something that would be governed by some set

9 of protocols or was it a matter of judgement for the individuals about how to get

10 to the bottom of things?

11 MS MUSGRAVE: Gosh, I don't know. I don't think I'd be able to reply to that.

12 PROF MONTGOMERY: You'd have probably seen a protocol if there was a

13 protocol, wouldn't you?

14 MS MUSGRAVE: I probably would have seen it –

15 PROF MONTGOMERY: Yes.

16 MS MUSGRAVE: – but I can't say that there isn't one.

17 PROF MONTGOMERY: I understand.

18 MS MUSGRAVE: I've worked in regulation since 2004, so I'm probably attuned with

19 how I need to do things.

20 PROF MONTGOMERY: That's helpful. And I think there's a couple of things that

21 come out and there's a mention – in May 2009, so I appreciate that's earlier

22 than we're talking about – about a CQC investigation team looking at a

23 maternity SUI, referring it to the North West regional team and a decision being

24 taken not to investigate it further at that stage. And I'm asking about the

1 process, really, about understanding – what's the difference between the investigation team and the regional team? Would that be similar to what came later on, the inspector and the Regional Director, or are you not able to help us understand that?

5 MS MUSGRAVE: In 2009, there was a national investigation team.

6 PROF MONTGOMERY: Right.

7 MS MUSGRAVE: I sat in the national enforcement team, but I wasn't close enough to the workings of the national investigation team to be able to give comment on that sort of relationship and how it happened.

10 PROF MONTGOMERY: Okay, that's helpful. It may – if we need to pursue that, we'll try and pursue it with someone who was in that early on. Okay. And I think the other sort of generic questions are around the process of registration and what you look at when someone applies to the CQC to register, because we'll go through it a bit later on. I hope, you know, we've got a set of sequences around when the Trust we're interested in was registered without condition, but after quite a lot of preparation from that – and then various things happen later on, so I'm not so much asking about what happened in Morecambe Bay at this stage, but to understand what the process is and what needs to be given to you to enable you to register someone. Can you help us with that?

21 MS MUSGRAVE: I'm afraid I can't, because at the time when NHS Trusts were registered I worked in the national enforcement team and I only worked in independent healthcare. And I have never worked in a capacity as a registration assessor or manager, so I don't lead on registration.

PROF MONTGOMERY: Okay. And can you help us on what triggers an inspection and how decisions are made when to inspect organisations?

MS MUSGRAVE: I think I can help you on that point, because obviously that was my remit as a Compliance Manager. We are required to conduct a certain amount of scheduled inspection activity, so there will be a programme of activity, in accordance with the organisations that we have in our portfolio of how often we would inspect them.

Apologies for being a little bit vague, because I've been out of inspection for a while working in the Foundation Trust assurance team, so I'm not quite sure of the time periods, but if we say we had a programme where some services would be inspected annually. I believe some of the independent sector ones are now inspected biannually – every two years – but I'm not sure.

PROF MONTGOMERY: And that's some form of risk base, is it, that you would decide, on a particular organisational basis, if you felt you should do it more or less frequently than that normal pattern – or is it automatic?

MS MUSGRAVE: We would have a scheduled activity of where we would touch ~~tough~~ an organisation, either yearly or every two years. Again, I'm not close to what the current guidance is in terms of some of the independent healthcare organisations. Absolutely we would look at scoping of information that we have in our system. It would involve some dialogue with partner agencies to see if there's any concerns that they have.

If it's an aspirant Trust, you may glean information from any organisations that's involved in that aspirant Trust. It also involves – I think

they were called the LINk networks at the time. Obviously, we've moved to Healthwatch now, so we would elicit information from them in order to formulate which of the core standards – I'm moving back to PVH (Private and Voluntary Healthcare) ~~PBH~~, saying national minimum standards – that we would include in our inspection activity.

So, that's the scheduled activity. Just because we've done an inspection that's a scheduled inspection doesn't mean that we don't have the ability to go back in and do what we term a responsive inspection. That would be in direct response to any concerning information that we receive that would mean that the only way that we can determine whether or not we're assured that there have been breaches to the regulations or any veracity to the information we're given would necessitate a site visit. So, there are the two approaches that we can take.

PROF MONTGOMERY: And can you also say – at various stages in the story we're interested in, that process is done in collaboration with other people. So, there's a Nursing and Midwifery Council joint review with the CQC at one point. What level in the CQC would the decision be taken of whether it's appropriate to work in partnership with another organisation?

MS MUSGRAVE: I think it's collegiate. It's about looking at what the information is that's presented to you at the time. From personal experience, if it was an organisation I had ~~have~~ concerns about, I'd want to make sure I've got knowledgeable doers around the table to make sure we've got the correct amount of information that we're going to follow up in lines of inquiry.

I think it's particularly important... Coming with my enforcement hat

1 on, if the concerning information that we've received is something that's subject
2 to a criminal investigation by the police, clearly we would have to have dialogue
3 with them to make sure any action we're taking wouldn't contaminate their
4 evidence and the activity that they're doing.
5 An example that I can give is where we had concerns about an
6 independent care practitioner that involved a dialogue with the GMC to
7 determine if they'd got similar concerns and what action they were taking. It's
8 all about the risk assessment and the mitigation and controls to ensure that
9 patients receive safe, effective, quality care.
10 PROF MONTGOMERY: And, if I've understood what you just said, that happens
11 sort of before, during and after this process.
12 MS MUSGRAVE: Yes.
13 PROF MONTGOMERY: So, you'd also be agreeing who would take things forward.
14 MS MUSGRAVE: Yes.
15 PROF MONTGOMERY: How would you document that process of who's
16 responsible for doing what?
17 MS MUSGRAVE: How I would do it... I would document it on a management review
18 document. That's the CQC document that we have where we sit and we
19 discuss what the concerns are we're being presented with and what possible
20 action we feel as a regulator we need to take in order to mitigate that action.
21 PROF MONTGOMERY: And, if your decision was on the basis that you were
22 satisfied that the GMC was picking up, that's where you would record that, from
23 your point of view, you didn't need to follow this through next, because the
24 GMC was doing it.

1 MS MUSGRAVE: I think it's too rigid to say we wouldn't do anything at all.

2 PROF MONTGOMERY: No, I'm not implying –

3 MS MUSGRAVE: We may say that, 'That's an action that another body's taking. Is

4 that action sufficient to mitigate the risk that I'm presented with?' If I don't

5 believe it is, I have a duty as a regulator to embark on my own lines of inquiry.

6 PROF MONTGOMERY: That's really helpful, but I'm trying to understand... If we

7 find there are some pivotal stages in the history that we do want to understand

8 better and we were trying to figure out where would we go to find it out, if we

9 would come to the CQC, it would be whoever produced that document –

10 MS MUSGRAVE: Yes.

11 PROF MONTGOMERY: – for the decision that will be the person who could help us.

12 MS MUSGRAVE: Or if it was logged elsewhere in a [inaudible] explaining what the

13 process is of the document that's in place in order to record such

14 decision-making. Some may record it in their own notebooks.

15 PROF MONTGOMERY: That's really helpful. In a little while I want to ask about the

16 report and how that emerged and your role in that – and maybe some bits of it,

17 but perhaps pause in case there are questions about how the CQC works.

18 DR KIRKUP: Okay, we'll do a round of the table on that specific point, then, if

19 anybody would like to pick up any points. Catherine...?

20 DR WALTERS: Hi. Sorry if you feel you've answered this already, but just in case I

21 can't understand some of what you've said... So, when you took over in May

22 2010, did somebody sort of hand over to you in any way the status of the

23 organisations in your patch?

24 MS MUSGRAVE: In terms of the services that I had on the inspectors' portfolio...?

1 DR WALTERS: Or in terms of concerns or...?

2 MS MUSGRAVE: The patch that I took over, I had – four of my five inspectors had
3 already worked in that patch. So, they already had a relationship with the
4 services. The other inspector that joined the team – whilst we received some
5 information, coming from an enforcement background, I would always look to
6 establish my own information when interrogating the data that we had.

7 DR WALTERS: Right, so you move into that new job, then. Was there anything to
8 indicate, 'Right, Trusts or services, blah, blah, blah, they've been successful in
9 their inspections so far. Trust X and Y – there are some concerns about, blah,
10 blah.' Would you get that sort of pattern so you'd know where the sort of peaks
11 and troughs in your patch were?

12 MS MUSGRAVE: We were able to elicit that information from where the
13 information's stored in our system, so we could go and establish the previous
14 inspection activity, what it's shown, if there were any outstanding actions –
15 were there any issues about registration? That's all part of the familiarisation
16 of the inspectors with the caseloads that they're allocated.

17 DR WALTERS: So, some –

18 PROF MONTGOMERY: Would that database bring together all the information held
19 by the CQC about a particular provider?

20 MS MUSGRAVE: We have – it's called our
21 Customer Relationship Management System, where inspection activity is
22 logged. Information is presented to CQC as part of the inspection process, so
23 all the evidential documents that are presented by organisations are stored
24 within our system.

1 DR WALTERS: So, you would have to go and actually look at it. Nobody would
2 say, 'Right, in your patch, your risk areas are this Trust, this Trust and this
3 Trust. And these places seem to be – if you wanted to put them higher in your
4 agenda in terms of risk and inspection, there are more sort of alarms around
5 these organisations and these...' Would you have to actually go to this
6 database and find that out yourself or would somebody be saying to you, in
7 terms of handover...?
8 MS MUSGRAVE: I think I can only talk about my experience when I took over the
9 patch and I wasn't handed that information.
10 DR WALTERS: Right.
11 MS MUSGRAVE: I did my own analysis and risk rating of the services in conjunction
12 with the inspectors.
13 DR WALTERS: So in your analysis, then, where did Morecambe Bay fit in this sort
14 of barometer of concern?
15 MS MUSGRAVE: I don't – I didn't...
16 PROF MONTGOMERY: You weren't responsible for Morecambe Bay.
17 MS MUSGRAVE: I had no responsibility for Morecambe Bay until I started leading
18 the investigation.
19 DR WALTERS: In 2012...?
20 MS MUSGRAVE: In 2012, in January.
21 DR WALTERS: Okay, thanks.
22 DR KIRKUP: Stewart?
23 PROF FORSYTH: Just the issue about clinical competence – and I wonder how do
24 you, from a CQC perspective, if you're going into a service, detect substandard

1 competence? Do you...? I mean, this is obviously something which is
2 occasionally missed when inspecting, actually, individual competence of
3 clinicians, whether they're doctors, nurses, whatever. How do you pick that up
4 in your inspections?
5 MS MUSGRAVE: Are you talking about at the time that the investigation – what led
6 up... At the time of the investigation or –
7 PROF FORSYTH: Well, any inspection, if you're going into any service –
8 MS MUSGRAVE: – now, because it's different.
9 PROF FORSYTH: Well, at the time and now. How's it changed?
10 MS MUSGRAVE: At the time, during the planning phase, there was a facility to
11 engage support from our national professional advisers, who we would need to
12 support us in conducting that inspection activity. So, there was a facility to take
13 experts with us. Predominantly, we're looking for compliance with the
14 regulations. It isn't a clinical service review; we're looking at compliance with
15 regulations.
16 I think it's absolutely out there, following the review of our
17 methodology, that the methodology has subsequently changed and the
18 inspections now – we talk about 50:50. You would have experts practising in
19 the field that support the inspectors in their inspection activity. So, it's two very,
20 very different approaches.
21 PROF FORSYTH: And the inspectors, the specialists – they're basing their
22 evidence on what information during inspection they're gathering – case note
23 reviews or do they look at operational results, outcomes? How do we know
24 from the inspection that the standard of clinical care by the clinicians is

1 adequate?

2 MS MUSGRAVE: And, again, it's the difference between where we were at this time

3 and where we are now, because you have clinical experts who are

4 interrogating that information. The other ability that we have is to seek advice

5 and support outside of the inspection if there are specific areas of concern that

6 arise during the course of inspection. And we do have a medical adviser at

7 CQC – we did at the time – who we could seek guidance from. Indeed, I did

8 that in one instance when I worked in the enforcement team.

9 PROF FORSYTH: Okay.

10 DR KIRKUP: Thanks, Stewart. Julian?

11 MR BROOKES: Just a couple of points for clarification, if I can. And it's probably

12 because I've got of recollections of doing this myself a couple of years ago. I

13 just want to be clear in my mind I'm not prejudicing what I think because of the

14 way I think it happened, if you see what I mean. But, first of all, just in terms of

15 the caseload you talked about of 35-40, again, I know it's not precise, but how

16 many big, acute Trusts would normally be in that kind of portfolio?

17 MS MUSGRAVE: It depends on the patch. The patch I had, North and North East

18 Lincolnshire – we had one. Some other patches had more.

19 MR BROOKES: Yeah.

20 MS MUSGRAVE: It really does depend on the patch that you're working on.

21 MR BROOKES: Yeah, okay. My recollection is there used to be memoranda of

22 understanding between the different organisations, which would lead to risk

23 summits etc and activate – and also an annual review of information held by

24 different organisations to try and assess what were the likely high-risk

organisations, which then might link to the planned inspection regime. Is that something that sounds right or is that just...?

MS MUSGRAVE: I don't think I'm in a position to comment. I wasn't exposed to discussions at that level.

MR BROOKES: Okay, thank you. No further questions, thank you.

DR KIRKUP: Thanks, Julian. Jimmy?

PROF WALKER: I've got a couple. In the situation where you have a prompted visit because there's been concerns flagged up by wherever source, how precise and directed is the visit for the review team or how flexible is it for the review team to see at what they see and then adapt their review or report to focus on what they think a problem is?

MS MUSGRAVE: Again, I can't talk generically about how other Compliance Managers worked; I can only talk about how I would work – and it's a mixture of both.

PROF WALKER: Okay.

MS MUSGRAVE: You would absolutely go with key lines of inquiry that you need to follow to get to understand, to get – to try and get to the crux ~~nux~~ of the problem, but, equally, you have to adopt a flexible, adaptable approach to meet what you're not anticipating.

PROF WALKER: Okay. And, then, so there's no – when that review team went in, then, there wouldn't... Would there be a particular almost terms of reference that they would have for that? Or is there a generic terms of reference they would work to in how they do the report, so that it's really investigating if there's a problem as much as producing a report to a problem they're being told to

1 investigate?

2 MS MUSGRAVE: If I can sort of just draw the difference, this is inspection; this isn't

3 investigation.

4 PROF WALKER: Okay.

5 MS MUSGRAVE: So, an inspection activity, they would have an inspection planning

6 document where they would distil down the information they've received and

7 then determine which of the outcomes were required to be followed up and

8 then they'd determine the resources that they'd need in terms of conduct that.

9 PROF WALKER: Okay. If you've gone into a Trust and you've flagged up certain

10 problems that, let's say, have been fed back to them, what's the mechanisms

11 of following that up to see what happens next? And can the Trust get itself

12 signed off for the problems that you flag up?

13 MS MUSGRAVE: Once an inspection report is produced – if it helps, I'm going to

14 talk through the process of what happens. You would come back; you would

15 review the intelligence – when I say 'you', I mean the inspector initially, but it

16 will involve the team if it's a bigger organisation and there may be some

17 involvement from the manager. Personally, I would always want to be involved

18 in the review; I'd want to be on it as well.

19 And then the report is produced and it's sent to the Trust for factual

20 accuracy for 10 working days. If there are actions that need to be taken – and

21 when I say 'actions that need to be taken' I'm meaning where there's been an

22 identified breach of regulation. So, we term that as a compliance action. You

23 may have seen that terminology in some of the reports you've seen.

24 We would expect and we would require the Trust to produce an action

1 plan of the actions they're going to take in order to address the areas of
2 concern that have been identified. The action plan would be looked at for
3 things like, 'Is there a relationship owner for the actions that are there? Are the
4 timescales right or are they giving themselves far too long to do something that
5 needs to be urgently addressed?'

6 And then it would be the ongoing engagement with the organisation in
7 terms of updates in respect to actions – but I must stress that's the way I would
8 work; I can't talk generically about how other people did work or, indeed, do
9 work.

10 PROF WALKER: So, as far as you know, there's no sort of definite SOP for a
11 person in your position to do these things. It's very much up to the individual,
12 how they develop the relationship with the Trust they work with.

13 MS MUSGRAVE: I think it's evolving is what I'd want to say. In the
14 Healthcare Commission we did have regular engagement meetings; in the
15 CQC we didn't have regular engagement meetings. Then that evolved; it was
16 an ever-evolving process.

17 PROF WALKER: Okay.

18 DR KIRKUP: Thank you. Jonathan, back to you.

19 PROF MONTGOMERY: Thank you. Just on the back of that. If I've understood
20 rightly, the place where all that would be visible would be in the
21 Customer Relationship Database, where... All the various things that people
22 did decide to do – it all gets recorded in that one database, does it?

23 MS MUSGRAVE: The things that people did decide to do...?

24 PROF MONTGOMERY: So, again, there are various ways in which you might

1 decide to investigate, keep the relationship managed, follow up on things, but

2 they'd all get recorded in that Customer Relationship Database, would they?

3 MS MUSGRAVE: They should.

4 PROF MONTGOMERY: Yeah. So, if we were trying to find out what did actually

5 happen in a particular area, that would be where the CQC would hold its

6 records?

7 MS MUSGRAVE: They should be in there. But, again, as I reflected –

8 PROF MONTGOMERY: I appreciate what should be there and what is there may

9 not be the same thing.

10 MS MUSGRAVE: – in previous responses, they may equally be in notebooks.

11 PROF MONTGOMERY: Thank you.

12 MR BROOKES: Sorry, just one... It's the relationship between inspection and

13 investigation; would an inspection ever generate an investigation?

14 MS MUSGRAVE: Not a single inspection. The difference between an inspection

15 and an investigation is an inspection is often scheduled activity or responsive

16 to individual specific concerns. An investigation is far more breadth and depth,

17 looking at the whole health and social economic within the patch in order to do

18 a diagnostic to understand the systems and processes that are place that are

19 resulting in the many different aspects of failing you're seeing in individual

20 services. It's a diagnostic to understand: is there systemic failure within an

21 organisation?

22 MR BROOKES: Thank you.

23 PROF WALKER: Can I just come back in? Just a brief thing about terminology of

24 risk... At the end of any sort of review of something, was there really a binary

1 answer of 'there's a problem/there's no problem' or was there more of a
2 RAG-type assessment that you've got a problem, not got a problem or you've
3 got something – or a worry which is not bad enough to flag up as a problem,
4 but for you, as an organisation, that you flag up this organisation as being
5 someone to keep an eye on.

6 I don't know if I've explained that correctly, but it's maybe, well, a
7 yellow-card system, so to speak, rather than a red-card system – that, if you
8 have some concerns, but they're not bad enough to put a major report in about
9 them, there are concerns that you as a body – or within your region you're
10 aware you need to keep an eye on organisation X, because they're running
11 into problems.

12 MS MUSGRAVE: I can answer the question, I think, you're asking me, but it isn't
13 over a period of time when I was exposed to it and I don't profess to know what
14 currently is happening, because I've been distanced from that. We did have –
15 and I can't remember what they were called now, but we did have a monthly
16 meeting where we looked at the risks within the patch, that all the
17 senior-management team sat on, where you would look at what's evolving.

18 And it was RAG rated, so, if we had concerns of some organisations
19 that were red rated, they were constantly looked at to see whether or not the
20 actions that we were taking were – resulted in the desired improvement to call
21 that the intention of the action would... Sorry, I'm losing my words now – would
22 get the desired outcome, I think, is what I want to say. So, yes, there was a
23 system for continual review. And that was also reported on a weekly basis up
24 to our corporate office.

1 PROF WALKER: And if there were a number against a Trust, would there be
2 dialogue with the Trust just for you to say, 'We're a bit concerned by this area
3 where you're working', rather than an official level thing – but more of an
4 informal level of flagging up a concern you had so the Trust know there's a
5 problem they can act on before they become red?
6 MS MUSGRAVE: I think, if I can put some context around it, the information that
7 was presented in the regional risk registers – a lot of the information concerned
8 the outputs of the regulatory activity, so the inspection activity would be logged
9 in there and other information. Part of our process for an inspection is to give
10 the Trust or any other organisation feedback at the end of an inspection of any
11 concerns that we've identified.
12 Certainly, if there were areas that needed to be addressed immediately
13 – but you would always give information, because what we don't want to do is
14 come away with information and patients be at risk and then action not taken
15 and it's delayed. So, that process was an ongoing dialogue; does that help?
16 PROF WALKER: Okay, thank you. Jonathan?
17 PROF MONTGOMERY: Thank you. Can we turn to the report?
18 MS MUSGRAVE: Yes, please.
19 PROF MONTGOMERY: That's been really helpful, because we've found it very
20 hard to make sense of how the system operated. So, can you just take us
21 through how you became involved, what prompted that and how it worked?
22 MS MUSGRAVE: Yeah, absolutely. I think I've already explained I didn't work in the
23 North West; I worked in the North East. I was approached by the Director of
24 Operations. I received an email – I believe it was on 19 December – asking

me if would be willing to lead an investigation. It didn't identify the organisation at that point. I can't remember the detail of the email; that's the crux ~~nux~~ of my recollection. That was the first time I was invited to be involved.

I responded to say I would be interested. And, I think, from some of the other answers I've given, it's clearly I'm a trained – I'm an advanced investigative practitioner, so it is my passion, with the patient at the centre of it, to do investigative work. So, absolutely – but I needed to know some context of the organisation and timescales. It was December, after all. What was the expectation of the organisation of when it would start and when it would conclude – that sort of thing.

I received an email back from the Head of Operations to say that the Head of Regulatory Risk would be in contact with me to give me that further information. I received a call later that day and the information that I was given that it was Morecambe Bay. At that point I disclosed that I'd had some previous involvement with the Trust. I didn't want my involvement to compromise the quality of the work. I couldn't have felt that to be contaminated, so I did disclose that.

The response I received later that day was that that had been considered, that because that contact had been – and I don't know if you're aware of the contact that it was.

PROF MONTGOMERY: We are aware, but for the record it'd be very helpful if you'd just tell us what it is, now.

MS MUSGRAVE: Okay. In 2004 – I think it was February; it may have been March – I was made redundant as a Deputy Matron's role in an independent

1 healthcare organisation and between 2004, February or March to September I
2 wasn't in an employed role, but I have always had a passion for leadership,
3 training and development – I'd been a participant in the King's Fund UK
4 nursing leadership programme and I'd used some of the skills and techniques
5 within the Trust.
6 And I had a reputation that I could do that, so I was approached by the
7 people that I knew that worked at the organisation to deliver some leadership
8 work with the nurses in the surgical directorate. And I think I did one as well
9 with the specialist nurses, because I'm also a tissue viability specialist by
10 background, in a previous role, so I have a passion there as well. So, I did
11 some work with the specialist nurses, because I can be tuned to that mindset.
12 That was the only contact that I had with the organisation and my
13 understanding was that the people that I'd previously been engaged with no
14 longer worked at the organisation. I don't mean the nurses; I mean the people
15 that approached me to do the work.
16 PROF MONTGOMERY: Thank you. So, go back to the investigation.
17 MS MUSGRAVE: Okay. So, I was given further information. That was 20 or
18 21 December and then on 29 December, I think – don't quote me on the dates
19 – I met with the Head of Regulatory Risk, who had been charged with
20 responsibility of supervising me in terms of delivery of this piece of work. And
21 just to get an understanding of what it entailed, start looking at terms of
22 reference, looking at when I would be released from region – and I was finally
23 released from region, I think it was on 6 January.
24 At that point I started looking at planning the investigation, looking at

1 how I'm going to resource it, what specialist practitioners we would need in
2 order to meet and satisfy the terms of reference, looking at what inspectors we
3 needed, where we were going to get them from – bearing in mind I wanted
4 people who'd worked in the NHS, people who were skilled in order to be part of
5 the team – just setting up the administrative, making sure that the planning was
6 tight and robust.

7 Again, coming with an enforcement hat on, I know how important it is
8 to plan – and that can't be rushed. The planning is all. What I should have
9 mentioned at the beginning was I was told initially it was a joint investigation
10 with Monitor. When I had the first meeting with Monitor with the Head of
11 Regulatory Risk, it became clear to me that Monitor's involvement was in
12 regards to the sharing of the four independent reviews that they'd conducted
13 and wasn't actually to provide any resource on site or, indeed, in conduction of
14 the investigation, so that was the first time I became aware of that, that Monitor
15 were heavily involved in the development of the terms of reference.

16 I also met with the regional team shortly after that meeting to get an
17 understanding, from their perspective, of what they felt the issues were on the
18 ground, what activity had taken place, what outstanding non-compliance was –
19 just to get an understanding of what we were going to face when we went out
20 onto patch. That enabled me to develop an escalation plan.

21 PROF MONTGOMERY: And what did they brief you was the tone of the relationship
22 with the Trust?

23 MS MUSGRAVE: Sorry, could you...?

24 PROF MONTGOMERY: What did they lead you to expect in terms of the response

1 you'd get from the Trust when you got involved?

2 MS MUSGRAVE: That the Trust were willing to engage, but perhaps didn't

3 challenge, were accepting of the findings that were presented to them. Without

4 my notebook – it's two years ago; I can't remember the exact detail of the

5 dialogue that I had with the regional team.

6 PROF MONTGOMERY: I interrupted the flow. So, you had the briefing from the

7 regional team.

8 MS MUSGRAVE: Okay. The escalation plan for me was important, following that

9 brief, because we had some outstanding non-compliance in the organisation.

10 And by the 'escalation plan' I mean that the investigation does not

11 permit us to take regulatory action in the event that we find concerns. I don't

12 want to hold onto concerns, because that's going to impact patients; therefore,

13 what method do we have available to us as the regulator in order to take

14 immediate action?

15 So, it was quickly determined, in the event that I saw high risk to the

16 health, safety and wellbeing of patients, that would be escalated to the regional

17 compliance team to take the necessary enforcement action – and indeed that

18 is what happened on the third day of the site visit at the

19 Royal Lancaster Infirmary.

20 PROF MONTGOMERY: And what particular bit of that site visit triggered it?

21 MS MUSGRAVE: It was mounting information in terms of concerns and the general

22 safety, privacy, dignity that were patients were being afforded. Referring to the

23 inspection report, you'll see I've made specific mention to the clinical decisions

24 unit, whereby patients were being accommodated for over 24-hour period.

1 If my recollection serves me correctly, some had been in there two or
2 three days alongside patients who were receiving ambulatory care, so you had
3 a scenario – if I can visualise it for you – were I think there were five or six beds
4 with patients with curtains around with no visual stimulus, with then a whole
5 cohort of ambulatory care patients, some of which were – they were mixed sex.
6 We saw men and women there, so you had female patients in night attire
7 walking in front of the patients of mixed sex to access toilet facilities.

8 PROF MONTGOMERY: Okay, so that triggers you escalating it. What happens to
9 the rest of the investigation?

10 MS MUSGRAVE: That and other things. I think that's just one example of what we
11 saw. We also saw patients – patients weren't being monitored appropriately
12 within the emergency department. And, picking up on your point, Stewart, in
13 terms of the clinicians that we had on the team, that was a real concern – of
14 the emergency nurse, the consultant that we had on the team on that day.
15 There were real concerns about the safety management of patients.

16 So going back to your point – about what did the escalation look like –
17 we had corroboration meetings each evening. The position mounted and
18 mounted in terms of the concerning information. I felt action needed to be
19 taken in order to mitigate that concern. Nobody else was taking the action; we
20 needed to do it. I rang the Director of Operations that evening. My escalation
21 normally would have been to go to the Head of Regulatory Risk, who was
22 supervising me, but she was on leave. I'd already anticipated that and got
23 another escalation plan prior to going out.

24 So I rang the Director of Operations. I verbally advised her of the

1 concerns we had and she suggested calling a management review meeting the
2 following day. I then went on to prepare a briefing paper of all the concerns
3 that we had at that point that had resulted in my escalation and I think I
4 emailed that to her at about midnight that day and then continued with the
5 planning for the following day's activity.
6 And I telephoned in to the management review meeting for obvious
7 reasons, once I'd tasked my team and briefed them of what they needed to do
8 that day. I dialled in to the management review meeting and formally handed
9 over to the regional compliance team, who'd all had sight of the briefing at that
10 point. And at that point I raised the question with the Director of Operations,
11 'Do you want me to continue with the investigation?' and I was instructed to
12 continue with the investigation.
13 PROF MONTGOMERY: Okay, so let's go back to your investigation, then. So,
14 you've proved it's worth doing by identifying patient risks –
15 MS MUSGRAVE: Yeah.
16 PROF MONTGOMERY: – and getting them addressed. So, take us through the
17 next stage in your investigation.
18 MS MUSGRAVE: We continued to collect information at the Royal Lancaster
19 Infirmary for the four days we were on site there. I think it's fair to say on the
20 Thursday the Trust – they had a black-ice day where they had an inordinate
21 amount of ambulances that were attending the organisation that morning. We
22 had to be mindful of that and not get in the way of the clinicians in delivering
23 care and take that into consideration in our findings. It would be
24 disproportionate not to and we're duty bound to be proportionate and not

1 overburdensome.

2 I'd then factored into my planning a review in the middle week to look
3 at the terms of reference to see what we'd found at the initial site visit. Did the
4 terms of reference need refining or expanding? I met with the Head of
5 Regulatory Risk to do that and we determined to continue with the terms of
6 reference as they stood, so I then went on to conduct the three days of site
7 visit at Furness General Hospital.

8 I think what I also need to say as well... You'll see the report talks
9 about – the investigation was of the emergency pathway at
10 Royal Lancaster Infirmary and Furness General Hospital. That was because
11 Westmoreland General Hospital didn't provide emergency care facilities. They
12 –

13 PROF MONTGOMERY: I think one of the things we're interested in is how at the
14 same time you have the CQC having issued warning notices around maternity
15 and then the focus becomes on the emergency care and understanding how
16 the maternity fell away. I think the report points out it's just a proxy for other
17 things, but it seems slightly strange that maternity phases away. So, it appears
18 quite strong in the early phases of the report about context, and then it's all
19 about emergency care. So, can you help us understand that?

20 MS MUSGRAVE: To join back on previous discussions about other regulators
21 taking action, Monitor had already conducted two clinical service reviews of
22 maternity services. It was determined, because of that, if we were to go and
23 look at maternity again, arguably we could have found the same things. We're
24 going over the same ground. The Section 48 is looking at the whole system.

1 The emergency pathway is the ideal way to look at the whole system, because
2 you're looking at the point of presentation all the way through to the point of
3 discharge and the associated relationships in managing that patient flow.
4 PROF MONTGOMERY: And, so, was it clear to you right from stating the terms of
5 reference that the bulk of the work would be on emergency care?
6 MS MUSGRAVE: Yes.
7 PROF MONTGOMERY: Yeah, so that wasn't triggered by what you found and had
8 to escalate.
9 MS MUSGRAVE: No.
10 PROF MONTGOMERY: It was already – you had to go through that.
11 MS MUSGRAVE: No. And I think what I would draw your attention to is the terms of
12 reference were signed off by the Director of Operations as the responsible
13 officer for the investigation. They were also signed off by Monitor.
14 PROF MONTGOMERY: And can you help us – you may not be... But there's a
15 similar sort of escalation question around the maternity services, because there
16 are these reports that Monitor has produced and there are various things going
17 on in the health system thinking about the maternity questions. You've got the
18 Gold Command being established by the SHA. So, was part of the discussion
19 around who was taking actions forward or were you party to those sorts of
20 discussions?
21 MS MUSGRAVE: I wasn't party to those discussions. I purely was tasked with the
22 job of delivering the investigation, which is what I did.
23 PROF MONTGOMERY: And maternity was never really in those terms of reference.
24 MS MUSGRAVE: No.

1 PROF MONTGOMERY: Although it appears quite a lot in the context, for
2 understandable reasons.
3 MS MUSGRAVE: It appears in the context to draw the path of the reasons why the
4 Section 48 powers were invoked. It's not something that CQC does; it's not
5 our business-as-usual activity. It is an unusual set of circumstances that it
6 leads us to conduct an investigation – and I think that's demonstrated by the
7 few investigations that CQC have conducted.
8 PROF MONTGOMERY: I see. That's helpful. Can I ask you to say a little bit more
9 about how you found the responses of the Trust? Because I know you were
10 talking about the briefing – and I appreciate you don't remember it really
11 precisely, because people wouldn't that far back.
12 But you talked about the fact that what you were told was something
13 along the lines of the Trust were willing to engage, but they had a tendency to
14 take it on the chin rather than challenge the criticisms and that could be, for a
15 number reasons – but one answer that would concern us, if it was like this, was
16 it's a way of defusing the situation, by saying you're going to do something and
17 then you get the immediate pressure off and then that leaves a question of
18 what really happens on the back of that.
19 Now, you have this escalation you had to manage. Can you tell us a
20 little bit about how aware the Trust seemed to be to you of issues and how they
21 responded when the escalation happened and how helpful they were as you
22 moved on to the next stage of the investigation, given all those things are
23 happening?
24 MS MUSGRAVE: I didn't have the dialogue with the Trust in regards to the

1 escalation, because the escalation was being managed by the regional compliance team.

3 PROF MONTGOMERY: But you were going in to the Trust again for a week.

4 MS MUSGRAVE: Yes.

5 PROF MONTGOMERY: How helpful were they?

6 MS MUSGRAVE: How helpful were the Trust?

7 PROF MONTGOMERY: How did they respond compared to the previous week?

8 MS MUSGRAVE: I wasn't involved in how they previously responded, so I can only talk about how they responded to me as the lead investigator for this investigation.

11 PROF MONTGOMERY: So, you weren't in there until it became something you had to escalate.

13 MS MUSGRAVE: I was in there, as you put it, from the beginning of the investigation.

15 PROF MONTGOMERY: So you're on one site in the same Trust.

16 MS MUSGRAVE: Yes.

17 PROF MONTGOMERY: And you're finding these things out.

18 MS MUSGRAVE: Yes.

19 PROF MONTGOMERY: So, you have a sense of how responsive and helpful they're being to you trying to find out what's going on. And then suddenly, from their perspective, the game changes a little bit, because you have found things out that have to be actioned. And then you're in the same organisation on a different site the following week. And we're just wondering whether –

24 MS MUSGRAVE: There was a difference: there was a high visibility of the Chief

1 Executive on the second week, who was present in the second week when he
2 wasn't present at all in the first week, at Royal Lancaster Infirmary, despite the
3 fact it was an announced visit. The Chief Executive was not present to receive
4 me when I arrived at the organisation.

5 Indeed, I asked to speak to the Chief Executive on the Wednesday
6 morning – yes, Tuesday evening. I saw him on the Wednesday morning – I
7 can't recollect the dates; just say the timeframe of that week – and had that
8 discussion with him of how surprised I was that he wasn't present at the time I
9 presented and did he really appreciate the seriousness of the action CQC was
10 taking within the organisation?

11 His response to me was that, when I'd met with him prior to
12 commencing the investigation – when I did the preparatory work, shared the
13 interview schedules and the documents that I needed to see. And he had
14 made it clear that, although these were the areas that we were looking at,
15 should we receive information during the course of the investigation and in
16 accordance with the terms of reference, then we had the powers to look
17 wherever we wanted to look – and indeed that's what we would do.

18 I think his response to that was, 'What you're telling me is you'll ferret
19 away' – I think he regretted saying to me 'ferret', because I kept replying, 'Yes,
20 I will ferret away until I'm satisfied that the line of inquiry is being followed to the
21 end.' So, his response to me, when I called him in, was he made it clear at the
22 preparatory meeting that he didn't want me to interfere.

23 And my response to that was, 'There's a difference between
24 interference and being present and understanding. And the professional

courtesy afforded to somebody who's leading an investigation, making sure that you're there to see I'm getting what I need, that the investigation is going in accordance with how – that they're happy. Are his staff happy about how my team are conducting themselves? Because, equally, that's important. We need to make sure that we are making sure that people are comfortable and confident to give the information that we need. Otherwise, we wouldn't be able to conclude the investigation'

PROF MONTGOMERY: So, you saw a lot more of him in week two.

MS MUSGRAVE: In week two. I think at this point I think it's pertinent to say I didn't see the Director of Nursing at all.

PROF MONTGOMERY: Right, I was going to ask exactly that question, about which other directors you saw. So, you didn't see the Director of Nursing.

MS MUSGRAVE: No, no, she never introduced herself to me. I didn't conduct the interviews of the executive level. I think I interviewed the Medical Director and one of the General Managers, but that was purely the circumstance of one member of the team, the inspector that I had conducting those interviews, who was very experienced – I chose her purposefully, lots of experience. She'd been a previous CHAI ~~child~~ reviewer, knew how to conduct interviews at that level. She had to leave for two latter ones, so I stepped in there. We didn't see the Director of Nursing other than that interview, throughout the course of the investigation.

PROF MONTGOMERY: So who were the most senior clinicians that you saw?

MS MUSGRAVE: Consultants out in the patch. A number of them were very engaging with us, were – although they weren't on the schedule for interview,

1 were very keen to have interview, so we accommodated that and added them
2 to the list. On the black ice, Wednesday into Thursday, we saw – I think,
3 again, it's written in the report – a predominance of ambulances. We were
4 concerned. I'd sent my team there early in the morning. There'd been some
5 staff that hadn't attended for duty, which was compounding the problem. That
6 was escalated to me by my team, and I brought that to the attention of the
7 Chief Executive to say, 'What are you doing in regards to this escalation?'
8 because we couldn't see that it was being managed at the time. I then went,
9 as soon as I'd had that discussion – it was happening at the same time as the
10 telephone conversation, so I couldn't go straight over myself, but I had skilled
11 people out there, so knew that they would be keeping sight of it. Then, when I
12 went over, the Medical Director arrived, and I think there was somebody who
13 managed emergency escalation. I can't remember the titles, I'm afraid. I deal
14 with a lot of Trusts and people call things different things, so there were other
15 people there, but that was the visibility.
16 PROF MONTGOMERY: And the most senior nursing staff that you saw?
17 MS MUSGRAVE: Would be matron level.
18 PROF MONTGOMERY: And did you see any midwives, or maternity staff you
19 weren't looking at particularly so you wouldn't...?
20 MS MUSGRAVE: We didn't go to maternity services. It fell out of scope of the
21 terms of reference.
22 PROF MONTGOMERY: And did you get any sense of who was taking
23 responsibility for those quality questions that you were escalating? We're
24 trying to track the clinical governance processes and how they operated. Did

1 the Trust put you in touch with the people who were responsible for those
2 quality questions that, clearly, you were picking up?
3 MS MUSGRAVE: Part of my planning is I identified... I understand health. I've got
4 lots of experience. I understood who I needed to see. If other things cropped
5 up during the course of the interview, my role as lead was to ensure that those
6 people were also brought for interview. If they were in clinical work, then,
7 obviously, we would go and visit them in the clinical setting. My focus is always
8 we don't interfere with the delivery of patient care.
9 PROF MONTGOMERY: So were there people that you identified that you wanted
10 to see but you weren't able to see?
11 MS MUSGRAVE: I don't think so, from the best of my recollection. What was
12 interesting was that we would normally interview people on their own so that
13 they can be honest and open. The complaints team chose to come as a team,
14 and the governance team also came as a team, but we asked the manager to
15 leave and interview separately.
16 PROF MONTGOMERY: What was the difference? Did you see them with the
17 managers in and without the managers in?
18 MS MUSGRAVE: My view is, if we want an honest, open dialogue, people have to
19 feel safe in order to be able to disclose exactly what they want to disclose. My
20 view is that can be inhibited by having a manager there, for fear of
21 repercussion.
22 PROF MONTGOMERY: I fully understand, and I think we all understand why you
23 think that. I think it would be interesting to know what your impression was
24 when you did interview them.

1 MS MUSGRAVE: When we interviewed them separately, absolutely – told us

2 exactly as it was.

3 PROF MONTGOMERY: So what did they tell you about the culture of the

4 organisation?

5 MS MUSGRAVE: I think the big pattern across the organisation of all the interviews

6 that we conducted was that there were distinct personalities, that staff aligned

7 themselves to the hospital that they worked in. There was no sense of Trust

8 identity, and an example I would give there is, at the Furness General Hospital

9 site, they had developed, 12 months previously, a very comprehensive

10 fractured neck of femur pathway, very comprehensive, that they were following.

11 The pathway at Royal Lancaster Infirmary was introduced on the first day of

12 our site visit at the Royal Lancaster Infirmary, so you had practices being

13 developed in isolation, and I'd go as far to say we saw excellent care on one of

14 the orthopaedic wards – absolutely exemplary leadership. We went onto the

15 second orthopaedic ward in the same hospital – totally different experience.

16 PROF MONTGOMERY: What did you pick up about the clinical hierarchy

17 structures? What did people tell you about them? You didn't see the Medical

18 Director very much; what did the consultants tell you? You didn't see the

19 Nurse Director at all; what did the matrons tell you?

20 MS MUSGRAVE: I think it's fair to say that there was a difference. The pattern that

21 emerged was that there was a disconnect between the senior managers of the

22 organisation and the senior clinicians. There was no collegiate working in

23 order to address the problems that they were facing. It was depending on

24 which department you went to was depending on the response that you got, so

1 the emergency department felt that they were blamed for the situation that they
2 were being left to cope in, and I have to say they worked blooming hard to try
3 and manage the situation that they were presented with, but they developed an
4 almost – and I termed it in the report as a 'learned helplessness', that they
5 cascaded it up, and they saw nothing improve as a result, and I think that's
6 absolutely similar for the medical consultants that were working in emergency
7 department.

8 PROF MONTGOMERY: So there's a learned helplessness that comes from 'Why
9 do you report things if nothing changes?' Was there also a sense of a blame
10 culture that people got penalised for reporting, or do you not...?

11 MS MUSGRAVE: I didn't feel that, to be fair. I wasn't privy to all the interviews, and,
12 without looking through the interview notes, it would be difficult for me to give a
13 comment. I think it's clear to see, in some of the interviews, some of the staff
14 at RLI felt that they were bullied. They described situations where they were
15 shouted at in public areas. There was tensions between one area and
16 another. As I said, the emergency department felt that they were blamed for
17 what was happening and they weren't seeing the whole system working
18 together, but I think nor did they look at solutions. They weren't engaged in
19 that mind-set of 'What can we do to make things better? How can we work
20 better as an organisation?' It was like, 'This is the lot that we're in. Nobody
21 understands the lot that we're in. This is the lot that we've got to deal with.'

22 PROF MONTGOMERY: Two last questions, and then I think if we go round. One
23 is: was there any quality culture? Was there a sense that there was a way in
24 which the organisation could improve, or did people feel that they had to

1 abandon that because they escalated something, reported something and
2 nothing ever changed?
3 MS MUSGRAVE: My view was there wasn't a quality culture.
4 PROF MONTGOMERY: That's helpful.
5 MS MUSGRAVE: If I may just give an example of how I would demonstrate that, is
6 that, when the organisation was presented with a problem, I think it's clear from
7 our inspection reports, they took action to address that problem. They didn't
8 look at 'Is that problem elsewhere in the organisation that we need to take a
9 proactive approach to manage?' That's where my viewpoint is there wasn't a
10 quality culture.
11 PROF MONTGOMERY: That's a very helpful way of illustrating it, explaining it.
12 The last one from me is around what the response was from the Chief
13 Executive, as presumably you've explained some of these emerging findings
14 and things that you were hearing to the Chief Executive. What sort of
15 response did you get?
16 MS MUSGRAVE: The findings that I shared with him – because I think we have to
17 remember, with an investigation, we're looking at analysis of a vast amount of
18 information. The findings that I shared with the Chief Executive was some
19 concerns that had been raised through an interview about a blood bank, and
20 that one had been broken for some time, which was causing delays in theatre
21 staff accessing it, so I asked him for the risk assessment document that had
22 determined the location to ensure the safety and speed of access for blood for
23 all departments that would need to access it on the Royal Lancaster Infirmary
24 site. He provided me, the following day, with the said risk assessment

1 document.

2 I also raised with him concerns in terms of paediatric cover. You'll

3 recall, within the investigation report, they had a vacancy for some

4 considerable time for a paediatric nurse within the emergency department at

5 RLI, and some concerns had arisen about presentation of ill children and how

6 that was managed, bringing staff from other areas.

7 Can I recollect whether I felt that he would take action in response of

8 it? I think the feeling that I'm left with is he knew that that was an issue. Was

9 there impetus and drive in order to address it? I've no evidence to support

10 that, but I'm not sure that there was, because it had gone on for some

11 considerable time, with staff having real concerns about it.

12 PROF MONTGOMERY: But you did think he knew about it before you told him.

13 MS MUSGRAVE: Yes.

14 PROF MONTGOMERY: Thank you.

15 DR KIRKUP: Okay. Thanks. We'll go round again and ask if there are any

16 supplementaries on that aspect. Catherine.

17 DR CALDERWOOD: Thanks very much. That's been very helpful indeed. You

18 alluded to the fact that the maternity services, although part of the initial reason

19 for starting the investigation, that Monitor had done inspections and therefore

20 you weren't going to cover that ground again. That wasn't a decision made by

21 you having then looked at what Monitor had discovered. That was taken

22 separately to you continuing this investigation.

23 MS MUSGRAVE: Yes.

24 DR CALDERWOOD: So you didn't see the Monitor –

1 MS MUSGRAVE: I saw the clinical service review as part of the planning, but I
2 wasn't the person with responsibility for authorising the terms of reference.
3 DR CALDERWOOD: So that was then removed. You then got on with what you
4 were tasked with doing.
5 MS MUSGRAVE: I think I could only say factually I don't know whether it was ever
6 actually in the frame to be looked at. When I looked at the terms of reference,
7 it was only ever – in the formulation of the terms of reference – focusing on the
8 emergency care pathway.
9 DR CALDERWOOD: Okay. Thank you very much.
10 DR KIRKUP: Can I just ask, on that very point, whose decision was it, then?
11 MS MUSGRAVE: I don't know.
12 DR KIRKUP: Okay. It was communicated to you as a received point. There wasn't
13 any debate about it.
14 MS MUSGRAVE: In terms of the emergency care pathway, I think I answered
15 earlier that the terms of reference was developed in conjunction with the Head
16 of Regulatory Risk, and approved and authorised by the Director of Ops.
17 PROF MONTGOMERY: Just so that we don't get confused, can we have their
18 names?
19 MS MUSGRAVE: Yeah. The Head of Regulatory Risk is Louise Dinley, or was at
20 the time, and the Director of Operations was Amanda Sherlock.
21 DR KIRKUP: Okay, thanks.
22 [Sotto voce discussion]
23 DR WALTERS: Did you get the global perception of what clinical governance meant
24 to the people you were interviewing?

1 MS MUSGRAVE: My global view is it varied, depending on how close people were
2 within the organisation. I'm not sure the staff at the shop floor had a full
3 understanding of it. I think it's fair to say – and to be fair to the organisation –
4 they'd just had a governance review by PwC. It was one of the commissioned
5 reports by Monitor. Our focus very much was on the impact. We looked from
6 ward to board, rather than Board functionality, in terms of governance. I think
7 their lack of understanding was reflective in the fact that incidents were not
8 reported, staff were not risk aware. They didn't realise what constituted a risk
9 that needed escalating. Again, an example I would say within the report is in
10 respect of escalation of the Trust, moving from level 1 to level 3. I can refer
11 back to the report where it was very, very clear in an interview I conducted
12 where I asked, 'How would we see the difference, because your policy says
13 that this is what will happen?', and, during the course of our observation, they
14 did move through the different levels, and I couldn't see any difference, and the
15 response was, 'Actually, there probably isn't any real difference'. That tells me
16 there isn't a risk awareness management culture.
17 DR WALTERS: Did anybody talk about SUIs that they might have reported or
18 anything like that?
19 MS MUSGRAVE: They didn't talk in that term, but I think what I did – to put context
20 around it – I did not conduct the majority of the interviews with staff, so I'm not
21 close enough to that. In the engagement that I had with some of the clinicians
22 – so, for example, the clinical decision unit that I went to, where staff were
23 saying to me, 'We've got these inpatients. I'm really worried because there's
24 some maybe infectious patients here. We haven't got the number of staff in

1 order to... It really isn't right what we're doing.' My response would be, 'So
2 have you escalated that as a risk?', because clearly it is a risk to patient safety.
3 The response was, 'No, because nobody listens to us, so what's the point?'
4 They also had two different systems. One was an electronic system;
5 another, staff were filling paper documents in. We were initially told that, but,
6 enforcement hat on, I went to look for myself. Similarly, going back to your
7 point, Jonathan, in relation to the Trust taking action, when we'd escalated it
8 about the clinical decisions unit, being the investigator mind-set that I had,
9 even though the Trust had assured the regional compliance team that they'd
10 taken action, I visited it myself the following week, and, though we'd not
11 planned to go to RLI, I went myself to look at that service to see whether or not
12 the action had been taken
13 PROF MONTGOMERY: And had it?
14 MS MUSGRAVE: Yes.
15 DR KIRKUP: Stewart.
16 PROF FORSYTH: Just to be clear, was paediatrics included in the emergency care
17 pathway?
18 MS MUSGRAVE: No.
19 PROF FORSYTH: Why not?
20 MS MUSGRAVE: Because the... I don't know why not. We did receive factors in
21 terms of paediatric management through the interviews that we conducted that
22 are reported within the report in terms of the staffing and the equipment, but
23 that was the extent of it. We were looking at systems and processes, rather
24 than specific clinical areas.

1 PROF FORSYTH: But, obviously, most of paediatrics is acute, emergency
2 admissions to hospital, and I therefore just wondered why they're excluded
3 from your assessment of the emergency care pathway.
4 MS MUSGRAVE: We used the emergency care pathway as a proxy and considered
5 a certain patient group as an area that we would be able to see an end to end
6 process, and how the professionals allied to medicines – how the interaction
7 with the local authority, social services worked, and the fractured neck of femur
8 pathway seemed to fit with that, so that's the one that we looked at.
9 DR KIRKUP: Thanks. Julian.
10 MR BROOKES: I just wanted to follow up on a couple of things in your report
11 around leadership. I know you've touched on some of this already, but I'd quite
12 like – that section is quite depressing reading in some ways. There's a lot of
13 quotes in there about aspirational policies, about dysfunctional groups etc. In
14 terms of the Board management of that organisation, we'd have some flavour
15 of that from what you've said, but what was the assessment you came to in
16 terms of the overall leadership of the organisation?
17 MS MUSGRAVE: I think I mention it as there being a disconnect. I'm not sure the
18 organisation was fully sighted of the risks within that organisation. From the
19 interviews that we had, there seemed to be a lot of performance data that was
20 presented to the Board. It wasn't presented in an analytical way to be able to
21 identify any themes or trends in order to take any action.
22 MR BROOKES: Okay, so was the problem in the information that the Board
23 received or the action the Board took or both?
24 MS MUSGRAVE: I think it probably was both, but I think, to be fair, if I just go back

1 to a previous response, we looked from the ward to board. We wanted to look
2 at the impact on patients. Monitor had already conducted a review of Board
3 leadership. Therefore, a lot of the information that would have been presented
4 by the Board had already been disclosed to Monitor. I think they may be in a
5 better position to give commentary in relation to Board functionality.
6 MR BROOKES: And we'll follow that up, but, when I've done similar pieces of work,
7 you get a pretty good flavour of what the organisation is like in its leadership
8 and disconnect from the kind of work – particularly when you're in over an
9 intense period, so I'm just interested in your view on that.
10 MS MUSGRAVE: My view was that there was no strategic oversight of the concerns
11 within the organisation. I formulate the view on the basis of the pockets of
12 concern that were arising in different services and the lack of strategic
13 oversight to draw those issues together to establish, 'If it's happening there, is
14 it happening there?' The focus was very narrow, almost like firefighting, I think,
15 probably would be the term that I'd use.
16 MR BROOKES: Okay, thank you very much.
17 DR KIRKUP: Okay, thanks. Jimmy?
18 PROF WALKER: Can I go back to the Monitor reports? The decision by whoever to
19 make a decision that maternity isn't going to be looked at because Monitor has
20 looked at it – is that a common thing the CQC does, that, if someone else has
21 looked at it, we don't need to bother looking at it, or would you normally, in a
22 situation, if you're concerned about something, irrespective of another
23 organisation monitoring it, would you not expect to look at it from your
24 viewpoint yourself?

1 MS MUSGRAVE: I don't think I'm in a position to say if that's a common approach
2 that CQC would take. I'd go back to the point that the purpose of a Section 48
3 investigation is to look at whole systems. It's to look to see if there is systemic
4 failure within an organisation; taking into consideration outcomes of individual
5 reviews, are there some commonalities? So are there governance issues; is
6 there a pattern of staff not working together; is there whistleblowing, bullying?
7 All those could be drawn into the review of the emergency pathway, which is
8 what we did, without looking at that specific service again.
9 PROF WALKER: So you looked at the Monitor reviews as part of your review.
10 MS MUSGRAVE: Yes.
11 PROF WALKER: Because you said, I think, you saw them prior to – when you were
12 doing your preliminary work. Did you do it as part of the actual review process
13 itself, investigation itself?
14 MS MUSGRAVE: To be honest, I can't really... It's over two years ago that I
15 actually did the planning, and I don't want to give the perception that I did
16 something at any point when I'm thinking, in hindsight, what I might do now.
17 What I was aware of is that four reviews had taken place, and one of the
18 reviews was the Manchester University Hospitals review of maternity service.
19 Indeed, they'd had two reviews, so we were sighted on that report. The other
20 three reports, I was sighted on – gosh, I think it was maybe a week or two
21 weeks prior to the site visit, because I was chasing them with Monitor. They
22 told us that they were about to be available; they'd be available in draft form. I
23 wanted to make sure that issues that had arisen in terms of governance,
24 relationships, that they were all factored in. Had we covered it with what we

1 were looking at with the terms of reference?

2 PROF WALKER: In principle, then, as a body, you'd look for other reports that had
3 been carried out by external bodies, or even internal bodies, as part of your
4 process of looking to see how things had been assessed, how processes have
5 changed or recommendations are implemented.

6 MS MUSGRAVE: I can talk, in this instance, that, yes, we were aware of other
7 reports that had been produced. We'd looked at them. It gives you a sense
8 check of what action – responding to your point, Jonathan, about the speed of
9 response of the executive team to concerns that had been arisen. As we were
10 going after some of those reviews, it was helpful to see if there'd been any
11 direction of travel in terms of action being taken.

12 PROF WALKER: Okay, thanks.

13 DR KIRKUP: Thank you. Jonathan?

14 PROF MONTGOMERY: Thank you. That takes us on, really, to the last bit, which is
15 what happened at the end of the report, really, your sense of how the Trust has
16 responded to that.

17 MS MUSGRAVE: I have no involvement with the Trust after the point that the report
18 was published. Other than some involvement acting as a critical friend to the
19 team that went to do the follow up, I've had no involvement with the Trust. The
20 reason I didn't lead the follow up: it would be wrong, because I'd be auditing
21 my own work. It's important that there is a sense of a fresh pair of eyes going
22 to look at what's been presented.

23 PROF MONTGOMERY: So, if we wanted to find out about the follow up, who did
24 lead the follow up?

1 MS MUSGRAVE: If you want the name of the person, that was Bev Cole – Beverly
2 Cole. She led it. I acted as that critical friend to provide the context. I think it's
3 – similar to some of the questions you've asked me around the context of
4 some of the information that's presented, whenever you write a report, you've
5 got a vast amount of other information that is represented by those analytical,
6 formulated thoughts. I wanted to make sure that we covered off some similar
7 things, to make sure that we really got to the CRUX ~~nux~~ of those things that
8 really concerned me.
9 PROF MONTGOMERY: In which case, I think there are probably only a couple of
10 questions I could ask about that. One was: you talked us through the Chief
11 Executive's absence in the first week and presence in the second week. I
12 mean, how did the investigation – did it end? Did he escort you from the
13 premises?
14 MS MUSGRAVE: Nobody ever escorts me from the premises, I can tell you.
15 PROF MONTGOMERY: I can imagine. Just give us a flavour of how you left it with
16 the Trust's senior management.
17 MS MUSGRAVE: In the second week, we interviewed – 'we' meaning the team –
18 interviewed Tony Halsall, the Chief Executive. We were looking to re- interview
19 him further on, because I like to get a sense check to put things forward.
20 During that point, he left the Trust, so I didn't leave – I didn't engage with him
21 at all as I was leaving the organisation. I have to say, when he was there at
22 Furness General, he was very shocked when my team tipped up and I sent
23 them straight to the departments. It was almost he couldn't control my team,
24 because that's my job.

1 PROF MONTGOMERY: So he leaves during the late stage of the investigation, so
2 who did you liaise with as the most senior person in the organisation as you
3 were finishing?
4 MS MUSGRAVE: The point of contact I was given was Mary Moore, who I think was
5 the interim Head of Governance – forgive me, I can't remember her exact title.
6 She was the one we were told to liaise with as a single point of contact.
7 PROF MONTGOMERY: So at no point in that, despite the departure of the Chief
8 Executive, did you see any of the chair, non-execs – any of those.
9 MS MUSGRAVE: No.
10 PROF MONTGOMERY: And you still didn't see the Director of Nursing.
11 MS MUSGRAVE: No.
12 PROF MONTGOMERY: Interesting. Okay, thank you.
13 DR KIRKUP: Thank you. Any final questions from anybody? I'll go round again.
14 Catherine? Geraldine?
15 DR WALTERS: Just quickly, so, after this, they had the report for factual accuracy,
16 and then they would have to come back with an action plan, and the follow up
17 would have been done by somebody with a view to that action plan.
18 MS MUSGRAVE: In accordance with the terms of reference, my exit point was at
19 the point that the report was published – was prepared and presented. The
20 regional compliance team took over at that point, and I went back to my region
21 from whence I had come.
22 DR KIRKUP: Thank you. Stewart? Julian?
23 MR BROOKES: Just one quick question: you've quite nicely articulated the purpose
24 of this review, which is about systemic failure. I think I know the answer, but,

1 for the record, did you find systemic failure?

2 MS MUSGRAVE: Yes.

3 MR BROOKES: Thank you.

4 DR KIRKUP: Jacqui? Jimmy?

5 PROF WALKER: Can I just follow up on something you said to me, about, when
6 you looked at the other reports, you wanted to look at other reports to see if
7 there's a direction of travel – I think the term you used? Did you see a direction
8 of travel or improvement from the previous reports?

9 MS MUSGRAVE: I think it's fair to say, and it is cited within the report, particularly
10 about governance, there was – clearly, actions had been taken in terms of
11 redrafting terms of reference and developing means of better governance
12 within the organisation. What we weren't able to see is the quality of that or
13 the consolidation of those actions. What we did see was some of the intention
14 to improve the information sharing from ward to board and board to ward.
15 There wasn't good attendance at those meetings. That is included in the
16 report, so, although the intention was that that's how it worked, I didn't get a
17 sense, going back to the quality question, of how well it was evaluated that the
18 actions to improve the situation were actually effective.

19 PROF WALKER: Following on from that, then, one of the things – you obviously
20 found problems that you were concerned about and you put recommendations
21 for change. How confident were you that the system had mechanisms in place
22 that they could implement this change?

23 MS MUSGRAVE: Confident in the system? I think it's alluded to within my report
24 about the difficult relationships between the PCTs and the Trust and the SHA

1 oversight of the organisations working together. I haven't touched the Trust
2 since. What I would say is they had an inordinate amount of
3 recommendations, not least for my report but also from the other reports, that
4 had been taken. The Board was being strengthened. There were – a new
5 interim Chief Executive arrived; a new interim Chair arrived. I didn't have any
6 interaction with them, so my confidence would be borne out through when the
7 review of the recommendations and the follow up report took place. I think
8 that's the only way that I could answer. I could only be confident when they'd
9 proved to me that things had happened.
10 PROF WALKER: I think that answers the question. Thank you.
11 DR KIRKUP: Can I just pick up that point about the SHA? Did you take into
12 account the relationship between the SHA and the Trust as part of your
13 review?
14 MS MUSGRAVE: I interviewed a senior member of staff at the SHA.
15 DR KIRKUP: Give me a flavour of how the dialogue went.
16 MS MUSGRAVE: The dialogue was one that they were cognisant of the lack of
17 collegiate working with the commissioners and the Trust, that they had felt that
18 they had had an awful lot of intervention at the Trust, both pre FT authorisation,
19 which was quite within their scope of responsibility, because they were the
20 performance managers at that time, but they also felt that they'd had a lot of
21 intervention following, even though it became an authorised FT. So, I think,
22 overall, it was they were cognisant of the concerns. Concerns of whether the
23 SHA had really got the partners to engage – yes, I did have those concerns.
24 DR KIRKUP: Okay, thank you. Is there anything else that you would like to tell us

1 that you don't think that we have covered?

2 MS MUSGRAVE: No, I don't think so. It's all in the report.

3 DR KIRKUP: Yes, okay. Unless there are any other final points, then I'll draw the

4 final part of the interview to a close. Thank you for coming.

5

6 [The meeting concluded at 3.34 p.m.]

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